

Health in Rural Wales

A research report to support the development of the Rural Health Plan
for Wales

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EXECUTIVE SUMMARY

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1.0 INTRODUCTION

The report sets out to gather evidence for the Welsh Assembly Government to develop a Rural Health Plan. In order to do this health data sets from Wales, literature and case studies are examined.

2.0 METHODS

The project answers the following three questions:

1. What are the current critical health and service delivery issues for rural Wales?
2. Is there any geographical variation in these key issues across rural Wales?
3. What are effective models of service delivery to meet the health and well-being needs of people in rural Wales?

Data were collected in the following ways:

2.1 Review of published data

The review sought data to identify critical rural health issues in Wales and to identify geographic variation. Data were categorised under three main headings: the wider determinants of health; health status, access to services/service delivery issues.

2.2 Review of the literature

Literature was identified for the review through the following methods:

- o Electronic database searches
- o Networking with national and international colleagues
- o Website searches

The STOX classification was used to classify the literature found. Applying the STOX classification to literature identified in this review enables an overall review of the level of evidence available and allows the reader to make an informed decision on the weight given to evidence from individual papers.

2.3 Case studies

Case studies were sought which tackle the key themes identified through the review of data and the review of literature. These were identified through three main avenues: from the literature, the database of Rural Health Good Practice and IRH networks.

3.0 FINDINGS FROM THE DATA

Various data sets were used and included the health needs assessments compiled by the NPHS, the Welsh Health Survey, the Welsh Index for Multiple Deprivation, Quality and Outcome framework data (QOF), data from the Welsh Cancer Intelligence and Surveillance Unit (WCISU), the Wales Ambulance Trust and prescribing data from the NPHS. Additionally demographic data was sourced from the Office for National Statistics, Newidïem, the Wales Rural Observatory and the StatsWales website. The findings from published data sets show the following:

3.1 Rurality in Wales

In 2004 the ONS published a rural-urban classification which defined populations of less than 10,000 as rural, while those above a population of 10,000 are defined as urban. Both urban and rural areas are then divided into sparse and less sparse. In Wales therefore, rural areas not only include the nine traditional rural authorities¹ but also parts of the Valleys and areas in some urban authorities. Many traditional rural coastal and inland rural areas will see their populations expand during the tourist season and this has implications for healthcare. Lower and middle super output area data were used in this report (wherever available) as this type of data picks up pockets of mortality, morbidity and deprivation.

3.2 Demography of rural Wales

The population throughout Wales is projected to increase at an average of above 10% between 2006 and 2031. However over the same time period the population of older people within the traditional rural authorities is projected to increase by an average of 39.10% (range 24.5% - 51.7%), in comparison to urban areas which will increase by 27.73 % (range 16.8% - 39.50%). Figures in rural areas also show that population profiles are distorted by outward migration of young people and inward migration of older people in rural areas. The older population is increasing faster in rural authorities than in urban authorities therefore the need to introduce wide ranging services in rural areas to meet these growing needs should to be taken into account.

3.3 Geographical access to services

The Welsh Index of Multiple Deprivation shows that rural areas in Wales have wide ranging deprivation when it comes to geographical access to food shops, leisure centres, GP surgeries, NHS dentists, primary schools, secondary schools, post offices, public libraries and transport nodes by drive times, bus and walking. Additionally drive times to district general hospitals (DGHs) in much of rural Wales are over 40 minutes whereas in urban areas most drive times to DGHs fall between less than 10 minutes and up to 20 minutes. Community hospitals have shorter drive times in rural areas. However these hospitals do not offer the same specialist and wide ranging services as DGHs. Minor injury and out-of-hours services are also inconsistent. People living close to the border use DGHs in England as they are closer.

The Welsh Assembly Government is currently exploring the concept of 'deep rural'. Deep rural is being considered as anywhere more than 30 minutes drive time to a population of 10000 or more. However, it cannot be assumed that all settlements with a population of 10000 will provide a good concentration of health services. Therefore, from a health service point of view 'deep rural' requires further exploration.

3.4 Health status in rural Wales

Describing the health status in rural Wales highlighted a series of difficulties. Many data sets are only available at local authority level meaning there is a lack of detail necessary to examine intra-rural variation or to remove the influence on the data of urban towns within rural authorities. Data sources vary in their robustness and so further research is required to obtain a complete picture of the health status of people in rural Wales.

¹ Traditional rural authorities originate from the definition developed by the Organisation for Economic Co-operation and Development in 1994 where areas that have fewer than 150 persons per square km were deemed to be rural. Based on this classification Anglesey, Carmarthenshire, Ceredigion, Conwy, Denbighshire, Gwynedd, Monmouthshire, Pembrokeshire and Powys are rural authorities in Wales

3.4.1 Mortality data

Mortality data in rural Wales shows a mixed picture. The HNA data show that rural areas, (except for some areas in south Wales and the Valleys) have low rates of mortality for coronary heart disease, and respiratory disease. For malignancy (excluding skin) rural areas have low mortality except for a few pockets where there is a high rate of mortality. For stroke high rates of mortality are shown in parts of Pembrokeshire, Gwynedd, Wrexham, Powys and the Valleys. A high rate of mortality for injuries occurs predominantly in rural Wales as opposed to urban areas. It is noted that Welshpool in Powys, has a high rate of mortality for all four diseases depicted (coronary heart disease, respiratory disease, malignancy and stroke). There is a statistically significant high level of suicide within Denbighshire and Conwy compared to the rest of Wales.

3.4.2 Morbidity data

Data on morbidity was collected from a number of sources:

- The Welsh Health Survey shows that overall the data, when categorised by urban/non urban and sparse/less sparse, appears to suggest that health in sparse and non urban areas is generally better than health in less sparse and urban areas. This data however does not provide detail on variation within non urban or sparse areas (the same data categorised by Local Authority *does* show that there is variation between rural Local Authorities). Combining four or more years of Welsh Health Survey data for more detailed groupings of LSOAs would allow a more in-depth analysis of rural areas.
- The HNA data for Long Term Limiting Illness (LTLI) show that rural areas have a lower level of LTLI than in urban areas, except in some rural areas of the Valleys and some parts of south Wales. These findings are similar to those found in the Welsh Health Survey.
- Cancer incidence data from WCISU show that there are significantly higher incidence rates in Anglesey (colon cancer for females); Conwy (prostate cancer and breast cancer); Denbighshire (lung cancer for females); and Gwynedd (breast cancer). While there are significantly lower rates found in Ceredigion for lung cancer (male and female), prostate and bladder cancers. Powys has significantly lower incidence rates for lung and bladder cancers. Pembrokeshire (male only), Carmarthenshire and Monmouthshire also have significantly lower rates for lung cancer than Wales as a whole.
- QOF data show that rural areas have a high prevalence of depression and in some areas a high prevalence of cancer and dementia. However QOF data has only been collected for four years, and this data was taken from 2006/7 only, and not standardised for age. Therefore this data should not be seen as robust; rather it should be continually monitored to understand further about trends that develop.

3.5 Prescribing data

Prescribing data revealed little difference between rural and urban practices in the six therapeutic areas studied. The notable exception was the higher level of cardiovascular prescribing in rural practices. More detailed work is required to draw firm conclusions from prescribing data.

3.6 Ambulance response times

Ambulance response times for category A have been shown to be below the acceptable limits (target of 60%) in some rural authorities. Between April 2007 and March 2008 in Powys the target was achieved 47.20% of the time and in Monmouthshire the target was achieved 48.90% of the time. Compared to the rest of Wales these two authorities had the lowest achievement

rates. Elsewhere it is difficult to ascertain if urban settlements such as Prestatyn, Holyhead and Rhyl helped to bring these response times above the national target of 60%.

3.7 Key issues from the data review

The following issues have emerged from the data:

- Access to data for rural areas is not straight forward. A significant amount of data is presented at LHB or unitary authority level, rather than lower or middle super output areas. This leads to the inability to separate rural and urban areas.
- This project has used the definition of 'rural' published by the ONS in 2004. However, another definition is used by the Wales Ambulance Trust which defines Cardiff as the only urban area.
- Overall the data suggests that rural areas are generally healthier and have healthier lifestyles than urban areas. This is shown through the Welsh Health Survey data comparing urban/non urban areas and sparse/non sparse areas. However underlying this overall picture there is geographic variation and mortality and morbidity data does highlight pockets of ill-health in rural areas. Therefore whilst the overall picture is of better health, detailed analysis of particular disease categories and small area data does highlight variation.

3.8 Key themes for rural health from the data review

From the review of data the main health issues for people living in rural Wales are:

- the increasing population of older people
- long-term limiting illness
- mental health problems (to include suicide and dementia because of the increase of the older population)
- injuries
- access to services
- emergency services.

4.0 FINDINGS FROM THE LITERATURE REVIEW

The literature review searched for evidence about the key themes identified in 3.8 and the main findings are described below.

A total of 1985 references were identified from databases and websites, of these 383 articles were retrieved, with a total of 137 used in the review. The articles were of a mixed quality including: 12 systematic reviews; 2 randomised controlled studies, 75 observational studies and 48 reviews (with no evidence of systematic activity).

4.1 Older people

The evidence indicates that older people living in rural areas have a good quality of life which is supported by informal social support structures. However, emerging evidence suggests that these support structures are eroding due to in and out migration leading to changes in the structure of rural communities. As age increases older people become susceptible to bereavement, loss of independent transport, lack of mobility and loneliness. These are exacerbated in rural areas by a poor public transport infrastructure and isolation.

4.2 Long –term illness

Wales has the highest rate of long term limiting illness in the UK. Two-thirds of over 65 year olds report at least one chronic condition and one third have multiple chronic conditions. Three-

quarters of over 85 year olds report having long term limiting illness. This is important to note because of the increasing proportion of older people in rural areas.

The evidence shows a mixed picture for levels of morbidity and mortality between urban and rural areas. For cancer it is noted that more research is required, as differences in experience in different areas and among different population groups are hard to explain in full. There is an indication that those living in rural areas, in low income groups and have no independent transport, have a higher incidence of cancer and lower survival rates.

For palliative care evidence suggests there is a lack of symptom control, nursing help, assistance with transport and bathing, communication with professionals and bereavement support. Carers were also found to need more information and experienced financial problems. The evidence in this area is not robust and further research is needed.

4.3 Injuries

The evidence indicates that farms are dangerous places both for children and adults and most farm accidents occur in the harvest months of August, September and October. However there is an evidence gap in this subject and more research is required to understand exactly how farm accidents occur. Road traffic accidents in rural areas are also under researched in the UK. Most evidence is from the USA which argues that because rural roads tend to be narrow, have less road demarcation and few traffic controls more accidents will occur. The evidence is conflicting regarding the length of time spent at pre-hospital stage (time spent between the incident and hospital admission) and whether this has an effect on mortality and length of stay in hospital.

4.4 Mental health issues

Mental illness has a lower prevalence in rural areas than in urban areas. However, with an increasing older population, the number of people with dementia in rural areas is likely to increase and the evidence indicates that rural areas are not equipped to deal with these increasing numbers. Additionally some parts of rural Wales has a continuing high rate of suicide within the farming community, whilst in other rural areas this rate is decreasing. The literature shows that farmers may or may not exhibit depressive thoughts prior to suicide. There is also evidence that services can be inappropriate in treating mental health problems in rural areas.

4.5 Access to services

The evidence indicates the following issues when accessing services in rural Wales:

- a) A minority of people in rural Wales have difficulty in accessing the following services: getting to dentists (18%), cinemas (18%), hospitals (13%), police stations (12%) and leisure centres (10%).
- b) The main problem lies in transport where 11% of households in rural Wales do not own or have the use of a motor vehicle. People on low incomes and people over the age of 65 years make up a high proportion of this category. Over twice the proportion of those without a car have difficulties getting to a hospital than those with private transport.
- c) Access to primary health care in rural areas is complex and although it has been described that stoicism and stigma are barriers to using these services, the evidence is inconclusive. There needs to be more direct comparisons between urban and rural areas. However, evidence suggests:
 - Access is more difficult for people living in hamlets, villages and open countryside than for those living in rural towns

- The longer the distance to a GP the poorer the prognosis and survival rates in certain cancers
 - In Wales, 16% of people over the age of 65 years have difficulty in accessing GP services
 - In rural mid-Wales travel time to a GP is predominantly above 21 minutes. Increased travel time is related to delayed diagnosis of cancer and other chronic conditions resulting in poorer prognosis
- d) Distance to specialist health services has been shown to decrease survival rates from some cancers and asthma. Travel time to specialist services can be costly in terms of time, energy, finance and emotions.
 - e) An evidence gap exists when exploring access to social care. From the evidence available it suggests that access to social care is poor in rural areas where there are low levels of social housing, residential care and day care. Choice can also be poor with difficulty in finding people to carry out social care.
 - f) Lack of local skilled community care can lead to below optimal care in rural areas especially for those with dementia, other mental health problems and those needing palliative care. This shortage is due to recruitment difficulties, low morale, professional isolation, lack of support and training facilities.
 - g) Rural residents may not be as assertive when using out-of-hours services as their urban counterparts, thus leaving them vulnerable when urgent help is required. There is a need in rural areas for out-of-hours nursing and support care for people with chronic and terminally ill conditions.

4.6 Emergency care

People living in rural areas are at greater risk than in urban areas of not receiving thrombolysis and defibrillation within the stated time limits. Evidence to give thrombolysis for acute ischaemic stroke suggests this treatment is underutilised in hospitals throughout the UK and its use at the pre-hospital stage is currently unlikely.

4.7 Models of Service Delivery

The following solutions were explored from the literature:

4.7.1 Outreach services

Outreach services delivered in local clinics (and within the patient's home for cardiac care), have been well evaluated and have shown to benefit patient access, outcomes and service use. Assertive outreach (used in mental health to give a high level of care for those living in the community with severe mental illness) requires more robust research and evaluation to understand how the model could be effective for other conditions and populations.

4.7.2 Mobile services

An evidence gap exists in order to fully understand the effectiveness of mobile services. However, they may have a role in reaching farmers and older people, especially if practitioners have a background in farming or rural culture, and the service is tailored to meet specific needs.

4.7.3 The use of technology

The use of technology, in particular telemedicine and interactive health communication applications, all of which can be termed as telecare, have been found to be effective interventions. Telemedicine has a role in rural healthcare, so long as guidelines are subscribed to. Staff need to be committed and prepared for a different practitioner-patient relationship. The use of telemedicine in rural areas has been shown to be effective in trauma, psychiatry, cancer,

caring for older people, supporting those with neurological injuries and supporting carers. Interactive health communication applications, which use the internet to give patients information, have been shown to have a positive effect on knowledge, social support and clinical outcomes for those with chronic illness. This may help those who are isolated bringing them closer to information and support. Telecare is a useful intervention for users of services and can be provided by the voluntary, social and health care sectors.

4.7.4 Social support and transport

More research is required on social support and transport systems in rural areas, so that it is clear which interventions work in the best way to improve health and social care outcomes. Nevertheless, in order to support vulnerable people including the elderly, the available evidence shows that the use of multi-purpose centres and community development initiatives are helpful. They can provide a variety of activities, such as friendship and social support schemes, telecare and transport services and are run by various agencies including the voluntary sector.

4.7.5 Emergency and out-of-hours care

Innovative care such as thrombolytic therapy and defibrillation given within time limits is needed in rural areas. Research has shown that pre-hospital thrombolysis can be effectively given by GPs and paramedics, whilst volunteers based in rural areas can successfully defibrillate patients before the emergency services arrive. For a rural out-of-hours service the options are limited and more evidence is required to find a service to fit, though more use of NHS Direct, assessment and treatment centres and nursing services may help to meet a gap.

4.7.6 Injuries

There is an evidence gap about how to reduce accidents both on farms and on rural roads although it is suggested that health and safety guidelines are taken up on farms.

4.7.7 Recruitment of health and social care students

Recruiting students from rural areas and offering as many students as possible placements in rural areas are evidence based strategies to increase staff levels in rural areas.

4.7.8 Workforce issues

Particular skills are desired to equip practitioners to work effectively in rural areas. Enhanced skills are required in mental health care, trauma and chronic illness and managing work in a rural environment. These skills can be delivered through mobile road shows, e-learning and traditional methods. The challenge to deliver care to those with long-term limiting illness is a priority. Here primary care plays a pivotal role and it is recognised that a Chronic Condition Care Co-ordinator based on an Integrated Model for Chronic Conditions is the recommended way forward. A multi-agency approach is vital, whilst using GPs and nurses with special interests working across practices will enhance care. The strength of evidence for generic workers is unclear, however, it would be feasible to take on generic workers who are effective across agencies and can support vulnerable people in their homes. The evidence for shared care shows only that prescribing behaviour is improved for chronic conditions.

4.7.9 Community hospitals

Community hospitals have the potential to be an asset to rural care, supporting an infrastructure of telemedicine and outreach services, and providing a range of local in-patient services (these services could also be carried out in health centres). However, any expansion needs to keep in mind clinical governance and patient safety issues.

4.7.10 A model for rural healthcare

A model for rural healthcare has been proposed in Scotland and has similar potential in Wales; it suggests that services should be examined in terms of how well they meet the following themes:

- Community resilience
- Self care
- Anticipatory care
- Long term condition management
- Planned care
- Emergency care
- Out of hours service.

5.0 CASE STUDIES

A number of case studies were found from the UK, Europe and Australia. They show the need for collaboration with multiple agencies, including the voluntary sector, social and health care agencies. Many of these case studies have been initiated because of local need. Examples fell into the themes of social support, mental health and farming outreach, life limiting illness and palliative care, transport, emergency care, technology, out-of-hours services, access to services, accident prevention, and education.

6.0 RECOMMENDATIONS

The evidence contained in this report shows that rural areas are characterised by low numbers of people who live in sparsely populated areas that are at a distance from urban centres and the associated services. Rural people suffer from the same illnesses and injuries that affect people who live in urban areas but there are additional perspectives, such as the lack of a transport infrastructure, that provide challenges to both the service users and the service providers. In rural areas the most significant demographic that differentiates rural populations from urban is the proportion of older people. This is anticipated to become more apparent over the next two decades and has implications for service providers.

The recommendations can be summarised under five main headings:

- Access to services
- Health services provision
- Older people
- Research and data
- Philosophy

6.1 Access to services

Access to services, in its broadest sense, is the critical issue facing rural people. Rural areas are remote from centres of excellence. It is recognised that resources are limited and that not every community can expect to have the full range of health services available to it locally, however, it is recommended that

- ***An integrated transport system*** should be developed, in partnership with other organisations, to ensure that health services are as accessible as possible to rural people

In addition, consideration needs to be given to bringing services closer to the population when it is safe to do so:

- **Outreach services** should be provided for specific conditions (for example Consultant or GPs with special interests (GPwSI) -led outreach clinics) but also targeted at potentially vulnerable groups such as older people, those without transport and farmers who have been shown to be resistant to accessing services.
- **E-health, telemedicine and telecare** - use of new technology has a role in bringing services and information closer to rural people. New service developments need to be patient and user driven in order to meet identified need.
- **Support for people to stay in their own home / communities** - in combination with the above approaches development of integrated social support interventions would enable people to stay in their own homes for longer, which is important in the context of the ageing rural populations.
- **Rapid access to secondary care – emergency and unscheduled care** -
 - Systems should be developed to ensure that the ambulance service and GPs are able to respond quickly and effectively to perform thrombolytic therapy and, with volunteers, to give defibrillation
 - A comprehensive out-of-hours service should exist that not only meets the needs of emergency or unscheduled care but also the needs of those with chronic disease and requiring palliative care
 - There should be crisis intervention teams in mental health, palliative care and nursing, and linked to other service providers.
- **Access to cross border services**
Links to specialist and secondary care services across the border in England should continue to follow natural flows. These have developed over time to reflect the most appropriate, quickest and effective services for patients.

6.2 Health Service Provision

To achieve the highest level of health care possible at a local level in rural areas there are implications for the health and social care service planners and providers. Health services must be fit for purpose and being remote from a centre of excellence poses challenges to the providers to ensure that safe quality services are available at the right time and in the right place. It is recommended that:

- **Review of effectiveness and gaps in existing services** - using information on health need and health status of populations at a local level, existing services for the critical health issues identified in this report (i.e. injuries, older people, depression, suicide and long term conditions) should be reviewed and evaluated for their effectiveness and gaps identified.
- **Minimum essential health and care services** – that are required by a community should be established using the information above and in parallel with health service planning.

- **Workforce configurations – extended primary care**

Primary care is pivotal in rural health care and therefore needs to work effectively and efficiently, keeping people in their own homes as much as possible and reducing hospital admissions.

Local care teams (LCTs) involving a range of health and care workers should:

- be developed within a general practice and managed locally within the primary care setting
- use the Integrated Model for Chronic Conditions when appropriate
- develop networking with voluntary and statutory organisations so that there is an awareness of local services that will help to address rural health issues
- work together with other LCTs to achieve the necessary number of patients to support more specialist care.

- **Community hospitals**

Provision of community hospitals should be considered within the context of the essential services needed by rural populations and the services provided should take into account clinical governance and patient safety issues.

- **Recruitment and retention**

New strategies should be developed to encourage qualified practitioners to work in rural areas including:

- Provision of specific training, skills acquisition and supervision for practitioners to work in a rural environment and maintain their skills
- Provision of flexible and responsive continued professional development, that is made as accessible as possible
- Provision of flexible employment opportunities
- Development of practitioners with specialist skills (known as the generic specialist), supplemented with generic staff.

- **Future workforce**

A broad range of strategies should be implemented to encourage health and social care practitioner students to work in rural areas:

- Encouraging rural secondary school students to consider a health and social care profession,
- Ensuring that all under-graduate health and social care students have substantial rural placements and providing funding where appropriate to cover any additional cost of travel and accommodation,
- Ensuring that curricula provide students with the essential skills in order to work within a rural environment and the facility to work with specialist services 'at a distance'.

There should also be provision for the voluntary sector and rural communities to have influence on the provision of services

Rural communities are often peripheral communities and it is recommended that:

- **Rural and border proofing** - all future policies and guidelines should be rural and border proofed at the development stage (by the policy author and a multi-sectoral group representing key stakeholders with the appropriate expertise and knowledge) and, when implemented, should be further monitored for their appropriateness in rural areas.
- **Climate Change** – the impact on the climate change agenda should be taken into account when planning future service configuration i.e. carbon footprinting.

6.3 Older people

The Rural Health Plan must address the needs of older people in rural areas as the predicted demographic changes have major implications for the provision of care.

6.4 Research and data

Further research is required if an in-depth understanding of rural health in Wales is to be achieved that will continue to inform service delivery across rural Wales and achieve improved outcomes for patients. In order to achieve this organisations that collect health data should publish this at least at the LSOA level where possible and categorise data as urban and rural according to the ONS classification. Using this information it should be possible to more clearly identify health need and health status of populations at a local level.

6.5 Philosophy

In order to work towards excellence in health and social care in rural Wales an underlying philosophy should be developed and as a starting point the following model of service delivery should be considered, taking into account the recommendations made above:

- Community resilience
- Self care
- Anticipatory care
- Long term condition management
- Planned care
- Emergency care
- Out of hours service.