

# Health and wellbeing in rural areas



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# Foreword

Nearly 10 million of our fellow citizens live in areas of England defined as rural. This number is increasing and the population is growing older. Their health is as important to us as the health of the 45 million who live in our cities and large conurbations.

We don't know enough about the health of people living in remote farming areas, in the small market towns and in the coastal villages that make up much of what we think of as 'the countryside'. These are very diverse environments which cannot all be lumped together for analysis or understood together as a whole. Although many rural areas are, in general, affluent, even wealthy in some cases, this is not true of all rural areas (the 'north/south divide' can be seen in the countryside as well as in cities). And within even the most affluent areas, there can be real hardship, deprivation, ill health and inequalities. These are some of the issues discussed in this document.

One of our concerns is that, while poverty, deprivation and the ill health that accompanies them look much the same everywhere that they exist in England, they can nonetheless be more difficult to identify in the official statistics for rural areas than they are in urban areas. This is because the statistics are often not sufficiently fine grained to pinpoint the pockets of deprivation that exist among rural affluence. Indices recently and currently in use have tended to focus on the type of material disadvantage that is most prevalent in an area, with the result that an area can be classified as 'not deprived' when in fact there is serious endemic poverty and deprivation within it. We are pleased that there is work going on in the University of East Anglia in collaboration with Norfolk County

Council and in Imperial College, looking at measures that could more accurately capture rural deprivation and ill health.

We know also that local authorities and Directors of Public Health (DsPH) have come up with innovative ways to identify and reach out to groups and areas experiencing deprivation and ill health that is not typical of a country or region as a whole. And in some parts of the country such areas and groups can encompass significant numbers within the population. Part of our purpose in producing this publication is to encourage local authorities to build on and share their work, not only in disaggregating their populations, but also in designing health and care interventions that target those most in need in rural communities. Such targeting is necessary because of the different ways the social determinants of health impact on rural populations. For example, services need to take account of difficulties of transport in remote areas. The resource-intensive nature of the work required for population-level interventions to be redesigned effectively to meet the specific needs, culture and lifestyles of different groups (including people living in remote or isolated locations, and/or working in farming, seasonal work and the fishing industry) makes it difficult for local authorities and public health teams to invest sufficiently in this work.

However, despite the financial constraints they are working under, local authorities and their public health teams are doing imaginative work that responds to the specific needs of people living in many different rural settings. The case studies throughout the text below illustrate the variety of interventions taking place around the country. We are

particularly pleased to read of examples that go far beyond the traditional 'medical model' of public health and build on some of local authorities' other responsibilities, for example in planning, housing, economic regeneration and leisure services, working with other parts of the public sector. A 'Health in All Policies' (HiAP), place-based approach builds both on the strengths of public health and on the reach and influence of local government's many other functions.

We hope that this publication is useful in sharing what is known about the health of rural communities, where certain social determinants may have a greater impact in the countryside than they do in cities and how local authorities and their public health teams are developing innovative partnerships to address the health inequalities that we know exist within and between rural areas.



**Councillor Izzi Seccombe**  
Chair, LGA Community Wellbeing Board



**Duncan Selbie**  
Chief Executive, Public Health England

# Executive summary

Nineteen per cent of the population of England live in rural areas which make up 85 per cent of the land. These areas are very diverse, ranging from open countryside with a scattering of small towns and villages to coastal communities dependent on fishing or tourism, former mining areas and commuter villages.

One local authority area can contain a number of different rural communities as well as cities and towns and can exemplify health inequalities with life expectancy differing across different groups by up to 10 years. Because of this diversity, local authorities need to understand in some detail the character of their rural populations and the health issues facing them.

Overall, health outcomes are more favourable in rural areas than in urban areas. But broad-brush indicators can mask small pockets of significant deprivation and poor health outcomes. There is an absence of detailed statistical information on health outcomes in rural areas, as national statistics often do not reveal differences within small areas. Work is currently under way in a number of universities and local authorities to develop more appropriate indicators for rural areas.

Both sparsity and rurality appear to affect poverty levels and consequently the health of people in rural areas. Sparse areas on the fringes of towns and urban settlements have the highest proportions of poor households, although no area type is poverty free.

Rural communities are increasingly older. The younger population tends to decline the more rural the settlement type. 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. Health and care needs are difficult to separate for those with multiple and complex needs and reductions in resources for social care are compounded by high delivery costs and organisational challenges in sparse areas.

Reductions in resources to care for the older population, issues of access to health and care services, travelling and transport issues and lack of community support in some areas contribute to pressures on local government and the NHS to take a place-based approach to health needs.

Many local authority functions have a health impact. Local authorities can therefore influence health outcomes in rural areas through working with the NHS to improve access to services, but also through tackling the social determinants of health through their public health, social care, planning, housing, economic, education, regulatory and other roles.

District councils in rural counties are key players in addressing health issues, being responsible for planning, housing and leisure services as well as environmental health. Town and parish councils can also play a part, both in developing understanding of the health profile of their residents and in a proactive role of promoting health in their communities.



Certain social and economic factors have a disproportionate impact on people's health. These include:

- **poverty** – 15 per cent of households in rural areas live in relative poverty after housing costs are taken into account, as compared with 22 per cent in urban areas
- **housing** – house prices tend to be higher in rural areas and more households experience deeper fuel poverty
- **employment** – in 2015 77 per cent of working age people in rural areas were in employment, as compared with 73 per cent in urban areas: household incomes in rural areas can be lower due to part-time or seasonal working
- **access to transport** – rural residents travel longer distances than their urban counterparts and spend longer travelling.

## The health of rural communities

The health of people in rural areas is on average better than that of urban areas with higher life expectancy and infant mortality and a lower number of potential years of life lost (PYLL) from cancers, coronary heart disease and stroke. However, as the rural population is older, the prevalence of these conditions is higher.

Those living in town and fringe settlement types have higher mortality rates than those living in village and dispersed areas. Overall, around one sixth of areas with the worst health and deprivation indicators are located in rural or significantly rural areas.

However, indicators currently in use to assess poverty and deprivation may not reflect cost of living and other wellbeing issues in rural areas. A place-based approach in which all local partners work together is important in addressing the multi-factorial determinants of the health of rural populations. For example, as the largest employers in many rural areas, councils and the local NHS can model healthy employment practices and work with the many small enterprises located in rural communities.

## Health risks in rural areas

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**  
Changing population patterns, including outward migration of young people and inward migration of older people, are leading to a rural population that is increasingly older than the urban population, with accompanying health and care needs.
- **Infrastructure**  
Sparsity and the increasing scarcity of public transport links have a significant impact both on daily living costs of rural households and on access to services.
- **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, that are available online.
- **Air quality**  
Pollution from traffic is increasing in rural areas where levels of ozone are generally higher and where there are a significant number of Air Quality Management Areas (AQMAs). Air quality remains a serious health risk.
- **Access to health and related services**  
Rural areas have worse access in terms of distance to health, public health and care services. Longer distances to GPs, dentists, hospitals and other health facilities mean that rural residents can experience 'distance decay' where service use decreases with increasing distance. Different models of service delivery may be needed for rural areas, including new models of workforce development. These also include the development of rural hubs providing a range of services, and more services provided on and through the internet.

- **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. The fact that social isolation influences health outcomes in its own right suggests that this and the emotional and mental wellbeing of people in rural areas is an important and hitherto neglected area in the promotion of public health.

- **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 per cent higher in rural areas and there is much less housing association and council housing. There is a much higher proportion of 'non-decent' homes and of houses which are energy inefficient and many areas are not on the gas grid which leads to higher prices.

- **Employment and under-employment**

Unemployment and under-employment are taking younger people away from their families and work is low paid and intermittent.



# 1. Why is this important?

Some people who live in cities and large towns may think of rural England as a homogeneous array of green fields and farming land. However, this is far from the real picture. The Office of National Statistics defines areas as rural if they fall outside settlements with more than 10,000 resident population. Areas are further divided into six categories:

- town and fringe
- town and fringe in a sparse setting
- village
- village in a sparse setting
- hamlets and isolated dwellings
- hamlets and isolated dwellings in a sparse setting.

## Rural communities are very different

Areas that fall within these categories can encompass a widely varying range of different types of place including:

- open countryside with a scattering of small towns and villages, like Norfolk or Kent
- different types of farming communities, including dairy and livestock farming, crop cultivation, market gardens and orchards where farming methods can vary widely from the most labour-intensive seasonal work to highly-automated commercial enterprises
- sparsely populated upland areas, such as the Yorkshire Dales and the Lake District

- coastal communities in places like Cornwall, Cumbria and Northumberland, dependent on fishing or tourism where in the tourist season the population can increase tenfold
- former mining areas in places like Derbyshire or Durham
- commuter villages on the periphery of large towns and cities.

Population profiles of different rural areas can, therefore, be very diverse in relation to their level of affluence and their health outcomes. One local authority area can contain a number of different rural communities as well as one or two cities or large towns and can exemplify significant health inequalities within its own boundaries to the extent that life expectancy can differ by up to 10 years between the most and the least affluent groups. It is important for local authorities to understand in some detail the character of their rural populations, their diversity and the health issues facing them.

Rural areas make up 85 per cent of the land in England and 9.8 million people (19 per cent of the population) live in these areas. The majority of these (9.2 million people) live in the less sparse rural areas in the categories listed above. Between 2001 and 2010 their population increased by 7 per cent, greater than any other rural or urban area type. In 2009/10 net internal migration to rural areas was plus 54,000, compared with minus 75,000 for urban areas<sup>1</sup>.

## Pockets of deprivation can be masked by statistics

There is a widespread belief that people who live in the countryside are better off, both in monetary terms and in terms of health and wellbeing than those who live in towns and, especially inner cities. For some groups in the population, this is certainly true. Overall, health outcomes are more favourable in rural areas than urban areas; the most recent statistics show that life expectancy is higher, infant mortality rate lower and potential years of life lost from common causes of premature death lower in rural areas than in urban areas. But for a number of years, there has been a growing realisation by national and local government that broad-brush indicators measuring the largely positive health, wealth and wellbeing of rural communities can mask small pockets of significant deprivation and poor health outcomes.

One of the difficulties in writing this document is the absence of statistical information on health outcomes in rural areas, as they are usually sub-divisions of the larger areas for which statistics are available. Another difficulty, as we have pointed out throughout the document, is that rural areas are themselves not homogeneous so that even if we had more information about health outcomes in rural England generally, it would be misleading about individual areas unless it was further broken down. We hope that the case studies used throughout the text give some indication of the differences between rural areas and what the particular health challenges may be for different rural populations. There is also work under way to identify what health issues may be masked by overall statistics so that, in future, DsPH and councils generally can have a clearer picture of disparities in health within as well as between different rural areas.

For example, evidence currently being examined at the University of East Anglia suggests that there may be hidden unemployment and under-employment in rural areas with higher levels of low-paid

seasonal work (annual earnings are lowest in areas with at least 80 per cent of the population in rural settlements<sup>2</sup>) contributing to misrepresentations of rural employment. The negative health effects of unemployment are well known and include increased mortality, worse mental health status, higher morbidity and long-term illness and increased exposure to lifestyle related risk factors like smoking and drinking, affecting families and the wider community<sup>3</sup>. Young people living in rural areas appear to have been disproportionately affected by unemployment following the financial crisis of 2007<sup>4</sup>. Such young people face a number of uniquely rural barriers, particularly concerning access to transport, careers advice, employment and training support, and youth services. Given the relationship between unemployment, ill-health and mental illness, it is important for young people, as well as older retired people to uncover the deprivation that may be concealed by broad-brush indicators.

Within all rural communities pockets and scattered households experiencing deprivation exist, and there are certain areas of the country where there is a high degree of deprivation, lower life expectancy and poorer health. Such areas include:

- Cumbrian coastal areas
- certain small seaside towns with a 'bedsit economy'
- former mining communities
- areas where there is a high degree of seasonal work
- areas with very sparsely scattered populations.

Both sparsity and rurality appear to affect poverty levels. Sparse areas that fall into the town and fringe or urban settlement types have the highest proportions of households below the poverty threshold. However, no area type is poverty free – there is often more variation within area types than there is between them<sup>5</sup>.

There is also growing concern that, for a number of reasons, the most disadvantaged rural communities do not have good access to some health and other public services.


The Index of Multiple Deprivation (IMD) is the official source of information on relative deprivation across the country. The map below shows how the IMD has classified rural areas according to their level of deprivation, based on the indicators in current use.

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## Index of Multiple Deprivation 2015 in Rural Areas

**Key:**

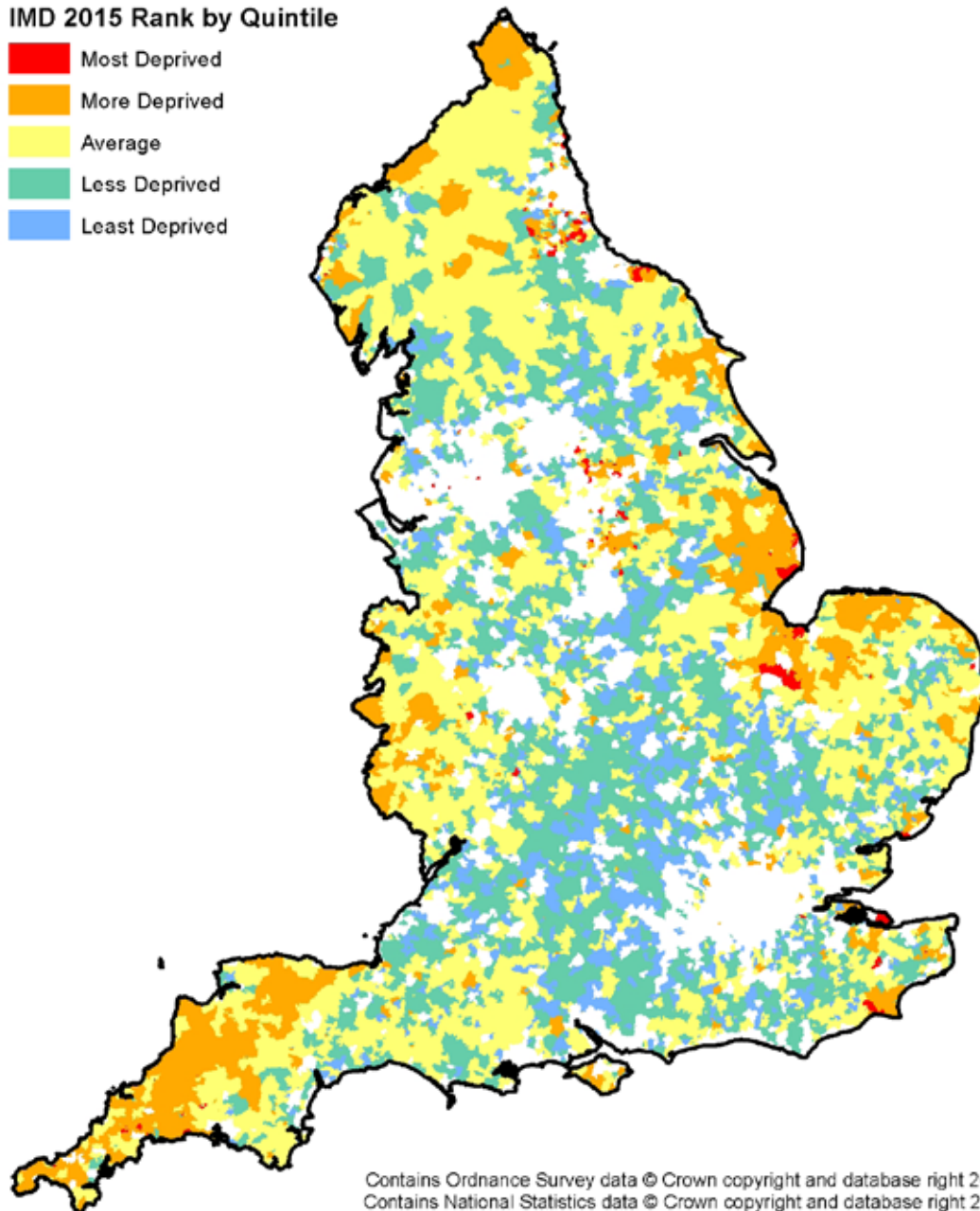
**ONS Urban/Rural Classification (2011)**

 Urban Areas

**Index of Multiple Deprivation (IMD) 2015**

**IMD 2015 Rank by Quintile**

-  Most Deprived
-  More Deprived
-  Average
-  Less Deprived
-  Least Deprived



## Rural populations are increasingly older and are less diverse

Rural areas have a larger proportion of older people and smaller proportions of young adults. Rural areas have on average 23.5 per cent of their population over 65 compared with 16.3 per cent of urban areas aged over 65<sup>6</sup>. Areas with the highest proportions of older people include Cumbria, Devon, Dorset, Lincolnshire and Somerset. The oldest older people (those over 85) are overrepresented in rural areas especially the South, the South West and East Anglia<sup>7</sup>. People over 45 years make up more than 50 per cent of those living in rural areas compared with about 40 per cent in urban areas. Financial poverty in rural areas is also highly concentrated amongst older people, with around one-quarter of those in poverty in pensioner households<sup>8</sup>.

The proportion of the population aged under 45 years tends to decline the more rural the settlement type<sup>9</sup>. The young adult (15 to 29 age group) is smaller in rural than in urban areas (14.7 per cent as compared with 20.4 per cent)<sup>10</sup>.

Differences between age groups in rural and urban areas have a variety of causes but may largely be explained by younger people moving to urban areas to study and work and by older people leaving urban areas on retirement from paid employment.

Thus, a significant proportion of the population live outside towns and cities and this proportion is increasing and growing older. We know that older people experience worse health and have greater need of health and care services. For many older people, a large number of whom experience multiple chronic conditions, their 'health' and 'care' needs are difficult to separate, existing side by side along a continuum.

Along with reductions in central government grant to local authorities, expenditure on adult social care services has declined and this has led to provision focusing on those assessed as having either critical or substantial needs<sup>11</sup>. While the 'personal budgets' awarded to people in rural areas are lower, charges for social care are, on average, higher in rural areas, significantly so with respect to home care charges<sup>12</sup>. Reductions in resources for social care are compounded by the fact that population sparsity leads to higher delivery costs and makes it more difficult for commercial providers to keep their staff. Wide geographical areas also create organisational challenges for the large and complex health and care economies in rural county areas. These issues have reduced opportunities for public health teams and social services to work together on the prevention agenda, for example in supporting older people whose needs are not yet substantial or critical to live independently for longer.

Rural areas have more 'white British' people living in them (95 per cent as compared with 77.2 per cent in urban areas). Minority ethnic groups are therefore represented in very small numbers and may lack social and community support found in urban centres. A high proportion of migrant workers have moved into work in areas such as Herefordshire, Lincolnshire and Cambridgeshire, as well as areas around Somerset and Devon, the Fens, Norfolk, parts of Cumbria and the Vale of Evesham. These workers tend to be young adults, compared with the older settled rural populations<sup>13</sup>. There have been tensions in such communities because of certain perceptions of migrant workers. Local authorities and voluntary sector organisations have been at the forefront of good practice in supporting migrant workers and in establishing their contribution to the local economy<sup>14</sup>.

Distinct from those groups discussed above, the only group (identified for the first time in the 2011 Census) to be represented more in rural areas than in urban was the 'Gypsy or Irish Traveller' group (0.14 per cent of the population in rural areas, compared with 0.09 per cent in urban areas). The census identified just under 58,000 people living in England and Wales in this category, although there may be considerably more, perhaps up to and beyond 300,000 (this does not include people who identify as 'Roma')<sup>15</sup>.

When taken together, reductions in resources to care for the older population, issues of access to health and care services, the demands of travelling around rural areas and in some sparser and more rural areas, the lack of community support, all contribute to pressures on local government and the NHS to respond imaginatively with a place-based approach to the health needs of its communities. This is another reason for local authorities and the whole of the public sector to focus on understanding and supporting our rural populations.

## Local government has many roles

We now know that many, if not all, local authority functions have a health impact and that local authorities are therefore in a position to influence health outcomes in rural areas; not only through working with the local NHS to improve access to health services, but also through tackling the social determinants of ill health, both mental and physical; not only through their public health and social care roles, but also through their planning, housing, economic, education, regulatory, and other roles which contribute to health outcomes. The comparatively favourable overall statistics on health outcomes in rural areas can mask significant deprivation and consequent health inequalities as discussed above. Local councillors, council officers working with GPs and the local NHS are some of the groups best placed to identify areas in which these inequalities persist and to know how best to target them.

## District, town and parish councils are key players

There are 27 non-unitary county councils in England covering the areas of 201 district councils. Most district councils cover rural areas. In two-tier areas, district councils have responsibility for functions which can have a significant health impact, including planning, housing and leisure services and environmental health. In rural areas, town and/or parish councils also have the potential to play a role in developments that impact on health, for example in organising consultations on local planning issues and in running various public amenities like parks and sports facilities. Unless district, town and parish councils have a good understanding of the role of public health and the potential impact of their own functions, opportunities will be lost to involve those functions in a public health agenda. In many two-tier areas, public health teams work closely with district councils but these relationships are still being explored in some two-tier areas.

- District councils spend more than £2.2 billion a year on helping residents remain independent in their own homes.
- District councils provide schemes to improve insulation and reduce heating costs and excess cold; and adaptations to homes to support independence and prevent falls – a major cause of hospital admissions for older people.
- In 2015, district councils prevented or relieved 67,358 homelessness cases (31 per cent of the England total).
- District councils invest in innovative reduced-cost schemes and free access to leisure services, generating up to £23 in value for every £1 invested.<sup>16</sup>



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## Joint public health initiatives in Hertfordshire

Recognising the contribution of districts in delivering a significant portion of the day-to-day work around the wider determinants of health, Hertfordshire County Council and the districts set up the public health partnership, often called the 'district offer'. This is a unique mechanism that sees 'public health leadership of district and borough councils alongside county council leadership', enabling the 10 district and borough councils that make up Hertfordshire to jointly deliver a number of public health initiatives. Each district sets its own priorities, and often county-run services then wrap around these local plans. Projects are agreed by the chief executive of the council and the director of public health, and monitored through the countywide Public Health Board.

The initiative is backed up by a package of funding, equivalent to £100,000 per district per year, allowing the districts to deliver public health and wellbeing schemes in their communities. In addition, the county council have made one-off funding available for improving air quality and enabling disabled access to physical activity. Districts have in some cases added their own funding to the pot, as well as incorporating match-funding from national bodies.

[www.lgcplus.com/idea-exchange/partnering-to-solve-public-healthproblems/5074498](http://www.lgcplus.com/idea-exchange/partnering-to-solve-public-healthproblems/5074498).  
article

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District councils have an important role to play in supporting social capital by strengthening social networks and community-centred approaches to health, potentially through enabling greater volunteer involvement in healthcare support. These approaches have been shown to have strong and direct links to health, being as powerful predictors of mortality in older populations as common lifestyle risks, such as moderate smoking, obesity, and high cholesterol and blood pressure<sup>17</sup>. Community-centred approaches facilitated by partnership between counties,

districts, town and parish councils, are particularly important in rural areas which have lost increasing numbers of community facilities, such as post offices, village shops and libraries in recent years.

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## District councils' support for mental and physical health

Timebanking – where members of the community contribute their own skills or help in return for similar support from fellow timebank members – is receiving support from a large number of district councils. There is strong evidence that this promotes social inclusion, and can improve physical and mental health impacts, and employment prospects, while reducing reliance on certain types of support. Evaluation of Spice Time Credits, which support people in giving their time to strengthen communities and to design and deliver better services, suggests an array of benefits including reported lower need to use the NHS, feeling healthier, and wider impacts that are linked to health.

Spice and Apteligen (2015). Spice Time Credits: impact. Summer 2015 findings. [online]. Spice website: [www.justaddspice.org/our-work/scaleimpact](http://www.justaddspice.org/our-work/scaleimpact)



## 2. Health in rural communities

There are few statistics differentiating the health of people living in rural areas from that of the urban population. We do know that the health of people in rural areas is on average better than that of urban areas. Average life expectancy is higher, infant mortality is lower and the number of potential years of life lost (PYLL) from common causes such as cancers, coronary heart disease (CHD) and stroke is lower<sup>18</sup>. This means that people living in rural areas are less likely to die prematurely than those living in urban areas. Life expectancy has been highest in districts with at least 80 per cent of their population living in rural settlements and larger market towns. Men born in these areas in 2008/10 were expected to live over two years longer than men born in major urban areas, and women were expected to live one and half years longer than women born in major urban areas<sup>19</sup>.

However, the rural population is older than those living in towns. So, although rates of ill-health from common causes are on average lower, the prevalence of these conditions will be higher with concomitant pressures on health and care services.

We also know that these statistics can mask deprivation and ill-health and the diverse experience of rural communities. For example, within rural areas, those living in the town and fringe settlement types have higher mortality rates than those living in village and dispersed areas. Gypsies and Travellers, the only group who live in greater numbers in rural than in urban areas, experience some of the poorest health of any group in society<sup>20</sup>.

Overall, around one sixth of areas with the worst health and deprivation indicators are located in rural or significantly rural areas<sup>21</sup>. These indicators in the Index of Multiple Deprivation (IMD), which measures relative deprivation across the country, cover years of potential life lost (YPPL), comparative illness and disability, acute illness and the proportion of adults under 60 suffering from mood or anxiety disorders.

It cannot be assumed that health and social care needs amongst older rural people are or will be evident. Research for Defra in 2013<sup>22</sup> identified evidence of significant unmet needs from health services but found that these were often hidden. Service users themselves tend not to identify unmet need, and are also reluctant to discuss challenges around getting the health care that they require. Also, many older rural residents do not seek out preventative health care or even acute treatment, and in some cases avoid seeking care even in moments of emergency and health crisis. Amongst the reasons given for this are a 'make do' attitude, reluctance to make a fuss and the explicit and implicit fear of emerging age-related health issues<sup>23</sup>.

There is still much that we don't know that could help to pinpoint pockets of deprivation and health and care needs, particularly in very small areas where national statistics may not be sufficiently fine-grained. The national statistics and the IMD cannot tell us precisely how much of the rural population is impacted by social deprivation, particularly extreme deprivation which may be persistent across generations and how this translates into poor life chances and health outcomes. Currently-used indices tend to have a focus on the type of material disadvantage that is most

prevalent in urban populations. A second problem is that rural deprivation differs in that it tends to be present in small pockets (for example a few isolated houses on the edge of a village)<sup>24</sup>. This is not revealed by indices which provide an aggregate measure of disadvantage for the whole population in an area.

Nor do we know how the experience of being poor in areas of affluence affects individuals, particularly in relatively small rural communities where inequalities may be very obvious to those living there. The adverse effects on individuals and communities of inequalities in income has been demonstrated by recent research<sup>25</sup>.

DsPH working in rural areas believe that the IMD may not reflect cost of living and other wellbeing issues in rural areas. These can arise in areas where there is reduced choice and availability of services, shops and amenities; where access to transport and communications may be more limited; some unemployment or underemployment may be hidden, the prices of fuel, food and other items may sometimes be higher and there is poor or no digital access. Older rural housing stock is also less energy efficient and more expensive to heat. None of these is fully measured by the current IMD which cannot, therefore reflect the heterogeneity of deprivation in rural areas.

Public Health England (PHE) and the Association of Directors of Public Health (ADPH) are looking at improving data collection techniques to support local organisations and working with the University of East Anglia, which is piloting new systems of data gathering with Norfolk County Council to look specifically at assessing health needs in small populations of 1,500 or less. They are also considering possible new indicators that might capture some of the indicators of rural deprivation that are currently masked in official statistics.

The Small Area Health Statistics Unit at Imperial College, working with PHE and DsPH has produced maps that allow more precise spatial mapping using IMD for rural areas. These maps show that communities in rural coastal areas tend to experience more deprivation than other types of rural communities<sup>26</sup>.

# 3. What are the health risks for rural populations?

A number of the factors outlined above create health risks specific to rural communities. As has been seen many of these relate to the wider social determinants of health as well as to access to health and care services. As public health authorities and leaders within the health and care system, it is important for councils to take a 'Health in All Policies' (HiAP), place-based approach to health improvement and reducing health inequalities. Considerations of the potential and actual impact on health of all the council's strategies, policies and work with local partners need to be embedded in its policy-making and operational frameworks.

The health and wellbeing board (HWB) is an important vehicle to bring together demographic information through the Joint Strategic Needs Assessment (JSNA) and to agree priorities and plans for action through the Joint Health and Wellbeing Strategy (JHWS). But it is also important for councils with rural populations to have a strong corporate commitment to disaggregating information about their residents in order to pinpoint sections of the community at greatest risk of experiencing ill health and to ensure strategies and services are designed to meet their needs. This requires the active understanding and commitment of the council's leader and chief executive, all cabinet members and chief officers, not just the cabinet members for health and social care and the Directors of Public Health (DsPH), adult social services and children's services. In particular, in rural areas, the role of planning, housing, transport and digital infrastructure are important in contributing to improved health outcomes.

A place-based approach in which all local partners work together is also important in addressing the multi-factorial determinants of the health of rural populations. For example, in many rural areas, the local council and the local NHS will be the largest employers. This gives them the opportunity to model good employment practices that respond to the needs of people living in rural communities and to work with the many small enterprises to be found in the countryside and small towns and hamlets.

As well as relying on national statistics such as the Index of Multiple Deprivation (IMD) to help identify demographic changes, councils need to do their own intelligence work to gain a deep understanding of the communities they represent. National statistics rely heavily on the census and therefore become gradually out of date. And, as discussed above, the indicators used, for example in the IMD, may not capture some aspects of rural disadvantage (such as households in fuel poverty and the impact of poor public transport). All councils collect data about their communities and develop profiles which are put to many uses. Increasingly, councils are drawing on the data-gathering and analytical expertise of public health teams to inform their work across the board.

## Changing population patterns

Changing population patterns, including outward migration of young people and inward migration of older people, are leading to a rural population that is increasingly older than the urban population with accompanying health and care needs.

The average age in rural areas is 5.3 years older than in urban areas and this is increasing. Settlements in sparse areas tend to have the highest proportion of their populations amongst the older age groups. This reaches its peak in rural villages and hamlets in a sparse setting where on average over 27 per cent of the population are over 65 years old and 60 per cent of the population are over 45<sup>27</sup>. As older people are more likely to experience health and care problems and to need health and social care services, there is a proportionately greater demand on services in rural areas, especially in those areas with the highest numbers of older people.

The percentage of people over 85 will double over the next 20 years. This means there are likely to be more people with complex health needs – more than one health problem – who require a combination of health and social care services. However, the range of services is rarely fully integrated, even now. For example, people are admitted to hospital or stay in hospital too long when it would be better for them to receive care at home. In rural areas, this is exacerbated by apparently simple issues like access to transport to and from hospitals and other health and care facilities.<sup>28</sup>

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### A place-based approach to supporting vulnerable people – Tees Valley

Tees Valley Rural Community Council (TVRCC) has established a Community Agents project supporting older people to remain at home. The project is delivered by TVRCC and is commissioned by Redcar &

Cleveland Borough Council through public health and Better Care Funding (a pooled budget to develop integrated care).

TVRCC works alongside health and social care practitioners and the aim, with positive support from the voluntary sector, is to enable vulnerable people to remain independent in their own homes, particularly those who live alone and those that are frail and elderly. Three Community Agents work with voluntary organisations and facilitate people getting to the right group or service.

Volunteers offer a range of services; general advice, befriending, being in the home of someone who is not mobile when a delivery is expected, transport to a GP or hospital, help with shopping and help with completing forms. The needs identified by the Community Agents project has led to the development of a car volunteer recruitment scheme. They also identified gaps in befriending support which has subsequently been funded by the council. The service is monitored by a public health commissioning manager and was evaluated by Teesside University. Outcomes of the service include:

- reduced non-attendance at GP appointments
- time saved for professionals
- people less isolated
- increased income for individuals through benefit checks
- reduced anxiety
- people feeling more independent.

TVRCC and the service is a key partner in the development of a wider programme of social prescribing to support people through ‘non-medical’ means.

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## Tackling obesity in a diverse rural population

An example of the challenges of developing population-level public health strategies for specific health needs in a rural area, can be seen in Norfolk.

Two thirds of the Norfolk population are overweight or obese. In the rural county (approximately 2,000. mile<sup>2</sup>), obesity prevalence is higher in urban areas such as Norwich and Great Yarmouth, however there are significant numbers of overweight and obese adults and children scattered across rural communities, market and seaside towns, which because of their rurality are 'hidden' from view. Three of the five mosaic population types identified as obese in Norfolk, are a subgroup of the 'Rural Reality' classification.

The population profile of Norfolk is changing, with both rural and urban areas set to see rapid expansion; the population of the county is growing older, with 23 per cent aged over 65+; and Norwich having an increasing black and minority ethnic population.

Thus, the healthy weight strategy needs to address obesity issues in remote and sparsely-populated countryside, as well as in large and small towns, and a growing city – all in a large and geographically spread-out county. There is the additional complexity of having limited travel options, which makes accessing services difficult for many residents. This impacts significantly on commissioning weight management services, requiring either a very large budget for universal county-wide services or having to make difficult targeting decisions.

Engaging partners in tackling obesity is key to ensuring that rurality is not a barrier to healthy weight. Jointly prioritising actions that develop social, cultural and physical environments, and support and enable healthy choices for a healthy weight, are more likely to have a far reaching and sustainable impact. These actions could include; creating environments that support healthy weight; educating communities to make positive

lifestyle choices; developing the wider public health workforce; and empowering people to manage their weight.

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Statistical data is vital, but other forms of intelligence gathering are also important, especially in rural areas where small area statistics (for example, at the level of postcodes) may not be available. Both cabinet members and community councillors are in a good position to contribute to building up a detailed picture of their communities and where there may be hidden deprivation and health risks. A combination of local councillors working with GPs can be a powerful source of information about the health and wellbeing of communities that may not find its way into the statistics.

Advantage West Midlands (a former Regional Development Agency) developed a rural disadvantage indicator (RDI) to monitor rural areas. It wanted to identify indicators that would reflect more accurately than the English IMD the nature of rural disadvantage and could draw some distinction between rural areas as places to live and places to work<sup>29</sup>. The indicator comprises two sub-indices: a Community Disadvantage Index and an Economic Vulnerability Index. Individual indicators were:

- housing affordability
- mortality rate
- Jobseekers' Allowance claimants
- job density
- total working age claimants
- household income under £20,000
- the percentage of people employed in the knowledge economy. This latter indicator was employed because the knowledge economy can be used as a measure of 'economic vitality' and is calculated using Annual Business Index.



The RDI was able to pick up deprived estates in the market towns, villages and former coalfield communities in North Warwickshire, demonstrating that the RDI was capable of isolating rural disadvantage. The RDI demonstrates that whilst urban areas tend to exhibit a similar ‘overlapping’ pattern of disadvantage across a range of indicators, in rural areas different facets of disadvantage are important in different areas and do not overlap to the same degree.

### Questions to consider

- Is your council’s intelligence and data-gathering function contributing to discussions and research on how to identify small pockets of deprivation in rural communities?
- Are you making the best use of councillors’, GPs’ and local organisations’ (such as voluntary sector organisations and churches) knowledge of your communities and where there may be previously unidentified deprivation and health needs?
- In two-tier areas, is your public health team contributing to district and town councils’ understanding of public health and how their demographic knowledge can help?

## Infrastructure

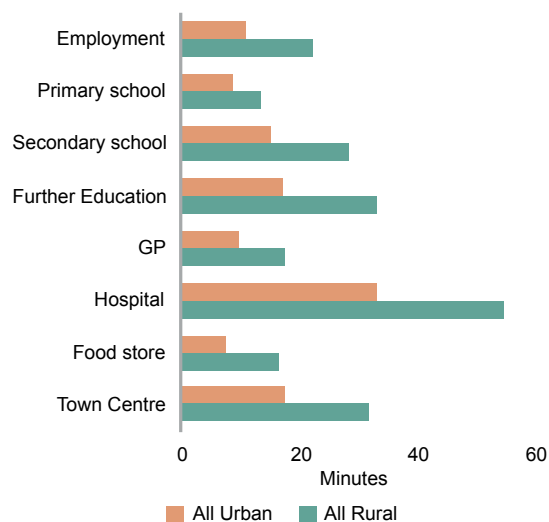
Sparsity and the increasing scarcity of public transport links are recognised as having a significant impact both on daily living costs of rural households and on access to services.

Transport plays an essential role in allowing people to access employment, education, health services, shopping and leisure, and problems with transport make a significant contribution to a whole range of different types of disadvantage. Despite high levels of household car ownership, transport-related disadvantage is more widespread in rural areas than might be commonly perceived. Costs, travel time and carbon emissions resulting from transport tend to be higher in rural areas<sup>30</sup>.

In rural towns and fringe areas, 14 per cent of households do not own a car or van (6 per cent in the most rural and isolated dwellings), as compared with 33 per cent in urban conurbations<sup>31</sup>. Almost three quarters (73 per cent) of rural households who were in the bottom fifth of incomes had access to a car meaning that low income rural households are 70 per cent more likely to have access to a car than low income urban households. Rural households spend a relatively large share of their disposable income on transport (12.5 per cent per week at 2013 prices, compared with 10.8 per cent for urban households)<sup>32</sup>. When travelling, rural residents are more likely to be using a car than their urban counterparts. One reason for this may be that people have to walk for longer in rural areas to reach a bus stop. In rural villages, hamlets and isolated dwellings, only 72 per cent of people can walk to a bus stop in under six minutes, as compared with 95 per cent in urban conurbations (14 per cent of people in the most rural category take more than 14 minutes to walk to a bus stop, as compared with 0 per cent in all urban areas)<sup>33</sup>.

Only 49 per cent of households in the most rural areas have a regular bus service<sup>34</sup>. This results not only in social isolation of both older and younger people but also in less good access to services of all kinds, as the chart below shows.

Average travel time by public transport / walking to reach nearest key services, urban and rural areas, England, 2014



**Source:** Department for Transport, Journey Time Statistics: Access to Services 2014:



Taken together, the above figures indicate that a low percentage of car ownership is not as great an indicator of deprivation in rural areas as it is in urban areas. And, for the small but significant percentage of people living in rural areas who do not have access to a car and for households with two adults and children with one car only, this can be a serious disadvantage.

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## Taking hepatitis C support out to the community

Recent PHE statistics suggest that only 3 per cent of the national population with hepatitis C are successfully treated for the virus, which in turn directly impacts on the increase in transmission rates.

Addaction Recovery Partnership Warwickshire have around 90 hepatitis C positive service users engaged with the hepatitis C support team over the four bases, Stratford, Leamington, Rugby and Nuneaton.

Given the chaotic lifestyle of many of the service users and the current hospital referral and appointment systems, in addition to the logistics of coordinating appointments to hospitals from far reaching rural locations there was a huge 'did not attend' rate which had both a financial impact on Addaction, the service provider, and NHS local trusts, and a long-term impact on the health and wellbeing of service users who, by the nature of their addiction, may lose motivation and disengage.

Public health commissioners and the service provider worked with consultants and viral hepatitis nurses to bring their clinics to service users. Starting from 2016 the Recovery Partnership holds community clinics for clients with hepatitis C in locations across the area.

There has been an increase in motivation, attendance and ongoing engagement in the treatment process.

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More difficult physical access to services is exacerbated by digital exclusion (see next section).

The Department of Transport<sup>35</sup> recently identified road traffic accidents as a major problem on rural roads. It found that 60 per cent of fatalities occurred on country roads; three people died each day on average which is nearly 11 times higher than on motorways; a quarter of drivers have had a near miss and one driver in 20 has had a collision on a country road. It is not specified whether these were rural or urban drivers, but the issue is stark for all users of rural roads.

### Questions to consider

- Do you understand the patterns of demand for transport across your rural areas and between different groups (eg young people travelling to college, employed people travelling to work, older people, access to the nearest health and social facilities)?
- Have you 'rural proofed' your approach to concessionary travel to maximise access by the most disadvantaged people to public transport?
- Are you using your role as a public health authority and leader of the HWB to ensure that rural communities' travel time to services is an integral factor in the planning of services in the care sector?

## 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.

A significant minority of the UK population, 13 per cent (6.4 million) of adults, have never used the internet, with 18 per cent saying that they do not have internet access at home.

There is a growing social and economic gap between those who are connected and those who are not – the ‘digitally excluded’<sup>36</sup>. There are a number of reasons why this is a particular issue for rural areas.

Older people are disproportionately represented among those who do not have internet access. There is also evidence that older people experience more loneliness and social isolation which could be mitigated in part by greater access to the Internet. For example, voluntary organisations such as Age UK and the Royal National Institute for Blind people are increasingly using internet technology to communicate with and link together older people in networks.

High speed broadband and mobile phone networks are generally less available in rural areas compared with urban areas. As remoteness and population sparsity increase so too does the likelihood of an area having no or very poor broadband connectivity<sup>37</sup>. Poor or no digital provision can have a number of negative effects on a rural community including economic implications for businesses unable to use email or have a website, restrictions on people wishing to work at home (of which there are a disproportionately high number in rural areas – 33 per cent in rural hamlets and dispersed areas<sup>38</sup>), fewer learning opportunities with an increase in online learning, difficulty searching for employment, social isolation and lack of access to services such as online banking and food shopping<sup>39</sup>. Figures produced by Ofcom indicate that adults in rural areas with access to the internet are more likely to use key types of internet site, including health-related sites, social networking sites, banking sites and council sites<sup>40</sup>. The internet seems to compensate for poorer access to physical services. This means that in rural areas those with no or inadequate internet access are disproportionately disadvantaged.

Digital exclusion in rural areas is a particular problem in relation to health services because access to the internet may provide one solution to issues of rurality and sparsity. In a number of areas, digital technology is being used creatively to link people living in areas

that are geographically remote with both health and care services. Some uses are controversial in relation to issues of privacy and dignity, others clearly provide a ready solution for service users – a public debate is needed to develop society’s views on how far technology should be used as a supplement or an alternative to personal interaction. This, together with its potential impact on the social determinants of health, makes digital access and exclusion a significant issue in rural areas.

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## Using digital technology to improve access to services

The Cumbria Rural Health Forum, led by the University of Cumbria, brings together around 50 public, private and third sector organisations with the common aim of exploring whether ‘digital can help as part of the rural solution’. Within local government, partners in the forum include Carlisle City Council, Cumbria County Council and South Lakeland District Council. The forum receives funding from the Academic Health Science Network for North East and North Cumbria. As part of this funding, it is developing a Cumbria Strategy for Digital Technologies in Health and Social Care alongside a knowledge base in ‘what makes good rural health and social care’.

So far, the Cumbria Rural Health Forum has mainly focused on health and care services rather than public health. However, Cumbria County Council has piloted the [www.kooth.com](http://www.kooth.com) web-based counselling service which offers emotional and mental health support for children and young people. The DPH has been very impressed by the service and is hoping to be able to continue it. Cumbria Partnership NHS Foundation Trust has also been working up a text-based service called Chat Health that is used by school nurses whose work is now part of the remit of public health. The service is at an early stage but it is hoped to develop it further.

“I do think there’s a lot of scope for web and app-based public health – this is going to be a major strand of Cumbria’s new health and wellbeing system” says Colin Cox, Cumbria’s

Director of Public Health.

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**Website of the Rural Health Network:**  
[www.ruralhealthlink.co.uk](http://www.ruralhealthlink.co.uk)

### Questions to consider

- Have you mapped broadband access and use across your communities? Have you developed partnerships with broadband providers for your area to help identify and support people experiencing digital exclusion?
- Where you or your public sector partners provide online services, do you know how accessible these are to people in your rural areas? If they are not accessible, are there alternative means to deliver them?
- Are there opportunities in your area to use online access in imaginative ways to tackle loneliness and isolation and to enable people in remote areas to access services?

## Air quality

Pollution from traffic is increasing in rural areas where levels of ozone are generally higher and where there are a significant number of Air Quality Management Areas (AQMAs). Air quality remains a serious health risk.

Air pollution can have an adverse effect on people with asthma and those with heart conditions or lung diseases. People also at particular risk include children aged 14 and under, older people aged 65 and older and pregnant women. More than five per cent of deaths in England are attributable to long-term exposure to particulate air pollution<sup>41</sup>. This estimate makes air pollution the largest environmental risk linked to deaths every year. Emissions of primary pollutants are significantly greater in urban areas. However, although there is clustering of AQMAs in

predominantly urban areas, a significant number of AQMAs have been declared in areas classified as 'rural', many of these being in small market towns. AQMAs are places in which the local authority for the area finds that the national air quality objectives are unlikely to be achieved by agreed deadlines. In these areas, the local authority must put together a Local Air Quality Action Plan. Pollution in these areas may be caused by a build-up of slow moving traffic at peak times in a small town with narrow streets. Peak times for pollution caused by traffic can coincide with times when children are walking or cycling to school.

Furthermore, levels of ozone are generally higher in rural than in urban areas, by on average 20 per cent to 40 per cent, because of the atmospheric chemistry of ozone<sup>42</sup>. Formed by the oxidation of primary pollutants in the presence of sunlight, ozone is scavenged by nitric oxide which is more abundant in urban areas. Consequently, ozone usually occurs in higher concentrations in rural rather than urban areas. There is some evidence of a decline in peak ozone concentrations although no general downward trends have yet been detected. Pollution from traffic is increasing rather than declining, so air quality remains a health issue in rural areas<sup>43</sup>.

### Questions to consider

- Do you know what the air quality is like in your area and whether and to what extent it meets the national objectives? Where there is pollution do you know its causes and which populations are most likely to be affected (poorer households are more likely than more affluent households to live along major traffic routes)?
- What is your authority doing to reduce road-traffic-related emissions (eg by reducing overall mileage, improving public transport, altering the type of fuel, aiding dispersion or deposition of pollutants, reducing people's exposure to pollutants, for example, by providing clean air walking and cycling routes?)

## Access to health and related services

Rural areas may have worse access to health, public health and care services and may need different models of service delivery, including new models of workforce development to meet needs.

National models of service delivery tend to be based on urban/semi-urban settings and are less likely to consider or test delivery in sparse rural areas. In general, centres dealing with acute illness and emergencies and specialist treatment are further away.

- Eighty per cent of rural residents live within 4km of a GP surgery, compared with 98 per cent of the urban population.
- Only 55 per cent of rural households compared to 97 per cent of urban households are within 8km of a hospital.
- Fifty-seven per cent of rural residents live within 4km of an NHS dentist, compared with 98 per cent of the urban population.

These longer distances mean that rural residents can experience ‘distance decay’ where there is decreasing rate of service use with increasing distance from the source of health care.

Research by Age UK found that cuts to bus services had made it more difficult for older people in particular to access their doctor’s surgery and to get to hospital appointments; and that getting to hospital appointments can require two or three bus journeys<sup>44</sup>.

Access to mental health services varies from area to area, and there is little statistical or other information about rural areas specifically, making it hard to assess access issues to these services.

For some types of medical condition, such as stroke, where clinical staff have experience of larger numbers of patients there are better health outcomes in larger specialist centres. This means that some concentration and centralisation of specialist centres is a trend that is likely to continue. Nonetheless, other recent moves are bringing some services to

people’s homes, using outreach, technology, mobile services and localised delivery.

Such approaches into communities were adopted in relation to provision of mental health support to the farming community after the foot and mouth outbreak, which reached farmers in their settings and also deployed support from veterinary staff and others<sup>45</sup>.

Research on ageing in rural areas identified a tendency for older people to present to health services in moments of crisis resulting in significant challenges to health service providers and often necessitating “more intensive, immediate, invasive and complex responses”<sup>46</sup>. This highlights the need for service providers for older rural people to prompt/facilitate older people to voice their unmet need, and/or to screen for need.

However, bringing services closer to rural communities where people are more spread out, is more costly, economies of scale may be less available and it may be more difficult to retain staff. One way of finding economies where economies of scale are not available in one service area is to provide a range of services from a rural ‘hub’. Aside from the potential economies in premises and staffing, such hubs can address real needs in rural areas, including social isolation, the loss of community meeting places such as post offices and libraries and the reluctance of older people and unemployed people in rural areas to express their health and care needs and/or claim benefits until they are in a crisis situation.

Public health interventions such as NHS Health Check and Making Every Contact Count (MECC) rely for their effect on a whole population on reaching large numbers of individuals. In rural areas, these initiatives may still reach large sectors of the population, but some people may be disadvantaged because of remoteness, sparsity and for many of the same reasons as more deprived people in urban areas. Public health teams are relying increasingly on e-delivery, for example of sexual health services. Although it is potentially a way of reaching remote and sparse homes, it may also put rural



communities at a disadvantage where internet access is poor and may therefore need special attention in rural communities.

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## Access all areas in Suffolk

Increasing access for rural communities is one of the key objectives of Suffolk County Council, and rurality is an additional factor within the County Council when undertaking Equality Impact Assessments (EIAs). There is evidence that there are small pockets of significant deprivation even within the county's relatively affluent rural areas, many of which are below Lower Super Output Area (LSOA) level.<sup>47</sup> Some initiatives are highlighted below:

For the delivery of health checks the public health team maximises the use of GP practices and pharmacies together with separately commissioned outreach for areas where GP coverage is low. There are higher levels of uptake than the national average and the proportion of those accessing a check who are from the 20 per cent most deprived communities has increased from 17 per cent in 2013/4 (when there was not specific targeting) to 22 per cent in 2015/6. Commissioners aim to keep the proportion above 20 per cent as going below this could potentially increase health inequalities.

The county's integrated drug and alcohol treatment service is delivered by Turning Point. They started working in Suffolk in April 2015 and have been working with commissioners to develop initiatives to tackle the rurality issue across the county in the context of reducing resources. Organisationally, Turning Point are working towards offering remote support via video link and Suffolk is intended to be one of the pilot sites for this. The first stage will be to provide medical consultant support to workers with their clients across Suffolk through telemedicine with the potential to extend to include nursing interventions and frontline worker sessions. This should reduce the need for extensive travel by both workers and clients who can be supported to access the video link at satellite services in more rural

areas. Turning Point also aim to modify the way in which some service users can access treatment by offering a 'digital front door' which will enable clients to access information such as screening tools and other useful information. A range of 'smart' documents will be available online for those clients who have the skills and capability to access services in this way. Clients will also have access to online treatment and support packages which can be accessed directly by the client.

For sexual health services there is a hub and spoke integrated service model which improves access to all sexual health services except level 3 (complex service provision) which is provided in the hubs for the three key geographical population areas (linked to CCG boundaries). Suffolk is also upskilling the wider workforce via the sexual health network so that sexual health and workers can use this information in their day to day work with individuals across the county. Additionally they will soon pilot opportunities for a "digital front door" offering assessment and testing for asymptomatic patients.

For 0-5 year services there is a joined up approach between public health and early years services. Although commissioned separately there is close working on the ground particularly between health visitors, children's centres and homestart.

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## Responding to the needs of rough sleepers in the woods – a district council initiative

Mendip District Council has a large number of rough sleepers for its geographical size – an average of 16 at any one time, compared to an average of three in other Somerset local authorities. The lifestyle of rough sleepers means they face huge risk of poor health. The population of rough sleepers is also distinct, with many choosing to live in social isolation in wooded areas outside Mendip towns.

The council commissions Elim Connect to provide outreach support to homeless people through a street level access programme.

In 2013/14, Elim worked with 86 people, of whom 52 were helped to move off the streets. However many remained homeless.

Elim leased a rural premises on a farm surrounded by hundreds of acres of woodland, orchards and garden, to allow a 'softer transition' to a structured way of living for rural rough sleepers. The project provides six beds and operates on a community basis. Structured activities are on offer including art, pottery, animal care and horticultural work, including access to employment skills. The project also helps people to improve their health and wellbeing, through access to doctors, dentists and other healthcare professionals.

In previous years, Elim has run healthcare campaigns around mental health awareness, suicide risk, smoking, sexual health, overdose, TB, staying safe, relapse prevention, fire safety etc and provided GP and dental access points as well as podiatry and drop-ins and weekly community lunches including for medical appointment as well as a free counselling service. This work was supported by short term grant funding from public health. Elim is exploring alternative ways of providing these services and public health continue to work closely with Mendip, the other district councils, the NHS and voluntary sector partners to address the housing and health and support needs of homeless and vulnerable populations across Somerset.

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## Fish Well health improvement project in Norfolk

Fish Well was an outreach health improvement project for fishermen in the coastal areas of Norfolk, brought to the quayside by Norfolk County Council. Its objectives were:

- To engage with a 'hard-to-reach' male workforce working in partnership with the trusted charity, the Fishermen's Mission, building on the welfare culture of their organisation.
- To identify fishermen in Norfolk at risk of cardiovascular disease and support them to change their lifestyles to reduce risk.
- To deliver and manage three Fish Well events in the fishing ports and fishing areas in Norfolk, providing the opportunity for NHS health checks, risk checks, access to behaviour change support with the Health Trainer Service and information about men's health.
- To discover the dental needs of this population.

Making use of the Fishermen's Mission connections with the fishing community and their mobile office, services were brought to the workplace with quayside health checks and health professionals available for advice and support. This enabled local fishermen to access services they wouldn't otherwise have been able to benefit from, due to their long unpredictable hours at sea. The men engaged well with the project and the Fishermen's Mission wish to replicate this project around the coast with other fishing communities.

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## Supporting young parents in North Yorkshire

North Yorkshire is a large geographical area spreading 3,100 square miles with seven district councils, five CCGs and served by a number of acute hospital trusts. There are an estimated 433 young parents aged 19 and under in North Yorkshire at any one time.

A decision was made to decommission the Family Nurse Partnership in order to establish a more equitable service for all young parents aged 19 and under. Three specialist health visitors were appointed in April 2016 through the 0-5 Healthy Child Programme (HCP) contract and are based in localities in Prevention Service hubs. A multi agency implementation group has also been established.

The specialist health visitor allocates each case either to the core 0-5 HCP team or keeps the young person on their caseload. This decision is based on capacity, need and geographical location. The programme is usually delivered on a one to one basis but where antenatal groups for pregnant teenagers exist some of the sessions may be delivered through this group setting. The aim is also to engage with young fathers to improve outcomes.

Due to the geographical size of North Yorkshire, the specialist health visitors are supported by champions from both health and the prevention teams in each locality. The champions will have a role in cascading training and ensuring the training resource packs are kept updated as required.

The programme is delivered jointly with North Yorkshire County Council's Prevention Service which encompasses youth services, children's centres and troubled families.

The resources to date have been well received, with many of the professionals seeing the benefit of using the resources for work with a wide range of families and not just the young parents. Basing the specialist health visitors in the prevention service hubs has helped improve joint working between the two services.

Setting up referral pathways with a number of different hospitals some of which are out of area is complex but essential to ensure young parents don't slip through the net.

The next steps are to fully roll out the programme so that the full range of antenatal and postnatal resources are in place across the county.

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## Increasing the uptake of NHS Health Check in isolated settings – support from district council

Cambridgeshire County Council is working to increase the uptake of NHS Health Check among the predominantly male manual workers in the Fenland district. The Fenland economy is largely built on farming and food industry with higher levels of unemployment than many other areas of the county and low scores on a number of lifestyle-related health indicators. There is a well-established culture of smoking, unhealthy eating and low levels of physical activity among the indigenous population which has been supplemented by significant numbers of migrant workers from Eastern Europe. This population also has an established culture of unhealthy lifestyle choices and people are often not aware that primary care services are available.

In Fenland, health trainers are delivering NHS Health Checks in workplaces as well as GP practices. They are also able to provide ongoing support for lifestyle changes following the health check. Further support is being provided by a local community pharmacist who has expanded her pharmacy-based NHS Health Check service into local workplaces. The ongoing engagement of employers is crucial to the delivery of the project. Fenland District Council Environmental Health team has provided introductions to employers and acted as an advocate for the programme. A community centre for migrant workers and the police are also involved, the latter

because of the high levels of alcohol intake in the migrant population which is associated with community safety issues. The local health trainer programme has a Lithuanian interpreter and also a health trainer from the migrant community who promotes NHS Health Checks amongst these communities. . An NHS Health Check van was commissioned to provide a flexible space to deliver the checks outside factories at lunchtimes and other breaks.

Initial outcomes indicate an increase in the number of health checks in the district and among the target population.

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## Maximising council services for health objectives

East Riding Council works to meet its health and wellbeing objectives by making maximum use of all council services around its area, where over half the population live in dispersed rural communities. Thus its award-winning 'Live Well' personalised one-to-one support programme is delivered through its leisure centres, in some of which Health Trainers have their base.

The sexual health service has been re-commissioned to be more dispersed in the community and the health check service uses leisure centres and pharmacies across the area as well as some GPs. The council is also working with local small and medium sized employers (SMEs) to improve the health of the workforce. The initial approach was a partnership between public health and the council's economic development team. A 'double health check' was offered to local SMEs (checking blood pressure, weight etc of employees while looking at the financial health of the business). This provided an opportunity to talk more generally about healthy workplaces. A survey was then distributed to find out more about SMEs to inform a council-wide health improvement strategy.

The public health team has its own vehicle

which can tour round the area, facilitating health promotion with video resources, a seating area, and a full kitchen. Its visits to seaside resorts and coastal caravan parks have showcased healthy cooking, living and Fit 4 Life activities. Its attendance at many community engagement events (particularly in areas where some of the poorest health in East Riding exists) have resulted in hundreds of health checks on local residents.

The lessons learned from current services are being applied in both directly-provided council services and other services commissioned from external providers. One example is the Fitmums and Friends group. Initially established as a small community group focusing on post-natal depression and exercise, it has been supported by public health and has now grown into a thriving social enterprise, working with a children's centre and a breast feeding peers initiative and has expanded to include a choir, a cycling group and early years sessions. It has grown from four women to over 400 members in four years and has become a highly visible dynamic community asset.

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## Action on alcohol in a deprived market town

The Wisbech Alcohol Project was set up in January 2015 in response to growing concerns about the impact of alcohol misuse on the local community and an entrenched culture of street drinking. The traditional market town of Wisbech has some of the most deprived wards in Cambridgeshire and poorer health outcomes. Premature mortality from preventable causes in Wisbech is higher than the England average. The age-standardised rate of hospital stays for alcohol-related harm is statistically significantly higher in Wisbech compared with the England average.

The Alcohol Project brings together professionals from county and district councils, police, treatment services, housing and homelessness, local security staff and voluntary sector providers, including mental health services. All partners are signed up to a joint action plan which has delivered the following:

- a range of joint public engagement events with around 1,500 people being spoken to about health harms linked to alcohol
- harm reduction and publicity material available in key venues. Local supermarkets have provided free space for public engagement and Tesco on-line deliveries included alcohol scratch cards in their shopping deliveries
- a simple health card for the EU Community explaining the need to register with a GP to reduce unnecessary A&E attendances
- public health considerations in licensing representations helping prevent six licence applications being granted in an Alcohol Cumulative Impact Zone
- increasing the number of people accessing alcohol treatment services
- alcohol identification and brief training to 120 professionals
- 103 street drinker profiles have been developed and recovery walks are taking place to engage with street drinkers and encourage them into treatment
- NHS Health Checks are provided via local employers in the area.

The Alcohol Project group has recently submitted a bid to become a Local Alcohol Action Area. Key priorities of the LAAA project will be to try engender a sense of social responsibility with sales of alcohol in local offlicences and work to target resources to address street drinking via enforcement around alcohol related crime and support to drinkers themselves.

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## Virtual sexual health services

The YorSexualHealth service in North Yorkshire was launched in July 2015. Initially, a number of clinics were set up in rural areas of the county close to the scattered populations of the Yorkshire Dales. However, it became clear that people were reluctant to attend such clinics. Therefore, the clinics were closed.

Plans for virtual services were made before commissioning a new contract, with a view to enhancing choice for those who prefer not to attend clinics, and reducing overheads. Feedback from young people consulted was that a virtual service offers greater privacy and easy rapid access, particularly for those in rural areas. A free, confidential postal testing service has been launched for chlamydia, gonorrhoea, HIV and syphilis for men and women aged 16 and over living in North Yorkshire and York. Testing kits can be ordered online. Kits are small and discreet and fit through letterboxes. Results are made available via the chosen method of delivery of people tested. If chlamydia tests show an infection, sexual health nurses will carry out a telephone consultation and may then be able to post treatment to the person consulted. If HIV, syphilis or gonorrhoea test show an infection, subjects are asked to attend a clinic in more urban centres for further tests and treatment.

The service is supported by a comprehensive sexual health website with contact details for telephone advice around contraception, STIs and HIV and information about where to get help in cases of rape, assault or abuse. There is also a counselling service which can be contacted directly or by self-referral online and a clinical outreach team to support more complex cases and vulnerable people.

There are plans to work with young people to explore the option of an internet 'quick chat' as a potential future development. Commissioners and service providers will continue to review the online testing services and will consider the option of these being targeted, either geographically and/or for the most at risk populations. The priority will be to offer choice to service users to encourage

quick and easy access to sexual health care, particularly for those who need it most.

**Further information:**

[www.yorsexualhealth.org.uk](http://www.yorsexualhealth.org.uk)

**Contact:** Liz Hare, Partnerships and Communications Lead, YorSexualHealth

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## Baby Steps in Wiltshire

Wiltshire Council commissions Baby Steps, a nine-session group programme to support parents with additional needs and vulnerability developed by NSPCC and the University of Warwick. Baby Steps was introduced by the NSPCC's centre in the garrison town of Tidworth and has now been extended to children's centres in a number of small market towns. The programme helps to prepare expectant parents for the birth of their baby in addition to supporting parenting skills. It is designed to attract and engage parents with additional needs, including those who might not otherwise take up antenatal classes.

Over the three years to 2015 around 185 parents took part in the programme. Commissioning the service was then taken on by Wiltshire Council's Public Health team and rolled out across the county as part of the council's Early Help Strategy. Eight facilitators from local organisations were appointed and trained and the programme is jointly delivered by children's centre staff and health visitors and midwives. The aim is to deliver 36 programmes a year in six sites across the county with approximately eight to 10 parents per site. Most referrals come from midwives and health visitors but other practitioners are welcome to contact the programme if they know of parents who may benefit.

Staff have found Baby Steps an exciting programme to be involved in which has made a difference to outcomes for participants. Positive feedback from participants suggests they find the sessions helpful in preparing for parenthood. A full evaluation of the service is due to take place in January 2017.

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## Unintentional Injuries Pathway, toolkit and text messaging programme

North Yorkshire County Council's Prevention Service and Harrogate and District NHS Foundation Trust's 0-5 Healthy Child Programme (Health Visiting) Service have worked in partnership to develop a number of new programmes designed to reduce the number of children under five sustaining unintentional injuries in the home.

The programme has been developed following the findings in a report by the county council's public health team which identified unintentional injuries in children as an area of concern in North Yorkshire.

The programme includes a multi-agency integrated home safety pathway designed to create a standardised and systematic approach for professionals involved with all children aged 0-5, and will support local decision making. A home safety toolkit to support the pathway has also been developed. The toolkit provides a systematic evidence based tool to assess and reduce risk of unintentional injuries in and around the home. The aims of the toolkit are specifically to increase parenting ability to identify home safety risks to their child and increase a parent's ability to make the change required to keep their child safe.

A text messaging service which will send parents safety messages at key points in the child's development has also been developed.

The programme is in its infancy and currently brings together the work of the Healthy Child Programme and the prevention service. However it is hoped that in time a broader range of partners will be involved.

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## Questions to consider

- How well do your council and its health partners use data to identify areas in which take-up of services is low and access is a problem?
- What initiatives do you have in place to deliver services to rural communities in new and innovative ways?
- Can you work with other council departments, NHS partners, voluntary and/or faith organisations and, in two-tier areas, district councils, to build on the model of an integrated services hub to enable people to access a number of services in one locality?
- How are you using technology to help deliver services to outlying and isolated areas?

## Lack of 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. The fact that social isolation influences health outcomes in its own right suggests that this is an important and hitherto neglected area in the promotion of public health.

Rural areas have a unique set of circumstances that can exacerbate the social isolation of older residents in particular, leading to poor health, loss of independence and lower quality of life.

To compound this situation, poor health, physical disability, proximity to mortality and life events such as bereavement are known risk factors for social isolation. These factors are all associated with demographic ageing. A recent systematic review found that loneliness can increase the risk of premature death by 30 per cent so that people in the most high risk groups can be subject to a vicious circle of poor health or disability leading to social isolation and loneliness

which in turn lead to worse health<sup>48</sup>.

A number of factors are contributing to isolation and social exclusion in rural areas:

- demographic changes meaning that older people in rural areas don't live near their families
- the lack of affordable housing for young families
- the growth of commuting (people have less free time to become involved in their local community)
- increasing mental health problems
- the increase in single person households (rural areas have fewer one person households than urban areas, but projections suggest that they will grow significantly in number)
- the disproportionate closure of shops, post offices and pubs in rural areas
- the withdrawal of subsidies to scheduled bus services (which has a disproportionate impact on older people who are more dependent on public transport)<sup>49</sup>
- the growth in internet-based communication, which is not possible for or desired by some older people (for example some of those with visual or hearing impairments or dementia), and more remote methods of work rather than face-to-face contact.

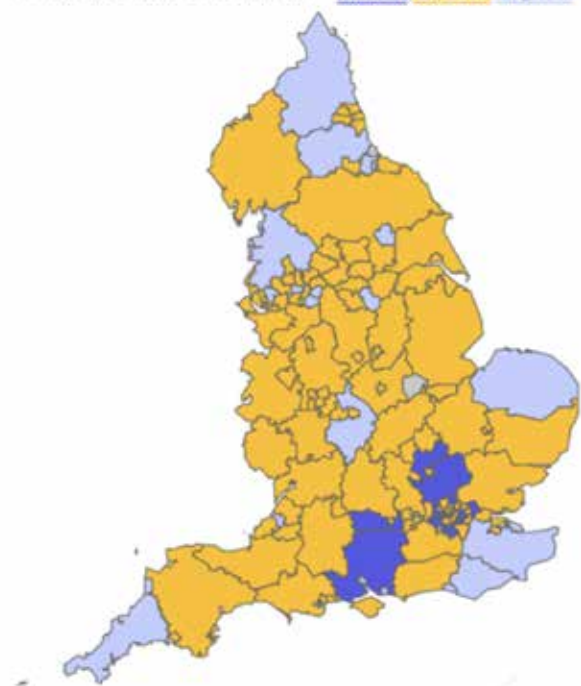
Social networks and local community support play a critical role in helping people either to avoid or to overcome their experience of disadvantage, by providing emotional or practical support such as help with shopping, transport and money. Recent research has highlighted the increasing importance of lack of community support and social isolation leading to disadvantage, as rural social networks are breaking down<sup>50</sup>.

These circumstances now include the financial situation for local government which is forcing councils to restrict social care to the national minimum and which is causing providers of social care to go out of business – the additional costs of providing care in rural areas are exacerbating this problem<sup>51</sup>.

The risk of suicide and undetermined injury may be higher in farming communities and may be due to various factors related to isolation and ease of access to the means of suicide such as guns and poisons<sup>52</sup>.

The map below shows higher suicide rates in areas that are rural and sparsely populated, although some deprived urban areas also have higher than average rates (the benchmark is England average).

Compared with benchmark **Lower** **Similar** **Higher**



### Suicide rates compared with England average

**Source:** Public Health England Suicide Prevention Profile Contains Ordnance

**Survey data © Crown copyright and database right 2016**

Councils across the country have developed a wide range of strategies to tackle isolation and social exclusion in rural areas, including harnessing the willingness of older people themselves to volunteer as community activists keeping people in touch with each other. The case studies below give some examples and see also the LGA's recent publication on Loneliness.<sup>53</sup>

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## Strengthening communities in Fenland

Fenland is a rural area of Cambridgeshire with four small market towns and 29 villages and other rural locations. Seven of the top 10 most deprived wards in Cambridgeshire are situated to the North of the Fenland District in the town of Wisbech and surrounding villages. The area has been prioritised for action on health inequalities. The Healthy Fenland Project is part of the Engaging and Strengthening Communities in Fenland Programme funded by Cambridgeshire County Council. As part of the project there is a team based in Fenland who are working with communities to help them make the changes that they want to improve their health and wellbeing. The 'on the ground team' work with people who want to make a positive change in their community, which may be geographically defined, or by interest or experience.

Support is offered both to existing organisations wanting to do something new, and to members of the public who want to get involved and have no previous experience. The help is based around the 'Five Ways to Wellbeing' devised by the New Economics Foundation.

As well a practical support and guidance, the project also offers financial support from the Health Fenland Fund which offers small grants normally from £250 to £5,000 to projects seeking to improve the health and wellbeing of people living in Fenland.

### Further information:

<http://www.cambscf.org.uk/healthy-fenland-fund.html>

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## Suicide awareness training in Derbyshire

Rural Action Derbyshire has been delivering suicide awareness training seminars throughout Derbyshire since 2009 and has trained over 1,000 people. Throughout the Government's National Suicide Prevention



Strategy (launched in 2012) there is an emphasis on the importance of training: in support of this and due to the on-going demand for our seminars, we are pleased to be in a position where we are able to continue providing this valuable training.

**Further information:**

<http://www.ruralactionderbyshire.org.uk/suicide-awareness.html>

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### Gloucestershire Village and Community Agents – providing older people with easier access to services and information

Village Agents began as part of the LinkAge Plus scheme funded by the Department for Work and Pensions in 2006. The aim was to provide older people in the county's rural communities with easier access to information and services. Ninety-six of the most isolated rural parishes were selected. By the end of the pilot in 2008 the scheme covered 162 parishes with 30 agents. Gloucestershire Community Agents, working with black and minority ethnic (BME) communities across the county, were introduced initially as a pilot for the first six months of 2008 and are now an integral part of the team. Today, 39 Village and Community Agents operate countywide in the rural areas and the urban centres of Cheltenham and Gloucester. They have a track record of befriending socially isolated older people and bringing them to a network of services and social activities. Gloucestershire Rural Community Council manages the Village and Community Agents. The Village and Community Agents are funded by Gloucestershire County Council and the specialist agents by Gloucestershire CCG.

**Further information:**

<https://www.villageagents.org.uk/>

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### Promoting mental health awareness in the farming community

The YANA (You Are Not Alone) project works with the farming communities in Norfolk

and Suffolk. The project provides a support service for those in farming affected by stress and depression, including people contemplating suicide. The project has a website ([www.yanahelp.org](http://www.yanahelp.org)) and a dedicated helpline and has distributed thousands of leaflets advertising its services to GPs, health professionals, land agents, agricultural engineers, the Women's Institute, Young Farmers and professional businesses. Funding for counselling is available to those who work in farming, agriculture or any related profession and who live in Norfolk or Suffolk.

**Further information:**

<http://www.yanahelp.org/>

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### Improving health outcomes for victims of domestic abuse in Warwickshire's rural communities

IRIS (Identification and Referral to Improve Safety) is a general practice-based domestic violence and abuse (DVA) support and referral programme for primary care staff.

In 2010 WCC commissioned an independent review of domestic abuse support in the county. The report specifically considered the needs of Warwickshire's rural communities. Each year, between 3,500 and 5,000 women and girls aged between 16 and 59 living in rural areas in Warwickshire will experience domestic abuse. Research has found that victims living in rural areas may experience more barriers accessing services, therefore services need to be targeted to overcome potential barriers.

There are centres across the county where victims can access support and are used as a base to go into the local community. However due to the rurality of some districts, accessibility of these centres was considered to be a problem for some of the clients interviewed. Research has found that women in rural areas valued health practitioners, particularly GPs, in providing confidential and safe services for women, making it all the more important for GPs to be able to identify and respond effectively to DVA.

IRIS provides a targeted intervention for patients aged 16 and above experiencing current or former DVA. The Warwickshire

IRIS service model rests on three full-time advocate educators working with 77 GP practices. The advocate educator is a specialist domestic abuse worker based in Warwickshire County Council's commissioned specialist domestic abuse support service. The advocate educator works in partnership with a local clinical lead to deliver the service model. As well as supporting victims at crisis and working to increase their safety, the advocate educator can refer and assess victims' needs in relation to other areas of their lives/wellbeing such as housing, finances, mental health, children and substance misuse.

IRIS provides a unique opportunity for primary care clinicians and their patients to talk about DVA. General practice can play an essential role in preventing and responding to DVA by intervening early, providing treatment and information, and referring women on to specialist services. Since introducing IRIS in Warwickshire, the following benefits have been identified:

- victims of domestic abuse are identified earlier
- the right support is adopted sooner
- victims' safety is improved
- victims' quality of life has improved
- recurrence of domestic abuse has reduced.

The programme provides a flexible and responsive approach to victims' needs. Seventy-six of the 77 GP practices have achieved full 'Domestic Violence Aware' status and are operating the services. Training has also been provided for the county's two main hospitals.

A very high percentage of clients have reported increased safety, and improved quality of life and health.

## Questions to consider

- Does your council's asset-based strategic needs assessment identify rural areas in which there is a high risk of social isolation? Does it include mapping of community assets in rural areas (such as lunch clubs, faith groups and befriending services)?
- Do you have a specific strategy for tackling loneliness and social isolation in your rural areas?
- Does your domestic violence reduction strategy take into account issues of rurality and how to reach out to those who are most isolated?
- Do you know what the provision is of informal local meeting places in rural areas (such as village halls, post offices, pubs)? Where such venues are lacking, what can you do to encourage multi-service outlets and joint location for a range of services? Can you encourage wider use of existing places such as schools?
- Are you making the most of older people themselves as paid or unpaid volunteers providing community services which address social isolation?

## 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.

The lack of affordable housing for groups who cannot afford to rent or buy in rural areas is well documented. Housing in the most rural areas is, on average less affordable than in other types of area.<sup>54</sup> Rural house prices are 26 per cent higher than in urban areas and there is much less housing association and council housing (12 per cent of rural housing stock is social housing compared with 19 per cent in urban areas).<sup>55</sup> A lack of affordable housing in some areas now extends to those on average incomes, not just people on lower incomes. It is leading to people moving out of rural areas and increasing concerns about the sustainability of rural communities<sup>56</sup>.

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## Integrating housing and care needs of older people in a rural area

Pencric is an Extra Care development in the South Staffordshire village of Penkridge. An effective collaboration between South Staffordshire (District) Council, Staffordshire County Council, Homes and Communities Agency and Trent Dove Housing Association, the integrated housing, health and social care scheme was opened in 2014. It provides 82 new homes for older people with strong connections to the village. The project is now complete and successfully occupied by a range of people who are either choosing to rent, to 'part rent/part buy' (shared-ownership) or full ownership.

All units are provided with wet rooms for greater accessibility, supplemented by shared spa bath facilities. Energy efficient lighting within the wet rooms is automatically extinguished on exit. Wide corridors accommodate mobility aids and there is space for scooters in the reception areas of every home. A higher than usual amount of storage space has been incorporated into homes and within communal areas, popular with residents downsizing from larger properties. Access throughout the building is by fob, rather than key. If mislaid, a fob can easily be disabled and replaced for greater security.

Grounds incorporate raised beds and potagers so that residents who enjoy gardening can maintain their hobby. A 'garden gate' gives direct access to the heart of the village.

The scheme is set within the village apron, overlooking common land. It combines secure, private accommodation for residents with a range of open-access facilities designed to enhance amenities for the community and strengthen social integration. The restaurant, bistro, bar, hairdressing salon and meeting spaces are all open to the public. Partnership links have made possible joint membership of the local swimming pool and Pencric gym for residents and villagers alike.

Both residential and public spaces have wifi connectivity and there is an IT suite for the use of residents. Pencric serves as a hub for elderly people within the wider village community; being used by a snooker club, whist group and those who access interactive musical workshops for dementia sufferers and their carers. In so doing, the relief of social isolation for older people extends very significantly beyond the remit of residency of the scheme. The project also delivers care and support tailored to the needs of individual residents. A team of carers based at Pencric provide flexible care packages for residents as well as domiciliary care in the local community.

### Further information:

<http://www.ruralhousingalliance.net/case-studies/older-people/pencric-penkridge-staffordshire/>

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The proportion of homes which are classified as 'non-decent' is much higher in more rural areas: around 50 per cent of homes in the most rural areas and villages compared to around 30 per cent in small towns and urban areas. The proportion of homes which are very energy inefficient is much higher in the most rural areas: 50 per cent in the most rural areas and 25 per cent in village centres compared with 7 per cent in urban areas<sup>57</sup>.

Two in five homes in rural areas are off the gas grid and many depend on more expensive fuel; and if of solid wall construction, houses can be difficult to insulate.

Households in fuel poverty are at risk of being unable to heat their homes to an adequate standard, and less able to spend their income on other amenities. The higher rates have declined since 2006 but the rates are still high in sparse rural areas.

	Urban	Rural	Sparse rural
Households in fuel poverty 2006	10.7%	15.3%	38.9%
Households in fuel poverty 2010	15.9%	18.4%	34.1%
Households off the gas grid 2009	9%	38%	64%

**Source:** Defra (2013), Fuel and energy: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/538906/Fuel\\_and\\_Energy\\_Final\\_Jan\\_2013v2.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/538906/Fuel_and_Energy_Final_Jan_2013v2.pdf)

Using the low income high cost (LIHC) measure of fuel poverty, National Energy Action (NEA) identified in a 2013 report that there were 2.6 million households in England that were fuel poor, of which 500,000 were in rural locations, which is a much higher proportion relative to total population. The properties in rural or off gas locations were statistically more likely to be larger, detached or older, and the conclusion of the report was that while there were more fuel poor households in urban areas, the problem of fuel poverty is “likely to be most acute in many rural and off gas locations.”<sup>58</sup>

### Affordable rented energy-efficient homes in rural Wiltshire

The scheme in the village of Minety was designed to meet the housing need identified by a Housing Needs Survey undertaken by Wiltshire Council and Minety Parish Council. Additional partners were the Wiltshire Rural House Association, White Designs (architects), the Homes and Communities Agency and Triodos Bank. As a ‘rural exception site’ it was important that the development was accessible to local amenities and provided high quality, energy efficient homes to people in housing need within the community. (Rural exception sites

are ‘small sites used for affordable housing in perpetuity where sites would not normally be used for housing’.) The 10 houses were designed with high levels of thermal insulation and airtightness. They use a passive stack system to provide ventilation and air source heat pumps for heating. The houses achieve Code for Sustainable Homes Level 4 and also meet Secure by Design and Lifetime Homes standards. They also benefit from modern, high capacity kitchens and water saving bathrooms, directly addressing the issue of fuel poverty in rural areas.

A small piece of land to the side of the development has also been landscaped to provide public open space for the whole village to enjoy.

#### Further information:

<http://www.ruralhousingalliance.net/case-studies/energy-efficiency/meadow-close-upper-minety-wiltshire/>

### Warm homes and fuel poverty: Shropshire

Shropshire’s HWB and its partners are aware that fuel poverty is a significant issue that affects people in the county and that the warmth of homes has a direct link to cold-related ill health and excess winter deaths and as such, the HWB wants to prioritise tackling fuel poverty in local communities. It promotes a number of schemes across the county to support people who are living in fuel poverty. These include:

#### Heatsavers

A scheme formed in 2011 by Shropshire Council, public health, Age UK and Marches Energy Agency to provide advice and assistance to vulnerable households on heating and energy efficiency. It is specifically seen as part of the HWB’s prevention strategy. The scheme accepts referrals from trained frontline workers who have identified concerns for the health of vulnerable people through lack of heating and poor housing conditions.



**Further information:**

<http://new.shropshire.gov.uk/media/3750/lgc-award-broucher-a4.pdf>

**Rural community council oil buying scheme**

Shropshire's Rural Community Council organises a fuel buying scheme for residents of the county. This is the largest oil bulk buying scheme in the Shropshire. It has helped local people save thousands of pounds since it started in September 2011.

**Further information:**

[www.shropshire-rcc.org.uk/services/individuals/oil-buying-scheme/?hid=#-anchor](http://www.shropshire-rcc.org.uk/services/individuals/oil-buying-scheme/?hid=#-anchor)

**Live4Less**

An action-budgeting course run by Marches Energy Agency aimed at helping people to live well and more sustainably on a limited budget, including providing information on grants and sources of support. The course facilitates 'crowd wisdom' and encourages participants to share knowledge of local services, tips and tricks for living well for less.

**Further information:**

[www.mea.org.uk/what/live4less](http://www.mea.org.uk/what/live4less)

## Using thermal imaging to identify heat loss in Kirklees

Knowing that fuel poverty is an issue in rural areas and being aware that some of this may be due to heat loss from older or large houses in which older people are living, means that councils need to find ways to pinpoint these houses. A number of local authorities have used aerial infrared thermographic imaging enabling them to see the amount of heat leaking from individual buildings and to plot data on maps of the area.

Kirklees Council offered insulation free to people in areas where the most amount of heat was being lost from properties. The district council for the rural area of South Derbyshire commissioned a colour-coded digital temperature map of the area using the results of a night time aerial survey by special heat-seeking sensors. The map was used to target individual properties with relatively high levels of heat loss, and therefore potentially poor

insulation, for provision of energy efficiency advice and remedial action. By overlaying the thermal image within the council's Geographical Information System (GIS), the council was able to identify specific properties that could benefit from advice, monetary or practical support.

### Questions to consider

- Is your housing strategy rural proofed – does it recognise the specific housing issues of the most rural areas?
- How do you identify and address issues of fuel poverty in your rural, remote and sparse areas?
- In two-tier areas, are county council and district councils working together to identify and tackle housing issues in the most rural areas? (This could include initiatives like case-finding for the Disabled Facilities Grant and handyperson services as part of your preventive public health and social care strategies.)
- Are you (or in two-tier areas, your district council partners) making the best use of Section 106 agreements to leverage better provision of health and social facilities in rural areas?
- Are you or your district council partners using your enforcement powers effectively in rural areas to ensure minimum housing standards and good property management?

## Employment and unemployment

Unemployment and under-employment are taking younger people away from their families and the work available is low paid and intermittent.

In the fourth quarter of 2015, 59.2 per cent of the rural population over the age of 16 were employed and 3.1 per cent were unemployed, while in urban areas 61.2 per cent were employed and 5.2 were unemployed. Average annual employee earning for those working in predominantly rural areas have tended to



be lower than those working in predominantly urban areas. The proportion of businesses that have a small number of employees is larger in rural areas, with 29 per cent of businesses employing up to nine employees over all, compared with 18.7 per cent in urban areas. Twenty-two per cent of workers in rural areas are home workers, compared to 12 per cent in urban areas.<sup>59</sup>

Among the rural population, 38.9 per cent were classified as economically inactive, of whom 27.1 per cent were retired. In urban areas, 19.2 per cent of the 35.4 per cent economically inactive were retired. This gives some indication of the additional pressure on health and care services in rural areas.

Rural employment disadvantage is not just about unemployment – the focus of most policy – but is more often about job insecurity, poor quality work or lack of training, where some face repeated periods of worklessness. Lack of public transport makes it difficult for unemployed people to access new jobs. Rural residents travel longer distances than their urban counterparts and spend longer travelling. The State of Rural Services reports, compiled annually by the Rural Services Network, found people living in villages and dispersed settlements to be travelling 10,000 miles per year on average as compared with 6,400 miles in urban areas and that they were more likely to make these journeys by car – even if they were living on low incomes.<sup>60</sup>

Disproportionate numbers of people in rural areas are on no wages, low wages or small pensions. In terms of income, the most rural and the least sparse areas do best, sparse areas having lower incomes than average, suggesting that, as in other policy of areas, rurality and sparseness should not be conflated when considering the impact of the social determinants of health.

Many rural areas are tourist destinations in the summer months and in some areas throughout the year. Tourism is one of the most important sectors of the rural economy, worth £17 billion a year in England and accounting for over 12 per cent of rural

employment. It is highest in the National Parks where it is a significant proportion of the economy and accounts for over 27 per cent of employment. However, tourism in rural England is falling – from 22 per cent to 18 per cent from 2012 to 2014 as a proportion of overnight trips.<sup>61</sup> In most areas, employment arising from tourism is seasonal in nature.

Under-employment (those who work intermittently) and marked seasonal variations in unemployment are thus more common in rural areas than elsewhere, particularly in those areas where agriculture or tourism provides much of the local employment. A high proportion of those who are economically inactive, but want a job, in rural areas are prevented from working due to a limiting long-term illness, or through other barriers, such as a lack of childcare or transport.<sup>62</sup>

Self-employment and working from home (or being based at home) are both more common in rural areas of England than in urban areas. They are more common still in sparse areas, where people are twice as likely to be home-based or self-employed, as those in less sparse areas (one in four in sparse areas compared with roughly one in eight in less sparse areas).<sup>63</sup> Self-employment can bring insecurity and isolation and, in rural areas, where agriculture, forestry and fishing are among the most significant industries, it can also have a seasonal character, resulting in significant variations in income across the year. For the better paid areas of self-employment, this may not present serious problems, but for the less well paid occupations such as the fishing industry, savings may not be sufficient to subsidise the lean times. This may mean a greater need for welfare benefits and a greater demand on services at different times in the year, one reason why local authorities, including their public health teams, need to have a deep understanding of patterns of employment, under-employment and unemployment in their areas.

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## Cornwall Works

Inclusion Cornwall (Cornwall Works) is a partnership of organisations and services committed to social justice. It challenges inequality, joins up services and celebrates difference, striving for a Cornwall where people, communities and services work together for better outcomes. Established by Jobcentre Plus and Cornwall Council, it brings together over 60 partners and their 120 local projects, programmes and services to redefine the back-to-work offer for disengaged young people in Cornwall, one of the most rural parts of the country.

The scheme has helped 10,000 people into work since 2006. It mitigates incentives in the national funding system that encourage organisations to work in isolation on the ground by taking a programming approach, brokering providers to share funding and incentives for the benefit of the individual – making clear the role of different organisations in the progression of people towards work. The model has been successful in areas with high levels of long-term worklessness, where provision is plentiful but uncoordinated. Cornwall Works links social enterprises working with young people unlikely to otherwise engage, slowly brokering progression into back-to-work services.

Additional schemes have been routed through the model. For instance from 2008 – 2011 it received £1.5 million to help people with learning disabilities, with five specialised organisations within the partnership delivering provision in line with existing services. Over three years 600 people were supported, with 100 securing employment. Since 2013, Cornwall Works takes all customers applying to Cornwall Council's discretionary funds (the most excluded) through a 'Cornwall Works Conversation' providing support and signposting to remove barriers.

The Helston and the Lizard Works project working with Jobcentre Plus (runner up National Association of Local Councils (NALC) Local Project of the year) tackles rural unemployment with a business and community

led solution, and is run by Helston Town Council and coordinated by Inclusion Cornwall. Its success has seen 104 unemployed local people move into work in its first year with the original target being 40. Local businesses give their time to inspire and support jobseekers and community projects provide opportunities for jobseekers to get experience and confidence through contributing to the community. For the past six years Winter Wellbeing has linked health, heating and work, supporting over 9,000 households to be able to afford heating which enables them to be healthier and sustain work.

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### Questions to consider

- What can you do to support the establishment and sustainability of more smaller enterprises in your rural areas – for example, does your planning strategy recognise the need to incentivise such enterprises?
- Are you taking measures to ensure that people in rural communities are supported to take up their benefits entitlement (low take-up of welfare benefits should not be assumed to be indicative of low levels of need)?
- Are you working with rural employers to ensure that employees receive the benefits of the National Minimum Wage?
- What are you doing to ensure that people living in rural areas able to access employment through public transport?
- Is local support for unemployed people tailored to the needs of those who work only intermittently or seasonally?
- What do you know about childcare provision in your rural areas – can you take action to ensure greater provision for those who want to work but are prevented from doing so by lack of accessible childcare?

# 4. Questions to consider in developing strategies for rural health

## Questions for local authorities with rural communities to consider in identifying

- What do you know about childcare provision in your rural areas – can you take action to ensure greater provision for those who want to work but are prevented from doing so by lack of accessible childcare?
- Are you making the best use of small area based data to identify areas of deprivation and ill health and the factors impacting on it? Have your public health and economic intelligence and data-gathering units identified innovative ways of pinpointing groups in sparse and rural areas who most need health and care support?
- Do your HWB and other joint forums with the NHS and partners regularly discuss issues of sparsity and rurality and how they can be addressed to improve access to health and care services and tackle health inequalities?
- Have you considered alternative means of providing and accessing services for people in rural areas, including working with voluntary and community organisations, social enterprises and faith groups?
- Can you make better use of existing rural networks and meeting points like post offices, pharmacies and village halls to deliver support services such as signposting to health and care services, welfare benefits, smoking cessation and sexual health services?
- How can you reduce the need to travel by using outreach, mobile services, localised delivery and telehealth techniques?
- What are you doing to reduce social isolation and exclusion, particularly among the older residents of rural areas and those with mental health problems?

# 5. Further information

The Statistical Digest of Rural England provides a wide range of useful statistical data on the issues affecting rural England:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/554505/Statistical\\_Digest\\_of\\_Rural\\_England\\_2016\\_September\\_edition.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/554505/Statistical_Digest_of_Rural_England_2016_September_edition.pdf)

The rural/urban definition (England and Wales) and local authority rural/urban classification are available to help examine the differences and similarities of rural and urban areas:

[www.ons.gov.uk/ons/guide-method/geography/products/area-classifications/rural-urban-definition-and-la/rural-urban-definition--england-and-wales-/index.html](http://www.ons.gov.uk/ons/guide-method/geography/products/area-classifications/rural-urban-definition-and-la/rural-urban-definition--england-and-wales-/index.html)

<https://www.gov.uk/government/organisations/department-for-environment-food-rural-affairs/series/rural-urban-definition>

Defra's population statistics:

<https://www.gov.uk/government/publications/rural-population-and-migration/rural-population-201415>

The Rural Services Network advocates on behalf of rural areas. Its online resources can be found at: [www.rsnonline.org.uk/](http://www.rsnonline.org.uk/)

Public Health England publishes mortality and life expectancy statistics for urban and rural areas:

[www.healthierlives.phe.org.uk/topic/mortality](http://www.healthierlives.phe.org.uk/topic/mortality) and [www.phoutcomes.info/](http://www.phoutcomes.info/).

A health profile for each local authority area can be found at:

<https://fingertips.phe.org.uk/profile/health-profiles>

The English indices of deprivation for 2015 (the most recent update):

<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>

The Rural England Community Interest Company has a library of research on life in rural England and carries out its own research:

<https://ruralengland.org/>

Birmingham University's Health Services Management Centre publishes an overview with links to research and resources on the latest research on rural health inequalities:

[www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/hsmc-library/snappy-searches/Rural-Inequalities-in-Health.pdf](http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/hsmc-library/snappy-searches/Rural-Inequalities-in-Health.pdf)

Action with Communities in Rural England is the national voice for the 38 rural community councils who make up the country's largest rural network. Together, we reach 52,000 grassroots organisations in 11,000 rural communities:

[www.acre.org.uk/](http://www.acre.org.uk/)

## The role of district councils in health

The District Councils' Network (DCN) provides a national voice for district councils in England within the LGA. Its priorities include promoting health and wellbeing: <http://districtcouncils.info/what-we-do/health-and-wellbeing/>

King's Fund (2016), The district council contribution to public health: a time of challenge and opportunity: [https://www.kingsfund.org.uk/sites/files/kf/field/field\\_publication\\_file/district-council-contribution-to-public-health-nov15.pdf](https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/district-council-contribution-to-public-health-nov15.pdf)

## Use of digital technology to support health in rural areas

Website of the Cumbria Rural Health Forum: [www.ruralhealthlink.co.uk](http://www.ruralhealthlink.co.uk)

Peck, F., Jackson, K. and Marshall, A., 'Digital health and its application in rural areas: a review of international experience', North West Coast Academic Health Science Network: [www.ruralhealthlink.co.uk/assets/uploads/reports/Report\\_on\\_international\\_learning.pdf](http://www.ruralhealthlink.co.uk/assets/uploads/reports/Report_on_international_learning.pdf)

## Housing and fuel poverty

Website of the Rural Housing Alliance, a group of housing associations that develop and manage affordable homes in rural areas across England – website contains a large number of case studies: [www.ruralhousingalliance.net](http://www.ruralhousingalliance.net)

The ONS house price index is a useful source for comparing house prices: <https://www.ons.gov.uk/economy/inflationandpriceindices/bulletins/housepriceindex/sept2016>

## Isolation and loneliness in rural areas

The Campaign to End Loneliness' online resource - Loneliness and Isolation: Guidance for Local Authorities and Commissioners is regularly updated with factsheets, templates, case studies and videos on how to deliver the interventions set out in this framework: <https://ruralengland.org/>

Combatting loneliness: a guide for local authorities (LGA): [www.local.gov.uk/documents/10180/7632544/L15-431+Combating+loneliness+-+a+guide+for+local+authorities/b4b88757-2623-4696-ae04-565892a58909](http://www.local.gov.uk/documents/10180/7632544/L15-431+Combating+loneliness+-+a+guide+for+local+authorities/b4b88757-2623-4696-ae04-565892a58909)

The National Suicide Prevention Alliance (NSPA) is the leading England-wide, cross-sector coalition for suicide prevention: [www.nspa.org.uk](http://www.nspa.org.uk)

The Samaritans is the UK's largest suicide prevention charity. Local branches have become involved with some multi-agency group work: [www.samaritans.org/branches](http://www.samaritans.org/branches)



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