Social Care in Rural Areas

Discussion material

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IMPACT Improving Adult Care Together

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How you can use this discussion material

This discussion material is based on evidence from research, lived experience and practice knowledge. You can use it to reflect on your current services and to open up conversations with people, families, colleagues and partners about ways to make evidence-informed changes to what you do.

This discussion material is about social care in rural areas. There are three key challenges related to delivering adult social care in rural areas it focuses on:

1. Characteristics of population in rural areas
2. Loneliness and isolation
3. Workforce issues.

We've also included some case studies where organisations have tried to tackle these challenges.

What is the issue?

In 2020, **9.7 million people lived in rural areas in England** (Department for Environment, Food & Rural (2022b) and 25.4% of people living in rural areas were aged 65 and over, in comparison with 17.1% of those living in urban areas. There are differences across the UK: **17% of people in Scotland** live in rural areas (6% in *remote* rural areas), **32.8% in Wales** and **36% in Northern Ireland** (Scott 2020). **Delivering adult social care in rural areas is challenging** due to barriers such as physically accessing services; staff recruitment and retention; limited choice and higher costs. Despite the evidence suggesting the existence of a strong sense of community in rural settings, **loneliness is a common problem** that needs to be addressed.

Rurality is also complex. There are debates about how to define 'rural'. **Size and density** of population and **accessibility** to urban areas generally used for statistical analysis (Department for Environment, Food & Rural Affairs 2021; Department for Environment, Food & Rural Affairs 2022b; Scottish Government 2022) but in reality, rurality is more complicated. For example, the Review of the Statistical Classification and Delineation of Settlements (Northern Ireland Statistics & Research agency 2015) suggested that defining rurality only based on size, population and density is too rigid and a more flexible approach should be used based on the specific characteristics and needs of the area.

Rural areas are also not all the same- local context is important, so understanding **local population characteristics and historical and social background** is vital in crafting effective policy, practice and interventions. For example, when we look at age as a population characteristic, Scotland has a higher proportion of individuals aged 45 and above living in rural areas, particularly in the 65 and over age group, while the percentage of residents aged 16 to 44 is lower (Scottish Parliament Information Centre 2022). In England, the Department for Environment, Food & Rural Affairs (2022a) reported that the rural population is older in comparison with urban areas, and has a slightly higher life expectancy.

Box1: Rural populations and policies in the four UK nations

Northern Ireland: The Rural Needs Act (Northern Ireland) 2016 states that public authorities must consider the needs of people in rural areas in policies and public services. In this context, a report produced by the South Eastern Health and Social Care Trust in 2023 recommended the promotion of community health care and investments in initiatives to meet rural healthcare needs. This includes increasing "GP surgeries, district nursing, allied healthcare professionals, carers, care homes, and an enhanced care/acute care at home model" (South Eastern Health and Social Care Trust 2023, p.40), as well as enhancing the availability of public and community transport options, thereby enabling people access services.

Scotland: Certain health and social care challenges have a greater impact on rural areas, including access to services, recruitment and retention of staff, as well as training for staff, and health outcomes (Scottish Parliament Information Centre 2022). The Remote and Rural General Practice Working Group's report in 2020 led to the Scottish Government accepting recommendations for enhancing primary care in remote areas, including the development of a National Centre for Remote and Rural Healthcare. The Scottish Government introduced the National Care Service (Scotland) Bill, with island communities' impact assessments addressing concerns such as flexibility in social care approaches for islands, accessibility issues and recruitment challenges. Additionally, funding models for social care in island areas need to accurately reflect the higher costs associated with service delivery (Scottish Parliament Information Centre 2022).

England: Rural areas health services can be less accessible to users, because of geographical distances; it has been calculated that while in urban areas the average minimum travel time to a hospital is half an hour, in rural areas is approximately one hour. As a consequence of having a more sparsely populated area, the delivery of community-based care can be more expensive. Difficulties in recruitment of health care professionals was also raised as a challenge in rural contexts (Department for Environment, Food & Rural Affairs 2022b).

Wales: 32.8% of the population live in rural areas (Office for National Statics 2013)**.** Wales experienced a decrease in the proportion of rural residents who reported to be of good health, comparing 2001 and 2011 census. In addition, male carers (aged 19 to 88 years old) living in urban areas of Wales reported better mental health than male carers in rural areas and female carers in both settings (Public Health England 2019b). Distance from services is key as this is another driver of health inequalities experienced by older populations in rural areas. In a study of hypothetical NHS scenarios it was found that centralisation of hospital services in Wales would reduce geographical access for rural older (75+) people (Public Health England 2019b).

Adult social care in rural areas: main challenges

1. Demographics and socio-economic characteristics of population in rural areas

Providing care in rural areas requires the understanding of the cultural aspects involved, including family configurations McCann et al. (2005). For example, in rural parts of Northern Ireland, there is a notable prevalence of family care in contrast to urban areas (McCann et al. 2005), and while carers provide more support in rural areas they then are more likely themselves to experience psychosocial stress, isolation and geographical distance from support services (McCann et al. 2005).

The evidence also shows that rural areas require an approach that works with the whole

community, and not only a targeted group. It should be considered that rural areas, though seemingly homogenous compared to diverse urban settings, also include ethnic minorities (Pugh et al. 2007). Assuming homogeneity can lead to inadequate health and social care provision of services for minority groups in rural settings, and the reproduction of negative perceptions, which can cause isolation or stigma (Pugh et al. 2007). In this regard, the Scottish Government commissioned a study of a multidisciplinary team (MDT) model for rural primary care. Based on interviews with key informants, it was found that the effectiveness of GPs in rural regions is closely tied to their in-depth understanding of patients, their circumstances, and needs (Scottish Government 2020). Other studies have also advocated for a collaborative approach to service design and delivery to ensure they meet the needs of rural populations. For example, Corcoran (2018) states that along with changes in the national legislation to address the particular issues of rural and coastal areas, supporting community co-design and evidence-informed strategies, involving anchor institutions and public authorities procuring services from locally-based practices that know and rely on the town for their business.

Below is a case study that highlights how collaboration can help with the design of services in rural areas which then meet the needs of local populations.

Case study 1- Northern Ireland: The Recovery College

To promote the **active engagement of users in their own care and well-being**, the South Eastern Health and Social Care Trust (SEHSCT) established a Recovery College in March 2015 that covered rural and urban locations in Northern Ireland. The Recovery College aims **to boost knowledge, skills, and promote self-management**, through providing free courses on **mental health and recovery**. The courses took place between September 2021 and December 2021 and were open to anyone interested in mental health, including users of services, their carers, family, and friends, as well as staff, community members, and voluntary sector (Health and Social Care 2022).

The Recovery College **improves the accessibility of non-acute services for rural residents** and aims to **enhance the capability of rural service delivery through collaboration** and implement **preventive initiatives that promote healthy lifestyles and well-being**. In particular, courses involve co-production and co-delivery by tutors with learned and lived experience in the subject area, merging clinician (learned experience) and service user (lived experience) expertise. Additionally, the College conducts brief Recovery sessions (up to 40 minutes) on acute inpatient mental health wards, providing students knowledge about recovery, and how this process can be linked with the community, upon discharge (Health and Social Care 2022). In terms of impact, the programme has shown an increase in coverage and participant numbers. Over the last three years, despite no additional financial resources, the program expanded its service provision by over 35% (Health and Social Care 2022). For instance, in 2021/2022 the RC conducted an average of 85 group engagement sessions per 12-week, compared to 55 group sessions in 2018. Regarding student growth, in 2018, the Recovery College supported an average of 110 students per semester, increasing to 200 in 2021/2022, reflecting a 40% growth (Health and Social Care 2022).

2. Rurality and isolation

Physical isolation and the remoteness of rural populations can create challenges in terms of delivering services to clients in their homes and in clients accessing services outside their homes (McCann et al., 2005). Studies have also highlighted loneliness as an issue in rural areas, and the importance of formal care provision to people to provide emotional support. One study found that "some care assistants also worked privately for the client and were a 'lifeline' who could be called through emergency alarm systems provided by local charities" (McCann et al. 2005, p.465), but also that informal support networks were also important to prevent loneliness. Another study, focused on the experiences of older parent carers of adult children with learning disabilities in a rural part of England, reported that "the carers in this study felt that they were becoming more isolated as they aged because of their own poor health or their rural location. Home visits from support workers were therefore vital in helping those in areas where lack of public transport impacts access to services" (Deville et al. 2019, p.213).

In rural areas, transport are conditions that impact on the social care provision, particularly in certain periods of the year (McCann et al. 2005). This study found out that the weather rarely interfered with the provision of services, largely because of the goodwill and the 'sense of community' among rural areas. Therefore, the study observed that despite harsh road conditions, service provision was rarely disrupted, thanks to the assistance of care assistants' partners, family caregivers, and the community, as well as care managers and coordinators had contingency plans in place to ensure care continued if a scheduled assistant is cancelled. Likewise, healthcare professionals acknowledged that longer travel times in rural areas meant fewer specialist visits, and they responded by ensuring that those with the patients understood the situation (McCann et al. 2005).

Measures to improve access to services in rural areas are associated with a wide range of benefits including social inclusion, reduced costs of service delivery, and in some instances economic benefits, for example helping benefit claimants to understand their entitlements. They often need to be combined with measures to improve transport provision and the blend of approaches needs to be tailored to local circumstances. One example is Village Agent-type schemes may be particularly effective in more sparsely populated areas, where other forms of service delivery are expensive, or service centres not easily accessible. In particular, Village Agent is a strategy implemented in England that aims "to support people living in rural communities to access services, along with helping to shape service delivery by feeding back information from the 'bottom-up'"(Powel et al. 2018, p.34). The programme consists of developing community-based agents, who are trained to help older people to improve their access to services, demonstrating being effective in shaping the delivery of the services, as well as improving the coverage and quality of them (Powel et al. 2018). Below is an example of a service which integrated online provision to support care delivery in remote rural areas.

Case study 2- Scotland: Video conferencing in care homes

In rural settings, accessing specialised psychiatric expertise poses challenges for staff and residents, consultant visits are infrequent, and travelling long distances for secondary care heightens anxiety (Public Health England 2019a). To overcome challenges in delivering specialist psychiatric care, the Highlands team developed Technology Enabled Care (TEC) in three rural care homes. **TEC aimed to enhance psychiatric service access**, **minimise unnecessary admissions**, **reduce antipsychotic use** in dementia patients, and manage **behavioural symptoms associated with dementia** (Public Health England 2019a). The psychiatric team expressed that video conferencing was effective, prompting a desire for a cost-effective evaluation. It was found that video conferencing was **equally successful as face-to-face consultations** (Public Health England 2019a), resulting in quicker psychiatric assessment, treatment review, and monitoring, making the intervention more responsive to residents' needs. The programme helped **home staff gaining knowledge, confidence, and skills, becoming more involved in residents' psychiatric care.** The ongoing evaluation emphasised the intervention's **low-cost effectiveness for remote clinical consultations in the Highlands** (Public Health England 2019a).

3. Workforce and care provision in rural areas

There are a number of workforce challenges associated with delivering care in rural areas. For instance, **practitioners in rural areas might need to offer diverse services compared to urban counterparts**, and need to be more proactive to develop and maintain their practice (Pugh et al. 2007). Another challenge is recruiting adult social care staff, which is more difficult in rural areas when compared to urban settings (Coleman 2023), with remoteness and **physical isolation also impacting on recruitment**. Long travel distances result in the need for 'more carers and more care' (McCann et al. 2005, p.466). Overall, the consensus among professionals was that **adequate resources and improved terms and conditions**, recruiting more care assistants in rural areas would be feasible (McCann et al. 2005). In addition, this study observed that these challenges could be overcome by care teams, thanks to the goodwill of individual care assistants and support of the communities (McCann et al. 2005).

Related to this issue, **higher costs of delivery care services in rural areas** in comparison with urban areas was also evidenced by Pugh et al. (2007), whose report for the Social Care Institute for Excellence considered this issue as an obstacle for the sector. Consistently, according to Public Health England (2019b), ensuring fair outcomes in rural areas is more expensive due to factors such as remoteness, limited economies of scale, and concentration of a higher proportion of older individuals. Nevertheless, older populations in coastal and rural regions receive relatively **less funding per patient** compared to their urban counterparts (Public Health England 2019b; County Councils Network and Rural Services Network 2021). In this sense, “local authorities, alongside business and community leaders, have a crucial role to play in providing vision, leadership and enforcement, enabling partnerships, and setting a favourable planning environment” (Corcoran 2018). Over the page are two case studies that showcase partnership working in rural areas.

Case study 3- England: The Midhurst Macmillan Service

The Midhurst Macmillan Service, established in 2006, is a consultant-led palliative care service in a rural community in southern England, covering Surrey, Hampshire, and West Sussex. Initially responding to the closure of a local hospital with a Macmillan Cancer Support unit, the service has evolved to **community-based service delivery, including end-of-life care at home** (Thiel et al. 2013a). The service involves a **multidisciplinary team**, that included palliative care consultants, specialist nurses, health care support workers, allied health professionals and volunteers (Thiel et al. 2013a). Clinical nurse specialists provided ongoing care, while volunteers supported such shopping, gardening, and other activities. Regular multidisciplinary meetings were held in order to share patient information, which were also used for updates and coordination with GPs and community health teams. Among the outcomes, it is possible to highlight that during 2011/2012, 99 percent of the patients who were part of the project died in the place of their choice, which was home (Thiel et al. 2013a). A key element in the delivery of the service was the coordination and multidisciplinary approach. In particular, **the service helped in relationship-building with key stakeholders**, including GPs, community staff, social services, hospital consultants, volunteers and local people. This was expressed in the referrals, as all partners in care were able to refer patients, benefiting the decision-making process and co-ordination within the team, as well as in the development of a **holistic approach for the assessment and care planning,** which includes both, health and social care needs of the patient and family. This multidisciplinary approach also helped to achieve rapid access to care, in which the team was able to work with flexibility, according to the specific needs of the patient. Likewise, collaboration with GPs and community services beyond the core team was essential to guarantee the efficient delivery of services (Thiel et al. 2013a).

Case study 4- Wales: Community resource teams (CRTs)

Community resource teams (CRTs) in Pembrokeshire include **integrated and coordinated teams of health and social care oriented to work with people living at home** (Thiel et al. 2013b). The main goals of the programme are to **improve or restore the quality of life and confidence for people with complex health and social care needs, and to reduce admissions to hospital.** Four community-based teams bring together professionals from health, social care and the third sector to provide care for patients with complex needs at home (Thiel et al. 2013b). Care co-ordinators act as the main point of contact for patients and work with the team, patients and carers to tailor individual care packages that enable people to manage their long-term conditions and avoid unnecessary hospital admissions. Professionals in the CRTs include social workers, occupational therapists, physiotherapists, district nurses, voluntary sector service brokers and specialist nurses (Thiel et al. 2013b). The programme benefits from **voluntary sector integration**, allowing the inclusion of non-statutory services in care packages, collaborating with acute-based teams to prevent unnecessary admissions and aids discharge, and facilitating the ability of people receiving care to remain at home. This multidisciplinary approach also helped to achieve rapid access to care, in which the team was able to work with flexibility, according to the specific needs of the patient. Likewise, collaboration with GPs and community services beyond the core team was essential to guarantee the efficient delivery of services (Thiel et al. 2013a).

Things to discuss:

- Do the challenges outlined in this material sound familiar? In your rural area, are the issues the same or different?
- Were there any ideas in this document that you think could facilitate people living in rural areas accessing social care services?
- Is there anything in the document you didn't agree with, or doesn't match your experience?
- Are there other ways social care services can support people living in rural areas?

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