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APPG Rural Health and Care Major Inquiry – February 2022

"*….As we have seen, undiagnosed and unaddressed health conditions usually end up resulting in higher costs, poorer health outcomes, poorer economic opportunity and, in every sense, a poorer community. Therefore, policy makers need to focus on how we design, commission and deliver health care in these areas. Our rural communities deserve better health and care…*"

Anne Marie Morris MP, Chair of APPG on Rural Health and Social Care

Key Facts:

- Almost one fifth of the population in England live in rural or coastal areas
- The mechanisms used to collect data, although reliable in more densely populated areas, are often inappropriate for more sparsely populated localities
- In 2041 it is projected that over 65s will account for 31.6% of the predominantly rural population
- Alongside funding, workforce capacity is perhaps the greatest impediment to the delivery of equitable health and social care in rural areas

The Inquiry resulted in 12 recommendations encompassed in the Call for Action to tackle the urban-rural divide as part of the Government's Levelling Up agenda, much of which reflects our findings below.

COVID-19 Impact

'The evidence we have reviewed suggests that the biggest and most serious mental health impacts will manifest over a longer period of time. For many of the people whose mental health will be most seriously affected, the harm may have been done but the effects may take longer to manifest. Trauma, loss and grief may take months or even years to translate for some people into poor mental health. People who have been bereaved during the pandemic, people who have been seriously unwell with the virus, and people trapped in homes facing violence and abuse, face a higher risk of poor mental health that will last beyond the crisis itself. Health and care staff facing burnout may be coping in the midst of an emergency (which for many goes on) but that may come at a price later on. We're already seeing an increase in referrals for mental health support, partly resulting from the low level seen in most of 2020, and partly because of the extra distress caused by the pandemic.'

Centre for Mental Health, October 2021

Many of the factors contributing to health risks in rural communities relate to the wider social determinants of health as well as to access to health and care services.

- **Changing population patterns** Outward migration of young people and inward migration of older people is leading to a rural population that is increasingly older with accompanying health and care needs. Demographic changes meaning that older people in rural areas don't live near their families and therefore have less support
- **Digital access and exclusion** a combination of the older demographic and the unavailability of high speed broadband and mobile phone networks are leading to an increasing digital gap between urban and rural areas. This is made more serious by the growing number of important services, such as job search opportunities, banking and increasingly, health-related services available online. The growth in internet-based communication, is sometimes not possible for or desired by older people (e.g. those with visual or hearing impairments or dementia)
- **Inequity of access to support, facilities & services** Access to health and support services in rural areas is a serious issue. People are expected to travel longer distances to GPs, dentists, hospitals and other health facilities and can experience 'distance decay' where service use decreases with increasing distance. Those living in rural areas face less choice and higher costs when having to travel to access services
- **Community support, isolation and social exclusion** rural social networks are breaking down with a consequent increase in social isolation and loneliness, especially among older people. Due to the reduced opportunities to engage, i.e. village shop, post office and the other usual places of support, mental health can remain a hidden issue
- **Housing and fuel poverty** Affordability, poor quality housing and significant fuel poverty in the most rural areas are threatening the wellbeing and sustainability of communities. House prices are 26 prices higher in rural areas and there is much less in the way of social housing
- **Unemployment and under-employment** Unemployment and under-employment are taking younger people away from their families, and work is low paid and intermittent affecting the basic framework of rural communities
- **Mental Health stigma –** although there has been much improvement, people living in rural areas often suffer the stigma of having a mental health issue and being known in their community. Unlike a physical condition, mental health issues often can't be seen and are often misunderstood because of lack of knowledge and understanding

Who is suffering poor mental health?

- **Older People** - Rural communities are increasingly older. Older people experience worse health and have greater need of health and care services. Financial poverty in rural areas is highly concentrated amongst older people, e.g. Isolation and loneliness for older people has worsened since lockdown

One older lady, aged 90, used to have an active and varied village social life but now isn't able to participate in the same way as many of her friends are bereaved, have lost transport options, suffer ongoing ill health, have poor mobility and are nervous about re-engaging in activities. She is now extremely lonely

- **Young people –** Due to lockdowns, disrupted education and other mental health related factors, the demand for CYP support has continued to rise with lengthy waiting times and higher thresholds/eligibility criteria, whilst services continue to struggle with lack of capacity and increased sickness and absence. Provision of CAMHS services continues to be challenging. The pandemic has had a disproportionate effect on children and young people and is stretching provision further in rural areas
- **Domestic Abuse –** often hidden and exacerbated by COVID. Those living in abusive relationships/households were trapped and unable to seek the help they might have before lockdown. High levels of older people/carers suffering DA
- **Carers -** It is recognised that carers providing mental health support or support with memory and cognition often have an illness, disability or mental health problem themselves
- **Farming community –** recognised high levels of suicide. Hidden mental health issues as most don't ask for help. Digital interventions like those adopted by RABI have supported farmers in a way that is flexible, gives choice and allows them to seek help anonymously, particularly out of hours. We know sharing their concerns in forums and online counselling has proved extremely helpful, in addition to the more traditional face to face options offered
- **Ukrainian refugees** – With many refugees being placed/hosted in rural communities it is becoming apparent that there will be a growing need to provide support for mental health issues such as PTSD and Trauma
- **People awaiting surgery or living with Long Term Conditions –** long waiting lists have a detrimental impact on the mental health of patients awaiting surgery or with a Long Term Condition, and being unable to access local support. E.g. Dementia. Dementia is not clearly defined as either a physical or a mental health issue

ACRE network examples of rural mental health issues

- **Access to services**. Mental health services are not being sufficiently rural proofed in the development or review stage, e.g. North Yorkshire rural district where the majority of statutory mental health services are provided 'in reach' from a metropolitan city (Bradford) which is 20 – 30 miles away from some communities
- **Current overspends on the NHS 'Community Mental Health Services Transformation'** early adopters is being recovered from the VCSE investment allocation in second wave transformation programmes. Where this is planned, it is rural areas and communities where services are already stretched that are at risk of not being transformed, which is a national problem and will have a disproportionate impact on those communities

- **Public/Volunteer transport** Clients not always able to get to groups in the locality using public transport. Community transport is available but at a cost. Lack of private taxis in rural areas. This problem exacerbates isolation and loneliness Access to primary care services is beginning to improve with the appointment of primary mental health workers
- **Digital exclusion/inequality** some choose not to have the internet, some cannot afford computer/broadband or struggle to find basic one to one support in use of a tablet/PC. As a result clients are disadvantaged financially/socially and also unable to access many useful online Mental Health support services
- **Continued difficulty in accessing face to face GP appointments** There continues to be an issue with patients unable to access face to face appointments with their GP or experiencing long wait times to be seen
- **Long waiting lists**. Many statutory services continue to have long waiting lists and often time limited interventions. Some counselling services have waiting times of six months even after assessment, due to high demand and lack of capacity
- **Lack of local activities/early intervention/increase social isolation and loneliness** - Lack of activities/groups/early intervention in rural areas. Groups tend to be based in larger communities that are often inaccessible, because of lack of public transport. Many of the most vulnerable have become fearful of leaving their homes due to extended periods of shielding and isolation. Community buildings are under more pressure because of rising costs, which is likely to result in reduced footfall into these venues if these costs are passed onto the service user
- **Specific Groups** – lack of support activities for men and other health related groups
- **Food poverty/Energy Prices** – With the rise in fuel and food costs, those who are most vulnerable suffer the greatest hardship, with ever increasing demands on food banks. Escalating costs for farmers around fuel, feed and fertiliser will result in them having to pass on those costs to survive and thereby causing further hardship for those most disadvantaged and vulnerable
- **Flooding** – It is known that those at risk of repeated flooding have higher levels of stress, anxiety and depression, with the risk increasing because of more frequent adverse weather events/climate change

Mental Health in Gloucestershire

The Office for National Statistics (ONS) has classified Gloucestershire as a 'Predominantly Rural County'. This means 42.3% of the County's population live in rural settlements and large market towns.

Digital Mental Health Support

Digital mental health support was commissioned in Gloucestershire for Children, Young People and Adults at the start of the pandemic and has proved to be a valuable resource in helping to release vital capacity in the system, which was facing unprecedented demand, and offering choice to the individual in terms of how they access support.

Data shows that the top presenting issues for children and young people remains anxiety/stress, friendships, suicidal thoughts, and self-harm, despite being out of lockdown for a number of months, but coinciding with the narrative above from the Centre for Mental Health around the effects of the pandemic being felt for years to come. With regard to adults, again, anxiety/stress, depression and suicidal thoughts dominate as the top issues across both genders.

Social Prescribing Referrals

- '**Mental Health & Wellbeing'** is consistently the most common reason for referral across all areas of the county, with 51.5% of Cotswold patients presenting with this as one of their reasons for referral in 2021/22 (up to December 2021).
- **'Social Isolation'** was the second most common reason with 31.6% of Cotswold patients presenting with this
- **'Loneliness'** was the third most common reason for referral in the Cotswolds in 2021/22, with referrals trebling from **9.9% in 2018/19 to 30.0% in 2021/22**

Some examples of existing statutory mental health services – CAMHS, IAPT, MH Liaison Team, MH OTs, MH Social Workers, Primary Mental Health, Recovery team, Recovery College, MH Integrated Care Teams, Crisis Team, GRIP (Glos Recovery in Psychosis team)

Issues – long wait times, access usually by referral, higher thresholds/eligibility criteria, time limited, lack of capacity with difficulty recruiting and retaining staff. Value often placed on numbers rather than outcomes. The real value is early intervention preventing crisis.

Solutions

- Recognise mental health should sit within physical health services and not separately. They are equally important. **Without mental health there is no physical health**
- Need for rural proofing as per the APPG report recommendations, in particular delivery of services suited to rural needs, reviewing core health and care pathways to better meet rural need, development of a rural tech health and care strategy, enablement and empowerment of place based flexibility within ICS structures, integrated, holistic, person-centred care and the empowerment of the VCS to own prevention and wellbeing
- Need to normalise mental health messaging and providing positive statements relating to mental wellbeing. It is important to let people know it's ok to not be ok
- Mental Health education/early intervention should be increased in primary schools to ensure support is provided through building self-awareness and emotional resilience, as we know half of mental health conditions in adults begin before the age of 14

- Community based options for physical activity to support mental wellbeing in decline. More support to the VCS to allow them to deliver vital community based early intervention with longer term, sustainable funding models, eg RCCs, Men's early intervention mental health support - Lions Barber Collective (International) and Andy's Man Club (69 nationally) and befriending services. Funding often short term and non-recurring (use of underspend and slippage to 'plug the gaps' or pump prim, causing recruitment and staff retention issues
- Increased longer term investment in Social Prescribing
- Better and increased access to localised mental health support. Use of digital options as an enabler
- Mental Health nurses working alongside VCS
- More affordable/fit for purpose housing
- DEFRA to work more closely with DHSC
- Need for ICS to work more closely with VCS in the use of Population Health Management as an identifier of need and evidence base
- NHS to review data collection mechanisms as present system inappropriate for rural areas

John's Story

The Social Prescriber first saw *John, who had been sofa surfing for the past few years in Cirencester after losing his accommodation due to addiction issues. The SP started working with him 4 months ago in January 2022 when he was not in a good place. Using coaching, connecting to all parts of his life and with encouragement John engaged with the partner organisations that could help him including the GP, P3, the District Council and Cirencester Signpost Homeless Charity. John is now looking to volunteer with this homeless charity. By working with the SP and engaging with the support organisations available, John has now been offered a flat by Bromford Housing. He has also decided what he wants to do in the future which is 'helping people'. He really is turning his life around and it is amazing to see how with the right support he was able to do this.

Robert's Story

Robert is in his early 70s and lives in the Cotswolds. Pre-COVID he was self-employed and despite poor sight/hearing and not being able to drive he regularly travelled around the country. As a result of the first lockdown in March 2020 Robert's world shrank. He lives alone in a remote rented property and has no internet. In 2020 he went into hospital for surgery and following this, felt vulnerable, anxious and demotivated, overwhelmed by normal day to day activities and struggling with domestic chores and life in general.

He discovered over the next few months that his energy levels were very low, but was supported by friends who helped him shop and would regularly phone him. Robert wanted to remain in his home living independently, despite losing confidence in himself and his ability to cope. He was referred into the Cotswold Wellbeing service (Social Prescribers). Robert engaged with the Social Prescriber who has been working with him over the phone, jointly setting small goals. He has purchased a new mobile phone and uses it to set himself targets relating to daily exercise. He has been able to get back on top of his domestic chores and his friend will be helping him to purchase a laptop and broadband package. Robert has visited the DigiBus in Moreton in Marsh and now has a better daily routine and works around his low energy levels. In addition, the Social Prescriber made a direct referral to DWP who completed an application for Attendance Allowance which has now been granted. This extra amount will allow Robert to obtain help with his domestic chores and any personal care needs.

Robert is hoping to return to work, however if this is not feasible he would like to become a volunteer. Robert feels the Social Prescriber has been really helpful, in having someone to work with him on his goals and giving him the time that he needs to adjust, which has increased his motivation.

26th April 2022