Health inequalities in rural and coastal areas

June 2021

Lev Pedro, Aimie Cole, Emma Baylin and Alex Boys

Executive summary

NAVCA wishes to better support the role of the voluntary, community and social enterprise (VCSE) sector, in particular local infrastructure organisations (LIOs), and health and care systems more widely, in addressing health inequalities in rural and coastal areas. We are particularly interested in:

- enablers and examples of good practice in addressing health inequalities, taking a community-centred approach
- systemic barriers that are preventing inequalities to be addressed
- how health and care systems might work together to overcome those barriers.

This report draws together insight gathered from NAVCA members and key policymakers in NHS England[1] and makes specific recommendations for different stakeholders that will enable those health inequalities to be better addressed.

In summary, the recommendations are:

(1) Make a clearer distinction between ***rural*** and ***coastal*** areas, recognising the needs, barriers and issues faced are distinct in these areas, rather than treating them as the same.

(2) Define and capture health inequality data more rigorously and consistently in rural and coastal areas.

(3) Redress the inequity in accessing grant funding.

(4) Develop system level (ICS) strategies for bringing partners and funding together to address health inequality in rural and coastal areas.

(5) Work across system areas to ensure sustainability of services provided by small organisations and sustainability of infrastructure provision.

(6) Embrace lessons learnt from Covid and continue 'new normal' ways of working more collaboratively.

(7) Promote asset-based community development (ABCD) and ensure the approach is used genuinely and properly.

(8) Promote better understanding of the professional nature of the VCSE sector in rural areas.

[1] 'NHS England in this document refers to NHS England and NHS Improvement.

Table of Contents

Summary of recommendations for specific stakeholders

Recommendations for NHS England

How health inequalities are defined and captured	Public bodies (e.g. CCGs) should be measured on and required to report on how well they are tackling rural health inequality as a distinct aspect. 'Rural' should become a measured demographic along the lines of a 'protected characteristic', or something similar. Colleagues supportive to this agenda in NHS England can act as champions and advocate for these issues within NHS England.
External grant funding	NHS England could support the improvement of access to grant funding by rural and coastal areas by bringing together information on which systems, places and primary care networks are receiving central funding through development, innovation or other programmes.
Commissioning and design of local services	NHS England should clarify policy on moving away from competitive tendering and more towards a social value-based approach to commissioning and support the VCSE sector to adapt. NHS England could support this by sharing good practice around effective commissioning for rural and coastal communities and explore how data is collated and used.

Recommendations for integrated care system leaders and local commissioners

How health inequalities are defined and captured	Levels other than 'super output' need to be used to analyse health data, such as neighbourhood, ward, parishes etc. For example, ACRE has analysed census data at 'output' rather than 'super-output' level.
External grant funding	ICSs can bring public sector partners together to take a more strategic view on tackling inequality and addressing multiple health issues in rural and coastal areas, particularly in small 'hidden pocket' areas of inequality, and work with the VCSE sector to address these strategically.
Commissioning and design of local services	Integrated care systems (ICS) should provide a coordination function for inequality issues in rural and coastal areas to be addressed more effectively. ICSs that contain rural and coastal areas should have a strategy for addressing inequality in their rural and coastal areas and address the organisation of service delivery and resources accordingly. The intrinsic higher cost of delivering services in rural areas should be taken account of in commissioning and planning.
Size and scale of VCSE infrastructure	Small local VCSE organisations need to be valued and sustained, instead of encouraging organisations to merge or scale up, or outsourcing to big providers. Commissioners and funders should invest in local infrastructure organisations that can provide support to the sector that facilitates improvement of sustainability, good governance and engagement, particularly focusing on the smaller VCSE organisations that tend to exist in rural areas.
Partnership	New ways of working collaboratively (post-Covid) should be maintained, and lessons learnt about the impact of working in this more co-productive way to inform future working practices.

Recommendations for NAVCA

How health inequalities are defined and captured	NAVCA could have an advocacy role in ensuring that when health inequalities are talked about, the discussion is not just based on the 'deprived inner city neighbourhoods' rhetoric, but accurately and equally reflects the inequality issues faced by rural and coastal communities.
External grant funding	NAVCA, in partnership with ACRE, and by working through NAVCA members, can play an advocacy and brokerage role in improving access to grant funding, helping to unpick and articulate the barriers, and enable better understanding between the grant-giving sector and rural communities. NAVCA should work to better understand the specific barriers that prevent rural community groups from accessing funding and support its members to engage in dialogue with funders to overcome those barriers. LIOs have already developed solutions, such as micro-grant programmes, so NAVCA could explore, amplify and promote these.
Commissioning and design of local services	NAVCA and other partners such as National Voices and NCVO should have a voice in discussions at national level about how commissioning moves away from competitive processes and better addresses social value.
Partnership	New ways of working collaboratively (post-Covid) should be maintained, and lessons learnt about the impact of working in this more co-productive way to inform future working practices. NAVCA could have a role in promoting examples of where this is working well.
Asset-based community development	NAVCA could support its members by bringing together asset-based community development workers in a peer support network and provide a heads up on trends, big issues and best practice. This network could then go onto train public sector partners in what these concepts actually involve and help them to embed these ways of working properly. NAVCA could help to design a toolkit or resource that would help their members articulate these ways of working and embed them in local service design.

Understanding the role and scope of the VCSE sector	NAVCA and ACRE should work together to combat the misconception about the voluntary sector in rural areas being 'just volunteers' whilst also highlighting the value of those small groups and including and championing those small groups in the whole system.

Recommendations for grant funders

External grant funding	Grant funders could work through local infrastructure organisations or regional collaboratives of LIOs, as partners in dispersing grant schemes. Grant funders could consider creating grant schemes specifically targeted at addressing inequality issues in rural and coastal areas.
Size and scale of VCSE infrastructure	Small, local VCSE organisations need to be valued and sustained, instead of trying to pressure organisations to merge, scale up or outsource to big providers. Commissioners and funders should invest in local infrastructure organisations that can provide support to the sector that facilitates improvement of sustainability, good governance and engagement, particularly focused on the smaller VCSE organisations that tend to exist in rural areas.

Background

About NAVCA

NAVCA is the national membership body for local infrastructure organisations (LIO) which provide support and development for voluntary and community organisations. Our 180 members across England support over 200,000 local charities, voluntary groups and social enterprises at a community level, helping them to thrive and deliver essential services. NAVCA has been a member of the VCSE Health and Wellbeing Alliance since its inception in 2017.

NAVCA members play an integral role in local health and care systems by:

- bringing the voice of people and communities to bear in decision making and strategy setting
- using their intelligence and relationships to influence and coordinate
- acting as the local VCSE sector's voice in strategic discussions
- supporting frontline organisations to deliver effective services and foster collaborations.

NAVCA members (LIOs) are good barometers of the state of public services and the effectiveness of policy and service delivery in addressing inequality issues because they play a strategic role in local areas and are in touch with a large number of frontline local charities that are dealing with such issues on a day-to-day basis.

Many NAVCA member organisations serve rural or coastal areas and are therefore aware of and concerned about issues of inequality that affect those areas, and NAVCA wishes to further support its members in their work to support their local community organisations to better address inequality issues and improve community health and wellbeing.

Methodology

NAVCA commissioned Lev Pedro & Associates to design and deliver a programme of 'collaborative policymaking' with key stakeholders on health inequalities in rural and coastal areas.

This involved:

1. Initial one-to-one conversations with a few NAVCA members, one NHS England policymaker and NAVCA staff, from which we defined the research questions
2. Two one-hour workshops, as part of a two-day health and wellbeing conference on 24 February and 2 March, from which we wrote up learning so far and drafted recommendations
3. Further one-to-one conversations with NAVCA members
4. One 'sense-check' workshop with NAVCA members as part of a health strategy day on 31 March, from which this report was drafted.

Approximately 50 NAVCA members were involved at one or more stages of the engagement.

Policymakers from NHS England were involved at all stages of the process.

Key research questions

These research questions were drawn up collaboratively by the consultants, NAVCA staff, national policymakers and a small sample of senior staff from NAVCA member organisations.

(1) What are the health inequalities that affect people in rural and coastal areas, and what are the barriers to the sector in addressing them?
(2) What can NHS at local and national level do to support this?
(3) What infrastructure organisations exist, and where are gaps?
(4) How successful is the VCSE in rural and coastal areas in accessing grants from national funders? What are the barriers and potential solutions?
(5) What can NHS England learn from good practice and what can NHS England do to scale up good practice and support sector?

Key health inequality issues in rural and coastal areas

Throughout this document we refer to 'rural and coastal', but it should be noted that issues for rural communities and coastal towns are not the same, indeed even issues from one rural community to the next can be very different.

The experience of NAVCA members is that issues of health inequality in rural and coastal areas are well known among those working in those areas but are not widely acknowledged.

These issues include:

- access to services
- prescription drug misuse and black market in prescription drugs (more in coastal than rural areas)
- transient population in coastal areas and people moving to coastal areas with complex health needs
- inadequate or non-existent public transport
- digital exclusion (more in rural areas)
- housing – both affordability and housing quality
- increased risk of isolation
- predominance of men's health issues
- mental health issues, for example caused by lack of sense of purpose, economic uncertainty, and costal seasonal employment activity
- demographic differences (for example, elderly people lacking in social networks due to retiring to these areas, and lack of social cohesion in places with a predominance of second homes)
- higher cost of service delivery.

We recognise that it is not the role of the NHS on its own to tackle all of these problems. A much more connected approach across government departments is required. Integrated care systems provide a useful platform for this to be accelerated.

Enablers and examples of good practice

Discussions with NAVCA members highlighted a number of different roles that LIOs and others can play to either directly address health inequalities in rural and coastal areas or enable the work of others. Examples include:

- An LIO that has developed a team of 15 full time community builders across 30 neighbourhoods in their area, that take an asset-based community development approach and support people in communities to work together to build the connections, activities and support that they want to improve their community, their lives and their health and wellbeing.
- Another LIO acts as a 'VCSE single point of contact' (SPoC)[2] and holds a £1 million contract which is then subcontracted out to smaller groups and organisations that do not meet commissioning criteria on their own, to provide access to health and wellbeing support across the area.
- A GP surgery that holds one day of appointments for patients from a certain village as that is the only day that the Ring-and-Ride bus operates.
- A LIO is working closely with acute hospital and the ambulance service on supporting people who are recorded as 'high intensity users' of services. These people generally have complex lives and need personalised assistance. It is proving to be very successful for the individuals and reducing system costs.

Barriers and recommendations

(1) How health inequalities are defined and captured

The research found that health inequalities that relate to rural and coastal communities are often not adequately measured and can be overlooked when making policy at a national level, or ICS level, because the discourse around inequality often focuses on the 'deprived inner city'. Various factors contribute to this including the numbers of people affected and the fact that rural and/or coastal is not captured as a standard demographic. NAVCA members involved in the research argued that just the fact that a community is rural leads to health inequality.

There is often a misperception that rural and coastal areas are more affluent than urban areas. However, there are some very deprived coastal towns, and there are often pockets of deep deprivation in rural areas that do not show up in headline statistics because of the comparatively low numbers of people affected in comparison to areas with greater population density. Our members suggested that we all need to be more open to visualising a more diverse picture when thinking about rural and coastal areas, not just the 'rural idyll' or the 'affluent coastal town'.

[2] For more information about 'Single Point of Contact' commissioning models see https://files.constantcontact.com/ca3da02a001/b4b7c883-f956-49dc-a347-40e0ef5776d4.pdf

Participants highlighted how issues arise from the statistics used in decision making. For example, health statistics are often measured at super output level, an average population of 7,500 residents or 4,000 households. While all agreed that this is a useful structure for collating, processing and aggregating data, many highlighted this as problematic because the boundaries often cut across neighbourhoods and do not align with real communities on the ground. This then leads to the problem where small areas of deprivation are 'hidden' amongst larger more affluent geographies.

NAVCA members, from their anecdotal experience, felt that where budget is allocated predominantly against numbers of people affected in a geographical patch according to the Index of Multiple Deprivation, small areas of deprivation may get missed or a larger population groups with mid-level needs may get prioritised over smaller numbers with a higher level of need.

Recommendations

Public bodies (like clinical commissioning groups) should be measured on and required to report on how well they are tackling rural health inequality as a distinct aspect. 'Rural' should become a measured demographic along the lines of a 'protected characteristic', or something similar.

NAVCA could have an advocacy role in ensuring that when health inequalities are talked about, the discussion is not just based on the 'deprived inner city neighbourhoods' rhetoric, but accurately and equally reflects the inequality issues faced by rural and coastal communities, and we all need to reimagine how we visualise rural and coastal areas.

Levels other than 'super output' need to be used to analyse health data, such as neighbourhood, ward, parishes etc. For example, ACRE have analysed census data at 'output' rather than 'super-output' level.

Colleagues supportive to this agenda in NHS England can act as champions and advocate for these issues within NHS England.

(2) External grant funding

NAVCA members reported anecdotally that rural communities are far less successful in drawing down funding from grant funders than urban areas, yet at the same time, funders complain that they can't reach rural communities. Barriers to small rural community groups being able to access grant funding include eligibility criteria on size and turnover of organisation, as well as skills and operational capacity within organisations. Attempts among LIOs to combat this, for example micro-granting, where the LIO heads up a bid and then disperses small grants on to locally based organisations, have been rejected because they do not fit the funder's criteria. Again, this points to a mismatch between the need and the response to the need.

Specifically on inequalities, funding is often allocated to areas based on Index of Multiple Deprivation statistics, which (as explained above) often excludes deprived areas in rural areas.

More generally national grant funding schemes still tend to be very 'top-down'. There are attempts by funders to be more locally driven but even these often do not take into account the reduced capacity in smaller rural organisations. For example, there are often onerous and lengthy forms to complete for even relatively small amounts of grant funding.

Funders are also attempting to encourage more collaborative bids for funding, yet without recognition of the costs and time required to make collaboration work. For example, some of the funding schemes that emerged during Covid were unrealistic in terms of timescales and deliverables, and expectations to form collaborations in short timeframes.

Funding programmes often create unnecessary competition among providers.

Recommendations

NAVCA, in partnership with ACRE, and by working through NAVCA members, can play an advocacy and brokerage role, helping to unpick and articulate these barriers, and enable better understanding between the grant-giving sector and rural communities.

NAVCA should work to better understand the specific barriers that prevent rural community groups from accessing funding and support its members to engage in dialogue with funders to overcome those barriers. LIOs have already developed solutions, such as micro-grant programmes; NAVCA could explore, amplify and promote these.

Grant funders could also work through local infrastructure organisations or regional collaboratives of LIOs, as partners in dispersing grant schemes. Any funding flowing through LIOs would clearly have to be separate and over-and-above funding arrangements for VCSE infrastructure. For example, a LIO should not be excluded from applying for grant funding for core infrastructure work if it is engaged in some kind of brokerage arrangement with the same funder.

Grant funders could consider creating grant schemes specifically targeted at addressing inequality issues in rural and coastal areas.

There is also an opportunity for ICSs to bring public sector partners together to take a more strategic view on tackling inequality and addressing multiple health issues in rural and coastal areas, particularly in small 'hidden pocket' areas of inequality, and work with the VCSE sector to address these strategically.

NHS England could support this by bringing together information on which systems, places and primary care networks are receiving central funding through development, innovation or other programmes.

(3) Commissioning and design of local services

There has been a tendency in local authority areas that cover both towns and rural areas to aggregate or consolidate service provision in a central location, which is inevitably the town. This is often to meet 'value for money' criteria, and it does indeed save money. But the

unintended consequence is that the cost is transferred to the service users, who are often in difficult and vulnerable situations, and may not be able to afford the cost of travel to the service.

Services are often weighted, possibly unintentionally, to urban areas, or more accessible to town and city dwellers because of the lack of consideration of specific issues in rural areas around access to services, transport and digital connectivity. For example, we heard a sad example where, due to people in a rural area not having internet access, they would need to physically go to a job centre to access its service, and in order to get there for a 10am appointment they had to take multiple buses the previous evening and sleep on the street overnight.

Projects in rural areas naturally cost more due to the cost of travel, and the cost of making services accessible to people spread over large areas with poor public transport. However, this is often not recognised or built into commissioning decisions for services.

A significant challenge in rural and coastal areas is how the VCSE, via NAVCA members, gets the system to hear and understand the real challenges in a language they understand.

Now is an ideal time to influence this agenda because of a current policy shift away competitive tendering in health delivery and greater focus on social value.

Recommendations

Integrated care systems (ICS) should provide a coordination function for inequality issues in rural and coastal areas to be addressed more effectively.

All ICSs that contain rural and coastal areas (which is most) should have a strategy for addressing inequality in their rural and coastal areas and address the organisation of service delivery and resources accordingly.

The intrinsic higher cost of delivering services in rural areas should be taken account of in commissioning and planning.

NAVCA and other partners such as National Voices and NCVO should have a voice in discussions at national level about how commissioning moves away from competitive processes and better addresses social value.

NHS England should clarify policy on moving away from competitive tendering and more towards a social value-based approach to commissioning and support the VCSE sector to adapt.

NHS England could support this by sharing good practice around effective commissioning for rural and coastal communities and explore how data is collated and used.

(4) Population health management

The population health management (PHM) approach is an important aspect of how we could deal with health inequalities, particularly in rural and coastal areas. PHM work has to be undertaken in collaboration with a wide variety of partners as it not only deals with health but also other issues affecting wellbeing, such as work, community connections, concerns around

safety etc. Primary Care Networks (PCNs) have a crucial role in this alongside public health. LIOs should be engaging the PCNs particularly around the ICS maturity matrix which stipulates how they should be building relationships with their communities. There is a growing awareness that primary care starts with the person, family, and community in additions to, if not prior to general practice. NAVCA has an important role to play to ensure that PCNs connect to their communities via LIOs and understand that they do not have to build this capacity themselves. This could also include identifying support gaps and collaborating to find resources to fill them.

(5) The size and scale of the VCSE and infrastructure

VCSE organisations in rural and coastal areas tend to be smaller and more hyper-locally based. This is for a very good reason, as organisations have developed in response to very specific local needs. However, this raises issues of sustainability and capacity, and the ability of those organisations to have strategic influence.

Unfortunately, there are now place areas that are no longer covered by a local infrastructure organisation, and in many areas, where LIOs do still exist, their core funding has been reduced to unworkable levels. This is a great disadvantage for all sorts of reasons: the lack of (or lack of capacity of) an infrastructure organisation impacts on the VCSE sector's ability to generate income, recruit volunteers, form partnerships, have a strategic voice, work collaboratively with the public sector, and many more. This means that the work of addressing health in equalities falls on lots of small organisations, all doing their bit in a small community or for a small community of interest, without the benefit of a collective focus or voice.

There is also a tendency over recent years for infrastructure organisations to merge across coterminous districts or across a whole county. Whilst this creates obvious benefits, there can be a risk of losing connection to the small local communities, particularly in the rural areas of the patch, as it makes economic sense to locate services where the greatest demand is.

LIOs are being increasingly required to play a role in system reform and development of ICS, yet not in receipt of funding or resource to support this, which puts additional pressure on already-stretched organisations.

Recommendations

Small, local VCSE organisations need to be valued and sustained, instead of trying to pressure organisations to merge, scale up or outsource to big providers. Commissioners and funders should invest in local infrastructure organisations that can provide support to the sector that facilitates improvement of sustainability, good governance and engagement, particularly focused on the smaller VCSE organisations that tend to exist in rural areas. The NHS England VCSE Leadership Programme aims to build collaborative structures at system level that help the VCSE sector to gain more strategic influence.

(6) Partnership

The Covid crisis has forced new ways of doing things, and many of these are positive and should not be lost when we go 'back to normal'. For example, intelligence is being shared across sectors and organisations in order to pick up actual vulnerable households due to shielding, or job losses, and so on.

Recommendations

Where possible, these ways of working collaboratively should be maintained, and lessons learnt about the impact of working in this more co-productive way to inform future working practices. NAVCA could have a role in promoting examples of where this is working well.

(7) Asset-based community development

Public bodies often talk about coproduction or asset-based community development (ABCD), but then sometimes do not really know how to do it properly. Traditionally NAVCA members play this role, through community builders and community connectors. These roles, embedded within communities, identify assets and work with local people and organisations to connect them and fill gaps when identified. With increasing focus on an asset-based community development approach by public health and other public sector partners, NAVCA members have observed a tendency for the public sector to try and do this themselves rather than draw on the skills, expertise and community reach that already exists in LIOs and among their members.

Recommendations

NAVCA could support its members by bringing together asset-based community development workers in a peer support network and provide a heads up on trends, big issues and best practice. This network could then go onto train public sector partners in what these concepts actually involve and help them to embed these ways of working properly.

NAVCA could help to design a toolkit or resource that would help their members articulate these ways of working and embed them in local service design.

(8) Understanding the role and scope of the VCSE sector

The VCSE sector in rural areas is still very much seen as 'just volunteers'. There is of course a place for grass roots volunteer-led groups, but the fact that these are more prevalent in small rural communities has meant that this is seen as the norm, compared to urban areas where larger and more 'professionalised' service providers are the norm.

Recommendations

NAVCA and ACRE should work together to combat the misconception about the voluntary sector in rural areas being 'just volunteers' whilst also highlighting the value of those small groups and including and championing those small groups in the whole system.