Health and care in rural areas

Summary

1. Health service provision for rural communities is strongly influenced by some wider pressures acting on the health service that lead to centralisation, clustering of health specialisms and thus make access for rural people more challenging.
2. Non-health service challenges for rural communities, such as access to affordable housing, digital connectivity and public transport also have an impact on the deliverability of health and social care. A joined-up strategy for rural would add value and enable all these challenges to be properly tackled.
3. Technological and practice developments can either be harnessed to benefit health provision to rural areas or, if this is not done, could quickly make provision much more difficult for rural people.
4. The best interests of rural areas may not be found in retaining a relatively local DGH. The relationships between regional centres of excellence, local 'health hubs', general practice and social care may need to be explored and organised differently in rural areas if the best outcomes are to be achieved for rural people.
5. Health and Social Care need to be thought about together but with a strong awareness of the differences especially in relation to resources, capacity and control/organisation and therefore with differing solutions.
6. The bulk of resources for social care, including the important preventative, wellbeing and health promotion activities operated by voluntary organisations come from social care recipients, their families and the local community. This must be reflected in local control and organisation.
7. Partnership and co-design with rural communities and rural organisations is essential if the resource provided by communities, volunteers and families are to be sustained into the future.
8. Micro-providers / social enterprises in rural areas should become the default approach in rural areas over and above the procurement practices that tend to favour large scale social care commercial providers.

---

1. Introduction

It is possible to make the assumption that the issues that have the most impact on the delivery of health and care to rural populations arise predominantly from the nature of the rural areas themselves. We believe that the nature of the services that are being delivered, their organisation, management and funding are just as big a factor in accessibility of these services to rural people. It has also become a commonplace to assume that health care and social care must be addressed together. Whilst an integrated approach to these is very important, there are some very different pressures and drivers acting on each, not least the requirement for one to be free at the point of delivery whilst the second is a means tested service. This submission therefore covers each separately.

The ACRE Network covers all of England through its 38-member charities. Our focus is on the wellbeing of all people living in all rural areas of England, especially those who are at risk of isolation and disadvantage and for whom rurality brings an additional challenge and cost to their daily lives. In the context of health and care services we believe that nobody

should be unreasonably disadvantaged in their access to public services by the rural location in which they live.

2. The rural challenge for the Health 'system'

2.1 Drivers of change

There are drivers for change within the whole of the health system that are having, and will have, a greater impact on delivery in rural areas than the 'rural specific' ones on which the APPG, and others, could be drawn to focus. They are not labelled 'rural' as they are characteristics of the whole system. Some key drivers are:

- The required **population catchment area** both for a District General Hospital, or equivalent (DGH), for specific treatments/procedures and for regional centres of excellence continues to rise inexorably.
- Local **political pressure** to keep all existing DGHs open appears to be irresistible. There is no lobby group so powerful as the one to keep a hospital open, irrespective of the quality of its services.
- Despite all efforts to the contrary NHS England management is still heavily focused on a single/group hospital and its catchment area, not on achieving ideal **health outcomes of a whole administrative area**. Some local NHS/CCGs in rural areas, however, are starting to break this hospital catchment area way of thinking. It is a distinction that can easily be seen as meaningless in a large urban area with multiple acute hospitals, but takes on a much greater significance in a large rural area that falls under a patchwork of CCGs and Health Trusts where relationships can vary widely.
- **Technological improvements** in treatments/procedures continue apace placing great pressure on training of clinicians in ever increasing specialisations and leads to a requirement for ever larger teams of clinicians.
- Although nothing close to the level in the USA, a **litigious approach by patients** to any failings in their care is growing, making clinical teams more defensive and also tending to a trend for larger sized clinical teams in order to ensure adequate supervision and oversight.
- Technological and practice development increasingly wants all major **specialisms clustered around major accident and emergency provision**. The additional, apparent, need for maternity services to be consultant led, and also to have access to other specialisms on hand, lends further weight to clustering and centralisation. An 'adult' conversation with women in rural areas about both their needs and preferences has been difficult in many areas due to the strong political weight behind DGHs.
- For the above reasons, and also for more intuitively obvious personal ones, **doctor training and junior doctor placement** in anything other than major urban centres with large clinical teams is relatively unattractive. For the remainder of the NHS workforce there is also a considerable personal cost and limited incentive to working for the NHS in high house price rural areas.
- Changes in technology and practice in emergency response is resulting in increasing emphasis being placed on the **first few minutes of intervention wherever this might occur**. Specialisation in this as, almost, a new hybrid medical/paramedical

field of expertise is developing. Despite the implication of these developments even reduced 'blue light time' targets in rural areas remain stubbornly hard to achieve in some areas.

- Small GP practices face constant **pressure to merge and rationalise**, ending up with rural areas having increasingly distant access to primary care and, as a result, making inappropriate use of A and E.
- Economic pressures have resulted in **revenue savings needing to be made and estate to be rationalised**. However, this has tended always to protect the District General Hospital (DGH) or equivalent at the expense of more local community facilities serving rural areas. Figures are not easily available for the numbers of 'cottage hospitals' that have closed in the last twenty years, but it must be considerable.

2.2 Fragmentation and organisation

Fragmentation between health and social care is a well-understood issue. What receives less attention is the fragmentation and poor communication within the health system between Clinical Commissioning Groups, Acute Trusts, Community Trusts, GPs and their staff and Mental Health Trusts. This is not high level, management communication; it is day to day, patient specific, failure to align the actions of all of these 'players' in the system. In a compact catchment area, ie an urban one, all of these management units may have sufficient critical mass of patients to enable them to have an efficient, centre based, approach specific to their service. The management and clinical staff also may have frequent contact with each other and with their counterparts in other parts of the system. For rural areas this is much more difficult to achieve within an alphabet soup of organisations. The NHS Long Term Plan is setting out to achieve greater integration, but the descriptions lead one to think that most of the thinking over this relates to urban scenarios.

So, before even addressing very specific rural issues, such as the preponderance of older people, relatively high housing costs, relatively high suicide rates etc., what might all this mean for rural areas?

Major towns will always fight to protect/retain 'their' DGH, even when continued investment in it is clearly not going to be the best use of resources given the centralising pressures on the whole system. If resources are used in this way, they will <u>not</u> be available to improve community services but, crucially, neither will every DGH be able, in the long term, to keep pace with new technology/practice developments. Rural areas could be left with barely adequate proximity/access to their local, traditional, large town DGH but this hospital will itself be gradually falling into a second tier of practice.

2.3 Re-thinking health services for rural communities

For the reasons outlined above centralisation in the provision of health services, especially acute services, is not going to go away. It is important, therefore, to ask some fundamental questions about how the best possible provision can be organised for people living in rural areas. We raise these questions in the context of the new NHS Long Term Plan and have appended a short paper about some of the specific issues that it raises:

1. Would people living in large rural areas be better served by **Regional / Tertiary centres** than by a relatively local DGH even if this meant longer journey times? Is

there a better way of structuring acute, community and general practice services in rural areas than is currently possible under the NHS commissioner/provider split? By planning services with the access of people from large rural areas in mind (rather than as an afterthought to urban populations) it might be possible to make access easier even if distances are longer. To achieve this the priority for investment would be on accessible out of town locations, not on legacy town/city centre sites.

2. If major acute services were to be located in regional centres (and possibly freeing up scope for investment) what combination of minor injury, acute, maternity and recuperation services would rural areas require at a relatively close proximity? How can these then be best integrated with General Practice, community services and social care? Should we be more ambitious for new **"Health Hubs"** serving rural areas that integrate services locally whilst also drawing on the expertise held in Regional Centres but enable the creation **of 'step up/step down' beds** for very local communities. The NHS Long Term plan is seeking better integration between elements of the NHS, but does the clustering of services need to be different for rural areas if technological and practice change is tending to centralise major acute functions.
3. Is there scope more fully to draw into planning health services in rural areas an **'advanced' ambulance service**, including where necessary air ambulance. It has often not been possible to achieve blue light time targets in very rural areas and, rather than adjusting the targets downwards for these areas, there may scope to re-think the ambulance service's place in the provision of acute services in rural areas and have different, but achievable targets.
4. People active in their communities will become and remain so if motivating factors outweigh de-motivating factors. The latter are often heavy-handed regulation, 'marketing speak' communications and crude attempts to co-opt voluntary activity into providing statutory services. Engagement with the community will be essential for some initiatives e.g. social prescribing. However, different skills will be needed by NHS management if these are to be implemented in rural areas where a 50,000 locality covers multiple communities and GP practices. What training or wider cultural change is needed in **senior health service management** if they are to understand better the community sector and how to work with it.
5. **Technological change**, and practice-change facilitated by technology, is clearly playing a major role in the evolution of the health system. Rural people and rural communities could either be disadvantaged by the unintended consequences of this, or their access to health (and social) care could be dramatically improved. **It would be very helpful if research were carried out, from a rural perspective, into both sides of these developments.** It is easy to focus just on the possibilities of telemedicine without taking account of any disadvantages to patients. Equally, the pressure for improved procedures facilitated by technology, but requiring greater centralisation, could be chased by senior clinicians without considering the risks to rural people of greater centralisation of capacity in the system.

6. The NHS Long Term Plan promotes integration between NHS organisation and starts to break down some of the 'commissioner/provider' received wisdom of the past thirty years. In order to make this work, for rural areas, it would be worth exploring in detail whether **integrated Health Trusts** incorporating CCGs, Minor Acute services, Community and Mental Health Trusts would be more satisfactory than the current fragmented arrangements. This would minimise management

duplication and duplication of patient contact and assessment. It would also make the most effective use of resources without having to staff multiple interfaces between purchasers and providers.

The concept of an internal market that drives up quality and performance simply cannot exist in some rural areas because there are not enough patients in the system to create choice amongst NHS providers. Instead management effort should be reserved for planning and delivering good care and forging effective links with regional centres of excellence.

7. The commitment of the NHS to **social prescribing** is very welcome. In rural areas there have been many VCS and ACRE Network initiatives to establish this approach. It is essential that a 'top down' commitment to funding 'social prescribers' in GP practices is delivered in rural areas through the development of existing initiatives to create Village and Community Agents. This will ensure that the practice that has grown up in an organic, local way is not sacrificed in favour of a nationally defined approach that will not be sustainable in rural areas.

3. The Social Care 'system' in rural areas

3.1 The rural community

It must be stated clearly at the outset that social care encompasses a wide range of non-medical care to people of all ages and whose need for such care arises from an equally wide range of medical conditions, disabilities etc.. The age profile and pressures on the social care system in rural areas, however, means that emphasis here is bound to fall on social care needs of a **disproportionately ageing population** and one with a **historically high incidence of mental health issues** and **isolation leading to poor self-care**.

3.2 The health and social care conundrum

The second important issue to note is the underlying statutory requirement for **health services to be free at the point of delivery but for social care to be means tested**. The second issue is generally seen as a crude accountability 'mis-match' when fine distinctions are being made over an individual's needs. Indeed, the term 'accountable care' has been coined for initiatives that attempt to bring these two strands of funding and service together. Irrespective of this difference, there are other distinctions of particular importance in rural areas where people may live a long way from centralised health provision or the increasingly contracted out and administratively centralised/call centre-organised statutory social care services. These are to do with where capacity and control over services exist, rather than their statutory basis

In the health service resources, and thus control over the purchase of capacity to deliver services, flow from the centre. The channels down which they flow are complex and convoluted, there are purchaser/provider interfaces (each of which have to be staffed on both sides) along the way but, essentially, it is a flow from the tax raised centre to local points of delivery.

3.3 Resources for social care

The definition of social care, especially in rural areas, must encompass preventative activity, health promotion, social prescribing, community activity that promotes well-being and a panoply of other activities. These are all important if recourse to the ultimate cost of 'heavy' domiciliary and residential care is to be kept to an affordable minimum. For social care to be effective, however, capacity must be available in or close to the recipient's home. The involvement of neighbours, family, community and local carers means that, in the most part, this is also where the bulk of the resource and capacity to provide care is being found anyway.

Resources used to deliver social care, especially in rural areas, are not, therefore just the limited budgets now available to County Council Adult Care departments but:

- Care recipients own means, until they are spent down to a defined maximum
- Care recipients' families, either financially or through their own caring activity
- Housing organisations – usually the charitable ones – adding value to their housing offer.
- Voluntary work contributed by active citizens to a wide range of services
- Charitable resources derived from a wide range of large-scale grant making organisations to local village fundraising for local services
- Hospices and related services raising money from a mix of voluntary and statutory services.

It is worth reflecting that the time input alone from carers to the care system in the UK is estimated to be around £132b, the other areas listed above are harder to quantify. Management of Adult Social care must, therefore, see one of its prime functions, especially in rural areas, to be making sure that those providing all of this extra resource do not either break down or walk away. Budgeting to support voluntary sector groups who, in turn, help to keep all this in place has to be seen as an investment not a cost.

Those in need of social care services are often also recipients/beneficiaries of a wide range of other public and voluntary sector services aimed at vulnerable people. All of these share the same challenges when it comes to delivering to people in relatively remote settings. The following list is not exclusive:

- Benefits and Job Centre Plus services
- Citizens Advice
- Housing advice and support
- Fire Service, fire prevention services
- Support from energy network and other utility providers
- Fraud and scam prevention initiatives – PCC and Police initiatives

What many of these sources of resource to provide support to vulnerable people, have in common is that control is in very local hands, they cannot be 'controlled' either by the statutory health or statutory social care organisations. Indeed, to try to do so can make much of the voluntary elements evaporate away. Attempts to co-opt informal voluntary services into the delivery of statutory social care provision has already had this effect in some places.

The process of **assessment** for social care, and also assessment by health services for ongoing medical care, has become the point of 'passive conflict' between the health service, statutory social care, voluntary social care organisations and the family/carers. In rural areas there is a clear danger that assessment is coloured by what can easily be found and affordably provided in a rural location rather than by the individual's needs.

3.4 Control and organisation

Especially in rural areas, then, the distinction between health and social care is not just one of the statutory basis on which they are delivered and paid for, it is also one of resource control and organisation of capacity. **Health services are resourced and controlled from the top down; the bulk of social care is resourced, controlled, and capacity needs to be found, from the bottom up.**

Part of the answer for delivery of sustainable social care to rural populations has to be found by the statutory sector using its limited resources in such a way as to motivate the resources, control and capacity that arises from within rural communities to meet their local needs. In addition, they then need to operate in partnership with other organisations seeking to meet the other needs of those benefiting from social care.

This means organising integration between statutory health and care services requires a strong initial commitment to fully engaging the voluntary and community sector. In rural areas this also requires an understanding that the strength of the sector is at its most local level. Integration at a catchment area of 30k to 50k population in rural areas is meaningless unless a method of working with the voluntary sector at a community level is included. At this geographical level the lead is best taken by the voluntary and community sector itself and often the local ACRE Network member will well placed to provide this lead.

3.5 Re-thinking social care in rural areas and for rural people

Unlike the previous section on rural health care where we pose questions, here we propose particular actions that arise from our experience working with communities throughout rural England. From the perspective of rural communities, it is helpful to look at resources, capacity and control/organisation separately:

Resources:

- Statutory Social Care organisations **must factor distance into all their costings for domiciliary care**, this will give them a financial incentive to work with local communities to unlock local capacity for the 'heavy' care for which they remain responsible. Care workers employed by large contractors based at a distance from rural areas cannot be a sustainable long-term proposition.
- The resources available for health promotion, preventative social care intervention, social prescribing etc must be integrated together and, for rural areas, the default way of using these budgets should be through **partnership and co-design with local village and rural organisations**.
- The resources available from other organisations who are also seeking to reach out to vulnerable people in very dispersed areas need to be clustered with resources

from the social care system in order to make the **most efficient operational use of all these budgets**.

Capacity

- There will not be capacity to provide social care within villages if there is no workforce to provide it. If the **cost of housing** is beyond the reach of those employed in this sector. An age and socially balanced community will be more able to viably and sustainably provide for its own needs including social care. The requirements of social care need to drive policy in other areas, especially housing, planning and regeneration to support achievement of this.
- **People active in their communities will become and remain engaged if motivating factors outweigh de-motivating factors**. The latter are often heavy-handed regulation, poor communication and crude attempts to co-opt voluntary activity into providing statutory services. Senior public service management needs to be trained to better understand the community sector and how to work with it.
- Rural villages almost all own their own assets such as community buildings, minibuses, recreation grounds etc all of which can be used both to provide social care and access to it. They should be viewed as essential capacity in themselves, but they are also a way of focusing voluntary activity in support of social care in local areas. For this reason, **investment in community owned assets should, in rural areas, be the subject of public sector capital investment on the same terms as investment in statutory owned estate** and plant in urban areas. However, the emphasis has to be on supporting those who own and run these facilities, rather than on their capital transfer as might be the case in urban areas.
- There are good examples of micro-enterprises and community enterprises being developed in rural areas and, thereby, growing the capacity to meet local needs. This needs to be actively pursued and received wisdom on **County Council procurement** overturned if this is what is required to make this development possible.

Control/organisation

- Whilst there is a **market for the delivery of social care in rural communities** it is not one that lends itself to large-scale procurement practices by local government. The default for delivery of care to those assessed by statutory local social care organisations as eligible for their intervention should be through local social enterprise, micro-providers, care co-operatives or voluntary organisations.
- Where services are not defined through individual assessed interventions (ie health promotion, preventative activities and wellbeing initiatives) **statutory social care funds should be used through co-design with local village and rural organisations** to build local capacity and control to promote good health and informal care.
- In order to use their resources efficiently in rural areas, **statutory social care organisations must work in partnership with other organisations** seeking to reach the same vulnerable people. Together they can co-design networks of

Village/Community Agents who will connect local village organisations into a broad range of statutory and voluntary sector services.

- In rural areas, very local voluntary sector resources can be critical to the quality of outcomes for vulnerable. **Localities of 30k to 50k population are too large in rural areas** for this to be accomplished. Engagement and support must happen at a more local, community, level especially for initiatives under the NHS' 'social prescribing' banner.

Jeremy Leggett

ACRE Policy Advisor, September 2018

Contact: j.leggett@acre.org.uk +44 (0)7787573658

Action with Communities in Rural England, Corinium Suite, Unit 9, Cirencester Office Park, Tetbury Road, Cirencester, Glos, GL7 6JJ w: acre.org.uk t: + 44 (0)1285 653477
e: contact@acre.org.uk

Company Limited by Guarantee 3336101, Registered Charity No. 1061568

Appendix to ACRE Health and Care position statement

NHS Long term plan, January 2019

1. Introduction

The ACRE Network covers all of England through its 38-member charities. Our members are known locally by their local names eg Action with Communities in Rural Kent, West of England Rural Network, Community First etc.. Our focus is on the wellbeing of all people living in all rural areas of England, especially those who are at risk of isolation and disadvantage and for whom rurality brings an additional challenge and cost to their daily lives. In the context of health and care services we believe that nobody should be unreasonably disadvantaged in their access to public services by the rural location in which they live.

This initial set of comments on the NHS Long Term Plan take a national perspective and do not seek to go too far into operational detail. Many of our members are engaged in Sustainable Transformation Plans and in local partnerships that are seeking to put in place Integrated Care Systems. This is the best place at which to address rural people's access to health care in the local area or region.

Overall, ACRE welcomes the focus that the Long Term Plan places on integration between NHS organisations, on leavening the effects of competition and internal markets and on placing the user of the health service at the centre of all decisions. We can see the scope for digital advances to improve some aspects of healthcare for rural people and look forward to a time when these services are both technologically possible and affordable for all people in rural areas. With the age profile in rural areas rising faster than in the rest of the UK we also welcome the urgent intent to take pressure off emergency services by improving community services, especially for older people and their carers.

However, we have some serious reservations about some assumptions that underpin the Plan. One, at least, of these is also very urgent due to its potential impact in the 2019/20 financial year. These reservations are set out below.

2. Access, equity and equivalence

From a rural perspective the most striking element of the NHS Long Term Plan is an error of omission, rather than commission. There is no clear commitment to making NHS services fairly accessible to the whole population, especially those living in rural areas.

Rural people are realistic and practical, they know that it will never be possible to have the services of a major teaching hospital available in every market town. However, a truly **national** health service must have a commitment, at the core of its planning, to ensure that nobody will be unreasonably disadvantaged in their access to its services by where they live. As there is no commitment to geographic accessibility there will be no drive to monitor it and, consequently, no pressure to achieve, report or improve on it.

The Plan mentions the NHS' Public Sector Equality Duty under the Equality Act 2010, but this is narrowly defined solely in terms of specific 'protected characteristics'. One approach that the NHS could choose to take – and one that has been implemented by some local NHS organisations – would be to treat rurality as if it were a protected characteristic under this legislation.

Accessibility for rural communities may be difficult, and the few mentions in the plan suggest an awareness of this difficulty, but simply failing to address it is not the answer. At the very least the cost to an individual of accessing any service must be included within the true resource cost of providing that service. If this is not done there will little incentive for NHS Trusts to seek the most accessible and efficient ways of delivering to their rural populations. The consequences of rural people is either limited or no care being received and this will lead to even greater calls on emergency services, more acute episodes and worse ultimate outcomes for these members of the population. There are clearly financial and performance implications for both rural Trusts and CCGs that include rural populations.

ACRE calls on the Department of Health and NHS England to treat potential limitations of access to NHS and Social Care services as a result of an individual's rurality as a form of discrimination. They must put in place the same monitoring and mitigation measures that are used to prevent discrimination resulting from other protected characteristics.

ACRE further calls on NHS England to include in the calculation of Weighted Activity Units (WAU) for all procedures the cost to an individual of gaining access to the location where a procedure is carried out and include this as a cost to the Trust. The 'Model Hospital' management tool should, thereby, be amended in order to reflect the full opportunity cost of gaining access to a service; the cost that is currently passed on to the patient.

3. Targeting health inequalities

It is worth reflecting at the outset that the NHS Long Term Plan is a ten year strategy for one of the largest organisations in the world. Despite all efforts to break the NHS up into manageable units the whole is centrally funded from the Treasury, has the highest possible national political profile and is resource managed by a complex and largely invisible national management structure.

It is understandable that the 'fine grain' of the NHS Long Term Plan is defined by population localities of around 50,000 people, roughly the size of an urban GP practice. It is at this level of population that improved integration between social care, primary health care and community health care is being sought. Unfortunately, much of the policy set out in the Plan gives the very clear impression that the authors had in mind relatively compact areas with this size of population. In the rural context a population of 50,000 will be geographically much larger, consist of many communities and could easily be a considerable distance from an acute hospital that it shares with ten similar 'localities'.

The Plan continues the historic practice of the NHS and the Joint Strategic Needs Assessments (JSNA) of directing resources on disadvantaged people primarily through geographic targeting. This approach consistently misunderstands the nature of disadvantage in rural areas, allowing it become 'lost' in the averages.

As a result, rural health inequalities are not targeted and therefore some rural people are left to become multiply disadvantaged ie disadvantaged by poor health, disadvantaged by their rurality and also disadvantaged by the crude, pro-active, targeting of resources by the NHS into primarily urban 'hot-spots' of disadvantage. The plan leaves little doubt that this is central to its policy and is chilling for its likely effect on disadvantaged people dispersed throughout apparently affluent and healthy rural areas:

> NHS Long Term Plan "2.25. **NHS England will continue to target a higher share of funding towards geographies with high health inequalities** than

> would have been allocated using solely the core needs formulae. This funding is estimated to be worth over £1 billion by 2023/24. For the five-year CCG allocations that underpin this Long Term Plan, NHS England will introduce from April 2019 more accurate assessment of need for community health and mental health services, as well as ensuring the allocations formulae are more responsive to the greatest health inequalities and unmet need in areas such as Blackpool. Furthermore, no area will be more than 5% below its new target funding share effective from April 2019, with additional funding growth going to areas between 5% and 2.5% below their target share. NHS England will also commission the Advisory Committee on Resource Allocation to conduct and publish a review of the inequalities adjustment to the funding formulae." (Page 40)

The very rapid implementation of a shift in resources arising from the part of the Plan make this an urgent issue that needs equally urgent correction. The JSNA and Index of Multiple Deprivation assist in the targeting of small geographies by ranking them. Most disadvantaged people do **not** live in the small number of disadvantaged areas that relative ranking is used to target ie the most deprived 10% or 20%.

ACRE calls on the Department of Health and NHS England to review urgently the approach taken in the Long Term Plan to targeting resources intended to tackle health inequalities. The current methodology risks making an assumption that most, if not all, people at risk of disadvantage and poor health live in locations where the average level of health inequality is relatively high. This is not true and leaves the Plan silent over dispersed disadvantage and poor health across all of rural England.

4. Small acute hospitals

Prior to the publication of the Plan, NHS England commissioned the Nuffield Trust to carry out research into smaller acute hospitals serving, in the main, rural areas. The population catchment area for these hospitals can be in the region of 150,000 population compared to the current trend of acute general hospitals serving populations of around 500,000 and tertiary centres / regional centres of excellence requiring a population of over 1m. The Nuffield Trust's report carried many sensible, pragmatic and important recommendations, few of which seem to have made it into the Long Term Plan. It is hoped that this is an omission that NHS England intends to correct over time and at a more local level.

The sole mention in the whole Plan of rural areas, and the particular operational differences in delivering services to them, comes in section 1.32 . This in, turn, is focused just on emergency and same day care in smaller acute hospitals. This paragraph, whilst carefully written, is a serious indictment of the failure of the rest of the NHS' planning to take account of the need to operate differently if the stated objectives of the plan are to be met for rural people. It carefully avoids reflecting that it is these hospitals that are often in 'special measures', are most challenged by the NHS' wider workforce issues and do not, on the face of it, perform well in the current internal competition regime.

> NHS Long Term Plan "1.32. We will develop a **standard model of delivery in smaller acute hospitals who serve rural populations.** Smaller hospitals have significant challenges around a number of areas including workforce and many of the national standards and policies were not appropriately tailored to meet their needs. We will work with trusts to develop a new operating model for these sorts of organisations, and how they work more effectively with other parts of the local healthcare system." (Page 21)

This very brief mention, however, opens the door to a new approach to the place of smaller acute hospitals within a planned and managed NHS as opposed to one driven by internal competition and activity costing. This is welcome, but if it is not accompanied by an understanding of growing centralisation throughout secondary health care, and how its effects can be mitigated, will make only a limited difference to these rural hospitals.

We would welcome national standards specific to care and promotion of well-being in rural areas. This would be a more effective long term way of promoting quality standards in locations where internal markets will not do so.

ACRE welcomes the Plan's commitment to work with smaller acute hospitals to find new operating models and urges NHS England to recognise that market mechanisms – internal or external – often fail to drive standards in rural areas. We hope that NHS England will move to a planned approach to delivering acute services in rural areas that places equity of access to services ahead of competition and fully engages rural communities in service decisions. ACRE stands ready to help and support through its network of Rural Community Councils.

Our Network has a unique involvement and understanding of a wide range of rural issues from housing and transport to supporting village community care groups. There would seem to be a great deal of sense in the ACRE Network being represented on any cross-sector taskforces addressing both rural delivery of services and planning/retention of a rural workforce for the NHS and Social Care.

Jeremy Leggett

ACRE Policy Advisor

January 2019