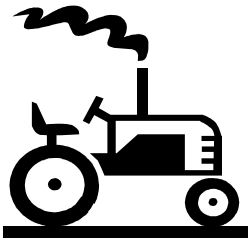
High Peak and Dales NHS
Primary Care Trust



Farm Out Health Project

A Participatory Health Needs Assessment of the Local Agricultural Community

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Executive Summary

1 Background

1.1 The *Farm Out* Health project is a 3 year initiative set up by High Peak and Dales Primary Care Trust and jointly funded by East Midlands Development Agency in response to the economic decline in farming over the last decade and the deleterious effect this might have on the health of the agricultural community living within the West Derbyshire Rural Development. A key task was to conduct a health needs assessment of the agricultural community from which public health solutions could be identified to meet need.

1.2 The agricultural community is defined as those individuals and families involved in farming or farming related occupations through direct employment or family ties.

2 The Conduct of the Health Needs Assessment

2.1 A participatory health needs assessment was conducted using a range of qualitative and quantitative research methods. This included focus group interviews with community groups who represented the different interests and concerns of the agricultural community and a comparative health survey of agricultural families (n=248) and non-farming (n=248) local families registered with Tideswell surgery in the heart of the *Farm Out* patch.

2.2 The findings have been presented to the agricultural community and the wider health and social care community at a Health and Agriculture Conference held in Bakewell on July 9th 2002. Workshops were conducted to validate the findings of the needs assessment and to generate public health solutions.

3 Key Socio Economic Findings

3.1 The area is characterised by small, family run, dairy, beef and sheep hill farms. The high altitude, lower temperatures and shortened growing season mean local farmers have to work hard to maximise the nutritional potential of the land.

3.2 Across the country farming incomes are on average some 25% of their original level 10 years ago. The reasons are complex but include the strength of the pound and weakness of the Euro in which many subsidies are calculated. The BSE crisis, the long-term decline in beef and lamb consumption and the continuing rise in the cost of farm inputs such as tractor fuel, animal feed and fertilizers.

3.3 Although there were no confirmed cases of Foot and Mouth disease in the area the 2001 national outbreak had and continues to have a devastating affect on the economic and social well being of the agricultural community. The average annual farm income country-wide

was £5,000. Locally the average income was £2,500 although many farmers had no income at all.

Changes in the social and population structure of rural communities has threatened the position of the small family run farm. Whilst the family is the core unit of farming, families are no longer in a position to meet all their needs. Many are not ready to utilise 'outside' community resources such as health and social support services. There is a strong culture of stoicism and self -reliance.

The local agricultural community is as a consequence experiencing significant hidden deprivation. This is illustrated by a decline in income, social exclusion, disadvantage in the housing market and limited education opportunities.

4. Key Health Findings

4.1 The agricultural community has a poor health profile and one that is worse than that experienced by non-farmers. Whilst there are individual farmers within the community who enjoy good health this appears not to be the common experience.

4.2 In the Tideswell survey, farmers reported an exceptionally high level of health problems, as measured by the EQ5D (a short self completion questionnaire for the measurement of health status). In many cases, most notably the pain/discomfort dimension, the prevalence of problems significantly exceeded even that reported by social classes IV and V in the national survey (Kind, 1998). This finding was repeated when the single EQ5D index score was analysed.

4.3 The commonly held view that farmers are stoic and self- sufficient was endorsed by the Tideswell survey which asked respondents to rate their own perception of their health. No significant difference between primary farmers and other occupational groups was found despite the higher level of ill health identified in the survey amongst the farming population.

4.4 Mental health is a significant expressed as well as normative need. In the Tideswell survey the observed prevalence of depression was almost twice as high among primary farmers than among secondary and non-farmers. The most worrying finding was the high prevalence of depression among male primary farmers - almost 8% reached the threshold for clinical caseness.

The causes of mental ill health are complex and include rural isolation, financial worries and occupational problems. However the most significant stressor cited by farmers is the over burdening pressure of the increasingly complex paper work demanded by DEFRA.

4.5 Across the country farmers have a higher proportional mortality rate from suicide that the general population and suicide rates are expected to rise following the Foot and Mouth crisis. Almost 9% of farmers in the Tideswell survey had thought of suicide during the past year, it is

important to note that this includes almost one in five (18.5%) primary farmers in the age group 18-34 years.

4.6 The agricultural community experiences significant levels of musculoskeletal problems such as arthritis. Even young farmers reported chronic joint problems.

4.7 Occupational health related problems were important areas of expressed and felt need. They included musculo-skeletal injuries and health problems attributed to agri-chemical usage and zoonoses.

4.8 Nationally fatal injuries on farms rose by 20% over the last year. The high prevalence of accidents was regarded as inevitable by many members of the agricultural community. Although many conceded that a shortage of labour and time contributed to the high accident rate.

4.9 In *all* areas of health-care, access to preventative interventions, appropriate information, and treatment was a significant problem for the agricultural community. Cultural beliefs, social norms, stigma, distance decay, are the backcloth to these access problems.

4.10 Historically the healthcare providers have not viewed the agricultural community as a vulnerable population group and many are ignorant of socio-economic problems they face. As a consequence appropriate structures and mechanisms are not in place to deliver preventative Interventions, treatment or support, to meet the needs identified within this health needs assessment.

Conclusion

The indigenous population of the High Peak and Dales PCT is the agricultural community and it is the agricultural practices of this population that have shaped the geographical as well as socio/economic characteristics of the area.

This health needs assessment reveals the significant hidden deprivation experienced by a large section of the farming community. It also identifies significant health needs most notably with regard to mental health and musculoskeletal problems.

Despite the greater health problems experienced by the agricultural community they make less use of local health services than the local non- farming population.

The 116 recommendations generated from this assessment offer public health solutions to the health needs identified. They are pertinent to the wider health and social care community and require a partnership approach if they are to be successful implemented. These recommendations are commended to High Peak and Dales Primary Care Trust for their consideration.

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1. Background

The *Farm Out* health project was set up in June 2001 through joint funding from East Midlands Development Agency and High Peak and Dales Primary Care Trust. The initiative was conceived by the steering group (appendix one) of the Rural Health Information Kiosk (formerly the Information kiosk) at the Agricultural and Business Centre in Bakewell.

The kiosk is a walk-in community resource open to farmers and members of the public attending the Monday agricultural market. During the first eighteen months of it opening there were a significant number of enquiries at the kiosk regarding health issues including depression and suicide, benefits and musculoskeletal problems.

Farm Out was set up in response to these enquiries and in the wider context of the economic decline in farming over the last decade (MAFF 2000) and the rising incidence of suicide amongst farmers (Malmburg 1999).

It is set within the boundaries of High Peak and Dales Primary Care Trust and targets the agricultural community living and working within the West Derbyshire Rural Development Area of the Peak District National Park (appendix 2). Such Rural Development areas were identified across the country by the Rural Development Commission to address issues of rural deprivation.

The agricultural community is defined as individuals, families, and groups engaged in farming or farming related occupations such forestry, farriers and agricultural advisors.

Farm Out was established on the premise that the health needs of the local agricultural population would be best met through a public health approach. A part- time public health nurse was therefore employed to take the project forward. It is believed to be the first such initiative to be established in the UK.

2. A Public Health Approach

Public health is a way of looking at health from a population perspective. It concerns collective multi- agency action delivered in partnership with communities to identify and address the wider determinants of health such as poverty, unemployment, social exclusion, transport, education and the environment. Acheson (1998) summarises this as,

'The art and science of preventing disease, promoting health and prolonging life through the organised efforts of society.'

This can be achieved through a range of activities including health promotion, health protection and disease prevention as well as healthy public policy and individual and community empowerment (DOH.2001)

The starting point however for any systematic public health activity is an assessment of the health needs of the population concerned. Need is a contentious term and open to a wide range of interpretation, for the purposes

of this report Bradshaw's (1972) definitions of need will be used. He argues that 'real' need can be identified when the following needs coincide:

- Normative needs are those defined by professionals or experts according to their own professional standards
- Felt needs are needs that those perceived by an individual or community
- Expressed needs are felt needs that have progressed to a demand
- Comparative needs are identified when a community sees that it lacks services or resources that another area has.

What is important is that in looking to understand and describe need in its widest sense efforts should be made to identify new information about a local population through quantitative and qualitative research such as health surveys and focus group interviews rather than relying on existing health information such mortality and morbidity data (Porteous1996).

There is still however a concern that traditional research approaches have a tendency to work *on* people as subjects rather than working *with* them to gain a fuller understanding of the pertinent health issues. Participatory appraisal, first developed by anthropologists requires public participation as an integral part of the research process. A precedent for this type of approach has already been set in North Derbyshire (Cresswell 1992). In her study on the links between unemployment and health needs Cresswell used information from interviews with key health professionals to help shape questions posed to members of the community. The interviewees had their responses fed back to them to allow them to check and modify comments if they wished. Cresswell suggests that in so doing the community 'has done the thinking' whilst she worked as a catalyst for their ideas.

3. Participatory Health Needs Assessment

3.1 Methodology

The chosen methodology for the *Farm Out* health needs assessment exercise is therefore a participatory approach that seeks to utilise all existing information sources about the agricultural community as well as to generate a new understanding of the health needs through;

- Listening events with service providers from the wider health community including health, social care and the voluntary sector
- Focus group interviews with community groups who represent different interests and concerns of the agricultural community
- Informal discussion with older farmers attending farmers gathering social events
- Informal discussions with self selected farmers and key personal from the agricultural community
- Informal discussions with wider agricultural community at the Bakewell Show 2001
- Health survey of agricultural families (n=250) registered with Tideswell surgery in the heart of the West Derbyshire Rural Development Area
- A Health and Agriculture Conference was held in Bakewell to present the findings to the agricultural and the wider health community.

Workshops were conducted with delegates to validate the findings and generate public health solutions.

3.2 Listening events

A series of listening events were set up with a wide range of service providers from health and social care, voluntary organisations and individual community members, (appendix 3). Letters were sent to all 17 General Practices in the area with a flyer about the project and an offer to visit the practice during their monthly practice educational session (QUEST) to talk about the project and elicit views from the primary health care team about the health needs of their local practice agricultural population. Listening events with other providers were set up either through telephone or personal contact or by request from the providers themselves. The format varied but essentially involved a short scene setting presentation about *Farm Out* followed by a group discussion.

3.3 Farmers gatherings

Three farmers gathering events were convened between September and December 2001 at the Agriculture and Business Centre in Bakewell in partnership with Frances Ward from the Rural Health Information Kiosk. The events were primarily set up to meet the social and mental health promotion needs of farmers that had been further compromised as a result of the Foot and Mouth disease restrictions. In February 2001 the weekly livestock markets were suspended and remained closed for a year, during this time farmers lost the opportunity to talk as well as to conduct business. The gatherings provided a valuable opportunity to meet and talk with farmers about a whole range of health issues. The first event was used to launch *Farm Out* whilst the theme of rural reminiscence was used for the other. Approximately 200 farmers attended each event.

3.4 Focus group interviews

Focus group interviews are essentially discussion groups in which people are brought together to talk about a particular issue. They were used to simulate a microcosm of the larger agricultural community and as such produce locally relevant knowledge and insights into health and agriculture.

Focus group interviews were conducted with the Tuesday Group, Buxton Young Farmers Group, the East Midlands branch of the Women Food and Farming Union (WFU) and Derbyshire Rural Help-line volunteers. The groups were selected in order to reflect the different ages sexes and agricultural experiences of the farming community.

- The Tuesday group was set up some 18 months ago under the auspices of the Peak District Rural Deprivation Forum's Amethyst Project to promote social support for women with young children living in rurally remote areas, almost all members come from farming families.
- Buxton Young Farmers are a large active group who meet weekly and organise a range of socially activities for like-minded young people whose ages range from 13 to 29 years.
- The WFU is a national organisation that seeks to help consumers understand food production and farming and offers women the chance to make their views heard on topical food and farming issues of the day. Four local farming women attended the discussion group (22 members also contributed their views on health at a separate event)

- The Derbyshire Rural Help-Line is part of the umbrella organisation, the Rural Stress Information Network that evolved in 1993 in response to the then BSE crisis. It is primarily a telephone help-line that provides a listening and sign posting service and will sometimes make farm visits. Just prior to the Foot and Mouth crisis the organisation as working with six Derbyshire farmers it is now supporting over 100 farmers. Volunteers all come from a farming background and are in a good position to comment on the wider issues affecting farming and the mental health consequences.

The interviews were facilitated by the *Farm Out* public health nurse and recorded on an audiotape to promote accuracy and facilitate a thorough analysis. An independent observer was present for three of the interviews to keep written records in the event of the audiotape failing. All focus group members gave signed, written consent in advance of the interviews. An interview schedule was produced that encompassed health issues identified from a search of relevant published literature. The schedule was also broad enough to ensure that the facilitator's own assumptions were not imposed on the groups being interviewed. All the tapes were transcribed and copies of the full transcripts are available for interested readers to scrutinise. The information from the transcriptions was analysed thematically and the findings are presented within the text of this document in a subsection of each of the key health and social areas addressed.

3.5 Tideswell health survey

This piece of research was conducted collaboratively research fellow Carol Saul from the School of Health and Related Research (ScHARR) at the University of Sheffield and Tideswell GP Dr Phil Cox. Dr Cox was concerned to find out about the level of undiagnosed depression amongst his farming population and kindly offered to work with *Farm Out* to conduct a wider health survey. The project was part funded by the Countryside Agency. A postal survey of 500 Tideswell patients was conducted in April 2001. The sample comprised 250 patients from the local agricultural community and they were matched for age and sex with 250 non-farming patients who lived and worked locally. The survey tool was a specially designed questionnaire comprising pre- validated health assessment questions including general health status, health service usage, mental health, accidents and cardiac illness (appendix 4). The survey received an overall response rate of 77% with a slightly higher response rate from the farming community. A full and separate report has been published for the Countryside Agency but relevant findings are presented in this document in the appropriate sections.

3.6 Informal discussions

Informal discussions took place with a significant number of individuals from the agricultural community often on farms. Initially these were set up following introductions from three local primary care professionals. From these introductions new contacts were made through a snowball technique in which one person identifies another to be interviewed. Snowballing is a useful technique for reaching people in closed or marginalized communities and proved very valuable in working with the farming community. There were also three contacts that were unsolicited and resulted from farmers wives contacting *Farm Out* directly in response to publicity flyers

3.7 Health and agriculture conference

Approximately 150 delegates attended a conference hosted by High Peak and Dales Primary Care Group on July 9th 2002. Representatives from the local agricultural, health and social care communities were present (appendix 3). The Duchess of Devonshire who's Chatsworth Estate provides significant local agricultural work kindly agreed to give the opening address. The results of the health needs assessment were presented and delegates were invited through small workshops to discuss the findings and identify public health solutions. Workshops were held on mental health (3), education (1), accidents (1) musculo-skeletal problems (1) and access to services. These solutions are recorded within the recommendations of the relevant section of this report.

3.8 Participatory needs assessment results

The results of the needs assessment are presented in two parts. Section 4- 8 describe the wider political, social and demographic context whilst sections 9-15 use the framework described Dahlgred and Whitehead (1994) within which to report the results of the qualitative research and other relevant published and unpublished health and social care research. The results of the Tideswell survey and other qualitative research evidence in contained in Sections 15-23.At the end of each section recommendations for public health activity to meet the needs identified are presented.

4. The Policy Context

In this section central government policy relating to the agricultural community will be examined. This will include policy from the Department of the Environment, Transport and the Regions, Department of Health and Department of Rural Affairs.

The government has indicated that farming is going through its most difficult period since the before the second world war whilst others have suggested that farming will have to undergo a change as radical and significant as that witnessed in the middle ages with the advent of the enclosure system of farming (personal communication). Essentially the economic decline described in section 12 has resulted in an industry that is no longer sustainable in its present form.

The white paper, *Our Countryside: The future a Fair Deal For Rural England* (DETR 2000) sets out the government's policies for rural England. Chapter eight *'a new future for farming'* addresses decline in farming. Of most significance in this chapter are the proposals to reform the European Union Common Agricultural Policy (CAP). At present all UK farmers receive a range of beef and land subsidies to offset the effect of exchange rate movements and milk is produced within a quota system to cap production (see section 7). Farmers were initially accepting of the CAP but as the value of the Euro has dropped and confidence in British beef has slumped since the BSE crisis there is widespread criticism of it. Many argue that it is the public rather than farmers who have benefited from these subsidies.

The root cause is we're heavily subsidised, but really if you put thought to it, we're not subsidised one bit. The consumer is subsidised, because the food we're producing is leaving our farms at a far cheaper rate than it should. (Dairy farmer and Derbyshire Help-line volunteer)

The Department of the Environment, Transport and the Regions, recommends in its report a range of proposals to encourage farmers to diversify away from farming towards agri-environment schemes. Although the White Paper states that there will still be room for large and small farms these will be more diverse in terms of structure, business organisation and the mix of agricultural and non-agricultural activities. For the small hill farmers in High Peak and Dales where diversification opportunities are small many commentators believe the future is very bleak.

The white paper also stated the government's commitment to ensure that all its policies take account of rural circumstances and need. The Countryside Agency have developed a Rural Proofing Checklist (2001) to be used by policy makers at all levels. Policy makers can use the checklist to assess whether their policy is likely to have a different impact in rural areas and what adjustments or compensations might need to be made to reflect rural need and circumstances. The local health community should aim to rurally proof all policies.

The theme of 'Modernisation' runs through central government policy in all departments. Modernisation has come to be a euphemism for decentralisation, increased local accountability and user involvement. However within the Department of Rural Affairs (DEFRA) modernisation equates with centralisation through the planned closure of regional offices and a communication system that is heavily bureaucratic and electronically focused with little opportunity for personal contact between individual farmer and the various farming agencies. Politically, local farmers feel they no longer have a voice and are marginalized from decision-making. Very recently the Peak District Rural Deprivation Forum has launched Peak District Hill Farmers Group to address this concern.

A further perceived infringement to the individual farmers integrity has been the Countryside and Rights of Way Act (2000). The Act has enshrined the rights of walkers to roam freely in open country although, in practical terms, ramblers are likely to have access to only 12% of England and Wales. Landowners can appeal against the provisional maps of open countryside currently being drawn up. Many were so absorbed in the foot and mouth sequela that they failed to address this and whilst an appeal system is available many local farmers feel weary at the prospect. One farmer's wife for example described how part of their farm land has been designated as open access and as a consequence they can no longer run a bull there as has been their practice for years. It is reported that some farmers have felt so angry about the governments disregard for farmers that they have already taken direct action in the Peak District by ploughing up open moorland in an attempt to keep the land private.

The Policies of the Health and Safety Executive (HSE) and the publication, *Securing Health Together* have significant implications for the farming community. In 2000 the HSE produced a long-term strategy for Occupational Health in England, Scotland, and Wales. The strategy represents a joint commitment by government bodies including the Department of Health to work together to 'reduce ill health both in workers and in the public caused or made worse by work'. Agriculture has been identified as one of the priority

industries. A series of targets to be achieved by 2010 were identified and are elaborated on more fully in Section 22.

Within Department of Health the key policy documents of relevance are *Saving Lives: Our Healthier Nation* (DOH 1999) and the *NHS Plan* (DOH 2000). S*aving Lives* is the government' s action plan to tackle poor health and within it contains an acknowledgement of the link between health and poverty and the importance of public health approaches to improve health as well as prevent ill health. It identifies four priority areas for action with specific targets attached;

- Cancer: to reduce the death rate in people under 75 years by at least a fifth
- Coronary heart disease: to reduce the death rate in people under 75 years by at least two fifths.
- Accidents: to reduce the death rate by at least a fifth and serious injury by at least a tenth
- Mental illness: to reduce the death rate from suicide and undetermined injury by at least a fifth.

For the agricultural community all the four target areas are important however this report will highlight the especial relevance of the targets relating coronary heart disease, accidents and mental health.

The NHS Plan (DOH 2000) sets out the governments plan for investment in the NHS. The goal, through reform and investment is to secure modern, high quality and convenient health services. The plan stresses that the future of the NHS rests on the strengths of its primary care services (DOH 2001). It endorses the importance of public health approaches to health especially with regard to reducing inequalities and pledges to '*increase and improve primary care in deprived areas'*. The Plan presents a challenge to High Peak and Dales who must address health- inequalities that may be as great as those identified in inner city areas albeit on a smaller scale.

Implicit in the Plan is inter agency working and the bringing together of Health and Social services. Local government boundaries are not co-terminus with health boundaries. For example, Social Services and Education Services are provided by Derbyshire County Council, whilst Derbyshire Dales District Council and High Peak Borough Council are responsible for environmental, housing and leisure services. At present the County Council is leading the development of *Local Strategic Partnerships*. The newly formed partnerships are charged with the production of a Community Strategy that will address six themes including *Healthy Communities.* It is essential that the specific needs of the agriculture community are acknowledged in the Community Strategy and that the plans are 'Rurally Proofed'.

5.The Geographical Setting

The Peak District National Park covers 555sq miles at the southern end of the Pennines between Manchester and Sheffield. About 38,000 people live in the park.
The major industries are farming, mineral extraction and tourism. The area can be broadly divided into two areas; the Dark Peak and the White Peak.

The former is named after the grey millstone grit rocks which underlie the moorland area and borders the central White Peak named after the underlying pale limestone rocks. The White Peak is divided by valleys into dramatic craggy dales. The whole area attracts large numbers of visitors each year and is one of the most heavily visited National Parks in the world. In landscape terms much of the Peak District's appearance today results from upland hill farming practices. The White Peak is punctuated by the market town of Bakewell and the large estates of Chatsworth, Haddon and the National Trust.

6. Rural Poverty and Deprivation.

Britain is now one of the most inequitable industrialised countries in the world. The gap between the richest and the poorest has grown. Whilst the majority of peoples lives have benefited from economic improvement the poorest ten per cent of households are now poorer than they were at the start of the 1980s.

The existence of rural poverty is gradually being acknowledged however historically the lack of a set of indicators that adequately reflects the true level of need in a rural area means that much need remains hidden. Difficulties arise primarily because poverty is scattered in rural areas. However, ward level statistics alone will not identify poverty since,

'*Even on the smallest spatial unit rural income disparities occur on a house to house basis not on a ward to ward scale'.* (PDRDF 2000)

The recent development of the Cambridge Bundles of rural disadvantage indicators examining employment, low income, housing access to services and physical isolation are proving a useful tool in redressing this problem (Dunn *et al* 1998) and these have been tested locally by the PDRDF (2000). Across the country there nevertheless remains a paucity of evidence to counter urban prioritisation and attract regeneration funds.

Rural deprivation exists within High Peak and Dales Primary Care Trust. Scott, Shenton and Healey (1991) highlighted this in their research *Hidden deprivation in the Countryside*, a collection of local studies within the Peak District National Park. The report identified different combinations of deprivation in the Peak District. Significant numbers of people were found to be on low incomes, or needed to work long unsociable hours to obtain an average wage. There was also widespread evidence of social deprivation as local people were moved away to seek employment and affordable housing. The authors conclude that whilst,

'Much has been done to understand the landscape and the built environment, less has been done to understand the issues faced by the people who created the place'.

The Peak Park Trust, a small voluntary group who commissioned the research by Scott *et al,* later evolved into the Peak District Rural Deprivation Forum (PDRDF). The Forum was established in 1992 with an aim to,

'*Improve the quality of life of those who are disadvantaged in the Peak District by addressing the causes and symptoms of hidden deprivation' (Forum manifesto).*

Through joint working with the PDRDF and other agencies, High Peak and Dales Primary Care Trust have successfully bid for lottery funding to develop a range of services to address rural deprivation and dispel the myth of the rural idyll. Under the umbrella of a Healthy Living Centre a range of services were developed. They include the establishment of Citizens Advice Bureaus to help combat poverty and promote empowerment in all but one of the Trust's 17 GP practices. The agricultural community has not been targeted directly and there is work to be done to promote access to this service as well as primary care services per se.

Identifying rural poverty is important in itself but also because poverty and ill health are inextricably linked (DOH 1980). Research in this area continues to refine our understanding of this relationship. For example, in developed countries as the gap between the richest and poorest has grown so has the difference in their health status (Wilkinson 1999).

'Health appears to be related less to people's absolute material living standards than to their position in society as expressed by their income.'(Wilkinson1999).

Wilkinson expands this idea by hypothesizing that the mechanisation for this is through the effect that poverty has on social status and affiliations and the added impact that poor early childhood emotional development can have on health. Evidence that an individual's social environment becomes less supportive and more conflictual where income differences are bigger, is cited by Wilkinson (1999). This research evidence is highly relevant to the agricultural community. Later in this report the economic decline in farming is explored in more detail, as is community's social status, affiliations and physical and mental general health. The findings lend support to Wilkinson's theories and also mirror the link between poverty and ill health that is so well documented in inner city populations.

The findings of the *Farm Out* health needs assessment also echo much of what Scott *et al* (1991) identified in their research. It also mirrors themes identified by a working group of the Forum who produced a report *Health, Social and Community Care in the Peak District National Park (1997).* The *Farm Out* needs assessment will however present the specific health sequela of the rural deprivation experienced by the agricultural community and in that sense should be seen to compliment rather than duplicate existing research.

7. The Demographic Profile of the Agricultural Community.

The population of the High Peak and Dales is illustrated in Map one. It can be seen that that age is normally distributed with a slight shift towards the older age group.

Within the local agricultural community however that shift towards older age is accentuated. The average age for a farmer is now 58years.The economic decline in farming has resulted in a reduction in the number of young people choosing a career in farming and a reluctance amongst older farmers to retire. The Young Farmers Federation is lobbying for political action to attract youth into agriculture. They report that the UK is the only country in the European

Union that is not actively promoting farming to young people through set- up grants. Local Young Farmers view this a political move to downsize the UK farming industry in preference for an increased global industry. Further south where farms are larger and more successful not least because of the more favourable terrain farming may still be an attractive viable occupation for young people however in the Peak District this is increasingly less likely. Diversification and Countryside Stewardship are being promoted by the Peak District National Park in recognition of the fact that the visual appeal of the area is primarily a result of generations of hill farming and the building by farmers of miles of dry stone walls (Hill Farms Task Force 1999). '*Farm the View*' (2001) is not an economic option for young people as diversification schemes per se are considered not to be economically viable. There are other specific problems for tenant farmers for example a landlord is legally bound to only let his land to a farmer who can prove that at least 50 % of the farm's income will be generated from farming.

The government wants the countryside looked after but I don't know who's going to do it ('Retired' farmer)

The sex distribution within the agricultural community is difficult to ascertain. What is well established is that women in the study population are a vital part of the agricultural communities sustainability. They generally fall into two overlapping groups. Farming women and farmer's wives. There are a significant but small number of women who farm in their own names and are responsible for all activities relating to the farm business. Some of theses woman have come together just before the foot and mouth disease outbreak under the auspice of the PDRDP, to form a local Women in Farming Group. They meet primarily to promote social support amongst each other but are rapidly becoming aware of their potential as a lobby group.
Farmer wives are the unsung heroes of the community. In addition to their roles of home-maker, parent and carer they work on the farm often undertaking work beyond their physical capabilities and frequently they are responsible for the farms book- keeping and paper work. They are increasingly likely to also take on work outside the home to sustain the farm financially.

I can't think of one farmer's wife that isn't a home help or cleaner. (Former farmers wife)

Within the workforce of High Peak and Dales Primary Care Trust there are many employees who are farmers, farmers' wives or daughters. They are a valuable resource from which a greater understanding the health needs of the agricultural community can be gleaned. Farmers' wives also provide enormous emotional support to husbands, brothers and sons.

I often ask have you got a good marriage? And that ' yes' they do is invariably their cornerstone to hang on to. (Farmer, Derbyshire Help-line volunteer)

8. Upland Hill Farming in High Peak and Dales Primary Care Trust

Across Derbyshire as a whole there are over 3,700 registered farm holdings covering around 71% of the land (DEFRA 2001). Of these approximately 700

registered holdings were identified in the West Derbyshire Rural Development Area of High Peak and Dales Primary Care Group (appendix 5). It is generally agreed however that it is not possible to obtain a truly accurate data on the number of farms in the local area as data held relates to holdings and not farm businesses. Some farmers may have more than one holding while 'hobby farmers' may also have a registered holding (Seabrook 2000).

The average farm holding comprises 49 hectares (1 hectare= 2.471 acres) which is smaller than in the rest of the East Midlands (63 hectares) and England as a whole (78 hectares) (DEFRA 2001) In practice the area is characterised by small family run holdings used predominantly for sheep, beef and diary farming on rough grazing and grassland in the north and grassland alone elsewhere.

A local farmer's wife and Occupational Therapist suggests that local farmers can be divided into two groups: Stockmen and Businessmen. Stockmen are driven by their overwhelming love of animals whilst businessmen have more financial acumen. Occasionally a farmer will have both characteristics and these will have the most viable farm businesses in the main she believes local farmers are stockman.

There are also two types of farm tenure in the Peak District. Owner-occupiers who own their own farm and the land associated with it and tenant farmers who pay rent to an owner based on acres. They may employ farm workers from outside the family who may live in accommodation that is tied to their employment, privately owned or rented.

The high altitude, lower temperature and shortened growing season mean farmers have to work hard to maximise the nutritional potential of the grassland available through careful mowing and fertilising. Farmers generally harvest two crops of silage per year compared with lowland farmers who collect three crops per year.

Beef cattle are sold to farms further afield to be 'finished' as the small size of the farms limits the their capacity to meet the growing animals nutritional needs. It is possible to supplement the diet of the cattle with corn and other nutritional supplements however this brings with it significant economic considerations. Local farmers have an additional burden as they try to maximise yields from a comparatively unforgiving environment.

Dairy farming is now based on a system of quotas as part of the Common Agricultural Policy to cap milk production. Individual farm quotas were based on the previous year's production and financial penalties are imposed for over production. Diary farming has become rapidly mechanised and computerised. Milk quality is constantly assessed and payments are based on cell counts, sematic cell counts and total bacteria counts. Farmers are also penalised financially for exceeding these limits.

Years ago we just used to send away so many gallons of milk and that was it, now we're paid on the weight of fat and the weight of protein and all these other things- its much more complex. ('Retired' dairy farmer's wife)

The Increased mechanisation of milking has brought with it additional pressures.

People are milking more cows because you've got to keep running faster to stand still. There's pressure on having to get on with it because there are another 200 cows coming on behind. You've got to keep on at it because the tanker will be there at 8 o' clock and if your milk isn't ready – so you've got – you can't sort of stop and have a cup of tea half way through. (Farmers wife)

There is a presumption amongst non-farmers that cows get milked twice a day and turned out into a field till next milking. There is however much more to consider.

Your looking at each cow as it comes through thinking Oh that one needs it feet doing or that one has mastitis, its not just comes coming in, units on and out again. You've got to be thinking of a lot of – how the cows looking as it comes in. (Farmers wife)

Many would like to be able to promote their products directly to the public but feel hampered by legislation and lack of capital. For example: Dairy farmers are no longer in a position to donate milk directly from the parlour for village events as they once did. A very small number of local dairy farms are licensed to sell un-pasteurised milk (green top) at the farm gate. However they are required to adhere to strict inspections and however, all dairy farmers drink their own un-pasteurised milk and baulk at the idea of purchasing it back! Across the country the number of farmer's markets has now increased from single figures in 1997 to more than 200. Locally farmer's market are held regularly Bakewell but are used by producers across the region and not representative of High Peak and Dales farmers.

8.1. Foot and Mouth Disease 2001

The 2001 outbreak of Foot and Mouth Disease (FMD) has had, and continues to have devastating effects on agricultural communities across the country. Hundreds of farmers had their livestock destroyed while others had their businesses severely compromised by animal movement restrictions. The outbreak compounded the economic effects of the ongoing Bovine Spongiform Encephalitis (BSE) crisis in England and Wales.

Everybody were just starting to go alright everybody's making a little bit more, the profits were just, just starting to come back and then it nailed us good and proper. And this - this is going to take ages to get back. (Young farmer)

A report by the Countryside Agency (2001) demonstrated the vulnerability of rural economies and showed the inter-dependence between agriculture, rural tourism and the provision of local services. The report estimates that the impact of FMD on the national economy in terms of the Gross Domestic Product could be as much as £6.3 billion.

The National Council for Voluntary Organisations also produced a report on the impact of the FMD on rural communities, landscapes and economies (2001). They highlighted the problems of delivering services due to movement restrictions noting an increased demand for some services e.g. advice lines and a reduced demand for others as people cancelled attendance at group activities and clubs. They noted also that some services such as home helps, had great difficulty in operating, as guidance recommended the cancellation of all non- essential visits.

Health and Social Care provision was also effected in a similar way. In areas where animals were being slaughtered mental health services were stretched (Osborne 2001), and in all areas domiciliary visits by health and social care professionals were limited to highly essential visits only. To date the impact of these operational difficulties on the health of rural communities has not been documented by health and social care providers.

Although the East Midlands region had few cases of FMD, agriculture and related business and tourism were still affected. Results of a study by the Government Office for the Region (2001) found that businesses in Derbyshire suffered the greatest losses due the highest number of confirmed cases and the high dependence of tourism in the Peak District National Park.

Within the *Farm Out* patch there were no confirmed FMD cases. Nevertheless as a result of animal movement restrictions local farmers had to keep and feed increased numbers of stock that ordinarily they would have sold on.

Most people are drastically overstocked and everyone's tired and getting grumpy, and you're all just falling out and, well, that's what its been like in our house anyway. (Young farmer January 2002)

There was provision for farmers to have animals slaughtered on welfare grounds but many felt that this was misused.

Not mentioning any names but you hear lots of rumours and eventually you think why don't we do that? Why don't we rake the money in while we can? But you don't do that not if you're a decent person, like some people aren't. (Young farmer)

Local farmers made no profits and many borrowed heavily to sustain their businesses. In addition local livestock markets were suspended and did not re-open until March 2002. The market provided a weekly anchor as well as social support for many farmers and their closure resulted in an increased feeling of social isolation.

There's no markets or anything like that so everybody's been pretty much shut down to their own small groups or some people to their own farms. (Young farmer January 2002)

We've had the knock on effect of - my Mum and Dad are farmers and - you know- because farming has not been making any money at all. So my brother went on the farm and there was just nothing coming out of it for him to have a living really. So he decided that he had had enough and went to work elsewhere (lorry driving). *So then Foot and Mouth came along and Mum and Dad couldn't sell the cows so they were stuck milking the cows and my Mum's like 65 years and my Dad's nearly 70. My Mums got leg ulcers and it's just been a nightmare really. And the knock on effect has been on all of us because she has not been able to help out with the children because she has been up all night calving cows – and we are all worried about her and my dad because they are always shattered. So its been a bad year all round and also they are getting up in the night and calving these cows and lambing these sheep and they're like, worth nothing, and you are definitely trying to keep your animals alive because farmers do that because that's the way, but they are worth very little – you know- its soul destroying. (Farmers daughter, mother of three, January 2002)*

The FMD crisis has had a damaging effect on the local agricultural economy. It has also damaged the health and social well being of the local agricultural community. The effects are likely to be long lasting.

9. Social Support and Affiliations

9.1 The Family

The core of farming in High Peak and Dales is the family. Historically it has been a universal provider meeting individual members needs for love, support, companionship, child -care, health and social care, farm labour, income and housing.

However the modernisation of farming, the development of global farm trade and the economic decline of farming had threatened the position of the family as has the changes in social and population structure described earlier. Families are no longer in a position to meet all these needs but many are not ready to accept this and utilise 'outside' community resources.

This withstanding there are still a significant number of farmers and farm workers who have never married. They now live alone managing the farm that their parents, and very likely several generations before them ran.

You've got your immediate family –like my husband farms with his brother and you think well, at least there's two of you but there are people on their own and that's even worse. (Farmers wife)

There is also a generation of children of whom many have rejected the farming life and moved away to undertake other work leaving fathers and uncles to maintain the business. Sons who remained on the farm may have married a girl from a non-farming background something unthinkable a generation ago and for some families today still unacceptable. One young wife described the hostility she had experienced from her in- laws who rejected her because she came from a non- farming background despite being a local girl.

Those who remain in farming have chosen a life style as well as an occupation. Today they are less likely to have a large extended family from

whom they can draw support nor will there be a vibrant farming community around them. Villages are rapidly changing as more and more farms are sold as accommodation for incomers.

Villages are changing so much –people are moving in that are a lot wealthier than yourself and you just feel – I mean the villages are changing. There not this great community spirit that there was- helping each other if you are having a bad time – everybody just turning up and doing – you know - there isn't that- people keep themselves to themselves a lot more and all the children go to different schools- you know- some of the children go to private schools in my village and so my children never get to know their children. (Farmers daughter and mother of three)

We would like very much to feel valued, we would like to feel you are doing a job that the country values, 15 –20 years ago I think it was valued now everything revolves around the service industries (farmers wife)

For rurally isolated mothers the absence of an extended family and friends can have devastating effects.

When my three children were little I had very little adult company and I think its the key to how you cope with any situation but definitely when you are bringing up children, at that stage if I'd have had a good support system with relatives and friends with children that knew what I was going through I could have coped a lot better than I did- where as I never got any of that and I just went stir crazy to be honest. (Farmers wife and mother of three school primary school children)

Bringing up children on a farm can also be tough for other reasons for despite the fact that many fathers on technically 'working at home ' contact with the rest of the family is often minimal during the week. Some wives talked of how they desperately looked forward to talking to their partners only to be thwarted when their partner fell asleep as soon as they sat down.

He goes out at 4.30 am and comes in at 6.30 pm so he won't see our daughter properly until the weekend. (Farmer's wife and mother of three)

They haven't got time to spend with the family. It's very stressful for him. It puts a lot of pressure on the family and your relationship. (Farmers wife and mother)

Wives felt they could not ask husbands or partners to take on any child -care activities at night to enable them to pursue other interests because they would be too tired.
Despite all the trial and tribulations of rural life few wanted to live in a city and felt life would be harder there.

I think being in the farming community, that's very much the thing isn't it. Your parents have brought you up to get on with it haven't they, because they did. I mean they had it a lot worse they we did. (Farmers daughter)

9.2 The Church

Apart from the family it has been the church that has traditionally provided social support for the agricultural community. The Arthur Rank Centre (ARC) based at the National Agricultural Centre at Stoneleigh Warwickshire is an ecumenical partnership between the churches, the Royal Agricultural Society of England and the Rank Foundation. It was established in 1972 and leads and supports range of initiatives aimed at improving the quality of life in rural areas particularly for those who may be disadvantaged, vulnerable or socially excluded. They have funded rural chaplains across the country to offer pastoral and spiritual support to the farming community. Very recently an agricultural chaplain has been appointed to work in the East Midlands and enhance the existing work of local churches.

Locally views about the church and other general village activities today are mixed. There were some villages where the church was reported to be very active, in one village the vicar was at one time the Rural Officer for the diocese and had taken a particular interest in the agricultural community. In other areas the situation was different.

Things like the church and other village activities are not as prominent as they used to be, certainly in our village there's very little goes off now, I suppose people are more mobile now so they go out of our village but for people who haven't got transport, there really isn't much at all. (Retired farmers wife)

The buck stops with the family you know, there is nobody else (*Farmers wife*)

9.3 Carers

Carers are women and men who look after family or friends who need support because of age, illness or physical or learning disability. They may be adult or child carers. This year the government published the *National Strategy for Carers* (DOH2001) outlining the governments plan to improve the health and social care support that carers receive. As part of this strategy the government has developed and approved a set of five quality standards for local services to support carers. These address carers information needs, provision of respite care, provision of emotional support, support to care and maintain the carer's own health, and lastly carer empowerment.

Across the UK there are estimated to be some 5.7 million carers. In Derbyshire the Carers Association have registered with them some 375 carers from High Peak and Dales PCT. They believe this to be the tip of the iceberg.

Within the agricultural community caring for a dependent relative was considered a family role and there was a low expectation of outside help. Several farmers who looked after their dependent wives and for many years described daily routines that were quietly heroic. Similarly there were farmers wives who fulfilled numerous domestic and work roles as well as caring for a dependent relative.

It's very difficult. I mean at the moment my son and I live together so if we – if I want to go out, I have to make sure my son is at home but he's getting married this year so it will then be just be, my father and myself which will make life very difficult. (Farmer caring for her father with dementia)

Several farming families could recall days gone by when villagers took it upon themselves to provide informal care to another supporting them for years. A farmer's daughter could recall a time in her village when people baked cakes or meals for someone struggling or in crisis and lamented that those days were long gone. There is no longer an informal network of supportive neighbours to support carers and many carers felt isolated.

The tendency of the agricultural community to make less use of health services compared with the local non- farming population suggests that carers from this community are unlikely to be receiving all the practical and social support that they require and are entitled too.

Social services staff highlighted the unmet social needs of older single, male, agricultural workers who were receiving formal and informal care in their own homes but had become estranged from their farming backgrounds. These gentleman did not wish to join traditional group activities as provided by the local day care centre but instead wanted to talk 'farming' with other interested individuals. *Farm Out* worked Derbyshire Rural Community Council to establish the *Farming Life Centre Project* that has recently assumed registered voluntary group status. It is working towards the setting up of a Farming Life Centre within the Peak District. The Centre will celebrate and record local hill farming practices and provide amongst other things a focus for social activities for older farmers.

9.4 Recommendations

- *Farm Out* should work with the East Midlands ecumenical Rural Chaplain to promote greater knowledge of this role amongst Primary Care professionals.
- The Health Improvement sub- group of High Peak and Dales PCT should consider the contribution that the Rural Chaplain might be able to make to the group's work.
- High Peak and Dales PCT should continue to support GP practices to establish a register of carers.
- Registers of carers should be used by primary care to identify and target carers from the agricultural community to ensure they receive benefits and other entitlements.
- *Farm Out* should promote the role of the Carers Association to the agricultural community through the farming press and local markets.
- High Peak and Dales PCT in preparing its Carers Strategy should seek to encompass the special needs of the agricultural community.
- Efforts should be made to identify a representative from agricultural community to sit on the Carers Strategy Group and the committee of the Derbyshire Carers Association.

10 Social and Leisure Activities

10.1 Families

Many families from the agricultural community raised the same issues identified by other researchers who have examined the effects of rurality and use of social and leisure activities (NCH 2001). These included the need for adequate transport, affordable activities and interventions to reduce social exclusion

Common activities for parents with young children included swimming and walking especially on the Tissington Trail. Accessing local mother and baby groups and toddler groups was more difficult. For some mothers getting off the farm during the day was essential for their sense of mental well being but finding somewhere to go where they felt comfortable and welcome was not always possible.

*I went to one (*mothers group*) in a different village and I went three weeks in a row and every time I went no one spoke to me- I mean the village isn't isolated but the people in it were very rude- I mean they just didn't speak to me. (Mother 18 month son)*

I think in some villages there is a clique isn't there. You either fit in or you don't. (Mother 18 month son)

Well I was a lot younger than everyone else. I felt like a bit- 'Oh my God look at her, she's this age and she's got these kids. (Farmers wife and mother of three)

Meeting up at the Tuesday group, established by the Rural Deprivation Forum's Amethyst Project, was hugely valued. The Tuesday Group was set up with women who are living in isolated areas. Many have not been able to access traditional Mother and Toddler groups either because of transport difficulties or because they felt social excluded. For example some villages the mother and toddler group is dominated by middle class incomers who were often a lot older and who appeared to have little interest in the local mothers. The group meets in a pub on the A515, it is a bleak spot but one that is easily reached by mothers living in the surrounding area.

Mother also identified the time it took to travel to groups or outside activities as an issue. A total journey time of one hour was not unusual and this might make it difficult to attend groups if children had to be picked up from school at a certain time. Others found the driving children to and from playgroups and school costly and exhausting. One commented that she had been driving some 150 miles a week before she found the emotional strain too much and withdrew her child from playgroup.

Having a car was seen as an essential not a luxury.

They see us driving a four by four and think oh they must be doing alright but really it's a terrible struggle we live about a mile from a proper road and you've got to be able to get out' (Young farmers wife)

Many farming families commented on how devastating it is to loose a driving licence as a result of ill health or not to have access to transport to get away.

I'd just kill myself; I couldn't bear the thought of not being able to go out. (Farm workers wife and mother of two children under five years old)

10.2 Adults

Farmer's wives felt it was often difficult for their husbands to commit to any regular or long term leisure activities such as golf and tennis. Going to the cinema in Chesterfield was an occasional activity. A few farmers' wives identified Reading as a leisure activity and husbands were reported to read the farming guardian and farmers weekly regularly.

For other farmers leisure time just wasn't an option.

My husband is well past retiring age and is still virtually working a full day and doesn't feel able to do a lot of things he would really like to do because there really isn't enough time and as with many people we are managing with a man less but the workload doesn't lessen. (Farmer's wife)

Some said they did have holidays but acknowledged that this was a lot more than other farming families might have.

You don't have a holiday if there's work to be done. The only time you really have a holiday is when you physically leave the farm. (Young farmer)

I have one night a week off from milking other than coming here (to young farmers meeting) but I don't go and sit in the house. I wouldn't sit and let my Dad and my cousin do the work, I'd go and help them till its finished. (Young farmer)

10.3 Young Farmers

For young farmers social life centred around activities organised by the local branch, bowling, going to the pub, county quiz nights. Buxton Young Farmers did not socialise outside of the group although this may be different for other young farmers groups in the Peak District.

You can do exactly the same as everybody else can in their normal lives apart from; you haven't got enough, as much time as everybody else has to do it. (Young farmer)

Whilst alcohol was considered a legitimate way to relax smoking and drug taking was not.

Drugs are for people who've got nothing better to do. (Young farmer)

I can honestly say I don't even know anyone who'd try any. (Young farmer)

I saw some the other night in err Burlingtons weren't it, it were a bit of green stuff in a bag. I were driving so I hadn't anything like to drink and these two rough uns were talking about, I listened to them talking about nicking a car or something, they didn't get up till 2 o'clock, and they must've been off Fairfield or something. Then he grabbed this bag out of his pocket and there were green stuff in it and I knew they were doing something illegal' so I made a sharp exit! (Young farmer)

At a *Healthy Heart* event held at the Bakewell Agricultural Centre on market day May 2002 the health promotion workers identified a negligible number of smokers from the local agricultural community. This was borne out in the findings from Tideswell Health Survey. The results showed that there was no significant difference in the prevalence of current smoking between primary, secondary and non-farmers. However, among those who do not currently smoke, primary farmers are significantly more likely than non-farmers to never have been a smoker, rather than to be an ex-smoker.

10.4 Recommendations

- *Farm Out* should raise awareness amongst Primary Care professionals about the level of social exclusion experienced by some members of the agricultural community.
- Public health activities conducted by Primary Care to address mental health promotion should target the agricultural community.
- The particular social and leisure needs of the agricultural community should be included in Derbyshire Dales District Council and High Peak Borough Council's new Community Strategy.

11. Housing

The report of the Independent inquiry into health Inequalities, chaired by Sir Donald Acheson, (1998) traced the roots of ill health to social and environmental factors. Central to these were the living standards of poor households. Over the last decade there has been a rapid economic decline in farming When this is considered alongside the particular housing needs of this community they emerge as a high risk vulnerable group.

Poor housing has a direct and indirect effect on health. Cold, damp and overcrowding impact on physical as well as mental health. Poor environments can increase accident risks while inadequate food storage and cooking facilities also carry health risk. Palmer and Molyneux (2000). Insecurity of tenure raises stress levels that can in turn and causes significant mental health problems. However arguably the most serious implications of housing problems are through the deleterious effect on an individual's sense of control, self-determination and social status.

Generally rural housing is appreciably more costly than housing in non-rural Areas. For example in the first quarter of 2000, the average house price in the East Midlands rural districts was £80.455 compared with £62,315 in non rural districts (HMLR.200O) Properties in the Peak District National Park command especially high prices A survey conducted by the Peak District National Park Authority (1999) revealed that Bakewell had the highest house prices in the East Midlands. Demand for housing in this area continues to outstrip supply.

It's a two up, two down for ninety grand in Coombes and that the cheapest you'll get. (Young farmer)

As a result of in-migration, the population of rural districts is growing twice as fast as the national average. Many of the newcomers are older and wealthier and can out bid local residents in the competition to buy homes (DETR 2000).

All townies are coming in and buying offering them silly prices for little cottages in the country. (Young farmer)

For many in the Peak District especially younger people the disparity between high house prices and average earning puts the purchase of a home locally out of reach (Countryside Agency 2000). Social housing stocks are much reduced as right to buy has taken effect further compounding the housing options for young people. The Peak District Rural Housing Association was set up in response to these issues and seeks to provide housing either for rent or for sale on a shared ownership basis.

In the Rural Development Area of the Peak District the agricultural community is especially disadvantaged in the housing market. Farm workers living in tied accommodation have little security of tenure and their seasonal low incomes result in poor mortgage credentials. Locally young farmers felt they had very few housing options. In the main they tended to stay living at home on the family farm or in a caravan until such time as they might be able to afford to build their own home subject to the strict Peak District National Park Authority planning restrictions. Ward (2002) calls for a planning system that is flexible enough to give homeless people in rural areas a chance and rejects the,

'Suffocating nimbyism of the countryside lobby with its Range Rover culture'.

He advocates a place in every parish where people can build their own homes starting in a simple way and improving the structure as they go along. He believes it is ridiculous that a house should be completed one go before you can get planning permission and a mortgage.

11.1 Owner- occupiers are considered most secure since they own their farms. If such a farmer was forced to sell the business, 'he is likely to survive' because property commands such a high price in the Peak District. There are however many privately owned and rented farm houses that are in a very poor state of repair with inadequate sanitary and heating facilities. The Housing Best Value Inspection Report (DDDC 2001) acknowledged this and noted that in recent years the council had under- spent the capital available for Renovation Grants. Derbyshire Dales Environmental Health Officers and those working for High Peak Borough Council believe that there are complex reasons for the low uptake of grants from the farming community. They include a culture of self- sufficiency, stoicism and a reluctance to share information about finances, sometimes combined with a general suspiciousness and mistrust of those outside the agricultural community. The report recommended the need to identify and target properties in a state of unfitness or poor repair and to give greater publicity to grant availability. The close involvement of all those agencies working with farmers will be required if the uptake of these grants by the agricultural community is to be achieved.

11.2. Tenant farmers and their families are the group whose housing needs are most severely compromised by the present economic decline in farming.

The idea of a tenant farmer is usually he saves until he's bought himself a house to retire in you see. So that's his security. They've nothing to save now, they can't do that now, its impossible cos the property's gone up and his profits have gone down (dairy farmer).

Locally tenant farmers rent from three main estates; Chatsworth, Haddon, Stanton Park and the National Trust and a number of private landlords. None have any special system in place to support farmer when they retire or have to give up the farm for economic reasons. This needs assessment identified high levels of stress experienced by tenant farmers as a result of insecurity of housing tenure. There are some initiatives that are seeking to redress this problem. The ARC – Addington Fund administered by the Arthur Rank Centre in Stoneleigh was originally set up to provide financial support to farmers during the FMD crisis. Across the country £10.2million have now been passed on to members of the agricultural community in an attempt to offset the additional expenses encountered by farmers during the FMD crises. The fund is now being used to support farmers to remain in their rural environment when they have lost their farm businesses. It is currently now seeking to support tenant farmers who have had to give up their tenancy by purchasing local property for them to rent. To date no one in the Peak District has been supported in this way.
Derbyshire Dales District Council have appointed Rural Housing Enabling Officer to support the Council's work on developing and implementing an *Empty Homes Strategy.* In the long term such an officer is ideally placed to work closely with the farming community, especially tenant farmers and their families.

11.3 Recommendations

- The PCT should work with Derbyshire District Council and High Peak Borough Council through the Health Improvement Sub group to consider how the housing needs of the agricultural community could be best met
- The work of Arthur Rank Centre in supporting the housing needs of tenant farmers should be widely promoted by the PCT, High Peak Borough Council and Derbyshire Dales County Council to all tenant farmers and professionals working with the agricultural community
- *Farm Out* should work with Derbyshire Dales District Council to promote Renovation Grants to the agricultural community through the farming press, Citizen Advice Bureaus, and primary care professionals.
- *Farm Out* should be a partner agency with the Rural Housing Enabler in order to implement the *Empty Housing Strategy*.
- Consideration should be given by Peak Park District Authority to the, *build as you go* approach advocated by ward (2002) that would favour the agricultural community.

12. Income

12.1 Background

Seabrook (2001) prepared a comprehensive discussion document for the Peak District Rural Deprivation Forum on Farming Incomes in the Peak District National Park. His research yielded results in line with other research from the wider farming community and showed that in real terms farmer's

incomes were on average some 25% of their level 10 years ago (Nix 2000). The reasons are complex. Seabrook identifies them as,

- The strength of the pound making food exports expensive but food imports cheaper.
- The weakness of the Euro, in which many subsidies are calculated
- The BSE crisis altering the demand pattern and hence prices for beef and other red meats.
- The long term decline in beef and lamb consumption exemplified in the decline of the 'Sunday lunch'.
- The continuing rise in the cost of farm inputs such as fuel tractors and fertilisers.
- The fact that farms have generally remained the same size and have not been able to achieve economies of scale.
- The high cost of land making farm expansion difficult.

Most recently the economic decline in farming has been further accelerated by the impact of the Foot and Mouth Crisis in 2001 resulting in a national decline in farm numbers.

12.2 Local Experiences

Tideswell Survey

In the Tideswell Survey participants were asked if their income had changed over the last year. Table one shows the results for household income compared with one year ago.

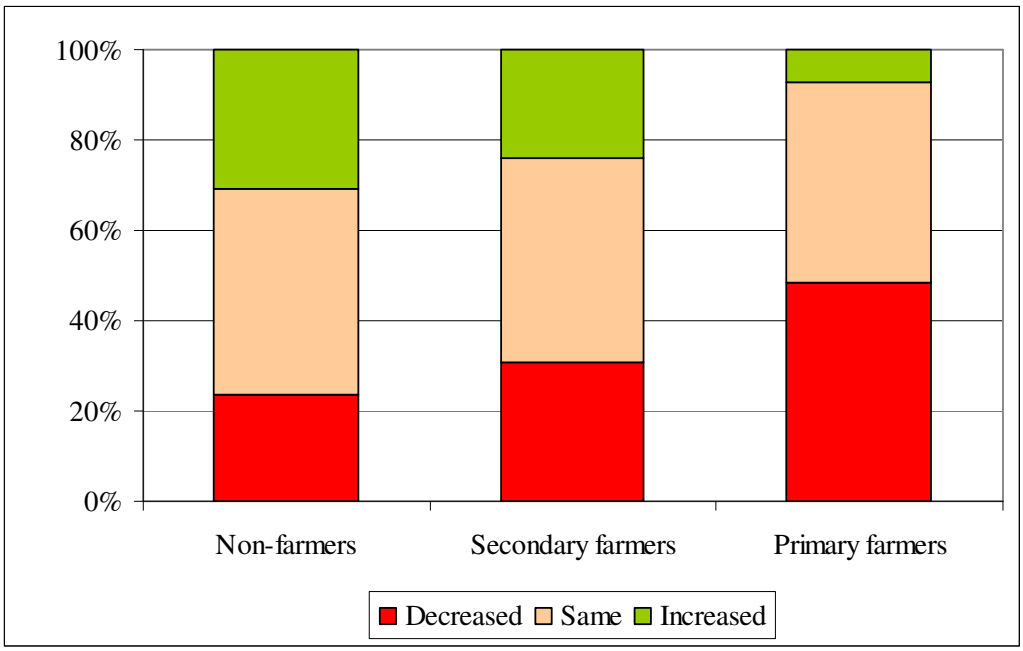
Table One: Household income compared with one year ago by occupation

	Non-farmers	**Secondary farmers**	**Primary farmers**
Income decreased			
%	**23.6%**	**31.0%**	**48.2%**
(n)	(43/182)	(22/71)	(55/114)
95% CI	18.0 - 30.3%	21.4 - 42.5%	39.3 - 57.3%
Income stayed same			
%	**45.6%**	**45.1%**	**44.7%**
(n)	(83/182)	(32/71)	(51/114)
95% CI	38.5 - 52.9%	34.0 - 56.6%	35.9 - 53.9%
Income increased			
%	**30.8%**	**23.9%**	**7.0%**
(n)	(56/182)	(17/71)	(8/114)
95% CI	24.5 - 37.8%	15.5 - 35.0%	3.6 - 13.2%

It can be seen from this table that farmers were significantly more likely than non-farmers to report that their household income had decreased compared with one year ago. Just over 48% of primary farmers reported a decrease in income - and about half of these said that their household income had decreased 'a lot'. Primary farmers were also significantly less likely than either secondary or non-farmers to report that their income had increased.

Figure one is a graph to show the income changes over the last year.

Figure one: Household income compared with one year ago by occupation



Tenant farmers

Clearly the effect of the economic decline on local hill farmers has been devastating and tenant farmers have been especially vulnerable. For example locally a tenant farmer is likely to have to pay rent of between £20-£30 per acre, so for example a 250- acre dairy farm might command an annual rent of £20,000 per annum. The *average* income of farmers across the country last year was estimated to be £5000. Locally financial advisors believe that many farming incomes dropped to £2500 and many had no income from farming at all. As a result of the dramatic drop in milk prices many tenant farmers have borrowed heavily to subsidise the farm whilst others look to family savings to sustain them. Dairy farmers are presently receiving as little as 18p/litre while production costs are around 22p/litre. The farm gate price of milk has been depressed to below the cost of production. Tenant farmers have the additional problems of financing their retirement. Historically they would sell their livestock and other material assets and this would constitute a pension, today where there are assets to sell these are required to pay off debts

Farm owners also have financial problems relating to succession. In planning for future ownership of the farm a decision has to be made as to whether the farm is to be a pension for the outgoing generation or a business for the next generation. In practice it often has to be both and it happens that parents may pass on their assets to their children only to find their children begrudge their reliance on the farm for an income and which is struggling to provide for one household let alone two.

The Arthur Rank Centre (ARC) - Addington fund was established at the onset of Foot and Mouth disease crisis in 2001 to offer financial aid to farmers. Grants were made available to farming families or individuals in financial

distress through a referring organisation such as the Derbyshire Rural Voluntary Help-line service. A total number of 335 applications were received from farmers in the Peak District. Of theses 333 grants were awarded to the value of £147,215, with an average value of £442 per grant. Appendix 6 shows the geographical distribution of these grants. It can be seen that the greatest concentration of grants is around Buxton and Ashbourne.

Despite the enormity of the financial problems faced by farmers, locally young farmers showed little resentment, more resignation to the situation. Their incomes are low. Some earned £160 per week for a 40-hour basic wage another quoted £300 per month but board and lodgings were free. Some received no salary from the family farm but worked extra days on another farm to get pocket money.

I earn nothing, but I have the use of a car, and board is free and I get a bit of an allowance for going out and stuff. (Young farmer aged 19 years)

I don't mind cos they're keeping a record of what I earn and when I get the farm they'll give me all that in stock. (Young farmer)

What is clear from young and older farmers is that farming is a way of life.

Y*ou do it cos you want to, not for the money. You'd be a head case to do it for the money*

Others noted that whilst it was a way of life the lifestyle had changed and '*the enjoyment gone'.*

There was a concensus amongst farming families that staffing farms adequately was an issue. Firstly in the present poor economic situation farm businesses simply could not financially support the staff required. There was also a paucity of suitably skilled stockman and dairyman.
Often the current generation retains exclusive control of the farm while the children provide the labour

We have had terrible staff problems this year terrible and several people who rang applying for the job were in their 50s or late 50s and we looking for someone younger and one man who rang from Kent said that they were not getting any young men going into the dairy sector at all. ('Retired' farmers wife)

Where suitable applicants were available posts were turned down work because of the 5am start!

Farmers have responded to the economic pressures by taking on other work outside farming such as lorry driving. In the main it has been farming women that have taken on extra work such as home help, cleaners and care assistants to boost the farm income. However through the duration of this need assessment exercise it has been evident that the financial pressure on the agricultural community is intense.

Financial and agricultural advisors, Derbyshire Rural Help-line staff have all commented on the agricultural communities rural stoicism and reluctance to seek help. Hirst and Taylor (2002) describe rural stoicism as

A culture of self-sufficiency and pride, which militates against help-seeking behaviour.

They describe how the establishment of Citizens Advice Bureaus (CAB) within GP practices in the High Peak and Dales PCT successfully increased the benefits uptake in the rural community. However there is much anecdotal evidence to suggest that the farming community are reluctant to visit their GP practice. This has been supported by qualitative data collected for the needs assessment. The Tideswell Survey also showed that the agricultural community was significantly less likely to visit their GP compared with the local non- farming community. It is therefore likely that the existing provision of welfare rights information is not being accessed by the most needy members of the community.

Finally many members of the agricultural community expressed a view that the non -farming community was dismissive of the farming crisis. They believed that non- farmers saw farmers as being supported by over generous subsidies and despite evidence to the contrary, believed that many farmers were still economically very successful. Many said that there was a time when they felt proud to be farmers but now when meeting strangers they do not wish to disclose their occupation for fear of stigma. This was an attitude that was voiced by some health and social care professionals during the listening events.

12.4 Recommendations

- The PCT, through the health Improvement Sub Group and the Primary Care Sub Group should work with *Farm Out* to improve health professionals understanding of social exclusion and the local agricultural community
- The PCT through the Health Improvement Sub Group may wish to lobby widely for retirement schemes for farmers such as those available in other European countries to be reassessed
- *Farm Out* should work with the CAB to consider ways of promoting the service to the agricultural community.
- Farm Out should work with the newly established CAB services in Hartington village hall to evaluate the use of CAB services in a non-medical setting by the local agricultural community.
- Primary care nurses looking to undertake public health work should consider the promotion of free school meals to children in the farming community in a non stigmatising way
- Primary care nurses looking to undertake public health work should consider working with farming organisations to support farmers to plan for retirement with reference to *Sustainable Food and Farming* (DEFRA2002)

13. Education

13.1 Background

Farming has traditionally been a practical, hands- on occupation where manual skills, animal husbandry and land management were best learnt through practical experience observation and mentoring. However the gradually shift towards a more bureaucratic electronic system has become accelerated since the BSE crisis. Increasingly DEFRA will only communicate with farmers electronically. There is a raft of paper work to be completed by farmers much of it complex in nature. For example each cow has to have its own numbered passport. A typical farmer could have 100 animals and more at calving time. If there is any error in the recording of the passport digits DEFRA will withhold premium payments. Many farmers simply do not have the numeracy or literacy skills to undertake such work. Other farmers who attended agricultural college at the start of their farming careers and who are more confident with paperwork now found that they not only have to become computer literate but also need to invest in computer hardware.

13.2 Local Experiences

Agricultural advisors have commented that many older farmers left school at 14 years with no formal qualifications and several in the area never learnt to read or write.

My husband left school at 14 to go into farming. Its what he knew he'd always do. Farming was never paper orientated; he finds keeping records very difficult. (Farmers wife)

Others however have noted that teachers in several local schools 'gave up on farming children' believing them to be a poor investment for education. How far this attitude prevails today is not certain.

Many farmers' wives have taken over the farm paperwork and bookkeeping. They too have found the work demanding especially as many also had to take on work outside the home to boost the farm income.

Some young farmers expressed a desire to have more educational opportunities but were restricted by the pressures on the farm.

I would have liked to have gone, (to college) *full-time if my Dad could manage on his own. You need to keep the stock ticking over, but he can't manage. I'd have gone without even thinking about it if I didn't feel so guilty. (Young farmer)*

Young farmers commented that they believed the local college to be not of a high enough standard but anywhere else was too difficult to travel to. Others noted that very few agricultural colleges were offering courses exclusively in farming most now were leisure and equestrian studies. These issues have in part been also been highlighted in the DEFRA report *Sustainable Food and Farming* (2002).

Locally solutions are slowly emerging. Very recently one village agent has succeeded in gaining funds to give local women formal farm secretary training. Bagshaws the local agricultural auctioneers were also mindful of the

problems that increased bureaucracy was having on local businesses. Stock was reportedly arriving at market but could not subsequently be sold because the relevant paperwork was incomplete. An IT support service has now been established providing a variable service for farmers to purchase ranging from the creation of simple data bases of farm stock to overseeing all the farm administration. Perhaps it is worthy of comment that General Practitioners who like farmers run small businesses have received considerable government funding to purchase information technology equipment. However farmers who provide food for the nation receive nothing.

13.3 Recommendations

- *Farm Out* should work with the Arthur Rank Centre to consider the funding for farmers and other agricultural workers to change occupations.
- Educational providers should deliver specific training packages for farmers, delivered to their farms on an individual basis (e.g. extension of the ESF Farming and Rural IT programme)

14 Food and Farming

14.1 Background

In 2001 The Countryside Agency published *Eat the View* a report prepared prior to the Foot and Mouth Disease outbreak highlighting the need to improve the market for local and sustainably produced food to close the gap between local producers and local consumers. Food and farming was placed high on the political agenda during the Foot and Mouth Crisis. A Policy Commission on the Future of Farming and Food led by Sir John Curry was established. They reported their findings in January 2002.The Commission produced a vision for the future for the future of food and farming in England.

"We look for a profitable and sustainable farming and food sector that can and does compete internationally, that is a good steward of the environment and provides a healthy diet for people in England and around the world'.

The Commission looked six areas or practice as follows;

- Joining up the food chain
- Improving farming performance
- Farmer's contribution to sustainable rural communities
- Protecting and enhancing the environment
- Improving public health
- Improving animal health

A full analysis of all these areas is beyond the scope of this health needs assessment although clearly any changes to farm income and sustainability will impact on the health of the food producers. However the improvement of public health and animal health will impact on health of whole population as well as that of the local agriculture community. The choices people make about food and the types of diet they eat are shaped at every stage of the food chain. Similarly the experiences of BSE and Foot and Mouth show

clearly the effects animal diseases can have on public health. Dietary factors account for around a quarter of deaths from cancers (World Cancer research Fund 1997) whilst diet related ill health and death are linked to cardiovascular disease diabetes and strokes (DEFRA 2002b). On this issue a group of academics and public health specialists responded to the policy Commissions report in a separate report emphasising the centrality of health to any vision for the future of food and farming (Lang and Rayner 2002).

The Commission recommended that the Department of Health, The Food Standards Agency and DEFRA should come together to produce a strategy for healthy eating. They also recommend that Primary Care Trusts as part of local strategic partnerships should ensure that a food dimension is included in health Improvement and community plans which should include the monitoring of food inequalities.

The government's ideas for taking forward the Policy Commission's recommendations are outlined S*ustainable Food and farming – Working together* (DEFRA 2002). On completion of a process of discussion the government plans to produce a *Strategy for Sustainable Food and Farming*.

14.2 Local Perspective

There is tremendous cynicism about the government's commitment to the sustainability of local farming. Many believe that in calling for farmers *to work together to improve their business performance* (DEFRA 2002) there is a move towards much larger farms. In such an arena there will no longer be a place for small family run hill farms.

There's a 1000 cow herd in Cheshire now. Well that's the type of farming we're going to get if we don't watch it now. Is this acceptable to the general public? I don't think it is, 'cos these cows are virtually battery cows. They never leave the premises, never out of doors, they're just machines. I don't ever want to farm like that. (Dairy farmer)

Local farmers also feel it will be difficult to compete in the global market.

There's a feeling of bitterness because things are still coming into this country from countries where all theses regulations don't apply because it's cheaper but we have to comply to all this animal welfare

There is a lot of support for the idea of local markets and the WFFU are active in the area promoting the use of local produce. They have organised local seminars to promote the issue. There are inequalities in access to local food, which might be addressed by local food co-operatives. Some local women however would like to have access to internet supermarket shopping believing it to be cheaper given the cost of petrol and their rural isolation.

Anyone who is isolated should be funded for a computer! (Farmers wife)

14.3 Recommendations

- High Peak and Dales Primary Care Trust's Health improvement sub group should address the Policy Commissions recommendations that PCTs as part of local strategic partnerships should ensure that a food dimension is included in health Improvement and community plans which include the monitoring of food inequalities.
- High Peak and Dales Primary Care Trust's Health Improvement sub group should consider the commission's recommendation to extend the National School Fruit Scheme up the age range.
- High Peak and Dales Primary Care Trust's Health Improvement sub group in addressing the National School Fruit Scheme should look to establish initiative promoting the supply of local fruits such as apples pears and rhubarb.
- High Peak and Dales Primary Care Trust's Health Improvement sub group should assess the impact of promoting online food shopping as well as local food co-operatives when considering food inequalities locally.
- Farm Out to explore how High Peak and Dales PCT can further promote the sourcing of local food to meet the requirements of the Trusts four community hospitals. These experiences should be shared with the wider health community including County Councils.

15 Pesticides and Health

15.1 Background

Pesticides pose a potential health risk both to farmers and food consumers. Despite a growing trend towards organic farming practices pesticides are still widely used in agriculture to control unwanted or harmful plants fungi, invertebrates and vertebrates. The use of pesticides amongst the hill farmers of High Peak and Dales is considerably less than those used in intensive arable farming however within the High Peak and Dales pesticides are primarily used in relation to sheep farming to control scab mite, blow-fly, ticks, keds and lice. Sheep can either be totally immersed or sprayed down their backs with a pesticide. There are health and environmental risks to all the chemicals available to dippers however those containing organophosphates (OPs) cause the most concern to farmers. Some farmers dip their own sheep others employ professional dippers. The health risks are not confined to the dippers themselves but also family members, those handling sheep after they have been treated including market handlers and shearers. The wider community is also at risk if careless disposal of chemical solutions result in the contamination of water supplies.

15.2 Organophosphate Pesticides and Health

Between 19 and 1992 sheep dipping with OPs was compulsory in the UK**.** Today many farmers continue to use it as non –OPs are not an effective treatment against scab.

The safety of OPs in agriculture has been questioned as far back as the 1930s (Alston 2002) but it wasn't until 1991 that an unpublished Health and Safety report led to the secret withdrawal of phenols and other chemical

additives from OPs after it emerged they increased toxicity (Booker 2002). In 1992 compulsory dipping ended but there was no official acknowledgement of the health risks of cumulative exposure.

The Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment (COT) is a Department of health Expert Committee. In 1999 COT was asked by ministers to advise whether prolonged or repeated exposure to OPS in doses lower than those causing acute toxicity could damage health. They issued a very cautious report suggesting that they can cause some forms of illness and they went on to identify areas of future research including the recognition that people suffering long term illness should be studied. Commentators suggest that fear of compensation is responsible for the extraordinary delay in acknowledging the health risk.

Recently an epidemiological study examined the relationship between exposure to OP pesticides and neurological illness in UK sheep farmers and dippers (Pilkington *et al* 2001). The researchers found a consistently strong association between exposure to OP concentrate and neurological symptoms but a less consistent association with sensory thresholds. They suggest that long- term health effects may occur in at least some sheep dippers exposed to OPs over a working life. Mental health problems including depression and manic depression have also been linked with exposure to OPs (Davies 2000).

15.3 Pesticides and Health and Safety

By their nature pesticide are biologically active and as well as their effects on target species many are toxic to humans and as such their use is regulated.

Under the Control of Substances Hazardous to Health Regulations (1988) farmers must carry out a risk assessment in relation to the particular circumstances in which they will use the pesticide. Certain class of operators are required to hold a certificate of competence in the use of pesticides. Protective clothing, including gloves, waterproofs and sometimes respiratory protective equipment, are all recommended. Health and Safety research suggests that dippers do not always wear the equipment and therefore are even more vulnerable. Locally some farmers have suggested that the equipment may compound risk if splashes or drops of concentrate or dilutant seep under protective equipment.

15.4 Local perspectives

Some farmers wives expressed a general unease about the hidden risks from agricultural chemical usage. Others were more pragmatic

I'm sure the general public think we just go out and spray everything but they are incredibly costly and are used very sparingly. (Diary farmer's wife)

On spraying sheep down their backs to prevent scab young farmers expressed concern.

My Dad won't let me use spray because he says its better that the old folk die first before me, I've got plenty of years (Young farmer)

My Granddad's not too, er, safe with the spray he goes in his normal trousers and boots so about two days later he ends up with spots all over his legs. (Young farmer)

Its just getting your mask on, its not practical when it's hot and sunny and you should be wearing stuff like, buts its too hot and stuffy with the mask on so you just takes it off (Young farmer)

Dips used to give me Dad and me Uncle bad, you know give a bit like flu for a few days, and then you're back okay again
You wouldn't go back to it too many regulations about chemicals and storage

Many had stories to tell of accidents with chemicals, one district nurse explained how as a child she had fallen into the sheep bath. Others described spouses getting dippers flu – an acute episode of runny nose, raised temperature and malaise. One farmer said she was so sensitised to organophosphates that she couldn't go within yards of the dip without feeling ill. She attributed her atypical multiple sclerosis symptoms to her previous exposure to sheep dip.

15.5 Accessing Expert Health Advice

Amongst the local farming community there is uncertainty about who to go to for expert advice should they experience a health problem that might be related to chemical usage.

You hope that you would go to your GP and he would put you in touch with somebody who knew. To me that would be obvious. (Farmer's wife)

GPs consulted in the High Peak and Dales however would be unable to put people in touch with 'somebody who knows'. Many by their own admission are ignorant of the health effects of agricultural chemicals and certainly are not aware of any experts to whom they could refer. None were aware of the health card that the Women Food and Farming Union are trying to promote. The health card is designed to be carried by farm workers who can use it to record details of the chemical s they are working with to share with GP's.

Some GPs have referred farmers with neurological symptoms to consultant neurologists but it has been apparent to the farmers concerned that neurologists do not have an expertise in this field of work. One young farmer commented that at the end of his consultation for early onset motor neurone disease he volunteered his occupation, the neurologist responded by laughing as he saw him out the door. He did not return.

Apart from GPs other farmers suggested that the National Farmer Union (NFU) might be very helpful or the National Sheep Association. Many would rely on a visiting vet for advice.

15.6 Tideswell Survey

Respondents to the Tideswell survey were asked whether they use agricultural chemicals and, if so, if they had ever had health problems involving their use. If they had such health problems, the nature of the

problem was described. Table Two shows the use of agricultural chemicals amongst the survey respondents.

Table two: Working with agri-chemicals

	Secondary farmers	**Primary farmers**
Work with agri-chemicals % (n)	**16.2%** (12/74)	**28.4%** (75/117)
Health problem involving use of agri-chemicals % (n)	**4.1%** (3/74)	**6.8%** (8/117)

Use of agricultural chemicals was much more common among primary than secondary farmers, and almost 7% of the total number of primary farmers reported associated health problems. However, if the denominator is limited only to those farmers who use agricultural chemicals, then 25.0% (3/12) of secondary farmers and 10.7% (8/75) of primary farmers had problems.

15.7 Recommendations

- High Peak and Dales PCT should give serious consideration to the appointment of a primary care specialist nurse or GP in agricultural occupational health.
- *Farm Out* should ensure that the health cards developed by the WFFU are made available to all GP practices to promote to their farming population.
- *Farm Out* should make contact with the Organophosphate Users Support Group OPUS to improve local knowledge of the relevant issues.
- *Farm Out* should seek membership with the Institute of Rural Health to remain informed about OP issues nationally.
- Farm Out should consider organising a seminar on OPs for the local health community as well as local farmers.

16 General Health

16.1 General Health of High Peak and Dales Residents

The health of High Peak and Dales residents is broadly similar to that of residents across the UK as a whole. The commonest causes of death are also similar to the rest of the country although they are slightly better than North Derbyshire as a whole. They include coronary heart disease, cancers and accidents and this is reflected in the Trust's health Improvement and Modernisation Plan (High Peak and Dales PCT 2001)

16.2. General Health of the Tideswell Practice Community

In the Tideswell Survey participants were asked to indicate whether they had ever been told by their doctor or by any other health care professional that they had any of the conditions shown in table three.

Table Three: General Health by Occupation

	Non-farmers	Secondary farmers	Primary farmers
Anaemia	5% (9/183)	4% (3/75)	1% (1/119)
Angina or heart disease	4% (7/183)	1% (1/75)	7% (8/119)
Arthritis (*)	20% (36/183)	20% (15/75)	30% (36/119)
Asthma	13% (24/183)	15% (11/75)	10% (12/119)
Bowel problems	7% (12/183)	12% (9/75)	6% (7/119)
Bronchitis	3% (6/183)	-	6% (7/119)
Cancer	5% (9/183)	3% (2/75)	1% (1/119)
Dementia	-	-	1% (1/119)
Depression	14% (25/183)	8% (6/75)	10% (12/119)
Diabetes	4% (7/183)	3% (2/75)	5% (6/119)
Dyspepsia	7% (13/183)	12% (9/75)	8% (9/119)
Epilepsy	2% (3/183)	-	1% (1/119)
Eye conditions	7% (12/183)	5% (4/75)	7% (8/119)
Hearing problems	9% (17/183)	9% (7/75)	10% (12/119)
Heart attack	3% (6/183)	1% (1/75)	2% (2/119)
Hernia (**)	6% (11/183)	4% (3/75)	15% (18/119)
Hypertension	23% (43/183)	11% (8/75)	25% (30/119)
Parkinsons disease	1% (1/183)	-	-
Stroke	2% (3/183)	1% (1/75)	4% (5/119)
Thyroid problems	1% (1/183)	4% (3/75)	2% (2/119)

* Arthritis $chi^2 = 4.74$ p=0.030
** Hernia $chi^2 = 6.73$ p=0.009

Table three shows that farmers were significantly more likely to report arthritis and hernia than either secondary farmers (those with additional occupations apart from farming) or non-farmers. There were observed variations for the other areas of illness, but none reached statistical significance. Of note is the high level of hypertension amongst farmers and non- farmers. The prevalence of common illnesses shown in table three may not represent the true prevalence in the community as the information was based on diagnosis by a health professional. It is well known that many individuals with ill health do not come into contact with the health service, and their illness is therefore not diagnosed and treated. Moreover, propensity to seek medical attention varies by social group, with more deprived and disadvantaged social groups being less likely to seek medical attention after controlling for levels of need. Farming communities are known to make less use of health services than other groups (see section 23 on Access). For this reason, the remainder of the Tideswell survey included various well-validated questions to enable estimates of symptoms and illnesses to be made independently of medical diagnosis.

EQ5D and Visual Analogue Scale

The EQ5D was developed by the EuroQol group as a short, self-completion questionnaire for the measurement of health status (Kind, 1998). The EQ5D has two parts: five questions and a visual analogue scale (*VAS et al*).

The EQ5D defines health in terms of mobility; self- care; usual activities; pain or discomfort; and anxiety or depression. Each of the questions (also called dimensions) has three levels: no problems; moderate problems; and extreme

problems. The results of self-rating on this three point scale on each of the five questions give 243 possible health states that are used to produce the overall index score which ranges from negative scores (worse than death) to +1 (best health). The VAS asks respondents to rate their health on a scale from 0 (worst imaginable health) to 100 (best imaginable health).

The original national study in the UK was a Department of Health-funded Measurement and Valuation of Health Survey conducted at York University in 1993 (Kind, 1999). This study produced population norms for the combined single index EuroQol score and for the VAS. The tool has also been used in other national health surveys, from which norms have been established for the general population (Kind, 1998). Table Four shows the EQ5D dimensions and the proportion of respondents reporting any problems.

Table Four: EQ5D dimensions: proportion reporting any problem

	Non-farmers	**Secondary farmers**	**Primary farmers**	**UK social class IV &V** (Kind, 1998)	**UK** (Kind, 1998)
Mobility					
%	**23.5%**	**20.0%**	**31.0%**	**23.6%**	**18.4%**
(n)	(42/179)	(15/75)	(36/116)	(191/811)	(623/3395)
95% CI	17.3-29.7%	11.7-30.8%	22.6-39.5%	20.6-26.5%	17.0-19.7%
Self care					
%	**5.2%**	**7.0%**	**3.5%**	**5.8%**	**4.2%**
(n)	(9/174)	(5/71)	(4/113)	(47/811)	(144/3395)
95% CI	2.4-9.6%	2.3-15.7%	1.0-8.8%	4.3-7.6%	3.6-5.0%
Usual activities					
%	**13.5%**	**18.1%**	**26.7%**	**21.0%**	**16.3%**
(n)	(24/178)	(13/72)	(31/116)	(170/811)	(551/3395)
95% CI	8.5-18.5%	10.0-28.9%	18.7-34.8%	18.2-23.8%	15.0-17.5%
Pain or discomfort					
%	**43.8%**	**43.2%**	**60.3%**	**41.6%**	**33.0%**
(n)	(78/178)	(32/74)	(70/116)	(337/811)	(1117/3395)
95% CI	36.5-51.1%	31.8-55.3%	51.4-69.2%	38.2-44.9%	31.3-34.5%
Anxiety or depression					
%	**25.0%**	**15.3%**	**27.4%**	**26.6%**	**20.9%**
(n)	(43/172)	(11/72)	(31/113)	(216/811)	(710/3395)
95% CI	18.5-31.5%	7.9-25.7%	19.2-35.7%	23.6-29.7%	19.5-22.3%

Table 2 shows that primary farmers had exceptionally high levels of problems. Figure two shows the proportion of respondents reporting problems on pain or discomfort. It can be seen that the prevalence of pain and discomfort significantly exceeded even that reported by social classes IV and V in the national survey (Kind, 1998).

Figure two: EQ5D - proportion reporting any problem on pain or discomfort dimension

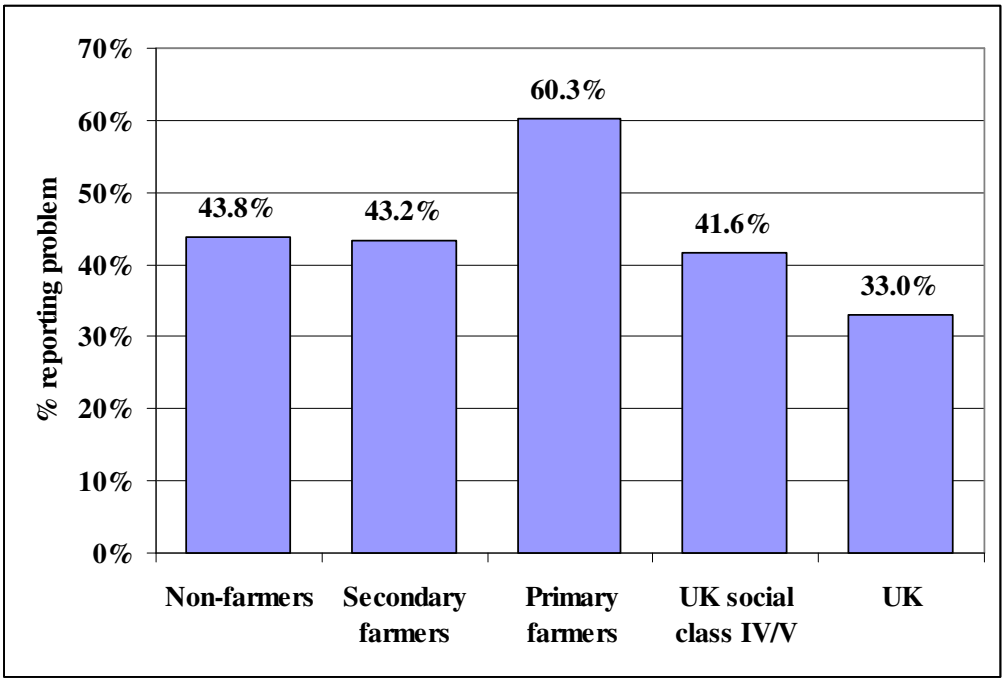


Table 5 shows the results of analysis of the single EQ5D index score. Once again primary farmers scored worse than non-farmers and significantly worse than that reported by the UK general population (Kind 1998)

Table Five: EQ5D index

	Non-farmers	**Secondary farmers**	**Primary farmers**	**UK social class IV &V** (Kind, 1998)	**UK** (Kind, 1998)
Mean	**0.850**	**0.838**	**0.785**	**0.820**	**0.860**
Standard deviation	0.177	0.230	0.250	0.260	0.230
95% CI	0.823-0.877	0.783-0.893	0.739-0.833	0.802-0.838	0.852-0.868
n	168	70	109	811	3392

(Low scores represent worse health).

The Visual Analogue Scale (VAS) asks respondents to rate their own perception of their health. Table 6 shows the result of respondents' ratings.

Table Six : Visual analogue scale

	Non-farmers	**Secondary farmers**	**Primary farmers**	**UK social class IV &V** (Kind, 1998)	**UK** (Kind, 1998)
Mean Standard deviation 95% CI n	**80.1** 15.5 77.8-82.4 178	**81.1** 14.4 77.8-84.4 74	**79.4** 16.9 76.3-82.5 117	**80.0** 18.1 78.8-81.2 811	**82.5** 17.0 80.8-84.2 3392

It can be seen that there are no significant differences between primary farmers ratings and either of the other groups included in the Tideswell Survey or the UK normative data. This is surprising given the high prevalence of illness amongst farmers identified in the EQ5D results. Farmers appear tolerant of this high level of illness suggesting that the traditional view of farmers as having a unique culture built on stoicism and a '*put up and make do'* attitude is accurate.

16.3 Recommendations

- There is scope for considerable more research into this area and a larger study across the region could yield more detailed information about the health of farmers. *Farm Out* should explore this further with SCHARR University of Sheffield

- *Farm Out* should share the Tideswell survey findings on general health, EQ5D and the visual analogue scale with rheumatologists, physiotherapy services, disability services and others caring for patients with arthritic and mobility problems.

- *Farm Out* should work with these groups to identify solutions to improve health outcomes for the agricultural community.

17 Coronary Heart Disease

17.1 Background

The reduction in coronary heart disease through prevention, early detection and treatment is both a national and local health priority.
Coronary heart disease manifests itself in hypertension, strokes and angina.

Lack of exercise, obesity and cigarette smoking are all risk factors for heart disease. Some commentators have noted that farmers are less active compared to previous generations as a result of increased mechanisation farming. Quad bikes are now frequently used to get from field to field, milking parlours are mechanised and much work can be done sitting on a tractor. However generally speaking a distinction between arable and livestock farmers should be made since the later continues to demands significant physical activity and in the High Peak and Dales where small livestock farms predominate there is also a lesser tendency to purchase labour saving or more modern equipment. Other local agricultural workers have noted that as more farmers wives are forced out to work there is a growing tendency

towards processed convenience foods know to be high in saturated fats and away from home cooked family meals.

Any visitor to the Bakewell Agricultural and Business Centre on market days will observe a population of men many of whom are significantly over weight. The majority of farmers who visit the markets are older men aged 50 upwards, obesity and reduced activity in this age group suggests that they are also likely to have a higher risk for coronary heart disease and type two diabetes.

17.2 Smoking

Smoking is the major cause of preventable illness and premature death in Britain and is directly responsible for one in five of all deaths (DOH, 1998). The link between smoking and ill health was identified almost 50 years ago (Doll, 1950). Smoking has since been identified as a causal factor in a range of diseases including various cancers, heart disease and respiratory illness.

Greater knowledge about the risks from tobacco contributed to a steady national decrease in levels of smoking in the 1970s and 1980s. However, the fall in smoking levels has not proceeded at the same rate across the whole of society. In particular, levels of smoking have decreased least among socially disadvantaged groups. In 1998, for example, 32% of people in manual groups smoked compared to 21% in non-manual groups (DOH, 2000).

The Tideswell Survey included a single question about smoking and respondents were asked to indicate whether they are a current or ex-smoker, or had never smoked. Table 7 shows the results of the analysis of smoking prevalence by occupation**.**

Table Seven : Prevalence of smoking by occupation

	Non-farmers	**Secondary farmers**	**Primary farmers**
Current smoker			
%	**16.7%**	**9.5%**	**18.6%**
(n)	(30/180)	(7/74)	(22/118)
95% CI	11.9 – 22.8%	4.7 – 18.3%	12.6 – 26.6%
Ex-smoker			
%	**35.0%**	**25.7%**	**14.4%**
(n)	(63/180)	(19/74)	(17/118)
95% CI	28.4 - 42.2%	17.1 - 36.7%	9.2 - 21.9%
Never smoker			
%	**48.3%**	**64.9%**	**66.9%**
(n)	(87/180)	(48/74)	(79/118)
95% CI	41.1 - 55.6%	53.5 - 74.8%	58.0 - 74.8%

The table seven shows that there is no significant difference in the prevalence of current smoking between primary, secondary and non-farmers. However, among those who do not currently smoke, primary farmers are significantly more likely than non-farmers to never have been a smoker.

The 1998 General Household Survey (DOH, 2001) found a prevalence of smoking of 27% (28% in males and 26% in females). In Sheffield in 2001 (Sheffield Health Authority, 2002) the overall prevalence of current smoking was 26.1% (95% CI 25.2 - 26.9%). A clear correlation was found between the prevalence of smoking and small area deprivation, with up to 40% of residents of the most deprived areas being current smokers. The observed prevalence of smoking among all occupational groups in the Tideswell survey is lower than both of these estimates.

17.3 Stroke

The reduction in the incident of strokes has been identified by the Department of Health as one of the targets of the National Service framework for Coronary Heart Disease (DoH 2000). The prevention of strokes is also identified in standard five of the NSF for Older People (DOH 2001).

The *prevalence* of stroke refers to the percentage of the population who have *ever* suffered a stroke, including those who consider themselves to have made a full recovery. The *incidence* of stroke is the percentage of the population who reported having had a stroke within the previous year. The Tideswell survey sought to identify stroke incidence and prevalence amongst a local farming population. The questions about stroke were developed by the Neurosciences Trials Unit, Edinburgh.

- Have you ever thought you had, or been told you have had, a stroke
- Was it within the last year
- Did you make a full recovery

The first question is designed to identify the prevalence of stroke, and relies on the respondents understanding of stroke. The second question identified incidence. Data on incidence provides one measure of the effectiveness of local policies in reducing the numbers of new cases suffering from stroke. However, prevalence data are more useful in assessing the impact of stroke on health service resources. Prevalence data can be used to measure the continuing health and care needs of patients who are still suffering from the effect of having had a stroke at some time in the past.
Table 8 shows the prevalence of stroke by occupation, age and sex.

Table Eight: Prevalence of stroke by occupation, age and sex

	Non-farmers	**Secondary farmers**	**Primary farmers**
Total %	**2.2%**	**2.7%**	**5.0%**
(n)	(4/179)	(2/75)	(6/119)
95% CI	0.6 – 5.6%	0.3 – 9.3%	1.9 – 10.7%
Age group			
18-34	-	-	-
35-54	-	-	3.4% (1/29)
55+	4.8% (4/83)	8.0% (2/25)	8.1% (5/62)
Sex			
Male	2.2% (2/93)	5.3% (1/19)	3.8% (3/80)
Female	2.3% (2/86)	1.8% (1/56)	7.7% (3/39)

The observed prevalence of stroke is highest among primary farmers, but the actual number of people involved is small and the confidence intervals are wide. As expected, the prevalence of stroke is highest in the oldest age group.

Three of the strokes were reported to have occurred within the last year – an overall incidence of 0.8% (95% CI 0.2 – 2.3%). This included two non-farmers and one primary farmer (numbers are too small to report incidence rates by occupation).

Three of the 12 people that had ever had a stroke (two primary farmers and one secondary farmer) reported that they had not made a full recovery. All three said that they need help from another person in their daily activities.

There is a shortage of reliable comparable data on the prevalence of stroke in the UK and elsewhere. In what is described as the first definitive study of stroke prevalence in the UK, Geddes (1996) estimated a prevalence of 1.5% in a health district in Yorkshire. O'Mahoney (1999) reported a prevalence of 1.75% in a study in Newcastle upon Tyne. However geographical variations in stroke mortality within the UK suggests the need for caution in generalising local results to wider areas with different demographic characteristics.

In Sheffield in 1994 (Saul, 1999) the overall prevalence of stroke was found to be 3.8% (95% CI 3.5 - 4.2%) and in 2001 (Sheffield Health Authority, 2002) the overall prevalence was 3.6% (95% CI 3.2 - 4.0%).

The results from the Tideswell survey are comparable with the Sheffield results, but are considerably higher than results from other settings. These differences, however, can largely be explained by methodological variations. For example, Geddes (1996) and O'Mahoney (1999) included only the more severe, clinically validated, cases and the 1999 Health Survey for England (Erens 2001) used data only from those who understood their condition to have been diagnosed as stroke by a doctor.

17.4 Chest Pain

Research into angina prevalence distinguishes between different levels of severity and different likelihoods that the reported symptoms indicate the presence of the clinical condition. Comparison between research findings, therefore, needs to take account of the various ways in which angina can be defined. Amongst self-report studies, the World Health Organisation questionnaire (also known as the Rose questionnaire) provides a source of validated questions that have been widely used to identify the likelihood and severity of angina (Rose, 1977). It should be emphasised that the Rose angina questionnaire is a screening instrument rather than a diagnostic test.

The Rose angina questions included in the Tideswell survey were regarding:

- Pain or discomfort in chest
- Pain when walking uphill or hurrying
- Pain when walking at an ordinary pace on the level

Table 9 shows the prevalence of angina symptoms by occupation, age and sex.

Table Nine: Prevalence of angina symptoms by occupation, age and sex

	Non-farmers	Secondary farmers	Primary farmers
Total %	**5.7%**	**2.7%**	**10.1%**
(n)	(10/174)	(2/73)	(12/119)
95% CI	3.2 - 10.3%	0.8 - 9.5%	5.9 - 16.8%
Age group			
18-34	-	-	3.6% (1/28)
35-54	3.0% (2/67)	5.4% (2/37)	-
55+	10.1% (8/79)	-	17.7% (11/62)
Sex			
Male	4.5% (4/89)	5.3% (1/19)	8.8% (7/80)
Female	7.1% (6/85)	1.9% (1/54)	12.8% (5/39)

Four of the cases of angina were at grade 2 (i.e. they occur when walking at an ordinary pace on the level - an overall prevalence rate of 1.1% (95% CI 0.4 – 2.7%). This included one non-farmer and three primary farmers (the numbers are too small to report grade 2 prevalence rates by occupation). All other cases were at grade 1 i.e. pain was experienced only when walking uphill or hurrying.

There were no significant variations between farmers and non- farmers for chest pain.

Data directly comparable to the Tideswell survey are available from two population surveys recently carried out in Sheffield using the Rose angina questionnaire. In 1994 (Saul 1999) the overall prevalence of definite (grade 2) angina was found to be 4.0% (95% CI 3.7 - 4.4%). In 2001 (Sheffield Health Authority 2002) the overall prevalence was comparable at 4.1% (95% CI 3.7 - 4.4%).

17.5 Conclusion

The farmers in the Tideswell study did not experience significantly higher levels of angina compared to the local non- farming population although the observed prevalence rates for strokes were highest amongst farmers. The numbers involved are very small and therefore results cannot be said to be statistically significant. The results across the occupational groups are in keeping however with other UK studies. Smoking status amongst farmers is similar to the non- farming population however farmers are significantly more likely to have never smoked rather than be an ex smoker. Doctor-diagnosed hypertension is also high across all occupational groups (see section 17.3). It may be that these hypertension rates are higher still as farmers are less likely to visit their GP compared with the non-farming population. What is evident therefore is that whilst outdoor rural life may be health enhancing for some but

it offers no health advantages to modern farmers with regard to coronary heart disease.

17.6 Recommendations

- *Farm Out* should explore with SCHARR, University of Sheffield, the scope for qualitative research into coronary heart disease and the agricultural community and further inform the health community about prevention and access issues.
- *Farm Out* should share the smoking data from the Tideswell Survey with the smoking cessation teams within the local Heath Promotion Department
- *Farm Out* should continue to work with Health Promotion to address specific CHD prevention strategies that could be employed to target the agricultural community such as *waist watchers*.
- *Farm Out* should explore further gender issues and CHD prevention with reference to the Men's Health Forum's policy for men's health (MHF 2002)
- The Primary Care Development sub-group of High Peak and Dales PCT should consider these findings with regard to access to primary care.
- Primary Care should consider the linking of stroke and Coronary Heart Disease registers in general practice as many of the risk factors over lap.
- *Farm Out* should work with the Health Promotion Department of High Peak and Dales PCT to consider the evidence of the effectiveness men's health clinics in the prevention and early detection of CHD and how this might be applied to the agricultural community.
- The Primary Care Development sub-group of High Peak and Dales PCT may wish to recommend a targeted approach to the identification of hypertension.
- The local agricultural community are food producers however no work has been done to ensure local farmers and the local community benefit from locally produced healthy foods. Farm *Out* should work with the Health Promotion, Women Food and Farming Union and Peak District National Park to explore this further.

18 Musculoskeletal Problems

18.1 Background

Musculoskeletal problems are a significant occupational risk for farmers. Problems result from of a lifetime of knocks and jolts from animals and years of walking and running over uneven surfaces in poorly supporting footwear, often carrying heavy loads. Low back-pain from prolonged periods in a tractor seat, Prolonged bending or heavy lifting is also common occupational event for farmers. Many local farmers are driving old tractor models with ergo metrically unsuitable seats. Hard repetitive activity damages joints and commonly results in osteo-arthritis. Whilst there is no cure for osteo-arthritis the condition can be management through weight reduction, correct footwear, physiotherapy, anti inflammatory medicines and joint replacement surgery.

The care and treatment of patients with joint problems is a major challenge for health care providers. A shortage of physiotherapy services is responsible for long waiting times for treatment whilst the waiting lists for joint replacement surgery represent one of the highest of all in- patient specialities both nationally and in High Peak and Dales PCT. (www.doh.gov.uk/waiting)

18.2 Local Experiences.
Physiotherapists working both in the High Peak and Dales have identified musculo skeletal problems amongst the farming community as a significant problem following a preliminary audit of referrals to their service. They intend to develop this audit facility to understand further the particular problems facing farmers and to inform any preventative interventions.

Any visitor to the Bakewell Agricultural and Business Centre on market days will observe a sizable proportional of agricultural workers with abnormal gaits and mobility problems. Even young farmers talk of 'bad hips and knees '. They attribute much of it to a frenetic work-pace, jumping off tractors and running over uneven surfaces.

I hardly ever walk, always in a rush just trying to get what needs done in the time I've got (Young farmer)

There's always something, there's always something that needs doing it's always beyond what you should be lifting, you're always pushing, pushing yourself, an extra load of muck in a barrow, anything to save you a journey. (Young farmer)

Tractor seats were identified as another source of injury.

They're only about half way up your back, and you're sat forward on the steering wheel and you're just going over bumps and you're backs bending like that. (Young farmer)

Local farmers have talked about the difficulties of living with chronic pain from joint problems and their frustration about health professional's advice on its management. The standard treatment of rest and pain- killers could not be adhered to when a farm was reliant on individuals to keep it going. Farmers felt that health professionals did not understand this and lost interest in them because advice wasn't followed.

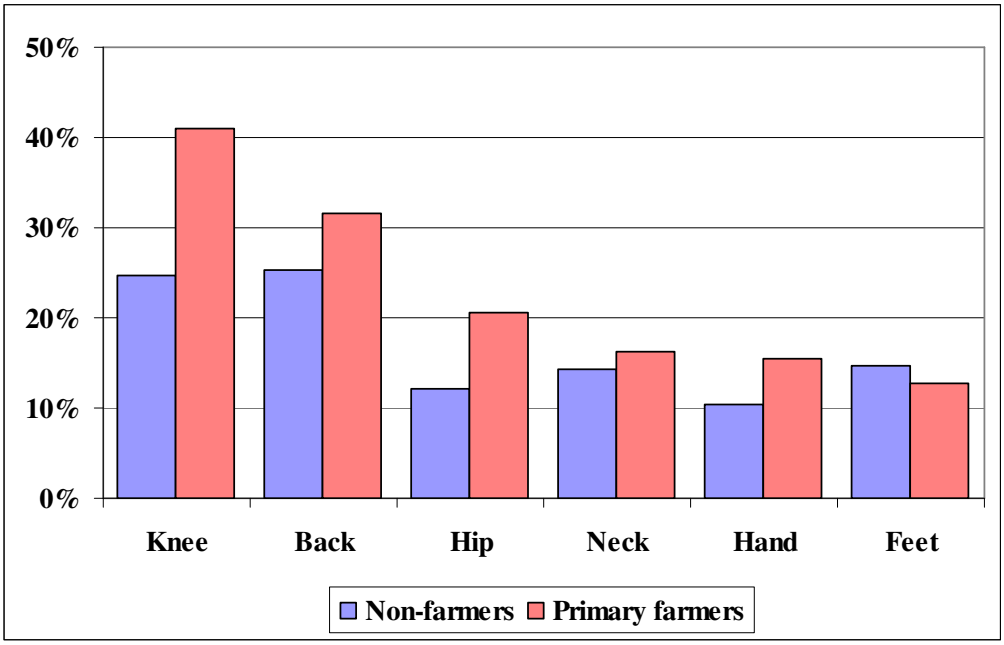
18.3 The Tideswell Survey
The Tideswell Survey asked respondents to indicate whether they had ever had pain in their joints (hips, knees, neck, back, hands, feet) lasting at least one month. Table 10 shows the prevalence of joint pain lasting at least one month by occupation.

Table 10: Prevalence of joint pain (lasting at least one month) by occupation

		Non-farmers	Secondary farmers	Primary farmers
Knees				
	%	**24.7%**	**23.0%**	**41.0%**
	(n)	(45/182)	(17/74)	(48/117)
	95% CI	19.0 - 31.5%	14.9 - 33.7%	32.5 - 50.1%
Hips				
	%	**12.1%**	**12.2%**	**20.5%**
	(n)	(22/182)	(9/74)	(24/117)
	95% CI	8.1 - 17.6%	6.5 - 21.5%	14.2 - 28.7%
Back				
	%	**25.3%**	**35.1%**	**31.6%**
	(n)	(46/182)	(26/74)	(37/117)
	95% CI	19.5 - 32.1%	25.2 - 46.5%	23.9 - 40.5%
Neck				
	%	**14.3%**	**16.2%**	**16.2%**
	(n)	(26/182)	(12/74)	(19/117)
	95% CI	9.9 - 14.3%	9.5 - 26.2%	10.6 - 24.0%
Hands				
	%	**10.4%**	**9.5%**	**15.4%**
	(n)	(19/182)	(7/74)	(18/117)
	95% CI	6.8 - 15.7%	4.7 - 18.3%	10.0 - 23.0%
Feet	**%**	**14.8%**	**20.3%**	**12.8%**
	(n)	(27/182)	(15/74)	(15/117)
	95% CI	10.4 - 20.7%	12.7 - 30.8%	7.9 - 20.1%

It can be seen that in all joints apart from feet, the prevalence of pain lasting at least one month was highest among primary farmers. The variation between primary farmers and non-farmers reached statistical significance for knees (chi^2=8.83, p=0.003) and hips (chi^2=3.88, p=0.049). Figure three shows these results in graph form

Figure Three: Prevalence of joint pain (lasting at least one month) by occupation



The authors of the Tideswell study were unable to find any similar studies in the UK with which to compare the results for farmers in the Tideswell survey. However outside of the UK in Sweden, Thelin *et al* (1998) carried out a survey of male farmer's (n=1782) health status and compared them to an age matched non-farmers from the same rural areas. Farmers in this study also had significantly more low back pain and hip pain than the non- farmer.

Data directly comparable to the Tideswell survey results for non- farmers are available from a population survey carried out using the same questions in Sheffield in 1994 (Saul, 1999). The findings from the Sheffield survey are broadly similar to the results obtained for the non-farmers in the Tideswell survey . For example, a Sheffield prevalence of knee pain of 27.1% (95% CI 26.3 - 27.9%) was found. This is comparable to the Tideswell non-farmers, but significantly lower than the Tideswell primary farmers (40.1%). Similarly, the Sheffield prevalence of hip pain of 11.0% (95% CI 10.5 - 11.6%) is also significantly lower than that among the Tideswell primary farmers (20.5%).

18.4 Conclusion

Musculoskeletal problems constitute a significant health problem for both young and older farmers. It is likely that these conditions are responsible for the high levels of pain and mobility problems experienced by farmers (see section 17 General Health) and will impact significantly on farmer's quality of life. This adds weight to the growing body of research literature noting the higher incidence of hip and joint replacement that is undertake in rural areas as compared urban areas (personal communication) suggesting that this an important area of public health. Due to the complexity of High Peak and Dales PCT Commissioning portfolio it is not possible to retrieve the relevant data on a PCT basis to corroborate this. The introduction of a new referral monitoring system in 2003 will help to redress this problem.

18.5 Recommendations

- A review of the literature regarding the geographical variation of hip and knee surgery should be undertaken and used to inform the high Peak and Dales PCT commissioning agenda and the other groups concerned with the orthopaedic care-pathway
- Given the high prevalence of muscloskeletal problems and the high personal and health costs associated with them efforts should be directed at preventative interventions. *Farm Out* should review the literature in the first instance.
- The Commissioning sub group of High Peak and Dales PCT should consider in a planned review of orthopaedic services the care-pathway experienced by farmers in addition to that experienced by the non-farming community.
- Physiotherapists offer a key service and Farm Out should work in partnership with them to identify and develop innovative preventive solutions particularly in accessing additional funding.
- Physiotherapist should be supported to continue to audit their referrals to analyse case mix with a view to consider targeted approaches to service delivery.
- Physiotherapy providers may wish to consider changes to the delivery of services (e.g. directly onto farms or through a 'drop in' facility at the local Agricultural and Business Centre) as well looking at self- referral options (as is presently available to chiropody service users).
- The development of an extended scope practitioner (physiotherapy) to work with the farming community should be considered by service providers and commissioners.
- High Peak and Dales PCT should pilot the Expert Patient Programme for farmers with chronic arthritis.
- *Farm Out* and therapy services should work with the PCT Communications section to raise awareness amongst the agricultural community about preventative issues and service provision through the farming press.
- Therapy services in partnership with the Health and Safety Executive (East Midlands) and *Farm Out* should review the literature on the effectiveness of traditional manual handling training to identify best practice with regard to the farming community.

19 Continence Problems

19.1 Background

Urinary problems may be symptoms of a range of disease. In men urinary symptoms may be indicative of benign or malignant prostate disease. Prostate cancer has increased by over 135 per cent since 1971 (DOH 2001). 18,300 men are now diagnosed with prostate cancer each year and 8,500 die. There remains insufficient evidence of benefit to introduce widespread screening for prostate cancer among men although the position remains under review by the national screening committee.

In the USA farming has been linked to prostate cancer mortality (Parker et al 1999). However other researchers have found that for a number of cancers

(non- Hodgkin's lymphoma, melanoma, colon cancer and rectal cancer) farmers have the same or slightly lower mortality risks when compared with the general population. Lifestyle factors are thought to play a major role in this In women continence problems may be a result of pelvic floor damage and once again lifestyle factors play a major role. Childbirth and heavy lifting are contributing factors. Children start to learn a 'lifting culture' early in childhood often boasting and competing with siblings to lift the heaviest sacks.

19.2 Local perspective

In High Peak and Dales PCT physiotherapists undertook a case review of women attending local continence clinics and noted a high percentage were from farming backgrounds. They suggest that women farmers undertake excessive heavy lifting and return to work too soon after childbirth.

19.3 Tideswell Survey

The Tideswell survey included five questions regarding urinary symptoms:

- Frequent strong, sudden urge to urinate
- Frequently visit bathroom 8 or more times a day
- Visiting bathroom during the night
- Loss of urine during physical activities
- Loss of urine when sneeze, cough or laugh

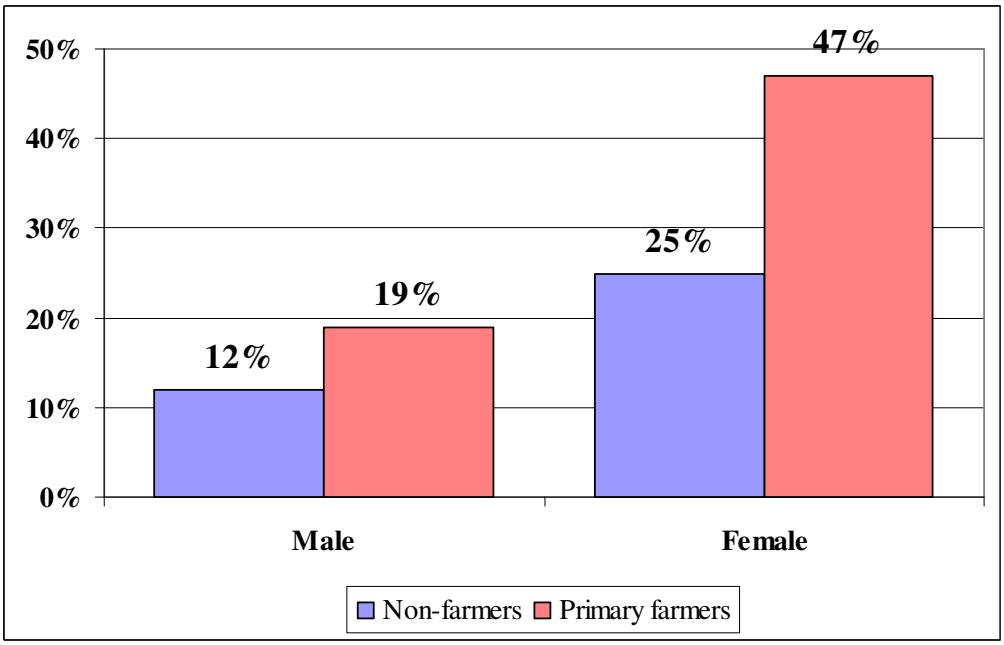
Presence of a problem is defined as positive response to two or more of the above symptoms. Table 11shows the prevalence of urinary symptoms by occupation, age and sex.

Table 11: Prevalence of urinary problems by occupation, age and sex

	Non-farmers	**Secondary farmers**	**Primary farmers**
Total %	**18.3%**	**20.6%**	**28.4%**
(n)	(32/175)	(14/68)	(33/116)
95% CI	13.3 - 24.7%	12.7 - 31.6%	21.0 - 37.2%
Age group			
18-34	10.7% (3/28)	-	3.6% (1/28)
35-54	14.7% (10/68)	16.7% (6/36)	21.4% (6/28)
55+	24.1% (19/79)	40.0% (8/20)	43.3% (26/60)
Sex			
Male	12.1% (11/91)	16.7% (3/18)	19.2% (15/78)
Female	25.0% (21/84)	22.0% (11/50)	47.4% (18/38)

The observed overall prevalence is higher among primary farmers than among non-farmers, although the confidence intervals are wide and so the difference cannot be said to be statistically significant. The variation by occupation is greater for women, where 47.4% (95% CI 32.5 - 62.7%) of primary farmers had problems compared with only 25.0% (95% CI 17.0 - 35.2%) of non-farmers. Figure 4 shows these findings graphically.

Figure 4: Prevalence of urinary problems by occupation and sex



There is a shortage of reliable comparable data, mainly due to difficulties and inconsistency with definition of the problem. The largest survey carried out in the UK to date used narrower definitions of incontinence and found a prevalence of 6.6% among men and 14.0% among women (Brocklehurst, 1993).

19.4 Conclusions

Continence problems are often hidden. Women particularly may be embarrassed and inhibited from seeking medical advice and treatment. For men continence symptoms may be tolerated or accepted as part of growing older. For farming men late nights and very early rising may mask problems. It is therefore important to consider the findings in relation male farmers use of primary care services.

In the Tideswell survey farmers are made less use of primary care services compared with non-farming local people (see section 24 access to health services).

19.4 Recommendations

- Farming women are more vulnerable than non- farming women to incontinence problems. Midwives and health visitors working with farming mothers should consider these findings in relation to pelvic floor care. They should consider new ways of primary prevention with this group.
- The cost of incontinence aids to the health community is great. *Farm Out* should work with disability services to consider other preventative approaches to incontinence amongst women.
- Primary Care professionals should be made that in the Tideswell survey the observed overall prevalence of continence problems was higher among primary farmers than among non-farmers. They should

consider this in relation to the provision of well man clinics or other initiatives targeting men.

- Given farmers' reluctance to access primary care services, *Farm Out* should ensure that prostate cancer awareness raising information is made available through a range of non health outlets and publications e.g. Bakewell Agricultural Centre and farming press.
- *Farm Out* should work with relevant organisations (e.g. Men's Health Forum) as well as the Health Promotion Service to develop suitable health promotion literature for the farming community.

20 Mental Health

20.1 Background

Mental health is a national and local priority. Targets to improve mental health are identified in the National Service framework Mental Health (DOH 1999) and standard seven of the National Service Framework for Older People (DOH 1999).

The Department of Health has identified the reduction of the number of suicides as one of their key health priorities (DOH 1999) and called for the number of suicides to be reduced by a fifth by the year 2010. A consultation document *National Suicide Prevention Strategy for England* (DOH) provides a framework for the prevention of suicide and identifies farmers as a high- risk occupational group.

Locally High Peak and Dales has identified mental health and mental health promotion as target areas for health improvement (High Peak and Dales Primary Care Trust HIMP Strategy 2001)

20.2 Depression and Suicide in the local agricultural community

Farmers and farm workers have a higher proportional mortality rate from suicide than the general population (Charlton 1993). In England farmers are twice as likely to commit suicide as general population and suicide is the second most common cause of death amongst farmers aged 15- 45 years (Read 1995)

Malmberg *et al* (1998) examined some of the reasons for this high rate of suicide in their study of farmers who had received an inquest verdict of suicide. By a process of psychological autopsy they reviewed as much information as possible about each farmer to ascertain and understand the circumstance of their death. The authors suggest that ease of access to a means of suicide is one factor. This is endorsed by O'Donnell *et al* (1996). They suggest that many serious suicide attempts are impulsive and therefore *some* of the increased risk in farmers is because they have lethal methods such as firearm and poisons readily available. However this is only part of an explanation and Malmberg *et al* identify high rates of depression and affective disorders (46%), rural stress, occupational problems, social exclusion, family problems and personality traits as contributory factors.

20.3 Organophosphate (OP) poisoning and suicide

Despite the potential neuro-psychiatric effects organophosphates Malmberg *et al* (1999) noted in their study that use of OPs was rarely commented on in inquest records or GP notes and relatives often did not know exactly what chemicals had been used on the farm. Epidemiological work from Spain supports the link between organophosphate exposure and increased suicide

rates (Parron *et al* 1996) and this link has also been recognised by the Royal College of Psychiatrists (1998). Davies, Ahmed and Freer (1997) used case studies to illustrate the psychiatric effects of organophosphate exposure. They describe mood swings, having the 'out of the blue' quality of endogenous depressive states but without the persistence and impulsive suicide behaviour sometimes resulting in a farmer 'coming to' with a gun in his mouth. They also note irritability sometimes resulting in explosive aggression aggressive behaviour.

Other researchers also report mental health side effects from sheep dipping including lethargy, memory loss and depression (Simkin, Hawton *et al 1998)*. OPs were used compulsory in sheep dips in the UK from 1976 unti1 1992 in the UK but although sheep- dipping with OPs in no longer compulsory there are farmers locally who prefer to use for husbandry reasons since it is a quick and highly effective against sheep scab. Organophosphate exposure is chronic and cumulative so even after a farmer has ceased to use such chemicals he is still vulnerable to its effects

To date there has been no work carried locally or regionally to exploring the usage of organophosphates and the possible impact they might have on the mental health of the agricultural community.

20.4 Depression

In the UK there is a paucity of published research studies addressing the mental health of the agricultural community. Hughes and Keady (1996) suggest that insular nature of farmers and farming community 'does not propitiate in depth study and social research'. The economic problems facing the UK agricultural community are similar to those experienced in the USA following the farming crisis of the 1980s. Researchers there have identified and an association between the 1980s crisis and the increase in mental health problems including depression and suicide in rural America (Mermelstein and Sundet 1986, Stallones 1990 and Walker and Walker 1986).

Eisner (1991) sought to identify undiagnosed depression in farmers registered with her Yorkshire general practice (n=66) and found 21% had a score of 8. Whilst 4 .5% had scores over 10. Eisner noted that this represented undiagnosed mood disorders and expressed concern that of the 14 farmers shown to have high scores all except two had been seen in the surgery during the previous year. Farmers in her study expressed concern about their financial and administrative burdens and isolation since the closure of a nearby auction mart. None had however discussed their problems with a professional agency. No other studies could be identified that examined depression prevalence rates within farming communities.

20.5 Farming and Stress

Stress is often cited as a contributory factor in the development of mood disorders such as depression and anxiety and suicide in farmers (Malmberg 1998). A study of stress in farmers by Simkin, Hawton *et al* (1998) surveyed 800 randomly selected member of the National farmers Union and 200 members of the Farmers Union of Wales to investigate potential sources of stress for farmers. They identified financial problems, difficulties in managing the increased record keeping and paper work and difficulty understanding and

completing forms, long working hours, social isolation and physical illness such as pain from chronic arthritis are significant stressors for farmers.

Parker (1999) conducted some qualitative research into factors affecting stress levels amongst hill farmers in the Peak District through ethnographic studies of two farming brothers. The results indicated that the brothers were experiencing only low levels of stress. The brothers as owner- occupiers were able to diversify into letting holiday cottages and this income helped to maintain their farming interests. They also had good extended family support and many friends and acquaintances. Parker recommended that further work be carried out to ascertain a wider understanding of the effects of stress locally

The nature of farming has altered dramatically over the last few decades and concern over new legislation, pressure to change farming practise and the need to become quickly accustomed to increasingly complex paperwork such as IACS forms which need to be completed correctly to avoid a financial penalty are also major contributors to stress. Locally young farmers have expressed their concern at the quantity and complexity of the paperwork required by DEFRA.

We had one form that was checked by the ministry and it was wrong and we didn't send it back in time and we didn't get paid (Young farmer)
There's more stress when you're filling in all the forms, you have to fill forms with a 0 or o and if you miss one out or get it wrong you don't get paid (Young farmer)

The emphasis on the new information technologies has proved to be a burden rather than a help to some farmers. Fax machines and the emphasis on electronic communication is a cause of anxiety.

Its beginning to worry me because I don't want to know- I can't raise the enthusiasm and I think a lot of older people must feel like that- I rang the government department about open access, I wanted information about a grant, and she said 'I'll give you our website number' and I said 'haven't you got a leaflet' and she' said no you have to look it up on the website'.(Farmers wife)

Increasing mechanisation and a shortage of farm workers has resulted in farmers becoming more socially isolated. Where a farm once employed seven workers today only two are employed and they may see little of each other during a working day.

*An elderly lady rings me. Her son is in a world of his own. He is farming where his father farmed and he doesn't communicate. He goes out early and comes in about two for half an hour then goes out. He comes back in at about six o'clock for an hour or so and finishes the day at half past ten. She just can't get into his world, but she's observing him just going down hill. (*Farmer and help-line volunteer)

As increasing numbers of farmer's wives are forced to take extra work outside of the farm, convivial communal meals round the kitchen table have for many

become a thing of the past. For the farmers long working hours remain a problem.

Farmers are working a lot harder, long, long hours and for nothing and they can feel they're on a treadmill that's over taking them and they are really in pretty big trouble. Very troubled. (Farmer and help-line volunteer)

I think farmers never feel completely free from worry about the job and that is sad. Sometimes people- it's not for me to speak about people in office jobs and how they feel – but sometimes they must be able to go home and leave the job behind them. ('Retired' farmers wife)

20. 6 Older Farmers Mental Health Needs

Interestingly some earlier studies on stress in farmers identified stressors that were not necessarily connected to the economics of farming. For example Weigel *et al* (1987) highlighted the issues of intergenerational disputes as a cause of stress.

Farming is a family business and retirement can be a source of stress. Many farmers are reluctant to retire and hand over the reigns to their son. This can result in men in their 40s 50s and even 60s working for their fathers who continues to hold the cheque book and have a casting decision on farm management. In some circumstances the son or daughter may not even has seen the cheque- book or accounts until the parents have died. Retirement can be especially difficult for tenant farmers who loose their accommodation as well as way of life whilst farm owners have to decide if the farm assets should be sold to provide a pension or become a business for the children; often it has to provide both. Inter-generational disputes are significant and are often difficult to resolve when family members are bound together by business as well as kin but marital disputes are equally significant. Retirement does not mean the loss of income or a home it can also result in the loss of a farmer's raison- d'être.

*My father lost his (*licence) *he had a stroke and they took away his licence and from then on he went downhill very fast - they had moved away from the farm but he still went back every day but when he lost his licence he couldn't do that any more and because he had worked such long hours before he never had any hobbies so he couldn't go to the farm and he couldn't drive he had nothing to do and he basically just gave up.(Retired farmer's daughter)*

These concerns have also been echoed by social services. They are in contact with many retired and often single male farmers who have lost the most significant thing in their lives through retirement. They have had no social life outside of the markets. Farmers recognise this and hang on to work as long as possible and don't retire until they are forced to, the farm is their livelihood as well as their hobby.

Nurses working in the local community hospitals and day care expressed similar views. They drew attention to the special needs of people with dementia who came from the agricultural community. Such people felt especially estranged in a hospital or care home environment away from the farms and fields of their earlier lives. Person Centred Care (Kitwood 1997) for

such individuals was seen as essential in order to improve the quality of life for the sufferer as well as carers. Some nurse felt that colleagues from a non-farming background did not appreciate the significance of a patient's rural lifestyle. Other nurses had a perception that a higher number of dementia sufferers came from the agricultural community and questioned an occupational link perhaps through organophosphate usage. Given the increasing longevity of people and the rapidly rising incidence of all types of dementia this may be worthy of further investigation.

20.7 Stress and the Wider Agricultural Community

Finally while much has been written about the stress experienced by farmers and their families less attention has been paid to the stress experienced by the wider agricultural community. Those involved with occupations directly linked to agriculture also experience many of the stressors described. They include agricultural and financial advisors, milk men and women, feed suppliers, Peak District National Park staff and vets who in the course of their work become sops absorbing a catalogue of tales of worry and angst. Given the social isolation that many farmers experience their appearance at farms and knowledge of farming issues make them ideally placed to listen to farmers concerns. Many however have been greatly troubled by what they have witnessed and find themselves gradually worn down by repeated negative exchanges. They have also expressed guilt about not doing enough to help but at the same time felt powerless to do anything. Some have questioned the professional advice they offered to farmers and others have wondered if they should have done more to encourage farmers act on the advice they had given. This was most acutely experienced during and in the wake of the foot and mouth crisis. There is evidently a need in these groups for listening and signposting training as well as skills in debriefing and relaxation.

20.8 Mental Health and the Tideswell Practice Farming Community.

The Tideswell Survey examined the prevalence of anxiety and depression using the Hospital Anxiety and Depression Scale (HAD) (Zigmond and Snaith 1983). The HAD scale consists of two separate scales, each with seven questions, measuring anxiety and depression. Responses are scores on a scale of 0 to 3, 0 indicating no problems and 3 indicating severe problems. A HAD score greater than or equal to eleven is considered to be a clinical case of anxiety or depression. Including borderline cases is defined as a HAD score greater than or equal to eight. Table 12 shows the prevalence of depression by occupation, age and sex.

Table 12: Prevalence of depression (HAD >=11) by occupation, age and sex

	Non-farmers	Secondary farmers	Primary farmers
Total %	**3.3%**	**2.7%**	**5.9%**
(n)	(6/181)	(2/75)	(7/118)
95% CI	1.5 - 7.0%	0.7 - 9.2%	2.9 - 11.7%
Age group			
18-34	-	-	-
35-54	1.5% (1/68)	2.7% (1/37)	10.3% (3/29)
55+	5.9% (5/85)	4.0% (1/25)	6.6% (4/61)
Sex			
Male	2.1% (2/94)	-	7.6% (6/79)
Female	4.6% (4/87)	3.6% (2/56)	2.6% (1/39)

The observed prevalence of depression was almost twice as high among primary farmers than among secondary and non-farmers, although the 95% confidence intervals overlap so this cannot be said to be statistically significant. Although the numbers are relatively small, perhaps the most worrying observation is the high prevalence of depression among male primary farmers - almost 8% reached the threshold for clinical caseness. The trend by age for primary farmers (with the highest prevalence in the 35-54 age group) is also at variance with the usual pattern where the greatest prevalence of depression is normally found in the oldest age groups.

Recently published normative data for the HAD (Crawford, 2001) found a UK general population prevalence of depression (HAD>=11) of 3.6% (95% CI 2.8 – 4.6%). The Sheffield SHAIPS study (1994) and the Rotherham Morbidity Survey (1991) both used the HAD. The researchers found a prevalence rate for depression of between 6.9% and 9% and between 12% and 17% for borderline cases. Table 13 shows the prevalence of anxiety by occupation, age and sex.

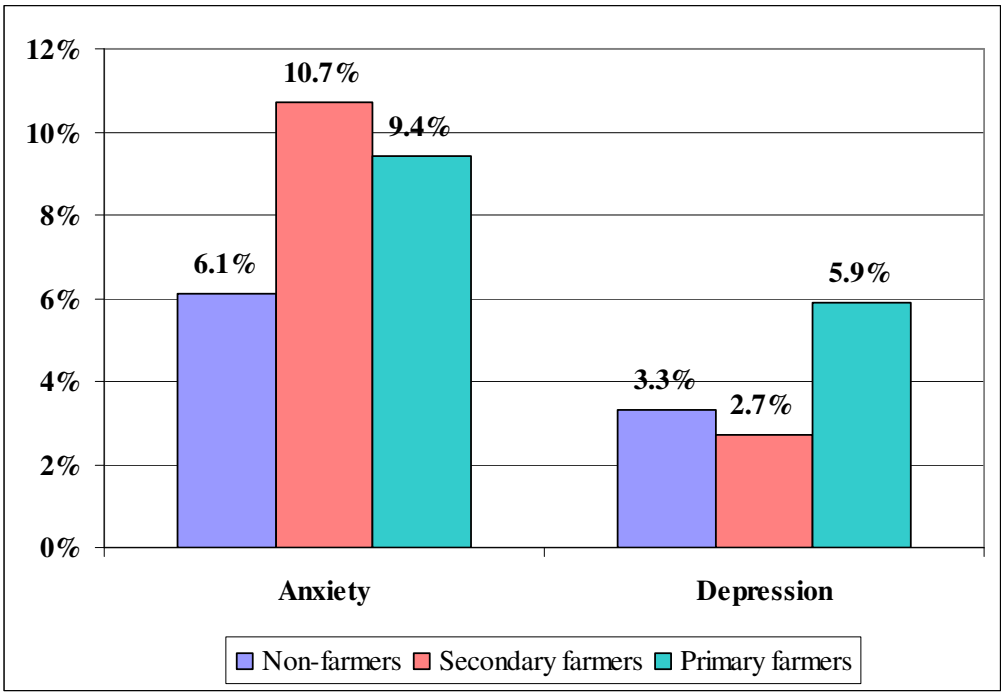
Table 13: Prevalence of anxiety (HAD >=11) by occupation, age and sex

	Non-farmers	Secondary farmers	Primary farmers
Total %	**6.1%**	**10.7%**	**9.4%**
(n)	(11/179)	(8/75)	(11/117)
95% CI	3.5 - 10.7%	5.5 - 19.7%	5.3 - 16.1%
Age group			
18-34	14.3% (4/28)	-	10.7% (3/28)
35-54	4.4% (3/68)	18.9% (7/37)	10.3% (3/29)
55+	4.8% (4/83)	4.0% (1/25)	8.3% (5/60)
Sex			
Male	2.2% (2/92)	10.5% (2/19)	7.6% (6/79)
Female	10.3% (9/87)	10.7% (6/56)	13.2% (5/38)

The overall levels of clinical anxiety were higher than for depression, but unlike depression there was no clear variation between the occupational groups.

Recently published normative data for the HAD (Crawford, 2001) found a UK general population prevalence of anxiety (HAD>=11) of 12.6% (95% CI 11.1 – 14.1%). Figure 5 summarises the results for depression and anxiety by occupation age and sex**.**

Figure 5: Prevalence of anxiety and depression (HAD >=11) by occupation



Suicide

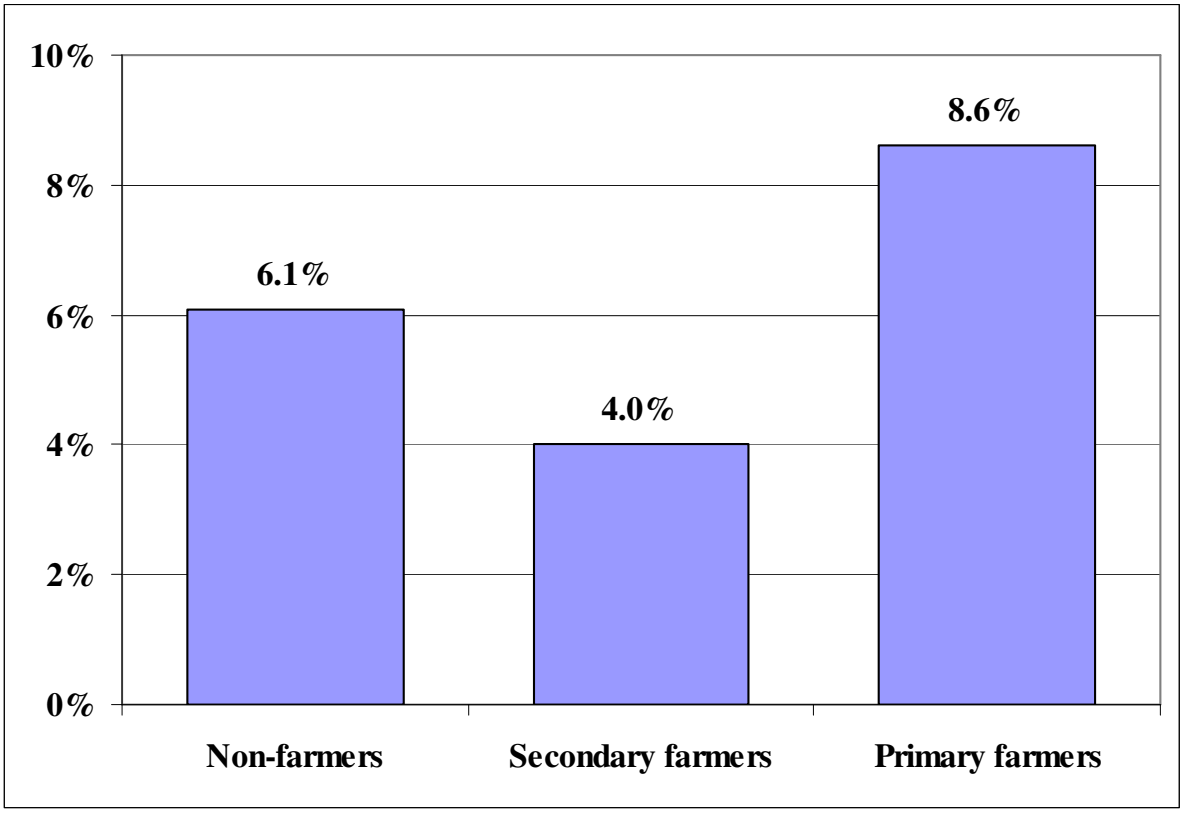
Tideswell survey respondents were asked to indicate whether they had thought about attempting suicide in past year. Table 14 shows the results for suicide ideation during the past year by occupation, age and sex.

Table 14: Thought of suicide during past year by occupation, age and sex

	Non-farmers	Secondary farmers	Primary farmers
Total %	**6.1%**	**4.0%**	**8.6%**
(n)	(11/180)	(3/75)	(10/116)
95% CI	3.4 - 10.6%	1.4 - 11.1%	4.7 - 15.1%
Age group			
18-34	14.3% (4/28)	7.7% (1/13)	18.5% (5/27)
35-54	5.9% (4/68)	5.4% (2/37)	14.3% (4/28)
55+	3.6% (3/84)	-	1.6% (1/61)
Sex			
Male	6.5% (6/93)	-	7.8% (6/77)
Female	5.7% (5/87)	5.4% (3/56)	10.3% (4/39)

Figure 6 illustrates these finding graphically.

Figure 6: thought of suicide during the past year by occupation



Almost 9% of primary farmers had thought of suicide during the past year. Although the numbers are small, and the confidence intervals therefore wide, it is important that this includes almost one in five (18.5%) primary farmers in the age group 18-34 years.

Conclusion

During this needs assessment exercise representatives from all members of the agricultural community identify poor mental health as a significant problem for the community. However there remains a stigma attached to mental health and many members of the community are reluctant to share their worries or confine in others. Mental health amongst farmers is frequently hidden and their mental health deteriorates further (ruralminds2002). The results of the Tideswell survey demonstrate significant areas of unmet need with regard to depression anxiety and suicide ideation.

Mental Health Service Provision

In the High Peak and Dales the two local mental health service teams have not responded to the agricultural community in any specific way and can only recall two or three farmers who have accessed their service. For many members of the teams the *listening events* conducted as part of the health needs assessment exercise were the first time that they had considered the mental health needs of the agricultural community within which they are based. Awareness was greatest amongst those that had connections with the community through family ties.

The reasons for this probably lie in wider mental health policy. Most recently the Department of Health has published a Mental Health NSF Implementation guide (2002). The new vision demands a whole systems change across health and social care and Local Implementation Teams are now in place to interpret and implement government policy locally. Mental health care will be provided in a range of settings by a variety of specialist teams as well as in Primary Care. For example Primary Care, Health Promotion departments and Local Authority departments will now have to address Mental Health Promotion (any action to enhance the mental well-being of individuals, families, organisations or communities). Primary Care will also take the lead in the diagnosis and treatment of people with depression and anxiety conditions. Community Mental Health Teams will continue to provide care for people with enduring severe mental illness (such as schizophrenia or a severe depressive disorder).

In this framework it is evident that the identified mental health needs of the agricultural community have to be met through planned mental health promotion initiatives and targeted primary care interventions. This is a significant responsibility and there are serious development issues to be addressed if primary care is to meet the agricultural communities mental health needs adequately. *Ruralminds* a branch of the mental health charity *Mind* go further and suggest that mental health services need to be organised differently in rural areas and that all major policies including health and social care are assessed for their rural impact (Countryside Agency 2001).

Ruralminds has recently launched *Connecting Minds.* This is an initiative designed to promote the provision of mental health support to the 28% of England's population who live in rural areas. The project aims to work with national and local partners offering direct support to mental health service users and people experiencing mental/emotional distress or stress who may not be formal service users. Local pilot projects have already been established in Shropshire Herefordshire and Northumberland.

In Wales a community psychiatric nurse led the development of a Strategy for Action in Farmers Emotions (SAFE), (Hughes and Keady 1995). The strategy addressed six key stages of intervention from the profiling of need through to prevention and treatment. Part of the initiative involved development of an outreach project aimed at improving the communication and access between the community mental health team and the farming rural community. Such an initiative might be successfully applied to improving the access and communication between Primary Care and the farming community.

Across the border from High Peak and Dales PCT another innovative approach to the mental health needs of the agricultural community has evolved. In South Staffordshire, following an assessment of the rural mental health services in the area a Rural Emotion Support Team (REST) was set up to respond to the needs of the 10,443 Staffordshire farmers. The service uses an assertive outreach model to target farmers and offers practical help, financial advice, mediation and health education. The team of three nurses and an administrative assistant are funded for four years by the Staffordshire Community Fund and work closely with other statutory and voluntary organisations.

Local Voluntary Sector Responses

Derwent Rural Counselling service (DRCS) is a charity providing counselling services directly to the local community and through GP surgeries within High Peak and Dales PCT. One counsellor from the service conducted a small retrospective study of service users from February to July during the 2001 Foot and Mouth crisis (Farley 2001). She identified the main issues that had prompted the referral. 170 clients were seen. The major themes that were identified were stress, family and relationship problems, anxiety and loss. The wider affects of the Foot and Mouth crisis on the rural community was an issue for 84% of the clients seen however only 8 % (n=14) were directly involved in farming. In an effort to seek wider engagement with the local farming community DRCS have received funding from Ruralminds to employ a counsellor to attend one livestock market per week at Bakewell Agricultural and Business Centre in an informal capacity based in the Rural Health Information kiosk. The project will be evaluated at the end of the year.

In contrast Derbyshire Rural Help-Line Service have engaged large numbers of farmers. The help-line is one of several support organisations overseen by the national Rural Stress Information Network. The help-line evolved locally in 1993 in response to the then BSE crisis as part of the Farm Crisis Network a church based group seeking to support farmers and the farming community.

The organisation is staffed by trained volunteers who all have a background in farming. They offer a confidential listening and sign posting service and also undertake support visits if required. Prior to the Foot and Mouth crisis the local help-line was working with six farmers in the West Derbyshire area, however over the last year their work has increased by some 500% and they are currently offering follow-up support to 30 local farmers. Despite this increase in work load volunteers feel they are just working with the tip of the iceberg.

The position we are in is we can't help anyone unless they come directly to us and say 'please can you help?' We can't go out canvassing for people so consequently I would imagine 90% of the problems we don't even see. (Dairy farmer and volunteer)

20.9 Domestic Violence

Domestic violence includes all kinds of physical sexual and emotional abuse within all kinds of intimate relationships. Most commonly abuse is carried out by men, against women, however it can occur by women against men and within same sex relationships. People experience abuse regardless of social group class age and lifestyle. The chief Medical Officer in his report *On the State of the Public Health (DoH 1997)* stated that ' *The health and social costs and consequences of domestic violence are extensive and serious enough to constitute a major public health issue.'* Despite this, little health information or research has been conducted on interventions to counteract its escalation and impact (Sethi *et al* 2001).

In England and Wales someone is injured as a result of a domestic assault every 10 seconds. In High Peak between April 1999 and December 2001 there 371 reported crimes of domestic violence assault. However police figures for attending incidents of a domestic nature total some 2,369 incidents. In Derbyshire Dales there were 188 reported crimes of domestic violence but in excess of 1,031incidents. National police statistics indicate that one in every four of all recorded assaults arise out of domestic violence. However within the High Peak and Dales PCT the figure is one in five suggesting an element of under reporting probably as a result of rural issues.

Domestic violence occurs across all sections of society and the agricultural community is no exception. During the conduct of the health needs assessment experiences were reported that suggest that women from the agricultural community are not aware of any support services provided locally and do not readily disclose their experiences to primary care professionals. Individuals working in farm related occupations had become aware of incidents of domestic violence during their contact with farming families. However they did not know who to share their concerns with and what agencies they might sign-post someone experiencing abuse towards.

Locally a High Peak and Dales Domestic Abuse Reduction Partnership has been established. The group with funding from the Home Office co- ordinates a group of volunteers to support women experiencing abuse and also employs a community outreach worker and a development worker. There is

only one refuge in the PCT area situated in Glossop it has a high level of occupancy and many families are turned away each year**.**

20.10 Recommendations

- *Farm Out* should work with nurse consultant for deliberate self-harm regarding the development of formal suicide prevention strategy for Derbyshire
- *Farm Out* should work with ruralminds to explore the potential for a connecting minds pilot in Derbyshire
- *Farm Out* should liase with staff involved in the SAFE and REST initiatives to consider the applicability of theses models of mental health care delivery locally.
- A rural Mental Health Interest Group (RMHIG) should be established to consider public health solutions and innovative approaches to mental health service delivery. (In the absence of another heath community group willing to take this work on e.g Primary Care Mental health Group)
- The High Peak and Dales should consider setting up, from the Agricultural and Business Centre, Bakewell, a specialist mental health outreach service for the agricultural community
- General practitioners need to be reminded of that routine health checks may provide an opportunity to assess and treat depression
- General practitioners should be more proactive about removing guns and if necessary revoking gun licences if there is evidence of suicidal behaviour or abnormal mental states
- The Primary Care sub group of High Peak and Dales PCT should continue to develop training opportunities for GPs and nurses in diagnosis and treatment of depression.
- The Primary Care sub group may wish to consider the adequacy of the existing depression protocol in alerting GPs to the high- risk occupations such as farming.
- The Primary Care sub group may wish to consider the promotion of targeted approaches to the identification of depression within the farming community
- The Primary Care sub group and the RMHIG should consider ways of improving access to primary care services for the farming community.
- The Primary Care sub group of the PCT should ensure that Mind's policy on Rural Issues and Mental Health is addressed where relevant to Primary Care.
- Farm Out and the RMHIG should examine care pathway for farmers with mental health problems who are identified by the voluntary sector
- Primary Care should consider the value of stress management initiatives in relation to the agricultural community *Farm Out* should establish a framework for publicising mental health promotion information and addressing.
- *Farm Out* should work in partnership with the Rural Education and Arts Project (REAP) to bid for monies to establish an artist in residence for

the agricultural community to address the stigma surrounding mental illness.

- *Farm Out* should consider ways of promoting listening and sign posting training for occupational groups working with farmers such as the Peak District National Park staff, vets and agricultural advisors.
- *Farm Out* should continue working with the Rural Reminiscence Group to promote the development of rural reminiscence in health and social care establishments.
- *Farm Out* should continue working in partnership with the Farming Life Centre Project to promote mental health promotion opportunities for older retired farmers
- *Farm Out* and the Public health department should explore the mental health implication of OP usage locally
- *Farm Out* should continue to work in partnership with the Rural Stress Information Network to support the development of a rural chaplaincy.
- *Farm Out* should become a partner in the Domestic Abuse Reduction Partnership and contribute to work addressing access to support services for the agricultural community in the first instance.

21 Zoonoses

21.1 Background

All farm animals naturally carry a range of diseases some of which can affect humans these are known as zoonoses. Although worldwide there are more than 200 infectious diseases of animals that are capable of being transmitted to humans zoonosis refer only to those that are transmitted from vertebrate animals to humans. A zoonotic agent may be a bacterium, virus, fungus or parasite. They may be transmitted by contact transmission, droplet transmission, vector borne, air-borne, or common vehicle (e.g. via food or water). For most zoonotic infections the normal life cycle does not involve humans rather humans are accidental hosts and represent dead end vectors.
Table 15 shows the important agricultural zoonoses, their animal host, transmission, and type of pathogen.

Table 15 Important Agricultural Zoonoses

Disease	Pathogen	Vector	Transmission
Viral Disease			
Orf	Orbivirus	Sheep	Direct contact (e.g. bite)
Rotovirus	Rotovirus		
Bacterial Disease			
Anthrax *	Bacillus anthracis	Cattle	Direct / indirect contact / inhalation
Brucellosis*	Brucella spp	Cattle sheep	Ingestion/inhalation
Campylobacteriosis*	Campyylobacter jujuni	Cattle sheep fowl, Dog, Cat Rats Fish	Ingestion
Leptospirosis	Leptospira interrogans spp Leptospira Hardjo	Rats Cattle	Direct contact/ Ingestion (e.g. urine in water) /inhalation
Listeriosis*	Listeria monocytogenes	Sheep	Ingestion
Ovine Chlamydiosis	Chlamydia psittaci	Sheep Goats	Direct contact
	Chlamydia psittaci	Fowl, birds	Inhalation
Q Fever	Coxiella burnetti	Sheep cattle	Inhalation
E Coli 0157 * Salmonellosis*	Escherichia coli Salmonella Enteriditis	Cattle sheep, deer	Ingestion Ingestion
Staphylococccal infection	Staphylococcus Aureus		Direct contact
Streptococcus infection	Streptococcus Suis	Pigs	Direct contact/ inhalation
Tetanus	Clostriduim tetani		Direct contact
Tuberculosis*	Myobacterium bovis	Cattle badgers, birds	Ingestion /inhalation
Fungi			
Ringworm	Dermatophytes	Cattle, pigs sheep, horses and dogs	Direct contact
Parasites			
Crytposporidium	Cryptosporidia spp	Calves, lambs deer goats	Ingestion
Echinococcosis*	Echonococcus granulosis		Ingestion
Toxocariasis	Toxocara canis, cati	Dog Cat	Ingestion
Toxoplasmosis*	Toxoplasma gondii		Ingestion

*= notifiable disease

Bovine Spongiform Encephalopathy(BSE) Variant Creutzfeldtt Jacob Disease Although BSE is regarded as a food borne zoonosis, the joint Department of Health/ Health and Safety Commission on Dangerous Pathogens (ACDP) recognises that there is still uncertainty as to whether there is any risk to people who may be exposed at work to BSE. They also concluded that there were no cases reported of CJD including the variant, or BSE being treated occupationally.

Bovine Tuberculosis
Bovine tuberculosis is a disease found in cattle. It is caused by the bacterium Mycobacterium bovis which can also affect humans. Today it is usually only found in people who caught it abroad or elderly people who caught it from drinking un-pasteurised milk. People who are working closely with infected animals for example farm workers could theoretically be at risk of infection. TB infected animals are slaughtered for welfare reasons and farmers are compensated at competitive rates. The infected carcase is inspected at the slaughter- house and meat inspectors remove any infected parts of the carcase and the remainder of the meat is passed into the food chain. The risk of catching TB from infected meat is very small since the bacteria are killed by normal cooking and to date there are no recorded instances of humans catching Bovine TB from infected meat.

At Risk Groups
Elliot (2001) identifies primary and secondary at risk groups as follows;
Primary at –risk occupations:

- Farmers and their families
- Pregnant women
- Agricultural workers
- Butchers
- Fisherman
- Forestry workers
- Veterinarians
- Stockman
- Slaughter-man

Secondary at-risk groups:

- Tourists to rural areas
- Walkers
- Visitors to farms
- Those who shoot and fish recreationally
- Visitors to agricultural shows
- Pet owners

Prevention
Prevention is generally through,

- Good animal husbandry (including vaccination)
- Good occupational hygiene practices including the washing of hands and arms before eating, drinking or smoking after contact with animals, or working in areas with animal dung.

- Appropriate use of personal protective equipment such as masks, goggles gloves aprons (especially when helping animals to give birth, handling of afterbirth, handling infected animals or if at risk of slashes of urine)
- Care of existing wounds cuts grazes (all wounds should be covered)

Zoonoses do however represent a significant hazard to pregnant women, children and the elderly

21.2 Public Health Issues

The Public Health Laboratory Service (PHLS) collects and summarises laboratory reports based on examinations carried out on clinical specimens and are collated by the Communicable Diseases Surveillance Centre (CDSC). The reports provide the most comprehensive source of disease data available in the UK. Within the UK agricultural industry there are some zoonoses which are notifiable to the Divisional Veterinary Manager of DEFRA and subject to animal health legislation. These include anthrax, brucellosis and rabies, bovine tuberculosis and bovine spongiform encephalopathy. Anthrax has not occurred in this country since 1997, brucellosis since 1993 and rabies since 1970. Bovine Tuberculosis has been found recently in herds in parts of the Midlands (DEFRA 2002) but there have been no humans affected to date.

Despite these reporting mechanism it is unclear to what extent zoonosis are a significant public health concern. With the exception of notifiable diseases the incidence of many zoonoses is simply not known and therefore it remains unclear to what extent zoonoses are a significant public health concern. Palmer (1982) Henk (1996) and Elliot (2001) argue that to date it is impossible to ascertain an accurate assessment of zoonotic disease since the existing surveillance systems rely on medical diagnosis and many diseases are frequently not recognised or are misdiagnosed.

Locally within High Peak and Dales PCT it might be possible to retrieve data at General Practice level where information systems are robust and Reed codes consistently used, but the reliability of this data would still dependant on accurate diagnosis.

Primary Health Care Teams Knowledge

Knowledge of zoonotic infections does exist in the agricultural community however the level of knowledge amongst primary health care professionals is not known. Elliot (2001) conducted a postal survey of community nurses (n=218) in Wales to assess their knowledge and practice with regard to zoonosis. The sample included midwives, school nurses, practice nurses district nurses and health visitors of whom 95% reported to have regular contact with farming families ranging from daily (47%) to monthly (9%).

The findings revealed a less than optimum level of knowledge amongst nurses suggesting that they did not have adequate knowledge to protect themselves or their patients from zoonotic infections. Elliot notes that community nurses and GPs do not take advantage of the wealth of information held by vets on this subject and have poor awareness of the

farming calendar. These findings were particularly of concern given that the study areas reliance on agriculture.

21.3 Local issues and experiences

Many farmers did not have confidence that their GPs understood zoonotic infections. This was attributed to the increased mobility of doctors and the fact that many had come from urban communities and therefore did not have an interest in rural issues.

> *You have to go in and tell them what it is with ringworm you see a lot of them you know have never seen it before. (Dairy farmer)*

Other commented that out of hours GPs and Accident and Emergency were even less likely to have a good knowledge of zoonoses

> *I was feeding three lambs and one lamb didn't like it that I only had two hands. So one decided to bite me, and it gave me orf, and it got infected and I had to go to hospital and the doctor said ' you got Foot and Mouth, you got Foot and Mouth'. (Young farmer)*

Generally farmers were happy to take health advice from the vet.

> *A lot of the time vets are better at diagnosing stuff than doctors, I mean I'm not saying that about all doctors but vets are pretty good they always have to go on what they see not what the patient tells em. They train two years longer than a doctor don't they?(Young Farmer)*

Farmers are unlikely to have confidence in their GP if historically they have failed to demonstrate any understanding of the occupational health problems they face.

21.4 Recommendations

- The PCT should consider how it provides adequate occupational advice to the agricultural community. This might be achieved by the development of a specialist GP or specialist nurse post.
- Primary health care teams serving rural populations should be aware of the local farming practices and likely zoonotic infections.
- The Primary Care sub group of High Peak and Dales PCT should ensure that newly appointed primary care professionals should have access to additional training in zoonoses and occupational health care for farmers as part of their induction.
- *Farm Out* should raise awareness of zoonosis amongst midwives and community nurses especially those working with high risk vulnerable groups
- *Farm Out* should work with the Workforce Development Confederation and local Training Department to consider the provision of a short course in zoonosis for all primary care professionals

- Accident and Emergency staff could use telemedicine to gain expert advice on zoonoses.
- Practice nurses, GPs and community nurses should consider recording the occupation of their patients in a retrievable electronic form and they should routinely ask farming patients about possible exposure to zoonoses
- Practice nurses working with significant numbers of farming patients may wish to consider a special clinic for farming families
- General practice surgeries should promote the use of patient held cards in which patients can record relevant occupational hazards such as has been designed by the Women Food and Farming Union.
- General practice surgeries should ensure information leaflets on common zoonoses are readily available, accurate and up to date.

22 Accidents

22.1 Background

In 2000 the Health and Safety Commission launched *The Revitalising Health and Safety* Strategy that set out the government's plan for health and safety in the UK. Central to the strategy was the idea that the health and safety system must promote a better working environment as well as prevent harm. In response to this *Securing Health Together* (2000) a long- term strategy for Occupational Health in England, Scotland and Wales was published. The strategy represents a joint commitment by government bodies including the Department of Health to work together to 'reduce ill health both in workers and in the public caused or made worse by work'. A series of targets to be achieved by 2010 were identified:

- 20% reduction in the incidence of work related ill health
- 20% reduction in ill health to members of the public caused by work activity
- 30% reduction in working days lost from work related ill health
- Half theses improvements by 2004.

22.2 Incidence

Agriculture has historically had a high incidence rates for accidents and ill health and the Health and Safety Commission has identified it as a priority industry.

In the UK the total number of fatal injuries in the mainstream agricultural sector between April 200 and March 2001 was 53.This represented a 20% increases on the previous year. Of these deaths 52% were over 50years of age. Seven members of the public were killed and included in the seven were four family members of which three were children. These were people who lived on the farm and were killed as a result of work activities (HSE 2001)

Transport activities accounted for a total of 13 deaths. Six of the accidents involved being struck by a moving vehicle and another three when vehicles

overturned. Almost half of the transport deaths occurred because of faulty maintenance (n=6). Of these 3 were caused by faulty handbrakes and two as a result of poorly maintained brakes (HSE 2001).

The second largest cause of fatal accidents was falls from a height (n=12). Five of the falls occurred during work on the roofs of farm buildings and were either falls through roof-lights or fragile roof-sheets that could hold a persons weight (HSE 2001).
Of note also are the three people who died through drowning or asphyxiation. One was a child who died in a slurry pit, a second was a child who was asphyxiated under silage and the remaining death was a farm worker who was overcome by fumes after entering a whey tank. Two people were killed by Bulls which was less than last year's eight deaths and the average over the last five years (n=6).

The most common causes of non-fatal injuries in 1996-97 present a similar profile,

- Handling lifting or carrying 19%
- Being struck by a moving object 18%
- Slip, trip or fall on the same level 19%
- Falls from a height 18%
- Contact with machinery 10%
- Being injured by an animal 8%
- Being struck by a moving vehicle 3%

22.3 Children
Between 1986 and 1999 67 children died and 400 serious injuries to children were reported to the HSE as a result of agricultural work. The most common causes of injury or death are as a result of being struck by a moving vehicle, or object (commonly hay bales) drowning or asphyxiation, contact with machinery or animals and fire. There are however several legal safeguards to minimise risks to children on farm;

- Children under 13 years old cannot be carried on a tractor, self-propelled agricultural machine or a machine or implemented mounted on, towed or propelled by a tractor or vehicle.
- Children under 13 years of age may only legally ride on a trailer, or on a load by a trailer if there are adequate means, such as edge protection to prevent them falling from it.
- Children over 13 should only be allowed to ride as a passenger in a tractor or other vehicle if they are seated on a properly designed and fitted seat, with a seat belt fitted and worn, inside a safety cab or frame.
- No child under 13 years may drive a tractor or agricultural vehicle.
- Children over 13 years cannot drive a tractor on private land unless they have received operating and safety training and are closely supervised by an adult.

Despite this legislative guidance children remain vulnerable to farm accidents as many local farmers were unable to define the regulations regarding

children and farm vehicles. Children are often to become members of the workforce and farm parents are grateful to have the help however in some instances children are doing jobs that they are not physically strong enough to do and they lack the maturity to know what to do if something goes wrong.

22.4 Accident Reporting

HSE statistics are unable to account for the frequency of near misses or provide level an accurate account of the number and nature of non- fatal injuries. At present around 2000 injuries a year are reported in agriculture to the HSE. However the HSE estimates that there are around 10,000 reportable (i.e. the most serious) non- fatal injuries. Each one involves a personal, social as well as business cost.

The statistics for non-fatal injuries serious enough to be reported to the HSE are therefore imprecise despite the presence of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). The HSE estimates that only 30% of accidents to employees in the agricultural sector are reported and only 10% of accidents to self- employed farmers are reported. The HSE acknowledges the need for more robust occupational health and accident data collection systems and are considering ways of working more closely with primary and secondary care organisations to achieve this. The legislative powers held by the HSE are thought to be a major contributory factor to the under reporting as many accidents can be attributed to faulty work practices.

22.5 Farm Accident Research

The hazardous nature of farming is a global phenomenon yet the UK lags behind the United States of America and Scandinavian countries in terms of research into practices and preventative initiatives (Ehlers, Themann, *et al* 1993, Hoglund 1990, Thu *et al* 1990).

In the UK Gerrard (1998) conducted a telephone survey of a random sample of UK farmers (n=150) to identify how far farmer's health and safety needs were being addressed. The responses from her sample suggested that farmers perceived themselves to be in a risky occupation however of the 67% of farmers who had received health and safety literature only 31% said they would actually read it and 29% said they would sometimes read it whilst. Farmers appeared to discard literature from the HSE as previous experience had shown that it contained advice which from their experience could not be put into practice. Farms are subject to statutory health and safety inspection and advisory visits from the HSE'S agricultural inspectors but Gerrard found that only about 25% of the farmers in her study had been visited in the last year. She noted that farmers were reluctant to seek advice from the HSE because they perceived it would provide 'warrant for inspectors to visit farms and 'snoop' round looking for faults'.

Hope *et al* (1999) noted that the development of appropriate health and safety intervention for farmers is important worldwide but that there was a paucity of data on present practices and attitudes to change. They sought to redress this through a series of focus group discussions with 47 representatives of

national farming organisations in the Republic of Ireland. They reported that farmers in workplaces with less than 20 employees had significantly lower levels of safety training.
Discussions revealed that '*farmers did not appreciate that the lack of a safety statement (farm safety audit) would 'place them in even greater jeopardy and perceived no monetary benefit for complying with health and safety regulations'*. Evidently the barriers to change were low perceived susceptibility, lack of time and resources.

Burnett (1994) studied accidents incurred by farmers in North Lancashire between 1981 and 1991 and he found that that the most at risk group were 20-29 year olds. In contrast Evans (1999) in his study of 112 consecutive accidents that presented between 1993 and 1994 to primary health care teams in mid-Wales found that 30- 40 year olds experienced the most accidents and that self- employed small farmers were most at risk. Walsh (2000) reported results from the first nine months of his research examining farming accidents (n=90) seen by eight GP practices in Cumbria and the accident and emergency department of Cumberland Infirmary Carlisle. As with Burnett and Evans, the research was able to identify accidents that would not be considered serious enough to report to the HSE. He also found that although the 40- 49 yeas old group that experienced the most accidents older farmers aged over 60 were more likely to incur accidents with livestock.

The nature of the accidents reported was generally consistent with HSE data although livestock injuries were found to be more prevalent than is indicated by HSE data perhaps unsurprisingly reflecting the regional variations in farming practice. All the researchers noted that most accidents were sustained just before lunch or late and that self -employed small farmers were most vulnerable. Four types of accidents accounted for the vast majority of injuries in equal proportions. They were falls, foreign bodies/projectiles and kicks knocks and crush injuries. The type of injuries identified by Evans (1990) and Walsh (2000) is summarised in table 16.

Table 16: Types of Injury

Type of Injury	Walsh (2000) Per cent	Evans (1999) Per cent
Joint injury or sprain	44.8	9.8
Laceration	24.1	38.4
Soft tissue injury	17.2	28.6
Foreign body	11.5	12.5
Burn	1.1	2.7
Other 1.1		0.9

Source: Walsh (2000)

The researchers all studied the area of the body affected. Despite being only 1 per cent of the body surface area hand and eye injuries accounted for 40 per cent of the injuries seen.

Walsh (2000) and Evans (1999) both asked patients if the accidents could have been prevented. A total of 75 per cent stated that the accidents was preventable either through taking more care, wearing protective clothing e.g. goggles, improved animal control and following correct procedures better. They also noted that an alarming lack of first aid measures had been taken (44 per cent).

22.6 Agricultural Accidents in the High Peak and Dales

The studies previously reviewed help to give more breadth of understanding of issues at farm-level as small area statistics are not available from the HSE. There are difficulties in profiling farm accidents in the High Peak and Dales. Local accident and emergency departments do not currently audit farm accidents and general practitioners do not record on their data -bases farm accidents in a retrievable way.

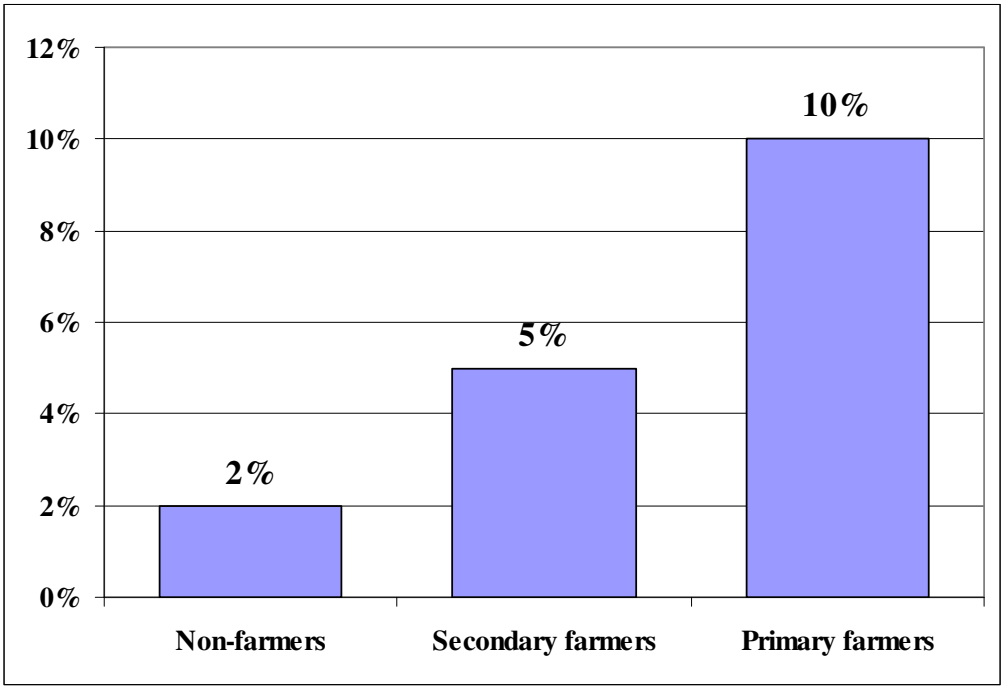
22.7 Tideswell Survey

Tideswell survey respondents were asked to indicate whether they had experienced any accidents at work during the last year and, if so, to briefly describe what happened. Table 17 shows the incidence of accidents at work by occupation, age and sex. Figure 7 shows these results graphically.

Table 17: Incidence of accidents at work by occupation, age and sex

	Non-farmers	**Secondary farmers**	**Primary farmers**
Total %	**2.3%**	**5.5%**	**10.3%**
(n)	(4/177)	(4/73)	(12/117)
95% CI	0.9 - 5.7%	2.2 - 13.3%	6.0 - 17.1%
Age group			
18-34	-	-	14.3% (4/28)
35-54	-	10.8% (4/37)	6.9% (2/29)
55+	4.9% (4/81)	-	10.0% (6/60)
Sex			
Male	4.4% (4/91)	5.3% (1/19)	13.8% (11/80)
Female	-	5.6% (3/54)	2.7% (1/37)

Figure 7: Incidence of accidents at work by occupation



Primary farmers reported significantly more accidents at work during the last year than non-farmers. In common with other surveys, the main mechanisms of accidental injury among farmers were animals, machinery/equipment and the general farming environment. Respondents' full descriptions of the accidents are in Appendix 7

22.8 Local Experiences

Information from the focus group interviews and conversations with local farmers were very similar to the type of accidents reported nationally and parallels can be drawn with the UK research described earlier.

Farmers of all ages described frequent near misses and accidents with machinery (e.g. a farm worker had his teeth knocked out by a bale wrapper after the safety guard swung back and hit him in the mouth, another worker described a foot injury sustained when a tipping trailer was dropped on his foot).

You don't go a day without getting some sort of knock or bump or cut. (Young farmer)

We had a near miss my son nearly turned a tractor over a few weeks ago and he's very careful – it's one of those things – could have been a terrible accident and these things do happen (farmer's wife)

Hay bales were a cause of injury (e.g. a child was reported to have fallen from a stack of bales breaking both her wrists). Several adults described their childhood play activities in hay barns and one described tunnelling under the

bales which could have resulted in her death (she now works in environmental health and safety!).

Young farmers expressed concern about the vulnerability of older retired farmers. Their concerns are reflected in HSE statistics and the research by Evans (1999) and Walsh (2000) that identify older farmers as being at higher risk for accidents.

Old folk are worse, they are totally ignorant to all safety…watching my Dad with his two dodgy hips wandering around, when you're driving a tractor you have to watch out for him like a little child cause he cant get out the way. (Young farmer)

If summat skids and you're in the way they ('old folk') *won't slow down they just keep driving and they just expect you to get out the way! (Young farmer)*

A farmer's wife in her forties disclosed a personal tragedy when she described the death of her first husband in a tractor accident,

Well he reached into the cab to get a spanner to put between the solenoids- to start the engine because he hadn't got the keys and he must have knocked the throttle open. It slipped and went over the top of him. (Farmer's wife 40yrs)

Livestock were acknowledged as a potential cause of accidents. One dairy farmer described the potential hazards of moving the family's dairy herd across a public road for milking twice a day, Ideally this a two man job but sometimes they were a man down. In these circumstances the procedure could be managed by one man but not without increased safety risks. In a similar vein caring for bulls was also a worry to farmers,

They say you shouldn't go in on your own but if you haven't got enough staff and they need to be fed? (Farmer's wife)

Many believed that accidents were difficult to stop. Farm workers were constantly taking decisions involving risk and almost every activity involves some kind of risk. Many felt the odds were stacked against them and even when they were aware of a potential danger a snap decision could result in injury or death.

It's not necessarily a health thing it's just human (Farmer's wife)

Because we are short of labour everybody is doing with a man less than what they are used to do. The chances are that you are going to take short cuts to try to hurry things up and that it when accidents tend to happen. (Farmer's wife)

There was a tendency to minimise injuries and a reluctance to seek medical advice as if this in some way suggested weakness or failure.

'E cut his fingers and hand open and he's like' stick a bit of tape around it- it will be fine!' (Farmers wife)

Farmers don't report accidents because they don't view them as accidents, it never crosses your mind to report it its just something that happens. (Middle aged male farmer)

22.9 Local Accident and Emergency Perspective

The type of incidents that farmer and their families described were similar to those observed by staff at Buxton Minor Injuries Department. The Nursing staff were insightful about farming accidents as one member of the team came from the agricultural community. Crush and kick injuries from livestock were seen regularly and needle stick injures were also common, farmers medicate their animals intramuscularly but poor handling and disposable practices can result in them injecting themselves. Staff were uncertain how farmers stored and disposed of used needles as common practice was to use syringes and needles more than once. In Cumbria farmers are reported to dispose of their needles in dry stone walls however when the condition of walls deteriorates others become at risk of accidental needle stick injuries (personal communication Nuttall 2001). Farmers were invariably found to be in need of prophylactic tetanus immunisation. Hand injuries were common. Staff noted that plastic surgeons at Derby City Hospital, no longer offered to replant missing digits on farmers as clinical experience had shown poor compliance with postoperative care resulting in increased treatment failure. Seasonal variations were also noted; pitch- fork injuries to feet occurred during silage making and accidents involving children were perceived to be more prevalent during the summer holidays. There was also noted to be some reticence amongst farmers to disclose full details about the circumstances surrounding an accident, *' They're worried we might tell someone'*.

Staff expressed an interest in conducting an audit of farm accidents across the minor injuries units at Whitworth and Buxton community hospitals which could provide a useful staring point for preventive interventions.

22.10 Conclusion

From the evidence reviewed there a number of implications for any accident prevention interventions in High Peak and Dales:

- Small family run farms typified in the area are at higher than average risk of breeching health and safety guidelines and incurring fatal and non- fatal accidents.
- The current economic decline in farming seen over the last two years is likely to compound this risk
- Older farmers (< 60 years) in the area are more at risk of accidents involving livestock than other age groups
- Younger Farmer (> 40 years) are less likely to view themselves as vulnerable to accidents

- Children remain a vulnerable group with accidents peaking during school Holidays
- Preventive measures are unlikely to be fully or consistently applied by farmers
- Published literature on safety is unlikely to be read particularly if it has been produced by the HSE
- Farmers do not seek advice on farm safety from HSE inspectors and cannot access it from any other sources

A range of strategies needs to be employed to address the issues of perceived vulnerability and behaviour change management. The promotion of health enhancing behaviours is core business for health promotion workers and community nurses and there is clearly a role for collaborative multi agency working. The effectiveness of awareness campaigns needs to be reviewed and best practice applied to accident prevention initiatives. Where specific accident training is offered consideration should be given to securing funding to provide substitute cover to enable farmers to attend however encouraging agricultural worker and families to identify and correct hazards more be more cost effective than training people to work safely around hazards.

Very recently *Farm Out* has been awarded a Department of Trade and Industry grant to address farm Safety. The Integrated Farm Family Safety Project will target farming families with children aged 0- 16 years. Farming parents will work alongside trainers, community nurses and the environmental health department of Derbyshire Dales County Council to design a training event to enable nurses and farming parents to conduct farm safety audits. Farming parents will also be offered follow up first aid training. Community nurses will be able to use their new skills in supporting other farming families on their caseloads to carry out safety audits or will undertake school interventions based on their newly acquired knowledge. This is believed to be the first such initiative of its kind and provides farmer a choice in accessing farm safety advice from a non –legislative organisation.

22.11 Recommendations

- There is a need to address the paucity of local data about farm accident rates. The results of The Tideswell Survey and Minor Injuries Unit will be informing but the Primary Care Trust should consider the value of recording accident events in a retrievable format at practice level. Practices serving agricultural populations should be targeted.

- Minor Injuries nurses are best placed to give first hand accident prevention advice. Following the results of their accident audit *Farm Out* should support them to develop relevant information displays information literature and most importantly direct advice.

- Consideration should be given to involving the Accident and Emergency staff of the local district general hospitals in a similar way *Farm Out* could provide a link between secondary and primary care in this instance.

- Practice nurses are the second most likely health professionals to come it contact with patients involved in farm accidents. Some nurses are from the agricultural community but others will have very little understanding of the issue involved. It is recommended that practice nurses and other frontline staff be offered training in accident prevention on farms.

- Older farmers are a vulnerable group. Physiotherapists, district nurses and health promotion workers may be ideally placed to deliver accident prevention initiative with this group. *Farm Out* should work with them to scope possible initiatives.

- Farmer's perception of their vulnerability to accidents and their acceptance of risk is complex. Health promotion staff with expertise in models of behaviour change should support *Farm Out* to develop a range of interventions with young farmers in partnership with the Federation of Young Farmers.

- *Farm Out* should engage with the agricultural community and relevant farming organisations to review printed health and safety material and consider the value of producing specific material for local use.

- The evaluation of the Integrated Farm Family Project should be published in a professional journal to share practice. Lessons learnt should be incorporated into any future farm accident prevention initiatives locally.

23 Access to Health Services

23.1 Background

An analysis of the nature of rural General Practice in the UK by Deaville (2001) has highlighted the importance of access to health services in rural areas. In terms of health care access includes not just distance from services, times of opening and so forth. It also includes the impact of age, sex education, occupation and culture on access.

There are a growing number of studies on distance decay that consistently show that utilisation rates decline with increasing distance between a patients home and the source of health care (Rousseau *et al* 1994 and Higgs 1999).

Deaville (2001) reviewed research evaluating the impact of distance decay on the outcomes of particular diseases. Asthma, diabetic retinopathy, cancer and myocardial infarction patients all show poorer outcomes for rural patients. She concludes that it is difficult to identify the particular components of access which are responsible for poor health outcomes, is it, for example a result of inadequate services? Or it is a feature of rural populations that they present later? She concludes that particular groups of rural residents may be more vulnerable to barriers to access than others. She identifies farmers as one such group and recommends further research into the impact access barriers have on their health.

23.2 Access to local Primary Care Services

The local agricultural community raised a wide range of issues relating to access to health services and primary care services in particular. A key factor was a general attitude that prevailed amongst many farmers, (with the exception of younger farmers wives) that was characterised by stoicism and a suggestion that any acknowledgement of illness was an embarrassment and weakness best kept quite about.

You don't go to the doctor cause you're not feeling very well, you won't get many farmers wasting Doctors time like that. (Middle-aged male farmer)

A lot of folks rather just put up with what they've got than go and see a doctor, they wait until the problems mount up and then go. (Young farmer)

Some of these beliefs may be explained by generational and gender differences as well as occupational differences. The Men's Health Forum (2002) note that,

'D*espite the recent social and economic changes in the roles of men and women traditional attitudes towards gender remain surprisingly and stubbornly prevalent. Boys and young men continue to be socialised to be tough and strong, to appear to be in control and to take risks'.*

The potential seriousness of delaying a doctor consultation is illustrated by one farmer's wife's experiencing of trying to get husband to see a doctor.

He'd had a cough for about 6months and I was getting fed up with it, but he wouldn't go to the doctor. Finally he said 'I think if it rains tomorrow you can make me an appointment'. He went on to receive treatment for a lung tumour. Farmer's wife

Unfortunately it appears very much the norm to delay seeking advice until a problem has become unbearable by which time it may also be untreatable.

Some members of the agricultural community and some health professionals have suggested targeting farming men through their wives. This approach is not endorsed by The Men's Health Forum who suggest that the idea that it is possible to tackle men's health problems by directing initiatives aimed at women should be abandoned.

Derbyshire Rural Help-line Volunteers acknowledged the pressures placed on wives whose loyalties were divided in this way. Some commented that older female relatives were scornful of health services and did not attend for screening tests, or take up immunisations and in fact would not seek a GP advice for what were apparently serious problems. For example one farmer's wife described how her husband had been severely burnt in a domestic accident as a boy but which medical attention was never sought and resulted in significant scarring on his torso. Another farmer's daughter recalled her mother dressing a suppurating wound on her daughter's leg for many months, which in retrospect she realise needed medical attention. This same farmer's

daughter recalled an event recently when the milk lady diagnosed her mother-in law's heart attack. The family believe that were it not for the milk tanker driver's advice and their mother's confidence in it she might have died. Clearly there are members of the older generation who retain a suspicious and mistrustful approach to the medical profession.

There was much enthusiasm about open surgeries when people could just turn up and be seen as this promoted the flexibility that farmers felt they needed. Generally the agricultural community felt that getting an appointment was not as troublesome as keeping it.

It's hard to plan for an appointment you usually turn up when you need it, you might take longer doing a job than you'd expect and you can't leave till it's done, you can't get someone else. (*Young farmer)*

Other farmers comment about the potential usefulness of services being tied into the market or market days, so if a farmer was coming into town on a Monday for market day it would *be* preferable to see a health professional that day rather than rather than I have to back into town another day.

Farmers commented on the timing of surgeries and many felt that surgeries should offer at least one late evening surgery.

Folks late evenings are about six, seven o'clock whereas our late evenings be eight, nine ten o'clock you know. (*Young farmer)*

Branch surgeries were also very much appreciated and some farmers articulated concern that they might close. None had considered the facilities a problem although it is generally acknowledged that branch surgeries held in village halls and private houses offer poor facilities than the main surgery. GPs accepted there were limitations with this type of surgery and believed it limited the level of care they could provide. A survey of branch surgeries in Derbyshire by Derbyshire College of Further Education (undated) found that branch surgeries differed greatly in the facilities they offered. The majority of patients attending branch surgeries are the elderly who access the service on foot (Fearn *et al* 1984).

The out of hours schemes that operates in the High Peak and Dales were generally acceptable and some commented on the good care they had received although they lamented the fact that could no longer see a GP that they knew.

He (the on call doctor) *was very good but you do feel that you have lost that personal contact with someone who knows you and has your records to hand. (Farmer's wife)*

The planned development of electronic patient records will improve patients out of hours experience

There's no longer the family doctor who's been there for years and years who knows, and goes down the street and talks to people, 'and how are you?' Mr so and so', the Peak Practice type of doctor he doesn't exist anymore. (Farmer and Help-line Volunteer)

There are also GP's who feel they are loosing contact with their patients and no longer know them or their families well. This was endorsed recently by a GP who had visited a farmer with suspected mental health problems and who lived alone on a very remote farm. He had learnt more about the farmer than he had gleaned over years of sporadic surgery contacts. '*I should be able to do this much more often he lamented'*. Unfortunately home visits by GP's are diminishing and are now strictly reserved for those too ill too travel. Although some GPs conceded that they often did make convenience home visits to patients who did not fulfil this criteria but who did live on a route close to the surgery or GP's own home.

Pressure of Department of Health targets is frequently blamed for the shift in working patterns experienced by GPs however it is possible that within practices GPs could revisit work patterns and perhaps consider a targeted approach to home visits. High risk groups such as single geographically isolated farmers could be identified for targeted visiting.

Other felt that it wasn't just the timing of surgeries that inhibited farmers from using primary care services and questioned the extent to which primary care really understood the needs of farmers.

We did have a nurse at Tideswell, she lived on a farm we all knew her and she knew everything and she wouldn't stand any messing about and just as we got to know her she left! (*Young farmer*)

Earlier in this report reference has been made to farmers lack of confidence in GP's who appeared not to understand the occupational health aspects of a farmers work, for example with regard to musculskeletal problems, zoonoses, mental health and health implications of working with argi-chemicals. Some farmers also commented on the lack of support they received from their GP during the Foot and Mouth disease crisis.

They're (the medical profession) laughing at us, they see us baking cakes for charity, cutting the grass round the church and think we're fine, doing nicely, they haven't a clue and don't ask (female farmer 56yrs)

There was a general acceptance amongst the agricultural community that occupational health support was not available to farmers in the way it is for other occupational groups. Essentially farming businesses in the High Peak and Dales are small family concerns and farmers and as such many believed that they should be able to get occupational health advice from Primary Care.

23.3 Community Nursing Services

There was praise for the evening nurse service by those who used it.

My father has awful problems with his catheter that always tends go wrong at evenings and weekends and I've found the evening service very good. (Farmer's wife and carer)

Some local farming mothers expressed satisfaction and praise of the health visiting service.

I've got a very good health visitor and she's very receptive to – understands the strains of how we live and you know how rural we are and she comes up with all theses groups we can go to- 'Get out of the house' is her great motto and she's right. (Farmers daughter with three children)

Well my experience has been with our health visitor - you only have to phone her up and she'll come no matter which of my three I'm worried about or want to talk about because she knows its difficult for me to go to the surgery. (Farmers wife and mother of three)

There were other mothers who were not satisfied. One mother explained that she had had three children and the health visitor supported her with frequent visits with babies one and three but she saw very little of her with baby two. She believed the explanation lay in the time of the year. Two of her children were born in the summer months and one in the winter when the health visitor would have to drive across unmade muddy tracks and get out of the car and open and close two sets of farm gates. Other mothers felt health visitors were not able to offer the support they needed after the children had had an 18month review.

There comes a point after 18months when you don't see her again until they go to school and so there seems a great lack of accessibility- someone to talk to and get that sort of information you might need in that period and that is quite often the worst period you go through with your children because they are getting very independent, very stroppy, the terrible twos. (Farm workers wife and mother of two)

This raises issues about the value of targeted health visiting as opposed to a service that is provided by some health visitors structured solely on a timetable of development checks.

23.4 Screening service

Women report using screening services including breast and smear tests however not all women appeared to receive adequate levels of explanation and women did not know of anyone else they could go to for further explanation.

23.5 Access to Accident and Emergency
Nursing staff had a good level of awareness regarding the difficulties experienced by farmers and their families in accessing A& E help. Local minor injuries units are at available in Buxton and Whitworth community hospitals however more serious injures need to be referred to the nearest Accident and Emergency unit attached to the district general hospital. In the High Peak this could be stepping Hill Hospital in Stockport or the Northern General in Sheffield.

It's a dreadful decision I always face where I live knowing what A&E is quicker if there is a referral and they can't cope with it I've got an enormous journey after it. (Farmers wife)

The introduction of Telemedicine links between Buxton hospital minor injuries unit and Stepping Hill Hospital Accident and Emergency unit (A&E) may go some way to alleviating this. The initiative has only just commenced but to date staff report that it has been useful in confirming clinical decisions but has not reduced the need for patients to be referred on to A&E

23.6 Emergency services
Emergency ambulance services are provided by East Midlands Ambulance Service (EMAS). The government has set national response times for ambulance services. For example all Category A calls must be attended within 8 mins. of the call being logged. Unsurprisingly this is a particularly challenging target for rural services.

Buxton's the worst place in the country to have a heart attack isn't it? Top hospitals are furthest away (Young farmer)

When my Dad rung the ambulance it weren't like the ambulance, it were trying to explain to the woman on the other end of the phone what had happened, cos, I had had an accident, and he were tying to explain- and she didn't understand, I got a bit of a rolling over by a cow and my neck split open and he like kept saying' oh the cows done me son in' she said cow are you sure its not a dog' and then 'what's it done bit him'!!
(Young Farmer, hospitalised for a week following livestock injury)

The ambulance service frequently has difficulty in finding farms. Some farms require the negotiation of unmade roads across several fields without the benefit of street lighting and sign -posts. Callers are stressed are often unable to give clear directions. Ambulances would be able to respond a lot more effectively if all isolated premises kept a note of their map co-ordinates.

23.7 NHS direct,
Not many people had utilised NHS Direct which operates independently of the Out of Hours Service in partnership with North Derbyshire Doctors. Two farmers wives had used the services to find out about specific health

problems and were full of praise. There appears a need to promote NHS Direct more actively to the agricultural community.

23.8 Secondary care

In general the problems articulated by the local agricultural centred on the long distances that families lived from secondary care provision. Several women recalled enormous difficulties having to attend a district general hospital for treatment. They often went unsupported because partners could not be spared from the farm and friends were utilised for child-care support. Other recalled having few or no visitors because of the distance and time involved in getting to the hospital. When visitors were able to attend the distance involved (a round trip of fifty miles or more) caused worry to older patients but young families also expressed concerns particularly for older people.

Yes I mean its like when you've had a baby. It killed my husband coming to see me at night and then I'd have him ringing the hospital to let me know he was safe and not fallen asleep at the wheel and I just didn't get any other visitors because it was just to far for anybody to come. (Farmers wife)

Other commented on the rigid appointment systems and wondered why it was not possible to have an outpatient appointment at the weekend. One farmer's daughter recalled reading about an innovative system being set up in Norfolk offering not just weekend appointments night time appointments. There was much enthusiasm expressed about this flexibility of service.

Accessing NHS dental services was a particularly in the High Peak where there are now no NHS Dental practices accepting new patients. In this area people without a dentist are reliant on accessing emergency dental care and receive no preventives care or advice.

23.9 Tideswell Survey

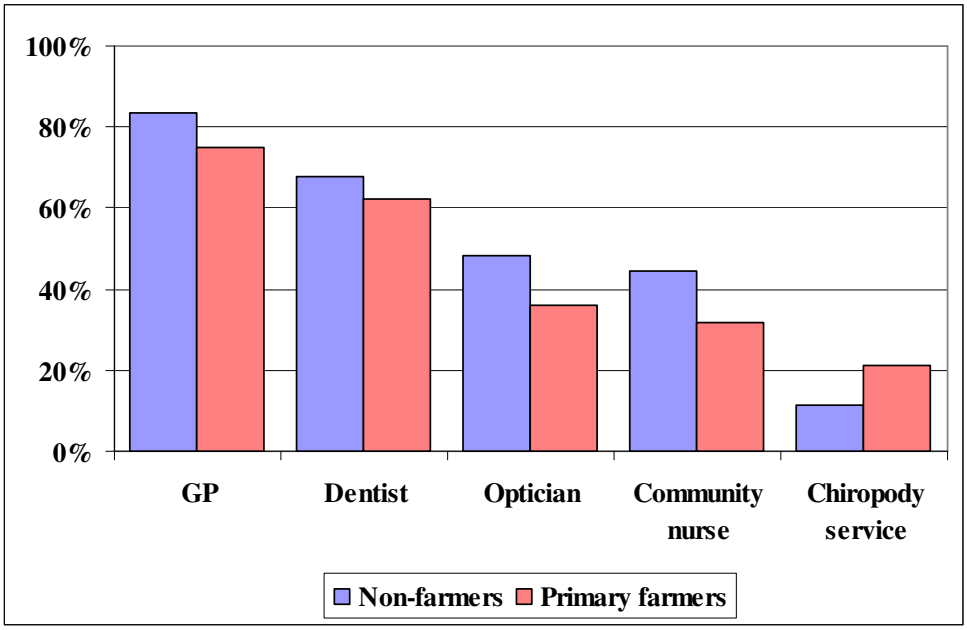
Tideswell survey respondents were presented with a list of different types of health services and were asked to indicate how often they had used the service in the past 12 months for their own health. This method of enquiring about service use was used successfully in a survey investigating service utilisation carried out by the University of Sheffield during 2001 (Saul, personal communication). The proportion of respondents using each service at least once, by occupational group, is shown in table 18 below.

Table 18: Health service use in last 12 months by occupation

	Non-farmers	Secondary farmers	Primary farmers
Family doctor (GP)	**83.6%** (153/183)	**72.0%** (54/75)	**74.8%** (89/119)
Community nurse	**44.3%** (81/183)	**41.3%** (31/75)	**31.9%** (38/119)
Dentist	**67.8%** (124/183)	**80.0%** (60/75)	**62.2%** (74/119)
Optician	**48.1%** (88/183)	**44.0%** (33/75)	**36.1%** (43/119)
Chiropody service	**11.5%** (21/183)	**20.0%** (15/75)	**21.0%** (25/119)
Therapy e.g. physio.	**6.6%** (12/183)	**12.0%** (9/75)	**7.6%** (9/119)
A & E	**10.4%** (19/183)	**12.0%** (9/75)	**9.2%** (11/119)
Hospital outpatient	**24.0%** (44/183)	**25.3%** (19/75)	**23.5%** (28/119)
Hospital day case	**2.7%** (5/183)	**9.3%** (7/75)	**7.6%** (9/119)
Hospital inpatient	**6.0%** (11/183)	**9.3%** (7/75)	**5.0%** (6/119)

For some services there appears to be little difference in utilisation rates between non-farmers and primary farmers (i.e. A & E, therapy services, hospital outpatients and hospital inpatients). Whilst hospital day case and chiropody services were both used more by primary farmers than by non-farmers. Figure 8 shows some of these findings in graph format**.**

Figure 8: Health service use in last 12 months by occupation



There were however other services where the primary farmer utilisation rates were lower than for non-farmers (i.e. GP, community nursing, dentist and optician). This is of particular concern given the higher rates of illness found among primary farmers in many of the areas investigated in this report. If service utilisation were commensurate with the need for services then one would expect to find higher service utilisation among those with greatest need. However, in the main, primary farmers utilisation rates are equal to or even lower than non-farmers

23.10 Specialist Occupational Health Service Provision

Access to health services has been a continuous theme throughout this needs assessment. In all areas of health, access to adequate health promotion, preventative interventions, information, advice and treatment has been highlighted as a significant problem for the agricultural community. Cultural beliefs, social norms, stigma, distance decay, are the backcloth to these access problems. At present appropriate mechanisms are not in place to deliver preventative intervention information, advice and other support on occupational health issues to the local agricultural community. Many health care professionals lack an understanding of these issues. More training opportunities on the wider occupational health implications of farming could go some way to mitigate against this as would the creation of a primary care specialist nurse or GP in occupational health.

23.11 Recommendations

- High Peak and Dales PCT should give serious consideration to the appointment of a primary care specialist nurse or GP in agricultural occupational health.
- High Peak and Dales PCT and the Primary Care sub- group of the PCT should consider urgently the provision of range of primary care facilities from the Agricultural and Business Centre in Bakewell. A task group should be convened to address this.
- High Peak and Dales PCT in their strategic planning work should note the value the local agricultural community places on locally delivered services and the greater use hospital day care services by Tideswell farmers compared to the local non- farming cohort.
- High Peak and Dales PCT should also note the research showing the deleterious impact of distance decay on the health outcomes of asthma, diabetic retinopathy, cancer, and myocardial infarction patients.
- High Peak and Dales PCT and the Primary Care sub- group of the PCT should note the finding of the Tideswell survey indicating that farmers have poorer service utilisation rates for GP, community nursing, dentist and opticians compared to the local non- farming cohort.
- High Peak and Dales PCT Primary Care sub- group should consider further the value of late evening surgeries and weekend provision.
- Within GP practices experienced and well informed practice nurses are valued by the agricultural community. The PCT should support practice

nurses who wish to enhance their knowledge and understanding of the agricultural community and their occupational health needs.

- The Head of Professional Practice and Development in considering the future development of the public role of health visitors should revisit the value of targeted health visiting as opposed to a service that is structured solely on a timetable of development checks.
- Health visitors in the High Peak may wish to consider dental health promotion in the light of the inadequate provision of NHS dental services in this area.
- GPs should revisit their home visiting policy and ensure that it does not disadvantage their practice agricultural population.
- GPs should consider a targeted approach to meeting the primary care needs of their practice agricultural population.
- Farm Out should collaborate further with the health promotion service to consider the recommendations of the Men's Health Forum on redressing gender differences in access to primary care.

24 Conclusion

The indigenous population of the High Peak and Dales PCT is it's agricultural community and it is the agricultural practices of this population over the decades that has shaped the geographical as well as socio economic characteristics of the area.

This health needs assessment reveals the significant hidden deprivation experienced by a large proportion of the agricultural community. This is illustrated in the juxtaposition of economic decline, housing disadvantage and social exclusion within a generally an affluent area. The health needs assessment also shows the agricultural community to have a poorer health profile than the local non-farming population. This is most notably with regard to mental health where farmers suffered more depression than non- farmers and where almost 1in 10 farmers in the Tideswell survey had contemplated suicide during the last year. Musculoskeletal and occupational health related problems also have a major impact of the agricultural communities health profile.

Despite the greater health problems experienced by the agricultural community the results from the Tideswell survey indicate that the farming community are not heavier users of health services. To the contrary, farmers in the survey made less use of primary care services than the local non farming cohort. The agricultural community are further disadvantaged in terms of access to health services not purely in terms of distance from services, times of opening and so forth but also in terms of age, sex, education, occupation and culture.

At the beginning of this research reference was made to Bradshaw's (1972) definitions of need. Normative need, felt need, expressed need and comparative needs have all been explored in this research. A range of recommendations have been proposed that offer public health solutions to meet these health needs. Some have come from the agricultural community themselves others from local voluntary groups and health and social care professionals. These are commended to High Peak and Dales Primary Care Trust for their consideration and action.

Summary of Recommendations

	Recommendations	Lead Agency
1	**Social Support and Affiliations**	
	1. *Farm Out* should work with the East Midlands ecumenical Rural Chaplain to promote greater knowledge of this role amongst Primary Care professionals.	*Farm Out*
	2. The Health Improvement sub- group of High Peak and Dales PCT should consider the contribution that the Rural Chaplain might be able to make to the group's work.	*PCT* HIMP Sub Group
	3. High Peak and Dales PCT should continue to support GP practices to establish a register of carers.	*PCT Primary Care Sub Group*
	4. Registers of carers should be used by Primary Care to identify and target carers from the agricultural community to ensure they receive benefits and other entitlements.	Primary Care
	5. *Farm Out* should promote the role of the Carers Association to the agricultural community through the farming press and local markets.	*Farm Out*
	6. High Peak and Dales PCT, in preparing its Carers Strategy should seek to encompass the special needs of the agricultural community.	PCT
	7. Efforts should be made to identify a representative from agricultural community to sit on the Carers Strategy Group.	Derbyshire Dales Carers group
2	**Social and Leisure Activities**	
	8. *Farm Out* should raise awareness amongst primary care professionals about the level of social exclusion experienced by some members of the agricultural community.	*Farm Out*
	9. Public health activities conducted by primary care to address mental health promotion should target the agricultural community.	Primary Care

	10. The particular social and leisure needs of the agricultural community should be included in Derbyshire Dales District Council and High Peak Borough Council's new Community Strategy.	Derbyshire Dales and High Peak Borough Council
3	**Housing**	
	11. The PCT should work with Derbyshire District Council and High Peak Borough Council through the Health Improvement Sub group to consider how the housing needs of the agricultural community could be best met.	Derbyshire Dales and High Peak Borough Council and PCT
	12. The work of Arthur Rank Centre in supporting the housing needs of tenant farmers should be widely promoted by the PCT, High Peak Borough Council and Derbyshire Dales County Council, to all tenant farmers and professionals working with the agricultural community	ARC Addington Fund and *Farm Out*
	13. *Farm Out* should work with Derbyshire Dales District Council to promote Renovation Grants to the agricultural community through the farming press, Citizen Advice Bureaux, and primary care professionals.	Derbyshire Dales District Council and *Farm Out*
	14. *Farm Out* should be a partner agency with the Rural Housing Enabler in order to implement the *Empty Housing Strategy*.	" "
	15. Consideration should be given by Peak Park District Authority to the, *build as you go* approach advocated by Ward (Arnot2002)) that would favour the agricultural community.	Peak Park District Authority
4	**Income**	
	16. The PCT Board and PEC, through the Health Improvement Sub Group and the Primary Care Sub Group should work with *Farm Out* to improve health professionals understanding of social exclusion and the local agricultural community	PCT
	17. The PCT through the Health Improvement Sub Group may wish to lobby widely for retirement schemes for farmers such as those available in other European countries	PCT HIMP Sub Group

	to be reassessed 18. *Farm Out* should work with the CAB to consider ways of promoting the service to the agricultural community. 19. *Farm Out* should work with the newly established CAB services in Hartington village hall to evaluate the use of CAB services in a non- medical setting by the local agricultural community. 20. Primary care nurses looking to undertake public health work should consider the promotion of free school meals to children in the farming community in a non stigmatising way 21. Primary care nurses looking to undertake public health work should consider working with farming organisations to support farmers to plan for retirement with reference to *Sustainable Food and Farming* (DEFRA, 2002)	*Farm Out* and Citizens Advice Bureau '' '' Primary Care Primary Care
5	**Education** **23.** *Farm Out* should work with the Arthur Rank Centre to consider the funding opportunities for farmers and other agricultural workers to change occupations. 24. Educational providers should deliver specific training packages for farmers, delivered to their farms on an individual basis (e.g. extension of the ESF Farming and Rural IT programme)	ARC Addington Fund and *Farm Out* Derbyshire District Council and Adult Education
6	**Food and Farming** 25. High Peak and Dales Primary Care Trust's Health improvement sub group should address the Policy Commission's recommendations that PCTs as part of local strategic partnerships should ensure that a food dimension is included in health Improvement and community plans which include the monitoring of food inequalities. 26. High Peak and Dales Primary Care Trust's Health Improvement sub group should consider the commission's recommendation to extend the National School Fruit Scheme up the age range.	PCT HIMP Sub group PCT HIMP Sub Group

	27. High Peak and Dales Primary Care Trust's Health Improvement sub group in addressing the National School Fruit Scheme should look to establish initiative promoting the supply of local fruits such as apples pears and rhubarb. 28. High Peak and Dales Primary Care Trust's Health Improvement sub group should assess the impact of promoting online food shopping as well as local food co-operatives when considering food inequalities locally. 29. *Farm Out* to explore how High Peak and Dales PCT can further promote the sourcing of local food to meet the requirements of the Trusts four community hospitals. These experiences should be shared with the wider health community including County Councils.	PCT HIMP Sub Group '' '' PCT HIMP Sub Group PCT Community Sub Group
7	**Pesticides and Health** 30. High Peak and Dales PCT should give serious consideration to the appointment of a primary care specialist nurse or GP in agricultural occupational health. 31. *Farm Out* should ensure that the health cards developed by the WFFU are made available to all GP practices to promote to their farming population. 32. *Farm Out* should make contact with the Organophosphate Users Support Group OPUS to improve local knowledge of the relevant issues. 33. *Farm Out* should seek membership with the Institute of Rural Health to remain informed about OP issues nationally. 34. *Farm Out* should consider organising a seminar on OPs for the local health community as well as local farmers.	PCT Primary Care Sub group *Farm Out* *Farm Out* *Farm Out* *Farm Out*
8	**General Health** 35. There is scope for considerable more research into this area and a larger health survey across the region could yield more detailed information about the general health of farmers.	ScHARR University of Sheffield and *Farm Out*

	36. The Tideswell survey findings on general health, EQ5D and the visual analogue scale should be shared with rheumatologists, physiotherapy services, disability services and others caring for patients with arthritic and mobility problems. 37. *Farm Out* should work with these groups to identify solutions to improve health outcomes for the agricultural community.	*Farm Out* *Farm Out*
9	**Coronary Heart Disease** **38.** There is scope for considerable more research into this area and a larger study across the region could yield more detailed information about the coronary heart disease and the agricultural community. **39.** The smoking data from the Tideswell Survey should be shared with the smoking cessation teams within the local Heath Promotion Department **40.** *Farm Out* should continue to work with Health Promotion to address specific CHD prevention strategies that could be employed to target the agricultural community such as *waist watchers*. 41. *Farm Out* should explore further gender issues and CHD prevention with reference to the Men's Health Forum's policy for men's health (MHF 2002) 42. The Primary Care Development sub-group of High Peak and Dales PCT should consider the Tideswell research findings in the context of the whole needs assessment document and in particular with regard to access to primary care. 43. *Farm Out* should work with the Primary Care Development sub-group of High Peak and Dales PCT to consider the evidence of the effectiveness men's health clinics in the prevention and early detection of CHD and how this might be applied to the agricultural community. 44. The Primary Care Development sub-group of High Peak and Dales PCT may wish to recommend a targeted approach to the identification of hypertension. 45. Primary Care should consider the linking of stroke and Coronary Heart Disease registers in general practice as many of the risk factors over lap.	ScHARR University of Sheffield, *Farm Out,* Public health *Farm Out* Health Promotion *Farm Out* Health Promotion *Farm Out* Health Promotion PCT Primary Care Sub Group PCT *Farm Out* PCT Primary Care

	46. The local agricultural community are food producers however no work has been done to ensure local farmers and the local community benefit from locally produced healthy foods. *Farm Out* should work with the Health Promotion, Women Food and Farming Union and Peak District National Park to explore this further.	PCT *Farm Out,* Health Promotion WWFU, Peak Park
10	**Musculoskeletal problems**	
	47. A review of the literature regarding the geographical variation of hip and knee surgery should be undertaken by *Farm Out* and used to inform the high Peak and Dales PCT commissioning agenda and the other groups concerned with the orthopaedic care-pathway	*Farm Out*
	48. Given the high prevalence of muscloskeletal problems and the high personal and health costs associated with them efforts should be directed at preventative interventions.	PCT Primary Care
	49. The Commissioning sub group of High Peak and Dales PCT in a planned review of orthopaedic services should consider the care-pathway experienced by farmers in addition to that experienced by the non- farming community.	PCT
	50. Physiotherapists offer a key service and *Farm Out* should work in partnership with them to identify and develop innovative preventive solutions particularly in accessing additional funding.	Physiotherapy Services and *Farm Out*
	51. Physiotherapist should be supported to continue to audit their referrals to analyse case mix with a view to consider targeted approaches to service delivery.	Physiotherapy Services
	52. Physiotherapy providers may wish to consider changes to the delivery of services (e.g. directly onto farms or through a 'drop in' facility at the local Agricultural and Business Centre) as well looking at self- referral options (as is presently available to chiropody service users).	'' ''
	53. The development of an extended scope practitioner (physiotherapy) to work with the farming community should be considered by service providers and commissioners.	PCT Physiotherapy Services *Farm Out*
	54. High Peak and Dales PCT should pilot the Expert Patient Programme for farmers with chronic arthritis.	

	55. *Farm Out* and therapy services should work with the PCT Communications Section to raise awareness amongst the agricultural community about preventative issues and service provision through the farming press. 56. Therapy services in partnership with the Health and Safety Executive (East Midlands) and *Farm Out* should review the literature on the effectiveness of traditional manual handling training to identify best practice with regard to the farming community**.**	Physiotherapy Services *Farm Out* Physiotherapy Services *Farm Out*
11	**Continence** 57. Farming women are more vulnerable than non- farming women to incontinence problems. Midwives and health visitors working with farming mothers should consider these findings in relation to pelvic floor care. They should consider new ways of primary prevention with this group. 58. The cost of incontinence aids to the health community is great. *Farm Out* should work with disability services to consider other preventative approaches to incontinence amongst women. 59. Primary Care professionals should be made aware that in the Tideswell survey the observed overall prevalence of continence problems was higher among primary farmers than among non-farmers. They should consider this in relation to the provision of well man clinics or other initiatives targeting men. 60. Given farmers reluctance to access primary care services prostate cancer awareness raising information should be available through a range of non health outlets and publications e.g. Bakewell Agricultural Centre and farming press 61. *Farm Out* should work with relevant organisations (e.g. Men's Health Forum) as well as the Health Promotion Service to develop suitable health promotion literature for the farming community.	Primary Care *Farm Out* ,Primary Care, Disability Services *Farm Out* *Farm Out* *Farm Out Health Promotion*

12	**Mental health**	
	62. *Farm Out* should work with nurse consultant for mental health and deliberate self harm regarding the development of formal suicide prevention strategy for the Derbyshire health Community	*Farm Out*
	63. *Farm Out* should work with *ruralminds* to explore the potential for a Connecting Minds pilot in Derbyshire	*Farm Out*
	64. *Farm Out* should liase with staff involved in the SAFE and REST initiatives to consider the applicability of theses models of mental health care delivery locally.	*Farm Out*
	65. A settings approach to mental health care is recommended.	
	66. A Rural Mental Health Interest Group (RMHIG) should be established to consider public health solutions and innovative approaches to mental health service delivery. (In the absence of another heath community group willing to take this work on e.g. Primary Care Mental health Group)	*PCT Farm Out*
	67. The RMHIG should consider the setting up of a specialist outreach service for the agricultural community	‘’ ‘’
	68. General practitioners need to be reminded that routine health checks may provide an opportunity to assess and treat depression	Primary Care
	69. General practitioners should be more proactive about removing guns and if necessary revoking gun licences if there is evidence of suicidal behaviour or abnormal mental states.	Primary Care PCT
	70. The Primary Care sub group of High Peak and Dales PCT should continue to develop training opportunities for GPs and nurses in diagnosis and treatment of depression.	
	71. The Primary Care sub group may wish to consider the adequacy of the existing depression protocol in alerting GPs to the high- risk occupations such as farming.	PCT/ Primary care Sub Group
	72. The Primary Care sub group may wish to consider the promotion of targeted approaches to the identification of depression within the farming community	
	73. The Primary Care sub group and the RMHIG should consider ways of improving access to primary care services for the farming community.	PCT/ Primary care Sub Group

	74. The Primary Care sub group of the PCT should ensure that Mind's policy on Rural Issues and Mental Health is addressed where relevant to primary care.	PCT/ Primary care Sub Group
	75. *Farm Out* and the RMHIG should examine care pathway for farmers with mental health problems who are identified by the voluntary sector	*Farm Out*
	76. Primary Care should consider the value of stress management initiatives in relation to the agricultural community.	Primary Care
	77. *Farm Out* should establish a framework for publicising mental health promotion information in partnership with the Health Promotion Service in North Derbyshire.	*Farm Out*
	78. *Farm Out* should work in partnership with the Rural Education and Arts Project (REAP) to bid for monies to establish an artist in residence for the agricultural community to address the stigma surrounding mental illness.	*Farm Out and REAP*
	79. *Farm Out* should consider ways of promoting Listening and Sign posting training for occupational groups working with farmers such as the Peak District National Park staff, vets and agricultural advisors.	*Farm Out Peak District National Park Authority*
	80. *Farm Out* should continue working with the Rural Reminiscence Group to promote the development of rural reminiscence in health and social care establishments.	*Farm Out*
	81. *Farm Out* should continue working in partnership with the Farming Life Centre Project to promote mental health promotion opportunities for older retired farmers	*Farm Out*
	82. *Farm Out* and the Public Health department should explore the mental health implication of OP usage locally	*Farm Out* Public Health
	83. *Farm Out* should continue to work in partnership with the Rural Stress Information Network to support the development of a rural chaplaincy.	RSIN *Farm Out*
	84. *Farm Out* should become a partner in the Domestic Abuse Reduction Partnership and contribute to work addressing access to support services, for the agricultural community.	DARP *Farm Out*

13	**Zoonoses**	
	86. The PCT should consider how best to provide adequate occupational advice to the agricultural community. This might be achieved by the development of a specialist GP or specialist nurse post.	PCT Primary Care Sub Group
	87. Primary health care teams serving rural populations should be aware of the local farming practices and likely zoonotic infections.	Primary Care
	88. The Primary Care sub group of High Peak and Dales PCT should ensure that newly appointed primary care professionals should have access to additional training in zoonoses and occupational health care for farmers as part of their induction.	PCT Primary Care
	89. *Farm Out* should raise awareness of zoonosis amongst midwives and community nurses especially those working with high risk vulnerable groups	*Farm Out* and Primary Care
	90. *Farm Out* should work with the Workforce Development Confederation (WDC) and local Training Department to consider the provision of a short course in zoonosis for all primary care professionals	*Farm Out* WDC and local Training dept
	91. Accident and Emergency staff could use telemedicine to gain expert advice on zoonoses.	Minor Injury Staff
	92. Practice nurses, GPs and community nurses should consider recording the occupation of their patients in a retrievable electronic form and they should routinely ask farming patients about possible exposure to zoonosis	Matrons Primary Care
	93. Practice nurses working with significant numbers of farming patients may wish to consider a special clinic for farming families	Primary Care
	94. General practice surgeries should promote the use of patient held cards in which patients can record relevant occupational hazards such as has been designed by the Women Food and Farming Union.	Primary Care
	95. General practice surgeries should ensure information leaflets on common zoonoses are readily available, accurate and up to date.	Primary Care
	96. Primary health care team serving rural populations should be aware of the local farming practices and likely zoonotic infections	Primary Care

14	**Accidents** 97. There is a need to address the paucity of local data about farm accident rates. The results of The Tideswell Survey and Minor Injuries Unit will be informing but the Primary Care Trust should consider the value of recording accident events in a retrievable format at practice level. Practices serving agricultural populations should be targeted. 98. Minor Injuries nurses are best placed to give first hand accident prevention advice. Following the results of their accident audit *Farm Out* should support them to develop relevant information displays information literature and direct advice. 99. Consideration should be given to involving the Accident and Emergency staff of the local district general hospitals in a similar way. *Farm Out* could provide a link between secondary and primary care in this instance. 100. Practice nurses and the second most likely health professionals to come it contact with patients involved in farm accidents. Some nurses are from the agricultural community but others will have very little understanding of the issue involved. It is recommended that practice nurses and other frontline staff be offered training in accident prevention on farms. 101. Older farmers are a vulnerable group. Physiotherapists, district nurses and health promotion workers may be ideally placed to deliver accident prevention initiative with this group. *Farm Out* should work with them to scope possible initiatives. 102. Farmer's perception of their vulnerability to accidents and their acceptance of risk is complex. Health promotion staff with expertise in models of behaviour change should support *Farm Out* to develop a range of interventions with young farmers in partnership with the National Federation of Young Farmers. 103. *Farm Out* should engage with the agricultural community and relevant farming organisations to review printed health and safety material and consider the value of producing specific material for local use. The evaluation of the Integrated Farm Family Project should be published in a professional journal to share practice. Lessons learnt should be incorporated into any future farm accident prevention initiatives locally.	PCT Primary Care Sub Group Primary Care professionals *Farm Out* *Farm Out Chesterfield Royal/ Stockport A&E* Primary Care *Farm Out* *Farm Out NFU NCUF* *Farm Out* Environmental health Derbyshire Dales District Council *Farm Out*

15	**Access to Health Services**	
	105. High Peak and Dales PCT should give serious consideration to the appointment of a primary care specialist nurse or GP in agricultural occupational health.	PCT
	106. High Peak and Dales PCT and the Primary Care sub- group of the PCT briefing paper should consider urgently the provision of range of primary care facilities from the Agricultural and Business Centre in Bakewell. A task group should be convened to address this.	PCT Primary Care sub group
	107. High Peak and Dales PCT in their strategic planning work should note the value the local agricultural community places on locally delivered services and the greater use hospital day care services by Tideswell farmers compared to the local non- farming cohort.	PCT
	108. High Peak and Dales PCT should also note the research showing the deleterious impact of distance decay on the health outcomes of asthma, diabetic retinopathy, cancer, and myocardial infarction patients.	PCT
	109. High Peak and Dales PCT and the Primary Care sub- group of the PCT should note the finding of the Tideswell survey findings that farmers have poorer service utilisation rates for GP, community nursing, dentist and opticians compared to the local non-farming cohort.	PCT Primary Care Sub Group
	110. High Peak and Dales PCT Primary Care sub- group should consider further the value of late evening surgeries and weekend provision.	PCT Primary Care Sub Group
	111. Within GP practices experienced and well informed practice nurses are valued by the agricultural community. The PCT should support practice nurse who wish to enhance their knowledge and understanding of the agricultural community and their occupational health needs suitable	PCT Primary Care Sub Group
	112. The Head of Professional Practice and Development in considering the future development of the public role of health visitors should revisit the value of targeted health visiting as opposed to a service that is structured solely on a timetable of development checks.	Head of Professional Practice and Development

	113. Health visitors in the High Peak may wish to consider dental health promotion in the light of the inadequate provision of NHS dental services in this area.	Primary Care
	114. GPs should revisit their home visiting policy and ensure that it does not disadvantage their practice agricultural population.	Primary Care
	115. GPs should consider adopting a targeted approach to meeting the primary care needs of their practice agricultural population.	Primary Care
	116. *Farm Out* should collaborate further with the health promotion service to consider the recommendations of the Men's Health Forum on redressing gender differences in access to primary care.	*Farm Out* health promotion

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Appendix 1 Farm Out Steering Group

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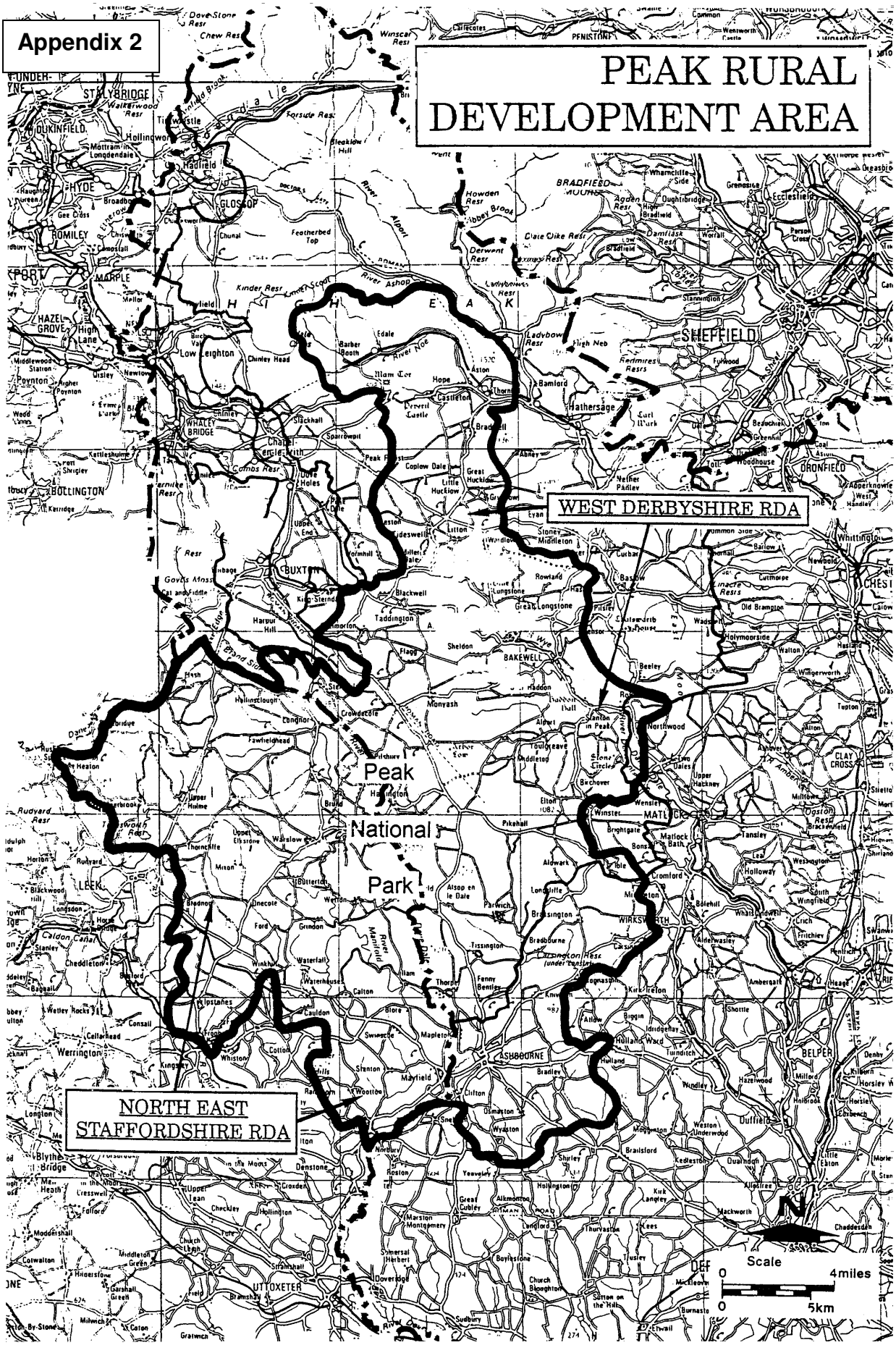
Appendix 2
PEAK RURAL DEVELOPMENT AREA
WEST DERBYSHIRE RDA
NORTH EAST STAFFORDSHIRE RDA
Peak National Park
STALYBRIDGE
DUKINFIELD
HYDE
GLOSSOP
ROMILEY
MARPLE
HAZEL GROVE
HIGH LANE
WHALEY BRIDGE
BOLLINGTON
BUXTON
LEEK
BAKEWELL
SHEFFIELD
DRONFIELD
CHESTERFIELD
MATLOCK
WIRKSWORTH
ASHBOURNE
BELPER
UTTOXETER
Scale
0 4miles
0 5km
N

Appendix 3
List of Health Needs Assessment Contributors and *Farm Out* Conference Delegates **(Sincere apologies for any omissions noted)**

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Tom W	Brocklehurst	Farmer
Pennie	Bradbury	Farmer
Pennie	Barker	Farmer
Bill	Gregory	Farmer
Wood	Linda	Farmer
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Fiona	Paul	Physiotherapist, Cavendish Hospital
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Pam	Bardwell	Practice Nurse, Baslow Surgery
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Mavis	Mycock	Women Food and Farming Union

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Dr's Chadwick, Newton and Jordan	Ashenfell surgery Baslow

Appendix 4

Farm Out Health Project

Tideswell Practice Health Survey

Confidential Questionnaire

Farm Out **is a health project set up by High Peak and Dales Primary Care Trust. One of its tasks is to find out about the health of people living and working within the agricultural community and work out ways of improving health services.**

Your local general practitioners Dr Cox and Dr Marks are working with *Farm Out* **and would like to find out more about the general well being of their patients - both farmers and non-farmers.**

Please would you tell us about your general health by completing this questionnaire. It should take no more than about 10-15 minutes.

It would be very helpful if as many people as possible complete a questionnaire so that we can have a full picture of the health needs of the local community.

All the information you provide will be treated in the strictest of confidence.

All the questionnaires will be analysed together by a researcher at Sheffield University and you will not be identified individually. We will not see responses to individual questionnaires at the practice so, should you feel that answering any of the questions draws your attention to problems which cause you concern, please contact us separately.

Thank you very much for your time.

Section A - Background Information

A1. How old are you? ……. years

A2. Are you: Male Female (*please tick*)

A3. What is the full title of your occupation? If you are currently retired or unemployed, please state your most recent occupation:

……
……

A4. Please briefly describe what you do (did) in your main job:

……
……

A5. Compared with one year ago, has your household income: (tick one box)

Decreased a lot	Increased a lot
Decreased a little	Increased a little
Stayed about the same	

Section B - Your General Health

B1. Have you ever been told by your doctor or by any other health care professional that you have: (*Please tick all boxes that apply*).

Anaemia	Dyspepsia (indigestion)
Angina or heart disease	Epilepsy
Arthritis or rheumatism	Eye conditions (e.g. cataract or glaucoma)
Asthma	Hearing problems
Bowel problems	Heart attack
Bronchitis	Hernia
Cancer	Hypertension (high blood pressure)
Dementia (e.g. Alzheimer's disease)	Parkinsons disease
Depression	Stroke
Diabetes	Thyroid problems

Section C - Using Health Services

Have you used any of the following health services **in the past 12 months** for **your own health?**

For each service you have used, please tick (✔) one box to show the number of times you have used the service. ***If you have not used the service, please leave the line blank.***

	The number of times I have used the service is:		
	1-2 times	3-6 times	7 or more
Family doctor (GP)			
Community Nurse e.g. practice or district nurse			
Dentist			
Optician			
Chiropody Service			
Therapy service e.g. physiotherapist, occupational therapist, speech therapist			
Accident and Emergency department (Casualty)			
Outpatient hospital consultation			
* Hospital day case operation			
* Inpatient hospital stay			

* If you had an inpatient hospital stay or day case operation please say what it was for:-

Section D - Your General Health

By placing a tick (✔) in one box in each group below, please indicate which statement best describes your own health state today**.**

Do not tick more than one box in each group.

D1. **Mobility**
I have no problems in walking about
I do have some problems walking about
I am confined to bed

D2. **Self-Care**
I have no problems with self-care
I do have some problems washing and dressing myself
I am unable to wash or dress myself

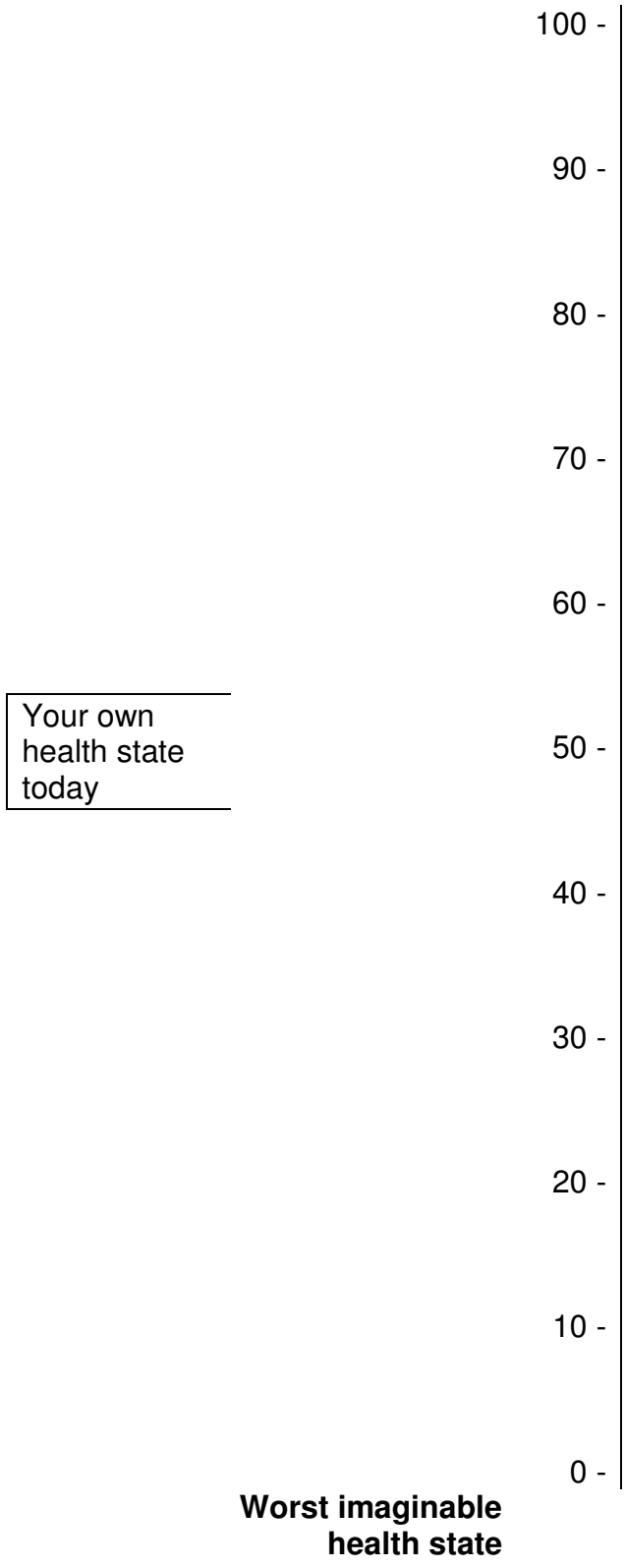
D3. **Usual Activities (e.g. work, study, housework, family & leisure)**
I have no problems with performing usual activities
I do have problems performing my usual activities
I am unable to perform my usual activities

D4. **Pain** / **Discomfort**
I have no pain or discomfort
I do have moderate pain or discomfort
I have extreme pain or discomfort

D5. **Anxiety** / **Depression**
I am not anxious or depressed
I am moderately anxious or depressed
I am extremely anxious or depressed

To help people say how good or bad a health state is, we have drawn a scale (rather like a thermometer) on which the best state you can imagine is marked by 100 and the worst state you can imagine is marked by 0.

We would like you to indicate on this scale how good or bad your own health is today, in your opinion. Please do this by drawing a line from the box below to whichever point on the scale indicates how good or bad your current health state is.



Section E - Joint Problems

E1. Have you ever had continuous swelling, for at least one month in at least two of your joints? Yes No

E2. Have you ever had pain in any of the following joints, lasting at least one month?
Neck Back Hips Hands Feet

E3. Have you ever had pain in or around one or both of your knees, lasting at least one month? Yes No

If YES, did the pain follow directly from an injury? Yes No

Section F - Hearing

F1. Can you hear ordinary one-to-one conversation? Yes No

F2. Can you follow conversation in a group of people? Yes No

F3. Do you have problems hearing or using a telephone? Yes No

F4. Can you hear the doorbell? Yes No

F5. Do you have problems hearing oncoming traffic? Yes No

Section G - Breathing

G1. Do you usually cough first thing in the morning in winter?
Yes No

G2. Do you usually cough during the day, or at night, in winter?
Yes No

If YES to G1 or G2 do you cough like this on most days for as much as 3 months each year?
Yes No

G3. Do you **usually** bring up any phlegm from your chest first thing in the morning in winter?
Yes No

G4. Do you **usually** bring up any phlegm from your chest during the day – or at night – in winter?
Yes No

If YES to G3 or G4 do you bring up phlegm like this on most days for as much as 3 months each year?
Yes No

G5. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill?
Yes No

G6. Have you had any attacks of wheezing or whistling in your chest at any time in the last 12 months?
Yes No

G7. Have you had any attacks of shortness of breath with wheezing?
Yes No

If YES to G7 is/was your breathing absolutely normal between these attacks?
Yes No

G8. Have you at any time in the last 12 months been woken night by an attack of shortness of breath?
Yes No

G9. Are you:
A current smoker An ex-smoker Never a smoker

Section H - Stroke

H1. Have you ever thought you had, or been told you have had a stroke?
Yes No

If NO to H1 please go to Section I

H2. Was it within the last year?
Yes No

H3. Did you make a full recovery?
Yes No

If NO to H3 do you need help from another person in your daily activities?
Yes No

Section I - Chest Pain

I1. Have you ever had any pain or discomfort in your chest?
Yes No

If NO go to I1 please go to Section J

I2. Do you get the pain when you walk uphill or hurry?
Yes No

I3. Do you get the pain when you walk at an ordinary pace on the level?
Yes No

Section J - Continence and prostate problems

J1. Do you frequently have a strong, sudden urge to urinate?
Yes No

J2. Do you frequently go to the bathroom 8 or more times a day?
Yes No

J3. Do you get up 2 or more times during the night to go to the bathroom?
Yes No

J4. Do you have a loss of urine when you are doing physical activities e.g. lifting heavy objects or exercising? Yes No

J5. Do you sometimes have a slight loss of urine when you sneeze, cough or laugh? Yes No

Section K - Working with Agrichemicals

K1. Do you use agricultural chemicals?
Yes No

If NO go to K1 please go to Section L

K2. Have you ever had health problems involving the use of agricultural chemicals?
Yes No

If YES, please briefly describe the nature of the problem(s), including when they occurred:

Section L - Accidents

L1. Have you had any accidents at work during the last year?
Yes No

L2. If so, what part of your body was injured?

Please briefly describe what happened:

Section M - Feelings

For questions 1 – 15 please read each item and tick the box next to the reply which comes closest to how you have been feeling in the past week. Don't take too long over your replies; your immediate reaction to each item will probably be more accurate than a long thought out process.

M1. I feel tense or 'wound up':

Most of the time
A lot of the time
From time to time, occasionally
Not at all

M2. I still enjoy the things I used to enjoy:

Definitely as much
Not quite as much
Only a little
Hardly at all

M3. I get a sort of frightened feeling as if something awful is about to happen:

Very definitely and quite badly
Yes, but not to badly
A little, but it doesn't worry me
Not at all

M4. I can laugh and see the funny side of things:

As much as I always could
Not quite so much now
Definitely not as much
Not at all

M5. Worrying thoughts go through my mind:

A great deal of the time
A lot of the time
From time to time but not too often
Only occasionally

M6. I feel cheerful:

Not at all
Not often
Sometimes
Most of the time

M7. I can sit at ease and feel relaxed:

Definitely
Usually
Not often
Not at all

M8. I feel as if I am slowed down:

Nearly all the time
Very often
Sometimes
Not at all

M9. I get a sort of frightened feeling like 'butterflies' in the stomach:

Not at all
Occasionally
Quite often
Very often

M10. I have lost interest in my appearance:

Definitely
I don't take as much care as I should
I may not take quite as much care
I take just as much care as ever

Please turn over ….

M11. I feel restless as if I have to be on the move:

Very much indeed
Quite a lot
Not very much
Not at all

M12. I look forward with enjoyment to things:

As much as I ever did
Rather less than I used to
Definitely less than I used to
Hardly at all

M13. I get sudden feelings of panic:

Very often indeed
Quite often
Not very often
Not at all

M14. I can enjoy a good book or radio or TV programme:

Often
Sometimes
Not often
Very seldom

M15. During the past year have you thought about attempting suicide?

Very often indeed
Quite often
Not very often
Not at all

Should you feel that answering any of the above questions has drawn your attention to problems which cause you worry or concern at the present time, you are advised to contact your GP.

THANK YOU VERY MUCH FOR YOUR ASSISTANCE

Please return the questionnaire in the envelope provided

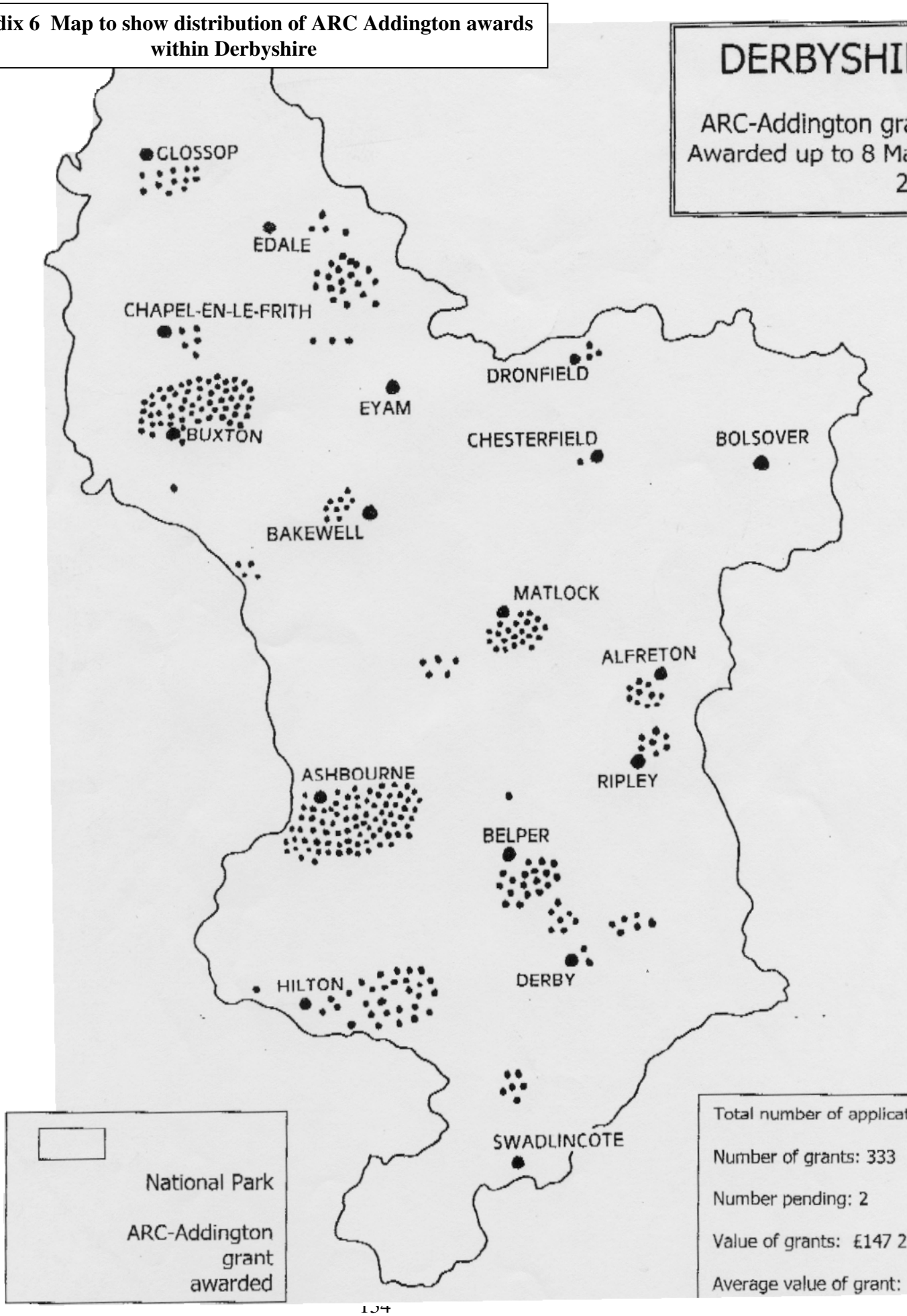
Appendix 5

Registered Farm Holdings in West Derbyshire Rural District Area

Parishes & Parish Numbers	**Number of Holdings**
Edale -144	41
Castleton – 140	22
Hope 147	37
Aston 134	5
Bradwell – 138	26
Hazelbadge – 89	6
Little Hucklow – 91	7
Great Hucklow – 82	17
Tideswell – 109	50
Wheston – 111	13
Litton – 93	24
Wardlow – 110	15
Harthill – 85	9
Gratton – 81	4
Elton – 75	19
Monyash – 95	40
Flagg – 78	24
Taddington – 108	44
Blackwell in the Peak – 69	8
Middleton & Smerrill – 94	21
Grindlow – 84	4
Great Longstone – 83	15
Little Longstone – 92	3
Brushfield – 70	3
Ashford in the Water – 64	16
Rowland – 102	1
Hassop – 87	9
Bakewell – 65	47
Over Haddon – 99	22
Nether Haddon – 96	1
Rowsley – 103	6
Stanton – 105	12
Birchover – 68	17
Aldwark – 283	11
Hartington Middle Quarter – 86	40
Chelmorton – 72	22
Youlgreave - 113	33
TOTAL	**694**

Source: DEFRA 2001

Appendix 6 Map to show distribution of ARC Addington awards within Derbyshire



Appendix 7 Accidents Reported in the Tideswell Survey

Primary farmers

- Cow kicked
- Tractor overturned
- Heavy fall on frozen ice. When carrying bucket
- Knocked over by cows into steel bar
- Heavy object dropped on the foot and broke a bone in the foot
- Broken nose when knocked over by sheep
- Slipped on wet concrete floor while cleaning calf pens out causing injury to shoulder
- Hit my index finger with a hammer
- Fall off ladder
- Went to go on to loading machine and when I was climbing up the steps, I slipped under them and pulled a muscle at the top of my leg
- Cut arm when repairing a tractor
- Pick up hitch on the back of the tractor landed on big toe. Front of toe including nail hanging off

Secondary farmers

- Cut hand on machine, had two butterfly stitches
- Dog bite
- Pulling a horse up and tore some tendons in arm causing tendonitis
- Knocked right shoulder alighting from dumper, leaving a constant ache

Non-farmers

- Trapped between wall and concrete post (finger)
- Jumped out of back of van and broke bone in left foot
- I stood up suddenly under a low rack and caught my back on a cross member

Hand & elbow twisted by children – in general course of work