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healthwatch North Yorkshire

Rural health inequalities

A study of people's experiences using health and care services

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Summary and recommendations

> "Living rurally, we feel dismissed when it comes to healthcare. It feels like 'out of sight, out of mind.'"

Summary

We wanted to explore the relationship between in-land rurality and people's experiences of accessing and using local healthcare services, including GPs, dentists, pharmacies, or hospital care.

A focus on the county is timely given the recent creation of North Yorkshire Council (as a unitary authority), NHS Humber and North Yorkshire Integrated Care Board and NHS West Yorkshire Integrated Care Board, and the UK Government's levelling up agenda, which includes rural proofing. The research involved a survey and focus groups. The following summary is based on 213 survey respondents and 31 participants across nine focus groups.

The research is a collaboration between Healthwatch North Yorkshire and the Institute for Social Justice at York St John University.

We identified five key areas that have impacted on people accessing and using health care services across rural North Yorkshire.

1. Access

Living in a rural area negatively impacted on people's ability to access health services.

Key barriers were interlinked around a loss of health provision caused by increasing distance to services, inadequate transportation, and the inaccessibility of health care professionals.

Deprivation (personal funds and lack of services) limited access to services and people's ability to find alternatives creating inequalities in health care. For those without a car, public and community transport options were limited. The distance from services made taxis very expensive.

2. Cost

Health care in rural areas costs more.

Service provision and development is often limited by short-term funding. It does not always take account of people using services, for example as travelling tourists, with budgets based on the local population. Providing more digital health care could increase access but would not suit everyone and in-person options should still be made available. A key challenge for rural areas is the availability and reliability of digital signal and connectivity. A further challenge is recruiting and retaining health care staff in rural areas.

3. Community support

Community services fill the gaps where local health services had been withdrawn.

However, these services were heavily reliant on volunteers who were stretched across multiple services. Having more outreach provision and organising services in community hubs would improve access. Reducing the distance patients travel would address the issues around transport, missed appointments, and not adhering to care that can lead to health complications and prove more costly in the long run.

4. Reduced services

The withdrawal of local services contributes to problems of distance not just in terms of 'decay' but 'disappearance' of health services and support.

The challenge of accessing services is not only about the physical means of transportation, but reflects limitations in local services, restrictions around appointments and the mental energy needed to organise travel and endure long journeys. An urban-centric mindset among some health providers contributes to a lack of understanding of these complications.

5. Wellbeing

The barriers to accessing local health services mean people feel abandoned and are less likely to seek help affecting their long-term health and wellbeing.

Whilst some of the issues raised relate to general health service provision affecting urban as well as rural areas, the fact that there are few alternatives and the impact of distance, exacerbates the rural effect of health inequalities.

Key recommendations

Using the feedback and insight gathered from this research, the following key recommendations have been developed.

These we believe will help address the issues and concerns raised by people about the difficulties they face accessing and using health services due to living in a rural location.

Action to take

We recommend:

- Our health care commissioners and providers work collaboratively to ensure services provided for people living in rural North Yorkshire meet their needs via the rural proofing of services.
- People living in rural areas are included in the design and delivery of health services.
- The provision of transport in rural areas is reviewed to ensure it meets the needs of local populations and their ability to access health care.
- Addressing health inequalities of rural populations, including healthcare access and provision, is prioritised by the Humber & North Yorkshire and the West Yorkshire (covers Craven) Integrated Care Boards.
- Further research is undertaken to examine health inequalities across districts within urban, rural and coastal areas in North Yorkshire.

Additional recommendations based on the rural effects of people using and accessing services are included within the four areas identified (access, transport, governance & infrastructure, and community) later in the report.

Introduction and methods

Introduction

The geography of health inequalities has been identified for many years.[1]

Issues known include lack of services, resources and infrastructure (digital and physical connectivity), and the challenges of recruiting and retaining healthcare staff. These issues disproportionately impact rural communities[2] and the poorer, older and more remote residents within them.[3]

Over a decade ago, the classification of 'Rural' was recognised as "a significant and independent contributing factor to health-related inequalities."[4] Despite the introduction of 'rural proofing' in UK policy[5] to improve equity of access to health and other services, and opportunities for people living in rural and remote communities, geographic inequalities are still identified as a 'striking feature of the UK'.[6]

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[1] Curtis S and Jones IR (1998) Is there a place for geography in the analysis of health inequality?, *Sociology of Health & Illness*, 20(5), 645-672

[2] DEFRA (2022) Delivering for rural England – the second report on rural proofing, DEFRA: London. Haighton C Dalkin S and Brittain K (on behalf of Public Health England) (2019) *An evidence summary of health inequalities in older populations in coastal and rural areas: Full report,* PHE publication: London. Local Government Association (2017) Health and Wellbeing in rural areas: Case studies, Public Health England: London. McGrail MR and Humphreys JS (2009) Geographical classifications to guide rural health policy in Australia, *Australia and New Zealand Health Policy, 6(28), 1-7.* Muller L, Maguire R, Zeidler L, Cairns M, Hopkins SAH and Mitchell P (no date) *Defining and Measuring Rural Wellbeing: Guidance for Defra policymakers and evaluators,* Centre for Thriving Places: Bristol. Palmer W and Rolewicz L (2020) *Rural, remote and at risk: Why rural health services face a steep climb to recovery from Covid-19,* Nuffield Trust: London

[3] Mungall IJ (2005) Trend towards centralisation of hospital services, and its effect on access to care for rural and remote communities in the UK, *Rural and Remote Health*, 5:390 (online) https://doi.org/10.22605

[4] Lutfiyya MN, McCullogh JE, Haller IV, Waring SC, Bianco JA, Lipsky MS (2012) Rurality as a Root or Fundamental Social Determinant of Health, *Disease-a-Month,* 58(11), 620-28. [Page 621]

[5] DETR (1999) *Rural England: a discussion document*, The Stationery Office: London. DETR (2000) *Our countryside the future – a fair deal for rural England*, The Stationery Office: London

[6] HM Government (2022) *Levelling Up: Levelling Up the United Kingdom,* London: Her Majesty's Stationery Office, pxiii

In 2022, the UK Government launched its Levelling Up White Paper, using a devolution framework to address economic inequalities, and the Health and Care Act 2022, establishing 42 new Integrated Care Systems to tackle growing health inequalities.

This policy and legislation have impacted health care decision making and implementation in North Yorkshire (as well as across England). This research is therefore timely in that it seeks evidence to the broader question; if rurality is, and should be, considered as a health inequality.

Health inequalities are defined as unjust and avoidable differences in the health status of different population groups.[7] There are many kinds of health inequality and the causes are complex, but generally they are associated with a variation in a range of social conditions that influence our ability to lead healthy lives.[7] These social conditions have been identified as interrelated layers of individual-level factors, social and community networks, living and working conditions and general socio-economic, cultural and environmental conditions (Figure 1). Whilst health inequalities can exist across these different contexts, in this research our focus is to qualitatively explore peoples' lived experience of accessing health services in rural areas.

[7] Kingsfund, 2022 What are health inequalities? Available at https://www.kingsfund.org.uk/publications/what-are-health-inequalities. World Health Organisation (2018) *Health inequities and their causes*. Available at: https://www.who.int/news-room/facts-in-pictures/detail/health-inequities-and-their-causes

Figure 1: Determinants of health: Dahlgren and Whiteheads Model, 1991[8]

Research aims and objective

Healthwatch North Yorkshire's mission is to understand the needs, experiences and concerns of people living in North Yorkshire and address them through influencing decision makers and making them accountable.

The Institute of Social Justice's mission is to pursue and promote a fairer society through collaborative partnership-based work with voluntary, community or social enterprise organisations, with people, partners and communities, adding to critical mass through participation, implementation and change.

[8] Image sourced from https://www.researchgate.net/figure/Determinants-of-Health-Dahlgren-Whitehead-1991_fig1_315214544

The aim of the research was to understand how rurality impacts on people's access to, and use of, health services in North Yorkshire. The objective of this aim was to contribute towards ensuring that the provision and delivery of health services meets the needs of people living in rural areas.

Research on health inequalities has tended to focus on urban and coastal communities, heavily informed by social deprivation.[9]

Nevertheless, Healthwatch North Yorkshire, were aware from regular public feedback that many people in rural communities reported significant issues accessing local health care services, such as their GP or dentist, and faced similar challenges accessing hospital care. This points to a dearth of accessible health care services in inland rural areas worthy of further scrutiny.

Funding and research

The research was funded for six months via a York St John University community research grant and guided by a steering group consisting of members from Healthwatch North Yorkshire, York St John University and North Yorkshire Council. This research is **exploratory in nature** given the changing political landscape (detailed above and below) and breadth of issues which can be difficult to define and measure at scale given the budget and timeframe for this project. The research therefore does not seek to identify causality but rather demonstrate relationships. The emphasis on exploring local voices seeks potential new, and nuanced understandings of the needs and concerns of health care use and provision in rural North Yorkshire.

[9] Chief Medical Officers Annual Report 2021, Health in Coastal Communities, available at: Chief Medical Officer's Annual Report 2021 - Health in Coastal Communities (publishing.service.gov.uk). Marmot M (2020) Health equity in England: The Marmot Review 10 years on, *BMJ*, 368:m693, available at: https://www.bmj.com/content/368/bmj.m693.full

Why North Yorkshire?

On April 1st 2023, North Yorkshire Council came into effect as a new devolved authority combining the former North Yorkshire County Council and seven district and borough councils: Craven, Hambleton, Harrogate, Richmondshire, Ryedale, Scarborough and Selby.[10]

North Yorkshire Council is the third largest council in the country at 8,037 square kilometres, the majority (98%) of which is sparsely populated with a third of the population residing in rural locations. Although not among the least deprived local authority areas in England, some areas fall into the most deprived quintile, some parts to the east of the county fall within the most deprived 1% nationally.[10] North Yorkshire also has a higher proportion of the population over the age of 65 compared to the average for England (Table 1).

Table 1: North Yorkshire profile

	Craven	Hambleton	Harrogate	Richmondshire	Ryedale	Scarborough	Selby	NY	England
Population (2021)	56,923	90,691	162,666	49,764	54,709	108,736	91,990	615,487	56,490,045
Area (km sq)	1,177	1,311	1,308	1,319	1,507	816	599	8,037	
Population density	49	70	123	41	37	133	151	77	432
Depviation (IMD 2019)	12.76	11.99	10.9	12.14	15.67	26.28	12.73	14.8	21.7
Population aged 65+ (2021)	27.5	27	23.3	23.4	27.6	27.5	20.4	25.1	18.3

Source: North Yorkshire Council, 2020; Office for National Statistics, Census Data 2021

[10] North Yorkshire Council (2020) *A unitary council for North Yorkshire: The case for change,* North Yorkshire Council, Northallerton

The unique geography and demography make North Yorkshire a suitable location for a case study into rural health inequalities.

According to North Yorkshire Council, on average it is more expensive to deliver services in sparsely and super-sparsely populated rural communities than in urban areas.

Traditional care markets do not operate in super sparsely populated areas often leading to 'care deserts'. This is a concern given that the aging population in North Yorkshire will continue to place substantial pressures on social and health care services, particularly in remote rural areas.

In addition, remote and rural areas experience physical and digital isolation, and difficulty accessing services, jobs and public transport, leading to inequalities in health and social outcomes.[10]

Within the new local authority structure, health service provision will come under the responsibility of the NHS Humber and North Yorkshire Health and Care Partnership[11] and the NHS West Yorkshire Integrated Care Partnership (for Craven)[12].

They aim to tackle health inequalities with a particular emphasis on rural communities who are considered to have the greatest need. The health strategy emphasises a reduced reliance on professional help through enhancing partnership with the voluntary, community and social enterprises (VCSE). VCSEs are seen as playing a key role, representing the voice of people and shaping the design of health services.[13]

[11] Humber and North Yorkshire Health and Care Partnership (2023) *Reimagining Health & Care – An Integrated Strategy*, Willerby: HNY Health and Care Partnership
[12] West Yorkshire Integrated Care Strategy- West Yorkshire Health and Care Partnership
[13] https://humberandnorthyorkshire.org.uk/our-work/vcse/

Methods

The research adopted a mixed methods approach co-produced around themes identified by Healthwatch North Yorkshire:

Theme 1: Experiences of accessing health services
Theme 2: Key challenges/benefits of living in a rural area
Theme 3: Impact on people's health and wellbeing

The research was conducted in two phases:

Phase 1: Quantitative analysis

A survey was co-designed by Healthwatch North Yorkshire, volunteers from the charity, and the Institute for Social Justice. This was available online (using the secure Qualtrics survey system) or as a paper copy[14] to people, aged 18 or over, living in rural North Yorkshire (defined as populations of less than 10,000).[15] A link and QR code were created for people to access the survey, which was available between 7th March and 9th May 2023.

Taking part in the survey

Healthwatch North Yorkshire and North Yorkshire Council recruited survey participants using their existing means of communication among service providers and user groups. In total, 319 responses were received, 88 were excluded as respondents identified as living in or close to cities or towns beyond the geographic scope of the analysis, or responses were incomplete, giving a sample size of 231. Responses were received from all seven districts within North Yorkshire (Figure 2).

[14] Participants could return completed surveys to a designated drop-off point or by using a freepost address.
[15] This combined categories of 'sparce' and 'super-sparce' areas as defined by NYC.

Demographics

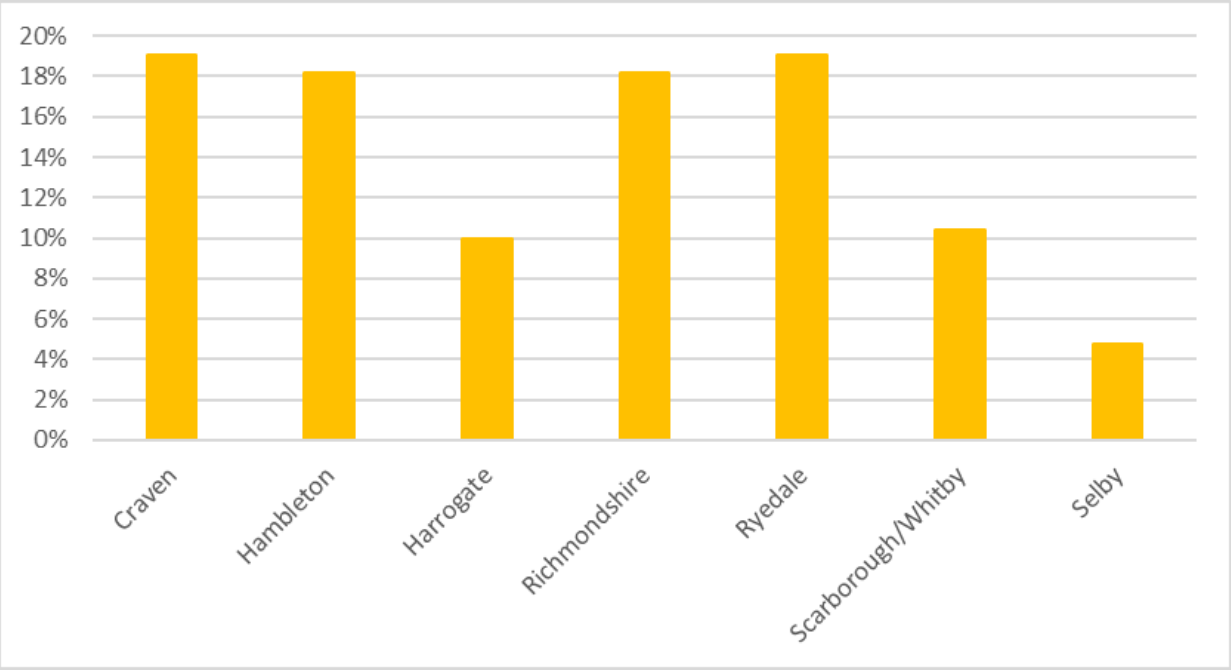
Over half the respondents lived in villages (55%), followed by small town (25%), hamlet (11%), open countryside/national park (9%). Most respondents had lived in their current location for more than 10 years (57%), of which, 32% had been there more than 20 years and 6% were born there. Only 2% had lived there for less than a year.

42% of respondents in our sample were 65 or older compared to the North Yorkshire population where 25% are over 65 (Table 1).

The majority were female (69%) although 13% did not identify their gender.

Respondents tended to self-identify as being in good health physically (63%) and mentally (67%), although 60% reported having a long-term health condition and 23% had a disability (see Appendix 1, Table A).

Figure 2: Location of survey respondents by district:



Phase 2: Focus groups

A total of nine focus groups were conducted between 17th and 26th April 2023. Two online focus groups and one telephone interview were conducted with health care professionals. Seven focus groups (one in each of the districts of North Yorkshire) were conducted in person with a mix of users and health care professionals. In total, 31 users and health professionals participated (see Appendix 1, Table B).

In-person focus groups were held in community buildings in rural and remote locations. This was in recognition of the challenges that an urban-centric approach to data collection may pose to rural residents, who may not have access to their own or public transport.

Discussion, guided by open-ended questions and prompts, was facilitated by members of the York St John University Research Team and Healthwatch North Yorkshire volunteers. To ensure anonymity, individual participants will not be identifiable in this report. Focus group participants and survey respondents will be reported generically as people. Inverted commas around certain words denotes phrases used by respondents.

Access to services

Access to services

A key component of understanding wellbeing in rural communities.

The barriers to accessing health care services highlights the impact of rurality across several areas of people's lives.[16]

People were **asked if living in a rural area had an impact on their access to health services** and of the 186 survey responses, **66% said it did**. The most common issues related to distance (travel time and cost), lack of transport and the loss or lack of local services. Among the 34% for whom it did not impact, there was often a caveat that it would become a problem if they could no longer drive. People also told us delays in getting treatment, not getting diagnosed, and the 'battle' of accessing services had negatively impacted on their mental health.

The areas highlighted by people are discussed over the next pages, organised into four themes of 1) accessing services, 2) transport, 3) governance & infrastructure and 4) community. Although themes are reported individually, they are not presented according to a hierarchy and the issues raised do not exist in isolation with many examples demonstrating the interconnectedness of rural health inequalities.

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[16] Muller L, Maguire R, Zeidler L, Cairns M, Hopkins SAH and Mitchell P (no date) *Defining and Measuring Rural Wellbeing: Guidance for Defra policymakers and evaluators,* Centre for Thriving Places: Bristol

People reported using a wide range of health services via private, public and voluntary sector providers.

Among the people who completed the survey, 91% had used their GP in the last 12 months, 87% had used a pharmacy, 58% had used hospitals for routine appointments and 28% had used A&E or urgent treatment centres.

Inequalities in rural health service provision are demonstrated by differences in opinions of what works well, ranging from 'everything' to 'can't think of anything'.

GPs tended to be the first port of call and an aspect of health services that 43% of people felt worked well. Some people reported better treatments and shorter waiting times for hospital appointments than they had experienced in some larger urban areas, although these examples mostly related to small urban (cities and town) facilities. Most people had access to a facility that dispensed prescribed medication.

People particularly welcomed the convenience of having pharmacies located within GP surgeries, although for some this meant no separate pharmacy facility was available locally.

People also welcomed pharmacies in supermarkets with extended opening hours, in contrast to those who struggled to get access after work or at weekends. We found that a key challenge for rural pharmacies was that they tended to be smaller branches that carried limited stock, necessitating a longer journey to the nearest town or city:

> "A local pharmacy often does not have and cannot order my prescription requiring a 25-mile round trip into Ripon to try the pharmacists there."

Home delivery services were also a positive aspect for many. These services were considered vital, enabling adherence to treatment, and providing a useful means of checking in on those who may otherwise be isolated.

Health professionals were concerned that delivery services in some rural locations were only available to vulnerable patients, or not offered at all, and often incurred charges that may contribute to inequalities in health care provision.

Barriers to accessing services

A common barrier in accessing services was getting through in the first place.

As one respondent candidly noted, getting to see a GP is "a right old pain in the arse". Figures 3 and 4 demonstrate some reasons that stopped or made it difficult to access health services.

The most common issues included difficulties with appointment times and it taking too long to get to appointments, which also reflected the challenges people had getting to health services because of limited public transport.

Other responses highlighted challenges in getting through to anyone to make an appointment. Not being able to see a preferred health care professional was the main reason stopping people using services, along with services being too far away, having to take time off work, not wanting to burden the NHS, and not having services available locally. Other reasons included being blocked by the receptionist, not having a health condition taken seriously, or service providers being rude which was damaging and not worth the stress of seeing anyone.

Figure 3: What makes it difficult to accessing health services (multiple options can be selected):

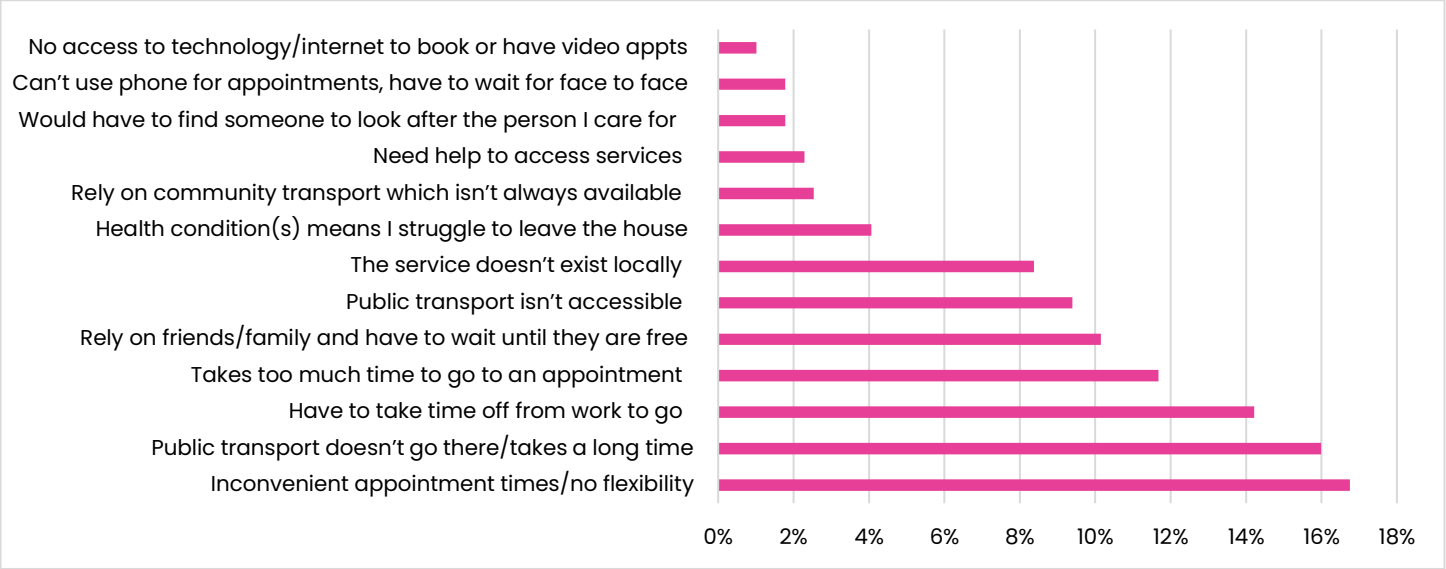
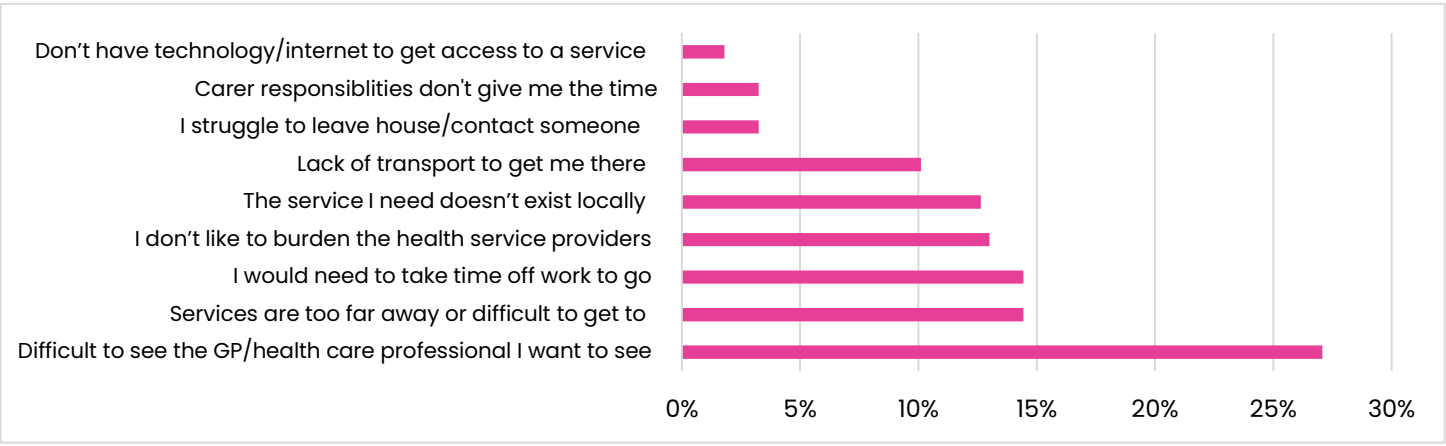


Figure 4: What stops people from using health services (multiple options can be selected)



Rules around accessing prescribed medicines were deemed 'cock-eyed' where prescriptions cannot be dispensed to patients living within one mile of the surgery.

They would need to use a pharmacy, although this could be five or more miles away. In one example, volunteers had to collect a

handwritten script every month from a housebound patient and take it to the GP because 'they won't let her ring up for a prescription'.

Another barrier people reported was a lack of local health facilities.

These include hospital specialist services, surgeries, and dentists. Other shortfalls mentioned included mental health, dementia, end of life care, care homes, women's health (menopause), carers, and respite for unpaid carers. Where services were available, people described limited provision where GPs, mental health nurses, and physios, among others, were being shared across multiple locations. The threshold for what was an acceptable level of care was also considered 'appalling', and there were accounts of health professionals not always treating patients with the dignity they deserved:

> "When you move to a rural area and the consultant shouts at you for not bringing your notes with you, whilst you are semi naked, recovering from breast cancer surgery and generally feeling very low, is not good. No dignity - just an invisible, middle-aged women."

The loss of services at local hospitals or specialisation of services made 'hospital access a lottery' and often meant having to travel to multiple locations for treatment.

According to one health care professional the lack of acute care facilities in hospitals contributed to 'major disparities in care'.

Where patients needed to be referred through their local hospital, this could lead to delays during a crucial time window for care. The lack of facilities also added to uncertainty, not knowing which hospital patients were being taken to, or indeed whether it would be the right place for care.

> "Too many specialities are being removed from Scarborough Hospital."
>
> "Having to be taken to York on a busy A64, especially in the summer, is unrealistic and life threatening. To get there and if found to have had brain haemorrhage rather than a stroke means a further journey to Hull. This could all be decided at Scarborough, then if needs must, transfer to the appropriate hospital."
>
> "My husband had chest pain one night. The ambulance took 40 minutes to attend. On taking him to hospital, they could not tell me where he was going! Darlington, James Cook, or Harrogate? I would be phoned by A&E wherever they were directed to. I waited six hours until I was informed."

Inequalities in service provision were also evident with people having moved to a rural location.

However, due to a lack of health service availability, notably dentistry, they remained registered with their former urban practice. Anxieties over losing the ability to drive were often linked to concerns about having to move house due to a lack of service provision or transport.

One example included an individual who had relocated to a more urban location to access the health services needed:

> "I do know somebody that moved from here to Harrogate so that they are nearer to health services because of the issues her husband has."

Overall, people's experiences illustrated how access was more complex than just physically getting to services.

Difficulties included the availability of local services, having to go through gatekeepers, having fixed time slots for making appointments or ordering repeat prescriptions, waiting for call backs, short 10-minute consultation times, having little if any control over which healthcare professional you saw, and having the emotional capability to make contact and engage with services. A detailed example of one participant's experience is presented in Appendix 2. We acknowledge that these examples may be issues also experienced in urban areas, but in rural areas "it's just more exacerbated, because you are so far away".

Distance

"They keep moving health services further and further and further away. It's that distance problem all the time."

A key challenge for rural areas is the loss of local services, thereby increasing the distance that people needed to travel to access treatment.

Table 2: Nearest service (survey responses):

	GP	Pharmacy		A&E
Walk: within 10 mins	22%	25%	up to 5 miles	7%
Walk: within 30 mins	9%	9%	6-10 miles	15%
Drive: 5-15 mins	36%	30%	11-20 miles	42%
Drive: 15+ mins	30%	32%	More than 20 miles	37%
Drive: 30+ mins	3%	4%		

In rural areas, 19% of households do not have access to a general practice within 30 minutes of public transport or walking. And 78% do not have a hospital within 45 minutes.[17]

Distance means additional time and cost considerations when attending appointments, having treatment, or collecting prescriptions. People frequently described dentists and hospital services as being over 20 miles away, in some instances up to a 100-mile round trip.

For 42% of people the nearest A&E or urgent treatment centre was 11-20 miles away. For 37% of people this was over 20 miles (Table 2).

[17] DEFRA (2023) *Unleashing Rural Opportunity,* DEFRA: London.

Many respondents described hospital appointments as taking all morning or even all day. For acute medical needs, the increased distance can mean that patients are less likely to get the response they need, putting them outside the critical time limit for effective treatment or transfer to a trauma centre.

Although GP surgeries and pharmacies tended to be closer (22% of GPs and 25% of pharmacies within 10 minutes walking distance), 66% of people reported driving distance (Table 2).

Whilst 15-30 minutes driving time may seem accessible in urban environments, this can still present a challenge in rural areas where transport options are restricted.[18] People reported limited or a lack of public transport meaning that they were reliant on driving, which given that people need to attend for medical treatment further complicates the issue adding to pain, anxiety or stress. Where people are unable to drive, they needed to organise transport through community services or relied on family or friends for a lift, which some were reluctant to do:

> "I could get there because I can drive. But then you get the appointment letter through, and it tells you, you can't drive because of what's being done. And then it's difficult because you're either relying on accessing help from a service that will give you it or relying on someone's goodwill."

The distribution of specialist services across multiple sites also added to the distance travelled and was challenging for providers

[18] Local Government Association (2017) Health and Wellbeing in rural areas: Case studies, Public Health England: London. Coleman C (2023) In Focus: Health care in rural areas, London: House of Lords, UK Parliament. Available at: https://lordslibrary.parliament.uk/health-care-in-rural-areas/. DEFRA (2023) *Unleashing Rural Opportunity,* DEFRA: London.

of community transport when trying to coordinate patients' appointments.

Even when services were closer, the rural location caused additional problems due to the lack of infrastructure. For example, when a key route was closed the 'back roads' were considered a less favourable option, other people who relied on bus services described them running as infrequently as every three hours.

Rural areas are more likely to experience 'distance decay', a concept referring to how the quality and quantity of services decline the further people are away from a central location.[19]

The further people are away from services the less likely they are to access them.[20] When accessing health care, the time it takes, the cost and convenience of transport and the effort needed are potentially more important considerations than physical distance per se.[21] This is supported by the experiences of people in rural North Yorkshire: "It's not just about time and length of journey, but the complexity of that journey … you can get disruption due to snow, and the winds blow harder. If you're frail and ill this impacts you more".

Travelling across rural locations means there are no places to stop along the way, an important consideration for people who are in pain or incontinent.

[19] Pen-Cheng LSC (2017) Distance Decay. In D Richardson, N Castree, MF Goodchild, Ay Kobayashi, W Liu, and RA Marston (Eds) *The International Encyclopedia of Geography*, Wiley & Sons Limited.
[20] Powell M (1995) On the outside looking in: medical geography, medical geographers and access to health care, *Health and Place*, 1(1), 41-50
[21] Powell M (1995) On the outside looking in: medical geography, medical geographers and access to health care, *Health and Place*, 1(1), 41-50.

The difficulty and discomfort of being on a long journey means 'it's such a slog to go to hospital' and can put people under 'immense stress', which for some was a reason for not pursuing treatment:

> "It's cruel to insist that a cancer patient attends sometimes daily appointments 50 plus miles away by putting them under immense physical, emotional, and financial stress. Its grossly inadequate and scary for a lot of people."

> "It's a 26 miles journey with nothing. You can't just pop into M&S or Tesco for a wee or have a break in a place sheltered from the wind and weather."

> "It's not uncommon that some of our patients to have to travel over an hour to get to a specialist service. And if they've got pain, they've got fatigue, they've got incontinence issues, they just can't travel that far."

International research shows that health resources are concentrated in urban areas, with the assumption being that 'eventually everyone will move to the cities.'[22]

People we heard from spoke of services being urban-centric and how some health care professionals did not appreciate where people travelled from. It was felt that main offices 'haven't a clue what the landscape' is like and the challenges that rural communities face.

The distance and cost of fuel was also a disincentive for volunteers and carers to cover rural and remote areas.

One of the problems is how rurality is defined. Typically, this is by population size and the distance from urban areas.[23] One health

[22] Strasser R (2003) Rural health around the world: challenges and solutions, *Family Practice*, 20(4), 457-463.

[23] Lutfiyya MN, McCullogh JE, Haller IV, Waring SC, Bianco JA, Lipsky MS (2012) Rurality as a Root or Fundamental Social Determinant of Health, *Disease-a-Month,* 58(11), 620-28.

professional however felt the distance from specialist health services was also an important definition of rurality, and by association definitions of urban where towns and cities could have very different specialist health facilities available.

Deprivation

We heard from people how poverty impacts their access to services in rural areas where they are unable to pay for taxis or privately provided health services, highlighting the challenges of deprivation and rurality.

Remote and rural communities impacted by deprivation are disproportionately affected by 'diseases of despair' (substance overdose and suicide).[24] These issues are, however, often masked in the quantitative evidence underpinning policy decisions which fail to 'pinpoint the small pockets of significant deprivation within rural areas made up of diverse environments (often a few isolated houses on the edge of a village) that cannot be lumped together for analysis'.[25]

Health professionals noted that deprived people tended not to access services and for rural deprived people there were additional barriers. Health professionals talked of the 'toxic blend' of poverty and rurality. For some services 'most of the user group are on low incomes', the lack of, and cost of transport is a huge barrier to accessing services:

> "The combination of throwing rurality and then deprivation in the mix is the patients become less likely to seek help."

[24] UCLan (2020) *A Tale of Two Countrysides: Remote and Rural Health and Medicine*, University of Central Lancashire.
[25] Local Government Association (2017) Health and Wellbeing in rural areas: Case studies, Public Health England: London.

> "Someone told me it was £80 to get to and from their appointment. And he's like, 'I just can't afford to spend £80 every time I need to go to this clinic'."

It was felt that where services had moved to private provision this also created inequalities between those who could afford to pay and those who could not. The same problem was felt to exist between those who could drive to services and those who could not. Given the sparsity of services available, it was felt that poorer people were a 'bit stuck'. Through deprivation (personal funds and lack of services), it was felt people were less likely or less able to find alternatives creating a barrier to accessing health services.

Assessing needs also does not seem to take account of the distance and transport issues that rural communities face. One participant who cared for her husband 'didn't know which way to turn to get some respite':

> "So you might have rural communities that are very affluent where the patients can drive themselves to appointments. But if you throw in some deprivation, yes, you might have that in a city with really good bus, public transport links for those that don't drive that actually works slicker to get into the centre of Leeds from the suburbs than actually trying to drive. If you throw that back into rural North Yorkshire, with deprivation in the mix, as well as no bus service, you are a bit stuck."

> "You got assessed, you have a need. But you get told 'I'm sorry, you can afford it. You get on with it. Here's a few telephone numbers and everything was in Selby, York whatever."

> "Patients are trapped between a rock and a hard place because they don't have any other means to get themselves to hospital."

Impact of rural health services

Negative impacts of living in rural areas arise as people age and their abilities and needs' change affects their independence.

Health care professionals reported that rural residents tended not to get the same end of life care and access to hospices. They believed that people had the same cancer rates but there was a higher death rate in rural areas due to a lack of health services and care.

Health care professionals also highlighted that the lack of services or access to them meant there was more morbidity and pathology in rural areas. They felt that older people may be going into care sooner than they needed to, due to lack of services to support independent living, which can shorten their life span.

> "I was genuinely really sad when Age UK went because I was thinking of all those people that wait for that minibus to come out their front door. And now a lot of those I find interesting are now in a care home. I'm not saying that it's because of Age UK, but I think it's contributed to the fact they couldn't remain independent and had started to fail because they couldn't get things like shopping in their home or go pick up their prescription and be independent."

Living in rural areas impacts ambulance response times. One respondent 'never waited more than 15 minutes' but the experiences of many people was long wait times, putting pressure on patients to make their own way there:

> "I have previously tried to call an ambulance to transport my son to hospital with what turned out to be a ruptured appendix. I was told it'd be two hours, so I took him myself. If I had waited for the ambulance he may not have survived."

> "So in the end, I had to drive him. He's anxious. And I'm anxious having to drive at six in the morning because he couldn't breathe. We just couldn't really wait because it was quite critical."

We found that the challenge of getting to hospital in an emergency was further compounded by patients not arriving by ambulance, resulting in them struggling to get a bed creating a "double whammy in that you couldn't get their first time, and then you're going to struggle to access those services".

This issue is particularly relevant in rural areas where people reported having to make their own way to hospital due to a lack of direct, or in some cases any, bus or train services. For those without a car, access to hospital was deemed 'impossible' and A&E 'inaccessible'.

In the experience of health care professionals, the problems of accessing services can mean some medical conditions go undiagnosed or people do not follow up treatment.

Given the 'long list' of ailments that many people have, and the barriers to access, some treatments are considered low priority, and often cancelled, even though they are preventative in nature and could assist with quality of life. It was felt that rural people 'will put up with more pain' which impacts their mental health, depression and employment. The systems and processes in place appeared to further inhibit people seeking help.

> "I've had more ups and downs with my mental health than I've had when I didn't live in a rural area."

> "I could access services before. I find it very frustrating. If it wasn't for getting help from someone, I would give up. People with mental health do."

We found that people in rural areas also experienced challenges in using or accessing rehabilitation when they are often isolated and find it difficult to maintain prescribed exercises or where unsuitable equipment is provided and they are unable to 'just nip back to the hospital' to sort things out:

> "People who've had hip replacements - they've discharged them with walking sticks, and they can't manage walking sticks. They just don't have the balance for two sticks and a cup of tea and whatever."

> "The time between appointments - if they struggled, where did they go? You can't just nip back to the hospital and say 'I can't manage with this - the length of time waiting for any physio'."

> "9 times out of 10 it's miles away anyway. Its nowhere near, so they have to pay to go locally."

The lack of service provision left people feeling forgotten about 'abandoned' or 'dismissed' and less likely to use health services.

This can be a false economy where patients ended up having to use 'expensive services rather than inexpensive preventative ones'.

> "It's 'out of sight, out of mind' in terms of rural location. And that's a shame."

> "I feel as though have been dismissed by local health services and always need to push for further check-ups/ tests/ treatments. This re-enforces the stigma of not using health services as much as 'they won't do anything'. So early diagnosis becomes less likely."

> "I don't think this is exclusive to rural areas, but in rural settings like farming communities. There is a strong sense of it being better to be self-sufficient rather than ask for help."

Summary and recommended actions

What are the issues to fix?

1. **People would like to see their GP and attend hospital appointments quicker, as there were often long delays in being seen.**

This links to more clinical staff being available or longer GP opening hours to include evening and weekend appointments. We heard that the system for booking GP appointments needed to be quicker and easier, such as being able to book in advance and removing the fixed morning appointment booking slot.

2. **That health care professionals should have a greater understanding of the rural landscape of North Yorkshire**.

This is so they are more aware of where people are located and can factor in transportation issues when organising appointments for patients.

3. **A provision for more crisis response vehicles that are quicker than an ambulance would improve their experience.**

Having someone on site can provide vital early treatment and put patients and family members minds at rest.

4. **People would like pharmacies to have increased stock, quicker prescription collection times and free delivery.**

They would like fixed times to phone in repeat prescriptions to be removed and be able to get prescriptions for previous ailments without having to see a GP. It would help if hospital prescriptions were delivered through a local pharmacy.

People are often unable to cover the costs of attending appointments or visiting their GP or hospital in the first place.

The nature of the rural landscape means it is often difficult to identify and support these communities when they are so hidden. The way health provision is measured or monitored (for example: national target setting) often influences priorities and how services are delivered. Changing this could have a significant impact on how services are provided. For example, shifting the emphasis from response times and payment by results, to cutting down the distance patients travel for their care would address issues around missed appointments and not adhering to care (medication and rehabilitation, for instance).

Action to take

- Encourage GP practices in rural areas to open longer hours during the week and be available at weekends.
- Improve the system for booking GP appointments to ensure this is quicker and easier for people.
- A patient's location and their ability to access transport should be considered when arranging appointments.
- Pharmacies should have adequate stocks of medication, and the ordering and collection of prescriptions is improved, including free deliveries where appropriate.
- Hospital prescriptions should be available via a local pharmacy.
- Health service commissioners should look to address the issues of poverty by designing health services (access and location) that meet the needs of those people and communities who face the greatest health inequalities.
- Health service commissioners should consider the value of including patient experience measures, around access and transport within their outcome measures and pathway designs.

Transport

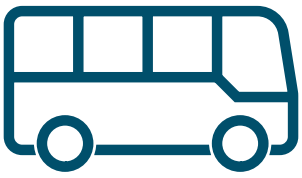
Transport

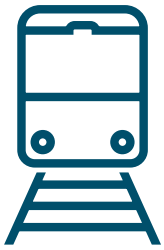
A common theme to emerge across all aspects explored in the research was transport.

When participants talked of the availability of health services, challenges in accessing them, and the impact of living in rural areas, these often linked into difficulties with transport. Limitations of transport are a well recorded problem for rural areas.[26]

Reflecting that this has been a long-standing issue, one health professional commented that they were tired of reporting transport problems 'because it doesn't progress anywhere' and another participant recognised the scale of the challenge: "It's no good tinkering at the edges with repeated attempts to try and solve the problem of transport".

Not all the transport discussed fell neatly into specific categories, however, for ease of reporting, the issues are grouped into: personal (cars and general mobility); public (buses and trains, but also taxis); and community (volunteer/charity transport and patient transport).





[26] Coleman C (2023) In Focus: Health care in rural areas, London: House of Lords, UK Parliament. Available at: https://lordslibrary.parliament.uk/health-care-in-rural-areas/. DEFRA (2023) *Unleashing Rural Opportunity,* DEFRA: London. Local Government Association (2017) Health and Wellbeing in rural areas: Case studies, Public Health England: London. Mungall IJ (2005) Trend towards centralisation of hospital services, and its effect on access to care for rural and remote communities in the UK, *Rural and Remote Health*, 5:390 (online) https://doi.org/10.22605. Strasser R (2003) Rural health around the world: challenges and solutions, *Family Practice*, 20(4), 457-463.

Personal

Having a car was reported as being essential to get to health services.

Without it many people told us they would have either struggled or not known how to get to appointments or treatment. There was a concern that having a car was seen as the norm, with the assumption that people could drive to appointments. The irony however, as noted previously, is that for certain treatments patients are advised not to drive, or their health issue means they cannot drive.

Limited parking was also mentioned as a problem in terms of accessing GP surgeries or where 'it costs a fortune' parking on site at hospitals. The reliance on cars was also problematic for ageing rural populations who may lose confidence or their ability to drive, or 'there are people driving who just shouldn't be'.

> "If you haven't got friends and family and older people that's stopped driving like, you know, most of my friends have stopped driving, you're a bit snookered, you really are snookered aren't you."

> "My major gripe is the lack of convenient transport to any of the hospitals."

> "I can still drive but as I am nearing 80 years, I can envisage a time when I may not be able to drive, and I should not have to rely on begging lifts from friends and neighbours. Nor should I have to move home to somewhere nearer to a hospital."

As one health professional noted, 'When you can't drive that's a real moment of change – a tipping point – a cut-off from the community'. People anticipated this 'tipping point' aware that this would

significantly impact on their ability to access services, and potentially where they may be able to live.

> "I can drive so I have no problems getting to health appointments. If I become unable to drive, I will either have to move or use taxis. There is no regular bus service in my village."

Considering personal mobility more generally, one of the benefits of living in rural areas was being able to go for walks. This included for the purposes of accessing services or as part of an effort to maintain health. However, this had become a problem where village footpaths had 'all vanished' and there was a lack of lighting that created a barrier to getting around:

> "We would like to get involved with a lot more, but one of the problems of course is that there's no street lighting. So of course, that would mean me pushing a wheelchair from Helperthorpe to Weaverthorpe for the film night or anything that's happening on a night when it's dark. We wouldn't do it, but we would like to."

Public

For many people public transport was an essential part of their quality of life to the point that without it they would struggle and 'seriously have to think about moving, because we'd be really isolated up here'.

Despite being an essential service for many, several challenges emerged. We heard that in rural areas bus services were limited, many people reported that there was no bus service in their village, whilst others only had two buses a day:

> "I never knew when we bought the house nearly half a century ago that the bus stop was going to be such a critical part of the life."

Train stations also tend to be located in towns and cities and some services only ran every three hours.

In terms of accessing health services, journeys often required multiple buses, or a combination of buses, trains and taxis. Ironically for one participant the only through service for the 40-mile trip to hospital was on a Sunday, 'and there are not many medical appointments on a Sunday'. This issue also linked to what was referred to as 'lazy definitions of rurality' as places of leisure:

> "North Yorkshire Council had a policy of not supporting any Sunday services unless they're commercial, because living rurally is seen as leisure."

> Now going to Northallerton, you'll get people going to work or coming home from nightshifts. You get people going for all sorts of visits to hospitals and shopping and economic benefit, all sorts, access to the countryside.

For years we have made the case to North Yorkshire councillors, that this is not just leisure, and even if it is it's supporting the economy and health."

For some health treatments patients were advised not to use public transport because of possible infection.

The alternative to public transport was to use a taxi. Given the distances involved, journeys were frequently reported as being very expensive, £50 each way was not uncommon. We heard that there was often a limited number of taxis in rural locations meaning they were not always available when people need them to get to appointments. Those with mobility problems were further impinged and people reported that taxis were not always willing or able to accommodate wheelchairs or mobility aids.

Community

Many people relied on community forms of transport to get to health services. This included formal community buses or cars and more informal arrangements with family, friends or neighbours.

Whilst community transport provided a 'lifeline', nevertheless the same problems emerged. Some services required booking through an app or online which did not suit many elderly people. Services were limited, did not cover all rural areas even though 'the rural places, that's where you need the transport'. Even where transport was available a lift was not guaranteed:

> "Well, it depends on who has already booked. And it's dependent on whether the cars available whether they've got a volunteer to drive it."

It was also considered difficult to coordinate transport around appointment times (from patient and volunteer driver perspectives), whereby in some instances 'we sometimes have to turn people down, say you're going to have to make another appointment'. Having to be ready two hours beforehand and waiting for transport after appointments meant people could be at the hospital all day. Relying on family and friends was also limited to times they were available and not at work.

Given the challenges faced, some people offered their own support to help others get to appointments. Some people felt that they should not have to be the ones sorting out their own transport, and that this is something that the health service providers should be organising: "The lack of provision for elderly to get to the surgery without waiting/relying on friends and family is atrocious".

Patient transport was often mentioned as an alternative to community buses.

However, we found that this was only available to patients meeting certain criteria and was limited in rural areas. One participant recalled a freedom of information request on patient transport in their 'very rural area' which "show without any doubt at all, that there is discrimination against rural areas. They simply don't want to do it, and so they make every excuse possible not to provide the service". Even where it is provided there was no guarantee that people would get to their appointments:

> "We had an appointment at Scarborough we had patient transport, it came with 15 minutes to get to Scarborough because they had to drop off two other patients. And we got on the ambulance, got to Weaverthorpe and then he turned around and took us back because they wouldn't accept us this late."

The cost of transport was also an issue for people.

Although community transport was subsidised, it was still considered a lot to pay for people on a low income. The flip side of this was those providers often had to run at a loss, or as one participant discussed, must cross-subsidise with other business initiatives:

> "Some buses that are more popular than others and will probably break even. Some of them run at a loss. We also have other businesses, which we use surplus revenues from that to support a loss-making bus service."

Impact

In rural areas with few alternate transport options, this adds to the difficulty of making and keeping appointments or adherence to treatment.[27]

Seventeen percent of people reported that they had missed or cancelled a GP or Hospital appointment, 8% an NHS screening appointment, and 6% a vaccination appointment. This compares to 6.4%[28] of hospital and 5%[29] of GP appointments nationally. Of the 98 reasons given for missing appointments, nearly half (47.3%) were due to transport. This included no public transport being available, not being able to arrange a lift, taxis being too expensive, and trains being on strike.

Timing (18.3%) was also an issue with appointments being too early or late in the day, trying to organise the trip around other caring or work commitments, or fit in with transport timetables, and appointment notifications being too short notice to make arrangements.

Other reasons included weather (snow) preventing travel, having problems arranging appointments, not having support, and the hospital being too far away. People also missed appointments because of inadequacies in public transport or simply because "it's too difficult to go".

[27] Distance or problems with travel was also among the reasons given for avoiding or not taking up treatment. Other reasons were due to: people 'don't want to be a bother' or are too proud to ask; problems getting appointments; lack of services available and it takes too much effort; and not being in a mentally good state.
[28] https://www.england.nhs.uk/2023/01/nhs-drive-to-reduce-no-shows-to-help-tackle-long-waits-for-care/#:~:text=Of%20the%20122%20million%20appointments,for%20an%20appointment%20or%20treatment
[29] https://www.england.nhs.uk/2019/01/missed-gp-appointments-costing-nhs-millions/

Participants described having to become knowledgeable or shrewd when booking appointments (Table 3):

Table 3.: How transport impacts appointments
Distance is a problem "I was unable to find someone to take me to the appointment at the time I was given and there was little understanding of the difficulties involved in finding a suitable driver given the long distance to any hospital."
Limited bus services "I don't drive. The bus is once every three hours through the village. To get to a main road there are no pavements or lighting. The road out of the village is usually waterlogged and muddy. I'm recovering from cancer and it too great a risk to negotiate traffic."
Aligning with bus timetables "We have to be very careful how we do our appointments on the basis that sometimes the bus can be late, so we always have appointments at least 20 minutes after when it's supposed to get in."
It's too difficult to organise "The problem literally is access if you do not have your own transport. This is a crucial issue as not being well and needing to access healthcare without elaborate transport arrangements just adds to stress and anxiety. It also means that you delay getting an appointment/treatment because it is such a faff organising it and you don't want to rely on others."

Many missed appointments could be avoided if they were more closely aligned with transport availability. People are however reluctant to re-arrangement appointments for fear of being put to the bottom of the list:

> Respondent 1: "We get people come and say I've got this appointment at 9am, so we need someone taking you at 7am, so we don't do that, we'll say ring them up and change the appointment, no I can't do that. People feel like if they're given an appointment, they should take it, as they don't want to put them out or they think they won't get another one.
>
> Respondent 2: "That's the primary one. It takes that long to get an appointment."
>
> Respondent 1: "You'll be put to the end of the list."

Summary and recommended actions

Insufficient consideration

It was felt insufficient consideration was given to the challenges faced by rural populations in being able to get to local health services, such as hospitals.

We heard that the distance to travel to services required 'a lot of effort' both physical and mental, but when your travel distance is even longer, and you are travelling for health-related reasons, this effort and commitment is exacerbated.

Action to take

We recommend:

- Community and public transport should be organised to support people's needs, such as aligning timetables with local healthcare services, appointment times or health service opening hours.
- There should be adequate provision for wheelchair users across all community and public transport, including taxis.
- Transport provision should be better integrated to meet the needs of people having to use multiple modes of transport, and transport should be affordable.

Governance and infrastructure

Governance and infrastructure

Governance

The spatial organisation of health services means inequalities in health care are more likely to occur in rural areas.[30]

This was the view of one health professional who felt inequalities were created by the organisation and guidance on health service provision. The emphasis is on centralisation of services or acute sectors (hospitals) that are not designing services around the needs of rural areas. Whilst centralisation of care has cost benefits, these are passed on to rural patients in the form of time and travel expenses, contributing to 'distance decay'.[31]

It was felt that there is 'a massive misunderstanding in secondary care' of these challenges, meaning "the impetus to change how care is provided is not there because health professionals do not really understand the issues and practicalities facing those in rural and remote locations". The potential to address this may exist through the creation of regional Integrated Care Systems who have more ability to influence local services and provide community-based care in accordance with local population health needs.[32]

An issue of governance that people told us about was finance. Whilst the population of remote and rural areas, by definition, is smaller the needs are often higher 'coz they're older and disabled people'. Despite this need, 'funding doesn't extend to rural areas'

[30] OECD (2021) *Delivering Quality Education and Health Care to All: preparing Regions for Demographic Change,* OECD Rural Studies, OECD Publishing: Paris.
[31] Mungall IJ (2005) Trend towards centralisation of hospital services, and its effect on access to care for rural and remote communities in the UK, *Rural and Remote Health*, 5:390 (online) https://doi.org/10.22605
[32] NHS (2019) The NHS Long Term Plan, National Health Service England. Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

meaning choice is superficial, based on 'inequality and the practicalities' of getting to health services.

> "It's more expensive in rural locations and I don't know how you get round it."

As one respondent noted: "there is an investment from us all into this county's NHS and social care. It is the government's responsibility to make sure that, that is spread throughout the country and meets need". According to the Rural Services Network (2022), this does not appear to be happening. They calculated that in 2022/23 compared to urban areas, rural areas would receive 37% per head less in grant funding and 14% per head less in social care support overall.

The small population size of rural areas makes them a 'low priority' and the health need 'doesn't register on the policy decision-making'. The funding challenges were recognised. It was felt that there needs to be more accountability for organisations that are publicly funded and the services they are delivering particularly where "there's lots of community groups that aren't recognised as they should be, that are actually filling the gap for ones that are getting the funding".

> "We've been doing so much around health and wellbeing in our communities that we never get funding for. We've relied whole heartedly on volunteers."

It was felt that more time is needed to build up services in rural areas as it takes longer for people to become aware of services that are available and put in place the arrangements to get to them. This process is often impeded by short-term funding, and a focus on numbers using services which, by definition, will be lower in rural areas. The limitations of short-term funding were also issues for those trying to maintain community services:

> "I could buy a bus, get 75% discount. I could buy a computer, I could buy anything, but I couldn't get anything for the cost of servicing the vehicle."

Some rural organisations however, it was suggested, preferred to maintain independence from Government "so they don't have Government meddling. I don't think Government mean to make a mess of things, they just live a different life down there".

One health professional noted that rural populations can be predominantly tourists who are not accounted for in funding allocation or service provision. This is important given that people who cannot go on holiday abroad for health reasons are visiting places like North Yorkshire, meaning "it's not just a tourist population. It's at times quite a sick tourist population". Tourists tend to 'gravitate to the hospital' for care as they do not know where else to go. It also meant there was no respite during the summer that you can see in urban areas:

> "Certainly, when I've been working in tertiary centres years ago, you get hot summers, weekends, and if you're working in urban centres, it can be a bit quieter if everyone has gone away for the weekend. It's the opposite; there is no respite, but it's about how you ensure the service provision matches it."

It was felt there 'needs to be a level playing field' in particular 'funding needs to be there to support the voluntary sector'. However, people were concerned that recent changes to create North Yorkshire Council and Government cuts to local councils would lead to reductions in funding.

One organisation reported a reduction from £25,000 to 'a miserable' £15,000. Another was concerned that whilst "there's going to be more work pushed down to the parish councils. I don't think the money will follow it".

Digital

Getting a signal and keeping connected

A key challenge for rural areas noted in the literature[33] and by the people in this research is the availability and reliability of digital signal and connectivity. This is due to a lack of infrastructure but can also be a result of weather conditions. Lack of signal impacts health care professionals where patient records are accessed online, thus limiting the services they can provide during home visits. It also has implications for patients receiving vital care:

> "They are very conscious at the moment with the change to the unitary authority (North Yorkshire), because previously they would get a chunk of money from Harrogate and a chunk from North Yorkshire. I suspect that will go down."
>
> Respondent 1: "We've had the odd occasion … when the phone line's cut out, where they've been on the call to emergency services."
>
> Respondent 2: "It's a nightmare."

[33] Coleman C (2023) In Focus: Health care in rural areas, London: House of Lords, UK Parliament. Available at: https://lordslibrary.parliament.uk/health-care-in-rural-areas/. DEFRA (2022) Delivering for rural England – the second report on rural proofing, DEFRA: London. DEFRA (2023) *Unleashing Rural Opportunity,* DEFRA: London. Muller L, Maguire R, Zeidler L, Cairns M, Hopkins SAH and Mitchell P (no date) *Defining and Measuring Rural Wellbeing: Guidance for Defra policymakers and evaluators,* Centre for Thriving Places: Bristol. UCLan (2020) *A Tale of Two Countrysides: Remote and Rural Health and Medicine*, University of Central Lancashire.

> Respondent 3: "Yes, it can be. We've had like a delayed response, but the ambulance service couldn't get in touch with us here."
>
> "It's going to be very interesting to see what happens now with North Yorkshire Council. They spent £6m on public transport six years ago and it's now £1.6 million in the year just gone."

Where technology is being developed within the health sector and beyond, it was felt rural and remote areas were being left behind:

> "Modern technology and clinical practice these days is very much interrelated. The hospital sector are doing amazing things in local communities, but not rurally because of the IT infrastructure being far too unstable and the network not being there. So that's just an example of where we are losing out."

The use of technology

72% of people that completed our survey used the internet for health care either themselves or with the help of others, whilst 20% did not (3% can't do it, 17% choose not to use it).

In contrast, among the focus groups we facilitated many people did not have and did not want to use technology and would prefer to speak to someone on the phone (landline) or see them face to face. This may reflect the difference in age profiles; the average age of survey participants was 36 compared to around 63 for the focus groups.

Whilst it should not be assumed that preference for digital technology is age related, a digital gap linked to ageing populations has been

recognised.[34] Older people are also more likely to accept digital health services where these are complementary to, rather than replacing in-person services.[35] This is an important consideration given that rural areas, and North Yorkshire in particular, have an ageing population.[36]

Health care professionals were concerned that as people age health needs can become more complex people may find it more challenging to use digital access to discuss health needs. Many people told us that online services were 'not ideal' and not enough consideration was given to health issues which may impede them.

We also heard that people have concerns that a 'substandard level of assessment' was being provided when diagnoses was more difficult where people may be less willing or less used to discussing symptoms over the phone.

> "Often they'll say, you can't have an appointment but the doctor will ring you back. And we have a few people who've got early stage dementia, but they've also got hearing difficulties. And it's very difficult for them to understand what's being said."

> "The other problem is that if you ring somebody, they'll say "Oh I'm fine" when they're not. We know they're not, but if we say,

[34] Local Government Association (2017) Health and Wellbeing in rural areas: Case studies, Public Health England: London.

[35] Currie M, Philip L and Roberts A (2015) Attitudes towards the use and acceptance of eHealth technologies: a case study of older adults living with chronic pain and implications for rural healthcare, *BMC Health Services Research*, 15:162 DOI: 10.1186/s12913-015-0825-0.

[36] Hart J (2016) *Older people in rural area: Vulnerability due to loneliness and isolation paper*, Rural England. Available at: https://ruralengland.org/wp-content/uploads/2016/04/Final-report-Loneliness-and-Isolation.pdf. North Yorkshire Council (2020) *A unitary council for North Yorkshire: The case for change,* North Yorkshire Council, Northallerton. UCLan (2020) *A Tale of Two Countrysides: Remote and Rural Health and Medicine*, University of Central Lancashire.

> "Well, have you got this?", they say "No, I'm not so bad, not so bad."

There was also concern where people were continually able to order repeat prescriptions without anyone checking how they were doing:

> Respondent 1: "I have one prescription only - a painkiller. I ring them up for it each month, instead of doing it online which I could, just so they know I'm alive. I don't think I've seen a doctor since my husband died five years ago."
>
> Respondent 2: "But that is a good point; five years on a painkiller, not reviewed face-to-face. That's not good practice. How does [R1] know she is not now dependent?"

Whilst these issues may be relevant in urban areas as well, given the higher incidence of isolation in rural areas,[37] the lack of alternative health support services discussed previously, and the reluctance of older rural populations to discuss the challenges of getting the health and care they require,[38] these issues could be seen as important considerations for rural health care provision.

[37] Bourke L, Humphreys JS, Wakeman J and Taylor J (2012) Understanding rural and remote health: A framework for analysis in Australia, *Health and Place*, 18, 496-503. Hart J (2016) *Older people in rural area: Vulnerability due to loneliness and isolation paper*, Rural England. Available at: https://ruralengland.org/wp-content/uploads/2016/04/Final-report-Loneliness-and-Isolation.pdf

[38] Local Government Association (2017) Health and Wellbeing in rural areas: Case studies, Public Health England: London

Staffing

Improved resource to support community–based staff and care coordinators was identified as a positive contribution to health care (by the staff themselves), although funding for these roles was often short-term.

> "Your travel time is significantly increased when you're covering a rural area."

> "That means you can get less visits in during a day, which means we can see less patients overall in that service. And that's not necessarily accounted for when services are planned. So, you won't have a greater staffing ratio in a rural area. If anything, you might have a greater staffing ratio in an urban area because it's seen as a more traditionally deprived area."

It was felt staffing ratios do not always consider the practicalities of working in rural areas, in particular limited staff trying to get round everyone given the distances they need to travel.

We heard that service delivery was considered 'patchy' in part due to a lack of district nurses and home visits by health care professionals. It was felt that qualified health care professionals were being replaced by unqualified staff and carers and the skills mix needed to be re-addressed. Health care professionals were seen to be working hard but described being stretched to the limit and having to 'prioritise the nearest patients first' as a means of managing their workload.

Health care professionals were frustrated when people could not access all the support they needed and often ended up reaching a crisis point in care. This impacted job satisfaction and contributed to a lack of staff moral:

> "When you see all your work unfold because of something that could have been prevented? You just, yeah, that's in the job satisfaction way. That's probably as low as it gets when that happens."

It is difficult to recruit and retain health care professionals in rural areas.[39]

People recognised the lack of incentives to work in areas which cannot provide the services or resources to support the networks or lifestyles of health care professionals and their families. GPs now 'are a different breed', they are 'not prepared to commit' and are no longer seen as being part of the community as they once were. The public reported GPs rarely live in the remote locations they serve and often work across multiple practices doing a few hours at each. In some areas, retired GPs had come back into surgeries 'to help out'.

Services slowly developing and a call for creativity.

We heard that one practice was seen as working particularly well because it had developed slowly over several years. The GPs had worked there for some time, and it was felt this meant they had a closer working relationship so when new GPs were appointed, they were 'joining more of a family than a business', compared to other services run with multiple part-time staff. One health care

[39] Bourke L, Humphreys JS, Wakeman J and Taylor J (2012) Understanding rural and remote health: A framework for analysis in Australia, *Health and Place*, 18, 496-503. Esu EB, Chibuzor M, Aquaisua E, Udoh E, Sam O, Okaroafar S, Ongom M, Efa E, Oyo-ita A, Meremiksu M (2021) Interventions for improving attraction and retention of health workers in rural and undeserved areas: a systematic review of systematic reviews, *Journal of Public Health*, 42, Issue Supplement 1, ppi54-i66. McGrail MR and Humphreys JS (2009) Geographical classifications to guide rural health policy in Australia, *Australia and New Zealand Health Policy*, 6(28) 1-7. Mungall IJ (2005) Trend towards centralisation of hospital services, and its effect on access to care for rural and remote communities in the UK, *Rural and Remote Health*, 5:390 (online) https://doi.org/10.22605. OECD (2021) *Delivering Quality Education and Health Care to All: preparing Regions for Demographic Change,* OECD Rural Studies, OECD Publishing: Paris. Palmer W and Rolewicz L (2020) *Rural, remote and at risk: Why rural health services face a steep climb to recovery from Covid-19,* Nuffield Trust: London. UCLan (2020) *A Tale of Two Countrysides: Remote and Rural Health and Medicine*, University of Central Lancashire.

professional also noted that rural GPs needed to be more 'creative' and are expected to 'engage in different ways of working compared to a city practice' which is also a disincentive to recruitment.

People recognise that the system is not working:

> "The doctors themselves are excellent, but the system seems to be broken sadly."

> "If we don't look after them and provide the structure to support them then they will only move elsewhere which will worsen the issue."

More people to take care of

According to one health care professional, in rural areas care needs are higher but the working age adult population is below the national average, meaning there are not the people available to take jobs in the care sector.

They went on to say that people are also less willing to work in the sector given a lot of health care work is low paid, but fuel costs are high and domiciliary care staff do not get paid for mileage. This means people cannot afford to work in rural areas leading to a 'care crisis'. Even where supported living arrangements are in place organising care can still be 'a bit hit and miss', particularly overnight care where a lack of staff cover means 'basically we would be relying on emergency services.'

The attitudes of some health care professionals were also a cause for concern, reflecting a lack of knowledge and understanding of rural barriers.

Assumptions are made by some (urban based) clinical staff about people 'choosing' not to have care, when "the reality is that it is not

practical to receive care in the way it is provided. Clinicians wrongly assume people don't want diagnosis, but it's the ordeal of the journey".

As discussed earlier, travelling long distances across remote locations with nowhere to stop can be distressing for vulnerable patients and something they do not want to endure.

Summary and recommended actions

Due to need, populations and cost, health provision has often been developed and provided for 'centrally'.

This has meant services have not always met the needs of rural populations. Whilst centralisation of care has cost benefits, these are passed on to rural patients in the form of increased time and travel costs.

Additionally, whilst the population of remote and rural areas is smaller than urban centres the needs of the rural population is often greater due to age and disability. Consideration needs to be given to the patient composition of rural areas which may differ from the residential population.

There was overall recognition that rural areas needed better infrastructure and connectivity to help support patients as well as health professionals to use and access digital services.

Whilst many people used and benefited from being able to use online and digital health support, there was also a number of people who didn't or couldn't use digital support, so the ability for people to choose their method of support was important. Many people spoke of preferring face-to-face communication, more direct access to a GP and not being screened by a receptionist over the phone.

It was felt there needed to be a change in some staff attitudes, for example a more empathetic and understanding approach as often people didn't feel listened to or understood.

Some people said they would prefer seeing the same health professional, GP etc. rather than always seeing a different person. People called for health professionals to come to them rather than people having to travel all the time, for the example the 'community hub' approach.

Actions to take

We recommend:

- Funding for health services should meet the needs of rural populations, to ensure they receive the same quality of care as those people living in urban areas.
- Improved digital infrastructure and connectivity is required to adequately support people in rural areas to use and access digital support and information.
- Provide digital training and support (e.g., digital buddy schemes) to help people feel confident and able to use online technology.
- Incentives should be put in place to encourage more health care professionals to both live and work within rural communities.

Community services

Community services

The role of communities and the support they provide are increasingly identified as a means of addressing rural health inequalities.[40]

Enhancing social support can help address the challenges of isolation and social exclusion which contribute to poor health and wellbeing in rural areas.[41]

Harnessing community capacity in rural areas enables the development of adaptive, innovative locally responsive health services.[42]

Services

A recurring theme was the loss of community services, particularly in the aftermath of COVID-19 where services had stopped being provided but had not subsequently re-started.

The pandemic exacerbated existing urban/rural inequalities in NHS health services.[43] What we have found is the problems extend to community service provision as well, presenting the loss of a 'lifeline' to rural communities:

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[40] Humber and North Yorkshire Health and Care Partnership (2023) *Reimagining Health & Care – An Integrated Strategy*, Willerby: HNY Health and Care Partnership. Kenny A, Hyett N, Sawtell J, Dickson-Swift V, Farmer J and O'Meara P (2013) Community participation in rural health: a scoping review, *BMC Health Services Research,* 13(64), 2-8. NHS (2019) The NHS Long Term Plan, National Health Service England. Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

[41] Coleman C (2023) In Focus: Health care in rural areas, London: House of Lords, UK Parliament. Available at: https://lordslibrary.parliament.uk/health-care-in-rural-areas/. Local Government Association (2017) Health and Wellbeing in rural areas: Case studies, Public Health England: London.

[42] Kenny A, Hyett N, Sawtell J, Dickson-Swift V, Farmer J and O'Meara P (2013) Community participation in rural health: a scoping review, *BMC Health Services Research,* 13(64), 2-8.

[43] Palmer W and Rolewicz L (2020) *Rural, remote and at risk: Why rural health services face a steep climb to recovery from Covid-19,* Nuffield Trust: London

> "AGE UK have gone. Dementia People went. Everybody that provided those lifelines just disappeared. And a lot of them have never come back."

Although the services have been withdrawn, the needs of those in rural communities still exist.

This puts health care professionals in a difficult position because the support is now not available and the alternatives would incur a 'sometimes extortionate' cost, limiting access to services to those who could afford it. The loss of community services also has implications for people's independence where they no longer have the support or transport to go shopping or collect prescriptions. They may also require further care and support, including going into care homes which were reported as being in short supply.

People felt services in rural areas were good at pooling resources because they had to.

Emergency services (air ambulance, mountain rescue, police, fire) 'knit' together as a 'soft infrastructure'. Services being coordinated around a community hub was also seen as a positive development in rural areas. Community hubs make use of local buildings to provide a base for hosting and providing a range of activities and services that reflect local needs. Activities can be delivered by community groups and organisations or public agencies.[44]

[44] https://mycommunity.org.uk/what-are-community-hubs

Support

The draw of living rurally

There are many reasons people were drawn to living in rural North Yorkshire connected to the benefits of the natural environment, the potential for a healthy lifestyle and the sense of community that creates a supportive environment:

> "The environment is also better for my health - none of the town/city stress, cleaner air, more community, less crime and a greater sense of wellbeing. All contribute to better mental health."

People described a lot of goodwill and people looking out for each other. This extended to local workers, for example using 'the postman or pub landlord' to check in on people, and bus drivers who will 'drop you at your gate with your shopping'. Some suggested this neighbourliness was an 'unofficial eye' filling the gap where other services have been withdrawn.

> "It's a plus because it's a healthier place to live. There's always a social life just walking down the street."

> "People pop in and see their neighbours. And I think it's getting better, as ironically as all the services are going, those sorts of things are improving."

> "There are more 'unofficial eyes' watching out for people. I think it's probably more like the professional eyes aren't there, so everyone's doing what they can and supporting each other as much as they can."

We heard that there was a wider range of activities and groups that people could engage with enhancing social connectedness and

combatting isolation and loneliness. Although, it was reported that there was a gender imbalance in social activities, with a lack of men's groups. We acknowledge that people do have to make the effort to engage and not everyone wants to, indeed some have moved to remote areas for the solitude. There is also a sense of pride that was deemed specific to rural communities, where people do not want to ask for help, or do not want to be seen as a 'charity case'.

> "I'm including myself in this, but I think there's a generation that are proud, and don't want to put on others. They don't want to be a charity case and I hear that a lot. They say 'I shouldn't need to ask people to do this for me or do that for me'."

Whilst these positive aspects draw people to rural locations they often come with 'unrealistic expectations of what life in the country is' and the perception that individuals 'don't think about accessing health care then retire/semi-retire here and put extra strain on already strained services.'

When people retire in rural areas, they can feel lonely without family around to support them, as well as being isolated from resources (health services and others) which can impact continuity of care and mental health. Social connections are important for health and longevity,[45] but the likelihood of isolation and loneliness increases as people age. The risks may be higher for those in rural and coastal areas, yet there is little evidence of the relationship between social connections and inequality in later life.[46]

[45] Pinker S (2015) *The Village Effect: Why face-to-face contact makes us healthier, happier and smarter,* Atlantic Books.
[46] Haighton C Dalkin S and Brittain K (on behalf of Public Health England) (2019) *An evidence summary of health inequalities in older populations in coastal and rural areas: Full report,* PHE publication: London

It was also felt strong social ties in rural and remote areas do not necessarily provide a supportive community for everyone, for example LGBTQ+ communities.

Those with severe illness or mental health problems can find it 'hard to create a small support community without the whole town finding out about it.' The examples given were HIV, abortion or contraception.

Given that local people are working in health services makes it hard to maintain confidentiality. Because of the limited services available it is not like people can easily go to another pharmacy or clinic.

We learnt how rural populations can be quite transient with an increase in holiday lets and younger generations moving out.

This impacts a sense of community, creates a low stable population density, and contributes to loss of business or lack of support for social and sports groups, which we heard are disappearing from rural communities. Village shops are also disappearing as people drive to supermarkets. This was seen as a loss of another place where people socialise and check-in on each other:

> "What a fantastic place a village shop is for chatting and getting to know other people in the village. That's how we first, my wife and I first met people was down at the village shop."

It was felt that some local services see themselves as an all-round 'one-stop-shop' for community support, where multiple services are coordinated under one roof even including a place 'people can go report stuff' following the loss of the local police station, for example. Overall, the strong sense of community 'can be amazingly strong and multi-generational, linked to the land and giving to the community.'

Volunteers

A lot of service provision in rural areas relies on volunteers.

Volunteering was seen as something that is emphasised in rural areas, particularly where they are 'filling the void' left by formal health and public services. Those who did volunteer enjoyed it and found it rewarding; "It's nice to do, you do enjoy it, it's fun and you meet people." For patients and health care professionals knowing someone would be around can be reassuring:

> "The whole medical economy, anything that doesn't make a profit tends to end up relying on volunteers, like us."

Volunteers are not necessarily qualified to be in charge of those with serious health issues. Where this falls to spouses (as unpaid carers), people described how little consideration was given to their needs or the support available. With many services in rural areas operating through volunteers there was often not enough people to go round:

> "It is a problem. At the moment, we have the meals on wheels, but they want volunteers, the library service want volunteers and the minibus want volunteers."

> "Their volunteers not only took her on the transport, and door to door, they stayed with her and made sure that she had that support and reassurance as well. But that is so heavily reliant upon those voluntary services and the availability of that."

> "They took somebody [to hospital] who they were really worried about because she was wheelchair bound. If she got anybody to drop her off at the hospital, she would then be stuck in the waiting room, unable to move, and didn't know if anyone would be around to push her to the bathroom, for instance."

We heard that the lack of volunteers made it difficult to coordinate services which become fragmented.

Trying to recruit volunteers was challenging, often linked to issues of health and safety: not feeling physically capable of lifting people, or their equipment; the need for different car insurance; issues of safeguarding and associated responsibilities.

Some of the aforementioned factors were linked to perceived changes in society: people working and taking more responsibility for looking after their own family members; not having a sense of community and feeling the need to give something back; or preferring to donate money rather than time. In rural and remote areas, fuel costs also presented a problem and people indicated that volunteers 'don't want to go out so far.'

> "There are not as many volunteers as there were because of all the health and safety litigation and insurance that comes with volunteering. People say: 'I can't do that what if something happens.' That's why people aren't coming forward."

Summary and recommended actions

What people want

People told us that they would like more permanent local resources and services, particularly hospitals, but also assets such as village shops.

We also heard that there needs to be a change in the way services are provided, being less rigid, organising care around patient needs and not clinician convenience. Services could still be organised centrally but with more focus on peripheral teams with health care professionals travelling out to communities rather than patients travelling to health provision sites.

Action to take

We recommend:

- Increased numbers of mobile health services, such as screening services and mobile pharmacies should be made available in rural and remote areas.
- Utilise community venues (community hub model) to provide health services and appointments for people living in rural areas to address transport issues.
- Health service providers, North Yorkshire Council and the community voluntary sector should work together to support, promote, and value volunteers.

Conclusion and acknowledgements

Conclusion

People in rural areas experience multiple barriers in accessing and using health services.

A key factor is geographic isolation and the complications that arise with distance regarding both services reaching people and people being able to access services.

The withdrawal of local services contributes to problems of distance and exacerbates the challenges and complexities people face in receiving health care and support.

The reduction or loss of services in rural locations is often linked to financial outcomes and pressures rather than the value or positive experiences this would bring to people.

Often, the short-term 'project' focus, rather than longer-term 'maintenance' of funding puts many services at risk of closure or services become increasingly reliant on volunteer support. This is further compounded by problems with recruitment and retention of staff in rural areas. Among health service professionals, this issue is linked to maintaining a lifestyle, among care providers, it is because of being unable to reconcile the cost of fuel travelling between patients. This highlights inequalities within the health services sector itself.

Inequalities also exist within rural areas depending on where services are located.

There are inequalities between those who can, and those who cannot, pay for private healthcare provision, between those who can, and those who cannot drive, and between locations with, and locations without, regular alternative transport.

The challenge of accessing and using services is not only about the physical means of transportation, but the mental energy needed to organise travel and endure long journeys.

An urban-centric mindset among some health care providers and commissioners often contributes to a lack of understanding of these complications and a failure to appreciate that lack of adherence to treatment and missed appointments are not through choice. The perception of feeling abandoned further inhibits a desire to seek help. This can lead to the need for more urgent and costly care.

People welcomed the sense of community and social support, which some thought was specifically 'a rural effect' and was considered an asset.

This 'rural effect' was thought to address issues of isolation and loneliness and provided an unofficial eye where formal health service provision had been withdrawn. Building on community assets would improve access to health services. Organising services locally in community hubs would address the distance-transport challenge. It would also re-align care around patients rather than health care professionals' needs. Although digital health could improve service access in rural areas not everyone was supportive of this and connectivity and poor signal remained a barrier.

Whilst some of the issues raised relate to general health service provision, affecting urban as well as rural areas, the lack of alternatives and the impact of distance exacerbates the rural effect of health inequalities.

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- Dr. Sarah Baker, Institute for Health and Care Improvement, York St John University
- Dr. Beverley Searle, Institute for Social Justice, York St John University

Appendices

Appendix 1

Table A: Survey participants

Characteristics	N	%
Age (min =24; max = 90+)		
24-34	9	4%
34-44	14	7%
45-54	32	16%
55-64	63	31%
65-74	54	27%
75+	31	15%
	203	100%
Gender		
Male	41	19%
Female	151	69%
NA	28	13%
	220	100%
Sexual orientation		
Hetrosexual	183	79%
LGBTQ+	14	6%
Not applicable / prefer not to say	34	15%
	231	100%
Ethnicity		
White	199	99%
Non-white or mixed	3	1%
	202	100%

Education		
None or not known / not applicable	31	13%
Primary (left before/at 11)	2	1%
Secondary/high school (left after 16)	36	16%
Post-secondary vocational/technical	48	21%
University (1st Degree)	60	26%
Post-graduate (2nd or further degree)	53	23%
Growing up	1	0.4%
	231	100%
Employment		
Self-employed	12	6%
Employed full-time	44	22%
Employed part-time	47	24%
Retired	79	40%
Unemployed (including unable to work)	8	4%
Family care	3	2%
Volunteering	7	4%
	200	100%

Income		
0-24,999	59	31%
25-39,999	52	28%
40-59,999	41	22%
60-89,999	25	13%
90,000 +	11	6%
	188	100%
Tenure		
Owned-outright	125	63%
Owned with mortgage	45	23%
Private rent	21	11%
Social rent	9	5%
	200	100%
Household		
I live on my own	48	24%
Spouse	122	60%
Spouse + children	13	6%
Children	14	7%
Parents/In-law	4	2%
Lodger / non-family members	2	1%
	203	100%

Table B: Focus group participants

Focus Groups	Number of participants	Participant characteristics
In-person		
Craven (Settle)	4	Male (60 yrs) - Community support officer Male (52 yrs) - User Female (65 yrs) - User Female (39 yrs) - Health professional
Hambleton (Bedale)	4	Male (83 yrs) - Spent decades involved in local voluntary-led community bus services Male (84 yrs) – North Yorkshire Council councillor Male (84 yrs) - Parish councillor Female (37 yrs) - Community support worker
Harrogate (Patley Bridge)	2	Female (76 yrs) - Part-time support worker Female (68 yrs) - Community volunteer
Richmondshire (Hawes)	3	Female (68 yrs) - User Female (56 yrs) - Councillor Female (late 50s) - Community support officer
Ryedale (Weaverthorpe)	4	Male (70+ yrs) Female (67 years) Female (70+) Female (71)

Scarborough (Botton Village)	4	Female (33 yrs) Male (29 yrs) Male (40 yrs) Male (57 yrs)
Selby (Tadcaster)	7	Female (81 yrs) Female (75 yrs) Male (81 yrs) Male (67 yrs) Female (63 yrs) Female (64 yrs) Female (78 yrs)
Online: (one telephone interview)		
	3	Health professionals

Appendix 2:

What 'rurality' means in terms of health inequalities

A personal story:

"I believe that living in a rural area, especially here, means we are second-class citizens when it comes to the provision of healthcare."

"My experiences of local healthcare is very poor - in respect of our immediate locality. Our GP Practice is still not open following COVID-19 and it is almost impossible to get an appointment to see a GP. If you need the help of a GP, you must phone between 8.30-9.00 am in the morning. That is extremely difficult for anyone working, especially as the line is almost permanently engaged. However, if you are fortunate enough to get through, you then have to explain to an unqualified receptionist what you think is wrong with you and why you think you justify having an appointment. I feel this is absolutely inappropriate!

I trained as a medical receptionist many years ago, and one thing we were told very forcefully was that we must never make a clinical judgement as we were not qualified to do so. This no longer appears to be the case as it is the receptionists who are deciding, from a few words the patient provides, as to whether they deem it appropriate to offer an emergency appointment with a GP!! This is a very dangerous practice!

Anyway, if you pass this first hurdle, then you are put on the list for a call back by a medical professional (not always a GP). That call can be at any time and they will only try three times before striking you off the list for the day!! If you are working or relying on a mobile signal in this very rural area, or indeed working from home where the phone is very busy, this is almost impossible, so you end up back at square one for the next day!

Let's assume you pass that test though and you have received a call where you can explain what you think is wrong with you. At that point, you will then be told if you can actually go to the surgery to see a real medical professional! Sometimes, there can be a wait of up to two weeks, for both the phone consult or the physical appointment!

This is just not a service and in such a deeply rural area, where we are miles from any other form of healthcare (a drop-in clinic or an urgent treatment centre) it is completely unacceptable.

Patients are terrified as they cannot seek reassurance and I have been made aware of people who have actually died for lack of medical care! The population here has a high proportion of elderly people and it is often not possible for them to access services elsewhere.

Indeed, I am now unable to drive and there is limited public transport so without the help of friends I would be unable to get to any other form of healthcare service.

I hope you can see therefore why I have decided to omit the local practice from my healthcare options as it is so difficult to be seen. Despite the 40-mile trip to the nearest urgent treatment centre. I know that I will be seen when I get there, even if I have to wait. This used to be the case at our local practice where an open surgery operated every morning until COVID-19. I can see no logical reason for this not returning now and am horrified that every time I have been to the surgery (usually to collect medication) the place is deserted! I presume the practice is still receiving government funding for every patient on their list and yet those patients are not actually receiving any form of service from the GP practice. This is criminal and extremely dangerous!

Aside from that, there are numerous healthcare services that used to be provided at the GP practice which are no longer offered (eg chiropody, physio, ear syringing etc). For many, particularly the elderly, it is almost impossible to seek these services elsewhere, but if they can, there is usually a very long waiting list - or the suggestion to pay privately! This is also not good enough!

I don't doubt that the idea of 'centres of excellence' works brilliantly in an urban area, but in a rural area, this is just not practical. We need excellent healthcare services, but closer to home.

Our nearest trauma centre is about 70 miles away and our nearest A&E is around 40 miles away, as is our nearest urgent treatment centre. This is fine, assuming you are

able to drive, have access to a car and are actually well enough to drive it - and that is not taking into account the difficulties we experience with weather in this area!

For a good part of the year, most people would not relish the thought of any of these journeys, and indeed many would not even contemplate it at night at any time of year!

In short, I believe that living in a rural area, especially here, means we are second-class citizens when it comes to the provision of healthcare. I was recently told I lived too far away from the hospital to access the volunteer car service which is potentially my only option to get to a hospital now that I can no longer drive.

Where does that leave me?!"

A North Yorkshire resident

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