University of Central Lancashire
UCLan

A tale of two countrysides:

Remote and rural health and medicine

About this report

This report was commissioned by the University of Central Lancashire National Centre for Remote and Rural Medicine to explore some of the challenges facing healthcare practitioners and rural communities. ZPB Associates conducted the data research on behalf of the University of Central Lancashire (UCLan) and wrote and designed the report. This report was first published in February 2020. Some parts have been updated in January 2022.

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- Professor Michael Bewick, Independent Consultant to UCLan
- Professor Catherine Jackson, Executive Dean, Faculty of Clinical & Biomedical Sciences and Head of the School of Medicine
- Dr John Howarth, CEO and Medical Director of North Cumbria Primary Care Alliance and Professor of Primary Care at UCLan
- Professor Stuart Maitland-Knibb, Director, National Centre for Remote and Rural Medicine
- Jamie Reed, former Member of Parliament
- Dr Vincent Argent, Emergency Department Consultant, Dorset
- Dr Julian Nesbitt, Chief Executive and Founder of Dr Julian
- Dr Vincent Connolly, former System Medical Director, North Cumbria Integrated Care NHS Foundation Trust
- Dr Tim Sanders, Senior Clinical Lecturer in Rural Medicine, GP and former Training Programme Director, North Cumbria GP Training Programme

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Foreword: time to level up the health outcomes of rural communities

I was born and educated in Workington, West Cumbria, in the 1960s and 1970s. A then-significant steel and coal town, its health services were the local GP and hospitals in the town and nearby Whitehaven. At that time, no one could have been aware of the explosion of medical knowledge, technologies and communication that we have experienced since. But, to all intent and purposes, the expectation of the health service is unchanged, as most citizens receive their own and their families' care from the same institutions. Healthcare has shown a continuum and the NHS remains the principle source of it. However, for places such as West Cumbria, time hasn't moved on at the pace of our metropolitan conurbations and, like many other remote communities, the area hasn't seen the same progress in health and health outcomes.

Since this report was first published in February 2020, the Covid-19 pandemic has seen lower mortality rates in rural areas than urban, but rural hospitals have been affected by longer waiting times and workforce issues. Covid-19 has accelerated the uptake of digital healthcare, however connectivity to fast internet and mobile reception remains out of the reach of so many people living in remote and rural areas.

In general, as clinicians we focus on diseases rather than the population's health, and the determinants of the latter are often neglected at source. A good childhood, education, stable work and a healthy lifestyle are fundamental to a prolonged active life. Resource allocations by population density and health profiling do not often take into account the remoteness of the delivery of that care in challenged remote and rural areas.

The University of Central Lancashire Medical School has established a National Centre for Remote and Rural Medicine. Its aims are to attract a different approach to the development of local healthcare, where the future doctors have a 'buy in' to the needs of the communities that they will often come from themselves.

Working with local government, educators, industry and politicians is central to the success of raising aspirations for a healthy life. This paper seeks to look at the evidence as to why a focus on remote and rural areas is justified and uses Cumbria – a county where there are gross levels of inequalities of outcomes and ageing – as a case in point. Contrasting coastal towns with market towns and their hinterlands gives us the measure of how far we have to go to "level up" the communities.

As tourists flock to the Lakes and gasp at the property prices in the estate agent windows, pockets of deprivation and health inequalities pass them by. They aren't aware of the towns with "epidemic" levels of drug abuse, alcoholism and mental health diagnoses. Like many communities in remoter parts of the UK, workforce and recruitment issues predominate. The national crisis in recruitment is asymmetric and one that affects the GP and hospital communities of the coastal and remote towns more acutely.

This paper discusses how UCLan and its partners hope to tackle the problems head on and examine the different priorities that clinical staff focus on, not instead of the day-to-day need but because of it. This should have happened decades ago, and the system in general has been slow to respond. A regional medical school, an inclusive-population health approach and the new faculty of Remote and Rural Medicine offers us the prospect of "catching up" over the coming years. As a Cumbrian, I hope that this is the beginning of a renaissance in health and wellbeing for our population and other similar ones.

Professor Mike Bewick

The impact of Covid-19 on rural health

The Covid pandemic has impacted rural and urban areas differently. Analysis by Office of National Statistics early into the pandemic has shown that mortality rates are lower in rural areas than in urban areas[1]. However, a Nuffield Trust report published in December 2020 found that rural hospitals face more detrimental effects on waiting times and the pandemic has exacerbated workforce issues in remote hospitals[2].

Case rates

Case rates across Cumbria have been varied:

- Throughout the whole pandemic, Barrow-in-Furness had 27,659 cases per 100,000 compared to South Lakeland, which had 18,769 cases per 100,000 (as of 21st of January 2022)[3].
- Copeland had 25,424 cases per 100,00 and Eden had 18,934 cases per 100,000.
- In terms of inequality of mortality rates within rural areas, Barrow-in-Furness has a total death rate of 363 per 100,000 whereas Eden has a death rate of 298 per 100,000 (as of 21st of January 2022)[4], highlighting that while rural areas might have a lower mortality rate than urban areas, there is variation between different communities within that.

Waiting lists

Analysis carried out by the Nuffield Trust[5] in December 2020 revealed the following:

- Waiting times in rural and remote trusts have been affected more by Covid-19 than urban trusts. In April 2020 compared to April 2019, the proportion of cancer patients seen for their first consultant appointment fell by 66% in rural trusts compared to 59% in urban trusts.
- Emergency admissions indicate a fall in activity in rural areas. Compared to the previous year, emergency admissions fell 57% in April to June 2020 for rural trusts compared to 45% elsewhere.

[1] *Deaths involving COVID-19 by local area and socioeconomic deprivation - Office for National Statistics (ons.gov.uk)*
[2] *Rural, remote and at risk: Why rural health services face a steep climb to recovery from Covid-19 | The Nuffield Trust.*
[3] *Cases in the UK | Coronavirus in the UK (data.gov.uk)*
[4] *Deaths in the UK | Coronavirus in the UK (data.gov.uk)*
[5] *Rural, remote and at risk: Why rural health services face a steep climb to recovery from Covid-19 | The Nuffield Trust*

Finding the hidden story of health in remote and rural England

For this research, the University of Central Lancashire analysed a number of available indicators to understand more about health inequalities and the healthcare system in rural areas.

Analysis of health outcomes for a range of indicators (including life expectancy, cancer survival, admissions and readmissions) shows that rural Clinical Commissioning Groups (CCGs) have better or similar outcomes to urban ones. This is probably because the rural population is generally more affluent than in urban areas.

However, all is not well in rural communities. The statistics mask the huge disparity and health inequalities that exist in remote and rural England. For example, in Barrow-in-Furness on the Cumbrian coast, rates of life expectancy for men are significantly worse than the national average and, within this area, life expectancy is 11.9 years lower for men in the most deprived areas compared to the least deprived[6].

[6] *Office for Health Improvement and Disparities, Barrow-in-Furness Public Health Profile (2022)*

Mental health: the diseases of despair

Deprivation and unemployment really affect pockets of remote and rural communities, and health indicators reveal rural areas are disproportionately affected by 'diseases of despair'[7]. In County Durham in the North East, the rate for alcohol- related-harm hospital admissions is 758 per 100,000 population – significantly worse than the average for England. This represents 3,972 admissions to hospital per year. The rate for self-harm hospital admissions is 197 per 100,000 population. This represents 1005 admissions per year[8].

Jamie Reed, MP for Copeland from 2005-2017 who assisted with this research, says: "During the last two years of being an MP, of the people coming to see me for help with unemployment, debt or family breakdown, the root cause of it all in as many as half of the cases was a kind of mental health collapse. Over these past few years, there seems to be something like a mental health epidemic in rural areas.

"Mental health becomes a pathway into all manner of different types of physical difficulties and ailments as well. It's affected significantly by a lack of economic opportunity and by a lack of a positive identity in the place in which you live, and which you may not find yourself able to get out of."

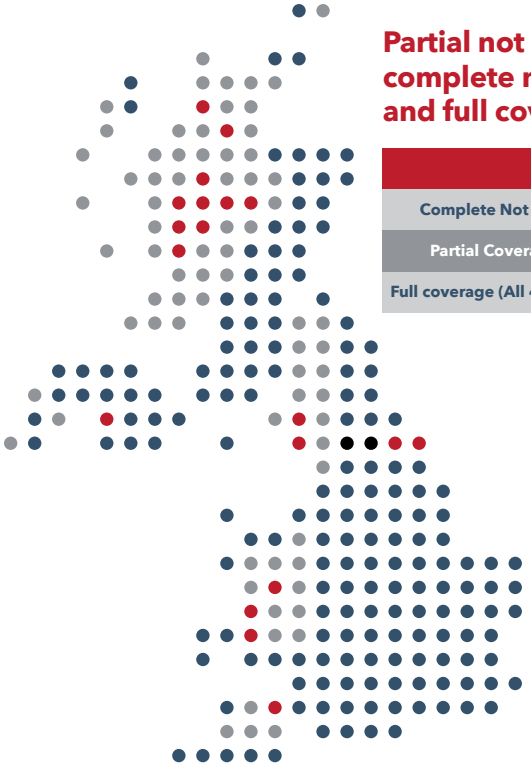
Poor mental health in the farming community has been well reported. In the UK, more than one farmer a week dies by suicide[9]. The pressures on the farming community are immense, as traditional rural employment such as farming has been mechanised and the need for physical labour has declined. Professor Stuart Maitland-Knibb, Director of the National Centre for Remote and Rural Medicine at the University of Central Lancashire, has worked with remote and rural communities for many years.

"In the UK, more than one farmer a week dies by suicide"

He says: "We've got this perfect storm created by higher levels of low educational attainment, low level of employment and low levels of socioeconomic status, and this all leads unfortunately, to increased levels of drug and alcohol abuse. Rural and most seaside communities that are significantly remote in their geographical location have a problem with issues like this that aren't being addressed. The rural community doesn't have the resources to deal with these mental health and addiction needs that are disproportional to the population status, due to the challenges outlined."

[7] *Drug overdose (including alcohol overdose), suicide, and alcoholic liver disease*
[8] *Office for Health Improvement and Disparities, County Durham Public Health Profile (2022)*
[9] *Office for National Statistics (ONS)*

Unconnected: rural health technology being left behind



Partial not spots, complete not spots and full coverage

	2019	2021
Complete Not Spot	9%	8%
Partial Coverage	25%	23%
Full coverage (All 4 MNOs)	66%	69%

People are geographically isolated and psychologically lonely. It is known that a good social support system is invaluable in the treatment of mental health, but if the nearest neighbour is 20 miles away that's not going to help a person's prospects of recovery. Rural mental health services are struggling to meet the needs of the population and so, as in urban areas, a different strategy is starting to be adopted.

Dr Julian Nesbitt is the Chief Executive and founder of Dr Julian, an app that provides therapy with counsellors and therapists by video and text. He says: "We know that people are finding it more difficult to access help, more so in rural areas because there's no transport and people get very isolated. We work in Lancashire, which is mainly rural, and the feedback we've had is that now they are able to get help, and it's improving access to mental health talking therapies. They can have treatment in their home and do it when it suits them. And it works for all groups. You might think it's only for kids, but actually we find it works really well for a lot of older people because they find it more difficult to leave the house."

However, rural communities still face connectivity problems. According to the UK's communications regulator Ofcom, 234,000 people in rural England are unable to receive decent broadband from a fixed line[10]. Large rural areas in the north of England and in the southwest are unable to get outdoor 4G coverage (see graph, above right).

Jamie Reed says that he wants to see more investment in communications infrastructure. He says: "Isolation in its true form is when the telephone line's not working and you can't get a mobile signal. The internet doesn't work or it's down, which happens in a lot of these remote and rural areas. If they were able to be better connected, or ideally had somebody that could go out and see them and actually give them that essential, physical and human interaction, then they're getting a bit of interactivity somehow."

The connectivity issues notwithstanding, there's clearly an opportunity to support people with frailty and long-term conditions with digital technology in their homes. Professor Stuart Maitland-Knibb says: "If we had wearables that worked on WiFi and broadband that were measuring the elderly population's heart rate and temperature, oxygen saturations and movements at home, it could signal an alarm to health and care professionals if a patient hasn't got out of bed that morning and if that's unusual for them. That's the sort of technology that we need, where we're proactively managing people, as opposed to just reacting to a crisis when it happens."

Digital technology is also able to support acute medicine. Dr Vincent Connolly, former System Medical Director, North Cumbria Integrated Care NHS Foundation Trust, says: "It's a huge opportunity and we should be at the forefront of developing how we align digital technology with clinical services. We can be more efficient and more effective, and support patients with digital communications and prevent the need for travelling long distances for consultations, for example, picking up blood results and radiology. We do it to some degree for multidisciplinary teams internally as well. One of the proposals around the long-term future for emergency departments would be to have a specialist consultant in a central location available from other injury units or departments as well to review the patient and work with clinicians remotely."

[10] *Ofcom Connected Nations 2021*

Health crisis: old and forgotten

Some rural and coastal areas are facing a rapidly ageing population, including Maldon in Essex and Copeland in Cumbria, which are ageing twice as fast as the rest of the UK. The proportion of residents over 65 in Richmondshire District Council in North Yorkshire rose from 15% in 2001 to 21% in 2018, according to research from the Resolution Foundation published in October 2019. The average age in North Norfolk is 53.8 years, the oldest average of any local authority[11].

Professor Catherine Jackson, Executive Dean of the Faculty of Clinical & Biomedical Sciences and Head of the School of Medicine at UCLan, says: "A lot of people would like to retire to the countryside or by the seaside, and I can totally understand that, but those are remote and rural locations. So, not only have we got an ageing population, but they want to live in rural locations and, therefore, that puts a strain upon the system that supplies that care to those people."

Dr Tim Sanders is a GP in Appleby-in-Westmorland in Cumbria. He says: "We've the largest elderly population in any ward in the UK and although we might not be classified as a deprived area, many of our elderly are living in poverty. Some are living in poor conditions, such as damp housing, which has an impact on their health. Social care is a real challenge, as we don't have the people to do the work in rural areas, so it puts more pressure on the rest of the health system."

Rural communities face similar public health challenges to urban areas, with pockets of the countryside affected by high levels of alcohol abuse and smoking. Almost two-thirds of the Norfolk population are overweight or obese, slightly higher than national average. This is echoed in Cumbria and Northumberland, where over 20.2% of children at Year 6 are classified as obese[12], similar to 22.2% in Lincolnshire[13].

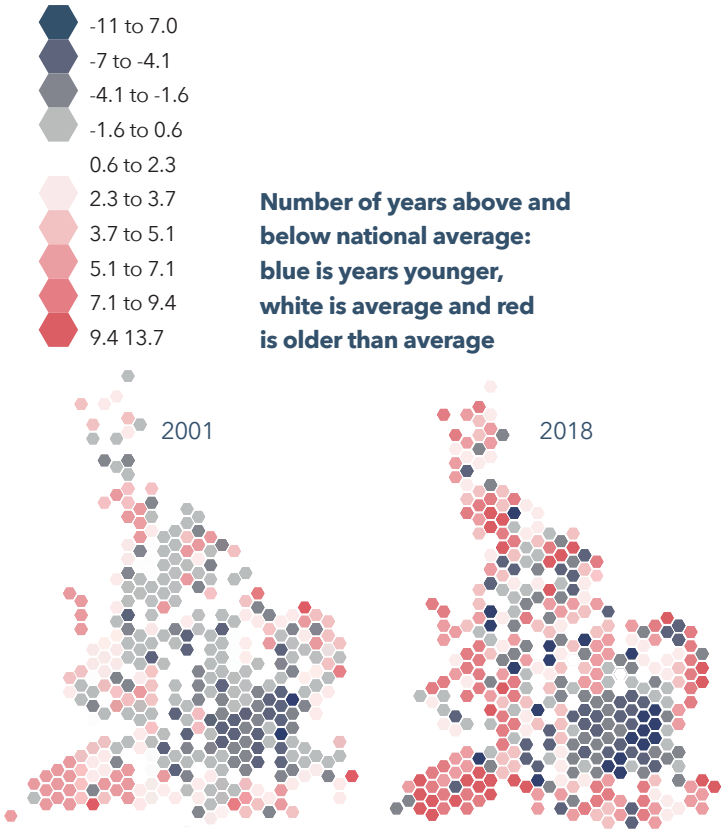
Jamie Reed says: "There's no real surprise that where you've got some small towns or villages with incredible numbers of fast-food takeaway shops, you've also got enormous levels of obesity, childhood obesity and Type 2 diabetes.

In many ways, this isn't rocket science. The root cause of it does appear to me to be education, opportunity and affluence."

Trauma from road accidents is a major cause of death and harm in rural areas. In Lincolnshire, between 2016-18, there were 1,518 people killed or seriously injured, which equates to a rate of 67 per 100,000 people.[14] Professor Stuart Maitland-Knibb says: "You've got significantly larger amounts of trauma – whether that be agricultural trauma, road-traffic trauma, pedestrian trauma – in much larger areas.

So, while you're much more likely to be knocked off your bike in London, your response time and your time to definitive care is significantly shorter, compared to that in Lincolnshire – where it can be hours."

Growing divergence in population age across the country



[11] *Resolution Foundation – Ageing, fast and slow (2019)*
[12] *Office for Health Improvement and Disparities, Cumbria Public Health Profile (2022)*
[13] *Office for Health Improvement and Disparities, Lincolnshire Public Health Profile (2022)*
[14] *Office for Health Improvement and Disparities, Lincolnshire Public Health Profile (2022)*

Seaside towns: poor health outcomes in pockets of deprivation

Coastal towns and villages have some of the highest rates of deprivation in the country. Eight out of 10 of the most deprived neighbourhoods in England are in Blackpool, and Jaywick on the coast in Essex is named as the most deprived area in the country, according to government statistics[14]. Health outcomes are worse than the English average with mental health problems, more homeless people and more alcohol and drugs problems.

Dr Vincent Argent, Consultant in Rural Emergency Medicine at Dorset Rural County Hospital, says access to health services intensifies the problem: "They have poor access because, of course, they've got the sea on one side of them. They don't have 360-degree catchment and, quite often, the roads to seaside towns are not very good – there aren't any seaside towns that have a motorway coming into the centre of town. Places like Hastings and Rhyl are quite difficult to get out of. People often don't have jobs, so they don't have cars, and the public transport is inadequate."

[14] *https://www.bbc.co.uk/news/uk-england-49812519*

Focus on Cumbria: health inequalities

To see the variation of outcomes within rural Clinical Commissioning Groups (CCGs), we looked more closely at one area, Cumbria, and the other CCGs that the Office for National Statistics classify as Mainly Rural or Largely Rural. This analysis was done in 2019.

We discovered that Cumbria/North Cumbria CCG is consistently one of the poorest-performing CCGs within the rural peer group[15].

In 2019, we ranked the rural CCGs from best to worst performing and found that Cumbria/North Cumbria CCG's performance is worse than average for 14 of the 15 indicators. The only indicator where Cumbria/North Cumbria CCG had better-than-average performance is its percentage of referrals to Improving Access to Psychological Therapies services, which indicated a reliable improvement following completion of treatment. This further illustrates the case of this report, that rural medicine needs its own curriculum to focus on the impending issues this data points to.

Professor John Howarth

Professor John Howarth is a senior clinician with 36 years' experience, who currently works clinically in the Cumbrian town of Whitehaven. He is also CEO and Medical Director of North Cumbria Primary Care Alliance and Professor of Primary Care at UCLan.

During the 1990s, John worked in 13 different conflicts and natural disasters and was medical director of an international charity. He was a runner-up in the first national NHS Leadership Awards in 2010, is a Fellow of the Royal College of General Practitioners and received a Fellowship in Public Health through distinction in 2011. He received an MBE in 2019 for services to general practice and the wider NHS.

Within Cumbria, there are striking differences and inequalities. To the east and south of the county, including the Eden Valley and Appleby-in-Westmorland, communities are generally affluent and life expectancy is long.

However, to the west, there are small towns all along the coast with significant deprivation. In the borough of Copeland, for example, the rate of alcohol-related admissions is 774 per 100,000 population – worse than the average for England. The rate of alcohol-related admissions in South Lakeland is better than the average for England – 539 per 100,000 population[16].

Similar differences can be seen across child health and life expectancy not just between those two boroughs but also between Eden and Barrow-in-Furness. Year 6 child obesity in Eden rate is 16.2% compared to 25.5% in Year 6 child obesity in Barrow-in-Furness. Life expectancy in Eden is 82.0 years. Life expectancy in Barrow-in-Furness is only 77.1 years[17]. This highlights the existence of pockets that often get overlooked when it comes to rural medicine, indicating that a more unique approach to rural healthcare is needed.

An equation for results in Cumbria

North Cumbria Health & Care was one of the 14 national exemplars for integrated care systems. Describing the design principles behind building a "population health system" in a rural and coastal setting, Professor John Howarth explains: "Improving the health of the population is a different exam question to just delivering services. By definition, we need to build strong partnerships and look beyond the NHS. We express this ambition in the following equation."

Integrated health and social are teams
(building real teams around neighbourhoods and standardised pathways)
+
Activated Individuals, supported carers and families
(activated individuals use services less and have better outcomes)
+
Communities mobilised at scale for health and wellbeing
(the community as part of the local leadership and local delivery team)
+
Changed drivers in the health system
(if the drivers continue to promote competition and silos, this will always defeat us. We need to build the new and dismantle the old. i.e. system leadership, system architecture, system culture, changed financial rules, impacting on commissioning and provision)
=
A population health and wellbeing system

"While this is clearly complex, there are essentially four components – the set of rules and how we lead, standardised pathways, sustainable small hospitals and local integrated neighbourhood teams (Primary Care Networks are one element of this) working to improve the health of their local population."

[15] *Please note that the latest datasets as of 2019 have been used, but because they are not all from the same years, NHS Cumbria CCG is included in the majority of indicators while NHS North Cumbria CCG is included in others. The number of CCGs also varies from year to year due to mergers and reorganisations, so the total number of rural CCGs is slightly different from year to year.*
[16] *Office for Health Improvement and Disparities, South Lakeland Public Health Profile (2022), Copeland Public Health Profile (2022)*
[17] *Office for Health Improvement and Disparities, Barrow-in-Furness Public Health Profile (2022), Eden Public Health Profile (2022)*

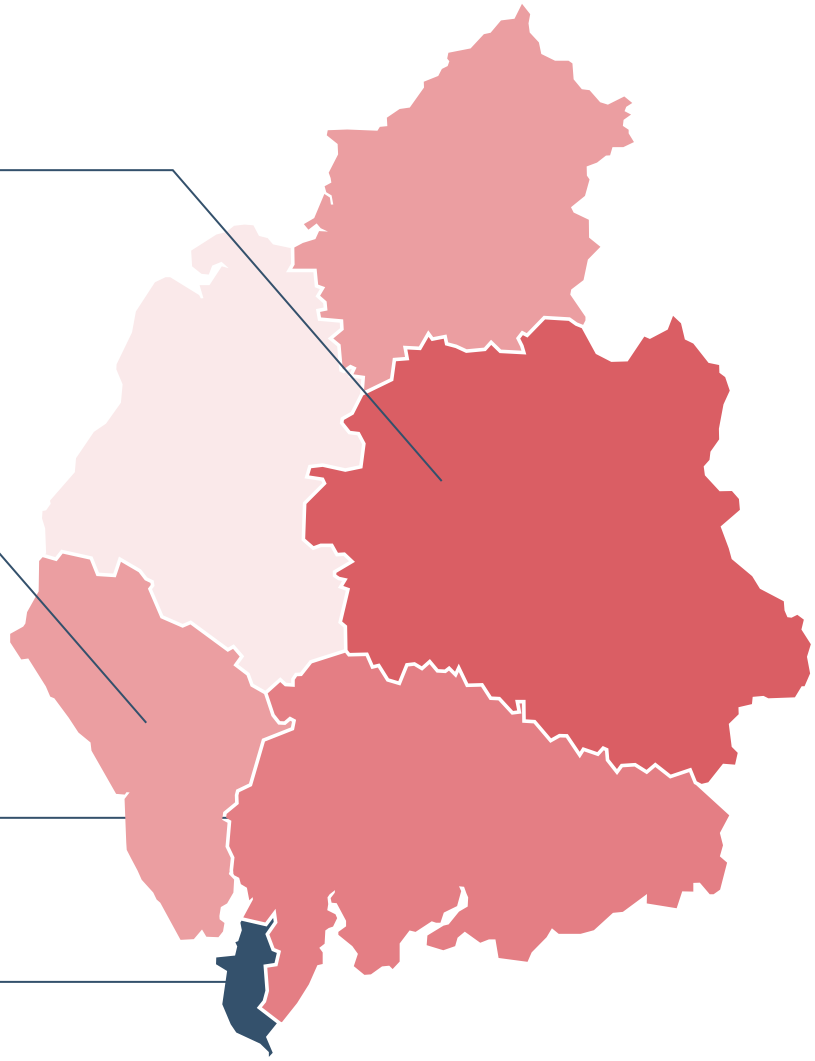
Differences between regions in Cumbria

Eden
Year 6 child obesity rate 16.2%
life expectancy 82.0 years

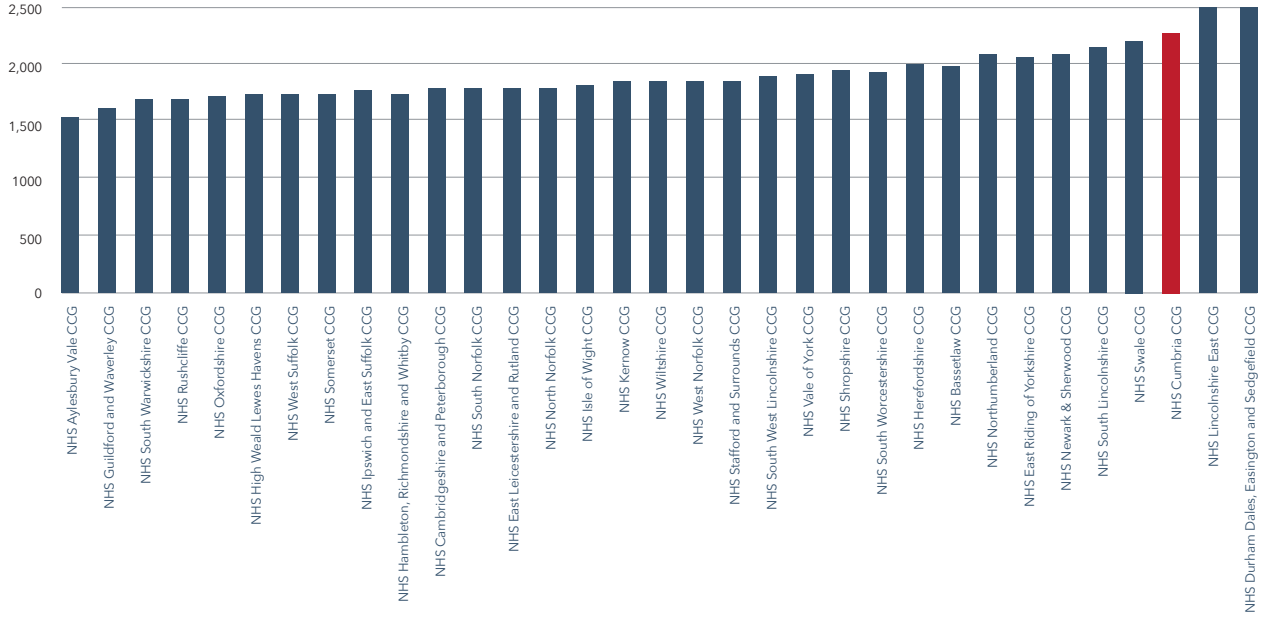
Copeland
The rate of alcohol-related admissions in Copeland is 774 per 100,000 population

South Lakeland
Alcohol-related admissions rate is better than the average for England, 539 per 100,000 population

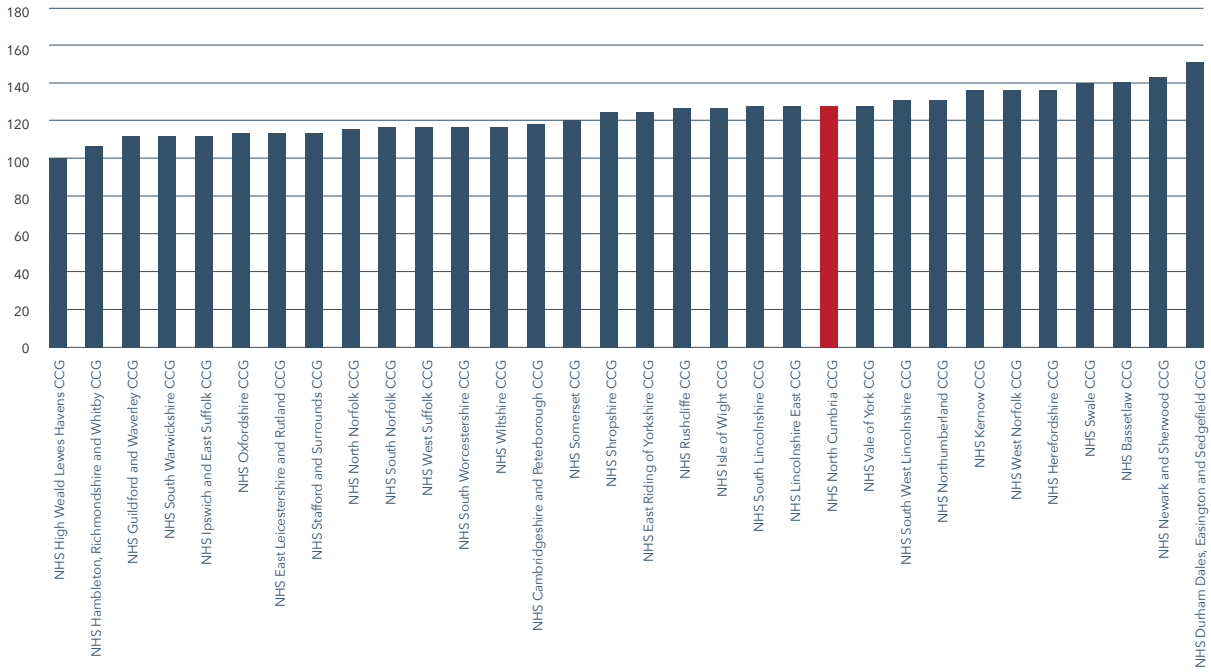
Barrow-in-Furness
Year 6 child obesity rate 25.5%
life expectancy 77.1 years



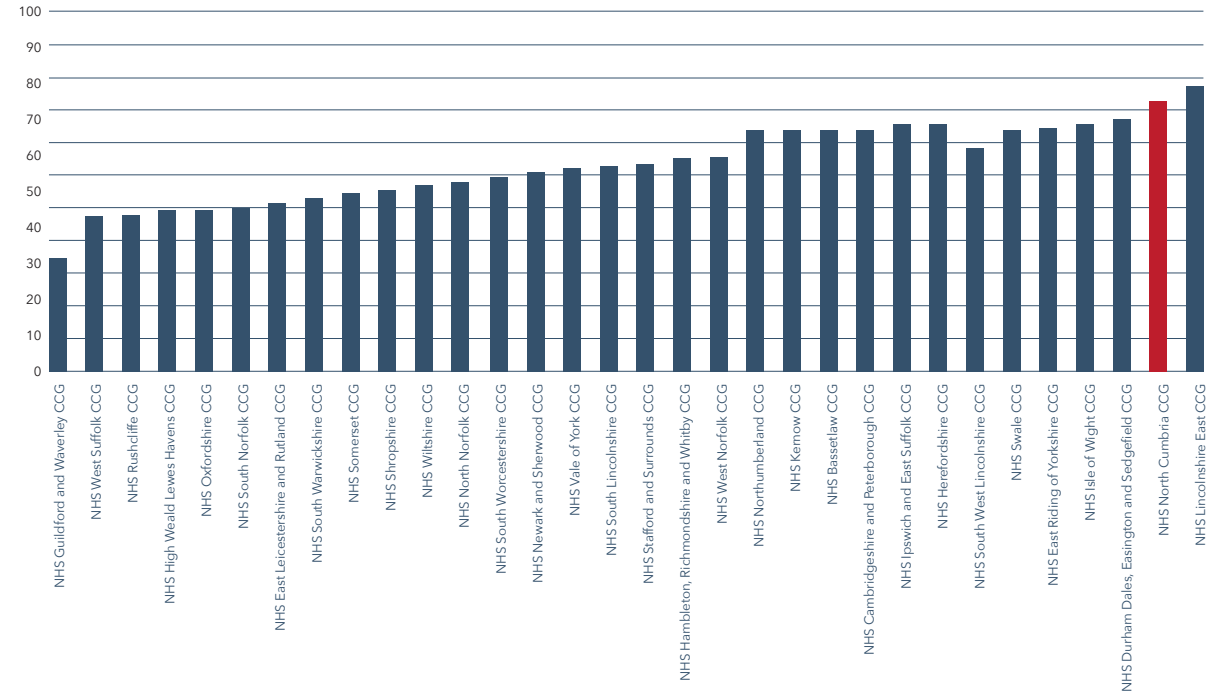
Rural CCGs ranked from best (left) to worst (right) for potential years of life lost from causes considered amenable to healthcare. Data from 2012-2014.



Rural CCGs ranked from best (left) to worst (right) for under-75 cancer mortality. Data from 2017.



Rural CCGs ranked from best (left) to worst (right) for under-75 cardiovascular mortality. Data from 2017.



Workforce challenges: recruitment and training

Rural hospitals are struggling to find consultants to fill their vacancies across the country, with some hospitals not able to fill a single vacancy in a year. A recruitment crisis amongst senior clinicians was revealed in research by the Royal College of Physicians published in October 2019, showing that just 13% of consultants appointed in England last year went to hospitals serving mainly rural or coastal areas, with the other 87% being hired by those with mainly urban populations.

This has an impact on the standard of care provided in rural hospitals. Dr Vincent Connolly, former System Medical Director, North Cumbria Integrated Care NHS Foundation Trust, says: "There's an issue around professional standards, in that rural systems are often really dependent on locums. While some locums are of a very high standard, there's concern that locums come and go through the system, which means that standards are not quite as good. The locum system means that they aren't really involved in the developmental aspects of the service and care standards, supporting training and long-term commitment."

"The reality is that wherever you are, anywhere in the world, be it in the jungle, the Arctic or, in fact, central London, there's always going to be primary care. Everyone's always got a sore throat or a sore ear, but at some point, somebody's going to get seriously injured or sick, and the options for simply taking them to a hospital when you're in those very remote areas or in a military conflict, are significantly reduced. I am trained to be able to deal with that and to stabilise patients and keep them within that environment for several hours or days, until definitive care can be provided."

Some of the reluctance for consultants and, indeed, GPs to work in rural areas is the increased specialisation of the medical workforce over the last quarter of a century.
Dr Vincent Connolly says: "Nationally, the medical training of consultants leads them to be not only specialised but subspecialised. In a rural setting, you don't have the numbers to justify subspecialisation. The national training requirement and the national training programmes don't, in my opinion, adequately address the needs of rural hospitals."

A highly specialised workforce has been very effective for the health system in urbanised areas, but it doesn't necessarily work in rural locations. Rural hospitals don't have the numbers of patients or the resources to employ large teams of highly trained specialists, and what they need more of is generalists.

Professor Catherine Jackson

Professor Cathy Jackson is Executive Dean of the Faculty of Clinical and Biomedical Sciences and Head of the Medical School at UCLan within which sits the National Centre for Remote and Rural Medicine.
In addition to being an academic, Professor Jackson has spent many years in practice in remote and rural settings in both primary and secondary care.

She says: "Because doctors specialise at a much earlier stage, both primary-care and secondary-care doctors feel uncomfortable in a remote and rural setting. Primary-care doctors of my generation who went to work in remote and rural locations had usually all done something else beforehand – they'd been a surgeon or an anaesthetist or, as in my case, a physician – so they brought additional experience. Because of the training routes for doctors that increasingly doesn't happen anymore.

"At UCLan, we've created a number of courses specifically designed to train remote and rural practitioners, basically wherever help isn't coming very quickly. They could be working here in the UK or on oil platforms or in the middle of the desert or in an aeroplane. It's to provide people the skills and competencies and confidence to practice, so they feel able to go and work in these places – to be able to practice safely and to provide a very good standard of care. We're not after a second-class service, we're after a first-class service, but it has to be delivered differently."

Many rural and coastal areas struggle with GP recruitment. Cumbria is no different and several towns have over 40% GP vacancy rates. Professor John Howarth describes how the whole system has mobilised to sustain local practices: "The traditional business model for General Practice is often no longer viable and rural communities face losing their local practices and having to travel for care. North Cumbria Primary Care Alliance (NCPCA) is a new system supported by a GP-led, not-for-profit model set up to sustain a network of great family practices.

"In NCPCA, GPs stay as partners but take a fixed salary, surpluses are reinvested in patient care and system partners (local Trust and UCLan medical school), and patients and the third sector join the partnership board. Established as a company limited by shares and working as a social enterprise, it is strongly influenced by the seven international cooperative principles. By mid 2020, it will cover 12 practices and 110,000 population. We have raised funds to buy out GP premises and have experienced early successes with recruitment of young GP partners attracted by the ethos and the fact that they don't need to worry about the business aspects or buy into buildings."

Primary-care practitioners training has changed significantly over the years. General practice has been focused on better management of chronic diseases to reduce hospital admissions. Professor Stuart Maitland-Knibb says: "The acute ability of general practice has been taken away, which, in an urbanised centre, could be argued is okay, as you're always going to be within easy reach of an emergency service. But in a rural setting, you've now got doctors in general practice that haven't been trained in acute medicine and, therefore, when somebody presents with an acute injury or an acute illness that is serious, their initial response is to reach for the phone, but if you are in parts of Cumbria, it may be two hours before the emergency services get to you."

Professor Maitland-Knibb says training matters a great deal: "I know I wouldn't want to do a job that I wasn't trained in. That's going to cause me a great deal of anxiety, self-worry and self-doubt, and it's not going to be great for my patients. If you've got any inclination to work in a rural setting, you need to be prepared to be able to provide that level of care."

Rural medicine training is offered at the University of Central Lancashire and it equips healthcare professionals with the necessary skills to work in remote and rural settings. This will appeal to some as a professional bonus.

Dr Vince Connolly says: "I think there's something potentially attractive but not yet well exploited around saying to a stroke specialist, 'you can be a specialist across a range of areas' as well. Similarly, being a GP in a remote area provides the opportunity to develop skills that are less traditional. We need to see rural medicine as a speciality in itself."

Dr Tim Sanders, the former GP Training Programme Director in North Cumbria, offered trainees integrated training with the local hospital one day a week in their chosen specialty. "We need to offer the training people want to do," he says. "Being flexible and giving people specialist skills, we hope they'll be happier doing the work they want to do."

For the last few years, GP training has attracted a one-off payment of £20,000 under the Targeted Enhanced Recruitment Scheme. This helps fill vacancies and because these trainees are hard to recruit, they attract overseas trainees as well. Tim had 12 student doctors from Nigeria who he hoped would remain in the area, as they are all excellent doctors. He says: "We give them support to adapt to working in the NHS and, hopefully, they will settle in and stay working in the region."

Does the rural lifestyle live up to the high expectations of today's consultants? "Rural communities are never going to provide the opera and Premier League football for consultants to go to," says the former MP and Shadow Health Minister Jamie Reed. "If you look at the consultants, as individuals they are pretty high earners and what goes along within our society with earning a high income is choice. If you can, you want to live in a good area with good schools, with lots of shops, with leisure activities. They're not going to provide the wives and husbands of top-class consultants – unless they're in a similar field themselves – with jobs that are going to stimulate and satisfy them either."

The lack of a salary enhancement in rural areas isn't helping to attract the right skills. Dr Maitland-Knibb says: "You get London weighting – you don't get Cumbria weighting."

Jamie Reed believes more incentives are required to solve this issue: "I think when it comes to the provision of equitable health services between rural areas and metropolitan areas, we've somehow got to incentivise people to work in these kinds of areas. If that means paying people more to do a 'tour of duty', that's what we should look at. I know it's difficult but we should then have in place further career structure advancements for those people once they return to Sheffield or Manchester. If you like fell-walking, come and practice in Cumbria. If you're in love with the fells and all that kind of thing, then great. Good on you, you're not going to leave. Even then, even once you've got people, there's got to be ways for them to remain cutting edge and current – not just for their own wellbeing as professionals, but for the benefit of the health of the general population."

Solutions: an equitable health service for everyone

We are calling on the NHS to be an equitable health service for all individuals, whether you live in a city or in the countryside.

1. Better training for rural clinicians

Rural medicine training should be seen as a specialty in itself and offered to a range of primary and secondary healthcare professionals – and on a regular basis, too. Adding more specialist knowledge is key to the healthcare of rural communities. Upskilling professionals gives them more confidence and the ability to support both the area's ongoing health needs and the acute needs, such as trauma.

2. More training for pharmacists and professions allied to medicine

All medical-related professionals play important roles in supporting the health of the community. We want to see an increased role for pharmacists and professions allied to medicine as primary-care practitioners. The enabler being improved and integrated educational programmes.

3. Connectivity in rural areas to reduce isolation and accelerate the uptake of digital health solutions

Too many places in England suffer from a lack of investment in crucial infrastructure to allow people to connect to the internet, as well as mobile internet.

4. Accelerate digital uptake and training on digital health skills for clinical workforce

The ever-promised communication revolution has failed remote and rural communities. While successive governments have promised improved access to telecommunication, there has been a systemic failure in doing so. With limited traditional fast communication between remote communities and health hubs, this is a level of inequality that requires urgent attention. There is a dual apartheid resulting in harm. The digital health revolution can support the health of rural communities, whether it is by accessing health treatment digitally or by the increased use of wearables and home diagnostics to manage long-term conditions. We would like to see more digital innovation focus on rural communities.

5. Solve the recruitment crisis in rural areas by incentivising clinicians to take rural jobs

Rural health systems face long-term vacancies and a reliance on temporary clinicians. To reverse this, we want to see "Cumbria weighting" – not just "London weighting". It's not just offering more money that attracts people, it's also about helping create a better life for new recruits, for example, finding jobs for partners. We want to see sustainable workforce development through local recruitment of committed personnel to the needs of remote and rural medicine through an innovative recruitment process and curriculum. Jamie Reed says: "It's a massive injustice. Don't forget these people pay the same amounts of general taxation, and do not have accessibility to the same level of services that you supply."

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