Llywodraeth Cynulliad Cymru
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Rural Health Plan

Improving integrated service delivery across Wales

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Ministerial Foreword

It is with great pleasure that I introduce the "Rural Health Plan – Improving Service Delivery Across Wales". Its publication delivers one of our key One Wales commitments and marks an important step forward in developing rural health and rural health services in Wales. I wish to express my thanks to Lord Elystan Morgan and his team for the work and for the important conclusions they have drawn from the widespread engagement with the public, patients and other stakeholders which their Plan represents. In particular, I welcome the Plan's focus on the three key themes of Access, Integration and Community Cohesion.

Developing the Primary Care Workforce

It is clear from the steering group's work that new workforce models are required to deliver improved services across the NHS and also within social care. These new models will need to be based on multi-skilled roles and will be especially important in primary care. I believe there is real merit in the notion of a new Rural Practitioner role, spanning the health and social care systems, and will commit the Welsh Assembly Government to carrying out further work to develop this concept in practice.

The contractor professions within primary care are at the heart of service delivery in rural areas and the work on rural health has highlighted a number of issues of concern about the current contractual framework for rural GPs. I am not convinced that the current arrangements are consistent with the development of new service models. Further work will now be carried out, with the profession, to review how the current contract works in rural settings and to identify ways in which this can be improved. Developments in this area will be central to our ability to develop shared care between the hospital and the community and in developing the new clinical roles envisaged within the community.

The Role of the Pharmacy

Pharmacies are a vital element of rural health services provision and the pharmacy is a cornerstone of the high street in most small towns. But there is more that can be done. Pharmacies can do much more than dispense medicines, through the treatment of minor ailments, the provision of diagnostic tests, offering healthy lifestyle support and acting as information centres. I want the new LHBs to pay particular attention to developing the network of pharmacies across rural areas. To aid this process, the Welsh Assembly Government will review the current system of pharmacy location decisions and appeals in order to develop a more planned approach to the provision of these essential services across Wales.

Community Hospitals

Wales has a strong network of community hospitals, but many need modernisation. New technology can provide a new local access to diagnostic services, clinical assessment and specialist opinion. There are opportunities too for using community hospitals as a base for out of hours services, as well as telemedicine, therapy services, rapid response, specialist outreach care, respite and active rehabilitation services.

I want to see a renewed mission and purpose for our community hospitals, which fully exploits their potential to bring services closer to rural communities. I am encouraged by the innovative thinking now being undertaken in some communities, such as the new model of care being

developed at Builth Wells and the potential to pilot a new, nurse led, walk in service at Cardigan Hospital, another of our One Wales commitments.

General Hospital Services

The development of community hospitals will reduce unnecessary demand on general hospital services. At the same time, we need a better balance of service provision between local general hospitals and specialist centres.

I intend to work with the professional bodies in Wales to seek their support in developing new proposals, in this area, which command public support. I have asked my officials to undertake preliminary work in this area in conjunction with the Royal Colleges and Professional Advisory Bodies. I will look for a report shortly on the actions required both in the short and longer term.

Transport and Emergency Response Times

A sensible and guaranteed emergency response in times of crisis is one of the issues which was most regularly raised with the Steering Group. There is a clear perception that such services are not meeting the needs of rural communities in Wales. I will ensure that we review alternative models for providing emergency response in rural areas, drawing on best practice from around the world, so that we can develop a set of measures which deliver a realistic and achievable service which meets local needs.

At the same time, non-emergency patient transport services need to be reviewed, at local level, so that appointment systems, both in hospitals and primary care, are sensitive to the needs of people who have to travel and who are not independently mobile.

Pilot Site

The broader definitions of rurality adopted by the Steering Group mean that rural health issues will be on the agenda for each of the seven new LHBs, this is everybody's business. However I also recognise the special nature of the areas such as Hywel Dda and Powys in addressing the challenges that rurality presents and they are well placed to act as a focus for innovation in rural healthcare to concentrate attention on developing new models of integrated, community based care and to do this through enhanced partnership working with the County Councils and other key stakeholders. I believe that these areas can provide a lead in rural service provision.

Strengthening What We Know About Rural Health

One of the messages which comes through clearly from the Steering Group's work, is the need to develop the evidence we have, here in Wales about rural health policy needs, and to embed this improved knowledge in our policy-making structures. I will explore, with the research community in Wales, the potential for the development of a Chair for Rural Health that can help ensure we develop cutting-edge practice in Wales through both teaching and research and to strengthen working between the Institute of Rural Health, the Rural Observatory, the developing Rural Networks and other health institutions.

There is, of course, a great deal more in the Plan than I can hope to cover in this brief introduction. I have already taken action to respond to emerging conclusions from the Plan. I am also able to announce my intention to establish a Rural Innovation Fund, to promote the improvements we want to see and further guidance on this will be available.

The next step following the publication of this document, will be to establish an Implementation Group to oversee the development of rural health services in Wales and to ensure we deliver on the changes required and further details will be worked through in the development of the implementation plan.

In summary, I believe that this Plan offers a real opportunity to provide health and social care services which meet the needs of rural communities across Wales.

Chairman's Introduction

The Minister, Mrs Edwina Hart, has set us a challenging and exciting task.

Many of the factors and conditions affecting health and well-being in rural Wales are common to urban communities also. Yet there are many whose effect in the rural community is harsher than in the urban setting. The circumstances of the individual are compounded by the reduced capacity of the rural community to alleviate that person's hardship.

An increasing proportion of the population moving into the over 65 age group is a general feature, but in the case of rural areas its effect is infinitely more acute than elsewhere (the proportion of people over 65 in rural communities is expected to increase by about 30% in the next 23 years). The implications of this factor in the context of rural Wales are obvious to all.

Two features, more than any others, fundamentally distinguish the rural from the urban scene in Wales. Neither of these is classically a health factor but in each case it impacts massively upon health conditions. They are firstly, the problem of access to services for those living in the remoter communities; and secondly, the difficulties experienced in integrating the services provided for the individual, some of which are NHS based with the remainder emanating from local government.

In approaching these matters, we have constantly reminded ourselves that health cannot be regarded in isolation from the backcloth of social, economic, housing, transport (both private and public), and social care matters. A more holistic approach is called for.

In our deliberations we have studied the available published data, both from Wales and the rest of the UK, as well as from as far afield as New Zealand. We have examined the reports of Ministerial reviews into proposed service changes. We have concentrated attention both upon the invited responses of the public to health issues as well as the representation of various focus groups, managers and administrators from NHS, local government and charitable backgrounds.

We are acutely aware that the planning of health and social services in rural areas inevitably involves striking a balance between factors of access, quality, cost, and critical mass, but the last named should not be regarded as the ultimate determinating factor.

The aim at all times must be to provide services at a point as near to the patient as possible, consistent with safety and quality whether those services consist of hospital admission/ attendance, domiciliary visits or telemedicine.

Health like every other public service should always be open to improvement by way of progressive and enlightened reform. We very much bear in mind the Welsh proverb "Nid da lle gellir gwell" (nothing is good which can be improved upon).

It is in the inspiring spirit of such a challenge that we have looked at the question of rural health in all its aspects. We have delved into and scrutinised scores of issues. These include matters ranging from:

- the interface between NHS and local government provision to rural proofing of all Welsh Assembly Government policies;
- the equitable formulae for financing rural health to the establishment of community hospitals, retirement homes, sheltered housing, and pharmaceutical services all on a common campus;
- improved ambulance services to co-operative transport schemes, and
- developing more generic skills among health and social workers, to more humane and reasonable timetables of appointment for rural dwellers.

We have in preparing our final plan taken fully into account the wide range of responses received in relation to the consultation. In all cases, the responses were wholly relevant, constructive and stimulating.

We are very conscious that for any such plan as this to command success, it must gain the broad approval of the community at large. We appreciate too, that every worthwhile proposal must steer a middle course between unrealistic aspirations on the one hand and unimaginative stagnation on the other.

I would wish to record my sincerest thanks to my colleagues Jane Jeffs and Professor Marc Clement for their sterling contributions and also the Department's previous Director of Strategy & Planning, Bob Hudson, and the Senior Strategic Advisor, Helen Howson and secretariat Rachel Brown, together with their colleagues, for the very great assistance and support which we have received at all times.

Lord Elystan Morgan

October 2009

Summary

- Rurality can be difficult to define but it is clear this should be a nationwide concern and a key element within each LHBs planning and service delivery processes.
- Rural health will be an important issue for **all** 7 Local Health Boards but a particular challenge for those areas with a high degree of rurality.
- Rural health cannot be considered in isolation from social, economic, transport, housing and social care matters, reinforcing the need for rural proofing and integrated planning and service delivery. This document is not an alternative health strategy but is a template for translating the delivery of all-Wales strategies into meaningful service delivery mechanisms, tailored more specifically to the needs of rural communities.
- The ageing population factor is increasing faster in rural authorities than in urban authorities, compounded by outward migration of young people and inward migration of older people. This will have a significant impact on local service needs and support systems across health and social care. Immediate action is needed to address this.
- The crucial issues identified within this work revolve around **access, integration and community cohesion and engagement**, which are not exclusive to rurality, but are deeply affected by the prevailing conditions in rural life.
- Rural health is generally good in comparison to urban, however distance from services and more general support can impact greatly upon this and is a cause for concern. **Accessing services is the foundation of effective rural health and a basic human right**.
- Access in terms of getting timely services to people and people to services across primary, community, secondary/ specialist and social care needs to be improved across the spectrum, from emergency survival to the convenient delivery of routine services. More creative and flexible solutions will be necessary to ensure that the needs of those people living in rural areas are met in the most appropriate way, as well as strengthening existing developments such as telehealth and telecare.
- Central to improving services is the crucial factor of integration. So much waste can be prevented and better care and support provided by eliminating duplication. Integrated service models, workforce planning and systems are necessary to improve future provision and ensure the effective use of all resources and skills within communities. This will necessitate a vastly improved cohesion across organisational/ professional and business boundaries and between NHS, local government and third sector services.

- Transport plays an essential part in rural health. Regional Transport Consortium are preparing Regional Transport Plans that will set out transport priorities and planned interventions. It is important that plans for rural health services are shared at the earliest opportunity with the Consortium so that transport issues can be identified and resolved at the earliest opportunity.
- The sustainability of smaller community hospitals is not specifically a rural issue, nevertheless, the crucial role that they play in the life of the countryside gives them greater significance and importance than would be the case in urban areas. It is essential that services are based on local needs, requiring more holistic and multifaceted solutions, some of which are beginning to evolve across Wales.
- Cost is a relevant factor for all services and a balance is needed between quality, critical mass, access and costs to ensure that the needs of local people are met safely and effectively. However, in the context of rurality critical mass should not be the ultimate determinant. The balance and allocation of financial provision requires further analysis and consideration.
- The improvements we would like to see brought about may involve re- thinking of existing plans or policies or better links between them. In other cases quick and simple improvements such as improved appointment systems can be made immediately. The challenges of distance and resources will always prove difficult, but by working together and pooling our knowledge, resources and skills more effectively; we should be able to ensure the delivery of efficient and appropriate services to the most rural of communities.
- Community cohesion is an important resource and a factor of immense potential to both rural and urban settings, but the remoteness of rural communities places even greater emphasis on this. Community cohesion, engagement and ownership needs to be actively supported and nourished within mainstream service planning and in supporting services delivered locally. The third sector has an important part to play in this.
- Ensuring the trust and support of local communities will be essential, as will the part they have to play in enabling this to happen. Doing nothing is not an option and we have an ideal opportunity through NHS reconfiguration to make a real success of this.

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Putting People First – Why a Rural Health Plan?

Aim of the Plan – To focus on the health of people living in rural communities – their well-being, their healthcare and health and social care needs to enable them to live happy and fulfilled lives as independently as possible.

1.1 A Rural Perspective

1.1.1 Living in rural communities has many advantages – being amongst beautiful scenery, open spaces, fresh air, access to nature, freedom and safety for children, community neighbourliness and trust. All of these are greatly valued not only by local people but also those who visit and enjoy these amenities.[1]

1.1.2 Inevitably living in such rural communities comes at a cost as the very nature of its isolation also presents challenges. The majority of people who have grown up and live in these communities tend to accept these, hence the need to have checks in place to ensure that we are doing everything possible to support local needs.

1.1.3 This work will focus on the health of people living in rural communities – their well-being, their healthcare and health and social care needs to enable them to live happy and fulfilled lives as independently as possible.

In doing so it clearly recognises that health is inextricably linked to many other aspects of life within local communities such as housing, transport, work and leisure and has taken this into consideration.

"We need to train and develop staff to be multiskilled. Often you have a number of different professionals visiting people, which is inefficient. People need someone to visit and have an holistic conversation about the entirety of their needs"

"The worst part of the treatment was the ambulance car service … we went via Morriston hospital and it took three hours". Case study: cancer patient

1.1.4 To ensure we have a real understanding of life in rural communities and the factors affecting their health and well-being, the work starts with the views and feedback of local people and their needs and concerns.

We have used this to help us learn more about their experiences and the issues they face each day in living healthy and sustainable lives and in accessing health services and other support mechanisms. The following provides a brief insight into life in rural communities and the foundations upon which we need to build.

Putting People First – Why a Rural Health Plan?

1.1.5 We can begin to see from this brief snapshot, that many of the answers lie in better planning and integrated provision of care, along with a sound transport infrastructure underpinned by local support mechanisms.

This document will lay out a wide range of evidence from local people, professionals and the literature to expand upon these and help establish some firm foundations for future health and social care planning in rural communities across Wales.

1.1.6 Defining rurality is not straightforward and differences in classification make national and international comparisons difficult. There is no single definition of rurality which applies for all purposes.

There are many options, which may be more or less appropriate in different situations. When looking at "what is rural Wales?" different definitions will be required when considering "rural people", "rural land" and "rural activities".

1.1.7 The Organisation for Economic Co-operation and Development (OECD) 1994 definition of rurality uses a population threshold of fewer than 150 persons/sq km and by this measure nearly half of the unitary authorities in Wales are defined as rural.

The 2004 Office of National Statistics published a rural-urban classification which defined populations of less than 10,000 as rural, while those above a population of 10,000 are defined as urban. Both urban and rural areas are then divided into sparse and less sparse[2]. (Definitions are based on the ONS rural and urban and found at: http://www.statistics.gov.uk/geography/urban_rural.asp)

"If you don't drive it's difficult to get there and to visit, but its also expensive. My husband had an operation on his shoulder and I had to get up at 5:30am to get there in time for it – hang around all day and not get back until late in the evening." Wife and mother (family with young children)

"My son was injured in a school football tournament in Aberystwyth. I had to go from Aberaeron to Aberystwyth to take him to hospital. He was left by those organising the tournament lying on the football pitch – Where was the first aid? – you should have that in a tournament."

"There is a lot of co-operation (as a counselling service) to use other organisations' premises for free… community centre and GP surgeries for examples – these are available if we want to meet with young people, even if the meeting is at six o'clock out-of-house. Liaison and referrals, the system is working well. We are learning together." Counselling service

"Many elderly women have never learnt to drive and when their husband dies are unable to get to hospital appointments."

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1.1.8 In Wales therefore, rural areas not only include the nine rural authorities, but also parts of the Valleys and areas in some urban authorities. Many traditional rural coastal and inland communities will see their populations expand very considerably during the tourist season and this has implications for healthcare. It is therefore evident and reinforced in *Figure 1*, that rural health is everyone's business across Wales and not just the concern of a few. Each of the newly configured 7 unified Local Health Boards will need to demonstrate how they address rurality within their planning and service delivery.

1.1.9 Work is also underway to identify and address the needs of Deep Rural Areas. Deep rurality is defined as places that are over thirty minutes drive time from a settlement of ten thousand people.

Towns of around ten thousand people normally have a good concentration of health, financial, leisure and other services, whereas smaller more remote communities either do not have or need to travel to access the same range of services. *(Figure 2)*

Figure 1

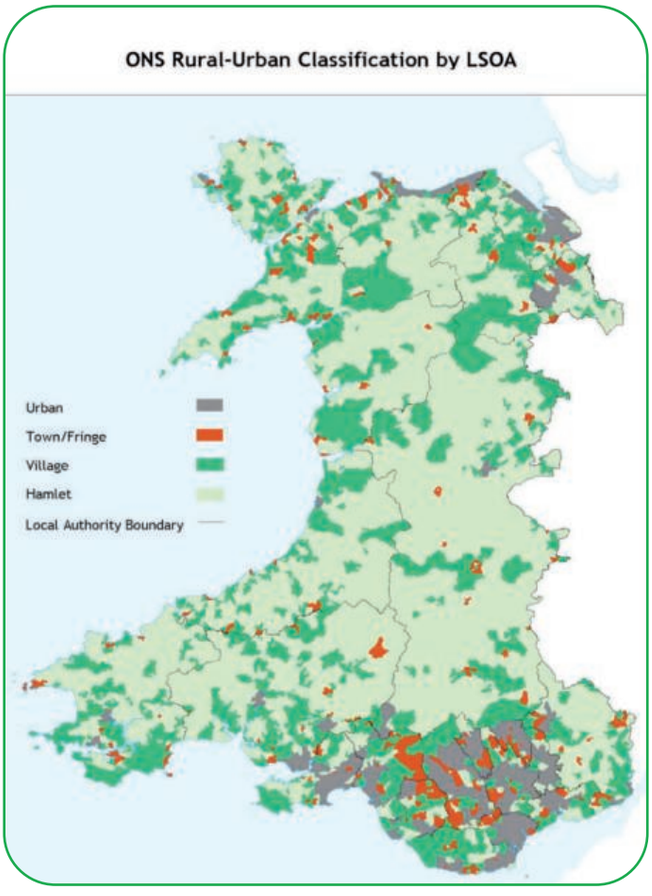
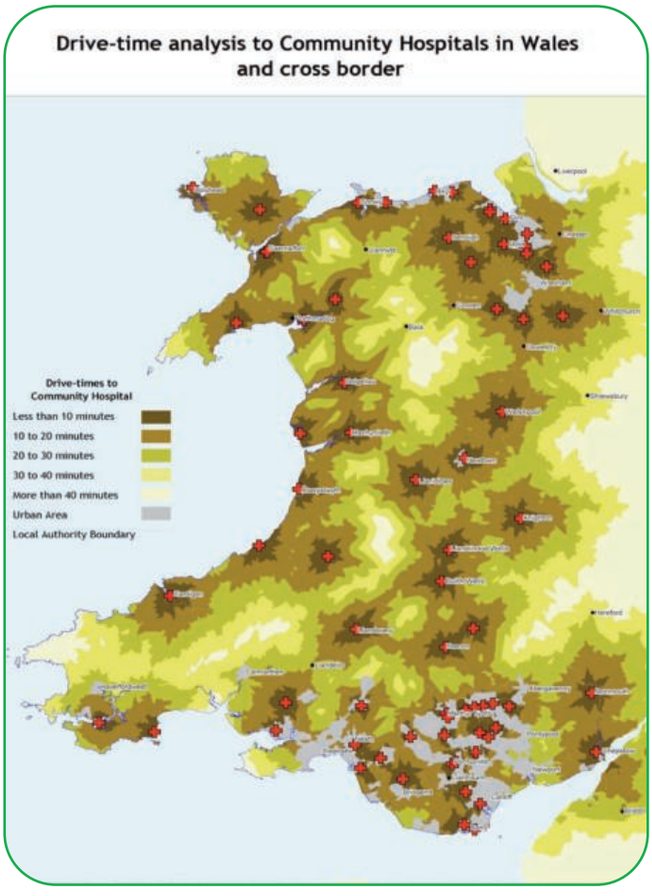


Figure 2



Putting People First – Why a Rural Health Plan?

1.1.10 Rural populations throughout Wales are projected to increase at an average of above 10% between 2006 and 2031. However, over the same period the population of older people within the traditional rural authorities is projected to increase by an average of 33% by 2020 in comparison to urban areas which will increase by 28%. Figures for rural areas also show that population profiles are distorted by outward migration of young people and inward migration of older people. The ageing population is increasing faster in rural authorities than in urban authorities.

1.1.11 Although the balance of population demonstrates an outward migration of children and young people, we are also aware of the needs of children and young people in rural areas and this needs to be taken into full consideration in the planning and delivery of health and social care services in rural areas to meet these needs. Whilst an ageing population will present additional challenges for planners and service providers we should be mindful that an ageing population can also be enriching and positive bringing different skills and experiences into communities. The old will continue until the end of their days to have an invaluable input into the life of the family and the community.

1.1.12 Rural areas in Wales have wide ranging deprivation when it comes to geographical access to services by drive times, public transport and walking. Drive times to district general hospitals tend to be over 40 minutes, and people living close to the border use hospitals in England as they are closer. The concept of 'deep rural' needs justifies more investigative examination in terms of health service access.

1.1.13 Overall, the data suggests that people living in rural areas are generally healthier and have healthier lifestyles than their counterparts living in urban areas. Mortality data for Wales presents a mixed picture and when adjusted for deprivation indicates that mortality rates are similar between rural and urban areas. That said on a more macro level, rural areas tend to have much lower levels of mortality overall.

However, the Health Needs Assessments (carried out by the National Public Health Service) showed pockets both in some valleys and more traditional rural areas that have high levels of mortality for multiple diseases. Of significance are the high levels of accidents throughout rural areas and
the high levels of suicide, especially in North Wales.

To regard a certain level of age as being effectively the end of a meaningful life is both barbaric and unrealistic, particularly in light of increasing longevity. The terminal boundary does not exist. The Welsh poet Dewi Emrys has a couplet (in an Englyn to ''The Horizon") which is most appropriate to this factor:

'Hen linell bell nad yw'n bod,
Hen derfyn nad yw'n darfod'

Comment from Lord Elystan Morgan

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1.1.14 The morbidity data set in rural areas presents a confusing picture. Much of it is not wholly reliable and not readily available in a rural-urban format. Whilst the health needs assessments show life-limiting long term illness is generally at a lower level of prevalence in rural areas than in the rest of Wales; the data from the General Medical Services Contract, Quality and Outcomes Framework (QOF)[3] and the Welsh Health Survey[4] identify a number of rural areas have a higher than average prevalence of cancer, depression and dementia. These data sets need to be carefully monitored in the future to see if these patterns remain.

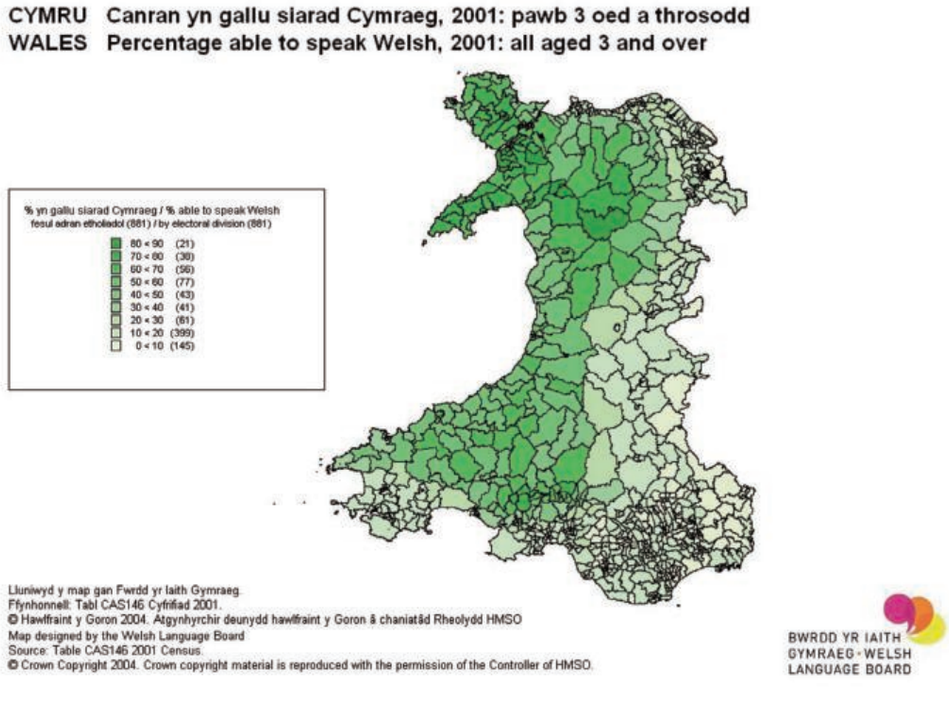
1.1.15 Overall, data from the Welsh Health Survey[5] suggests that adults living in rural areas generally report healthier lifestyles than those in non-rural areas (for instance, for behaviours such as smoking, alcohol consumption, consumption of fruit & vegetables, physical activity, and levels of obesity).

1.1.16 Mental health is an important issue in rural areas as dementia is likely to increase with an ageing population and in some areas of rural Wales suicide rates have increased. The development of the "*National Action Plan to Reduce Suicide and Self Harm*"[6] will look to raise awareness of suicide and self harm particularly in rural areas.

1.1.17 The Welsh Language plays an important part in rural life and in particular in health and social care.

Data from the most recent census in 2001 *(Figure 3)* identifies that the highest proportion of Welsh speakers in Wales reside predominantly in the rural communities (with the exception of Monmouthshire and eastern parts of Powys where inward migration is highest). Between the 1991 and 2001 census there was an increase in the number of Welsh speaking children in Wales by 13.4% with the figure now standing at a total of 37.7%.

Figure 3



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1.1.18 The correlation between community structure, service provision and Welsh language need is exemplified in the management of older people's services within the rural communities in Wales, which have the highest numbers of older people, have the highest number of people where Welsh is the first language, and have some of the lowest levels of residential and nursing home provision particularly for the older people who are mentally ill.

In extreme cases older people with significantly reduced functionality are placed in homes miles away from their community with no Welsh speaking staff, no visitors and a complete lack of any ability to communicate with those caring for them.

1.1.19 Workforce strategies need to consider the specific requirements of communities in terms of both clinical and language skills if true equality of provision is to be achieved.

This is exemplified in the rural communities indicating a need for more innovative approaches to workforce development including "home-grown" approaches to the future caring professions.

1.2 Why Do We Need A Rural Health Plan? And How Do We Get There?

"We will develop and publish a Rural Health Plan, ensuring that the future health needs of rural communities are met in ways which reflect the particular conditions and characteristics of rural Wales."
(One Wales: A Progressive Agenda for the Government of Wales, 2007)

1.2.1 *One Wales: A Progressive Agenda for the Government of Wales, June 2007*[7] was developed as an agreement between the Welsh Labour Party and Plaid Cymru to form a coalition government in the Welsh Assembly Government for its third term. The agreement includes a commitment "to develop and publish a Rural Health Plan, ensuring that the future health needs of rural communities are met in ways which reflect the particular conditions and characteristics of rural Wales". In January 2008, Edwina Hart AM, MBE, Minister for Health and Social Services announced the formation of a steering group with Lord Elystan Morgan as Chair, supported by Jane Jeffs and Professor Marc Clement as Vice Chairs to take this plan forward; a copy of the terms of reference can be found at *Annex A*.

1.2.2 To address this challenge the steering group undertook a comprehensive process of evidence gathering, engaging with a wide number of experts as well as lay members to identify key issues in Rural Health. A list of the experts and lay members which engaged in this process and the papers received from the Group can be found at *Annex B*. The Steering Group also took account of two major elements of work commissioned to collate and consolidate

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the evidence base for the work. Opinion Research Services (ORS) undertook a study to gather evidence from local people on their perceptions of health issues in rural Wales and the Institute of Rural Health undertook a literature and research review of the published information on health and service models in rural areas. Terms of reference for the review can be found at *Annex C*. Further details of the Technical Documents supporting this work can be found at *Annex D* and accessed on the WAG website: http://wales.gov.uk/topics/health/nhswales/healthstrategy/ruralhealth/?lang=en.

1.2.3 Previously, there has been no specific policy focus on rural health or the challenges faced in providing services and support in these areas. Elements of generic policy work have particular applicability in rural areas for example telemedicine, however, the current strategic framework for health and social services set out within the twin strategies of "*Designed for Life, 2005*"[8] and "*Fulfilled Lives Supportive Communities, 2007*"[9] does not adopt a specific rural focus. The first phase of the implementation of "*Designed for Life*" has concentrated on concerns about the long term sustainability of secondary and specialist services and addressing key targets and waiting times identified within Access 2009[10].

1.2.4 Alongside these, a strategic framework for public health, '*Our Healthy Future*'[11] is being developed. The two key goals of '*Our Healthy Future*'[12] are to improve people's quality and length of life and to promote good health on equal terms for everyone in Wales. The importance of fair access to health systems in rural areas has been highlighted in the work to develop '*Our Healthy Future*'[13].

Everyone in Wales deserves to have a long, healthy life and have support to ensure they have the best possible health and well-being wherever they live. (Our Healthy Future, Welsh Assembly Government, 2009)

1.2.5 The wider long-term aim however, is to achieve a better balance within the healthcare system from one dominated by hospital based medicine to one focussed on securing population health improvement, through better community services and earlier intervention and support within the community, helping reduce inappropriate demands on secondary care.

This can be seen within the "*Chronic Conditions Model and Framework*"[14] which aims to prevent conditions arising as well as proactively manage and anticipate care needs and co-ordinating services across all agencies.

Other developments underway such as "*Workforce Planning*", the "*Community Nursing Strategy*" and the "*Primary and Community Strategy*" will help complement the work and thinking to date and its application within rural health planning.

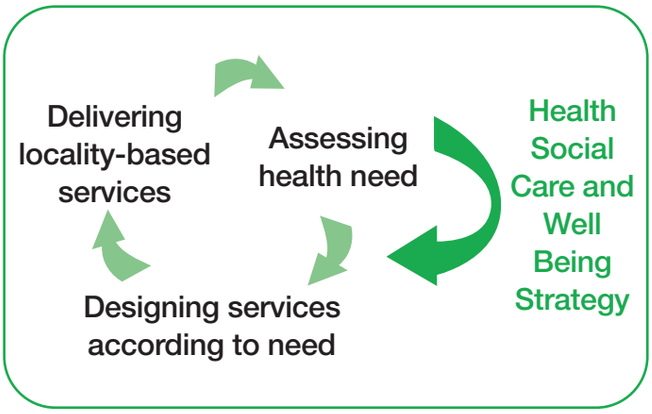
1.2.6 Whilst many of these health policies will address some of the issues identified, rural problems often accentuate these problems further. This calls for greater emphasis on rural proofing and on more flexibility in finding solutions.

Putting People First – Why a Rural Health Plan?

1.2.7 The NHS in Wales is already based on a cyclical system of needs assessment, design and delivery, focussing on locality needs and the alignment of services in partnership with all stakeholders, including local people, to ensure these needs are met *(Figure 4)*.

The development of Health Social Care and Well-being Strategies[15] already provide an opportunity for local focus and partner engagement in joint planning as well as joint actions to improve well-being and a reduction in inequalities.

Figure 4



1.2.8 It is therefore important that the rationale for developing a separate Rural Health Plan is clearly articulated. This will need to build on and strengthen the above cycle with full engagement from local people as well as identifying differentiating factors unique to rural communities. Where necessary alternative or reinforced mechanisms to the design, delivery and performance management processes; will need to be made. We must not be constrained by existing systems or processes but find innovative solutions to better care for those living in rural localities.

1.2.9 The information relating to health in rural communities indicates that in very broad terms:

- The general health and well-being of people living in rural communities appears to be better than the all-Wales average;
- There is a greater proportion of older people living in rural communities which creates the potential for increased frailty and dependency on community and social care services;
- Some of the wider determinants of health such as physical and social isolation, access to transport services, housing and lower than average earnings, impact disproportionately on rural communities. This factor will inevitably assume increased importance over the next few decades.

1.2.10 None of these factors identify a need for wholly independent health strategies for rural Wales. However, they do indicate a clear requirement to look at the way in which the implementation of the extant health strategies can take further account of the specific features of rural communities.

1.2.11 The satisfaction of Wales' aspiration to an equitable condition of health outcomes for its citizens, does not mean a blanket approach to delivery of services.

Understanding the health and social dynamics of different communities is critical to determining need therefore differential provision will be an inevitable consequence of bespoke service design.

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1.2.12 Therefore, the Rural Health Plan is not an alternative health strategy but is a template for translating the delivery of all-Wales strategies into meaningful service delivery mechanisms, tailored more specifically to the needs of rural communities.

1.3 The Wider Policy Context

1.3.1 Rural health does not exist in a vacuum. This work which will eventually crystalise must integrate with other strategic initiatives across Wales.

1.3.2 A policy review was undertaken to help understand and draw together related areas addressing rurality. The wider policy context underpinning the Rural Health Plan is therefore informed by a number of key strategies including:

- *Wales Transport Strategy (2008)*[16],
- *Rural Development Plan for Wales (2007 – 2013)*[17],
- *Fulfilled Lives, Supportive Communities (2007)*[18],
- *Economic Development and the Welsh Language (2006)*[19],
- *Making the Connections (2006)*[20],
- *Wales: A vibrant economy (2005) – Welsh Assembly Government's Strategic Framework for Economic Development*[21],
- *Designed for Life (2005)*[22],
- *Wales Spatial Plan (2004)*[23],
- *Deep Rural Project (2008),*
- *Sustainable Development (2007)*[24],
- *Health Social Care and Well-being Strategies*[25],
- *Children and Young People Plans*[26],
- *Fuel Poverty Strategy, shortly out for consultation,*
- *National Transport Plan (2009)*[27],
- *Community Nursing Strategy (2009) shortly to be published,*
- *Talk to me – A National Action Plan to Reduce Suicide and Self Harm in Wales*[28],
- *Rural Proofing Toolkit*[29],

1.3.3 Across all of these there is a high degree of thematic consistency emerging that identifies the challenges and needs of rural communities. These include:

- Access to public services (including transport infrastructure);
- The need for innovative approaches to service and workforce integration including robust developments of more generic skills amongst health and social care workers;
- Recognition of the economic pressures associated with living in sparsely populated communities;
- The social and economic impact of higher numbers of self-employed individuals;
- The potential for a high degree of community empowerment.

Putting People First – Why a Rural Health Plan?

1.3.4 These themes are equally applicable to health and the delivery of health services. We need to apply these existing policy frameworks to the specific health needs of rural communities, accepting that the implementation mechanisms will need to be tailored to local need but that standards and outcomes can be equitably delivered.

1.3.5 "*The Rural Development Plan for Wales*" provides a framework to strengthen farming and forestry industries; safeguard and enhance our environment and rural heritage and foster businesses and thriving rural communities.

In this it has recognised the need to explore the issues surrounding service provision faced by communities and service providers in more remote parts of rural Wales. Results of the four study communities in Aberdaron in Gwynedd, Llangammarch in Mid Powys, Llanfihangel in North Powys and Clydau in North Pembrokeshire, will be available in late 2009 and will help inform future thinking.

1.3.6 We recognise that the economic aspects of rural life will continue to play an increasingly important role in the health and well-being of rural communities and strategies to support this are fundamental to maintaining health and well-being in these communities.

The declining economic environment will impact greatly upon the Welsh people and on those in rural areas, and hence the case for pooled budgets as a product of joint planning is strong in the current economic climate but the same priorities and problems will remain.

1.3.7 It is important that this work dovetails with the "*Wales Spatial Plan*" where priorities such as transport and digital connectivity are of particular relevance.

1.3.8 Finally, it is important to see this work firmly positioned within the context of the Government's commitment to Sustainable Development[30], that foresees a Wales that is healthy, strong and prosperous, living within environmental limits.

Rethinking the organisation of health care in rural areas offers a significant opportunity to apply the principles of sustainable development, for example in reducing travel and using technology and skills in a new less wasteful and more creative way and tackling fuel poverty which has already started to be addressed in the development of the Fuel Poverty Strategy. As a result there could be a substantial saving in carbon emissions.

Making the changes it requires will not be easy however the quality of life of people living in all parts of Wales will be immense and taken together, this Plan with that approach, will help ensure that communities of all sizes can become and remain healthy and sustainable.

Section 2
What Does the Evidence Tell Us?

"Train and develop staff to be multi-skilled. Often you have a number of different professionals going in visiting a patient in an outlying area; if you looked at the needs of the client they need someone to visit and have a holistic conversation about the entirety of their needs – exercise, healthy eating, treatments." Stakeholder in Carmarthen

2.1 Introduction

2.1 The steering group has undertaken a comprehensive evidence gathering process which has included two pieces of work commissioned from the Opinion Research Service, Swansea University and the Institute of Rural Health. The evidence h as been categorised into three sections "What The Public Tells Us", "What The Professionals Tell Us" and "What The Literature Tells Us".

2.2 What The Public Tell Us

2.2.1 To make sure that the Rural Health Plan addresses the real needs of the people living in rural areas we communicated widely with local respondents to understand their issues and experiences.

The ORS was commissioned to do this through a public and stakeholder engagement exercise which would allow them not only to contribute their own views but for these to then be taken forward in the early stages of the planning process.

2.2.2 The aim of the study was to understand perceptions of health issues in rural Wales and also capture the reality of their personal experiences. The questions that were posed centred around three key themes – What works well in rural health services? What are the problems? and How may services be improved?

In the summer of 2008 a wide engagement process was undertaken through a series of focus groups, stakeholder forums, one to one interviews and postcard questionnaires.

What Does the Evidence Tell Us?

The evidence presented represents the views and perceptions of those interviewed at the time. Whilst we do not seek to adjudicate on the factual accuracy in each individual case (in some instances the issues raised are already being addressed or improved), this provides us with invaluable information and a clear message on the need to communicate with local people more effectively. The following nine areas of concern were identified:

2.2.2.1 Improve Access To All Services In Relation To Transport, Appointment Times And Waiting Lists

Improvement in access to services through improved transport, organisation of appointment times and improved waiting lists was seen to be the key priority for improvement in rural health. For many in rural Wales the cost of travel is higher than for those in urban areas, this is mainly due to the lack of availability together with the time it would take to travel from certain areas to the closest services. This phenomenon also coincides with the general factor of a lower income per head in rural as compared to urban areas.

However, while many people recognise that acute and technical services cannot be provided wholly locally, and some clearly appreciated the benefits of having specialist centres, the majority were still concerned that as many medical services as possible should be available locally.

2.2.2.2 Improve The Collaboration And Communication Across All Services

A more co-ordinated approach is needed across communities, statutory bodies and voluntary organisations to avoid duplication of effort.

The development of a more collaborative process was seen as a key way to improve rural health services across Wales particularly through the sharing of information.

2.2.2.3 Review The Funding Formula To Recognise The Extra Cost Of Service Delivery In Rural Areas

Many believed the funding formula for Unitary Authorities led to inequalities in care. Stakeholders in particular felt there should be change from the current ‘per capita’ formula to an assessment which equitably and realistically took into consideration the degree of rurality.

They suggested this should include: travel time to district general hospital/ dentist/ physiotherapist/ podiatrist/pharmacy; patient list size in specialist clinics; ambulance response times; poverty and low income; access to appropriate transport; age of population; activity of voluntary sector; patch size; population density. Stakeholders referred to some work done in Scotland on resource allocation which has estimated that there is an extra 10% – 15% extra cost of delivering service in rural areas.

Funding streams are sometimes a barrier to collaborative working. Stakeholders felt pooled budgets would improve patient care and eliminate gaps.

Section 2

2.2.2.4 Undertake Workforce Planning For Future Public Service Needs

Workforce issues were high on the list of priorities where the key message is basically to have enough people with the right skills in the right place.

Workforce planning and development must look to empower people and make them valuable and also to look at the barriers to recruitment and retention for example lack of childcare, housing or fuel.

2.2.2.5 Improve Hospital Care, Particularly Hygiene

Many local hospitals were praised for the quality of their staff and care, with staff attitudes improving. There was concern about the amount of help given to patients in hospital who cannot care for themselves; however, others were particularly complementary about the services they or members of their family received.

One idea to improve organisation in hospitals was the re-introduction of the "old style" matrons. The main concern was hygiene with many people feeling that hospitals were not safe places to be in. For users of mental health services, their experience of some discharges from hospital being done without planning or support arrangements had caused distress.

2.2.2.6 Review GP Services In Relation To Appointment Times And Out-Of-Hours Services

The main concern for GP services is appointment times, particularly 8:30am appointments for those needing to travel substantial distances which can mean that people have to find overnight accommodation or get up extremely early.

Many were very positive about their GP practices, particularly their involvement with preventative health. There is a variable pattern across Wales with regard to the appointment systems within GP practices – some only have a walk-in service, some only have appointment systems and others have a variety of combinations. Whilst some found the out of hours service provision to be efficient and responsive, others did not have such a wholesome experience.

There is a general feeling of frustration with access to services from rural areas with difficultly in accessing home visits identified as a problem. Some of those living near the border between Wales and England, who are registered with English GPs were concerned that their after-hours service would not respond to call in Wales.

2.2.2.7 Recruit More NHS Dentists

The lack of access to NHS dentistry was mentioned by most groups. However, migrant workers in Llandudno had access to Polish dentists and found services to be excellent.

Some participants felt that dentistry needs to be seen as more than just about teeth as it is part of holistic healthcare insofar as bad teeth can impair general health as for example in the early identification of cancer.

What Does the Evidence Tell Us?

2.2.2.8 **Enhance The Role Of The Third/Community Sector In Service Planning And Delivery**

The significant contribution made by the third/community sector was recognised but it was felt by those working within the third sector felt that their expertise and experience is not seen as professional.

It was felt that this sector should be able to participate fully in designing and planning of local services, commissioning, delivery, evaluations and scrutiny.

The vital services provided by the third/community sector were stressed by many. Those with mental health problems who used the MIND drop-in centre in Carmarthen particularly appreciate the social contact and meals at the centre and also the help available there for practical problems, such as household bills.

2.2.2.9 **Improve Access To Information Technology**

Information technology itself is seen as being enabling in rural areas with the development of electronic repeat prescriptions, letters, tele-care, choosing and booking appointment and consulting a specialist online all possible.

Further improvement in information technology would assist in health in rural Wales in particular the increased use of tele-health would have huge potential for rural areas

2.3 What The Professionals Tell Us (Evidence from Practice)

2.3.1 There are a number of consistent themes drawn from the experiences and evidence provided by Health and Social Care professionals and providers currently working in rural areas. These challenges are seen as follows:

- Whilst health is generally better, the impact of frailty linked with a higher proportion of older residents is proportionally higher and it is suggested that people delay accessing healthcare because of lack of local provision – a phenomenon known as “distance decay”;
- Critical mass is such that economies of scale are often difficult to achieve. This means that the historic use of unit cost comparisons as indicators of efficiency are neither appropriate nor equitable for rural services;
- Costs of delivery are higher when services are dispersed to cover wide geographical areas;
- Providing high quality care packages in the community for patients with complex needs presents high sustainability risks due to workforce constraints and proximity to acute care;
- Transport services is poor generating challenges in terms of access and cost for both patients and staff;
- Travelling distances for health and social care staff limits time spent engaged in direct patient contact. This creates tensions between outreach services, which deliver maximum access for patients, and centralisation of services which deliver maximum patient contact;

- The current response-time targets forambulance services in rural areas are unrealistic due to the nature of the communities and the distances involved. Consideration should be given to a different model for emergency services in rural areas that is focused on achieving equitable outcomes for patients as opposed to timed responses;
- The training and development of rural healthcare staff needs to be tailored to specific service models and modes of delivery should not be dependant upon significant travelling.

2.3.2 With these challenges also come a number of opportunities. The need for change has been widely debated and generally accepted with a high community interest. We must use this positively, building on the strength of the community infrastructure, its social capital and third sector organisations.

The opportunity to develop an integrated unscheduled care service jointly across primary, secondary and ambulance services, providing prompt and appropriate response to needs not solely dependent upon an ambulance turning up within a given time.

The misuse of ambulance services can contribute to the diversion of services to less appropriate needs as can their use in general transport of non emergencies.

This supports the consensus on the need to develop an integrated transport plan with all sectors that will maximise access and along with the use of technology, wherever possible, avoid the need to travel.

In addition there is clear recognition of the advantages in joint workforce development. An integrated locality-based workforce across health, social care and the third sector developing generic skills and the specialist generalist amongst both health and social care workers will be part of the solution. This will be dependent upon harmonisation of terms and conditions between the NHS and Local Authorities.

2.4 What The Literature Tells Us

2.4.1 The Institute of Rural Health as part of the work commissioned undertook a literature review for evidence to support the key themes identified. The following is a summary of the results of the literature review.[31]

- The Increasing Population Of Older People;
- Long-Term Limiting Illness;
- Mental Health Problems (to include suicide and dementia because of the increase of the older population);
- Injuries;
- Access to Services;
- Emergency Services.

What Does the Evidence Tell Us?

2.4.1.1 Older People[32]

The evidence indicates that older people living in rural areas in general have a good quality of life which is supported by informal social support structures.

However, emerging evidence suggests that these support structures are eroding due to in and out migration leading to changes in the structure of rural communities. As the general age increases older people tend to become more susceptible to bereavement, loss of independent transport, lack of mobility and loneliness. These are exacerbated in rural areas by a poor public transport infrastructure and isolation.

The process of ageing should not be regarded as a terminal tragedy but as one of the experiences of a complete life cycle.

2.4.1.2 Long-Term Illness[33]

Wales has the highest rate of long term limiting illness in the UK. Two thirds of over 65 year olds report a least one chronic condition and one third have multiple chronic conditions. Three quarters of over 85 year olds report having a long term limiting illness. This is important to note because of the increasing proportion of older people in rural areas.

The evidence shows a mixed picture for levels of morbidity and mortality between urban and rural areas. There is some indication that those living in rural areas, in low income groups and have no independent transport, have a higher incidence of cancer and lower survival rates.

For palliative care, evidence suggests that there is a lack of symptom control, nursing help, assistance with transport and bathing, communication with professionals and bereavement support. Carers were also found to need more information and experienced financial problems.

2.4.1.3 Injuries[34]

The evidence indicates that farms are dangerous places both for children and adults and most farm accidents occur in the harvest months of August, September and October.

However there is an evidence gap in this subject and more research is required to understand exactly how farm accidents occur. Road traffic accidents in rural areas are also under researched in the UK. Most evidence is from the USA which argues that because rural roads tend to be narrow, have less road demarcation and few traffic controls more accidents will occur.

The evidence is conflicting regarding the length of time spent at pre-hospital stage (time spent between the incident and hospital admission) and whether this has an effect on mortality and length of stay in hospital.

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2.4.1.4 Mental Health Issues[35]

Mental illness has a lower prevalence in rural areas than in urban areas. However, with an increasing older population, the number of people with dementia in rural areas is likely to increase and the evidence indicates that rural areas are not well equipped to deal with these increasing numbers.

Additionally, some parts of rural Wales has a continuing high rate of suicide within the farming community, whilst in other rural areas this rate is decreasing. The literature shows that farmers may or may not openly exhibit depressive thoughts prior to suicide.

There is also evidence that services can be inappropriate in treating mental health problems in rural areas. The degenerating economic climate will do nothing to improve this particular aspect of the rural health situation.

2.4.1.5 Access to Services[36]

The evidence indicates the following issues when accessing services in rural Wales. A minority of people in rural Wales have difficulty in accessing the following services: getting to dentists (18%), cinemas (18%), hospitals (13%), police stations (12%) and leisure centres (10%).

The main problem lies in the provision of transport services where 11% of households in rural Wales do not own or have the use of a motor vehicle. People on low incomes and people over the age of 65 years make up a high proportion of this category.

Over twice the proportion of those without a car have difficulties getting to a hospital than those with private transport. Access to primary health care in rural areas is complex and although it has been described that stoicism and stigma are barriers to using these services, the evidence is inconclusive.

There needs to be more incisive comparative analysis between urban and rural areas. However, evidence suggests that access is more difficult for people living in hamlets, villages and open countryside than for those living in rural towns. The longer the distance to a GP the poorer the prognosis and survival rates in certain cancers.

In Wales, 16% of people over the age of 65 years have difficulty in accessing GP services. In rural mid-Wales travel time to a GP is predominantly above 21 minutes. Increased travel time is related to delayed diagnosis of cancer and other chronic conditions resulting in poorer prognosis.

Distance to specialist health services has been shown to decrease survival rates from some cancers and asthma. Travel time to specialist services can be costly in terms of time, energy, finance and emotions. An evidence gap exists when exploring access to social care.

From the evidence available it suggests that access to social care is poor in rural areas where there are low levels of social housing, residential care and day care. Choice can also be poor with difficulty in finding people to carry out social care.

What Does the Evidence Tell Us?

Lack of local skilled community care can lead to below optimal care in rural areas especially for those with dementia, other mental health problems and those needing palliative care. This shortage is due to recruitment difficulties, low morale, professional isolation, lack of support and training facilities.

Rural residents may not be as assertive when using out-of-hours services as their urban counterparts, thus leaving them vulnerable when urgent help is required.

There is a need in rural areas for out-of-hours nursing and support care for people with chronic and terminally ill conditions. There are emerging models such as self-referral for patients to professionals such as physiotherapists which frees up the time of the medical profession but supports multi skilling and the "one-stop-shop" approach.

2.4.1.6 **Emergency Care**[37]

People living in rural areas are at greater risk than in urban areas of not receiving thrombolysis and defibrillation within the stated times limits.

Evidence of the use of thrombolysis for acute ischaemic stroke suggests this treatment is underutilised in hospitals throughout the UK and its use at the pre-hospital stage is currently unlikely.

2.5 There is significant synergy between the issues identified by the public, professionals and in the literature relating to the challenges and opportunities associated with the planning and delivery of rural health and social care services. This is reassuring in terms of both consistent acknowledgement of the issues and the need for change.

Building upon the information obtained through the engagement process, the key themes identified are critical to informing the future mechanisms that will secure improvements in the health and health services of rural communities.

Section 3
Key Issues and Themes

This section summarises the key issues emerging from the evidence gathered and proposes three key themes to help take this forward, namely Access, Integration and Community Cohesion and Engagement.

3.1 Key Issues

- Definitions of rurality vary.

  Approximately one third of the population is rural in Wales however; almost all areas are within 60 minutes (emergency travel time) of a District General Hospital and 90% within 30 minutes. Rural health, social care and well-being will be an important issue for all 7 Local Health Boards but a particular challenge for those with a high degree of rurality.

- One cannot consider health in isolation from social, economic, transport, housing and social care matters. A more holistic approach is therefore required taking account of the many factors that impact upon health and well-being.

- There is a need to consider whether there is a requirement for a completely different service model or just a change in emphasis so that the existing / emerging model across Wales is more flexible and able to respond to needs appropriately.

- Planning health and social care services within rural areas needs to balance factors of quality, critical mass, access and costs to ensure that the needs of local people are met safely and effectively. Although critical mass is a factor that needs to be taken into consideration when providing services, it should not be the defining factor for rural areas.

- There was felt to be a cost premium for providing services in rural areas. The balance and allocation of financial provision will need further analysis and consideration in assessing any additional financial implications or cost premiums of providing services to meet rural needs. In New Zealand, they offer a number of financial incentives to support service delivery in rural areas.

- The key issues emerging tend to be focused around three main headings – **Access, Integration and Community Cohesion and Engagement** more than those specific to health status. This includes both access to services by patients, friends and family, through more sustainable local and community transport, sensitive appointment systems and local service provision.

Key Issues and Themes

It also includes services accessing local people in new ways, through integrated IT systems and developments such as; e-health, diagnostics, telemedicine, telecare/telehealth, mobile unit/services etc.

- Whilst the sustainability of smaller rural district hospitals is not specifically a rural issue, nevertheless, the crucial role that they play in the life of the country side gives them greater significance than would be the case in urban areas. Whilst changes to hospitals must inevitably reflect changes in clinical practice and changes in the conditions and needs in rural areas, every care should be taken to ensure that the public is aware of progressive reformative changes that are well developed before any curtailment of extant services is announced.
- The important role of smaller community hospitals and other community facilities and the services which they provide will need to be considered within the wider context of local community service needs and in close collaboration with local communities and other stakeholders. The future lies in a more integrated approach to service provision across agency and sector boundaries and the development of locally integrated networks of services.
- Integrated workforce planning will be important to ensure that we plan for and use all skills to best effect. The generic worker and specialist generalist will have particular significance to rural communities.
- Ensuring access to local, primary, community as well as more specialist services such as diagnostic services will need to be addressed. Primary and community based services will play a key role in ensuring local access.

To achieve this there will be a need to consider increased capacity, extended services and new roles such as the developments in independent prescribing by nurses and pharmacists.

- Transport is a key factor. This should be considered as part of wider integration and planning of local bus and community transport services including ambulance services. Opportunities to share service delivery mechanisms across services should also be explored more widely. There is also a need to look at services supporting emergencies whether building on schemes such as Heartstart and local First Responder Schemes as well as identifying how the role of paramedics can be used most effectively within localities and in preventing unnecessary admissions to hospitals.
- Better integration of existing services across organisational/ professional and business boundaries needs to happen inside and outside of health and social care. More creative solutions need to be developed utilising all resources to best effect and building on models such as Monnow Court, Pembroke Dock and the emerging model in Builth Wells. This should also include using other local delivery mechanisms such as post vans, mobile day centres and other peripatetic services and bases such as, schools, garages and post offices to better effect.
- Location of services need to be focused on patient flows but differences such as waiting times between English and Welsh patients will need to be considered. This is not just a rural health matter but does affect a number of rural areas contiguous with England.

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- Other issues such as bed funds, out of hours, dispensing, incentives to practice and efficiency measures were also identified. These will need to be reviewed to ensure greater consistency and support for better local care in rural areas.
- The third and community sector plays an important role in both providing services to local people as well as providing the essential infrastructure and support outside of the statutory sectors.
- Other significant factors that may affect health in rural areas are unemployment and debt due to the decline of agriculture as the main occupation, domestic abuse and the isolation where people can feel cut off and vulnerable.

  Economic factors such as the cost of housing and demographic change are also important, as well as the effect of an ageing population.

3.2 Rural Health Framework

3.2.1 The wide ranging evidence gathered from various sources has provided us with a considerable amount of information to digest and assimilate.

To make this more manageable and more likely to succeed, we have consolidated it into, what we believe are the essential drivers for change likely to make the most significant improvements. Improving rural health cannot be achieved in isolation.

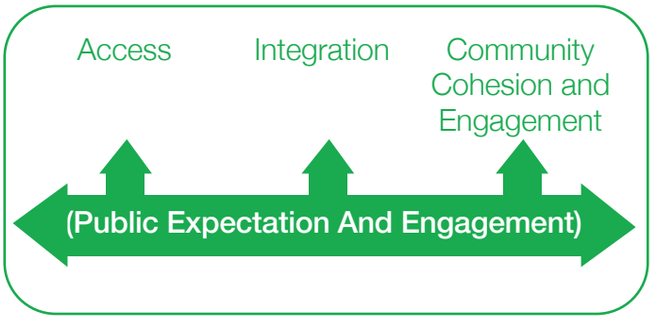
This requires a combination of successful collaboration and where appropriate service integration, combined with securing sound access to services whether through better transport, IT or outreach.

The following key themes will provide a simple clear framework underpinning the diverse range of issues identified:

- **Access**
- **Integration**
- **Community Cohesion and Engagement**

3.2.2 This section will attempt to bring together the issues in a thematic way to underpin the plan and its recommendations. It will also describe the fact that these 3 themes cannot be considered in isolation and that they are influenced by public expectation and addressed through engagement and co-design.

Figure 5



Key Issues and Themes

3.3 Access

3.3.1 Getting people to services or services to people – in this section both public access to services and support as well as the access of services and support to local people will be addressed.

3.3.2 Access to Services

Accessing services and support in its broadest sense, is the critical issue facing people living in rural communities. Rural areas are remote from centres of excellence and individuals are often distant from basic services. Bringing key services together in localities such as those needed for intermediate or respite care will help.

It is well recognised that resources are limited and that not every community can expect to have the full range of health services or expertise available to it locally. There are however many ways in which we can strengthen and improve access through:

3.3.3 An Integrated Community Transport and Appointments System

This is essential to enable people to get timely access to appointments, emergency treatment and other services and support. It will also have considerable impact on the carbon footprint.

A strong network of local bus and community transport services should be developed, in partnership with other organisations, to ensure that local people have safe, reliable, convenient and efficient access when needed. This includes third sector schemes such as Country Cars and statutory services addressing emergency care including Air Ambulance.

Mapping transport needs for health and social care and aligning these alongside broader transport requirements will be essential for a sound network of services. This work will need to be supported by responsive and flexible appointment systems, which take account of these and other social issues faced by individuals when arranging appointments.

Case Study 1:
Car Linc Mon Transport Services

Enables local people to make essential journeys where there is no other suitable transport available. They offer individuals transport for shopping, GP and hospital appointments, and to visit families. The service is undertaken by volunteers. Car Linc Mon work closely with the Red Cross Transport service as well as Social Services.

Case Study 2:
WRVS Country Cars (Carmarthenshire)

Is run in partnership with the local authority. It is a wellbeing project that adds value to the lives of so many people who would otherwise be unable to leave their homes which could lead to isolation and loneliness.

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3.3.4 Outreach / Mobile Services

Further consideration needs to be focused on where and how services can be brought closer to local people when it is safe to do so. This should include services for specific chronic conditions for example Consultant or GPwSI (GPs with Special Interest) led outreach clinics and targeted at potentially more vulnerable groups such as older people, those with disabilities or without transport and farmers who have been shown to be resistant to accessing services.

They could also include a range of pathology and screening tests and services supporting more local diagnosis and treatment, minimising the need to travel for healthcare.

The Diagnostics Modernisation Programme have produced a more detailed paper to help inform this area further. The provision of mobile services will need to be considered alongside investing in fixed assets. They can include more primary/community care services, specialised support or prevention services such as smoking cessation or the "*Designed to Smile Programme*".

Mobile or peripatetic services will help provide greater flexibility in the range of services provided and when and where they are provided. They may also be quicker to procure. In some rural areas for example a range of day/ rehabilitation services are jointly provided in local community centres on a visiting basis. These facilities are successfully providing local access without extensive capital investment.

Other opportunities to learn from and or combine outreach services with existing service provision such as Breast Test Wales and mobile library services should also be fully explored.

3.3.5 The following section includes a number of case studies drawn from real experiences. The names of the patients in all these have been changed to ensure anonymity.

3.3.6 E-health, Telemedicine and Telecare

Use of new technology has an important role in bringing services and information closer to people in rural areas. ICT can support and enhance citizen's lives in diverse areas such as: medical care, independent living, quality of life and assisted care.

New service developments need to be patient and user driven to meet their needs. There are many innovative developments and technologies that are already being used and these could make an even bigger impact if they were

Case Study 3:
Designed to Smile

*The **Designed to Smile** programme, which in January 2009 was rolled out through two super pilots in North and South Wales sees a team of dental health support workers providing toothbrushes and toothpaste to school children along with oral health advice. Part of this service is delivered via mobile dental health units that will play a key role in providing specialist preventive care and treatment to schools.*

Key Issues and Themes

properly harnessed and commissioned as part of a mainstream and integrated system.

Rural areas, especially, are disadvantaged when it comes to access to broadband services although the Welsh Assembly Government is working to address this issue. Assistive technologies, remote monitoring and telecare have been tried and tested but have yet to be fully integrated and achieve their potential. For example, home-care monitoring equipment provides considerable opportunities to support patients with long-term conditions and reduce the risks of unnecessary hospital care, yet it is still relatively under-utilised.

Planners and providers may not always be fully aware of all the opportunities available or how best to procure them with support from clinicians who need to deploy them.

We need to learn from and build on the developments and lessons to date and apply these further in rural communities in a focused and integrated way.

Case Study 4:
Renal Dialysis in Rural Communities

Jane is a 39 year old mother of 2 young children, living in Mid Wales. She has kidney problems that require her to have renal dialysis twice a week.

Jane had to travel to Carmarthen for her treatment having ambulance transport pick her up at 7am and, despite her treatment taking only a few hours she would not arrive home until about 7 o'clock in the evening because they had to wait for all the patients to complete their treatment.

Being out of the house for 12 hours twice a week put an intolerable strain on Jane's family life and significantly contributed to her fatigue. Since the satellite Dialysis Unit opened in Aberystwyth this has made Jane's life very different. She can get her children ready for school in the morning; her husband can drop her at the satellite dialysis on his way to work; her sister picks her up after lunch and she is home before the children get back from school.

Case Study 5:
Dermatology in Rural Communities

Mary is 43 years old and notices a mole on her arm has changed shape and colour and her GP agrees that it should be looked at by a Specialist. She is referred to a Specialist GP who holds a fortnightly Dermatology clinic in a practice in the neighbouring town 11 miles away.

During the consultation the GP uses the teledermatology equipment to obtain a real-time opinion from a Consultant Dermatologist at the Regional Centre. They jointly agree that this mole should be removed and because of its size and location that it would be best undertaken in the Specialist Centre.

Mary is happy to travel the 75 miles for her specialist procedure as a day case with the arrangements made sympathetic to her travelling time and distance. 5 days after her procedure, Mary attends her own GP practice to have her sutures removed. 2 weeks later she returns to see the Specialist GP who confirms that the malignancy has been removed and no follow-up treatment is needed.

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3.3.7 Support for People To Stay In Their Own Home / Communities

In combination with the above approaches, development of integrated social support interventions, both formal and informal, helps people to stay in their own homes for longer, which is important in the context of the ageing rural populations. This support can take a variety of forms including informal volunteer support and networks to schemes such as Care and Repair as well as statutory services such as those providing aids and adaptations.

Opportunities to maximise the skills and resources of local people, carers, patients and local communities should be more fully explored. Whilst ensuring that we enable local people to remain in their own homes living as independently as possible, we must be mindful that rural isolation, particularly in those living alone, is an important factor.

Community pharmacists and nurses play an important role in supporting this and models of care, to best fit local needs should be developed.

3.3.8 Rapid Access To Secondary Care – Emergency And Unscheduled Care

Access to high quality, safe, specialist care in rural areas is important. Whilst it is accepted that not all specialist care will be available in rural areas, greater effort and thought should be given to improving access for the patient, visiting families and for after care.

Care Pathways should be developed with the patient, setting out where and when specialist care is provided, and how the maintenance and follow up can best be managed closer to home, either through outreach services or more localised rehabilitation support packages.

Case Study 6:
Chemotherapy in Rural Communities

Mr Jones is 68 years old and has been diagnosed with bladder cancer. Mr Jones needs to go to his Regional Cancer Centre for his operation due to its complexity. This means being in hospital 100 miles away from home for about 10 days, which he and his family are happy with as he will receive the best possible care.

After his discharge home, he is cared for by his local community team and attends his local hospital for his follow-up outpatient appointment with his Consultant, which is conducted via teleconference.

Mr Jones is given the choice for his chemotherapy to either go back to the Regional Centre as a day patient once every 2 weeks or to have the exact same treatment administered in his local general hospital.

The network arrangements mean that the treatment decisions and the overall management of his ongoing care will be conducted by the same team of clinical experts irrespective of where he receives his treatment.

The local arrangements involve Specialist Nurses, under the supervision of an Oncologist who is part of the network, administering his treatment and negating the need for travel. Mr Jones opts for local delivery which will guarantee quality and minimise the travel burden on him and his family.

Key Issues and Themes

3.3.9 **Access To Emergency Support**

This will need to be readily available as and when needed and well planned involving members of the local community. It will need to take account of effective use of all resources in local communities including local people, volunteers and carers and making the best use of all skills available.

This should include the role of local community and volunteer support for Schemes such as 'Heartstart' or basic First Aiders, as well as the ambulance service, paramedics, GPs and third sector agencies. The rural GP will need to provide emergency care services for minor surgery and other emergency care that may not need a hospital admission.

Communities will need reassurance that we are able to respond quickly and effectively to address demands such as thrombolytic therapy, and with volunteers, to give defibrillation

Case Study 7:
Breast Cancer in Rural Communities

Mrs Evans is 63 years old and whilst attending the mobile breast screening unit is referred to a one-stop-breast-clinic at her Local DGH 23 miles away. She receives an appointment for the following Thursday.

At the appointment she has a number of tests and is examined by the Staff Grade Doctor who decides that a biopsy is advisable. Mrs Evans is introduced to the Specialist Nurse Counsellor who together with the Doctor explains that there is a possibility that the lump found on the mammogram is malignant and that the results of her biopsy will either rule this out or confirm the diagnosis. The Nurse Counsellor agrees to keep in regular contact with Mrs Evans over the next 2 weeks.

An MDT meeting is held the following Friday. Members of the Breast Cancer network are connected together by telemedicine technology to jointly review the results. Malignancy is confirmed and the advised course of treatment is mastectomy followed by chemotherapy.

Mrs Evans returns to the clinic the following Thursday where arrangements are made for her to have her surgery undertaken by the visiting specialist Breast Surgeon in her local hospital the following Thursday.

Surgery goes well; Mrs Evans is discharged home 5 days after her operation. She has a follow-up outpatient appointment with the Consultant 4 weeks later at her local DGH, a course of chemotherapy is advised which is conducted at her Local DGH.

Section 3

Case Study 8:
"Are you fibbing?" Community Responder Recruitment Campaign

The aim of the project is to train as many members of the public as possible in emergency life support skills, including resuscitation techniques, defibrillation, dealing with choking, unconsciousness and bleeding. These trained people "community responders" are used to attend scenes of cardiac arrests and other non-trauma incidents, providing additional resource whilst an ambulance is on its way.

South Western Ambulance Services provides each group with a comprehensive training programme which is followed up with an opportunity to spend time with local ambulance crews. Each group also receives uniforms, a pager, a green bag containing equipment and a defibrillator.

Source: www.ruralhealthgoodpractice.org.uk

3.3.10 Comprehensive Out-Of-Hours Service Should Exist That Not Only Meets The Needs Of Emergency Or Unscheduled Care But Also The Needs Of Those With Chronic Conditions And Those Requiring Palliative Care

This should also have plans and services to support crisis intervention whether in mental health, palliative care and or general nursing and with good links to other service providers.

This fits well with the "*Chronic Conditions Management Model and Framework*" which through a predictive risk tool, is able to pre-empt care, responding in a more proactive way. This approach should also be able to identify early on those who are more vulnerable or at greater risk of an admission to hospital and prevent emergencies and the needs for out of hours care arising.

3.3.11 Appropriate Care for Frail Elderly

Although healthier in general than people of a similar age living in urban areas, elderly rural dwellers frequently live in more isolated and hazardous surroundings. For example, they often occupy unmodernised cottages and farms with uneven ground around them, and struggle with wood/coal fires instead of instant central heating. As a result falls can be more frequent, and access to support more difficult.

Elderly people in such circumstances often end up as inappropriate acute admissions. This is in itself a risk, as such vulnerable and frail elderly are then exposed to hospital infections and all the attendant problems that come with the intermittent care of hard pressed ward staff.

In rural areas the best care close to home for these valued elder citizens is short term respite or reablement in care/nursing homes with immediate assistance and attention when necessary, homely surroundings and en-suite facilities which preserve their dignity and respect.

Key Issues and Themes

Case Study 9:
Twilight Service (Carmarthen)

Aims to prevent hospital admissions from A&E and enable earlier discharge home. Targeting the 50+ age group the service provides integrated support for older people across the county, by employing a project lead and two care support workers whose role will be to enable the older person to be discharged from A&E and to "self care" at home. The average number of patients supported is two per night.

Case Study 10:
Advanced Clinical Assessment Team (ACAT) (Torfaen)

The ACAT was set up in Torfaen as part of a holistic model for urgent response and intervention with the aim to reduce medical emergency assessments and admissions to hospital based assessment units and wards. The clinical team comprises of a senior consultant geriatrician, SpR on training rotation, six highly experienced senior nurses with advanced clinical skills, clinical support workers and administration support officers.

An effective and widely supported communication strategy was developed, which incorporated all stakeholders and engaged essential leaders in the development and the implementation phases. This allowed any management and performance issues to be dealt with through one point of contact. The ACAT team provides a holistic assessment and prioritised treatment plan within the home and are co-located with and integrated into a network of community teams who provide professional support across the health and social care continuum.

3.3.12 Access To Cross Border Services

Feedback from local people indicates that links to specialist and secondary care services across the border in England following 'natural flows' are appreciated. These have developed over time to reflect the most appropriate, quickest and effective services for patients. The flow of patients from England to Wales is estimated to be approximately one quarter of the flow from Wales to England.

3.3.13 Access To Trained Staff (Recruitment, Retention And Education)

Some rural areas indicated difficulties in attracting and retaining appropriately trained staff at all levels and across both health and social care. It is essential that the right skills are accessible in all areas.

Workforce planning will need to identify and develop opportunities to overcome barriers and ensure that flexible workforce approaches are adopted and promoted to ensure attractive and flexible work arrangements and training and education schemes are available. Within this, further consideration will also need to be given to harnessing the third sector/community workforce skills available.

Developing opportunities for joint workers and other new roles and responsibilities across health and social care will enable a more diverse workforce to develop. Opportunities to address gaps utilising the skills of the third sector should also be explored. Services provided by organisations such as Carers Wales and other voluntary organisations can help provide solutions.

Section 3

Case Study 11:
Crossroads Care

My wife and I became carers the day our son Chris was born. Chris was profoundly and multiply handicapped. At the age of 15 he underwent more surgery to remove both his hip joints that had become very painful. Although the orthopaedic results were mainly good, it led to him developing a post-surgery trauma induced condition known as neurological intestinal pseudo-obstruction.

Brecon and Radnor Crossroads support workers in turn undertook the 40 hour training programme required to become totally conversant with the tasks they needed to perform and confident they could deliver them to ours and Chris' satisfaction. The team occasionally needed new members but the core of the team remained stable for the next 6 years right up to his death in August 2004.

3.3.14 Joint education and training utilising appropriate technology and long distance approaches to learning, as well as sound career development routes will be essential to make the most of the local workforce and attract others in as necessary.

Other incentives will also be needed to ensure that essential key skills are attracted from outside.

3.4 Integration

3.4.1 The provision of services to people in rural communities, whether by statutory, third sector or private agencies, all face similar challenges. Understanding this and identifying how and where services, whether within or out with the health sector, can be provided and integrated to ensure best use of all resources will be essential. It is vital that we should always remember that integration **within** services (that is between one so called speciality and another) is quite as important as integration **between** services.

3.4.2 We need to explore opportunities to achieve this across organisational and professional boundaries, building on best practice to date and finding common solutions to common problems. The policy frameworks in "*Beyond Boundaries*"[38] and "*One Wales*"[39] calls for even greater cross-sector collaboration and integration within rural communities. Developments within the Local Service Boards have already begun to strengthen this and their experiences will need to be built on in the future.

3.4.3 Solutions to better services do not lie in dealing with single specific issues in isolation, whether ambulance services or beds in hospitals. Integrated thinking and planning will provide a sound basis from which to build a better infrastructure that best fits the needs of people in rural communities best, in the most effective and efficient way.

It will also support the ethos of sustainable communities and help reduce the carbon footprint across Wales. This approach should support more and more services moving towards more holistic approaches through the use of:

Key Issues and Themes

3.4.4 Integrated Planning and Service Models

The way that services are planned and delivered in rural areas will be different to urban areas. The principles and processes underpinning this however are the same, but may require more innovative solutions to overcome some of the challenges. In particular the need to plan and deliver services in close partnership with other key stakeholders will be essential.

Rural areas do not have the economies of scale that larger urban areas are able to benefit from and will therefore need to link with others to help achieve efficiencies. Fuel costs along with travel times will also have a significant impact on service delivery, and needs to be factored into the way that services are planned in the future. It will be essential in rural areas that we avoid duplication of resources whether in transport or service provision where more than one agency is visiting a household or local community.

This also applies to more specialist areas of care where clinical networks, particularly in rural areas, will help ensure that relevant knowledge and expertise is utilised effectively. This will demand more creative planning and service models to ensure that both generic and more specialist care needs can be met in a more integrated and efficient way. Specifically in the case of unschedule care (including ambulance services) consideration will need to be given to whole system planning and redesign that moves away from traditional delivery models. Earlier interventions and moving more services into communities will also require further thought and financial balancing.

The newly configured Local Health Boards (from 22 to 7) will have opportunities to address this across the whole of their system balancing needs within both rural and urban communities. It may also be necessary to review national policy and targets to reflect differences.

3.4.5 Integrated Service Delivery

Delivering services into small rural communities will demand real collaboration and partnership working, based on trust and with local people at the centre.

Developments to date in partnership working will need to be expanded on and where they have shown to be effective mainstreamed through wider service delivery. They should be based upon actual needs of local people and not the systems or processes in place.

Starting from where people are in their own homes and using case studies to think through more innovative and integrated service solutions will be an important starting point and a useful basis to think through more creative and flexible solutions. Developing seamless solutions whether across primary, community, secondary and social care, meets the totality of a patient's needs more effectively.

Working with the third sector through consortiums such as that being developed in Conwy addressing intermediate care may help provide solutions. RCN Cymru and the Royal Pharmaceutical Society of Great Britain – Wales Board are working closely to develop a joint strategic plan for developing non medical prescribing in Wales. This work will target the skills

of those nurses and pharmacists who have been trained as prescribers and would provide opportunities for new ways of delivering health care services in rural areas.

In the case of ambulance services and general access to emergency care traditional models have been proven to be ineffective in rural communities.

Achieving equality of outcome will require differentiated clinical and transport mechanisms that are integrated at community level with innovative practices across professional groups to secure integrated provision with maximum coverage.

Increased use of pooled budgets between health and social care and other means to support integrated services, overcoming issues of governance and professional boundaries, will need to take place.

3.4.6 Integrated Workforce

There will also be a need to take a fresh look at local health needs and align these to the necessary skills and competencies required to meet these across health and social care organisations.

Specific emphasis must be given to developing a multi skilled professional and support workforce with generalist skills on the widest practicable basis amongst both health and social care workers. Some work has already been undertaken by NLIAH on the generic health and social care worker as part of the chronic conditions work. This is of particular relevance to rural communities and should be tested further and applied more widely.

The role of the specialist generalist health worker as an expert within rural communities will be key, whether rural practitioners, nurses or allied health professionals. Further work is already taking place to review the role of the community nurse and their generic role in supporting core nursing needs within local communities. Being clear about core needs and co-ordinating more specialist health needs as and when necessary will be essential to good care in rural communities.

Training programmes will be needed to develop appropriate skills to meet these needs at all levels including voluntary, community, undergraduate and post graduate levels.

Imaginative planning and means of delivery is needed in relation to generic educational courses and qualifications, as well as negotiation with regulatory and professional bodies representative of the skill boundaries now existing.

Opportunities to engage volunteers and the wider third sector as part of workforce planning should be identified as well as providing incentives and professional development/career opportunities and pathways for example Credit for Patients, the recognised training of the third sector work by NLIAH. The awareness of the benefits and incentives of working in a rural environment should be raised to help support a sustainable workforce for the future.

Key Issues and Themes

3.4.7 **Integrated Systems**

Ensuring effective communication and information links both within and across organisations and systems will be important to help support effective service delivery and service mapping in rural areas. ICT developments such as the patient held record and other opportunities to ensure the safe and effective sharing of patient information (subject to appropriate restrictions in confidentiality) will help improve this. Informing Healthcare (IHC) is currently developing work in this area within the CCM pilot in Carmarthen and this will need to be more fully tested and shared across other rural communities.

Integrated transport planning will be central to effective delivery and use of resources in rural communities. Collaboration between statutory, voluntary and private organisations will help to ensure a sound infrastructure to enable this to happen and planning should start immediately.

3.4.8 Despite the progress made in service integration and joint commissioning, health and social care sectors still have difficulty in understanding each other's context, culture and financial and governance constraints. While at a local level a range of methods have evolved to secure greater integration in joint service delivery, planning, commissioning and funding, they still remain inefficient and many will not stand the test of the resource constraints and sustainability that are affecting public services. Future NHS reconfiguration plans however provides a real opportunity to get this right.

3.4.9 The overriding challenge in providing care in rural communities will inevitably be linked to cost. We have to re think the way we provide care for people living in rural communities. Partnership working and integrated planning and delivery is central to improving and sustaining services in communities. This is a prerequisite in rural areas where we have fewer people and larger areas to cover with limited resources. We have to move away from gaps between different packages of care provided by either health or social care and work more holistically joining up our thinking and finding joint solutions.

3.4.10 Whether dealing with episodes of clinical care or supporting long term care at home or in the wider community we need to start with public, patient and community needs, if current and future demands on services are to be met. The closer that care providers get to delivering care to patients in their homes, the more they will need to engage with the individual's wider social circumstances and their whole range of care and support needs.

3.4.11 Increasingly as budgets are stretched, support will be restricted to those most 'critical' reacting to emergency circumstances. We need to work towards a more proactive, planned and managed approach, integrated across organisations, consistent with the "*Chronic Conditions Model and Framework*".

Here local government and the health service will need to determine collectively how individual needs can be met at all life stages, including in the earlier and preventable stages of dependency or where community support is an enabling

mechanism to allow the individual to be cared for at home as an alternative to hospital or more acute provision. Innovative solutions for integrating intermediate, respite and rehabilitation for the frail elderly already exist in some parts of Wales and these will need to be further developed in rural communities.

At all costs we must avoid situations where local service providers are duplicating effort and resources.

3.4.12 Much debate remains around the Townsend Formula and its appropriateness to the needs of rural communities. The volatility of the formula will be greatly reduced when it is applied to the new 7 Local Health Board areas.

In addition, the Expert Group that advises on the maintenance and development of the formula, has proposed the introduction of ranges for target allocation shares, taking account of the confidence limits for the Welsh Health Survey data on which the formula is based.

A transition plan will be developed in 2009 as part of the finance work stream of the Health Reform Programme to outline a timescale for implementing the formula for the new Local Health Boards. The rural health challenges identified in this report will need to inform this work.

Further effort is also needed to increase the use of joint planning and pooled budgets which are essential in this agenda. Other opportunities to support additional financial demands and incentives in rural areas such as a rural health premium will also need consideration and tie in to the work being undertaken by the Finance Working Group.

3.4.13 The allocation of resources more broadly to rural areas has already been widely researched and published in the Welsh Assembly Government report on Rural Poverty and Deprivation. Comparisons were made in this report with England where rural authorities are given a greater rural premium weighting in the Local Government Settlement.

The recommendation of this report need to be implemented so that more resources are allocated to reflect the cost of service delivery in rural areas. Furthermore, many funding programmes are allocated based upon deprivation indices and statistics that work against rural areas because the measurements used are not sensitive enough to identify the 'hidden' deprivation that exists. These indices need to be reviewed. Rural authorities face many challenges due to the lower numbers of staff that exist to meet demands on services, as well as to respond to and implement policy requirements placed upon them by the Welsh Assembly Government.

3.4.14 Combined effort will need to drive change whether in:

- joint delivery schemes using the same transport systems;
- joint service provision recreating joint packages of care;
- the creation of combined health and social care campus where housing, health care and social support is combined or
- new roles and responsibilities.

Key Issues and Themes

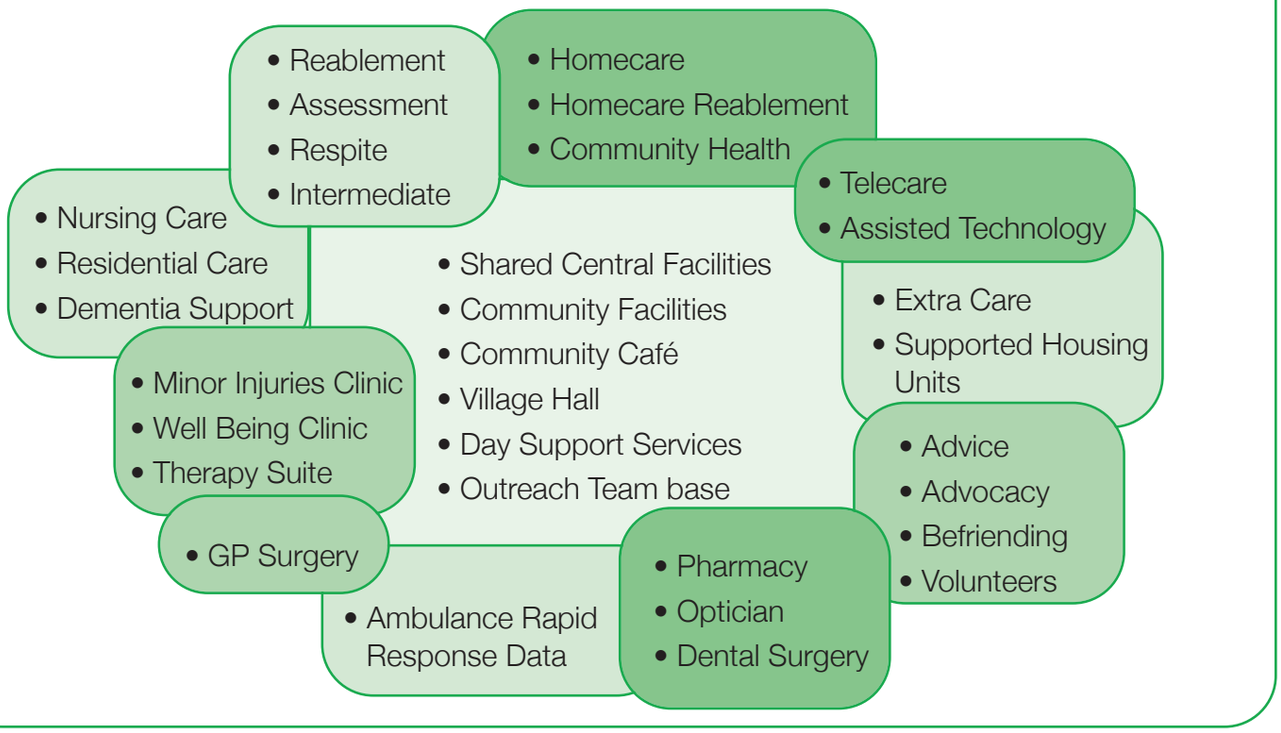
3.4.15 There are some examples of good joined up solutions that provide such support but these are not consistently available and far more needs to be done and linked into wider estates planning and funding.

The integrated model reflects the need to develop schemes that deliver greater flexibility and operating economies of scale that supports small group living environments. This model could be considered as part of the reinvigoration of community hospitals where such is appropriate. The scheme will provide support to both the people who live within it and the local communities, via the integrated location and delivery of health and social care facilities/services such as:

- The co- location of a modern GP surgery / Pharmacy / Optician / Dental services;
- A modern Minor Injuries Clinic and potential outpatient's clinic;
- A Well-being Clinic to promote healthy lifestyles;
- Modern day-care facilities, community activities, drop in Information, advice and advocacy function, laundry, hairdressers and café;
- The base for outreach and community health and social care services, such as chronic conditions management, therapist and reablement teams;
- A base for 24 hour planned / emergency homecare services and telecare;
- Intermediate care facilities providing respite, rehabilitation and other support for frail elderly within localities.

Figure 6

Builth Wells – Integrated Health and Social Care Service Model showing proposed service relationships



3.5 Community Cohesion and Engagement

3.5.1 There is much ambiguity around the terms 'cohesion' and 'community' and what they are in essence but it is true to say that there is some evidence that social integration and understanding can have significant impacts on both individual and community health and well-being.

Considering health in the context of the wider or social determinants of health (that health is not just about physical health and health services but also mental health and well-being) some health impacts are discussed below:

3.5.2 There is evidence to suggest that improved community cohesion can have a direct impact on individual and community lifestyles factors such as diet and nutrition by improving mental and physical well-being and widening access and knowledge to other food choices/cultures.

Economically and socially it has also been suggested that social cohesion can provide a link between income inequalities, social inequalities and have a powerful influence both at an individual and community level.

3.5.3 The culture within rural communities is seen to be one based upon one of self sufficiency and self reliance, where the ethos of self care is often out of necessity. As a result rural communities have strong social networks and infrastructure of local support and help.

They often heavily rely upon enthusiastic local individuals or practitioners (in primary, community and voluntary sectors) who may be involved as retired workers or employed as one of many services or initiatives with finite funding. Self reliance and over reliance on enthusiastic others can mean that the provision of services may be unsustainable in the long term. Fear of stigma for both mental health and sexual health can also make it more difficult to reach those in need due to lack of services available in rural and isolated communities.

3.5.4 The third and community sector plays an important role in supporting social capital and providing an informal network of support for those in need.

Volunteers and carers provide essential support much of which enhances and supplements basic statutory provision in remote rural communities. This should not be considered as an 'optional extra' but as an essential basic service provision within rural communities.

Key Issues and Themes

3.5.5 Maintaining and sustaining health in these communities, building self reliance and independence should be central to any rural health plan. Building strong and sustainable communities where people take greater responsibility for their own health and well-being as well as for those in their localities will be essential. Planners must enable and support people to self care whether through good access to health information or services to maintain a healthy lifestyle.

3.5.6 There is a need to ensure that formal and informal, flexible support such as respite care and home delivery to those in need is reliable and sustainable. In particular low level basic services and support (such as shopping, basic foot care, gardening, window cleaning etc) are needed to increase basic activities of daily living for older people in rural areas to help them remain independent longer and improve their quality of life.

3.5.7 The Welsh language plays a very important part in rural communities, socially as a means of communication and as a basic statutory feature. It is therefore a significant and growing practical and cultural consideration in the planning and delivery of health services. This is particularly relevant at the extreme ends of the age continuum:

- In children's services, the ability to undertake effective assessments through the language of choice is not just a matter of cultural need but can play an important role in identifying appropriate intervention which can, in turn, impact on future capacity to learn and develop;
- In adult services communication through the first language is critical to securing effective informed decision making, particularly in securing compliance with treatment regimes and with individuals with reduced capacity through physical or mental illness or as a consequence of learning disabilities;
- In older people, loss of capacity through stroke or dementia can mean that the ability to communicate in a second language is diminished and therefore achievement of maximum potential can be directly related to the ability to interact with health and social care workers through the medium of Welsh.

3.5.8 In the development and delivery of health and social care services it is therefore imperative that there is full consideration of language factors to ensure effective provision with Welsh speaking staff available to satisfy these needs.

3.5.9 Whilst fully recognised within the service, in shaping the workforce it can be extremely challenging to balance the often competing demands for clinical skills and the ability to speak Welsh. Whilst this is true across the whole of Wales, it is particularly relevant in rural communities where the prevalence of Welsh speaking is generally higher and recruitment of specialist health care workers generally more difficult.

Section 4
A Model of Care for Rural Communities

4.1 The Rural Challenge

4.1.1 Getting the right services to the right person in the right place and in the right time is a challenge. Maintaining and supporting health and social care in rural communities will need to involve the full engagement of local people, organisations and professionals working in partnership. The provision of a broad, effective and affordable range of health and social care services which focus on supporting health, well-being and promoting independence, represents a challenge to all areas across Wales.

4.1.2 This is of even greater significance in rural areas which often cover significant land mass with sparse and increasingly ageing population and associated health problems. In doing so we will need to take account of and balance four competing factors when planning service delivery to achieve good access to services; quality, critical mass, travel times and cost *(Figure 7)*. In the context of health care, access is not just about travel distance or time to facilities, it is a combination of 4 key dimensions to service delivery:

Figure 7

4.1.3 Accessibility is a central theme, with remote rural communities served by relatively small market towns. Health and social care planners have made efforts to provide as broad a range of services as possible that are accessible to people in their locality.

However, in rural communities this means that the services must serve relatively small numbers of people. “Critical mass” of potential customers and economies of scale are hard to achieve as is the need to maintain quality standards and sound governance.

An emphasis on accessibility of services effectively drives up their cost and can adversely affect their quality. A balance between these factors must be found but a totemistic adherence to critical mass cannot be justified.

A Model of Care for Rural Communities

4.1.4 Traditionally, significant emphasis has been placed on the accessibility of service, sometimes as the expense of the quality of the care, particularly more specialist medical care.

This work recognises the need to review this balance in the light of the evidence gathered and the increasing demands for an improved range of affordable, high quality services.

Internationally there are trends toward the concentration of highly complex, specialised care in fewer locations largely on the grounds of clinical sustainability. This trend however is being counterbalanced by the potential to provide major elements of more routine care (that has been traditionally hospital based) more locally than now e.g. outpatient services, assessment and diagnosis and less complex surgery.

4.1.5 The richness of the current network of major hospital sites across rural Wales is a significant asset and there should be a presumption toward local provision in the min of planners and decision makers in designing the service models of the future.

Where decisions have to be made that change the balance of provision across the network it is also important that a full range of factors are given due consideration in policy making in line with the sustainable development principles being adopted by the Welsh Assembly Government.

4.1.6 In finding solutions we will need to consider a model which finds the best balance of all these aspects.

This may require the balance between reduced access or a need to travel to more specialist or institutional services provided they are underpinned by a network of modern, primary and community facilities delivered as close to or within people's own homes.

Providing appropriate care closer to home will require better use of all skills and resources available with a multiplicity of providers working together in a fully integrated pathway, working in partnerships beyond health and social care to include housing, leisure, education and other services.

Section 4

4.2 A Model of Care

4.2.1 Providing the right care in the right place and by the right person in rural communities presents additional challenges. From our research, it is broadly recognised by people living in isolated communities in Wales that the delivery of more complex healthcare may need to be centralised in a small number of specialist centres where the expertise is concentrated to provide best possible outcomes.

Such models will require patients and their families to travel, sometimes making long journeys, to access care and where this is proportional to their need. This appears to be accepted as an inevitable consequence of rural living.

4.2.2 Alongside this however, we need to ensure that core services and less specialist care are accessible within local communities, drawing on specialist care as and when necessary.

It is useful to compare this with other every-day activities undertaken such as shopping, providing a powerful illustration of acceptability and appropriateness.

Case Study 11:
Shopping in Rural Communities

Mrs Jones lives in a rural village in Mid Wales. She expects to be able to buy her basic provisions such as bread and milk in her village shop as and when she needs them.

Every Saturday she goes to her local town which is 17 miles away to buy her meat from the local butcher and to visit her nearest supermarket to stock up on key essential items that she cannot buy in her local shop.

At Christmas and when preparing for special occasions Mrs Jones makes a day-trip to her nearest major retail centre, 55 miles from her home, to stock up on all those luxury items she cannot source locally or via the internet.

When her washing machine breaks down she uses the internet to purchase a replacement which is delivered to her home within 72 hours.

4.2.3 If we take these same principles, which are entirely acceptable in terms of shopping, and apply them to healthcare, the broad parallels would look something like this:

A Model of Care for Rural Communities

A Model of Health Care in Rural Communities

Figure 8

4.2.4 This approach will also require a different kind of workforce with an emphasis on multi disciplinary teams with generic and flexible competencies, as well as access to enhanced, specialist skills.

This builds on the chronic condition management model where the voluntary sector and patients/service users are also providing support and self management of their care.

4.2.5 An holistic approach will be essential to provide comprehensive community services and to make the most effective use of all resources locally available whether public, private or community.

Section 5

Responsibilities and Actions for Improvement

5.1 This work provides an essential first step towards improving health and healthcare provision in rural communities. We have taken a comprehensive review of the evidence and the comments received on the consultation document and identified clear improvements that we believe will make a real difference.

This now needs to be translated into actions and driven forward through the implementation plan.

5.2 To ensure that we all take responsibility for its implementation both in the short and long term we have identified actions and responsibilities at all levels nationally, regionally, locally and individually for all participants. These boundaries may not always fit perfectly but provide an indication of where they may best fit.

This will provide us with a comprehensive plan and basis for accountability and performance management. Improving rural health is everyone's responsibility and whilst further work will be necessary this will be the product of joint enerprise on the part of the following bodies at each level.

Responsibilities and Actions for Improvement

5.3 This work provides a starting point from which to build. In some areas further work and analysis will be needed to inform future implementation. Some aspects can be taken forward immediately and included within future planning requirements for the LHBs, there are some immediate improvements that can be made which can make immediate impact on people in rural communities.

5.4 **In Conclusion**

A wide range of evidence and responses has informed this work and it is clear to see that much of its success centres around a limited number of critical changes focusing on better access, integrated service provision and community cohesion.

5.5 In addition to statutory and voluntary bodies, communities and individuals have an important part to play if we are to maximise all the resources we have available to us. The challenges of distance and resources will always prove difficult but by working together and pooling our knowledge, resources and skills more effectively, we should be able to ensure the delivery of effective, efficient and appropriate services to rural communities.

5.6 Gaining the trust and support of local communities is essential as is the part they have to play in enabling this to happen. Doing nothing is not an option and we have an ideal opportunity through NHS reconfiguration to make a real success of this.

Annex A

Terms of Reference for the Rural Health Plan Steering Group Improving Rural Health in Wales

Purpose

The One Wales agenda for the government of Wales gives a commitment to develop and publishing a Rural Health Plan, ensuring that the future health needs of rural communities are met in ways which reflect the particular characteristics of rural Wales. The Minister has requested that work to progress this is established and that a draft is produced by the end of the year. The final paper will contain an outline Model for Wales with key themes and actions to enable this to improve the health and well-being of people in rural communities

Structures

This would comprise of a small core Steering Group comprising of:

- Lord Elystan Morgan,
- Jane Jeffs,
- Professor Marc Clements,
- Bob Hudson,
- Helen Howson,
- Rachel Brown.

Their role would be to help steer, guide and approve a final plan for consultation by the end of the year. The work would be supported by a small reference group of people with knowledge and understanding of working within and planning for rural health needs. This may be transient and call on additional expertise as necessary.

Health and Social Care Needs in Rural Areas

Identifying the health needs of rural communities is a fundamental starting point. Common issues should be drawn from recent health needs assessments undertaken as part of Health Social Care and Well-Being Planning. The support and skills of NPHS would be used to help undertake this. Health needs in rural communities should also be identified from within the localities and local people themselves. This should use and build on existing infrastructures and networks and organisations such as CHCs to help determine a clearer picture and involve local people in the process. NLIAH will be used to help enable this to be achieved.

Evidence of Effectiveness

An evidence review of current research will need to be undertaken. This will aim to draw together the current academic evidence supporting effective rural health care and service support. This work will be supported by WORD and the Institute for Rural Health.This academic review will need to be supplemented with evidence drawn from local health and social care practitioners to ensure that the solutions are appropriate for the needs of Wales.

Developing a Model for Wales – Key Themes and Actions

The above work themes will help support the development of a Rural Health Model and Action Plan for Wales. It is envisaged that this will identify a number of themes and supplementary actions and support needed to deliver this in Wales.

Monitoring and Evaluation

Further consideration will need to be given to how we can determine the progress and impact of the action. Baseline health data will need to be established to ensure we can measure progress

Annex B

Individuals consulted by the Rural Health Steering Group

Dr Alan Axford	Former Medical Director of Ceredigion & Mid Wales NHS Trust,
Alan Brace	Chief Executive of Carmarthenshire Local Health Board,
Mr Martin Turner	Chief Executive of Hywel Dda NHS Trust,
Ms Trish Buchanan	Health & Social Care Facilitator, Powys,
Dr Chris Jones	Chair of Rhondda Cynon Taff Local Health Board,
Mrs Judith Paget	Powys Local Health Board,
Mr Phil Robson	Powys County Council Social Services,
Mrs Allison Williams	Former Chief Executive of Ceredigion & Mid Wales NHS Trust,
Jane Randall-Smith	Institute of Rural Health,
Dr John Wyn Jones	Institute of Rural Health,
Pat Davies	Institute of Rural Health,
Jane Parry	Institute of Rural Health,
Jenny Deaville	Institute of Rural Health,
Ms Grace Lewis-Parry	Chief Executive of Gwynedd Local Health Board,
Mr Dafydd Lewis	Strategic Director of Care at Gwynedd Council,
Dafydd Jones-Morris	Welsh Ambulance Trust, Regional Director (North),
Andrew Jenkins	Welsh Ambulance Trust, Consultant Paramedic (South),
Mr John Howard	Chief Officer for Rural Health, CHCs,
The Staff and residents	Plas Y Mor, Integrated Care Facility,

Organisations Consulted by The Rural Health Steering Group

Brecknock & Radnor Community Health Council,
Community Health Councils,
British Medical Association,
Diagnostics Modernisation Team,
Institute of Rural Health,
Mid & West Cancer Services,
National Leadership and Innovations Agency for Health (NLIAH),
National Public Health Service,
NHS Chief Executives,

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Organisations Consulted by The Rural Health Steering Group *continued*

NHS Confederation,
Royal College of Nursing,
Royal Pharmaceutical Society of Great Britain, Wales Board,
Opinion Research Services, Swansea University,
WLGA,
Welsh Medical Committee,
LHB Chief Executives,
Association of Directors of Social Services, Cymru,
Welsh Ambulance Trust,
WCVA,

Papers tabled for Consideration by The Rural Health Steering Group

- Draft Project Scope,
- NLIAH proposal on programme for stakeholder engagement,
- Institute of Rural Health proposal for data and literature review,
- The work of the Scottish Remote and Rural Steering Group – Issue for Wales,
- Goodwin Review – Independent Inquiry Report into the processes on consultation and implementation of the reconfiguration of general surgical services in Carmarthenshire,
- Burns Review – Llandudno Hospital Designed for Local Services – A report on the future of Llandudno Hospital,
- Williams Review - Review of Public Consultation in Blaenau Ffestiniog undertaken by the Gwynedd Local Health Board in 2005, and a Review of Public Consultation in Prestatyn undertaken by the Denbighshire Local Health Board in 2005,
- Jones Review – A review of the impacts of developments in primary care and community care in relation to Designed for North Wales,
- Dr Alan Axford Review – Review of the Alignment of Services between the Proposals for the Development of new Community Health facilities at Aberaeron, Cardigan and Tregaron and services provided from Bronglais Hospital, Aberystwyth,
- Rural Health in New Zealand,
- Outline Structure of Rural Health Plan,

- Pharmacy and Rural Health tabled by the Royal Pharmaceutical Society,
- The role of Health & Social Care Facilitators based in Rural Wales tabled by Trish Buchan, Powys Health & Social Care Facilitator,
- Imaging and Pathology Paper supplied by the Diagnostic Services Programme (with input from the Welsh Scientific Committee and Imaging and Pathology Services).
- A Social Services perspective on Rural Health by Phil Robson, WLGA,
- Interim report on emerging issues by NLIAH,
- Programme of Citizen Engagement by NLIAH,
- "Part of the Solution – the Rural Strategy for Wales. A Welsh Therapies Perspective" by the Welsh Therapies Advisory Committee,
- Rural Health by the College of Occupational Therapists,
- Health Provision in Rural Areas by Montgomery Community Health Council,
- Citizen Engagement by Ceredigion County Council,
- Rural Health Strategy by Screening Services,
- Rural Health Plan for Wales by Clwyd Community Health Council,
- Developing the Rural Health Plan for Wales by Gwynedd Community Health Council,
- Developing the Rural Health Plan for Wales by Pembrokeshire Local Health Board,
- Developing Rural Health Plan for Wales by the Wales Council for Voluntary Action,
- Access to dental care in rural areas by the British Dental Association,
- Rural Health Plan by the Directors of Public Protection Wales,
- Rural Health Plan for Wales by NEA Cymru,
- Developing the Rural Health Plan for Wales by the National Public Health Service for Wales,
- Developing the Rural Strategy/Rural Health Plan for Wales by the Chartered Society for Physiotherapy,
- Rural Health Provision by Gwent Community Health Council,
- Rural Health Plan for Wales by Pembrokeshire Community Health Council.

Work Commissioned by The Rural Health Steering Group

- A systematic review of the national and international literature and on baseline data by the Institute of Rural Health.
- A programme of work to gauge public views on rural health issues by Opinion Research Services, Swansea University.
- An analysis of a sample of the revised Health and Social Care and Well-being Strategies from rural communities by the NPHS.

Annex C

Rural Health Plan Research Project Steering Group Terms Of Reference

Background

The Welsh Assembly Government has committed to "develop and publish a Rural Health Plan, ensuring that the future health needs of rural communities are met in ways which reflect the particular conditions and characteristics of rural Wales".
(One Wales: A Progressive Agenda for the Government of Wales, 2007).

Purpose of project

To provide background information to support the development of the Rural Health Plan through answering the following three questions:

- What are the current critical health and service delivery issues for rural Wales?
- Is there any geographical variation in these key issues across rural Wales?
- What are effective models of service delivery to meet the health and well-being needs of people in rural Wales?

The work will be undertaken in three main parts:

- Review of published data in Wales to identify key issues for rural health;
- Review of the national and international literature;
- Identification and summary of examples of good practice in rural service delivery.

Membership of steering group

The Group will include representatives from the Strategic Planning and Direction Unit, Wales Office of Research and Development, the Institute of Rural Health, PHIRN, DECIPHER, PHHPD and the NPHS.

Responsibilities

- Meeting on a regular basis to monitor progress.
- Assessing and managing risks associated with the study.
- Ensuring value for money and the delivery of outputs to time, quality and budget.
- Offering advice and guidance to ensure the research fully meets the requirements of the Assembly.
- Ensuring best use is made of existing research in order to avoid duplication of work.
- Providing feedback on draft outputs, and assessing outputs for quality. The relevant outputs are the data review (due June 2008); the literature review (due end July 2008); and the draft final report (due end August 2008).
- Considering the most appropriate ways of disseminating results.

Timescales

It is anticipated that the project will last for 22 weeks with the final Rural Health Plan due for publication in December 2008.

Confidentiality

In instances where material which is commercial-in-confidence or of a sensitive nature is discussed, members of the steering group are required to treat the information on a strictly confidential basis.

Annex D
References

[1] Rural Health, A profile of rural health in Wales, Wales Centre for Health (2007)

[2] http://www.statistics.gov.uk/geography/nrudp.asp

[3] General Medical Services Contract, Quality and Outcomes Framework
http://www.wales.nhs.uk/sites3/page.cfm?orgid=480&pid=6063

[4] The Welsh Health Survey – http://wales.gov.uk/topics/statistics/theme/health/health-survey/?lang=en

[5] The Welsh Health Survey – http://wales.gov.uk/topics/statistics/theme/health/health-survey/?lang=en

[6] Talk to me – A National Action Plan to Reduce Suicide and Self Harm in Wales 2008-2013
www.**wales**.nhs.uk/documents/**talktome**e%5B1%5D.pdf

[7] One Wales Agenda – http://wales.gov.uk/about/strategy/1wales/?lang=en

[8] Designed for Life – http://wales.gov.uk/topics/health/publications/health/strategies/designedforlife?lang=en

[9] Fulfilled Lives, Supportive Communities, 2007 –
http://new.wales.gov.uk/topics/health/publications/socialcare/strategies/fulfilledlives?lang=en

[10] Access 2009 – www.**wales.nhs**.uk/documents/WHC_2005_098.pdf

[11] Our Healthy Future 2009 – **wales**.gov.uk/docs/.../**healthyfuture**/090331**ourhealthyfuture**en.pdf

[12] Our Healthy Future 2009 – **wales**.gov.uk/docs/.../**healthyfuture**/090331**ourhealthyfuture**en.pdf

[13] Our Healthy Future – **wales**.gov.uk/docs/.../**healthyfuture**/090331**ourhealthyfuture**en.pdf

[14] Chronic Conditions Management and Framework 2007 –
http://new.wales.gov.uk/topics/health/publications/health/strategies/designedimprovechronic?lang=en

[15] Health Social Care and Wellbeing Strategy Guidance 2007 –
new.**wales**.gov.uk/docrepos/40382/dhss/4038226/DHSS-cons-**strategy**-cover.pdf?lang=cy

[16] Wales Transport Strategy 2008 – http://new.wales.gov.uk/topics/transport/?lang=en

[17] Rural Development Plan for Wales 2007-2013 – Part 1:
http://wales.gov.uk/topics/environmentcountryside/farmingandcountryside/ruraldevelopment/ruraldevelopmentplan20072013/ruraldevelopmentplan4wales2007/archiveruraldevplan20072013/ruraldevelopmentplan2007pt1/?lang=en
Rural Development Plan for Wales 2007-2013 – Part 2:
http://wales.gov.uk/topics/environmentcountryside/farmingandcountryside/ruraldevelopment/ruraldevelopmentplan20072013/ruraldevelopmentplan4wales2007/archiveruraldevplan20072013/ruraldevplan2007pt2/?lang=en

[18] Fulfilled Lives, Supportive Communities 2007 –
http://new.wales.gov.uk/topics/health/publications/socialcare/strategies/fulfilledlives?lang=en

[19] Economic Development and the Welsh Language 2006 – www.assemblywales.org/**welshlanguage**.pdf

Annex D

[20] Making the Connections 2006 – http://new.wales.gov.uk/about/cabinet/cabinetstatements/2005/140606-SE-Makingtheconnections?lang=en

[21] Strategic Framework for Economic Development – http://wales.gov.uk/about/cabinet/cabinetstatements/2005/231105-ADWalesavibranteconomy?lang=en

[22] Designed for Life 2005 – http://wales.gov.uk/topics/health/publications/health/strategies/designedforlife?lang=en

[23] Wales Spatial Plan – http://wales.gov.uk/publications/accessinfo/drnewhomepage/governmentdrs/Governmentdrs2008/pprondelivryofspatialplan/?lang=en#

[24] Sustainable Development – http://new.wales.gov.uk/topics/health/publications/circulars/2007/WHC2007034?lang=en

[25] Health Social Care and Wellbeing Strategies – http://addysg.cymru.gov.uk/topics/health/publications/health/strategies/hscwbstrategies;jsessionid=nGvQKYldrXP4DnTW28p1D7CXqHv2LBpn23Grh3VPKv8nz6WG3TNy!1458373683?cr=1&lang=en

[26] Children and Young People Plans – http://wales.gov.uk/topics/educationandskills/policy_strategy_and_planning/schools/children_and_young_people/cypplansfinal/?lang=en

[27] National Transport Plan 2009 consultation – http://www.adjudicationpanelwales.org.uk/consultations/transport/ntp/;jsessionid=710yK25YygJQ8sZ0gDjQMgvpXqQTKjHx4xK4x6KSsbB7zHPfLLSJ!814594471?lang=en&skip=1

[28] Talk to me – A National Action Plan to Reduced Suicide and Self Harm in Wales – www.**wales**.nhs.uk/documents/**talktome**e%5B1%5D.pdf

[29] Rural Proofing Toolkit, Institute of Rural Health, 2005 - http://www.ruralhealthgoodpractice.org.uk/,

[30] Sustainable Development – http://wales.gov.uk/topics/sustainabledevelopment/?lang=en

[31] Literature review undertaken by the Institute of Rural Health – http://wales.gov.uk/topics/health/nhswales/healthstrategy/ruralhealth/publications/3018733/?lang=en

[32] Literature review undertaken by the Institute of Rural Health – http://wales.gov.uk/topics/health/nhswales/healthstrategy/ruralhealth/publications/3018733/?lang=en

[33] Literature review undertaken by the Institute of Rural Health – http://wales.gov.uk/topics/health/nhswales/healthstrategy/ruralhealth/publications/3018733/?lang=en

[34] Literature review undertaken by the Institute of Rural Health – http://wales.gov.uk/topics/health/nhswales/healthstrategy/ruralhealth/publications/3018733/?lang=en

[35] Literature review undertaken by the Institute of Rural Health – http://wales.gov.uk/topics/health/nhswales/healthstrategy/ruralhealth/publications/3018733/?lang=en

[36] Literature review undertaken by the Institute of Rural Health – http://wales.gov.uk/topics/health/nhswales/healthstrategy/ruralhealth/publications/3018733/?lang=en

[37] Literature review undertaken by the Institute of Rural Health – http://wales.gov.uk/topics/health/nhswales/healthstrategy/ruralhealth/publications/3018733/?lang=en

[38] Improving Services http://wales.gov.uk/topics/improvingservices/strategy/deliveringbb/?lang=en

[39] One Wales – news.bbc.co.uk/1/shared/bsp/hi/pdfs/27_06_07_**onewales**.pdf