GP SERVICES - TESTING THE DEEP END RURAL MODEL

A PRACTICE CASE STUDY

Report produced by
Devon Communities Together, April 2023

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Devon Communities Together (DCT) has led on this project, working in partnership with the Mid Devon Medical Practice. DCT has been working alongside rural communities in Devon for over 60 years and is part of the ACRE network (Action with Communities in Rural England). The work has been funded by Devon County Council Public Health Contain Outbreak Management Fund (COMF), Department for Environment, Food & Rural Affairs (DEFRA) and ACRE.

1. HEADLINE SUMMARY

WHAT?
Pilot practice case study with Mid Devon Medical Practice

WHY?
To establish whether bringing people together who live and work in/have responsibilities for a rural area with pockets of deprivation (Deep End Networks) can lead to improvements and benefits in the same way it has in urban communities

HOW?
Meetings and conversations with primary care staff, VCSE representatives and people living and working in the area

KEY ISSUES IDENTIFIED

- Transport
- Loneliness/isolation
- Cost of delivering services in a rural area
- The way in which organisations work together
- Specific challenges faced by farming communities (often present late to services)
- Stigma regarding mental health and drug and alcohol issues
- Workforce challenges

POTENTIAL SOLUTIONS

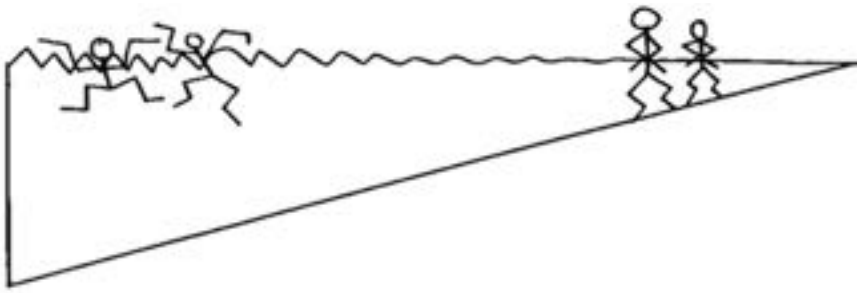
- Improved community and public transport and better roads
- Greater collaboration between services (needs to be resourced)
- More community-based, face-to-face localised support, including 'wellbeing' and 'social' groups, which normalise support for mental health issues
- Funding formula which recognises costs of delivery in rural areas
- Support to enable people to access digital services
- Micro-level data
- Supporting people in farming communities (via networks/local 'champions')

THEMES
Similar themes explored by Deep End Networks were discussed, notably workforce, community engagement and joined-up services and systems. Different themes discussed were transport, loneliness, stigma, local services, delivery costs in rural areas and specific issues for farming communities.

BENEFITS AND WHAT NEXT?
The evaluation respondents cited a range of benefits to having further similar meetings (e.g. joint advocacy/ gaining understanding of potential solutions). It is suggested that further investment in similar place-based rural groups representing the system, is considered as a vehicle to rural proofing services, addressing rural inequalities and meeting local targets.

2. INTRODUCTION: DEEP END GP NETWORKS

Deep End GP Networks are networks of GP practices that work in areas of blanket high deprivation. Deep End Networks have been established in Australia and Ireland and in many areas across the UK, including Scotland, Lincolnshire, Yorkshire and Humber, Manchester, and Plymouth. Their common goal is to mitigate health inequalities and champion the role of primary care.



Dr Julian Tudor Hart is best known for first describing what is called the inverse care law[1]. This states that the availability of good medical care tends to vary inversely with the need for it in the population served. The analogy of 'the deep end' arose from the observation that whilst the prevalence of health problems rises as socioeconomic conditions fall, the distribution of GPs is almost flat. In severely deprived areas this results in a major mismatch of need and resources. The metaphor was coined by Professor Graham Watt (Glasgow University) in 2009[2]. He used the idea of a swimming pool to represent GPs working 'at the deep end' in more deprived areas and needing to tread water, whilst GPs working in less deprived areas are better able to keep their heads above water. He suggested that the slope of the swimming pool represented a slope of need, whilst the flat line of the water at the top represented the distribution of resources.

In coming together, Deep End GP Networks have focused on several areas of work/themes and have often attracted resources whilst doing so. The themes have included:

- **Workforce**
- **Education and Training**
- **Advocacy**
- **Research**
- **Community engagement and empowerment**
- **Joined-up services and systems**

1 https://doi.Org/10.1016/S0140-6736(71)92410-x published in The Lancet in february, 1971

2 Watt G. The inverse care law today. Lancet. 2002;360:252–4

In general, the steps for establishing Deep End GP Networks have included:

Whilst the social determinants of health (e.g. income, housing, education) have been recognised as the main drivers of health outcomes, networks have championed the difference which primary care teams can make. Indeed, Julian Tudor Hart's work, as a GP in West Glamorgan in Wales (an area of high deprivation), was ground-breaking in this respect. By taking a population health approach, he made a significant difference as a GP to health outcomes. Many Deep End Networks have advocated for GP practices as health hubs for the local system.

The focus which Deep End Networks have had on the themes outlined above has led to some improvements in these areas where there is 'blanket deprivation'.

The picture in Devon

In Devon, most rural and coastal areas do not have 'blanket deprivation'. They are often characterised, however, by deep 'pockets of deprivation', which can be masked in the data by the surrounding affluence or by weightings applied to particular factors. Even Lower Layer Super Output Area (LSOA) data can mask what is going on in one street or a cluster of dwellings. Rural and coastal areas have their own challenges to positive health outcomes[3] (e.g. transport, quality of housing, cost of fuel, connectivity and the 'coastal excess', which was referred to in the Chief Medical Officer's Annual Report 2021 – 'Health in Coastal Communities').

3 The issues faced by rural area are well documented in the APPG report on Rural Health and Care published 2022

Whilst it can be argued that the distribution of resources to GPs can benefit rural areas (a higher rate is paid for working with older people and there are usually more older people living in these areas), rural GP practices often have to meet costs which urban practices do not have (e.g. satellite surgeries, travel, less economies of scale and dispensaries) and it takes more time to work in a rural community. These challenges could be described as the 'rural deep end'. The area served by the Mid Devon Medical Practice is typical of many rural areas in Devon.

In addition to exploring whether it would be helpful to explore the same themes as other 'Deep End' networks have done, the case study also sought to explore whether it would be more beneficial to focus on different themes.

3. METHODOLOGY

The work began with desktop research to understand 'Deep End' networks, including those that cover a mix of rural and urban areas (e.g. Lincolnshire and Yorkshire and the Humber), and what has been achieved. Broad outcomes have been considered as potential outcomes for similar networks in rural areas. This was followed by meetings with a range of stakeholders to ascertain interest in, and ideas regarding, the potential benefits of the case study and where it could be piloted. This included several academics/ researchers, clinicians, and representatives from Devon Public Health.

Following the above, the Mid Devon Medical Practice was identified as a Primary Care Practice working across a very rural area in Devon, where GPs had encountered hidden pockets of 'deep deprivation'. The Practice agreed to host three meetings (between January and March 2023) for primary care staff representatives and others living and working in the area.

A wide range of staff working at the practice attended the meetings, in addition to representatives from the Primary Care Network and Devon Public Health. There was also attendance from VCSE organisations working in the area and a representative from the Mid Devon Patient Participation group. Further consultation was undertaken with several people working in the area who couldn't attend the meetings.The focus of the three 1-hour sessions was planned as follows:

Session 1 (20th January)

A focus on what the key issues are and exploring potential solutions.

Session 2 (24th February)

A brief look at the Devon Joint Strategic Needs Assessment (JSNA) headline tool, a focus on how the rural proofing for health toolkit (produced by ACRE) can help to tackle health inequalities in the area and exploration of some of the questions in the toolkit.

Session 3 (24th March)

Further analysis of data, a focus on mental health (using the questions from the toolkit (above) and exploration of case studies.

Briefings were sent to attendees in advance of the meetings.

4. OUTCOMES FROM SESSIONS AND CONVERSATIONS TO DATE

4.1 Session 1 – 20th January

4.1.1. Attendees

18 people attended the first meeting. 9 were from the Mid Devon GP Practice as follows:

- 1 Operations Manager
- 3 Site Leads/Practice Managers
- 1 GP/Partner
- 2 Practice Nurses
- 1 Social Prescriber
- 1 Patient Participation Group Representative

In addition, the following attended:

- 5 representatives from VCSE organisations (including 2 from Devon Communities Together)
- 1 representative from the Primary Care Network
- 1 Public Health Consultant
- 1 Researcher from Exeter University (former GP Partner at the Mid Devon Practice)
- 1 Medical Student

3 people working in the area contributed to the information gathered at this first meeting – a representative from the Farming Community Network (FCN), a volunteer from the foodbank in the area (Lapford) and the Community Mental Health Development Lead.

4.1.2. Content of Session

Following an introduction and explanation of the pilot case study, we looked at the questions in the following section, using Mentimeter software, which allows people real-time access to share responses via a mobile or desktop device.

4.1.3. Responses to questions

Question 1. What are the best things about working in the area covered by the Mid Devon Practice?

Responses focused on the environment, the opportunity to get to know patients better in a small community and provide a personalised, responsive service and a sense of community spirit. The responses were backed up in the additional conversations.

Question 2. What are the biggest challenges to working in this area?

Responses centred on transport (poor quality roads, poor public transport/links) impacting on staff time and costs, and the accessibility of services for people living in the area. The need for generalists to have a wide skill set and cover 3 sites was raised, as well as challenges regarding the recruitment and retention of staff (NB cost of living, travel, and affordable housing). It was stated that the funding formula doesn't reflect the additional time required to serve a rural community. The lack of local VCSE services was raised. The transport issue was backed up in the further conversations and the rural nature of the area (not close to many towns) was mentioned.

Question 3. What would make it easier to work in this area?

Responses focused on improved transport (better public transport system/links, improved roads, community transport), increased funding (one person suggested a supplement to attract staff and another suggested better wages), community groups, more micro community health and wellbeing support and affordable housing. More staff, jobs and social facilities were each raised individually. In conversations outside of the meeting better connections to centralised agencies and farmers needing to be valued and appreciated were raised.

Question 4. What helps people in this area to be healthy?

A word cloud was used for this question (meeting attendees were asked to respond with one word).

Support was the most popular response. Other responses focused on the benefits of the rural outside environment (including exercise) and the benefits of contact and connection through family, community, and social opportunities. A good GP service and clinical education were put forward. These were all backed up in the additional conversations. The Community Mental Health Lead talked about how 'face-to-face', person-centred support, without limits on time, has been found to be helpful in supporting people in Devon with a mental health diagnosis who are on the waiting list for secondary mental

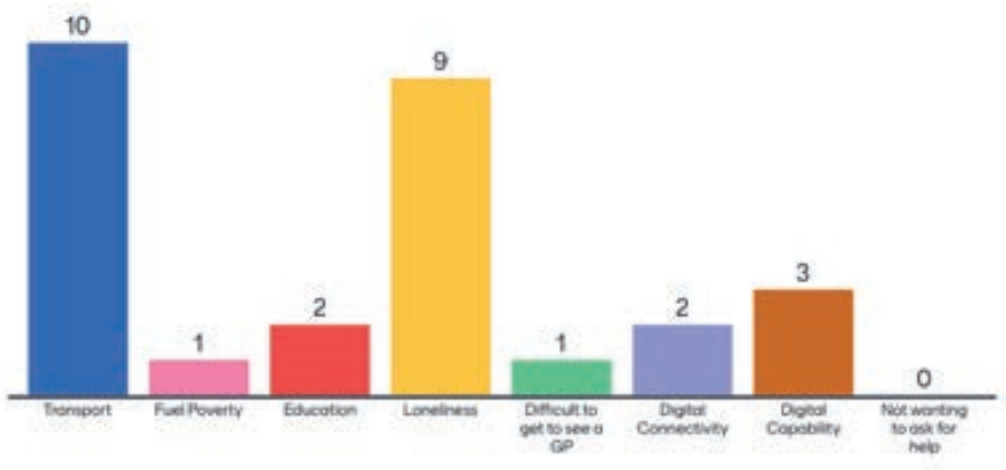
health services. For some people it has resolved their need for further support and for others it has helped them to manage whilst waiting to be seen by mental health services. Face-to-face support has also been identified as a need, leading to setting up a drop-in/café space for people in Tiverton. From recent work locally and further national examples which have come to the attention of the Community Mental Health Lead, it is apparent that person-centred, face-to-face work, can both prevent issues from escalating and be helpful as an intervention in itself.

Question 5. What are the barriers to people in this area having healthy outcomes?

Participants were asked to use one word to respond to this question. The word put forward most was isolation. This was followed by access. Finance, distance, transport, poverty, and knowledge were all mentioned. The representative from the FCN said 'stress'. The representative from the foodbank talked about the difficulties with transport (with some people having to rely on expensive taxis) and the benefits of having more services delivered locally, both in terms of transport and people feeling less stressed and intimidated.

"Delivering food parcels has led me to some pretty lonely places, beautiful if you have everything you need but very lonely if you are struggling to exist."

Question 6. Which of the following are the greatest barriers to healthy outcomes for people living in this area? Participants were asked to choose two barriers.

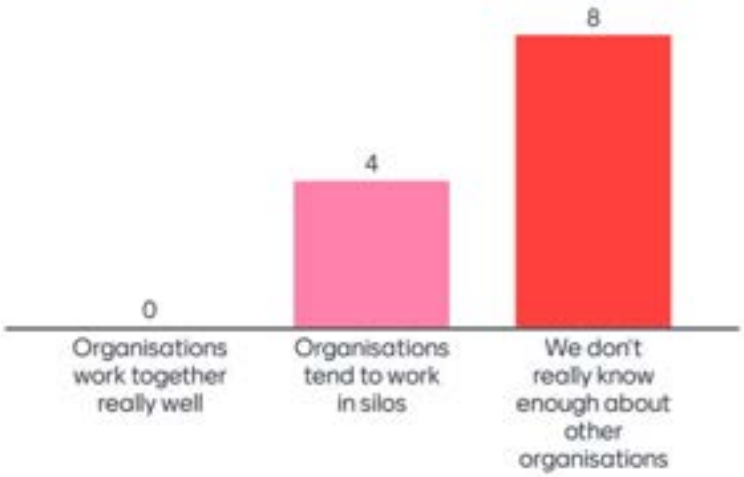


Transport and loneliness were seen as the greatest barriers followed by digital connectivity/ capability. Taking into account the external conversations, 3 people in total mentioned education.

Question 7. What evidence do you come across in your practice which suggests people in this area live in 'deprivation'?

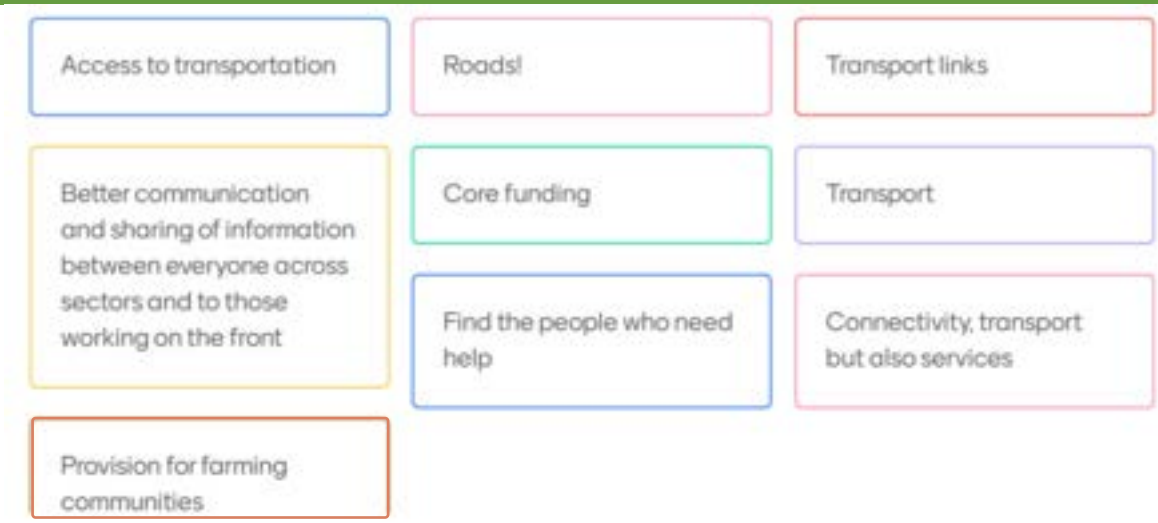
Responses to this question centred around peoples' inability to afford food and heating. Individual responses included not being able to afford prescriptions and the resources to use online interventions. The representative from Farming Community Network (FCN) advised that 25% of farmers live below the poverty line. The volunteer from the foodbank said she could see that people were living in 'deprivation' when she delivered food parcels and talked with them about how they are managing.

Question 8. How would you describe the way in which organisations in this area work?



The predominant response to this question was that organisations don't really know enough about other organisations. One of the people from the additional conversations said organisations work well together.

Question 9. If there was one thing you could change to improve living or working in this area – what would that be?



Most meeting attendees saw transport as the one thing they would change. Core funding, better communication/information sharing between people working in the area and provision for farming communities were the other things put forward. The volunteer from the foodbank suggested a local hub, with local people working there, would make the most difference. The representative from the Farming Community Network (FCN) said that a sensible return for food produced would be the one thing that they would change.


Cheriton Fitzpane Village Hall

"I'm all for keeping things local, it helps keep the community coming together, instead of moving everything to central points."

4.2 Session 2 – 24th February

4.2.1. Attendees

11 people attended the second meeting. 4 were from the Mid Devon GP Practice as follows:

- 1 Practice Manager
- 1 GP/Partner
- 1 Practice Nurse
- 1 Social Prescriber

In addition, the following attended:

- 2 representatives from the Primary Care Network
- 4 representatives from VCSE organisations (including 2 from Devon Communities Together)
- 1 researcher from Exeter University (also former partner and GP in the Mid Devon Practice)

4.2.2. Content of the Session

Joint Strategic Needs Assessment (JSNA) Data

This session began with looking at the JSNA data for the LSOAs which included the towns of Witheridge, Cheriton Fitzpaine and Morchard Bishop.

The LSOA covering Witheridge (E01020138) has a decile which is midway compared to other LSOAs regarding overall deprivation. The deciles for barriers and environment, however, are low (decile 1), likely reflecting barriers to accessing services and the condition of older housing in the area. Other areas where this area scores less favourably to the rest of Devon is the percentage for child poverty (in Devon the figure is 12.2% and in this LSOA it is 21.3%). Houses classed as fuel poor is higher than the Devon average (Devon 10.7% and this area 13.5%).

The LSOA covering Cheriton Fitzpaine (E01020077) has a decile which is midway compared to other LSOAs regarding overall deprivation. The deciles for barriers and environment, however, are low (decile 1), likely reflecting barriers to accessing services and the condition of older housing in the area. In this area there aren't any measures

where the figure is notably less favourable compared to the Devon average.

The LSOA covering Morchard Bishop (E01020070) has an overall deprivation decile of 6, suggesting less deprivation than 60% of all the LSOAs. The deciles for barriers and environment, however, are low (barriers decile 2 and environment decile 1), likely reflecting barriers to accessing services and the condition of older housing in the area. Other domains where this area scores less favourably to the Devon average is the percentage for child poverty (in Devon the figure is 12.2% and in this LSOA it is 19.2%). Houses classed as fuel poor is higher than the Devon average (Devon 10.7% and this area 13.1%).

It was suggested that postcode statistics in Devon are not representative of deprivation, as 'mansions' and poor-quality housing co-exist within one area. It was suggested that data needs to be examined at a macro level. The current relevance of the data was questioned, due to dates the information was collected. It was confirmed that the information will be updated soon with recent census information. It was also pointed out that the low employment rates seen in all the areas correlated with the difficulty in recruiting staff to posts.

Rural Proofing for Health Toolkit

The rest of the session was spent looking at the Rural Proofing for Health Toolkit – what it can be used for, by whom and for what benefits in terms of addressing rural inequalities. One of the issues highlighted when looking at the toolkit was the increased workload for staff working in rural areas. This is due to there being less people to cover specialisms whilst requirements for services remain the same, so additional functions are added to the roles of existing staff. There are also higher expectations for some functions (e.g. dispensing).

Using Mentimeter, we specifically focused on some questions which were drawn from the section in the toolkit on primary and community health services.

Question 1. How far do you think NHS funding for primary care services in this area reflects what is needed? What do you think the gaps are?

Several attendees said that funding did not reflect the additional costs of providing services in rural areas (specifically costs of hidden deprivation, travel (for staff and patients) and recruitment and retention of staff). Gaps noted were physiotherapy and limited opening times in Cheriton Fitzpaine, preventative screening services, domiciliary staff (with clinical staff often having to do this work for frail elderly people), health and wellbeing support services, remote appointments, and use of AI for remote digital monitoring.

Question 2. What thoughts have you got about delivering medical services more locally (e.g. in GP practices or in community spaces such as village halls)?

Responses to this question centred around different services working together, knowing what was available and the non-threatening nature of community spaces for some services. It was noted that midwifes and health visitors don't come to the surgery anymore and that GP surgeries are often the first point of contact in rural areas.

During the discussion it was suggested that services can be run outside of GP practices and that collaboration and promotion of services are needed to make this viable.

A manager from the Drug and Alcohol Service ('Together'), delivered by the charity EDP Drug and Alcohol Services, informed the group about satellite clinics which were currently being offered at community halls, GP surgeries and wellbeing cafes. They advised that most reach was achieved when these were offered at a 'one stop shop'. Collaboration with mental health services and GPs is working well and holistic services are being offered.

The Clinical Lead from the Primary Care Network advised that virtual mental health clinics were currently being offered and agreed to liaise with the Together service regarding the involvement of Drug and Alcohol Services in these clinics in the future.

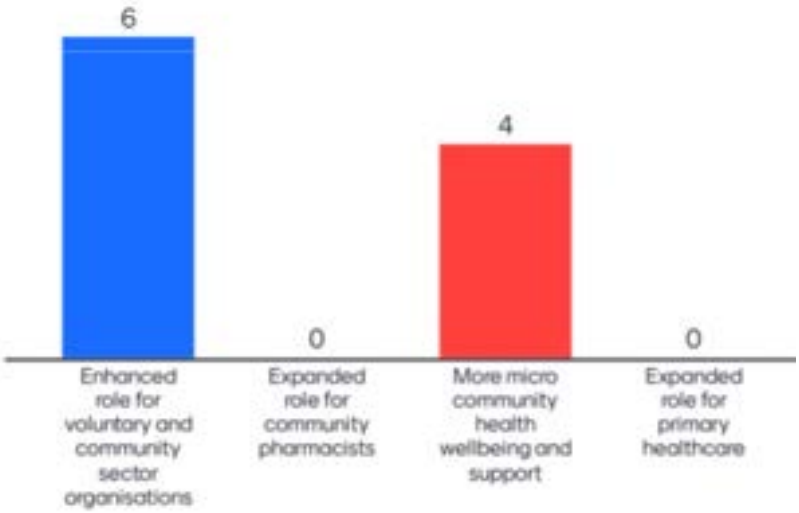
Question 3. How could public transport options to help people to travel to health facilities be improved? Should there be more community transport schemes?

Attendees thought that community transport needed to be improved and more volunteers were needed. One person suggested that it needed to be demand led and one suggested it needed to be targeted. The need for permanent cheaper public transport fares was highlighted. It was pointed out that transport is not just required for health appointments – transport to green spaces and social groups can prevent poor health. Transport needs to be recognised as a preventative resource and the focus should not solely be centred around commuting/access to more urbanised areas.

Question 4. How could virtual consultations for patients living in this area be improved/ increased?

Issues were raised regarding IT capability and connectivity. It was pointed out that in the levelling up White Paper, Devon was cited as having the worst broadband. Most people thought that funding for services to support people to access healthcare online was what was most needed. It was suggested that appointments should be rearranged if people had difficulty accessing them. A couple of people highlighted that people increasingly want face-to-face appointments and that we need to be cautious regarding digital exclusion.

Question 5. In what way (if any) do you think the role of community pharmacists could



It was highlighted that covid demonstrated a more developed role for community pharmacists but pointed out that some pharmacists/pharmacies are experiencing challenges currently. Linking community pharmacists and social prescribers was suggested as was the ability to buy over the counter products. Opportunities for staff working in dispensaries to train to NVQ level 3 was raised as a need. The PCN is hoping to expand their referral to community pharmacy scheme to support same day demand.

Question 6. If you were commissioning more community health services in this area (e.g. to address loneliness/isolation), which of these would you prioritise?

Attendees said they would commission an enhanced role for voluntary and community organisations or more micro community health and wellbeing support.

Question 7. What's the biggest challenge to working collaboratively/networking with other organisations across the area? Choose one word.

Time and funding came out as the biggest challenges (capacity linked to these), with awareness (communication) next. Other challenges were awareness, access and distance.

Question 8. What can be done to alleviate networking and collaboration challenges?

Attendees wanted to see more collaboration opportunities and several thought that increased funding to support protected time/backfill personnel was necessary. It was suggested that someone needed to coordinate collaboration opportunities, events, social opportunities, and resources. Better communication and information sharing was also mentioned.

4.3 Session 3 - 24th March

4.3.1. Attendees

12 people attended this last meeting. 6 were from the Mid Devon GP Practice as follows:

- 1 Practice Manager
- 1 GP/Partner
- 2 Practice Nurses
- 1 Social Prescriber
- 1 Site Lead

In addition, the following attended:

- 1 representative from the Primary Care Network
- 4 representatives from VCSE organisations (including 2 from Devon Communities Together)
- 1 researcher from Exeter University (also former partner and GP in the Mid Devon Practice)

4.3.2. Content of the Session

Further time was spent discussing data (including the Mosaic Data for the area). It was highlighted that many people assume that the majority of people living in rural areas are living the 'rural idyl'. The Mosaic data suggests that this is not the case.

Using Mentimeter, we focused on the questions below, which were drawn from the section in the rural proofing toolkit on mental health services.

Question 1. Do you know if people in this area with mental health needs present late? If so, what do you think are the reasons?

Most people said that awareness regarding what is available and attitudes towards seeking

help (people are embarrassed, worried, afraid, not wanting to bother anyone and there is perceived stigma) were the main reasons for people presenting late. One person specifically mentioned agricultural workers presenting late and suggested that this was due to their health beliefs. One person mentioned young families, who are 'time poor' and may not feel they have the time to invest in psychological services and another mentioned lack of accessible services.

The value of online consultations with TalkWorks was raised (e.g. to address issues regarding stigma and accessibility), although the group were aware that online services were not suitable for everyone and there were issues with internet connection in Mid Devon.

Question 2. What ideas have you got for improving mental health or wellbeing initiatives which reach out to farmers in this area?

Responses focused on targeting farmers and raising awareness via places farmers go to and people/networks they come into contact with. This included markets, Young Farmers, events, county shows, village shops, pubs, farm vets, shopkeepers, and landlords. It was suggested that support should be given to people who farmers are in contact with so that these people can identify people who would benefit from mental health support.

The GPs in the group talked about farmers not accessing primary care. It was suggested that farmers tend to think they haven't got time to be sick. One GP recently had sight of a coroner's report, where the patient had been unwell, but hadn't accessed a GP in 5 years. A previous GP partner of the Practice said that sometimes the farming community can 'take their health into their own hands'. They are used to dealing with 'life and death, therefore their own health needs seem less important. Some of the farming community have been known to self-administer animal medication, rather than 'bothering a GP'. One of them stated that a farmer's request for help should always be taken seriously.

One person talked about the value of animal therapy, another suggested a 'buddy system' and a couple of people suggested more local services (village-based groups and activities) would be helpful.

The potential stigma of seeking support in a rural community was raised and the tendency for some people to say they are ok. It was highlighted that Young Farmers' groups are now doing talks on mental Health to try to address this and that the Trading Standards Service is running a Mental Health in Farming support service . It was suggested that creating spaces and opportunities for people to talk about their mental health, in a way which normalised it, would be helpful (e.g. evening sessions not badged as mental health, but maybe advertised as educational talks about wellbeing to start the conversation and help people realise that they are not alone with their feelings).

Question 3. What ideas do you have for improving support to people with mental health issues living in this area?

Again, the group talked about quicker, easier access and availability. This included local 'support groups' with peers and 'wellness' support services to prevent people reaching a crisis stage. One person suggested using schools as community hubs. One person highlighted that courses that have been offered in Witheridge have not had a high uptake, despite being well promoted. Again, the point was raised about not labelling groups as 'mental health 'support, in order to make them more accessible (e.g. having weekly chat/social groups). It was also

suggested that groups needed to be held on the same day of the week, as it becomes too complicated for people to access when they are sporadic (e.g. on the third Thursday of the month).

Befriending (buddying) was raised again as was supporting local trusted champions (e.g. shopkeepers and landlords) to identify and signpost people needing support.

It was suggested that linking with what is currently available is important and having a joined-up approach with Community Mental Health Services, using all means to encourage people to raise concerns, including social media.

The social prescriber present talked about the importance of getting to know the person and about the work they do. Social prescribers can put people in contact with a range of services, e.g. Grief Cafes, Citizens Advice Bureau. They can help to set up community connections, offer support and coaching and visit people in their own homes. Anyone can refer to a Social Prescriber. For example, pub landlords, shop keepers and clergy are actively encouraged to make referrals, as this can help to address needs before they reach crisis.

It was highlighted that GPs are equally as important as social support (needed for diagnostics and to exclude health conditions) and that all services need to be working together as a large team.

Question 4. How might support to those seeking help for drug or alcohol issues be improved? How might it be better coordinated with other mental health services?

Responses focused on improving access by ensuring local services and support, enabling people to get help in a shorter time frame and not having to go through a GP. One respondent mentioned the importance of support for people before they approach the system because they are in crisis.

A representative from the local drug and alcohol services highlighted that living in a rural area and having drug/alcohol problems is very isolating, and there can be a lot of feelings of shame for people in smaller communities. They advised that support needs to be hybrid (i.e. online, in addition to face to face support), which the service offers. There can be problems in accessing face to face support due to lack of transport options.

One of the GPs talked about changes in prescribing regulations. The service representative advised that Buvidal (opiate substitute) injections can now be given, which last up to two weeks and are helpful for people living rurally as this mitigates against problems of needing to travel more regularly (e.g. to a town/city to pick up methadone from a pharmacy).

In the final part of the third session, we looked at both a theoretical and a live case study, which one of the GPs presented. The live case study presented led to a discussion regarding how GPs should respond to patients who are dependent upon alcohol but are 'in denial' about this. The evidence base for IBA's (Information and Brief Advice) in primary care was alluded to and the importance of GPs relating alcohol consumption (measured by AUDIT-C tool) to other medical conditions which patients present with. It was recognised that denial is a huge factor in alcohol dependence and suggested that continuing to offer Brief Interventions is worth persevering with. It was noted that sometimes people who are in denial regarding alcohol dependence, may end up being detoxed from alcohol following admittance to hospital, due to another medical condition. However, it was pointed out that

this is often unsuccessful (i.e. people often relapse), as the medical detoxification is only part of the potential solution. The underlying reasons why people are dependent on alcohol need to be explored, and detoxification should ideally be planned, with an aftercare plan in place. Post detoxification support could include AA (Alcoholics Anonymous) and/or prescribing of Acamprosate alongside counselling. There was a discussion regarding boredom and lack of purpose leading to alcohol dependence and the need to address this as well as physical dependence.

5. EVALUATION

An online survey evaluation questionnaire was emailed to the nineteen participants. Twelve people completed the questionnaire. Eleven respondents thought the meetings had been useful – and all twelve thought there could be benefits to bringing people together in this way in the future. The benefits of the meetings which were most cited centred around networking, connecting with others in the area, gaining better understanding of what other organisations do and more joined up working with other organisations. This was evident in the meetings, where several participants agreed to make contact outside of the meetings and shared information about what their organisations did. Several evaluation respondents said there had been useful ideas following discussion of a live case. Gaining a better understanding of issues and solutions for the area were also cited as benefits.

Half of the respondents said they hadn't previously come across the Rural Proofing for Health Toolkit (only two respondents said they had). Three respondents said they would use it again in the future and five said that they thought the questions in the toolkit were helpful in exploring local issues.

Whilst most people weren't aware of improvements which had happened as a direct result of the meetings, all respondents cited benefits which they thought could be realised by bringing people together in the same way in the future. Joint advocacy for rural issues, gaining a better understanding of potential solutions and more joined-up working practices were most frequently cited. Several people again thought getting to know what other organisations offer, connecting with others in the area and gaining ideas from case discussions would be beneficial. Piloting new ideas and joint approaches to local issues, gaining a better understanding of issues in the local area and influencing education and training were also cited as potential benefits.

> *"...the forum for networking, joint learning and problem identification and solving seem to be key reasons..." (for bringing people together in this way in the future)*

6. SUMMARY

The people who attended the first meeting (and the other people spoken to) were very clear about the benefits of living in a largely rural area, in terms of the beauty of the natural environment and the benefits to health which this can offer. Being part of a smaller community, knowing patients and being able to offer a more personalised service were also highlighted as the best things about living and working in the area. It was clear, however, that there are many people living in the area who are lonely and isolated and/or living on low incomes and struggling to afford food and heat their homes. There was a discussion in the meeting about couples who retire to the area with dreams of an idyllic life, which are

shattered when one person dies, and the other person becomes ill and can no longer drive.

Alongside isolation and loneliness, transport was seen as a huge issue, which impacts on both working and living in the area. Poor links, poor roads and an inadequate public transport system were all discussed, and it was the thing which most people said they would change to improve the experience of living or working in the area. The need for more responsive community transport options and volunteers to enable this to happen was seen as critical. It was highlighted that transport was important as a preventative health measure (e.g. to take people to green spaces) as well as to take people to healthcare appointments.

Face-to-face personalised support, contact, connection, community, and family were seen as critical to positive health outcomes. The importance of GP services in rural areas was also highlighted. Several people spoke about the importance of having more local services, organisations, and community groups in community spaces, so that people didn't have to travel. This would enable people to have more face-to-face connection.

Issues regarding stigma and lack of awareness of mental health services (including drug and alcohol services) were raised with regard to people living in small rural communities. It was thought that local groups could be promoted as more general social groups, to encourage people to seek support with regards to mental health and help to prevent difficulties from escalating. Supporting local 'champions' (e.g. shopkeepers, landlords) to identify people needing help was put forward. This is something which the social prescriber already does. Participants suggested more accessible local drug and alcohol services would be helpful. The representative from Together Drug and Alcohol Services advised that hybrid options to address stigma and Buvidal prescribing improved access.

In general, participants said they didn't know enough about organisations working in the area and that organisations tended to work in silos. The importance of collaboration and promotion of local services were stressed. To do this, attendees thought that there needed to be additional infrastructure funding, so that collaboration could be co-ordinated, and staff could have more protected time for this. When asked at the second meeting which community health services attendees would prioritise in commissioning to address loneliness and isolation, they said that they would commission an enhanced role for voluntary and community organisations, or more micro community health and wellbeing support.

The additional costs of delivering services in a rural area were raised at both meetings. These included providing satellite surgeries and dispensaries, costs of hidden deprivation, travel (for staff and patients), recruitment and

retention of staff and being unable to realise economies of scale, which GP practices in urban areas can benefit from by sharing resources with neighbouring practices. It was highlighted that the funding formula doesn't reflect these additional expenses and there was a suggestion that staff working in rural areas should be paid a supplement. The lack of affordable housing and transport costs were suggested as key factors in the staff recruitment and retention challenges. Staff in rural areas also have increased workloads due to there being less people to cover specialisms and gaps locally for some specialist services (e.g. physiotherapy, domiciliary services), whilst requirements for service standards remain the same.

Specific issues were raised regarding the farming community. The representative from Farming Community Network advised that 1 farmer dies each week from suicide in the UK and a farmer has an accident every 11 days. The Farming Community Network helpline has more calls from Devon than any other county. 25% of farmers live below the poverty line and farmers do not get sufficient return for the food which they produce. The representative advised that farmers often don't feel they have time to go to see a GP. This was backed up in some of the discussions with primary care staff, with a concern that when people from farming families contact their GP, their health problems have often reached a more critical point.

Participants thought that farmers needed to be targeted to raise their awareness and challenge stigma regarding health issues (including mental health). It was suggested that this should be done by focusing on places farmers go to and people they come into contact with. Again, it was suggested that creating spaces and opportunities to talk about mental health, in a way which normalised difficulties (e.g. sessions not 'badged' as 'mental health' sessions), would be helpful.

Currently the Public Health outreach team in Devon are looking to set up a health hub at the livestock market, as farmers have some time to spare there whilst they wait for their livestock to be sold.

It was highlighted that, although some of the 'deprivation' issues could be seen by looking at the Joint Strategic Needs Assessment (JSNA) data, postcode statistics in Devon are not representative of deprivation, as very mixed housing can co-exist within one area. It was suggested that data needs to be examined at a more micro level. In the last session, Mosaic data was looked at. It was pointed out that this illustrated that not everyone living in rural communities live the 'rural idyll', which many people outside of those communities might assume.

Whilst digital exclusion and some peoples' wishes to have face-to-face appointments were recognised, most attendees thought that what was most needed regarding digital healthcare was locally accessible trained support to enable people to access this, in terms of connectivity and capability. Digital support for mental health issues was seen as one option for people who felt

embarrassed/stigmatised in seeking support from face-to-face services and the use of AI for monitoring purposes was proposed as a potential solution to gaps in social care services.

There was an interest in a more developed role for community pharmacists, but it was pointed out that some pharmacists/ pharmacies are experiencing challenges currently. Opportunities for staff working in dispensaries to train to NVQ level 3 was raised as a need. The PCN is hoping to expand their referral to community pharmacy scheme to support same day demand.

Some of the themes explored by other Deep End Networks were discussed, notably community engagement, joined-up services, funding, systems, and workforce (though the issues discussed with reference to the rural workforce are likely different). Themes discussed which were different were transport, loneliness, stigma, localised services, specific delivery costs in rural areas and issues for farming communities.

All respondents cited benefits which they thought could be realised by bringing people together in the same way in the future. Joint advocacy for rural issues, gaining a better understanding of potential solutions and more joined-up working practices were most frequently cited Several people again thought getting to know what other organisations offer, connecting with others in the area and gaining ideas from case discussions would be beneficial. Piloting new ideas, gaining a better understanding of issues for the area and influencing education and training were also cited as potential benefits.

The learning from this Rural Devon Pilot Case Study was included in the evidence presented to the House of Lords Inquiry into ICS and health inequalities on 27th March, 2023. Nora Corkery, Chief Executive of Devon Communities Together (DCT) presented oral and written evidence to the House of Lords Inquiry Committee into progress with Integration of Primary and Community Care Committee systems development and how rural health inequalities are being tackled, as part of a delegation from Action with Communities in Rural England Network (ACRE). We were informed that the Committee is very interested in work like this which aims to reduce rural health inequalities in the integration of primary and community care services within the wider health system. The Committee Chair requested that we share a copy of this report and the Committee were also interested in hearing about joint VCSE/ ICS work around reducing health inequalities arising from rurality in Devon.

7. CONCLUSION

There have been some real benefits to bringing people together who live and work in a rural area of Devon. Whilst tangible improvements to local services have not been actioned at this stage (the group met for three one-hour meetings), many respondents to the evaluation found it beneficial to connect with others in the area, understand what work they do and join up their working practices. Gaining a better understanding of issues and solutions for the area were also cited as benefits to meeting together. Whilst some similar themes were explored, which have been explored by other Deep End Networks, there were some notable differences, which are pertinent to rural areas. These were transport, loneliness, stigma, local services, the nature of workforce issues, delivery costs in rural areas and issues for farming communities. The concept of ‘a rural deep end’ was a useful approach to exploring the specific challenges to working in a rural area and the health inequalities faced by people living rurally were made very clear.

It is also clear that the roles played by primary care, the VCSE sector and local communities have a significant impact upon these challenges and that there are benefits to bringing together people working

in different organisations across the system. Several respondents to the evaluation noted the usefulness of using the questions in the Rural Proofing for Health Toolkit as a framework for exploring rural issues.

Some of the potential benefits cited by participants regarding future meetings, were similar to those realised by other Deep End Networks. These included joint advocacy, more joined-up working practices, influencing education and training and gaining a better understanding of potential solutions. From this case study, we conclude that further investment into rural place-based locality groups, with representatives from across the system, could be an important vehicle to rural proofing services, addressing rural health inequalities and meeting identified targets. Given some of the solutions posed in this study to address a range of rural issues, there may also be benefits to working with groups such as this one to explore alliance-based commissioning models.