NATIONAL CENTRE FOR RURAL HEALTH AND CARE

National Centre for Rural Health and Care - Response to the NHS Long Term Workforce Plan

NATIONAL CENTRE FOR RURAL HEALTH AND CARE

EXECUTIVE SUMMARY

The National Centre for Rural Health and Care is a membership body exceptionally placed to help address the acknowledged health and care inequalities experienced by rural and coastal communities.

Rural and coastal communities experience significant additional workforce challenges by virtue of their particular circumstances. With growing rural populations and associated ageing and morbidity, rural communities are often distant to services; their hospitals regularly struggle to recruit to characteristically small teams and experience greater costs by virtue of their size. This can lead to less equitable health and care provision.

Rural primary care, whilst also experiencing significant workforce challenges, plays a unique part in supporting the local health and care system, with development of extended skills, an emphasis on generalism, and multidisciplinary integrated working. This enhanced role can and should be harnessed to support health and care provision in rural communities.

Place-based solutions which involve communities in **redesign**ing the workforce to meet their particular local needs should be actively supported by regional and national bodies. Generalist skills, extended practice and competency-based teams will need to be at the heart of approaches across both primary and secondary care.

The geographical narcissism that has viewed rural clinical practice as inferior to its urban counterparts must be addressed through **train**ing, with development of Rural Clinical Schools which recruit from local communities, links to (or creation of rural) academic campuses, 'in-reach' attachments, universal opportunities for rural experience, and potential for additional rural qualifications. Special rural GP training programmes will promote the opportunities as a rewarding career. Widened access into medical professions that consider rural needs will ensure sustainable success. Appropriate training facilities and training, support and recompense for tutors are essential. Shared-learning, flexible working practices and peer support including use of comprehensive clinical networks will all be important in **retain**ing health and care professionals in rural areas.

Dental access needs particular attention with consideration given to the potential for redistribution of longitudinal integrated training programmes and further development of a multi-professional dental workforce with associated rural training opportunities.

Use of technology has proved a significant enabler in improving access to health and care in rural as well as other areas and can be further harnessed so long as attention is given to issues of connectivity and the digital divide experienced by some groups.

Whilst national approaches are clearly important, we believe that more local level devolution and planning will be necessary to enable a more nuanced response to rural workforce challenges.

We would propose that as part of national 'Next Steps' arrangements a Place-Based workstream be established to support implementation in specific geographical and other contexts such as (but not exclusively) rural communities. We would be pleased to advise and provide expertise from our organisation, members and via our wider national and international networks to aid this and ensure that the excellent opportunities outlined in the National Workforce Plan are fully realised for rural and coastal communities.

1. INTRODUCTION & PROPOSAL

The National Centre for Rural Health and Care welcomes the NHS Long Term Workforce Plan for England, June 2023 and would like to offer support to its implementation.

The National Centre is a representative body with a core membership of Trusts, Local Authorities and Voluntary and Community Bodies from across England and structures its work around four core themes of workforce, data & insight, technology and research. Recent activity includes providing the secretariat for an All-Party Parliamentary Group Inquiry into Rural Health and Care and the development of a Rural Proofing for Health Toolkit. It is currently engaged in the partnership development of an innovative approach to clinical research, social care innovation and enhanced provision of primary care services at the Campus for Future Living exemplar project in the rural area of Mablethorpe.

We commend the Workforce Plan's proposals in terms of the overall ambition and the principles on which this is to be pursued, particularly in this context, welcoming the recognition of the increasing burden of disease in rural areas and commitment to address geographical inequity in training distribution.

We suggest, however that the unique circumstances of rural and coastal communities need further understanding and specific attention if we are to be successful in not only addressing their challenges, but also harnessing the very real opportunities that rural teams can offer to the wider health and care workforce.

We would propose that as part of national 'Next Steps' arrangements a Place-Based workstream be established to support implementation in specific geographical and other contexts such as (but not exclusively) rural communities. We would be pleased to advise and provide expertise from our organisation, members and via our wider national and international networks to aid this.

2. CONTEXT

A. Rural Issues & Challenges

The rural population has been growing: 21% of the population now live in Predominantly Rural areas (2021 Census) – some11.7m in 2021 compared to 9.1m in 2011. More people live in rural areas across England than live in the whole of Greater London.

There has been a 27% increase in the 65 years and over age group (Census 2011 to 2021) in Predominantly Rural Areas - meaning this age group now accounts for 24% of Predominantly Rural population (increased from 20% in 2011). This age group represents 16% of the Predominantly Urban population.

The APPG inquiry into rural health and care which concluded in February 2022 identified the following key distinctive characteristics of rural communities:

1. **Ageing population**: rural areas have a disproportionate number of older people leading to higher levels of morbidity and consequent demand with more complex and costly interventions often required.
2. **Mental health**: isolation and loneliness can heighten mental health issues in rural areas, also noting the limited data available on rural mental health
3. **Distance from services**: in general, people in rural areas need to travel further to access care and often experience reduced access to specialist provision and emergency services. With poor public transport infrastructure, unlike in urban areas car ownership is a necessity not an indicator of affluence. Poorer rural broadband and mobile phone connectivity exacerbate this situation. For example, 39% of rural premises in England have Gigabit capable fixed broadband coverage from at least one operator. The percentage is 78% for urban.
4. **Housing**: issues in rural communities such as the cost of housing, prevalence of older poorly maintained and inefficient properties, fuel poverty, and older populations living alone increase vulnerability to poor health and chronic illness.

5. **Cultural and attitudinal differences**, combined with remoteness from specialist provision, can lead to rural patients seeking medical help late. Rural poverty and deprivation are linked to lack of confidence and aspiration but too often pockets of severe deprivation are hidden within areas of relative prosperity.

Analysis has shown that if all the rural areas across England were treated as a single Region it is that 'region' which has the greatest need for 'levelling-up' using the Government's metrics.

Many remote rural and coastal areas are synonymous with the term 'medical deserts' a metaphor which is gaining significant global traction. This concept describes areas with inadequate access to healthcare due to a diverse array of barriers - not just reduced workforce but also health and social care facilities, transport issues and other socio-cultural barriers.

More information about the distinctive nature and challenges of rural areas is set out in our response the recent major conditions consultation as an Appendix to this report.

B. The Unique Role of Primary Care

The focus for health care must be fundamentally based on primary care where 90% of the interactions take place. As noted by Barbara Starfield a nation's health outcomes are predominantly dependent on the quality of its primary care.

The role of General Practice is even more crucial in rural settings where the alternatives of A&E, urgent care centres, pharmacies and dentists are less readily available – a disproportionate additional burden falls on our rural primary care teams. As a result, these teams must provide a wider range of services and skills than their urban counterparts.

We believe that enhanced primary care is key to sustainable healthcare provision for people in rural settings. Effective care must be delivered by multi-professional teams trained to meet rural needs. Enhanced services are vital, ensuring that staff can be trained, given recognition and recompensed for their provision, and that there is the right primary/community estate available from which they can operate.

We also recognise the hugely important role of community services and the benefits of closely aligned skills and expertise with primary care. Any workforce developments should take account of the wider team requirements to ensure effective use of blended skills as highlighted in the recent Fuller Stocktake Report.

C. Secondary Care Workforce Challenges:

Rural and coastal NHS Trust providers often face unique workforce challenges, which manifest themselves in unfilled posts and temporary staffing approaches creating a vicious cycle of recurrent recruitment and retention difficulties.

More widely in terms of secondary care the following challenges predominate in rural health systems:

- Smaller team sizes due to serving smaller populations compared to urban areas leading to:
  - Onerous and unattractive rotas
  - Less peer support and potentially more team dynamic tensions
  - Reduced case mixes which are less interesting for hospital clinicians
  - Consequent reduced opportunities to sub-specialise.
  - Reduced access to in-area training opportunities

- Reliance on locums and other temporary staffing solutions leading to:
  - High staffing costs which result in over-expenditure
  - Poor continuity of care resulting in a worse experience for patients
  - A diminished sense of being a 'team' for substantive staff.
  - A lack of familiarity with team/Trust policies and procedures engendering greater potential for negative impacts on care quality and adverse incidents
  - Diversion of both clinical and managerial resource and energy into managing shifts/filling rotas
  - Reduced levels of the leadership necessary for service improvement and staff cohesion
  - Reduced staffing available for supervision and support of students and trainees (including Apprentices in the future) this can result in trainee absence which further impacts on workforce and costs.

- The following characteristics of rural setting also distinctively impact the health and care workforce:
  - Higher costs and reduced availability of affordable housing (including rental)
  - Increased travel costs to/from work.
  - Higher costs-of-living.
  - Less opportunity for career progression without relocating.
  - Reduced employment opportunities for partners.
  - Reduced access to education options for children and young people of all ages.
  - More limited leisure and social opportunities.
  - More limited broadband and mobile phone connectivity.

Small hospitals require staff to develop generalist skills unlike their larger urban counterparts. As things stand there is little provision for generalist training in secondary training programmes in England.

It is generally acknowledged that small rural NHS health care providers face higher costs than their larger urban counterparts. A NCRHC report by the Nuffield Trust in 2019 noted that "those trusts which are unavoidably small due to their remoteness generally have high-cost pressures, longer waiting times, more delayed transfers of care, higher average unit costs and a worse financial position. Of the seven most remote rural hospitals in England, six are in deficit": these 3% of all trusts accounted for 23% of the overall trust deficit in 2017/18. The report's author Professor John Appleby recommended a re-examination of the true scale of costs and approach to funding allocation.

D. Primary Care Workforce Challenges - and Opportunities

Challenges exist well beyond secondary care: in recent years primary care has experienced significant recruitment and retention difficulties for GPs and other members of the primary care workforce with rural and inner-city areas particularly affected. This equally impacts on dental services, where a BBC report identified there are only 8.6 dental practices per 100,000 population offering NHS access, compared to 10.1 in urban areas.

Workforce challenges seen in secondary care can however become opportunities in primary care when there is a full supporting primary care team and good supporting community networks, making rural general practice potentially extremely rewarding.

Smaller list sizes tend to improve continuity, and the small teams (when comprised of permanent staff not locums) lend themselves to innovative solutions with a focus on extended skills, emphasis on generalism and multidisciplinary working with integration across physical health, mental health and social care. These opportunities need to be harnessed, not only to support rural communities but also as a testbed for all health and social care provision.

The reminder of this document proposes context-specific solutions to these challenges:

3. REDESIGN/REFORM

A. Place-Based Approaches to Workforce Improvement

The NHS is a huge system which can often be 'place blind' despite best intent, and which lacks an appreciation of the granularity needed to address the challenges facing individual places – not least our rural areas. Indeed a 'big is beautiful' mentality often unwittingly drives health inequalities. The ongoing split between health and social care exacerbates effective planning and delivery. Training across the NHS has always been generic in nature rather than targeted at specific areas of need.

There are many innovative solutions which we might apply and a huge amount of international good practice which can and should inform future policy development focused specifically on rural places as the antidote to this situation.

Integration can begin to make a difference at the local level where:

- Measures and drivers of health inequalities are collected and can shape decision making at a much greater level of granularity than currently, based on a nuanced understanding of the importance of place.
- Partnerships can be brokered in terms of the distinctive challenges facing rural communities in terms of housing, education, transport, and social care as part of a holistic approach – with a focus on prevention through better multi-agency working.
- A meaningful commitment to rural proofing can be embedded in the design and delivery of services to plan for impactful delivery and monitor if the plans are working in different geographies.
- A local rural technology health and care strategy and platform can be developed to, where possible, enhance access to services (albeit technology should be seen as a means and not an end in this agenda)
- The voluntary and community sector is far more involved in the provision of particularly preventive health and care services, which must also be appropriately funded.

Work with the Royal Colleges and NHS England to review the match between the existing health and care professional structure and the skill needs of rural areas is essential. This should be done with a view to deploying a wider variety/diversity of health and care professionals, with more nurse practitioners, physician associates and pharmacist independent prescribers operating in rural communities.

At the heart of this workforce agenda there should be a commitment to hard-wire generalist skills training across the medical and other clinical professions and in the remotest areas a far heavier emphasis given to the "see treat" concept.

In summary: radical and disruptive approaches which put more emphasis **on primary care, multi-agency working and community ownership, in an environment which accommodates at least some appetite for risk** are important.

We see evidence of a focus on these issues within the Workforce Plan but not to the intensity or specificity we believe is necessary.

We believe the rural context is so distinctive that there is a strong argument for people living in rural settings to be treated with the same level of focused concern as other groups with protected characteristics. This is due to the impact distance from facilities has in driving health inequalities for rural dwellers particularly those in remote coastal settlements which are literally "at the end of the line" in terms of their position and access to services.

B. Community Involvement

Whilst there is little reference to the role of communities in the Workforce Plan international evidence stresses the importance of community engagement and emphasis on a bottom-up approach to developing workforce models in rural areas dependent of the diversity that exists in rural and coastal communities. In the words of Professor Roger Strasser (University of Waikato), "**When you have seen one rural place, you have seen one rural place**".

Rural communities have a crucial role in shaping the future workforce and it is important to they are engaged especially when hosting health care students and helping to retain a rural workforce.

C. Generalism, Extended Practice and Competency-based Teams

Rural general and hospital practice both require a broader scope of practice and range of skills given the less immediate support from colleagues compared to urban areas.

Generalism focuses on seeing the patient in the context of their family and wider environment; whilst this is of course important in all care the particular role of the generalist is to provide holistic care – as opposed to specialists who have expertise and necessarily focus in on relatively small areas of care.

Medical care has tended to become increasingly specialised but there is now an understanding that in isolation this is not always helpful and may result in at best fragmented and at worst contradictory care. Where patients have multiple conditions which is often the case in older

populations it is important that a holistic approach is taken, with shared care co-ordinated between a range of professionals.

Generalist skills are particularly valuable in rural practice where access to more specialised care may be delayed, allowing patients to be competently managed by a generalist - in primary or secondary care – with a broader range of skills such as mental health, public health, emergency medicine and dermatology.

In primary care, an increasing emphasis on rural generalism will see GPs developing skills in a wider range of specialisms that can help tackle workforce shortages and bring care closer to where people live.

The Australian College of Rural and Remote Medicine (ACRRM) defines a Rural Generalist Practitioner as one "who is trained to meet the specific current and future healthcare needs of rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialties".

In secondary care, general physicians traditionally took more a holistic approach but in an era of specialisation these secondary care roles have been gradually disappearing; 'care of the elderly' physicians have partially stepped into this breach albeit that care fragmentation is not just an issue for older people. With specialties only available at more distant hospitals, an extended range of skills can be essential in both emergency and planned care setting.

In some rural areas dual trained doctors have been essential in maintaining local services. In others, 'composite team' approaches have been taken to ensure services can be maintained, with skills and competencies within the multidisciplinary team although not necessarily all individual team members.

The concept of extended practice includes nurses and other health care professionals as well as doctors and the focus on nurse practitioners, physician associates and other "shoulder professions" within the Workforce Plan is thoroughly welcomed. Based on the experience of health care provision in other international settings a move away from rigorous professional boundaries and an increase in the number of roles which appeal to a wider range of people in terms of age and second career options significantly increases the scope for rural settings to develop a bigger stock of health care professionals to address local need.

One way to support the development of extended skills and generalism would be to develop a voluntary credential process for doctors and nurses working in community hospitals. This could be developed using the principles of the "Rural Generalist Programme" in Australia.

4. TRAIN

A. Expansion of Medical School Training Places

We would like to see a process whereby the proposed planned expansion is focused at least in part on addressing the challenges of the supply of doctors in rural settings.

Marlin Fors (Finmark, Norway) coined the term "Geographical Narcissism" to describe the urban prejudice that has ensured that rural has always been regarded as second rate. It is essential if we are to address rural workforce issues that this misconception be thoroughly dispelled, and this must start with students viewing the opportunity to train in rural areas as an asset to their future careers.

There is significant evidence at an international level that the recruitment and training of individuals from rural settings leads to better engagement and retention as part of the rural workforce, post training and this should be factored in as an issue in the expansion of training programmes. This could include the following:

- Engage with rural secondary schools, providing health related work experience, academic support where necessary and an understanding of the health and healthcare systems. Local and medical and nursing students can provide some of the direct support and teaching.
- Designate some Medical and Nursing Schools as Rural Clinical Schools to serve underserviced rural areas with a mandate to recruit local rural students.
- Identify and advertise more rural and coastal areas as academic campuses - as has been achieved in Keele and Mid Wales, and as planned in the University of Cumbria and Imperial College London initiative. The Lincolnshire Campus for Future Living referenced earlier could develop over the years into a more structured entity. There is significant good practice in this regard to draw on from Australian rural clinical schools and in Scotland with SCOTGEM.
- Consider offering an additional rural qualification alongside basic training.
- Ensure that some of the teaching and training provided (undergraduate and postgraduate) involves joint learning to promote the fact the 'learning together promotes better working together'.
- Redesign training programmes which are clearly advertised and recruited into rural areas with links to academic centres. This 'flipped model' would distribute training capacity, provide immersive training opportunities within designated rural settings and deliver curricula requirements without impacting on quality of training. Academic linkages between rural and urban centres would relieve pressure on local clinicians, drive technological

adoption of virtual learning whilst ensuring trainees are provided with a blended support package.
- Ensure sustainable rural undergraduate programmes refocus on attachments being 'in-reach', rather than 'outreach', experiences to ensure students appreciate the added value of these placements.

All medical and nursing students should have the opportunity to experience rural practice, but investment will be needed in rural accommodation, the physical estate and a preceptor/tutor in every setting/practice to create the necessary capacity. This will require innovation and changes in programme design and delivery, for example, rural preceptors should be offered university positions with encouragement to undertake Masters' qualifications. However, the core principle is to ensure all trainees, regardless of field, acquire experiential knowledge and skills, which include rural settings.

The 'Blueprint for Rural Practice in Europe' makes an exceptionally strong case in this context, and the engagement in the experience of General Practice can only be a positive from our perspective, particularly as we have evidence that where medical professionals engage with rural settings, they develop more insight and potential long term professional commitment to working in them.

EURIPA (The European Rural and Isolated Practitioners Association) produced the Blueprint as a response to the deteriorating workforce issues across Europe and the expansion of medical deserts in many countries. The Blueprint provides a broad view of solutions based on the needs of its members and the extensive rural evidence from Australia, New Zealand, the USA, and Canada.

B. Internship & Apprenticeship Training Models

We have some concerns regarding the apprenticeship model which is as yet untested in medicine and may take some time to be incorporated into medical training with the appropriate GMC approval. However, the broad principle of widening and rebranding access routes into key medical professions, should it be effectively managed to take account of the specific needs of rural communities is welcome. We recognise the potential that apprenticeships could bring to encourage new recruits from diverse backgrounds to develop their skills and careers though this will depend on the careful crafting and delivery of each programme.

We believe very strongly that based on commissioned research from the University of Birmingham (Rural Workforce Issues in Health and Care) broadening the scope and points of access into medical training for people considering second careers with the ability to study both more flexibly, will increase the number of people from rural settings participating in medical training and being retained in the rural medical workforce. The move from 5/6-year degree programmes to four-year

courses incorporating medical internship could support this ambition, although further detail is required.

C. Increasing the Number of GP Training Places

The removal of the Minimum Practice Income Guarantee and the relatively limited effectiveness of the Enhanced Recruitment Scheme which effectively offered a premium to those working in rural settings shows the need for a more structural and framed approach to creating a satisfactory rural GP agenda that addresses the primary care recruitment and retention challenges

Significant effort is needed to recruit experienced practitioners as trainers. In general GPs are keen to be involved but the most significant barriers to increasing the number of trainers in general practice are:

- The significant workload demand on general practice. Practices must be given paid protected time to achieve this.
- Expansion of the extended workforce has led to pressures on the estate, resulting in limited space for GP registrars.

There should also be a greater emphasis on community engagement in the recruitment and support of GPs.

We are told that prospective GP Trainees/Registrars are not keen to undertake a rural career and would prefer to stay in urban settings. International evidence points to 3 factors that impact on rural recruitment and retention. These are:

- Choose students from rural areas (Grow your own)
- Provide significant rural experience at an undergraduate level.
- Create special rural GP training programmes.

Although attempts are being made to address the first 2 areas, it is significant that no rural training programmes exist. A generic approach based on urban centred training will always set a preference for later career choices. Rather than portraying a negative image of rural, a programme providing the extended skills needed and the lure of working in a beautiful rural setting with access to the great outdoors should make the opportunity attractive and at the same time provide the skills needed to practice in a different challenging environment.

D. Increasing Nurse Training Places

Meeting the unique challenges of rural areas, in terms of affordable housing, peer support, and potential social isolation are key to increasing the number taking up nurse training places.

The key issues raised by Dame Ruth May in giving evidence to the parliamentary inquiry are at the heart of the challenge of achieving this huge new target: Dame Ruth identified that urban areas are often the main attractors for nurses, albeit that she believed it is easier to retain staff in rural settings.

Dame Ruth also identified a distinctive profile of rural students many of whom are mature. The lack of the cost-of-living allowance makes it difficult for mature students to participate in training who often have more extensive cost commitments.

The importance of nursing to rural health care cannot be over emphasised. The Albuquerque Statement on Rural Nursing was produced at the 2019 WONCA, World Rural Health Conference. The statement pledges:

- support the rural and remote nurse and midwife voice by inviting nurses and midwives to participate in decision making and leadership.
- promote the importance of generalism in nurse training and practice.
- promote collaboration in reviewing Rural WONCA's mandate, to further promote nursing and midwifery inclusiveness.
- actively embed research and data collection to demonstrate a better understanding of the value of rural and remote nursing and midwifery and of nursing and midwifery led care.
- actively promote full scope of practice in rural generalist nursing
- support an integrated patient and family centred, team-based care that addresses community needs.

5. RETAIN

Continuing professional development, peer support and career opportunities are key to retaining staff whilst as noted above retention can be less of an issue in rural areas, it is essential to maximise this given the relative difficulties with recruitment, particularly for medics. Key themes include:

- Clinical Networks – which are important in providing ongoing educational as well as peer support to potentially isolated substantive post-holders, their development across the range of

specialties/professions should be encouraged and actively facilitated through the ICB Provider Alliances
- Flexible working - we wholeheartedly welcome the commitment to the development of more flexible working as a key means of delivering a more robust and effective achievement of services in rural settings.

A. Shared Learning

The work of the Cumbria Leaning & Improvement Collaborative (CLIC) which promotes and enhances multi-agency approaches to health care delivery through innovative CPD arrangements is a key exemplar. It provides a very potent example of how along with the principle of enhanced generalist working, health care services in rural settings can be made as effective as possible taking account of the challenges linked to low density of population and distance from main service centres.

B. Dental Services

The acute lack of NHS dentistry in rural settings is one of the most profound examples of health service failures faced by rural dwellers. Whilst the proposed postgraduate tie in period might have some influence in addressing this challenge, a far greater system change to the resourcing and location of NHS dental services is needed to reverse the current lack of access.

Delivery of dental services is almost entirely through primary care commissioned services. However, the current funded under- and postgraduate training programmes are delivered predominantly within secondary or tertiary care, which doesn't adequately prepare for independent practice in isolated rural areas. While we acknowledge this is a complex issue with no simple solutions, redistribution of longitudinal integrated training programmes into rural settings is a potential option to explore.

A refocus on developing a multi-professional dental workforce is essential, as this could rapidly expand the rural provision, Reviewing the opportunities at rural universities for Dental Hygiene, Therapy and Technician training programmes, underpinned by adjusted offers to encourage applications from widening access / widening participation candidates from local communities.

C. Technology

Digital approaches can potentially improve the experience of patients in a wide range of contexts, including remote appointments, care co-ordination, multi-disciplinary working, and virtual discharges.

Social media, videoconferencing and mental health apps can help address isolation and loneliness and improve well-being. A particular benefit of technology in rural areas is improving access to services, where local availability or travel distances would otherwise cause difficulties. The lack of a critical mass of users / organisations in rural areas, however, may militate against the development of rural focused digital products.

The pandemic enabled greater innovation in relation to regulation in the context of technology and the NHS Digital representatives who attended the Parliamentary Inquiry indicated that this environment was more conducive to more effective service delivery. It would seem highly likely that more technological innovation could contribute to the enhancement of the skills and knowledge of people working in clinical settings. The ability of technology to overcome distances and to provide training and supervisory support on a remote basis provides real opportunities to enhance the functioning of the workforce in rural settings. Incorporating formal digital readiness into programmes could introduce the benefits for all parties, encourage remote monitoring and virtual wards in rural areas.

Poorer broadband and mobile phone connectivity, especially in hard – to- reach areas will hold back such improvements until rectified. We acknowledge there is progress to transfer parts of the UK rural areas from wire to fibre networks that will increase both access and stability of broadband services, however this may not narrow the inequalities divide if vulnerable and low-income households are unable to access appropriate hardware.

Digital solutions are key to improving access to health care and meeting some of the inequalities mentioned earlier. However, it is important to note that digital interventions are tools rather than solutions and rural communities need access to face to face interactions similar to those available in urban communities.

D. Proposed Place-based Workforce Approach

Whilst national approaches with some scope for adaptation to take account of the challenges and opportunities associated with rural settings are clearly important, we believe that more local level devolution and planning will be essential in enabling a more nuanced response to workforce challenges.

Greater devolution of decision making to enable ICBs to really shape their service offer in a way which relates to the specific needs of their communities would put place-based planning at the heart of service delivery. It would involve less central regulation and less central reporting. It would involve a more intensive joining up of services outside of the traditional envelope of the NHS agenda, including more co-design and delivery of services with the VCS sector.

It would involve ICBs taking well thought through risks in developing models which respond to the workforce challenges facing rural areas around innovative models of multi-agency working.

6. CONCLUSION

The National Centre for Rural Health and Care has a pivotal role as the recognised representative of rural stakeholders in England with unique expertise in this area. We would welcome the opportunity to assist NHSE in supporting place-based approaches to workforce improvement in rural areas.

References

In addition to the hyperlinks in the document the following references may be of use in helping frame the wider and particularly the international context for the rural insights associated with the implementation of the Long-Term Workforce Plan.

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https://www.academia.edu/94066265/It_takes_a_community_to_train_a_future_physician_social_support_experienced_by_medical_students_during_a_community_engaged_longitudinal_integrated_clerkship

APPENDIX

Rural context (needs and characteristics, social and environmental circumstances) – NCRHC response to the NHS Major Conditions Consultation.

In rural areas there is a very strong connection between other major social, environmental, and economic issues, such as quality and availability of housing and the nature of employment, when it comes to the quantum of demand for health services. Respiratory illnesses are influenced by housing conditions and type of employment.

Because of the older age profile of rural areas long term conditions have a greater incidence in rural areas. This is also reflected in a higher prevalence of co-morbidities. The proportion of older people is growing more rapidly in rural areas than is the case in more densely populated communities.

The NHS funding formula partially reflects the older age groups in rural areas, but this is not then acknowledged through the way in which urban centralisation dominates the way in which services are delivered. That said the funding formulae for both the NHS and Social Care (through the local government funding formula) are not fully reflective of the whole range of factors which impact on the costs of delivering services to rural populations and the disproportionate impact that people living in rural deprivation has on health and social care demand. In short, the true cost of ensuring that people living in rural and coastal communities have equal access to the same level of care as the rest of the population is not reflected in the level of funding.

Both primary and secondary service configuration is based on an urban model of delivery which is singularly inappropriate and inefficient in rural and coastal settings. The population profile and socio/economic factors in rural areas also means there is a paucity of younger family relatives who can offer informal caring and support. Moreover, voluntary organisations tend to be less well resourced and co-ordinated.

The structure of care in rural areas has a strong emphasis on primary teams & public health, coupled with a much more tenuous connection to secondary and tertiary acute services. A consequence is that there is limited health care estate, and less critical mass within the system overall. The increasing centralisation of secondary care has reduced access for those living in rural and coastal communities.

Whilst there may be greater emphasis and reliance on primary care in rural areas, the ability to recruit and retain appropriately qualified personnel is even more difficult than in more densely populated areas. An additional constraint is that fewer career paths are readily available for partners, housing is more expensive, and one or more reliable vehicles is essential. It may be uncomfortable to raise the issue here, but medical, nursing and health professionals also raise concerns about access to quality post-16 education in some rural areas.

Some of the technological back-up for primary care, eg. diagnostics and telecare, is limited in rural areas either because this has been consolidated in urban centres or as a result of limited connectivity.

Digital connectivity in rural areas, both broadband and 4G/5G, still lag well behind urban areas in capacity, if they exist at all. They are likely always to be behind the 'cutting edge'. It will be very important either to invest substantially in this or ensure that the major conditions strategy does not make assumptions about availability that cannot be realised in practice.

People who live in rural areas are used to making the 'trade-off' between the benefits of living in a rural area and easy access to large scale infrastructure, such as major hospitals. There is, however, more scope than is often supposed for an intelligent dialogue with rural people about the balance between receiving the highly specialised services and the potential need to travel further to access them and receiving less specialised but high-quality services locally.

Health disparities/inequalities are highlighted in the consultation as one issue that needs to be addressed in the strategy. It is very important from a rural perspective that intra-regional disparities are given as much weight as inter-regional ones, as they can be just as great if not greater.

This fact is often overlooked because of the "averaging" impact of comparing large scale populations with each other and combining rural and urban in population analysis, rather than looking at urban and rural separately. Just as the planning and delivery of health and social care is based on a model designed for people living in concentrated populations, so too are the formulae for measuring disadvantage in rural areas.

Tackling the burden of 'major conditions' is not just an immediate issue that should be addressed in the proposed Strategy, it is also a longer-term public health matter as well. In general and perhaps surprisingly, the public health indicators in childhood and adolescence are worse for those living in rural and coastal areas than for those resident in towns and cities. These indicators often translate over time into the ill health challenges reflected in the identified major conditions. It is essential, therefore, to invest now in the public health, prevention and health promotion measures that will mitigate against avoidable demand in the longer term.