



Commission for
Rural Communities

Tackling rural disadvantage

Report on the Rural
Advocate visit to
look at aspects of
Healthcare Services
in Cambridgeshire

Healthcare Services Cambridgeshire, 10-11 December 2007

1. Background

The focus of this Rural Advocate visit to the Fenland area of Cambridgeshire was to listen to the views and experiences of residents, patients, family, staff, voluntary groups and organisations regarding the provision and delivery of healthcare in rural areas. A copy of the full agenda is provided in Annex 1.

The Rural Advocate, accompanied by David Latham (Improvement Foundation), Jessica Bawden (Cambridgeshire Primary Care Trust (PCT)), and Jaki Bayly, Amy Beddis and Jean Scott (CRC Access to Services Team) met with patients, volunteers, residents, councillors and staff from a number of voluntary forums and groups and healthcare service providers¹:

- Fenland Association for Community Transport - <http://www.fenland.gov.uk/ccm/content/events/golden-age-fair/fenland-association-for-community-transport-ltd.en>
- Cambridgeshire Patient and Public Involvement Forum - <http://www.cambsacre.org.uk/health/health.htm>
- Doddington Medical Centre
- Doddington Community Hospital - <http://www.eastcambsandfenland-pct.nhs.uk/default.asp?id=17>
- Ramsey Health Centre - <http://www.ramseyhealthcentre.co.uk/default.asp>
- Princess of Wales Hospital - <http://www.eastcambsandfenland-pct.nhs.uk/default.asp?id=19&query=Prince%20Wales%20hospital#highlight>
- Wimblington Parish Council - <http://www.wimblingtonandstonea-pc.gov.uk/index.htm>

On the 11th December 2007 the Rural Advocate hosted a dinner discussion to canvass the views of national, regional and sub-regional based organisations, with a specific focus on healthcare delivery, including patient choice, local accountability and accessibility of services. The individuals and organisations that attended the dinner included²: Archdeacon of Huntingdon and Wisbech; Blue Sky Events and Media; Cambridgeshire ACRE (Access with communities in Rural England); Cambridgeshire County Council; Cambridgeshire Primary Care Trust; Cambridgeshire Rural Forum; CRC; Doddington Medical Centre; East of England Rural Affairs Forum; Fenland District Council; Hills Road Sixth Form; Improvement Foundation; Institute of Rural Health; Lord-Lieutenant for Cambridgeshire; Professional Executive Committee; Ramsey Health Centre.

The issues recorded within this paper are a summary of and directly reflect the discussion and comment observed on the visit.

1. Recorded in the order of the visits.

2. Please refer to Annex 2 for a full list of attendees.

2. Overarching Messages

The following messages capture the main themes recorded from the visit. Further detail and examples are provided in section 3 below:

- Rural areas are diverse and thus problems need to be addressed in different ways depending on local circumstances, a one-size fits all approach is not acceptable and will not work. Local healthcare delivery professionals, as well as patients and residents should be involved in shaping the future of service delivery and in taking responsibility for difficult choices that need to be made;
- Additional resources are required to deliver healthcare services in rural areas;
- Increased flexibility for local service providers and a joint approach to the provision of services will enable more appropriate, effective and often innovative solutions to be developed;
- As 'acute' services are centralised, care in the community services are essential for tackling accessibility problems, effective rehabilitation and improved quality of life and health;
- The accessibility of healthcare services, even in neighbouring villages and towns, is an ongoing and worsening problem for many rural residents and reinforces the need to develop effective outreach and transport solutions;
- The national healthcare funding formula needs to be refined to take into account the impact of rurality on budget allocations.
- Healthcare tariffs must be able to be split between acute and rehabilitation costs, to enable the effective application of resources at a level appropriate to the patients needs;
- The third sector (charity, not for profit and voluntary organisations) plays a vital role in the development and delivery of services and the provision of advice and support to rural residents. Funding threats to their viability must be addressed with long-term solutions and issues around recruiting and maintaining volunteer numbers recognised and managed.
- The energy and commitment of healthcare professionals and volunteer groups is unquestionable and must be recognised as an invaluable resource.

3. What we were told during the visit?

3.1 Fenlands Area Profile

The Fens, predominantly rural in character, form a defined geographical area with social, economic and environmental characteristics that transcend local authority boundaries. The area falls between the cities of Peterborough to the north and Cambridgeshire to the south, linked as part of the London-Stansted-Cambridge-Peterborough growth corridor. The area is mainly flat topographically, with rich fertile soils and a dispersed settlement pattern including villages, isolated hamlets and market towns.

During the visit a number of general socio-economic characteristics were described by the people that the Rural Advocate met, for example but not exclusively, aging population, high levels of deprivation, changing role of agriculture, decline in public transport provision, lower

life expectancy levels and low aspirations and educational attendance and achievement. For further social, economic and environmental information about the area, please refer to Annex 3.

3.2 Fenland Association for Community Transport (FACT)

FACT is a not-for-profit community transport association serving, within the Fenland area of Cambridgeshire, people who have difficulties using conventional modes of transport. Their aim is to provide accessible, affordable and safe transport services.

Adding value to transport provision: FACT has developed its facilities and expanded its services to capitalise on the opportunities made available to them, examples include training facilities within their office accommodation and working with the County Council to run the volunteer drivers car scheme. In addition to the wide variety of groups and individuals assisted by the transport services, enabling small groups who cannot afford to run their own minibus to access healthcare and leisure services, FACT are also a source of 'good' (described with regard to salary levels for the area and flexible working terms) local employment. Furthermore, a number of individuals commented not only on the invaluable transport service that FACT provides but also the helpful drivers who provide essential informal help to rural residents, as one individual described it, 'Helping me to close the windows and secure the house before I get onto the bus'.

Funding: The main barrier to operation raised was funding. Issues included: the short-termism of funding and implications on the sustainability of service provision, even where need is demonstrated; the fact that most sources of funding do not cover core costs, (such as the running and development of the association and co-ordination of services to secure sustainability); the reducing public funding available, with Cambridge services being prioritised; and the inflexibility of some funding schemes only allowing vehicles to be utilised for specified services.

3.3 Cambridgeshire Patient and Public Involvement Forum

The Patient and Public Involvement (PPI) Forums aim to make sure the public is involved in decision making about health and health services in England. There are 394 PPI Forums, one for each NHS Trust in England. They work with all sectors of the community, to find out what people really think about health in their local areas. The Forums, which are currently undergoing structural changes, are supported by the Commission for Patient and Public Involvement in Health (CPPIH).

Focus of the PPI Forum: The PPI is represented on a broad range of working groups both within and outside the PCT and undertake a wide range of projects, looking at issues of healthcare service delivery and the inequalities that exist. The PPI recognises that they have to be realistic about what projects they undertake in order to prioritise 'where they can make a difference and manage public expectations'. Currently, the PPI has a position on the PCT Board but does not have a right to vote.

Future of the PPI Forum: Members of the Forum were frustrated at the current uncertainties around the future function and finance of PPI, 'especially given all of the valuable work that they had completed' and were looking for clarification from the PCT in order to adapt and plan their future. The reliance on volunteers was raised, in terms of the difficulties in retaining existing and attracting new volunteers. Indeed, this was an issue raised throughout the visit affecting a wide range of organisations and services. The Forum observed that this trend was being compounded by 'SKI's' retirees (conventionally a large source of volunteers) 'Spending the Kids Inheritance' by going on extended holidays for 6-12 months and thus not being available to volunteer.

The voice of service users: In addition to the continuation of the PPI Forums to act as a bridge between individuals and PCTs and a voice for the users of healthcare services, the Forum considered it essential to extend the ways in which individuals and groups can inform and shape services. They were keen to stress that there is not one answer but that a number of approaches were needed to enable individuals to give their view and opinions, not simply through consultations but also by 'going to the places where people are, such as shops and leisure facilities'.

Budget allocations: There was a general feeling that 'Cambridge is like a sponge, soaking up all of the funds, which in turn means that rural areas suffer'. It is generally accepted that while increased time and funds are needed to deliver services in rural areas, due to sparse and low population densities and increased travel time due to greater distances between patients and difficult road infrastructure, this is not taken into account by the funding formula utilised to decide budget allocations.

Pressure on healthcare services - Implications of an aging population: Within Fenland the number of retirees and older people is increasing, resulting in a number of common characteristics developing, including an increasing number of older people living alone (resulting in companionship, social, mental and support problems developing), not having access to private transport (either due to a disability, cost or age) resulting in not being able to access shopping, health and leisure services and facilities and an increased occurrence of strokes (without accessible treatments and rehabilitation locally, much of which could be delivered through community hospital day care services and outreach home visits).

Range of services appropriate to scale of need: The PPI Forum was clear in their conviction that service provision should be appropriate to the scale of need. The Forum recognised the benefits of centralising specialist treatment but not to the detriment of more local and accessible service provision for assessment, consultation and diagnosis, as well as treatment of general medical conditions and rehabilitation through care in the community - community hospitals, healthcare centres, GPs and outreach. There was frustration that although efficiency savings and solutions to the delivery of improved and more appropriate local healthcare services could be demonstrated, budget allocation processes did not take the impact of rurality into account. There were many successful examples of services delivered via community hospitals, poli clinics, practice-based commissioning and outreach care in homes and communities, that demonstrated efficiency savings, not obtained where patients are referred to larger hospitals.

Access to services: A number of specific services were raised as being inaccessible and not meeting need, these included out of hours GPs and NHS dentist services (including out of hours services). The inefficiencies of this system were highlighted, illustrated in particular by the fact that, 'the 16 weekend emergency dentist appointments, available for the whole of Cambridgeshire, were allocated by 10am on a Saturday morning, resulting in an increase in GPs having to prescribe strong painkillers to get individuals through the weekend'.

The extent of service accessibility was also discussed in terms of the geography of the area, with difficult road infrastructure (due to many watercourses and few bridges) resulting in increased time and cost associated with the delivery of outreach services. Linked to this, the Forum observed that there was little appreciation within centralised services of the impact of distances on patients and their relatives. An example was given where a rural resident was allocated a 9am chemo appointment but lived 45 miles away in a rural area. Due to difficult road infrastructure, rush hour and lack of parking, the patient had to leave at 7am which was 'not helpful in aiding the general recovery of the patient!'.

Furthermore, lack of access to services is compounded by the decline in the provision of public transport, with services being reduced to main arterial routes, resulting in difficulties for residents living in many of the smaller villages accessing healthcare services even in neighbouring larger villages and market towns. In this situation distance becomes irrelevant, 'where there is no public or community transport support five miles is the same as 50'.

Both the distances to certain centralised services, as well as the lack of public transport reduce the time that relatives and friends can visit inpatients, which in turn has been connected to longer recovery periods, with the increased budget implications.

Education adapted to meet local needs: Within the Fens there are families who have never worked, living on social security. These circumstances are creating a generation of young people with low aspirations and who grow up with an attitude of, 'Why should I bother to work, if my parents don't have to?' that is in turn leading to low school attendance and an attitude of 'Why should I bother to get an education, if I don't need to work', exacerbated by parents who are 'not bothered' if their children attend school or not. This situation has knock on negative impacts on the health of the population, resulting in greater pressure on healthcare services to support an inherently unhealthy section of society. There was a strong feeling in the PPI Forum of the need to break the cycle of low aspirations and that this could only be addressed by empowering local education providers to shape a more locally focused service, language clubs were stated as an example of an approach that was successful but not supported by the schools inspectorate.

Pressure on healthcare services – the increasing migrant worker population: The increasing numbers of migrant workers are not simply putting pressure on the system due to their healthcare needs but also because of the additional costs associated with delivering a service to individuals who do not speak English. In certain circumstances where booklets and flash cards are produced or interpreters contracted in, these costs are not allocated for within existing budgets. This is compounded by

the lack of general national support for the nationalities of migrant workers that migrate to rural areas, e.g. Portuguese, which differ from those that mainly travel to urban areas. The dilemma was raised as to whether translation should continue or whether greater resources should be directed to teaching English, in reality there will not be a single answer and will depend on the area and circumstances in question. During the visit solutions were illustrated, such as using the internet for translating during consultations, as well as using bilingual migrant workers to volunteers as interpreters or receptionists in GPs surgeries.

Patient pathways: There was recognition that patient pathways were not always fit for purpose creating budget and accessibility problems. The Forum recommended that both services providers and users were involved in future development and that community hospitals, GPs and practice-based commissioning centres worked together to explore and co-ordinate the most effective provision.

Choose and book systems: These systems were considered irrelevant in a rural context, as not only is there often no service choice, but even where there is access becomes an issue. Furthermore, accessing the system itself is problematic where internet access is difficult, or for older people who do not know how to use the internet and due to hearing problems, have difficulties in using the telephone.

Impact of inflexible national standards on service provider contracts: Procurement processes to contract out for services result in smaller, more local service providers not being able to meet national standards, resulting in larger providers securing the contracts but who have little understanding of local circumstances such as geography and road infrastructure. This exacerbates service access issues and misunderstandings of the additional time and cost it requires to deliver many rural healthcare services.

Planning for future healthcare provision: With such a diversity and complexity in rural circumstances, with rural deprivation hidden as small pockets within wealthier areas and debates around what constitutes a sustainable community, population forecasts could be used more effectively to inform budget allocations and health and social care planning and patient pathways.

Supporting the rural voice: In addition to the role of the PPI, the PCT was keen to develop better monitoring of service delivery at a more local level to generate usable data, thus even where an area or PCT does not have a powerful voice politically to influence decision making, the evidence will exist 'to back up the rural voice'.

3.4 Doddington Medical Centre

The Centre, located next to the Community Hospital, has a medical staff that consists of three part-time and two full-time doctors, one full-time and one part-time nurse and three district nurses. The Centre serves an area of 200 square miles, with the nearest alternative general medical facility 15 miles away and the nearest acute facility 30 miles away. The Centre focuses on 'delivering care in the community and keeping patients out of hospital', this is especially important in rural areas, where the closure

of inpatient facilities impacts more greatly as there are fewer alternative care options.

A new approach to developing healthcare services locally: In line with the Centre's drive to keep patients out of hospital, they want to develop intermediate care facilities more locally, to enable patients to get home more quickly or even receive short term home care to support recovery. The current funding formula and budget allocations would not enable this level of service to be developed, thus the model of a social enterprise or community interest company is being used to develop a bid to the Cabinet Office's Future Builders Fund. The concept is to develop a single community interest company to deliver primary and secondary services through the Community Hospital and Medical Centre, enabling efficiency savings and profits to be reinvested into local services, in turn incentivising staff to develop innovations and ideas. Currently where savings are made they are funnelled back into the central budget rather than the locality benefiting from their own efficiency.

Patient choice: A recent survey illustrated that 95% of patients would prefer to receive care at Doddington Hospital, primarily due to accessibility issues, such as lack of private transport and even when access to a private car is possible to access an appointment at a centralised service provider, 'parking is expensive and limited to two hours – no good if your appointment is delayed by three hours!' The Falls Unit at the Community Hospital is an example of a welcome service enabling patients to receive physiotherapy and rehabilitation more locally.

Budget allocations: Even though the Centre secured huge efficiency savings by focusing on care in the community, the inequality in service provision between rural and urban is increasing due to funding formulas that do not recognise rurality, e.g. one of the Centre's GPs had to travel '65,000 miles in three years to undertake home visits'. This inequality is exacerbated by a higher than average disease incidence of diabetes, heart disease from an older more obese population who have lead unhealthy live styles (also linked with low aspirations and inactivity discussed by the PPI Forum).

Due to the way that treatment is costed, where rehabilitation is delivered more locally, its cost is being paid twice, e.g. 'for a hip replacement the total cost includes both the operation and rehabilitation at the acute hospital, as these two elements cannot be billed for separately, where the rehabilitation is then delivered more locally (often leading to quicker recovery times, due to more convenient access and having friends and family around to help), it is billed for again, effectively paying for the rehabilitation twice, even though it is only delivered once'.

3.5 Doddington Community Hospital

'Doddington Community Hospital lies at the heart of the Fens and provides a wide-range of services to local people'. The PCT currently provides substantial out-patient and diagnostic services at Doddington Hospital – over 10,000 attendances at consultant clinics each year. Clinics offering most specialities provided by visiting consultants and other professionals from Peterborough and Hinchingsbrooke Hospitals. The PCT is already developing services further, as far as existing facilities

allow, e.g. X-ray department and an echocardiography service with a mobile MRI scanner. The PCT is currently developing its Business Case to provide an Urgent Care Centre on the Doddington site. The proposed development will offer better accommodation for the existing Doddington practice with more space, combined with out of hours GP services, and NHS dentistry. Local people will also benefit from the development of a minor injuries service.

The Rehabilitation and Falls Unit offers assessment for people in the South Fenland area for falls mobility and long term conditions performed by a multi professional team, with the overall goal of helping people to remain in their own homes. Rehabilitation needs are assessed and an individualised programme is devised with goal setting by the individual to improve function and quality of life. The rehabilitation and falls team work in close liaison with the integrated therapy team and locality community teams to offer a comprehensive seamless service.

Services provided include:

- 6-8 week sessions of individualised rehabilitation
- Balance and postural stability groups (for falls and poor balance)
- Chair based exercise groups
- Nurse led falls clinic
- Home based exercise programme
- Home assessments for rehabilitation goals

Delivering care closer to home: The request for and benefits of delivering healthcare services closer to the community was expressed by several members of staff, who found nurse-led clinics and visiting consultants an effective mechanism for the hospital. The hospital has also reduced its outpatient waiting times down to the target of five weeks, staff commented that this was mainly due to the PCT and hospital working closely together to identify extra capacity and explore alternative methods for delivering services, such as nurse-led clinics, which 'reduce bureaucracy and benefit from motivated and innovative teams'.

Nurse-led Ear, Nose and Throat clinic: This is an outreach service from the Peterborough Hospital, enabling the nurses to prescribe medication and offer post surgery results and advice. In addition, the nurses hold telephone consultations for rural patients that cannot easily access the clinic in person, this is not only more convenient for individuals but it also means that patients can receive their results quicker and saves staff time as consultations are shorter. This service is due to be expanded, including better publicity to explain how the service works and the benefits that it can offer patients.

Ely for the Blind: This charity was established in 1923, to offer support and advice for the visually impaired. The link was made with the Community Hospital and an information desk set up within the hospital to offer practical advice, e.g. 'helpful changes to your kitchen' to patients who are often at the end of a long waiting list. The charity also run advice sessions to demonstrate the range of technical support available and produce a quarterly newsletter. Both hospital staff and patients considered this a valuable voluntary support service and one that they were keen to see continue.

CAMTAD: This volunteer run service has been operating for 15 years and offers support and advice to individuals with a hearing impairment. With funding from Cambridgeshire Community Foundation and using the County Council's social services equipment, free advice sessions are run monthly, no appointments are needed. This voluntary service offers important support both to patients who 'have often delayed seeking help and then have to join a long waiting list for an audiology referral', as well as to families and friends. The issue of retaining and attracting new volunteers was raised as crucial for the future of the service.

Physiotherapy Department: This department runs an open access service to enable individuals with a long term disability to access support when they need it, this includes physical appointments as well as telephone consultations. Patients commented that this has had a huge impact on their lives, raising their quality of life and providing them with the reassurance that support was available. The Department also runs the community rehabilitation team, enabling patients to return home more quickly after surgery.

As a rural alternative to urban walk-in clinics³, the Department are piloting a self referral outpatient's physio scheme in order to encourage individuals to discuss potential health problems at an early stage and reduce referral waiting times. Patients also commented that this service was useful, as it meant that they did not have to discuss their problem over the telephone but could see a professional quickly. The Friends of Doddington Hospital have worked closely with the team to raise funds to donate specific pieces of equipment to the Department, which have 'enhanced the service that they can offer and made all the difference'.

Wendreda Unit: The focus of this Unit is to help keep people in their homes and reduce the need to 'go into hospital'. The Unit and the Physiotherapy Department work closely together to deliver support and healthcare both at the Unit and in peoples own homes. The patients themselves appreciate the service not simply because it is more accessible to them, being delivered at the Community Hospital or through outreach, but because 'being local they know the nurses and physio's and they remember individual patients needs – it is a more personal service, that makes all the difference'.

The Unit are currently developing their services to Multiple Sclerosis (MS) patients, this includes a weekly MS support group to share and discuss ideas for helping individuals manage and remain independent living at home, raising the profile of the range of therapies that are available and support and advice to family and friends.

Friends of Doddington Hospital: Both staff and patients recognised and praised the huge level of support that the voluntary group had given the hospital. Indeed, over the last three years the group have raised £12,000 from running the shop and café and following discussions with individual Departments and services they have donated equipment such as a slit lamp, treadmill, exercise bike and play equipment.

3. These walk-in clinics aim to encourage individuals to present any health issues they have at an earlier stage than they might ordinarily do if they had to book an appointment with their GP.

3.6 Ramsey Health Centre

Ramsey Health Centre is a medium sized practice on the edge of the Fens. Its practice area extends in excess of 50 square miles. Its partners have been at the leading edge of practice based commissioning. The practice has been actively involved both at a cluster level and within the practice and this two pronged approach has meant that Ramsey Health Centre's projected savings this year are significantly greater than its own core budget, thus effectively making its core primary care costs to the tax-payer a negative figure. The practice has helped with service redesign and has shifted services closer to the patient. Its partners are working hard to ensure that the projected under-spend becomes a reality, as this should release significant sums of money to re-invest into local care for patients in the 2008-09 financial year.

Realistic timescales for developing and delivering services: The pace of policy change and development must take into account the reality of delivery on the ground, i.e. it has taken the Ramsey Health Centre two years to develop and see the rewards from implementing a practise based commissioning approach and there is still much to develop if the Centre is empowered and enabled to do so 'if policy is changed quickly again and existing services destabilised, it will take another two years to get to back to where we are now with the provision of services'.

The delivery of a broad range of services, taking a 'whole centre team' approach: Providing a broader range of services from the Centre, e.g. poli clinics, visiting consultants, mental health clinics, alcohol and drugs clinics, blood tests, podiatry, speech therapy etc. increases the quality of care offered to patients by reducing travel time, distance and cost, provides a more 'friendly and trusting environment' for treatment, advice and support, reduces the waiting time for a consultation, results and diagnosis and the continuity in care that is provided helps patients help themselves, 'because they know the staff and so feel more relaxed and thus more readily impart information that often aids efficient diagnosis'.

Through 'coffee break' meetings and by encouraging the broad variety of staff that practice from the Centre, to discuss clinical issues and good practice, many patients can be treated locally rather than having to be referred to a distant hospital. The savings made by reducing referrals can then be applied to address bottlenecks in service delivery. The importance of involving both patients and professionals delivering healthcare in the development of future services was emphasised as crucial. Furthermore, the effective future delivery of healthcare will also rely on the joined up planning between services, such as tackling transport problems in rural areas.

Dispensing Unit: Not only does this Unit enable patients to access medication more conveniently, especially important where they have had difficult and costly travel into the Centre and do not want to have to make a return visit just to pick up a prescription but also it enables the GPs to take drugs with them on home visits. In addition, with the Unit being run as part of the Centre, any profits can be reinvested back into the service.

Health Visitor and District Nurse Services: Outreach is a fundamental part of these services, but there is little allowance made in budget allocations or in the expectations of central non-Healthcare Centre management of the impact of increased distance and travel time due to the geography of the area, a situation that is made worse by bad winter conditions and flooding. 'Similar case loads exist in rural and urban areas but fewer resources are made available to deliver them in rural areas, where indeed the service delivery itself costs more and takes longer'. Currently, the lack of staff capacity to deliver the services was being stretched further with the introduction of the new NHS computer system, which it is felt is not set up for outreach staff, who have to spend more time in the office inputting data, thus taking time away from patient contact.

Staff had observed that for many of the families in the area, isolation (due to lack of private transport) is a huge issue, compounded by low incomes, many parents and children had to rely on friends to provide a lift to doctor/nurse appointments.

In addition to the outreach services, telephone consultations were successfully being used to offer advice and reassurance and Centre post-natal clinics, run from the health promotion room, were a 'popular resource both in medical and social terms'.

Reception Services: Regular problems that the reception services encounter include busy phone systems, operating at full capacity resulting in many patients being unable to contact the Centre easily and front-line management of the expectations of often angry and emotional patients and relatives.

From their regular informal contact with patients, staff observed specific issues that caused patients problems, these included lack of transport to attend appointments and having to rely on friends, having to attend clinics at certain times for specific advice that do not easily fit in with work patterns, an increase in agricultural injuries during the summer months needing minor surgery, language barriers for the migrant worker population and difficulties in making sure that they have understood a procedure or treatment.

There was a lot of support for weekend surgery, however the main concerns were around staffing capacity and the equitable distribution of potentially popular appointment spaces.

The patients' perspective: Patients raised a broad range of issues that both supported the current services available and highlighted areas where problems needed to be addressed, these included:

- The quality of life benefits of being able to access a wide range of services from a single health centre, e.g. GPs, physiotherapy, occupational therapy, health visitor, minor surgery.
- The importance of the personal patient knowledge of staff and 'just knowing the doctors and nurses, so that they recognise you – the personal touch, it really does make a difference when you are going through a difficult patch'.

- Being able to access such a range of services more locally not only reduces the need to be admitted to a large 'unfriendly and unclean' hospital but also cuts down on the distance that patients have to travel or arrange transport for.
- Patients raised the problem of securing convenient appointments and were concerned that services would become even more stretched, if additional resources were not made available, due to the increasing numbers of people moving into the area.

Patients also raised broader issues around the changing role of the countryside and agriculture, these included increased insect problems due to the managed flooding of areas, food security, the real cost of food production, the over reliance on food imports, the huge role that rural areas had to play in managing climate change and contributing to reducing the nations carbon footprint and the limited impact that reducing set aside will have due to the increasing quantity of non-food crops that are being grown.

3.7 Princess of Wales Hospital

RAF Ely, as it was known became a much loved district general hospital providing medical and surgical care to servicemen and women as well as local people. It was renamed the Princess of Wales Hospital in 1987, but was closed by the RAF in 1992. The hospital was saved by a local pressure groups, Action for a Community Hospital in Ely (ACHE). In 1993, Lifespan Healthcare NHS Trust took it over and began to develop services. The hospital became part of East Cambs and Fenland PCT in 2002 following the disbandment of Lifespan Healthcare and now sees more than 40,000 patient a year through specialist outpatient services such as, gynaecology, ophthalmology, paediatrics, orthopaedics, obstetrics and ENT, nurse led dermatology and audiology.

In addition, accommodation is provided for partner agencies including: Services for Adults with Learning Difficulties; Addenbrooke's day surgery unit; Lloyds Pharmacy; The Cottages Day Hospital; An out-of-hours GP service; Alternative therapies, such as acupuncture and reflexology; A major diabetic research project with Cambridge University; and Dietetic, palliative care, Community Access Team, child and family psychiatry.

Rehabilitation and Falls Unit: The focus of this service is to help rehabilitate inpatients after surgery and reduce the likelihood of outpatients needing to be referred back to hospital or residential care. This not only drives down the dependency of individuals, improving their quality of life but also makes large efficiency savings for public funds in the long run. The service runs morning and afternoon sessions everyday of the week, involving over one hundred patients, to prevent future falls and aid co-ordination. This service both helps to keep individuals living independently in their own homes but patients also appreciated being able to access the support so locally, rather than having to travel large distances to access acute care hospitals.

Funding issues often hinder the provision of rehabilitation in the community as inpatient acute care tariffs cannot be separated from rehabilitation tariffs, so where the a patient would prefer to receive

outpatient rehabilitation locally their rehabilitation costs are paid for twice or they are forced to receive inpatient rehabilitation which is not as effective, especially for rural residents that have to travel long distances to access the service.

New Cottages Day Service: This service offers support and advice to address mental health issues of individuals and their families. The art therapy has been a particularly popular and successful initiative linking with the broader hospital 'art in the corridors', where local artists can display and sell their work, giving a 15% of their sales to hospital funds. Further funds are needed to continue the art sessions, which have made a real difference to patients lives – 'patients often start a session saying that they can't do that activity, then with time and help realise that they can, this has a huge impact on their self confidence and belief and make an enormous contribution to the therapy process'. Again, staff commented on the benefits of this service being available locally via the community hospital.

Outpatients Department: A wide variety of services, including gynaecology, ophthalmology, paediatrics, orthopaedics, obstetrics and ENT, nurse led dermatology and audiology are provided by the Department, through nurse-led clinics, visiting consultants and drop in sessions. Services could be developed, expanded and made more convenient for patients and staff are keen to progress. However, staff capacity issues exist and patient pathways need to be reviewed to ensure that they are receiving the most appropriate and local healthcare, 'however to achieve this GPs, community hospitals, nurses and consultants must work together'. Due to budget allocations, particular pressure points exist around practicing healthcare professionals that have management responsibilities 'tacked-on' to their healthcare roles and while this is helpful to maintain a reality check on management decisions, additional support is needed to 'avoid paperwork being prioritised over patients'.

Minor Injuries Unit: Much like the Ramsey Health Centre, staff observed a seasonal shift in the problems being treated through the Unit, with an increase in agricultural and machine related injuries during the spring and summer months putting pressure on resources.

While both patients and staff appreciate the local provision of such a service speeding up access to treatment, technological advances have also improved the convenience and speed of consultations, for example x-ray results can be e-mailed to Addenbrooks to enable a consultant to make a diagnosis, rather than the patient having to travel.

While the numbers of migrant workers using the Unit to access treatment are currently at a manageable level, taking into account the increased diagnosis time needed to account for slow translation, (using the internet or a translator over the telephone); if footfall increases, the support of a translation service will be required.

Wicken Ward: This ward provides geriatric support for rehabilitation and the assessment of continuing care. Both patients and relatives benefit from the service being provided more locally, as it reduces the time that patients have to spend in acute care, (distant from friends and relatives) and so speeds recovery, i.e. 'the patients are often in their 80s, with friends of a similar age and sons, daughters and other relatives in their 60s so they don't want to have to travel hours to an acute hospital to visit'.

The Friends of Princess of Wales Hospital: The Friends of Princess of Wales Hospital regularly purchases much-needed equipment, such as x-ray machines, beds, hoists and commodes for Departments through its many fundraising activities. The Wicken Ward has recently been refurbished to enhance the privacy and dignity of its patients by providing enclosed walkways away from the bedded areas. Like many other voluntary groups they are finding it increasingly difficult to recruit and retain volunteers to continue to run this valued and necessary source of support and funding for the hospital. Members also expressed a worrying trend of finding it increasingly difficult to raise funds.

3.8 Wimblington Parish Council

Wimblington is situated by the A141 between March and Chatteris. The Parish Council consists of eight Councillors and the Clerk. At the meeting that the Rural Advocate joined, there were approximately twenty-five members of the public present and the Fenland District Council link officer.

A wide variety of issues were raised with the Rural Advocate, including:

- The benefits of twinning arrangements with European countries and the opportunities for expanding ties, given the rising migrant worker population. Currently, in response to the large number of Polish migrant workers, twinning arrangements with Poland are being explored.
- Social isolation is a real threat for the growing elderly rural population, with 'less and less community support to help older people with their shopping, gardening or just to see if they are okay, indeed people are proud and often do not like to ask even if they do need help'.
- The village shop and post office are important assets, not simply for provisions and postal services, but to provide a meeting place and social exchange.
- House prices are increasing, out of the range of affordability for local individuals. This is exacerbated by the fact that many individuals and families are moving here as house prices are still less than in many other parts of Cambridgeshire. New housing developments are being built but these tend to be market housing rather than affordable housing.
- Access to services is an issue where individuals do not have access to private transport or where a parent and child are 'stuck at home during the day, while their partner uses the car to get to work'. Indeed, access to services are often judged on the distance to that service, e.g. there are shops, community halls, post offices available in neighbouring Doddington and March, three and a half miles away but 'this is not helpful if you don't have access to private transport and public transport is not available or easily accessible in itself for elderly, less mobile individuals and parents with prams (- the bus is a coach with steep steps)'.

- Future service planning must take into account the growing local population, due to high fertility rates, migrant workers and high levels of incomers.
- Health and transport services must work together to ensure that services are joined up and accessible.
- Community Hospitals are essential to help keep people out of hospital and living independently in their own homes. 'Through the information, advice and support that they offer they also promote healthier living and the staff, nurses and doctors provide residents with a peace of mind'.
- There was a strong sense of protecting the sustainability of rural communities, through delivering services at the scale appropriate to the setting and through using alternative solutions, such as mobile services. The need for a post office was raised again as an example of a service relied on by many small rural businesses and individuals working-from-home and many examples were presented of way in which rural communities reduce their carbon footprint in comparison to their urban neighbours.

3.9 Rural Advocate Dinner

On the 11th December 2007 the Rural Advocate hosted a dinner discussion to canvass the views of national, regional and sub-regional based organisations, with a specific focus on healthcare delivery, including patient choice, local accountability and accessibility of services. The individuals and organisations that attended the dinner included⁴: Archdeacon of Huntingdon and Wisbech; Blue Sky Events and Media; Cambridgeshire ACRE; Cambridgeshire County Council; Cambridgeshire Primary Care Trust; Cambridgeshire Rural Forum; CRC; Doddington Medical Centre; East of England Rural Affairs Forum; Fenland District Council; Hills Road Sixth Form; Improvement Foundation; Institute of Rural Health; Lord-Lieutenant for Cambridgeshire; Professional Executive Committee; Ramsey Health Centre.

The PCT faces a number of challenges that they cannot tackle and respond to on their own and in isolation, specific examples include obesity, rural stress, an aging but generally less healthy population, lower life expectancy, high accident rates on rural roads and high level of immigrants with the associated language barriers. Added to this, public expectations and aspirations of healthcare need to be managed honestly and appropriately and much work is required to deliver care in the community, enabling individuals to access services closer to where they live. The need for care in the community and preventative healthcare has been exemplified throughout the visit, indeed the dinner discussion reiterated the inefficiencies in the current system, where many elderly people are 'trapped' in acute hospital care, simply because the rehabilitative care is not available closer to where they live or home support not available in rural areas.

The need to develop a joint sense of responsibility and joint approach to tackling health issues together, across the public, private and voluntary sector was compounded by the emphasis of the pockets of hidden deprivation and diversity of rural areas and thus the importance of enabling different solutions to be developed, often to address similar problems but more appropriate to the local circumstances. Furthermore,

4. Please refer to Annex 2 for a full list of attendees.

the importance of 'getting down to individual localities, to understand the needs of an area' was emphasised, stressing that 'there is not one template that can be applied to every situation, local communities, including young people, need to be involved in the choices that have to be made and the solutions that fit their circumstances'. The necessity of a joint approach was emphasised in particular with regard to accessing services and making provision for appropriate transport solutions, especially given the aging population and the breaking down of informal, community support.

The PCTs, as well as the service providers (GPs, community hospitals etc) need to be given the flexibility to develop creative and innovative solutions, as appropriate, to meet that local need and to manage social and cultural changes in society. Examples were discussed, such as developing doctors surgeries and healthcare centres to become a hub for a community, including not simply health services but broader provision of educational, support and spiritual well-being assistance. Practice-based commissioning was discussed in terms of the local commitment and buy-in that the approach fosters, using the knowledge of the local population and situation to invest effectively in the future.

The current development growth agenda and discussion around planning for sustainable rural communities, if not carefully managed will have a significant impact on the provision of healthcare. The expansion of a new town was used as an example of a community that will continue to see population growth but without any of the necessary community support services, e.g. high fertility rates will put pressure on the school facilities, healthcare funding is priorities toward young people, with little regard for the needs of the increasing numbers of elderly residents and because of a general shift in societal actions, the community or voluntary sector that used to provide vital but informal support is being eroded.

The problems associated with budgeting for healthcare services were outlined, including:

- Silo budgeting, which creates a continual barrier to the public sector developing joint responsibilities and approaches, e.g. tackling obesity requires input from health, education, and access and recreation professionals;
- Large service providers are securing contracts for healthcare delivery simply because the local, smaller providers cannot compete. However, these local providers are often more appropriate for effective delivery as they are aware of the circumstances and needs of the communities on the ground;
- Although the PCT is responsible for managing the budgets and staff for health and adult social care, further work is needed to join up delivery;
- The funding formula that is applied to decide on PCT budget allocations is inherently urban biased, not taking into account the increased costs of delivering services in rural areas or taking into account the growing needs of an aging population (- greater weighting is given to deprivation than ages, thus resources are skewed towards urban deprivation). Indeed, 'the PCT is being funded for 77,000 people less than actually live in the area'.

The commitment and energy of healthcare professionals and volunteers were praised and acknowledged as crucial to the level of service that is delivered.

It was recognised that the third sector plays a vital role in rural communities, service delivery and future-proofing the planning of sustainable rural communities and that they needed continued support and longer-term funding.

Finally, the stability of policy approaches was emphasised as crucial in delivering a healthcare service fit for purpose. It was felt that the necessary policy exists currently but that time is needed to implement approaches and ideas – ‘it has already taken us two and a half years to get to where we are now, if there is a significant change in policy it will take us another two and a half years simply to get back to where we are now again’.

4. People involved in the visit

The Rural Advocate and Commission for Rural Communities would like to express their thanks to the following individuals who gave up their time to share their experience and knowledge:

Andrea Prime	PCT, (contact for hospital visits)
Andrew Pallant	PPI Forum
Bill Jarvis	PPI Forum
Bobbie Heather	PPI Forum
Carol Turton	Doddington Hospital
Cat Rees	Prince of Wales Hospital
Cathy Michel	Hills Road Sixth Form College
Charles Jenkins	FACT
Cheryl Havard	Ramsey Health Centre
Chris Bank	Cambridgeshire PCT, CEO
Chris Pugh	Ramsey Health Centre
David Latham	Improvement Foundation
Dennis Cox	Professional Executive Committee
Dick Poole	CAMTAD, Doddington Hospital
Elizabeth Welcher	Doddington Medical Centre
Grace Roberts	Ramsey Health Centre
Helen Curtis	Patient
Hugh Duberly CBE	Lord-Lieutenant for Cambridgeshire
Venerable Hugh McCurdy	Archdeacon of Huntingdon and Wisbech
Ian Moore	Ramsey Health Centre
Irene Callicott	Ramsey Health Centre
Janet Brooks	Doddington / Princess of Wales Hospitals
Janet Fisher	Ely for the Blind, Doddington Hospital
Jeff Edwards	Patient
Jessica Bawden	Cambridgeshire PCT, Director of Communications, Public Engagement and PALS
Cllr Jill Tuck	Fenland District Council, Cambridgeshire County Council

John Yates	East of England Rural Affairs Forum
K. D. Long	Friends of the Princess of Wales Hospital
Dr Kaufman	Doddington Hospital
Kirstie Flack	PCT, (contact for hospital visits)
L. S. Howard	Friends of the Princess of Wales Hospital
Laura Andrews	Doddington Hospital
Cllr Lister Wilson	Cambridgeshire County Council, Health and Adult Social Care Scrutiny Committee
Kirsten Bennett	Cambridgeshire ACRE
Len Moore	Ramsey Health Centre
Lesley Jones	Institute of Rural Health
Liz Robin	Cambridgeshire PCT, Director of Public Health
Lynne Sales	Princess of Wales Hospital
Dr Luke Twelves	Ramsey Health Centre
M. J. Richer	Friends of the Princess of Wales Hospital
Maggie Appleby	Doddington Hospital
Mandy Hill	Doddington Hospital
Matt Coll	Patient
Maureen Donnelly	Cambridgeshire PCT, Chair
Maxine Parker	Princess of Wales Hospital
Mike Cornwell	PPI Manager
Mike Oldham	Doddington Hospital
Mike Royce	CAMTAD, Doddington Hospital
Natasha Day	Princess of Wales Hospital
Norman Lee	Princess of Wales Hospital
Nick Roberts	PPI Forum
Dr Patrick Byrne	Ramsey Health Centre
Pam Close	Princess of Wales Hospital
Pat Skelton	PPI Forum
Pamela Close	Princess of Wales Hospital
Pauline Austin	Doddington Hospital
Pauline Katy Amey	Princess of Wales Hospital
Ruth Clapham	PPI Forum
Sally Stewart	Doddington Hospital
Steve Wilson	Doddington Hospital
Dr Simon Brown	Ramsey Health Centre
Dr Simon Hambling	Doddington Medical Centre
Dr Stuart Shields	Doddington Medical Centre
Susanne Lindsay	Prince of Wales Hospital
Richard Poole	Doddington Hospital
Wendy Endersby	Princess of Wales Hospital
Wimblington Parish Councillors and residents, including Liz Wright (Chair) and Russell Wright (Clerk)	

There were additional individuals and patients who kindly gave up their time to share their experiences and knowledge but did not want their names recorded.

Rebecca Frost
21st January 2008

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Annex 1: Visit Agenda

Monday 10th December 2007

- 17.00-17.30 Briefing for evening and filming arrangements
- 18.00-18.30 Fenland Association for Community Transport Ltd
Discussion with Mr Charlie Jenkins, Chair
- 18.30-21.30 Cambridgeshire Patient and Public Involvement Forum
and Director of Public Health.
- Forum volunteers – Nick Roberts, the Chair of the Cambridgeshire PPI Forum, Ruth Clapham, Pat Skelton, Andrew Pallant, Mrs Bobby Heather, Bill Jarvis; Liz Robin, Director of Public Health for Cambridgeshire Primary Care Trust and Cambridgeshire County Council

Tuesday 11th December

- 08.30-08.45 Briefing for the day – David Latham (Improvement Foundation), Jessica Bawden (Cambridgeshire PCT) and CRC Services Team will be joining the visit
- 08.45 Depart for Doddington
- 09.30-09.45 Doddington Medical Centre
- Met by Matron – Janet Brooks and Community Specialist Service Manager – Maggie Appleby
- Elizabeth Welcher and Dr Hambling will talk through the following services; patients will be present – GP referrals into hospital; Nurse-led clinics; Mid-wife visits; Community mental health; Drink Sense; Dispensary Service
- 09.45 Walk to main hospital
- 09.50-11.00 Doddington Hospital
- 09.50 Outpatients Department – Meet Outpatients Department Sister – Sally Stewart and patients.
- Nurse-led Ear, Nose and Throat Clinics – Meet Specialist Nurse Carole Turton, Carole holds the telephone consultation clinic.
- CAMTAD – Meet Dick Poole and Mike Royce, talk through the service and how it connects with the community and ENT clinics.
- Ely for the Blind – Meet Janet Fisher, to talk about the service.
- 10.15 Physio. Department – Meet Extended Scope Physiotherapist – Pauline Austin and patients
- 10.30 Wendreda Unit – Meet Community Geriatrician – Dr Kaufman, Manager – Mandy Hill and patients, to talk through the falls, rehabilitation and occupational therapy services.

10.45	Refreshments at the shop – Meet Friends of the Hospital, X-Ray Department – Mike Oldham, Icen Unit Minor Treatment Centre – David Gwilliam and Anti-coagulation Department – Julie Braine.
11.00	Depart for Ramsey
11.30-13.30	Ramsey Health Centre
11.30	Discussion of generic GP and rural issues – Dr Luke Twelves
12.00	Meet with Health Visitor – Chris Pugh; and District Nurse – Cheryl Harvard
12.15	Meet with Reception Team – Grace Roberts, Irene Callicott; and Practice Manager – Ian Moore
12.30	Meet with patients
13.00	Lunch – GPs – Dr Browm, Dr Byrne, Dr Twelves; and Dispensary Team rep. – Cherry Toyer; Patients; Practice Manager; District Nurse.
13.30	Depart for Ely
14.30-16.30	Princess of Wales Hospital
14.30	Meet Wendy Endersby, visit Rehabilitation and Falls Unit to meet patients.
14.45	New Cottages Day Service for Older People – Mental Health. Meet Pamela Close
15.00	Meet Art Co-ordinator – Norman Lee and Friends of Hospital and hospital volunteers
15.15	Outpatients Department – Meet patients
15.30	Lantern and Minor Injuries Unit – Meet Pauline Hawes and patients
15.50	Refreshments in Café – Meet patients using café
16.00	Wicken Ward – Meet Consultant Geriatrician – Rhian Simpson and patients
16.30	Depart for March
17.30-18.45	Oliver Cromwell Hotel
18.15	Depart for Wimblington
18.30-19.30	Wimblington Parish Council meeting Discussion with Parish Councillors and residents Chair and Russell Wright – Parish Clerk
19.30	Depart for March
19.45-22.30	Rural Advocate Dinner – Discussion around healthcare delivery – Attendee list attached below

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Annex 2: Rural Advocate Dinner Attendees

The Oliver Cromwell Hotel, Cambridgeshire, Tuesday 11 December 2007, 7.45pm for 8.00pm

Cathy Michel	Hills Road Sixth Form
Chris Bank	Cambridgeshire Primary Care Trust CEO
Cllr Jill Tuck	Fenland District Council / Cambridgeshire County Council Cabinet Member
Cllr Lister Wilson	Cambridgeshire County Council - Health & Adult Social Care Scrutiny Committee
David Latham	Improvement Foundation Director
Dennis Cox	Professional Executive Committee Chair
Dr Luke Twelves	Ramsey Health Centre GP
Dr Simon Hambling	Doddington Health Centre GP
Hugh Duberly CBE	Lord-Lieutenant for Cambridgeshire
Jaki Bayly	Commission for Rural Communities Programme Manager – Services Team
Jessica Bawden	Cambridgeshire Primary Care Trust Director of Communications, Public Engagement & PALS
John Yates	East of England Rural Affairs Forum Chair
Kirsten Bennett	Cambridgeshire Rural Forum / Cambridgeshire ACRE CEO
Maureen Donnelly	Cambridgeshire Primary Care Trust Chair
Venerable Hugh McCurdy	Archdeacon of Huntingdon & Wisbech Lesley Jones Institute of Rural Health
Rebecca Frost	Commission for Rural Communities Senior Officer – Rural Advocacy Team
Richard Bratton	Blue Sky Events and Media Director
Stuart Burgess	Commission for Rural Communities Chairman and Rural Advocate

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Annex 3: Background Information on the Fenland Area

(Text courtesy of Cambridgeshire ACRE)

Geography

The Fens form a defined geographical area with social, economic and environmental characteristics that transcend local authority boundaries. The area is predominantly - though not exclusively - rural in character with mainly flat topography and rich fertile soils. The terrain rarely passes 10m above sea level, with much of the land relying on pumped drainage and sluices to maintain its agricultural viability.

The “Peaty Fens” or “Black Fens” comprising this area are characterised by broad rectilinear fields, straight roads and the raised banks of the artificial drainage channels. The dispersed settlement pattern includes villages, isolated hamlets and market towns reflecting the area’s agricultural heritage. The area falls between the thriving cities of Peterborough to the north and Cambridge to the south, linked as part of the London-Stansted-Cambridge-Peterborough growth corridor.

Economy

The economy of the area has traditionally been heavily dependent on agriculture and food production. Farm businesses are generally large and highly commercial with many externally owned. There are however a significant number of small farm businesses, a number of which are likely to be part-time. A strong agri-food cluster has developed with a number of food processing companies located close to the source of production particularly around Wisbech. However, only a small proportion of the produce grown or processed in the area is marketed locally.

Employment in agriculture has declined sharply in recent years with businesses looking to amalgamate and increase efficiency to compete in a global market for large contracts. At the same time local seasonal labour has been largely replaced with migrant labour, particularly in the labour intensive vegetable businesses. Migrant workers are crucial to agricultural production, however the influx of large numbers of migrants to rural communities has put pressure on limited services and threatens community cohesion.

Two of the districts in the area (Fenland and King’s Lynn and West Norfolk) are classified as lagging areas by Defra, with GVA/head in the lowest quartile nationally. Economic and social deprivation is found across the area. Index of Multiple Deprivation 2004 data shows some wards in Fenland are in the worst 25% in the country for deprivation relating to health, skills, income and a range of other issues.

Although unemployment is low, deprivation and economic underperformance are under-pinned by a low skills, low wage economy. In the districts of Fenland and East Cambridgeshire the largest employment sector is wholesale and retail trade. In Fenland District, worst affected by low skills, only 36% of children attain 5 or more GCSEs at A*- C compared to a national average of 53%. Average life expectancy is 80.3 years and 74.7 years for women and men respectively compared to national averages of 80.6 and 75.9. 38% of people aged 16-74 hold no formal qualifications, compared to a national average of 29%. The Fens economy is set to undergo a period of change and growth, as part of a

government designated growth area. The district of East Cambridgeshire is recognised as one of the fastest growing in the country.

As yet the Fens haven't shared the benefits of economic growth in its neighbouring cities. High levels of out-commuting and increasing house prices have resulted, with the growth in local jobs failing to keep pace with the growth in population.

Social

There are a large number of small, remote communities often cut off by the extensive drainage network. A sparse population and poor road and transport infrastructure mean many communities do not have access to basic services. The exception is the rail-line along the eastern edge of the area connecting London and Kings Lynn via a high-speed link that takes in the market towns of Ely, Littleport and Downham Market. The presence of this link undoubtedly increases the proportion of commuters living in these communities. Levels of out-commuting are high across the whole area, caused by the economic success of Cambridge and Peterborough and local population growth that has far outstripped jobs growth. High levels of commuting impact on the social cohesion of communities and additionally the viability of local services, with people leaving their communities for the day having no need of a local shop, post office or other basic services.

Environment

The Peat Fens were drained between the 17th and 19th century with the loss of numerous animal and plant species, to create the rich fertile farmland of today. The landscape, of considerable historic interest, is increasingly fragile and vulnerable. Centuries of intensive agriculture, drainage and wind erosion have led to degradation and irreversible shrinkage of the peat soils. At risk of flooding from both the rivers and the sea, the Fens are especially susceptible to the effects of climate change. At the same time rainfall is amongst the lowest in the country and water supplies are under increasing pressure from new housing development. These factors combine to provide particular challenges for the sustainable development of the area.

Access to the Fens countryside has traditionally been limited because of the pattern of intensive agriculture. However here are examples of good work in relation to rights of way in the sub-region: the Cambridgeshire and Peterborough County Farm Estates have invested in public access schemes and recreational woodland trails; a number of District Councils have invested in public walks and helped ensure public rights of way. There is a growing interest in waterway access using the existing complex of rivers and drainage canals, with real potential for recreation and tourism in the area. The Environment Agency's Fens Waterway Link Project will open up 240km of waterway for recreation, tourism and the environment through the Fens.

After centuries of drainage a number of high-profile projects are underway to restore the original fenland habitats for wildlife and recreation. These developing environmental assets provide new opportunities to secure economic and social benefits for growing local communities and attract visitors from the tourism honeypots of Cambridge and Ely.

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