Briefing Note on Rural Healthwatches

There can be huge variations among the areas covered by individual local Healthwatch organisations regardless of whether they are metropolitan or rural. This paper seeks to draw out some of the characteristics peculiar to rural areas that affect local Healthwatches and how they need to operate. It is not possible to pick up all the issues in a short paper so I apologise if I have missed anything important.

Many rural authorities are large, but size is not just about the distance from one end of the local authority to the other but how services are provided. While each area covered by a local Healthwatch organisation has only one local authority commissioning adult social care and children's services, there may be more than one clinical commissioning group and acute trust, and a multiplicity of other providers of health and social care providers and a healthy and varied voluntary and community sector. (The area in which I work has five CCGs and three acute hospitals.)

The multiplicity of local providers does not necessarily mean more choice for the local population. A rural county which is remote in the sense that it is not on the way to anywhere else may not attract larger providers, so providers are often small and can be very local. For many local people, the decision on which service to use is based on which one(s) they can gain access to. Public transport is an issue everywhere, but in rural areas services, where the services are infrequent, if they exist at all, patient choice may be limited to what is available in the nearest market town. Even choice of an acute hospital may be limited by whether a patient can get home from a clinic appointment. Transport remains high on the agenda of many a rural Healthwatch.

The demographics of a rural authority can be surprisingly diverse:

- Areas of deprivation in the urban areas, particularly seaside towns
- Pockets of rural deprivation, which new ways of presenting census information have revealed
- Concentrations of retired older people in coastal areas
- Migrant workers in agriculture and food processing
- An immigrant population whose members do not necessarily have the support of large communities

The absence of broadband, and mobile phone, connections in rural areas that are not necessarily particularly remote can affect how rural Healthwatches manage their communications.

Key issues rural Healthwatch organisations face as a result of this diversity may include:

- How to set realistic priorities
- How to build up a knowledge of local services to fulfil the information, signposting and advocacy role
- How to build working relationships with the key players
- How to keep track of what is happening across the whole of the area (especially at a time of funding cuts)
- Encouraging equity of access to services across the authority
- Monitoring the quality of services provided by a large number of providers, some of them very local and very small
- How to ensure that we get a representative sample of views from the local population, resisting the temptation to go for the easy options
- Where to locate staff to the best effect, especially if the road system is poor
- How to keep in touch with members and volunteers

Approaches to delivering a local Healthwatch in a rural area will of necessity vary, but include:

- Putting a communications network in place that reaches out to as many areas as possible is important. This may include accepting every available invitation in the first few months to raise awareness.
- Developing partnerships and partnerships of partnerships to share knowledge and intelligence, avoid duplication and make the best use of scarce resources
- Involving partners in delivering the local Healthwatch work plan, and reciprocating the effort
- Being realistic and honest about what can be delivered within what timescale rather than raising expectations and failing to deliver

Mary Ledgard
November 2013