Rural Policy
GROUP

Briefing Note: Rural Health & Social Care
25th February 2021

Rural Policy Group is a visionary think tank shaping the future of the rural economy; established by Mark Lumsdon-Taylor in Spring 2020 it supports economic actors in the rural economy with a programme of knowledge exchange and debate. The group brings together the best minds in politics, economics, business, finance, medicine and science to discuss the big issues of the day and support rural leaders to find and seize opportunities for progress and growth.

The Speakers

Anne Marie Morris MP: Conservative MP for Newton Abbot, Chair of the All Party Parliamentary Group on Rural Health & Social Care and former Member of the Health & Social Care Select Committee

Anne Marie Morris was first elected the Conservative Member of Parliament for Newton Abbot in 2010 and was re-elected in May 2015, June 2017 and most recently in December 2019 increasing her majority each time. Anne Marie dedicates much of her time in Westminster to issues relating to health and social care, small businesses and the UK's future outside of the European Union. She has set up three APPGs since her re-election in 2017 and is the current Chairperson of these groups. The first is on Rural Health and Social Care, inspired by the problems faced in the health and care sector in the South West because of the region's rurality. The second, is on Business Brexit, considering how businesses can overcome the challenges and make the most of the opportunities presented by Brexit. In Autumn 2018, she also set up the APPG on Access to Medicines and Medical Devices which examines pricing, funding and wider access issues relating to the availability of medicines and medical technologies on the NHS in England. Anne Marie was a member of the Public Accounts Committee during the last Parliament, a committee that oversees and analyses government expenditure to ensure that money is well spent, and regularly led on matters regarding health and education expenditure. Towards the end of the last Parliament, she also joined the Health & Social Care Select Committee. Anne Marie continues to champion local issues by understanding the issues on the ground and representing them in Westminster. She continues to champion fairer schools funding, a Clean Air Act, environmental and planning issues, flooding, broadband infrastructure and transport infrastructure. Before becoming a member of parliament in 2010 Anne Marie served as a County Councillor having been elected to the West Sussex County Council where she was Chair of the Health Overview and Scrutiny Committee.

Graham Biggs MBE: Chief Executive, Rural Services Network and Director, National Centre for Rural Health & Care

Graham has led the RSN since its creation in the early 2000s. For over 20 years he was Chief Executive of the former South Shropshire District Council, one of England's most sparsely populated districts. He has a wealth of experience in the management and delivery of services across sparsely populated districts. Graham is a Chartered Secretary and Fellow of the Chartered Institute of Secretaries and Administrators. He is also a Fellow of the RSA (Royal Society for the Encouragement of Arts, Manufacturing and Commerce). He was awarded an MBE in 1995 for 'Services to Local Government'. Graham has given evidence to several Parliamentary Select Committees relating to the Local Government Funding Formulae and rural policy. He acts as Principal Advisor to

the All Party Parliamentary Group on Rural Services for which the RSN provides the Secretariat. He is a Director of the recently formed National Centre for Rural Health and Care and represents the RSN on the Executive Committee of the National Rural Crime Network.

Andrew Leal: Healthcare Partner at MHA MacIntyre Hudson and Lecturer in primary care finance

Andrew joined MHA MacIntyre Hudson in April 2019 following the merger with Kent-based accountancy practice Percy Gore & Co, where he had been a partner since 1990. Andrew has a diverse portfolio in the healthcare sector comprising a range of GP Practices, Locum GP's, GP Federations, Dentists, Hospital Consultants and other healthcare professionals, mainly in Kent with a cluster of practices in the hard-to-reach highlands and islands of Scotland. Andrew regularly lectures and runs seminars on Primary Care finance.

Rob Verkerk PhD: Founder and Chief Executive & Science Officer, The Alliance for Natural Health

Rob is an internationally acclaimed expert in health, agricultural and environmental sustainability. During the course of his work over the last 35 years, he has focused on a diverse array of issues ranging from environmental protection, to reducing synthetic chemical load among urban and rural communities, to assisting the development of natural and sustainable approaches to healthcare. In Europe, Dr Verkerk has made substantial contributions to the development of more appropriate legal and scientific frameworks for the regulation of natural products used in healthcare.

Mark Lumsdon-Taylor (Chair): Senior Corporate Consultant to MHA MacIntyre Hudson, CFO (seconded) and Founder & Chair of Rural Policy Group

Watch again

A link to the full RED Talk can be found on our website www.ruralpolicy.group.

Summary of insights

Rural communities do not receive equal access to health and social care. This systemic failing is largely the result of:

- Lower levels of funding and higher costs of delivery compared to urban settings.
- A policy of health and social care centralisation developed in isolation from consideration around how people access those services. A transport and infrastructure strategy which would have widened access to more remote location was not only not considered, health and social care provision was often funded at a cost to transport which made the services and facilities even less accessible.
- Rural populations aging more rapidly than in the UK as a whole.

There are many challenges involved in creating a health and social care model suited to sparse and elderly rural populations, and the post-Brexit and post-Covid recovery is providing an opportunity to lobby government for investment in rural areas as a means of stimulating the entire UK PLC economy. Systems-thinking and fair funding for rural settings will lead to rural regeneration, rural economic growth and support the government's plans of a green recovery.

Political Speaker: Anne Marie Morris MP

The first problem with developing a rural health and social care strategy is that the concept of 'rural' is not clearly defined. In this context, rural does not mean leafy Surrey villages. Rural applies to those parts of the British Isles which are remote and relatively isolated with poor infrastructure. There is not even a unified definition across government departments, or even within them. The Housing Department is looking at rectifying that but only for its own Ministry.

When we look at rural communities and ask whether people have cars, they do. That by definition makes people affluent and not needy. However, anyone who lives in an isolated location knows that a car is essential and without one, isolation becomes very deep indeed.

So, how do we rectify the lack of local provision in rural areas? The question itself raises the issue of measurement. Provision of health and social care is measured at too high a level, it needs to be more granular. Let us look at the Ambulance Service to illustrate this point. In Devon, many areas are no-go areas, but this is completely masked by the figures which cover a large swathe across two counties. So, we have problems with definition and measurement.

There is a disproportionately high level of need in rural communities.

There is a disproportionate number of older people with complex comorbidities in rural areas as people tend to retire to the country. That changes they type and level of health & social care support needed in rural locations. The isolation leads to a disproportionate level of mental health challenges; my own part of the country (Devon) has one of the highest levels of suicide. The farming community is also particularly severely affected by mental health problems. The challenge for us in government is finding a way to meet those needs. There is an interesting pilot where vets have been trained to identify mental health issues and provide some of the hands-on support.

Deprivation in rural areas is partly a nature of the geography, but also due to the lack of infrastructure. It is not often possible to get to the nearest large hospital in time. Therefore, the one-size-fits-all centralised model which assumes we can all easily get to a hospital simply is not working. So, what do we actually need?

People in rural communities need more specialist-generalist practitioners and new care pathways to deliver the support and care they need.

We need more specialist-generalist practitioners. We do not have the luxury, nor does distance allow, for a patient to see multiple consultants and nurses. There is a recognition among all the Royal Colleges that too many people have been trained as specialists and that training needs to change so they have a greater degree of generalism. There is also a recognition that there needs to be a rural element to training and an element of social care. Health and social care cannot be put into separate boxes; they must be delivered in tandem.

Geriatricians in rural areas are necessary but there are not enough of them and their training needs greater scope in mental health and social care. They are doctors foremost, but today's elderly patients require all those elements to be integrated. Because of this complexity, we need to develop new care pathways to help individual patients get all the care and support they need. That is not straight-forward and it does mean we have to look at how patients are triaged.

To use the Ambulance Service as an example again, there are some extremely difficult questions to ask. Does an ambulance respond to a call if we know it will not reach that person's home and onward journey to A&E in time to save their life? The moral imperative and the practical use of scarce resources appear to diverge making this one of the questions nobody dares ask, and because we do not have sufficient granularity in measuring ambulance responses, it is not something that has been addressed.

We also need to look at how we can expand and be best-in-class for truly integrated care including voluntary care. We would not be able to provide the level of support we need without the volunteers.

We have some particularly good primary care networks – and some of the best are in rural parts of Devon – but they are not big enough or bold enough. Crucially, they are not well-funded enough. They also do not fully get to the heart of integration yet.

Private sector and state-funded care must be fully integrated
to provide enough nursing home care.

There is also the problem of integration of private and state care. We understand that GPs are in the private sector but see them as part of the NHS family. Private care in homes and auxiliary care is not seen in the same way. It is not just a matter of funding; we will never reach a fully integrated solution unless we accept the whole of the private sector into the NHS family. The consequence of the current separation is that the number of nursing homes is dropping like a stone and we do not have the number of beds we need. For all the talk of care being better at home, the reality is that not everybody is fit enough or able to muster enough carers to make staying at home a reality. The bed base issue urgently needs to be addressed.

The way ahead begins with better definition and measurement of rural issues. We need to measure what the input into rural communities is (financial or otherwise). We need to measure the output, and we need to measure the outcomes.

We also need to look at the research into complex comorbidities because right now there is no real understanding of how to deal with these patients and it is a more pressing concern for rural areas than their more urban neighbours due to the older demographic. Often the most acute issue is dealt with first and that may not be the best course of treatment. Very often the individual will then go on to die of something else.

We need to create new care pathways, we need to address shortfalls in training programmes, we need to rework the geriatrician role, we need to invest in infrastructure such as roads and broadband, and we need to look at how can create a truly place-based system. Then we need to look at how we get the right sorts of funding into rural communities. At this point in time rural areas are penalised; the funding formula is not fit for purpose. The health and social care system is not set up for rural care, so when nearby hospitals miss their targets because they cannot meet the demands of rural patients, they are penalised with a further reduction in funding. That downward cycle must change.

Going forward we need to look at how we build resilience and sustainability into the system. How can we make sure we make the most of AI? How can we make the most of the volunteers? How can we do the most to make sure communities are self-reliant and resilient so when isolated locations are cut off entirely (e.g., by snow) they can continue to provide good care and support to residents? Ultimately, rural communities must be part of the levelling up agenda.

mha MACINTYRE HUDSON
RURAL SERVICES NETWORK

Question from the audience: How does the closure of local health centres and demise of the village doctor play into the rural health & social care agenda?

Anne Marie Morris MP: It is a mistake to close the cottage hospitals and the new White Paper indicates the NHS Bill will change that. We absolutely need to keep these community hubs but need to ask what they will look like and what services they should be offering. Do we revitalise and repurpose the cottage hospital or do we do something entirely new? The key is that there must be something local. Rural areas simply cannot survive on a centrist model and the assumption that everything will be referred to the district general hospital.

Mark Lumsdon-Taylor (Chair): Your point about the hospitals is spot on. Here in Kent rural areas are not terribly remote but the public transport infrastructure means villages can be quite isolated in health terms as it is difficult to reach the bigger, more well-serviced hospitals without a car. Even with a car, the hospitals can be a long drive upwards of 30 minutes.

Policy Speaker: Graham Biggs MBE

Many of the Rural Services Network's members are council and unitary authorities with social care responsibilities. We do also have relationships with the National Centre for Rural Health & Care and non-local authority providers.

Social care is not just about adults, you also need to look at social care for children. The need for and costs of children's social care have increased dramatically in the past five or so years. Pre-pandemic directors of social care told us the issues were bigger for looked-after children than for the older population.

**There is a higher demand for social care in rural areas,
yet less funding per head to deliver it.**

In terms of age profiles, the rural population is substantially older than the national and urban averages and it continues to get older. The Office of National Statistics produced a report predicting the average age of the rural population will rise dramatically by 2035. It is not just the overall figure for elderly people that is higher, the number of people in the upper 85+ bracket is significantly higher in rural locations. And the difference in average age between the rural population and the nation as a whole continues to diverge. This matters when older people need social care because within the higher age range the issues are more complicated and complex, and more costly to deal with.

Let us look at some of the funding for local authorities from government for social care and general service purposes. The financial settlement that comes into play on 1st April this year sees rural areas get £11 less per head in social care funding and 16% less per head for the new social care grants. This is despite an acknowledgement that it costs more to provide care in a rural setting.

If you are going to care for someone in their own home when it is practical and safe – which everybody agrees is the ideal way – carers spend more time moving between clients. They can easily travel upwards of 10 or even 20 miles between appointments. In an urban setting, carers can go almost door-to-door or from one street to the next. One of the more serious impacts for patients in rural environments is the pressure that puts on the carer's time and it limits how long they can spend with any one person. Those carers may be providing the service very well, but the social interaction is curtailed and they may be the only person the elderly client sees throughout the day. That is a serious consideration, contributing as it may to feelings is loneliness and isolation.

The question of funding goes beyond social care. Looking at government funding to rural local government as a whole, rural residents pay £96 per head more in council tax than their urban counterparts and get 42% less in government-funded spending power. Despite the increase in council tax, which is there because rural areas are not getting a fair share of government grant, rural areas overall are still getting £16 per head less in the monies they have overall to spend. That is important from a social care perspective, but social care is a statutory function and although the statute does not define precisely the service levels that are required, the social care departments and directors of social care know what those targets are and that they must be met. If the government is not providing sufficient money for the council to meet them, the council will divert money away from other services to meet the shortfall. During the 'austerity years' rural areas have seen massive reductions in public transport which is one of the budgets local governments can draw on to bolster social care funding. The reasoning is that public transport is discretionary and social care is statutory.

Issues are best by solved by systems-thinking.

One of the things I think is a fundamental weakness of policy development is that we look at issues in isolation. We talk about health as separate to social care and public health funding discussions are separate again. As an aside, public health funding is also much less for rural areas than it is for urban areas. And all of those are talked about separately from broadband and mobile connectivity in rural areas. Advancements in AI and digitisation of healthcare will not make an impact in rural areas until the broadband issue is sorted out. The issues of isolation and loneliness can be addressed by technology if there is connectivity. One school in Devon recently surveyed the families of its children who are remote-learning and only 1.6% had a good broadband connection. A massive 77% rated their broadband service as inadequate.

We need more integrated thinking to solve the problems within rural communities. For the rural economy to play its part in the national economy, we need to look at broadband, transport, health & social care and further education, training & skills. They interplay in people's lives and so need to interplay in policy. Unless we see a change in all these things, we will continue to have a situation where younger people feel they have no opportunity but to leave rural areas in search of work and affordable housing. Imagine the population imbalance if this continues unchecked and ask, who will look after the people who need looking after in rural areas when the younger generations have left?

Question from the audience: Brexit brings opportunities. How can rural communities get involved in deciding what type of trade agreement benefits them? Especially given the lack of a clear definition of what constitutes rural.

Graham Biggs MBE: My personal view is that there is no single definition of 'rural'. Even within rural. The issues which face people in remote isolated Uplands communities are different to those in rural lowland areas which are in reasonable distance of a town or city. Local delivery may be the answer. We need a policy framework from central government with sufficient nuance to reflect the different characteristics of different areas, which funds delivery in areas where cost diverges from the norm and relies as much as possible on local delivery. Only local delivery can truly reflect the local circumstances and only they can fully understand their local circumstances.

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Primary Care Business Speaker: Andrew Leal

I work with 120 practices serving 1,000,000 patients. They are mostly in Kent with a cluster in the Scottish islands, so I fully support the previous comments about the definition of 'rural' being unclear. The rural locations in Kent [which are mostly near towns and relatively good infrastructure] have very different issues compared to those faced by islanders in Scotland.

Primary care performs well in rural settings but faces a number of challenges.

Generally, rural areas are dominated by a larger number of small practices; they do not have the larger practices we have seen develop in urban areas. There are some incredibly positive developments within rural practice and much that bodes well for the future of provision in rural locations. Customer satisfaction is higher in rural areas than in their urban counterparts. If you look at Care Quality Commission (CQC) data, there is a higher proportion of outstanding practices in rural areas than urban ones.

However, rural communities pose unique challenges too. One is the distance problem – this distance from the patient to the surgery. This is problematic for patients and clinical staff. Second, there is less access to additional services. In urban areas we have seen services come out of secondary care to be provided in the local community whether that is ophthalmology for age-related macular degeneration (AMD) or a variety of other services. Generally, that is not the case in rural settings because you do not have the larger practices available to make that happen. Third, it is considerably harder to recruit good staff in remote settings. Fourth, it is difficult to recruit new GP Partners and this creates problems with succession. This can be managed more easily in larger practices, but small rural practices find it harder. It becomes harder still when you talk about extremely remote areas such as the isles of Scotland. You are not just looking for somebody to join the practice, you are looking for someone who is willing to relocate their family and embrace a new lifestyle. From experience, new recruits to island-life often stay for a few years but find it does not work for their family as a whole and they move back to the mainland.

Primary Care Networks have been good for rural settings.

Primary Care Networks (PCNs) were introduced just under two years ago. Neighbouring practices join to collaborate and cover an area of 30,000-50,000 patients. Overall, the networks are working well. The COVID-19 vaccination programme has shown just how well; 75% of vaccinations are delivered through primary care networks with one practice taking the lead and bringing the others with it. The plan is that PCNs will scale up over the next four years which is good news for rural communities.

PCNs are working well in rural settings. They have brought together practices, which may have barely spoken to each other, to collaborate and share resources. In the process of doing this they have built trust, and in some cases practices have even merged. It is through mergers that you can build in some resilience and grow to a scale where you can provide additional services such as the ophthalmology I mentioned earlier. PCNs have been a positive development for rural communities but there are some problems.

The PCN funding provided a lot of money for additional roles enabling them to recruit for clinical pharmacists, physiotherapists and other health care professionals. The problem in rural settings is that there is an extremely limited supply of those people. In some areas two or three PCNs are competing for the same staff and with a

large amount of funding available there is a risk of creating wage inflation. That just puts up the cost without providing any additional service, or just a minimal increase in service.

Another problem is that when setting up a PCN you ideally want to collaborate with practices with shared goals. It is more difficult to find practices with shared goals in rural settings and some PCNs are fairly dysfunctional because they do not have enough in common. They can also be dysfunctional because when a PCN is dominated by small practices, as practices often are in rural areas, there is no-one to take the lead. Going back to the COVID-19 vaccination programme, one practice took the lead for the entire network and organised deliveries, storage and other logistics. Where there was no practice taking the lead, those PCNs simply opted-out of the programme and communities were left with a hole in the delivery of their medical care. Central delivery was arranged to cover those areas, but there was a delay and it caused headlines about healthcare being a postcode lottery.

Over the years primary care and healthcare policy in general has swung between centralised and localised. When policy is centralised there are calls for more local accountability and responsiveness to local need, so we begin to decentralise. However, in the process of decentralising different local areas will make decisions specific to them and the cry goes up that healthcare is a postcode lottery. So, policy moves back towards the centre. It is not necessarily a problem; it is just a function of how we think about healthcare.

Primary care delivery in the Scottish Isles has a profound implication
on the development and communities of the islands.

Primary care in Scotland is fascinating and over the last decade there have been significant changes. Historically, every island had a full time GP. One island I can think of with a full time GP had 82 people living on it. The cost of that is phenomenal and not sustainable. As a result, we have seen GPs being withdrawn from smaller islands and replaced by a single practice covering a few islands. Coming back to the island of 82 people. The practice that took them on is on an island 20 minutes away by launch. It keeps an unlocked car by the quayside with the keys in the ignition, and clinical staff go across to run surgeries and make house visits a couple of times a week. It is more cost-effective than having a full time GP on an island, but the decision has profound implications for the development of those islands. Taking a GP off an island has been shown to lead to depopulation. Young families will move away and that begins a downward cycle for the island community and economy. We can discuss this in practical terms, but the reality is that when a woman is nine months pregnant in the middle of winter with howling gales, she does not want her doctor 20 minutes away by boat.

Going forward there are some potentially radical changes with the restructure of healthcare. We have got the development of integrated care systems (ICSs) coming up. "ICSs are new partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduces inequalities between different groups" (England.nhs.uk). ICSs have been out for consultations and important decisions about how they work, such as whether they will be integrated horizontally or vertically, will be made soon. There are also still questions around the role of PCNs within the ICS model to be answered.

I am concerned about the disruption introducing the ICS model will cause, but my greater concern is about the skills loss. The brighter people in key posts know their job is going to disappear and they are the first to look for a new job. In the interim they are replaced by acting roles recruited from within the NHS family and over the course of this process a lot of corporate memory is lost, either because people have dropped out of the system or because they are not in the most suitable roles. It will take a few years for the new system to bed down and have the right people recruited into the key roles, but the corporate memory will not be replaced. The

knowledge about why something did not work is lost, so errors of the past are repeated. I hope that the restructure comes through in a way that delivers a better system of health and social care.

Panel Q&A:

Question from the audience: We are hearing a lot about how people are leaving cities in large numbers and moving to the countryside. Will this population redistribution impact on funding formulas and policy?

Andrew Leal: In primary care money follows patients so the money will follow out to the rural setting. The problem will come from the infrastructure. Rural practices are smaller buildings and will struggle with the increase in demand. Changing their infrastructure, such as moving to larger premises, will take a lot longer to put in place. It takes around seven years from starting the process of planning and applications to opening the door.

Graham Biggs MBE: One of the consequences of people moving into rural areas is that it puts up the price of the housing stock even further beyond the reach of local people. Broadband is also needed to enable people to work from home. By the time any gains flow back into funding for general local government services, if more houses are built as a consequence, there will be higher service costs such as for refuse collection. The increase in service costs will largely offset any increase in the general grant as a result of population, and any increase in council tax revenues are offset in the formula too. It is an extremely complicated scenario. The most important point about population redistribution into rural areas is that it pushes up house prices and younger people are still driven to towns.

Question from the audience: What is the impact of inadequate health and social care in rural areas, on a human level and on a business & economic level? Research has highlighted that 88% of under 40s working in rural occupations have mental health concerns and this has a serious impact on the productivity of rural businesses.

Anne Marie Morris MP: There is clearly a link between a community's health and its productivity. That is true for rural and urban environments. When we look at the rural setting where we acknowledge there are problems with support and supply of healthcare, there is going to be an impact on the economy. That said, in rural areas 'community' means something. Those communities put some fuel in the tank to help level up the input into the community resource which enables the economy to grow. We should also not overlook the post-Covid and post-Brexit domestic opportunities. There has been a much greater focus on sustainability and travelling & staying at home; there will be growth in staycations and eating high-quality local produce. We know that we are going to have to grow more of our nation's food and become more sustainable in terms of food supply. Rural communities are at the heart of these opportunities. This ought to be the burning platform we need to argue with government that investing in these communities is not a sunk cost, it will deliver real rewards and return on investment. Investing in rural communities is a win not just for those communities but for UK PLC as a whole.

Rob Verkerk: When we look at the idea of re-skilling some of the health and social care workers in rural communities, we need to train people in looking for health markers that tell us when things start to wrong. AI is one of the technologies we can use for early detection of disease markers so problems can be dealt with before they become too manifest and expensive to treat.

Secondly, drawing attention to Henry Dimbleby's work on the National Food Strategy, it is important to understand the relationship between the food system, sustainability and health status. There are huge opportunities in the post-Brexit and post-Covid environment and now is the time to invest in rural communities. One of things we have historically not done well is to value nature when we invest in rural communities. 85% of the UK is essentially farmland. If we respect the importance of dealing with big issues like sustainability, climate change and biodiversity when we invest in rural communities, 90% of the problem can be dealt with if we improve the use of rural land as carbon sinks. We need to create living soils and diversify these rural environments. Rural communities are unpaid and unvalued stewards of those lands, so we need to change the economic model of how we value nature. We really have an opportunity to bring the rural economy into questions relating to how the country recovers from Brexit and Covid.

Question from the Chair: Where do care homes sit in the rural health and social care infrastructure? And are we reliant on doctors and nurses to deliver healthcare?

Anne Marie Morris MP: Nursing care homes in rural areas have simply died. In my patch in Devon, there is a local area where the community hospital is closing and there is not a single care home left. That is simply not acceptable. It is partly because there has been a drive to wards centralisation since the 1960s and an attempt to remove this sort of provision whether we are talking about health or social care. We need to debunk the concept that beds are no longer needed; beds are needed and their provision needs to move back up the agenda. Nursing and care homes are an essential part of the ecosystem and providers must feel they are valued and belong, rather than just paid for.

For too long we have retained a very rigid definition, description and career structure for those providing medical care. There are some new roles coming into the system such as nursing care associates and associate role within A&E and GP practices. The now roles face two problems. Patients do not recognise the titles or understand the roles and training so feel fobbed off with a lower level of clinician. While addressing this cultural issue, we also need to recognise that we will never be able to meet the level of need with the current model of awfully long training. We need a more layered system of a greater variety of roles all doing different jobs while working together. The NHS is up for the change, the Royal Colleges are up for the change. The patients and some of the clinicians are not.

Graham Biggs MBE: Care homes are incredibly significant features of the rural economy and are a big contributor to the rural economy, particularly given the age profile of those populations. Care staff must be given more respect and valued more; the service they provide is worth more than minimum wage. The seasonal economy in many rural settings mean that hotels, bars and restaurants are competing for the same minimum wage staff during the summer and it simply cannot be right that skilled social care professionals can earn just as much for a less demanding job. The rise of the staycation could lead to seasonal care staff shortages. The priority issues for me are how we support care homes. That comes back to local authorities giving them a fair amount of funding, which in turn goes back to government giving local authorities enough budget to do that. Let us not forget that care homes, particularly in rural areas, are part of the problem of delayed hospital transfers because there are no care places or support at home for hospitals to be able to discharge elderly patients. In 2016/17 delayed transfers were 19% in rural areas compared to 13% in urban areas. Rural areas also see a huge number of older people caring for older people on an entirely voluntary basis. That is not a sustainable situation and local authorities and care home providers need to work collaboratively to develop and fund a model which fills these gaps in provision, and it needs to be realistically costed and funded. We know costs of delivery are higher in rural areas. It is time we got on with it.

Andrew Leal: Care homes predominantly sit within the private sector and the private sector is generally very efficient at providing services where it can make money. Health and social care are recession-proof because even when the economy takes a nosedive the level of demand remains constant. The reduction in supply of social care is all down to funding. Ig the government and local authorities get the level of funding right, existing providers will expand and new providers will move into the sector. Lack of funding is stifling the social care sector.

Primary care is already a long way down the road of patients not always seeing a GP, although less in the rural setting. In urban settings we see a shift towards nurse practitioners, physiotherapists, paramedics, and the new physician associates. A role which benefits from shorter training. There was resistance from patients to start with, but the cultural shift is happening as more and more patients have a good experience. One such example is where paramedics visit frail patients at home instead of the GP. The problems with frail patients are usually quite minor and not a good use of a GP's time. A paramedic is more cost-efficient and so can spend more time with patient whereas a GP would need to rush back to the surgery. The downside is that it ramps up demand among isolated or lonely elderly patients who enjoy the time with the nice paramedics. It is easier for large urban practices to employ paramedics as there is need within their large patient base. For smaller rural practices, it becomes more difficult as they are less likely to need or be able to afford a full time paramedic to make house calls. How do we make the paramedic model work in rural settings? Hopefully, a paramedic can be employed at PCN level to work across multiple practices.

Rob Verkerk PhD: The long-term solution is to reduce the throughput into care homes. Much of the need for care homes comes from elderly patients with difficult to treat diseases and multiple comorbidities. Most of this burden is caused by people's dietary and lifestyle habits. We need to upskill health professionals – and individuals – to address these lifestyle factors early on.

One of the key points today is that health and social care services need to be flexible and local so they can be adapted for the community in which they sit. There is almost a segregation of the elderly and care homes away from communities and in a holistic model of care we would need to reverse that. There are some fantastic initiatives in social prescription and nature prescription where you are looking at greater levels of community interaction (bringing children into care homes for example), music & art therapies and interaction with nature so care homes can be part of the community, rather than isolated.

The Polls

Two polls were taken during the debate to capture the thoughts of local business leaders, policymakers and health & social care practitioners.

Poll One: Would better health and social care provision help revitalise rural communities?

77% Yes
06% No
09% Maybe
08% Do not know

Analysis: Seven out of 10 businesspeople and care practitioners operating in rural locations believe making improvements to health and social care delivery will lead to revitalising rural communities.

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Poll Two: What do you believe to be the number one priority for policy change?

12% Ensuring that patients can get to secondary and tertiary health services.
36% Delivering quality primary health care locally within rural settings.
20% Making sure social care reaches those who need it in remote locations.
32% Benefitting rural clients through improved health and social care integration.

The priorities above have been borrowed from the RSN's *A Fair Deal on Health and Social Care.* For more information on their campaign and template strategy, visit:
https://rsnonline.org.uk/page/a-fair-deal-on-health-and-social-care

Analysis: Opinion is split over what aspect of health and social care policy will have the biggest benefit to rural communities. Delivering quality primary care locally is viewed as a priority by three times the number of people who would prioritise secondary and tertiary care. There is also high demand for a greater level of integration of health and social care services. However, only one in five people would make social care their top priority.