Herefordshire Council

AGENDA

Health and Wellbeing Board

Date:	**Tuesday 15 September 2015**
Time:	**2.00 pm**
Place:	**Committee Room 1, The Shire Hall, St. Peter's Square, Hereford, HR1 2HX**

Notes: Please note the **time, date** and **venue** of the meeting.

For any further information please contact:

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Agenda for the Meeting of the Health and Wellbeing Board

Membership

Chairman	**Councillor PM Morgan**	**Herefordshire Council**
Vice-Chairman	**Diane Jones MBE**	**Clinical Commissioning Group**
	Councillor JG Lester	**Herefordshire Council**
	Jo-anne Alner	**NHS England**
	Jacqui Bremner	**Healthwatch representative - Carers Support**
	Jo Davidson	**Director for Children's Wellbeing**
	Paul Deneen	**Healthwatch Herefordshire**
	Martin Samuels	**Director of Adults Wellbeing**
	Prof Rod Thomson	**Director of Public Health**
	Dr Andy Watts	**Clinical Commissioning Group**
	Jo Whitehead	**Herefordshire Clinical Commissioning Group**

AGENDA

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. NAMED SUBSTITUTES (IF ANY)

To receive any details of Members nominated to attend the meeting in place of a Member of the Committee.

3. DECLARATIONS OF INTEREST

To receive any declarations of interests of interest by Members in respect of items on the Agenda.

4. MINUTES 7 - 10

To approve and sign the Minutes of the meeting held on 21 July 2015.

5. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive questions from Members of the Public relating to matters within the Board's Terms of Reference.

(Questions must be submitted by midday eight clear working days before the day of the meeting (ie on the Wednesday 13 calendar days before a meeting to be held on a Tuesday.))

6. SAFEGUARDING ADULTS - PROGRESS REPORT

To receive a progress report on Safeguarding Adults.

7. SYSTEM WIDE TRANSFORMATION

To receive a report on the Systems Wide Transformation Programme.

8. NHS HEREFORDSHIRE HEREFORD CLINICAL COMMISSIONING GROUP COMMISSIONING INTENTIONS 2016/17 11 - 36

To outline to the Board the context and constraints that are impacting on the development of NHS Herefordshire Clinical Commissioning Group's Commissioning Intentions, the delivery against previous years stated intentions, the process being undertaken in the development of this year's intentions and plans, including ensuring alignment with Herefordshire's Joint Health and Wellbeing Strategy; and key priorities and intentions for 2016/17.

9. CARE ACT IMPLEMENTATION

To receive a report on the implementation of the Care Act.

10. BETTER CARE FUND (BCF) SUBMISSION UPDATE

To receive a report on the Better Care Fund (BCF) Submission Update.

11. HEALTH & WELLBEING BOARD DEVELOPMENT DAY - UPDATE

To receive a report on the recent Health & Wellbeing Board Development Day.

12.	**ITEM FOR INFORMATION** To note the Public Health Grant Consultation Response 2015/2016, for information.	37 - 94
13.	**WORK PROGRAMME** To note the Work Programme.	95 - 98

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- Inspect minutes of the Council and all Committees and Sub-Committees and written statements of decisions taken by the Cabinet or individual Cabinet Members for up to six years following a meeting.

- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting. (A list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.

- Access to a public Register stating the names, addresses and wards of all Councillors with details of the membership of Cabinet and of all Committees and Sub-Committees.

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HEREFORDSHIRE COUNCIL

SHIRE HALL, ST PETER'S SQUARE, HEREFORD, HR1 2HX.

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HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Health and Wellbeing Board held at Committee Room 1, Shire Hall, Hereford on Tuesday 21 July 2015 at 2.00 pm

Present: **Mrs D Jones MBE (Vice Chairman in the Chair)**

Members: Ms J Alner, Ms H Braund, Ms J Bremner, Ms H Coombes, Mrs J Davidson, Mr P Deneen, Councillor JG Lester, Prof Rod Thomson and Dr A Watts

In attendance: **Councillor PA Andrews**

14. APOLOGIES FOR ABSENCE

Apologies were received from Councillor PM Morgan and Mrs J Whitehead.

15. NAMED SUBSTITUTES (IF ANY)

None.

16. DECLARATIONS OF INTEREST

None.

17. MINUTES

The Minutes of the Meeting held on the 17 June 2015 were approved and signed as a correct record.

18. QUESTIONS FROM MEMBERS OF THE PUBLIC

None.

19. UNDERSTANDING HEREFORDSHIRE - JOINT STRATEGIC NEEDS ASSESSMENT 2015

The Board received a report on Understanding Herefordshire – the Joint Strategic Needs Assessment. The document provided a single integrated assessment of health and wellbeing needs of the people of Herefordshire and meet the statutory requirement to produce a joint strategic needs assessment (JSNA) to inform corporate business planning and commissioning intentions across the council.

In the ensuing discussion, the following points were made:

That there were three key areas within the document that should be regularly considered: Children's Services, Adult Social Care and Economic Growth. These were particularly important as there were different populations moving into the county.

That the economy of farming and tourism were areas where clearer data would be helpful, especially that of the patterns of work and employment in these areas. Farming communities were unlikely to claim for free school meals which had a knock on effect on school funding.

That it was an important part of community resilience planning for vulnerable communities such as the care home sector in the case of power cuts.

Resolved: the Joint Strategic Needs Assessment 'Understanding Herefordshire' Report be approved

20. CHILDREN AND YOUNG PEOPLE'S PLAN 2015-2018

The Board received the Children and Young People's Plan 2015-18. The Children and Young People's Partnership had been tasked by the Health and Wellbeing Board to develop the Plan, which reflected the priorities that had previously been agreed by the Board and had been set out in the Joint Strategic Needs Analysis, the Children's Integrated Needs Analysis and the Health and Wellbeing Strategy. Partner Agencies would also need to approve the plan.

In the ensuing discussion, the following points were made:

- That this was a useful document that could be referenced by other organisations. One of the challenges would be how the health strategy for a systems wide approach should be tied into the plan.

- It was suggested that the plan be shared with school governing bodies to help them consider ways of being involved in some of the preventative work. Consideration should also be given to the contracts for health visitors and school nurses in order to ensure their involvement.

- That financial support was available from Sport England.

- That there was a significant variation in suicide rates as a result of childhood experiences, and that the Plan appeared to lack a singular message in the area of life experiences and the impact of health and diet.

- That there had been insufficient work with children and young people in the safeguarding and mental health areas up to this point, but that there would be positive movement by January.

Resolved: that the Board approve the Children's and Young People's Plan.

21. MENTAL HEALTH SERVICES INTEGRATED PATHWAY

The Board received a presentation on a project to develop a joint, integrated, all age pathway for mental health services based around the needs of the population and the outcomes they required. During the presentation, the following issues were highlighted:

- That the catalyst for the work had been the imminent expiration of the existing provider contract, which offered the opportunity to reconfigure service as part of an integrated pathway.

- The project had been set up and there was a target contract completion date of 30th September 2016 and target contract commencement date of 1st April 2017.

- There would be an extension to the current contract with 2Gether NHS Foundation NHS Trust to allow the time to develop the joint mental health services specification with Herefordshire Council. As a result of the first workshop, employment, education and housing were being included as part of the pathway model. The next workshop to be held would consider the scope of the review.

- Artificial boundaries existed with the commissioning of services, and service users would benefit by the removal of duplication and commissioners from a reduction in waste in the system.

- That spend on mental health was £25m, and that once the scope had been finalised, the budget for the service would be set.

The Director of Adult Wellbeing pointed out that as Mental Health was the main priority for the Health and Wellbeing Strategy, the Board would need to be assured that the approach laid out in the pathway would deliver the appropriate outcomes.

Dr Watts said that there were gaps in service provision at the moment and difficult decisions might have to be made in areas of the pathway in order to address these.

It was suggested that milestones toward achievement be provided for the Board until April 2017.

Resolved:

That

a) The report be noted;

b) That the Communications Plan be organised through the Engagement Gateway in order to involve communication leads; and;

c) An updated report be bought to the Board in six months' time.

22. ITEMS FOR INFORMATION

The Board noted briefing notes on the:

- Better Care Fund Submission
- Safeguarding Adults Peer Challenge Self-Assessment and Questions
- Youth Justice Plan 2015-18

Resolved: That the reports be noted

23. WORK PROGRAMME

The Board noted its Work Programme.

Resolved: that the report be noted.

CHAIRMAN

The meeting ended at 15:40

Herefordshire Council

Meeting:	**Health & Wellbeing Board**
Meeting date:	**15th September 2015**
Title of report:	**NHS Herefordshire CCG Commissioning Intentions 2016/17**
Report by:	**Director of Operations (NHS HCCG)**

Classification

Open

Notice has been served in accordance with Part 2, Section 5 (Procedures Prior to Private Meetings) of The Local Authorities (Executive Arrangements) (Meetings and Access to Information) (Regulations) 2012.

Key Decision

This is not a key decision.

Wards Affected

Countywide

Purpose

To outline to the Health and Wellbeing Board:

- the context and constraints that are impacting on the development of NHS Herefordshire Clinical Commissioning Group's Commissioning Intentions;
- delivery against previous years stated intentions;
- the process being undertaken in the development of this year's intentions and plans, including ensuring alignment with Herefordshire's Joint Health and Wellbeing Strategy; and
- key priorities and intentions for 16/17.

Recommendation(s)

That the Health and Wellbeing Board:

(a) review and comment on content of the report;

(b) recognise the quality and financial challenges facing Herefordshire's health and social care system and the process being followed to ensure the CCGs Commissioning Intentions take account of these; and

(c) recognise the alignment of the CCGs Commissioning intentions with

Alternative options

1. No alternative options. The CCG is expected to outline to the Health and Social Care system, and its key providers, its key commissioning intentions for the forthcoming financial year (2016/17) annually in the autumn of each year. This is part of the annual commissioning process that all CCGs follow. The intentions themselves outline the issues and priorities the CCG will take into account in the development of contracts with providers and its service redesign plans in 2016/17.

Reasons for recommendations

2. The CCG is a core member of the Health and Wellbeing Board, Transformation Board and Joint Commissioning Board and is keen to ensure its plans and intentions are shared, reviewed and developed jointly, where appropriate, with partners and stakeholders. It needs to ensure its plans meet national requirements and adhere to NHS England guidelines and frameworks, but importantly it also needs to make certain it reflects local challenges, priorities and needs. The Health and Wellbeing Board is one of the key bodies where the latter needs to be reviewed and considered.

Key considerations

3. Herefordshire CCG is responsible for commissioning the following services for the people of Herefordshire

    - Urgent & Emergency Care
    - Out of hours primary care
    - Planned hospital care
    - Services for people with learning disabilities
    - Rehabilitation services
    - Mental health services
    - Children's healthcare services
    - Maternity & New-born services
    - Community health services
    - NHS Continuing healthcare

4. It is currently jointly responsible, since April 2015, for the commissioning of Primary Care Services (excluding dental, pharmacy and ophthalmic services) with NHS England. During the remainder of 2015/16 the CCG will be working with NHS England to consider how the CCG may take on full delegated responsibility in relation to primary care commissioning. It is not responsible for commissioning:

- Specialist services e.g. radiotherapy
- Some primary care services e.g. Dental and ophthalmic services

5. In developing its commissioning intentions for 2016/17 the CCGs will build on and take account of:

    - The priorities identified in HCCG's Operational plan, also reflecting the aspirations in HCCGs 5 Year Strategic Plan for the healthcare system, developed with partners.
    - HCCGs Quality, Innovation, Productivity and Prevention (QIPP) and Commissioning for Quality and Innovation (CQUIN) plans;
    - National and local priorities including delivery of NHS Constitutional standards and quality improvements
    - The latest information available in Herefordshire's Joint Strategic Needs Assessment (JSNA): 'Understanding Herefordshire'
    - Joint working with the Local Authority and the Health & Well-Being Board and associated work plans.
    - Herefordshire's refreshed Joint Health and Wellbeing Strategy and the priorities outlined and agreed by the Health and Wellbeing Board in April 2015.
    - The CCG's financial recovery plan and associated measures and actions designed to deliver an improved financial position for the Health and Social Care system

6. It is widely accepted that existing patterns of care and demand cannot simply be replicated, particularly in light of the widely rehearsed statements around predicted demographic changes, and that local system change is critical to deliver improved patient outcomes and productivity throughout the system for the long term. Commissioners will therefore require providers to collaborate in the development and delivery of the system plan; demonstrating commitment to change even in the absence of business benefit. The CCG will be pursing joint working to achieve responsive, proactive care which systematically meets the needs of individuals regardless of organisational boundaries and which will ultimately achieve improved patient outcomes.

7. The health system, in addition to a failure to meet key constitutional standards e.g. 4 hour waits and some cancer waiting time targets over the last year, has also seen some significant quality challenges. This includes an acute provider currently in Special Measures; concerns around mortality rates, and mixed sex ward breaches. Improvement plans are in place, and the CCG is working with providers and NHS England to ensure that these are delivered, but these all have an impact on resources and capacity within the system. Herefordshire also faces a challenge regarding workforce sustainability. This is increasingly evident across the health system from the recruitment of nurses in the acute sector to GPs in primary care.

8. In line with national requirements, the CCG will continue to measure its delivery of improved outcomes against the NHS Outcomes Frameworks; local targets agreed with partners, as well ensuring a continuing focus on meeting the commitments to patients outlined in of the NHS Constitution. For example, the CCG expects patients to receive treatment within 18 weeks of referral, unless there is a valid reason for waits beyond this performance standard.

9. Every year the CCG identifies within its commissioning intentions 5 key work areas that it had assessed as a priority area. The priorities agreed for 2015/16, along with a summary s, are outlined below.

a) Community teams

- New model for community teams (across health and social care) developed incorporating learning and developments to date.
- CCG has provided investment to providers to support and resource roll-out of community teams across the county.
- Focus in roll-out continues to be on personalisation, decreasing emergency admissions, maximising independence and improving end of life care.

b) Stroke services

- Clinical model and resulting resource requirements agreed by WVT and CCG. NHSE Assurance process achieved.
- Work with third sector around service user and carer voice in implementation and evaluation of Early supported discharge progressing.

c) Cancer services

- Cancer strategy drafted and being consulted on with partners, patients and public.
- Survivorship is central theme of cancer programme.
- Improvement against NHS Constitutional standards, will continue to be managed through contract process

d) Dementia developments

- Provision of support to care homes through the creation of a dementia care home in-reach team
- Reduction in dementia waiting times for memory assessment
- Improved community support for people with dementia with ongoing post diagnosis support from the Alzheimer's Society

e) End of life provision

- End of life programme in place, supported by Marie Curie
- A business case for end of life packages has been developed with partners and approved by CCG, alongside an anticipatory care planning framework.

A fuller list of delivery against the CCGs intentions is contained in appendix 1.

10. Building on 2015/16 the CCG's Governing Body, with input from Clinical colleagues, has initially identified the following areas as priorities for the coming eighteen months. The CCG will be working with providers to ensure that these priorities are both recognised in 2016/17 plans and considered in service redesign programmes;

- Urgent Care pathway
- Demand Management schemes, in particular improvement in diagnostic services
- Community services redesign and continued development of community teams
- Cancer and stroke services inc delivery of constitutional standards
- Mental Health Pathway, overseen by the partnership approach to the Mental Health Programme, focusing on prevention and enhancing CAMHS

11. Additionally two significant cross-cutting themes, that also underpin the wider System Transformation Programme, have also been identified by the CCG as essential enablers to delivering change. These are: System Wide Workforce Development and Better Use of Technology. The system has traditionally struggled with recruitment and retention issues, and is also focused on using its current workforce more effectively it is therefore developing a clear workforce strategy. Significantly it has also not levered the advances in IT that could benefit a rural county and its residents e.g. development of telecare and telehealth services. Both these areas are proposed as requiring increased focus from the CCG in 2016/17 and beyond.

12. The CCG will continue to undertake further modelling in collaboration with partners to assess opportunities for investment/disinvestment and service redesign. This will include benchmarking against best practice; use of Commissioning for Value information and programme budget analysis, as well as participation in the Right Care programme. The CCG will also carry on engaging and involving stakeholders in the development of its intentions over the coming months. The CCG draft commissioning intentions will be shared with partners and providers over the coming month.

Community impact

13. In developing its commissioning intentions the CCG has taken account of the Joint Health and Wellbeing strategy. The CCG's Governing Body recently reviewed its

plans and intentions to assess their strategic alignment against the JHWS. It noted particularly the top priority of mental health and reiterated its commitment to the development of an improved Mental Health pathway, with its local authority partners, as one of its core work programmes over the next 18 months.

14. The CCG's Governing Body also noted the need to enhance its work around Children and Young people, and will continue to work ever more closely with the Local Authority on this agenda in the coming months. The CCG is fully committed to the Children and Young Peoples Partnership, and via the Joint Commissioning Board, and its engagement in the wider C&YP structures, will continue to develop this programme of work. This will include pursuing via the mental health programme its intention to ensure an improved CAHMS offering with Local Authority partners.

15. The CCG's Governing Body also noted that information and signposting was an area that needed strengthening as part of its support to the delivery of the Joint Health and Wellbeing Strategy, to this end key initiatives, like the establishment of a Care Co-ordination Hub, and the development of a directory of services are integral to its plans.

16. The delivery of an efficient and effective urgent care pathway is also of paramount to the community and patients. This has come through in CCG consultation events and exercises, and the CCG is also mindful of underperformance on key NHS constitutional targets associated with the pathway. This is a major focus of the CCG system resilience plans and service redesign programme and will involve partners from across the system, including Herefordshire Council, NHS Wye Valley Trust and GP Practices.

Equality duty

17. The CCG ensures that its key programmes of work require an Equality Impact Assessment and it also adheres to the NHS Equality Development scheme, designed to ensure it pays due regard to the public sector equality standard and improved outcomes for vulnerable groups. This will include undertaking reviews on any proposed de-commissioning or disinvestment decisions.

Financial implications

18. Herefordshire CCG (HCCG) is facing a challenging in-year position in 2015/16. This has necessitated the requirement of an in-year recovery plan as identified as part of the national planning process in May 2015. During the early months of 2015/16 HCCG's in-year risk has increased. At this stage the CCG is currently assessing savings requirements for 2016/17 which is dependent on delivery during 2015/16.

Legal implications

19. The CCG has several statutory duties that it needs to comply with and that its Commissioning Intentions must take account of and respond to. The most significant of these include duties to:

- promote the NHS Constitution;
- publicise and promote information about choice;
- exercise its functions with a view to ensuring that health services are provided in an integrated way;
- whilst carrying out its functions, act with a view to enabling patients to make choices in respect of aspects of health services;
- protect vulnerable adults and children and young people from abuse and neglect and promote their welfare;
- exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals;
- whilst carrying out its functions, promote the involvement of patients, and their carers and representatives;
- act under guidance from the Secretary of State specific to autism;
- make "joint commissioning arrangements" with local authorities in respect of the education, health and care provision to be secured for children who have special educational needs

20. In developing its intentions the CCG will be ensuring it complies with its statutory duties, in particular this will include meeting its obligations around the NHS Constitution and putting in place improvement plans and programmes designed to deliver nationally stipulated standards. It will also be ensuring it consults and involves patients and the public on any decommissioning or disinvestment decisions it may need to consider in light of the financial challenges the health and social care system faces.

Risk management

21. The CCG ensures it identifies and manages its risks across its work programmes and reports this to its Governing Body. The key areas of risk are focused on the delivery of financial sustainability across the health system; potential inability to deliver NHS Constitutional standards, and non-delivery of transformational change. Mitigating actions are in place including the development of a financial recovery plan and clear improvement plans for key targets.

Consultees

22. The CCG will be ensuring it consults and involves patients and the public on any decommissioning or disinvestment decisions it may need to consider in light of the financial challenges the health and social care system faces. It will work closely with

partners across the system to understand any possible adverse impacts on partners' plans its commissioning decisions could have, and put in place mitigating plans.

Appendices

Attachment 1 – 2015/16 Commissioning Intentions update

Attachment 2 – 2016/17 Draft list of potential Commissioning Intentions

Background papers

None

Attachment 1: Herefordshire CCG Commissioning Intentions Summary Update 2015/16

1. In developing its outline commissioning intentions for 2015/16, the CCG took into account national requirements, the local financial context, areas of underperformance and patient experience. It also consulted and engaged CCG members via the CCG GP Parliament and through feedback from practice visits. This work shaped and informed the schemes and intentions agreed by the CCGs Governing Body, as well as the CCGs operational plans for 15/16.

2. The CCG continued through 15/16 to also work jointly with other commissioners to co-ordinate commissioning intentions where it was the Lead Commissioner. The CCG has worked closely with Herefordshire Council (Public Health, Adults and Children's Commissioners) and NHS England and Public Health England to align objectives and ensure co-ordination of plans. This work has continued a pace with the embedding of a Joint Commissioning Board, Better Care Plans and an agreement to jointly commission Mental Health Services with the Local Authority. These plans will become be part of our intentions for 16/17, as we continue to align commissioning resources and plans with partners.

3. The CCG continues to lead the County's System Resilience Group to ensure that Herefordshire's urgent care system works together to manage demand in the system and deliver its system resilience plans. For example a key measure of success is the delivery against the NHS Constitutional commitment that *there is a maximum four-hour wait in A&E for patients from arrival to admission, transfer or discharge*, an area we continue to underperform as a system. These issues will need to be considered as we develop our intentions for 16/17.

4. HCCG's commissioning schemes for 15/16 were grouped according to the NHS Outcomes Framework domains and indicate how each intention was intended to support the delivery of the CCGs priorities and objectives. Table 1 describes in further detail the current status/detail of work against the original intentions outlined to the CCGs Governing Body in September 2015.

5. In developing the Commissioning intentions for 16/17 the learning from the 15/16 process, and status/success of delivery and how these have been contracted for will one of the key elements in determining this year's priorities. This will involve prioritisation sessions with stakeholders and assessment and use of JSNA. The Commissioning intentions document will be presented to the CCGs Governing Body in September.

Table 1 NHS HCCG

NHS Outcome	CCG Work stream/priority(s)	Service area	Commissioning Schemes	Relevant to current providers	Status
Preventing people from dying prematurely	Enhancing and improving planned care	E-referral	• E-referral - develop work programme and ensure implementation of a single electronic referral process across all specialities, underpinned by agreed pathways of care	All providers	Key work stream of the demand management programme. Developments linked to the national programme and changes to choose and book and underpinning local processes. Has been contracted as a QIPP for 15/16 and agreed with Wye Valley in the Clinically-led Specialty Pathway CQUIN. This includes the below specialties only: • Dermatology * • Cardiology * • Gastroenterology* • T&O* • ENT • Urology * starred specialties have met with CCG representatives and action plans are in the process of being produced and agreed
	Enhancing and improving planned care	Supported Self-management	• Supported self-management: development of patient held records and self-management plans (Inc. roll out and development of risk stratification systems, processes and tools)	All providers	Local Long Term conditions strategy agreed - now being embedded in local clinical practice. The objectives of the strategy: • Improve supported self-care • Reduce unscheduled admissions and readmissions • Maintain and improve quality of care • Reduce health care costs Developed care plan templates in EMIS especially for the top 2 per cent most at risk of admission worked with primary and secondary care as well as nursing homes to embed use. This has been key focus of education days over last 12 months, and will continue

NHS Outcome	CCG Work stream/priority(s)	Service area	Commissioning Schemes	Relevant to current providers	Status
					to be so.
	Enhancing and improving planned care	Cardiovascular disease	• CVD: collaborate with partners to deliver Herefordshire action plan that underpins the County's CVD outcomes strategy. To include commissioning of integrated Familial Hypercholesterolemia for Hereford and Worcester, an integrated community focused diabetes service and review tier 2 and tier 3 obesity pathways for priority patients.	WVNHST with other providers	Commissioning of FH will remain a priority for CCG. The CCG have engaged with and participated in all relevant FH meetings led by West Midlands Strategic Clinical Network. A single FH service is still planned for West Midlands Area. Integrated Community Focused Diabetes Service over the past 12 months we have developed local care pathways to support integration across whole pathway e.g. Diabetes Foot care Pathway and a Transition Pathway for young people with diabetes The CCG have also engaged with wider partners across West Midlands including West Midlands Ambulance Trust with view to developing a single Hypoglycaemia Pathway for West Midlands s area The CCG have and continue to work closely with partners to achieve a more integrated pathway for Obesity; key strands of work include listening to peoples experiences of weight management via our involvement in the Putting Patients in Control Programme, working with LA Herefordshire has also secured Sport England funding to help increase access to physical activities and a range of sports with support to help people to access the most appropriate activity /ranges of activities.
	Enhancing and improving planned care	Stroke	• Continue to implement outcomes of the Stroke Review across the whole pathway including Stroke Prevention in AF, a networked approach to a fully serviced	WVNHST	• Clinical model and resulting resource requirements agreed by WVT and CCG, NHSE Assurance process achieved • Work with third sector around service user and

NHS Outcome	CCG Work stream/priority(s)	Service area	Commissioning Schemes	Relevant to current providers	Status
			HASU/ASU, greater use of early supported discharge, through to work with stroke survivors to improve quality of care for stroke patients and delivery of national TIA standards		carer voice in implementation and evaluation of ESD in progress • Immediate medical recruitment to improve TIA performance from March 2015. • Increased nursing and therapist levels.
	Enhancing and improving planned care	Cancer	• Ensure compliance with NHS constitutional commitments & delivery of Strategic Clinical Network priorities for local cancer care to achieve better outcome for people living with and beyond cancer.	WVNSHT and Gloucestershire Hospitals NHST	• Cancer strategy drafted and being consulted on with partners, patients and public. • Survivorship is central component of cancer programme. • Improvement against NHS Constitutional standards will continue to be managed through contract process, current poor performance focused on breast symptomatic waits.
	Enhancing and improving planned care	End of Life Care	Improve end of life care pathways including: • Secure integrated end of life care packages which are available 24/7 • Ensure advanced care plans in place for all appropriate patients • Secure educational model for EOL care for whole health & care economy (inc Care homes)	All providers	• End of life packages – a business case to address this is currently being worked up jointly by St Michael's Hospice and Marie Curie, for consideration by HCCG. • A planning for your future framework (patient held ACP document) has been adapted, based on Gloucestershire CCG, and will be piloted within Herefordshire. • Educational model - work is ongoing with St Michael's Hospice to deliver this. Pilot sessions have been delivered, further discussions are taking place in order to learn from the sessions to date, and feed into future content design.
	Enhancing and improving planned care and improving ill and preventing ill-health	Diagnostics	• Improved rapid access to diagnostic tests ensuring that NHS organisations are delivering a maximum wait of 6 weeks for tests across all specialities	All providers	• Part of our demand management programme of work that is being developed jointly with WVT. • Improvement Trajectory requested from Trust • Has been contracted as a QIPP for 15/16 and agreed with Wye Valley in the Clinically-led Specialty Pathway CQUIN
	Modernising	Inpatient care	• Evaluate the provision of liaison	2gether	• Agreed Greater access to mental health liaison in

NHS Outcome	CCG Work stream/priority(s)	Service area	Commissioning Schemes	Relevant to current providers	Status
	Mental Health & Urgent Care		psychiatry service within the Urgent Care pathway. Consolidating existing provision in a comprehensive service. • Maintain appropriate access to inpatients services by & Involvement of Crisis Intervention Team prior to admission, and follow-up discharge within 48 hours to reduce risk of harm	NHS Foundation Trust & WVT NHST	ED, and Hereford Hospital and community hospitals wards • Agreed CQUINs focusing on care planning, discharge planning, engagement of vulnerable groups in IAPT and personality disorder care pathway development
	Modernising Mental health	Strategy development and delivery	• Develop system wide mental health and wellbeing strategy with partners building on findings of the Mental Health Needs Assessment • Ensure patient access to psychological therapies is improved and NHS England targets are met	2gether NHS Foundation	• Mental health needs assessment developed, is now being use to inform commissioning, strategy development being led by Herefordshire Council • Progression towards national target on waiting times for early intervention in psychosis and IAPT during the national shadow year to enable Herefordshire to start 2016 achieving the target. • Joint MH Procurement project agreed with Herefordshire Council.
	Modernising Mental health	Mental Health rehabilitation	• Review access and criteria for rehabilitation to improve the provision of recovery services, long-term treatment and care available within the county, with the outcome of more people regaining independent living skills and continued repatriation of patients	2gether NHS Foundation	• This intention forms part of the mental health re-provision; and in addition a QIPP saving has been identified with the provider for 15/16, this will be the main focus for 15/16.
Enhancing quality of life for people with long-term conditions	Improving Health Outcomes for Children & Greater Integration of Care & Preventing ill-	Children with disabilities and complex needs	Work with partners and providers to continue the implementation of the Children and Families Act 2013 by: • Developing operational arrangements for integrated education, health and social care plans and reviews. • Continuing the redesign of short breaks provision and work with WVNHST to	WVNHST (and Herefordshire Council)	*Agreed* • Development of Consistent care planning arrangements across the pathway, particularly with Community Children's services; • Agreement to review all children's community services • Agreement of principles of single assessment at point of entry, including risk assessment, which is

NHS Outcome	CCG Work stream/priority(s)	Service area	Commissioning Schemes	Relevant to current providers	Status
	health and promoting Health		engage in associated transition arrangements • Continue the implementation of the Herefordshire Transition protocol for children with long-term conditions.		consistently revised] • Transition arrangements for short breaks agreed • Transition arrangements for children for diabetes and CAHMS in place.
	Improving Health Outcomes for Children & Greater Integration of Care	Adult Care and children with Long-term conditions	• Supported self-management: development of patient held records and self-management plans (Inc. roll out and development of risk stratification systems, processes and tools)	All providers	Local Long Term conditions strategy agreed now being embedded in local clinical practice. The objectives of the strategy: • Improve supported self-care • Reduce unscheduled admissions and readmissions • Maintain and improve quality of care • Reduce health care costs Care plans for epilepsy, PD and diabetes developed and being launched in June 2015, and further training underway, to support self-management of LTCs
	Preventing ill-health and promoting health	Neurology, PD, MS & Epilepsy	• Develop additional capacity to advise patients, carers and clinicians and improvement of care pathways including transitions process,	WVNHST	• Funding for epilepsy nurse has been secured • Care plans for epilepsy, PD and diabetes developed and being launched in June 2015, and further training underway, to support self-management of LTCs
	Preventing ill-health and promoting health and greater integration of care	Personal health budgets	• Enhance use and availability of personal health budgets in line with national requirements .	All providers	• Personal Health Budgets are being offered to people aged 18 and over in receipt of continuing healthcare funding for longer than three months. The National Requirement states that from October 2014 everyone who is eligible for continuing healthcare has the right to have a PHB if they want one. • The CCG are also offering PHB to people who have recently met CHC criteria but were in receipt

NHS Outcome	CCG Work stream/priority(s)	Service area	Commissioning Schemes	Relevant to current providers	Status
					of a direct payment through Adult Social care previously to ensure continuity of care.
	Greater Integration of Care & Mental Health	Dementia	• Dementia: work with partners to implement living well dementia strategy including community memory service and ensure delivery of national delivery targets	2gether and Primary care Providers	• Provision of support to care homes through the creation of a dementia care home in-reach team • Reduction in dementia waiting times for memory assessment • Improved community support for people with dementia with ongoing post diagnosis support from the Alzheimer's Society
	Greater Integration of Care	Falls	• Development and implementation of integrated falls service; this will include focus on a whole system approach including early intervention, early self-management, tele care options, and a mobile response service	WVTNHST	• Falls service commissioned and in place, review and evaluation of service will continue during 15/16.
	Modernising mental health	Mental health	• Re-procurement of Mental Health services during 2015 to commence April 2016, in line with contractual requirements.	2gether NHS Foundation Trust	• Agreed with Herefordshire Council a joint commissioning approach to commence now April 2017.
	Modernising mental health	Acquired Brian injury	• Review current care pathway and identify gaps/ barriers / challenges	WVNHST & 2gether NHS Foundation Trust	This work is intended to begin during 15/16. Resources and capacity to begin work are being established.
Helping people recover from episodes of ill health or following injury	**Improving Urgent Care**	**Urgent Care**	• Review, evaluate and reform the Urgent Care pathway focusing on acute care, intermediate care, community health and social care services. • Re-commission Community Teams as a single integrated resource including the county-wide roll-out of community teams and implementation of RAAC • Review urgent care provision, GP OOH	WVNHST & NHS 111 Provider, Prime care, West Midlands Ambulance Trust	• Pathway developed and implemented for ambulatory care • WVT and local providers developed outline model for redesigned integrated urgent care pathway. CCG are taking this forward through development of a local urgent care network. Utilising existing contracts to align incentives across the health and care economy. CCG dialogue with incumbent providers to deliver model, procurement decisions will be made subsequent to this dialogue.

NHS Outcome	CCG Work stream/priority(s)	Service area	Commissioning Schemes	Relevant to current providers	Status
			services, WIC & MIUs to re-procure services using outcomes based commissioning approach. • Retain oversight of the effectiveness of the new 111 service and shape delivery. • Explore an Urgent Care hub with a single point of access to hospital services and to community health and care services. • Review pathways for ambulatory care sensitive conditions to enable patients to be treated in 'non bed based' settings where ever appropriate • Redesign paediatric emergency and urgent care pathway.		• Additional resources agreed with WVT to roll out Virtual Ward (inc Hospital at Home) countywide. • Regional NHS111 procurement did not result in contract award for our area, potential to align future model with urgent care network development above. • Single point of clinical access will be delivered through a Care Coordination Centre • Urgent and emergency Paediatric pathway will be accessed via the newly emerging Care Coordination Centre.
	Modernising Mental Health & improving health outcomes for children	CAHMS	• Seek adoption of the WMQRS standards • Seek improvement in the delivery of provision through involvement in CYP IAPT (Improve access to psychological therapies). • Continue to ensure implementation of the Herefordshire Transition protocol, including provision up to age 25 from children's services.	2gether NHS Foundation Trust	• CAHMS draft specification developed and under review • CYP IAPT externally reviewed by DH; assurance provided that service is doing well.
Ensuring that people have a positive experience of care	All work streams	Patient Experience & Involvement	• Seek further engagement activities that improve the extent of participation by patients and their carers in service developments across all health services. • Seek opportunities to improve the extent of participation by patient and carers in shaping and evaluation of care pathways so that people understand the role they can take in their own health and health	All providers	• Putting Patients In Control programme piloted with obesity patients, designed – to help and co-produce obesity pathway - this methodology will be used to support other programmes e.g. care planning during 15/16 • Patient and carers groups continue to be involved in design of pathways and referral routes e.g. long-term conditions management and mental health needs assessments

NHS Outcome	CCG Work stream/priority(s)	Service area	Commissioning Schemes	Relevant to current providers	Status
			care • Utilise patient feedback via e-Consultation pilot to inform steps in future e-referral processes • Work with HeathWatch to develop a systematic approach to patient and public engagement to establish effective sustainable processes that ensure patient and public views are considered in the steps of service re-design. • Harness opportunities to work with Herefordshire Carers Support to help embed and evaluate local care pathways and referral processes (e.g. Heart Failure support group) • Children and young people's experiences are collated and shared with commissioners		• CCGs is continuing to use CCG membership scheme to promote and engage patients with the CCGs work programme(s) • Strengthened arrangements already in place across partners e.g. HealthWatch and local authority to ensure co-ordinated approach to engagement and involvement, includes joint communication group for transformation programme. • The Council, Herefordshire Clinical Commissioning Group and Healthwatch Herefordshire have joined together on behalf of the children and young people's partnership to commission the 'Participation People' to work with children and young people from across Herefordshire to gain their views and opinions on local services.
Promoting good health for all people	Preventing ill-health and promoting health	Healthy lifestyles	• Work with key partners, including Hereford Council Public Health, to improve and promote smoking cessation services and alcohol abuse services to promote healthier lifestyles • Embed MECC into every consultation and contact with people in appropriate settings and within the educational programme • Support education across primary, secondary care and care homes	All providers	• The Council recently undertook an any qualified provider re-commissioning exercise and from 1st April 2015 has 12 providers capable of providing stop smoking behavioural support services in pharmacies, G.P. surgeries and community settings. • Herefordshire Council has been retendering substance misuse services for the county. The service will include in-reach to hospital settings and closer working with primary care services when it goes live later this year. Services will be configured to offer prevention, early intervention and interventions which lead to recovery from substance misuse." • CCG education programme includes education sessions with Primary Care and Nursing homes to

NHS Outcome	CCG Work stream/priority(s)	Service area	Commissioning Schemes	Relevant to current providers	Status
					ensure targeted interventions that deliver CCG outcomes, key focus has been embedding of LTC strategy in clinical practice

Attachement 2 - NHS Herefordshire CCG -DRAFT COMMISSIONING INTENTIONS for CONSULTATION - Version 0.1

CCG Work Programme	Area	Draft Commissioning Schemes	Relevant provider (s)
Childrens	Children with disabilities	Development of a joint commissioning plan with Herefordshire Council to include: •Integrated pathway moving from pre-birth to transition into adulthood. Inc. Autism pathway •Commissioning direct services (including respite fostering) to support children with disabilities in family settings rather than requiring residential care •Commissioning of post 19 opportunities to support young people in local education and training •End of life pathway for Children and young people •Continuation of the implementation of the Herefordshire Transition protocol for children with long-term conditions. •Continuing the redesign of short breaks provision •Continuing development operational arrangements for integrated education, health and social care plans and reviews. •Increasing use of personal health budgets. •To progress the recommendations arising from the 2015/16 review of community health services for children	All providers and Commissioners
Childrens	Emotional Health and Wellbeing	•Improvements to Perinatal mental health provision •Enhancement of community eating disorders service •Revised Crisis Care pathway and 24/7 assessments •CAMHS/ GP/ School Link (tier 1 and 2 improvement) •Sustainability of CYP engagement and participation •Roll out of ROM (reported outcome measures) across CAMHs and making better use of technology •Increase in tier 2 capacity, e.g. primary mental health / CYP-IAPT. •Delivery of CYP-IAPT programme (continuation of staff training) •Improvement against compliance of WMQRS standards for CAMHS	All providers and Commissioners
Childrens	Safeguarding	•Joint Commissioning with Herefordshire Council to meet the needs of looked after children – e.g. care placement strategy, fostering framework and potential regional framework approach. •To improve the arrangements for Designated Doctor, with increased sessions.	All providers and Commissioners
Childrens	Maternity Services	•To seek improvement to local maternity services including Early Booking, access to patient records, midwifery-led unit, pathways; perinatal parental mental health; recording and reporting.	WVT NHST and 2gther Foundation Trust
High Quality Clinical Services	Stroke	•Continue to implement outcomes of the Stroke Review across the whole pathway including Stroke Prevention in AF, a networked approach to a fully serviced HASU/ASU, greater use of early supported discharge, through to work with stroke survivors to improve quality of care for stroke patients and delivery of national TIA standards	WVT NHST
High Quality Clinical Services	Education	•Co-ordinated education programme for clinicians, and other key stakeholders, to support pathway and redesign development	All providers
Integrated Care	Community Services	•To redesign adult bed based community services in order to improve clinical outcomes and deliver a clinically sustainable and financially viable model of services that Maximises independence and self-management, provides choice and control over the services that individuals receive and reduces emergency admissions and facilitates timely hospital discharge	WVT NHST

CCG Work Programme	Area	Draft Commissioning Schemes	Relevant provider (s)
Integrated Care	Dementia	As part of the dementia partnership: •Increase availability of early diagnosis of dementia and support (inc delivery of national dementia standards) •Support people with dementia, carers and families to live with dementia •Drive a Herefordshire wide culture change through awareness and understanding •To review the community dementia service in terms of activity and demand •To continue to promote dementia and support identification of people requiring diagnosis	All providers
Integrated Care	Better Exploitation of Information & Technology	Working with partners to exploit IMT to support delivery of CCGs and systems vision to include: •Ensuring access to the right information, in the right place at the right time •Using technology to support best clinical practice, moving to paperless working, this facilitating service efficiency, effectiveness and safety •Enabling care to be brought to the individual, rather than individuals travelling too far to receive care	All providers
Integrated Care	Care Coordination & Local Directory of Services	•a single point of contact for clinicians and health practitioners wishing to access acute or specific community services or alternative assessment pathways for those with physical health or care needs, moving to inclusion of mental health support services during 16/17 • To actively divert admissions from acute ED where appropriate, leading to a reduction in overall admissions. • To maintain an up to date directory of local services • To assist in effective assignment of community hospital and reablement beds, including the repatriation of patients from acute providers out of county •To maximise the utilisation of alternative community services and consistently identify the most relevant service. •To facilitate safe discharges and transfers with good quality handover information to a service that meets the holistic needs of the patient. • Identify mechanism for public access to support and advice	All providers
Integrated Care	Managing the Care home market	As part of the Better Care Programme develop integrated and improved working across health and social care, where people receiving housing with care will receive cost-effective, personalised support that enables them to be independent as long as possible including seamless assessments and improved experience of care. Will include assessment of market and new care home market strategy.	All providers
Medicines Optimization	Joint Formulary and local Herefordshire or/and national guidelines	• Pharmaceutical service providers must supply medicines approved within the local Herefordshire joint formulary and forward or advise on requests for non approved medicines to appropriate agencies. • Providers must ensure all medicines use and prescribing is in line with the agreed Herefordshire Joint Formulary and local Herefordshire or/and national guidelines e.g. NICE and policies	WVT NHST

CCG Work Programme	Area	Draft Commissioning Schemes	Relevant provider (s)
Medicines Optimization	medicines optimisation contracts and minimum standards	•All community inpatient facilities must have a minimum of one clinical pharmacist visit per week. •All community hospitals must hold controlled drugs stocks as per locally annually agreed site stock lists to enable 24/7 patient access, reduce waste resources e.g. medicines costs and the need for witnessed CD destructions. •Home Office Licence should be held by relevant provider sites to ensure that Controlled Drugs can be provided, transported, stored, monitored closely to ensure equitable access to medicines across sites for all patients e.g. all community hospital sites •Pharmaceutical service providers must ensure systems are in place to assure all community and provider services dealing with	All providers
Medicines Optimization	medicines governance	• Pharmaceutical service providers must work within the relevant sections of the Herefordshire CCG Medicines Management Quality Schedule 2014/15/16. • Pharmaceutical service providers must ensure systems are in place to assure all community and provider services dealing with medicines have appropriate pharmaceutical advice and support including appropriate skill mix support. • Providers must ensure compliance with legal and statutory requirements and good practice where medicines are supplied i.e. • Wholesale dealers licenses •Home office licenses for controlled drugs •under patient group directions and/or non-medical prescribing and support for systems and staff.	All providers
Medicines Optimization	Information Technology and Medicines (Secondary Care)	Providers of secondary care services involving medicines are: · encouraged to adopt e-prescribing as part of wider patient safety initiatives · utilise electronic database and scheduling to proactively manage patient outcomes and costs of key High Cost Drugs e.g. biologics in rheumatology and ophthalmology · expected to supply Electronic Patient Records for medicines on discharge to GPs and in the future community pharmacies	All providers
Medicines Optimization	Information Technology and Medicines (primary	Providers of primary care services involving medicines are expected to: · Enable and substantially increase the percentage of Patients accessing online repeat prescriptions ordering through secure IT portals e.g. EMIS Patient Access.	All providers
Medicines Optimization	Information Technology and Medicines (all providers)	Locally commissioned services from any qualified provider involving medicines should record electronically: medicines supplied , service implementation parameters , patient outcomes, exception reports, enable patient recall, invoicing/claims to facilitate performance monitoring by the Commissioner.	All providers

CCG Work Programme	Area	Draft Commissioning Schemes	Relevant provider (s)
Medicines Optimization	Medicines Optimisation Service Redesign (WVT)	Specifically for 15-16: 1. Community hospitals all including NHS and NHS commissioned minimum standards to apply across all 2. NHS community based stoma nurse service – continue to implement service re-design in line with contract details : a) Implement additional EMIS Web IT functionality to support patient record management , b) integration with practice information and undertake non- medical prescribing of community stoma patient appliance and devices. 3. Wound management a) District Nursing support dressing supply and leg ulcer management primary care b) TVN support for primary care including care homes 4. Anticoagulation community service clinics to move to point of care testing for all patients including i.e. housebound and potentially 5. Pathology/haematology to professionally support point of care testing for primary care commissioned services e.g. web based quality assurance 6. Rheumatology gain sharing agreement- details integrated into main points	All providers
Medicines Optimization	Medicines Optimisation Service Redesign (2g)	2g must ensure all medicines use and prescribing is in line with the agreed Herefordshire Joint Formulary and local Herefordshire or/and national guidelines e.g. NICE and local prescribing focus i.e. quetiapine MR venlafaxine MR	2gether Foundation Trust
Integrated care (Learning Disabilities)	Learning Disability	•Develop a shared strategy for Learning disabilities Inc. Promote wellbeing and healthy lifestyles, supporting access to employment, extending choice and control over care and support and better understanding need, and strengthening pathways between primary and community care •Deliver an outcomes based procurement of agreed areas of the pathway as part of the mental health re-procurement process •Implementation of autism strategy Deliver continuous improvement in response to Winterbourne Review and out of county placements	All providers
Modernising Mental Health	Mental health	•Jointly commissioned re-procurement of Mental Health services during 2015/16 to commence April 2017 •Agree and implement whole system mental health strategy and ensuring parity of esteem of Mental Health with physical health •Delivery of Crisis Care Concordat - 24/7; information & advice; crisis care planning; crisis care pathways • Improve early access intervention for psychosis • Improved mental health care pathways • Ensure access to psychological therapies is improved and NHS England targets are met • Review access and criteria for rehabilitation to improve the provision of recovery services, long-term treatment and care available within the county, with the outcome of more people regaining independent living skills and continued repatriation of patients •Seek system-wide approach to aid the early identification of those people in greatest need or risk of developing a mental health condition •Continuation of improvement to care planning for all people using secondary mental health services	2gther Foundation Trust

CCG Work Programme	Area	Draft Commissioning Schemes	Relevant provider (s)
Planned Care	Cancer	•Ensure compliance with NHS constitutional commitments and standards (2 week aits, 31 and 62 days) & delivery of Strategic Clinical Network priorities for local cancer care to achieve better outcome for people living with and beyond cancer. • Local Herefordshire Cancer work programme/strategy drafted, to be agreed with partners, patients and public, supported by a clear implementation and evaluation plan • Survivorship and prevention at heart of the cancer strategy and programme	WVT NHST and Gloucestershire Hospitals
Planned Care	Demand management	•E-referral - continue to develop work programme and ensure implementation of a single electronic referral process across all specialities, underpinned by agreed pathways of care •Diagnostics - Improved rapid access to diagnostic tests ensuring that NHS organisations are delivering a maximum wait of 6 weeks for tests across all specialities •Focus on demand management by specialities including review of adherence to low priority treatment policy and measures to improve new to follow-up ratio	Primary Care and WVT NHST
Planned Care/Integrated Care	End of life	Improve palliative and end of life care pathways, for Children, Young People, Adults, and Older People, including: •Increased identification of end of life needs – Gold Standard Framework surprise question •Person centred end of life care plans (including advance care plans) •Whole system EoL & Palliative Care coordination •Virtual Hospice; whole system EoL care •Consistent educational model for EOL care for whole health & care economy (Inc. Care homes, WMAS, GPs, Domiciliary Care Agencies)	All providers
Planned Care/Integrated Care	Management of LTCs	•Supported self-management: continued development of patient held records and self-management plans (Inc. roll out and development of risk stratification systems, processes and tools) •Implementation of LTC strategy with focus on improved supported self care and reduction in unscheduled admissions and readmissions	All providers
Planned Care/Integrated Care	Cardiovascular disease	•CVD: collaborate with partners to deliver Herefordshire action plan that underpins the County's CVD outcomes strategy. To include commissioning of integrated Familial Hypercholesterolemia for Hereford and Worcester and Implementation of National Diabetes Prevention Programme	All providers
Preventing Ill-health and improving health	Healthy Lifestyles	•Work with key partners, including Hereford Council Public Health, to improve and promote smoking cessation services and alcohol abuse services to promote healthier lifestyles •Embed MECC into every consultation and contact with people in appropriate settings and within the educational programme •Support education across primary, secondary care and care homes • Obesity - A whole pathway approach to Obesity prevention and management. Joint working with LA implement an integrated Pathway for Adults, Young People and children.	All providers
Preventing Ill-health and improving health	Personal Health Budgets	•Enhance use and availability of personal health budgets in line with national requirements	All providers

CCG Work Programme	Area	Draft Commissioning Schemes	Relevant provider (s)
Primary Care	Primary Care	• Develop the Herefordshire CCG primary care strategy and implementation plan (including stakeholder and GP input) • Deliver a robust primary care development and Education Programme 2015/16 • Undertake effective Practice Engagement and Communications programme • Produce a Primary Care Estate Strategy •Establish a Primary Care IM&T strategy underpinned with clear information governance •Work with the SRG to deliver Primary Care Service Resilience •Develop a model for seven day working including access to urgent care services.	Primary Care
Putting Patients at the heart of Everything we do	All programmes	• Seek opportunities to improve the extent of participation by patient and carers in shaping and evaluation of care pathways so that people understand the role they can take in their own health and health care • Work with HeathWatch to develop a systematic approach to patient and public engagement to establish effective sustainable processes that ensure patient and public views are considered in the steps of service re-design • Harness opportunities to work with Herefordshire Carers Support to help embed and evaluate local care pathways and referral processes (e.g. Heart Failure support group) • Children and young peoples experiences are collated and shared with commissioners	All providers
Urgent Care/integrated care	Urgent Care	•Continuation of Outcomes based commissioning and contracting of a whole system community focused urgent care pathway •Review, evaluate and reform the Urgent Care pathway focusing on acute care, intermediate care, community health and social care services. •Re-commission Community Teams as a single integrated resource and evaluate the county-wide roll-out of community teams, integrated care practitioners and implementation of RAAC •Explore 7 day primary care working to deliver community point of contact for minor urgent healthcare need •Redesign paediatric emergency and urgent care pathway. •Develop a model for seven day Primary Care working including access to urgent care services. •Primary Care service to work seamlessly with in hours 7 day Primary Care developments.	All providers

Herefordshire Council

Directorate Adult Wellbeing

Ref: RT/ PH Grant Consultation

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PRIVATE & CONFIDENTIAL

Consultation on Local Authority Public Health Allocations
Department of Health
Public Health Policy and Strategy Unit
Room 165
Richmond House
79 Whitehall
London
SW1A 2NS

27 August 2015

Dear colleague,

PH Grant Consultation Response 2015/2016

This is our formal response to the consultation on Local Authorities Public Health Allocation 2015-16 in-year savings. Herefordshire Council has very reluctantly chosen Option C as the least, worst option for our local population of the choices available. We also would like to submit the following documents in support of submission:-

- Final PH Grant consultation for Herefordshire 27 August 2015
- Appendix 2 Adapting national deprivation indices for rural areas v2
- Appendix 3 PHE14-01 Rural health (20150120)
- Appendix 4 PHE15-01 Rural health cover paper

Yours sincerely

Rod Thomson

Professor Rod Thomson FRCN FFPH
Director of Public Health for Herefordshire

Public Health Grant Consultation Response

Overview:

Herefordshire Council objects to the decision made by the Chancellor of the Exchequer to make a significant in year reduction to the public health grant. In its rationale for establishing a ring fenced public health grant within local authorities rather than the NHS, the former Secretary of State for Health, Andrew Lansley stated that the government wished to prevent public health resources being raided as had happened within the NHS. Whilst the current Secretary of State has emphasised the importance of prevention, this in year cut in public health resources will adversely affect local authorities' ability to commission accessible and effective services for their local populations. An in year reduction at such short notice also does not take into account the contracts that are already in place or the severe funding pressures already placed on local government. Reluctantly Herefordshire Council has identified Option C as the least, worst option for our local population of the choices available.

Preferred Option: C Flat Rate reduction for every Local Authority

Rationale:

The Department of Health has stated that its preferred option for implementing the £200m cut in the national Public Health grant is a universal 6.2% reduction. Whilst this may have the advantage of ease of administration for the Department of Health, it ignores the fundamental inequalities in the current allocations and does nothing towards moving towards the Department of Health's stated ambition of achieving a fair funding formula. Rural Authorities such as Herefordshire have the costs of providing services that are not adequately taken into account by the current funding formula.

Rural Health Inequalities:

As was made clear in the presentations to the Public Health England Board in January 2015, rural councils have the same responsibilities to commission public health programmes as their urban counterparts, however given the nature of their dispersed communities, there is a significant challenge to make such programmes accessible. Whereas urban authorities can achieve economies of scale and concentrate services in a small number of centres that are relatively well served by public transport, rural authorities cannot do so. Public Health England has now commenced a programme of work to review the data available as the current deprivation profiles do not adequately take into account rural factors compared to urban indices.

The current funding formula used by the Department of Health takes into account the cost pressures of funding services in major urban centres such as London, but fails to take into account the costs of delivering services in rural communities, including the travel time of staff; the need to utilise multiple sites in order to provide appropriate access to patients, the cost of fuel and the difficulties of achieving economies of scale. The current Market Forces Factor (MFF) that is used to take into account these cost variations gives a significant weighting to London boroughs such as Westminster at the expense of rural counties such as Herefordshire, e.g. MFF of 1.21 compared to Herefordshire's MFF of 0.94. The use of such a weighting adds to the inequalities in funding rather than reducing them.

The Rural Affairs Select Committee, the All Party Parliamentary Group on County Councils, the Rural Services Network and the County Councils' Network have in the last 18 months highlighted their concerns that the current national funding formulae being used do not adequately recognise the needs of rural communities compared to their urban counterparts.

Option A: Devise a formula that claims a larger share of the saving from LAs that are significantly above their target allocation.

There are merits in this proposal as several local authorities are significantly over their target allocations by more the total public health grant for Herefordshire. For rural counties such as Hereford there are some fixed costs that it must incur in order to meet the legislative requirements such the employment of appropriately qualified staff. As highlighted above the current funding formula for the grant does not adequately reflect the challenges of commissioning public health services in rural areas. Therefore though Herefordshire is identified as being as being over its target allocation this is by a comparatively small amount compared to many other Councils.

Option B: Targeting of Local Authority Reserves

Option B proposes the targeting of the unspent reserves of Local Authorities that were carried forward into 2015/16. Whilst this may be appropriate for those Local Authorities that are significantly over their target allocations, this could adversely affect the plans of those authorities that have tried to use their resources prudently. For example there have been protracted negotiations with NHS England regarding the transfer of commissioning responsibility for health visiting services. For many local authorities there has been uncertainty regarding whether NHS England was transferring sufficient funds to meet the current service and future service. In view of this uncertainty Herefordshire has had to be cautious in committing resources for local programmes until appropriate assurances have been given by NHS England regarding Health Visitor funding. In addition Herefordshire Council is facing pressures from changes in health services in Wales with increasing numbers of people resident in the principality choosing to attend sexual health clinics in Herefordshire.

As we approach our third year of local public health teams being based in local authorities several major contracts are now in the process of being tendered, including substance misuse, sexual health and some health promotion services. Experience has taught that even in the most well conducted procurement exercises there is often the need to incur one off costs as a service transfers from one provider to another, to ensure continuity of care for particular groups of patients.

Option C: **Flat Rate reduction for every Local Authority**

A flat reduction may at first glance appear to be the fairest way of making the national £200m one off reduction in the grant however it does not address the fundamental inequalities in the current allocations that have been recognised by Public Health England. A flat rate reduction perpetuates these inequalities rather than moving each local authority towards its own target. The purpose of the increased allocation to underfunded local authorities in 2013/14 and 2014/15 was to move towards a fairer funding settlement therefore a flat rate reduction to every council undermines that policy. As the attached appendix 1 show there are eight local authorities that are currently over funded (based on Department of Health figures) by more than the total public health grant that Herefordshire Council receives, i.e. by more than £7.8m. (Prior to the inclusion of the Health Visiting budget.)

Option D: Special Need

As indicated above, rural local authorities face significant challenges in commissioning the range of accessible services that their populations need. Programmes such as sexual health and substance misuse treatment need to meet national quality standards and be accessible to populations that are dispersed over a wide area. In Herefordshire's case connectivity is a

big issue, we have five market towns and the public transport links between them and the county town of Hereford are limited. The public transport links from the surrounding villages and hamlets are even more restricted. These include a number of isolated hill villages and hamlets with poor infrastructure. In view of that the option open to urban areas of commissioning a single specialist centre close to the public transport routes is not an option. For services such as school nursing, the travel times for staff between the schools that they serve are significant, particularly during the winter months. As Herefordshire shares its long western border with Wales our services are accessed by the residents of Welsh towns such as Hay on Wye. With changes in service provision in Wales, our sexual health services are seeing an increase in the number of patients that we are seeing who prefer to access provision in Herefordshire rather than in Powys. Several factors influence such choices including perceived anonymity of the Herefordshire service, employment in Herefordshire makes our services more accessible relatively speaking and clinic visits are combined with other activity such as a major shopping trip to Hereford.

As Herefordshire CCG will confirm over many years the cost of running acute hospital services within the county have been and are a major drain on NHS resources. The former Herefordshire PCT was therefore force to prioritise acute care over prevention whilst dealing with the financial deficit that it faced. This has meant that spend on public health programmes was lower than it should have been for a population of 186,000 people.

Healthier Lives

According to Public Health England's Healthier Lives report Herefordshire rates 30th out of 150 local authorities in terms of its premature mortality rates. This compares to Kensington and Chelsea's rating of 2nd out of 150 local authorities, yet this London borough currently receives in its public health grant £21.9m compared to Herefordshire's £7.8m. The population of Kensington and Chelsea is 155,600 compared to Herefordshire 186,000 people. For the ten Healthier Lives categories, Kensington & Chelsea's rating is higher than Herefordshire's on six of them. This London borough also benefits from access to higher levels of grants and business rates than Herefordshire as well as having a smaller geographic area to serve. Kensington and Chelsea's public transport links includes access to an extensive rail and bus service that makes the service that it commissions readily accessible to its population.

Conclusion

The Health and Social Care Act 2012 and its supporting guidance recognised the importance of a strong focus on prevention and the need to invest in a range of health promotion programmes to reduce the prevalence of long term conditions. The proposed in year reduction in the public health grant to local authorities undermines this government commitment. For rural authorities such as Herefordshire, the challenge of making these public health programmes accessible to its dispersed population is not fully acknowledged within the funding formula used by the Department of Health. The attached supporting information commissioned by Public Health England highlights the case for a fairer funding settlement for rural councils. In addition the significant in year reduction in the public health grant that is proposed will undermine local programmes to promote the health and wellbeing of our population.

Appendix1: Briefing Note: Public Health Funding Cuts
July 2015
Prof Rod Thomson, Director of Public Health

Local Authority	Allocation per head	Total 15/16 Budget	Funding in Addition to Target Grant (approx.)	
Blackpool	£126	£17.9m	51.5%	£9.2m
Camden	£112	£26.3m	42%	£11.m
County Durham	£88	£45.7m	72.5%	£33.1m
Darlington	£67	£7.1m	11.7%	£0.83m
Derbyshire	£46	£35.6m	11.4%	£4m
Doncaster	£66	£20.1m	9.1%	£1.8m
Dudley	£60	£18.9m	28.9%	£5.46m
East Sussex	£46	£24.5m	27.6%	£6.7m
Gateshead	£78	£15.8m	23%	£3.63m
Hackney	£117	£29.8m	29.4%	£8.7m.
Hammersmith	£114	£20.8m	72.4%	£15m
Hartlepool	£91	£8.4m	22.3%	£1.87m
Herefordshire	£42	£7.9m	16.2%	£1.27m
Hull	£87	£22.5m	10%	£2.2m
Islington	£116	£25.4m	22.3%	£5.6m
Kensington & Chelsea	£133	£21.2m	90.3%	£19.1m
Kingston	£54	£9.3m	30.6%	£2.84m
Knowsley	£111	£16.3m	44.1%	£7.2m
Middlesbrough	£117	£16.3m	35.7%	£5.8m
Nottingham	£89	£27.8m	4%	£1.1m
Portsmouth	£77	£16.1m	13.7%	£2.2m
Redcar	£81	£10.9m	46%	£5m
Richmond	£40	£7.8m	18.1%	£1.4m
Sefton	£73	£19.9m	33%	£6.6m
South Tyneside	£86	£12.9m	44.4%	£5.7m
St Helens	£74	£13m	22.2%	£2.8m
Stockton	£67	£13m	9.3%	£1.2m
Stoke	£80	£20.2m	11.1%	£2.2m
Sunderland	£76	£21.2m	24.5%	£5.2m
Telford	£64	£10.9m	21.9%	£2.38m
Torbay	£55	£7.3m	29.2%	£2.1m
Tower Hamlets	£116	£32.2m	16.2%	£5.2m
Wakefield	£62	£20.7m	3.7%	£0.76m
Wandsworth	£80	£25.4m	42%	£10.6m
Westminster	£133	£31.2m	27%	£8.4m
Wigan	£73	£23.6m	18.9%	£4.6m
Wirral	£82	£26.4m	28%	£7.4m
Wolverhampton	£76	£19.2m	13.3%	£2.5m
Worcestershire	£46	£26.5m	23%	£6.1m

Inequalities in Rural Communities: Adapting national deprivation indices for rural areas

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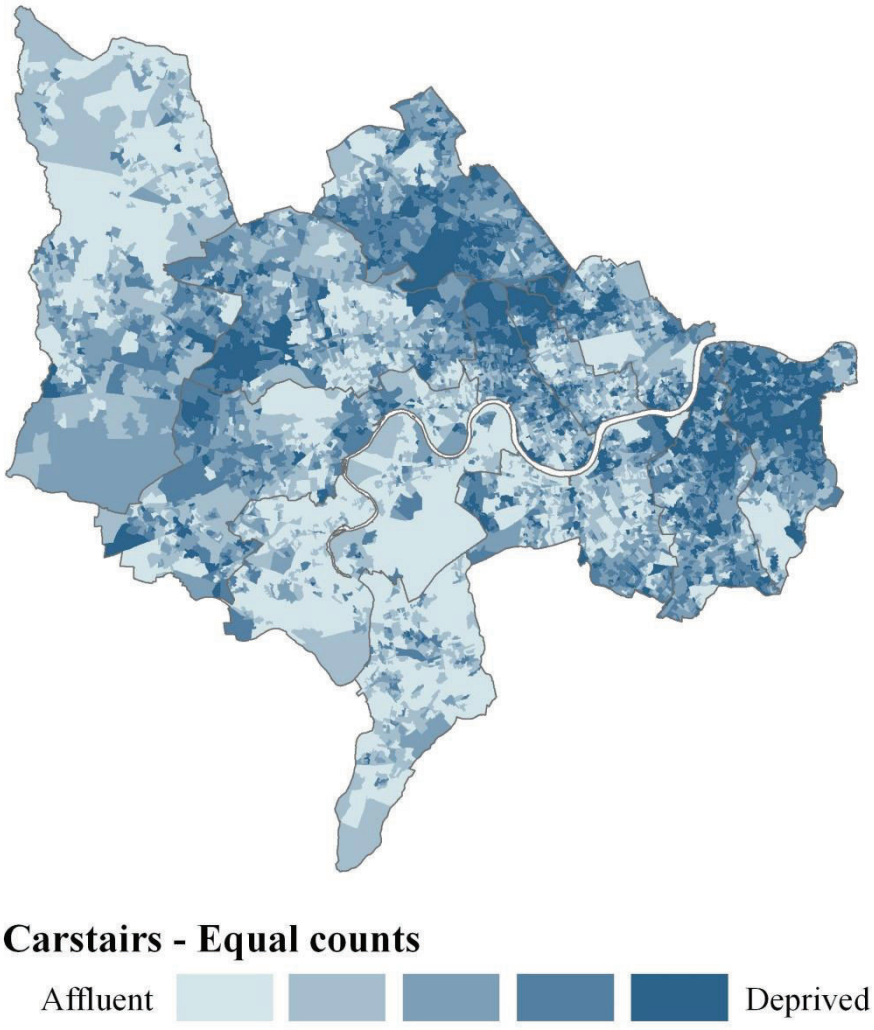
MRC-PHE Centre for Environment and Health
Imperial College London

Small Area Health Statistics Unit

MRC-PHE
Centre for Environment & Health

Public Health England | MRC Medical Research Council | Imperial College London | King's College London

National area-level deprivation indices



Based on census data:

Measures of material deprivation:

- Carstairs Index
- Townsend Index

Need for primary care services

- Jarman Underprivileged Area score

Based on other data sources:

- Index of Deprivation
- Department of the Environment index

Census based indices: composite measures of deprivation

Name	Carstairs Index	Townsend Deprivation Index	Jarman Underprivileged Area Score
Census variables	• No car ownership • Unemployed males over 16 • Overcrowding: more than 1 person per room • Head of household in low social class	• No car ownership • Unemployed males over 16 • Overcrowding: more than 1 person per room • No home ownership	• Unemployed males over 16 • Overcrowding: more than 1 person per room • Head of household in low social class • Lone pensioners • Single parents • Borne in New Commonwealth • Children aged under 5 • One year migrants
	… expressed as percent of households in an area with the relevant characteristics	… expressed as percent of households in an area with the relevant characteristics	… expressed as percent of residents in an area with the relevant characteristics
Weighted	no	no	yes

Derivation of Carstairs score for an area

$$CAR = \sum_{i=1}^{n} \frac{X_i - m_i}{s_i} \qquad X_i = \frac{n_i}{d_i}$$

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n_i is the numerator of deprivation variable X_i (e.g. number of unemployed males)

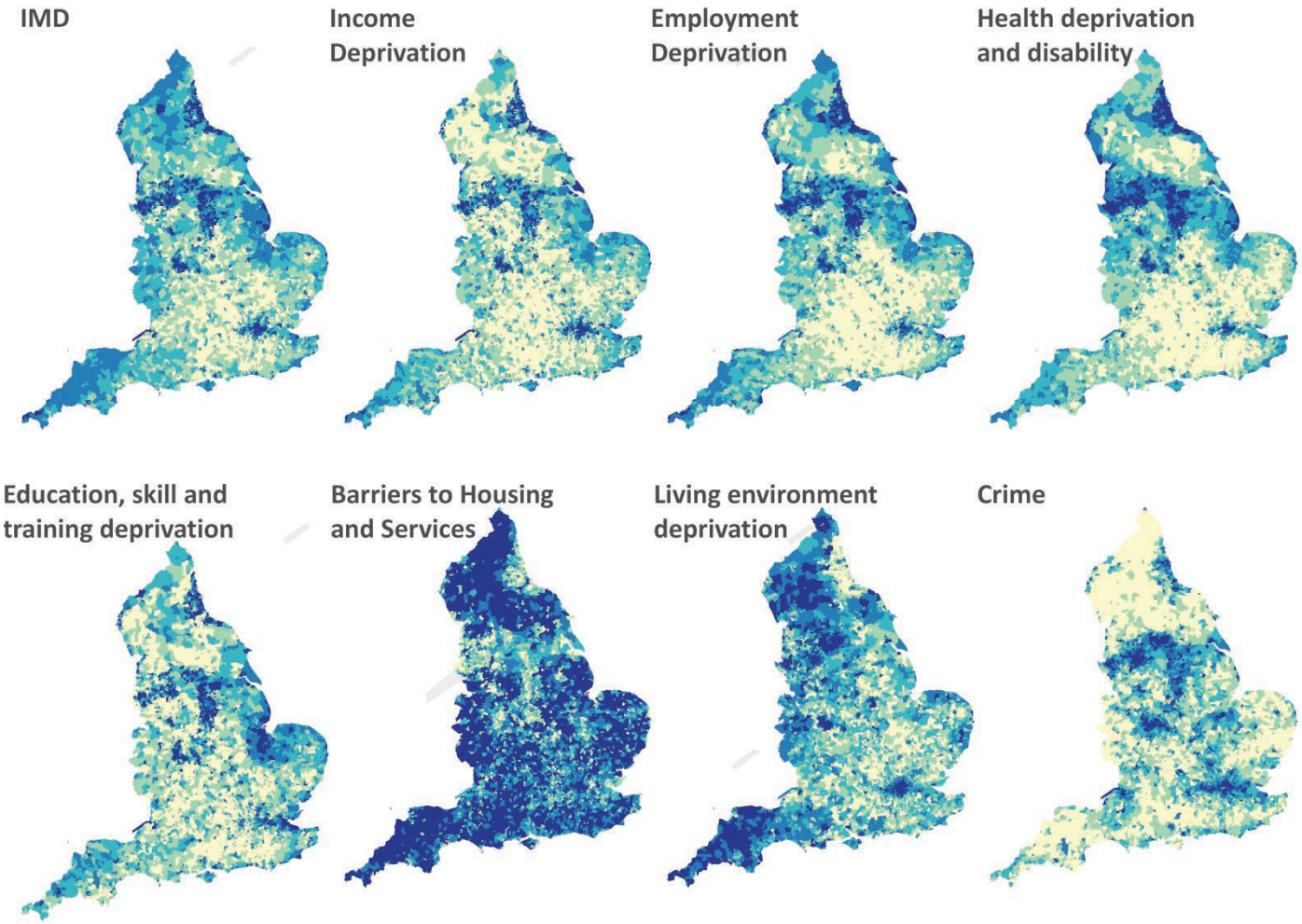
d_i is the denominator of deprivation variable X_i (e.g. number of economic active males)

m_i is the mean of X_i

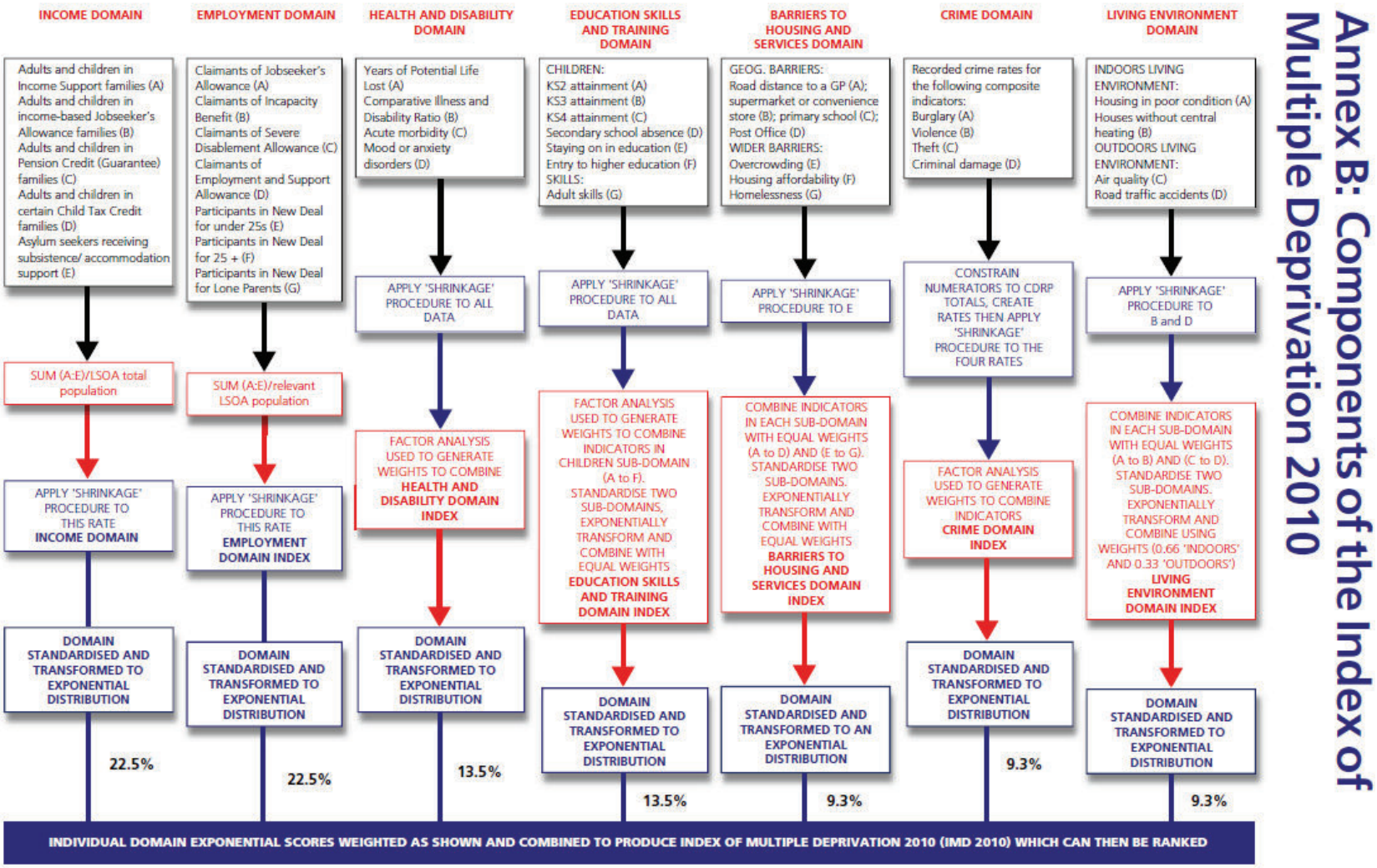
s_i is the standard deviation of X_i

Index of Multiple Deprivation (IMD)

• Originally developed by the **Office of the Deputy Prime Minister** (2000, 2004), now **Communities and Local Government** (2007, 2010, 2015 [to be released September 2015])



IMD Derivation



Department for Communities and Local Government. 2011. The English Indices of Deprivation 2010 – Technical Report.

Methods: Define rural areas

Rural areas were defined using:

- ONS *Rural and Urban Area Classification 2004*

  for LSOAs 2001

  Rural areas include:

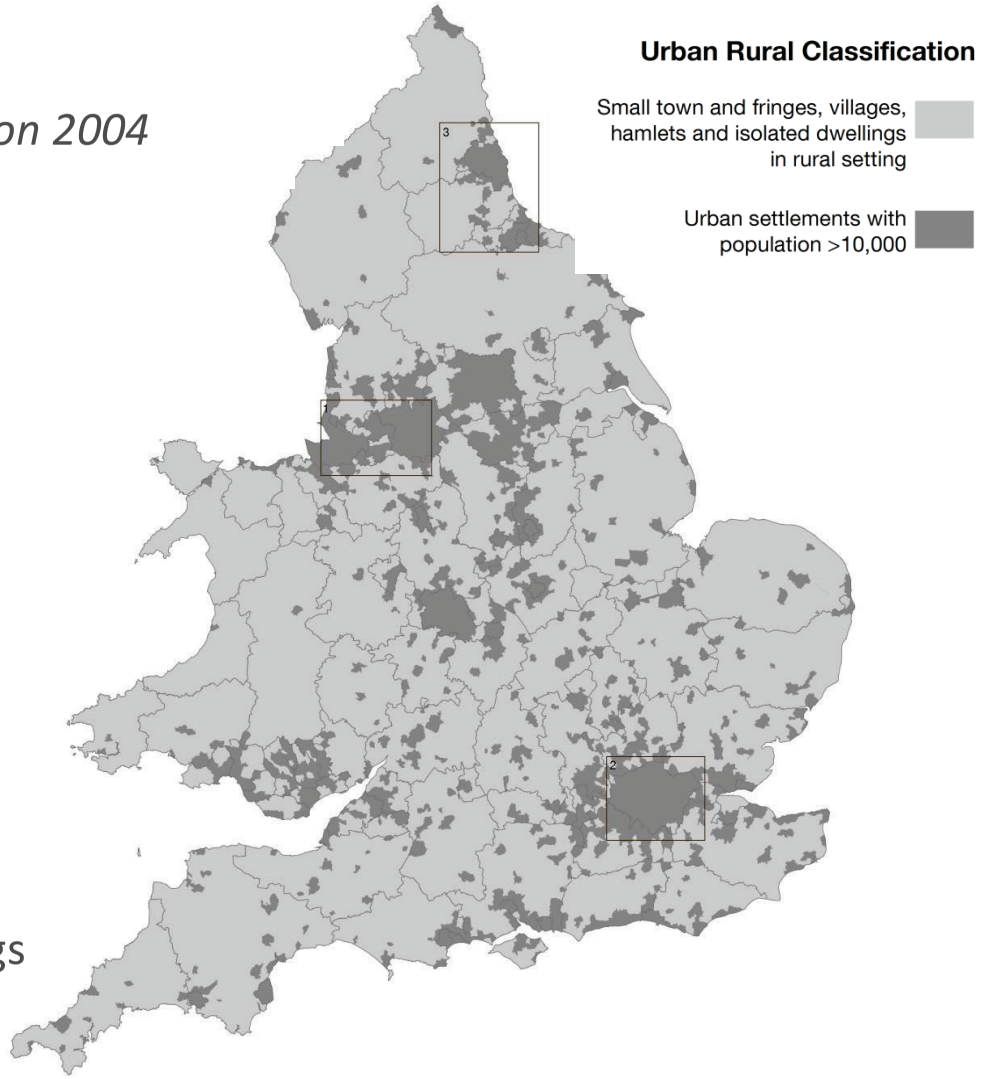
  - small town and fringes
  - villages
  - hamlets and isolated dwellings

- ONS *Rural-urban Classification 2011*

  for COAs 2011

  Rural areas include:

  - rural town and fringe
  - rural village
  - rural hamlet and isolated dwellings



Methods: Adapting to rural areas

- **Areas (e.g. COAs, LSOAs) classified as urban were removed from the data**
- **Deprivation index was standardised to rural areas only where possible**
- **Deprivation index score was divided into quintiles**

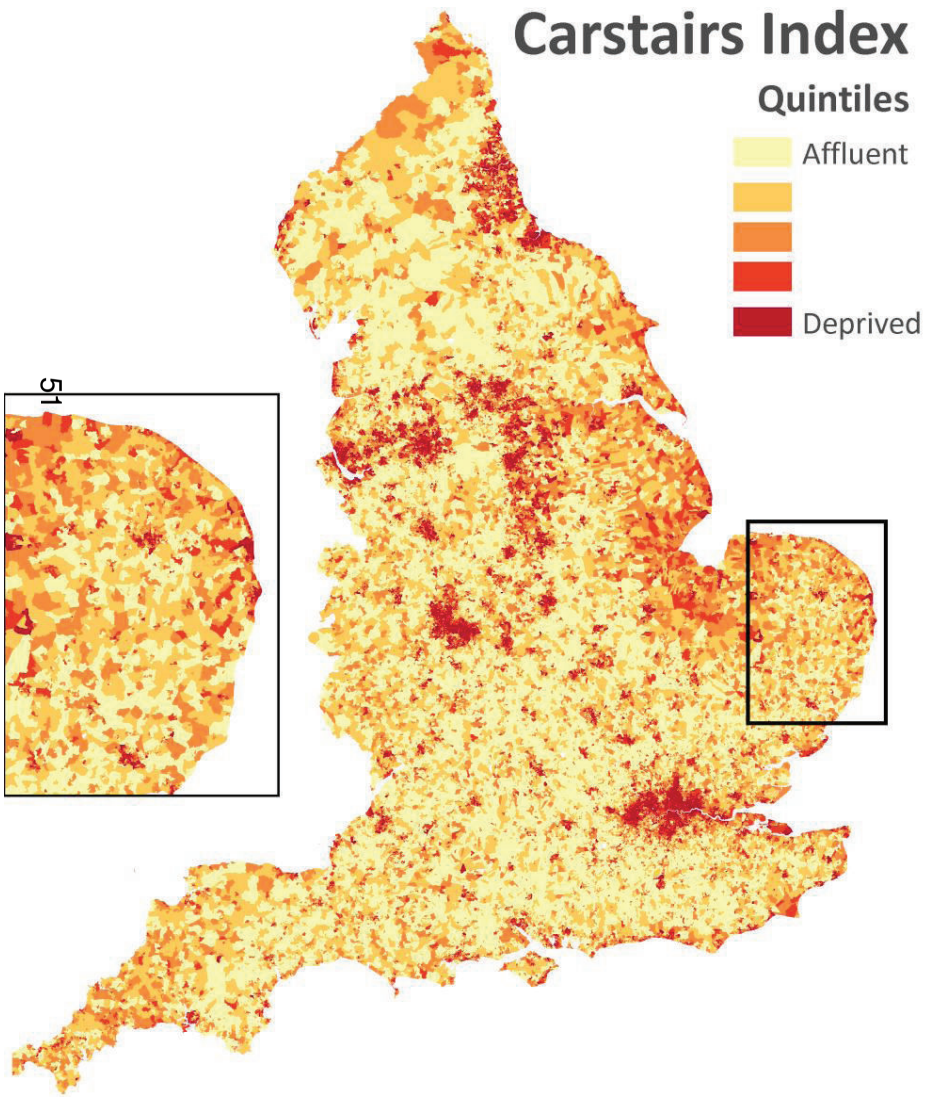
Carstairs Index 2011 for COAs 2011

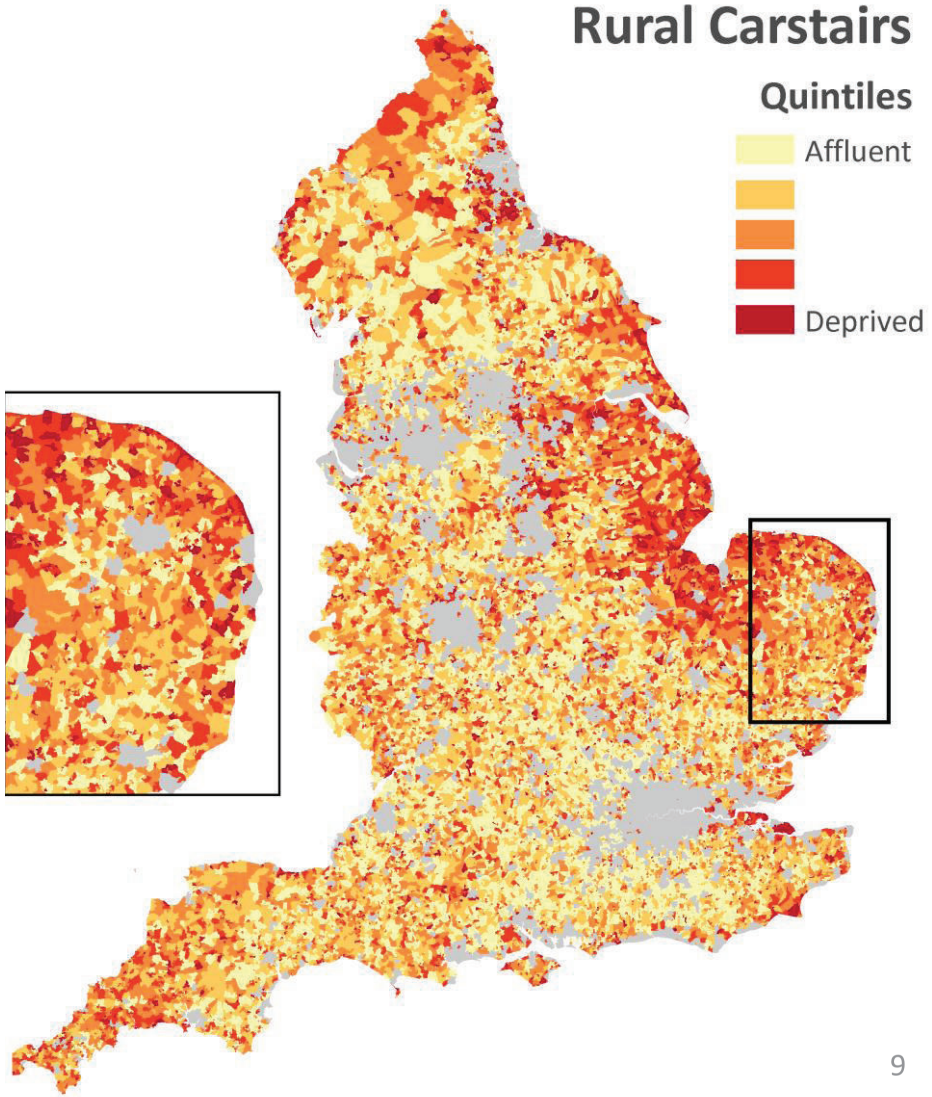
- Due to the relative simplicity of the methodology (see slide 4), this deprivation index can be re-standardised to rural areas.
- Records of urban COAs were removed from the input variables and scores were then re-standardised and summed (following the equation shown on slide 4) to create the Rural Carstairs Index (see slide 9).
- **Carstairs index includes car ownership, so although it can be standardised to rural areas, the components of the measure may not be ideal for rural areas**

Index of Deprivation 2010 for LSOAs 2001

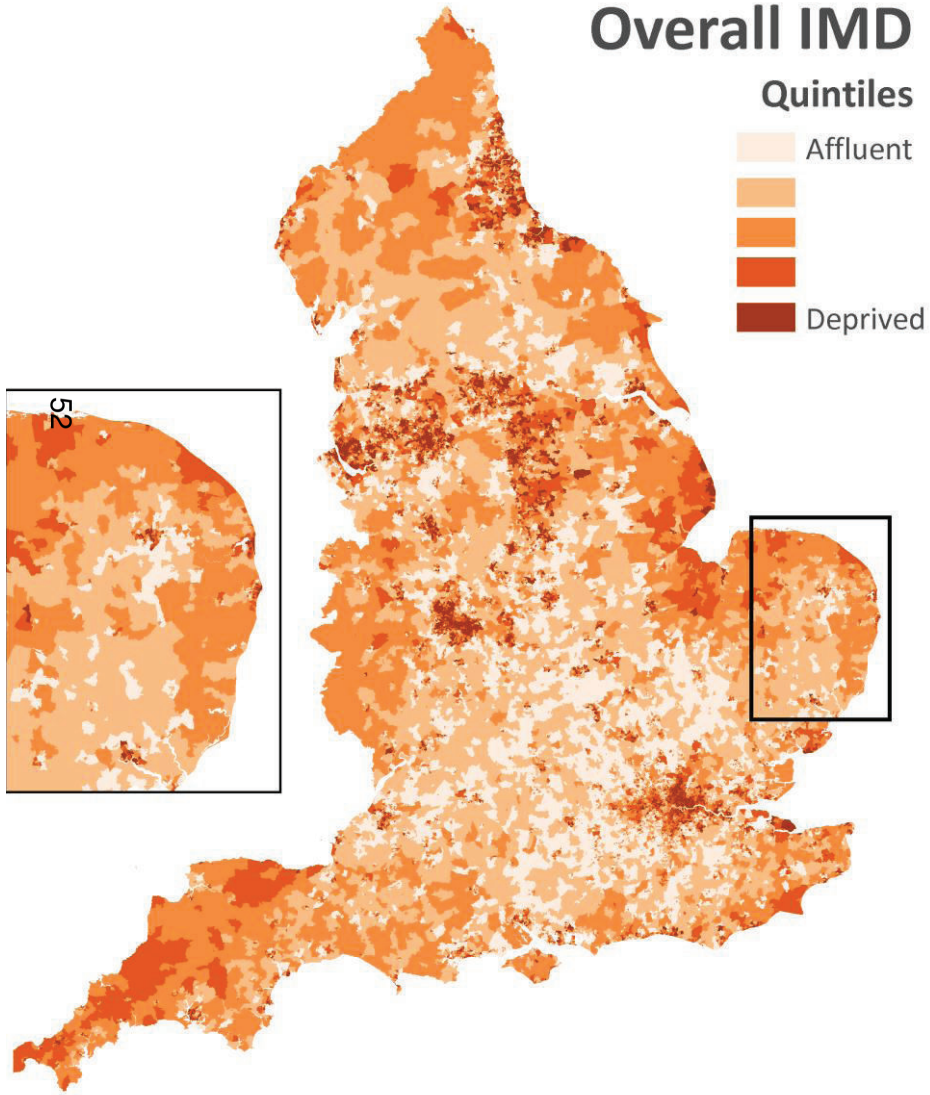
- Due to complexity of IMD calculation (see slide 6) the IMD cannot be re-standardised to rural areas without substantial methodological effort.
- To display the heterogeneity of the IMD in rural areas the IMD (and its domains) was instead mapped using quintiles specific to rural areas only (see slides 10 - 17).
- **In the IMD calculation shrinkage estimation is used to move LSOA scores of areas with small population counts (and large standard errors) towards the more robust Local Authority mean (see slide 6). This might potentially distort the rural IMD in areas close to urban centres.**

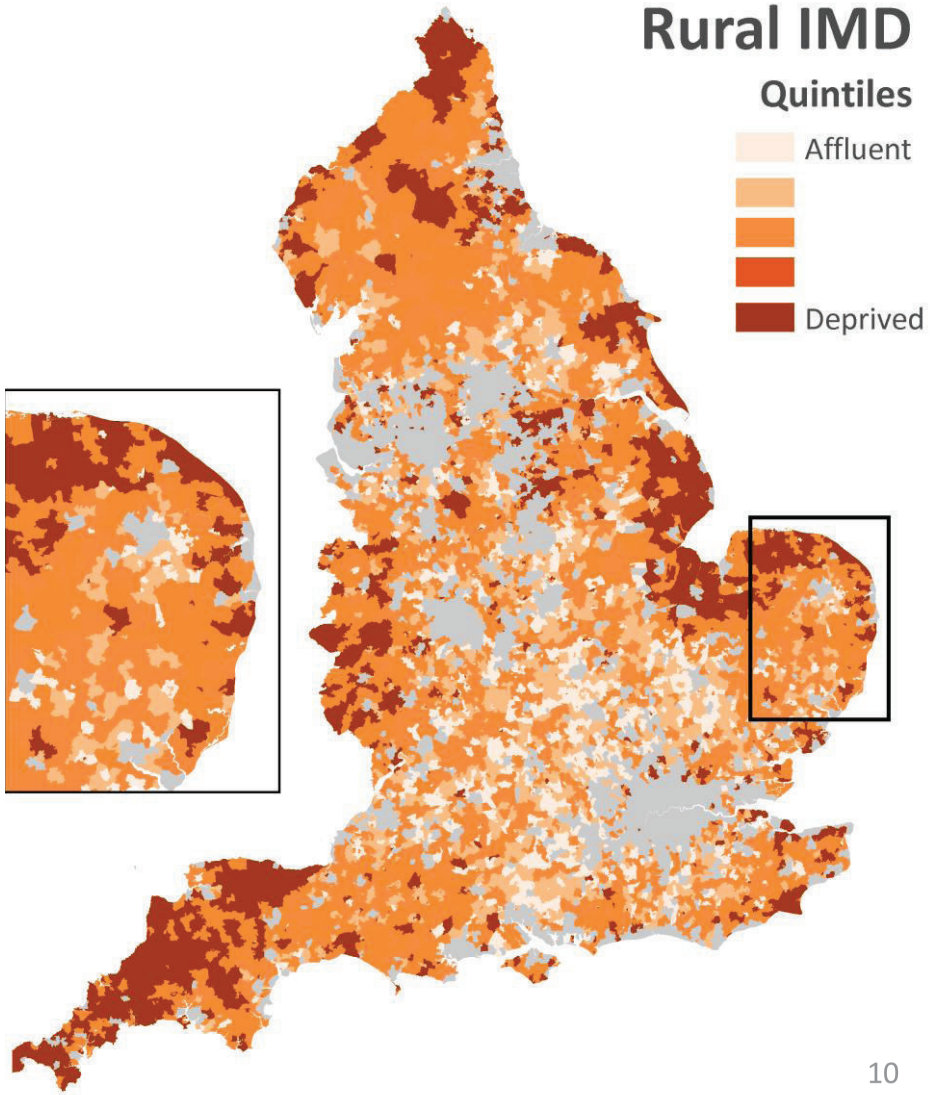
Rural standardisation:
Carstairs Index 2011 for COAs 2011



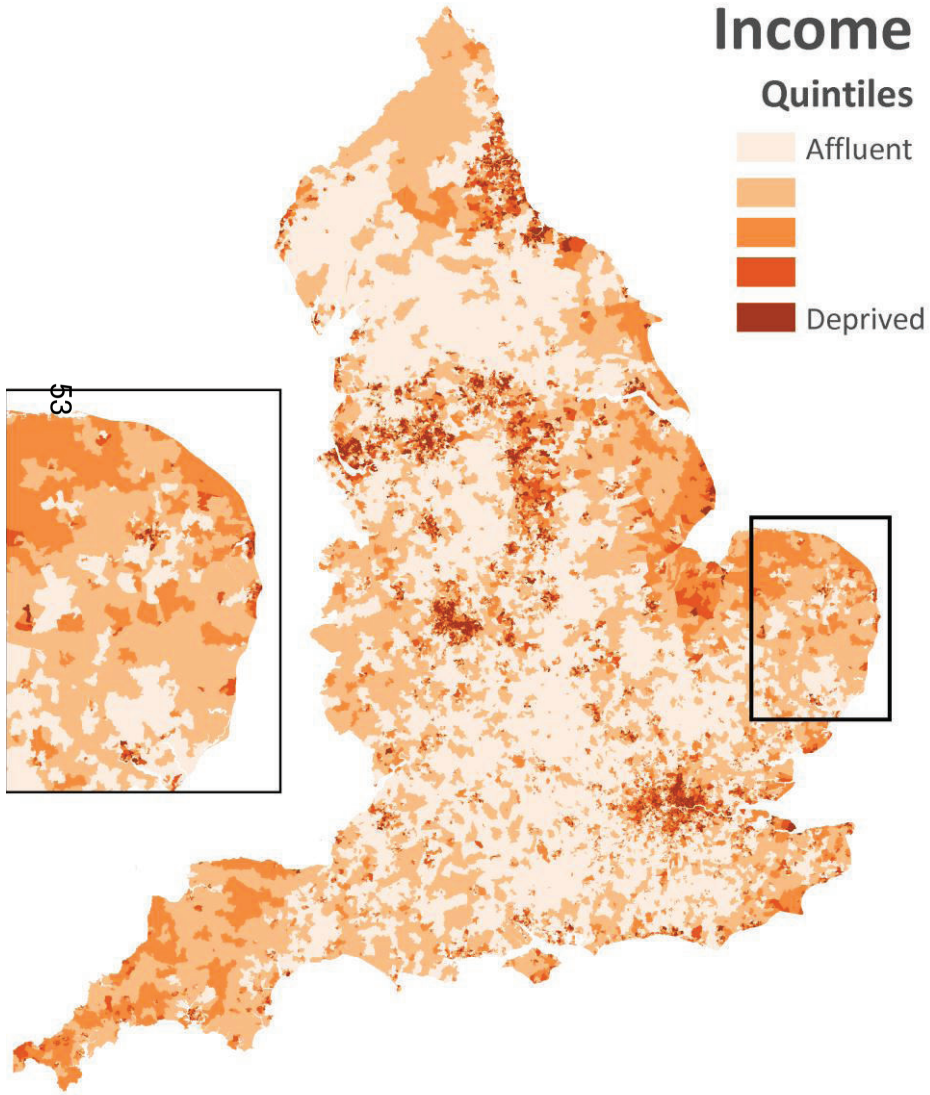


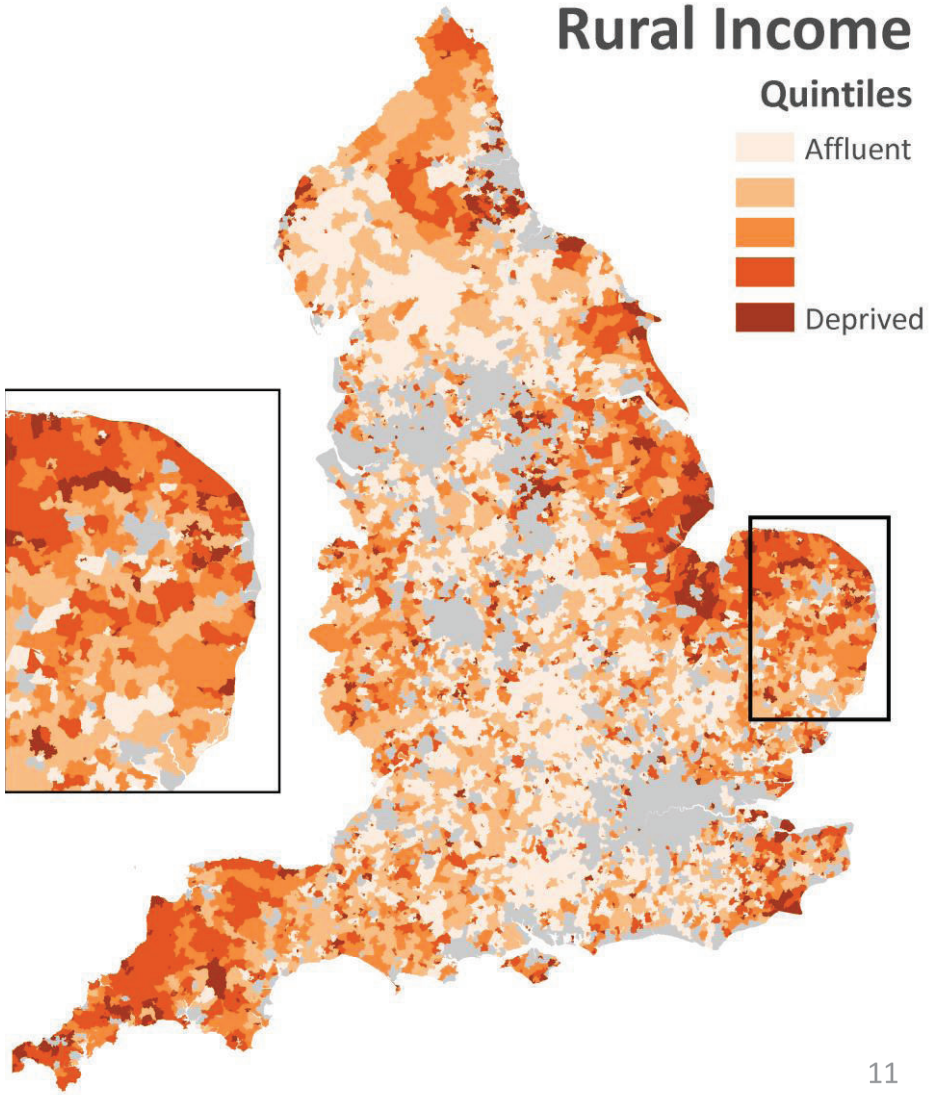
Rural standardisation:
Index of Multiple Deprivation (IMD) 2010





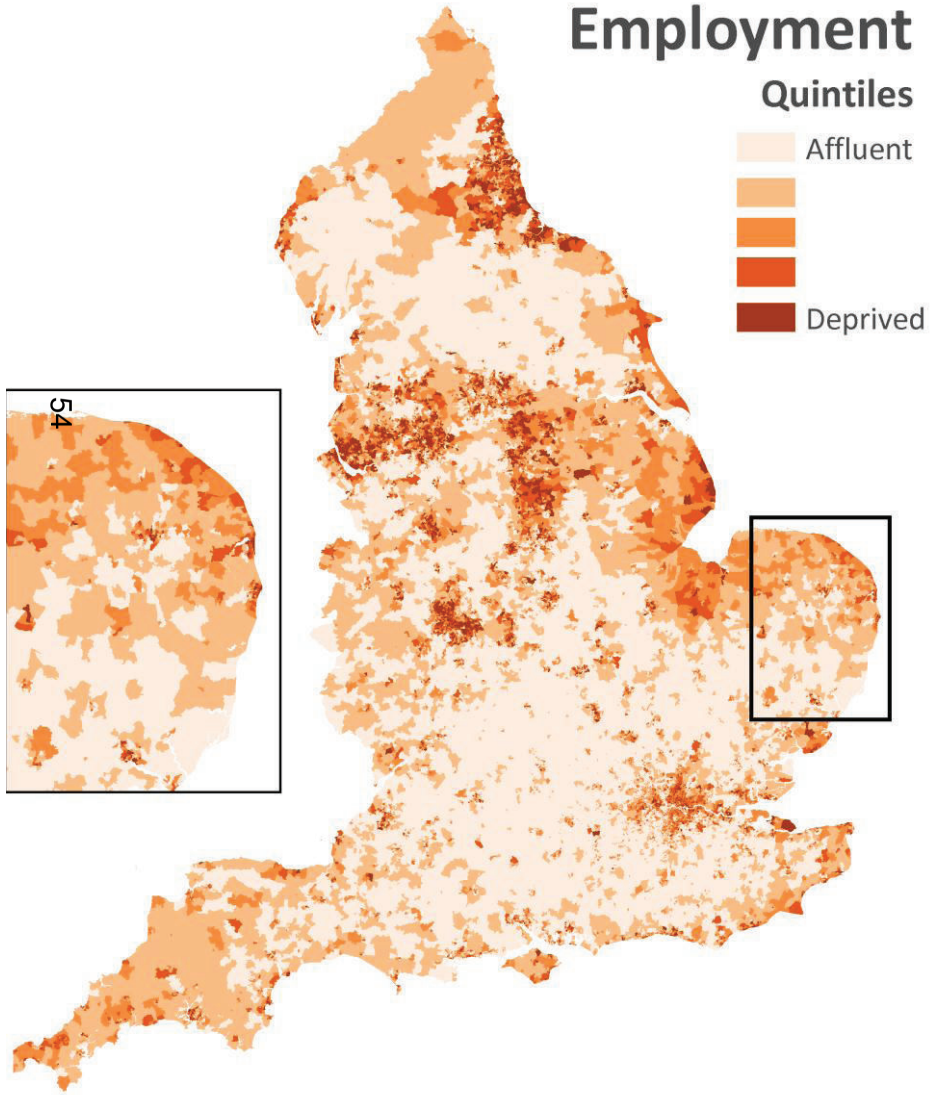
Rural standardisation:
Index of Deprivation 2010 – Income Domain

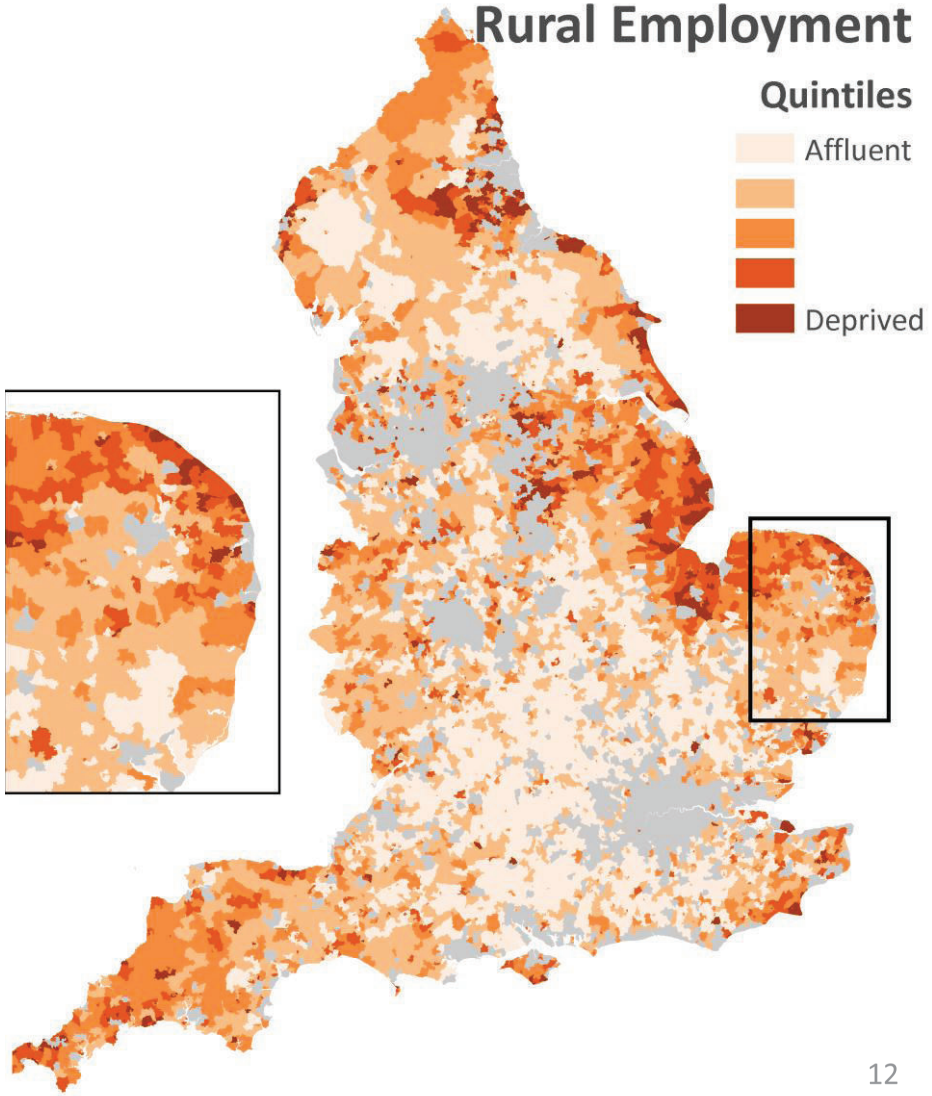




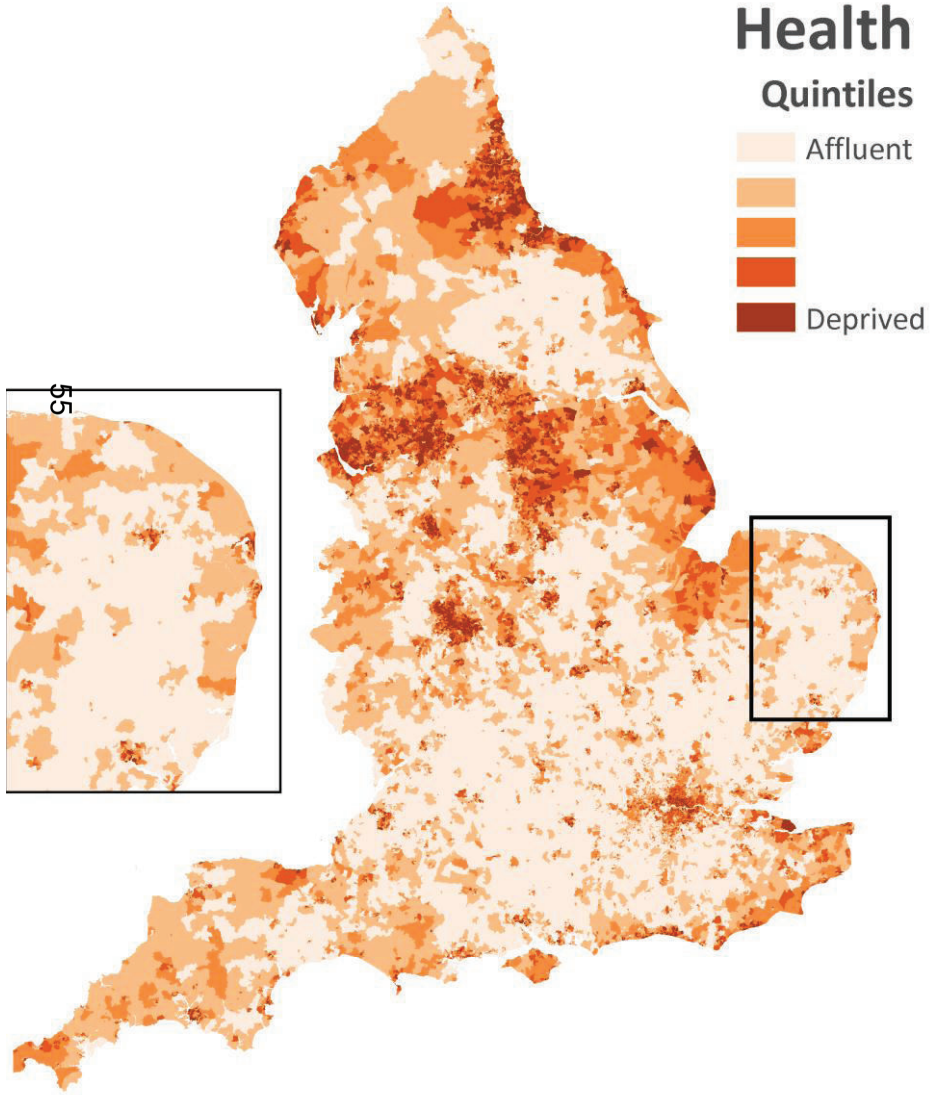
Rural standardisation:

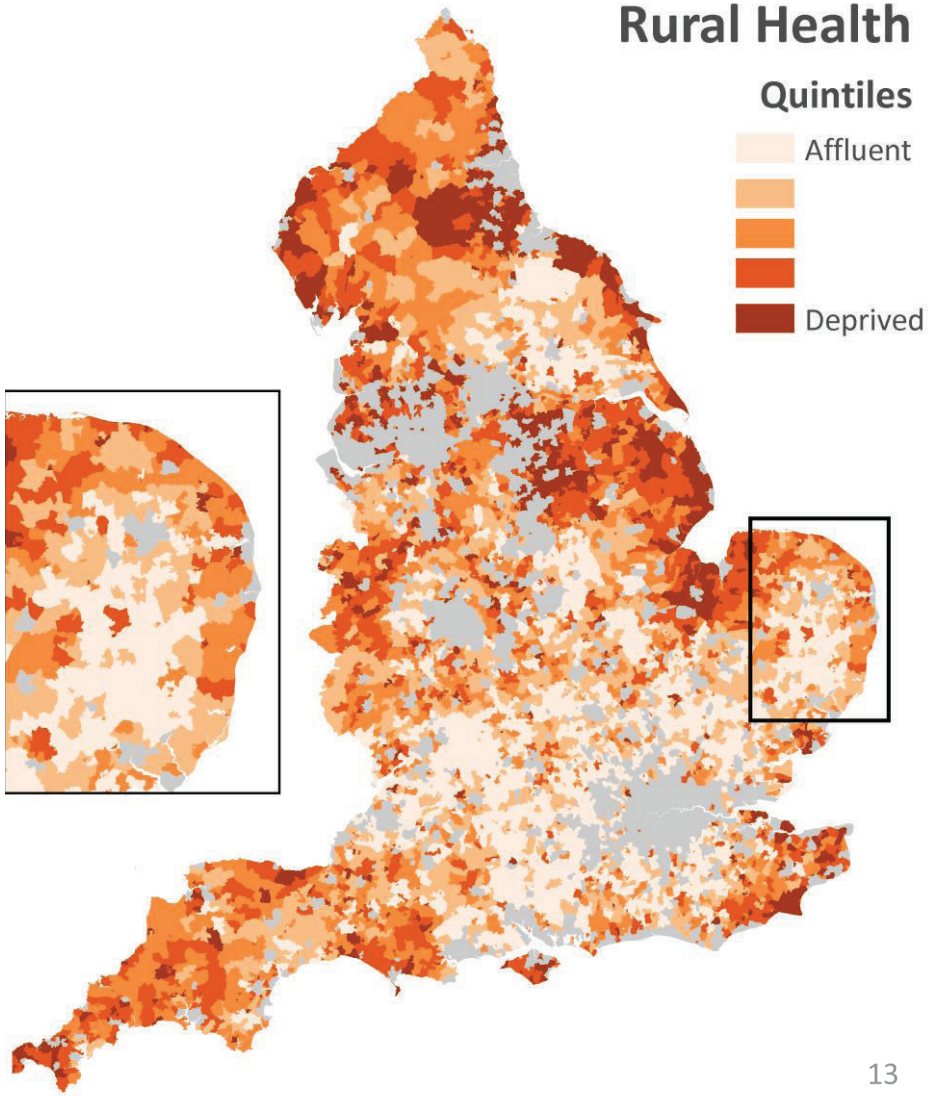
Index of Deprivation 2010 – Employment Domain



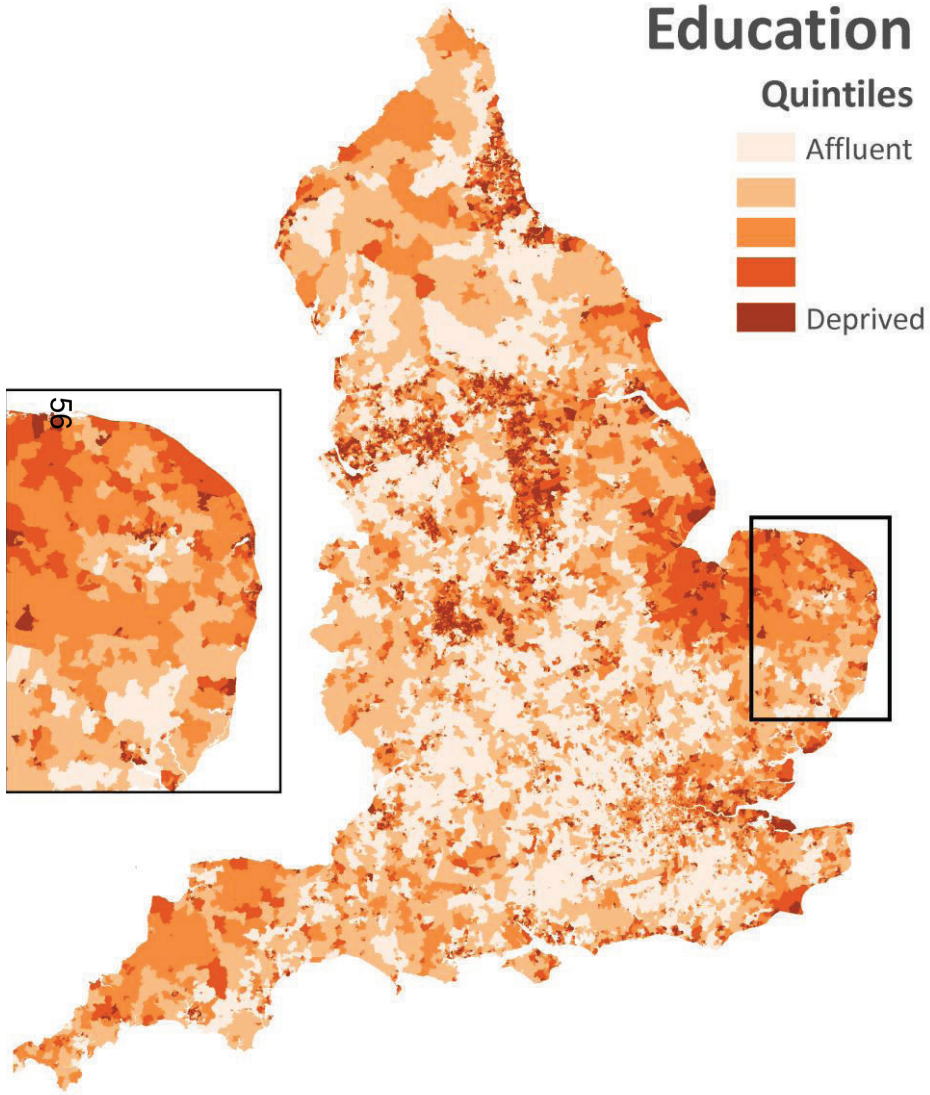


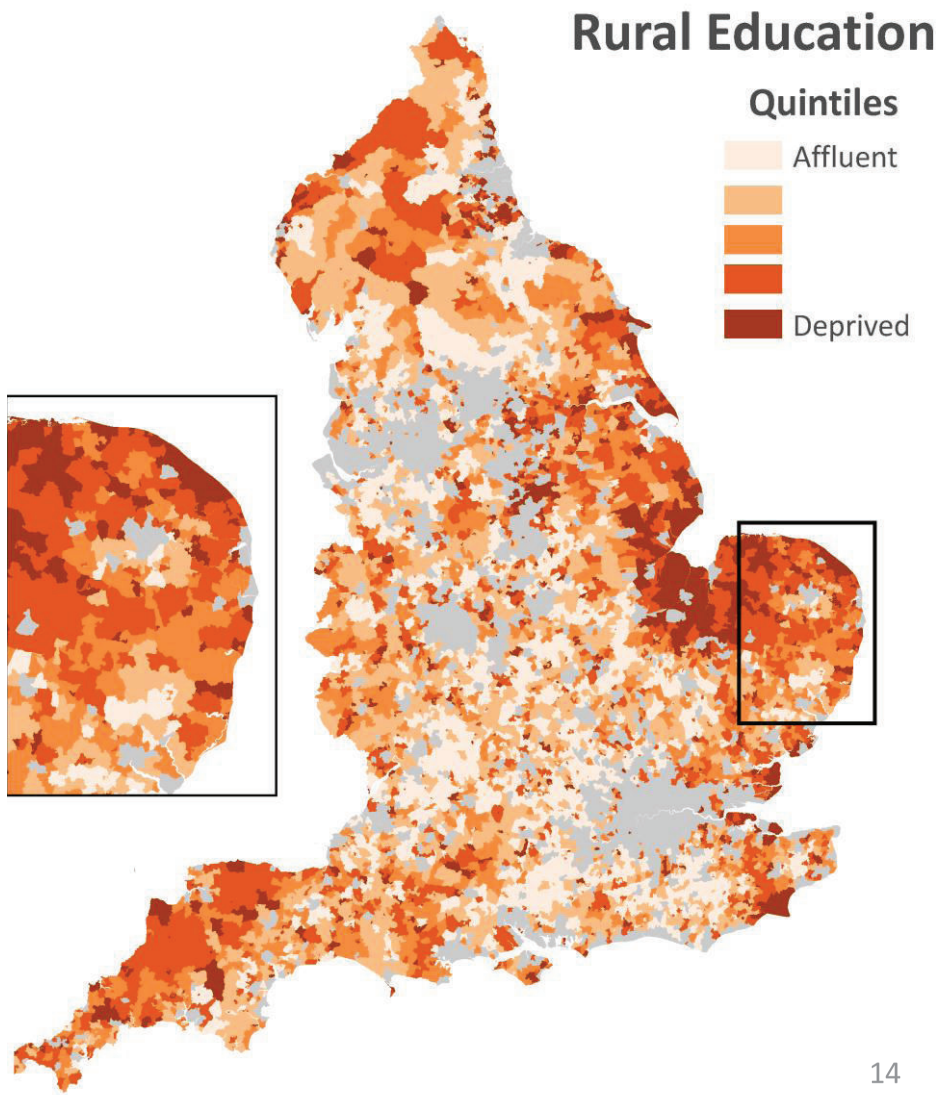
Rural standardisation:
Index of Deprivation 2010 – Health Domain





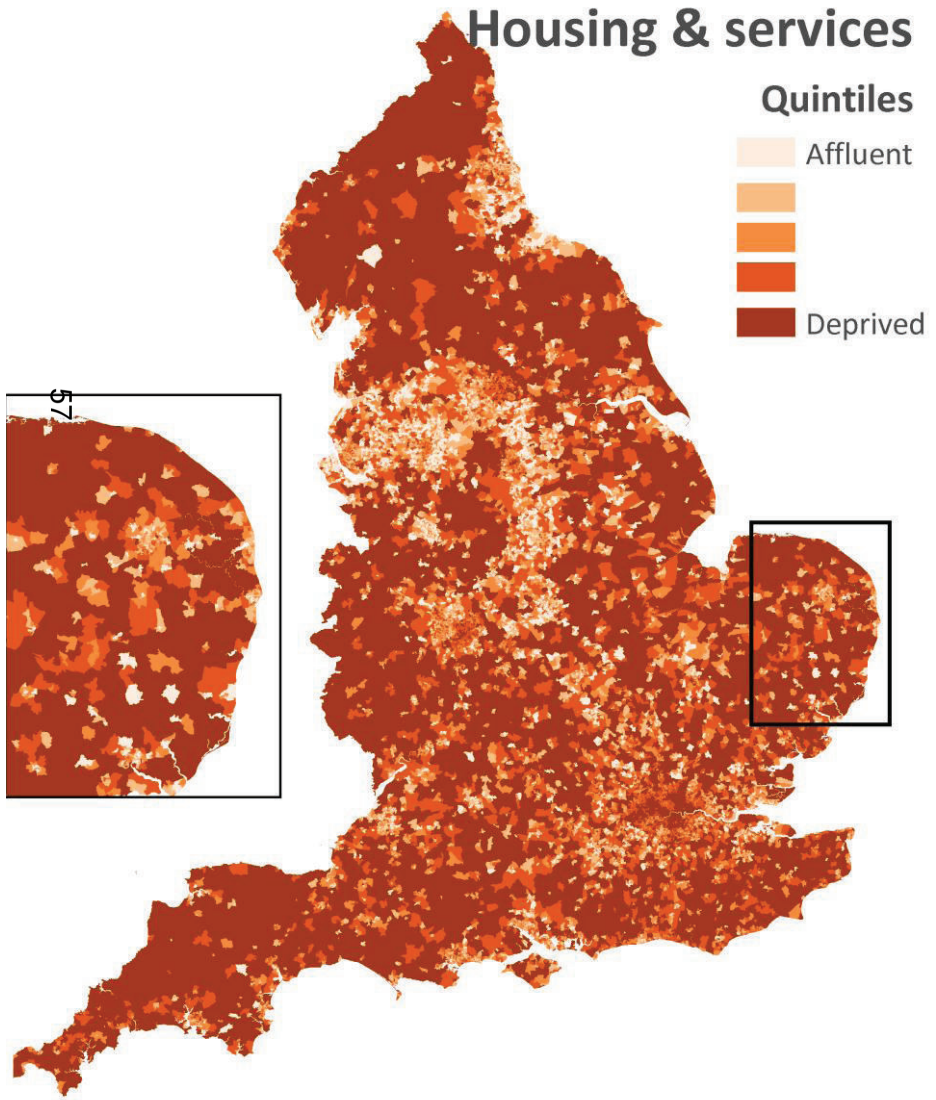
Rural standardisation:
Index of Deprivation 2010 – Education Domain

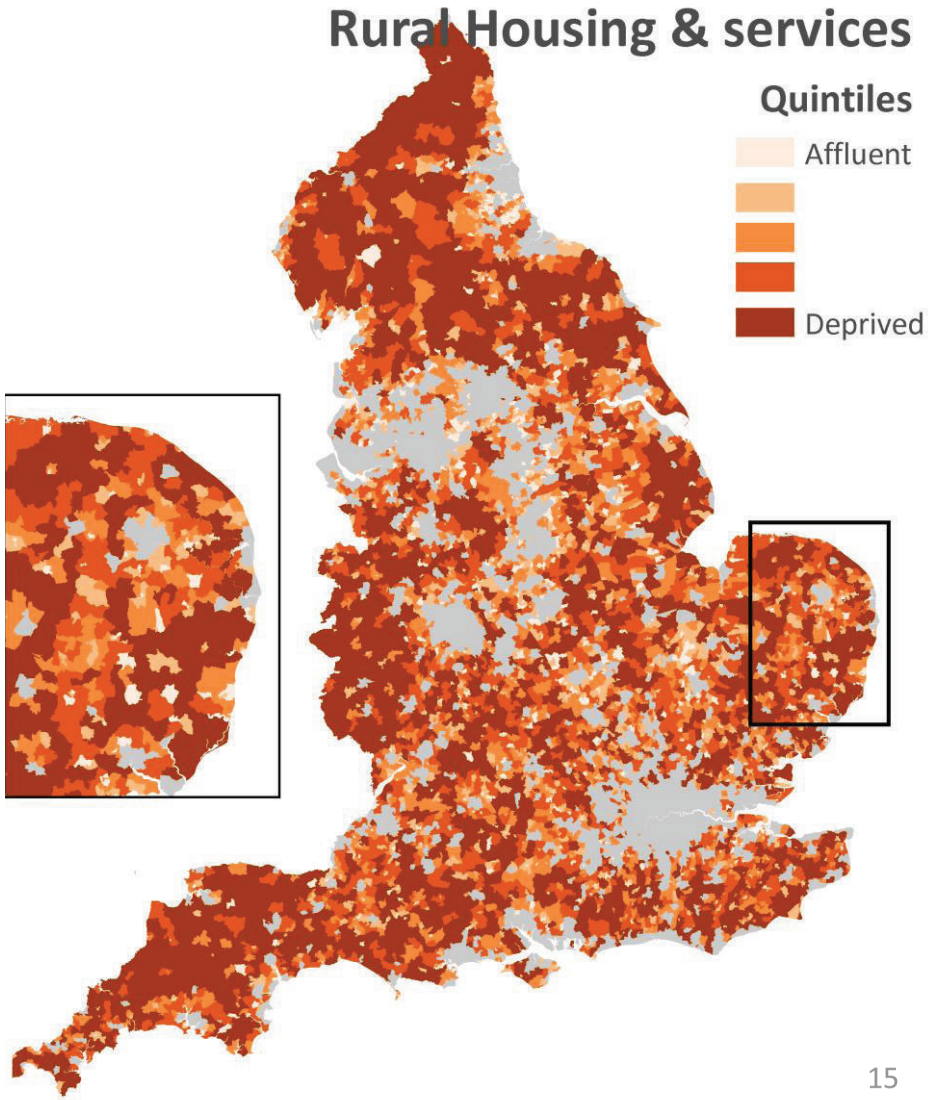




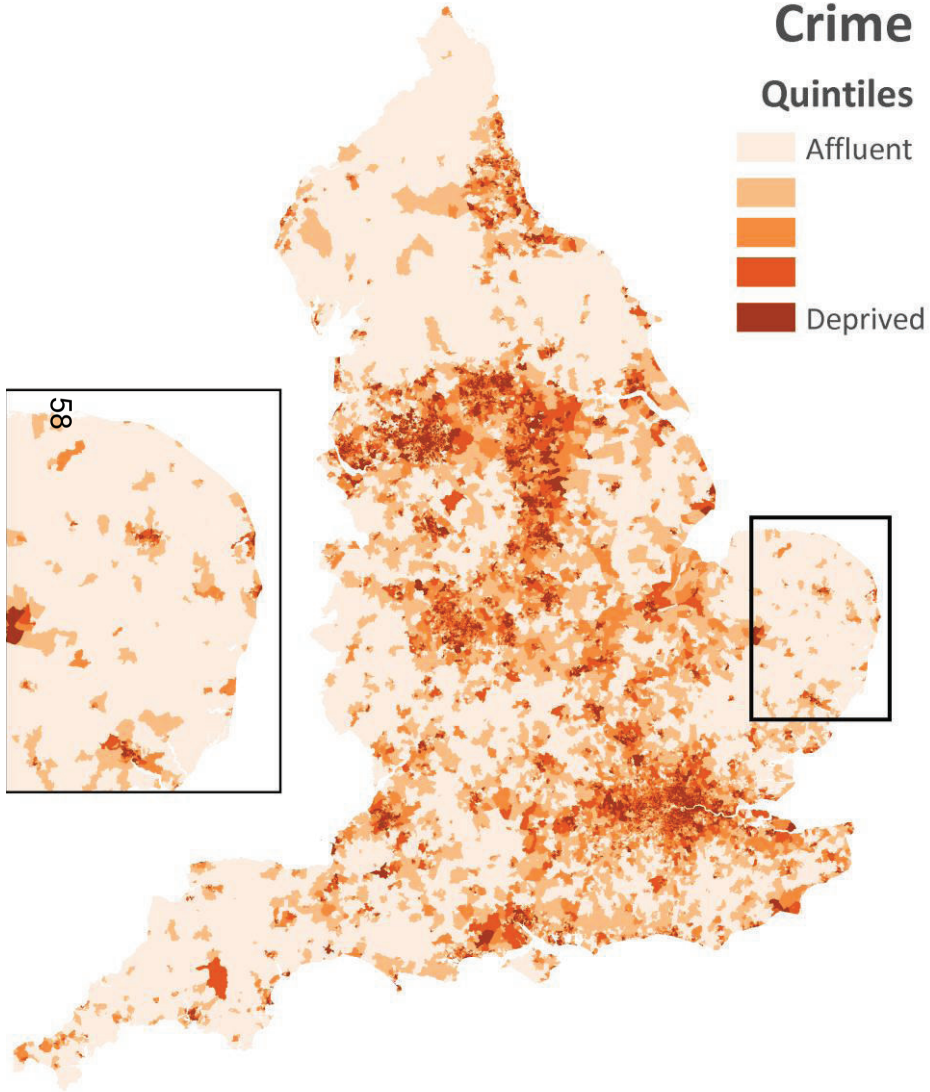
Rural standardisation:

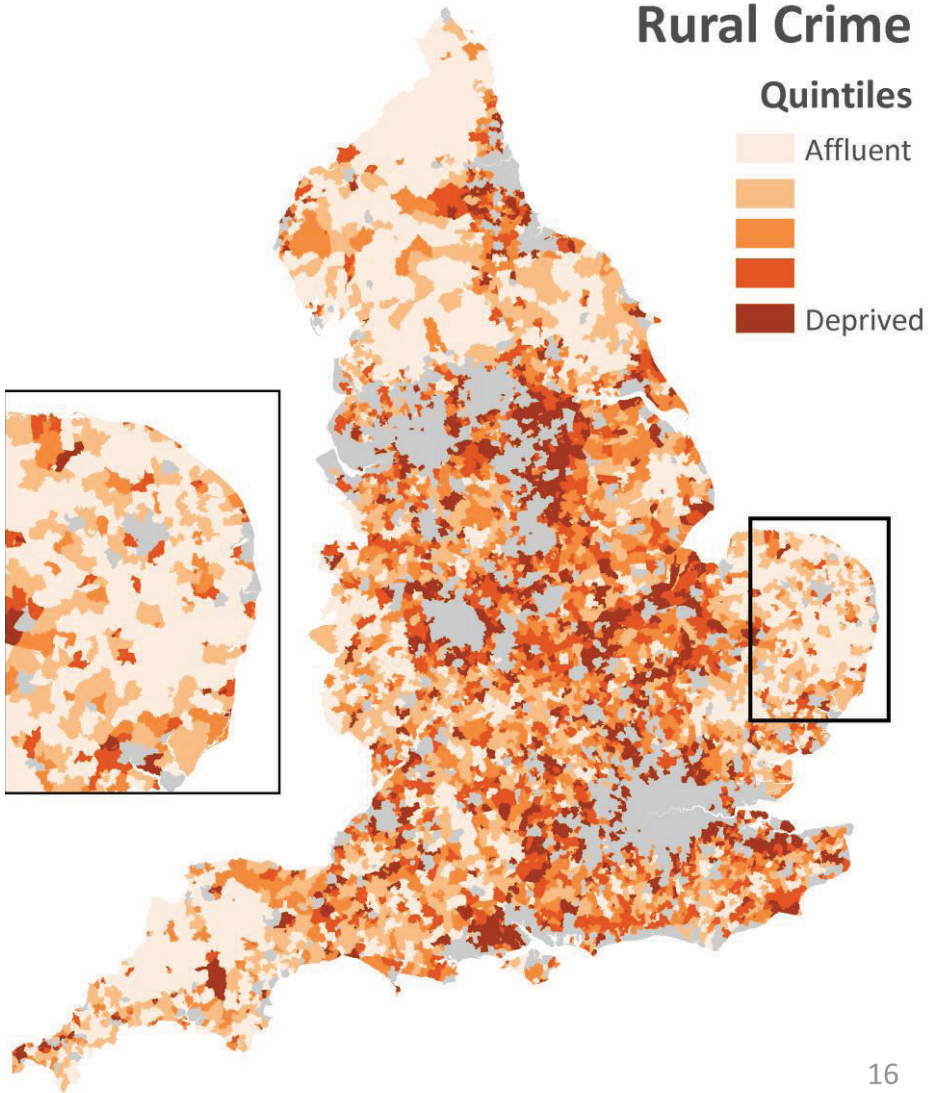
Index of Deprivation 2010 – Barriers to Housing & Services Domain





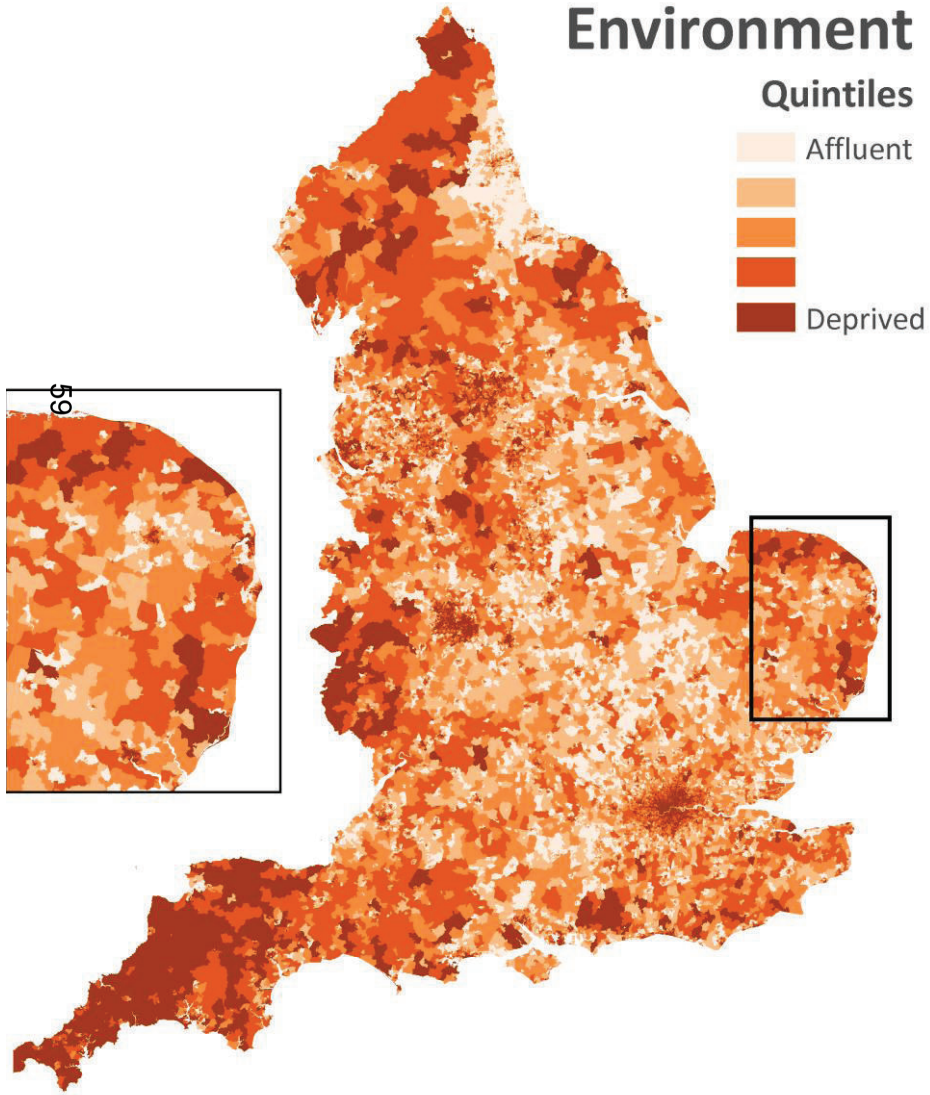
Rural standardisation:
Index of Deprivation 2010 – Crime Domain

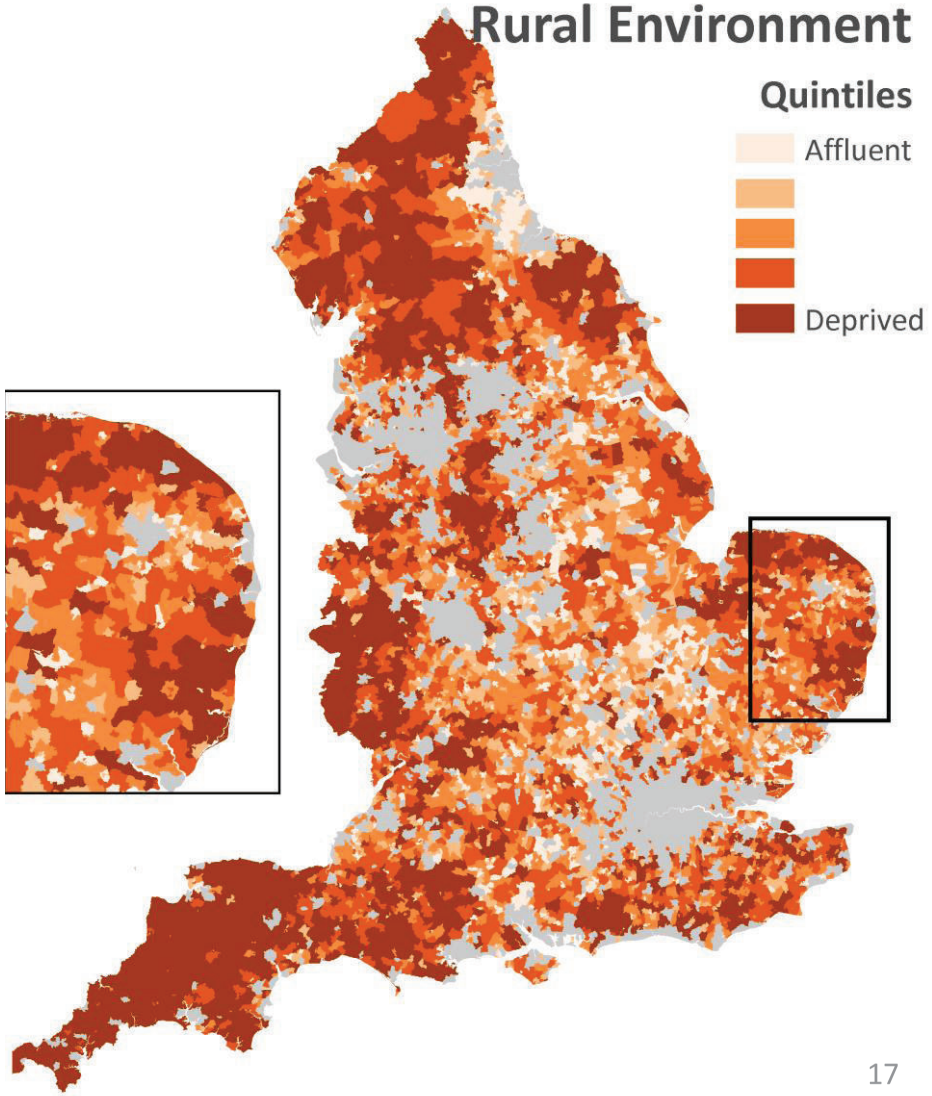




Rural standardisation:

Index of Deprivation 2010 - Living Environment Domain



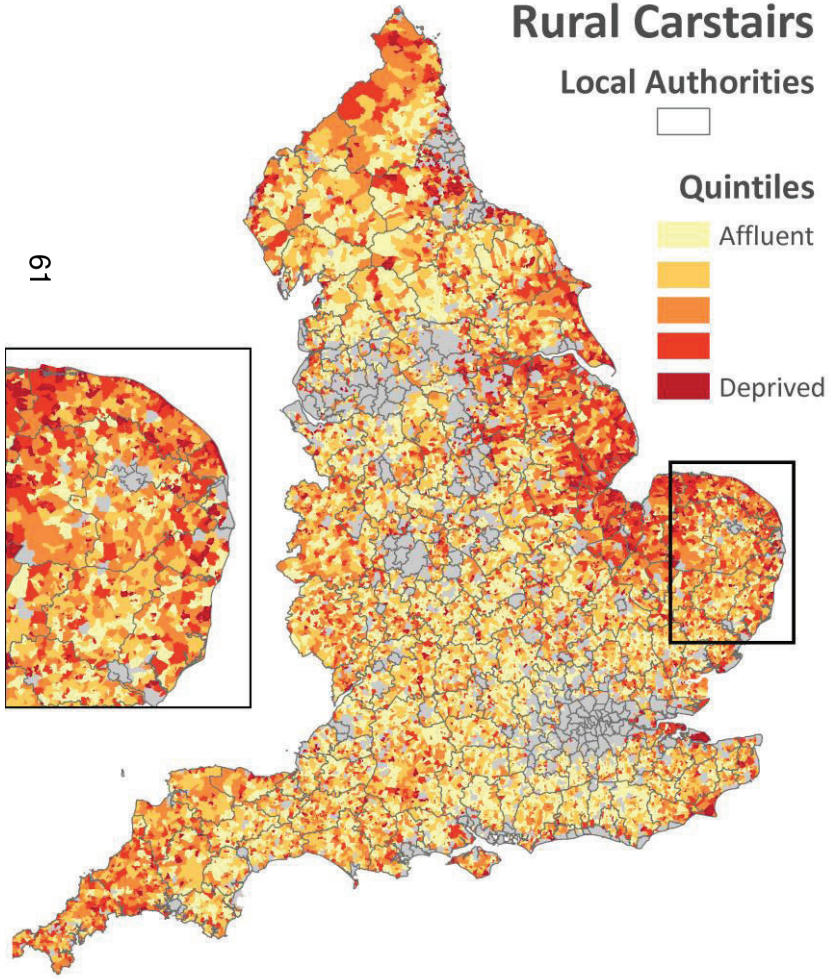


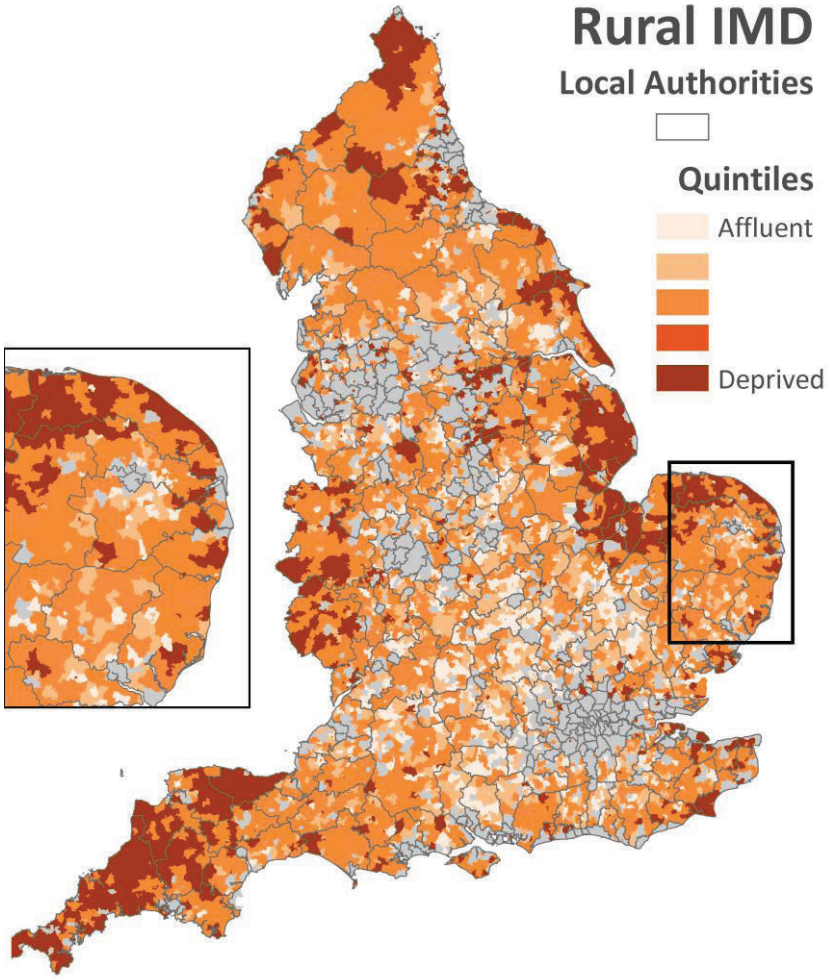
Correlations between IMD and its domains: overall IMD and rural IMD (light grey)

	IMD	Income	Employment	Health	Education	Housing	Crime	Environment
IMD		0.958	0.936	0.854	0.817	0.069	0.661	0.566
Income	0.893		0.899	0.787	0.786	0.040	0.592	0.478
Employment	0.896	0.893		0.856	0.781	-0.109	0.539	0.391
Health	0.764	0.736	0.820		0.685	-0.125	0.554	0.430
Education	0.815	0.844	0.793	0.653		-0.168	0.490	0.262
Housing	0.066	-0.239	-0.260	-0.257	-0.264		-0.050	0.202
Crime	0.377	0.374	0.359	0.298	0.365	-0.258		0.468
Environment	0.383	0.169	0.118	0.132	0.056	0.413	-0.018	

Conclusions

- Adaptation of national deprivation indices for rural areas highlights differences between rural areas that can be masked by using national indices
- More work would be needed to investigate and construct rural-specific indices, drawing on previous work (e.g. by OCSI for Norfolk in 2008 http://ocsi.co.uk/spotlights/rural_exclusion/)





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Public Health England

Rural Health and Health Services

Appendix to the PHE National Board paper PHE/15/01

1. Background

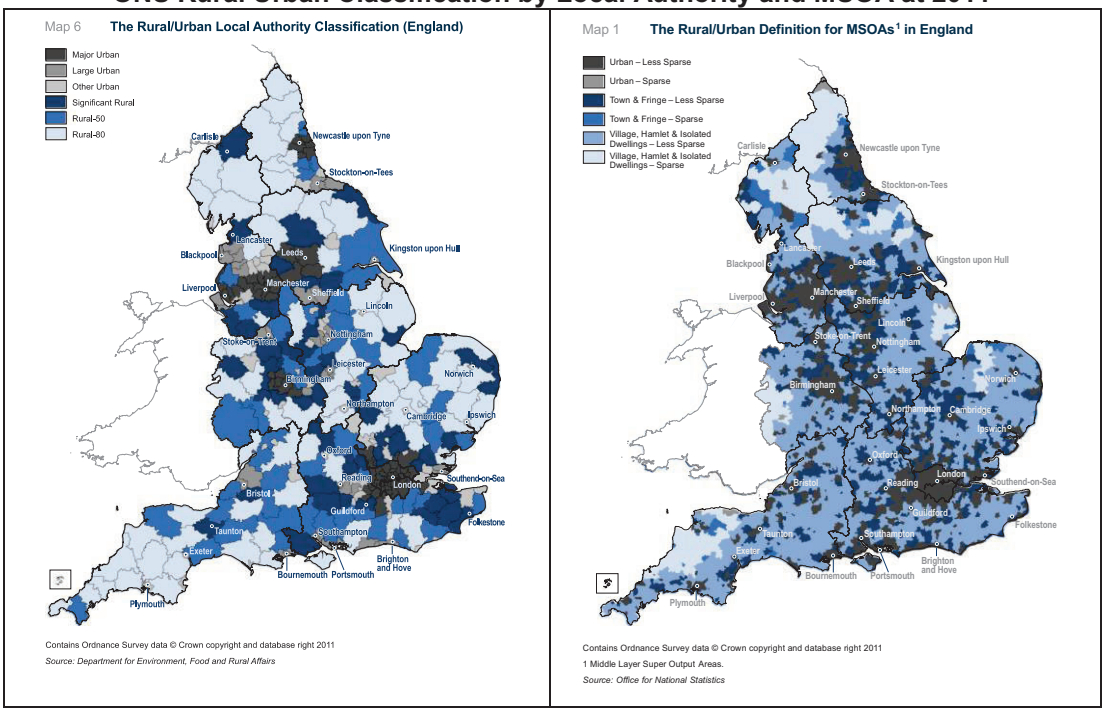
1.1. Directors of PH and PHE Centre Directors in rural areas have raised challenges and opportunities in relation to rurality and improving public health outcomes. The purpose of this paper is:

- To explore the issues relating to rurality and health, with guidance from each of the local areas represented; and
- To consider the implications for PHE support and action either at regional and/or national level.

2. Rurality

2.1. The Office of National Statistics Rural-Urban Classification[1] defines areas as rural if they fall outside settlements with more than 10,000 resident population. This provides for a distinct rural/urban distinction, and further division into six categories: Town and Fringe; Town and Fringe in a sparse setting; Village: Village in a sparse setting; Hamlets and Isolated Dwellings; and Hamlets and Isolated Dwellings in a sparse setting. The picture of urban and rural areas by local authority and middle-layer super output areas are shown below.

ONS Rural Urban Classification by Local Authority and MSOA at 2011



2.2. Rurality has also been described by socio-economic, cultural and other dimensions, and rural areas are as varied and difficult to typify as urban areas. In brief, making a circle of England clockwise starting in the north, they include the north east and upland farming communities, the Yorkshire dales, the agrarian Lincolnshire farms, the fens and east coastal communities, the home counties, the south west where in the tourist season the population can increase tenfold, the market gardens of Evesham Vale and the orchards of Herefordshire, the Marches with many tenant sheep farmers, the Lancashire moorlands to the Lake District national park and back into the north of Cumbria to the borders.

3. Rural Populations[2]

3.1. Rural areas are 85% of the English landmass, and on 2011 census data, about 9.3 million people (17.6 per cent of the population) lived in rural areas and about 570,000 people (1.1% of the population) lived in settlements in a sparse setting.

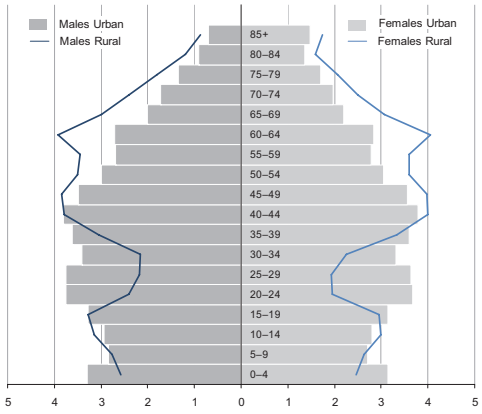
3.2. Rural areas have a larger proportion of older people and smaller proportion of young adults. The population pyramid below shows the hollowing out of the younger age group and increased proportion of older men and women relative to urban areas.

Population Pyramid for England - mid 2009: Rural/Urban for Men and Women

Figure 52 **Population pyramid for England: by area type, mid-2009**

England

Percentage of rural/urban population



3.3. The young adult (15 to 29 age group) is smaller in rural than in urban areas; they are 21.2% of the urban population but only 14.6% of the rural population. People over 45 years are more than 50% of those living in rural areas compared with about 40% in urban areas. This is even greater in Rural Town and Fringe areas where on average 26% of the population are over 65 years old and 54% of the population are over 45. There are various factors involved and include both population ageing and migration, inward for older adults and outward for younger adults moving for education and employment.

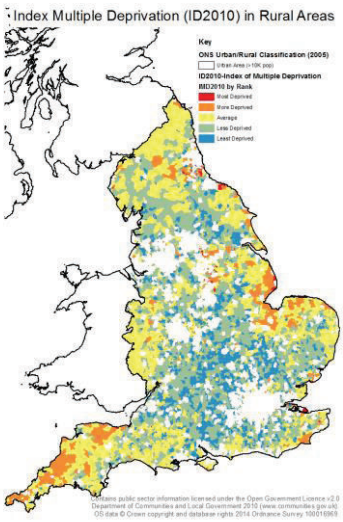
3.4. Minority Ethnic Populations[3]. The percentage of people identifying themselves as 'White British' in 2011 was 95% in rural areas compared with 77.2% in urban areas. The 'White Other' was the largest of the ethnic groups in both rural and urban areas, 'Indians' the third most common in rural areas and 'Pakistanis' and people of African descent were both less than 0.2% of the rural population.

3.5. Migrant Workers[4]. The Commission for Rural Communities looked the position of migrant workers in rural areas, including the challenges posed by language, culture, tensions with local communities and other factors. They found a high proportion of migrant workers moving into work in areas such as Herefordshire, Lincolnshire and Cambridgeshire, as well as areas around Somerset and Devon, the Fens, Norfolk, parts of Cumbria, and the Vale of Evesham. These workers also tended to be young adults, compared with the older settled rural populations.

3.6. Tourist Populations[5]. Tourism can swell population numbers greatly in the short or longer term, and while very important to the economy in rural or remote areas, also poses challenges. For example, in Lincolnshire many people retire there but to static caravans (around 27,000) with issues of winter warmth, temporary residence (planning requirements prevent 52 week residence) and lack of GP registration.

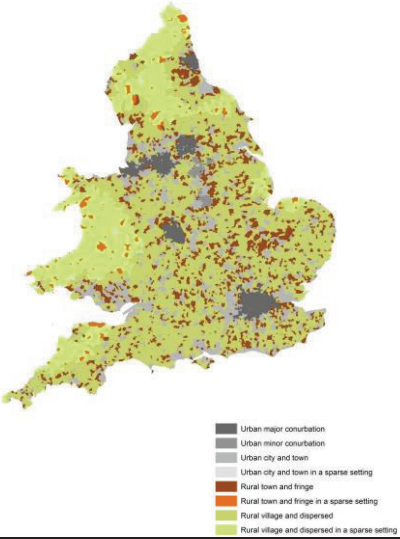
4. Issues for Inequalities in Rural Areas

4.1. The maps below show Super Output Areas by rank quintile of the Index of Multiple Deprivation 2010 for English rural areas (excluding urban areas) alongside a map of rural/urban definitions at 2011[6].



Source. PHE West Midlands KIT

England & Wales; 2011 LSOAs: Rural-Urban Typology



4.2. It suggests that comparing deprivation between rural areas, there are higher levels in the rural north east, south east, south west and the Marches, and pockets in central generally less deprived areas.

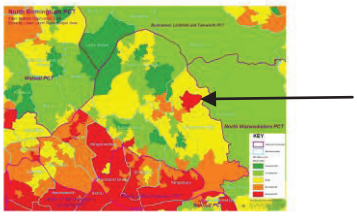
4.3. It is uncertain how much of the rural population is impacted by social deprivation, particularly extreme deprivation which may be persistent across generations, and how this translates into poor outcomes.

4.4. There is also the experience of being poor in areas of affluence and how this gap between wealth and poverty is experienced by individuals, particularly in relatively small communities where it may be very marked. The adverse effects on individuals and communities of this differential in wealth has been shown by various researchers.[7]

4.5. There are challenges to mapping inequalities in rural areas which include both the relevance of indicator sets and how to identify pockets of deprivation. The IMD 2000 excluded 'car ownership' which tends to reflect lack of good public transport rather than wealth,[8] and included 'geographical access to services'. The IMD 2010[9] included indicators which tend to reflect rural inequality better including; road distance to services such as GPs; housing affordability; housing without central heating; and road traffic accidents.

4.6. There are still questions from the DsPH on the working group about the current IMD 2010. For example it may not reflect cost of living issues in rural areas stemming from reduced choice and availability of services, shops and amenities; where transport and communications access may be more limit; and the prices of fuel, food and other items may sometimes be higher in rural areas. Older rural housing stock is also less energy efficient and more expensive to heat.

4.7. In relation to small area deprivation, it can be at a very small level as shown below with a housing estate on the border of Birmingham with rural Staffordshire and Warwickshire. On the urban/rural fringe is a small, deprived housing estate, which was only identified by analysis at a small level.



Source: PHE West Midlands KIT

4.8. The list of IMD 2010 indicators is given in Annex A, and it would be interesting to understand how well this indicator set does or not provide an accurate depiction of relative inequalities in rural or urban areas. The IMD is being updated for 2015 and PHE has submitted a number of comments including

proposals on increasing accessibility to non-technical audiences, a common approach with DCLG on assigning LSOAs (lower super output areas) to deprivation categories within geographies, and enhancing the 'housing affordability' indicator.

4.9. Also as important is the identification and analysis of pockets of deprivation. Small area analysis is fairly well understood and there is much literature to draw on but there needs to be caution because of the risks associated with small numbers, eg appropriate geographical boundaries and denominators, statistical problems and risks to confidentiality. PHE could commission work on small area public health statistics from the Small Area Health Statistics Unit[10] (SAHSU) to support public health work in rural areas.

5. Socioeconomic Factors: Some Rural/Urban Comparisons[2]

5.1. An analysis of the socio-economic status of rural areas published in 2010/11[11] found that in general the quantitative evidence showed rural areas to be better off on average than urban areas but worse off for some measures including higher fuel and transport costs and high house prices. This study also suggested that for rural England, for some indices, there are 'two countrysides' – a better off, less sparse and more accessible one, and a less populous and isolated sparse countryside. The following data would appear to show this where sparsity is distinguished, but they do not reveal small pockets of greater deprivation.

5.2. Employment and Earnings[2]

In 2012 - Employment	Urban	Rural	Rural sparse
Working-age (16-64) people in employment	70.1%	75.3%	74.0%
Working age people in full-time employment	74.7%	71.9%	
Working age people in rural settlements in part-time employment		28.1%	31.3%
Males living in urban/rural areas in full employment	88.4%	89.6%	
Females living in urban/rural areas in full employment	58.8%	52.6%	
Economically active people who were unemployed	8.6%	5.0%	
Working age people not available for work or not seeking work	23.3%	20.9%	23.0%
In 2012 - Earnings	**Major urban**		**Rural sparse**
Average workplace-based earnings	£26,900		£19,700

5.2.1. Levels of employment appeared to be higher in rural than urban areas and there were fewer people unemployed or not available/seeking work, apart from in sparse rural areas. There are fewer rural women in full employment. For part-time rural workers there appeared to be more in sparse areas.

5.2.2. Employment types include farming, home working (or working from home) and self-employment which in rural areas is well above national average. Rural areas also have higher proportions of small local business units (excluding farming) relative to population but they tend to employ fewer people than those in urban areas.

5.2.3. For people living and working in their areas, average workplace-based earnings are generally lowest in sparse rural areas (around £19,700), and highest in major urban areas (around £26,900). However, less sparse areas in less sparse areas there are also high levels of household income, and the low levels of poverty.

5.2.4. Earnings data are problematic as it is difficult to distinguish between people who live in rural areas but commute to work in urban areas and generally have higher incomes from those who live and work in rural areas who generally have lower incomes; rural incomes are at least partially dependent on the ability to commute, especially for full-time workers and for men.

5.3. Education, Qualifications and Skills[2]

% leaving Key stage 4 with 5 A-C GCSEs (based on residency)	**2007/8**	**2012/13**
Urban areas	63.4	83.2
Rural areas	69.7	83.1
Full-time entrants to higher education/1,000 18-20 year olds	**2004/5**	**2011/12**
Predominantly urban	117	151
Predominantly rural	121	165
Proportion of working age population with at least one qualification (residency based)	**2004**	**2011**
Predominantly urban	84.1	88.8
Predominantly rural	87.1	91.3
Proportion of working age population with NVQ level 4 (residency based)	**2004**	**2011**
Predominantly urban	25.2	32.6
Predominantly rural	27.1	31.9
Qualified to degree level: Urban – lower, Rural - higher		

5.3.1. The pattern for both urban and rural is one of improvement from 2004 to 2011. The levels of people qualified to at least degree level or equivalent, or working in higher managerial or professional occupations are higher than average in rural areas but average or below average in sparse areas. It should be noted that the patterns are complicated by the issue of residency of person and location of institution as some pupils or students will travel to urban areas for education or vice versa.

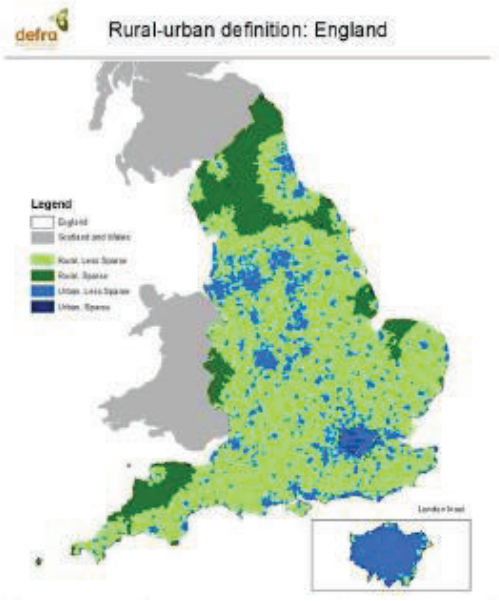
5.4. Crime[2]

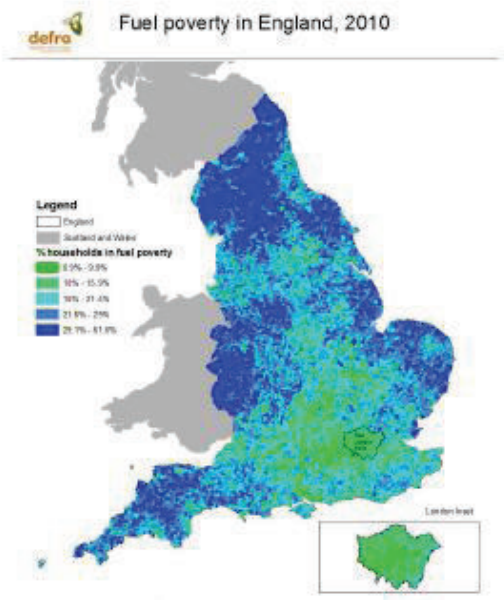
2012/13	Predominantly urban	Predominantly rural
Rate of violence against the person/1,000 people	12.3	7.2
Rate of sexual offences/1,000 people	1.1	0.7
Rate of recorded crime for robbery offences/1,000 people	2.6 (9x rural)	Much lower
Rate of recorded crime for domestic burglary/1,000 people	12.8	4.8
Rate of vehicle offences/1,000 people	8.4	4.2

5.4.1. For violent and other types of crime, the rates in rural areas are much lower than in urban areas, making it a safer place to be on the face of it. However, this does not include business crimes that affect rural communities such as theft of livestock and machinery.

5.5. Fuel Poverty

5.5.1. Households in fuel poverty are at risk of being unable to heat their homes to an adequate standard, and less able to spend their income on other amenities. As the maps and data below show, there are higher rates of fuel poverty in rural than urban areas, and this increases with greater rurality. The rates have declined since 2006 but the rates are still high in sparse rural areas. The following maps show the distribution of fuel poverty set alongside rural/urban definitions.





	Urban	Rural	Sparse rural
Households in fuel poverty 2006	10.7%	15.3%	38.9%
Households in fuel poverty 2010	15.9%	18.4%	34.1%
Households off the gas grid 2009	9%	38%	64%

Using the low income high cost (LIHC) measure of fuel poverty, National Energy Action (NEA) identified in a 2013 report that there were 2.6 million households in England that were fuel poor, of which 500,000 lived in rural locations, which is a much higher proportion relative to total population. The properties in rural or off gas locations were statistically more likely to be larger, detached or older, and the conclusion of the report was that while there were more fuel poor households in urban areas, the problem of fuel poverty is '…likely to be most acute in many rural and off gas locations.'[12]

5.6. Rurality and Income

5.6.1. A report in 2011 looked at the question of needs and costs of households in relation to rurality, in particular how costs for rural households might be different from those for urban households.[13] It found that, based on April 2010 prices, some things might be cheaper for rural households (eg primary school children leisure activities), many household requirements were the same, and in some critical areas, rural households faced additional costs. Their overview is summarised below.

Overview of areas of different and additional rural costs by commodity

Commodity category	Rural difference
Transport	Key difference in terms of mode of transport and distances travelled.
Fuel (heating and power)	Key difference in terms of fuel type and housing type.
Food	No difference except additional transport costs.
Clothes	Some difference in terms of outdoor wear. Additional transport costs.
Household goods	Some difference: heating back-up and gardening. Additional transport costs.
Communication	Some difference: Internet and newspapers.
Personal goods and services, including healthcare	No difference except additional transport costs.
Social and cultural participation	Some direct cost difference for some households; additional transport costs for all households.

Additional weekly rural costs for four rural household types.

	Rural town	Village	Hamlet
Pensioner couple	£2.26 (1%)	£43.00 (19%)	£48.08 (22%)
Single working age adult, no children	£15.98 (9%)	£31.92 (18%)	£41.37 (24%)
Working age couple, two children	£46.67 (12%)	£59.52 (15%)	£72.20 (18%)
Lone parent, one child	£21.98 (9%)	£33.65 (14%)	£36.81 (16%)

What these data show, for costs at that time, and using the minimum income standard methodology, is the major impact of sparsity and transport costs, and the significant impact that the additional costs would have for poorer households.

6. Health of Rural Populations

6.1. The health of people in rural areas is on average better than that of urban areas. Rural health and services have been the subject of reports in recent years in England,[14,15,16] Wales[17] and Scotland[18] and all note that rates of ill-health by many indicators are worse in urban areas. A DEFRA summary[19] of recent key indicators shows that:

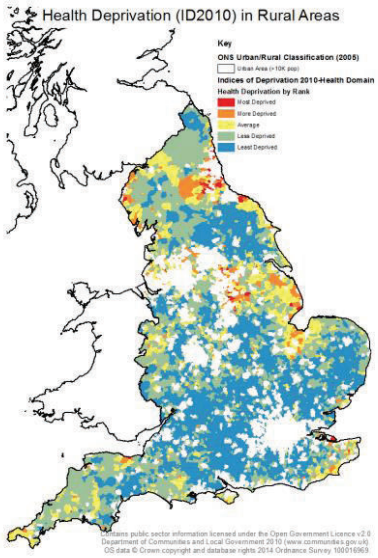
- Overall health outcomes are more favourable in rural than urban areas, particularly in sparse areas.
- Average life expectancy is highest in *Rural-80 areas*.
- Infant mortality is lower in rural areas than in England as a whole.
- Potential years of life lost (PYLL) from common causes of death such as cancers, Coronary Heart Disease (CHD) and stroke is lower in rural areas.

Potential years of life lost per 10,000 in England 2010-12

	All cancers	CHD	Stroke	Suicide & Undetermined injuries
Predominantly urban	144.5	44.3	14.6	32.5
Predominantly rural	128.7	31.8	11.0	34.3

6.2. The same reports also, however, acknowledge the masking of deprivation and ill-health and the diverse experience of rural communities, just as much as urban communities. The map of IMD 2010 indices for rural health show some of the distribution of ill-health across rural England, in the north east, east coastal, south west and Marches stand out, but also high levels in south Yorkshire and north/central east Midlands, much of it town fringe.

IMD for Health in Rural Areas by Quintile



Source. PHE West Midlands KIT

6.3. There are, moreover, some clear problems for rural areas.

6.3.1. Older populations growing older. While rates of ill-health on common conditions associated with ageing such as cancers, stroke and heart disease are on average lower in rural areas, the prevalence of these conditions will be higher, although older rural populations are healthier.

6.3.2. Road traffic accidents. The Dept of Transport[20,21] recently identified road traffic accidents as a major problem on rural roads. It found that 60% of fatalities occurred on country roads; three people died each day on average which is nearly 11 times higher than on motorways; a quarter of drivers have had a near miss and 1 driver in 20 has had a collision on a country road. It is not specified whether these were rural or urban drivers, but the issue is stark for all users of rural roads.

6.3.3. Suicide and undetermined injury risk where this may be higher in farming communities, and may be due to various factors related to isolation, and ease of access to the means of suicide such as guns and poisons.

6.3.4. Risks associated with farming populations such as accidents, and ill health related to zoonoses. Zoonoses are a problem both for diseases spread to humans (eg E coli) and between animals, which pose both a health and business impact. For example, the foot-and-mouth outbreak of 2001[22] involved the deaths of nearly four million animals in the UK, and profoundly affected thousands of farmers' livelihoods. The Countryside Agency estimated the cost to UK farming in 2001 at between £800m and £2.4bn and the cost to tourism at about at least £2 - £3bn.

7. Resource Allocation for Rural Communities

7.1. The costs of providing care in rural areas and the development of appropriate funding formulas have been considered over a period of years by the independent Advisory Committee on Resource Allocation (ACRA) which advises on the distribution of health funding. Indeed the ambulance funding formula has had an element to cover additional rural costs. While there is limited evidence of additional costs there is a strong logic case for the additional costs associated with the provision of community services in particular. Scotland uses an approach to adjust for extra costs based on travel times, and approach which might provide the basis for an adjustment to the NHS funding formula used in England.

8. Rural Proofing of Products and Tools

8.1. NHS England, the Dept for Environment, Farming and Rural Affairs (DEFRA), the Welsh Assembly and the Scottish Government have developed strategies and tools for rural proofing over the past few years. These include challenges of rurality and service design,[23,24] rural proofing guidance[25] and NHS England

commissioner guidance for rural Clinical Commissioning Groups[26]. The DEFRA Rural Proofing Guidelines make suggestions as follows.

DEFRA Rural Proofing Guidelines - Summary

How to Rural Proof. Possible Actions to Take

- Allow for higher rural unit **delivery costs** in funding formulae or allocations
- Look at **alternative means** of providing and accessing the services in rural areas, e.g. through the use of volunteers or social enterprise
- Encourage **alternative delivery** through the possible use of volunteers or the mutualisation of service delivery
- **Reduce the need to travel** by using outreach, mobile services or localised delivery
- Consider better **integration or improvement of transport links**
- Allow local delivery bodies **flexibility to find the best local solution**(s); avoid a "one-size-fits-all" approach
- Use the **rural networks and meeting points** that do exist, for example post offices, village halls, parish notice boards
- Ensure the **needs of smaller businesses** are specifically addressed
- **Use small area based data** to identify social, economic and environmental differences that need to be accounted for in the policy
- **Engage with rural stakeholders** and their networks so you can gather evidence and test your proposals

8.3. Rural Proofing for PHE Products and Services

Public Health England has a responsibility to all localities to support them to deliver effective provision for public health. PHE could play a key advocacy role to support the investigation and monitoring of rural health experience and to ensure proofing of public health tools and products. The development of small area analytical support is major contribution and there is also a question of how to make these initiatives work in small communities. For example, interventions such as NHS Health Check[27] and Making Every Contact Count rely for their population effect on reaching large numbers. In rural areas, these initiatives will still reach large sectors of the population, but there are

some who may be at a disadvantage because of small numbers, sparsity, and for many of the same reasons as more deprived people in urban areas.

Some examples of how the DEFRA proofing might apply to public health are as follows:

Higher rural unit delivery costs: It is not clear whether NICE or other expert bodies look at the rural dimension in their work on the evidence-base and cost effectiveness methodology for public health. As their guidance is fundamental to PHE advice giving to others it may be useful to open discussion on this to support advice to the rural PH community.

Alternative means of provision, access and delivery: Placing less reliance on people accessing services and looking at the options for provision in community or work settings. Such approaches were adopted in relation to provision of mental health support to the farming community after the foot and mouth outbreak, which reached farmers in their settings and also deployed support from veterinary staff and others.

Reduce the need to travel by using outreach, mobile services or localised delivery. This picks up the previous theme but also raises questions about PHE products that rely on e-delivery, unless internet and mobile access is available, fast and reliable.

Better integration or improvement of transport links. This relates more to health and care service provision but also has a bearing on public health service delivery. It does raise questions about the role of PHE in supporting localities to promote better transport in rural areas.

Flexibility to find the best local solution(s) (to avoid a “one-size-fits-all”). As an example, PHE currently promotes walking as a strategy for physical exercise. The evidence suggests that rural people walk about half the distance of people in urban areas, which probably relates to the dangers of rural roads, including the lack of pavements. An approach to physical exercise needs to recognise this.

Rural networks and meeting points. There are facilities in many rural settings, such as post offices, schools and village halls and other communal settings, but rural communities are also often faced with the loss of these amenities so there needs to be caution by PHE about assumptions about what is available, and what is used by the community.

Needs of smaller businesses. There are many small businesses in rural areas, and they are significant small local employers, both in farming and other sectors. It is important to consider how to support and work with them in recognition of how they help to sustain rural communities, and also to help prevent problems they may pose to health. One example is that of farm visits,

which attract visitors and hence revenue but where it is important to ensure they do not pose infection risks such as E-Coli.

Use small area based data. This has already been discussed as an important factor for rural areas.

Engagement with rural stakeholders. Rural localities build a lot of engagement with their local communities and organisations. National organisations such as the Action for Communities in Rural England[28] and National Council for Voluntary Organisations[29] would provide a route for national engagement in addition to being a resource around community needs and action through the contacts and support they give.

9. Sustainable Health and Care Service Delivery in Sparse Rural Areas

9.1. The issue of service access[30] is a major concern for rural areas. Reports cite factors such as distance, time taken in travelling for both users and professionals, access to public transport, limited choice of provision and limited service operating hours. This is complemented by what anecdotally is thought to be rural user reticence to make demands on services, due to a culture of self-sufficiency or other factors. The issues around service provision are also complicated by fluctuating populations including migrant workers and holiday populations.

9.2. There is a complex and difficult problem of how to design in choice and plurality in service access while maintaining a high level of quality and safety. Choice and plurality is strongly governed by having ready access to a spectrum of service provision. This has been identified as an important issue for rural communities across many services, not just health[29]. It has several components including:

- Access in relation to distance both for patients travelling to services, and for service professionals travelling to people in their homes. Journeys are longer, and hence costlier, to patients and to services.
- Access in relation to telecommunications and other infrastructure.
- Opening hours and appointment times have an extra edge for people who have to make long distance journeys; an 8.30 appointment may involve an overnight hotel stay.
- Concerns about ‘distance decay’ where people may delay accessing services due to distance from provision.
- Access to rapid interventions, where timeliness is essential for a good prognosis, such as acute CVD episodes.

- Workforce issues including both capacity and capability; some rural areas indicated difficulties in attracting and retaining appropriately trained staff at all levels across both health and social care and that this was impacting on the ability to sustain safe, high quality services.

- Spectrum of service provision (this dimension has been termed clinical peripherality[31]) which is a mix of what services ostensibly provide with what rural health care workers actually do;

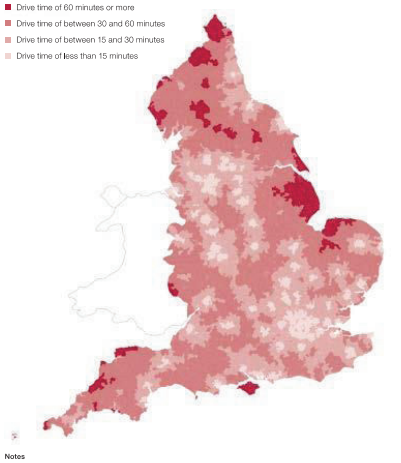
- Concerns about delivery of high quality community care for people with chronic and complex needs, in particular the frail older population, in the context of an increasingly ageing population. Scotland has also noted a higher palliative care workload as people in remote areas had a higher preference for dying at home.

- People's expectations of health care; they may use primary care more where urban people would access hospital services, eg for heart pain.

9.3. Examples of Challenge for Rural Areas

The National Audit Office recent review of maternity services looked at drive time for obstetric and midwifery-led units[32]. It found that between 2007 and 2013, the average drive time to the nearest unit was constant at 13 minutes and the estimate of women of childbearing age living within a 60-minute drive increased from 97% to 99%. However, there were still a few areas where women lack a meaningful choice of type of maternity unit. For instance, in the areas shaded in dark red on the map, women have over an hour's drive to reach both types of unit.

Figure 10
Average drive times to both an obstetric and a midwifery-led unit, 2013



Notes
1 Some women living on the border of Wales or Scotland may have access to a choice of services in those nations. If so, they may be within shorter drive times than the figure key suggests.
2 The drive times are estimates and rely on the accuracy of the software used to calculate them.

Source: National Audit Office

Distance is also a challenge for access to hospital and primary care services as the data below show, particularly in sparse areas.

			No of households by distance		
		Distance	**Sparse**	**Rural**	**Urban**
GP surgeries (All sites) (4km)	2011	<= 4K	22,810	3,513,500	18,171,910
		>4K	47,220	899,100	11,570
Hospitals (8km)	2011	<= 8K	15,370	2,424,150	17,585,520
		>8K	54,670	1,988,460	597,960
Pharmacies (4km)	2011	<= 4K	15,540	2,891,860	18,171,770
		>4K	54,490	1,520,730	11,710

Distance decay[33]
Pharmacy and GP experience suggest that the further people live from primary care services, the less likely they are to access those services.

Rapid access
Stroke Units (SU) and thrombolysis have rationalised services for wider patient benefit and the hyperacute stroke service model is being rolled out in some areas. It has been noted that in rural areas, long travel times may offset some of the benefits of SUs, and rapid specialist review may rely upon a greater use of telemedicine, communication technology that allows specialists to diagnose and advise treatment of patients remotely[34].

Workforce
There is evidence of challenges in recruitment of health care workers to rural areas. Scotland is developing strategy to address the needs for health care professionals.[35]

Social care[36]
A SCIE report from 2007 asserted there was considerable variability in the provision of services to people living in rural areas and that overall, they are less likely to receive services comparable with their urban counterparts. They noted that they cost more to deliver, and that efforts to ensure equity, in terms of the standards and levels of service provision through policy initiatives such as 'rural standards' and 'rural proofing', have had mixed success.

9.4. Developing Models of Health Care for Rural Areas

9.4.1. NHS England has recently launched its Five Year Forward View which proposes both a strong emphasis on prevention, and starts to suggest how services should start to look in the future, with particular emphasis on expanding and strengthening primary care and out-of-hospital services.[37]

9.4.2. The document recognises that 'one size does not fit all' and makes reference to the differences between an urban area such as Coventry and a rural area with a lot of sparsity such as Cumbria. It cites examples of models of care

and notes that 'Cumbria, Devon and Northumberland have quite a lot in common in designing their NHS of the future.' It would be a good opportunity to take this as framework and apply rural proofing principles in relation to the future design of services for rural areas.

9.4.3. It is also an opportunity to look at how best to use resources in rural areas. Service costs are often cited as a problem for rural areas. These may or may not be greater than for urban areas but the distribution of resource within local authorities means there may be far less actual provision for rural communities. The issues include having to maintain funding for existing provision such as unviable hospitals which are not appropriate and where alternative forms of provision would be a much better use of the resource, in line with the approaches in the NHS Five Year Forward View.

9.4.4. The examples of models proposed in effect shift all but the most specialised and emergency and urgent care away from large hospitals into community-based service models which bring together a range of provision to build care around the patient. The types of model proposed are:

- **Multispecialty Community Providers** where groups of GPs combine with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care.

- **Primary and Acute Care Systems** which integrate hospital and primary care provision –– combining for the first time general practice and hospital services, similar to the Accountable Care Organisations now developing in other countries too.

- **Urgent and emergency care** redesign across the NHS to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services.

- **Smaller hospitals** will have new options to help them remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals to provide more local services.

- Midwives will have new options to take charge of the **maternity** services they offer.

- More NHS support for frail older people living in **care homes**.

9.4.5. The focus on models of out of hospital care, the maintenance of smaller hospitals and greater service integration resonate with some of the proposals for rural proofing but would need to be worked on and tested by commissioners and providers. It would be important for rural expertise to be engaged in work on health service design.

9.5. Cross Boundary Flows with Devolved Administrations

9.5.1. There is a need to take account of the cross-boundary flows with devolved administrations. This particularly affects English local authorities and health trusts bordering Wales and Scotland. Current local government and NHS boundaries do not reflect the 'natural' communities and how populations use public and commercial services, due to factors such as public transport routes, proximity of the cross border service and location of employment. For example, Shrewsbury is seen by many people in Powys as their market town and the Royal Shrewsbury Hospital their local hospital.

9.5.2. As some of the services offered by the NHS vary between England and Wales there is the potential for variations in access to health care programmes. This, for example, affects population screening services. This can be particularly complex where patients are resident on one side of the border but are registered with a GP surgery on the other side of the border.

9.5.3. In relation to NHS funds, the Scottish health board would be the responsible commissioner for any patients resident in Scotland who are treated in England. Similarly, there is national agreement about how patients will be managed by the NHS regarding responsible commissioner between Wales and border CCGs in England,

9.5.4. However, there is an issue for Local Authority commissioned open access services such as sexual health, for which demand continues to rise. There is no explicit arrangement and it is down to the LAs to agree arrangements individually. For sexual health services, Welsh residents accessing a clinic in England do not have their Local Authority of residence recharged for the cost of this service as would happen if they resided in England. This places a burden of the host local authority particularly as rural councils generally receive a lower per capita grant than urban areas. Local Authorities that border Wales have been in discussion with the Welsh administration on how best to manage cross boundary issues regarding open access services.

10. Transport, Telecommunications, Utilities and Other Services

10.1. Transport is essential in providing people with access to work, learning, health care, food shops and leisure activities[38]. It is an ongoing issue for rural areas, many of which are poorly supplied with both bus and rail provision for both long and short journeys.

Transport Data Comparing Rural and Urban Areas

2008-12	Trips /person	Trip length (m)/person	Distance travelled (m)/person	Walk (m)/person
Urban	959	6.4	6,158	202
Rural town & fringe	1002	8.7	8,763	152

Rural villages, hamlets, isolated dwellings	990	10.2	10,057	109
2012	**Car/van access**		**Regular bus nearby**	
Urban households	72%		96%	
Rural households (more likely to have two cars)	89%		49%	

10.2. The data above show how people in rural areas travel longer distances than people in urban areas, and have much less access to bus services. About 88% of trips in rural areas were made by car compared with 76% in urban areas. Travel is also more costly; the same report cites the figure that households in the smallest rural settlements spent £90 per week on travel in 2009, both because of distances, and having to pay more at the pump. [39]

10.3. Bus availability is expressed as the percentage of households where the nearest bus stop is within 13 minutes walk, and where there is a service at least once an hour. This access is far less for rural than urban areas, although it is reported to have increased from 38-49% between 2011 and 2012. Notwithstanding this increase, it still leaves half the rural population with limited bus accessibility.

10.4. The 'walking' data are also interesting and show that people in rural villages, hamlets and isolated dwellings walk about half the distance of people in urban areas. Access to activities such as running or walking is a particular challenge for rural areas; roads often have no pavements, and 'green space' may not be readily accessible due to factors such as land layout and access permissions.

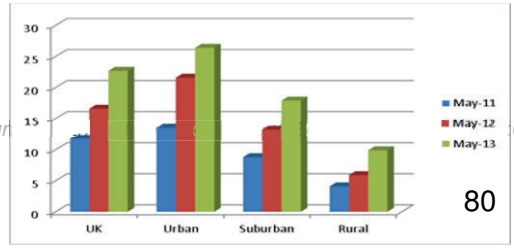
10.5. **Telecommunications**

Telecommunications have been proposed as a means of improving access, including for example, telemedicine. While rural people are big users of these services and many get a good service, utilities need to recoup the costs necessary to roll out and maintain services which make it a challenge to provide services to the same level as more highly populated areas.

10.5.1 **Broadband coverage**

The uptake of broadband[40] is high in rural areas, but the performance, particularly in sparse rural areas is poor. Average actual download speeds are lower in rural areas because of longer line length and lower availability of both fibre and cable broadband. This has also prompted fewer rural customers to upgrade to superfast broadband. Broadband speeds are increasing but at a lower rates than in rural areas as the figure below shows[41].

Average download speeds (Mbits/s) for fixed broadband connections over time

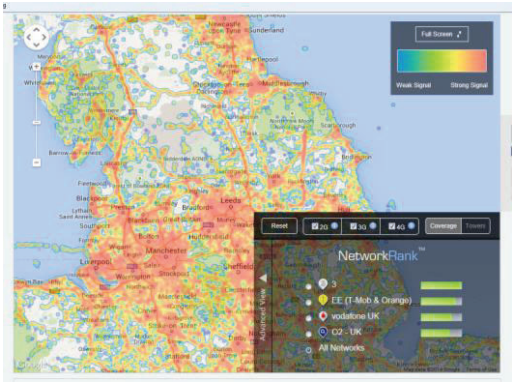


The position is improving and the government has pledged to improve access and achieve full coverage, with particular recognition of rural areas[42], but it leaves questions about the options for remedies such as telemedicine, which requires a lot of data for processes such as image transfer, is a viable service option until superfast broadband is available to everyone.

10.5.2 **Mobile coverage**

Mobile phone coverage is also a problem in sparse rural[43] areas as a screenshot map showing parts of the midlands and north shows.

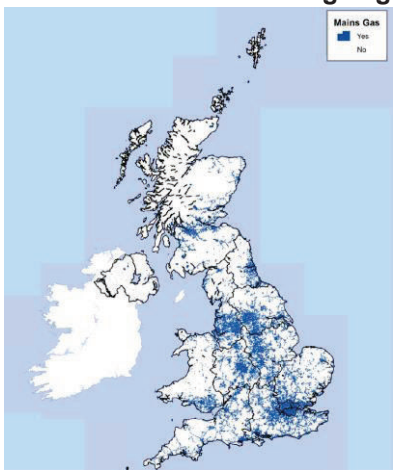
UK Mobile Coverage (the four main providers): to October 1st 2014



10.6. **Other Utilities**

Gas utility provision is estimated by household gas meter point.[44] Being off gas grid affects both urban and rural households. In urban areas it is usually because there is no connection within properties such as blocks of flats, whereas in rural areas it is because of distance from the grid. Being off-grid forces people to rely either on electricity or more expensive canister gas or fossil fuels. The following map shows postcodes of the UK which do and do not have access to a gas supply; those that do not are in white.

Postcodes of areas on and off gas grid



10.7. **Other Infrastructure and Amenities**

Other infrastructure such as postal deliveries, shops, leisure, education and other amenities are a major issue for rural areas. The Plunkett Foundation estimates that around 400 commercial village shops close each year and around 28 pubs a week[45]. The Royal Mail offers a universal service but there are concerns about future commitment to current service to remote areas[46]. There are concerns about access to over-the-counter banking services[47], which will affect both urban high streets and market towns, where the impact on rural communities will not be easily alleviated by remedies such as relocation to supermarkets and greater use of broadband.

11. Developing Communities of Interest

11.1 There is reference throughout the literature to the strength and resilience of rural communities, although there is also some reference to more negative aspects such as being 'different' within a rural context and the stigma and isolation that people can experience[48].

11.2. Rural communities have considerable resources and experience and a wide spectrum of skills and knowledge. They are areas where small business appears to be the most flourishing business model, and there is either real or potential scope for serious voluntary sector and community engagement on how localities are developed and run. Some government initiatives are likely to foster this and the Action with Communities in Rural England is taking a close interest, which suggests the benefit which they could bring to rural communities. They include:

- An emerging government programme the Rural Development Programme[49] for England, which aims to improve the environment, support business or promote growth in the local economy.

- The DCLG programme 'Giving people more power over what happens in their neighbourhood' [50] which gives communities new rights in relation to amenities, local service delivery and the planning of new developments. It offers, for example, the Community Right to Bid, which gives community groups the right to buy community buildings and facilities; and the Community Right to Challenge, which allows voluntary and community groups, and others to bid to run a local authority service where they believe they can do so differently and better.

11.3. Local councils and services in rural areas have a lot of expertise in relation to engagement and there are many good examples of local initiatives in Norfolk, Shropshire, Lincolnshire, Suffolk, Cornwall and other areas with rural populations [51].

11.4. Rural communities are themselves responding to the challenges of provision by setting up their own community-owned enterprises such as shops and pubs, food and farming enterprises and other forms of community ownership. An organisation that provides support for these initiatives reported that by the end of 2013, it had helped 319 community shops and 22 co-operative pubs to open and start trading.[52]

11.5. There are questions for public health about how to engage with these initiatives, both with localities and working with stakeholders such as Action with Communities in Rural England which is already a source of expertise, acting to help build communities of interest; providing advocacy, expertise, platforms for information sharing and other support.

12. Acknowledgements

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Jonathan Marron	PHE Director of Strategy
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Lucy Macleod	Director of Public Health (interim), Norfolk County Council
Debra Lapthorne	PHE Centre Director, Devon, Cornwall & Somerset
Jane Rossini	PHE Centre Director, Cumbria & Lancashire

Annex A. Index of Multiple Deprivation 2010 Indicators

Income Deprivation Domain	Adults and children in Income Support families 2. Adults and children in income-based Jobseeker's Allowance families 3. Adults and children in Pension Credit (Guarantee) families 4. Adults and children in Child Tax Credit families 5. Asylum seekers in England in receipt of subsistence support, accommodation support, or both 6. Claimants of Jobseeker's Allowance 7. Claimants of Incapacity Benefit 8. Claimants of Severe Disablement Allowance 9. Claimants of Employment and Support Allowance 10. Participants in New Deal for the 18-24s who are not in receipt of Jobseeker's Allowance, 11. Participants in New Deal for 25+ who are not in receipt of Jobseeker's Allowance 12. Participants in New Deal for Lone Parents
Health Deprivation and Disability Domain	13. Years of Potential Life Lost 14. Comparative Illness and Disability Ratio 15. Acute morbidity 16. Mood or anxiety disorders
Education Skills and Training Deprivation Domain	17. Key Stage 2 attainment 18. Key Stage 3 attainment 19. Key Stage 4 attainment 20. Secondary school absence 21. Staying on in education post 16 22. Entry to higher education 23. Adult skills
Barriers to Housing and Services Domain	24. Household overcrowding 25. Homelessness 26. Housing affordability 27. Road distance to a GP surgery 28. Road distance to a supermarket or convenience store 29. Road distance to a primary school 30. Road distance to a Post Office
Crime Domain	31. Violence 32. Burglary 33. Theft 34. Criminal damage
Living Environment Deprivation Domain	35. Housing in poor condition 36. Houses without central heating 37. Air quality 38. Road traffic accidents

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Public Health England

PHE Board Paper

Title of meeting	PHE Board
Date	Wednesday 28 January 2015
Presenter	Rashmi Shukla
Title of paper	**Rural health – The issues and proposals for PHE engagement**

1. Purpose of the paper

1.1 The purpose of the paper is to outline existing work to protect and improve health in rural areas of England and to agree how best Public Health England can support local areas to secure improvements in health.

2. Recommendation

2.1 The Board is asked to **NOTE** and **COMMENT** on the contents of this paper and the recommendations of the invited panel of external experts. It is expected that through this discussion, key actions for PHE will be agreed to support rural areas in improving health outcomes.

3. Rural Health and Health Services

3.1 Introduction

The attached briefing paper at Appendix 1 provides an overview of rural health and health services and some current initiatives. It is not a comprehensive literature review, but aims to provide an overview of rural issues, challenges for service provision, and to enable the Board to identify areas where PHE may have the most impact in supporting local areas. The focus is on England, but draws on work undertaken in Wales and Scotland, which have specific challenges of their own.

The focus on rural health came about in response to issues raised by Local Authorities in rural areas in the Midlands and East Region, in particular from the Directors of Public Health from Shropshire Council, Lincolnshire Council, Suffolk Council and Norfolk Council. A working group was set up in the region that agreed the key points and proposals, summarised below for PHE to consider in its role in supporting rural areas to improve health. (Please see appendix, page 21 for membership of the working group).

3.2. Overview – Rural Health and Services

Through analysis and discussion by the working group, the following factors were identified as important considerations. These relate to indicators and measures of deprivation; resource allocation; proofing of products and tools for rural communities; specific issues for service delivery; transport, telecommunications and utilities and developing communities of interest and expertise.

Rural Indicators and Deprivation

- Rural areas are as diverse as urban areas. They are about 85% of the land mass but only 17.6% of the population live in rural areas and 1.1% in sparse areas.

- There is a larger proportion of older people and a smaller proportion of young adults.

- There are clear inequalities in rural areas, but these are not always obvious as they may be small populations living alongside wealthier people, and their deprivation 'masked'.

- Indices such as the Index of Multiple Deprivation may not always be suitable for demonstrating inequalities in rural areas as the indices do not include some key factors, and may not be sensitive at a 'small area level'.

- Socio-economic comparisons suggest that on average rural areas are better off than urban areas in relation to income, employment, education and crime, but not for some factors such as housing affordability and quality, fuel poverty access and cost of living.

- Overall health comparisons suggest that on average the health of rural people is better than that of people in urban areas, but there are some clear problems including the ageing population, road traffic accidents and possibly excess winter deaths.

- These comparisons are problematic as it is difficult to distinguish between, for example wealthier people who happen to live in rural areas, from people who both live and work in rural areas, and are more dependent on the rural economy.

Resource Allocation

- The national Advisory Committee for Resource Allocation (ACRA) formula for funding health services and the PH ring fence grant in England may need to be looked at in relation to adjustment for additional travel costs in rural areas.

Rural Proofing of Products and Tools

- Service developments should be 'proofed' for rural areas to test whether they are effective and whether there are alternative means of delivery.

- Public health products should be similarly 'proofed', and there needs to be monitoring of public health initiatives in rural areas.

Service Delivery in Rural Areas

- Health and care services in rural areas may present challenges to access, choice and quality, due to issues of distance, access, workforce capacity and capability and the spectrum of service provision.

- The NHS England 5-year Forward Look sets out a vision for health service development. Rural communities need to be engaged with this work and consider how these models could work and be developed in rural areas.

- There are issues around cross-boundary patient flows for rural areas bordering Scotland and Wales. National agreements are in place for health care funding but not for local authority commissioned open-access services such as sexual health.

Transport, Telecommunications, Utilities and Other Services

- Access to services and infrastructure is a key issue for rural communities. Transport links are poor, and while broadband and mobile telephony services may be improving they still lag behind urban areas.

Developing Communities of Interest

- There is considerable expertise already in rural areas, and there are central and local government initiatives to foster rural engagement and action. Public health needs to learn from these initiatives.

3.3 Proposals for PHE to Support Rural Areas

It is proposed that Public Health England could play a part in some or all of the areas described below. These are by no means a comprehensive set of issues. It is imperative to note that whilst the focus of the discussions with the Directors of Public Health has been on the challenges, there were many examples of the assets in rural communities that need to be acknowledged and celebrated such as high levels of volunteering and social networks.

There are a number of areas proposed for discussion, as follows below.

Rural Deprivation and Rural Indicators

1. Determine whether the current indices of deprivation indicators sufficiently capture and describe rural deprivation and whether there should be some changes, if so what and how, as part of an aggregate index.

2. Small area analysis methodological development and support for localities for

local use, where there are clear benefits in using this. PHE will consider commissioning the Small Area Health Statistics Unit (SAHSU) to help with this work, focusing on lower super output areas.

3. Considering some key health and health-related indicators for rural populations, and agreeing which ones best reflect rural experience. These could include: road traffic accidents, fuel poverty, and conditions related to older age.

Resource Allocation

4. Considering the application of the Advisory Committee Resource Allocation formula to rural areas. There is concern amongst rural DsPH that the costs of commissioning and delivering services in rural communities may not be sufficiently accounted for in the ACRA calculations. PHE could consider how the variables and weightings used in the formula apply to rural and urban populations.

Rural Proofing of products/tools

5. Developing and adopting a 'rural proofing' model for public health products and tools. Various tools are now available including the DEFRA proofing tool (see appendix section 8.1) and the NHS England CCG tool. The issue raised is that the advice and support available from PHE is not readily transferable to rural settings. For example, what would be the implications of the use of tools developed by PHE for improving workplace health in local authorities where 90% of businesses have less than 10 employees?

Service Delivery in Rural Areas

6. The development of sustainable service delivery; whether NHS or PH or other LA services was a common feature from the discussion with all the DsPH involved. National models of service delivery tend to be based on an urban/semi urban setting and are less likely to consider or test delivery in sparse rural communities. Rural areas may need different models of service delivery, including new models of workforce development to meet needs.

7. Monitoring ageing and other rural population trends and implications for future health and care needs.

8. There is opportunity to develop shared understanding in collaboration with NHS England with the publication of the Five Year Forward View. This could include delivery of prevention/early intervention services such as Making Every Contact Count or NHS Health checks, as well as use of the tools for CCGs, how to apply rural proofing tool etc. and in the design of health and care services.

9. There are issues of cross-boundary patient flows for services bordering Wales and Scotland. This may be a particular problem for local authority commissioned open access services such as sexual health services, where there are no national agreements in place for how this is managed. PHE in conjunction with

Local Government Association and Association of Directors Public Health have encouraged local areas to develop agreements with authorities in the devolved administrations in managing sexual health services and cross charging.

Transport, Telecommunications, Utilities and Other Services

10. There needs to be explicit recognition of the particular challenges in rural areas of providing accessible transport. This results in not only isolation for older people but also young people. Better support for how to connect communities and improve wellbeing specifically targeted at rural communities was raised.

11. More often than not is the added burden of higher levels of people killed or seriously injured in road traffic accidents in rural areas. The challenge of developing sustainable local travel is a particular issue, despite the many opportunities for cycling and walking.

12. Investment in competitiveness and skills tends to lag behind the investments in urban areas. The issue of broadband and mobile access is a particular issue.

Developing Communities of Interest

13. Developing a platform for learning from local experience, for sharing rural and rural/urban experience specifically for public health outcome improvement.

14. Developing the visibility and engagement of PHE in relation to rural health issues, including closer links with stakeholders.

3.4 Summary

Based on the usual indicators used to describe inequalities, there appears to be no major disadvantage faced by rural communities as a whole, when compared with urban areas. However, as in urban areas there are some significant inequalities within rural communities, which are both difficult to identify and typify. The current indices and datasets may not effectively capture these pockets of deprivation. Methodologies such as small area analysis at lower super output areas/neighbourhoods will be important to develop, describe and understand the health needs of rural communities. Rural communities may also face challenges of access and choice in relation to transport and communications, work opportunities, amenities and services, and this needs to be understood in the future development of health, wellbeing and care service delivery.

PHE has a role in supporting the identification of such inequalities and supporting local areas in meeting these challenges.

Rowena Clayton, Deputy Director, PHE Midlands and East
Rashmi Shukla, Regional Director, PHE Midlands and East
January 2015

Herefordshire Council

MEETING:	**HEALTH AND WELLBEING BOARD**
MEETING DATE:	**15 September 2015**
TITLE OF REPORT:	**Health and Wellbeing Board Work Plan**
REPORT BY:	**Director of Children's Wellbeing**

1. Classification

Open

2. Key Decision

This is not an executive decision

3. Wards Affected

County-wide

4. Purpose

4.1 To seek the views of the Board and finalise the quarterly forward plan

5. Recommendation

THAT: The report be noted

6. Appendices

Appendix 1 - An outline work programme for the Committee.

7. Background Papers

None identified.

HEALTH AND WELLBEING BOARD

WORK PLAN 2015/2016

TIMELINE OF ACTIVITIES AND DECISIONS UPDATED

September 2015

DATES	BOARD MEETINGS
10 November 2015	• Safeguarding Children – Progress Report • Health and Wellbeing Strategy - Mental Health Services • Public Health Commissioning Progress update • Update on the HCCG integrated urgent care pathway project • BCF Submission Update
20 January 2016	• Progress report on the Engagement Gateway • Health and Wellbeing Strategy - For children, starting well with pregnancy, maternal health, smoking in pregnancy, 0-5 immunisations, breastfeeding, dental health, pre-school checks, children with disabilities, young offenders, young people not in education, employment or training, looked after children. • BCF Submission Update • Care Act Implementation
23 March 2016	• Local Authority Adults and Children's Well Being Commissioning Plans 2016/17 • Health and Wellbeing Strategy - For older people – quality of life, social isolation, fuel poverty • CCG Commissioning Plans 2016/17 • Public Health Annual Report • Update on the HCCG integrated urgent care pathway project
May 2016	•