DHSC Major Conditions Strategy consultation

This is a joint response to DHSC from:

- The National Centre for Rural Health and Care (NCRHC)
- The Rural Services Network (RSN)
- Action with Communities in Rural England (ACRE)
- The Rural Coalition

A. Introduction

We are submitting a written response to the consultation instead of using the online form provided as we make recommendations and proposals that do not easily fit into the framework provided in the online form. These concern the way in which DHSC and NHSE approach a strategy for major conditions, and access to treatments and care under the strategy for people from rural areas.

Health disparities/inequalities are highlighted in the consultation as issues that need to be addressed in the strategy. Inequalities are not just a reflection of socio-economic circumstances or the north-south divide; difficulties of access to health and social care for people living in rural, remote and coastal areas also result in disadvantages of health outcome. It is very important from a rural perspective that intra-regional disparities are given as much weight as inter-regional ones, as they can be just as great if not greater. This fact is often overlooked because of the "averaging" impact of comparing large scale populations with each other and combining rural and urban in population analysis, rather than looking at urban and rural separately. Unlike urban and suburban populations where socio-economic disadvantage can usually be correlated to specific postcodes, this is not the case with sparsely populated communities. Disadvantage is much more dispersed and as a result 'hidden' from readily identifiable view and, as a consequence, not so easily analysed.

We make these recommendations in a spirit of positive contribution and would be pleased to help the Department work through the best way in which services to support people with these major conditions can be made more accessible to those in rural areas. We would be more than pleased to provide more detailed evidence for our comments and observations, if this would be helpful.

We understand that in all planning of healthcare there are six significant components that must be addressed:

- needs and characteristics of the population served,
- social and environmental circumstances in which services are delivered, including the inter-dependence of health care and social services,
- workforce,
- finance,
- estate,
- digital services.

The rural context of this response encompasses the first two of these and we have consolidated, the remaining headings to bring into focus the specific factors that make delivering healthcare (including social care) to dispersed rural and coastal populations different:

- workforce (including practitioners' partners and families) and local partnership,
- finance, transport
- place / community, estate, infrastructure, digital

We are structuring the bulk of our comments under these three headings.

In view of the recent inquiry carried out by the EFRA Committee into rural mental health services, and the imminent response by both DEFRA and DHSC, we are content that we do not need to make specific comments about the availability and delivery of these services. We will, however, come back together and comment further when the Departments have published their response to the Inquiry recommendations.

We are very pleased that the Chief Medical Officer has recently devoted his Annual Report to coastal health inequalities, which also mirror many of the challenges facing inland rural communities. We have, therefore, sought to add value, and intelligence, to this from those working in these areas and not repeat his key messages. The 2022 Parliamentary Inquiry into Rural Health and Care also underpins the recommendations contained in our response and provides the references for much of the evidence submitted here[1].

B. Rural context (needs and characteristics, social and environmental circumstances)

In rural areas there is a very strong connection between other major social, environmental, and economic issues, such as quality and availability of housing and the nature of employment, when it comes to the quantum of demand for health services. Respiratory illnesses in particular are influenced by housing conditions and type of employment.

Because of the older age profile of rural areas long term conditions have a greater incidence in rural areas. This is also reflected in a higher prevalence of co-morbidities. The proportion of older people is growing more rapidly in rural areas than is the case in more densely populated communities. The NHS funding formula partially reflects the older age groups in rural areas, but this is not then acknowledged through the way in which urban centralisation dominates the way in which services are delivered. That said the funding formulae for both the NHS and Social Care (through the local government funding formula) are not fully reflective of the whole range of factors which impact on the costs of delivering services to rural populations and the disproportionate impact that people living in rural deprivation has on health and social care demand. In short, the true cost of ensuring that people living in rural and coastal communities have equal access to the same level of care as the rest of the population is not reflected in the level of funding.

Both primary and secondary service configuration is based on an urban model of delivery which is singularly inappropriate and inefficient in rural and coastal settings. The population profile and socio/economic factors in rural areas also means there is a paucity of younger family relatives who can offer informal caring and support. Moreover, voluntary organisations tend to be less well resourced and co-ordinated.

The structure of care in rural areas has a strong emphasis on primary teams & public health, coupled with a much more tenuous connection to secondary and tertiary acute services. A consequence is that there is limited health care estate, and less critical mass within the system overall. The increasing centralisation of secondary care has reduced access for those living in rural and coastal communities.

[1] https://www.ncrhc.org/about/parliamentary-enquiry-into-rural-health-and-social-care/session-1-details

Whilst there may be greater emphasis and reliance on primary care in rural areas, the ability to recruit and retain appropriately qualified personnel is even more difficult than in more densely populated areas. An additional constraint is that fewer career paths are readily available for partners, housing is more expensive, and one or more reliable vehicles is essential. It may be uncomfortable to raise the issue here, but medical, nursing and health professionals also raise concerns about access to quality post-16 education in some rural areas.

Some of the technological back-up for primary care, eg. diagnostics and telecare, is limited in rural areas either because this has been consolidated in urban centres or as a result of limited connectivity.

Digital connectivity in rural areas, both broadband and 4G/5G, still lag well behind urban areas in capacity, if they exist at all. They are likely always to be behind the 'cutting edge'. It will be very important either to invest substantially in this or ensure that the major conditions strategy does not make assumptions about availability that cannot be realised in practice.

People who live in rural areas are used to making the 'trade-off' between the benefits of living in a rural area and easy access to large scale infrastructure, such as major hospitals. There is, however, more scope than is often supposed for an intelligent dialogue with rural people about the balance between receiving the highly specialised services and the potential need to travel further to access them and receiving less specialised but high-quality services locally.

Health disparities/inequalities are highlighted in the consultation as one issue that needs to be addressed in the strategy. It is very important from a rural perspective that intra-regional disparities are given as much weight as inter-regional ones, as they can be just as great if not greater. This fact is often overlooked because of the "averaging" impact of comparing large scale populations with each other and combining rural and urban in population analysis, rather than looking at urban and rural separately. Just as the planning and delivery of health and social care is based on a model designed for people living in concentrated populations, so too are the formulae for measuring disadvantage in rural areas.

Tackling the burden of 'major conditions' is not just an immediate issue that should be addressed in the proposed Strategy, it is also a longer term public health matter as well. In general and perhaps surprisingly, the public health indicators in childhood and adolescence are worse for those living in rural and coastal areas than for those resident in towns and cities. These indicators often translate over time into the ill health challenges reflected in the identified major conditions. It is essential, therefore, to invest now in the public health, prevention and health promotion measures that will mitigate against avoidable demand in the longer term.

Recommendation 1

We agree that it is right to carry out a Major Conditions Review, but we believe the process of doing so should have been **'rural proofed'** from the outset. There is little evidence of this to date in the way the online response questions have been posed. We strongly recommend that the subsequent Strategy be fully rural-proofed and can offer help and advice the most appropriate mechanism for doing so. Any strategic components that that focus on centres of excellence must be clear that there must be a rural element to each to ensure equitable access for people from all rural/remote/coastal areas. It is not acceptable to focus resources on centres of excellence without a very clear access strategy alongside it.

C. Recommendations on extended workforce and local partnerships

There is a balance of risk to be found between having the optimal critical mass of specialists required to achieve the best possible outcomes and making services genuinely accessible to

people living in rural areas. Whilst this has an estate/infrastructure dimension, it is primarily a workforce/training and CPD issue. There is a balance for rural areas between what people want/need to have available near to them in an accessible way, and the ultimate standard of care/procedures that the Royal Colleges believe must be available. Finding the right balance of risk needs creativity and flexibility within the NHS, as well as a sensible level of rural proofing and consultation with rural populations. A more flexible, trained and innovative deployment of the existing workforce could deliver better access to local care, such as an enhanced role for pharmacists, community dietitians, or nurse practitioners, and use of the composite workforce to meet the full range of competency requirements.

The current received wisdom is that medical professionals do not want to train in rural areas, but the causality of this is complex and poorly understood. What comes first, the lack of training programmes oriented to rural practice or a reluctance to take them up?

It is clear, however, that the training of professionals across all areas of healthcare practice is limited in rural areas. The costs of housing, distances travelled, a lack of public transport, reduced employment and educational opportunities for other family members, etc all compound the difficulties in recruitment, retention and training in rural areas. Recruitment, sub-specialist opportunities, casemix exposure, CPD, access to mentors, and critical mass for size of clinical teams are all key elements that can push towards an over-centralisation of services for major conditions unless a specific strategy is in place to counter this. One way of achieving this would be to create 'enhanced health care practitioners', sometimes referred to as Rural Generalists. with skills specifically developed in relation to the major conditions strategy.

Care of the Elderly consultants who also have the generalist skills needed to manage multi-morbidities should be predominantly community based, in addressing patient flow at the front and back door of the acute trusts.

Evidence from other countries shows that the three major impacts on recruitment and retention of the rural workforce are:

- Choose students from rural locations for undergraduate places (Grow your own)
- Provide substantial rural exposure during undergraduate training
- Provide rural-focused postgraduate training

The focus in a number of countries is on creating rural career pathways taking each of these three recommendations into account.

Enabling health professionals to live and work in rural areas needs special, and additional, action as part of an overall Workforce strategy. This requires a focus on whole families and, by definition, this entails a partnership approach with other employers, school, colleges etc. 'Quality of life' could have a major pull effect if handled effectively and through key worker housing, perhaps using the NHS estate. Extending this to other partners in order to capitalise on the benefits of "one public estate" could result in better and more sustainable ways of attracting family units to rural areas, rather than looking a single professional groups.

Social care providers - both residential and domiciliary - struggle to deliver sustainably in the more remote areas, with transport for staff a key factor. The population profile, a lack of educational opportunities, and other socio/economic factors in rural areas also mean there is a paucity of younger family relatives who can offer informal caring and support to older relatives. Moreover, voluntary organisations tend to be less well resourced and co-ordinated.

Recommendation 2

Create **rural career pathways** in primary care with an emphasis on developing rural generalists. This will help create a strong link of expertise between those services that are necessarily centralised and the accessible primary care service that serves rural areas. This should be supported by improved digital access to specialist advice and diagnostic services.

Recommendation 3

Due to the age profile of the rural population, when it comes to **dementia and geriatric care**, what is now needed is a universal community-based dementia care/older people's health service. This should form part of the rural-enhanced primary care service.

Recommendation 4

Create a rural set of **health and care career pathways**, including apprenticeships and late career options, that can give opportunities to people from school age onwards to choose options in all parts of the health and social care system. The specialist skills that relate to a 'life course' approach that could help inspire young people over the contribution they would be able to make. The specialist skills needed to manage major conditions across the 'life course' should be assessed and the special circumstances in sparsely communities identified.

Recommendation 5

The **voluntary and community sector in rural areas**, whilst strong and widespread, often does not have the same level of specialism or capacity that can be available in urban areas. A programme to marry specialist national/regional VCS organisations with networks of smaller village-based ones may be able to overcome this. There is a willingness to participate in voluntary support, but distance has an effect on capacity and organisation in this sector as well. Social prescribing needs greater support, not just for the process of prescription, but also to support the activity to which patients are prescribed.

Recommendation 6

Integrated Care Boards should support local 'Place' delivery of mutually aligned health and social care planning to enable those with long-term conditions to live as independently as possible, using the flebilities embodied in Section 75 of the 2006 NHS Act and close working with local community and third sector partners.

D. Recommendations on finance

The financial architecture of the NHS tends to budget in silos. This is unhelpful when managing services that need to be focused on place, as is clearly the case in rural areas. Whilst the NHS retains its commitment to being 'free at the point of delivery', considerable costs are placed on rurally-located patients to get to the 'point of delivery'. The same magnitude of costs (both time and money) are not incurred by those living in urban locations. Many people trying to access major conditions treatment end up travelling constantly to and from care. Some research suggests many patients being treated in major urban centres for major conditions end their lives in transit. There is little incentive for the NHS to deliver services in a way that is most convenient to people in rural areas, because centralisation enables savings/economies to be made at the expense of these patients.

The cost of unavoidable smallness due to remoteness (ACRA) focuses on acute providers. Unavoidable costs associated with community services, elective provision other than A&E and service provision in highly remote areas are not currently factored into funding formulae. This needs to be corrected in the formula for funding.

Research also shows that a small number of rural NHS Trusts contribute disproportionately and significantly to the total, cumulative NHS deficit, which is itself indicative of the systemic underfunding of rural health services over many years. This underfunding is driven by the additional costs associated with, for example, maintaining safe staffing rotas with a lower number of professionals. Mitigating the risk associated with remote settings requires additional investment, longer lead times for treatment, and the higher cost of addressing equipment failures.

Recommendation 7

To ensure that people from rural areas are treated appropriately for one or more of the identified major conditions, it is **important that distance is taken fully into account in the funding formula** within the NHS. This should not just be 'free at the point of delivery' at the expense of being 'free for the patient'. A positive financial incentive should be found for those delivering the strategy to reach a balance between accessing more specialised services and receiving the highest quality locally.

E. Recommendations on place/community, estate, and infrastructure

In line with our comments under 'Workforce' we believe that, in order to serve rural patients well, the Major Conditions Strategy must have both a patient centred and community / primary care driven approach. It is important to make use of major centres of excellence for what they alone can provide, but ensuring everything else can be provided at the level of place.

By definition, this means that the Major Conditions Strategy must be supported by a dedicated workforce plan that reflects the unique circumstances of rural and coastal areas. This will help in managing co-morbidities in a patient centred way, which are more common in rural areas due to the demographic profile of the population. This will also reduce over-complex referrals to multiple secondary care centres that may well be located in different major centres, significantly impacting on the continuity of care and ultimately leading to poorer outcomes and lower levels of productivity.

Recommendation 8

The right care will only be delivered if it is in the right place. A resurgence of thoroughly modernised **community 'hospitals' and other community based facilities is needed in rural areas** and, with our other recommendations, these should, over time be able to deliver what can practicably be provided in the community as part of the Major Conditions Strategy.

Ends

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The National Centre for Rural Health and Care (NCRHC)

The National Centre for Rural Health and Care has been established as a Community Interest Company, national in scope with a HQ in Lincolnshire.

It acts as a governance vehicle for formal collaboration amongst partners interested in the four key drivers of impact in rural health and care, as well as influencing policy and strategy:

- Data – scoping and measuring the challenge and the response to it
- Research – identifying and testing what works
- Technology – shrinking distances between and adding to the human capacity in rural communities
- Workforce and Learning – making the case for rural settings as the location of choice for ambitious health and care professionals

The Rural Services Network (RSN)

The Rural Services Network is a Special Interest Group of the Local Government Association. We are a membership organisation and work on behalf of our members as the national champion for rural services.

We support our member organisations through the sharing of best practice and rural expertise, and advocate on their behalf to ensure that the rural voice is raised up the agenda with parliamentarians and decision makers.

Action with Communities in Rural England (ACRE)

ACRE is a national charity speaking up for and supporting rural communities.

We work to create thriving, inclusive and economically active rural communities which have the services they need. We believe no one should be disadvantaged because of where they live.

The Rural Coalition

The Rural Coalition is thirteen national organisations who subscribe to a vision for a living and working countryside in England.

Given many shared values, the Coalition seeks to be more influential by joining in common cause to influence government decision making and seeks to ensure that all policies are rural-proofed; that policies and funding deliver a fair deal for rural communities; and that decision-making, funding and delivery are devolved and involve rural communities.