Shropshire Council
Legal and Democratic Services
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

19 February 2024

Committee:
Joint Health Overview and Scrutiny Committee

Date: **Tuesday, 27 February 2024**
Time: **2.00 pm**
Venue: **Council Chamber, Third Floor, Southwater One, Telford, TF3 4JG**

You are requested to attend the above meeting. The Agenda is attached

This meeting is being hosted by Telford and Wrekin Council, please see agenda also available from here: Browse meetings - Joint Health Overview & Scrutiny Committee - Telford & Wrekin Council

Tim Collard
Assistant Director - Legal and Governance

Members of Joint Health Overview and Scrutiny Committee

Cllr Geoff Elner	Cllr Ollie Vickers (co-chair)
Kate Halliday	Cllr Nigel Dugmore
Heather Kidd	Cllr Derek White
Lynn Cawley (co-optee)	Simon Fogell (co-optee)
Louise Price (co-optee)	Hilary Knight (co-optee)
David Sandbach (co-optee)	Dag Saunders (co-optee)

Officer Contacts:

Sophie Foster - Overview and Scrutiny Officer
Shropshire Council
Tel: 01743 257714
Email: Sophie.foster@shropshire.gov.uk

Paige Starkey - Senior Democracy Officer (Scrutiny)
Telford & Wrekin Council
Tel: 01952 380110
Email: paige.starkey@shropshire.gov.uk

AGENDA

1 **Apologies for Absence**

2 **Declarations of Interest**

3 **Minutes of the Previous Meeting** (Pages 1 - 6)

4 **Urgent & Emergency Care & Winter Planning Update**

To receive a verbal update on Urgent & Emergency Care and preparedness for Winter Pressures across Shropshire Telford & Wrekin.

5 **Rural Proofing in Health and Care** (Pages 7 - 38)

To receive the report of the Shropshire Health & Overview Scrutiny Committee on Rural Proofing in Health and Care.

6 **Co-Chair's Update**

SHROPSHIRE AND TELFORD & WREKIN
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Minutes of the meeting of the Joint Health Overview and Scrutiny Committee held on 24 October 2023 1.00 pm – 4.00 pm in the Shrewsbury Room, Shirehall, Shrewsbury

Members Present:

Shropshire Councillors: Geoff Elner (Chair)
Telford & Wrekin Councillors: Ollie Vickers (co-chair) Derek White
Shropshire Co-optees: David Beechey, Lynn Cawley, Louise Price
Telford and Wrekin Co-optees: Simon Fogell, Hilary Knight, Dag Saunders

Joined via Teams (and therefore not able to be recorded as present, or able to vote)
Kate Halliday (Shropshire Councillor)

Attending from Shrewsbury and Telford Hospital Trust
Louise Barnett, Chief Executive
Sara Biffen, Chief Operating Officer
Hayley Flavell, Director of Nursing,
Dr John Jones, Medical Director
Nigel Lee, Director of Strategy and Partnerships
Helen Troalen, Finance Director

Shropshire Telford and Wrekin Integrated Care Board
Simon Whitehouse, Chief Executive

Others Present:

Sophie Foster, Overview and Scrutiny Officer, Shropshire Council
Lorna Gordon, Democracy Officer, Telford and Wrekin Council
Amanda Holyoak, Committee Officer, Shropshire Council (minutes)
Rachel Robinson, Director of Public Health, Shropshire Council (via Teams)
Paige Starkey, Senior Democracy Officer (Scrutiny), Telford and Wrekin Council

The recording of the meeting is available to view in two parts available from the links below:
Joint Health Overview and Scrutiny Committee - Tuesday, 24th October, 2023 1.00 pm (youtube.com)
Joint Health Overview and Scrutiny Committee - Tuesday, 24th October, 2023 1.00 pm Part 2 - YouTube

1. Apologies for Absence

Apologies were received from Councillors Heather Kidd, Kate Halliday (not able to be present in the room but joined via Teams)

2. Declarations of Interest

None declared.

3. Minutes of the last Meeting

Minutes of the meeting held on 5 July 2022 were confirmed as a correct record.

4. Shrewsbury and Telford Hospital Trust (SATH) Performance

The Chairman welcomed the representatives from SATH and NHS Shropshire and the Chief Executive of Telford and Wrekin Integrated Care Board, and thanked them all for attending the meeting. The Committee asked questions under the following headings:

Quality Improvement and CQC Rating

Members asked a number of questions about the amount of time that SATH had been rated as inadequate; the help and support provided to SATH since 2018: why University Hospitals Birmingham (UHB), a low performing trust itself had been chosen as an improvement partner by NHSE to support SATH; the actions agreed with NHSE to move forward to achieve an improved rating; whether these actions had been delivered as planned, whether it was possible to demonstrate the impact of the support in terms of effect on patients; and what would happen if SATH continued to be inadequate and still did not improve;

Responding to these questions, officers from SATH explained

- The national support programme had provided a team with a focus on culture change; as well as funding to support activity, fund specific roles and provide additional expertise for teams.
- UHB had provided oversight of quality improvement in nine different areas, supported with leadership capacity, and identified particular individuals to help take forward change.
- The choice of UHB to support SATH was one made by the regulators, an extremely positive outcome of that relationship had been the appointment of a high calibre Director of Nursing; A different Trust, Sherwood Forest, had provided maternity support
- Funding to support quality had been used for quality matron roles; increase support around dementia and falls and supported the safeguarding team. Two quality matron roles were now permanently funded.
- A Medical Director and Operational Director had been appointed to focus on delivery of services needed and ensure focus on a 'getting to good' programme.
- A consistent approach had been developed to incidents affecting patients with a more systematic approach to learning.
- It was difficult to measure success in terms of patient outcomes, it was easier to identify when things went wrong, but qualitative information from other organisations was used alongside more quantitative information such as number of infections and time spent in hospital.

- As well as consistent quantitative data, verbal feedback and qualitative information was used to understand progress
- The Trust was currently in the middle of a CQC assessment of core services including end of life, medicine and urgent emergency care. Initial feedback from the CQC team was that significant improvements had been made since the 2021 assessment.

The Chief Executive of the ICB believed that the reasons for an inadequate rating over such a lengthy period included silo working partly due to two acute hospital sites; serious site and estate limitations; different commissioning arrangements and complications of serving patients across two countries, all compounded by issues caused by delivering services in a rural area. He reiterated the determination to move forward to a rating that was good.

However, if SATH's rating were to remain as inadequate, the Trust and ICB would continue in segment 4 of the NHS Oversight Framework and remain within the NHSE Recovery Support Programme. Further work on the Recovery Plan would be needed and this would be the responsibility of all system partners as well as SATH, with a focus on delivering better integrated care allowing access to the right care in the right place at the right time.

The prevention work undertaken by the Health and Wellbeing Boards was crucial and work in local neighbourhood teams.

Performance

The Committee went on to ask questions about:

SATH's service performance against national standards – as it was repeatedly reported as being among the worst performing trusts; reasons for poor cancer performance and the reasons for this; the number of critical incidents - the causes of them; lessons learnt and how quantitative and qualitative feedback was used; and whether organisational culture and issues such as bullying had contributed to performance issues

Officers from SATH explained that

- Measuring performance required the collection and presentation of consistent data, but in addition verbal feedback and qualitative information was systematically collected to reflect patient experience;
- Critical incidents and overcrowded emergency departments were often a consequence of an excess number of patients who did not need to be in hospital, and work continued on preventing unnecessary admissions as well as discharging those who were medically fit for discharge. At the current time there were 150 patients with 'no criteria to reside', or fit for discharge - 100 of these were in beds ready to be discharged into an appropriate place of residence, and 50 were awaiting assessment.

- Cancer performance had declined, with a backlog partly caused by patients choosing not to attend during covid, and a downward trajectory over 62 days for treatment. Diagnostic equipment now included mobile CT and MRI scanners, two endoscopy rooms were in operation and a business case for recurring funding for three in total had been submitted. Radiographers were in short supply nationally and international recruitment efforts had taken place. It was anticipated that performance would meet the standard required by end of March 2024.

In responding to questions about organisational culture, the Medical Director said that in any organisation employing 7,000 people, problems and challenges such as bullying would be a feature. However risks were greater in a health care organisation and action had been taken to support good relationships and establish a culture where staff felt safe to speak up, with the ability to do so anonymously. He was confident that an open and consistent approach was taken when concerns raised about bullying, harassment and poor conduct were raised.

Service Development

The Committee asked questions about:

Future bed provision and whether planned numbers would be adequate to meet the needs of a growing population with an older demographic; impact of less money than expected being available for hospital reconfiguration; specialist services delivered on a hub and spoke model and what ambitions there were to retain specialist services in Shropshire where SaTH would be a hub rather than a spoke meaning that people would have to travel further as was the case with urology and neurology.

In responding to these, NHS officers reported that:

- Extensive capacity and demand analysis had been undertaken for the next ten years, taking into account information such as Cancer UK projections and developments in treatments and options, for example, some treatment that five years ago would require overnight admission could now be undertaken as a day case.
- SaTH was committed to provision of services as close to home as possible, however workforce challenges and the numbers needed to provide a service meant that some specialised provision needed to be grouped together across hospitals - meaning that people would have to travel further to access it. People having to travel further within the county rather than out of the county was always the preferred option.
- Despite less money than originally anticipated being available for the reconfiguration, core objectives could still be met and the strategic outline case commensurate with £312m had been approved. Increasingly places of work

were for integrated teams, involving social care, mental health staff and others. Other funding had been identified for the elective hub.

Questions for Integrated Care Board

Responding to questions from the Committee regarding the timeframe for strategic planning in the NHS, drivers for this and how plans complemented each other at a strategic level, the Chief Executive of the ICB reported on the establishment of Integrated Care Boards through the 2022 Social Care and Health Act. A Joint Forward Plan had been published earlier in the year which set out how all partners in the Integrated Care System would work together to deliver the priorities jointly agreed over the next five years., taking the view of communities into account.

Members referred to presentations about maternity services provided to the Committee on previous occasions and expressed disappointment that the opportunity to report on neo-natal mortality data had not been taken at these meetings, to allow the chance of questions around reasons for higher rates than the national average.

The Committee wished to support the NHS in understanding and addressing problems as they occurred and would rather have heard about this issue and others directly, rather than from the media. The Chief Executive of SaTH and her colleagues made a commitment to work with the committee going forward and thanked members for the opportunity to attend the meeting, recognising the committee had an important role to play in addressing key issues.

Committee members had also asked questions in relation to the following during the course of the meeting

Please provide in a table format what investment both capital and revenue has been made into the cancer/diagnostic service.

1. What investment has been made?
2. What has been purchased with it?
3. What was it expected to deliver?

How many critical incidents there have been and how does this compare with other similar hospitals?

The Chief Operating Officer had agreed to provide this information

A member had asked if minutes taken at meetings of the common committee with University Hospital Birmingham be made available now that the arrangement with UHB had concluded be made available to the Committee?

The Chief Executive, SaTH had said she would look into this.

The Committee also said it would welcome sight of the Hospital Transformation Plan.

The Chair and Committee thanked such a large contingent of SaTH representatives for attending the meeting, along with the Chief Executive of the ICB. This had been much appreciated and members looked forward to working together on a positive basis into the future.

The Committee then went on to discuss its next steps in light of the discussion at the meeting. Discussion covered:

- The possibility of the committee developing a data set that could be easily refreshed and understood to allow focus and allay concerns;
- how best to utilise reports available online regarding SaTH performance and outcomes;
- The need to understand fully why patients with no criteria to reside were consistently between 110 and 160 ;
- The need to talk to the Community Health Trust about admission prevention and discharge;
- The need to take up the issue of the social care situation and impact on discharge with each council;
- The reasons for assessment delays impacting on discharge rates;
- The possibility of buying community step down beds in a way that is sustainable for those supplying them, to facilitate discharge;
- Issues around lack of therapists and lack of incentivisation to join or return to therapy services;
- The need for advanced communication from Trusts when issues arose;
- The possibility of meeting CQC to ask about 'red flags'

It was agreed to recommend that each authority's HOSC should undertake further work on numbers of patients remaining in hospitals with no criteria to reside and that further work leading on from today's meeting be conducted along the following themes: the nature of reports needed from SaTH showing performance and outcomes; finance, virtual wards, recruitment and securing information from CQC in relation to understanding 'red flags'.

10. Co-Chairs Update

The Chairs said that consistent common areas could be reported back to Joint HOSC Informal sessions which could then be used to prioritise and plan to get the best out of formal meetings.

.

The meeting concluded at 4.00 pm.

Joint Health Overview and Scrutiny Committee

27 February 2024

Item

Public

Healthy People | Healthy Economy | Healthy Environment | Healthy Organisation

Report of the Health Overview and Scrutiny Committee- Rural Proofing in Health and Care

Responsible Overview and Scrutiny Officer:	Sophie Foster		
email:	sophie.foster@shropshire.gov.uk	Tel:	01743 255248
Health Overview and Scrutiny Chair:	Cllr Geoff Elner		
Task and Finish Group Chair:	Cllr Heather Kidd		

1. Synopsis

To report the findings and recommendations of the Rural Proofing in Health and Care Task and Finish Group following their investigation looking at the options to effectively 'rural proof' the amendment or introduction of strategies, plans, policies and service design and provision in health and care in Shropshire which have been adopted by the Health Overview and Scrutiny Committee.

2. Executive Summary

2.1. This is the report of the Health Overview and Scrutiny Committee which adopted the report of the Rural Proofing in Health and Care Task and Finish Group. It sets out key findings, conclusions and recommendations of their work considering delivering health and care services to rural communities. The members of the Task and Finish Group have been clear from their first meeting about the topic, that addressing any inequalities of service provision between rural and urban areas requires a system wide understanding of the opportunities and challenges. Having this will help to identify the most suitable and effective options that need

to be explored and implemented to effectively 'rural proof' the amendment or introduction of strategies, plans, policies and service design and provision in health and care in Shropshire.

2.2. This work arose from Members of the Health and Adult Social Care Overview and Scrutiny Committee (now Health Overview and Scrutiny Committee) frequently highlighting concerns about rurality and access to health and care services through their work. This Task and Finish Group was therefore commissioned to draw together the key points and observations that have arisen through the work of the committee during 2022/2023, to review the latest local and national evidence on rural proofing, hear from local system providers and take the opportunity to learn from other areas of the country.

2.3. Against this context, the Task and Finish Group has looked in detail at the available data and information, carrying out a desk top review of the available research and case studies into rural proofing and the impact of living rurally on access to health and care services. Hearing from customers, service users, and patients about their experiences of accessing health and care when living rurally. Hearing from providers of health and care services about current approaches to delivering/serving rural communities and sought evidence and learning from other areas of the country.

2.4. The system and organisations that have fallen within the scope of this work are complex, multi-dimensional and dynamic. With national, regional and local actions and activity being identified and reviewed whilst the task and finish group has been in operation.

2.5. The Group have made 14 recommendations which they believe will contribute to addressing inequalities of service provision between rural and urban areas including recommendations:

- to Shropshire Council
- to the Integrated Care Board
- promoting a system working approach across all Integrated Care System stakeholders
- promoting a consistency of approach with local and regional partner Councils

3. Recommendations

Members are asked to:

3.1. Consider and comment on the report and recommendations of the Task and Finish Group attached at appendix 1.

3.2. From the 14 recommendations that were outlined in the report, the JHOSC are asked to endorse those which are included in section 7 of this report.

Report

4. Financial Implications

4.1. Whilst there are no direct financial implications from this Task and Finish Group report, should the committee adopt the report then appropriate financial advice on the costs involved should be sought.

5. Climate Change Appraisal

There are no identifiable impacts on the climate from the recommendations made to this committee in this report.

6. Background

6.1. Members of the Health and Adult Social Care Overview and Scrutiny Committee (now Health Overview and Scrutiny Committee) had highlighted concerns about rurality and access to health and care services through their work. This Task and Finish Group was commissioned to draw together the key points and observations that have arisen through the work of the committee during 2022/2023, to review the latest local and national evidence on rural proofing, hear from local system providers and take the opportunity to learn from other areas of the country.

6.2. The task and finish group has carried out its work with a strong focus on learning from the available information by organising its review around three stages:

- Carrying out a desk top review of the available research and case studies into rural proofing and the impact of living rurally on access to health and care services.
- Hearing from customers, service users, and patients about their experiences of accessing health and care when living rurally.
- Hearing from providers of health and care services about current approaches to delivering/serving rural communities.

6.3. This has included learning about the findings of the work completed by the National Centre for Rural Health and Care to produce the Rural Proofing for Health Toolkit.

6.4. They have heard from a wide range of people and organisations via written submissions and through witnesses attending their meetings; providing the opportunity to share their knowledge and experience of receiving or delivering health and care services in rural communities.

6.5. Their key findings, conclusions and recommendations are set out in their report, attached at appendix 1.

6.6. Specific points of focus in the recommendations include:

- That an end-to-end evaluation of the travel and transport infrastructure which supports the Shropshire health and care system should be completed by the Integrated Care System to understand how accessible and effective the current provision is and to identify current and future demand. The evaluation should include:
  - Patient Travel Support
  - Public Transport
  - Concessionary Travel
  - Community Transport
  - A review of how health and care transport is co-ordinated at a system level
  - A mapping exercise to identify community capacity available to deliver voluntary community transport schemes, and whether there are sufficient services available and how best to provide an equitable service closing the gaps overall and in specific locations.

- The Group were very pleased to learn that the Rural Proofing for Health Toolkit had been recommended for use within the Integrated Care System (ICS) by Simon Whitehouse (Chief Executive Officer for Shrewsbury Telford and Wrekin Integrated Care Board) and Cllr Cecelia Motley (in her role as Co-Chair of the Health and Wellbeing Board.) The Group recommends that the Toolkit be fully adopted into the Integrated Impact Assessment process of the ICS and all organisations whom it commissions and should be accepted as a mandatory document to be completed when making changes to or introducing a new strategy or plan making process, so it can inform thinking from the outset.

6.7. The Group also propose that the Shropshire Health and People Overview and Scrutiny Committees adopt the Rural proofing for Health Toolkit as a part of their own overview and scrutiny processes to act as a framework to support them in maintaining a robust view on the needs of local rural populations when they review strategies, initiatives and service delivery plans.

6.8. The Group also believes there exists the opportunity that the Rural Proofing for Health Toolkit be recommended at a regional level for use by its partner local authority of Telford and Wrekin to support the work of the Joint Health and Overview Scrutiny Committee. That this could be broadened to include the Shropshire Association of Local Councils for use in their work with Parish Council's, creating a consistency of approach to rural proofing, and making the links to the local Joint Strategic Needs Assessments that are being developed.

6.9. There is then opportunity and scope to expand the use of the toolkit to Herefordshire, Monmouthshire and Powys to help provide evidence for cross border working and shared outcomes for the newly founded Marches Forward Partnership. The formal adoption of the toolkit could be stated as part of the Memorandum of Understanding by all the authorities, helping to embed rural

proofing of health and care, contributing towards a greater shared understanding of the opportunities and challenges of delivering health and care services to rural communities.

7. Report Recommendations

7.1. The Group agreed that the use of the Rural Proofing for Health Toolkit be recommended to all partners of Shropshire's Health and Care system. That the Toolkit also be adopted for use by the HOSC and JHOSC to review any changes or new services that are being implemented to ensure they have been 'rural proofed'.

7.2. That a deep dive be carried out into recruitment and retention policies and practices in the local health system by the Joint Health Overview and Scrutiny Committee including a review of best practice nationally encompassing the approaches recommended by the Rural Services Network to see if they would work in Shropshire and Telford and Wrekin.

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)

Local Member:	All

Appendices

Appendix I: Report of the Rural proofing in Health and Care Task and Finish Group

This page is intentionally left blank

Shropshire Council

Health Overview and Scrutiny Committee

Report of the Rural Proofing in Health and Care Task and Finish Group

20 November 2023

Acknowledgments

The Task and Finish Group would like to thank the officers, partners and witnesses who have given up their time to share their knowledge, experience, and perspectives on the challenges and opportunities associated with delivering health and care services to rural populations. The Group were very appreciative of the positive levels of engagement from all parts of the health and care system and have used the evidence collected to propose a consistent set of criteria to be recommended for use to evaluate rural proofing in strategies, plans, policies and service design and provision in health and care in Shropshire.

Members of the Task and Finish Group

- Cllr Heather Kidd (Chair)
- Cllr Geoff Elner
- Cllr Roger Evans
- Cllr Julia Evans
- Cllr Julia Buckley
- Cllr Edward Towers
- Cllr Ruth Houghton
- Cllr Roy Aldcroft

Contents

Report

Introduction

Context

Ensuring access to health and care services is a complex, multi-dimensional challenge which has become more pressing with the impact of wider societal factors such as the coronavirus pandemic and the cost-of-living crisis. Dimensions of access are particularly evident in rural health and care systems such as Shropshire where additional structural barriers make access more challenging.

Members of the Health and Adult Social Care Overview and Scrutiny Committee (now Health Overview and Scrutiny Committee) frequently highlight concerns about rurality and access to health and care services through their work. This Task and Finish Group was therefore commissioned to draw together the key points and observations that have arisen through the work of the committee during 2022/2023, to review the latest local and national evidence on rural proofing, hear from local system providers and take the opportunity to learn from other areas of the country.

The members of the task and finish group have been clear from their first meeting about the topic, that addressing any inequalities of service provision between rural and urban areas requires a system wide understanding of the opportunities and challenges. Having this will help to identify the most suitable and effective options that need to be explored and implemented to effectively 'rural proof' the amendment or introduction of strategies, plans, policies and service design and provision in health and care in Shropshire.

With this clarity, the Task and Finish Group scoped their work around three key stages:

- A desk top review of the available research and case studies into rural proofing and the impact of living rurally on access to health and care services.
- Hearing from customers, service users, and patients about their experiences of accessing health and care when living rurally.
- Hearing from providers of health and care services about current approaches to delivering to/serving rural communities.

The view from the national perspective

The challenges of delivering health and care services to rural communities have been identified nationally by several organisations and observers, including the House of Lords Select Committee on the Rural Economy, which considered rural health services as part of its 2019 inquiry into the rural economy. Amongst its findings, the committee's report, 'Time for a strategy for the rural economy'[1], published on 27 April 2019, said challenges included:

- Older populations
- Funding challenges
- Access to services
- Poor connectivity
- Issues of isolation and loneliness

The House of Lords reaffirmed their concerns over how health care was being delivered to rural populations nationally in the 'In Focus' article published on 17 February 2023[2], which included recommendations from the Royal College of Nursing, Nuffield Trust, Organisation for Economic Co-operation and Development (OECD) and the All-Party Parliamentary Group on Rural Health and Care which was published February 2022. With the government currently

reviewing the issue of health and care in rural areas as part of its wider 'Levelling Up' agenda which incorporates twelve 'missions', including health.

In March 2021, the Department for Environment, Food and Rural Affairs (Defra) published its report 'Rural proofing in England 2020'[3]. The term 'rural proofing' describes when policy makers and analysts consider how to achieve their policy objectives in rural areas. The report was published in response to recommendations made in the House of Lords Select Committee on the Rural Economy's report, 'Time for a strategy for the rural economy 2019[4]'.

The foreword to 'Rural proofing in England 2020' said that it aimed to "improve transparency and accountability by illustrating how rural proofing is planned and coordinated across government, and by demonstrating the various innovative ways in which rural needs are being successfully identified and met".

Defra's second report on rural proofing published in September 2022 'Delivering for rural England'[5] sets out the national 'rural position' as follows, which reflects the findings of other organisations:

- In 2018 in England, the average life expectancy was 79.6 years for men and 83.2 years for women. Life expectancy is slightly higher in rural than in urban areas.
- The rural population is older than the urban population and its average age is increasing faster with implications for health and social care needs.
- Distance can mean that some health services are less accessible. The average minimum travel time to a hospital is approximately one hour in rural areas, compared with approximately half an hour in urban areas, with difficult road conditions meaning that emergency transfers can take longer for rural residents.
- Delivering community-based care can be more expensive in more sparsely populated rural areas.
- It can be more difficult to recruit health care professionals to rural areas.

The report, noted that the government had a number of measures in place to address challenges of delivering health care in a rural setting:

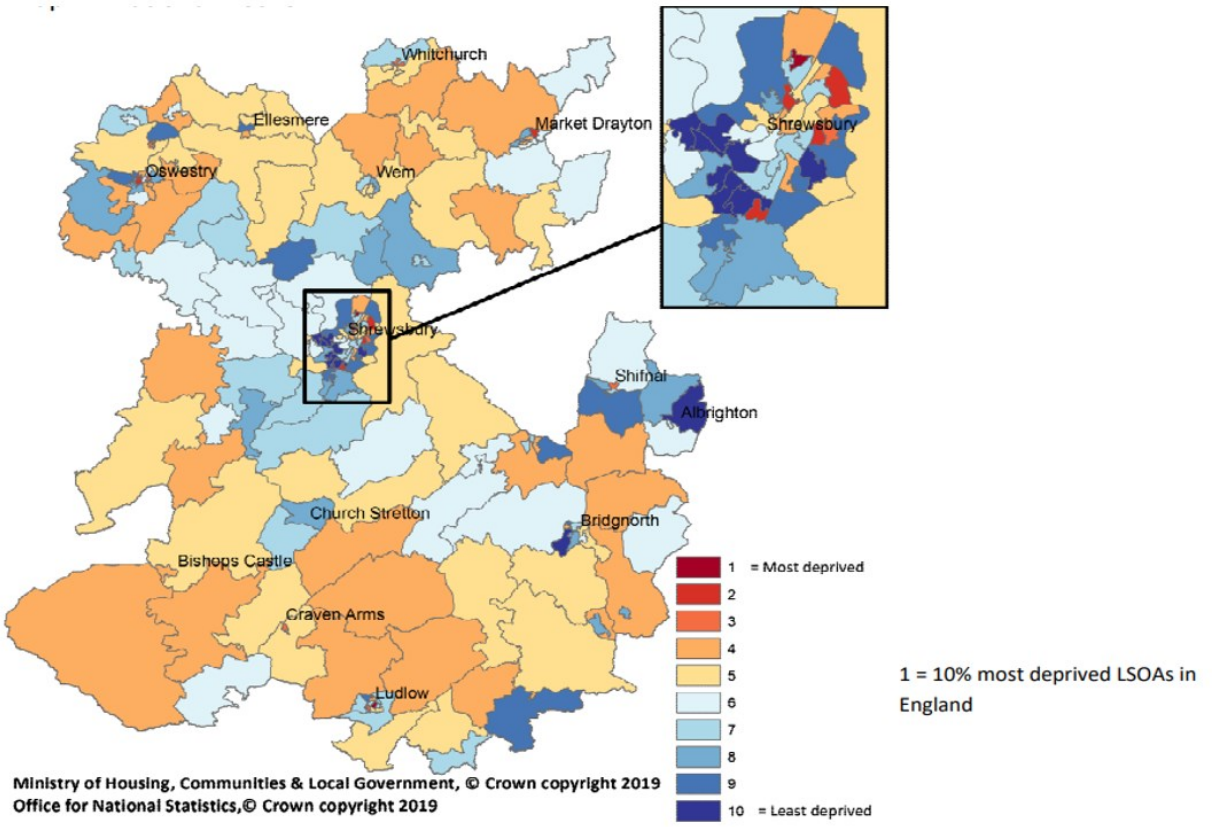
- Pharmacy access scheme. This £20mn scheme provides funding to support pharmacies to stay open to provide accessible primary care. The government has said that there are 1,230 rural pharmacies in England and 46% of these qualify for support under the scheme. The scheme will remain in place "until at least the end of 2023".
- NHS community pharmacist consultation service. This scheme, launched by NHS England in October 2019, enables patients to get same-day appointments with a community pharmacist for minor illnesses or the urgent supply of a regular medicine. The government has said that this improves access to services and provides convenient treatment closer to a patient's home. The service includes referrals from general practice and the government has said that it is looking at whether the approach could be further expanded.
- Targeted enhanced recruitment scheme. This scheme funds a £20,000 salary supplement to encourage trainee GPs to work in areas where training places have been unfilled for a number of years. The government has said this includes rural communities. The government has been increasing the number of places on the scheme. There were 550 in 2021 and 'Delivering for rural England' said the government would fund 800 places in 2022. The government has also said that trainees on the scheme "usually stay after training, helping to sustain the GP workforce in rural areas".
- 'Delivering for rural England' also considered health care in rural areas as it is impacted by other factors. On transport, Defra said that rural areas typically suffered

from poor connectivity. It said that the Department for Transport's forthcoming 'Future of transport: Rural strategy' would "guide local authorities, transport operators, and the private sector towards a future transport system which maximises the benefits of new technologies and business models for rural and remote communities". The report said this would make it easier for people to access health care. A written answer given on 9 February 2023 said that the 'Future of transport: Rural strategy' was "soon to be published".

In a November 2022 written answer[6], the government stated that integrated care boards (ICBs) are responsible for making appropriate provisions to meet the health and care needs of local populations. It has said that the core ICB allocations formula is adjusted to allow for differences in the costs of providing health care between rural and urban areas. P5-10

The local perspective

Shropshire is the second largest inland county in the country and whilst there are eighteen market towns, the remainder of the county is more rural and sparsely inhabited. Although there are no stark levels of deprivation across the county, there are pockets of deprivation in market towns and rural areas, particularly with issues of low pay and poor physical and digital access to services and facilities.



The Task and Finish Group found that the rural nature of Shropshire and the opportunities and challenges this can pose are acknowledged in local health and care systems policy development and strategic planning. The Shropshire, Telford & Wrekin Integrated Care System Priorities include deprivation and rural exclusion. There is also an acknowledgement within the Joint Forward Plan 2023[7] that "a largely rural Shropshire in contrast with a relatively urban, deprived Telford & Wrekin provides challenges to developing consistent, sustainable services with equity of access and long drive times to access acute services." P27

Within Shropshire Council's strategic 'Shropshire Plan 2022-2025'[8] there is a commitment to "tackle inequalities, including rural inequalities, and poverty in all its forms; providing early support and interventions that reduce risk and enable children, young people, adults and families to achieve their full potential and enjoy life" P1

Within Shropshire Council's Health and Wellbeing Strategy 2022-2027[9] it is recognised that "Shropshire has many strong and vibrant rural and town communities. We will work with our communities to engage and find out what matters, reduce inequalities, promote prevention, increase access to social support and influence positive health behaviours. We will also pool information and resource to support people in our communities." P9

The Group was able to find the beginnings of these priorities translating into collective action form the Local Authority and Integrated Care Board. The Joint Strategic Needs Assessments data being identified by system partners as providing opportunities to further develop effective joined up working by identifying the strategic priorities which will inform the commissioning of services and activities by the Integrated Care System going forward.

On the wider issue of funding for rural residents, the Rural Services Network (RSN) has argued that rural local authorities such as Shropshire are not getting enough funding. Referencing the 2024 local government finance settlement[10], the RSN stated that:

- Rural areas in 23/24 will still receive some 38% (£135) less per head in Government Funded Spending Power (which excludes Council Tax) than their urban counterparts.
- Rural residents will pay, on average, 17% (£1040) per head more in council tax than their urban counterparts due to receiving less government grant.
- Rural residents will get 13% per head less in social care support overall.

The RSN said that "rural residents pay more, receive fewer services and, on average, earn less than those in urban areas and that is inequitable". They state that "closing the gap between the Government grant to the urban dweller and the rural dweller by only 10% over 5 years (for instance) would make a massive difference to rural services. In Shropshire it would provide an extra £13,000,000 per annum at the end of this five-year period."[11]

The RSN also states that in respect of Public Health Grant allocations for 2023/24 predominantly rural councils receive £45.70 per head of population compared to £73.85 for those councils serving predominately urban areas.

Scope and focus of the work
The task and finish group sought to:

- Set out/define what 'rural' and 'rurality' means for the Shropshire Council area, including inequalities and access to services
- Understand what rural proofing means for Shropshire
- Identify a view/position on rural proofing affecting Shropshire communities and services (based on work during the year), and through additional research
- Use the evidence collected to propose a consistent set of criteria to be recommended for use to evaluate rural proofing in strategies, plans, policies and service design and provision in health and care in Shropshire

What has the task and finish group done?
To conduct this review the group:

- Carried out an initial scope of the issues that it wanted to investigate and to determine the evidence that it would need to conduct the review.
- Conducted desktop research and analysis to inform the consideration of rural proofing in health and care services.
- Undertook desk top research to identify best practice from other parts of the country.
- Heard from a range of different witnesses across the voluntary, health, care, and public sectors.
- Heard from service users, customers, and patients about their experiences of accessing health and social care when living in a rural community.
- Members considered the findings of the work completed by the National Centre for Rural Health and Care and Rural England C.I.C to produce the Rural proofing for Health Toolkit.

Who the Task and Finish Group Heard From?
The Task and Finish Group heard from a wide range of people and organisations via written submissions and through attending their meetings; providing the opportunity to share their knowledge and experience of receiving or delivering health and care services in rural communities. Please see Appendix 1 for the full list of whom the group heard from during their considerations and meetings. Appendix 1

Key Findings
Rural living is often thought of and portrayed as idyllic and can have a huge appeal. For example, rural areas are perceived as offering more peace and quiet, a slower pace of life and access to beautiful countryside. Rural living is seen to offer opportunities to stay active and as having a greater sense of community spirit. Yet, as the findings of this report shows, for many of those living in rural areas, especially those with additional needs or vulnerabilities rural life can be very different. The Group found that the situation in Shropshire is reflective of what this report described in the national context for rural communities.

Shropshire contains significant areas which are sparsely populated, with scattered dwellings and settlements further apart from each other than in urban areas and with poorer transport infrastructure, making it harder to access vital services, get to work and maintain social connections. The evidence reviewed has shown that on average people living in rural areas have higher life expectancies and report slightly better wellbeing (Annual Population Survey, 2018[12]). There are higher levels of home ownership and evidence of stronger social capital compared to their urban counterparts; with 78% believing people in their neighbourhood could be trusted, compared to 61% of urban dwellers (Understanding Society, 2012[13]). National Statistics often mask the rural situation in local areas. Look beneath these figures and you can see that there are inequalities. The When the Safety net Fails 2023[14] report produced by Citizens Advice Shropshire outlined that those higher levels of home ownership disguise higher levels of fuel poverty, with many homeowners ‘asset rich’ but ‘cash poor’. The people they spoke to told them they must make tough choices with their money all day, every day, with no room for errors. For those they spoke to, this balancing act was often impossible. It was common for people they interviewed to have gone without essentials such as adequate shelter and food.

Strong community spirit and social capital mask pockets of social isolation. Higher than average life expectancies overall hide some communities with much poorer health outcomes. The geography of rural areas can prove problematic for delivery of and access to health and care. The Task and Finish Group sessions have identified a range of the issues and

challenges, as well as potential solutions and possible action areas for rural proofing of health and care services.

The general themes identified by Members from the evidence reviewed in relation to which areas needed to be considered when thinking about rural proofing health and care services were:

Geography
The largest population centres in Shropshire are located in the market towns, the remainder of the county is more rural and sparsely inhabited. There are communities living across the wonderful landscape unlike authorities such as Cumbria where there are areas which are uninhabited. The Group therefore recognised that their recommendations must be based on an understanding of Place that embraced the fact that different communities had different needs and therefore ways to meet them.

Shropshire's beautiful landscape whilst an undeniable asset can also pose issues. The Task and Finish Group heard from community transport voluntary sector organisations, care providers and service user case studies that some rural areas in Shropshire comprise such steep valley topography that it presents an accessibility challenge. The issue of the remoteness of some homes was also highlighted with them being described as very difficult to access safely as they are up steep roads with no pavements, no public transport which serves them and poor road conditions meaning that physical and social isolation is a real risk, especially in adverse weather conditions. The Group heard from voluntary sector organisations, service user testimonies and Shropshire Council Officers how it is very difficult to receive and provide care especially domiciliary care in these circumstances.

Provision

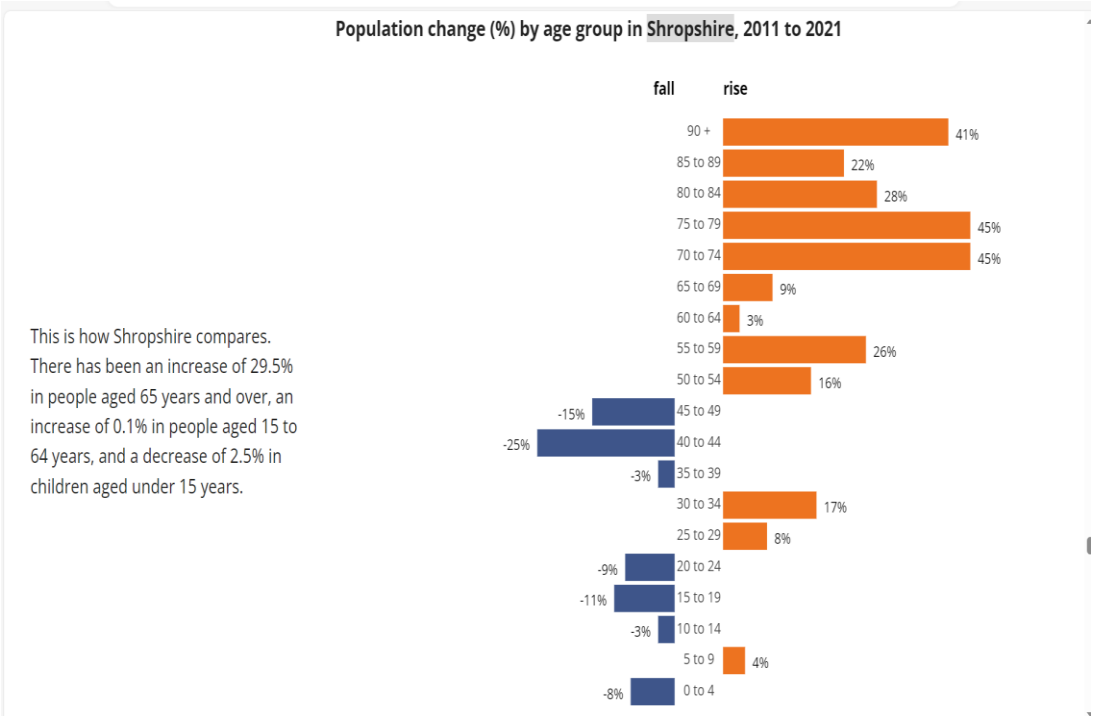
Comparison of geographic provision
(Locations identified as geographic neighbours/sharing services, and family group local authorities)

Local Authority	Area (sq. miles)	Population (Census 2021)	Population increase	65+ population	Population density (per hectare)	Additional comments	Hospitals in the area (Acute and Community)
Shropshire	1,235	323,600	5.7%	25%	circa 1 person per hectare	Households are spread across all areas of the geography.	1x Acute Hospital (RSH) 3x Community Hospitals (providing MIU) 1x Health Centre (providing MIU)
Telford and Wrekin	112.1	185,600	11.4%	17.6%	5.7		1x Acute Hospital (PRH)
Powys	2,008	133,200	0.2%	27.7%	0.26	Large areas are not inhabited due to landscape/ geography	9x Community Hospitals (4 providing MIU)
Northumberland	1,936	320,600	1.4%	24%	0.6	97% rural 50% live in 3% of urban land in the SE of county Large areas are not inhabited due to landscape/ geography	1x Specialist Emergency Care 3x General Hospitals (Urgent Care Centres) 5x Community Hospitals (3 providing MIU) 1x new integrated health and social care scheme for patients requiring inpatient support for people following illness, injury or time in hospital) 1x NHS Centre
Cornwall	1,376	570,300	7.1%	25%	1.4	40% live in communities of less than 3000 people 4m tourists per year	1x Acute Hospital 1x Hospital with 24hr Urgent Care Centre 10x Community Hospitals (9 providing MIU)

15

The Group observed that Northumberland having a similar sized population and specifically older population to Shropshire provides health services through a model which included a larger amount of local provision community hospitals. The Group did note that the distribution of the population within the two areas was very different with Shropshire seeing households spread across the whole county whilst in Northumberland most were clustered around a particular urban area in the Southeast.

Demography
The geography of rural Shropshire has huge appeal for many, including to those in later life who look to retire to the countryside. The table below [16] outlines the growth in the 50+ population and this is predicted to continue to grow in the future.



The Centre for Ageing Better summarises the findings of the Group in its Ageing in a Rural Place 2021 report.[17] Shropshire like society more widely, is undergoing an age shift with Shropshire showing a 29.5% increase in the number of people aged 65 and over between 2011 and 2021. The rapid demographic change in rural areas is often driven by inward migration of older people seeking to retire and the outward migration of young people heading to towns and cities for education and work opportunities. The increase in the older population presents a specific challenge to the delivery of health services owing to greater incidences of chronic illness, disability and mortality within this demographic. Those aged 85+ are, on average, likely to have more complex (and expensive to meet) needs. This all highlights the need for rural areas to focus on a preventative approach to ensure that those in mid-life now reach later life in good health, whilst staying financially secure and socially connected.

Transport
For most people the Group spoke to, transport was a big issue. Bus routes have been cut over many years, leaving a fractured public transport system and rural residents more dependent on cars. We know from 2021 Census Data that in Shropshire 28.5% of people in employment aged 16 years and over travel 10km or more to work. Of those, 54.8% travel to work by driving a car or van. There is therefore a reliance on private motor vehicles which can impact on those not old enough to drive, who can no longer drive or who don't have access to a vehicle. The Group heard that essentials such as fuel are more expensive in rural places with the Rural Services Network reporting that it is on average 1.2 p per litre more expensive. The cost-of-living crisis has intensified these pressures making affording a car or fuel for it more challenging than ever for some.

The RSN has produced figures for 2022/2023 which show that in respect of public transport, predominantly urban authorities budgeted to spend £76.3 per head of population being some

74% more than predominantly rural councils (at £20.1 per head.) Public transport is a discretionary service and overall RSN figures show for 2022/2023 that predominantly urban councils budgeted to spend almost double the amount on discretionary services per head compared to predominantly rural authorities (£131.3 compared to £67.0.)

Transport for young people in rural areas, in particular came through, with high costs and reductions in services causing anxiety for young rural residents and their families. Although not directly a health or care issue the Group felt it was important to highlight these concerns as it was likely to have an impact on their wellbeing, access to opportunities and may be a contributing factor to the changes explored in the demographics section of this report.

Challenges for people to access health and care appointments in rural areas, came through very strongly. Patient Travel Support which provides free transport to and from hospital for eligible people including:

- those whose condition means they need additional medical support during their journey
- those who find it difficult to walk
- parents or guardians of children who are being transported

was identified as posing several challenges. Patient and service user experiences laid out that the criteria for eligibility was complex and unclear with many rural residents being signposted to community transport groups to provide support with travel to hospital even though they were not within their delivery area. The Group heard that transport provision overall for health and care services was confusing for service users to navigate.

The Group heard from community transport providers who work across the England and Wales border that Powys has an effective Patient Transport System and could be investigated to identify best practice**.**

Community transport was identified as an essential feature of community life where volunteer drivers help people access social events, shops and services including health appointments. The Group identified some areas of the county where there is no public or community provision available, and people rely on expensive taxies or family and friends to support them. This is feasible for a one-off appointment, however the group heard that for patients requiring regular ongoing treatment that costs and pressures can make attending their appointments impossible. Several risks and issues were shared which prevent current schemes expanding or new ones being created to support those in need including barriers such as:

- Fuel
- Parking
- Rising costs
- Reduction in the numbers volunteering
- Growth in demand
- Increased legislation

It was highlighted by voluntary groups who co-ordinate and organise health and social support for those living rurally how vital community transport is to their service users. Many would not be able to access their services without it and highlighted that transport is a major potential barrier to access and more specifically to prevention initiatives being successful.

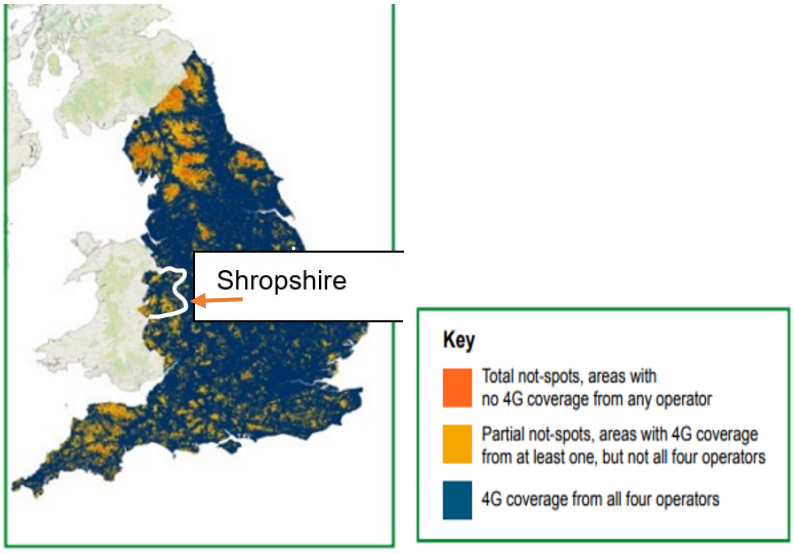
Concerns about the physical infrastructure of the road network in rural areas came through, as did safety whilst on the roads. This was highlighted by care workers and community transport volunteers who stated that with poor road surfaces, no pathways, lack of streetlighting and narrow roads that they often feared for their vehicles and at times themselves. Thus, making reaching some rural residents very challenging.

Digital Connectivity
Improving digital connectivity was highlighted as a national as well as local issue. In the government report Delivering for rural England – the second report on rural proofing [5] connectivity is described as “arguably the single most important way to support levelling up in rural areas. Digital connectivity is an important driver of productivity, enabling businesses and individuals to take full advantage of the growing opportunities available online, but it is more than just an economic necessity. It is also a matter of social justice. As more and more services, both public and private, are delivered electronically, the government does not want those who live in rural areas to be denied access to them simply because their broadband is not good enough or there is no mobile signal.” P15 The government has therefore introduced two initiatives to improve rural connectivity - Project Gigabit and the Shared Rural Network.

Project Gigabit is a national initiative to provide funding to support gigabit-capable infrastructure in hard-to-reach, rural areas. The government received over 3,300 responses to its call for evidence on ‘Improving Broadband for Very Hard to Reach Premises’. These responses highlighted the challenges faced by, and potential opportunities available to, rural and remote communities. The government will use this evidence to assess policy options to support those unable to access a gigabit-capable connection through either a commercial or government-funded roll-out. The government will publish further information later in 2023.

The Shared Rural Network is the second government initiative which aims to provide people with high-quality and reliable mobile coverage wherever they live in the UK. Typically, rural areas have tended to be less commercially attractive to mobile network operators and as a result some rural areas are underserved, lacking good quality reliable mobile coverage. The table below shows the 2022 levels of 4G coverage and areas with unreliable or no coverage.

In 2025 analogue copper phone services are planned to be withdrawn nationally. The Local Government Association (LGA) and National Farmers Union (NFU) have both identified potential risks with this approach. The LGA are concerned that there is a huge lack of awareness among residents about the coming changes and that there is a need for government to spread the message through communications campaigns, including adequate funding to support the above. The NFU highlights the risks to rural communities if they have to rely on a broadband connection for calling as it creates a vulnerability to power outages.
In most cases, mobile signal provides a backup in case of emergency, however, in areas of poor mobile signal, a battery back-up is expected be offered to customers so that during a power outage, emergency calls can still be made on the household phone.
The NFU and RSN are also working with BT and other providers to ensure that rural communities are not left without sufficient support and access to working home phones in any emergency situations and continue to press the importance of rural mobile access to industry and government. Members of the Group were able to provide their own experiences of vulnerable members of their communities who have been left without landline access due to analogue lines being downed in adverse weather and how it has taken up to six weeks to have these repaired, leaving residents without their emergency call buttons if they fall.



18

In Shropshire health and care system too, the local digital strategies all acknowledge the vital role played by online and digital services. They also highlight that Shropshire's geography poses challenges to providing equitable access to online and digital services, but not all are explicit about how to address these. [18, 19, 20].

The Shropshire Council ICT and Digital Strategy [18] sets out how it plans to deliver equitable service access to all citizens and acknowledges that "users need more than just encouragement and education, they need affordable connectivity, they need devices, and in some instances, they will also need specialist software that supports those with disabilities." P15-16 The Strategy proposes to support citizens who don't have a computer at home, by enabling them to use public access computers at a council face to face service point. The Strategy also suggests that if someone does not have their own device that councils elsewhere have participated in schemes to redistribute unwanted but serviceable laptops, tablets and smartphones from organisations which regularly replace their devices. The Group welcomed the ideas laid out in the plan. However, from the evidence they had heard from people living very remotely with little access to transport; the Group felt that there needed to be a more proactive element to the support on offer and recommended the investigation of the feasibility of utilising mobile vehicles such as library vans where the staff are already well known to the local population and have a transferable skill set.

Whilst the Group welcomed the national and local strategies; the evidence heard demonstrated that online and digital services and products whilst offering innovative and efficient methods of delivery can also act as a significant barrier to access for some. The service user case studies highlighted the risks of creating significant inequalities for rural service users, especially the elderly and other vulnerable groups who find the move towards digital becoming an increasing barrier to accessing services. The findings of the group were summarised in the report by the Greater Manchester Digital Inclusion Network, 'Issues of wider digital and technological exclusion for older people[21]' which identified the following as barriers to access to online and digital services:

- Finance
- Impairments
- Knowledge
- Connection

These experiences were echoed by the Group themselves who were able to provide several examples where the use of online/digital access as the only method to interact with a service had caused vulnerable people to be negatively affected.

The impact of wider digital and technology exclusion was also highlighted through the evidence, identified as including:

- Reduced independence and autonomy
- Limited mobility
- Negative impact on health and wellbeing
- Anxiety inducing
- Leading to people paying more than necessary

The evidence heard by the Group bore out the findings of the LGA report Health and Wellbeing in rural areas[21] that to provide services in rural geographies an innovative mixed delivery approach is required. Including multiple points of entry to access into health and care services, multi-channel options for the use of these services including the use of mobile or outreach vehicles. This approach has been shown to provide meaningful alternatives to digital, with some face-to-face support available within accessible locations or being taken to the most vulnerable.

The direction of travel for many organisations is to online, with digital application processes as default. Whilst the Group acknowledges there are many benefits to this way of working, they were presented with robust evidence that many rural areas in Shropshire still lack the infrastructure to deliver a consistent phone signal or allow people to get online. The Group also identified the fact that there will always be individuals who need alternative ways to access services. With these individuals often being some of the most vulnerable.

Recruitment and Retention

The Group heard that there are nationally recognised challenges to recruit into both the health and care sector. The national NHS Long Term Workforce Plan 2023[23] seeks to put staffing on a sustainable footing and improve patient care. It is focussed on retaining existing talent and making the best use of technology alongside a large recruitment drive. This includes creating skills to work in multidisciplinary teams and to enable more digital adoption especially in helping to address geographical inequity. The approach is described in the plan as addressing "[I]mbalances in geographical distribution of training posts and is not confined to medical training. Other professional groups also require a more equitable spread of training opportunities, based on current and future patient need. ICS's will be able to consider local needs and respond to geographical inequity, via reform of education funding policy, and increased use of apprenticeships and blended learning opportunities. Work is already underway within pilot ICS's as part of the rural and coastal workforce transformation programme to implement education, training and workforce transformation solutions, aimed at improving attractiveness of jobs and retention of the healthcare workforce in these locations." P85

Locally the Group heard lots of anecdotal evidence from service users, voluntary sector organisations and Members that the Shropshire health system is finding it hard to recruit in rural areas. This was confirmed by the Integrated Care Board and the Shropshire Community Health Trust and that both were investigating new ways of attracting and retaining staff in rural areas.

The Rural Services Network has drawn together some options for addressing these issues in their article 'Working with Rural Communities; Promoting Rural Best Practice[24].' Which outlines the headline findings from a lecture by Professor Roger Strasser on his widely appraised rural workforce research. Professor Strasser is a leader in the global reform of health professional

education and has become one of the world's foremost authorities in rural, socially accountable medical education. His lecture included examples of available strategies which health organisations can employ to attract their workforce to rural areas:

- The NHS England's **programme to help tackle health inequalities in rural and coastal areas**;
- The importance of, "access to digital online resources [as being] key to reaching out to rural communities."
- The **knowledge and library services** gives all NHS staff the right knowledge and evidence to achieve high-quality, safe healthcare and health improvement;
- Highlighted the retaining of staff is as important as recruitment, stating, "It's important to recruit but also to ensure we keep the people we've got." The **RePAIR**(Reducing Pre-registration Attrition and Improving Retention) project has enabled us to gain an in-depth understanding of the factors impacting on healthcare student attrition and the retention of the newly qualified workforce in the early stages of their careers; and also said, "The first step to a facilitated rural career pathway is the promotion of health careers," whereas our **Health Careers website** offers information of over 350 career choices in the NHS.
- In addition to these programmes, through **the Enhance Generalism Leadership and Social Medicine Programme**, we are training healthcare professionals to fully understand the needs of rural and coastal communities by working with and for the communities to better healthcare provision.

Within the social care sector, high vacancy and turnover rates are also a notable feature, most obviously in domiciliary care services which has been accelerated through societal factors following the Covid Pandemic and the Cost-of-Living Crisis. However, rural health and care workforce issues are much broader. It was heard that care agencies were not able to accept some rural clients as they could not guarantee being able to provide regular care workers due to:

- Damage to cars from narrow or potted roads
- Distance
- Lack of affordable housing
- Cost of fuel
- No public transport
- Narrow roads with no footways
- Travel time

Shropshire Council Officers agreed that workforce is a significant issue both internally and externally' with 66% of external care providers surveyed by Shropshire Council finding recruitment and retention difficult.

Several local solutions were outlined by Shropshire Council Officers ranging from recruiting bank care staff on casual contracts to reduce the need for agency staff enabling Shropshire Council to maintain a consistent service with their own well-trained staff. To working with the sector to ensure a fair wage, opportunity to training and career progression; supporting managers to create a supportive work environment. The Members were pleased to hear about these developments along with regional work which is taking place to develop an operating model for a social care apprenticeship academy.

System Working
From the evidence heard at the sessions Voluntary, Community and Social Enterprise (VCSE) involvement and leadership has been key to supporting people within the Shropshire health and care system. It is through a system wide approach supported by the VCSE sector that has delivered some progress towards addressing rural health inequalities and supporting people with complex and multiple needs.

However, the Group heard that demand for these services is increasing, and that funding is not keeping pace with this demand. VCSE organisations reported that they were not always included at an early enough stage of planning for the local authority and NHS Trusts to understand the operating realities of their organisations and for meaningful co-production to take place, producing the best outcomes.

The voluntary organisations explained that there are several factors which are making operating more challenging, they are:

- The impact from the cost-of-living crisis
- Increased levels of support required
- Charitable giving is lower
- The emotional and financial costs of the pandemic are still being felt
- Reduction in funding
- Fragility of sector

It was recognised by both the Group and the voluntary sector representatives that the Rural Proofing for Health Toolkit included prompts which addressed considerations regarding the VCSE especially what is already being provided in the community thus, avoiding duplication and an over reliance on the voluntary sector.

Shropshire Council Officers explained that the local Joint Strategic Needs Assessments (JSNA) being carried out by Public Health is a key element of being able to unpick what is happening in local areas with the eventual aim of being able to break that down further to household levels. Working in this way was identified as a national challenge, and that Shropshire Council are working with other rural partners and local authorities who have the same issues to share learning.

The Group identified from the evidence heard that Shropshire Council has a leadership role to play in co-ordinating and commissioning services, providing investment and building trusted relationships across sectors. Clear communication and recognition of the expertise, professionalism and reach of the voluntary sector will help to make sure that all players in the local support system feel like equal partners. The voluntary sector is grounded in communities and understands the nuances of the local context. It acts as an indispensable ally and advocate for local residents. Voluntary organisations and community groups help people to navigate support systems. They piece together information and entitlement from different sources. The voluntary sector does complex work. This needs to be communicated and understood across the local system. Voluntary sector partners will be crucial to meet the challenges we are all currently facing. Funding for the voluntary sector needs to be future-proofed, to ensure the sector is able to recruit and retain the skilled staff it needs as local support services are under a lot of strain. Voluntary and Community Sector Assembly (VCSA) study showed 80% of local voluntary organisations have struggled to recruit in recent months. 68% have concerns about staff leaving their organisations because of low pay. Their demand is growing, and they cannot do what they do without investment.

There were examples provided by the voluntary sector of strategic joined up working between Borderlands Rural Chaplaincy, The Mental Health Trust and Local Authority in Herefordshire

and outlined how this had improved the service being provided to people living rurally. The Group proposed that this could be a case study to learn from.

Mental Health
One of the challenges that were identified for health care providers is how to plan and design child and adult mental health services which are sustainable across larger rural geographies and are accessible to their dispersed communities.

VCSE representatives explained how there could be a real improvement in the strategic leadership and so provision of mental health services in Shropshire including addressing rural health inequalities if there was a dedicated mental health commissioner. They explained that Telford and Wrekin Council have a mental health commissioner and that it helps to provide strategy and direction which assists the system to provide appropriate services.

Officers at Shropshire Council agreed that it would be valuable to have a mental health commissioner for Shropshire in the same way that other local authorities do and explained that to support this a 12-month temporary role had been created but that it was hoped that this could be made permeant due to the expected positive impact it would have.

Role of Members
A frequent theme of the groups discussions was the role Members play in decision making and information sharing. It was agreed that councillors and officers are indispensable to one another and effective communication between both is essential for effective system working. There were numerous instances during the Groups sessions where the Members discovered they were unaware of the services which were on offer to the public and that they felt as elected Members that a real opportunity for them to communicate these to their constituents was being missed.

Another missed opportunity which the Group identified was for councillors to be made aware of planned alterations of or introductions of services across the health and care system so they could represent their communities and inform planning at an early stage.

Equality, social inclusion and health impact assessments (ESHIAs)

In Shropshire Council, the screening tool that is used to give due regard to the impacts of decisions on its citizens is referred to as an Equality, Social Inclusion and Health Impact Assessment (ESHIA). This is a single screening template, usually presented as an appendix to a committee report usually to Cabinet or to Strategic Licensing Committee, which sets out to ensure that “due regard” is being given to equality, equity, social inclusion and health and wellbeing, alongside economic impacts assessment and environmental/climate change impact assessment.

The group heard that social inclusion, health and wellbeing, and economic and climate change impact assessments are not legal requirements under the Equality Act 2010, but that together with the legal requirements in regard to equality, they add value or at least ensure that the council is visibly seeking to take a holistic view of impacts and identify where and how any anticipated positive impacts may be enhanced and where and how any anticipated negative impacts may be minimised.

The ESHIA screening thus sets out to ensure that “due regard” is being given to equality, equity, social inclusion and health and wellbeing, alongside economic and environmental impacts, in line with the local aspirations as set out in the Shropshire Plan as well as national legal obligations. Since 2014, the Shropshire Council equality impact screening assessment has encompassed consideration of social inclusion, including consideration of rurality impacts. These may also be considered within economic impacts.

The Integrated Care System uses an Integrated Impact Assessment Tool which is applied to understand which groups may be impacted by any proposed changes to the way health and care are delivered. This aims to identify whether to engage specific groups or individuals to help reduce inequalities and ensure they are not added to. This is also informed by the Shropshire and Telford & Wrekin Joint Strategic Needs Assessments and evidence on health inequalities. The ICB has an Equalities and Involvement Committee that reviews and scrutinises Integrated Impact Assessments. This is chaired by a Non-Executive Director lead for health inequalities and membership is from within communities.

The Group found there was robust evidence of Impact Assessments taking place but were concerned that despite harmful factors being identified in Equality Impact Assessments decisions are still able to proceed, and a course of action may potentially be agreed upon at committee despite negative impacts being identified.

Against this should be set that there are obligations not only to identify likely impacts and risks of proceeding but also to seek to adjust a proposal or service change or clarify why this is not going to be undertaken, and to review and monitor the effectiveness of mitigating actions taken to minimise negative impacts. This equally includes actions to enhance positive impacts.

Public sector equality duty – s49 Equality Act 2010

In summary,

“A public authority must, in the exercise of its functions, have due regard to the need to:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010;
(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; and
(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.”

Any decision made in the exercise of any function is potentially open to challenge if the duty under s149 has been disregarded. Not all decisions of a local authority will engage the duty; a decision-taker is obliged to consider an equality issue only where there is some reason to believe that the proposal may raise such an issue and it won’t arise where, on analysis, there has been no change to an existing policy.

There is a substantial body of case law in which the principles have been discussed and applied. The question whether there has been "due regard" has been paid to equality needs is for the court to determine and it will generally be dependent on the facts and circumstances. Some general principles have emerged, however, from the caselaw and they include:

- equality duties are an integral and important part of the mechanisms for ensuring the fulfilment of the aims of anti-discrimination legislation.
- The decision-maker must assess the risk and extent of any adverse impact and the ways in which such risk may be eliminated before the adoption of a proposed policy and not merely as a "rear-guard action", following a concluded decision.
- *"The concept of 'due regard' requires the court to ensure that there has been a proper and conscientious focus on the statutory criteria, but if that is done, the court cannot interfere with the decision simply because it would have given greater weight to the equality implications of the decision than the decision maker did. In short, the decision maker must be clear precisely what the equality implications are when he puts them in the balance, and he must recognise the desirability of achieving them, but ultimately it is for him to decide what weight they should be given in the light of all relevant factors."*

The undertaking of a formal Equality Impact Assessment is not mandated by the 2010 Act, but the production of an EIA in appropriate form in advance of the decision is usually convincing evidence that due regard has been had to the PSED.

Decisions in a wide range of contexts have been quashed (i.e. ruled as of no effect because they are unlawful) where there has been a failure to pay any or any sufficient attention to the PSED obligation. Conversely, in many cases authorities have been found on the facts to have paid "due regard" to the matters set out in s149.

Where a breach of the PSED is established, the court as a matter of discretion may decide not to quash the decision, but merely to grant a declaration that there has been non-compliance. This will depend on the facts of the case and whether the outcome would have been substantially different if a breach of the PSED had not occurred."

Rural Proofing for Health Toolkit (Appendix 2)

The Group heard from Graham Biggs in his role as Rural Policy Advisor at the Rural Services Network and a Director of the National Centre for Rural Health and Care and Brian Wilson from Rural England C.I.C who is one of the authors of the toolkit. The Group learned that the Toolkit seeks to help those in the health and care sectors to address the needs of their rural populations when they develop strategies, initiatives and service delivery plans.

The Toolkit is based around six main themes:

- Main hospital services
- Primary and community health services
- Mental health services
- Public health and preventative services

- Social care services
- Workforce

The Toolkit defined 'rural proofing' as a "systematic approach which identifies any notable rural differentials likely to impact on service effectiveness and outcomes. It assists service providers by enabling thinking about appropriate solutions, mitigations and opportunities. The objective is to ensure equitable outcomes for service users who live in rural areas."

Rural Proofing can help to:

- Optimise the outcomes achieved by strategies and plans
- Demonstrate a commitment to act equitably and benefit all communities
- Support locality-based approaches to working and services
- Design out any unintended gaps in service provision
- Identify opportunities to innovate or make better use of available resources
- Embed good practice within strategy and plan making" p4

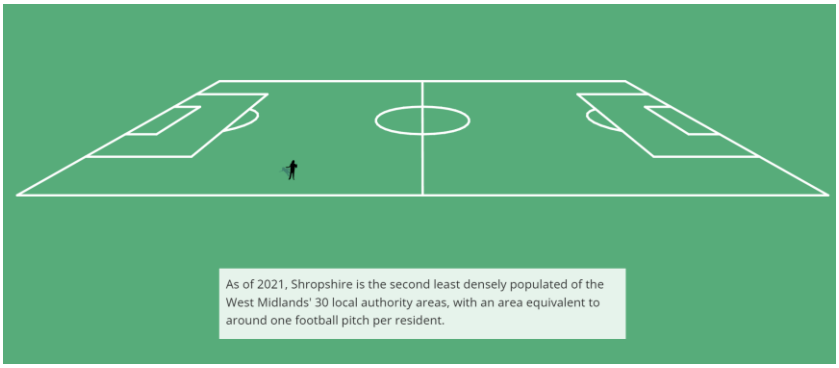
The Toolkit recognises that rural areas have distinct geographies, often characterised by a dispersed population and small settlements and that this presents challenges both for providers who deliver services and residents who use them and is therefore designed to be used across different types of rural geographies, from remoter or sparsely populated areas through to mixed areas, where a rural hinterland adjoins larger urban settlements.

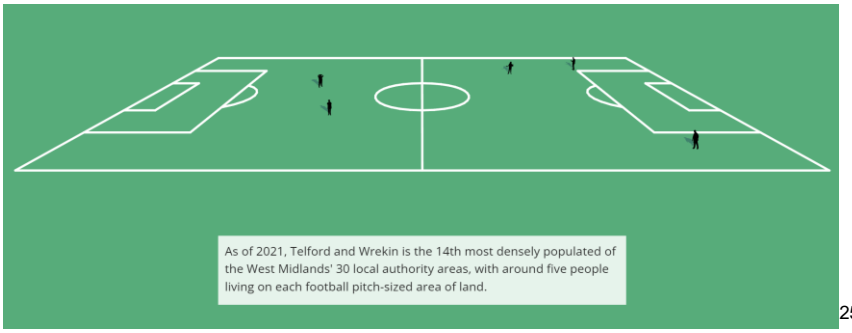
The Group felt from their own review of the Toolkit that through its structure it meant that all of the themes they had identified which needed to be considered when 'rural proofing' a health and care service were covered. This coupled with the evidence presented to them by the speakers and the endorsements for the Toolkit from bodies such as Health Education England and the World Health Organisation led them to feel confident that this Toolkit provides an effective framework for the Shropshire health and care system to work from when amending or developing strategies, initiatives and service delivery plans.

Conclusions

Objective 1: Set out/define what 'rural' and 'rurality' means for the Shropshire Council area, including inequalities and access to services

The official government definition is that urban areas are defined as settlements with populations of 10,000 or more people. Rural areas are those areas outside of these settlements. They make up over 80% of England's land and are home to around a fifth of the English population. In Shropshire around 57% of the population of 323,600 (2021 Census) live in villages, hamlets and dwellings dispersed throughout the countryside[26]. There are 18 market towns and key centres of varying size, including Ludlow and Bridgnorth in the south, Oswestry in the north, and Shrewsbury, the central county town. An additional dynamic is that unlike for example Cumbria, the population is dispersed across the entire county, rather than there being any areas where no one lives at all.





25

Therefore, the Task and Finish Group concluded that due to Shropshire's geographical make up; the national definition will in Shropshire include towns (below 10,000 population) as well as villages, hamlets and isolated dwellings. As the rural area types in Shropshire vary from sparsely populated areas through to areas adjacent to larger urban areas it is important that the individual characteristics of these differing areas are considered. The Task and Finish Group saw through their work that the national rural urban classification is often used as the basis for the analysis undertaken when 'rural proofing', but that this is often not sufficient as it lacks granular detail.

The Task and Finish Group have therefore concluded that in Shropshire the official government definition which is used by most organisations should be enhanced through the evidenced consideration of these four characteristics which are taken from the Rural Proofing Practical Guidance to Consider the Outcomes of Policies in Rural Areas 2022[27]:

• **Demographics:** There are proportionately more elderly people and fewer younger people in rural populations compared with urban ones.
• **Access to services**: The combination of distance, transport links and low population density in rural areas can lead to challenges in accessing and providing services.
• **Service infrastructure**: Lower levels of infrastructure such as low broadband speeds and variable mobile coverage can be a barrier for rural businesses and limit the growth in rural productivity.
• **Employment:** The variety of employment opportunities, the availability of people with the right skills, and access to training can be lower in rural areas.

The Group found that these four areas were comprehensively addressed within the Rural proofing for Health Toolkit (Appendix 2)

Objective 2: Understand what rural proofing means for Shropshire

The task and finish group have agreed to adopt the definition of rural proofing from the Rural proofing for Health Toolkit (Appendix 2)

"The term 'rural proofing' is used to define a systematic approach which identifies any notable rural differentials likely to impact on service effectiveness and outcomes. It assists service providers by enabling thinking about appropriate solutions, mitigations and opportunities. The objective is to ensure equitable outcomes for service users who live in rural areas." P4

Objective 3: Identify a view/position on rural proofing affecting Shropshire communities and services (based on work during the year), and through additional research

The group agreed that rural proofing should start at the earliest possible stages of policy development and strategic planning and continue beyond policy evaluation to be included in every development or significant change to policy, planning or service delivery. This does not need to be complicated and can be built into any consultation and policy development process.

Objective 4: Use the evidence collected to propose a consistent set of criteria to be recommended for use to evaluate rural proofing in strategies, plans, policies and service design and provision in health and care in Shropshire.

The group agreed that the use of the Rural Proofing for Health Toolkit be recommended to all partners of Shropshire's Health and Care system. That the Toolkit also be adopted for use by the HOSC and JHOSC to review any changes or new services that are being implemented to ensure they have been 'rural proofed'.

Recommendations

The members of the Task and Finish group are aware that there is ongoing work underway in the Shropshire health and care system, and at a national level, to address how health and care services are delivered equitably in rural areas. If work that would deliver all or part of a recommendation is already planned or underway, please can this be set out in the responses to any accepted recommendations including what is being done, the timelines for action, and how the impact and progress will be evaluated. Please note that the recommendations are ordered chronologically and carry an equal weighting.

1. **Recommendation:** That an end-to-end evaluation of the travel and transport infrastructure which supports the Shropshire health and care system should be completed by the Integrated Care System to understand how effective the current provision is and to identify current and future demand. The evaluation should include:
    - Patient Travel Support
    - Public Transport
    - Concessionary Travel
    - Community Transport
    - A review of how health and care transport is co-ordinated at a system level
    - A mapping exercise to identify community capacity available to deliver voluntary community transport schemes, and whether there are sufficient services available and how best to provide an equitable service closing the gaps overall and in specific locations.

2. **Recommendation:** The group recommends that rurality and the accessibility factors that are associated with it becomes a key consideration for Shropshire's health and care system (including Shropshire Council) when adapting or introducing a new service or policy and recommend the use of the Rural Proofing for Health Toolkit to achieve this.

3. **Recommendation:** That an evaluation be undertaken by Shropshire Council to understand the impact of digitalisation on protected and vulnerable demographics (including those living rurally.) Understanding more about the current and future needs in different communities and investigating alternative delivery models to provide the infrastructure, access to equipment and support to enable all communities to benefit from the advantages which digital services can provide. The evaluation should include:

    - Mapping mobile coverage and broadband access and use across Shropshire.
    - Developing/strengthening partnerships with broadband providers to help identify and support people experiencing digital exclusion?
    - Working with telecoms providers to ensure that vulnerable people are not left without the means to seek help in an emergency through line outages
    - Identifying the impact to vulnerable users of the plans to remove all analogue copper phone services nationally by 2025
    - Working with other council departments, NHS partners, voluntary and/or faith organisations and district councils, to build on the model of an integrated services hub to enable people to access a number of services in one locality

4. **Recommendation:** That an evaluation be undertaken by Shropshire Council in their role as commissioner and Place co-ordinator to understand how the ouncil's intelligence and data gathering function can contribute to discussions and research on how to identify small pockets of deprivation in rural communities. Testing how ambitious the strategic plans are about strengthening the power of community, leading the way by using robust data to identify the challenges facing different areas, building local capacity, embracing coproduction and community delivery, and devolving power and resources to neighbourhoods.

5. **Recommendation:** The Groups research has shown that local support from the voluntary sector does, and will continue to play, a vital role in supporting residents by providing access to health and care services in rural locations. However, as resources are required to do this; sufficient understanding of the needs of the voluntary organisations and planning time needs to be built into the system. The Group recommends that the Rural Proofing for Health Toolkit be completed alongside the impact assessment process, as in each section it includes prompts to consider the ask being made of the voluntary sector.

6. **Recommendation:** The Group were very pleased to learn that the Rural proofing for Health Toolkit had been recommended for use within the Integrated Care System (ICS) by Simon Whitehouse (Chief Executive Officer for Shrewsbury Telford and Wrekin Integrated Care Board) and Cllr Cecelia Motley (in her role as Co-Chair of the Health and Wellbeing Board.) The Group recommends that the Toolkit be fully adopted into the Integrated Impact Assessment process of the ICS and all organisations whom it commissions and be accepted as a mandatory document to be completed when making changes to or introducing a new strategy or plan making process, so it can inform thinking from the outset.

7. **Recommendation:** That the Shropshire Health and People Overview and Scrutiny Committees adopt the Rural proofing for Health Toolkit as a part of their own overview and scrutiny processes to support them in maintaining a robust view on the needs of their local rural populations when they review strategies, initiatives and service delivery plans.

8. **Recommendation:** Whilst this Group have focussed on rural proofing specifically in the health and care system their findings have shown that its impact is much wider ranging and relevant to all areas of the Council and the support provided to rural communities. The Group therefore recommends that the Shropshire Council 2020 Community and Rural Strategy be updated and implemented.

9. **Recommendation:** That the Rural Proofing for Health Toolkit be recommended for use to its partner local authorities of Telford and Wrekin to support the work of the Joint Health and Overview Scrutiny Committee. To the Shropshire Association of Local Councils for use in their work as Parish Council's, creating a consistency of approach to rural proofing. Then this be expanded to Herefordshire, Monmouthshire and Powys as with evidenced cross border working through shared interests and the new Marches Forward Partnership, the Group recommends that the adoption of this Toolkit forms part of the Memorandum of Understanding by all the authorities which will contribute towards a shared understanding of the opportunities and challenges of delivering health and care services to rural communities.

10. **Recommendation:** That communication between Council officers, system partners and councillors be reviewed to ensure that the best use of councillor's knowledge of their communities and where there may be previously unidentified health needs. It is recommended that regular briefing updates are provided to councillors from Council officers and system partners so that Members are aware of developments in service delivery and can feed in their local knowledge to the work being developed, sharing new developments and service offers with their communities especially supporting with facilitating communication with historically hard to reach groups.

11. **Recommendation:** That an agreed system approach to 'local' be defined to assist with having comparable data at a local rather than regional level. With Shropshire Council using its role as a public health authority and leader of the Health and Wellbeing Board to ensure that rural communities' travel time to services is an integral factor in the planning of services in the health and care sector.

12. **Recommendation:** That the process and legal obligations for Equality, Social Inclusion and Health Impact Assessment (ESHIA) in terms of responding to impacts identified through the ESHIA be clarified for Officers and Members and until then that this matter be logged on the Shropshire Council strategic risk register.

13. **Recommendation:** That a deep dive be carried out into recruitment and retention policies and practices in the Shropshire health system by the Joint Health Overview and Scrutiny Committee including a review of best practice nationally encompassing the approaches recommended by the Rural Services Network to see if they would work in Shropshire.

14. **Recommendation:** That a permanent Mental health Commissioner role be appointed for Shropshire Council to provide system oversight and strategic leadership.

Appendices

Appendix 1

Below is a list of the witnesses that the Group heard from over the course of their work:

Lois Dale- Performance and Research Specialist: Rurality and Equalities Shropshire Council (in person)
Heather Osborne- Chief Executive Age UK Shropshire Telford and Wrekin (in writing)
Marie Monk-Hawksworth- Chief Executive Officer The Friendly Transport Service (in person)
Nicola Daniels- Chief Officer Mayfair Centre **(**in person)
Graham Biggs-Rural Policy Advisor Rural Services Network and a Director of the National Centre for Rural Health and Care (in person)
Sue Chalk- Head of Service Community Resource (in person)
Brian Wilson-Rural England CIC Author of Rural Proofing for Health Toolkit (in person)
Clive Ireland- Chief Executive of Shropshire Mental Health Support Group (in person)
Nick Henry- WMAS Paramedic Practice and Patient Safety Director (in person)
Jason Evans- WMAS Associate Director, West Midlands 999 and NHS 111 Commissioning Team (in person)
Vivek Khashu – WMAS Strategy and Engagement Director (in person)
Gemma Smith- Director of Strategic Commissioning NHS STW ICB (in person)
Tracey Jones- Director of Mental Health, Learning Disabilities & Autism, and Children & Young People. **ICB Lead Health Inequalities and LTP prevention** (in person)
Heather Bowness - Chief Executive New Dawn Care Agency, Onibury (in person)
Sarah Price - Director, Clinical Lead and Nominated Individual CM Bespoke Care Ltd (in person)
Aston Price (AP)- Care Worker CM Bespoke Care Ltd (in person)
Rachel Wintle- Registered Manager New Dawn Care Agency, Onibury (in person)
Rachel Robinson -Executive Director of Health Shropshire Council (in person)
Bernie Lee- Public-Health Lead Shropshire Council (in person)
Cllr Cecilia Motley -Portfolio Holder Adult Social Care, Public Health and Communities (in person)
Laura Tyler- Assistant Director Joint Commissioning Shropshire Council (in person)
Natalie McFall- Assistant Director Adult Social Care Shropshire Council (in person)
David Shaw - Assistant Director Educations and Achievement Shropshire Council (in person)
Sonya Miller - Assistant Director Children's Social Care Shropshire Council (in person)
Rev'd Nick Read-Borderlands Rural Chaplaincy (in writing)
Jane Latter- Co-ordinator Shropshire Rural Support (in writing)
Andrew Bebb- Chair of Shropshire Rural Support (in writing)
Paul Bowers- Head of Operations MPFT (in person)
Inspector Gordon Kaye- West Mercia Police (in person)
Rabinder Dhami- Prevention Manager Shropshire Fire and Rescue Service (in person)
Dr Tim Little- Clinical Director North Shropshire Primary Care Network (in person)
Dr Jess Harvey- Clinical Director Southeast Shropshire Primary Care Network (in person)
Dr Deborah Shepherd - Clinical Director Southwest Shropshire Primary Care Network (in writing)
Sam Townsend- Divisional Clinical Manager, Adults and Community Services Shropshire Community Health NHS Trust (in person)

Appendix 2

Rural Proofing for Health Toolkit (1).pdf

References

1. Time for a strategy for the rural economy (parliament.uk)
2. Health care in rural areas - House of Lords Library (parliament.uk)
3. Rural Proofing Report 2020 (publishing.service.gov.uk)
4. Time for a Strategy for the Rural Economy | Baroness Young – Labour:Coast&Country (labourcoastandcountry.org)
5. Delivering for Rural England – the second report on rural proofing (publishing.service.gov.uk)
6. Written questions and answers - Written questions, answers and statements - UK Parliament
7. https://www.shropshiretelfordandwrekin.ics.nhs.uk/wp-content/uploads/2023/04/Joint-Forward-plan-version-5.2.pd
8. The Shropshire Plan 2022 to 2025
9. hwbb-strategy-2022-2027.pdf
10. Final local government finance settlement: England, 2022 to 2023 - GOV.UK (www.gov.uk)
11. shropshire fact sheet.pdf (rsnonline.org.uk)
12. Annual population survey (APS) QMI - Office for National Statistics
13. Understanding Society: Findings 2012 A complex and fascinating portrait of society | Understanding Society
14. When the safety net fails (Report) (cabshropshire.org.uk)
15. Date (shropshire.gov.uk)
16. Shropshire population change, Census 2021 – ONS
17. Ageing-in-rural-place.pdf
18. Appendix A ICT and Digital strategy final.pdf (shropshire.gov.uk)
19. Trust-Digital-Strategy-2022-25.pdf (sath.nhs.uk)
20. STW-Integrated-Care-Board-Appendices-FINAL.pdf (shropshiretelfordandwrekin.nhs.uk)
21. 211217 GM DIAN wider issues of digital + tech exclusion for older people.pdf
22. Health and wellbeing in rural areas (local.gov.uk)
23. NHS Long Term Workforce Plan (england.nhs.uk)
24. NHS England: Rural and Coastal Workforce Transformation Programme - Rural Services Network (rsnonline.org.uk)
25. https://www.ons.gov.uk/visualisations/censuspopulationchange/E06000051/
26. www.gov.uk/government/collections/rural-urban-definition
27. rural-proofing-guidance.pdf