Impact of an Ageing Population on Service Design and Delivery in Rural Areas

Qualitative Research

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Executive Summary

TNS BMRB and ILC-UK were commissioned by Defra to provide qualitative research on the impact of older populations on services in rural areas, demonstrate how services need to be tailored to meet the present and future needs of the rural ageing population and to develop an evidence base which supports proactive tailoring of services in these areas to meet current and future needs. Research focused on services related to housing, health and transport – key issues with significant impact on everyday life for older rural service users.

The qualitative research presented is one part of an iterative multistage research programme conducted by TNS BMRB and ILC-UK. The research was carried out between April and July 2013, and included 41 depth interviews with service users and 25 depth interviews with designers and deliverers of services provided in rural areas.1 Key findings are summarised as follows.

How is need understood by service users?

Service users in the sample did not strongly voice unmet needs in terms of the provision of public services and the implications of ageing on service need - linked to a variety of barriers in voicing current need or considering future challenges: e.g., not wanting to be a ‘burden’ on others; wider fear around acknowledging needs the consequence of these; low expectations and awareness of public service delivery; and an initial reliance on informal networks for support. Lack of forward planning can result in presentation to services only at critical moments, complicating service designers and deliverers’ ability to plan for and respond to user needs.

In response to this, service designers and deliverers typically recognised a need to proactively plan for ageing populations in their areas, although how these needs were identified and understood varied significantly across the sample. At one end of the spectrum, some had begun county-level research and needs-mapping of older populations and were developing targeted and holistic strategies to meet the challenges identified. Others were only at the beginning of understanding older users’ need and adjusting and tailoring services accordingly.2

General challenges for service delivery

1 To note: The findings detailed here are from the qualitative primary research includes respondents from rural areas only. As the research did not include an urban comparison sample, findings may not be specific to rural context exclusively. In the full report, the qualitative research findings have been cross referenced against national statistical profiles included in the evidence and policy assessment which did include a rural-urban comparison, and those that are referenced were relevant to frame the findings.

2 Further detail of targeted planning for service design and delivery for older users in rural areas can be found in the ILC-UK Policy Review conducted as part of this overarching research project.
The research highlighted a range of general challenges posed for service design and delivery for rural based older populations that cut across the three service areas. Common challenges were generally related to lower population density impeding economies of scale, and general cost of distance in terms of increasing travel and other service delivery costs. These challenges were exacerbated by the significant preference of older rural residents to age in their own homes and communities and therefore to have services available for them in these areas.

These general challenges outlined were intensified by range of secondary barriers to meeting the needs of service users. These included:

- diminishing funding resource and general financial pressures;
- a perception that government funding models and process of bidding for contracts were not adapted to the needs of rural services;
- the difficulties of maintaining diverse communities in rural areas in order to supply the delivery of service provision to older service users;
- dealing with the diversity of older populations and the subsequent fragmentation of demand in these communities; and
- barriers around efficient online service delivery due to the limitations computer literacy or limited broadband access in rural areas.

The subsequent sections below explore the challenges and implications for the three service areas – housing, transport and health – in more detail.

**Housing**

A strong preference was expressed by the service users to stay in their homes for as long as possible with appropriate care and support when required. Therefore the need for rural housing that supports both independent living for older residents and the provision of home-based care and support as required is likely to increase significantly as the size of this population grows.

However this research identified a number of issues affecting older people’s ability to age in their own homes or within their local area and move to more appropriate housing. These issues were around:

- limited awareness or take-up of home adaptation and maintenance services to help residents to remain in their homes safely;
- minimal availability and integration of personal and social care services provided in-home; and
- the lack of an appropriate range of housing stock.

The challenges of meeting these housing and social care needs tended to be very fragmented but where successful were achieved by a employing a range of principles that enabled users to maintain independence and engaged users in efforts to overcome the barriers to service take up. However as gaps in this area persist – and may exacerbate as the population ages further – the demand for in-home care and appropriate housing stock
will increase. Therefore the need for integration and coordination between the two will be needed.

**Transport**

Unsurprisingly, transport accessibility was critical issue with complex implications for social isolation and health service access. Service users were typically reliant on private transport until forced to give up their licences, usually due to health issues, and expressed a strong desire to maintain their independence in this way for as long as possible. However this initial reliance on personal transport had a knock on effect on the take up of public transport services, reducing their efficiency and sustainability and ultimately raising barriers around keeping these services running for users’ eventual needs.

In terms of bus services in particular, there were a number of challenges raised matching provision to service users’ needs in relation to routes and timetabling – linked to the aforementioned issues around population density and service efficiency. Additionally, it was broadly felt that bus services were often inadequate to ensure access to health services. There was evidence of informal private transport arrangements and services provided to fill this gap; however, there were a range of barriers to take-up linked to low awareness, a reluctance to ask for help from ‘strangers’, and then need to overcome entrenched habits in transport use.

Proactive signposting and other communications are required to increase service user’s awareness of alternative transport options. In the long term, there is a need for joined up transport planning with overall community planning to ensure accessibility for service users and prevent social isolation and related vulnerability.

**Health**

Health service providers noted a strain on services regarding older rural users presenting to them only at times of critical need. Access to health services for those who did not have private transport was also a key issue, resulting in the need for resource-heavy and costly home visits.

Providers were meeting the challenges of rural health service provision within the broader health policy context. This was mainly around decentralising health services and opening services for self-referral to eliminate the need for initial GP visits, promoting preventative approaches, and trying to integrate services across organisational boundaries to meet needs more efficiently.

Other key challenges in health service delivery and design remained in terms of ensuring accessibility for all older rural service users. Services were considered to be fractured and fragmented, with poor interworking between health and social care services. The funding and sustainability of in home care was also questioned by providers who were increasingly looking to the voluntary sector to provide services where there were gaps, in response to funding cuts. However it was noted that this may not resolve the situation and meet need
as these organisations would also suffer from the same barriers around economies of scale.

**Principles of Good Practice**

This research identified a range of good practice principles, including accessibility; identification; sustainability; responsiveness; encouragement of engagement and behaviour change; and promotion of independence; community involvement and engagement; partnership and joined up working; and taking a user-focused approach.

These are largely consonant with local level rural proofing principles of good practice, although there is no specific principle relating to ‘responsiveness.’ Given that this research suggests that the older rural population is likely to delay contact with services until critical moments of need, it is suggested that this may be an additional good practice principle important to consider for this group.

**Recommendations**

- Greater levels of **explicit needs mapping** and **targeted plans** for older users are required. This is required at both the district/regional level and at the service delivery level. Specifically, greater **matching** and **tailoring** of transport services is needed in terms of routes, timetabling and home pick-ups, and supporting the safe use of private transport for as long as possible.
- Service providers need to undertake **proactive identification** and **engagement** to address the barriers older service users have in articulating current and planning for future needs.
- Service providers should be alert to the tendency for older service users to present to services at critical moments while also focusing on preventative services. In addition to services that cater to crises and provide **urgent response**, service providers must undertake **holistic assessment, engagement, referral** and **signposting** for other vulnerabilities that are not otherwise likely to be picked up—this must include assessment and referral within and between services and sectors and is particularly important in the health domain.
- Providers must enhance the **integration** and **co-ordination** of services – health, social care and services provided in-home need to pay particular attention to integration and co-ordination within and between services and sectors.
- Increased levels of appropriate **housing stock** to support independent living is required, as is enhanced **availability and utilisation** of home based care and support.
- Strategies to maintain **diverse rural** populations are critical, particularly in terms of maintaining appropriate levels of workers (e.g. formal carers), volunteers and informal carers required within communities to meet the needs of older residents.

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- Local level communications should be initiated to increase user's awareness of social care and transport options available, and to overcome barriers to use of various services.
- As financial constraints are also likely to increase rather than lessen, creative solutions to service funding and efficient delivery must be explored to moderate the challenges of lower population density and the cost of distance. This is extremely important for social, personal and home based care.
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Chapter 1 - Introduction

TNS BMRB and ILC-UK were commissioned by Defra to provide qualitative research on the impact of older populations on services in rural areas and to develop an evidence base which supports proactive tailoring of services in these areas to meet current and future needs.

The qualitative research presented herein is one part of an iterative multistage research programme conducted by TNS BMRB and ILC-UK. The research was carried out between April and July 2013, and included 41 depth interviews with service users and 25 depth interviews with service designers and deliverers in rural areas.

The following section provides a background and context to the research, detailing its aims and objectives, and the approach taken to research.

1.1 Research background

Rural England is changing. Rural populations are ageing proportionately faster than urban ones, in part because of a tide of urban-to-rural migration among older people that is unlikely to wane (The Rural Media Company, Accessed 2012). A recent report by the Commission for Rural Communities highlighted this trend, pointing out that 23% of the rural population are over retirement age compared to 18% in urban areas (2012). It is evident that societal and systemic changes are required to respond to this growing challenge. In order to do so effectively – and to tailor service design and delivery to the challenge at hand – understanding is needed of not merely the demands raised by this growing cohort but also the impact this will have on service design and delivery.

In some cases, older populations in rural areas may be better equipped to face the challenges of aging than their urban counterparts. Recent research by ILC-UK (2011) has shown that, overall, older people in areas with lower population density – a proxy for the Office of National Statistics urban-rural classifications – were more advantaged; had a higher income; were more likely to be living in owner occupied housing; had higher level qualifications and had better self-rated health.

However, the evidence also clearly demonstrates there are substantial pockets of deprivation in rural areas generally, and among older residents specifically. For example, while older people in rural areas are healthier than those in urban areas, the gap narrows significantly when comparing older people in the poorest income quintile in rural and urban areas, and when comparing the oldest old (Cabinet Office, Social
Exclusion Taskforce 2009). In addition, older people in rural areas face specific challenges with regard to accessing transport, health and social care services and local amenities. Many older people are not just physically isolated in their rural localities, they are also isolated from services and support, hidden away from the gaze of commissioners and planners. The consequence of these difficulties, if left unchecked, is a higher likelihood of social isolation and other associated problems (Commission for Rural Communities 2012).

The preceding Government’s ageing strategy, led by the DWP, produced two ageing strategies and a housing strategy. Published alongside these, the Social Exclusion Task Force and Defra produced a report which considered some of the challenges older people face in rural communities and highlighted innovative solutions in an attempt to inspire and inform providers, commissioners of services and the voluntary sector.

The current Government has been keen to highlight its commitment to rural communities, alongside actions to reduce spending. In their Rural Statement in 2012 it was acknowledged that sustainable local solutions were required to address the fact that older people and other vulnerable members of the community may suffer most from the increased cost of living and the loss of local services. One such commitment included taking forward the legacy and learning from the Ageing Well programme to support local authorities to improve their design and delivery of services for older people. Furthermore, the Open Public Services agenda sets the Government’s intention “to make sure that everyone has access to the best possible public services, and that the best become better still.” As part of meeting this aim, Government requires an understanding of the demands placed upon public services by an ageing population.

For Defra, this translates as a specific need to understand the impact of older populations on services in rural areas and to develop an evidence base which supports proactive tailoring of services in these areas to meet current and future needs.

This qualitative research presents part of a package of work, commissioned by Defra and conducted by TNS BMRB and ILC-UK, to respond to this need. This includes a multi-staged, iterative research programme including: an evidence and policy review; qualitative research with older rural service users as well as rural service designers and deliverers; good practice case studies; and a Learning Lab with relevant stakeholders.

This report presents the findings from the qualitative primary research, which includes respondents from rural areas only. As research did not include an urban comparison sample, issues raised herein may not be specific to rural context exclusively. Findings have been cross referenced against national statistical profiles included in the evidence and policy assessment – which did include a rural/urban comparison – and these are referenced where relevant to frame the findings.

The specific aims and objectives of this work are discussed as follows.

1.2 Objectives and aims

This research aimed to:
Understand the impact of an older and ageing population in rural areas on service demand and delivery
Demonstrate where and how the design and delivery of key services need to be tailored to meet the present and future needs of an ageing rural population
Identify any underlying principles of good practice in designing and delivering key services to an older population

Underpinning these broad aims the qualitative research specifically sought to answer:

What effects do an older population have on the demand for key services in rural areas?
What are the implications of an older and ageing rural population for service design and delivery?
How are service designers and deliverers addressing issues relating to an older and ageing rural population?
What barriers and challenges to successfully meeting the needs of an older and ageing rural population exist from the service delivery perspective?
What barriers and challenges are experienced by older service users?
How do needs and experiences differ between different age groups of the older population, including comparisons between those of working (aged 50+) and retirement age?

The research also sought to identify a range of good practice case studies, the aim of illustrating lessons from successful and unsuccessful service delivery for an older and ageing rural population. These good practice case studies were matched to the underlying principles of good practice identified by Defra’s Local Level Rural Proofing project where examples of good practice from rural service designers and practitioners were compiled.4

1.3 Research approach

In-depth interviews were conducted with 41 older rural residents and 25 designers and/or deliverers of rural services. A depth interview approach was utilised for both groups in order to:

- probe on older service users’ context, attitudes and behaviour around service use in depth;
- engage a wide range of service users as well as designers and deliverers of service; and
- provide a flexible and convenient option for research participation for respondents.

Interviews with older service users were conducted face-to-face in their homes to aid rapport building and the understanding of respondents’ individual circumstance and

rural context. Service designers and deliverers were interviewed by telephone to provide maximum scheduling flexibility and convenience for busy professionals.

Fieldwork was conducted between May and July 2013, with iterative phasing between service user research (May 2013) and interviews with designers and deliverers (June and July 2013). Key challenges and context from service user research informed the topic coverage and areas of questioning for designers and deliverers, in order to understand how key challenges for older populations were being met, and to help identify any gaps between service user needs and service provision.

The research sample, location selection, recruitment approach, discussion coverage and analysis approach are detailed as follows.

1.3.1 Sample

To ensure diversity of coverage across key variables of interest, purposive sampling using a maximum variation approach was undertaken. The aim of this approach is not to create a statistically representative sample but to ensure representation of a range of potential variables of interest.

Working in conjunction with Defra key variables were selected, a sampling grid was created and individuals recruited to reflect combinations of the key variables (e.g., age, settlement type and district for service users; and a range of service areas and operational levels for designers and deliverers). The specifics of both segments of the sample are illustrated below.

Service users

In-depth interviews were conducted with service users living in seven English areas including areas of rurality and an urban authority with a minority rural population—South Northamptonshire, North Norfolk, Rother, West Devon, Herefordshire, Oldham and Craven.

Interviews were conducted across a mix of settlement types and age ranges, as detailed in Table 1. The service users sample also ensured that respondents included a mix of gender, income, housing type, health status, mobility level, connection to the internet and typical mode of transport (see Appendix A2.1 for details).

Table 1. Face-to-face in-depth interviews with service users – settlement types by age

<table>
<thead>
<tr>
<th>Age</th>
<th>Settlement Types</th>
<th>Town and Fringe</th>
<th>Village, Hamlet &amp; Isolated Dwellings</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Sparse</td>
<td>Less Sparse</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sparse</td>
<td>Less Sparse</td>
<td></td>
</tr>
</tbody>
</table>

5 Oldham only
6 Full details of location selection are found in Section 1.3.2.
Service designers and deliverers

Interviews were conducted amongst a wide variety of public, private and third-sector designers and deliverers of services in the districts of Craven, Herefordshire and North Norfolk. The sample focused on providers of services in transport, health and housing, as well as individuals with a role in overall strategic planning for older users in these areas (e.g., county-level planners).

Across the sample of 25; 11 interviews were conducted with people working in both design and delivery, one interview was conducted with a service designer and 13 interviews with those working in service delivery. Within this sample included were 9 government representatives (representing county, district and parish authorities), as detailed in Table 2. Tables 3 outlines the sample coverage of the 21 respondents with a policy area specialism across the districts (generalists are excluded).

Sample profile, excluding interviews detailed in Table 2, can be found in Appendix A2.2

Table 2. Telephone in-depth interviews with service designers and deliverers within County, District and Parish Councils

<table>
<thead>
<tr>
<th>Int No.</th>
<th>Government</th>
<th>Policy Area</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>County</td>
<td>Health</td>
<td>North Norfolk</td>
</tr>
<tr>
<td>2</td>
<td>County</td>
<td>Transport</td>
<td>Craven</td>
</tr>
<tr>
<td>3</td>
<td>Unitary Authority</td>
<td>Health</td>
<td>Herefordshire</td>
</tr>
<tr>
<td>4</td>
<td>Unitary Authority</td>
<td>Transport</td>
<td>Herefordshire</td>
</tr>
<tr>
<td>5</td>
<td>District</td>
<td>Generalist</td>
<td>North Norfolk</td>
</tr>
<tr>
<td>6</td>
<td>District</td>
<td>Housing</td>
<td>Craven</td>
</tr>
<tr>
<td>7</td>
<td>Parish</td>
<td>Generalist</td>
<td>Craven</td>
</tr>
<tr>
<td>8</td>
<td>Parish</td>
<td>Generalist</td>
<td>Herefordshire</td>
</tr>
<tr>
<td>9</td>
<td>Parish</td>
<td>Generalist</td>
<td>North Norfolk</td>
</tr>
</tbody>
</table>

Table 3. Telephone in-depth interviews with service designers and deliverers by district and policy area (excluding generalists)

<table>
<thead>
<tr>
<th>District</th>
<th>Interview Count</th>
<th>Policy Area</th>
<th>Interview Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Norfolk</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Craven</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Herefordshire</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>38</td>
<td></td>
<td>41</td>
</tr>
</tbody>
</table>
1.3.2 Locations

Service users

Fieldwork for the service users sample was conducted in seven districts of England:

- South Northamptonshire
- North Norfolk
- Rother
- West Devon
- Herefordshire
- Oldham
- Craven

Within these Districts, Office for National Statistics (ONS) Middle Layer Super Output Areas (MSOAs)\(^7\) with the following settlement types were used as the sampling unit:

- Town and Fringe (TF) - Less Sparse
- Town and Fringe (TF) - Sparse
- Village, Hamlet & Isolated Dwellings (VHID) - Less Sparse
- Village, Hamlet & Isolated Dwellings (VHID) - Sparse

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\(^7\) For further information on Middle Layer Super Output Areas see the ONS website:
ONS MSOAs were linked with postcodes to further target appropriate areas within which to recruit.

Appendix A2.3 provides a detailed profile of each district. Overall, the selection of these districts facilitated representation of:

- Seven (7) governmental areas: East Midlands; East of England; North West; South East; South West; West Midlands; and Yorkshire and the Humber.
- Four (4) uplands districts, with percentage of the district classified of upland ranging from 13% to 98%.
- One (1) unitary authority, five (5) non-metropolitan counties and one (1) metropolitan county.
- Four (4) Rural-80, two (2) Rural-50 and a major urban area.
- A range of deprivation ranks, with two (2) areas having high deprivation scores and two (2) with low deprivation scores.
- Representation across the age groups of interest, as well as areas that have significant ageing populations compared to the national mean.

**Service designers and deliverers**

Given the iterative nature of the research the location selection for the service designers and deliverers sample occurred following initial analysis of the users sample and took into consideration several options for how to appropriately include the districts within the 25 interviews. The options considered for this sample were:

1. To include all seven areas to ensure broad coverage but limited depth.
2. Focus on one area to facilitate in-depth analysis in a ‘case study’ approach.
3. To provide coverage of a small number of areas, allowing for some variation in the areas covered and identifying common patterns that cut across all.

Following consultation with Defra the third approach was agreed upon and three districts selected.

Taking into account the initial users analysis that suggested sparsity is critical to how people experience services – in conjunction with demographic and rural characteristics – Craven, Herefordshire and North Norfolk were selected for this phase of the research. Table 4, overleaf, provides district profiles and the rationale for the selected areas. Further profiling information can be found in Appendix A2.3.

**Table 4.** Telephone in-depth interviews with service designers and deliverers by district and policy area

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8 Only MSOAs that fell within the rural settlement types were utilised.
<table>
<thead>
<tr>
<th>District</th>
<th>Admin Geography</th>
<th>Classification</th>
<th>Upland (% of district)</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Norfolk</td>
<td>Non-metropolitan district</td>
<td>R80</td>
<td>No</td>
<td>• Diversity of settlement types, including sparse areas</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Very high proportion of ageing population compared to UK mean.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Mid to low deprivation rank</td>
</tr>
<tr>
<td>Herefordshire</td>
<td>Unitary Authority</td>
<td>R50</td>
<td>Yes (13%)</td>
<td>• Diversity of settlement types, including sparse areas</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Allows for inclusion of a Unitary Authority</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• A small proportion designated as uplands</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Mid deprivation scores</td>
</tr>
<tr>
<td>Craven</td>
<td>Non-metropolitan district</td>
<td>R80</td>
<td>Yes (98%)</td>
<td>• Primarily upland area</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Includes sparse areas</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Good representation of the age groups of interest</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Higher deprivation rank. Ranked 241 out of 326</td>
</tr>
</tbody>
</table>

1.3.3 Recruitment

Recruitment was managed by TNS BMRB’s in-house team of qualitative recruitment specialists. Recruiters for the service users sample used a combination of free-find (e.g., door knocking, on-street recruitment) and ‘snowballing’, whereby respondents were asked if they knew anyone who might be eligible for the difficult-to-recruit groups.

To recruit the service designers and deliverers sample TNS BMRB initially approached participants via email to introduce the research and our status as an independent, impartial research company working on behalf of Defra. Telephone contact was then made to confirm interest in the research and to set a date and time for interview.

Eligibility for participation was determined via a short screening questionnaire and quotas were set to ensure the sample was distributed across key variables. Approach letters and screening questionnaires were approved by Defra prior to use.

Service users were offered a £30 incentive to facilitate recruitment and as a thank you for their contribution. Although most service designers and deliverers participated gratis an incentive (£70) was offered to some harder to recruit audiences (e.g., GPs).

1.3.4 Discussion coverage

Semi-structured discussion guides were developed for use in all interviews to ensure consistency of topic coverage. The use of semi-structured guides allows participants to dictate the flow of discussions with guidance from the moderator, rather than the questions being administered in the question/response format. Guides were used flexibly and responsively by experienced research moderators.

Separate guides were prepared for sessions with service users and service designers and deliverers and approved by Defra prior to use. Broad topic coverage is indicated in Table 5 (overleaf) and full guides are included in Appendix 3.
A wide variety of services could be explored in relation to ageing in rural communities. This research focuses specifically on transport, housing and health. These service areas were chosen, in consultation with Defra and informed by the evidence review, as they were deemed most impactful on day-to-day life for the majority of older people living in rural communities as compared to, for example, issues such as end of life care which are less immediately pressing for the general older population.
<table>
<thead>
<tr>
<th>Service users</th>
<th>Service designers and deliverers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction</strong></td>
<td></td>
</tr>
<tr>
<td>A typical week; good and bad about where they live; what’s important in their life</td>
<td>Their job role and main aims (probe regarding older population)</td>
</tr>
<tr>
<td></td>
<td>Their locality – challenges, contextual factors, opportunities</td>
</tr>
<tr>
<td><strong>Mapping services</strong></td>
<td></td>
</tr>
<tr>
<td>What local services they use in day to day life - refer to typical month and probe key services, and services they would like to use but can’t / don’t, why?</td>
<td>Map out the service they design / deliver (probe specifically for older population)</td>
</tr>
<tr>
<td><strong>Usage and need</strong></td>
<td></td>
</tr>
<tr>
<td>Taking each service in turn – transport, health and housing - exploring needs, what is most important about that service, Whether meeting needs and how / why could be improved</td>
<td>Their understanding of the needs of their rural older population. Actions to meet needs (including future). View on how well needs are addressed</td>
</tr>
<tr>
<td><strong>Experiences – good and bad practice</strong></td>
<td></td>
</tr>
<tr>
<td>Describe a recent experience of each service. Good and bad – what made it good or bad, what could have been improved, why? Probe- anything specific to rural location?</td>
<td>Evidence of good or bad practice – specific examples of projects that have worked well to meet the needs of an older population</td>
</tr>
<tr>
<td><strong>Barriers and challenges</strong></td>
<td></td>
</tr>
<tr>
<td>What currently prevents their use of services and why / how could be overcome.</td>
<td>Challenges of providing services to an older rural population</td>
</tr>
<tr>
<td>Probe- anything specific to rural location?</td>
<td></td>
</tr>
<tr>
<td><strong>Expectations</strong></td>
<td></td>
</tr>
<tr>
<td>Explore expectations of ‘good services’</td>
<td>Reflection on experiences and needs of service users</td>
</tr>
</tbody>
</table>

**1.3.5 Analysis Approach**

TNS-BMRB’s qualitative analytical approach is inductive – building upwards from the views of respondents – and drawing on researcher observation, in-session notes, audio recordings of research sessions, and interview transcripts. Interviewers initially reviewed transcripts for key themes and patterns. Ideas and hypotheses were then tabled and debated by the qualitative project team at an internal analysis workshop. The data was then synthesised into a series of thematic charts. Researchers then interrogated the data using a content analysis approach called ‘Matrix Mapping’ which allows researchers to map the data and draw out key themes and patterns.
Chapter 2 - How is need understood?

This section explores how service users and designers identify and articulate the needs of older residents in rural areas. Research suggests that service users themselves have a variety of barriers around voicing current need or considering future challenges – which can result in presentation to services only at critical moments, and can complicate service designers and deliverers’ ability to plan for and respond to user needs. Although this may not be a unique feature of rural older service users – and may be a more general characteristic of some older groups - it provides important context in terms of how the older rural residents in this research spoke about and planned for service use.

Although service designers and deliverers typically recognised a need to plan for ageing populations in their areas, how these needs were identified and understood varied significantly across the sample. At one end of the spectrum, some had begun county-level research and needs-mapping of older populations and were developing targeted and holistic strategies to meet the challenges identified. Others were only at the beginning of understanding older users’ need and adjusting and tailoring services accordingly.

2.1 Service users

Overall, older service users in this sample typically did not name and identify many unmet needs in terms of public services – either currently or in terms thinking forward to support they might need as they aged within their rural communities. This was in part due to positive experiences overall with services provided, and due to the fact that many of the younger and/or healthier respondents in the sample felt they were ‘getting on well’ at present.

"I'm at a stage in life where I've got plenty of time and I'm quite independent and able to do things for myself, so I don't feel terribly dependent on public services."  
(68, Female, TF Less Sparse, Oldham)

However, this research also suggests that a variety of barriers exist to older service users identifying and expressing need around public services, and to planning ahead for future need. Whilst this research cannot conclusively determine whether this tendency is unique to rural users specifically (given the nature of the sample), it is important to
take into consideration for the research as a whole. These barriers underpin service users’ discussions and their demand and use of services.

**Barriers to identifying and planning for need**

The range of barriers noted by this research included:

- An attitude of ‘making’ do with what they have and not asking for more
- Not wanting to be a ‘burden’ on others
- Fear of admitting their need and denial about the implications of ageing
- Low expectations of services and a feeling of personal responsibility for their location choice
- Limited awareness of relevant services in the local area
- A tendency for initial reliance on the community for support
- Fear of external action being taken if they do express a need

We discuss each of these barriers and the implications of these as follows.

Many service users in this research expressed – explicitly or implicitly – a ‘making do’ attitude with existing services and a discomfort around finding out what they might be entitled to. Some respondents noted that they had always ‘just got on with it’ rather than complaining or ‘needing help’. This was particularly amongst the oldest age groups in the sample (e.g., 80+). At times linked to this barrier was respondents’ desire not to impose a burden upon others – at a personal level or as a ‘representative’ of the ageing population. Respondents noted that they were reluctant to seek out help and ‘bother’ others, or commented that they were aware that the ageing population as a whole was placing a strain on the country’s finances and public services.

"If I can do something I will do it, I don't depend on other people to help me...." (88, Female, TF Sparse, West Devon)

"It's that they don't want to be a burden on anyone so they might not see people for four or five days unless they've got a neighbour who checks on them and everything. And you've got families who are living further afield... we're a great British nation of a stiff upper lip and I don't need any help." (Herefordshire, Voluntary, Transport)

This limited future planning around demand for services by users was underpinned by a wider fear of considering need either currently or for the future. Service users generally found it uncomfortable to view themselves as potentially vulnerable as they aged. This mind-set was particularly strong among the ‘younger’ older service users interviewed (in their 50s and 60s); they tended to discuss need for services around aging in the context of taking care of elderly parents rather than in terms of what they might themselves need in times to come. Thinking ahead was reported as ‘unnecessary’ or ‘too hard to think about’ to worry about now. This reluctance to plan for
future need was evident in older age groups too – even when respondents were clearly vulnerable in terms of health (e.g., for those with worsening mobility issues) or social isolation (e.g., with no plans for how to cope when their partner or only family member passed away).

"The point is if I hadn't got a car and I hadn't got any neighbours to take me about, well I would be lost you see so that is the difference......I don't know what would happen. I hate to think about it." (89, Male, VHID Less Sparse, Herefordshire)

"It's difficult to say really, because if you haven't needed it yet. ...you're not quite sure what you'll need in the future." (92, Female, TF Sparse, North Norfolk)

In relation to these attitudes, was also a strong sense from many that they should not expect a lot in terms of service provision in rural areas. Reduced services were seen as a consequence of rural living. Service users noted that they had settled in their area with this knowledge, feeling that they had made the active choice to either remain in or move to a rural area and therefore could not complain. The general view was often that their personal attachment to the local area and appreciation of the rural lifestyle outweighed the drawbacks of living in an area sparsely populated with services.

"I think a lot of people who live in places like this accept it, because it's what it is do you know what I mean? You don't expect to live somewhere like this and have a number 57 going past your door every day, so I think if you move somewhere like this or you live somewhere like this you know what to expect " (56, Female, VHID Less Sparse, Craven)

Additionally, there was a sense that rural residents should rely initially on the community for support - asking for informal help from friends, family and neighbours rather than assistance from more formal support sources. This feeling was strongest amongst those who had lived in the area for a long time – many had grown up in the area or moved there as a young adult or family – and valued the ‘community spirit’ that they felt was part and parcel of rural living. Other users who had moved to the area more recently, typically upon retirement, were less likely to consider the local community as a source of potential support and assistance in times of need.

"We are a very close community and we keep an eye on each other whereas I've got two daughters who live in Central London and they hardly know the next door neighbour but I know everybody who lives down my lane and if there is anything wrong, we know about it, and that's the difference. We are very lucky. That might not be the case if you were isolated, you know, miles from here up in the hills..." (89, Male, VHID Less Sparse, Herefordshire)

However, some services users reported that the sense of community in rural areas is not as strong as it had been in the past. This was attributed to both the influx of urban retirees to the areas who were not familiar with the more ‘rural’ community way of life and (in respondents’ view) the decline of local services such as local libraries and post offices. If this decline continues, the potential for widespread social isolation is that
these communities could become more likely as the opportunities lessen for more elderly residents to interact with each other in communal spaces.

"I mean years ago, families took care of it. You know, if you had an old mum or an old dad, you took care of them. You didn’t think about public services, you know what I mean? You made sure that your mum and dad were okay, that kind of thing. And friends and family took care of it. That isn’t how it works now." (75, Female, VHID Sparse, North Norfolk)

Across the sample, there was also often limited awareness of services available - compounded by a belief that services were typically very complicated to identify or navigate. When probed, service users expressed an interest to know more about the variety of existing local services that they could be entitled to use and for these to be easier to identify. It was felt by some that this was becoming increasingly difficult at the moment as more services have moved their marketing and access points online. This exacerbated a sense of distance from services by the users as many had limited internet access and/or confidence to use it.

"I think the other thing you need is there’s got to be communication of what is available and how to access it because this is the one thing that I have found – you don’t know until things happen." (67, Female, TF Less Sparse, South Northamptonshire)

"I don’t know how- Whether they sort of offer transport. They’re not very good at advertising it. It needs a more proactive stance, not just a few people deciding to do it." (68, Female, VHID Less Sparse, Craven)

Finally, although service users did not mention it themselves, it was noted within the providers sample that some users may fail to interact with services due to fear of social services intervention.

“Some people wouldn’t like to admit that they’d had a fall and wouldn’t like to come to the service because they fear that if they admit they’ve had a fall then actually it means that they’re going to end up potentially needing to go into residential care.” (Herefordshire, Public, Health)

“There is still inherent fear amongst older people that they’re being judged, not being able to cope and you know the loss of dignity that may come from that. There’s fear that people, if they’re seen not to be able to sort of maintain their independence in the community that they will be... you know the next step is residential care.” (North Norfolk, Voluntary, Housing)

**Impact of lack of identification of and planning for need**

Due to the combination of barriers around considering and planning for potential needs related to aging – as discussed above – there was a tendency for service users to present to services at ‘critical moments’. For example, research found little evidence of respondents planning ahead for impaired mobility by making proactive home adjustments, making sure they had support available in case of emergency, or planning
alternative transport for the future in case they could no longer drive. Conversely, respondents put off considering these issues until forced to by emergency or circumstance, such as sudden worsening of health issues. Contact with services thus tended to be reactive and time critical, with a range of needs emerging at once.

The implications of this general challenge, with reference to specific challenges for service planning and delivery, are explored later in this report.

Service designers and deliverers’ understanding of users’ needs – within the context of barriers to self-identification expressed above – are discussed as follows.

2.2 Service designers and deliverers’ understanding of need

Our sample included a full range of service designers and deliverers, from local public transport providers through to county and district level decision makers. In contrast to service users’ relative lack of concern about the implications of ageing within their rural communities, service designers and deliverers were by and large keenly aware of the challenges posed by their ageing populations. Providers identified a range of challenges around adequate services and protecting their potentially vulnerable older populations – and noted that these challenges were due to increase exponentially in the coming years and decades.

"I think we’re expecting a 100% increase in the over-80-year-olds in the next 15 years. And so that’s sort of- that puts a huge amount of pressure. And where they live, obviously.... it’s in the more sparse areas that we see the highest densities of elderly people....So they’re a long way from services." (Craven, District, Housing)

However, as evidenced in ILC's Policy Review, the degree to which older users’ needs are strategically understood, communicated and planned for varies significantly across rural areas. Providers must balance meeting the needs of their older populations within the context a variety of conflicting priorities and concerns for the population at large. It was clear within the sample that many providers felt they were only beginning to understand the specifics of the challenges facing older users in their local area – including mapping the needs of their residents within this local context – and developing plans to meet these.

Demographic projections about likely future age profiles provided ‘broad brush’ needs estimates in some cases. There was also evidence of more complex and thorough needs mapping for older users specifically, which included the voices and opinions of users themselves. In Herefordshire county council a multi-stream data collection exercise had been undertaken combining data from the census, council health records, Department for Work and Pensions (DWP) initiatives and user feedback from adult social care surveys to understand needs across housing, home improvements, social care and issues such as domestic abuse. It was noted that this has helped to provide a more holistic picture of planning needs for older users in the area, and had already begun to inform specific planning and improvements.
General challenges posed by the older population for service designers and deliverers are discussed as follows, followed by discussion of specific challenges relating to the three key service areas of housing, transport and health.
Ensuring older rural residence have access to appropriate services is a significant challenge for service designers and deliverers – with common challenges related to lower population density impeding economies of scale, and the general cost of distance in terms of increasing travel and other costs for service delivery. These challenges were most keenly felt by those working in the sparsest areas.

The challenges of density and distance are further exacerbated by the following secondary issues:

- diminishing financial resource, highlighting a perceived lack of rural-friendly funding models and government policies (e.g., competition)
- fragmentation of demand via 1) the need to deliver in-home and localised services, and 2) the diversity of older populations and rural communities
- the challenges of ensuring diverse communities – resulting in reducing numbers of volunteers and younger age cohorts to support the provision of services to older populations
- the limitations of online delivery and inefficiencies of needing to provide information across multiple platforms and formats

Across the designers and deliverers sample, respondents indicated that ageing populations are already posing significant challenges, and are affecting both the composition and demand for services. Sections 4-6 of this report detail specific challenges across the key service areas of focus in this research (Transport, Housing and Health). However, research also identified a range of more general challenges for service design and delivery for older populations that cut across service areas. These are detailed as follows.

3.1 Inefficiencies due to lower population density and distance

Unsurprisingly, the lower population density in rural areas and the distances that need to be travelled by both service users and providers presented a key challenge for designers and deliverers of services for rural residents.
Service designers and deliverers reported that **lower population density impeded their ability** to maximise economies of scale, resulting in service inefficiencies and higher per capita unit costs for service delivery. **Greater distances** between service users and towns/villages also necessitated a high degree of travel to bring services to clients, which resulted in additional travel costs, opportunity costs and higher levels of unproductive time for staff.

Labour intensive services, such as health and social care, seemed to be hit hardest by the "penalty of distance". This is consistent with the findings of ILC’s evidence review, which also reported service provision in rural areas being hampered by the high costs associated with a dispersed population and long travel times (p.4, 31).

“For us it's really a case of us having the resources to go out and see people from the point of view of having enough equipment to take out to do the things with people at home that we’d like to do with them and from the cost of travel to actually go out – because occasionally some members of our team see people at home. So having the ability to travel and the equipment to take with them to travel to do those things is certainly for us a barrier...staff in our team that do cover the rural areas actually it may take a whole morning out of their workload and actually because of the time taken to travel to and from.” (Herefordshire, Unitary Authority, Health).

These challenges are further exacerbated by the overwhelming preference of older rural residents to **age in their own homes and communities**, and for services to be available in these locations. Not surprisingly, the delivery of in-home and less-centralised services increases the impact of the “penalty of distances” discussed above (as discussed further in Chapter 4).

The challenges of density and distance are further exacerbated by a range of secondary challenges detailed below.

### 3.2 Financial resources

Service designers and deliverers in rural areas noted that they are, like their urban counterparts, operating within a highly constrained environment of funding cuts – and or reduced revenue raising capacity – within the context of the economic downturn and austerity program. **Funding issues** were frequently noted as a key barrier to meeting the needs of rural service users.

"Any elderly person could say well look can we have a bus service and they [the council] would then come to the operator and say is there any way we could provide it and then it usually comes down to money and that's usually the stumbling block nowadays." (Herefordshire, Private, Transport)

"Funding is tighter everywhere and organisations are struggling harder and harder to get it." (North Norfolk, Voluntary, Transport)

Furthermore, many respondents also reported that the **additional costs of providing services in rural areas** were not recognised in government funding allocations,
policies, models and formulas. They suggested that this can mean they are disproportionately affected by general financial cuts, as lack of recognition of higher expenses involved in rural service provision acts as a de facto consequence for rural service budgets. This resonated with a perception voiced by some service users that rural residents pay higher taxes for fewer services.

Rural service designers and deliverers also indicated that general financial pressures are further exacerbated by ‘competition’ (reportedly related to the government’s reform agenda). Some participants stated the cost of bidding for contracts and consultation processes can impose additional costs – and that in some cases, this has diverted money away from service delivery and deterred smaller, more rural private providers from trying to compete. Supporting this, ILCs evidence review reported the policy of competition is more difficult to implement in rural areas and may be biased towards urban areas (p.33). Thus, the anticipated savings and value for money outcomes may not be realised to the optimum extent in rural areas.

Similarly, service charge or co-payments were reported to disadvantage rural service users and providers. These are payments made by individuals, usually at the time a service is received, to offset some of the cost of the service. For example, one organisation charges all users a set out-of-pocket payment of £12.50 per hour. These payments were said not to reflect the additional costs involved in delivering rural services, or the lower economies of scale that exist in rural areas. Moreover, service providers indicated that many older people can’t afford new or increased tariffs which results in decreasing demand. They reported that this could result in follow on effects of shifting service utilisation to more acute, and often free, services as well as reducing business volume. In one case this pattern of events had resulted in staff redundancies.

“We’ve charged a labour charge now for just over a year, and we’ve lost a lot of customers that way.... The council basically withdrew all the funding that paid for this free service...and that’s reduced the number that has been coming through to us. We had to make redundancies.” (Craven, Private, Housing)

3.3 Maintaining diverse rural communities

An additional challenge for service designers and deliverers is the difficulty of maintaining diverse communities within rural areas. Some respondents specifically mentioned the challenge of rural-urban migration, including 1) young adults leaving to undertake further education or find work in cities and 2) the ‘influx’ of older people retiring to rural areas who then age in-situ. Respondents noted that this poses particular problems in terms of reduced numbers of workers, taxpayers, volunteers and informal carers to meet the needs of older residents. They stated that imbalances in population

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9 ILC’s evidence review reports the sparsity allowance for health and social care do not cover the increased costs associated with providing services in rural areas nor recognise providers cannot benefit from economies of scale with sparse populations (p.35, 59).

10 This was research was not designed in a way that can evidence whether or not this perception was accurate.
profiles in rural communities at times also resulted in reduced volunteer bases – given the lack of younger age cohorts needed to support voluntary and community service provision.

Related challenges to restricted rural community profiles included:

- **concerns about the sustainability of communities** and the potential for ‘elderly ghettos’ to be created if communities do not maintain diversity and/or attract and maintain populations of families and younger people.

- **difficulties in attracting local staff** for careers that service older populations, because of the relative scarcity of those of working age and the low wages and status of caring jobs.

- **increasing reliance on volunteers** to provide services at the same time that there are decreasing numbers of volunteers to fill the gaps and, reportedly, a decreasing sense of community.

  “It’s difficult to get volunteers to help out because people don’t, they don’t want to know. People are very happy to keep themselves to themselves.” (Herefordshire, Parish, Generalist)

- **the higher investment and resource required to source appropriate volunteers** within this restricted volunteer pool. For example, a Home from Hospital service relying on volunteers to provide its services reported that due to the shrinking volunteer base they had been forced to engage in recruitment fairs to engage with the public and raise awareness of issues faced by older people in the area. This was reported as a time intensive effort and yet was required to help find the volunteers needed for the continuation of the service.

3.4 Heterogeneity

Many service designers and deliverers see their roles as serving the whole community and are struggling to juggle the competing needs of various groups within their community, not just older populations.

“It’s not possible to meet all the needs of the whole community in North Yorkshire because there’s so many different, competing needs, but we do the best we can with the resources we have.” (Craven, County, Transport)

Designers and deliverers noted that rural areas are not made up of homogeneous communities – rural communities within districts are different, other vulnerable/needy groups exist and older populations are also becoming more and more diverse. This diversity resulted in many different groups seeking different bundles of services, and
therefore further fragmentation of demand, within already constrained conditions (primarily related to population density, distance and finance).

When talking about differences within the older population designers and deliverers also indicated the **ageing of ‘baby boomers’ may also pose significant challenges.** There was a belief that their values, attitudes and preferences—e.g., assertive, individualistic, with weaker family ties—will be sufficiently different from other generations to significantly affect service demand (if not necessitate a radical redesign). Thus, there was a sense that services need to respond to the challenges of the current older population, whilst recognising that these challenges will swiftly change as a new generation of older users age in place.

"I think at a time when public services are declining, perversely I think there’s going to be a much more demanding older population who’s going to be demanding what it wants and how it wants it delivered." (North Norfolk, Voluntary, Transport)

### 3.5 Information provision across multiple platforms

As discussed in Section 2, service users often indicated **low awareness of the range of services available** to them in their local areas. Providers reported this as a significant general challenge in terms of service delivery—but also noted the limitations of online delivery and the cost of providing information across multiple platforms and formats.

Many felt the **push towards digital platforms was problematic** for older rural populations given the limitations of broadband in rural areas, and for older people who are not computer literate or don’t want to access information online.

"I do get a bit concerned when people tend to go too much down the online route and I think, you know, you’re actually excluding another section of people, and you need to remember they’re there." (Craven, County, Transport)

The limitations of online delivery means services are required to duplicate processes in order to provide information across multiple modes—e.g., print, telephone and online—to ensure older people have appropriate access to information. The follow on affect of this for providers was the requirement for larger investments to get information to those who need it.

Sections 4-6 explore specific challenges—and implications for design and delivery of services for older users in rural areas—across three key areas of service delivery: Housing, Transport and Health. These three areas were chosen as having significant impact on the lives of rural residents and were recommended to be explored further by ILC’s initial Evidence Review.
Chapter 4 - Housing

The ageing population of rural England, and older people’s strong preference to stay in their own homes as long as possible, will undoubtedly increase the need for rural housing that supports independent living, and associated home-based care.

The research identified a variety of issues affecting older rural residents’ ability to remain living in their home and/or area of choice. Prominent among these were factors relating to staying at home and to moving to more appropriate housing, including issues regarding:

- awareness and availability of home maintenance and adaption services
- availability and integration of personal and social care services
- lack of an appropriate range of housing options

4.1 Staying in place

Service user respondents, including those with a chronic illness or disability, reported a desire for autonomy, self-reliance and independent living. By and large this translated into a preference for remaining in their own home for as long as possible, with appropriate care support as required.

Evidence regarding services to assist older residents to stay in place – as well key challenges and enacted solutions – are discussed as follows.

Home maintenance and adaption services

Support and care provided in home, and particularly home maintenance and adaptations (HMA) were seen as instrumental in allowing older rural residents to safely and independently continue living in their own homes and to retain access to their communities. Access to HMA services was seen by some to be particularly important in sparser areas given the difficulties in providing affordable, age appropriate housing within these communities (discussed further below). They were also seen as having a range of positive knock-on effects in terms older residents’ safety and health.

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11Linked to this is a strong attachment to their local communities. As reported in the Evidence Review older people in rural communities have a “pronounced sense of place-based attachment” (p.23).
“I couldn’t imagine living anywhere else. I’ll have to die here, because I aren’t moving. I am not moving at all.” (56, Female, VHID Less Sparse, Craven)

“A lot of people want to stay in their house until the bitter end.” (Craven, District, Housing)

“Adaptations are helping people come out of hospital sooner. It keeps people out of hospital, keeping people safer in their home, people who otherwise may end up having serious injuries through falls.” (Craven, Private, Health)

However, a number of challenges around service user take-up of HMA services was noted across research, including:

- **Awareness** of the availability of HMA services was fairly limited in the sample, as was service utilisation – often despite local efforts to publicise the offering. Most older service users expected that they would need to – or already had – privately organise and pay for services out of their own pocket as needs arose.

  “We’ve tried to market the village parish newsletters, all the different support networks that might go out to people, but there’ll still be people who, we’ve come across quite a few people who’ve said to us I never knew your services existed.... ” (Craven, Private, Housing)

- HMA was incorrectly seen as only offered for the severely disabled or those who are ‘particularly poor and poorly.’ As with social and personal care discussed below, HMA was primarily accessed only by the oldest age groups, disabled, and those with chronic conditions or receiving ‘Attendance Allowance’

- There was some evidence that service users preferred to access home support via third sector and private support agencies rather than Government providers, due to fear of social service intervention for those faring poorly

- Service providers raised concerns about the equity and sustainability of public-provided HMA services due to means-testing and co-contributions arrangements\(^\text{12}\)

- Although HMA services appear to lie at the intersection of health, social care and housing services for older people in rural areas, there was limited evidence of cross-service integration and coordination

**Social and personal care services**

Whether older rural residents are able to remain living at home was also understood as highly dependent upon the availability of in-home care support – either via publicly provided care or informal care arrangements – once residents required assistance.

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\(^\text{12}\) See Chapter 3 for further discussion of the impact of tariffs and co-contributions on demand for services.
However, ensuring that older rural residents would receive the in-home care they desired was considered challenging. As with HMA, publicly-provided or subsidised care in home was viewed as primarily for those with extreme needs, with limited evidence of service utilisation in this area. Providers also raised issues related to penalty of distance for care provision in dispersed residents’ homes. As discussed in Chapter 3, in-home service resulted in high travel costs, opportunity costs and higher levels of unproductive time for staff. For example, a service provider explained that the cost of travelling to patients’ homes is a key challenge for the service. It was noted that this is particularly difficult in terms of providing services to those living in the most sparse areas where it can take one member of staff a whole morning to complete a single in-home visit, resulting in inefficiencies and costly waste of professional time.

Research indicated that social care and domestic support for older rural residents was instead primarily being provided via informal care arrangements with friends, family, neighbours and community or charity groups (e.g., church groups). Informal assistance took many forms, from help with domestic tasks (e.g., shopping and maintenance), paperwork, transport (discussed in Chapter 5) and personal affairs. Informal carers also played a key role in coordinating formal social and health care and housing transitions. ILC’s evidence review supports this finding and indicates levels of informal care increase as levels of rurality increase (p.32).

As such, informal carers play a critical role in providing care and support to older rural populations, and do so in a manner that fits with the way older people want to be cared for — by someone who they are connected to and who respects their right to make their own decisions and supports their independence.

”I’ve got no difficulties at all…….Well the reason being I’ve got a lot of good neighbours like Will you see and that helps a lot……And then of course my son lives fairly close.” (89, Male, VHI, Less Sparse, Herefordshire)

”I mean if anything goes wrong, the first person I would turn to is my son-in-law….and he’s down here in a flash.” (92, Female, TF, Sparse, North Norfolk)

However, providers reported that in conjunction with declining numbers of volunteers; the availability of informal carers is declining – coinciding with a period of increasing demand. It was noted that this will reduce the ability of some older people to receive home-based care in a manner acceptable to them.

Finally, there were also instances of assistance being provided by community businesses. For example, one supermarket provided an older-user friendly community bus for shopping trips; another ensured that extra staff were available to assist older customers on the days the community bus brought older customers.

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13 There were, however, some mentions of community nurse services, GP visits and assistance dressing. These examples tended to be amongst the oldest old and the most disabled. There was no evidence of private care or nursing in the sample amongst those living independently.
How are challenges being addressed?

The challenges of meeting social and personal care needs tended to be very fragmented, but where successful, was achieved by:

- Delivering services that help older residents maintain independent lifestyles, for example, Norfolk’s Red Cross Older People Outreach Service puts support and services into the homes of all the elderly who need them in their area.

- Promoting accessibility via enhanced delivery of services in home (e.g., ‘virtual wards’) and removing gatekeeper roles to open up services for self-referral.

- Timely and fast response for non-emergency situations in the home. For example, the Swifts and Night Owls service in North Norfolk is available to residents aged over 65 who requires immediate but not emergency assistance, such as personal care, help getting out of a chair or pulling the plug out of the bath.

- Individual service branding, to get around people’s fear of social services. In this way there is less association with the local authority. However, it is worth noting an unintended consequence of multiple brands is reduced depth and breadth of brand awareness. This may be reflected in services users’ low knowledge of service availability and desire for greater signposting.

4.2 Moving to more appropriate housing

Despite wanting to stay in their homes as long as possible, most participants recognised (when prompted) that as they aged their needs would change and that their homes might become unsuitable. In this case, respondents articulated a very strong desire to stay within their local community – in their words, they did not want to ‘be pushed off to another town’ or village. However, ensuring that rural residents could age in place posed a number of challenges.

Key challenges

First, only a minority were ‘planners’ around housing need, making arrangements or moving before pushed to by health or other urgent circumstance. In most cases, older service users indicated they would stay in existing housing ‘until they had to move’, without making prior arrangements. Although both groups require information and support, it was noted that the latter group pose significant challenges for service providers – both in terms of trying to nudge them towards planning and also in terms of responding to housing crises when they do occur.

“People themselves don’t see the need [for a full spectrum] of housing options, but we know it makes all the difference. We need public education to think about what they need” (Herefordshire, Unitary Authority, Housing/Health)
Second, in order to help people age in their rural communities – even if not in their home – there is a need for a range of affordable and appropriate housing options in the local area. Many service users expressed a wish for housing that was described as an intermediate step – lying between fully independent housing and a nursing home – e.g., flat, bungalow or small house (mostly two bedrooms). However, among both service users and providers there are widespread concerns that the supply of such accommodation is insufficient to meet current and future demands.

“There isn’t enough housing for older people anyway, so it sounds horrible, but you’ve got to wait till somebody dies before you can get in and then you get in and then somebody’s waiting for you to die.” (56, Female, VHID Less Sparse, Craven)

“The figures are saying that we’re going to have an extra 7 – 8,000 older people which translates to being an extra 300 houses, whereas our long term build rate will be about 180...“We’re expecting a 100% increase in the over 80 year olds in the next 15 years and that puts a huge amount of pressure and where they live, obviously they’re dispersed around the area but it’s in the most sparse areas that we see the highest densities of elderly people. So they’re a long way from services …The trouble we’ve got now is we haven’t got the housing stock.” (Craven, District, Housing)

A number of barriers to the provision of an appropriate range of housing stock emerged, including:

- Noted tensions between building sustainably/efficiently (i.e. near services) and meeting the expectations of older people for housing in their local area. A district lead in planning and housing recognised that this translated into houses not being built in very sparse locations; the broad assumption being that residents will have to move into town. He noted that this would potentially involve “breaking the bonds with their very local immediate community”

- Older participants considering downsizing cited a preference for bungalows, but providers noted market barriers to building these:

  “Because they’re so expensive, it’s not easy to actually get the plots, they take up so much land, and the costings to work out in terms of the market, but that’s often what people want, they want their own bungalow.” (Craven, District, Housing)

- To date there has been little progress in attracting private developers into rural communities, and then integrating housing for older people within new mainstream developments

- In some rural villages and hamlets there was resistance to housing developments

  “It’s very hard because the same people who long term we’re trying to cater for don’t want more houses to be built. NIMBYism is too harsh, they love the area dearly and so they don’t want more houses to be built or, so that’s a problem, so we’ll be having to build the bare minimum that we can get away with.” (Craven, District, Housing)
How are challenges being addressed?

Research evidenced a range of activities intended to help improve the housing options for older rural residents, including:

- **County and District level population-based or assessment-based needs profiling** – including a ‘strategic housing market assessment’ in one area – to identify housing stock needs and inform specific planning strategies
  
  “That’s the starting point really, trying to set out a long term shift in terms of how we provide for an elderly population” (Craven, District, Housing)

  “The joint strategy needs assessment will tell us what the current and developing needs might be...we know that old people aren’t good at planning for when their partner dies which is a major trigger...although older people might often want to stay in house they want something fit for purpose, they want a 2 bedroom house, people say that frees our house up for a family... now were encouraging developers to build 2 bedroom houses with life time adaptations and changing the guidance so it’s easier to get planning permissions” (Herefordshire, Unitary Authority, Housing/Health)

- **Establishment of Neighbourhood Development Plans** by Parish Councils, in close consultation with their communities, to establish general planning guidelines for the development and use of land in their area

- In one case, **working with developers** to achieve housing targets within their District, focusing on financial viability “on a site to warrant having that type of housing, or a mix of housing.” This council buys expertise from a much larger council and indicates this allows them “to be more assertive with the developers” and where there are sites that “aren’t viable we get a contribution from them in order to build houses elsewhere”

- **Public engagement activities** to garner support for new developments:

  “We’ve currently embarked on a six week grand tour of virtually every Parish where there’s likely to be any house building. And then so we’ll be having open days, discussing about what the issues are, actually listening to them about what the potential solutions could be” (Craven, District, Housing)

- **Potential District Council-level housing purchases** to fill stock gaps, particularly "full market rented properties"

4.3 Gaps and general implications for design and delivery

Older people’s strong preference to stay in their own homes as long as possible, with appropriate support as required, will undoubtedly increase the need for housing that supports independent living, and associated home-based care. Access to home-based HMA, social and personal care appears particularly important in rural areas given its
role in assisting older people to continue to live independently, as well as the challenge of providing enough affordable, age appropriate housing in rural areas overall, and particularly in the sparsest areas.

However, providers must address a range of barriers to take-up of public-provided support if older residents are to stay in place. Given the range of care provided by informal carers in rural areas and their declining numbers, the availability and linkages between formal services will also become increasingly important. Increased focus on integration between services and coordination mechanisms in rural areas appears warranted14. Within the housing domain there appears to be unmet need in terms of timely delivery of services due to poor linkages with other services; for example, delays in essential adaptations as a result of assessments and funding processes. Ideally, service providers also felt services delivered in rural areas should be funded in a way that has regard to the additional costs incurred in supplying the services to help ensure that services remain sustainable and thus available.

If older people do decide to move they have a very strong desire to stay within and connected to their local community. However, the current lack of appropriate housing stock – particularly for ‘intermediate’ housing – presents a challenge to service providers for older residents. Needs-mapping efforts and proactive housing planning is needed if older rural residents are to be able to age in place.

14 ILC’s evidence review concludes a focus on joined-up services is an important part of the overall service approach that should be adopted in the design and delivery of services for older people in rural areas.
Chapter 5 - Transport

Service users and providers indicated that transport is a critical issue for older rural residents, with complex interlinkages with health services access and social isolation. Service users were typically highly dependent on private transport – due both to desire for independence and flexibility as well as a variety of barriers to public transport use – which could pose key challenges upon loss of license of driving ability.

Although a variety of alternative transport options were evident – including private taxis, informal community networks, and formalised community transport provision – there was still evidence of significant unmet need. This was due to both the practical challenges of providing adequate transport in rural areas, particularly sparser locations, as well as a range of user-level barriers. In order to address these, research indicates that holistic planning across services is required, as is more joined-up working within and across rural areas. Significant user barriers to alternative transport use must also be addressed.

Research evidenced a range of provider responses to the identified challenges, and reporting summarises strategies used to tailor services to older users’ needs, reduce the need for travel, overcome user barriers to service take-up, and help develop more sustainable services.

5.1 What are the challenges?

As expected, transport emerged as a critical issue for older people in rural areas; access to adequate transport was considered a necessity of rural life given the far-flung and often decentralised nature of services and communities. Although in many cases residents had a variety of community supports on offer ‘on their doorstep’ – e.g., via local shops, parish halls and neighbourly interaction – even ‘local’ provision often involved some transport need, particularly in sparser areas. Respondents reported that transport barriers could limit access to basic services, social and civic participation, and pose critical challenges to engagement with health services.

The interaction between transport and health services access was particularly pressing. Many respondents noted that mounting health needs resulted in increasingly frequent visits to a range of health professionals, from GPs to critical care providers to a range of health specialists. As discussed in Chapter 6, it also necessitated more in-home care

15 Those within fairly close distance to market towns or cities often reported less transport issues overall; for example, many residents in Oldham praised the tram links to Manchester and stated that they had relatively few unmet transport needs.

16 This was a particularly key issue for those living in independent housing; those in retirement communities or nursing homes reported that travel was typically arranged by home providers.
from health providers for those unable to access services independently – posing significant financial and practical issues for providers of health services.

"We end up doing an awful lot of home visits just because the patients can’t get here on public transport, people who are physically capable of getting here but can’t." (Herefordshire, Unitary Authority, Health)

Access to basic services seemed to be more an issue for those living in sparser locations and this did not emerge as a key issue for most respondents in the sample. Many other respondents noted that they had begun having shopping delivered (e.g., via Sainsbury’s or other grocery-store schemes) whilst in other cases, local shops provided tailored pick-up/drop-off transport for older residents on dedicated ‘shopping days’.

Key transport challenges for older service users in rural areas and implications of these are discussed as follows.

**Reliance on private transportation**

Consistent with the findings of ILC’s evidence review, service users in this research were typically **heavily reliant on private personal transport** (i.e., use of a privately owned car) and preferred to remain so until forced to use public transport alternatives due to mobility issues or loss of license. 17 Ownership amongst those physically able to drive was near-ubiquitous across the service user sample, even amongst the oldest old and those with emerging mobility problems (e.g., arthritis and joint pain, or ankle and limb swelling due to cardiac or other issues). 18 Barring some concerns about rural drivers being ‘snowed in’ in the winter (particularly in sparser areas), private car use was considered to work well in terms of meeting the challenges of transport in rural life.

Older service users in this sample reported a strong **desire to stay independently mobile via private transport for as long as possible**, and often displayed latent or overt fear of the loss of independence that loss of private transport would bring. This was both due to a range of barriers and challenges around alternative transport options such as buses (as discussed below) as well as lack of awareness and forward planning around any additional options available. Rural service providers and designers thus noted that loss of personal license due to age, mobility or health issues often thus signalled a key **crisis point** in older users’ lives – a key moment raising heightened risk of social isolation and access barriers to health and social services.

"As time goes on, and as one or more of the members of the household ceases to drive, they will become more and more isolated, more and more dependent on services coming to them." (66, Male, VHI, Sparse, Herefordshire)

17 Although the ILC Evidence Review notes that affordability of personal vehicle maintenance can be an issue for many, it did not emerge as a key issue for older service users in this research. This may be due to the structure of the sample – which included a range of income levels including more deprived respondents, but did not focus heavily on the most disadvantaged users – or due to barriers to admitting need in this population as referenced previously.

18 Although there was some evidence of female respondents not having obtained licenses and thus being dependent on male partners as drivers of their family car.
Transport challenges for those without private car use, and implications of these, are discussed as follows.

**Bus services**

Supporting the findings of ILC’s Evidence Review (p.15), respondents frequently noted that bus services in rural areas often ran **infrequently or unreliably, with inconvenient timetables** sometimes tailored to the needs of other populations of interest; for example, focusing on morning and end of school day ‘runs’. Service designers and deliverers noted that providing the appropriate range of routes and timings across the rural population as a whole was exceedingly difficult, particularly in an era of service cuts. However, restricted bus timetables resulted in a range of negative consequences for the older service users in the sample, including:

- General reduction of engagement with bus services overall due to frustrations around waiting times, need for forward planning, or general unreliability
- Difficulty accessing health care for early morning appointments – particularly in terms of hospital access for morning surgery
- Lack of evening bus services restricting social life (even for some individuals with private car access, who had ceased driving in the dark as a safety precaution)

> “There’s sometimes issues with the timetable actually fitting health appointment times.” (Herefordshire, Unitary Authority, Transport)

> “The problem is that they finish so early. So there’s absolutely no possibility of, say, going into Ludlow or Hereford or Leominster say for a meal or to the pictures or something, because I have to think about getting back by, you know, five o’clock or something. What use is that to anybody?” (57, Male, VHI, Sparse, Herefordshire)

Respondents also noted that routes often did not provide **convenient pick up and drop off points** which reflected older users’ needs. This often reduced overall engagement and use of bus services, with knock on effects in terms of social engagement, access to vital services such as banking, and access to health services. Although a general issue, concerns about route convenience were typically exacerbated for those living in sparser areas. The range of problems raised by respondents are summarised as follows:

- Bus stops being located some distance from village centres (e.g., a mile away) – reducing overall access and convenience, particularly for those less mobile
- Market town drop off points located in bus stations outside of the town centre
- Lack of bus services in more remote villages – generally reducing resident access to town facilities
- A focus on connections to towns, with lack of linkage between villages – reducing social opportunities as well as potentials for linking services

- Lack of bus stops for all health service providers, e.g., local osteopaths, chiropractors, etc – in some cases resulting in failure to engage with preventative or even critical health care

  “I need to see the osteopath in the other town but I can’t. It’s only four miles but there’s no bus stop there.” (75, Female, VHID, Less Sparse, Rother)

Service providers noted that providing the full range of desired routes and pick up locations was near impossible, particularly given relatively low user demand and use of services. The problems noted above are likely to worsen as local authorities begin to strip back bus services and further cut the range and frequency of routes offered. Several designers and deliverers of transport services reported significant cuts to bus pass and operator subsidies, and raised concerns that if these trends continue operators may simply be unable to run services. More remote villages could be particularly hard hit. For example, a North Norfolk operator reported that they had recently cut services in some villages which only had one or two regular customers, noting, "They were really upset, but there were so few of them we had to."

Some respondents with more advanced mobility issues also noted that basic physical access to public buses could be an issue; they could find it difficult to get on and off bus services which could present a significant barrier to use. A private transport provider in the sample noted that adapting bus fleets to the aging population was an increasing concern and necessary to provide a more positive transport experience and avoid excluding those who were less mobile.

  "Buses tend to be better nowadays because they are all low floor accessible buses... So they can get on and off then easily without having to climb steps. That’s an important factor… it’s something we think about." (Herefordshire, Private, Transport)

Taxis and private hire

There was evidence that many older residents simply paid out of pocket for taxis and other private hire for transport to vital services such as health appointments. This raised some concerns about affordability, particularly for middle-income residents who might not fully be able to afford to subsidise frequent taxi trips, but were not eligible for carers allowances to bring health care to them. Within the service user sample there was evidence that some older residents paid for taxi transport because they were not aware of alternative options.

Family, friends and informal community arrangements

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19 As noted in ILC’s Evidence Review.
Although (as discussed in Section 2) service users often noted that their first points of call if needing assistance would be family and friends, the accessibility and practicality of this alternative transport solution was highly variable among the sample. Children had often moved out of the area and were raising families of their own, making frequent trips (e.g., to health services) difficult, and residents themselves were often reluctant to ‘be a burden’. In areas with high densities of older residents, service users didn’t always have relationships with younger neighbours capable of providing lifts, and there was some evidence of informal neighbourhood schemes beginning to disintegrate as the volunteer base aged and coordination began to fail.

"They are proud and they don’t like to ask. They feel they like they are bothering you all the time, so they don’t. So you know it’s isolation again." (Herefordshire, Parish, Generalist)

**Bookable car and mini-bus services**

In response to the noted challenges related to bus use, a variety of bookable car or mini-bus services had been developed by many of the rural areas in the sample – variously run by private companies, government providers or charity and community groups. These were considered vital in terms of ensuring access to social activities, health appointments and basic services for those with mobility issues. In many cases these transport schemes were subsidised by local councils or charities to provide a low-cost option for older residents. However, service users and providers noted a range of challenges around the take-up and sustainability of these schemes, and reported that they were sometimes inadequate to meet user needs. In summary, challenges included:

- Service user **awareness** of these schemes was often low
- As elsewhere, there was some **reluctance from older users to signal need**, particularly when schemes were provided or run ‘by strangers’.
- Some service users expressed reluctance around having ‘strangers’ provide transport services. For example, one respondent noted that if she were to dial an 'on demand' door to door service it would need to be from someone she trusted and felt safe with
- In some cases, **high expense** of use in sparser areas or for long-distance trips (e.g., to more remote hospitals or health care providers). For example, it was noted that some rural residents had not taken up a Herefordshire ‘Community Wheels’ scheme for needed hospital visits due to the prohibitive 30-mile charge
- **Changing engrained habits** of car and bus dependent older populations was considered difficult. For example, a Herefordshire transport provider noted that a village mini bus service had failed after only 2-3 years due to lack of use. It was raised that younger generations – more used to book-ahead services (e.g., via
online train bookings) – might prove easier to engage as they aged, and help provide the critical mass of users needed for financial sustainability

"You tend to think a bus service is going to be in a bus stop at a certain time of day. You don’t have to ring it up like a taxi and order it, and that’s, it didn’t work at all. I mean we have got one passenger who regularly used to use it perhaps once a week apart from that we struggled to get anybody to use it to be honest. And people don’t want to commit to it." (Herefordshire, Private, Transport)

- As for local bus services, ensuring access for more remote villages was considered financially and practically challenging; some providers noted they had cancelled routes into more remote locations due to lack of demand

- Schemes were often considered expensive to run, even with the use of second-hand vehicles, due to high costs for repair, maintenance and fuel. Providers faced cuts in subsidies and had found it extremely difficult to obtain grant funding for community transport schemes

5.2 How are these challenges being addressed?

Research identified a range of strategies employed to respond to the challenges above, centred around optimising the transport options currently provided to meet the needs of older users; reducing the need for older users to travel; helping overcome service user barriers to take-up of services; and helping to explore alternative funding and delivery models to develop more sustainable services. In summary, these included:

- **Proactive consultation and user feedback assessments** regarding preferred routes and reasons for cancelled services. For example, Herefordshire county council transport planners queried users about cancelled trips and lack of use to understand how services could be improved to better meet need

- **Prioritising adverse weather measures** in planning budgets to protect the most vulnerable. For example, a Craven district transport planner noted that significant effort and planning had gone into ensuring access routes were ploughed during winter snow, in part to help avoid older user isolation

- **Committing to quality measures specifically regarding older users’ needs** – for example, providing training for providers on how to help less mobile users (e.g., helping on and off the service, waiting for frailer individuals rather than driving away and sticking to time schedules, etc.)

- **Ensuring that alternative transport options are available both for health services and general visits.** Many areas had developed emergency or appointment-based health transport schemes – for example, West Devon had a bookable volunteer hospital taxi – but some providers noted that transport for more social activities could be lacking. Providing group services (e.g., to church
or parish meetings) was considered helpful in overcoming user barriers around ‘trust’ and ‘burden’

- **Helping to keep people (safely) independently mobile** – Schemes such as ‘95 Alive’ designed and delivered support to older rural residents to help keep them safely on the road, providing advice about key issues like timing medication use to avoid drowsy driving and other practical safety measures

- **Reducing the need for travel to services** – through mobile provision of health, social or personal services, either directly to rural residents or via village halls and other centralised locations. For example, North Norfolk frequently arranged visiting services such as hairdressing or chiropody for older residents, although barriers were noted around convincing providers to travel to sparser areas. Plans to roll out broadband to rural areas were also noted, linked to attempts to reduce the need for older users to visit services (e.g., GPs) in person

> "I went in and sort of helped her sort out a few money problems they had got and I also got in a chiropodist and various other people to help him with his mom, but they were totally isolated on top of a wind swept cliff." (North Norfolk, Parish, Generalist)

- **Awareness raising, and proactive identification and ‘warming up’ of potential service users** via conversation, ‘free trials’ and networking with local older ‘movers and shakers’– to overcome barriers around ‘asking strangers for help’; breaking habits of private rather than public transport use, and timetabled rather than on-demand provision; and unfamiliarity with services. Some providers were also providing signposting services at critical moments of vulnerability (i.e. loss of mobility, loss of license) via voluntary outreach (e.g., Red Cross Provision) – and working with a range of providers to identify potential users (e.g., local Age UK chapters)

> “One of the things that we’re starting to do is to promote community transport, because... loads of people don’t know about it and don’t know that it’s there... You have to have good links with the community to understand their needs – get locals talking to build awareness and get them used to it.” (North Norfolk, Voluntary, Transport)

- **Attempting to embed services in communities via volunteer provision** – to minimise ‘strangers’ trust issues, draw on local community strengths, and help reduce service costs. ‘You win we win’ approaches were seen as particularly helpful in overcoming user reluctance to ‘put people out’ by requesting transport – as in the example below. However, as noted in Chapter 3, volunteer pools were often seen to be shrinking which could cause barriers to third-sector ‘outsourcing’

> “We have a cinema scheme – someone takes people to the cinema in the village and the driver gets a free ticket. It’s brilliant, getting people out and about who wouldn’t go to the cinema in an evening... a nice community activity and having the
transport available means it’s accessible to everyone in the community.” (North Norfolk, Voluntary, Transport)

- **Joint working and coordinated services** to provide efficiency savings and more holistic planning. For example, there were collaborations noted between local authorities/parishes to help services cover larger areas and draw on larger volunteer pools. In North Norfolk, a social enterprise provided a range of transport options (Dial a Ride buses, community car schemes, and volunteer car schemes) under one coordinated offer.

### 5.3 Gaps and general implications for design and delivery

Despite the range of measures being taken to meet older residents’ needs, gaps in rural transport provision remained – with significant impact in terms of older users’ vulnerability, access to health services, and ability to participate in daily life. Research suggests a number of key implications for transport design and delivery in rural areas:

- Transport planning cannot occur in isolation – and particularly needs to link with overall community planning initiatives to help **build and maintain heterogeneous and vibrant communities** – to help ensure viability of alternative transport options via informal neighbourly links, and to provide volunteer bases for more formalised offerings.

  “If the planning policy was to allow more or rather prevent more big houses and encourage more small, affordable houses, the dynamic mix of the community would be different... so if we were surrounded by young neighbours for instance, I guess we wouldn’t feel quite so badly about saying to someone ‘You couldn’t just get me to the doctors, could you?’” (66, Male, VHI, Sparse, Herefordshire)

  “The third sector will step in but... volunteer drivers are often over 60 to start with, so as they get older, you'll probably find there are more and more gaps arriving because who’s going to drive these buses and taxis and coaches to get people to the services?” (North Norfolk, District, Generalist)

- Rural providers will need to continue to **bring services to users** where possible, in recognition of current barriers to health services and social activities, particularly for the most vulnerable. Home visits (particularly from health services professionals) are likely to be required for many. However, centralising services may also help reduce travel burden – e.g., via clustering multiple health professionals (pharmacists, chiropodists, osteopaths, etc) in one location. Some service designers also noted that working with users to combine trips can help provide efficiency savings.

- Providers may be able to better face challenges by increased **linked up working** – across public and private providers within areas, as well as across multiple parishes. This may help provide better economies of scale in terms of service planning and delivery, and in order to work together rather than compete against one another for limited funding and support.
"I'm talking increasingly to various voluntary organisations to say, well, we're doing this, and we want to do this in a rural area, but how do people get to it? Aha. Well, if you do that there on a Tuesday, there will be a bus coming through....So it's joining it up a lot more, I think, and making those services accessible to everybody in the population, which is as it should be." (North Norfolk, Voluntary, Transport)

- **Overcoming user barriers** to ensure sufficient service take-up is a key challenge. This will require **proactive identification** of potential users (via community partners, GPs, etc), **signposting** to the range of services available, and ensuring that services are **tailored to user needs**. Although Parish council members in this sample typically felt they had little input or impact in terms of transport provision in their areas, there could be a key role for them to play across the above.

  "With all the good will in the world, we can do as much PR as we want, but people are very- until they need the service, they don't necessarily go out there looking for it." (Herefordshire, Voluntary, Transport)

  "Its, it's really out of our hands. We can only ask you know please don't cut off public transport services because it's used by the residents, but that's as far as we can really take it." (Herefordshire, Parish, Generalist)
Chapter 6 – Health

Given the variety of barriers around admitting and acting on health needs (as discussed in Section 2), there was evidence that older rural service users in this sample were unlikely to engage in preventative healthcare, or (for some) to seek needed care for current issues. This could result in older residents delaying contact with health services until urgent moments of critical need, placing strain on health service providers, or increasing the possibility of older users ‘slipping through the net.’

Beyond this general consideration, key challenges related to health care provision centred around access to services. Some older residents struggled to travel to healthcare services or have the service delivered to them in their homes. These barriers were most strongly felt by older people who lived in the sparsest areas, those without private transport, and those suffering from complex and severe mobility or health issues (e.g., dementia). Rural deprivation was another issue reported as a challenge for access amongst older rural residents, with affordability of travel at times further limiting access of services.

Ways in which these challenges were being met depended largely on local response by particular GP surgeries or voluntary/charity organisations, and so consequently tended to be at community or parish level rather than developed as wider initiatives. However, there was also evidence of some county-level service planning.

6.1 What are the challenges?

Research indicated a range of challenges around service provision for older rural residents, including barriers around user identification of need and uptake of health services, as well as a variety of challenges related to service access. These are discussed as follows.

To note, some service users also discussed a range of frustrations with or challenges around health services access which were judged as more general issues rather than rural challenges per se – for example, around staff treatment. These more general issues have not been reported here.
User barriers around uptake of health services

Service users themselves tended not to identify unmet need in terms of health services, and were often reluctant to discuss challenges around getting the health care that they required. In part, this was due to many positive experiences with health providers – for example, with local pharmacists or GPs – or due to generally good health for many members of the sample.

However, there was also evidence of a significant ‘make do’ attitude in terms of dealing with health challenges (as discussed in Section 2) – as well as explicit and implicit fear of emerging health issues due to ageing – which suggested that service users may not always seek the health care they need. Indeed, there were some reports of older residents not seeking health care even in moments of emergency and health crisis.

Service designers and deliverers confirmed that lack of proactive planning around health needs, and time-sensitive management of current needs, posed significant challenges for health services providers. It was noted that many older users presented to health services in moments of crisis, thus requiring immediate and often complex response by services.

Distance and transport

Access to health services related to travel was a key barrier identified by both service users and service providers; older people in rural areas faced greater challenges in travelling to health services. This was a particular barrier if private transport was not possible or highly inconvenient (as discussed in Section 5), and had been exacerbated by the centralisation of specialist health services. Service users described the burden of travelling long distances to the nearest hospital to have routine tests and checks, which could have been done in a surgery nearer to their home. These experiences were underlined by a tension reported by service providers between the centralisation of health services due to efficiency drives, and efforts by CCGs to provide more community-based services.

"From what I can gather there is a hospital that does better hearts or one that will do eyes... they all seem to have their own individual thing, so although I could see to make it like a priority place is better in some ways, but... for a lot of older people who don’t drive it is hopeless." (55, Female, TF, Less Sparse, Oldham)

Where patients faced barriers to travelling to healthcare services, they looked to receive home visits from healthcare professionals. However home visits by healthcare providers were more difficult to achieve in rural areas due to the greater demands on time and resources of the service providers; this finding is echoed in ILC’s evidence review (p.33). Although a district nurse service was highly valued by service users, funding cuts meant that in some areas they could only visit patients who were physically incapable of leaving their house. Service providers in one area explained that the district
nurse service had been centralised and brought under control of the local NHS Trust, so that local surgeries no longer had easy access to their support.

"[District nurses] used to be based in our surgeries, which meant that we had quick access to them, which we haven’t got now." (Herefordshire, Unitary Authority, Health)

Consequently, the burden was passed on to GPs to do more home visits, and was exacerbated by difficulties with staff retention and recruitment experienced by GP practices in rural areas (as outlined in the ILC report p.33), which put further pressure on GP resources.

Another example of a healthcare provider facing barriers to visiting older rural patients was an NHS falls prevention service which could only visit older patients in most sparse areas fortnightly, whereas if the patient could visit the service in hospital they would be treated on a weekly basis. The service explained they could not justify allowing one physiotherapist to spend a whole morning visiting one patient in a remote area. Similarly, a privately-run pharmacy explained that it was not cost-effective for the business to deliver prescriptions to rural areas, even though around six rural patients each week called to ask if they could.

Impact of access challenges

Such barriers to accessing healthcare from rural areas had a knock on effect as it created limited access to preventative services, and consequently more vulnerable service users only interfaced with services when their need became urgent, whereupon they were likely to present with more complex needs and require acute health services.

"I ended up with pneumonia, because I couldn’t get in to town and a doctor wouldn’t come out to see me and that was bad" (50-59, Female, TF, Sparse, West Devon)

A pharmacist reported that some older customers in rural areas who could not access their prescription did not get the medication that they needed and, once their condition had deteriorated, they were likely to call an ambulance and be admitted to hospital.

As discussed in chapter 4, joint working between health and housing services was considered to be vital to effective service delivery, and GPs cited examples of inadequate social care having a knock-on effect on demand on health services. For example, one GP referred to an elderly patient who had no heating in her house, but social services were not able to install heating for another year. As a result of a lack of heating this patient was expected to place demands on the health service, due to problems with her physical and mental health. In this case, the GP thought a more integrated approach could have ensured appropriate social care was put in place in a more timely manner so that the older person’s needs were met.
6.2 How are challenges being met?

Although planned responses to improving accessibility of health services for older people in rural areas was generally localised, where it did occur, the approach was underpinned by the following principles:

- **Promoting accessibility.** This was achieved by:
  
  - **Decentralising health services** from hospitals to GP surgeries. One GP practice delivered as many services as they could on site so that patients did not have to travel to the nearest hospital which was 34 miles away from the surgery
  
  - Services offered in the GP surgery include a wounds clinic, which a nurse ran twice a week, physiotherapy, hearing tests, chiropody and an ulcer clinic, all of which were designed to prevent patients from needing acute services. In another GP surgery, cardiovascular checks were carried out by GPs, who then sent the results to a hospital consultant. The consultant then advised the GP on how to treat the patient accordingly, which prevented the patient from having to travel to hospital

  “What we can do on site we will do on site…it’s to stop people having to travel. So, to the nearest hospital is 34 miles, which is a 68 mile round trip for some patients.”  
  (Herefordshire, Unitary Authority, Health)

  - **Delivering services to the users’ home:** examples of innovative schemes included delivery of medical equipment by a volunteer van driver for the Red Cross Older People’s Outreach Scheme in Norfolk, while a GP surgery had developed a practice of delivering repeat prescriptions to Post Offices in neighbouring villages, so that older patients could collect their prescription at the same time as they collected their pension. Service users who had been visited by GPs or nurses in their homes greatly appreciated a timely, responsive service:

    “Father wasn’t so well one day and they said, right, we’ll send two nurses, and two nurses came and then the next day another nurse came and they were absolutely wonderful…a doctor did come but she didn’t come until quarter past eight at night, but the nurses had been earlier, and they were lovely” (86, Male, VHID, Sparse, Craven)

  - Opening up services for **self-referral** so that the initial GP appointment was not necessary. This method was used by a NHS Falls Prevention physiotherapy service so that older people could access their service more easily

- **Promoting prevention services:** the community services discussed above were aimed at improving accessibility of preventative services, in order to prevent the patient’s condition deteriorating to a point where they needed to access acute
services. This practice ties in with the suggestion made in the ICL report that community services that can prevent unnecessary hospital admissions are “likely to be the ongoing direction of travel”.\(^\text{20}\) An example of a preventative strategy targeted at those most in need was being trialled by one rural GP practice in the form of “virtual wards”. The practice had been told by their local NHS Trust that they could allocate 26 patients who were most at risk of admission to hospital to the “virtual ward”. A district nurse acted as a “virtual matron” by examining the cases and ensuring that the necessary healthcare was provided to the patients to reduce the risk of them being admitted to hospital.

- Taking a **user-focused** approach to designing and delivering services: for example a falls prevention service manager carried out a patient audit to ascertain why people were not attending appointments. They found that the distance to travel to the hospital where the service was based was deterring rural patients from attending. Consequently, the service set up satellite clinics in the area to bring the service closer to rural patients, making it easier for them to attend.

- Providing **‘joined-up’** integrated services across organisational boundaries: although not specifically aimed at rural service users, there was evidence of joint working to support older users at both service provider level and at a strategic level. An example of the former was a care coordinator role located in a GP practice, who could identify and arrange to be put in place a range of support for the patient, from statutory, voluntary or charity organisations, to meet needs identified by their GP. The Care Coordinator had the resources to advocate for older people to help them secure the services they needed, which GPs identified as something that other professionals did not have. The role was provided by Age UK, and as a third sector worker the post was considered to be ideally placed between health and social care to act as an effective bridge between the two. A physiotherapy service also described how they signposted patients to other services:

  “We’ve ended up being a bit more of a one stop shop…to signpost people for other services as well as just ourselves.” (Herefordshire, County, Health)

At a strategic level, a "Frail Elderly Pathway" was being developed by one CCG. The aim of this pathway was to achieve **co-ordinated care** for elderly patients provided by neighbourhood teams that included GPs, social services, district nurses, physiotherapists and occupational therapists.

As discussed in chapter 4, **joint-working** was considered to be particularly crucial between health and social care services, and services such as the Red Cross’s “rural agents” and the planned “Strong and Well” project in Norfolk aimed to enable service providers supporting older people in their homes to identify health needs at an early

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\(^\text{20}\) Defra Lit Review….p.33
stage. Joint-working was perceived as being particularly pertinent at the point of discharge from hospital, as a social worker could ensure older people had appropriate support in place in their home, which enabled them to be discharged. In one community hospital, a social worker attended multi-disciplinary meetings between the patient’s GP, an occupational therapist, physiotherapist and other staff to ensure that a multi-disciplinary approach facilitated a successful discharge process. This community hospital was moving to new premises which had extra space to locate physiotherapy, social worker and voluntary services, and this co-location of services was expected to further enable joint-working.

6.3 Gaps and general implications for design and delivery

Despite the good practice initiatives discussed above, gaps in provision remained, with important implications for service planning. A key implication was that services need to continue to improve accessibility, by bringing more provision closer to rural patients. The ILC report indicates the development of community-based services closer to people’s homes has been patchy (p.33), and the need for services that visited older people in their homes was stressed by both service users and service providers in this research, with both groups advocating greater numbers of elderly health visitors. Dementia workers who did home visits were suggested in order to fill the gap created by services that did not work for dementia patients. For example, the GP practice that delivered prescriptions to a rural post office highlighted that this service was not suitable for dementia patients who needed a medically-trained professional to administer and check on their medication. It was suggested that ideally, all rural patients would have their prescription delivered by a van driver who was a medical professional and could check that medication was being taken correctly.

Another key implication was that services need to be financially viable and sustainable. The lack of accessible healthcare services was directly attributed to a lack of funding, so it followed that any service designed to make healthcare more accessible needed to be financially sustainable. To illustrate the importance of financial viability, the cardiovascular checks provided at one GP surgery had been a result of a central government initiative to reduce the burden on hospitals by putting the service in to the community. However GPs believed that had they not had the central support of this initiative, their local NHS Trust would not have been able to fund this community service so it would not have run. Service providers were increasingly looking to the voluntary sector for service provision as local authority budgets were being cut.

“We’re quite interested in compassionate communities, the idea of volunteering as services wind down and there’s less money available, I think we need to look to the third sector for a lot of service provision.” (Herefordshire, Unitary Authority, Health)

However healthcare services run by voluntary, private and charitable organisations also required financial viability, which tended to be lacking in rural areas that could not offer economies of scale. For example, a privately-run pharmacy did not deliver prescriptions to rural areas because it was not cost-effective, while a charity that delivered medical
equipment to rural users relied on short-term, insecure funding to deliver the service. Other risks of voluntary organisations included that they were vulnerable to reductions in volunteer numbers, and service users with certain conditions, such as those with advanced dementia were considered less likely to appeal to volunteers. Further, volunteers would need to be medically trained to provide healthcare services, such as dressing wounds and explaining medication.

A final implication was that there needs to be better joint-working between health and social care services, as recommended in the ILC report (p.34). Currently, separate funding schemes and organisational cultures were seen as barriers to joint-working between these two sectors, and for example it was reported that there was an ongoing debate about whether funding for the Live Long Live Well strategy planned in Norfolk (discussed in Chapter 4) would come from the healthcare or social care budget. Multi-disciplinary working was reported to be more difficult if a patient lived in a different county or country to where they received medical treatment, as social services worked according to different structures and processes in different counties.

“All these different systems and the fractionation of these systems doesn’t help, it’s leading to less and less integration” (Herefordshire, Unitary Authority, Health)
Chapter 7 - Principles of Good Practice

The underlying principles of good practice have evolved from respondents' views on what makes 'good practice' as well as observations on services designed and delivered by respondents' organisations. Common themes arose across different types of service provision across the different rural areas and included:

- Accessibility
- Identification
- Sustainability
- Responsiveness
- Encourage engagement and behaviour change
- Promote independence
- Community involvement and engagement
- Partnerships and joined up working
- User focussed

Some services encountered took an approach that crossed over several of the principles described below. Specific services mentioned are detailed in Appendix A.

7.1 Accessibility

'Accessibility' can be delivered in different ways but essentially ensures a service is designed and/or delivered to be inclusive and provides suitable and/or innovative routes through which to access it to ensure those isolated because of location, lack of accessible transport, poor family/social networks or poor health can access the services they need, either to improve or maintain their lives.

"If you haven't got a car you can't get to the doctor's, there's no transport here, there's no buses..." (64, Female, VHI, Less Sparse, Herefordshire)

"I think they need....inclusion and they need to feel that they are included and not excluded, and I don't think that happens automatically. I think you have to make that happen." (Craven, County, Transport)

Designing for accessibility and inclusiveness can be challenging and there was evidence of a variety of approaches taken to ensure this. Some service providers proactively seek out the isolated or elderly to identify needs and deliver their service – such as 95 Alive, Red Cross Visitor services, and the Good Neighbour schemes.
Others specifically utilise or design routes into their services to improve accessibility by bringing services directly to users or reducing barriers to entry, such as GP/hospital e-clinics or self referral into physiotherapy services.

E-Clinics "Well, the impact will mean that they aren't travelling around to appointments miles and miles away. If they could be treated here, they could be treated here." (Herefordshire, Unitary Authority, Health)

Designing for accessibility was also a common element of Community Transport schemes (such as the Little Red Bus Company and RVS schemes) but was also seen in schemes such as the Herefordshire Falls Prevention Service (NHS) which recently decentralised from the county hospital to offer clinics in market towns, thereby easing patients’ distance, time and cost issues which were inhibiting use of the service by the rural elderly, and prescription delivery services which are designed to reach the isolated and housebound.

This principle links to the Defra published local level rural proofing principles\(^\text{21}\) of 'making an upfront commitment' and 'targeting spatial gaps' with regards to inclusion and serving more users, especially the isolated.

### 7.2 Identification

This principle stems from the need to ensure that those who require services do not fall through the net, particularly given noted barriers to service users’ self-identification of and planning for need. Many older users will not be aware of or use services without prompting therefore services need to be designed to go out and find those in need before crisis points are reached. A common observation was that a proactive stance needs to be taken in design and delivery.

"We have village halls all over the place and they’re all quite active, so I don’t see, you know once a quarter, why everyone couldn’t get out of the social services offices, bring their leaflets and their information and their laptops and come down and check if all the people that are eligible or might need or you know have slipped through the nets, because I know that people do." (57 Male VHI, Sparse, Herefordshire)

"....it's getting people to know their community and offer practical advice and support and get out there and actually meet those people and identify them." (North Norfolk, Voluntary, Housing)

This good practice principle was enacted in a variety of ways, including:

- building proactive user identification into their design (e.g., the Red Cross Older People Outreach Service and Strong and Well in Norfolk or the Red Cross Village Warden services).

• using cross referrals at ground level as an effective tool for identifying those that need most help and informing other relevant services (e.g. the VIP project in Craven or direct GP referral to Mental Health services in Herefordshire).

This principle links to the local level rural proofing principles of 'making an upfront commitment' and 'focusing on hard to reach groups' though is specifically proactive in its character.

7.3 Sustainability

The need for sustainability was a recurring theme related to continuing pressure on funding and resources. It was considered important to design services to be sustainable in the long term, versus just being a 'short term fix'. A range of approaches to delivering sustainable services were being taken, including:

• looking for new sources of funding outside government agencies (e.g., the RVS Good Neighbour scheme and the Norfolk Community Transport Association).
• looking for creative routes to maintain a service (e.g., 95 Alive are looking at ways to continue after funding runs out; GP/hospital e-clinics reduce costs).
• or using resources such as volunteers more efficiently - as are the RVS via their new ‘Coldharbour’ database system).

This combines the local level rural proofing principles of 'harnessing rural strengths' and 'reducing fixed costs', though with the addition of finding long term versus short term solutions.

7.4 Responsiveness

Speed can be of the essence to avoid crisis situations for the elderly (which often then increases costs elsewhere through e.g. acute hospital admissions) and services need to build in this principle to ensure users can obtain services in the moment of need.

The Swifts and Night Owls service in North Norfolk is specifically set up to provide a fast response service for falls and other emergency health issues whilst other services build in immediate cross referrals systems and signposting on the ground (versus using more time intensive structured referral processes up and down organisations). For instance, fast referral from a GP into Mental Health services benefitted the wife of an Alzheimer's sufferer at crisis point, enabling in home support to be quickly put in place.

"They're very good, they're excellent because when my husband was diagnosed they were here straight away and that was through the doctor obviously....they come about once a month, somebody comes and visits and makes sure everything is all right and also, you know, if there are any issues all I have to do is get on the phone and they'll come out." (64, Female, VHI, Less Sparse, Herefordshire)

There is no specific local level rural proofing principle that links with this element.
7.5 Encourage engagement and behaviour change

Older service users often need to be encouraged to engage. Services have to be proactive in helping them plan ahead for needs related to ageing. As discussed, there is often a lack of engagement with forward planning until a crisis point is reached, a situation which can be compounded by a lack of knowledge or trusted routes to gain it.

"I don't know, actually, about what's available, you see.....So if I don't know what's available, I don't know what's missing." (75, Female, T&F, Sparse, North Norfolk)

Successful services counter this in a variety of ways, for example using:

- proactive PR/advertising (e.g. 95 Alive visits agricultural shows in isolated areas).
- providing better alternatives to their current situation (e.g. by providing better quality housing options nearer services for the elderly to downsize into).
- by using non-threatening routes/people for the elderly to engage with (e.g. a local resident, or the trusted fireman versus a social worker).
- by signposting and cross referral at the point of contact – using these as moments of opportunity to help service users consider needs in other areas and how to meet these.

"But what we're having to think of, as well, is how we can provide better quality alternatives for them to give them that sort of nudge into making that movement." (Craven, District, Housing)

"We've ended up being a bit more of a one stop shop...to signpost people on for other services as well as just ourselves." (Herefordshire, Unitary Authority, Health)

This links to the local level rural proofing principle of 'offering a portfolio of solutions' but across all aspects of a service, whether it be publicity, channels of usage or identification of potential users.

7.6. Promote independence

This principle involves ensuring older service users can maintain their freedom of choice by designing and delivering services that help them maintain their lifestyles in a safe way, focussed on their personal needs. Many do not wish to leave their communities and/or want to stay in their own homes and furthermore, encouragement of this can help ease pressure on acute hospital services.

"I mean, if I ended up in a wheelchair, I would want to be as independent as I could-as long as I could in my own home." (75, Female, VHID, Less Sparse, Rother)

"....Independently, yes, because I don't know, you must talk to an awful lot of ancient souls....but one of the most important things I get from talking, from talking to older people is the desire to carry on living independently for as long as possible, so whatever produces that." (66, Male, VHI, Sparse, Herefordshire)
For example Norfolk's Red Cross Older People Outreach Service puts support and services into the homes of all local older residents who need them, whilst 95 Alive aims to maintain older people's access to services by keeping them on the road.

".. we have been doing some work for a number of years now focusing on older people, their travel, their access, and their involvement in road collisions in particular, and how we can keep them independently mobile, however, improve their road safety outcomes so that it's a safer thing for them to do as well." (Craven, County, Transport)

This relates to the local level rural proofing principle of 'starting from first principles' in that it is based on user needs.

7.7 Community Involvement and Engagement

Service design for older users needs to address the needs of specific communities so that such issues as location, access and population profile can be taken into account to e.g. link up different services or fill service gaps effectively.

Some service deliverers specifically set out to involve the community at the design stage, whilst others respond to service issues by for instance, actively seeking out non users and adjusting service delivery accordingly.

Community involvement can also benefit service delivery by aiding recruitment of volunteers and help communities identify routes to self help, for example by setting up a village community transport scheme.

For example:

- the Falls Prevention Service in Herefordshire decentralised after consultation with non users.
- the Dementia Arts Project was designed and delivered by a small market town community.
- a village in Northamptonshire set up a Good Neighbour scheme providing transport and all forms of general help to the elderly village residents.

". If that could be encouraged in some way by getting together, you know residents that are more able or those that have recently retired and still want something to do to be involved in that, if they hadn't thought about starting a scheme themselves, encouraging that sort of thought process..." (54, Male TF, Less Sparse, South Northamptonshire)

"So it wasn't a- in a district approach [unclear] a national approach, so it was something specifically to that rural community, so it was tailored to meet their needs and not anybody else's." (Craven, District, Housing)

This is clearly linked to local level rural proofing principles of 'taking a user focused approach to design'; and 'starting from first principles' in terms of dialogue with
communities when designing services though extends to ongoing dialogue by service deliverers.

7.8 Partnerships and joined up working

This principle of good practice was a common theme in successful service design and delivery and its absence was cited as a reason for service failure, for instance where a service's long complex processes could lead to long delays by both service users and providers. For example, long time consuming processes between Occupational Health assessments in hospital through grant approvals to a company being commissioned to do the work could severely delay the actual provision of essential adoptions to an elderly person's home.

Service users also recognised the need for a more joined up approach to help them access all the services they need more easily.

"...well I think all surgeries, all the various local groups for elderly, they should all be in touch with one another, they should all find, like you're doing, they should find out the need and then there should be an organisation or a committee that tries to sort that out." (75, Female, VHID, Sparse, North Norfolk)

This principle could take various forms from, for example, specific agency/organisation partnerships designing and delivering services together such as in 95 Alive and the Norfolk Community Transport Association; agencies working together on the ground to speed up signposting and referrals, such as the VIP Project in Craven, or a service specifically designed to join up different services such as the Red Cross Home from Hospital service in Norfolk and the Strong and Well project recently commissioned by Norfolk Council.

"I’m talking increasingly to various voluntary organisations to say, well, we’re doing this, and we want to do this in a rural area, but how do people get to it? Aha. Well, if you do that there on a Tuesday, there will be a bus coming through....So it’s joining it up a lot more, I think, and making those services accessible to everybody in the population, which is as it should be." (North Norfolk, Voluntary, Transport)

This principle is effectively the same as local level rural proofing principle of 'seeking collaborative approaches' with regards to crossing service boundaries in design and delivery.

7.9 User focussed

Services need to focus on the users' needs as a whole, versus being focused just on their own service, to ensure that all aspects of an older person's life are considered and responded to. As discussed, as users often present in moments of crisis, at the moment of presentation to services they often require a package of services crossing over housing, health and transport and extending into well being and their social interaction needs.

"Well, I think it's really the crossover between one agency and another and taking, you know, well, a holistic view, isn't it?...It’s looking at what does this person need
and how can we help or how can we get someone else to help, if there's a need?"
(Craven, County, Transport)

Some service providers signpost or refer to a range of services by ensuring workers are
knowledgeable about services available in their area, such as Red Cross Visitors and
the Norfolk Older People Outreach service. The RVS is using their new ColdHarbour
database to monitor service use and needs of each individual across their services,
versus just looking at the usage on a service by service basis.

"You can’t be arrogant and think you’re always the best service to do it. If you can’t
do it, signpost it to a better service. You know? If you can’t offer that, it’s not about
your funding. It's not about your service. It's actually about that service user, at the
end of the day, to make sure that they get the best- what they need." (Herefordshire,
Voluntary, Transport)

There is no local level rural proofing principle that is directly comparable but it is
reflective of 'taking a user focused approach'.
Chapter 8 - Conclusions & Recommendations

This research explored the challenges posed by aging populations in rural areas from the perspective of service users and service designers and deliverers. Research focused on understanding the context and challenges of rural areas specifically and did not include an urban comparison; the findings outlined above may not in all cases be specific to rural context, although we have drawn on the findings of the ILC evidence review to frame conclusions when possible.

How is need articulated and understood?

- Older service users in this sample presented a variety of barriers around articulating current need and planning for future needs related to ageing. These include barriers around attitudes of ‘making do’ to avoid placing burden on others; fear of admitting and discussing the implications of ageing on health and general ability; low expectations of services and feeling of personal responsibility for choice of residence; a tendency for reliance on informal community supports; and some fear of social service intervention if users do express need. Providers must thus be aware that proactive identification and engagement with older service users may be required.

- This can also lead to users presenting to services only at ‘critical moments’ (e.g. upon loss of mobility, health emergencies, or events such as loss of a partner) with a multiplicity of complex needs. This can present general challenges in terms of planning for and delivering services for this group; urgent response is often required, and providers need to be conscious that users presenting with one need may have vulnerabilities in a variety of areas and need signposting and engagement support.

- Providers widely recognised that ageing population posed challenges for design and delivery of services in rural areas – which were likely to continue or worsen as the population aged. There was evidence of a range of levels of progress in explicitly mapping and planning for older users’ needs – from general projections of need based on area demographic profiles to full, multi-stream research and older user consultation efforts. Providers indicated a key challenge of meeting older users’ needs as well as those of their general resident populations, and not had plans in place to respond to older residents specifically.

General challenges for service design and delivery

- Ensuring older user access to appropriate services posed a range of common challenges for providers, related to lower population density impeding economies of scale, and the general cost of distance in terms of travel and opportunity costs. These challenges were exacerbated by area sparsity (and further distance
between users and services); financial constraints; fragmented demand due to the need for in-home provision as well as the diversity of older populations; challenges around lack of community diversity and shrinking volunteer bases; and poor internet access in rural areas.

- Whilst many of these general challenges are unlikely to change for rural providers, there was a key consideration around need for attention to maintaining the diversity of rural communities. Although in-community and volunteer-based service provision can provide potential solutions within the above constraints, unless rural areas are able to attract and maintain populations of families and younger people there is a key risk that volunteer bases will continue to shrink and such approaches will become unsustainable.

- As financial constraints are also likely to increase rather than lessen, creative solutions to service funding and efficient conduct must be explored. Some examples of this are explored as follows and in the good practice case studies appended to this report.

- Pursuing fuller internet connectivity – including broadband and mobile access – in rural communities may also allow more efficient service and information provision to older populations. Although some providers and users mentioned that older residents had barriers around internet use and confidence, as a more computer-literate generation ages in place it will be important to ensure that internet infrastructure is in place to meet their needs.

### Housing

- Older people in this sample expressed a strong preference to age in place – ideally in their own home, or if this wasn’t possible to move into needs-appropriate housing within the local area.

- However, research identified some key challenges in terms of awareness and availability of services to help people age successfully within their own homes. This included low awareness and use of home maintenance and adaptation services (HMA); funded support was typically seen as the right only of the ‘poorest and most poorly’. Subsidised or funded social and personal care services were likewise typically not used by older service users – even those with likely eligible need – and the availability of informal care and support via friends and family was highly variable. User barriers around fear of engaging with support services was also noted.

- Providers engaged in a range of efforts to help combat these challenges – including outreach and in-home support services to support independent living, and some efforts to overcome user barriers to service take up. However, gaps in this area persist. As the population ages and need for in-home HMA and social care services increases, increased integration and coordination between services will likely be needed to avoid inefficiencies in service provision or access issues.
for older. Alternative funding and delivery structures also may be required to help ensure services are sustainable moving forwards.

- There were also a number of barriers noted to helping older rural residents age in their local communities by moving into appropriately supportive housing if and when this is needed. This was due in part to failure of proactive planning around future housing need by residents themselves, as well as housing stock shortages – particularly for 'intermediate' options such as older-user adapted flats and bungalows. A number of barriers to addressing housing stock imbalances were noted, including tensions with sustainable development and efficiency planning; market barriers; difficulty attracting private developers to build the kinds of homes needed (e.g. bungalows); and community resistance to new building in some areas.

- Research evidenced a range of activities to understand and address housing stock challenges, including in some cases specific profiling of older users' wishes and needs to inform planning strategies. Other strategies included the use of Neighborhood Development Plans to guide planning, collaborating with housing developers to achieve targets, undertaking public engagement to reduce resident-side barriers, or purchasing new council housing. Further needs mapping and proactive neighbourhood and community planning is needed, however, to address current shortages and ensure the future availability of needed stock as communities age.

**Transport**

- Given residents’ desire to remain in place as they aged, transport accessibility became a critical issue for older rural residents, with complex implications for social isolation and health services access. Service users were typically dependent on private transport (e.g. personal car use) until forced to give up their license by mobility or health issues, and expressed a desire to stay independently mobile for as long as possible. Some areas were engaging with services (i.e., 95 Alive) to help support older users to safely maintain independent driving ability. However, reliance on personal transport had follow-on effects in terms of limiting demand for public transport options – reducing services’ efficiency and sustainability, and raising risk that services could remain in place for when older residents eventually needed them.

- Bus services raised a number of challenges around service frequency, reliability, and timetabling – and there was often mis-match between what service users desired in terms of routes and what was currently provided or feasible. More remote villages in particular could be cut off from bus services. Across the sample bus services were also seen as often inadequate to ensure access to health services, with knock-on effects in terms of preventative health care and access to treatment. Alternative transport options such as taxi use and informal community arrangements were not sufficient to address this gap, given barriers
around affordability and availability, respectively. There was evidence of a range of strategies to address these issues, including proactive consultation and user feedback assessments to better tailor transport offerings; awareness and proactive engagement activities to ‘warm up’ potential service users; and attempts to provide efficiency savings by embedding offerings in local communities or joint-working initiatives between and across rural areas.

- Rural communities had often made available a variety of bookable car and mini-bus services for their residents – often targeted at older users in particular – but a variety of barriers to user take-up were noted to these. Awareness was often low and older service users were also often reluctant to signal need and accept help from ‘strangers’. There was also a key challenge around changing older users’ engrained habits to use book-ahead services. Sustainability and affordability of these schemes were also an issue given high running costs, shrinking volunteer bases, low user demand, cuts in subsidies and difficulty securing grant support.

- Significant gaps related to transport remained, with follow-on impact in terms of older users’ vulnerability, access to services and ability to participate in their communities. Proactive communications and signposting of services to older users is required in the first instance to help make users aware of what is already available and reduce barriers to use. There also appears to be a need for linked-up transport planning with overall community planning to ensure heterogeneous and vibrant communities – and in the short term, to continue bringing services to users to avoid vulnerability and social isolation from those unable to use provided transport options.

Health

- User barriers around identifying and seeking support for health needs could result in older residents presenting to services only in moments of ‘critical need’ which increased strain on providers. As discussed above, access to health services in terms of transport barriers was also a key issue, resulting in the need for resource-heavy and costly home visits.

- Alternatively, providers were also meeting the challenges of rural health service provision via decentralising health services and opening services for self-referral to eliminate the need for initial GP visits, promoting preventative approaches, and trying to integrate services across organisational boundaries to meet needs more efficiently.

- Key challenges remained in terms of ensuring accessibility of services for all older rural users – for example, around dementia services and prescription medication access – and ensure that vulnerable older people didn’t ‘slip through the gaps.’ Services were considered to be fractured and fragmented, with poor inter-working between health and social care services. The funding and sustainability of in-person home based services was also questioned, with NHS
providers increasingly looking to the voluntary sector to provide services in response to funding cuts. However, it was noted that voluntary organisations will also struggle to provide economies of scale, and simply shifting the burden to the voluntary sector may not be feasible or sufficient to meet need.

**Principles of Good Practice**

This research identified a range of good practice, including accessibility; identification; sustainability; responsiveness; encouragement of engagement and behaviour change; and promotion of independence; community involvement and engagement; partnership and joined up working; and taking a user-focused approach. These are largely consonant with [local level rural proofing](http://randd.defra.gov.uk/Default.aspx?Menu=Menu&Module=More&Location=None&Completed=0&ProjectID=18130#Description) principles of good practice, although there is no specific Defra principle relating to ‘responsiveness.’ Given that this research suggests that the older rural population is likely to delay contact with services until critical moments of need, it is suggested that this may be an additional good practice principle important to consider for this group.