Ensuring equitable access to health and social care for rural and remote communities. Increasing Centralisation and Specialisation within the NHS: the trend has some adverse effects on access to care for rural and remote communities

Foreword

The ideas in this paper developed following the meeting of the Rural Health Forum (RHF) at the Royal College of Physicians in London in 2001, a meeting attended by the then Secretary of State for Health, Frank Dobson. Many of the delegates had expressed concerns that the Medical royal colleges were, at least in part, responsible for closing services in remote and rural communities. It seemed appropriate to respond to this criticism, define the issues, and start a dialogue.

The ideas were debated within the advisory board of the RHF, and later within the Rural practice standing committee, and then the Council of the Royal college of GPs.

Subsequently, they were presented to the Academy of Medical Royal Colleges in early 2003. The Academy formed a working group with representatives of the Academy, the RHF, and representatives from various national government departments. The working group oversaw a substantial rewrite, and then the paper was presented to the Academy, and used as a basis for discussions within the Academy and its constituent Royal colleges, during 2005 and 2006.

I am extremely grateful for the help of the officers and staff of the Academy, past and present, for their help in facilitating the paper’s development, and my fellow members of the working group. I am happy to acknowledge the substantial support and constructive feedback from many colleges and individuals, which has greatly improved the paper. Notwithstanding this, the paper is the work of the authors, and does not in any way claim to represent the views of the Academy.

I hope it can now contribute to the wider debate on the configuration of health services and the necessary safeguards needed by all those in remote and rural communities throughout the UK

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Summary
There are trends towards centralising hospital care within the NHS, for many excellent clinical reasons. Yet this has a disproportionate impact upon those patients who live at greater distances from their hospitals. This report concludes that increasing centralisation and specialisation of hospital services has some adverse effects on access to care for rural and remote communities and that action must be taken to tackle this by, for example, enhancement of primary care and community services. This issue has not been well reported or researched though studies have demonstrated that utilisation of services is inversely related to the distance of patients from hospitals; so-called “distance decay”.

This paper examines the trend and describes the reasons for it and the impact on those people who live in remote and rural communities. It argues that health service planning should be patient-centred, in line with the White Paper in England, Our Health, Our Care, Our Say, Creating a Patient Led NHS, (1) and similar policy in each of the jurisdictions in the UK. It points out that, although providing services to rural communities is more expensive than for urban populations, a balance should be struck between cost-effectiveness and providing accessible and equitable services for all of our patients. It makes certain recommendations. The Scottish Kerr Report of 2005 (2) made very similar points, was debated by the Scottish Parliament in 2005; and is the basis for ongoing work by various implementation groups. Many of the recommendations from Kerr’s Rural Access Action Team are equally applicable throughout the UK, and should be considered by all bodies considering health policy in areas with remote and rural patients.

We argue for a debate to help to define where the balance point should be, and make certain recommendations. This debate is especially important, as the professions respond in England to the Department of Health’s document ‘Keeping the NHS Local - a new direction of travel’ (3) and elsewhere in the UK to similar policies in each of the other jurisdictions.

Why are we tending to centralise hospital services?
Research shows that there are better outcomes for patients who are cared for by professionals who are more specialised, for example for cancer survival (4), and for those people who are involved in serious accidents (5). As our health services move increasingly to measure and publicise outcomes, so, we think that, inevitably, these trends will grow. There is also a clear move towards centres of excellence and team based specialist care.

The costs of health service infrastructure and equipment are high, and with each technological advance, are likely to grow. Training and maintenance of skills is more easily accomplished where there is a high exposure to relevant cases. Recent legislation, such as the European working time directive (6), means that more staff are needed to man a unit continuously, and rotas are easier to arrange in large
establishments. Workforce shortages within the NHS probably exacerbates this trend.

There are clear and welcome trends towards the development of teams across disciplines, and these, similarly, are easier to arrange in larger establishments. Large units achieve economies of scale, and can make most efficient use of a scarce resource; but in this context, we need to recognise that some of the costs are in fact passed to the patients, especially those living at a distance; and a review by York University in 1997 suggests that there was no evidence that cost savings are necessarily made by increasing hospital size above approximately 200 beds (7).

**There is an ever-increasing degree of specialisation within hospital medicine**

There is a trend within medicine, in part related to this centralisation, to increase the degree of specialisation, and this, no doubt, adds to the need to centralise; in other words, we perceive a circular association between centralisation and specialisation. Little seems to have been published about increasing specialisation, and no Department of Health statistics show this clear trend (for example, the number of breast surgeons, or shoulder or ankle specialists). It is common for surgeons to concentrate on one particular area, such as breast disease, laparoscopic surgery or bowel surgery. Within orthopaedic surgery, it is common for surgeons to concentrate on one particular joint or parts of limbs, and there are similar examples throughout hospital medicine, as well as encouragement for some GPs to develop particular specialist skills. Whilst these are developments which are necessary to secure even higher clinical outcomes, it is important not to forget the contribution that generalists can make in improving patient care both in the community and in hospital practice.

**What is the impact of these trends on remote and rural communities?**

There is an impact of centralisation and specialisation on access to care; services are taken up less often or later. This negative impact is disproportionately felt by those people who have low incomes, poor access to transport, and by elderly and disabled people.

Haynes and Bentham have demonstrated in a study in Norfolk that the number of visits made by relatives and friends to see inpatients decreases with increasing distance from the patients’ homes to hospitals. (8)

A shorter time to arrival at hospital is known to reduce mortality in certain acute medical and surgical conditions.

McKee et al showed that the distance of patients from an emergency department was a major factor in lowering utilisation rates.(9) A study in Trent looked at inequalities in access to coronary angiography and revascularisation, and showed that practices that are over 20km from the centre had significantly lower rates of both.(10) Current guidance stresses the need for urgent hospital admission for certain acute medical conditions; for example, early CT scans for acute stroke; and early percutaneous coronary intervention in acute M.I. (11) Nakiamothu shows how treatment delays may reduce the advantage of this technique over on-site thrombolysis. (12)
Patients who live in rural areas in the UK have been found to be more likely to have advanced diabetic retinopathy than urban patients (13). A study in Scotland documented higher mortality from Asthma in more rural areas, which also had lower hospital admission rates (14).

Several studies show that trauma deaths are higher in more rural areas (15,16,17,18) (although a recent Scottish paper showed no such association(19)); and, especially, are higher if there is no major accident and emergency department in the district. ‘Dead on arrival’ rates vary between 23% and 74%; are lowest in a metropolitan area and the highest in a rural town. (7) Ian Watt, (20) and Rousseau and colleagues (21) have reviewed some of the relevant literature.

Rousseau and colleagues have commented that “the trend towards centralisation of trauma services pays too much attention to the advantages of centralisation and not enough to the extent to which delays in reaching hospital care contribute to preventable deaths. More research is needed into the wide variation in dead on arrival statistics seen in different hospitals, and in the extent to which delays in reaching hospital contribute to preventable deaths”.(21) This effect has been called distance decay, and it can lead to poorer health outcomes for patients who are remote from hospitals. It is recognised that there has been insufficient research in this area to give a totally clear picture, and more studies are needed.

Patients who live in rural areas may spend large amounts of time (and money) on travelling, both to gain access to health care, and to visit friends and relations in hospital, so some of the costs saved by the health service are in fact merely transferred to their patients. Baird and colleagues report a study of cancer patients in remote south west Scotland, and their experience of seeking specialist care. 22 days (13% of their remaining life) was spent in travelling to, or in, remote (by rural perspective) hospitals. One 84 year old patient who was receiving radiotherapy described a 7.5 hour one-way journey by the patient transport service from Edinburgh to Stranraer. Even by car this would have taken over three hours.(22)

As budgets become tight, small local hospitals are less able to attract and retain staff, and this is especially important when there is an overall shortage in the workforce. Small local hospitals can offer less experience to practitioners in training, and thus can lose accreditation for having junior doctors’ training posts. Although we could argue that some small units with low numbers of staff provide the training opportunities, that are often missing in large well-staffed units, to deal with uncertainty, for doctors to think for themselves, to practice procedures, and offer time for reflection. Increasingly, the Australian Clinical Schools are demonstrating the effectiveness of small rural teaching units (23). Much training also takes place in Scottish remote and rural hospitals.

Consultants also can become de-skilled and lacking in confidence if they have inadequate exposure to certain conditions or procedures. This is likely to increase if statistics are routinely publicised in league tables, showing differential outcomes, without publicising the important access issues at the same time.

There is a trend towards changing local accident and emergency units by having them nurse led or only open for certain hours, for example, Ayr Hospital. Part of this is offset by the tendency for rural practices to undertake a good deal of work with casualties(24), but there is much more travelling involved for patients who are remote from hospitals, and a big additional load put on rural ambulance services.
The loss of “general” physicians and surgeons is felt by patients and GPs. The tendency for ever more specialism leads to more tertiary referrals and the consequent opportunities for conflicting advice and confusion for patients. It is often not clear who is “in charge”, and communication needs to be much more efficient than is often the case currently. It is sometimes argued that GPs should be the general physician of the future, yet GPs do not always have access to the necessary diagnostics, specialist support and facilities. Correct initial referral becomes ever more important. Referring to the “wrong” specialist is a recipe for delay and, even, disaster!

If one part of a small hospital closes, it can have a knock on, domino, effect on other parts of that hospital (e.g. withdrawal of anaesthetic or paediatric cover has a direct impact on the ability to undertake obstetric procedures). Grantham Hospital in Lincolnshire suffered the withdrawal of consultant led in-patient paediatric services. The immediate effect of this was the loss of consultant led obstetrics followed by in-patient and acute gynaecology. Subsequently recognition of hospital GP training posts was withdrawn with the eventual collapse of all GP training, both hospital and Practice based within the catchment area. Grantham hospital continues to suffer domino cuts, with reduction in anaesthetic cover and ITU leading to a loss of major surgical procedures. Paediatric, acute or complex gynaecology and any surgical obstetrics are now provided at Lincoln County Hospital some 25 miles further away. Local hospitals are often major local employers in small communities, and their closure has a major impact on the local economy, as well as on the community’s sense of well being. There is enormous local pride in “their” local hospital. Similarly, within primary care, if a branch surgery closes, there are important issues of reduced access to care to be considered, along with a feeling of loss within the community.

There are important equity issues when citizens who pay an equal tax contribution have an unequal access to publicly funded services; indeed, the rural White Paper emphasises equity of access (25).

**Access and quality**

We recognise that, *within finite resources, the product of access and quality is a constant.* *(26)*

It is difficult to balance speed of access with quality of care e.g. If we improve access to care, the quality of that care might suffer in some circumstances. Expecting GPs to offer access to any patient within 48 hours has led to unacceptable difficulties for patients who wish to make appointments further ahead, and has probably reduced the length of the consultations.

If consultants routinely see patients in the community, they will see fewer patients and have less support from colleagues, and reduced access to complex investigations. Conversely, if we improve the quality of care while maintaining the same level of resourcing, then we are likely to reduce patients’ access to that care. For example, only one surgeon will have the very best success rate for a given operation, and he may well be based many miles away. If we were to stipulate that all outpatients should be seen by a consultant, the short-term outcomes might be better, but there would be fewer appointments. The best consultations are longer than average; the downside is that they are not available to all, within set levels of resourcing.
*(It is important to recognise that there are limits to this argument. It depends on all other things being equal; some have traditionally included good access as an element of quality; others have included continuity, an element of quality, within access. But we should recognise the tendency for the one to be affected by the other. Importantly, whenever decisions are being made about reconfiguring services, we should always question whether access to these services may be adversely affected for some patients, and how this will be mitigated.)*

But as noted above, **access to care is an important issue, just as is quality of care. We need to find an acceptable balance between the two.** This requires us to involve patients in the debate, and to have a clear focus on our patients rather than just on the services we provide.

**Cost Benefit analysis**

We need to recognise that providing services that are acceptably close to patients in rural communities will cost more than centralising all services, but our patients may wish that price to be paid. Additional funding will only be possible once rurality is recognised in the resource allocation formula, throughout the UK. In a patient led NHS (1) it will be increasingly important to recognise the importance placed on good access to care by rural communities.

However, many of our recommendations are, in fact, cost neutral, and relatively small sums could markedly improve the health service experience for rural and remote patients.

All reviews looking at relocating services need to take into account:

- Access
- Funding
- Quality
- Safety

**How should we address these problems?**

Possible approaches that may address the problems experienced by patients living at a distance from secondary care include:

**Defining best practice**

Many local communities have been working to address these issues in relative isolation. We need to identify best practice both from around the UK and from overseas, and disseminate this. For example, much thinking on these issues has been done by the Viking Surgeons, whose recommendations are available on the RARARI website. (27) In Scotland, an independent advisory group of local people is looking at how to manage two small remote District General Hospitals, in the light of the European Working Time Directive, and Colleges training requirements (28) and Wales has its Institute of Rural Health. The Scottish Kerr report (2) and its subsequent implementation groups, are working on further developing best practice

“Keeping the NHS local” (3) offers several models that are currently being developed which offer hope that reconfiguration of services may allow local hospitals to continue to offer high quality services despite all the pressures towards centralisation. For example, linking community A&E units in the Grampian area to the main hospital in
Aberdeen by videoconference link, reduced the referral rate by 70 to 80%, and was well liked by patients.

“Keeping the NHS local” supports the contention that centralisation has gone too far. “There is evidence that centralisation … does not necessarily deliver the expected benefits. The link between volume and outcome for surgical procedures is often overestimated.”(2)

The UK is largely seen as urban; the large majority of the population live within towns and cities, yet this makes the very real problems of rural people greater, as they can be seen as an unrepresentative and as an insignificant minority. Yet the 2001 census showed that 19% of the population of England live in rural areas. Many solutions are likely to be found from colleagues in other parts of the world, and there is much to be gained from contacts with the international community. Recent conferences of Rural WONCA have established strong links with others who are successfully addressing similar issues.

**Skills**

A thoughtful paper from Richard Garratt (29), who worked for many years in Africa before returning to the UK, offers a different view on skills from his unique perspective. He argues that we need to think afresh about the skills needed for those people who work in isolated small communities, and that the solutions appropriate for efficient working across the largely urban UK population are a hindrance for very isolated people.

He recounts his surprise, on returning to the UK, of reading that we should not be fitting IUCDs unless we are fitting at least 20 a year; yet he had undertaken countless hundreds of hysterectomies and Caesarean sections etc. in Africa, but only fitted very occasional IUCDs, and then only to teach the technique to others! Was he really to doubt his competence?

We think of skills purely within our own specialty boundaries, yet many skills are easily acquired and could help many isolated professionals if used outside the normally accepted job boundaries. For example, rural obstetricians could easily develop the skills needed for neonatal resuscitation, and thus not have to rely on the expensive necessity of having a paediatrician present.

Consider the paradox: most venesection is nowadays undertaken by trained phlebotomists, or nurses; yet for difficult cases, doctors, who rarely practice this, are called! Similarly, difficult Colles fractures are reduced by consultant orthopaedic surgeons, even though they do not undertake this simple procedure routinely. Many simple skills seem to be retained without the need for continuous practice.

We tend to think about skills in a very rigid way, and yet the successful development in recent years of many specialist nurse practitioners shows the potential for innovative thinking. One way forward might be to think of ‘good enough’ sets of skills but involving patients in this essential debate - for isolated situations.

**Enhancing teamwork**

The Royal College of Physicians has reported that acute medicine can be provided in the absence of acute surgery, with provisos. (30) The Senate of Surgery of Great
Britain and Ireland argued that a team based approach improves patient care. Changing the skill mix and improved team work could help to deliver European Working Time compliant rotas (31). Recent reorganisation at the newly built Hexham General Hospital in Northumberland, which serves a small scattered rural population, has seen training grade doctors in the surgical specialties replaced by nurse practitioners, who have undergone training alongside medical students. Similar models are proposed or are being implemented at Bishop Auckland in County Durham, and at the Downe hospital in Northern Ireland. (3) Two orthopaedic surgeons based at Hexham hospital are now replaced by a countywide orthopaedic service where some 28 surgeons can offer more specialised services. Within paediatrics, extended roles for nurses are being pioneered in Ashington and Southampton (Neonatal work), and Liverpool (Epilepsy). (32) Godden and colleagues have described innovative working patterns for remote communities in Scotland. (33) Early experience shows the vital importance of good communication, at all levels, when innovative practices are established.

A rural career path?

It might be appropriate to consider specific training elements for those hospital doctors who aspire to work in isolated communities. In Scotland, there have been successful schemes developed for Rural GP Fellows, and Rural Nurse training. Internationally, the WWAMI group of medical schools, and the Australian clinical schools have been successful in providing appropriate education for those practitioners who work in a rural setting. The WONCA working party on rural practice has also pioneered innovative thinking (WONCA is the World Organisation of Family Doctors). It is important that the special skills of these remote and rural specialists are fully recognised and valued by their colleagues in the region, and that they are seen as fully belonging to the region’s organisation, with regular sabbaticals etc. at the region’s hub.

Information Technology

Improving IT may provide a partial solution to the problem of having the appropriate skills far away from the patient who needs them, and this is certainly happening in many parts of the country, for example to support nurse run A&E departments. A major study in Finland showed the clinical value and cost effectiveness of telemedicine to serving a remote rural area. (34) Video conferencing can play an important role in improving access to specialists’ opinions, and it is possible to review remotely ECGs and X Rays, as well as surgical procedures. (3) Diagnosis of dermatological conditions can be made using high quality videoconferencing, (35) or indeed by high resolution plain photographs. There is much material now available for distance learning, for example, the Scottish telehealth initiative, to help practitioners in remote areas to maintain their knowledge.

Improving rural transport

Improving transport arrangements could reduce many of the problems of access. More positive discrimination towards funding rural ambulance services would be welcome, and we need to put in the additional funding that this would require, as well
as measuring the effectiveness of rural ambulances in their response and journey times.

Currently, statistics are only routinely available for a whole region or for ambulance services that, often, cover urban as well as rural areas, and it is difficult to obtain figures specifically covering the remote and rural areas. As it is frequently impossible to provide an emergency ambulance within the 8 minute ORCON standard in remote areas, Ambulance Authorities can be tempted to centralise their fleet, so that they can meet the response times within the target 75% of occasions, by focusing on the urban populations. Effectively, for the most remote 25% of the population, there is no minimum response time. A standard response time, which applies in all areas of mainland UK, and is published by village or postcode, would be likely to improve the responses.

There is clearly a need to balance the need for fast response times against the cost of having ambulances staffed at great expense, but which are rarely used. People who live in rural areas well understand the realities of travel, and do not expect to be attended within 8 minutes irrespective of geography; and the country cannot afford to fund dozens of idle ambulances. A reasonable compromise in most of the UK is that ambulances are located in rural areas so that they are usually within 30 minutes of where the most remote patients live. Occasionally, innovative solutions may need to be considered where such response times are difficult to achieve.

Responses to the problem have included First responders, Community Paramedics, and specially trained BASICS GPs. These are known to improve the time from the 1st call until help can arrive. GPs and Community Paramedics, for example, can do ECGs and initiate Thrombolysis, set up intravenous lines etc., however, they can not be a complete solution to the problem, since time to hospital for definitive treatment remains an important factor in many situations.

In rural areas, there are often transport difficulties not just affecting the health service, but also transport for education, for employment and leisure, so, often, the solutions lie in multiple use of available vehicles, and significant funding has been available to develop this in recent years.

It is worth noting that transport problems are a particular issue for those people who are on low incomes, as it can mean a very significant additional cost to arrange their own travel.

Ambulances need to be fully equipped to deal with any emergencies that their crew are liable to have to deal with, especially since the Ambulance paramedics may be solely responsible for caring for the patients for considerable lengths of time.

We should note that, particularly in extremely remote areas, there has been access to air ambulance transport. In England, this is usually funded by charities, at great expense; in Scotland, it is NHS funded, and there are proposals to develop the service further. A review of the costs and benefits of using air ambulances, the time saved and the limitations in their use is needed, along with reconsideration of whether they should be funded in the same way as other ambulances.

**Equitable funding**

We need to investigate and recognise the disproportionate costs of providing services for rural communities, and we need robust systems in place to ensure that
there is equitable funding to meet these additional costs. It is clear that rural areas incur additional costs because of travelling time, lack of economies of scale, and the need to have links to other units, for example.

Asthana and colleagues have noted that rural areas within England do not have these additional costs recognised; and she points out that England is the only country in the UK in which there is no allowance for rurality in the resource allocation formula(36) Recent, work (37) shows that rural commissioning organisations are heavily over-represented among those in financial difficulties, and this seems likely to be due to lack of specific rural funding.

White and colleagues (38) have studied the English NHS resource allocation system and describe it as fundamentally flawed. “It effectively takes money from rural and poor areas and gives it to the most affluent parts of the country”. They recommend that the whole of the UK should adopt the Scottish system, which was adopted following a fundamental review as described in the Arbuthnott report, “Fair Shares For All” (39) An authoritative, fundamental and UK wide review on this area would be welcome.

**Outreach clinics**

There is a long history of regional hospitals and centres of excellence providing a consultant service through outreach clinics and within General Practice. Perhaps we should try to define best practice in this area. There is a cost to the consultant in “dead” travelling time, but this could save the travelling costs for a considerable number of patients. An additional benefit is the opportunity to meet with local doctors and nurses, with the intentions of understanding their problems, contributing to their training, and developing closer understanding and relationships than are possible from the “ivory tower”.

“**Ambulatory care plus**” builds on existing primary and community services; Queen Mary’s Hospital at Roehampton is putting this concept into practice, with a minor injuries unit, general outpatient and rapid diagnostic as well as rehabilitation services.(3)

**A different relationship between hospitals within a region?**

There is the potential to change the way hospitals work together. Local hospitals could remain viable by specialising in the management of relatively straight forward cases, or for example in the management of convalescing patients, while the centre of excellence concentrates more on complicated investigations or operations. This would clearly involve more co-operation and dialogue than was previously the norm.

The “hub” of the organisation needs to take full responsibility for ensuring that the services to the remote areas are fully integrated and co-ordinated.

In Wales, a consortium of stakeholders who are particularly interested in the future design of the NHS came together to produce ‘A Picture of Health: how the NHS in Wales could look in 2015’ (40). It considers matters that are similar to those raised in this review including the tensions between specialisation and centralisation and designing, distributing and delivering healthcare services.
A similar range of issues and a vision for the future of healthcare is now embodied in the Welsh Assembly Policy, ‘Designed for Life: creating world class health and social care for Wales in the 21st Century’ (41). That policy endeavours to provide a blueprint for ways in which to meet the challenges that derive from economics, public expectations, and scientific development that are well summarised in the three, so-called, Wanless Reports for the UK (42), Wales (43) and public health in England (44), respectively. In particular, it considers the problems inherent in finding a better balance between promoting health, prevention of disease and delivery of interventionist healthcare services for people with established ill health against a fixed budget, which is a key facet of the rural healthcare agenda. In it, health promotion and prevention are seen as tasks for everybody and for all government departments much as we see meeting people’s transport needs and other requirements in rural areas as being better tackled as shared agenda items.

Particularly, Designed for Life considers the challenge that is the core matter in this paper; i.e. that of how to reap the benefits of scientific development and advances in practitioners’ skills and standards while endeavouring to achieve a proper balance between specialisation and centralisation and good standards of access to appropriately responsive services. Thus, the Welsh policy considers, albeit in brief strategic terms, the future distribution of services and the relationships required between highly specialised services with local services. The policy offers a model for service design that is based on four levels of care and, thereby, raises the potential for better patterns of healthcare services that can be tailored to the needs of local populations while having agreed pathways to and through specialised and highly specialised services and thus for creating networks of provision. This ambitious policy opens the way for different, but better planned and purposive relationships across Wales between primary healthcare and hospitals.

Our conclusion from this review is that, when considering models for resolving the problems that we raise in this review, policymakers, commissioners and practitioners might benefit from considering tiered and networked solutions. Certainly, there is evidence that they have made substantial progress possible for services that are based on them.

Realistic expectations

Plainly, we, that is healthcare policymakers, commissioners, providers and practitioners must discuss more with the general public the reasons for changing service configuration and the constraints, many of which are covered in this paper, on providing all services locally. People in rural communities understand all too well the limits imposed by geography; often they are prepared to accept longer journeys but they do need to be consulted, and to feel that their special circumstances are understood and that they have influenced planners, managers and practitioners.

Conclusion

Many decisions concerning how to reconfigure local, community and hospital services are being made throughout the UK. There is evidence that, in a number of areas, policymakers and commissioners are open to radical considerations. Ideas about how better to provide healthcare services in rural areas must be heard in the debate. We recognise that centralising services may all too easily adversely affect access to care for patients who live in remote areas, and this matter must be
addressed when service redesign is considered. As a result of our explorations, we believe that decisions could be helped by clear guidance that is issued from government and professional bodies centrally with the intention of informing discussions between professionals who work in our health services and those people who represent people who live in rural areas. Above all, we believe that the Medical Royal Colleges have a key role to play in this. In doing so, they must take due note of experiences from throughout the UK and elsewhere in the world, and develop and test more innovative solutions.
Recommendations

We recommend that:

1. College support

The Medical Royal Colleges should support their members who practice in rural areas, and encourage rural commissioning organisations and healthcare providers to develop sustainable solutions and to share best practice.

The Medical Royal Colleges should:

- Recognise the need and requirement for remote and rural practitioners.
- Establish an intercollegiate group focused on remote and rural practice, similar to that for children’s services.
- Value remote and rural practice and encourage the development of remote and rural medicine.
- Facilitate international collaboration.
- Recommend that inspection of remote and rural training involves experienced remote and rural practitioners.
- Approve training elements or modules specifically for remote and rural practitioners.
- Consider lay membership of the intercollegiate group, to ensure responsiveness to public demands.

( based on Kerr report recommendations )

2. Minimum standards of Access to care

The Medical Royal Colleges should be encouraged to develop guidance on minimum standards related to access to care (i.e. standards of response, assessment, intervention and healthcare that any person, no matter how remotely he or she lives, can expect from the NHS).

3. Communication standards

The Medical Royal Colleges should work together to define best practice in communications between members of specialist teams, patients and their GPs.

4. Transport

All planning of healthcare services should take an integrated approach and should involve the ambulance services, perhaps through the Joint Royal Colleges Ambulance Liaison Committee nationally as well as with individual ambulance services locally, throughout the process. There should be consideration of the use of innovative solutions, and other local transport initiatives and rural transport schemes, including community cars and the voluntary sector.

Minimum standards of Ambulance response times should be agreed for all parts of the country. In most of the UK, ambulances should be located so that they are within 30 minutes travelling time of all patients. Response times should be published by Post Code, (a minimum 6 figures.)
5. **Rural proofing**
Any health organisation that is considering reconfiguration of services should commit itself to ‘rural-proofing’ its proposals; items to be considered in doing so include the potential impact on access to care for patients who live in remote and rural areas, and steps should be taken to mitigate these effects. (45)

6. **Implementation of enhanced use of Information technology**
All rural hospitals should have video conferencing and other IT links so that they can consult with colleagues in networked units, and should make available appropriate training in using the equipment.

7. **Equitable funding**
All Commissioning bodies within the NHS should recognise the additional costs of providing acceptable standards of care to their rural communities, and provide additional funding as appropriate.

The resource allocation formula for England (and elsewhere in the UK, if what we recommend here is not already the case) should be reviewed so that it takes account of the additional costs implicit in funding healthcare services of acceptable quality in rural areas.

8. **The Kerr Report**

This report was commissioned by the Scottish Executive, and work is now progressing to implement changes. It has a clear Scottish focus; however it contains much of relevance to the rest of the UK.

All Medical Royal Colleges, UK healthcare commissioners, and NHS Trusts throughout the UK, that are responsible for patients who live in rural areas should consider the Kerr report, (2) and especially the section written by the Rural Access Action Team, and consider implementation of relevant recommendations.

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