Rural Health Challenges
and
The National Centre for Rural Health & Care

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Towards a National Centre for Rural Health and Care

Overview

- Characteristics of rural areas and rural demographics
- Key areas of need
- Challenges in identifying deprivation within rural communities
- Background to the development of a National Centre
- Key Themes
- Progress and next steps

Characteristics of Rural Areas

- Open countryside with scattering of small towns and villages, e.g. ***Norfolk or Kent***
- Different types of farming communities, such as dairy/livestock farming and/or crop cultivation, where farming methods can vary widely from the most labour-intensive seasonal work to highly-automated commercial enterprises
- Sparsely populated upland areas, e.g. Yorkshire ***Dales, the Lake District***
- Coastal *communities* in places like ***Cornwall, Cumbria and Northumberland***, dependent on fishing or tourism where in the tourist season the population can increase tenfold
- Former mining areas in places like ***Derbyshire or Durham***
- Commuter villages on the periphery of large towns and cities.

The population

- 9.3 million people in England, or 17.0 per cent of the population, live in rural areas in 2014.
- Around 581,000 people, or 1.1 per cent of the population live in settlements in a sparse setting.
- The population in rural areas has a higher proportion of older people compared with urban areas.
- Within rural areas, the greatest rate of population increase is in rural town and fringe areas (1.6 per cent), with the smallest increase in rural villages and hamlets in sparse settings
- *Rural* households spend a higher proportion of their disposable income on transport and recreation.

Health (2013-15 data)

- **Average life expectancy is highest in *mainly rural areas*** (in 2013-15 it was 79.4 years for men and 83.1 years for women in England.)

- Potential years of life lost (PYLL) from all causes of death is **lower in predominantly rural areas** (372 years of life lost per 10,000 population) **than predominantly urban areas** (475 years of life lost per 10,000)**.**

- **Infant mortality is lower in *rural areas* than in England as a whole:** In 2012, the infant mortality rate in *rural areas* was 3.6 deaths per 1,000 live births, compared with the England average of 4.1 deaths per 1,000 live births.

Describing the inequalities

- There are clear inequalities in rural areas, but these are not always obvious as they may be small populations living alongside wealthier people, and their deprivation 'masked'.
- Indices such as the Index of Multiple Deprivation (IMD) may not always be suitable for demonstrating inequalities in rural areas as the indices do not include some key factors, and may not be sensitive at a 'small area level'.

- Variation and Inequities within Rural areas
- Older demographic
- Infrastructure
- Access to care
  - Geographical
  - Digital
- Housing and Fuel

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https://www.gov.uk/government/statistics/rural-health

Access to Care

- **8% of rural residents** live within 4km of a GP surgery, compared with **98% of the urban** population.
- Only **55%of rural households** compared to **97% of urban households** are within 8km of a hospital.
- **57% of rural residents** live within 4km of an NHS dentist, compared with **98% of the urban** population.
- Rural areas may have worse access to health, public health and care services and may need different models of service delivery
- National models of service delivery are less likely to consider or test delivery in sparse rural areas
- Public health interventions such as NHS Health Check and Making Every Contact Count (MECC) might still be able to reach large sectors of the population, but some people may be disadvantaged due to remoteness and sparsity.

Housing and Fuel

- **Affordability, poor quality housing and significant fuel poverty** in the most rural areas are threatening the wellbeing and sustainability of communities
- Rural house prices are **26% higher than in urban areas** and are on average less affordable
- Around 50% homes in the most rural areas and villages **are classified as 'non-decent'** compared to around 30% in small towns and urban areas.
- Around 50% houses in the most rural areas and 25% in village centres are '**energy inefficient'** compared with 7% in urban areas.
- 2 in 5 homes in rural areas **are off the gas grid** and have to rely on expensive fuel options
- Households in fuel poverty are at risk of being unable to heat their homes to required standards.

Digital Access

- Average rural speeds are more likely to be slower due to lack of high speed broadband services
- A combination of the older demographic and the unavailability of high speed broadband and mobile phone networks **are leading to an increasing digital gap**
  - Digital exclusion in rural areas can **limit creativity for health and care services** in linking with people living in remote areas
  - Availability of broadband in rural areas is increasingly important **for economic development, access to services and wider social activities.**

	Mbit/s
Rural overall	13
Rural town and fringe	17
Rural town and fringe in a sparse setting	16
Rural village	9
Rural village in a sparse setting	8
Rural hamlet & isolated dwellings	7
Rural hamlet & isolated dwellings in a sparse setting	5
Urban overall	26
Urban major conurbation	27
Urban minor conurbation	25
Urban city and town	26
Urban city and town in a sparse setting	16
England overall	24

Average speeds by rural and urban classification in England 2014

s://www.gov.uk/government/collections/rural-living-statistical-indicators

Challenges Summary

- Rural areas themselves are quite diverse
- There are challenges in identifying the pockets of inequalities in rural areas, as these are not always obvious due to small populations living alongside wealthier people, which can mask the deprivation.
- Socio-economic comparisons suggest that on average rural areas are better off than urban areas in relation to income, employment, education and crime, but not for some factors such as housing affordability and quality, fuel poverty and access to services.
- We need other complementary ways to be able to describe the heterogeneity of rural areas in terms of the deprivation experienced.

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The Lincolnshire Context

- Lincolnshire is the fourth largest county with the 4th most dispersed population.
- Seasonal variation in population due to holiday makers along the coast
- We have a registered population of 768,688. 9.9% of the population is 75 + with an expected increase of 20.1% 75-84 yr. and 19.6% increase 85+ years by 2021 (above national average).
- The number of working age adults is not expected to rise.
- 14.2% of the population live in the most deprived areas in England.
- Significant housing growth planned across Lincolnshire with circa 5000 additional homes built in and around Lincoln alone over the next 5 years.

- The NHS struggles to deliver
  - Sustainable and affordable care

  which is always accessible
  - The Lincolnshire 5 year STP plan (Sustainability and Transformation Plan) offers a way forward but is ambitious and there are many risks to delivery
  - Workforce and recruitment lies at the heart of many issues.

- The challenges faced by Lincolnshire are seen throughout the United Kingdom
- There does not appear to be one place that brings together some of the potential solutions in terms of best practice and innovation:-
  - Workforce redesign
  - Research
  - Use of data
  - Technological innovation

A Centre for Rural Health and Care

- Literature Search and review (85+ documents)
- Interviews with 20+ stakeholders
- At a high level, the outcomes from this initial work suggested the following themes:

1. Data and intelligence
2. Recruitment, Education, Training and Professional Development
3. Research
4. Technology

1. Data and intelligence

- In other countries *provider to population* ratio is a key way of making rural/urban comparisons. In Australia and USA – common problems around recruitment and retention which are measurable via this ratio.
- There are challenges in identifying the pockets of inequalities in rural areas
- Rural health services face particular cost challenges – but this is not adequately quantified. Good practice in addressing rural factors which challenge delivery is not collected or shared.

2. Recruitment, Education, CPD

- There needs to be flexibility in areas where recruitment is difficult. Pay will only go some way to addressing shortages and a broader approach is needed (e.g. education, training, research, distance based professional relationships and activities).
- Recognition of the need for collective, collaborative and coordinated action: *rural areas have to host interesting, professionally satisfying and meaningful jobs.*

3. Research

We have identified dedicated research centres that seek to improve the quality, viability and sustainability of rural health care – breaking down silo based approaches to workforce planning by integrating primary, secondary and social care roles.

4. Technology

- Includes technologies that people can use to improve their independence (e.g. apps, voice prompt, software), technologies specific to supporting their health and care needs and clinicians sharing data with patients or triaging online.
- Some NHS Trusts have set up joint ventures to provide clinical support services – Airedale for example, has entered into a joint venture with “Immedicare” to deliver tele-health.
- We have found evidence where technology has led to clinical, financial and/or operational improvements.

Stakeholder Consultation

- General enthusiasm for the concept
- Recruitment and retention emerged as central
- Other themes: data, research, technology
- Opportunity to coordinate good practice
- Largely but not completely virtual
- Lincolnshire locus – international focus
- To engage health, public, private and VCS sectors
- To influence and engage policy makers

United Lincolnshire Hospitals NHS Trust | University of Lincoln, Lincoln Institute for Health | Lincolnshire County Council – Working for a better future | East Midlands Academic Health Science Network – Igniting Innovation | LEAP – Lincolnshire Economic Action Partnership

Public Health England

NHS Health Education England

Symposium, February 2017

- What would a centre look like?
- What targets might a centre be expected to deliver?
- How might a centre be funded?
- What current activities would it need to complement ?
- How might it be governed?
- What timescales are we talking about?
- Are there any early wins it might achieve?

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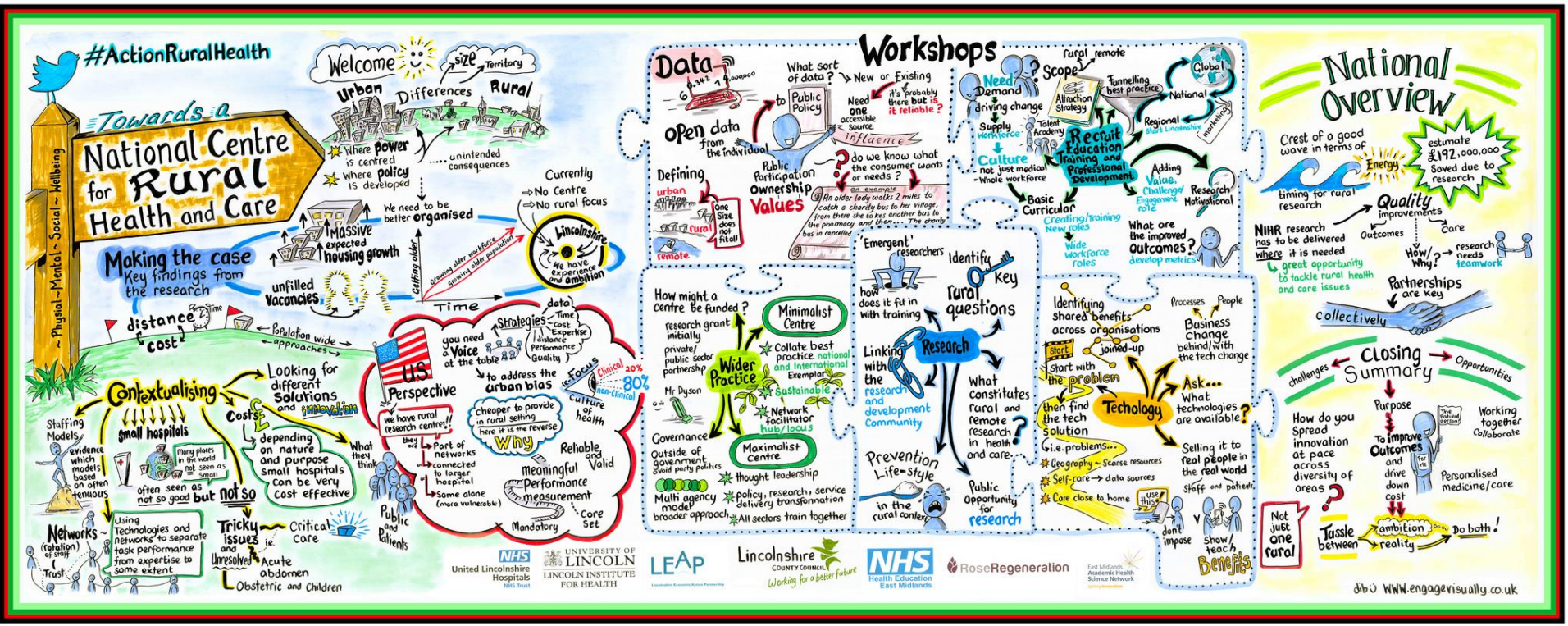

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Progress

- Steering Group formed
- Business Plan prepared
- Now establishing a legal vehicle for the Centre (CIC)
- Support received from Lincolnshire County Council, University of Lincoln, Public Health England, Health Education England, East Midlands Academic Health Science Network and LEAP.
- Recruited an Executive Chair
- Preparing a Mobilisation Plan

Next Steps

- How we can build on existing expertise and networks – locally, regionally, nationally and internationally.
- Resources – funding and collaborative bidding.