3rd November 2009

All-Party Parliamentary Group for Rural Services

Meeting Note – Rural Health Services

1. **Philip Dunne MP, Chair of the APPG**, welcomed the speakers, members, and invited guests.

2. **David Stout, PCT Network Director at the NHS Confederation**, outlined the role of the PCT Network and the PCTs themselves before discussing the proposed network of Rural PCTs. The Rural PCT Network is still in its formative stages, having only had one formal meeting, but David highlighted the following key issues which have been highlighted:

    i. Rural-proofing of national policies is key; we should move away from a one-size-fits-all urban-centric approach to policy-making. A good example of this is the choice agenda, which will harder to apply in rural areas.
    ii. Demographic and geographic challenges; The sparsity and physical geography of many rural areas can lead to bad transport links and associated difficulties, whilst the more elderly population and hidden deprivation are also an added factor. The solution to this is flexibility at the local level.
    iii. The design of health services needs to be different; For instance, the distance of a community from the nearest A&E or acute services will affect the design of the whole healthcare infrastructure. Again, local flexibility is the key; telemedicine may be any obvious solution for sparse areas, but may not be appropriate if the broadband speeds/connections aren't available.
    iv. According to the rural PCTs, the funding formula has been disadvantageous, although recent changes have given some gains. In addition, what the PCT receives is not the same as the theoretical formula, as there is an implementation lag:
        - The formula is the target for what the PCT should be receiving.
        - The Allocation is generally what the PCT received in the previous year, plus or minus a small differential for those who were above or below target.
        - Therefore the speed of moving towards the target can be very slow.

3. **Sheila Childerhouse, Chair of NHS Norfolk**, began by echoing David's comments and used Norfolk (which is under target by c.£50m) as a case in point. Sheila then outlined her experience of the key issues facing rural PCTs, illustrating with example from her own experience in Norfolk:

    i. Norfolk is typical of most rural county PCTs; it is BIG! This means it takes a long time to get around, which not only affects the accessibility of health services for patients, but also the efficiency of outreach services (e.g. nurses / health visitors). Hence, whilst a health visitor in an urban area may be able to see 8 patients in a morning, in a rural area, that may reduce to 4 or 5 (dependent upon responsibilities or caseload).

ii. Around 50% of the population live outside rural areas, but this ranges from market towns to hamlets.
iii. The ageing populations are often found in rural or coastal areas, which often have the least breadth of service.
iv. Low aspirations can have a significant impact on health outcomes, and work is one of the things which keeps you in good health; there are therefore interlocking agendas with other services and departments.
v. Binge drinking is often a problem in leafy affluent areas; a hidden issue which often doesn't tie in with national guidance and policy.
vi. Migrant workers can be unfamiliar with the UK way of accessing health services, in comparison to those in their home countries; for instance they may have no experience of the GP as a gate keeper.
vii. A strategy honed to rural areas needs to be flexible:
    - Using high-schools, 3rd sector groups, and others to deliver services:
    - E.g. Health trainers – drawn from local communities to work with peers (this can have a big impact with the elderly and those with long-term conditions).
    - High-schools as rural hubs; not just for sexual health, but also mental and wider young-peoples' health.
    - Integrated Care Organisations pilots and subsequent evaluations; these can be used to bring together all of the funding strands in a small market town area to provide integrated services with a local focus.
    - Shifting resources from acute into the community, to use GPs and Community Hospitals
        - This is particularly hard, and would be helped by support from central policy
viii. There are some other key blockages to achieving this:
    - Allocation of funding formula; especially given the extra equipment needed (e.g. to ensure timely access to acute services) and greater distances covered.
    - Flexibility of targets, which aren't always best for rural areas; should measure by health outcomes, not inputs.

4. **Julie Sharma, of the Community Hospitals Association**, pointed out the different roles of PCTs in commissioning and delivery of health services. In addition to representing the CHA, Julie also explained her role as Director of Bath and NE Somerset Community Health Services, and made the following points:

    i. Community Hospitals are not just a rural phenomenon. However, as they tend to serve sparser rural communities they are too often on the defensive against closure/centralisation. Instead, community hospitals should be seen as a solution rather than a problem.
    ii. It is difficult to define a Community Hospital, as the name is misleading; for instance, not all Community Hospitals need have beds. All are different but they share the goals of prevention and minimisation of hospital in-patient time, by providing relevant services in a local setting.

iii. Given the economic climate, it may prove difficult to sustain acute hospital services. They should exist to deliver quality high-end care. Does bolting-on services to acute units which could be better delivered at a local level give good quality and value for money?

iv. Community Hospitals are often highly valued by their local communities as they bring together health, social care, health wellbeing/lifestyle, and the voluntary sector.

v. In general, fewer beds are required at a Community Hospital than at an acute level to meet the same targets.
   - The length of stay at acute units is often longer, and the funding system can encourage admissions.
   - It would therefore be useful if the total cost of a patient's care could be "unbundled" to allocate some of the resource to a Community Hospital or other local level.

5. Questions were opened to the floor, with the following points raised and discussed:

PD: Is the new tariff helping Community Hospitals to get funding or not?
JS: There is currently no incentive for Community Hospitals – e.g. an acute unit receives the payment for an admission, but a community hospital doesn't get any additional funding to take the patient on after their acute treatment is over. Although some PCTs have come up with local solutions.

PD: Does any of the tariff attach to rehabilitation?
JS / DS /SC: It attached to a condition, and there is no tariff attached to community services. This has been suggested for a long time, but has not yet happened. Sometimes the rules can therefore be a disincentive to community care.

Duke of Montrose: Do large GPs and consortia take away from Community Hospitals?
SC: Many have grown organically and sometimes even tender for services; they are providing key services and are very innovative and entrepreneurial. But PCTs have to manage the market, balancing private delivery with traditional NHS and the 3rd sector.
DS: As Julie previously mentioned, it's difficult to define Community Hospitals, therefore a GP consortium could qualify as one.

Duke of Montrose: Does the agglomeration of GPs' surgeries reduce distribution?
SC / DS: They often actually take on the failing practices which cannot sustain themselves alone, but it is a good example of where local communities can lack choice in their health service providers.

PD: Can GP surgeries cross PCT catchment boundaries?
DS: Yes. And competition for service delivery encourages this.

David Drew MP: What are the panels' views on midwife-led maternity units?
SC: All of those in Norfolk are now midwife-led, but recruitment can be a problem. Often, women who elect for a home-birth have to go into hospital because of a lack of midwives.

DS: This highlights the general challenge of running hospital services in rural areas; there is both a lack of "critical mass" of patients required to justify services but units must also be maintained within reasonable distances.
SC: For instance, Kings Lynn hospital is coastal and will therefore always be more expensive per-head to maintain than an inland hospital because half of its catchment area is water, but not to have it there would endanger patients.

PD: Shrewsbury and Telford have similar staffing challenges; is the Working Time Directive causing problems for this?
DS / SC: Attracting staff is more of a problem; rural areas often lack the array of illnesses required to maintain training for junior doctors. Do you therefore have clinicians perform procedures or put a patient in an ambulance and ship them 40miles to the nearest larger unit?

PD: Is this getting worse, and if so, why?
DS: We are now much clearer about standards, therefore it is probably exposing a pre-existing problem.
JS: It also needs a more holistic view of the system. It may be that putting a service into a Community Hospital would encourage people to use the Hospital more generally.
DS: This is being trialled by Lincolnshire PCT; It wouldn't cope with trauma cases, but certainly common A&E. Such localised solutions could work equally well in urban areas, especially as resources are squeezed.
SC: There can also be a cost-benefit to this, as less medicalised surroundings help with elderly care and rehabilitation.

PD / Duke of Montrose: How were the rural PCTs identified, and what is the objective of the network?
DS: The NHS Confederation identified 20 PCTs out of 152 as being significantly rural, whilst DEFRA identify 24. The initial project was to identify interest in reinstating the group, which fell away after the recent PCT rearrangement. It has three objectives:

a) To identify the key issues for rural PCTs.
b) To identify key policy requests at a national level.
c) To help PCTs learn from each other.

SC: The earlier PCT Chairs group worked closely with DEFRA, which had some good results but sporadic. Therefore this presents a good opportunity to work cross-departmentally.

PD: Could Prof. Asthana give more detail on the funding formula?
Prof. Sheena Asthana: There are a couple of issues to consider:

a) Rural areas do well in health indices, but there is a mismatch between the standardized and crude statistics. Some less healthy rural areas are therefore masked.
b) Distance from target is also important, and previous reviews of the formula have underestimated the rural ageing population.

It is therefore definitely worth continually emphasising the unfairness of the formula.

6. Graham Biggs pointed out that the Rural Services Network will soon be launching its Rural Services Manifesto, which includes lots of the points raised during the course of the meeting.
    i. It is therefore important to monitor developments on an ongoing basis, especially on the context of constrained public finances.
    ii. All rural public services are ill-funded and ill-supported already, therefore any spending cuts will have far more impact per-£ in rural areas than in urban areas.

7. Philip Dunne MP closed the meeting by thanking the speakers, members and guests for attending. Those attending who had not had the chance to ask questions or comment were invited to submit short summaries of their points, which have been attached as appendices to this meeting note.

8. This session was concluded at 16h30.

Attendees:

Philip Dunne MP

Duke of Montrose

David Drew MP

Peter Bottomley MP

Sheila Childerhouse, NHS Norfolk

David Stout, NHS Confederation

Julie Sharma, Community Hospitals Association

Graham Biggs, Rural Services Network

David Inman, Rural Services Network

Dan Bates, Rural Services Network

Jane Randall-Smith, Institute of Rural Health

Prof. Sheena Asthana, University of Plymouth

Matthew Thomas, NE Commission on Rural Health

Jane Houghton, The Association for Children's Palliative Care

Fiona Smith, Royal College of Nursing

Claire North, DEFRA

Audrey Roy, CRC

Ruth Gibson, CRC

Matthew Hill, CRC

Jane Houghton, Networks Officer, The Association for Children's Palliative Care (ACT):

ACT is the only organisation working across the UK to achieve the best quality of life and care for every life-limited or life-threatened child or young person and their family. We:

- Campaign for the development of children's palliative care services
- Work with professionals to develop best practice and
- Empower and support families

Key differences between children and adult's palliative care:
http://www.act.org.uk/page.asp?section=162&search=children+adult+pal+care

Commonly used definitions/descriptions within the sector:
http://www.act.org.uk/page.asp?section=58&search=definitions

I would like to raise some key issues for APPG members to consider:

- **Travelling distance**: Most children who have palliative care needs are cared for predominantly within the tertiary care sector, which is even more remote, involving more or longer travel than adults going to secondary care facilities e.g. children in Cornwall will have to travel to Bristol for their tertiary services; children in Cumbria will have to travel, possibly to Newcastle, or Manchester or Liverpool, indeed some of them will have their care spread between different tertiary centres as their treatment is so complex.

- **Community children's nursing services are less established** than district nursing services, so many children are unable to be supported in their own homes over the 24hr period, which means children and families being moved away from the security of their own homes to receive care, when they need it most e.g. at end of life. There is a recognised need for the primary care team to be involved in the care and support, but rarely is training available in children's palliative care issues.

- Children's palliative care involves a **wide network of people**, including education and social care services, but provision is even more complicated in remote and rural areas.

- **Medication is often difficult to obtain** as local pharmacists do not have a wide enough stock, this is a challenge in urban areas, with parents reporting travelling from pharmacy to pharmacy to try to obtain the right medication, but in rural areas, this is not an option.

- There are **few children's palliative care consultants** - and those that we have are usually based in tertiary centres, so communication can be challenging, with community services relying on mobile communications, poor coverage in remote/rural areas adding to the burden of care.

Jane Randall-Smith, Institute of Rural Health (IRH):

Some further points on rural stress:

The IRH took over the management of the Rural Stress Action Plan (funded by DEFRA) in the summer of 2006 when the Rural Stress Information Network ceased to operate. The working group that supported the plan continued to meet until July 2007 but DEFRA stopped supporting it in July 2007. The RSAP itself ended in March 2008 and a final report was sent to DEFRA in summer 2008 to close the Plan.

The IRH attempted to set up Rural Support England during 2007-08 with members of the RSAP working group but this has proved difficult to get off the ground as there have been no resources. As a result there has been no England wide co-ordination on rural stress for some considerable time.

A number of the local projects funded by the final round of the RSAP did continue after the end of the Plan but I do not know how many are still going. If you would like and further information please let me know; janers@rural-health.ac.uk .

In terms of other points raised we would agree with what was said and our Manifesto can be found on our website at http://www.rural-health.ac.uk/pdfs/Manifesto2009.pdf

I think that there is an opportunity to do things differently i.e. a different service configuration in rural areas. Wales is looking at implementing a rural health plan: our research report for Welsh Assembly Government is at http://www.rural-health.ac.uk/publications/recent-publications.php . And you can view the Rural Health Plan for Wales consultation document on their web site at http://wales.gov.uk/consultations/healthsocialcare/ruralhealth/?lang=en&status=closed