



NHS Review – a rural response

Summary and Recommendations

The Commission for Rural Communities is pleased to submit this Dossier as our contribution to the Next Stage NHS Review.

The CRC has a longstanding interest in and knowledge of the delivery and planning of healthcare services in rural areas. We have prepared this response to ensure that rural needs and circumstances are fully considered in the review process. Our intention has been to build up a substantial body of evidence from a range of sources to illustrate and highlight the current situation with regard to the planning, provision and delivery of health care services in rural areas.

In compiling this Dossier we have spoken to a variety of NHS practitioners at all levels, including doctors, nurses, paramedics, PCT Directors of Commissioning, Directors of Public Health and chief executives of Strategic Health Authorities in person, by telephone and through on-line surveys. We have consulted with key stakeholders such as the Institute for Rural Health and drawn widely on current research findings. We have also talked at length with NHS users through a series of public consultation events across rural England.

The Dossier contains:

- A number of research based expert factsheets, using statistical data and published evidence to highlight key rural health issues.
- Academic papers focussing on resource allocation and the problems associated with the current NHS funding formula.
- An issue based paper focussing on the importance of investing in preventative medicine
- A DVD and report of a visit by the Rural Advocate to the Fenland area of Cambridgeshire to look at health care services and to talk with patients and practitioners.
- Examples of good practice in rural healthcare provision
- Feedback and analysis from the rural consultation events
- Feedback and analysis from the on-line survey of rural NHS professionals and practitioners

Key issues

Most people who live in rural areas experience a high quality of life. On average they live longer, have better physical and mental health and enjoy healthier lifestyles. Beneath these averages, however, is a more complex picture of poverty and disadvantage which is largely under-reported and overlooked. The poorest and most disadvantaged rural residents have much poorer health outcomes and experience consistently lower levels of physical and mental health. Targeting and addressing these problems is difficult given that much rural deprivation is hidden and masked by the prevailing affluence of many rural areas.

At the same time rural areas present distinct delivery challenges for service providers which need to be understood and overcome. Moreover rural areas do not all have the same characteristics which means that the delivery challenges and the most effective solutions are likely to be different in different areas.

That having been said, there are some common themes and key issues facing service users and service providers in rural areas today. These are:

Access to services

In a rural context this means physical access, including travel time, geography, opening hours, local provision of services, availability of public transport and regularity of service.

The problem of accessing services has been a significant concern voiced at all our public consultation events. Many of the participants, particularly the elderly, those on low incomes and those reliant on public transport, described their difficulties getting to hospital appointments or seeing their GP. The village in Cornwall where our consultation event was held had no public bus service and residents without their own transport were entirely dependant on a volunteer car scheme to get to appointments. In Norfolk one young woman spoke of a two hour round trip with her baby son to see a GP and an even longer journey at weekends when the GP surgery was closed. In Lancashire, the area served by the North Lancs PCT all the GP practices are concentrated in the coastal strip around Heysham and Fleetwood which comprises one third of the geographical area of the PCT. There are no GP practices in the entire remaining two thirds of the area which stretches across the rural Trough of Bowland. As the PCT notes 'we have significant access issues'.

The issue of accessing services also extends to preventive programmes, such as smoking cessation and sexual health/contraception services. As the paper on public health notes, people in general only tend to access preventive services if they are reasonably easy to get to. Unless rural accessibility at a very local level is specifically factored into the planning, commissioning and monitoring of preventive services, such services are usually concentrated in a small number of locations (often urban) with unrealistic expectations that rural patients will travel to them. Evidence shows that where preventive services are made more accessible to rural people, levels of uptake rise significantly.

The fact sheet on Distance Decay highlights the problems associated with distance from and poor access to services and the resulting poorer health outcomes.

Cost

At present the resource allocation weighted capitation formula which allocates resource to PCTs has very little reference to rurality except for ambulance services. Dept of Health 2005

The current approach to funding health care does not reflect the additional cost of providing healthcare services in rural areas, relating to time and distance. Nor does the formula reflect the health care needs of the dramatically ageing demographic profile of rural areas.

Studies confirm that healthcare services generally cost more to provide in rural areas. In Scotland it has been calculated that additional costs of between 7.5% and 10% are required to deliver health services to rural populations. In England CRC research indicates that for example, one rural PCT will spend 5% of their total salary costs on travel. Our discussions with individual PCTs also reflected the difficulties of managing tight budgets whilst seeking to provide services to scattered populations where economies of scale were hard to achieve.

In particular, as the paper on resource allocation clearly demonstrates, the current formula used to allocate money to fund the NHS in different areas systematically discriminates against rural areas and in particular the health needs of older people living there.

PCTs serving rural populations have tended to experience the greatest difficulties balancing their budgets. At the end of 2004-5 68% of the 25 PCTs that were in both the least deprived and most rural quintiles were in deficit. This is not a problem of local overspending, poor financial management or poor organisation of services. But rather it reflects the failure of funding formula to adequately capture the needs of older relatively affluent populations, which tend to be found in rural areas and also the failure to recognise the additional costs of providing services in rural areas with smaller more dispersed populations.

Per capita NHS funding is 30% lower for more affluent and rural areas than for more deprived and urban areas. The formula gives greater weighting to the 'additional needs' relating to deprivation, than to the demographic needs relating to the age profile of different areas. The standardised health status measures that are currently used are calculated to show the health needs of a population with a standard age. Rural areas however have more older people and since ill health and its associated costs are strongly correlated with age, to ensure equity it is the actual population profile in each area that should determine the absolute, not relative, burden of illness. Under the current system rural areas receive a lower than average per capita funding even though they have higher than average absolute healthcare needs which leads to needs of older people in particular being ignored or unmet.

Lack of flexibility in the design and provision of services

Research by CRC shows that even where PCTs undertake local consultations, final decisions about which services to prioritise tend to be based on cost effectiveness and the need to meet national targets rather than clinical need or local preferences.

The new GP led health centres, described in the Interim Report of the NHS Review, are an opportunity to provide a range of accessible services under one roof to all members of the local population.

However PCTs have indicated to us that local decision making is often constrained and market driven and as such does not accurately reflect local need and circumstances. In one case the decision to put new GP centre in an urban location has been taken in response to market forces – greater number of patients, better financial outcomes and profit margins rather than taking account of gaps in current provision (no GPs in a large rural area) and local need.

Many interview respondents in our survey of NHS professionals emphasised very strongly the need for flexible approaches to providing health services in rural areas. In addition to pointing out differences between urban solutions and those appropriate in rural areas, they also felt that solutions would differ between and within rural areas. The majority of interview respondents thought that health policy was based on delivering services in urban areas, referring to what they saw as 'one size fits all' approach, a lack of flexibility and the development of solutions that might work well in the inner city but are not practical in rural areas.

Response times and treatment of acute time critical and emergency conditions

The problem of providing time limited critical care in cases of serious illness or injury in rural areas is particularly challenging. The issue of emergency care has frequently been raised at our public consultation events, particularly by the elderly who fear that by living in a rural area they will suffer the 'postcode lottery' effect when it comes to receiving speedy and appropriate for life-threatening emergencies such as heart attack, stroke, ruptured aortic aneurysm, severe burns, head and chest injuries. It is generally agreed that for both heart attack and stroke, treatment should be within three hours of the onset of symptoms, earlier if possible, but in some areas this cannot be guaranteed..

Ambulance response times are much lower in rural areas and the delay in receiving treatment can have significant effects on survival and recovery rates. Where ambulance response times are poor or where road travel times to a specialist treatment centre are in excess of one hour some areas in both Scotland and Ireland routinely rely on air transport, using helicopters with the capacity to operate at night and in poor weather to transport some patients. Studies such as the National Confidential Enquiry into Patient Outcome and Death (2007), have found that patients were more likely to be transported to an appropriate specialist hospital if they travelled by helicopter.

In almost all the workshops, there was unanimous and very heartfelt support for the air ambulance service. In rural areas, regular ambulances can be at some distance from isolated villages or hamlets. Road traffic speeds can be kept low by poor road surfaces, narrow lanes, farm vehicles or animals on the road. In summer, holiday traffic slows things down further. Flooding or snowfall can make roads impassable. Accidents or emergencies can also happen far from a road. An air service that can overcome these problems is seen as essential.

The provision of local critical care intervention using paramedics and GPs is a further option which requires the development of a local infrastructure to support the work, additional equipment and training for staff and the use of telemedicine linking paramedics with specialists at main hospitals for example.

The fact sheet on this subject sets out the issues in more detail.

Ageing rural population

The demographic profile of rural England is changing with a trend towards an ageing rural population and fewer young people. CRC's State of the Countryside report 2007 shows that the median age in rural area is 44 years, 6 years higher than in urban areas and rose by 1.4 years between 2001 and 2004 compared with a rise of 1.1 in urban areas. The Report also shows strong geographic patterns with particular concentrations of older people in rural northern England, Lincolnshire, Shropshire, East Anglia and the South West. In one area in east Devon the median age of the local population was 62.9 years.

This ageing rural population has significant implications for the provision of both health and social care which are in general, more costly and more difficult to deliver in rural areas.

Providing accessible and appropriate services which contribute to the independence and well being of older people in rural areas requires the investment of resources and funding. It also points to a shift away from providing services through traditional channels towards a more holistic, joined up approach working with other service providers so that a range of services can be accessed at a single point of contact. Commissioners of services will need to develop strategies that actively encourage joint working across traditional boundaries so that services develop which are truly accessible to event the most remote rural resident.

The fact sheet on the ageing rural population provides more detailed evidence that older people do not use health services as much as they need to

The fact sheet on peripherality explores joint working and multidisciplinary approaches in more detail.

Recommendations

Our recommendations for changes that would have a significant impact and ensure the provision of high quality healthcare in rural as well as urban areas are as follows:

A change in the resource allocation formula to recognise the cost of delivering rural healthcare services and the ageing rural population

Accessible local services – with an emphasis on co-location of a range of services not just healthcare

Improved commissioning for rural areas and greater emphasis on joint commissioning of health and social care

An increase in the number and range of outreach and mobile services to address access issues

Better emergency response measures for life threatening conditions

A commitment to improved preventative medicine targeted at the hidden deprivation and disadvantage in rural areas

