Exploring possibilities: Integrated care for the elderly population in remote and rural areas - 8th October 2014 in London

Background for the event: why we need to look at this issue

Remote and rural economies face a specific set of demographic and geographic challenges. For example, the average age of the population in rural areas is increasing at a faster rate than in urban areas with nearly a quarter of all older people living in rural areas.

Whilst, in general, the elderly population in rural areas enjoy better health than those living in urban areas, depression, stroke, falls and dementia are projected to grow by between 50% and 60% in rural areas compared to increases of between 34% and 42% in urban areas. Furthermore, as they age, their requirements for access to services such as health, transport and social services are likely to increase. The elderly population in rural areas can also face difficulties in accessing health and social care services due to distance, poor transport provision, loneliness and isolation and poor service integration.

A combination of these factors provides a strong case for service commissioners and deliverers to understand how ageing impacts upon service delivery and to improve integrated care for the elderly population in remote and rural areas. This has to be supported by policy making that is underpinned by rural proofing principles to deliver the right outcomes.

Event presentations

John Coleman and Martin Gorringe, Department of Environment, Food and Rural Affairs (DEFRA): Rural proofing report

Key points:

- Rural proofing is a term used by policy makers when planning services in rural and remote areas for the best outcome;
- DEFRA combines anecdote, evidence and tries to find localised solutions by working with other government departments and key stakeholders;
- The department is working on improving transport to and from appointments through bus subsidies;
- The department invites NHS organisations to tell it how it can assist in the sharing of good practice;
- Lord Cameron is leading DEFRA’s work on this.
Ed Moses, Public Health England (PHE)

Key points:
- Integration is about working better together to streamline and improve services. We are trying to make best use of what we have, and not necessarily with more money.
- PHE tries to understand the epidemiology and needs of the population to map what commissioning is required to improve health outcomes in different communities.
- PHE also supports the local and system transformation needed to achieve this.
- PHE is helping the system to move away from its high cost crisis intervention spend towards health and social care integration.
- Practice in rural and remote areas is miles ahead of national policy, with many evidence based examples of integration.

Jo Holmes, Age UK

Key points:
- Charity working across a number of policy areas to address the needs of the ageing population in the UK.
- It achieves its aims through an advocacy arm and a social enterprise arm.

Success Story: Cornwall Pathfinder programme
- Older people rely on GPs, nurses and other clinicians for social contact.
- AGE UK employs school leavers and others interested in a health/social care career to coordinate care.
- Hospital Consultant in Cornwall attends the local breathing group to provide care instead of patients coming to hospital.

Ann Wagner, Airedale NHS Trust

Key points:
- Trust covers rural community and urban areas totalling 250,000 people. Many over 100 years old.
- Telemedicine and tele-health consultations are offered to prisons, care at home, nursing and residential care settings.
- In-prison healthcare started 9 years ago and is very effective.
- Services are reducing in-patient admission by 40% and A&E attendances by 15%.
- This has resulted in reduced lengths of stay and reduced costs.
- One of first hospitals to develop health and social care integration record for patients on the TPP IT system, with fully integrated EPR by April 2015.
- Integration work focuses on the patient’s life goals, ambitions, not simply working together.
- Distributed leadership is about sharing ownership for responses and solutions.
- Challenges faced include clinical engagement, technology evolving at pace and a need to respond to patients in their own homes, securing mainstream funding and the tariff system.
- Future plans include palliative care support on the phone and ceasing to use the long 111 form, enabling the hospital for full-site video capability and rolling out the Right Care model across the community.
Breakout session discussions

Whole system: key points from discussion
- Rural areas require tailored solutions focusing on outcomes and principles.
- Better Care Fund does not address complex historical health and social care issues.
- Distance between services serves to reduce competition as patients seek local care.
- Integrated services can be provided in clusters of teams working in a coordinated way to deliver care such as GPs; mental health teams, care coordinators and social workers.
- Provider trusts would benefit from a lengthening of the yearly contract process to a longer period to reflect the need for trusts to plan for better service delivery in the years ahead in the context of flexible spending limits.
- Poor broadband coverage is a barrier to rolling out tele-health technology.
- Resistance to technology may fade over time as more become computer literate.
- Those who rely on consultations for human contact may resist the change to tele-health.

Commissioning: key points from discussion
- Every single health economy designs its own solution based on central policy.
- Best practice should be rolled out uniformly.
- Joint ventures and capitated budgets are preferred over alliance contracting.
- Keep pace with integration agenda.
- Perverse incentive: collaboration models to align incentives.
- Commissioners must understand the importance of patient community and family support

Workforce: key points from discussion
- Need more geriatrician roles available.
- Need one stop shop 'pub is a hub' type arrangements as an integrated unit for health.
- Draw on current resources rather than waiting for new policy to drive changes.
- Achieving best practice is motivating for staff so that they can offer the best care.
- Low wages are a barrier to workforce planning and retention in rural areas.
- Need to take workforce pressures off the system so that we can fix it.

Event conclusions
Key points
- Everyone has a part to play in rural and remote service delivery, including clinicians.
- There is a lack of ability to deliver health and social care in remote and rural areas because of transport, distance and minimum wage.
- It would be good to abolish bureaucracy around continuing healthcare.

Next steps
- Everyone was encouraged to follow up and make linkages with Lesley Boswell, National Clinical Director for rural and remote care.