Fresh fields

Rural social care: research, policy and practice agendas

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The **Joseph Rowntree Foundation** has supported this project as part of its programme of research and innovative development projects, which it hopes will be of value to policy makers and practitioners. The facts presented and views expressed in this report are, however, those of the authors and not necessarily those of the Foundation.

Contents

1 The context to this report

In 1992–93, as the new community care reforms were being implemented, we investigated the attitudes of a number of key policy actors towards the new regime: these actors included senior social services/work managers, voluntary agencies and users, and carers groups in 11 local authorities in England and Scotland. The sample for that study was chosen to include authorities that were of differing sizes, some more rural, others more urban, and authorities were also chosen to reflect differing political control. The final part of the interviews focused on the potential impact of local government reorganisation (LGR), then (in 1993) at least three years away.

That research (Craig, 1993) indicated, notwithstanding the turmoil resultant on the introduction of the new funding and organisational arrangements for community care, that there was already considerable concern about the consequences of local government reorganisation (together with a huge degree of uncertainty, no firm outcomes having then been declared). The most striking area of concern related to the probable creation of large numbers of smaller local authorities, each with a distinct social services/social work department. Respondents suggested that this scenario was likely to lead to the following outcomes:

- a multiplication of working relationships between smaller local authorities and health authorities, e.g. for joint planning and commissioning

- a further fragmentation of local care markets with other providers 'playing the care market' and a reduction in the ability of local authorities to take a strategic planning role

- increased variation in the level of services, as between rural and urban areas (reversing the previous 20 or so years' trends towards equalising service levels across larger authorities)

- an enhanced need for joint working between authorities but in a context of resource limitations

- increased difficulties for local voluntary agencies involved in service provision, especially where they were dependent on declining local authority funding

- difficulties for smaller authorities in maintaining an adequate range of specialised and expensive services (both their own internal services, such as IT and training, and their provision for small but more 'expensive' groups of potential users).

In 1995, the Joseph Rowntree Foundation (JRF) funded a major study by the present authors of the impact of reorganisation on the work of social services departments and partner agencies. This study, based mainly on an in-depth study of York, North Yorkshire, Humberside and its four successor unitary authorities (North Lincolnshire, North East Lincolnshire, Hull and East Yorkshire), was originally due formally to end in November 1997. However, the authors continued to monitor developments as it became clear that many new and continuing local authorities had attempted primarily to maintain policy and service continuity across the crisis point of

transition and only began substantially to make distinctive policy shifts from year two onwards. A supplementary study was also developed, with additional support from JRF, from the Association of Directors of Social Services and a number of national children's charities, which surveyed the process of reorganisation across the whole of England, Scotland and Wales and examined its impact on both social care for adults and children's services. This second study, based on a combination of postal questionnaires, interviews, focused case studies and a literature review, was largely completed at the end of 1998.

A final report, incorporating the findings of both studies, has since been published (Craig and Manthorpe, 1999b) together with articles focusing on the impact of reorganisation on different players (for example, Craig and Manthorpe, 1996, 1997, 1998a, 1998b, 1999a; Craig *et al.*, 2000). Broadly, it was clear from these studies that many of the concerns voiced by respondents to the original 1993 study were beginning to be realised although their impact has been somewhat overshadowed by the raft of policy guidance, directives and legislation appearing since the 1997 General Election.

The size of local authority is, in population terms, a key factor in shaping its capacity to respond to community care (and other) needs. Competent research, suggesting that a minimum viable size for new unitary authorities should be of the order of 125–150,000 (Craig and Manthorpe, 1999b) was disregarded (for party political reasons) during the process of reorganisation. The majority of Welsh and many Scottish authorities formed by the break-up of the large Welsh counties and Scottish regions in fact have populations substantially

below this figure. The smallest authorities in England, Scotland and Wales are, respectively, of populations 33,000 (Rutland), 49,000 (Clackmannanshire) and 67,000 (Ceredigion).

In some respects, the arguments for smaller authorities are quite persuasive and were rehearsed by many respondents to our major study of LGR. They may be more sensitive to local needs or provide greater opportunity for local resident involvement in service planning and consultation processes. However, these arguments have to be set against other consequences of smaller size identified in our and other studies:

- the dilution of member and officer experience and expertise

- a reduction in the time senior managers can devote to social services issues

- reduced capacity to offer a full range of services, leading to constrained choices for users

- enforced (sometimes reluctant) joint working with other authorities

- more complex inter-organisational arrangements

- a weakening of social services departments *vis-à-vis* health authorities in joint planning

- a further marginalisation of voluntary agencies, users and carers.

Grant's earlier literature-based review for the Joseph Rowntree Foundation of *Community Care in Rural Areas* (1998) suggested that 'the restructuring of local government … and the attendant reduction in the scale of local

authorities provide an interesting context for continuing scrutiny and research, particularly in rural areas'. He also pointed to a range of issues identified by Craig in 1993 and underlined in our more recent research, particularly:

- the assumed benefits to be derived from a closer working relationship between housing and social services in the new unitary authorities

- whether and how local authorities managed the loss of specialist expertise

- the continuing viability of the marketisation model in contexts where collaboration may in fact be more helpful than competition

- how voluntary agencies within the smaller catchment areas of the new unitary authorities manage their dual roles of service provider and user advocate

- whether the smaller local authorities emerging from LGR enhanced a local sense of identity, thereby, for example, improving access and choice for users.

The present report is based on a study funded by the Joseph Rowntree Foundation which aimed to move the discussion on social care in rural areas forward in a modest way by utilising data already gained through the previous studies of local government reorganisation, reanalysing it to separate out concerns which had a clear rural dimension, and then supplementing this data by:

1   a small and focused exploration of structural and organisational issues of service provision in more rural areas (through a telephone survey of rural authorities)

2   a review of the more recent literature beginning to emerge in some quantity regarding rural issues generally and social care in rural areas specifically.

The following chapters of this report, therefore, *first*, review this more recent literature, in which we particularly sought to locate 'grey' literature which has important things to say but which is less publicly available as yet (Chapter 2); *second,* summarise the findings of the reanalysis of the data gained through the series of postal questionnaires sent to successive waves of reorganising authorities, during the course of our major study on LGR (Chapter 3); *third,* analyse the further data gathered through our telephone surveys of rural authorities (Chapter 4); and, *finally*, draw this material together to provide agendas for further research, policy and practice development for key funders and policy actors (Chapter 5). We also provide, in an Appendix, some examples of social care work in a number of rural authorities, chosen to demonstrate the range of initiatives emerging in remoter areas within Britain.

Although this is not particularly pertinent to rural areas (though there may be some association between rural authorities and a reduced enthusiasm to embrace the 'modernising' local government agenda of New Labour), it is perhaps important also to note that many of the authorities surveyed for this study were beginning another form of restructuring – particularly at senior political and departmental levels, as this study was conducted. It is clear to us, however, that, despite what was obviously

'restructuring fatigue' in many quarters, and the many difficulties facing those attempting to respond to the particular difficulties of service provision in rural areas, there is already a growing range of important innovation in rural service delivery. Much of this work has yet to be effectively publicised and used more widely and we hope that this report and the ideas in it will contribute to that process.

2 Rural issues for social care: a review of the recent literature

Background

The intention of this brief review was not to summarise the literature on rurality as a whole but to emphasise important aspects of previous work, relating it in particular to issues raised by the impact of reorganisation. From what has been, until recently, a relatively limited field, there is now interest in rural issues from a multiplicity of perspectives: economic (particularly agricultural), culture and leisure, transport and public services, and a more general concern with deprivation in rural areas. The literature is still relatively undeveloped in terms of evidence and research relating to social care although the recent report by the Social Services Inspectorate (Brown, 1999) will doubtless generate further work in this field.

In response to this growing general interest in rurality, the Joseph Rowntree Foundation has developed a small programme of work on rural issues and, as part of this, it convened a seminar in the summer of 1998 to help in the process of developing a rural agenda in the area of social care and disability. This seminar built on the overview developed by Grant and further emphasised some issues arising from local government reorganisation – whether:

- rural areas had lost out as a result of disaggregation from their urban cores, not just in terms of finance but also as a result of disruption to structures and working relationships

- the fragmentation of local government had emphasised the remoteness or rurality of some local authority and other local providers

- inter-organisational relationships had become more complex

- these issues were particularly pertinent to areas which had been reorganised or whether they were broadly common to all rural areas.

The seminar identified four key areas for future policy development. These were the need to start from the experience of service users in rural areas; an analysis of issues about service delivery and access in rural areas; the growing issue of race equality in rural areas; and the need to support a more 'bottom-up' approach to policy development, through, for example, community development work.

Responding to the rural agenda

A number of studies (e.g. Gould, 1994, 1995a), have pointed to the failure of community care plans specifically to incorporate a rural dimension where appropriate. This is a theme picked up substantially in the more recent literature despite the issues of rurality and rural deprivation having a much higher profile on the policy and political agenda. The National Council for Voluntary Organisations, on behalf of the voluntary sector at large (e.g. Young, 1994; Gould, 1995b; Gould and Young, 1995), and the Rural Development Commission more generally (see below) have each argued strongly both for a shift in the distribution of public funds by various mechanisms (such as a rural premium) and for a distinctively rural approach both to problem-solving and to the organisation and delivery of services. More generally, the

work of the Department of Environment, Transport and the Regions (DETR) on the Index of Local Deprivation (DETR, 1998b), which has been the subject of a further recent revision, has pointed to the need to develop rural-sensitive indicators of deprivation.

The key points identified in the most recent relevant literature are classified below in terms of the sectoral origin of the literature. The major over-arching themes are summarised at the end of the chapter.

Central government

Department of Environment, Transport and the Regions

The Standard Spending Assessment (SSA) sub-group of the central/local government Settlement Working Group (which reviews the basis of central government funding allocations to local government) currently uses a definition of rurality which is based on sparsity on either a ward or population basis. The discussions between central and local government on SSAs resulted in a proposal from rural authorities for a sparsity indicator to be introduced into the formula for Elderly Domiciliary Services from 1999/2000 onwards. The 80-strong Rural Group of MPs also lobbied the Minister, arguing that the funding formula 'used to work out allocations for individual authorities fails to recognise the costs of delivering services over long distances in sparsely populated areas' (*Guardian*, 11 November 1999). Late in 1999, the Minister announced that a very small shift in the resource allocation formula would be made to acknowledge the additional costs of providing domiciliary care in rural areas.

More recently, the Government has indicated

that it may give overall responsibility for rural affairs to a nominated Cabinet Minister rather than, as is currently the case, rural matters being the responsibility of a number of Ministerial portfolios. However, at present, the Social Exclusion Unit has no plans either to examine the issue of rural deprivation or to ensure that there is a clear rural dimension to the work of its policy action teams. A Rural White Paper is to be produced jointly by a number of government departments late in 2000. The Discussion Document preceding this White Paper (MAFF/DETR, 1999) argues simply that 'people living in rural areas should have opportunities to receive a wide range of public services such as health care and public transport', that social exclusion should be reduced and that the 'rural dimension' should be incorporated into national policy. In relation to social services, the Discussion Document merely observes that 'the sparsity and inaccessibility of rural areas present particular problems'.

Although some of the arguments put forward by rural authorities for increased unit costs of delivering services were based on incomplete data and a limited sample of authorities, there was nevertheless for rural shire authorities at least a clear indication, adjusting for deprivation, that sparsity[1] 'had an effect on the actual costs of delivering a unit of Elderly Domiciliary Care, such that it cost about 20% more to deliver the same unit of Elderly Domiciliary Care in rural areas, because of travel costs' (DETR, 1998a). However, against this, it was argued that travel costs were high in large urban areas because of traffic congestion (and that therefore a density factor might also be included) and that there might also 'be an inverse relationship between sparsity and need,

due to the existence of informal care networks which were larger in rural areas' (DETR, 1998a; see also Carr-Hill *et al.*, 1998).

Actual expenditure levels, which may, of course, reflect local political considerations as much as central government financial priorities, are published annually by the Chartered Institute of Public Finance and Accountancy (e.g. CIPFA, 1998a, 1998b). These show expenditure levels for differing services (e.g. residential care), for individual authorities and by groups of authority (e.g. shire counties) but are published some time after the period to which they refer and are often incomplete. They have therefore not been very helpful as a basis for a robust contemporary comparison between all authorities, although they do demonstrate that shire county areas are, by tradition (a result of a mix of factors but undoubtedly including political persuasion), low-spending areas.

Department of Health

The Department of Health's Social Services Inspectorate (Brown, 1999) undertook its first major examination of community care services for adults living in rural communities in 1998. Focusing on services for older people and for younger adults with physical disabilities, it inspected eight largely rural authorities. Of these, all but one (Lincolnshire) had been 'downsized' as a result of local government reorganisation and were therefore having to face many of the issues associated with LGR referred to above and later in this report: one (Lancashire) was reorganised in 1998, the other six (Bedfordshire, Derbyshire, Dorset, Durham, East Sussex and Wiltshire) in 1997.

Evidence was reported in respect of service user perspectives: a lack of choice was common,

services could be inaccessible and some services that were relied upon were inappropriate or unsuitable. From an organisational perspective, the Inspectorate reported that many services had developed on an incremental basis (and, in most cases, in the context of authorities which had previously had strong urban cores) and so their 'needs-led' element or capacity for flexibility or responsiveness was limited; moreover, the accentuated rural context required even higher levels of co-ordination and partnership working which were not apparent in general. This was generally problematic, although, on the ground, there were individual examples of collaboration at all levels. The report does, however, point to some excellent examples of support for individuals and of good practice more generally; for example, effective levels of collaboration between the local social services authority, health authority and district councils were noted within Dorset, and imaginative attempts to locate service provision close to users within Bedfordshire, Durham and Lincolnshire.

The Social Services Inspectorate (SSI) report observes that government efforts to achieve a greater consistency and equity to services would be challenged by issues of access in rural communities. Organisational developments were patchy, training was under-developed and minority issues were notably excluded from discussion in many areas. For example, very few planning documents considered the needs of travellers. Rural mental health services are also reported to have particular problems in the recruitment and maintenance of morale of staff, and in providing training and education for them.

Transport was a major cause of difficulties; when, as many authorities have found, services

have had to be rationed to those in greatest need, the impact on those outside the net has been disproportionate since alternative sources of help are less easily accessed.

The Government's Fair Access to Care Initiative, stems from the White Paper on Modernising Social Services (DH, 1998), and its emphasis on the need for greater consistency in approach to care provision. A project team has been working to translate these aims into policy guidance and a draft of such guidance is anticipated in the summer of 2000 with final guidance possibly ready by early in the following year. This guidance looks set to standardise access to services by drawing together eligibility criteria – at present variable between authorities. With its emphasis on access, the position of people living in rural or remote areas may well be further scrutinised. Costs can be significantly higher, as many commentators have observed, and a new emphasis on rights to support and choice may encourage rural communities to argue that their needs require particular attention and higher levels of resources.

Local government

County Councils Network
The County Councils Network (CCN) is a special interest group within the Local Government Association representing the 35 English shire counties. One recent report (CCN, 1998) details the low levels of SSAs and low levels of provision for shire counties as a group, and even lower levels for more rural counties. For example, the SSA for Elderly Domiciliary Care in Dorset is £175 per person aged 65 and over, four-fifths of the English average and

contrasting with the SSA in Inner London of £338. For Elderly Residential Care in North Yorkshire, the corresponding figures are £277, just under four-fifths of the English average, and less than half the figure of £632 in Inner London. For spending on older people as a whole, the 1996–97 funding formula suggested that shire areas would spend £417 per older person, compared to £485 in England as a whole and £878 in London. Conversely, in London, an average of about 24 hours per week of home care was available for each person over 65, compared with 15 hours in England as a whole and 11 hours in rural areas. The commentary also reflects the general criticism of the considerable use made of census indicators in determining SSAs, as these indicators, it is argued strongly, have a distinct urban bias.

To a small degree, this bias has been addressed in a recent revision of the Index of Local Deprivation (DETR, 1998b) which has, as noted, already been the subject of further review (with a stronger emphasis on rural-sensitive indicators), and in recent work commissioned by the Rural Development Commission to examine the nature of rural deprivation (Dunn *et al.*, 1998). The CCN also called for 'the adoption of a 1.5% sparsity factor to be included in the SSA formulae for domiciliary care from 1999–2000' and later argued for the SSA SubGroup report for 1999/2000, that similar adjustments might be appropriate for day care, meals service and equipment provision. This work is continuing, however, as the database for calculations is not felt yet to be sufficiently robust.

Dunn *et al.*'s work, 'reviewing the potential indicators of rural disadvantage that could be helpful in the development of rural policy'

concluded that there were no single indicators of disadvantage useful for this purpose but that 'bundles of indicators' might usefully be combined. Two such bundles cover 'access to services' and 'physical isolation', issues which repeatedly appear in analyses of difficulties in rural service provision.

Local Government Association
The Local Government Association (LGA) represents both urban and rural authorities across England (and Wales, to some extent, although there is also a separate Welsh Local Government Association, see below). The LGA's overarching review of rural issues (LGA, 1998a) calls for the Social Exclusion Unit to analyse social exclusion issues in rural areas and to propose a strategy for addressing these needs, for resource allocation formulae (including SSAs) to be 'fair as between rural, industrial, suburban and city areas', and for consideration to be given to 'preparing a new index to assess rural deprivation and needs': the latter is, as noted, now being addressed to some degree. The report also stresses the issues of access ('transport poverty') and of inequities in resource distribution for service provision in rural areas. A parallel paper from the LGA outlines some examples of best practice, including, in relation to services for older people, examples of meals on wheels delivery to older people in rural areas in Suffolk and joint assessment procedures by health and social services in rural Oxfordshire (LGA, 1998b). The LGA's Rural Commission submitted evidence to the Social Exclusion Unit arguing that rural deprivation had different features from urban deprivation, because of the dispersed nature of rural populations, and required different policy responses, in particular that rural deprivation should involve targeting deprived people rather than deprived areas (LGA, 1999).

The Association of Directors of Social Services
The Association of Directors of Social Services (ADSS) Research Group also supports the argument that SSAs do not yet take account of the costs associated with rural isolation (correspondence from Terry Butler, Director of Social Services, Hampshire County Council, 12 November 1998) citing as further evidence a study of the feasibility of private/public partnerships aimed at financing home care support needs through low-cost insurance (Orros and Howell, 1998).

English local authorities
In the autumn of 1999, the LGA/ADSS annual social services conference hosted a workshop to address the specific problems faced by rural local authorities in managing service provision. Presentations by representatives of a number of individual local authorities were made. The major issue discussed, as might be expected, was the cost of service provision, exaggerated in the case of those rural 'downsized' local authorities created from local government reorganisation. For example, Devon County Council reported that, following the creation of unitary Torbay and Plymouth councils, the remaining 'new' Devon council had calculated that it cost an additional £52 per household to maintain services at their pre-reorganisation level. Wiltshire County Council (also downsized, as a result of losing unitary Swindon) computed that a rural team social worker averaged 3,777 miles more per year than an urban team social worker; for the total rural team this equated to an approximately 0.65

extra full-time equivalent (FTE) posts and additional mileage payments of over £11,000 per annum.

The costs due to diseconomies of scale in rural areas are also reflected in data reported for the workshop by Wiltshire County Council, for provision for older people. This showed that the unit costs of residential care homes for older people were in the range of £230–£250 weekly for homes of more than 50 people, typically those in the more urban areas of the county. For the smaller homes (typically with less than 40 residents) in minor centres of population, the corresponding unit cost was £290–370, or approximately 15 per cent higher on average. The Council pointed out that this was just one of the costs consequent on its policy of locating services closer to where people wanted them to be. Dorset County Council noted that, of the 37 factors which affected the calculations for SSAs, only one involved measures of sparsity and this had an overall weighting of about one-third of 1 per cent of the total of Dorset's SSA. It argued that, just as SSAs had a weighting for small schools, they could also incorporate a weighting for sparse social care provision.

A number of individual local authorities also presented written evidence to the workshop. These included the following.

Gloucestershire. Gloucestershire had focused on rural issues as part of an ongoing audit of county council services (Gloucestershire County Council, 1999). Previous work on poverty in the county had highlighted the existence of rural deprivation and pointed to problems of poor transport links and access to services. The focus on rurality itself underlined these issues and identified the following problems:

- difficulties in recruiting staff in rural areas

- high cost of delivering services, often higher than the cost of the service itself

- the need to make shared or joint use of facilities to reduce costs

- the key role of local transport in improving access

- problems for service users in accessing information.

The County argued that better inter-agency working was critical in maintaining or improving local service provision, and that innovation in service delivery should be encouraged through, for example, extension of mobile provision, use of local community initiatives and exploitation of electronic communications networks.

Shropshire. Shropshire, alongside other rural counties, has campaigned for sparsity to be a stronger factor within the SSA formula. This study (Shropshire County Council, 1996) sets out the basis for this argument, drawing on data from a county which has super-sparse characteristics and whose rurality was accentuated soon after the publication of the report by the loss of Telford to become a unitary authority. The Council also argues that it is inconsistent for education and other services to be the only service blocks where sparsity is recognised in the SSA arrangements, and that the adjustments even in these two blocks of spending is inadequate. Specific issues facing rural areas that lead to higher expenditure per unit of service include:

- poor data

- lack of information availability for local people

- lower service standards

- more dispersed service users

- poor access facilities to services

- low population densities and population profiles skewed towards older people.

Specifically in social services, this results in higher unit costs to meet care in the community regimes; lower service take-up; and the social work task involving longer journeys, higher costs and lower caseloads.

Worcestershire. Worcestershire emerged from local government reorganisation as a two-tier county, separated from Herefordshire which itself became, unusually, a rural unitary authority. Worcestershire, however, was characterised by a mixed urban/rural profile with significant population centres at Worcester, Redditch, Bromsgrove and Kidderminster, in particular. Worcestershire (Worcestershire County Council, 1999) identified a familiar raft of issues facing rural authorities including local SSAs for shire counties, low wages, inadequate housing provision, poor transport and isolation of marginalised groups. Worcestershire's report outlines a range of innovations it has promoted in order to address these issues. These include:

- an emphasis on reablement and rehabilitation to enable older people to live longer in their own homes

- the development of mobile day centres

- more flexible forms of employment, including homeworking

- the development of innovative transport schemes with trained drivers

- better use of local community facilities and buildings

- improved partnership working.

Dorset. Dorset's evidence (Dorset County Council, 1999) summarises the characteristics of the county (which lost Poole and Bournemouth to become separate urban unitaries in 1997) affecting social services delivery: Dorset's difficulties were accentuated by the shape of the new county which left a small eastern part of the county beyond the Bournemouth unitary area (Craig and Manthorpe, 1999b). The new county's characteristics include a higher than average proportion of older people, an increase in lone parent and single pensioner households, low car ownership, low levels of community facilities, depopulation and second home ownership, difficulties in recruiting staff and high costs of delivery of care services. Staff travel costs, for example, are about four times as high in the Bridport rural area as they are in the Weymouth urban area, and domiciliary care providers are 10 per cent more expensive in rural areas. The county is also experimenting with innovative forms of service delivery, including:

- use of local facilities for day care

- the development of community involvement in service delivery

- voluntary transport schemes

- provision of information via telephone helplines and local shops and post offices

- various forms of outreach and satellite provision attached to but working away from service centres.

The Welsh Local Government Association
The Welsh Local Government Association (WLGA) stresses the need for a 'bottom-up' developmental approach to the provision of services in rural areas, facilitated but not necessarily controlled by local authorities. It argues for a transport policy that is not built around private car ownership and also stresses the importance of thinking about the question of access to service provision which might involve the more imaginative use of buildings and the development of the use of IT facilities at a local level. It has called for a review of 'the use and application of deprivation indicators in rural areas' (WLGA, 1998).

Scottish local authorities
A considerable amount of work, some of it referred to below, has been done in Scotland through the Scottish Office, the Convention of Scottish Local Authorities and the Rural Forum (based in Perth) on definitions of rurality and on rural deprivation. The Association of Directors of Social Work (ADSW) stresses the issues of transport, access to services and the social isolation of service users living in rural areas (letter from Sandy Cameron, Director of Social Work, South Lanarkshire Council, 8 December 1998).

Quangos

Audit Commission
The Audit Commission has recently published a number of reports on social care for older people. There is, however, no discernible

analysis of the rural dimension to its discussion, although some of the issues it raises will have considerable and differential implications for rural authorities. For example, the Commission makes the point that nearly two-thirds of social services gross expenditure on the care of older people is spent on residential and nursing care and that this reduces the amount of money available for community-based preventative services which could avoid readmission to hospital and disruption to the lives of older people. It argues for the need for joint planning and investment between health and social services, between first-tier and second-tier authorities (particularly pertinent to shire counties), for effective and accurate mapping of existing needs and for adopting more constructive relationships with the independent sector (Audit Commission, 1997, 1998). However, these proposals depend on a framework of providers and of levels of collaboration which may not be present in rural areas and which certainly has been disrupted at the local level by the effects of reorganisation.

Although the issue of charging has been of considerable concern to most, if not all, of the authorities which are the subject of this study, the Audit Commission's major report on charging (Audit Commission, 1999) also has no discussion on the particular impact of charging for services for users of services in rural areas.

Rural Development Commission
The key report here is that by Hale and Associates (1996) which examined public resource allocation systems and concludes that these systems 'operate to the disadvantage of rural areas … [because] … the resource allocation formulae tend to be based on

indicators which characterise urban life …'. Population sparsity is given little weight and this 'seems surprising given the extra distance that, for example, social workers need to travel in remoter rural areas'. The provision of domiciliary care is again singled out for attention. The general point is made that SSA calculations 'concentrate on the characteristics of the elderly people likely to need social services help, but ignore the availability and location of facilities'.

Hale and Capaldi (1997) returned to this issue from a different perspective to examine 'whether or not people living in rural areas receive the same range and standard of services as people living in more urban areas'. The common themes from the four areas of provision studied (one of which was social services) were that 'levels of service provision are usually lower in rural areas than elsewhere' and that 'ease of access is a key factor in determining whether people in rural areas receive the same level of service as people in more urban areas'. This also showed up some interesting trends in relation to the developing social care market: for example, despite there being 'more residential care places per 1000 people aged 75 years and over in the shire areas than in England as a whole, the level of local authority support for elderly people in residential and nursing home care is lower in many of the most rural counties than elsewhere'.

The Rural Development Commission (RDC) also commissioned research (Moseley and Parker, 1998) which reviewed the development of joint service provision 'in circumstances where service providers find it difficult to deliver services alone in areas of low population density'. This found, from reviewing evidence in three case study areas in the UK and in other countries, that there were few serious obstacles, at least in principle, to the development of joint provision although unsuitable accommodation might affect service quality, the different (political and organisational) perspectives of differing organisations might create co-working tensions and the private sector (particularly larger players) was found to be least co-operative in developing joint provision. The research was not able to quantify cost savings arising from these arrangements.

The RDC also publishes regular surveys of rural services (e.g. Spilsbury and Lloyd, 1997) to establish the proportion of rural parishes without the basic services of shop, school, post office and daily bus service. This information is critical in relation to the provision of social care services since it demonstrates the extent to which service providers requiring local meeting places or buildings, and service users requiring transport to get to more distant provision, are denied these by virtue of the paucity of basic service or facility infrastructure. Almost half of rural parishes, for example, have no local school of any kind and three-quarters have no daily bus service, 83 per cent have no local GP and 91 per cent have no day-care group for older people. Ninety-six per cent of rural parishes had no day-care for people with disabilities. This issue alone demonstrates the importance of inter- and intra-agency working, and indeed of corporate local government approaches, in terms of developing services. Very often, for example, village schools have been shut without serious consideration of alternative public service uses to which they might have been put.

Voluntary organisations

A number of voluntary organisations located largely through networking provided details of initiatives promoting social care in rural areas with which they were involved. These organisations were generally not engaged in research projects but service delivery initiatives; nevertheless, some of them have undertaken small investigations and the evidence provided raises some important issues which broadly support the points developed earlier and below.

The Scottish Community Care Forum

This is an umbrella organisation based with the Scottish Council of Voluntary Organisations. It provided details of seven community care forums in rural Scottish areas, including Highlands, Borders and the three island council areas, which have undertaken work in a number of user areas. For example, the Borders Forum has undertaken a survey of people with a visual impairment, researched users' views of day care for older people, undertaken a mental health consultation project and explored respite care provision through the views of carers. Transport difficulties (either absence of transport, low levels of provision, dependence on volunteers or lack of flexibility) were frequently mentioned. The carers' survey, for example, showed that only two-fifths of carers were getting help from the social work department and fewer were getting help from primary health care sources, more than a fifth of all carers citing (lack of) transport as a cause of difficulty. The Forum recommended that 'reference to transport arrangements are made within needs assessments'.

Difficulties with transport for those living outside towns was also an issue referred to in the mental health consultation, with additional difficulties caused by the fact that mental health users' greater dependence on public transport increased their sense of isolation. Day centre visitors commented that their participation in the centre was limited by lack of available transport. Several of these surveys also highlighted the need for much more locally available service access points: many users indicated that they had failed to access services because of a combination of distance and lack of locally available information, including information on welfare benefits. The issue of 'information poverty' underlines a general recommendation made by the National Federation of Women's Institutes (NFWI, 1993) and which was endorsed in the Carers' (Representation and Services) Act 1995.

Ruralminds

The position of mental health users in rural areas is highlighted in work done by Ruralminds (1998), which argued that 'people with mental health problems often have [additional] difficulties accessing help because of the stigma surrounding mental distress in rural communities'. The major reasons for their failure effectively to access services in rural areas are identified by Ruralminds as lack of transport; fear of stigma; lack of choice; and lack of information about appropriate help. Five user groups are identified as particularly at risk:

- farmers and farm workers; suicide is now the second most common form of death among farmers aged 15–45

- women with children, because of isolation, exacerbated by lack of transport

- minority ethnic community members, who are both isolated and potentially

stigmatised because of their visibility; local authority responses are usually inadequate because of structural racism

- young people, because of stress arising from inadequate housing, employment and recreational opportunities

- older people, because of a combination of isolation, poverty and increased costs arising from rural life.

Herzig and Murphy (1997) also draw attention to the reluctance of rural service users to engage with mental health practitioners, at least until crisis point. These commentators recommend enabling urban-based specialists to cover large rural areas by outreach and consultancy services, and to promote the use of telecommunications systems for developing service provision.

Nottinghamshire Rural Community Council
Work done by the Nottinghamshire Rural Community Council (NRCC) on the needs of rural carers also pointed to a paucity of information, including information on welfare benefits (NRCC, 1998). Six major areas for development were identified including provision of information, a peripatetic welfare rights service, access to services and professionals, and flexibility of service delivery. The Nottingham work also pointed to the dimension of ethnicity, emphasising the lack of a strong race dimension in most rural work, a point also stressed by a more general review of race and ethnicity in rural areas (Henderson and Kaur, 1999). A checklist for action for district and specialist planning teams has been developed as part of a Nottinghamshire rural community care strategy (RSG, 1996): this

emphasises the fact that GPs working in rural areas can apply for Rural Practice Payments which can be used to adapt local facilities or to amend surgery hours to fit better with local transport arrangements. Despite this progress, Lymbery and Millward (2000) referred to 'planning blight' arising from LGR experiences, which restricted a range of innovation and development around social care and health provision.

Wiltshire Living Options Partnership
The issue of ethnicity was emphasised by the Wiltshire Living Options Partnership (WSUN, 1998) which has been working, within a direct payments paradigm, to support black disabled people in rural Wiltshire. The obstacles to effective service use identified in other rural development projects – of access to transport, information, services and support, and of the need for more effective joint working – were further emphasised by the 'colour-blindness' of the service providers. There was a failure, for example, by providers to acknowledge that some health needs were race-related, to deal with language difficulties or to acknowledge and meet religious and cultural needs.

Sussex Rural Community Council
Taking a lead in this area, Sussex Rural Community Council (SRCC) has produced a rural strategy document for East Sussex Health and local authorities (SRCC, 1998). This identifies familiar issues for rural care users, including the cost of accessing services, an unfair distribution of resources to rural areas (and likely to be more so as the demography of rural areas are increasingly moving towards the older end of the population range) and poor availability of services at very local levels,

driven by many organisations' need to concentrate provision on fewer sites for (apparently) cost-effective reasons. The Sussex report also reflects both on the important work done by poorly resourced local voluntary and community organisations, and the potential for better use of local facilities for multiple functions. Their study makes very effective use of Geographical Information Systems (GIS) mapping (as has also been done by Lincolnshire County Council, 1996) to display the maldistribution of services and argues strongly for a much more local strategy for service delivery.

The work of these voluntary agencies in Sussex, Nottinghamshire, Wiltshire and others has been drawn on by the National Council for Voluntary Organisations (NCVO) to produce a good practice guide for working around health and social care issues (Barnes and Gould, 1997). This highlights by now very familiar themes: the importance of transport, local provision where possible, improving information, and identifying a clear rural dimension (as opposed to a formal 'add-on') to service commissioning and provision. The guide stresses the importance of a 'bottom-up' developmental model for local service provision in order to reach isolated and excluded user groups. As the SSI report (Brown, 1999) also notes, some rural staff are likely potentially to be isolated as much as their service users.

Community Council for Berkshire

Berkshire was split into six small unitary authorities at reorganisation in 1998, with the county itself being abolished. The Community Council remained as an over-arching voluntary sector umbrella organisation for the historic Berkshire county area and undertook a series of investigations of the rural areas in four of the unitary authorities: Bracknell Forest, Windsor and Maidenhead, West Berkshire and Wokingham (see, for example, Connold and Critchley-Salmonson, 1999a, 1999b). These studies ranged across the needs of rural communities in general but raised a number of common issues regarding social services and care provision. The studies also confirm key findings from other studies of rural disadvantage, namely, that there is extensive disadvantage, even in rural areas regarded as affluent, that there are no effective comprehensive indicators of disadvantage which would be regarded as acceptable by local people and that participatory techniques are necessary to explore this issue in detail. The particular issues identified in relation to care were:

- affordable and accessible transport

- the lack of support for carers of whom there were, in any case, too few

- marginal and potentially stigmatised groups such as mental health users were in particular need of support

- most people had difficulty accessing information about relevant services.

The second phase of this work will involve working alongside local people to develop sustainable action plans in partnership with formal and informal agencies.

Summary

The key issues emerging from this brief review of recent literature are strikingly clear.

Particular problems emerging for service users are:

- difficult access, because of poor transport provision, long distances to services and low levels of personal mobility

- low levels of service provision

- low levels of facilities and buildings, and poor use of them where they exist

- isolation and associated social and health problems, including difficulties of accessing support from informal carers and information on services and benefits

- higher levels of cost in accessing and using services.

These problems are exacerbated where groups of service users are few in number or easily stigmatised (e.g. mental health service users, members of minority ethnic groups) or because of general levels of poverty and deprivation (such as older lone pensioners).

Issues identified by service providers relate in particular to the funding of rural services, where it is argued that funding formulae, and the deprivation indices on which they are based, are unfairly weighted towards urban areas and do not take account of the high cost of providing services in sparsely populated areas or of levels of deprivation and the particular forms that deprivation takes in rural areas. Providers argue the need for a rural premium, both at a structural level in government funding discussions and at a local level, perhaps for individual staff, to provide and maintain adequate services on an equitable basis. The broader policy and service context in rural areas

also accentuates the difficulties of maintaining effective care provision; for example, the low level of social housing in rural areas (12 per cent compared with more than 25 per cent in urban areas) severely limits the scope for integrated housing and care provision. Service providers take relatively little account of groups that are numerically small and costs of provision generally fall on the public sector.

Joint working between health, social services and voluntary and community organisations is poorly developed and this impedes effective use of human, financial and physical resources. Some literature is now beginning to emerge regarding the effectiveness of partnership working in rural areas (e.g. CCRU, 1999; Edwards *et al.*, 1999), although there is relatively little specifically addressing partnership working between health and social services authorities. Service provision tends still to be too centralised, exacerbating the problems of distance and access in rural areas, and needs assessments (and thus charging systems) for many rural service users have yet properly to incorporate issues that relate to the rural context, such as transport costs. There are strong arguments put forward for developmental 'bottom-up' approaches to service provision that involve service users and local community organisations.

Note

1 Areas which have a population of 0.5 to 4.0 persons per hectare are defined by DETR as 'sparse': those with lower population levels as 'super-sparse'.

3 Local government reorganisation and rural issues

In this chapter, we review the data collected originally as part of our studies of local government reorganisation, to explore specific issues relating to rurality.

The sample of authorities

The most recent structural reorganisation of local government took place in England in four tranches (1995, 1996, 1997, 1998). The whole of Welsh and Scottish local government was reorganised simultaneously in 1996.[1] Our surveys (which covered not only local authority social services departments but councils of voluntary service, local MIND and Age Concern groups, and health authorities) gave us the samples shown in Table 1 of authorities from the tranches reorganised in 1995 (the Isle of Wight alone), 1996, 1997 and 1998. Our postal surveys were usually carried out some months after reorganisation to avoid seeking data from organisations in the midst of the process of difficult change; data from the last of the final set of authorities to be reorganised were therefore received early in 1999.

The analyses undertaken of data for our final reporting of the LGR studies were not particularly focused on the split between rural and urban authorities, although some of the issues identified (and summarised in Chapter 1), particularly those consequent on size, were clearly more associated with rurality than with urbanness. The major distinguishing division characterising our initial analysis was that between unitary authorities (generally, though not exclusively, urban cores of shire counties) and residual two-tier 'downsized' counties (largely rural in nature). However, the rural–urban divide cuts across this split and this is partly why it was felt that some reanalysis might be useful. For example, all of Scotland and Wales (whether in urban or rural areas) is now based on unitary local government. In England, some unitaries are largely rural (e.g. Rutland, East Yorkshire, Herefordshire), others entirely urban (e.g. Nottingham, Portsmouth, Blackburn, Reading).

Table 1 Samples of authorities

		Number of authorities created/surveyed	Number of completed questionnaires
1995/96	England	15	14
1996	Wales	22	15
1996	Scotland	29*	24
1997	England	23	19
1998	England	28	22
Totals of local authorities		**117**	**94 (80%)**

* The three existing Scottish Islands councils, Shetland, Orkney and the Western Isles, with boundaries unchanged by reorganisation, were excluded from our postal survey.

The meaning of rurality: a working definition

To reanalyse these data in terms of the rural or urban nature of authorities required us to devise a robust but relatively straightforward working definition of rurality. We did not set out to contribute directly to that particular debate but it is evident from the literature we reviewed that there is a continuing discussion about how rurality should be defined (for example, whether it is better to use area-based or population-based measures: see, for example, Wallace and Denham, 1996; Wilson *et al.*, 1996; Owen, 1997; Noble and Wright, 1999). The hitherto most commonly used measure of rurality, Cloke and Edwards' (1986) *Index of Rurality*, which uses principle component analysis of census data using eight indicators (see, for example, Barnes, 1993), has been criticised on a number of grounds and there is no doubt that measures of rurality will continue to be further defined and debated over the coming years. Noble and Wright (1999) note that rurality is generally defined by its characteristics but that it is important to distinguish between primary characteristics, such as, in particular, sparsity, and secondary characteristics, such as low service provision, low public transport provision and a higher proportion of pensioners, which are often consequential on the primary characteristics of rurality. The Rural Development Commission's working definition of rurality is 'all settlements with a population no greater than 10,000'. However, the RDC observes that use of this definition in practice is complicated by the fact that personal social services is a county council function (correspondence from Brian Wilson,

RDC Head of Research, 18 November 1998). It is also worth observing that the census data is now substantially out of date, and particularly so for groups, such as older people and members of minority ethnic groups, where there has been considerable migration relative to other groups.

The Welsh Local Government Association notes that there is no single useful definition of rurality for their purposes as Wales contains 'a very wide range of different types of rural community' (WLGA, 1998). The Institute of Rural Health in Wales with the University of Glamorgan has recently explored the differences between rural and urban general practice through a Delphi study of a panel of general practitioners (see NCVO, 1999). This study, which started from the position that Department of Health finance allocations are not 'rural-fair', sought to define rurality in order to address the issues faced by practitioners working in rural health settings and will identify a shortlist of key problems faced by them.

The Scottish Office Rural Challenge Fund's definition of rurality covers postcode sectors that have a population density of less than 100 persons per square kilometre and excluding settlements of less than 10,000. The Association of Directors of Social Work criticises this on the basis that postcode areas can be quite large and in the case of Lanark, for example, the definition results in half of the town being included as urban, half as rural, with its High Street being the dividing line. Relatively low-density commercial or industrial use also often results in rural categorisation. South Lanarkshire Council, after reviewing a range of options, has, following the RDC, also used a definition of

rural as comprising all those localities of population below 10,000 (based on 1991 census data).

As we have noted above, this debate is a critical one in relation to the present discussion because of its impact on political decisions about how such definitions should be used to compensate for rural factors (and rural disadvantage in particular) in, for example, shaping government subventions to local authorities through the various spending mechanisms which feed into current public expenditure arrangements (Hale and Associates, 1996; Chapman *et al.*, 1998; Dunn *et al.*, 1998). There is no doubt that the issue of rural poverty is now very firmly on the policy map, not just challenging the myth of the rural idyll (Cloke and Little, 1997; Chapman *et al.*, 1998; Noble and Wright, 1999) but requiring local government and national government to face some difficult policy and service issues about allocation of resources. Approximately one-quarter of those living in rural areas (themselves at least a quarter of the UK population, depending on the definition of rurality used) are in or on the margins of poverty. More sophisticated analyses and mapping of need, supported by improved computer-aided mapping (Alcock and Craig, 2000), will doubtless contribute to better targeting of care resources over time (see, for example, Mansell, 1997) although resource distributions also continue to be the subject of political contestation; the re-revised Index of Local Deprivation has, ahead of its publication, generated a robust challenge on behalf of the position of urban authorities. Most recently, the LGA Rural Commission has pressed the case on rural aspects of social exclusion and deprivation to the Social Exclusion Unit, arguing that it

needs to 'consider this challenge to the current basis of much needs-based targeting' and 'recognise and respond to the rural aspects of the social exclusion agenda' (LGA, 1999).

However, an important study (Kirkwood and Peck, 1997) in the Highland area, which aimed to identify those with severe mental health needs, provides a salutary warning about the efficacy of methods based on statistical and epidemiological approaches alone. This study, which used a networking approach through local agencies and professionals, was only able to identify approximately 110 of the 370 individuals who epidemiological evidence suggested should be resident in the area and who had severe mental illness. The authors conclude that the failure of the study to locate more than two-thirds of these individuals 'suggests not only that different approaches to identifying need in rural areas must be explored, but that services themselves need to look at how they present themselves to the public, at their relationships and communications with other agencies, and their accessibility and acceptability to clients and carers'. This provides powerful evidence for the need for qualitative and developmental approaches to working in rural areas (as argued by, for example, the Sussex Rural Community Council and Community Council of Berkshire studies reported in Chapter 2) which start from, but are not limited to, local quantitative mapping of need.

Hale and Associates (1996) make the defining observation in regard to general issues of resource allocation, that '[r]ural authorities are seldom compensated for the higher costs they may face in delivering services to sparsely populated areas – the sparsity factor which is

included in the SSAs for Education and the "Other services" is worth only £16 per head [1996 prices] to the receiving authorities – and little or no recognition is given to measures of rural deprivation such as the effects of social isolation on the need for social services for the elderly … [as a result] … [o]ur overall conclusion is that the systems used to allocate resources to local authorities, health authorities and the housing associations appear to operate to the disadvantage of the rural areas.'

It is perhaps worth observing that debates about the provision of health care in rural areas suggest that the issue of defining rurality and rural deprivation is equally problematic in that area of service provision. The Rural Voice Health Group has suggested 14 indicators of rural deprivation, including information deprivation, low income and seasonality of income, inadequate social facilities and stigma for certain social groups (Fennel, 1992; see also Cox, 1997).

A rural/urban classification of sample authorities

The particular analyses of rurality we employed in reaching a simple but reasonably robust means for categorising our sample of authorities were as follows.

- A special analysis of OPCS data undertaken by Telesis Scotland using the Postcode Index File of the General Registrar's Office, for all 32 Scottish unitary authorities. This distributed all the postcodes into six categories starting with Urban Code 1 (continuous block of localities with more than one million

residents) through to Rural Code 6 (not in a locality). For the purpose of this review we took authorities where a majority of postcodes were within Codes 1 and 2 as strongly urban, and those with a majority within Codes 5 and 6 as strongly rural. Codes 3 and 4 were mixed urban/rural to varying degrees and were discarded in our further analysis.

- Analyses undertaken by the Institute for Employment Research at the University of Warwick for the NHS Executive (Wilson *et al.*, 1996), and particularly a three-fold classification of areas (urban, intermediate [i.e. mixed] and rural) based on population. Although this is one of the less sophisticated categorisations provided in its analysis, and identified fewer areas as rural than had some other analyses, it had the advantage of again separating clearly urban areas from clearly rural areas.

- The analysis of the Office of National Statistics (Wallace and Denham, 1996) which is based on families, groups and clusters and which also identifies rural areas, urban centres and mixed urban/rural areas *inter alia*.

- The categorisation by the National Council for Voluntary Organisations (NCVO, 1997) based on the Rural Development Commission's population-based criteria of rurality which listed all local authority areas following reorganisation in 1996–98. This led to four categories, rural, mixed, urban and inner city, the last two both being regarded as urban for the purposes of this study.

As far as possible, all the local authorities emerging from reorganisation in 1995–98 were assigned a category from each of these approaches (some categorisations did not include all authorities). Where authorities were categorised urban in all relevant classifications, they were retained in the sample of urban authorities; where they were categorised as rural in all relevant classifications, they were retained in the sample of rural authorities. The remainder, which either were consistently classified as mixed or were designated in differing ways under different approaches, were all discarded as, in some way, 'mixed' urban/rural authorities. This approach gave, from the 117 authorities originally surveyed, the mix shown in Table 2.

The analysis that follows is therefore based on a sample of 24 rural authorities (83 per cent of the total number of rural authorities created through LGR) and 41 urban authorities (80 per cent of the total number of urban authorities created through LGR). The pool of 29 rural authorities provided the sampling frame from which the telephone interview survey sample was drawn (see Chapter 4).

Reanalysing the postal questionnaires

The 65 authorities included in the last two columns provided the sample of authorities, 24 strongly rural and 41 strongly urban, for our analysis. Postal data collected shortly after reorganisation were reanalysed to see if any further evidence emerged providing support for some of the key themes identified earlier. This reanalysis revealed the following evidence. The themes identified in this discussion are taken up in the list of proposals for further research, policy and practice development outlined in Chapter 5.

Structure and location of the social services department within the new authorities
Seven (17 per cent) of the 41 urban authorities had taken the opportunity of establishing entirely new joint departments at the point of reorganisation, covering both housing and social services (one or two further authorities have since moved to this form of structure). The precise form of the structure varied and in some cases there was some early anxiety that the

Table 2 Classification of sample authorities

	No. of rural authorities	No. of urban authorities	No. of 'mixed' authorities	No. of rural authorities returning postal questionnaires	No. of urban authorities returning postal questionnaires
England 1995/6	3	7	5	3	6
England 1997	5	10	8	5	10
England 1998	4	9	15	3	5
Scotland 1996	7	13	9	5	12
Wales 1996	10	12	0	8	8
Total	**29**	**51**	**37**	**24**	**41**

social services function might be 'submerged' by the housing function. Four (17 per cent) of the 24 rural authorities had also established joint housing and social services departments. None of these authorities was a 'downsized' county which had lost its urban core. They were all new unitaries created by the break-up of larger authorities. There were examples of these joint departments to be found in each of Scotland, Wales and England. The creation of new joint departments therefore appears to have been in part a response to the opportunity offered by the creation of an entirely new local authority to develop the kinds of closer working which earlier research on the division between housing and social services had indicated might be useful. Most continuing authorities of course remained on a two-tier local government basis with housing functions continuing to be exercised by district councils.

Emerging policy emphases towards the use of voluntary and private sectors

Local authorities were asked in our postal surveys (usually circulated approximately six months after the reorganisation date) whether they expected to make greater use of the voluntary sector or the private/independent sector in the delivery of care services as a result of reorganisation. Of the 24 rural authorities, half said they would make more use of the voluntary sector, three didn't know and the remainder (nine) said they would not. In

relation to the independent sector, the numbers of those likely to make greater use of the independent/private sector were larger (14) with two not sure and the remaining eight not likely to do so.

The split shown by the urban authorities is illustrated in Table 3.

There appears little significant difference in the stance of urban and rural authorities towards the voluntary sector. However, the stance of urban authorities was rather more resistant to use of the private/independent sector than rural authorities: this accords with the general profile of rural authorities as more conservative politically and with generally lower levels of direct provision or spending on services. Other information supplied in relation to this area of questioning suggests that, because the financing of the voluntary sector is tied very closely to funding from the local authority, particularly in the area of social care delivery (through contracts and service level agreements), the scope for greater use of the voluntary sector might be rather more constrained. The context of severe downward financial pressure on social services departments was also reflected in cuts in funding to voluntary sector organisations, as several respondents noted (see also Craig and Manthorpe, 1999a).

Half the Scottish authorities (both rural and urban) planned to make more use of the voluntary and independent sector, a stance

Table 3 Split shown by the urban authorities towards the use of voluntary and private sectors

	More use of	No more use of	Don't know
Voluntary sector	20	21	0
Independent/private sector	17	22	2

which went against historic trends in Scotland generally (Craig and Manthorpe, 1998c) and probably reflected what was regarded as the particularly harsh initial cash settlement to the new Scottish authorities. Ironically, it was only in Scotland that the Government was obliged to provide special additional funding to a number of voluntary agencies which were in danger of closing because of the impact of general cuts in funding from local authorities in 1996.

Age Concern Cymru, with an overview of the voluntary sector in respect of older people in Wales, reflected on the impact of LGR on its work (correspondence to authors, 29 July 1998). To some degree it felt that Age Concern had been protected by its status as a national movement. It had been able to maintain or had developed a local Age Concern organisation in 20 of the 22 Welsh unitary authority areas. It also felt that the smallness of local authorities had encouraged local involvement in decision-making, encouraged further by the breaking down in some cases of departmental barriers. However, against that, some areas were now too small and had too limited a resource base to sustain stand-alone voluntary organisations: the larger number of smaller authorities had, in its view, also engendered a more competitive culture which had obstructed the development of joint funding arrangements and had led to difficulties for some Age Concern organisations which had formerly straddled areas now covered by several new authorities. The small resource base at local level had also heightened competition within the voluntary sector and some significant projects had been squeezed out by funding cuts.

Funding and budgetary trends
Authorities were asked whether they were satisfied with the disaggregation of resources leading to the first STG (special transitional grant – or equivalent in Scotland and Wales) settlement after reorganisation; whether their budget for the first year after reorganisation had increased, stayed broadly the same or decreased; and whether there were likely to be difficulties for the following years.

In relation to the outcome of negotiations over funding for the first year's settlement, only six of the 21 (29 per cent) rural authorities which responded to this question declared themselves satisfied. Although several commented (some very strongly) that the overall sums distributed to social services by Government were inadequate, the majority of comments from those dissatisfied specified that they had also done badly from the disaggregation between the old authority and the two or three new ones which succeeded it. For the urban authorities, the corresponding numbers satisfied were 17 out of 40 (43 per cent). Several of the latter also commented that the database on which the disaggregation had been made was faulty and that they had later discovered that they had inherited a correspondingly larger number of potential or actual clients than they had budgeted for. Some rural authorities highlighted the failings of the distribution formula as unable properly to reflect the costs of provision in rural areas.

Funding trends for social care for the authorities in relation to the first year's settlement after reorganisation were reported as shown in Table 4.

Looking further ahead, both the rural and the urban authorities overwhelmingly anticipated difficulties in budgeting for the next

Table 4 Funding settlement in the year after reorganisation

	Decreased	Broadly same	Increased
Rural	17	7	0
Urban+	22	12	6

+ one no response.

year and subsequent years. Some of those few which did not predict difficulties observed that they would not have them only because they had made, or were going to make, budgetary cuts, effectively (from the users' perspective) a variation on the same theme.

The general picture which emerges here, confirmed by our wider analysis, is that the new unitary authorities, anxious to make a favourable political impression and to be sure that they could meet all likely initial social services demands on their budget, started life with rather more adequate (or conversely less pressured) budgets than their rural counterparts. This appeared to have been underpinned by, in general, a disaggregation which favoured the new unitaries somewhat (although this is likely to have been the result of a combination of factors, particularly the lower unit costs of service delivery in urban cores and, perhaps, the Government's desire to ensure that the new authorities were not undermined at the outset) and, in some cases, by local political decisions to increase social services spending. This is not, however, a consistent picture across all areas and a few urban areas complained strongly that the rural areas (that is, their 'ancestor' authorities) failed – or were unable – to provide adequate information to inform an appropriate disaggregation of resources. By the second and third years after disaggregation, however, these differences appear to have been

overridden by general funding pressures on social services as a whole and there then appears little to separate the sample of rural authorities from the urban authorities. As this report was being completed, the picture was emerging of many unitary authorities making substantial cuts in social services spending.

Patterns of service provision

Authorities were asked whether their policies had changed in relation to three policy areas: charging policy, residential and nursing care provision, and domiciliary care provision. These were chosen as areas which were central to social care strategies both in terms of the questions of 'who pays' for care (particularly as between state, local state and user) and 'who provides' it (broadly, the shape of the local mixed economy of welfare).

Twelve of the 24 rural authorities had changed their stance on charging, either newly introducing a charging policy or increasing charges. Twenty of the 41 urban authorities had also changed their policy by increasing charges or introducing new policies; however, two of the urban authorities had abolished charges in areas such as domiciliary care (a result of a political decision to align charging policy to the local anti-poverty strategy). The pressure to introduce or increase charges was marginally stronger, therefore, in rural areas and several of these authorities commented that it had been in part a

consequence of a loss of economies of scale resultant on their area becoming markedly more rural following reorganisation.

Ten rural authorities had changed their policy towards residential and nursing care, almost entirely by tightening eligibility criteria, but in three cases by moving to transfer ownership to the independent sector. A slightly greater number (13) had also changed their stance on domiciliary care, again largely through tightening eligibility criteria, increasing charges or by 'outsourcing' provision. The picture for urban authorities was of a move in the same direction but significantly less marked: 14 of the 41 urban authorities had changed policies (that is, had altered the policies they had inherited from their 'ancestor' authority) on residential and nursing care, and ten had altered policies on domiciliary care, in each case by a combination of the same sorts of change: tightening eligibility criteria, increasing charges and removing provision from public control.

Although the data from the questionnaires are not detailed enough for very firm conclusions, this does suggest a picture of rural authorities already under much greater pressure at the point of and then immediately after reorganisation. It is also worth emphasising that rural authorities were in any case already likely generally to have lower levels of provision than urban authorities, in part a reflection of cost limitations but also of local political priorities. In summary, these data appear to suggest that a further turn of the screw has been applied to more rural authorities as a result of reorganisation, to the pressures on (and political choices about) service provision faced by them and identified by Hale and Associates (1996) and others.

Staffing and political leadership

Authorities were asked what the impact of reorganisation was on staff in the social services/work department, and particularly in terms of losing or retaining key staff. Similarly, respondents were asked what the effect was in terms of retaining or losing elected members with significant social services experience.

Ancestor authorities were bound to 'lose' staff in the sense that a proportion were to be transferred either under protected arrangements or by publicly advertised recruitment, and responses from rural authorities – which is what most 'ancestor' (or, alternatively, continuing) authorities were – reflected this. However, several commented that they had lost more staff than they had anticipated pro rata and several more had only avoided this by special recruiting campaigns. Seven rural authorities had experienced actual staff losses through redundancy of some sort, perhaps a further reflection of financial pressure. Evidence from our present study also suggests that the brand new unitary authorities made emphatic attempts to attract good quality staff for newly formed departments, bidding up salaries in the process. This might suggest that there was some 'drift' of more senior and experienced staff from the rural ancestor authorities to the urban successor authorities.

This was not a trend simply across from rural to urban authorities, however, as some smaller urban authorities commented that they had lost staff to 'wealthier' authorities. There seems little doubt that these 'wealthier' authorities (by which respondents appear to have meant larger authorities with a large resource base and the capacity to offer salaries substantially above the market rate) were able

to use the point of reorganisation to recruit a disproportionate number (disproportionate in terms of equity between neighbouring authorities as opposed to in terms of the general quality of the service) of more experienced staff, although the extent of this tendency is impossible to quantify (see Craig and Manthorpe, 1999b for a discussion of staff loss at LGR more generally). A smaller proportion of urban authorities (about 20 per cent) actually had staff reductions greater than they had originally planned, three having fairly substantial redundancies. Both types of authority lost key staff, typically in central support functions, and rural authorities again commented strongly on the diseconomies of scale consequent on disaggregation that led to the loss of specialist staff.

Given the vagaries of personal interest, place of residence and the boundaries of new local authorities, we would not have expected to have found a clear pattern in terms of the impact on social services political leadership following reorganisation. Clearly all authorities will have lost some members, since roughly the same number of members were scattered across, on average, three times as many authorities. Nine rural authorities lost virtually all social services members, that is, had less than one-third of previous members with social services experience remaining. Two rural authorities, built essentially on a district council boundary, particularly commented that the new committees were dominated by members with district council experience with limited strategic experience: one respondent put it this way: 'we have lost the astute shapers and seen them replaced by the interferers'.

This again, however, is an outcome of reorganisation that they shared with urban authorities, many of which also had new social services committees on which few or no members had previous experience. Although many of the new urban authorities had previously had welfare functions, this generally had not been the case since the early 1970s. While some of the old county borough councils made much of this in their submissions to the Local Government Commission in England, there was not likely to be any residual experience from that period worth speaking of. As several respondents commented, in any case, the world of social services had changed beyond recognition in the previous 30 years. Any former county borough councillors who had been district councillors in the intervening period and who still retained an interest in local government after 1996 were unlikely to be equipped to deal with the strategic problems of managing a social care market or the complex and sensitive world of child protection.

Summary

While the overall pattern is not entirely consistent, this reanalysis of the postal survey data provides further evidence for the difficulties faced particularly by rural authorities. The elements of this involve inequities in resource distribution both in general and in terms of reorganisation itself, a loss of economies of scale, disproportionate pressure to increase charges to service users and to outsource services. The smaller size of rural authorities, as compared with their ancestor authorities, also undermined their ability to support the voluntary sector.

Note

1   The three existing Scottish Islands councils, Shetland, Orkney and the Western Isles, with boundaries unchanged by reorganisation, were excluded from our postal survey.

4 The telephone survey of rural authorities

A series of follow-up telephone interviews was conducted in the spring of 1999 in a sample of 20 rural areas (drawn from the 24 authorities identified in Chapter 3). This point in time was between three years and one year after reorganisation had occurred. The sample was chosen to give a selection of authorities by size, political control (as far as possible) and other key variables, again with both social services senior staff but also representatives of other key actors. The sample included quotas of authorities from England (eight), Scotland (six) and Wales (six), and also purposively included all those authorities within the rural sample from which no postal questionnaire had been returned. The sample for the telephone survey consisted of authorities shown in Table 5.

The telephone survey covered a number of key issues reviewed in our earlier research and thus, in many cases, served to update information available from that study. Interviews were conducted with key officers within social services and with representatives of health authorities and major local voluntary sector organisations.

Structure and location of the social services/social work department

The role of the social services department, in many of the unitary authorities responding, appeared to be affected less by the merger with the housing department (which generally occurred in the authorities around the time of LGR) than by new ideas within the authority about corporate and closer working. For example, one Welsh authority, which had kept separate departments, referred to continual 'pushing' from politicians to show that they were working more closely together with officers from housing and education. In another area, while housing and social services departments had merged, the environmental health department was linked with other departments (leisure, technical services, community development) and this still led to problems of communication. Other merged departments reported that issues about the comparative status of professional social services staff remained.

Table 5 The sample for the telephone survey

England	Scotland	Wales
Isle of Wight	Moray	Ynys Mon
Wiltshire	Borders	Ceredigion
East Riding of Yorkshire	Perthshire and Kinross	Flintshire
Devon	Aberdeenshire	Monmouthshire
Bedfordshire	Highlands	Denbighshire
Wokingham	Dumfires and Galloway	Pembrokeshire
Shropshire		
Rutland		

Among those authorities which remained two-tier, two expressed the view that this position might not be continued, i.e. that further reorganisation might be argued for. One respondent said that there was now a view that the county was 'over-governed' and that the neighbouring (one-tier) unitary appeared attractive locally as a model. This view was reinforced by attempts to promote more corporate approaches within two-tier areas.

While the structure of the departments varied in terms of departmental mergers or the centralisation of power among Directors of Social Services, we also found variations in the patterns within local areas. For some authorities, decisions had been pushed down to local managers who had considerable discretion over services and budgets and could forge local relationships. In others, control had been kept at the centre. In community care services, this centralisation (doubtless a reflection of financial pressure) was evidenced by the setting up of panels of managers to scrutinise every application for residential care.

Social services' relationships with other agencies also varied in rural areas. Some small departments now had to relate to voluntary groups which had wider areas of benefit (typically the former county): many of these, such as housing associations, were themselves becoming major service providers. In other areas, liaison was improved at local level. One authority provided an example of a first indication of local problem-solving when the knotty issue of 'special needs transport' was considered. Officers, councillors and the voluntary sector had met to discuss the availability of such transport and 'sorted out' ways of maximising its use. In other areas, new,

more formal, consultative structures had been established. Social services had increasingly to work with health authorities that were much larger in size and geographically distant in some areas. This was particularly the case in Wales where health authorities had been reorganised on a larger scale, which, for local authorities, had increased their perception that they were now the 'minor partners'. Health Action Zones, in shadow or actual form, had also prompted more links with health authorities, although the new local authorities found themselves increasingly working with colleagues from neighbouring authorities with whom relationships had been strained by the upheavals of LGR. Similar comments were made in respect of funding from the European Union.

Emerging policy emphases

One of the overwhelming concerns of rural areas was the issue of transport, as the literature confirms. However, respondents referred to the issue of transport from differing perspectives. For example, some respondents referred to it as an indicator of deprivation. Others linked it more to isolation and the impact of this upon mental health. Transport in community care services was also perceived as a problem in not getting users to services. Others revealed that problems lay, conversely, in getting staff to users. Most respondents identified that great reliance was placed on voluntary car or transport schemes but some recognised that these could be most beneficial for 'one-off' journeys and that there could, in any case, be duplication or gaps. Funding for such schemes was particularly important in areas where there are low income levels and transport co-

ordinators were appreciated, particularly if funded. Many voluntary car schemes, however, were not always able to help people with significant disabilities and, of course, even the provision of transport did not do away with the difficulties of a long journey for some service users. Within some remote rural areas, the issue of weather conditions was also raised as important. Transport problems could be affected by extreme weather conditions and there was anecdotal evidence that the risk of isolation during bad weather could shape decisions on offering residential care.

One theme that arose in interviews was the interest among respondents from all agencies to uncover and then interrogate data about local need and circumstances, at very local level. This was particularly so in the case of rural areas which were generally perceived to be affluent. Mapping of local data on deprivation has demonstrated that extreme polarisation of income and wealth can occur in every part of the UK (Green, 1994; Alcock and Craig, 2000). Service providers wished to be able to demonstrate that 'micro pockets of deprivation' existed and expressed the view that people with low levels of resources were socially excluded in areas where the majority possessed cars, were employed or had access to distant shops and facilities. As one respondent said, 'we're better at getting evidence, we have more statistics, more information'. The construction of Social Care Plans/Community Care Plans within smaller authorities has helped with such processes as they have been able to focus more on the dimensions of rurality. One respondent commented that such local detail was important to local councillors who could see the issues more clearly.

Finally, the telephone interviews revealed a new policy emphasis on closer working with health, particularly in respect of Primary Care Groups (PCGs)/Local Health Boards. PCGs were just coming into existence at the time of the telephone surveys and, unsurprisingly, all local authority respondents made reference to these developments. Overall, there was optimism that these would help to develop services across health and social care, and that they would constitute a forum to discuss issues at local level. The particular implications for the rural identity of the areas have not yet been established, however. One minor issue for some local authorities which had only recent redrawn their own locality or district boundaries after LGR was that PCGs' boundaries were often dissimilar. The matter of coterminosity – or, more exactly, the continuing lack of coterminosity (briefly commented on by the Health Committee in its review of the relationship between Health and Social Services [Health Committee, 1998]) looks set to continue to dog local government and its relationships with other agencies, particularly health authorities/boards, local health organisations and the bigger voluntary organisations.

Funding and budgetary trends

Issues in respect of rural authorities' provision of community care services focused on two main themes. The first, predictably, was the extra costs incurred by providing services in remote areas: the second, the problems associated with local government finance and the opportunities arising from extra funding sources. Those smaller authorities that had reduced geographical areas following LGR – the

majority of the authorities involved – also commented strongly on the loss of economies of scale. A small number of respondents identified the impact of increased charges upon service users and their contribution to a reduced quality of life among some rural populations.

The extra costs of rural provision have been documented at national level (see Chapter 2) but respondents gave examples of these from their own experiences. They commented, for example, on the need to pay for considerable travel time among home care workers. Even if provision was organised so that one agency operated in a particular locality there could still be considerable travel costs involved. One respondent recalled how a home care worker had been asked to consider using a bicycle to reduce mileage costs but in the event this was inefficient because the village where she worked was spread out and cycle use took a far greater time.

Other extra costs incurred in efforts to respond to rurality were also identified in respect of services which had to use a variety of premises and those which attempted to provide a form of mobile provision. In a number of areas, there was interest in developing the social facilities of rural communities, such as village halls, to provide community care services: one way of expediting this was to offer support to facilities through paying or subsidising rent.

While the potential for these developments was being explored at local level, there was also a number of comments made about local government finance. For some, these were general points about the balance of urban and rural funding, generally thought to favour urban above rural needs. For others, there were continuing issues arising out of LGR

disaggregation. While many authorities referred to problems in these areas, in particular, comments about demography (such as the higher proportions of very elderly people living in rural areas), there was no single view of a more rational or effective system of financial allocation. One other point of concern was the regional nature of some funding with some areas of the country reporting views that funds had shifted within their regional level and away from their area.

The opportunity for new streams of funding was raised by another large group of respondents. These extended from European funding, which was perceived as potentially very valuable, to small rural-based charities and partnerships across sectors. Rural authorities needed not only to have very precise details about their populations but also to be able to combine these with data about funding for economic development in respect of community care, and work was relatively undeveloped in this area of policy development. Local enterprises, for example, often focused on employment for marginalised adults. Less often mentioned were enterprises with community care provision as their aim, such as co-operatives for home care. Financial strategies were also beginning to be extended to thinking about the voluntary sector and ways in which its infrastructure could be supported or the direct costs of volunteers reimbursed. A number of respondents acknowledged that, while volunteers might be 'free' in rural areas, their activities often required a high level of co-ordination and, thus, staff time. This would frequently also entail support for expenses (which were felt to be much-needed but could be quite high), office space and provision of

equipment, and salaries. In some areas, grants from the National Lottery Charities Board had been helpful but gave no long-term guarantees of funding for innovative work.

For smaller authorities, the issues of economies of scale were mentioned in relation to two particular aspects of community care. First, it was noted that certain 'user groups' were likely to be extremely small in number. The example most frequently cited was of people with profound and multiple disabilities. Specialist provision was restricted and specialist personnel not able to be recruited. Equally, there was little mention of the needs of service users from ethnic minorities and how to respond to these; the relatively small numbers (generally thought, on the basis of 1991 census data, to be about 1 per cent of the adult population in rural areas but probably significantly higher in reality) meant that many authorities did not regard the issue as requiring specific provision to be made. Second, a lack of resource within the local authority could mean that certain basic activities were in danger of being 'blown off course' if certain unpredicted events occurred. A single major investigation or a very highly priced care package could disproportionately distort general activities and budgets.

Lastly, charges for services were commented on in relation to rural authorities. While these are generally levied on a widespread basis, particularly as a result of pressure from central government through the general funding formulae, supported by exhortations from the Audit Commission (Audit Commission, 1999), respondents pointed out that they impacted on people who were already paying higher than average costs for goods and services, such as provisions from local stores or mobile shops. It

was also noted that in rural areas there was less access to sources of help about welfare benefits. Those on the margins of community care eligibility, whist not actually paying directly for care, often were reported as having to pay neighbours or relatives directly for assistance or in the form of contributions to petrol costs. For a number of respondents, such issues were linked to economic deprivation in rural areas, often characterised in terms of unemployment, under-employment or in the form of seasonal, irregular work.

Patterns of service provision

The telephone interviews revealed that the mixed economy of service provision in rural areas, driven by the community care funding regime, had resulted in considerable local variation. It was not always possible to account for this variation on political grounds for there also appeared to be other factors at play such as tradition and local loyalties. Variations also existed between Welsh and Scottish authorities and their English counterparts, the latter having a far more commercially based pattern of provision of community care services, particularly for older people. The voluntary sector was most frequently referred to as a provider of services for people with learning disabilities but there appeared to be greater variation in the levels and types of social care support available to people with mental health problems. While some areas had no local services at all for people with acute problems, others had no residential care for those with enduring needs or at rehabilitation stages. Community teams, avoiding duplication by personnel, were not fully established in many

areas. Other geographical variables also existed in relation to the types of commercial provider: some were local enterprises, others had arrived as 'incomers' to set up business in the area and, it was suggested, to take advantage of inexpensive but available labour (which had often been 'trained' by local authorities) and cheaper property prices in remote or coastal areas. For some respondents, the availability, and at times choice, of residential providers in rural areas was perceived as beneficial but, for providers and users in most areas, and particularly the most remote areas, choice was a relatively rare commodity.

We found some evidence that rural authorities had to manage the market quite strongly, particularly in respect of home care. They were able to do this by adopting different patterns of contracting, for example, by pricing variations, by spot purchasing, by establishing a system of awarding a rural premium (see also, for example, the report on Wiltshire's rural premium, *Community Care*, 1999, p. 4), by paying for travel and by a number of other devices. Such strategies appeared generally to have developed, however, on a more or less *ad hoc* basis, often by attempting to skew patterns of provision inherited at reorganisation.

Smaller rural authorities had some experience of having to fund community care services for users from providers based outside their authorities. This could be, as implied above, in cases where specialist provision was needed but could not be funded from within the authority. Some authorities were attempting to reduce this practice on the grounds of economy but also because they were committed to local provision. The latter point was attractive to elected members who valued provision within

the area but the cost of doing so did not always work to their advantage. The alternatives, of buying in services from other authorities, or attempting to develop joint provision, were felt to be politically unattractive.

Staffing and political leadership

Rural authorities had experienced significant staff turnover in many instances at the time of LGR; this was in common with other areas although, as noted earlier, there may have been some drift of senior staff to new, unitary (and more usually urban) authorities which could 'bid up' market prices for senior staff. There were exceptions, however, where staff had remained fairly settled. At the level of residential and home care service provision, some changes had occurred as a result of putting services out to competitive tender or service closure. However, difficulties over staff recruitment in relation to community care within local areas remained regardless of provider and were seen as being the consequence of the dispersed population – available staff not always being near service users. Other staff shortages occurred with the migration of younger people to areas of better employment. Seasonal work, either in the spheres of tourism or agriculture, could mean that continuity of care was disrupted. While levels of car ownership varied (and, for many staff, car ownership was probably a necessity rather than a measure of comparative wealth), it was seen as helpful if staff such as domiciliary care staff could own their own vehicles; however, this was not always affordable for those on low pay. While volunteers are not staff, there were some concerns that they were not

always available in sufficient numbers to provide the network of social care services that formed the backcloth to rural life. For both staff and volunteers, issues of the personal safety and security of the service users needed to be addressed when working in remote areas in isolation.

Respondents from rural areas reported that local political leaders shared a variety of perceptions about local community care services. There were common references to local pride and traditions of mutual self-help. There were also some reports of a sense of obligation to older people and a wish to provide services for individuals who had often led hard lives and were not well-off in old age. Attitudes to people with learning disabilities were generally reported to be supportive, if somewhat paternalistic. Politicians in rural areas were often said to be knowledgeable about local networks and the voluntary sector but again might still have rather outdated attitudes to the role of voluntary organisations. In contrast, officers at the most senior level within authorities were at times reported to be interested in 'high level' work, typically major strategic developments and corporate working, paying less attention to the minutiae of service provision in remote areas.

A number of respondents offered ideas about the potential for community development work in rural areas. Health has clearly embraced – at least in principle – this model of improving the quality of life, and there were some suggestions that joint health and social services provision was being developed within this general paradigm. The knowledge, skills and capacities of local people remain a largely untapped resource in rural social care although

a forthcoming report for the Joseph Rowntree Foundation based on fieldwork in the Highlands Council area demonstrates how very local community organisations and networking in very rural areas can make an effective contribution to social care (Barr *et al.*, 2000, forthcoming).

Summary

Much of the evidence gained through the telephone survey emphasises issues identified in earlier chapters. The financing of social care in rural areas is a major issue, because of a perceived skew in funding arrangements and the additional costs of providing services in rural areas. Isolation, difficulties of access, the loss of economies of scale contingent on reorganisation, the difficulties of providing for relatively small numbers of groups with special needs (because of religion, culture or the nature of their disability, for example, or simply because of the geographical isolation of some groups with considerable needs), all featured strongly in responses. The seasonal nature of much employment in rural areas (particularly tourism, leisure and agriculture) also worked to undermine continuity of employment and provision.

Joint working was underdeveloped and was hindered by a lack of coterminosity, itself accentuated by local government and health service reorganisations; joint working with neighbouring authorities (particularly buying specialist services) was often regarded as an unwelcome necessity. The dependence on the voluntary sector and on volunteers was fragile in places, particularly again because of funding difficulties, and developmental approaches,

building on local community capacity, to social
care provision, were suggested but were
generally not in much evidence.

5 Conclusion: agendas for research, policy and practice development

From this brief review of issues emerging from recent literature and from our additional researches, there are some clear pointers for further research, policy and practice development by the Foundation and others. There is a considerable amount of detailed quantitative work ongoing involving government and local government, to determine a statistically robust and equitable distribution of resources through SSAs and the Index of Local Deprivation. This work needs to continue to address the strong dissatisfaction among rural authorities that the mechanisms for distributing resources to rural authorities are inequitable.

However, there is relatively little qualitative evidence to date to underpin this statistical work and this would undoubtedly be a strong candidate in general for further research. Given the difficulties rehearsed above of identifying and accessing information about the position of actual and potential service users, a qualitative approach is particularly appropriate, despite its relative costliness, although two caveats should be entered. Because of the fairly rapidly growing level of interest in this field, it is important to acknowledge that there is other work in progress and that the status of this should be reviewed. We suggest that this be done by speedy reviews of best practice in a number of areas itemised below. Second, there are some areas where quantitative work would be useful, despite the difficulties of getting contemporary robust data, to gain a picture of broad trends.

In line with the political goal of closer collaboration between health and social services

working, in undertaking this research, it would be important to establish what lessons for rural social care provision might be learnt from thinking about rural health care. At present, these debates appear to be travelling along parallel but not well-connected tracks. Yet, there is obviously a clear debate emerging around the provision of rural health care services, especially in Wales and in Scotland (e.g. McKie and MacPherson, 1997; NCVO, 1999) but also through the Royal College of Practitioners' Rural Practice Group. For example, an article by Cox (1997), Chair of this Group, identifies many of the same issues facing the provision of healthcare in rural areas, including problems in defining rurality, a shortage of competent staff, the difficulties of achieving equitable access faced by service users consequent on the centralisation of services, the use of para-professionals, the discrepancies between needs and resources, and the potential uses to which new technology can be put in promoting health care (see also Evans, 1997; Gerrard and Walsh, 1997; Heward, 1997; Whyte, 1997).

Most comparative work and discussion has tended to focus on the urban–rural divide, i.e. differences in funding, organisation and provision as between urban and rural areas. However, in areas of sparse population where there are some small urban settlements, there is probably an equally good case for examining the intra-rural differences in social care provision and organisation: it is as likely that there are significant differences in service provision, access to services and information availability, for example, as between those living in rural areas on the fringes of urban settlements

and those living in deeply rural areas, and an examination of these differences should be built into any future studies examining rural service provision.

Research development

1   There are a number of areas of service delivery where innovation is beginning to take place. It is important that the lessons of these are disseminated widely and we suggest that best practice reviews be undertaken, supported by appropriate research funders. Priority areas identified above are:

- use of community facilities and buildings for social care provision

- innovations in local transport provision to promote access

- decentralised and outreach work

- development of local community responses to social care needs

- exploitation of IT and telecommunications systems

- provision of information about services and benefits

- organising to meet the needs of numerically small groups of service users, such as those with profound learning disability, users from minority ethnic groups, and those with severe physical disability

- joint working between health, social services and voluntary agencies in a specifically rural context

- models of social care provision in specific rural contexts, notably islands.

Some, perhaps all, of these reviews could be undertaken simultaneously as innovations often cross these sectoral boundaries. For example, a bus service in the east Cumbria area, uses Global Positioning Systems (more usually employed in defence systems) to help users identify where the bus is and 'hail' it, and is provided with an induction loop and aids for physical accessibility. Similarly, a bus in the Exmoor area circulates effectively as a mobile day centre, collecting service users, dropping them at appropriate points, such as pubs for lunch, collecting them again and returning them to their homes.

The findings of at least some of these reviews could also be used, perhaps drawing on detailed case studies, to test the validity of the claim that informal care networks operate more strongly in rural areas than in urban areas, a claim which can be used to undermine effective professional provision, and which is challenged in Grant's earlier paper for the Joseph Rowntree Foundation (Grant, 1998). This might also look at the issue of social isolation and how this difficulty is addressed through informal care provision. A particular focus might also be on the position of carers and the support available to them in rural areas. Carers' National Association, for example, has called in its *New Carers' Code* (Carers' National Association, 1999) for carers in remote and rural areas to be 'fully recognised'. It would be timely to assess what might be effective in this regard.

These reviews (perhaps including some developmental work) will need to acknowledge work already undertaken on particular issues, for example, Moseley and Parker's work on the question of joint provision (Moseley and Parker, 1998). Where some work has been undertaken, these reviews might either draw evidence together from a wider range of examples to provide a more comprehensive and publicly available classification of initiatives, and/or focus on provision for particular user groups within the population, and/or differing service sectors such as use of buildings or of vehicles. Moseley and Parker themselves propose further work on the economics of 'tandem provision' and on service delivery by area-wide partnerships.

2 An examination of the way in which markets in social care provision in rural areas are developing as between statutory, voluntary and independent/private providers would also be particularly important. There is some anecdotal evidence from the field of children's services that private providers are 'moving in' to rural areas and this may have profound consequences in the medium to long term for the balance of local provision and for its financing. If it is true that this trend is also apparent in the area of social care, it would be important to examine whether there are particular kinds of services which are being targeted by independent providers (as being more profitable) and what the implications of this might be for other providers. This would lend itself to an approach based both on case studies and on an analysis of broader trends, and should

incorporate an examination of the extent to which choice is realistically available for service users.

More generally, and arising from reorganisation, the questions which suggest themselves in this area in relation to the changing shape of the local care market are what role private and voluntary care providers are playing in the new authorities and whether there are significant differences between the way these markets are developing in different types of authority (particularly in relation to the small size of some authorities). The background to an investigation of this kind is the almost completely arbitrary way in which 'capital assets' such as residential homes for children or older people were allocated between new authorities simply on the basis of their physical location (i.e. on one or other side of a new local authority boundary) rather than on the basis of need or demand. There seems little doubt that the way this has happened in most new authorities has left gaps in provision which have had to be filled either by buying services from neighbouring authorities, contracting with other providers, or making expensive investments in new facilities which may not be cost-effective.

3 There has been considerable feedback to us on the issue of a rural premium, expressed in differing ways but essentially reflecting a need for all accounting and financial systems to acknowledge the additional costs of service delivery in rural areas. Some largely anecdotal data have been reviewed earlier in this report and a detailed study of this issue would be a very useful complement to the

structural discussions on SSAs. This could incorporate an examination of the additional costs to all parties, including voluntary agencies, carers, providers and service users in rural areas.

4 Although very contemporary quantitative data are difficult to collect from published sources, it would now be useful (and is possible given the passage of time since the last round of LGR in 1998) to review the financial allocations to local authorities together with their social services budgets to establish whether reorganisation has, as predicted, emphasised the disparity between levels of funding for care as between rural areas and urban areas, and to contribute to the debate about whether funding allocations are equitable as between rural and urban areas.

5 Users' and carers' groups have felt marginal to the development of care planning and are more likely to be so in remote areas. A review of imaginative and innovative consultation procedures for involving sparsely populated areas in care planning would be helpful: to date, there is only limited material in the public domain (e.g. Clark, A., 1997). This might need to acknowledge important contextual factors such as provision/support for informal carers which takes account of travel difficulties and feelings of isolation. The National Strategy for Carers (HM Government, 1999), contains three paragraphs (paras 31–3) in its section on rural areas. It too calls for specific research on their needs and to evaluate existing projects.

6 There is a growing industry within local government, supported by academics, of mapping of local social and economic data (see Alcock and Craig, 1999), that is making use of computer-based GIS approaches. There are isolated examples of published work in this area relating to rural social and health needs (Nottinghamshire County Council, 1995; Clark, G., 1997) but no systematic thinking as yet about the kinds of social and economic data which, in appropriate combinations, might assist local care planning and prioritisation in rural areas. A review of evidence would be very useful and would help many authorities and agencies to avoid reinventing the wheel.

7 Rural areas have very high proportions of older people relative to the UK population at large. The local economic impact of these populations, in terms of the cost of services, the scope for development of the local economy through the provision of domiciliary and residential services, and, most imaginatively, the contributions which older people themselves can make to the local economy (for example, through supporting child-care provision or being involved in other intergenerational initiatives), are only just beginning to be explored. More generally, the opportunities provided by social care for generating local employment have not been reviewed in a positive sense: most literature reflects on the barriers to employment created by rural locations for different population groups (e.g. Cloke *et al.*, 1997). Given the unwillingness of many profit-oriented providers to offer services in high-cost areas, what scope might

there be, for example, for local co-operative ventures? A systematic review of the employment potential of social care in rural areas should be initiated, perhaps based on a sample of case study areas, which would explore the use of local residents and service users themselves as potential actors and providers. The context of the expansion of direct payments makes this a timely issue to explore.

Policy development

1 Many of the reports we reviewed from Government, major national agencies and local government have yet fully to integrate a clear rural dimension, if any, in their analysis. Those responsible for producing reports on policy development in social care must ensure that the rural dimension is treated effectively and explicitly. The Fair Access to Care Initiative (see Chapter 2) is a good example of work in progress where a strong rural dimension needs to be made explicit.

2 An evaluation of the efficacy of the joint 'community services departments' (as they are usually termed: i.e. joint housing and social services departments) created within a number of new unitary authorities for the delivery of more integrated care would now be very useful and should be initiated by the Department of Health (DH). The distribution of these departments offers the opportunity for a comparative study across rural and urban areas, based on a case study approach. There is growing interest in this model but its advantages in the development of social care have yet thoroughly to be scrutinised.

3 Since the NCVO's last review of local authority community care plans in 1995, there was no systematic analysis of the extent to which local authorities are addressing the issue of rurality in their planning and service delivery procedures until the 1999 SSI report (Brown, 1999) which demonstrated (albeit on evidence from only eight authorities), perhaps most of all, that rhetoric may not be matched by reality. The report highlighted some strengths and many deficiencies in the delivery of social care to rural users. There is no structured requirement that rural issues are addressed and the Social Services Inspectorate/DH could prepare guidance indicating to authorities how issues of rurality should be addressed in community care planning. The general debate about rurality has moved on considerably in the past five years and it may well be time, given the impact of reorganisation described elsewhere in this report, to revisit this issue, perhaps building on the model adopted by Bewley and Glendinning (1994). More broadly, a good practice guide for local authorities might be developed paralleling the approach taken by the NCVO for voluntary organisations. The need for this appears to be underlined by the review of rural child-care issues in children's services planning undertaken by the National Council of Voluntary Child Care Organisations (NCVCCO) and Action for Communities in Rural England (ACRE) which found that 'the level of local authority involvement in addressing specifically rural aspects of the needs of their rural populations was minimal' (NCVCCO, 1999).

4 Reorganisation had a substantial, and generally negative, impact on the possibility of joint working between statutory health and social services authorities, because of the loss of coterminosity in many cases. The House of Commons Health Select Committee examined the issue of joint working last year (Health Committee, 1998) but only considered this particular issue in passing. A short focused examination of the impact of the loss of common organisational boundaries would be timely, particularly given the arrival of Primary Care Groups/ Local Health Boards with yet another set of (usually non-contiguous) boundaries and the present Government's emphatic support for inter-agency partnership working. The first wave of Primary Care Trusts appears to cover a diverse range of geographical settings and might provide opportunities for comparisons.

Practice development

1 Social care systems, such as needs assessment processes and charging arrangements, have yet generally to incorporate elements which are of significance in rural areas. One obvious element is the cost of accessing services, which appears generally not to be factored into estimates of need and cost. Local authorities and those responsible for assessing the needs of care users should review their current arrangements. One way of approaching this issue for authorities covering both urban and rural areas might be to consider the 'careers' in social care of individuals from urban and rural

environments with similar levels of disabilities/illnesses, to identify possible outcomes, and issues around equity and access.

2 Social care staff employed by or for rural authorities often work in remote isolated areas. Authorities should review arrangements for the personal safety of their staff, with employees and their representatives.

3 Professionals working in rural areas appear, from the evidence gathered through this study, often to have to respond intuitively or 'on-the-hoof' to the difficulties of working in rural areas, particularly where structures and processes have not been put in place explicitly to support their work. The General Social Care Council should initiate discussions with training agencies about the need to devise, deliver and evaluate training in respect of rural matters for professionals at in-service and pre-qualifying levels. This discussion should also incorporate development of materials for para-professionals and community activists who are increasingly being drawn into care provision.

4 The experience of service users living in rural areas rarely permeates debates on rural social care other than through a simplistic listing of problems, notably around transport (or the lack of it). We know little of how they manage such difficulties or what they consider to be important or priorities for service development. We also know little about the positive aspects of rural life experienced in the context of receiving

support. The Social Services Inspectorate report (Brown, 1999) took some useful first steps in pursuing such inquiries; it would be useful to explore this further, to test their tentative findings and to refine their approach.

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Appendix: Some rural case studies

Island first: the Isle of Wight

The Isle of Wight was the first unitary authority (absorbing two second-tier district councils and the previous county) created in this current round of LGR (in 1995) and was dealt with on its own by Government because it appeared to represent the most straightforward authority to restructure. The Isle of Wight is the sole English island of any significant size and its rural nature is closely tied to its island status. This is exemplified by the cost of transport which is high within the island itself and also high when travelling from the island to the mainland for health or social care reasons. The island itself is an enclosed community and has many voluntary organisations (over 1,000) that provide support.

As a rural development area, the Isle has received extra funding and Single Regeneration Budget (SRB) money. However, it has notable economic problems and there was a feeling that, at the time of LGR, the previous county had 'run the coffers dry'. To counter this 'financial starvation', the new authority has set up the Isle of Wight Partnership, a federal body including the health authority and the voluntary sector. This sets the agenda for economic development, sets up New Deal programmes for young people and looks to issues of social exclusion.

Within the unitary authority itself, a variety of changes have occurred. The Leader of the council had been in position for 17 years and in many ways acted as Chief Executive. Until recently, there had been no Chief Executive, simply a clerk. In early 1999, an experienced Chief Executive was appointed and this was reported as affecting the level of departmental and service co-ordination. Policy has now

begun to develop rapidly. Politically, the authority is now regarded as 'significantly hung' with independents holding the balance of power. In terms of funding, at the time of our research, the statistical base for the island was still aggregated with that of Hampshire. It is not able to access some European funding programmes or to be an assisted area: its current status is that of an intermediate area. There are significant moves to attract European funding, in particular to access island funding programmes.

The intermediate assisted area status is important to the island as its levels of deprivation and social need demonstrate. The population has one of the lowest average incomes of the country, lowest male earnings and one of the highest proportionate retirement populations. Seasonal employment brings a high level of under-employment in the 'off season' and many young skilled or educated people leave the island. Local industries such as tourism and leisure are under-capitalised, though tourism accounts for 23 per cent of the employment. Among retired people, pension incomes are relatively low, although some have significant capital assets. Community care provision for older people is dominated by approximately 400 residential care homes – a substantial number in relation to the population. Community-based care reflects these social indicators, by being hard to develop. Transport difficulties mean it is difficult and expensive to get staff to people's own homes and seasonal work can disrupt continuity of care. Services for people with physical disabilities are relatively under-developed and not generally user-led. There are some early signs of joint working and this has

increased with the merging of housing and social services departments since LGR. A recent anti-poverty task force has been established, led by the voluntary sector, and there are indications of more cross-directorate developments to address social and care problems.

In common with many rural areas, the Isle is caught in the tension between centralising services and developing provision which helps make for both a wide range and cost-efficiency on the one hand, against the problems encountered by users in accessing services in towns, on the other. For some, these problems are exacerbated as travel for health care may be necessary outside the Isle. This poses difficulties for patients and relatives, particularly older people who find leaving the Isle worrying and stressful.

There is, however, an acute mental health unit on the Isle of Wight and mental health services have been protected by ring-fenced funding. Learning disability services have been developed over recent years, so much so that practitioners recognise that the Isle has attracted people who wish to benefit from these levels of service. The nature of the island community was considered to have contributed to these advances since the 'community feel' or close networks at professional level have facilitated good joint working and islanders are perceived to be supportive. A number of visionary individuals had also contributed to this progress. However, questions are now being asked about whether this level of development can be sustained or whether the service has become 'a victim of its own success'.

A high level of older people as a proportion of the local population is a common theme within rural areas and the Isle of Wight is no exception. As a retirement area, there are older populations with social networks and those with limited informal supports. Primary health care and community care services are stretched and these are particularly challenged by the emphasis on early hospital discharge. Basic home care at a preventative level has been curtailed over recent years by the development of stringent eligibility criteria.

The telephone interviews revealed a perception that joint working had been enhanced since LGR but that the island community had previously encouraged such approaches in any event. Whilst categorised as a rural area, the key finding of interviews in this area suggests that the impact of island status is far more significant than its rurality for those working in community care service areas.

Rediscovering rurality: the East Riding of Yorkshire

The East Riding of Yorkshire Council is one of England's largest rural authorities since LGR and was formed in 1996 by the abolition of the County of Humberside. The East Riding was created by the merger of three district councils and part of a fourth, and was welcomed in some quarters as a triumph for local politics: dissident local residents had never given up use of the term East Yorkshire, and had, for example, sprayed road signs obliterating references to Humberside. The current population is almost 310,000 covering an area of 933 square miles. Just over half the population live in rural communities, compared to 20 per cent in England on average, and 95 per cent of the land is agricultural. The new authority has a strong

rural focus and has specific staff allocated to rural issues and others with the word 'rural' in their job descriptions. The local feeling is that the rural areas are no longer dominated by the large city (Hull – to which it is adjacent) and the population of the East Riding is growing in contrast to Hull's declining and ageing population. A first Rural Strategy document was produced in 1998 and a community sub-group has been established.

Respondents in the East Riding believe that rural needs are also higher up central government's political agenda, which makes life easier for the authority. Rural needs are acknowledged as complex and interrelated, however, and include isolation and peripherality. There is a lack of locally provided services and access to services is difficult. Geographical and economic isolation may go hand in hand as some areas can be depressed, isolated and with low levels of income. Even in affluent villages, some households represent small pockets of disadvantage, particularly affected by a lack of local facilities. The 1998 Rural Services Survey identified many villages in the East Riding (and the 'mirror' rural areas of North/North East Lincolnshire on the south side of the Humber) as lacking banks, garages, shops, child care, schools, doctors and play facilities.

For many, the key to problems of rural deprivation lies in housing, and its affordability and availability. While many villages are becoming 'executive' housing areas, local young people cannot afford to stay in the area and so family networks are dispersed and local facilities eroded. The area has large numbers of residential care homes, which permit older people to live more frequently in familiar environments, but other community services are under-developed. In relation to home care, at the time of reorganisation, the East Riding estimated that the costs of travel time and transport expenses for home care in rural areas added half a million pounds to the costs of its services. It cites national research to argue that the cost of providing personal social services is inflated by 20–30 per cent in sparsely populated areas.

In party political terms, the council is 'hung' and a variety of alliances occur, not always on expected lines. Some issues become political footballs but the authority's main problems lie in its finances and these were compounded by a poor financial legacy from LGR. The new council wished to make an impact but lacked the resources to do so. Some early decisions were made about the disposal of some assets (e.g. Part III homes for older people and the contracting out of domiciliary care) and this policy trend continues. As in many similar areas, there is much 'shipping about' of service users as they travel to services and transport is a key area for many working in community and child care. The new authority has developed a network of local centres that are working to be the customer enquiry base for all enquiries. The merging of housing and social services departments has assisted in this and housing policy has developed now it is unitary authority rather than district-based. Both districts and (ironically) the County of Humberside are missed, there being a feeling that the quality and level of Humberside services would be hard to live up to. Districts were local but some of their policies and practices were seen as lacking clarity or a strategic approach.

The East Riding has chosen a corporate

approach with an early merging of social services, housing and environmental health. The social services section, it was felt by one respondent, still had a tendency to work on its own and needed encouraging to relate to other parts of the department. The merger, however, was perceived as helpful and as curtailing 'buck-passing' between departments. Nonetheless, the authority had significant resource problems, with high levels of need combined with high costs in provision (even where services had been contracted out). Staff were at times under great pressure and the authority had needed to tighten its eligibility criteria and maximise charges, leading to the view that it was 'lean and mean' while trying in reality to work co-operatively and imaginatively.

The authority plans to produce a social atlas but already has information about levels of income within an authority that is generally regarded as well-off. Some isolated villages and rural towns have lower average levels of income than even the poorest urban areas (e.g. Withernsea, on the coast, compared with Goole, upriver at the head of the Humber estuary) and are far less accessible. Future social mapping may look at parish rather than ward level and this should assist in identifying pockets of micro-deprivation. Poor incomes and limited transport combine to make access prohibitively expensive. Front-line staff from social services have identified the following needs relevant to rural areas:

- a shortage of services to supported housing

- limited transport leading to a loss of day centre opportunities, restricted provision

of meals on wheels (in some isolated areas these can only be provided as much as two or three times weekly)

- a lack of specialist day services in rural areas

- particular difficulties in commissioning a flexible and effective rehabilitation and preventative service for disabled service users.

East Riding Council plans to develop specific work in rural areas, such as planning and implementing a fair system of enhanced fees for home care in isolated rural areas, and setting up information kiosks in rural areas. It intends to establish a call centre for out-of-hours access to the authority and to work collaboratively, particularly around the newly established Health Action Zone, which covers both the unitary authority of East Yorkshire and the unitary city of Kingston-upon-Hull. In relation to central government encouragement of Healthy Living Centres, the East Riding will have to consider how such centres may be provided for large geographical areas – at a central point, or split into localities.

In this area, the significance of the rurality of its communities has been swiftly appreciated at strategic level. That the population is dispersed is one key element. In terms of community care this means, for example, that access issues do not simply affect service users but also community care staff, particularly those in domiciliary care. Some providers will not take on work in some areas because they cannot find staff willing to travel such distances, although whether such uncertainties promote swifter allocation to residential care services is not

established. Voluntary groups are also identified as rural-focused, with, for example, work on mental health and rural isolation concentrating on suicide and the establishment of a mobile 'bus' offering advice and support to older people.

Bedfordshire is ruralness

In 1997, local government reorganisation created the new unitary authority of Luton, leaving the County Council of Bedfordshire as a much more strongly rural authority (population 370,000) than the 'old' Bedfordshire. The second-tier district councils remain within Bedfordshire, making this a traditional shire county. At reorganisation, Bedfordshire (some respondents termed it New Bedfordshire) retained approximately 67 per cent of the budget round, locally regarded as inadequate. The consequent financial pressure was identified as impacting on social care provision in the form of cuts to services and enhanced charging for service use.

Bedfordshire is a small 'shire' county with a lower percentage of older people than many comparable shires. It is perceived as having low levels of social facilities despite its proximity to major transport routes and urban areas. For example, a survey of rural parishes by the Rural Development Commission showed that in Bedfordshire parishes were less likely to have a school, post office, shop, daily bus service or community transport schemes than the average English parish. Recent initiatives within the voluntary sector have tried to attract funding for transport schemes and village-based social care. Often, such voluntary sector support schemes are focused narrowly on health needs

such as visits to hospitals or prescription collection, and these may need to take on a broader role.

The isolation of village life was illustrated by a number of comments related to community care. Reductions in general services such as mobile shops were creating demands for meals on wheels that could not always be met. The cost of living was high for a number of less mobile people because of the higher prices charged in local shops and the costs of travel. It was reported to be hard to obtain help at reasonable costs with jobs in the garden or house. Such problems were experienced by older people but also impacted on other users of community care or social care services. For example, the lack of social activity in villages made a number of vulnerable people feel that young people 'hanging about' were threatening.

Bedfordshire had been inspected by the Social Services Inspectorate in late 1998 as part of its inspection of rural community care services in eight English local authorities. At the time of the inspection, the SSI team commented with surprise at the lack of explicit reference to rural issues in planning documents and policies. They appear to have been assured that rurality 'permeated' thinking but could not find specific evidence or outcomes. Their report appears to have been taken on board and we found evidence that more overt attention was being paid to rural factors. However, at the time of our interviews, the County was in the process of an internal reorganisation into a 'cabinet-style' corporate approach, and again seemed to be undergoing some rearrangements and reorganisations.

The Social Services Inspectorate also identified issues around co-ordination in the

authority. These extended to increased corporate thinking around rural strategies to better collaboration between transport schemes at local level. Initiatives around shared information were identified as helpful as well as the devolution of some financial responsibilities to managers at local level. The SSI also noted good practice at the level of individual care-managed services and suggested that these be brought together as examples of good practice and that these should influence a training strategy around rural dimensions to community care.

In response to these suggestions, discussions about rural issues are perceived to be 'higher up the political and policy' agenda, though it was noted that central government interest in rural issues was also prompting a rural response. Local government reorganisation was recognised as playing its part in throwing up 'overt' rural issues and at the same time contributing to rural problems through its financial pressures.

Bedfordshire illustrates some of the issues around rural recognition and the ways in which existing activities in community care need to make rural dimensions explicit. As the SSI noted, the slogan 'Bedfordshire is ruralness' was commonly voiced but evidence of policy and practice supporting this approach was less apparent. (By contrast, the same SSI report on rural social care concluded that 'rurality' was fundamental to the approach of social services in Wiltshire where a rural strategy had been in place since 1989 and a multi-agency rural forum met regularly – *Community Care*, 6 May, p. 4, 1999; Brown, 1999.) The relatively low populations of older people (in particular, the low levels of very old people) may mean that

the County has room to develop strategies to assist community care infrastructures. Thinking around the role of community development across health and social care boundaries may assist, particularly if some traditional and territorial problems can be addressed sensitively within the informal and voluntary sectors.

Rural relations: Flintshire

Flintshire is a small unitary authority formed from the break-up of the former Clwyd County Council in North Wales, in 1996. Despite being a distinctly rural authority, it incorporates some different perspectives on rurality, owing largely to its geography and the demography of the area. Flintshire is one of the largest unitaries in Wales and contains five significant towns, most of its population living within six miles of one of these. Four of the five towns have rail links and networks of communication are generally seen as good for rural areas.

Most community care services are grouped around these towns and provision is fairly evenly spread. Independent home help providers also cluster around towns but are able to reach most people in need to some extent. Flintshire has a high proportion of elderly people in its area, however, and services for older people are perceived as a matter of political priority. The authority retains a significant amount of its own in-house provision, with five Part III old people's homes, some day care and home care. Their costs are recognised to be higher than those of independent providers but they are seen to represent a safety net of local provision. More attention is needed, according to some respondents, to increasing the involvement of

older people in planning. Likewise, advocacy for other service users is relatively undeveloped though there is some commitment to its future provision.

Housing and social services remain as separate departments within this authority though there is more corporate working than hitherto. A smaller locality for the authority (compared with Clwyd) is said to have enhanced local networks among officers. Better relations are also perceived with departments such as Culture, Leisure and Tourism; Education and Public Protection. For vulnerable adults, there has been some progress in increasing the accessibility of leisure services. A Community Agency has used community development workers in areas of deprivation, to focus on social needs. This is in the context of a relatively well-developed voluntary sector, which is itself seeking to establish a firm basis for its relationship with the local authority. Recent work on building inter-agency relationships has had to consider the new Local Health Groups, which have brought together NHS and local authority staff to focus on commissioning. A local Health Alliance, again at senior level, has also been developing interest in a broad range of social change measures to improve health and well-being.

In this authority, and despite the lack of coterminosity between health and social services boundaries, joint working was seen as easier since LGR but to have been quite well established previously. Learning disability services, for example under the All Wales Strategy, had provided good examples of co-ordinated service development (though there were some perceptions that current resources were not keeping match with expectations). A

number of community transport schemes were in operation. Mental health teams operate as joint health/social services teams and they are developing user involvement around each area of work. There is also a group of service users who attend the Joint Planning Forum. Flintshire has no psychiatric hospital so some service users have to travel outside the area for appointments. Flintshire provides evidence that relationships within rural areas in respect of community care are easier to develop if there has been positive past experience. While basically a rural area, Flintshire has reasonable communication links and there is an appreciation of different needs between the towns and rural areas (for example, there are block contracts for some services in the towns but these are perceived as being too inflexible for outlying areas). There also appear to be indications that service users do not mind, or find too difficult, short travel to towns for services in many instances since this has been an established pattern. A continued programme of withdrawal of services and closure of offices in outlying areas may make access more difficult, however.

Small and scattered: The Scottish Borders

The Scottish Borders Council was one of the three new authorities based on the same boundaries as a former Scottish Region (Fife, and Dumfries and Galloway being the others) to emerge following LGR in 1996. The new Council replaces both the Region and four former district councils. It covers a large area of low population density, scattered among small hamlets and small towns. Travel and transport difficulties permeate discussions of community

care at the level of basic provision and more specialised services. Bus and train services are limited (particularly the latter – the East Coast line, for example, has frequent trains but no stations between Berwick in the south of the authority and Dunbar beyond the north of the authority), roads are regarded as in need of substantial improvement and even for townspeople there are difficulties in travelling from one town to another. Transport is an issue in the provision of informal care, since it is not always easy for families to provide the support they wish. It is a factor in respect of employment, leading to many younger adults moving from the area, leaving older family members, and thus steadily changing the population structure. According to our respondents, transport featured continually in consultation exercises on the subject of community care.

This area has also experienced severe economic problems with local factory closures and agricultural depressions. These impact on community care services in a variety of ways: in particular, supported employment for people with learning disabilities or mental health problems is hard to develop. This means that service users often do not have meaningful day activity and are poor. While rural areas are acknowledged to be very supportive of dependent individuals in many instances, it is also perceived that some individuals 'stand out' in small communities and may be excluded and stigmatised.

In a small and scattered authority, there is a problem in providing specialist services. This is particularly so for younger people with physical disabilities. They are relatively small in number and many prefer not to travel to centralised services; these are thus undeveloped. Some local solutions have been found and 'tailor-made' provision has been supplied, for example, combining home care with social care. At one level, this may be seen as positive and user-centred; however, such provision is restricted. Housing stock also needs to be developed to respond to demands to remain at home, but is currently felt to be under-resourced. The building of services around individuals' needs also extends to people with mental health problems. While this can again be individually responsive, it may be isolating and, because costs are higher, the service is more thinly spread.

The authority has remained committed to its own in-house provision for older people's services. Previous levels of service have been retained and it is felt that this provision receives a high level of public and political support, being seen as part of the local community. While there is authority provision, there have also been some closures of Part III homes for older people in a drive for quality. It is generally thought that such provision is now catering for residents with higher levels of need for services.

Scottish Borders is committed to a mixed economy of care, however, and the most notable change has been in the putting out to tender of the home care service some two years earlier. In the event, the in-house service was awarded much (75 per cent) of the contract. In relation to the 25 per cent externally provided home care, the authority found that no one voluntary or private provider had sufficient business to respond to 'spot purchasing'. This was linked to the rural nature of the population since no one area had enough business to enable independent providers to build up sufficient,

flexible provision. The authority has decided to introduce Preferred Provider Status to stabilise the market in the rural areas particularly. Home care staff from all agencies may be difficult to provide in rural areas with highly dispersed populations. It can be difficult to find staff to deal with sudden discharges from hospital or weekend work and there is, despite unemployment, no ready pool of labour in some rural areas for such work: this again may reflect both low wages and the high access costs borne by workers.

In respect of people with learning disabilities, the bulk of residential provision is now in the voluntary sector although day care is split between local authority and the voluntary sector. There is no residential care for people with mental health problems and the voluntary sector is a main provider of a network of support workers. It is clearly proving difficult, however, to sustain support groups in rural areas. Combinations of distance and transport difficulties result in much time and effort being required to build up relatively fragile groupings.

The Borders provides a graphic illustration of a rural area where transport difficulties and the scattered population combine to make service delivery problematic. To some, this brings advantages but questions remain about the ability of agencies to deliver costly services with no economies of scale. In poorer areas with relatively low levels of car ownership, reliance on voluntary car schemes is also difficult and these schemes may concentrate on acute and one-off needs rather than regular social care activities. Levels of car ownership are also affected by downturns in the local economy and this can impact on informal carers and paid care staff who may be unable to take on work if they do not possess their own transport or if their car is needed by another family member.

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