

Rural Workshop on Health & Health Services
GOWM
22 May 2007
Report

Present: David Howatson (Chair), Rev. Nick Read, Rowena Clayton, Alec Kendall, Jon Cooke, Zena Lynch, Jane Randall-Smith, Helen Porter, Carol Johnson, Sara Roberts

Apologies: France Howie (Herefordshire PCT), Claire Robinson (AWM)

Welcome and Introductions

David welcomed everyone to the meeting and introductions were made. A particular welcome was given to the Institute of Rural Health representatives as they had been commissioned to draft the West Midlands Rural Affairs Forum (WMRAF) consultation response to the Regional Health & Well-Being Strategy.

Rural Proofing – the Purpose of the Meeting

David outlined the rationale for the meeting - the need for rural proofing regional policy and strategy, both during the development and implementation stages and welcomed the early opportunity to systematically rural proof the region's two health strategies. Rural areas have different needs by virtue of their geography and their proximity to services. We need to assess the impacts and, if necessary, make suggestions as to how the strategy may be adjusted in order to meet particular rural circumstances and needs.

Presentation of regional statistics: See Appendix 1

David illustrated the regional differences through a series of slides:

- Rural Area Type – relating to remoteness, transport infrastructure and difficulties of travelling E-W, and in terms of economic output.
- Population – Rural 80, Rural 50, Significant Rural, Other Urban, Large Urban and Major Urban; noting that, in contrast to Cumbria, the whole of the rural area is populated.
- Population Split – 5.3 million, 80% rural; with four times more people in the accessible rural areas than the remote rural areas.
- Ageing Population and forward projections – Over 65s at present 13-26% in the Shire Counties potentially rising to over 50% by 2021.
- Single Pensioner Households – currently 13-15% but potentially rising to over 50% by 2021. The changing demographics and the demands of these people will present considerable challenges.
- Permanently Sick & Disabled – lower % in rural areas but more dispersed and access to services becomes a greater challenge.

Strategic Framework for NHS West Midlands – Investing in Health

Presentation: See Appendix 2

Jon Cooke, NHS West Midlands, introduced the draft document which would be presented to the SHA Board at the end of the month prior to it being released for wider sector engagement.

Discussion:

- What was the link between the NHS West Midlands Strategy and the Regional Health & Well-Being Strategy? They are very much dependent on each other with a number of direct links. With full engagement there are opportunities to bridge the gap – back to the NHS Strategy and their focus on investment. The focus in the Health & Well-Being Strategy is on “wellness” and very much reliant on the individual, encouraging them to take responsibility for their own health, leading to reduced demand on the health services and therefore reducing costs and strain on the service.

- Acute hospitals may be viable at sub-regional levels but are dependent on a vibrant and efficient range of primary and community-based services. Hereford Hospital was cited as an example where something different will have to be agreed– it has a huge catchment, catering for areas of Shropshire, Mid Wales and the county itself. A&E, high risk obstetrics, paediatrics, etc are expensive to provide but do need to be retained. The volumes of activity and throughput also pose problems in terms of “flying hours” – providing staff with sufficient training and practical experience to maintain high-level competence. The solution is around networks of providers and staff needing to be exposed to busier places and specialisms.
- For specialist care, people will have to travel; creating considerable problems for patients, family and friends. The paucity of public transport and travelling times (a tremendous and often hidden problem) all exacerbate the situation – often to the point in rural areas where people just “give up”.
- There is very little evidence re- travel time; it may be fine for people travelling by car but for those without it is a serious challenge. It is not the distance but how the transport works. There are thus important messages around transport and transport infrastructure to the planners, perhaps as part of the Regional Spatial Strategy Phase II and Phase III Revision.
- Living in rural areas imposes greater challenges in terms of the significance of risk. Achieving equity is impossible and therefore more guidance is required informing people of how they can help themselves, e.g. healthier lifestyles, more exercise, or more and better IT and alternative access solutions. Managing people’s expectations is important and better communication is recommended.
- Translating the Hereford situation to other rural areas in the West Midlands, raises issues around the quality of the health services and staff competence – sending out a message to people that their service maybe unsafe and is impossible to sustain effectively.
- Local authority and health funds are under huge pressure and a Public Service Trust, c.f. that proposed for Herefordshire, may provide a solution. Shared care arrangements with four levels of shared care designations would help provide care closer to home. N.B. Wychavon has acted as the developer for their PCT Hospital.
- Public Service Trusts should be urged to offer a better set of opportunities and joined up planning to link community hospitals with local authority services, e.g. health & leisure services.
- Rural areas cannot realistically expect the same level of health care as urban areas or for those closer to the conurbation. Below a catchment population of 10,000, services are less and less viable.
- Public transport is not a solution for sick people.
- Rural people will always seek and flow towards more convenient pathways
- Important how you engage local people and brigade their help in finding local solutions. Regional partners – GOWM, WMRA, AWM, WMRAF should identify how best to take some of this forward.
- Administrative boundaries should not create barriers, but they do. Cross border opportunities should now improve between Wales and the West Midlands with the signing of the Memorandum of Understanding. NHS West Midlands were urged to talk to their Welsh counterparts given the very serious anomalies that currently exist for the adjoining rural communities, e.g. prescription charges, waiting lists, levels of health care, etc.

Regional Health & Well-Being Strategy – Draft

Presentation: See Appendix 3

Rowena Clayton, Department of Health West Midlands, introduced the draft document which is currently out for consultation until July 11 2007. This was discussed chapter by chapter in conjunction with the draft Rural Commentary that had been prepared [See Appendix 4].

Discussion:

- The draft strategy has been drawn up under the auspices of the WMRA and approved by the Regional Health Partnership. It has been designed to sit alongside the SHA's NHS Framework being very people oriented and making connections with other strategies and strategic priorities at regional and sub-regional levels. It is very much an "inspirational" document reflecting issues and solutions over which the Partnership may have little control but provide a context to engage, influence and convince other partners to deliver.

Planning Transport & Health

- Reduce social exclusion and promote independence through improving public and other transport links; public transport alone is not the answer.
- The importance of the West Midland Spatial Strategy for rural areas – not just access to critical rural services but opportunities to build more health links to healthy and sustainable building for the future.

Housing & Health

- Provision of affordable housing – considering the exacerbation through out-migration, problems with land supply, and the difficulties in attracting sufficient "exception sites" for farmers and rural landowners. This affects the social cohesion of rural communities and the links to outward migration of young people.
- Currently there is insufficient appetite/incentive for the supply of building land for affordable housing in rural areas. Land supply is crucial as is the encouragement of more social landlords.
- Those people that settle in the countryside in search of the rural idyll do not have exclusive right and should not prevent others moving in.
- Reduction of energy costs through better insulation and other energy saving solutions – rural areas having fewer options with regards to energy supply.
- Improving the older housing stock – prevalent in rural areas and not easily improved.
- The WM RSS sets the number of houses but needs to consider their strategy in terms of sustainable and balanced rural communities with regard to care provision.

Environment & Health

- Making closer links with the environment showing how people can improve their health – making the connection through healthy eating and sustainable food and farming solutions supplied by the region's rural areas.
- More about addressing the affects of climate change and the health impacts that are facing society.
- Sustainability Environmental Assessments (SEAs) helping to show how much rural areas can contribute over and above urban ones.
- The countryside offers wider recreation space and is a considerable amenity to the urban population.
- Initiatives such as the Wye Wood and Wider Wood Projects have a track record for getting more involved in woodlands and health – fostering greater social inclusion and improving mental and physical health.

Economy & Health

- Being employed is healthier than not being employed. Improving the support and infrastructure of rural businesses is important.
- Without the influx of migrant workers and them carrying out low-paid agricultural and horticultural tasks the sustainability of many rural communities would be lost. Despite a degree of exploitation, they are vital for the economy.

Culture, Physical Activity & Health

- Rural communities often are less active – less walking and less exercise than their rural counterparts.
- Rural churches and faith groups make a vital contribution to the social capital and culture.
- Commission for Rural Communities (CRC) have carried out research into the vibrancy of rural communities. The voluntary sector often provides the vehicle for providing both physical activity and culture. However, the changing demographics and ageing volunteer workforce has the potential to erode the social fabric of rural communities.
- Making better use of the Public Rights of Way networks – a huge under-used public facility - getting them used by a greater number of local people and getting people out of their cars.
- Marketing local areas for local people – this will help to contribute to economic targets too.
- Rural sports facilities are invariably located in towns. There is a need to build the provision of accessible sport and leisure facilities into the LAAs.
- Finding the gatekeepers is key; PTAs, Healthy Schools, Guided Walks, Voluntary and Community Organisation activities, Church Trails – helping and encouraging people to take part in healthy activity.
- Encouraging further uptake of rural parish planning and supporting the implementation phases
- Care Farms have proved an important initiative to support people with mental health needs towards “wellness” and work opportunities for the future.

Safer Communities & Health

- Drug related crime and deaths per capita need to be identified in rural areas.
- Migrant workers in rural areas have less of an impact on primary health care provision than feared because they tend to be younger fitter people.
- The bigger problem in rural areas is alcohol abuse. Sadly there few alternatives in terms of “entertainment”. The Bulmer Foundation is running an innovative project involving counselling of offenders.
- Crime rates in rural areas are relatively low. However it is the fear of crime, exacerbated by the isolation that concerns rural residents, particularly the older people.
- The slashing of the number of rural post offices is a major problem with regards to the social fabric of rural areas and the lack of provision of viable alternatives being put in place before the cuts are made.

Children & Young People

- Rural children have the potential for a greater preponderance to obesity because of lack of exercise – being transported everywhere by car, lack of local sports facilities, road safety issues, etc.

Later Life

- Calls to the farmers’ Crisis Network have increased, particularly stress and cashflow related: initially the after-effects of the Foot & Mouth debacle, then Bovine TB, and Rural Payment Agency difficulties. The Rural Stress Action Group can provide further information.
- Making health, well-being and independence for older people a reality – particularly important with increasing numbers of older people moving into rural areas.
- Age Concern statistics have helped determine the increasing costs of health and social care in rural communities. If 10 year projections are accurate then greater numbers of over 65s and over 85s in dispersed rural communities will create a tremendous challenge.

Conclusions & Next Steps

- It is all about rurality and how the health services can respond to rurality. As the 5-year vision is rolled out, we will need to consider how regional partners may help to communicate the messages. It was agreed that they/we have a strong role to play in building consensus around this new approach. WMRAF and other regional partners are happy to be pro-active in this important work
- The final strategy must make links with other regional strategies and ensure that responsibility for action is taken by regional partners.
- Recommendation that many more rural case studies are incorporated into the final document – at least one for each of the chapters.
- The Strategic Framework for the West Midlands – Investing in Health will be presented to the Strategic Health Authority on 29 May 2007 for endorsement prior to a period of wider engagement.
- Cross border opportunities should now improve between Wales and the West Midlands with the signing of the Memorandum of Understanding. NHS West Midlands are urged to talk to their Welsh counterparts given the very serious anomalies that currently exist for the adjoining rural communities, e.g. prescription charges, waiting lists, levels of health care, etc.
- The consultation period for the draft Regional Health & Well-Being Strategy ends on 11 July 2007.
- Workshop attendees and others to be encouraged to upgrade/amend the Rural Commentary.
- The Rural Commentary and the Workshop outputs will be posted on the WMRA website.

Appendix 1: Presentation of regional statistics – David Howatson

Appendix 2: Strategic Framework for NHS West Midlands – Investing in Health

Jon Cooke, NHS West Midlands, introduced the draft document which would be presented to the SHA Board at the end of the month prior to it being released for wider sector engagement. As a result of the merging of the 3 SHA's in the West Midlands' region the new strategic body had set itself 6 high level objectives:

1. Set the strategic direction for NHS West Midlands for the next 5 years;
2. Lead, support and manage the PCTs for an interim period only;
3. Increase commissioning of services and assist the PCTs, independent companies and the third sector to adapt;
4. System reform;
5. Managing systems to the maximum benefit of its clients and customers;
6. Delivery of a number of strategic projects.

The Strategic Framework, he said, would be focussed and selective (50-70pages) and bold – looking for a significant step change but rooted in the real needs of the population. Importantly, rather than a “motherhood” document it should be linked to implementation, providing clarity over how the SHA intends to deliver the culture of transformational change. The Framework will be live and responsive leaving room for signalling further analysis/research and attracting stakeholder feedback continuously. The unifying concept was one of investment towards improving health, public confidence, levels of service responsiveness giving increased choice and more services closer to home.

At present the NHS faces a number of big challenges, e.g. despite improvements in overall health status, inequalities in health have widened; despite the substantial evidence about investment in prevention, the proportion of NHS spend remains minimal; the unjustifiable variability in the quality and safety of services; the costs arising from doing “more of the same” outstrips any conceivable rate of increased funding and patients and public (including staff) struggling to understand how services work. Priorities therefore have been set around the following:

- Full engagement
- Quality, safety and excellence of patient experience
- Care closer to home
- Sustainable services and sustainable health systems
- Organisations fit for purpose

With regards to the sustainability of services, the current situation and the five-year vision was discussed. It remains important that the acute sector is viable at sub-regional level but it is likely to be dependent on a vibrant and efficient range of primary care and community-based services. The present configurations for District General Hospitals (DGHs) cannot be sustained. The capital investment and revenue implications are unsustainable, e.g. for a £600 million capital investment, there is a revenue implication for some £1.6 billion. It is likely that the West Midlands will have 1-2 major hospitals only with the DGHs becoming more local and much more community-based.

Of course there will be risk-based analysis and the NHS has defined what the “ideal” community hospital should look like:

- Sitting in a clear catchment population in a sensible location;
- Offering a modernised NHS service that is synchronised to the 5 year commissioning plan;
- All healthcare needs to be integrated;
- Offering a wide range of services including private health care providers, local authorities and the voluntary sector;
- A strong position in wellness services;
- Commercial grade café and public spaces;
- Local ownership with strong and effective governance;
- Regular external quality audit of all clinical services.

Appendix 3: Regional health & Well-Being Strategy – Draft - Rowena Clayton

Appendix 4: Rural Commentary – Sara Roberts