

Briefing December 2020

Rural, remote and at risk: Why rural health services face a steep climb to recovery from Covid-19

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Key points

- Rural and remote areas experienced problems that differentiate them from their more urban counterparts even before the Covid-19 pandemic. However, the pandemic has both exacerbated some of these challenges, as well as thrown up new ones.
- Covid-19 has had a **more detrimental effect on hospital waiting times in rural and remote trusts** than in trusts in more urban areas. In April 2020, the proportion of patients seen for their first consultant appointment for cancer fell by two-thirds (66%) in rural trusts compared with April 2019, whereas a decrease of 59% was seen in trusts located in more urban areas.
- Activity has fallen particularly dramatically in rural areas. **Emergency admissions** from April to June 2020, compared with the year before, **fell by 57% in rural trusts** while they fell by 45% elsewhere. The level of **referral for talking therapies** – via the Improving Access to Psychological Therapies (IAPT) programme – **in rural areas was below half** the level in April 2020 than it was a year before.

- The pandemic has **exacerbated workforce issues in remote trusts**. Remote trusts spend more on temporary staff (8% of their staffing budget) compared with other areas (6%). While the number of hospital and community health staff increased by 7% nationally in the year to June 2020, the workforce of remote trusts grew by only 5% over the same period.
- The underlying **financial position** of rural and remote services was **worse than the position of more urban trusts** before the pandemic started, and the pandemic may well have exacerbated this. Remote trusts' debt was equivalent to more than half (56%) of their annual operating income in 2018/19. Remote trusts also typically do not seem to get their fair share of additional funding that goes into the NHS.

Context

The Covid-19 pandemic has repeatedly exposed the fault lines in the premise of a fair society and public services that are available to everyone. Health inequalities are a clear example, and for this paper we sought to explore briefly whether rural pressures might be another. There are many dimensions to the response of the NHS to the pandemic and the effect the pandemic has had on the service. For instance, initially across England there were efforts to free up hospital capacity to treat Covid-19 patients, which included increasing intensive care capacity, discharging patients and stopping elective care. Now services are seeking to address spiralling waiting lists for elective care.

The challenges of providing care can vary in unavoidable or uncontrollable ways in different areas of England. It has long been recognised that rural and remote services have particular pressures, for a number of reasons (see the figure on the next page), although quantifying the impact of these is challenging. If insufficient adjustment or compensation is made for the unavoidable costs involved, it is likely that some health services will not be able to afford to provide their population with the same access to, and quality of, care that others do.¹

In this paper, we explore the impact the pandemic has had on the delivery of rural and remote health services, highlighting some of the underlying challenges that services have faced and outlining how some of these are different in rural areas in comparison with more urban areas. We conclude with a discussion on how performance could be monitored to signal the risk of any significant service pressures over the coming months.

The pressures facing rural and remote health care services



Workforce

- Recruitment and retention difficulties
- Higher overall staff costs



Distance

- Higher travel costs
- Unproductive staff time when travelling



Size

- Scale of fixed costs, for example safe staffing-level guidelines
- Difficulties in realising economies of scale



Access to resources

- Some resources are more expensive or difficult to access, for example telecommunications, training and consultancy

This was a short scoping exercise and not an exhaustive assessment. It is also primarily limited to NHS services, with a lack of readily available information on social care, making an assessment of the social care sector unfeasible. It is also important to note that non-urban trusts include a diverse range of providers, and while they face some similar challenges, they also have individual challenges. In this report we sought to look at rural and remote services separately.

For the purpose of our analysis, we defined rural trusts as the 10% with the highest proportion of patients admitted from rural areas, and clinical commissioning groups and local authorities were defined by Office for National Statistics' 2011 rural-urban classification. Remote trusts are those considered to face higher costs due to their small size and location far from the next nearest service. For a list of the trusts defined as 'rural' and 'remote' for the purposes of this analysis, and for further details on our definitions, see Appendix A.

Health impact

Cases and deaths

Covid-19 has already had a direct impact on the health of many people. But the virus has a considerably higher health impact on older populations, which is significant for rural areas – 17% of the rural population of England are aged 70 and over, compared with 12% elsewhere. In the event, Covid-19 did not spread as early in rural areas as elsewhere: the peak of confirmed cases in non-rural areas (nearly one in 1,000 people in early April 2020) was evident about a month or so before the peak was seen in rural communities (which was around the same rate at the end of April). However, it remains unclear whether this trend is an artefact of the changing availability of testing.

As a result of the later spread to rural areas, mortality rates in these areas were initially lower than in urban centres: between March and May 2020, the age- and sex-standardised mortality rate from Covid-19 was highest in major urban conurbations (124 per 100,000 population), while rural towns and fringes saw a death rate of 59 per 100,000 population over the same period.

While the wider effect on public health is unclear, it is perhaps instructive to look at underlying influences, one of which is economic pressures. The most rural areas (those with more than 80% of the population living rurally) had the highest proportion of employees furloughed during both June and July 2020, at around two percentage points higher than in urban cities and towns (for example, 31% compared with 29% in the latter month).

Hospital waiting and ambulance response times

There are, of course, health effects not directly the result of Covid-19 but due to patients' and services' responses to the pandemic – such as delayed presentations and treatment. While the effect on patient outcomes is, as yet, unclear, the impact on waiting times and activity levels has been dramatic:

- From April to June 2020, with fewer patients presenting at Accident & Emergency (A&E),² the proportion of **A&E patients** seen within four hours (the waiting-time target) increased across all three geographies under study (rural, remote and all other areas). However, on average, A&E services still failed to hit the operational standard of 95%, with performance lower in remote trusts (91%) and rural providers (90%) compared with other trusts (93%).

- Since March 2020, hospital activity has dropped dramatically, with **elective** care postponed in many cases to release hospital capacity and many people apparently discouraged from using emergency services. By May 2020, elective activity had fallen by around two-thirds in rural and remote trusts – similar to that in all other trusts. However, rural trusts had a substantially greater fall in **emergency** admissions compared with all other providers. From April to June 2020, compared with the year before, emergency admissions fell by 57% in rural trusts, while they fell by 45% elsewhere.
- For **cancer waiting times**, in April 2020, rural and remote trusts fell short of achieving the target of 95% of their patients being seen within two weeks. As well as this, the number of patients actually being seen for their first cancer appointment with a consultant compared with the same time in 2019 reduced significantly (by 58% in remote areas and by two-thirds – 66% – in rural communities, compared with 59% in all other areas). However, over the same period, all trusts (including rural and remote) saw around a 25% decrease in the proportion of patients receiving their first cancer treatment within two months.

At the start of the pandemic, many **ambulance** trusts were already under immense pressure, with high rates of handovers to hospital emergency departments. Ambulance trusts tend to cover large areas, comprising big pockets of both urban and rural communities, making it difficult to unpick the particular effect of the pandemic on rural areas. However, the mean response time for Category 1 ambulance calls (those classified as life-threatening and requiring immediate intervention or resuscitation) over the past year in the Isle of Wight (the most sparsely populated area in England) was on average three-and-a-half minutes more than the England mean response time and on a par with the level seen during a large spike in March in London when it was a hotspot for Covid-19.³ In cases where ambulance services were diverted to other centres, the impact on patients with coronavirus would have been substantial due to these patients being prone to rapid deterioration – potentially leading to poorer health outcomes.⁴

Mental health and social care

Given our reliance on existing data, much of this commentary focuses on general acute hospital services. However, there are indications that rural and remote services are facing challenges in other settings, including in terms of certain mental health and social care interventions.

Levels of referrals to Improving Access to Psychological Therapies (IAPT) services have decreased for all clinical commissioning groups but this has been more apparent among rural and remote providers. The number of referrals in April 2020 from rural clinical commissioning groups decreased by 52% from the year before, while all other clinical commissioning groups saw IAPT referrals decrease by 44%.

‘NHS continuing health care’ may be provided to some adults who have complex health needs. Historically, remote and rural areas have struggled with providing timely access to this care: between April and June 2017, more than a third (35%) of all referrals made in remote areas exceeded the target of 28 days; this compared with 23% in rural areas and 11% in more urban communities. However, by March 2020, the proportion of referrals exceeding 28 days dramatically decreased to, at most, 6% for these three geographical groupings, although overall, fewer referrals were being made.

Arguably, demand for care packages for vulnerable individuals during the pandemic would have increased, particularly in more rural areas where there are higher rates of older people. However, clinical commissioning groups were instructed to suspend continuing health care assessments during the Covid-19 peak, with these services resuming in September 2020. Given the high rates of delayed assessments in remote and rural areas pre-Covid, clinical commissioning groups and local authorities in these areas in particular may struggle to complete all retrospective and prospective assessments.

Funding

In April 2020, the government ‘wrote off’ the historic debt of NHS trusts, totalling £13.4 billion. The intention to intervene on debts was signalled before the pandemic but occurred during it. At the time, the level of debt for rural services – while large – was not, on average, dissimilar to debt for non-rural services – at around a sixth of annual operating income. However, the seven remote trusts had, on average, a far worse underlying financial position. Their debt in 2018/19 was, on average, equivalent to more than half (56%) of their operating income and accounted for a 10th (£1.3 billion) of their total debt, despite accounting for just 3% of their annual income. This again highlights the scale of financial challenges some remote services face.

There are many unavoidable reasons why these debts might have been accrued. When comparing like-for-like activity, the most remote hospital providers cost 8% more. Size can also matter; in primary care, one estimate suggests that a 10% increase in patient list size is associated with a 3% reduction in cost per patient.^{5,6} Our previous work on health care in rural areas has highlighted some of the existing issues with allocations to rural areas,⁷ which might also be causing them undue pressure (see the text box below).

Previous findings on allocations to rural areas

Our previous review of the current mechanisms for funding services, which includes the approach to allocating budgets to local commissioners and the payment system for NHS trusts, suggests the following:

- The weight given to adjustments for health inequalities and unmet need has a strong influence on allocations to rural areas. These adjustments are not informed by evidence, but remain a matter of judgement. This has the effect of directing the target allocations primarily towards urban areas.
- The scale of the adjustment for unavoidable smallness (£33 million in total) is very small compared with both other adjustments and NHS Improvement's own calculation of unavoidable costs, which it used in adjusting the tariff for just one of the affected trusts (Morecambe Bay), which was equivalent to between £20 million and £25 million a year. In fact, subsequently published official documents suggest that around 80% of emergency care costs may be fixed.⁸

The actual allocations that specific areas receive are affected not only by population needs and unavoidable costs but also by historic funding levels. Policy-makers try not to destabilise local health economies by making large changes in funding. Overall, across the allocations for core, specialised and primary care services, this has the effect of moving money away from rural areas.⁹

History suggests that rural and remote services are at risk of not getting what might be deemed their fair share of the additional funding that is being injected into the NHS as a result of the pandemic. Much of the £32 billion that the Treasury has approved to support the health response to Covid-19 will be spent on national initiatives, but that will not account for all of it, with some being directed towards local services. However, looking back:

- the seven remote trusts received, in total, just 1.7% (£30 million out of £1,783 million) of the total allocation through the Sustainability and Transformation Fund in 2017/18¹⁰
- similarly, the Provider Sustainability Fund, paid to trusts that accept their control totals* and deliver on both financial and operational performance, had the effect of reducing rural and remote trusts' deficit by 0.7% and 0.3% respectively in 2018/19, compared with 1.6% for more urban trusts.

A lack of transparency about the flows of additional funding increases the risk that the funding is not distributed fairly and there is some evidence that rural services have been marginalised to some extent: for example, they have not received details about what equipment they might receive as a result of the pandemic as early as others.¹¹

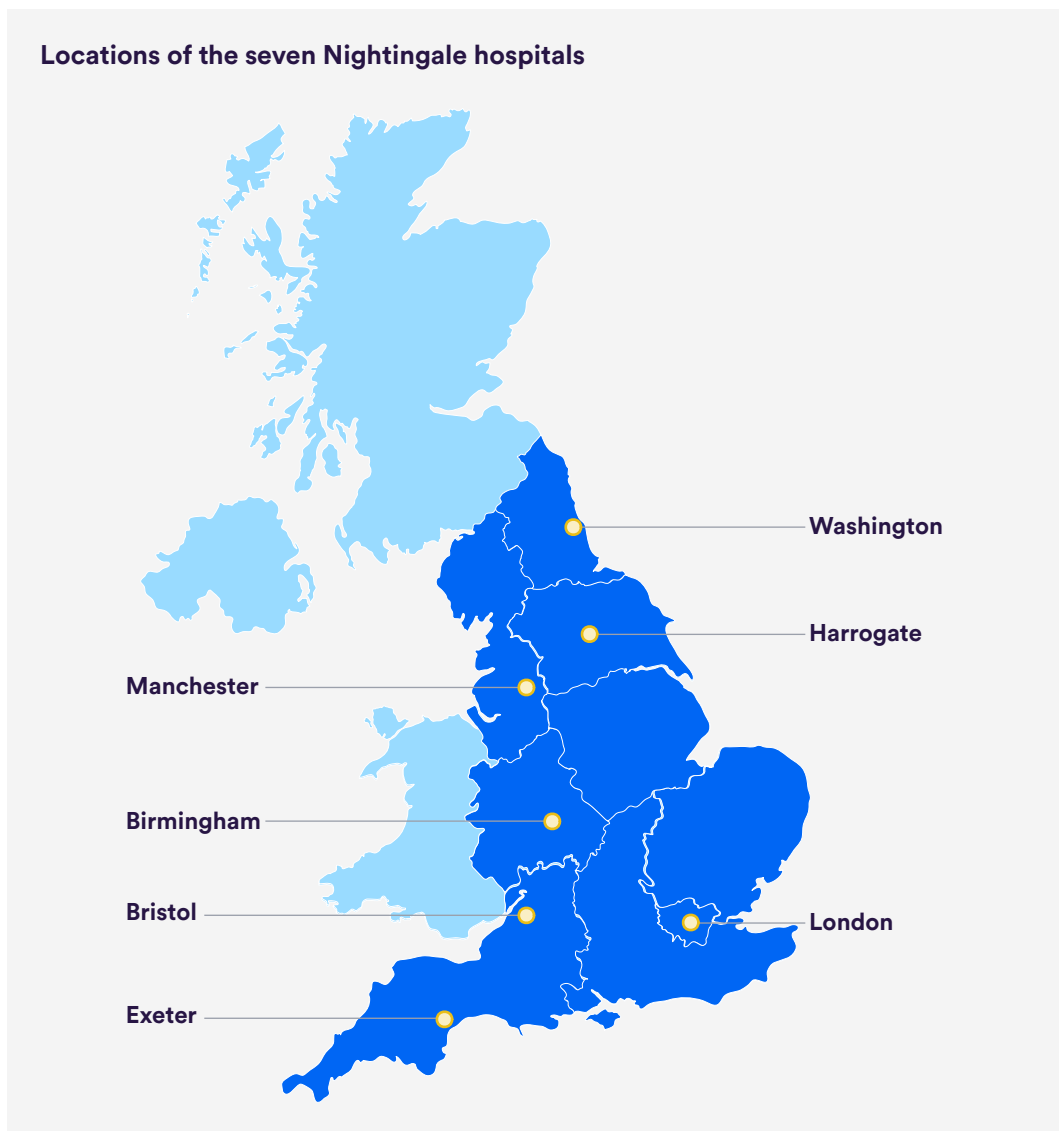
Capacity

Capacity to provide NHS care remains a key issue. Patients waiting more than a year for elective treatment grew exponentially from February to May 2020,¹² highlighting how trusts had to dramatically scale back their planned activity. Trusts have been told to return to near-normal levels of non-Covid services, delivering at least 80% of previous-year elective activity by September 2020, rising to 90% by October.¹³ However, there remain questions – as outlined below – over the ability of rural and remote areas to provide sufficient capacity, through freeing up existing capacity, expanding capacity and using local non-NHS capacity to provide NHS care.

* Control totals are annual financial targets that NHS trusts can accept in order to access additional funding. Trusts must deliver on their control total in order to access this benefit.

Nightingale hospitals

A key part of expanding capacity to cope with the pandemic was building a Nightingale hospital in seven locations across England (see the map below). Across all seven hospitals, there was the potential to provide up to 12,000 additional beds, albeit only two hospitals were used in the first wave of the pandemic, with no more than 200 patients being admitted.¹⁴ However, these hospitals were very much an urban model and their location was not appropriate for patients in many rural areas. As one commentator has noted: ‘the centralisation of acute and/or intensive care services ... makes much less sense for more rural and remote hospitals.’¹⁵ As a second wave of infections takes hold, some of the Nightingale hospitals again appear to be part of the proposed solution to help manage demand, and so this remains a live issue for some rural areas.



Independent sector

When the pandemic first hit the UK, independent providers played a pivotal role in extending services and facilities available to deal with the surge of Covid-19 patients. NHS England block-booked the equivalent of 8,000 beds and 20,000 clinical staff.¹⁶ There is no readily accessible data on the distribution of independent sector capacity. However, data from 2016/17 suggested that, nationally, local commissioners spent £12 billion on purchasing health care from non-NHS providers – about £1 in every £6 they spent. Perhaps surprisingly, those commissioners from remote trusts spent more on the purchasing of health services from non-NHS bodies (20%) than their non-rural counterparts (16%), although in part this may be due to community interest companies playing a more significant role in community services in rural areas.

More recently, following concerns that the NHS would struggle to bring back near-normal levels of activity and waiting times, a contract notice stated that the NHS could spend up to £10 billion on outsourcing work to private providers over the next four years.¹⁷ More work is needed to understand which areas have appropriate independent sector capacity to help clear rapidly increasing waiting lists for planned care.

Estates

In terms of trusts' ability to increase capacity within their current estates, it is important to note that rural sites typically have less unoccupied floor space, so possibly less flexibility; 8% of floor space in non-rural sites is unoccupied compared with a lower level – just 5% – in rural areas. As well as this, before the pandemic struck, remote trusts had fewer occupied general and acute beds (77% occupied) compared with rural trusts (93%) and all other trusts (89%). That said, in the latest quarter (April to June 2020), data show large decreases in occupancy levels across England, which are particularly striking in rural services. These trusts may have felt pressure to discharge more patients to free up as much capacity as possible, particularly as they were unlikely to be able to benefit from the support of Nightingale hospitals.

Staffing

Another challenge is that of hospital staffing. We have previously highlighted that sparsely populated areas have greater difficulties in recruiting and

retaining staff.¹⁸ While there was a 7% national increase in staff in the year to June 2020, the workforce in remote trusts[†] grew at a slower rate over the same period (by 5%, compared with 8% for rural trusts). Remote trusts appear, for example, to have been less likely to benefit from students extending their clinical placements, since many of them are located further away from academic institutions. There is also a greater reliance on temporary staff to plug these gaps in remote areas. This comes at a significant cost, with 8% of remote trusts' total spending on staff going towards bank and agency staff (compared with 5% in rural trusts and 6% elsewhere).

Building the workforce in primary care across England has been a struggle in recent years.[‡] Over the period between June 2019 and June 2020, the available data suggest that while more urban areas saw a 0.7% (+145) increase in the number of full-time equivalent general practitioners (GPs), rural communities in fact experienced an increase of 1.1% (+124). This may reflect efforts of a targeted recruitment scheme in England, which is offering a financial incentive to GP trainees who commit to working in 'hard to recruit' areas, many of which are rural.¹⁹ Despite this, previous analysis has found variation in the distribution of NHS dentists across England, with shortfalls being more apparent in rural and remote areas.²⁰ That said, the data for staff working in primary care is not complete nor comprehensive, with figures not including, for example, those employed by primary care networks. This needs to be rectified to provide appropriate assurance about the workforce.

Resilience

The uncertainty over NHS activity and the effect on capacity as a result of Covid-19 both to date and in the future is particularly problematic for rural and remote services. Generally speaking, rural and remote services are made up of smaller teams than those in urban services. Even small gaps in the workforce are felt more intensely if, for instance, sickness absence increases. Indeed, the latest data show that sickness absence this year increased to the highest levels ever seen in April – 2.1 percentage points higher than April 2019,

† This figure does not include staff employed by North Cumbria Integrated Care NHS Foundation Trust due to the transfer of mental health and learning disabilities staff to Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust and Lancashire and South Cumbria NHS Foundation Trust in October 2019.

‡ The primary care workforce does not include staff who are employed by primary care networks.

and exceeding winter peaks of sickness absence recorded over the past 11 years.²¹

The limited availability of services in rural and remote areas also means that, were there to be any disruption to a particular provider, then the population might be left without an accessible alternative. For example, even within the current levels of provision, only 19% of the rural population are within 20 minutes' walk of a community pharmacy, compared with 98% of the population in urban areas.²² If such services were to close, it would further amplify these differences.

Rural and remote trusts are, by their nature, more likely to be isolated from other health care services. There are 19 small acute hospitals where more than half of the population would have to drive more than 30 minutes to the next nearest acute hospital.²³ These providers are therefore more compelled to provide a full array of services in a single estate.

As well as this, remote areas typically have a single, dominant provider, which they commission most services from. For example, five of the seven remote clinical commissioning groups have a single trust accounting for at least 80% of their spending, whereas this is the case in only half of non-rural clinical commissioning groups. There is a risk that reliance on a single hospital makes it much more challenging to reconfigure the space in response to Covid-19.

Conclusion and recommendations

That rural and remote providers experience problems that differentiate them from their urban counterparts is nothing new. However, the Covid-19 pandemic has both exposed these further and thrown up new challenges. It is imperative to tailor responses to the pandemic to take account of such differences, in order for teams to best assist the communities they serve.²⁴ Yet many national standards and policies were not appropriately adapted to meet the needs of rural areas even before the pandemic struck.²⁵

Our work found that remote areas have specific workforce challenges, with the trend in workforce numbers failing to keep up with the national picture. We also discovered that remote commissioners tend to have one single, dominant provider that they commission most services from, potentially leaving them less resilient. In addition, rural trusts have less unoccupied floor space and

could well be less likely to benefit from ambitions to use the urban-centric Nightingale model or the independent sector to clear waiting lists.

Additionally, long waiting times have historically been a greater problem for remote trusts, and we found that remote providers had greater drops in elective activity, longer waiting times and more delays in completing NHS continuing health care assessments compared with non-rural trusts during the period when Covid-19 was starting to take effect. Rural areas may feel greater pressure when trying to pick up normal care without the growing resources or capacity apparent in more urban areas.

This work was a short, exploratory exercise. Given the small number of remote organisations and the heterogeneous nature of the rural and non-rural groupings, the findings need to be treated with some caution.

However, there remain many important analytical avenues that could be pursued to better understand the relative challenges facing rural and remote services. In particular, these could include (but are not limited to):

- analysing the distance (drive times) that patients from different geographical areas are having to travel to access treatment
- exploring how the different types of geographies, such as coastal regions, might be particularly affected
- investigating suitable comparators to rural and remote services, such as comparing them only to those with similar characteristics (other than geography).

In terms of further work, we scoped a dashboard as part of this study, comprising a series of measures to track over time, relating to hospital activity and capacity, mental health care, primary care and social care (see **Appendix B**). Some of the data on these measures are included in the findings we have presented in this paper and are also presented in **Appendix B**. The aim of such a dashboard is to help identify important service pressures and challenges facing rural and remote services. It also serves to highlight the pressures that rural and remote areas faced, both historically and at the brink of the Covid-19 pandemic.

Additional work should also seek to understand what particular mechanisms might be causing pressures in rural and remote services, such as the nature of the population they serve, capacity constraints or geographical characteristics. Given the importance of health services and the unique challenges that rural and remote services face, keeping a close eye on emerging pressures will be critical in these areas.

About this briefing

In summer 2020, the National Centre for Rural Health and Care commissioned the Nuffield Trust to explore the challenges faced by rural areas in addressing the pandemic and asked that we explore what indicators could be used to continue to monitor this issue. The work builds on the report we were similarly commissioned to produce in 2019, entitled *Rural health care: A rapid review of the impact of rurality on the costs of delivering health care* (see www.nuffieldtrust.org.uk/research/rural-health-care).

Acknowledgements

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Appendix A: Identifying rural and remote services

NHS services cannot be categorised as just rural or urban. Each service – and the population it treats – has its own set of characteristics (although that is not to say that some of the challenges are not fairly consistent across a number of providers). It is important, therefore, to explore which services are most susceptible to particular pressures. Characteristics that might make services more susceptible to challenges include being:

- rural – for example, because of the nature of the rural population and economy
- remote – for example, because of the distance between the service and other resources and capacity
- small – for example, because they would find peaks in demand more difficult to accommodate
- coastal – for example, because of having a tourism-based economy and catchment area issues
- junior – that is, where the health economy is dominated by another provider.

We carried out an informal survey of 106 service managers, which suggested that rural and coastal geographies would be most challenged in responding to the Covid-19 pandemic, followed closely by remote areas. For the purpose of this scoping exercise, we focused on rural and remote areas.

Defining rural and remote areas

Rural areas. We defined rural NHS trusts as the top 10% of trusts with the highest proportion of admitted patients living in rural areas in 2018–19 (based on patient postcode), calculated from Hospital Episode Statistics (HES).

For **clinical commissioning groups**, we based rurality on the Office for National Statistics' 2011 rural-urban classification of clinical commissioning groups²⁶ – any codes that were broadly described as 'urban with significant rural' and 'predominantly rural' were included in our rural definition (unless they were classified as remote – see below). As many clinical commissioning groups have merged since 2011, we redefined rurality for the newly configured

clinical commissioning groups by taking the average level of rurality from the 2011 classification. We used the approach taken to categorise clinical commissioning groups to also categorise lower-tier **local authorities**.

We categorised 20 trusts, 64 clinical commissioning groups and 139 lower-tier local authorities as rural, which reflects NHS organisation structures from June 2020 data.

Remote areas. We grouped seven trusts that were defined as those with ‘unavoidably small hospitals’ as a separate category – ‘remote’. This definition was used in our previous report on health care in rural areas.²⁷ We used the same mapping of remote trusts to their respective clinical commissioning groups as defined in our previous report.

We compared both rural and remote trusts to all other NHS trusts in England; the same applied for rural and remote clinical commissioning groups. Details on the measures used and the resulting data can be found in [Appendix B](#).

Rural trusts:

Cambridge University Hospitals NHS Foundation Trust
Cornwall Partnership NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust
Lincolnshire Community Health Services NHS Trust
Lincolnshire Partnership NHS Foundation Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
Norfolk Community Health And Care NHS Trust
Royal Papworth Hospital NHS Foundation Trust
Royal Cornwall Hospitals NHS Trust
Royal Devon and Exeter NHS Foundation Trust
Royal Surrey County Hospital NHS Foundation Trust
Salisbury NHS Foundation Trust
Shrewsbury and Telford Hospital NHS Trust
Shropshire Community Health NHS Trust
Somerset NHS Foundation Trust
Taunton and Somerset NHS Foundation Trust
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
West Suffolk NHS Foundation Trust
Yeovil District Hospital NHS Foundation Trust

Remote trusts:

Isle of Wight NHS Trust

North Cumbria University Hospitals NHS Trust (merged in October 2019 to form North Cumbria Integrated Care NHS Foundation Trust)

Northern Devon Healthcare NHS Trust

United Lincolnshire Hospitals NHS Trust

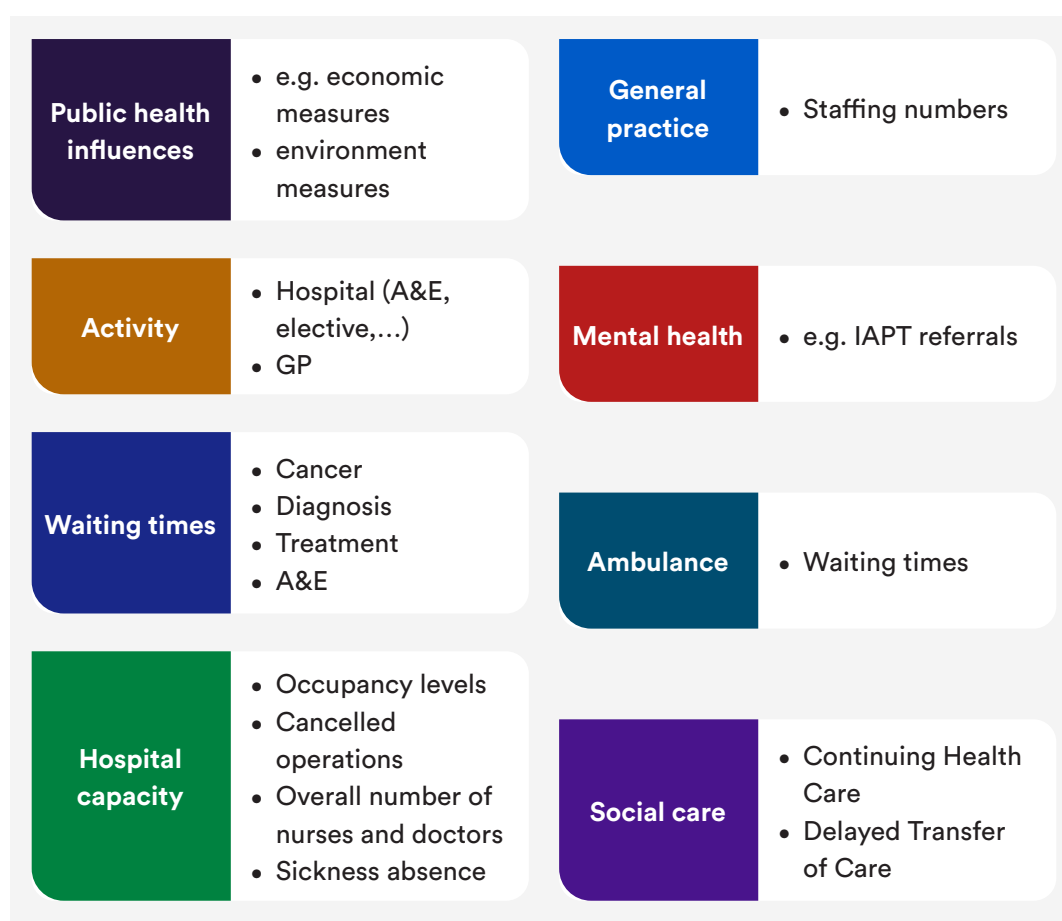
University Hospitals of Morecombe Bay NHS Foundation Trust

Wye Valley NHS Trust

York Teaching Hospital NHS Foundation Trust

Appendix B: Dashboard methodology and results

For the dashboard, we chose measures that would cover some of the key sectors within health care (see the figure below). We included those that were likely to signal specific service pressures and impact on the quality of care delivered. Given the intention that a dashboard would provide near real-time feedback, we also based our choice of measures on the availability and granularity of the data (that is, data that are published monthly/quarterly and at trust or clinical commissioning group level), which we could categorise using our definitions of 'rural' and 'remote' areas (see Appendix A). We are not, of course, suggesting that the list of measures is a definitive one, rather that this exercise should be considered a proof of concept for such a dashboard.



The table on the next page presents data on these measures, some of which we have presented in this paper.

Dashboard results

	Rural trusts/CCGs				Remote trusts/CCGs			
	Current performance	vs all other trusts/CCGs	vs 2019	Trend since 2019	Current performance	vs all other trusts/CCGs	vs 2019	Trend since 2019
Activity								
Total elective activity (indexed from May 2019)	35.9%	4.5%	-64.1%		28.6%	-2.8%	-71.4%	
Total emergency activity (indexed from January/March 2019)	42.9%	-12.5%	-57.1%		54.8%	-0.6%	-45.2%	
Hospital waiting times								
Patients seen within 2 months for first cancer treatment (April 2020)	72.4%	-2.1%	-5.7%		73.4%	-1.1%	-5.7%	
Patients seen for first consultant appointment for cancer following urgent GP referral (indexed from April 2019)	34.3%	-6.4%	-65.7%		42.2%	1.4%	-57.8%	
Percentage of A&E attendances seen under 4 hours from arrival to admission/transfer/discharge (April/June 2020)	90.2%	-2.3%	2.0%		91.2%	-1.3%	8.1%	
Capacity								
Occupied general & acute beds as a proportion of available beds (April/June 2020)	61.5%	-1.4%	-27.2%		62.2%	-0.7%	-28.3%	
FTE staff working in hospital & community health services (indexed from June 2019)	108.2%	1.3%	8.2%		105.5%	-1.4%	5.5%	
General practice								
General practitioners (full-time equivalent) (June 2020)	11,798	0.4%	+124					
Mental health								
Number of IAPT referrals received (indexed from April 2019)	47.5%	-8.5%	-52.5%					
Social care								
Number of referrals to continuing health care (CHC) exceeding 28 days as a proportion of all patients eligible for CHC (January/March 2020)	4.4%	0.6%	-18.6%		6.1%	2.3%	-28.9%	

Note: CCGs = clinical commissioning groups.

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