RURAL LENS REVIEW

Integration and Innovation

Health White Paper

RURAL SERVICES NETWORK

Published June 2021

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INTRODUCTION

The White Paper ***Integration and Innovation: working together to improve health and care for all*** was published on 11 February 2021 – **click here to view.**

The NHS remains place neutral in this White Paper with no effective recognition of the difference between rural and urban places. Big is still beautiful in terms of the structures and approaches in this document which does nothing to address the specific challenges facing rural settings – clearly no rural proofing has been applied.

The recent APPG for Rural Health and Care took evidence over two years (watch out for its report in the autumn) and identified the following core challenges facing rural communities:

- Workforce
- Ageing
- Mental Health
- Delayed Presentation
- Social Isolation

And some key determinants of inequality including: housing, seasonal (particularly coastal) economies and digital/broadband deficits.

Through a Rural Lens the White Paper has little or nothing to say about most of these issues. Perhaps most significantly in the context of rural communities it is largely silent on the issue which most challenges and exercises local authorities namely the funding of social care. It does not acknowledge the significant inter-relationship between health and care in enough detail and not at all in the context of its distinctive rural impacts.

This review summarises the White Paper and sets out our response to the issues in detail. It also draws attention to the **Rural Proofing for Health Toolkit** developed by Rural England and the National Centre for Rural Health and Care which provides a powerful means of testing the rural robustness of local organisational responses to the issues raised in the White Paper.

OVERVIEW

The White Paper sets out to achieve the following:

- A goal of joined up care for everyone in England.
- Instead of working independently every part of the NHS, public health and social care system should continue to seek out ways to connect, communicate and collaborate so that the health and care needs of people are met.
- Healthy, fulfilled, independent and longer lives for the people of England will require health and care services, local government, NHS bodies, and others to work ever more closely together.

Two forms of integration which will underpinned by the legislation:

- integration within the NHS to remove some of the cumbersome boundaries to collaboration and to make working together an organising principle; and
- greater collaboration between the NHS and local government, as well as wider delivery partners, to deliver improved outcomes to health and wellbeing for local people.

The NHS and local authorities will be given a duty to collaborate with each other. The White Paper will:

- Bring forward measures for statutory Integrated Care Systems (ICSs).
    - These will be comprised of an ICS Health and Care Partnership, bringing together the NHS, local government and partners, and an ICS NHS Body.
    - The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs.
    - The legislation will aim to avoid a one-size-fits-all approach but enable flexibility for local areas to determine the best system arrangements for them.
    - A key responsibility for these systems will be to support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector.

The Government intend to reform the existing legislation to support the workforce by creating the flexibility NHS organisations need – to remove the barriers that prevent them from working together and to enable them to arrange services and provide joined up care in the interests of service users. Thereby:

- Enabling the NHS and local authorities to arrange healthcare services to meet current and future challenges by ensuring that public and taxpayer value – and joined up care – are first and foremost.
    - This will require changes to both competition law as it was applied to the NHS in the Health and Social Care Act 2012 and the system of procurement applied to the NHS by that legislation.

In dodging the issue of funding for adult social care the White Paper says:

"These measures are not intended to address all the challenges faced by the health and social care system. The government is undertaking broader reforms to social care and public health which will support the system in helping people to live healthier, more independent lives for longer. In particular, DHSC recognises the significant pressures faced by the social care sector and remains committed to reform."

On current timeframes, and subject to Parliamentary business, the plan is that the legislative proposals for health and care reform outlined in this paper will begin to be implemented in 2022.

SCENE SETTING

The current health and care system is modelled on urban areas from both funding and formulae and a policy delivery perspective. As a result, **rural areas receive less grant** and **yet it costs more** to deliver comparable services in a rural area. The tables below demonstrate the health inequalities faced by rural areas:

Funding per head of resident population				
	Predominantly rural	**Predominantly urban**	**Difference**	
Public health allocations for local authorities to improve health in local populations. Public health grants: 2021 to 2022	£43.53	£68.25	£24.72	**36% less**
Social care grant within the final local government finance settlement: England, 2020 to 2021	£27.63	£32.08	£4.40	**14% less**
Improved Better Care Fund grant within the final local government finance settlement: England, 2020 to 2021	£33.08	£39.45	£6.37	**16% less**
Total government funded spending power within the final local government finance settlement: England, 2020 to 2021	£267.32	£379.67	£112.35	**30% less**

Examples of rural health impacts due to under resourcing include:

Impact	Rural v Urban
Alcohol specific conditions in under 18s*	30% higher
Mental health admissions in under 18s*	3% higher
Self-harm hospital admissions for 10–24-year-olds*	8% higher
Looked after children 5–16-year-olds*	15% higher
Ambulance response times**	Over 4 minutes slower
Stroke mortality rates*	4% higher
Informal care provision***	6% higher
Type 2 diabetes*	18% higher

Sources: *Public Health England Public Health Profiles. **BBC News 2019. ***Census 2011

A recent Nuffield Trust report from January 2019 - "A rapid review of the impact of rurality on the costs of delivering healthcare" showed that the seven NHS Trusts with "unavoidable small sites due to remoteness" on average had:

- **Longer** waiting times
- **Longer** lengths of stay
- More **delayed** transfers of care
- **Higher** unit costs
- **Worse** financial positions
- 6 of the 7 of these Trusts ended 2017/18 in **deficit** amounting to **over £¼ billion**
- These **7 Trusts account** for 3% of all Trusts but **23% of the overall deficit** for Trusts

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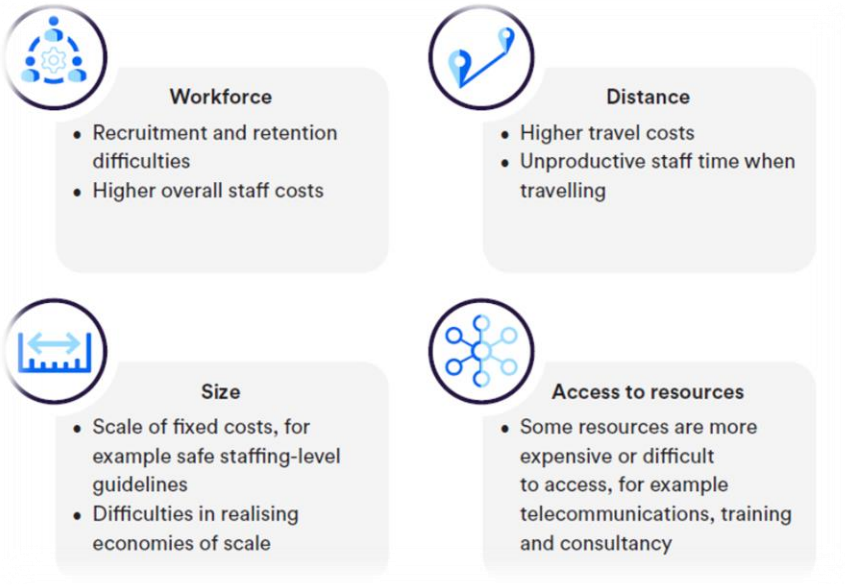

Source: Nuffield Trust Briefing Dec 2020 – "Rural, remote and at risk: Why rural health services face a steep climb to recovery from Covid-19"

The impact of COVID-19 in rural areas:

- COVID-19 has had a **detrimental effect on hospital waiting times**: the proportion of patients seen for their first appointment for cancer fell by 66% in rural trusts between 2019 and 2020, compared to 59% in urban trusts.
- Activity has fallen in rural areas: **emergency admissions declined by 57%** in rural trusts, compared to 45% elsewhere. Referrals for talking therapies in rural areas was below half the level in 2020 than it was a year before.
- The pandemic has **exacerbated workforce issues** in rural trusts. Rural trusts spend more on temporary staff (8% of their staffing budget) compared with other areas (6%). While hospital and community health staff increased by 7% nationally during 2020, the workforce of rural trusts grew by only 5%.
- The **underlying financial position** of rural trusts has worsened: with their debt equivalent to more than half (56%) of their annual operating income.
  Source: Nuffield Trust Briefing Dec 2020 – "Rural, remote and at risk: Why rural health services face a steep climb to recovery from Covid-19"
- The fragility of the **care market**: 43% of Directors reported that providers in their area had closed, ceased trading or handed back contracts [Source: ADASS Budget Survey 2020 Part #2 Impact of Covid-19 on budgets].

Can using digital technology to improve access to services and to support isolated and vulnerable people help?

The table below shows the average minimum travel times demonstrate the issue for rural residents in physically accessing health services.

Overcoming geographical and infrastructure challenges to deliver services				
	By public transport/walking		By car	
To reach the nearest:	Rural areas	Urban areas	Rural areas	Urban areas
GP surgery	23 minutes	11 minutes	11 minutes	8 minutes
Hospital	61 minutes	34 minutes	26 minutes	18 minutes

Source: Travel time statistics 2017 (revised), Department for Transport.

It is important to remember that these are the average times, and hence do not represent the reality for the most isolated. The figures also do not reflect the frequency **(or lack of) public transport services** in rural areas.

Tackling Health Inequalities

Professor Chris Whitty, Chief Medical Officer when appointed in 2019 set out tackling health inequalities as a priority for his tenure. Whitty has developed a special interest in the plight of people in rural and coastal areas, which has been long neglected in public health. The Department of Health recently said: “Addressing health inequalities that have been exacerbated by the pandemic and levelling up the health of communities across the UK is a priority for this government.”

Source: Sunday Times 27 June 2021

DEEP DIVE INTO THE ANNOUNCEMENTS

The below sets out a series of tables on the ***Integration and Innovation: working together to improve health and care for all*** White Paper which could impact on rural communities and service delivery, alongside (where appropriate) RSN comments on these from a rural perspective, including what the RSN will look out for as more detail emerges.

The tables are split under the following headings:

Working together and supporting integration
Reducing bureaucracy
Enhancing public confidence and accountability
Additional proposals

Key Statement from White Paper		RSN Initial Comments
Working together and supporting integration	**Integrated Care System Proposals** • An aim to legislate for every part of England to be covered by an integrated care system (ICS) • An intention to establish a statutory ICS in each ICS area (*currently voluntary arrangements*). These will be made up of an ICS NHS Body and a separate ICS Health and Care Partnership, bringing together the NHS, local government and partners. • The ICS NHS body will be responsible for the day to day running of the ICS, while the ICS Health and Care Partnership will bring together systems to support integration and develop a plan to address the systems' health, public health, and social care needs. • ICSs will be accountable for outcomes of the health of the population and the government are exploring ways to enhance the role of CQC in reviewing system working **The ICS NHS Body will be responsible for:** • Developing a plan to meet the health needs of the population within their defined geography; • Developing a capital plan for the NHS providers within their health geography; • Securing the provision of health services to meet the needs of the system population. This body will be responsible for developing a plan that addresses the wider health, public health, and social care needs of the system – the ICS NHS Body and Local Authorities will have to have regard to that plan when making decisions. NHS Trusts and Foundation Trusts (FTs) will remain separate statutory bodies with their functions and duties broadly as they are in the current legislation. • The creation of statutory ICS NHS Bodies will also allow NHS England to have an explicit power to set a financial allocation or other financial objectives at a system level. There will be a duty placed on the ICS NHS Body to meet the system financial objectives which require financial balance to be delivered. • NHS providers within the ICS will retain their current organisational financial statutory duties. The ICS NHS Body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged. • However, these arrangements will be supplemented by a new duty to compel providers to have regard to the system financial objectives so both providers and ICS NHS Bodies are mutually invested in achieving financial control at system level.	*This aspect of the White Paper speaks the language of partnership and place which is to be applauded. It gives with one hand, empowering partners to work together more closely at a local level but retains control with the other, highlighting that the status of the key delivery organisations will remain unchanged, and they will remain in the financial grip of the NHS nationally. From an RSN perspective there should be more guidance on the role of developing a plan to meet the health needs of the population within their defined geography, as this is the principal means by which the new NHS structures can become more rurally sensitive.*

	Key Statement from White Paper	RSN Initial Comments
Working together and supporting integration	**Other Key Aspects of the Working Together Agenda** **Duty to collaborate** This will be supported by a broad duty to collaborate across the health and care system and a triple aim duty on health bodies, including ICSs, as recommended by NHS England. This will require health bodies, including ICSs, to ensure they pursue simultaneously the three aims of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. **Reserve Power** As an additional safeguard for financial sustainability, the government will take a power to impose capital spending limits on Foundation Trusts, in line with NHS England's recommendation. **Joint Committees** This will involve action to remove barriers to integration through joint committees, collaborative commissioning approaches and joint appointments, as well as their recommendation to preserve and strengthen the right to patient choice within systems. **Collaborative Commissioning** • Give NHS England the ability to joint commission its direct commissioning functions with more than one ICS Board, allowing services to be arranged for their combined populations. • Allow ICSs to enter into collaborative arrangements for the exercise of functions that are delegated to them, enabling a "double-delegation". • Allow groups of ICSs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions (and not just commissioning functions). • Enable NHS England to delegate or transfer the commissioning of certain specialised services to ICSs singly or jointly, or for NHS England to jointly commission these services with ICSs if these functions are considered suitable for delegation or joint commissioning subject to certain safeguards.	*This aspect of the White Paper is largely centralising in its perspective and it encourages macro approaches such as joint ICS working arrangements. The scale of these arrangements runs a very specific risk of missing rural subtleties in a drive to make big scale efficiencies. Whilst the paper talks about the importance of place, if the frame of reference is at the level of an ICS then its approach lacks the granularity to respond to the needs of small and distinctive rural settings. The focus on data sharing is to be welcomed if it enables more effective e-medicine, however the White Paper doesn't touch on this opportunity, concentrating more on patient confidentiality. It makes no mention of the challenges linked to broadband deficits in rural areas.*

Key Statement from White Paper		RSN Initial Comments
Working together and supporting integration	**Data Sharing** • Legislate to ensure more effective data sharing across the health and care system, which is critical to effective integration, and will enable the digital transformation of care pathways. • Introduce powers for the Secretary of State for Health and Social Care to require data from all registered adult social care providers about all services they provide, whether funded by local authorities or privately by individuals (discussed further in the Adult Social Care proposals); and require data from private providers of health care. • Make changes to NHS Digital's legal framework to introduce a duty on NHS Digital to have regard to the benefit to the health and social care system of sharing data that it holds when exercising its functions; and clarify the purposes for which it can use data. • Introduce a power for the Secretary of State for Health and Social Care to mandate standards for how data is collected and stored, so that data flows through the system in a usable way, and that when it is accessed/provided (for whatever purpose), it is in a standard form, both readable by, and consistently meaningful to the user/recipient. **Patient Choice** This section identifies that integrated services provide an opportunity to offer joined up care to all and provide clear information on the choices people have in how and where their care is delivered. A patient's right to choose where and who will provide their health and care needs will be preserved and strengthened in the new system arrangements.	*See comments above*

Key Statement from White Paper		RSN Initial Comments
Reducing Bureaucracy	**Competition** Whilst competition can drive service improvement, it has in some cases hindered integration between providers therefore the paper aims to • Remove the Competition and Markets Authority (CMA) function to review mergers involving NHS foundation trusts. The CMA's jurisdiction in relation to transactions involving non-NHS bodies (e.g. between an NHS Trust/Foundation Trust and private enterprise) and other health matters (e.g. drug pricing) would be unchanged. • Remove NHS Improvement's specific competition functions and its general duty to prevent anti-competitive behaviour. • Remove the need for NHS England to refer contested licence conditions or National Tariff provisions to the CMA. **Arranging healthcare services** Government will use legislation to remove much of the transactional bureaucracy that has made sensible decision-making and collaboration in the system harder. It will reform the approach to arranging healthcare services and create a bespoke regime that will give commissioners more discretion over when to use procurement processes to arrange services than at present, with proportionate checks and balances. Where competitive processes can add value they should continue, but that will be a decision that the NHS will be able to make for itself. Legislative proposals will remove the current procurement rules which apply for NHS and public health commissioners when arranging healthcare services. They will do this by creating the powers to remove the commissioning of these services from the scope of the Public Contracts Regulations 2015, as well as repealing Section 75 of the Health and Social Care Act 2012 and the Procurement, Patient Choice and Competition Regulations 2013. The legislation will: • Develop a new provider selection regime which will provide a framework for NHS bodies and local authorities to follow when deciding who should provide healthcare services. • The provider selection regime will be informed by NHS England's public consultation and aims to enable collaboration and collective decision-making, recognising that competition is not the only way of driving service improvement, reduce bureaucracy on commissioners and providers alike, and eliminate the need for competitive tendering where it adds limited or no value.	*This section of the White Paper is effectively about the way the NHS procures services. It provides scope for sub-regional and individual trusts to move away from competition as a guiding principle in procurement.* *This is a positive and empowering opportunity for trusts operating in rural settings where the market is often faulty due to a lack of critical mass.* *The White Paper however is framed at a macro level and does not take the opportunity to look at this level of local detail.* *It will be important however to ensure that in taking this approach Health Education England doesn't move the level of analysis around workforce interventions to a higher level of geographical organisation which misses the specific challenges facing rural places.*

Key Statement from White Paper		RSN Initial Comments
Reducing Bureaucracy	• Commissioners will be under duties to act in the best interests of patients, taxpayers, and the local population when making decisions about arranging healthcare services. • Government anticipates that there will continue to be an important role for voluntary and independent sector providers, but want to ensure that, where there is no value in running a competitive procurement process, services can be arranged with the most appropriate provider. • The NHS will continue to be free at the point of care and these proposals seek to ensure that where a service can only be provided by an NHS provider e.g. A&E provision, that this process is as streamlined as possible. **National Tariff** Government will amend the legislation to enable the National Tariff to support the right financial framework for integration whilst maintaining the financial rigour and benchmarking that tariff offers. This includes: • Where NHS England specifies a service in the National Tariff, then the national price set for that service may be either a fixed amount or a price described as a formula. • NHS England could amend one or more provisions of the National Tariff during the period which it has effect, with appropriate safeguards. • Remove the requirement for providers to apply to NHS Improvement for local modifications to tariff prices. • NHS England should be able to include provisions in the National Tariff on pricing of NHS public health services where exercising public health functions delegated by the Secretary of State. **New Trusts** Proposals include a provision to allow the creation of new trusts for the purposes of providing integrated care, therefore bringing forward measures that will enable ICSs to apply to the Secretary of State to create a new trust. Any new trust will be subject to appropriate engagement and consultation. **Removing Local Education Training Boards (LETBs)** The White Paper is proposing to amend the Care Act 2014 (which sets out the functions and constitution of Health Education England and Local Education and Training Boards) to remove LETBs from statute. Government believes removing LETBs from statute with their functions continuing to be undertaken by HEE (and reporting to the HEE Board) will provide HEE with the flexibility to adapt its regional operating model over time.	*The most potent aspect of this section of the White Paper is the requirement for commissioners to: "act in the best interests of patients, taxpayers, and the local population when making decisions about arranging healthcare services." This clause will enable rural issues to be raised and rural challenges put forward by local authorities and other key champions of rural settings.* *The powers to create new trusts and to rearrange the system of workforce planning is broadly neutral from the perspective of rural places.*

	Key Statement from White Paper	RSN Initial Comments
Enhancing public confidence and accountability	**Merging NHS England, Monitor and the NHS Trust Development Authority and Secretary of State powers of direction** The White Paper identifies that the public largely see the NHS as a single organisation and as local health systems work more closely together, the same needs to happen at a national level. It introduces: • Legislative proposals focused on ensuring that accountability arrangements command public confidence, whilst also enabling systems to get on with doing their jobs and making appropriate changes to enable transformation and innovation. • An intention to formally bring together NHS England and NHS Improvement into a single legal organisation. **NHS Mandate** • When NHS England, Monitor and the NHS Trust Development Authority are legally merged, the current statutory mandate to NHS England will cover the whole of the combined organisation. • Proposing to replace the current legislative requirement to have a new mandate each year with a new requirement to always have a mandate in place. **Reconfiguration's intervention power** The Secretary of State is currently only able to intervene in such cases upon receiving a local authority referral and may commission the Independent Reconfiguration Panel to provide recommendations. After receiving these, the Secretary of State will communicate his final decision. • Proposing to broaden the scope for potential ministerial intervention in reconfigurations, creating a clear line of accountability, by allowing the Secretary of State to intervene at any point of the reconfiguration process. • The Secretary of State will be required to seek appropriate advice in advance of their decision, including in relation to value for money, and subsequently publish it in a transparent manner. • Government will introduce a new process for reconfiguration that will enable the Secretary of State to intervene earlier and enable speedier local decision-making. • Government will issue statutory guidance on how this process will work as well as removing the current local authority referral process to avoid creating any conflicts of interest. • Government will publish further details of proposed arrangements in due course. • Government will expect the Independent Reconfiguration Panel to be replaced by new arrangements.	*Whilst using the language of empowerment and reform this section of the White Paper increases the directive and centralising power of the Secretary of State and the Department of Health and Social Care.* *The statement that "the public largely see the NHS as a single organisation and as local health systems work more closely together, the same needs to happen at a national level" is loaded and whilst couched in the language of local cooperation betrays the longer term history of the NHS as a nationally focused and place blind organisation predicated on the mantra that big is beautiful.*

Key Statement from White Paper		RSN Initial Comments
Enhancing public confidence and accountability	**Arm's Length Bodies (ALBs)** • Proposing to create a power in primary legislation for the Secretary of State for Health and Social Care to transfer functions to and from specified ALBs. • This mechanism will allow Government to review where functions are best delivered in order to support a more flexible, adaptive and responsive system. • In cases where an ALB becomes redundant as a result of transfer of its functions, this power will also include the ability to abolish that ALB. • The power to transfer functions and the power to abolish an ALB will be only be exercisable via a Statutory Instrument (SI), following formal consultation. **Special Health Authorities (SpHAs)** Proposal will remove the three-year time limit on all SpHAs. Not only is this time limit unnecessary as the functions of the SpHAs are enduring, it is also inconsistent as the time limits only currently impact one SpHA, the Counter Fraud Authority (CFA); and any future SpHAs that come into being would also be subject to the time limit legislation. • By removing this time limit, Government is ensuring all SpHAs are treated equally in legislation and removing the bureaucratic, time consuming and duplicative process. **Workforce Accountability** The Department is proposing to create a duty for the Secretary of State for Health and Social Care to publish a document, once every five years, which sets out roles and responsibilities for workforce planning and supply in England. This document would: • cover the NHS including primary, secondary, community care and where sections of the workforce are shared between health and social care e.g. registered nurses, and health and public health e.g. doctors and other regulated healthcare professions. • describe the workforce planning and supply system including the roles of DHSC and its Arm's Length Bodies, NHS bodies and others and how they work together. • not give any bodies additional functions to those they already have in statute be co-produced with (at a minimum) Health Education England and NHS England	*As there is very limited recognition of the particular needs and challenges of rural very little cause for optimism that the reforms planned will lead to greater innovation, proportionate risk taking and overall better models of care for rural communities. It is worth remembering that the funding formula for acute trusts descries rural places as: "unavoidably small due to remoteness."*

Key Statement from White Paper		RSN Initial Comments
Additional proposals	**Social Care** The Government intend to bring forward proposals to reflect the themes of supporting integration, reducing bureaucracy and improved accountability in a manner that addresses the specific needs of the social care sector. DHSC will bring forward measures: • on system assurance and data, to ensure that there are appropriate levels of oversight on the provision and commissioning of social care • legislating to amend the Health and Social Care Act 2008 to expand the powers of the Secretary of State for Health and Social Care, which currently allows the Secretary of State to make payments to not-for-profit bodies engaged in the provision of health or social care services in England. The Bill will widen this to allow direct payments to be made to any bodies which are engaged in the provision of social care services in England. • and proposals that provide greater flexibility as to at what point assessments for care can be made. • ICS legislation will complement and reinvigorate place-based structures for integration between the NHS and Social Care, such as Health and Well-Being Boards, the Better Care Fund and pooled budget arrangements. • the ICS Health and Care Partnership will be a springboard for bringing together health, local authorities and partners, to address the health, social care, and public health needs at a system level, and to support closer integration and collaborative working between health and social care. • DHSC will support this by published guidance that will offer support for how ICS Health and Care Partnerships can be used to align operating practices and culture with the legislative framework to ensure ICSs deliver for the Adult Social Care sector. • the Government will also create a more clearly defined role for Social Care within the structure of an Integrated Care System NHS Board. This will give ASC a greater voice in NHS planning and allocation. • Which aim to work with local authorities and the sector to enhance existing assurance frameworks that will support our drive to improve the outcomes and experience of people and their families in accessing high quality care and support, regardless of where they live.	*The proposals in this section provide a welcome recognition of the need for reform of the social care system. They identify the need for greater structural working together. They do not however recognise the very significant financial burden that adult social care places on rural local authorities and the impact on discretionary services. Most frustratingly they remain silent on any changes to the funding regime for care. They do however contain proposals to make new ICS structures more receptive to the planning of Adult Social Care. They do not however recognise the specific rural challenges in this context. The White Paper also proposes a more interventionist and forceful regime for the regulation of local authorities in the undertaking of their social care duties to be led by the CQC.*

Key Statement from White Paper		RSN Initial Comments
Additional proposals	• To support these goals, the Government propose to introduce through the Health and Care Bill, a new duty for the Care Quality Commission to assess local authorities' delivery of their adult social care duties. • Linked to this new duty they also propose to introduce a power for the Secretary of State to intervene where, following assessment under the new Care Quality Commission duty, it is considered that a local authority is failing to meet their duties. • Any intervention by the Secretary of State would be proportionate to the issues identified and taken as a final step in exceptional circumstances when help and support options have been exhausted. Government will also create a standalone power for the Better Care Fund, separating it from the NHS mandate setting process. **Public Health** The Government will bring forward measures to: • make it easier for the Secretary of State to direct NHS England to take on specific public health functions; • Proposal is to create a power for the Secretary of State for Health and Social Care to require NHS England to discharge public health functions delegated by the Secretary of State alongside the existing section 7A provisions • help tackle obesity by introducing further restrictions on the advertising of high fat, salt and sugar foods; • as well as a new power for ministers to alter certain food labelling requirements. This will ensure consumers can be supported to make more informed, healthier choices about their food and drink purchases. In addition, the Government will be streamlining the process for the fluoridation of water in England by moving the responsibilities for doing so, including consultation responsibilities, from local authorities to central government.	*See above.*

Key Statement from White Paper		RSN Initial Comments
Additional proposals	**Safety & Quality** Government will: • bring forward measures to put the Healthcare Safety Investigation Branch (HSIB) on a statutory footing; to enable us to improve the current regulatory landscape for healthcare professionals as needed; • act to establish a statutory medical examiner system within the NHS for the purpose of scrutinising all deaths which do not involve a coroner and increase transparency for the bereaved, • allow the Medicines and Healthcare products Regulatory Agency (MHRA) to develop and maintain publicly funded and operated medicine registries so that we can provide patients and their prescribers, as well as regulators and the NHS, with the evidence they need to make evidence-based decisions. They will also be bringing forward measures to enable the Secretary of State to set requirements in relation to hospital food. And finally, they will take powers to implement comprehensive reciprocal healthcare agreements with countries outside the EEA and Switzerland ('Rest of World countries') – expanding our ability to support the health of our citizens when they travel abroad, subject to bilateral agreements.	*See above.*

NEXT STEPS

The RSN and National Centre for Rural Health and Care will be working together to closely review the contents of the Health and Care Bill referred to in the Queen's Speech as it is introduced and progresses through Parliament.

The RSN will be promoting our Revitalising Rural Campaign at every opportunity including pressing the issues with Ministers and Civil Servants. We will engage with the Rural Services All Party Parliamentary Group (and MPs from rural constituents generally) on the Rural Health and Care Services Chapter of the Campaign and when (a) the Health and Care Bill is introduced into Parliament and (b) when the Government's proposals relating to Social Care emerge.

The report, findings and recommendations of the Inquiry by the APPG for Rural Health and Care due in the autumn will be another significant opportunity for us, working with the National Centre for Health and Care, to highlight and represent the health inequalities relating to health and care in the rural context.

At the RSN Rural Social Care and Health meeting on 15th November (open to all RSN members) we will have the opportunity to consider the inequalities raised in this Rural Lens Review and any related issues/opportunities which emerge between now and then,

In our Rural Lens Review of the Queen's Speech, we flagged up the following significant concerns, namely:

- While the commitment to social care reform is welcome the words in the supporting document are similar to the announcement in the 2019 Queen's Speech.
- Coming forward with proposals (on Social Care) is not the same as a commitment to introduce legislation.
- The proposed reforms must be wide ranging and not limited to the introduction of a new cap on care costs to individuals (important though that is). The proposals MUST INCLUDE the funding of local councils to meet their statutory responsibilities and properly reflect the costs of providing care in the rural context. This includes recognition of the Social Care Sector in rural areas and the challenges that sector faces.
- Local government must be an equal partner in Integrated Care Systems and these bodies should be fully aligned to social care authority boundaries.
- The NHS has a Workforce Development Plan and the Social Care Sector needs one too.

THE REVITALISING RURAL CAMPAIGN

The full documentation which forms the RSN's Revitalising Rural: Realising the Vision Campaign can be accessed **here.**

The specific chapter relating to Access to Rural Health and Care Services can be accessed **here.**

We will ensure that the Campaign Documents are kept up to date and, where necessary the Rural Dimension and Policy Asks will be reviewed and amended in the light of the updating (RSN members will be kept informed and where appropriate consulted about such changes).

The RSN has always said that it wishes to add 'depth and texture' to the high-level Revitalising Rural documents. Comments and case studies from members would be much appreciated. To share a case study, email the RSN at admin@sparse.gov.uk

Set out below are the policy solutions and specific policy asks from the Access to Rural Health and Care Chapter:

Policy solutions

The direction of policy travel, as set out by reforms in the NHS Long Term Plan, poses both some real challenges and some opportunities for rural provision. The same could certainly be said, too, for the social care sector, where future policy is currently less developed. A core requirement is that health and care plans are rural proofed at both the national (policy) level and the local (strategic and delivery) level, so that benefits reach rural communities and properly address their needs. Better use could be made of digital health and care services for rural provision, learning lessons from the experience of virtual consultations during the Covid-19 pandemic, though this requires gaps in rural connectivity to be addressed.

Specific policy asks

Access and travel to hospitals: local health partnerships (STPs and ICSs) and trusts should take better account of accessibility and transport availability when drawing up plans to reconfigure acute and emergency services at their main hospital sites. This should address access for patients, visitors, and staff from rural locations, including those without a car or those unable to drive. It is especially important for patients whose treatments require a regular visit. Hospital transport schemes should also be made more widely available. This and other issues would be easier to address if funding allocations to local NHS areas were better aligned with the costs rural areas typically face from serving an older aged population. The hospital building programme should be used to improve access to hospitals in rural areas which are not well served.

Primary and community care services: local health partnerships should seize opportunities to create locally based multi-disciplinary teams and to develop health hubs in rural town locations. Hubs should aim to make a wide range of treatments and services more accessible to nearby rural populations, thereby avoiding the need for many patients to travel to main hospitals. They should provide services such as minor procedures, diagnostic tests, baby clinics, rehabilitation, and re-enablement. Local pharmaceutical services need to be retained in rural areas, which in some cases means supporting dispensing GP surgeries.

Public and mental health services: in the light of recent experience, Government should give more prominence to public health and mental health services. Both need better resourcing to become more accessible in rural areas. Historic funding allocations for public health cannot be justified and need urgent overhaul to even out provision. Good practice in rural provision of mental health services needs active promotion and encouragement. Large disparities in numbers of mental health professionals working in rural and urban areas need resolving.

Social care provision: Government should implement the findings of its Fair Funding Review to help level-up the provision of social care services in rural areas, taking full account of their delivery cost in more sparsely populated areas. This would also enable improved or more consistent engagement with and commissioning of 'low level' support services for vulnerable rural residents, which are typically delivered locally by voluntary and community sector organisations.

Workforce and recruitment: Government and the NHS should ensure that delivery of the NHS Workforce Plan includes an explicit rural dimension. Pay bonuses should be considered to attract recruits into those rural places with the highest vacancy and turnover rates. Medical training should include a rural placement, wherever possible, to give trainees exposure to work in rural settings. Similar initiatives are needed to cope with serious rural shortages in the social care workforce.