HSC Health and Social Care

Rural Needs Toolkit for Health and Social Care

How to Address the Needs of the Rural Population

Rural Community Network

RoseRegeneration

NATIONAL CENTRE FOR RURAL HEALTH AND CARE

INTRODUCTION TO THE TOOLKIT

Toolkit Aim

This Toolkit seeks to help those in the health and social care sectors to address the needs of their rural populations when they develop strategies, initiatives and service delivery plans.

For ease of use the Toolkit is based around six main themes:

- Acute hospital services
- Primary and community health services
- Mental health services
- Public health and preventative services
- Social care services
- Workforce

The Rural Needs Act (Northern Ireland) 2016

Background

The Rural Needs Act (Northern Ireland) 2016 ('the Act') came into operation for Northern Ireland departments and district councils on 1 June 2017 and for the other public authorities listed in the Schedule to the Act on 1 June 2018.

The Department of Agriculture, Environment and Rural Affairs (DAERA) has produced guidance for public authorities on the Act "A Guide to the Rural Needs Act (NI) for Public Authorities (Revised)" ('the guidance') to assist public authorities in understanding their statutory duties under the Act and in fulfilling their statutory obligations[1].

The guidance states that "the purpose of the Act is to ensure that public authorities have due regard to the social and economic needs of people in rural areas when carrying out certain activities and to provide a mechanism for ensuring greater transparency in relation to how public authorities consider rural needs when undertaking these activities"

It also states that "the Act was introduced to ensure that consideration of the needs of people in rural areas becomes more firmly embedded within public authorities. The Act seeks to help deliver fairer and more equitable treatment for people in rural areas by requiring public authorities to have

[1] https://www.daera-ni.gov.uk/topics/rural-needs/rural-needs-advice-guidance-information-and-other-resources

due regard to rural needs when developing, adopting, implementing and revising policies, strategies and plans and when designing and delivering public services. This will help to deliver better outcomes for people in rural areas and help make rural communities more sustainable. The Act also seeks to increase transparency by requiring public authorities to compile and publish information on how they comply with the due regard duty when carrying out certain activities and for this information to be published in an annual report"

Duties on Public Authorities under the Rural Needs Act (NI) 2016

Section 1(1) of the Act imposes a duty on public authorities to have due regard to rural needs when:

(a) developing, adopting, implementing or revising policies, strategies and plans; and
(b) designing and delivering public services.

The Act also imposes a duty on public authorities to:

(a) compile information on the exercise of their functions under Section 1 of the Act;
(b) include that information in their annual report; and
(c) send that information to DAERA.

DAERA has a duty under the Act to publish the information sent to it in an annual report and to lay a copy of the report before the Northern Ireland Assembly.

The Act interprets "rural needs" to mean "the social and economic needs of persons in rural areas".

The Schedule to the Act lists the public authorities to which the Act applies and includes the Department of Health, the Health and Social Care Trusts, the Regional Agency for Public Health and Social Well-Being (known as the Public Health Agency) and the NI Fire and Rescue Service

Rural Needs Impact Assessments

The guidance recommends that "public authorities undertake a Rural Needs Impact Assessment when developing, adopting, implementing or revising polices, strategies and plans and when designing and delivering public services".

A Rural Needs Impact Assessment (RNIA) is a six step process aimed at helping public authorities ensure that they comply with the due regard duty under section 1(1) of the Act. The six steps in the process are set out in Chapter 5 of the guidance and include identifying the needs of people in rural areas, considering rural needs and influencing the policy, strategy, plan or public service.

The guidance advises that "Public authorities should ensure that all information relevant to the Rural Needs Impact Assessment is documented on the RNIA Template" and that "the amount of detail recorded should be proportionate to the potential impact and relevance of the activity being undertaken."

This toolkit will assist Duty Holders in undertaking better quality Rural Needs Impact Assessments by ensuring that they are better informed on the needs of people in rural areas in relation to health [and social care].

The Rural Needs Impact Assessment process can help to:

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

Integrated Care System

The Minister of Health granted approval in October 2020 for the commencement of a programme of work to develop an Integrated Care System (ICS) model in NI in line with the vision set out in **Health and Wellbeing 2026: Delivering Together** which articulates the need to empower local providers and communities to plan integrated continuous care based on the needs of their population, with specialised services planned, managed and delivered on a regional basis.

In July 2021 a targeted consultation on the proposal resulted in overwhelming support for the development of an Integrated Care System based on a Regional, Area and Locality model.
The model will ensure that the planning, management and delivery of services are more agile, flexible and responsive to identified local needs, less bureaucratic and process driven, and more outcome focused than the current approaches. Importantly, the model will operate with the involvement of all key partners.

ABOUT THE TOOLKIT PROJECT

This Toolkit was adapted for use in Northern Ireland in partnership with health and social care trusts in Northern Ireland. It was authored by the National Centre for Health and Social Care, assisted by local partners Rural Community Network NI.

This is a Northern Ireland version of the initial toolkit that was researched and written in England by a team that consisted of Brian Wilson and Jane Hart from Rural England CIC, Billy Palmer from the Nuffield Trust and rural researcher Sonja Rewhorn.

TOOLKIT ENDORSEMENTS

"I applaud the Trusts for taking the lead in this initiative, and working closely with the Rural Community Network, Rose Regeneration Group and the Department of Health to create this valuable resource which, I have no doubt, will become a key tool for policy and decision-makers across the health and social care sectors to consider and improve outcomes for rural dwellers."
Robin Swann MLA,
Minister for Health NI

"This toolkit makes a positive contribution to that rural conundrum of trying to deliver high quality services, which are accessible for their users and in areas where it is typically hard to achieve economies of scale. The National Centre is pleased to offer its support."
Professor Richard Parrish, CBE
Chair of the National Centre for Rural Health and Care

"Rural and remote services face unique pressures when planning and delivering services for their patients. These challenges must not be overlooked if rural services are to be delivered effectively and provide good health outcomes for rural patients. This toolkit is a very welcome resource for commissioners and providers to identify and overcome these challenges."
Nigel Edwards
Chair Executive, Nuffield Trust

USING THE TOOLKIT

The Rural Needs Toolkit for Health and Social Care for Northern Ireland has been written mainly for those who are responsible for developing and designing health and care policies, strategies, plans and service delivery. They may be from health and care commissioners, providers or other partnership bodies.

The Toolkit was developed primarily with England's health and care systems in mind, but this version for Northern Ireland has been adapted by Rose Regeneration in partnership with Rural Community Network NI and an advisory group with representatives from all the NI Health and Social Care Trusts and the Department of Health.

Users of the Toolkit are likely to be working at the local or sub-regional level. This could include partnerships established for the transformation of services, integrated care system partnerships, commissioning bodies, primary care networks, public health partnerships, community planning networks and health and social care trusts. This list is not meant to be exhaustive.

The Toolkit may also prove useful to organisations representing the needs of health and care service users, including organisations from the voluntary and community sector. Their interest could involve providing input to championing a deeper understanding of the Rural Needs Impact Assessment process and the Toolkit.

It is intended for application across different types of rural geographies, from remote or sparsely populated areas through to mixed areas, where a rural hinterland adjoins larger urban settlements.

There is no fixed way to use the Toolkit. Its application needs to align with local priorities and with local policy, strategy or plan making processes. However, based on evidence of rural proofing in England to-date and the Rural Needs Impact Assessment process in Northern Ireland, the following key considerations are suggested:

- The **six theme pages** in the Toolkit can be used selectively to match the focus of policy, strategy, plan or public service development tasks. However, it is recommended that all the theme pages are reviewed to see if they contain points of relevance. This is likely to be especially true of the workforce theme, since that issue cuts-across the other themes;

- Rural needs impact assessment process should **start early** in the policy, strategy, plan or public service development process, so it can inform thinking from the outset.

- Rural needs impact assessment should, for maximum effectiveness, be **embedded** within the policy, strategy, plan or public service development process. This might cover stages such as those illustrated in the graphic below on page 10;

- The Rural Needs Impact Assessment should be informed by **evidence**[2]. Sources of information might include consultation with rural stakeholders, questionnaires, statistical data or research papers. Valuable rural (and locality) evidence could be generated both by gathering consultation responses such that those from rural areas are tagged and by disaggregating available data geographically, as far as possible;

- In undertaking a Rural Needs Impact Assessment duty holders should **be careful not to assume** (inadvertently) that rural areas are homogenous. Needs can vary according to location and settlement size. For example, what works for villages near to a city or large town may not work for villages in remoter settings;

- Where the Rural Needs Impact Assessment indicates that there will be a negative impact on people in rural areas **options to mitigate** these effects should be considered. This might mean revising proposals, adding local flexibility to proposals, introducing rural-specific measures and taking mitigating action;

- Subsequent monitoring or evaluation of policies, strategies, plans and public services can produce important lessons about service effectiveness and outcomes in rural areas, which can inform future change. This can include lessons about what worked well and what didn't in rural settings;

- A Rural Needs Impact Assessment should be easier to undertake and deliver the best return where it is built into and carried out as **an integral part** of the policy, strategy, plan or public service development processes.

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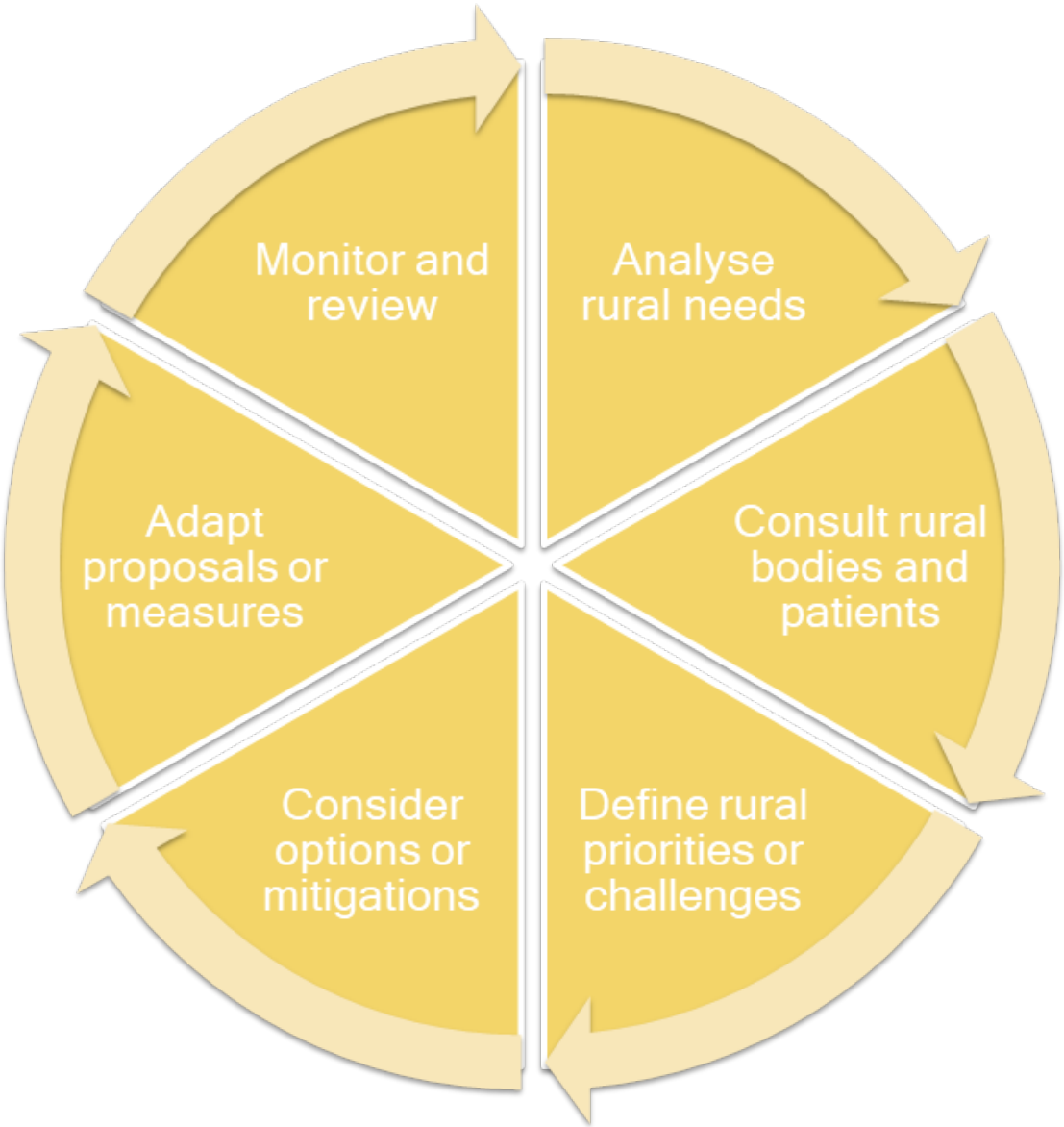
[2] https://www.daera-ni.gov.uk/articles/research-and-statistics

https://www.nisra.gov.uk/statistics

RURAL NEEDS IN A POLICY, STRATEGY, PLAN CYCLE



RURAL NEEDS KEY CONSIDERATIONS

In essence the Rural Needs Impact Assessment process seeks to ensure that policies, strategies, plans and public services take account of the needs of people in rural areas, so the intended benefits reach all service users. It aims to inform and improve service planning and design processes. Although it is likely to identify some challenges, it should also help to identify solutions and, in some cases, opportunities.

When developing health and care policies, strategies, plans and public services, the Toolkit should help to address considerations such as the following:

1. That services which must be located at an acute hospital, nonetheless, need to be sufficiently accessible to rural patients and their families (including those without a car or unable to drive), which could include putting mitigation measures in place.

2. That more non-acute services could be made accessible locally, closer to where rural residents live, at health centres, care hubs or community hospitals.

3. That services which deliver care to people in their own homes need to be designed so they work for people in outlying or harder-to-reach locations (whilst retaining the care time made available).

4. That rural delivery benefits could be realised from collaboration across health and care sectors and the creation of multi-disciplinary teams, including enhanced partnership working with voluntary and community organisations.

5. That preventative initiatives which encourage healthier lifestyles and wellbeing should be promoted in rural settlements and available to different rural groups, taking pressure off statutory health and care services.

6. That developments or innovations in health service provision, such as digital adoption, should be utilised wherever possible to seek rural solutions but should carefully consider digital exclusion in some rural areas and patient groups[3].

7. That workforce planning needs to be alive to issues arising in rural locations, including at smaller hospitals, such as recruitment or retention issues and access to professional training.

[3] https://www.daera-ni.gov.uk/publications/access-broadband-ni-ruralurban-comparison

8. That both statistical analyses and service user feedback on health needs or inequalities should be disaggregated to reveal local and rural evidence, thereby informing service planning.

The theme pages in this Toolkit provide more detailed material about six topics. They are intended to help those who carry out a Rural Needs Impact Assessment.

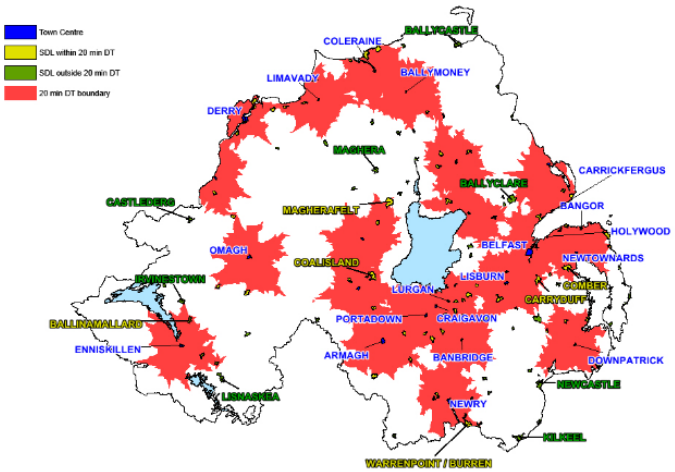
RURAL FACTS AND FIGURES SUMMARY

Defining Rural

All settlements in Northern Ireland with a population of 5,000 or less and open countryside are considered rural[4]. The rural classification also includes a consideration of service provision for each settlement. This was introduced by calculating estimated travel times to the location of a "service centre" defined as the town centre of a settlement containing at least 10,000 residents. Accordingly, areas have been classified by whether they are within a 20 or, 30-minute drive-time of the centre of a settlement containing at least 10,000 usual residents.

More than a third (36%) of Northern Ireland's (NI) population lives in a rural area.

Map 4: 20 minute drive-time boundary from settlements with population of 10,000 or more

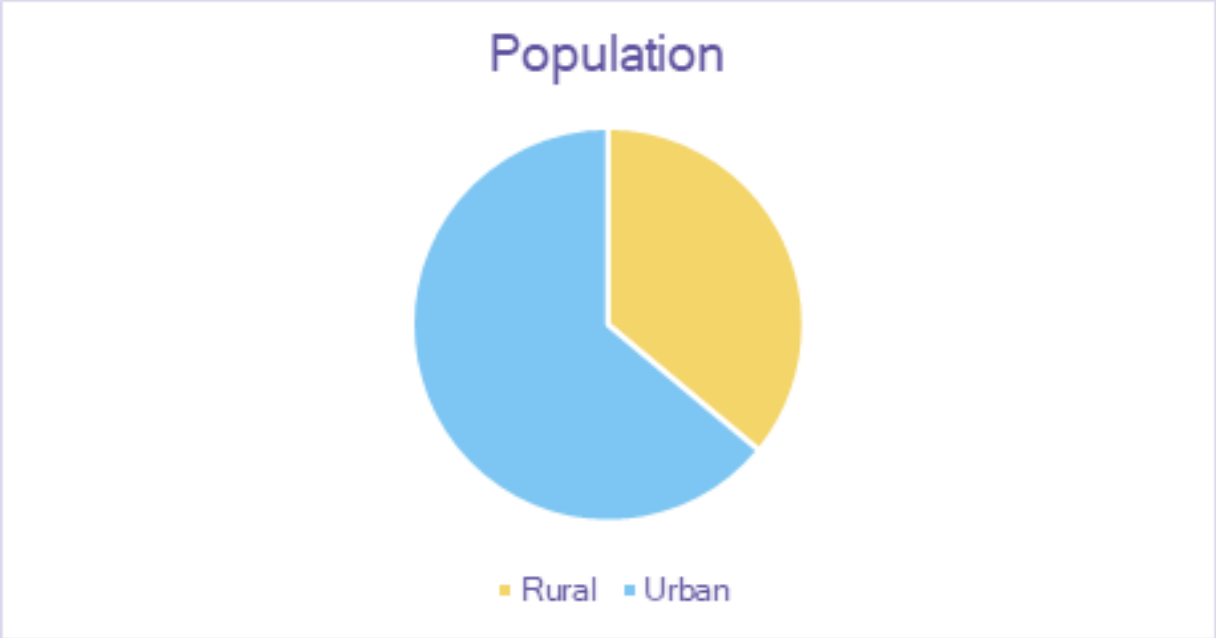


[4] https://www.nisra.gov.uk/publications/settlement-2015-documentation

The figures cited below[5] are for all rural areas across Northern Ireland. It should be stressed that, in practice not two rural places are alike and their needs will vary. Whilst some are remote, others are close to large urban centres. Analysis undertaken at the local level can usefully explore this variation.

Key Facts and Figures

Population - Between 2001 and 2020, the population of rural areas rose by 20%, compared to an increase of just 7% for urban areas. As a result, the rural share of the overall NI population grew from 34% to 36%. Areas with fastest growth were those close to urban centres, either in mixed rural/urban areas (36%) or less than an hour's commute from Belfast (22%).



Well-Being In 2019/20, people living in rural areas were consistently more likely than those in urban areas to report high happiness levels (44% compared to 36% in urban areas) and high life satisfaction (40% compared to 34% in urban areas). Similarly, rural dwellers were more likely to report lower anxiety levels than their urban counterparts (45% to 38%). On the surface, these figures suggest that the rural population benefits from better mental health overall. However it must also be considered that not all with mental health difficulties seek treatment, and difficulties with access, reporting, and proximity to mental health services could potentially contribute to the lower figures in rural communities.

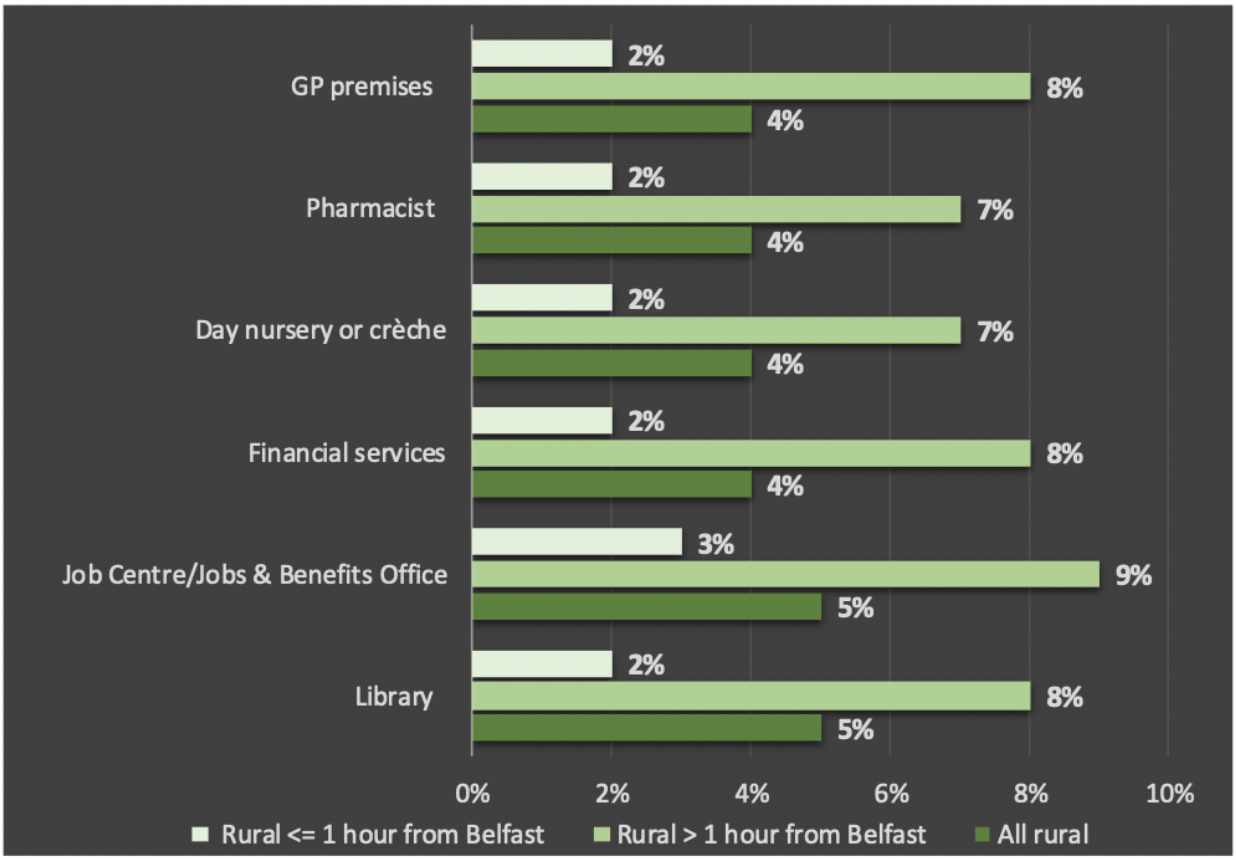
[5] Key Rural Issues – DAERA 2021 https://www.daera-ni.gov.uk/topics/statistics/rural-statistics

Access to Services - In terms of access to emergency services, ambulance and fire service response times are substantially longer in rural than in urban areas. People living in rural areas wait, on average, around seven and a half minutes longer for ambulance and fire service response than those living in towns and cities

Housing - Access to social housing is much more limited, and rates of owner-occupation are substantially higher in rural (80%) than urban areas (65%). As of Quarter 3 in 2021, average house prices are also higher in rural than in urban areas, with property in rural areas within an hour's drive of Belfast most expensive of all. The extent of the combined economic impact of the Covid-19 pandemic, and the end of the EU Exit transition period on NI house prices remains to be seen.

Access by Car - For rural dwellers travelling by car, journey times to key services are substantially higher as for those living in towns and cities, sometimes double or greater, and this disparity is again more pronounced in rural areas more distant from Belfast.
The greatest disparity in travel times are to hospitals with an accident and emergency facility, and to job centres/jobs and benefits offices. Those living in rural areas more than an hour from Belfast are, on average, a 26-minute drive away from an Accident and Emergency department, compared to an average 13-minute drive time for those living in urban areas.
The table below shows the significant disparity in access to services for rural dwellers, which imposes a specific burden for those with a need to regularly visit GP and outpatient services as a consequence of long-term conditions:

Figure 28: Proportion of Small Areas without Public Transport Access to selected services, 2017



Note: 'Financial Services' includes ATMs, banks, building societies and credit unions.
Source: Northern Ireland Multiple Deprivation Measure (MDM), 2017

Poverty - Poverty levels in both children and adults of working age are very similar in urban and rural areas as a whole. However, the reverse is true for pensioners. **Rural pensioners are significantly more likely to be in relative or absolute poverty as their urban counterparts** (12% compared to 8%).

Cost of Living - The cost of living is also higher in rural areas and rural households are twice as likely as urban households to be in fuel poverty - almost a third (32%) of rural households experience fuel poverty compared to 16% of those in urban areas. Private transport is also a necessity in many rural areas in terms of access to employment and basic services – 92% of rural households had access to at least one car or van in 2019/20. As a result, vehicle ownership and running costs may consume a greater share of available household income.

Life Expectancy - The most recent data (covering 2017-19) suggests that life expectancy is notably higher in rural areas than in towns and cities in NI. Males living in rural areas can, on average, expect

to live approximately three years longer, and rural females over two years longer, than their urban counterparts.

Healthy Life Expectancy - This disparity is further emphasised in the projected 'healthy' years of life –males can expect over 5 years and females can expect over 4 years more 'healthy' years of life than urban dwellers.

Educational attainment - The adult populations of rural and urban areas are very similar in terms of overall educational attainment. However, there are clear intra-rural differences in qualification levels. Rural dwellers who live more than an hour's drive from Belfast are less likely to have achieved degree level or higher qualifications (23%) than their urban counterparts (26%), and were more likely to have no formal qualifications (27% compared to 21%).

Employment - In 2020, people living in rural areas were more likely to be in employment, with almost three quarters (74%) employed either full or part-time. Similarly, this group was less likely to be economically inactive compared to those living in urban areas. Overall employment levels for both men and women were higher in the rural than the urban population, and employment was highest among those living in rural areas within an hour's commute of Belfast (76%)

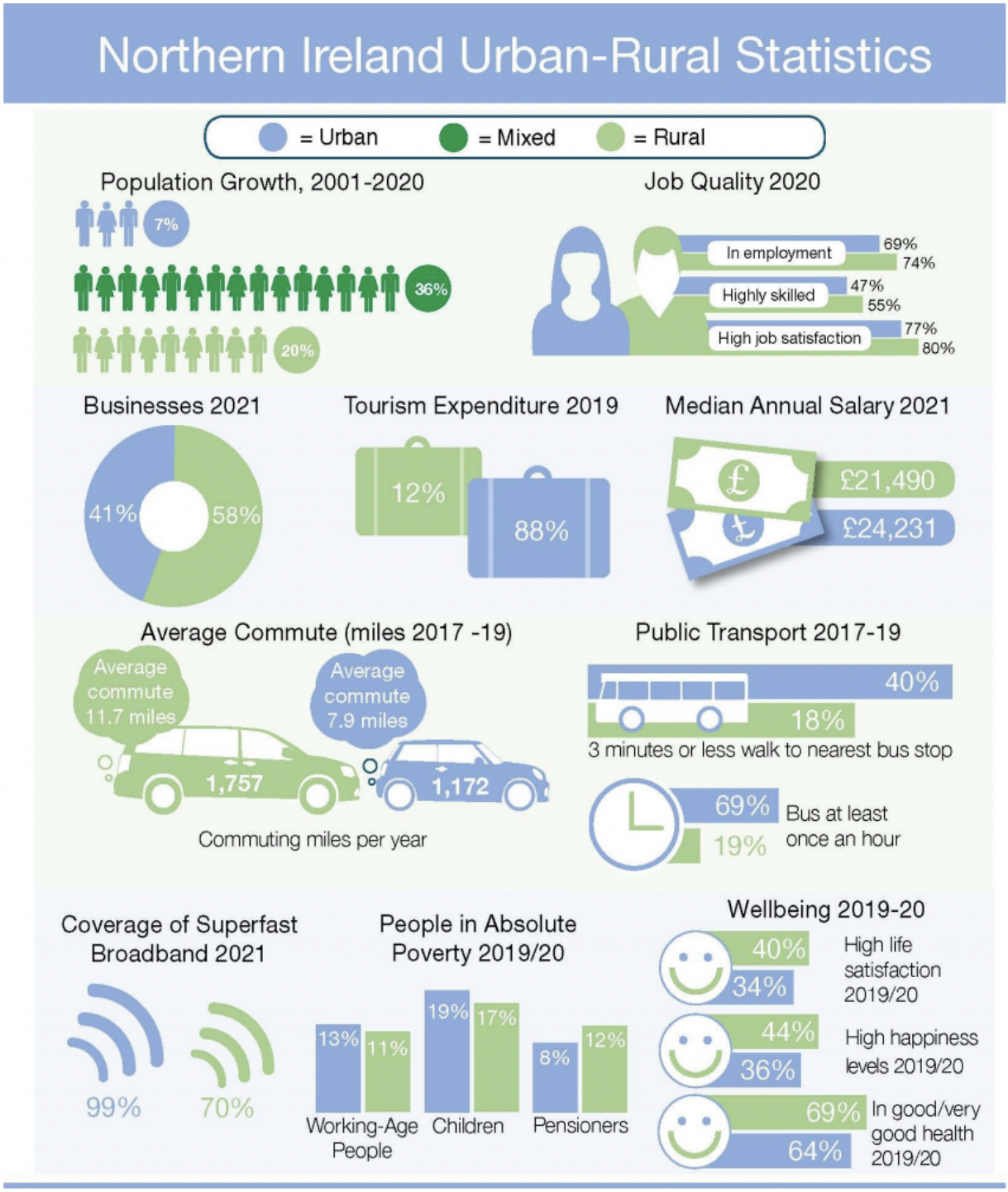
Broadband – Average download speeds and data usage have increased markedly in both urban and rural areas since 2018, yet both remain higher in urban areas. For some rural properties, access to a functional broadband connection remains an issue, with 19% of internet-enabled rural premises in NI still unable to achieve a 'decent' broadband speed in 2021.

Specific Health Inequalities

There are two areas where rural dwellers in Northern Ireland have a higher incidence of treatment need than their urban counterparts these are in respect of elective impatient admissions and circulatory admissions per 100,000 population.[6]

The Infographic below provides a useful summary of wider rural-urban statistics in Northern Ireland:

[6] Health Inequalities Annual Report 2022 Data Tables Urban Rural Analysis available at https://www.health-ni.gov.uk/articles/health-inequalities-statistics



Source DAERA website available at: https://www.daera-ni.gov.uk/sites/default/files/publications/daera/Key%20Rural%20Issues%202021%20Infographic.pdf

SIX TOOLKIT THEMES

ACUTE HOSPITAL SERVICES

There is a broad consensus that there are a number of clinical priorities where service improvement should make the greatest impact on health outcomes. They are cancer, cardiovascular disease, stroke, respiratory disease, diabetes, maternity and neonatal, and young people's care. Naturally, acute hospital services must play a crucial part in addressing these priorities. That said, there is a clear expectation that, in future, more services will be available outside an acute hospital setting and that fewer patients will need to attend them for treatment.

In some circumstances acute hospital estates and their services are reconfigured and this sometimes involves the creation of centralised specialist units. Irrespective of the merits, one challenge this brings is how to ensure that acute hospitals remain accessible to those from outlying rural areas who may have long or complex or costly journeys, be they patients, visitors, carers or staff.

The following questions are intended to help improve rural service planning and design:

1. If assessing options for reconfigured or new acute and elective services (including A&E and out of hours services), what can analysis show about **travel times** and transport options to acute hospital sites from settlements across the area served? What is considered a reasonable travel time?

2. What **transport options** to acute hospital sites exist, including from smaller or more outlying settlements? What are the implications for those who do not drive, do not have access to a car or who are too ill to drive? How far does transport service frequency limit the ability of patients to attend hospital outpatient appointments through the day?

3. What scope is there to collaborate further with the **community transport** sector, who manage volunteer car schemes and minibus services, and who may be able to bring patients to health appointments, especially those without access to a car? How widely are non-emergency hospital transport services available as an option for rural users?

4. What scope is there to provide some (until now) acute hospital services safely at a more local level or at **outreach** clinics within urgent treatment centres, community hospitals or care hubs? For example, minor procedures, diagnostics, in-patient rehab, baby clinics, re-enablement and end of life care.

5. What scope is there to offer outpatients greater **choice**, with options where they can go to receive treatment or care? Could further collaboration with neighbouring health authorities or providers in the Republic of Ireland enable cross-border options [7] or pathways?

6. How might the **number of visits** that patients are required to make to an acute hospital be reduced for those travelling from outlying areas? Could more examinations and tests be carried out during the same hospital visit or more common tests be carried out locally?

7. What opportunities might be pursued to offer **digital or online** consultations and advice, to reduce the need to travel to outpatient appointments? Could this include local health centres having access to online advice from hospital-based specialists?

8. How sufficient is provision for low-volume and **high-risk specialities** in geographies where population numbers are relatively small? (An example might be intrapartum care for childbirth involving high risk.) Could regional networks and cross-site working be strengthened?

9. What are typical **response times** for ambulance and paramedic services, when attending calls from rural and outlying areas? Could clinical emergency protocols take better account of rural needs, where time-critical intervention is necessary e.g. stroke, heart attack? How well distributed are resources such as ambulance bases, first responders and paramedics?

10. What is known about the location of public access **defibrillators** and those trained to use them, especially in rural settlements more distant from quick response services? Equally, how sufficient is **air ambulance** and rescue service cover to deal with time-critical cases which happen at remote locations or in coastal and mountainous settings?

11. What **resilience planning** is in place to work with the other first responder emergency services when incidents occur such as flooding and wild fires? Should this be reviewed?

12. Could **public and patient engagement** be used to gather feedback from service users who live in rural areas? How could this be used to generate useful lessons for service planning, design

[7] North West Cancer Centre at Altnagelvin Hospital in Derry delivers chemotherapy and radiotherapy treatment to patients from a cross-border catchment area of approximately 500,000 people for more detail see https://westerntrust.hscni.net/hospitals/north-west-cancer-centre/

and implementation?

- Community First Responder Schemes
- Supporting high intensity users of NHS services in Cornwall
- Near Me delivering remote care in NHS Highland region, Scotland

Other solutions to rural service delivery challenges could include:

- Taking the service to the patient, by holding outreach clinics at local health centres or community hospitals, with visiting consultants or specialists from acute hospitals.
- Upskilling and equipping GPs or Primary Care Teams[8] to carry out some specialist services locally, which are traditionally delivered at more centralised sites e.g. memory clinics.
- Provide services in people's home, such as Hospital at Home and other intermediate care services.
- Ensuring sufficient training is available for locally based healthcare workers in rural settings, so they can support patients returning home quickly from hospital and avoid others needing to go into hospital.
- Establishing a team of community-based paramedics, who can more quickly attend emergencies and provide a first response in hard-to-reach locations.
- Upgrading air ambulances so they are made capable of night flying, to reach emergencies at remote locations around the clock.
- Using Geographic Information Systems (GIS) to model and analyse typical travel times from different locations to acute hospital sites and other service facilities.

[8] As part of the Elective Care Framework, the HSCB (now SSPG) are working to develop and expand the delivery of appropriate elective procedures in a primary care setting.

- Maintaining a rural risk register, as part of a plan or strategy, to identify and monitor issues which need managing and addressing or mitigating.

PRIMARY AND COMMUNITY HEALTH SERVICES

Primary and community services are central to health and social care reforms, which place a growing emphasis on out-of-hospital care, plan for further service integration and adopt more of a place-based approach. There is real merit in a process which seeks to remove "the historic barrier" between primary and community health services. GP practices and other primary care providers such as community pharmacies are expected to work together to deliver more effective outcomes for patients.

This approach has the potential to improve primary and community health care provision in rural areas, depending on how it is implemented. Challenges could include the large areas to be covered in sparsely populated geographies, expectations that specialist health professionals can serve such large areas and ensuring that health centres or health hubs remain accessible. In addition, service demands may reflect the (typically) older age profile found in rural areas, which may mean more patients with multiple morbidities.

The following questions are intended to help improve rural service planning and design:

1. How far do the local **funding priorities** match locally identified priorities at the Primary Care level? What effort has been made to ensure that these, in turn, incorporate the needs of the area's rural communities?

2. What scope exists to expand the **range of services delivered locally** at medical centres, health hubs or community hospitals, to meet local needs and avoid patients travelling to acute hospitals? For example, for minor procedures, diagnostics, oncology blood tests, in-patient rehab, baby clinics, re-enablement and end of life care.

3. How easy do members of locality or hub-based **multi-disciplinary teams**, especially those who hold more specialist roles or who visit patients in their homes, find it to cover needs across the whole locality including any outlying areas?

4. Are there any proposals for **GP surgery alliances, mergers or relocations**? How are these likely to affect local access to surgeries and the services or clinics they host? If the proposals leave any local gaps in provision, how could these be addressed?

5. What **public transport options** exist to help patients travel to GP surgeries, community hospitals and other health facilities? Do those transport options serve the smaller rural settlements? Might community transport providers or schemes (such as volunteer car schemes) help to plug gaps?

6. What are the **travel costs and downtime** for health visitors, district nurses, etc if they are regularly visiting patients with long term conditions in their own homes in outlying areas? Is any additional burden from such travel accounted for in resource and workload planning?

7. What scope exists to offer and facilitate **virtual consultations** (by phone or online) for patients who may otherwise face difficult journeys to reach a traditional consultation? Similarly, could digital be used at surgeries or health centres to access advice from specialists based elsewhere (perhaps thereby obviating a hospital visit)?

8. What is the location of **community pharmacies** in the area and how adequately does that serve the dispensing and healthcare needs of residents from rural settlements? Can community pharmacies support provision of other healthcare needs in rural areas with limited access to GP practices?

9. What support services are provided to those who are living with a chronic condition or a disability and who **self-care**? What might improve the support and its delivery to those patients living in outlying areas?

10. When **commissioning community health services** what scope exists to do so from local providers or in ways that improve service availability in rural areas? Could this include an enhanced role for local voluntary and community sector organisations?

11. What **collaboration or networking challenges** arise, if any, for primary and community health professionals and managers where they are working across a geographically large rural area? Are there working practices which could alleviate these challenges?

- Digitally Connecting Care Homes
- South Eastern Trust Recovery College
- Connect North Model for Social Prescribing
- Farm Families Mobile Covid-19 Vaccine Pop-Up Clinics Winter 2021
- "My Journey"
- Farm Families Health Checks
- Guildford and Waverley Community Gynaecology Service in Surrey
- Enhanced primary care in Frome, Somerset

Other solutions to rural service delivery challenges could include:

- Mapping primary care services in the area (General Practice, dentistry, pharmacies, etc) to understand their distribution in relation to rural populations and transport networks.

- Deploying other trained healthcare professionals to undertake selected tasks that were previously carried out by a GP.

- Engaging with any local projects which help people, especially from vulnerable groups, to enhance their online skills, so more patients can take-up the option of virtual consultations.

MENTAL HEALTH SERVICES

Health Minister Robin Swann launched the publication of the new Mental Health Strategy 2021-2031[9] in June 2021. The Strategy sets out 35 actions under three overarching themes. The first – promoting mental wellbeing, resilience and good mental health across society – aims to ensure that we reduce the stigma around mental health, provide early intervention and prevention and provide support across the lifespan and to those caring for people with mental ill health.

[9]Mental Health Strategy 2021-2031 is available at: https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-mhs-strategy-2021-2031.pdf

The second – providing the right support at the right time – covers a range of service improvements, including improvements in child and adolescent mental health services, integration of old age psychiatry and psychology into mainstream mental health services, community mental health and in-patient services and specialist services. This theme outlines a number of service improvements that ensure better access to support when it is needed, putting the person's needs at the centre.

The third theme – new ways of working – sets out the changes that will support the improvements needed across the systems, including ensuring a regional approach to mental health with regional consistency in service delivery, data and outcomes, workforce planning and research. Northern Ireland's 10-year substance use strategy, "Preventing Harm, Empowering Recovery[10]", was launched in September 2021, with a vision that people across Northern Ireland are supported in the prevention and reduction of harm and stigma related to the use of alcohol and other drugs, have access to high quality treatment and support services, and will be empowered to maintain recovery

One challenge for health and social care is how to plan and design child and adult mental health services which are sustainable across larger rural geographies and are accessible to their dispersed communities. This may be true both for frontline support services and for referrals to specialist treatment.

The following questions are intended to help improve rural service planning and design:

1. How accessible to rural communities are organisations or facilities which can promote public **information** (e.g. from the Minding Your Head' website) and so help people to better understand and cope with common mental health conditions, such as stress and anxiety?

2. How geared up are smaller rural-located **GP surgeries** or health centres to offer mental health prevention services? Are there professional development needs for their GPs or primary care teams to improve diagnosis and early intervention? Is there evidence of late presentation by patients in small communities and how are confidentiality issues addressed?

3. Where is the nearest 24/7 service for those who have a mental health **crisis** and how can it be accessed or reached from rural locations? What other options could be adopted, such as an

[10] Preventing Harm, Empowering recovery is available at: https://www.health-ni.gov.uk/publications/substance-use-strategy-2021-31

outreach crisis team or having access to facilities across administrative boundaries?

4. In cases where individuals are referred on to specialist **in-patient** care services, how easy to travel to are those services, not least for visiting family or carers? Again, could there be cross-boundary solutions? Are there specific rural challenges if organising an admission under the Mental Health Act and how could they be addressed?

5. How effectively do **Child and Adolescent** Mental Health Services work with rural based schools and colleges in the area and can any gaps in this provision be plugged? Is the service in rural areas consistent with the statutory framework for children and young people?

6. How do local plans to improve mental health services address the needs of **older people** in rural communities, including care for those with dementia or co-morbid frailty? Rural areas (especially those on the coast) typically have a high proportion of older residents.

7. What mental health or wellbeing initiatives or projects exist that seek to reach out to (often isolated) **farming communities**? How could they be promoted by working with the sector (e.g. the UFU, NIAPA and Rural Support) or at specific locations such as livestock markets?

8. How is support delivered in rural areas to those seeking help for **alcohol or use of other drugs** and how can that support be improved? How might it be better coordinated with other mental health services, so those needing support do not fall through a gap?

9. Is there an Individual Placement and Support service (or equivalent) and how accessible is it to rural residents experiencing common mental health concerns, to help them to remain in or find **employment**? How could its rural delivery be improved?

10. What are the locations of **supported housing** for vulnerable people of varying ages who have mental health problems or learning disabilities? Are any in rural towns or otherwise accessible from rural areas? How might gaps in provision be addressed?

11. How does the health and wellbeing strategy seek to analyse mental health needs and inequalities in rural areas? What does it use for measuring need, if a simple count of service take-up is likely to be affected by external factors, including poor accessibility in rural areas?

12. When seeking to improve mental health services by **consulting** with patients, their families and carers, what effort is made to gather views from across the geographic area and to analyse responses such that any rural-specific findings can be identified?

13. What recruitment or **workforce** challenges are identifiable (including specialist professions, such as psychiatrists and therapists, and generalists with mental health skills) which need addressing to maintain mental health teams able to operate across the area?

- Digitally Connecting Care Homes
- Community Front Room in Bridport, Dorset
- MensCraft suicide prevention project in Norfolk

Other solutions to rural service delivery challenges could include:

- Providing intensive home treatment through Community Mental Health Teams, as an alternative to acute in-patient admission.

- Offering more anonymity for those using mental health services (for young people, in particular), by providing the option of video-conference or online chat facilities. (see case study on the Recovery College)

- Delivering mental health services within facilities which also host other types of service, so it is not obvious that those entering are there for mental health reasons.

- Using a 'whole life approach' to mental health service provision, which includes access to support on housing, money and employment issues, as appropriate.

- Enhanced working with rural-facing voluntary and community sector agencies, with resources allocated to help them deliver certain services. This could be especially suited to support for those with enduring mental health issues.

- Adopting a community asset-based approach to aid the provision of support to those with mental health needs. This would identify or map relevant support groups, skills and facilities that could improve support at a community level, and it would also identify gaps.

- Supporting Mental Health Champions who can raise awareness, change perceptions and encourage mental health initiatives in each rural locality.

- Seizing opportunities with organisations from the natural environment and outdoor leisure sectors, who can offer activities for those experiencing common mental health problems. This could include social farming, which offers activity on small farms as a support service.

PUBLIC HEALTH AND PREVENTATIVE SERVICES

Making Life Better; A Whole System Strategic Framework For Public Health is a ten-year public health strategic framework which provides direction for policies and actions to improve the health and wellbeing of people in Northern Ireland.[11] The Framework recognises that while in general the health of people in Northern Ireland has been improving over time, health inequalities remain. Too many people still die prematurely or live with conditions they need not have. The framework has been structured around 6 themes:

1. Giving Every Child the Best Start,
2. Equipped Throughout Life,
3. Empowering Healthy Living,
4. Creating the Conditions
5. Empowering Communities and
6. Developing Collaboration.

For each of the six themes long-term outcomes were set with strategic supporting actions and commitments over the current budgetary period that work towards these. They include actions which are particularly relevant to influencing the determinants of health and wellbeing.

One likely challenge is measuring and targeting health inequalities where needs are scattered across rural geographies and so less visible. Promoting public health messages to outlying communities may also require tailored approaches that make use of different opportunities. Furthermore, ensuring prevention programmes or projects are accessible to residents from both large and small settlements will inevitably impact their effectiveness.

[11] See https://www.health-ni.gov.uk/articles/making-life-better-strategic-framework-public-health

The following questions are intended to help improve rural service planning and design:

1. Does the health and wellbeing strategy (or plan) for the area seek to measure and monitor **indicators of public health** and its determinants at a locality level? What does doing so show about public health needs and priorities for rural localities?

2. When assessing **health inequalities** to target relevant initiatives, what attempt is made to account for varying spatial patterns? Does the approach identify both geographically scattered need, typical in rural areas, and clusters of need, typical in urban neighbourhoods? How well do inequality indicators used cover both urban and rural aspects of deprivation?

3. What approaches are used to promote **public health messages**, such as with campaigns on smoking cessation, a healthy diet and vaccination take-up? How well do those approaches work in rural areas? Could local government or community-based organisations assist, such as sporting organisations, community and voluntary groups , local communities and village hall committees?

4. How well equipped are those **community pharmacies** which are based in rural towns or settlements to offer health and wellbeing advice to their customers? What scope exists to use them to improve access to professional health advice in rural areas?

5. How are **public health programmes** providing lifestyle interventions delivered equitably and accessibly to rural communities, for example to reduce obesity or prevent diabetes? Is there scope to extend their reach by making use of rural assets, such as village and church halls?

6. How are programmes delivered in rural areas which assist with **personal or sensitive** issues, such as mental health, sexual health and alcohol or substance use? How do they seek to address the potentially additional confidentiality risk within smaller communities?

7. How are early years or best start in life programmes, which support the health and wellbeing of **young children and their parents**, delivered in rural areas? Are there geographic gaps in their provision which should be addressed?

8. To what extent are regular **screening or health check** programmes accessible to those from rural communities (including those who don't drive or don't have access to a car)? Is there any evidence of low take-up or feedback citing access issues from some locations?

9. What **social prescribing** opportunities, offering referral to non-clinical interventions, are available to or accessible to those living in rural communities? Could social prescribing practitioners be described as operating in ways that reach out to rural communities?

10. To what extent is the potential role of **digital technology**, such as mobile phone Apps, being exploited to help people adopt healthier lifestyles, including those from rural communities who may have less access to traditional wellbeing services?

11. Where public health goals are incorporated into **other local strategies** and plans, such as those for land use planning, transport planning and early years services, how far does that process consider whether there are particular rural needs or circumstances?

12. How widely and effectively is information disseminated to resident communities and countryside visitors to help them identify and deal with **outdoor hazards** they might experience, such as tick bites and Lyme disease?

13. Do **clean air and pollution** control programmes take account of issues which may affect specific rural communities, such as villages which sit astride busy trunk roads?

14. How do plans produced for **infectious disease control**, where outbreaks occur, ensure that they can be effective in rural areas, where there is likely to be less local capacity within the health care system?

- South Eastern Trust Recovery College
- Connect North Model for Social Prescribing
- Farm Families Mobile Covid-19 Vaccine Pop-Up Clinics Winter 2021
- Read Yourself Well
- "My Journey"

- Community First Responder Schemes
- Farm Families Health Checks
- E-enabled social prescribing in Lincolnshire
- Farming Health Hub providing health and wellbeing services in Cornwall

Other solutions to rural service delivery challenges could include:

- Engaging with voluntary and community groups and their partnerships in rural areas, who are already likely to run a wide variety of health and wellbeing activities.

- Running webinars on priority public health topics (which could be run jointly with primary care colleagues), giving residents an opportunity to improve their understanding.

SOCIAL CARE SERVICES

A public consultation on the Reform of Adult Social Care in Northern Ireland was announced by the Department of Health in January 2022. The consultation document sets out 48 proposed actions to reform the adult social care system over the next 10 years. It acknowledges that the adult social care system in Northern Ireland (NI) is under significant stress. Population demographics and projections are such that we are faced with rising demand for services as our older population increases and our working age population decreases.[12] However, a notable feature of social care provision is that it involves a wide array of large and small providers (regulated by the Northern Ireland Regulation and Quality Improvement Authority) that offer both privately and publicly funded care provision. Added to which, much care is given outside any formal system by families, neighbours and friends.

Social care services support children and adults of all ages. The highest volume of demand is that from older age groups, though a major financial pressure for the public sector is provision for profoundly disabled working age adults. Older people form a relatively high proportion of the rural population, especially in coastal areas, and that proportion is expected to increase further. There are more pensioners living in poverty in rural than urban settings in Northern Ireland. Other specific challenges for providers may be associated with providing domiciliary care to clients in outlying areas and ensuring that rural users have fair access to services, so they can continue living independently at home wherever possible.

[12] See https://www.health-ni.gov.uk/consultations/consultation-reform-adult-social-care for more details

The following questions are intended to help improve rural service planning and design:

1. What scope is there, when conducting service planning, to access information about the population **age profile** (and other relevant metrics) at a locality level, so that any spatial patterns which might impact on demand can be identified?

2. What scope is there, when planning service needs and designing commissioning processes, to involve some **rural based service providers** or rural interest groups, as a means to ensure that learning from rural experience is incorporated?

3. How well embedded are social care staff within any **locality-based structures** or multi-disciplinary teams? Does such a team approach offer opportunities to improve support to rural clients? Could further partnership working with other frontline service organisations also prove beneficial e.g. to information sharing?

4. Where domiciliary care providers visit clients living independently in outlying areas, what is known about their **travel costs and downtime**? How do contracts awarded for provision ensure that all locations are served and clients living in remoter areas receive an equitable service?

5. How robust and effective is the **lone worker policy** for those social care and NHS staff whose jobs involve them making home visits in or regularly travelling through rural areas, where mobile phone signal connectivity may be unreliable?

6. How readily can the rural **housing** stock, including older and more isolated dwellings, be **adapted** to meet the needs of residents, whether of working age or retired, who develop disabilities? Do local policies to support independent living address the needs of rural residents?

7. What is the geographic **distribution of residential and nursing home** settings across the area being served? Does that distribution provide users (or potential users) from rural areas with the option to remain close to the locality and community they have lived in?

8. How adequately supported by health professional are those that live in rural-located **residential care homes** (including nursing homes)? Do those residents and their care homes

have arranged access to a visiting team of health professions and to a named GP? Do they also have good access to health professionals who can provide end of life care?

9. What is the geographic distribution of **day care centres** and the activities that they offer across the area being served? Does that distribution provide users (or potential users) from rural areas with fair access to day care centres?

10. To what extent do rural communities in the area benefit from befriending schemes or good neighbour schemes that help combat **loneliness and isolation**? Are there gaps in provision and, if so, what local organisation(s) could support their development?

11. What support services are in place, which are accessible to rural residents, to help those that need advice with **financial planning** to help them manage their future care costs or to access allowances they are eligible for?

12. What initiatives or projects are in place to support and to provide respite for **those who care informally** for a partner, a parent or a child with special care needs? Are those initiatives or projects sufficiently accessible to informal carers in rural areas?

13. What opportunities exist to introduce **digital or online** solutions, to assist with the delivery of social care support? Could care at-a-distance prove especially useful as a means to enhance support to clients in outlying areas?

14. Do rural geographies create any additional challenge for social care teams and multi-agency networks seeking to deliver prompt and effective safeguarding and other support to **vulnerable children and young people**, including those requiring intensive intervention? What options exist to mitigate such rural challenges?

- South Eastern Trust Recovery College
- Connect North Model for Social Prescribing
- Farm Families Mobile Covid-19 Vaccine Pop-Up Clinics Winter 2021
- Read Yourself Well
- Farm Families Health Checks

- Commissioning local micro-providers of care in Somerset
- South West Care Collaborative improving care home provision in Devon

Other solutions to rural service delivery challenges could include:

- Plugging gaps in service provision by developing (or repurposing existing buildings to become) social care hubs located in rural towns, thus addressing rural needs whilst still achieving some economies of scale.

- Partnering with local voluntary sector organisations to ensure that befriending or good neighbour schemes are widely available across the area for vulnerable and older people in its communities.

- Supporting care sector providers to adapt to changing needs in their local area in a more coordinated and sustainable way, through a representative body which can offer them advice and development opportunities).

- Exploring the potential of digital innovation to complement domiciliary care provision in rural areas and to enhance support for those living independently at home.

- Utilising social farms or gardens to provide opportunities for older people with care needs (not least those in care homes) who have worked outdoors for much of their life and who may benefit from the stimulation that such facilities offer.

WORKFORCE

Health and social care in Northern Ireland needs to address workforce shortages, to build leadership capability and to develop a workforce with the skills to match future service delivery plans. This includes creating skills to work in multidisciplinary teams and to enable more digital adoption. Within the social care sector, which has a larger workforce than the primary care and acute hospital sectors high vacancy and turnover rates are also a notable feature, most obviously in domiciliary care services.

A particular challenge in rural areas has been attracting and retaining doctors, both in GP practice and at smaller hospitals, which can impact the availability of specialist skills. However, rural health and care workforce issues are much broader than this and partly reflect the impact that vacancies have within small teams. Small teams are also likely to offer fewer opportunities for career development. Relevant, too, is that most training institutions are based in urban centres.

Effective workforce planning is essential to ensuring health and social care services in Northern Ireland are sustainable and delivered to an appropriate safe standard. It is recognised as a key theme within the Health and Social Care Workforce Strategy 2026: Delivering for Our People and the recently published Second Action Plan (2022-23 to 2024-25). The aim is to develop and, by 2026, sustainably fund an optimum workforce model for the reconfigured health and social care services.

While operational workforce planning is a responsibility of employers (HSC organisations and otherwise), long-term, regional workforce planning is led by the Department of Health. It is strategic, including all of the HSC and the independent, voluntary and private sectors. The aim is to secure workforce supply across the entire HSC over a 5-10 year horizon. It is linked to, and an enabler of, the Transformation agenda. While concentrating on workforce supply, it also considers opportunities for workforce development.

All workforce planning follows the principles of the Regional HSC Workforce Planning Framework. Strategic workforce reviews involve consideration of relevant data, strategic advice and guidance documents, including agreed service delivery models and care pathways. Co-design and co-production is central to the process, with input and contribution sought across a wide range of stakeholders, including service users and carers. These are complex tasks that take time. As we move from uni-professional reviews to those that focus on all professional groups contributing to specific programmes of care, it is likely that these will take longer. Nevertheless, it is important that we invest that time to get the right information and recommendations to inform future workforce developments.

The following questions are intended to help improve rural service planning and design:

1. How well does **workforce planning** match with the evidence base about local health needs and trends? How can it ensure that any specific needs from rural locations are identified? How could monitoring of staff vacancy and turnover rates be used to gather rural data?

2. How realistic and sustainable are future workforce plans for rural parts of the area? How will those plans ensure there are professional teams with the capacity and **range of skills** to serve

across rural geographies? Is there a need to build team working or collaboration skills?

3. What options can be explored to ensure that professional staff have **career development** or progression opportunities, without them necessarily needing to move away from the area? Could this be expanded to offer some health research or teaching opportunities nearby?

4. In rural areas which have a modest resident population, but which experience a seasonal influx of **visitors or tourists**, how much variation in demand for services is experienced? What approaches could improve planning for and management of this variation?

5. What policies are in place to ensure the **wellbeing of professionals** who work in rural and more isolated settings? How accessible is support for any that develop mental health needs? Is a lone worker policy in place for staff whose jobs involve home visits or regular travel in rural areas, where a mobile phone signal may be patchy?

6. To what extent is the extra **time and cost** involved taken into account for staff whose roles involve home visits or regular travel to outlying locations and is that realistic? When such services are commissioned e.g. domiciliary care, how do contracts cover extra travel costs?

7. What training or development opportunities exist to prepare professionals, including GPs, who move into more remote areas, giving them the **breadth of knowledge** and confidence to work alone (with less access to professional back up)? How might that be improved?

8. How could rural based professionals be helped to access opportunities to maintain and update their knowledge, not least for **CPD and mandatory training**? For example, could training sessions be held at more local facilities or as outreach training on site?

9. How could valuable **networking and peer learning** opportunities be facilitated for rural based professionals, without them having to make long or time-consuming journeys? For example, can easier locations be found for face-to-face meetings and can these be supplemented by digital options?

10. What opportunities arise from the formation of Integrated Care Systems and community multidisciplinary teams to address workforce issues that are prevalent in rural areas? For example, could they assist professional networking, career development and gap filling where vacancies arise?

11. What opportunities exist to extend training and networking opportunities to those working or volunteering for organisations in the **voluntary and community sector**, that support or

complement statutory health and social care services?

12. What measures are in place to ensure that professionals moving into **agricultural areas** have sufficient knowledge of diseases most likely to be found among farming communities, such as zoonoses and farmer's lung?

- Digitally Connecting Care Homes
- Connect North Model for Social Prescribing
- Read Yourself Well
- "My Journey"
- Community First Responder Schemes
- Training GPs for rural practice in Northumberland
- Refugee doctors project in Lincolnshire

Other solutions to rural service delivery challenges could include:

- Deploying other trained health care staff into selective tasks that were previously carried out by a GP.

- Seeking to attract into vacancies in rural areas those health and care professionals who have plans to return to the workforce after a spell away.

- Development of non-salary incentive programmes to recruit and/or retain and/or deal with pressures in less popular specialties and locations.

- Develop multidisciplinary and cross-sectoral working that enables streamlining of care pathways across locations and teams.

- Addressing local gaps in specialist knowledge or experience by giving local professionals access to specialist support via digital means or telehealth.

- Making use of e-learning and distance learning approaches to improve access to training opportunities.

- Forging links with a university medical school in the region, who could offer rural skills teaching, placements or similar. Rural experience could be offered at different levels, from Foundation students to those achieving their Certificate of Completion of Training.

- Considering whether rural working can be turned into a selling point when recruiting to fill vacancies. Positives could include the rural environment, community strength and a chance to develop a broader set of medical skills.

- Putting in place buddying or mentoring arrangements for less experienced staff who may feel isolated working in rural locations. This could involve mentoring by recently retired professionals.

- Development of flexible working practices and support staff to access work remotely where possible.

NORTHERN IRELAND CASE STUDIES

Case Studies

The Recovery College

Fit:
This case study provides good practice in terms of considering rural needs:
Ref 2: making non-acute services more directly accessible to rural residents
Ref 4: enhancing the capacity of rural service delivery through collaboration
Ref 5: preventive initiatives which encourage healthy lifestyles and wellbeing

Introduction

South Eastern Health and Social Care Trust (SEHSCT) developed a Recovery College that was officially launched in March 2015. The **Recovery College** offers free educational courses about mental health and recovery which are designed to increase people's knowledge and skills and

promote self-management. Courses are available to anyone with an interest in mental health and wellbeing including: service users; family members and staff.

Context

The Bengoa report (October, 2016)[13] identified 14 recommendations for improving Health and Social Care reform in Northern Ireland. One of the key recommendations in this report is that patients should be active participants in their own care, not passive recipients. They should be treated with respect and empowered to stay healthy and care for themselves where possible. Patients should also be supported and encouraged to take greater ownership of their own health outcomes. This standard underpins the work of the Recovery College.

Practice

The College strives to support those who use or have used SEHSCT services to self-manage their own recovery and to make sense and meaning out of their experiences. The College endeavours to inspire all students to live well and make the most of their skills and talents. It provides a range of educational courses/workshops for people who use or have used services, their supporters (family, friends and carers), staff and members of the community and voluntary sector.

The Recovery College offers educational courses on mental health and wellbeing. With a focus on recovery the courses are designed to increase students' knowledge and skills and promote self-management. Using an educational approach, the College helps students to make use of and realise their talents and resources, whilst looking to the future and goal setting. Through learning together, students are enabled to make new connections, discover more about each other and continue on their recovery journey.

Each course is co-produced and co-delivered by tutors with learned experience and lived experience, each with knowledge of the subject area. Co-production is the meeting of two experts, clinician (learned experience) and service user (lived experience) each with valuable contributions to make. Together they share power, deliver and support each other. The Recovery College promotes three themes: hope, opportunity and control.

The College also facilitates short Recovery sessions (maximum of 40 minutes) on the acute in-patient mental health wards in the Trust. These sessions involve Trainers, with lived and learned experiences of Mental Health facilitating recovery programmes to students and staff on the wards. The sessions provide students with an opportunity to learn about recovery, and to begin to consider how the Recovery College can support their recovery journey within the community, upon discharge. Students are given information on the Recovery College and other supports available to

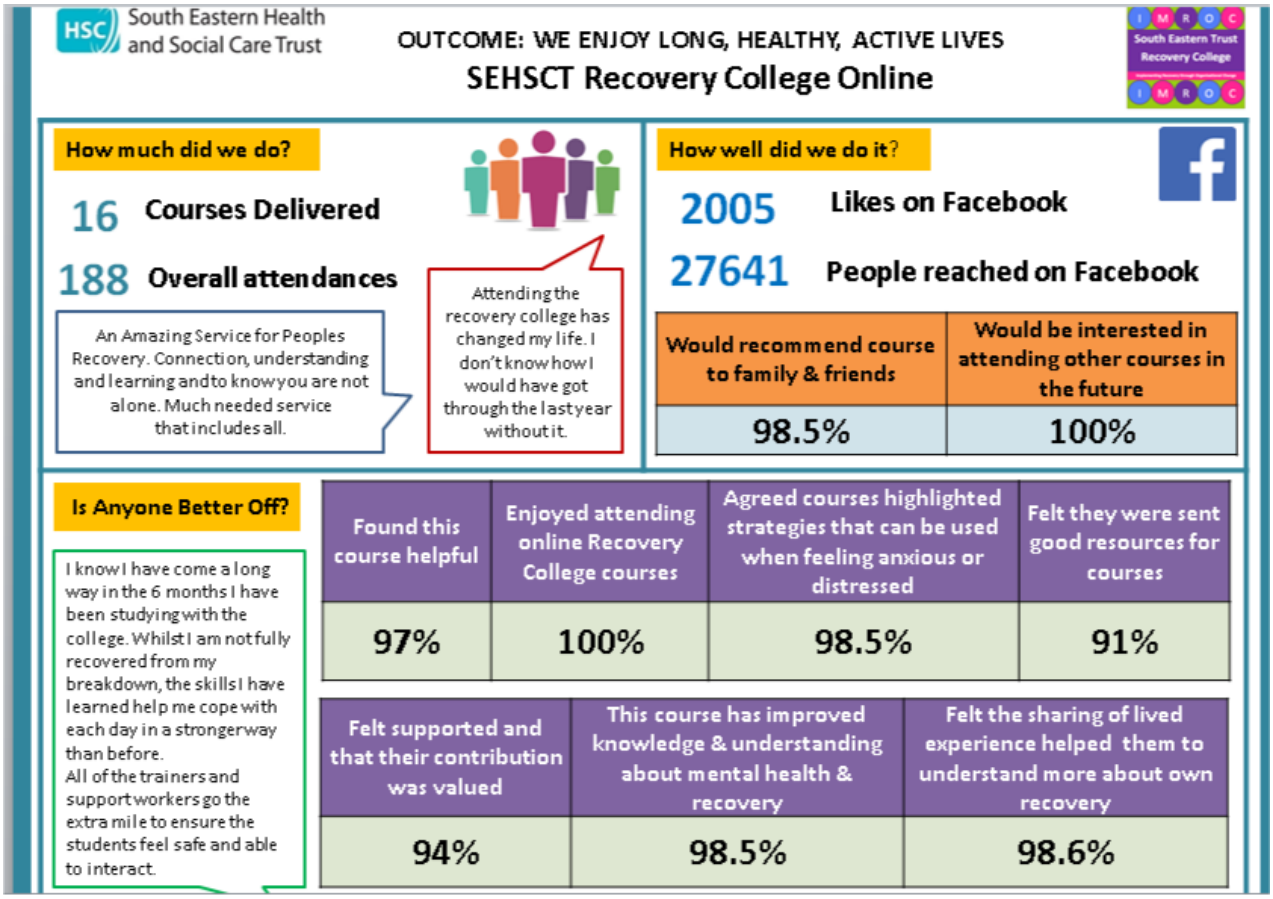
[13] https://www.health-ni.gov.uk/publications/systems-not-structures-changing-health-and-social-care-full-report

them in their communities. They are also offered the opportunity to complete a self-management plan to help them become more autonomous in relation to managing their personal Well-being and Recovery.

In response to the restrictions introduced by the pandemic several trials and pilot projects were undertaken and evaluated by staff, students of the RC and volunteers, A series of weekly webinars were introduced along with daily social media posts. One to one online enrolments and 1x1 peer support sessions have been introduced into the RC. In addition, a full suite of online courses has been added to the timetable of courses for the RC.

The Recovery College delivers a range of programmes across the South Eastern Trust area, including rural and urban locations stretching from the Ards Peninsula to Lisburn and Downpatrick. Where possible, course locations are carefully selected to ensure public transport links and good accessibility. The College aims to make courses as easy to access as possible, offering a blend of both face-to-face and online courses (introduced during the Covid-19 pandemic) and delivering courses at a range of times from morning to evening sessions.

Impact
The report card below shows feedback from users of the Recovery College between September 2021 and December 2021 (all courses were delivered online during this period).



Within the last year, the Recovery College has welcomed over 660 students to courses and engagement sessions.

Within the last 3 year period and with no additional financial resource, the RC has increased its service provision by over 35%. For example, in 2018, the RC averaged 55 group engagement sessions per 12x week period. In 2021/2022, the RC now averages 85 group engagement sessions per 12x week period. Student growth has also been identified as an outcome to the continuous improvement work in the RC. For example, in 2018, the RC provided support to an average of 110 students per semester. In 2021/2022, the RC has demonstrated an increase in student growth of 40% as it now provides support to an average of 200 students per semester.

Students report that the options available for engaging with the RC have increased their sense of control and choice in relation to their mental health recovery. Students also reported that the support offered by the RC helped them to stay connected and engaged to the support opportunities. Finally, feedback from some students, who believe that anonymity is very important for their commitment to engage in the RC, said that the digital RC model allowed them to access support without the fear of disclosing their identity to others.

Many students report that the Recovery College has bridged the gap between treatment and actively feeling a member of the community again. Students have also reported that their experience of the College has given them hope in their ability to achieve a more positive future for themselves. Furthermore, many students have reported that by being actively involved in College activity, especially in co-production, this has improved their confidence and self-esteem by developing a culture where lived experience is recognised and valued.

Another example of how new ways of working has demonstrated added value is in relation to the evidenced readiness and eagerness of students who report their motivation to further their skills to help others through the RC. 95% students report that the skills they learn through the RC have helped them to support others. Last year, 20% of students have completed accredited training courses in areas such as: Peer Advocacy; Train the Trainer; ASIST; and Safetalk. These courses form part of the pathway into paid and volunteer roles within mental health services.

“The lived experience of mental health was very useful for me, and the combination of this experience with clinical knowledge has helped me understand mental health from different perspectives” Recovery College Student

“I will use my new-found knowledge to help others” Recovery College clinician student
“Having input from someone who has been ‘through it’ was very valuable. I feel this will help me professionally with my work in mental health”

“Dealing with an illness and managing to inspire someone who has it is a lifetime achievement. You have really made a difference to me and my attitude to my condition and how to manage it. Thank you to you and your team.” Recovery College student (2022)

Digitally Connecting Care Homes

Fit:
This case study provides good practice in terms of considering rural needs:
Ref 2: making non-acute services more directly accessible to rural residents
Ref 3: services which deliver care to people at home
Ref 6: digital adoption

Introduction

The EU-funded mPower team based within the Southern Heath and Social Care Trust is working to help older people and those who have long-term health conditions and chronic illnesses to create wellbeing plans, in a bid to improve their day to day lives since 2019. mPower uses digital interventions to enable older people in remote areas to live safely and independently in their own homes by introducing them to various health and wellbeing technologies.

Context

At the outset of the pandemic, as Care Homes sought to protect residents, the mPower team was aware of the isolation and loneliness that residents would inevitably feel. Drawing on a recent consultation that the Trust's Health and Wellbeing team had carried out the month before the crisis hit, mPower devised a project to keep residents connected digitally, maintaining them Covid-19 safe and reducing feelings of isolation, something that was only going to increase once Care home doors had closed.

Project Manager Aidan McCabe said

"After speaking with just a few of the Care Homes initially, I knew the first challenge was to get the technology into the homes, many of which had no dedicated ways to get residents online. Wi-Fi was also an issue, often it was the case that it was only available in the activity room or the admin office, neither of which was practical. Many residents are bed bound but I felt this shouldn't have been something that stopped them from seeing their loved ones".

He continued "We purchased 10 devices and made them SIM enabled with pre-purchased Wi-Fi connectivity so they could be used anywhere in the Care Home and residents could have private calls with their family and friends."

Practice

The devices were cleared of all unnecessary features which might be off-putting for first time users and were pre-loaded with content and features that would be of interest and of benefit to Care Home residents, as indicated in the consultation.

Aidan explained "The results of the questionnaire showed some clear areas where people were lacking a sense of connection. The questionnaire was completed pre-pandemic so we knew that these areas would be even more appreciated in the lockdown. The devices were loaded with 5 simple folders for social and physical activities, clinical engagements and to support emotional wellbeing. The fifth and final folder was dedicated to staff to allow them to access online training and updates to regulations in a clear, simple and timely way and without having to travel."

The devices were set up to be as easy to use as possible, so that within 2 or 3 clicks a resident could access the app or tool they were intending to use. Within the Social Activity folder were all the various apps to allow video calling, social media, messaging and photo sharing. Within the Physical folder were various links to a range of physical exercises and activities, ranging from chair or bed bound sequences through to a more vigorous, catering for all levels and abilities. And within the Health and Wellbeing folder the content available related to being outdoors with live webcams to RSPB sites, Lochs and Rivers Authority, National Trust sites and a whole host of other outdoor spaces.

Because Church services had also been restricted at the time, the devices included religious content such as Scriptures as well as general library services where residents could download a whole range of books and magazines. As well as content that has been sourced specifically, residents can access music sites, Google, You Tube and all the usual internet content to enjoy, some have been listening to and reminiscing about their first wedding dance song and looking at pictures of old cars. The final folder is to enable clinicians to have interactions and appointments with residents using Southern Trust approved platforms and the team have been working hard to ensure all teams within the Trust know that this option is available to continue consultations with patients.

Impact
Aidan concluded "We are delighted that the project was literally an overnight success! Many of the Care Homes told us that after we had delivered the devices, the very next day they were being used and they didn't go off until they needed to be charged! We have just completed the 3-month review and I'm absolutely thrilled with the results that the data is showing us. At least 50% of the Care Home residents have been regularly using the devices, mostly for connecting with friends and family. We always knew it would be successful, but now we have the proof that this intervention has supported so many people through this difficult time and we know it will be successful when rolled out more widely".

Ingrid Stewart, Older Persons Lead, Promoting Wellbeing, spoke about the next steps for the project and said "We've been able to share the successful model with the wider community, not only within the Southern Trust – where 35 additional devices have been pre-loaded with the mPower content and are being distributed to all Care Homes in the Trusts area, but also with colleagues in the Western Health and Social Care Trust, HSE in Ireland and Scotland and that's creating a fantastic legacy. A huge well done to Aidan and the team, we couldn't be prouder of your work".

As of end April 2022 the project has completed 437 wellbeing plans with clients over 65 and 915 digital interventions and has exceeded targets set for it by SEUPB

…"within a couple of months of getting involved with mPower we had had our benefits reviewed and increased by almost £80 per week and backdated, a full home security assessment and lots of devices installed which gave us great sense of security, handles and rails fitted around the house and both myself and my husband now attend weekly social groups. With encouragement from mPower and help from my family and the extra money we now have I bought an Ipad which can I just say is fabulous I use it for Facebook and i do some shopping on it, I've joined the library online but my favourite is definitely Twitter , it all just there at my fingertips I can watch live videos of the grandchildren see photos and also keep up to speed on the goings on in the family as we are also on the family whats app group." 81 year old project beneficiary

For further information on the mPower project click here

Connect North Model for Social Prescribing

Fit:
This case study provides good practice in terms of considering rural needs:
Ref 2: making non-acute services more directly accessible to rural residents
Ref 4: enhancing the capacity of rural service delivery through collaboration
Ref 5: preventive initiatives which encourage healthy lifestyles and wellbeing
Ref 6: digital adoption

Introduction
The Connect North Model for Social Prescribing in NHSCT has been co-designed with service users and providers. It is reflective of the needs identified by, and expectations of, users and providers. The model builds in self-efficacy; service users can self-serve, self-refer, be supported to access services and better understand their own health and wellbeing.

Context
Providers told us that a unified directory of services and supports was essential. Of primary importance to service users was a need to know about what was available and to have easy access to it. Users also experienced confusion and frustration at being passed from pillar to post and felt it was vital to have an integrated service with an effective first point of contact to promote trust, confidence and engagement with the service. They also said it was imperative they could self-refer or refer a family member to benefit from a social prescription without the need for a 3rd party referral.

Practice
Connect North have invested in an electronic information portal to host a unified and accessible electronic directory where providers have responsibility for promoting and maintaining their own information about services and supports they offer thus optimising link worker capacity. A digital front door to this directory allows members of the public to directly access information about services and supports available with an option to self-refer. For those who aren't digitally connected or suffer poor connection due to geography this digital front door can be accessed by supportive services to provide signposting or referral into Connect North. On receipt of referral contact with the client will be via telephone, face-to-face or virtual based on the clients' preference, providing equitable access to information and supports. Promotion of the portal on relevant agency websites further increases credibility, awareness, reach and accessibility of Connect North while also creating more effective points of contact into the Connect North service.

Impact
The electronic collation of information enables Connect North to develop a robust community asset-based approach to social prescribing and build social capital by:-

- Effective signposting to ensure people can access and benefit from community-based services and activities in a way that meets their needs and expectations
- Mapping community assets and identifying gaps
- Helping and supporting local people to fill gaps based on need

Utilising technology to support social prescribing in the NHSCT provides a more flexible, equitable and accessible service, it also optimises link worker capacity to deliver client interventions. These are key enablers for our rural population to engage with positive health and wellbeing improvements through Connect North.

Farm Families Mobile Covid-19 Vaccine Pop-Up Clinics Winter 2021

Fit:
This case study provides good practice in terms of considering rural needs:
Ref 2: making non-acute services more directly accessible to rural residents
Ref 4: enhancing the capacity of rural service delivery through collaboration
Ref 5: preventive initiatives which encourage healthy lifestyles and wellbeing

Introduction
The aim of the project was to provide additional, accessible Mobile Covid-19 Vaccine Pop-Up Clinics in rural areas with low vaccine uptake within the southern sector of the WHSCT over the winter of 2021.

Context
The additional Covid-19 vaccination clinics were delivered in four rural areas in partnership with the Farm Families Health Checks (FFHC) service during October to December 2021. The four areas were agreed based on an analysis of data provided for each council area which identified the percentage of vaccination uptake per Super Output Area. The areas with the lowest uptake (less than 75%) were then selected as the four host locations for the Mobile Covid-19 Vaccine Pop-Up Clinics. These included Beragh, Fintona, Derrylin and Lisnakea.
Practice

The Health Improvement Equality and Involvement Department, WHSCT worked alongside the Public Health Agency, Fermanagh & Omagh District Council, Department of Agriculture Environment and Rural Affairs and the Farm Families Health Check (FFHC) Service from the Northern Health and Social Care Trust (NHSCT) in the planning of the project. The inter-agency agreement between the WHSCT and the NHSCT enabled two senior nurses from the NHSCT FFHC Service and their FFHC Vehicle to work alongside the WHSCT vaccination team at mobile clinics. To increase community awareness of the clinics, a press-release was shared with local newspapers, in addition to emails, social media posts and flyers advertised through various networks. Tele-calls with local community groups were also held in the week leading up to each clinic.

The success of the project was due to a combination of factors, but it started with an excellent partnership approach from all partners sets a precedent for future partnership working arrangements. Community facilities or council-owned buildings were used to host the clinics as it these were already well known to local people and reduced travel distances. The project has led to the development of a model for Mobile Vaccine Pop-Up Clinics that meets the needs of local areas/ communities and partners. Attendees welcomed the local nature and the fact that clinics were available in the evening which made it much easier for them to access the vaccine. Some of the community groups involved in hosting or publicising the vaccination clinics were unaware of the regional FFHC Service and have asked for details to book the FFHC Vehicle to come back to their area in the future for a health screening events at their premises.

Impact

As a result of the clinics being provided in local community buildings 192 participants were vaccinated at first dose clinics in October 2021 and 432 participants were vaccinated at second dose clinics in December 2021. Excellent feedback was received from participants who welcomed the opportunity to avail of vaccinations in their local rural area. Awareness of the remit of the FFHC Service was raised within these communities and positive links were made between communities and statutory partners that may facilitate future projects. Requests were submitted from two rural areas for the FFHC health screening service to come to their area.

The Multi Agency Group established to support the roll-out of Mobile Covid-19 Vaccine Pop-Up Clinics in WHSCT (FODC) council area resulted in a number of Mobile Covid-19 Vaccine Pop-Up Clinics in both urban and rural areas across the region, based on low vaccine uptake data in January 2022 to support the Covid-19 Booster Vaccination Programme. The WHSCT planned additional Mobile Covid-19 Vaccine Pop-Up Clinics based on this model in rural areas with low booster vaccine uptake during February and March 2022. This complemented larger WHSCT Covid-19 Vaccination Centres/Hubs in Omagh, Enniskillen and Derry.

‘The Farm Families Heath Checks programme, partnered with the WHSCT by using their staffing resources to assist in the delivery of 194 Covid-19 vaccinations to rural populations with low

vaccination uptake. This partnership not only enhanced future working relationships with the WHSCT and links with other agencies but also provided the communities with knowledge of the FFHC service and how they can avail of the service to enhance their population health and well-being.' FFHC Manager, NHSCT.

"DAERA were pleased to work in collaboration with partners to address an immediate need identified in a number of WHSCT rural areas. Having the flexibility to transition the services offered by the Farm Family Health Checks team has been important throughout the pandemic." DAERA

"PHA are delighted to have worked with WHSCT and FFHC on the delivery of the rural Covid-19 vaccine programme. The partnership approach has been critical to ensure that communities across WHSCT rural areas have access to the Covid-19 vaccines within their own local venues, ensuring equality of access for all." PHA.

Read Yourself Well

Fit:
This case study provides good practice in terms of considering rural needs:
Ref 4: enhancing the capacity of rural service delivery through collaboration
Ref 5: preventive initiatives which encourage healthy lifestyles and wellbeing
Ref 6: digital adoption

Introduction

In April 2018 the Northern Health and Social Care Trust and Libraries NI jointly launched the Read Yourself Well initiative in four libraries within the Northern Trust area. This set aside a space within each of the libraries to be developed providing access to a range of health books with the aim of helping people to better understand and manage their health and wellbeing using self-help reading. Read Yourself Well is an initiative being taken forward jointly by the Northern Health and Social Care Trust and Antrim and Newtownabbey Borough Council, as a partnership contribution to community planning.

Context

Titles in the range offer members of the public the opportunity to learn more about a variety of health issues including anxiety, grief, addiction, pain management and many other long-term conditions. The resources are free to access and the full collection is available for loan now at Theatre at The Mill in Newtownabbey.

Due to its success the scheme was extended to a further four libraries and is now available in eight libraries across the Trust area. The eight libraries initially identified are the largest libraries in the

Trust area as they were identified as being best placed to accommodate the additional health titles. Whilst this approach extended the reach of the initiative it was recognised that access within rural areas was a challenge and although e-versions are available on the Libraries NI website not all of the health titles are available in this format and often physical books are the preferred option.

Practice

In order to address the issue of rural accessibility the Read Yourself Well initiative has been and is continuing to be expanded to other community facilities. This has enabled access to be extended to rural communities and has ensured that the health titles are readily accessible in a wide range of locations in the centre of local rural communities across the Trust area including;

- Seamus Heaney HomePlace
- The Theatre at the Mill
- Northern Regional College libraries in Magherafelt, Newtownabbey and Ballymena
- Bushmills Community Centre
- North Antrim Community Network in Cushendall
- Vineyard Compassion in Coleraine
- Solas in Ballycastle
- Garvagh Community Building

In addition a number of further locations have been identified and plans are in place to further expand the initiative to include the following buildings;

- Antrim Courtyard
- Ballyclare Town Hall
- The Mill in Cloughmills (Cloughmills Community Action Team)
- Millennium Centre in Loughgiel
- Tilly Molloy's Centre (Armoy Community Association)
- NRC library in Coleraine
- The Prom Café in Larne Leisure Centre
- Oakfield Community Centre in Carrickfergus
- Blessings Café in Cullybackey

Mid and East Antrim Borough Council are also planning to identify a further five community locations/venues. Following the recognition that the Read Yourself Well initiative didn't meet the needs of people in more dispersed rural communities the extension and the further planned expansion has been instrumental in addressing this imbalance whilst also supporting and enabling the success of the initiative to be built upon.

Impact
"The Northern Health and Social Care Trust is committed to contributing to community planning and is delighted to have worked closely with Antrim and Newtownabbey Borough Council to support the expansion of the Read Yourself Well scheme to a community setting. This new collection offers free access to a wide range of health and wellbeing information for people to take away and read at a time that suits them." Hugh Nelson Northern Health and Social Care Trust

"On behalf of the Council I welcome this partnership initiative which aims to improve the health and wellbeing of our residents through better access to helpful, trustworthy and supportive books on a wide range of conditions. This should be of great help to many people and I would encourage everyone to use these free resources." Councillor Billy Webb MBE JP Lord Mayor of Antrim and Newtownabbey.

My Journey

Fit:
This case study provides good practice in terms of considering rural needs:
Ref 2: making non-acute services more directly accessible to rural residents
Ref 4: enhancing the capacity of rural service delivery through collaboration
Ref 6: digital adoption

Introduction
My Journey is a project co-led by Chris Smyth (Head of Specialist Services in Estates) and Dr James Nelson (Psychiatrist and Chief Clinical Information Officer) run from the Northern Health and Social Care Trust. This is a pilot project using podcasts, video and webinars to give high quality health information to patients, service users and residents in the Northern Trust area. Year 1 of the pilot ran from April 2021 to March 2022 and work is ongoing for a phase 2, due to start later in 2022.

Context
The pandemic severely impacted some Trust services and there was a need to provide high quality, trusted health information to our local population. It was identified that some information was repeated over and over again at individual appointments, and that it could be more efficient and helpful to present this in a pre-recorded digital format. The Trust had access to ZOOM software which includes the ability to run webinars, either as live events to groups or 'on-demand' where users can access relevant material at a time and place more convenient to them. These have been used to great effect for some services. Video production is also being explored as a way in which trust services can communicate highly visual material that will support users' care journey.

Practice
The project assigned one staff member to work on this full time throughout the pilot. They worked alongside clinical teams to design, produce and publish high quality health information, making this available on our Trust website and other platforms such as the podcast services Spotify and Google. The project has developed a range of patient information sessions via zoom with positive feedback, and have published a variety of videos, including a series of professionally recorded videos from the Specialist Occupational Therapist (OT) in our autism service, teaching families about sensory difficulties. These are available on our Trust website: https://www.northerntrust.hscni.net/services/autistic-spectrum-disorder-asd-services/paediatric-asd-services/asd-services-children/. The autism podcast series is available here: https://podcasts.apple.com/gb/podcast/exploring-asd-with-the-northern-trust/id1552605422 and has had more than 4000 listens with very positive feedback. The project recently launched a youth mental health podcast series which has had 1500 listens. It is available here https://podcasts.apple.com/us/podcast/youth-mental-health-with-the-northern-trust/id1588059161

Impact
The service has been well received by both staff and service users. Service users like having ready access to high quality, detailed health information at a time that suits them.

"It was very reassuring hearing other people calmly discuss some of the issues I've been facing, especially since they clearly know what they're talking about."
Autistic person

"I have an older child with ASD and a 3 year old awaiting assessment. These are issues we are having with our 3 year old. We've been begging for help. Health visiting have a behavioural programme which has been of no use but this podcast gives us some really helpful ideas and tips and understanding of what could be setting her off!"
Parent/carer to an autistic person

Community First Responder Schemes

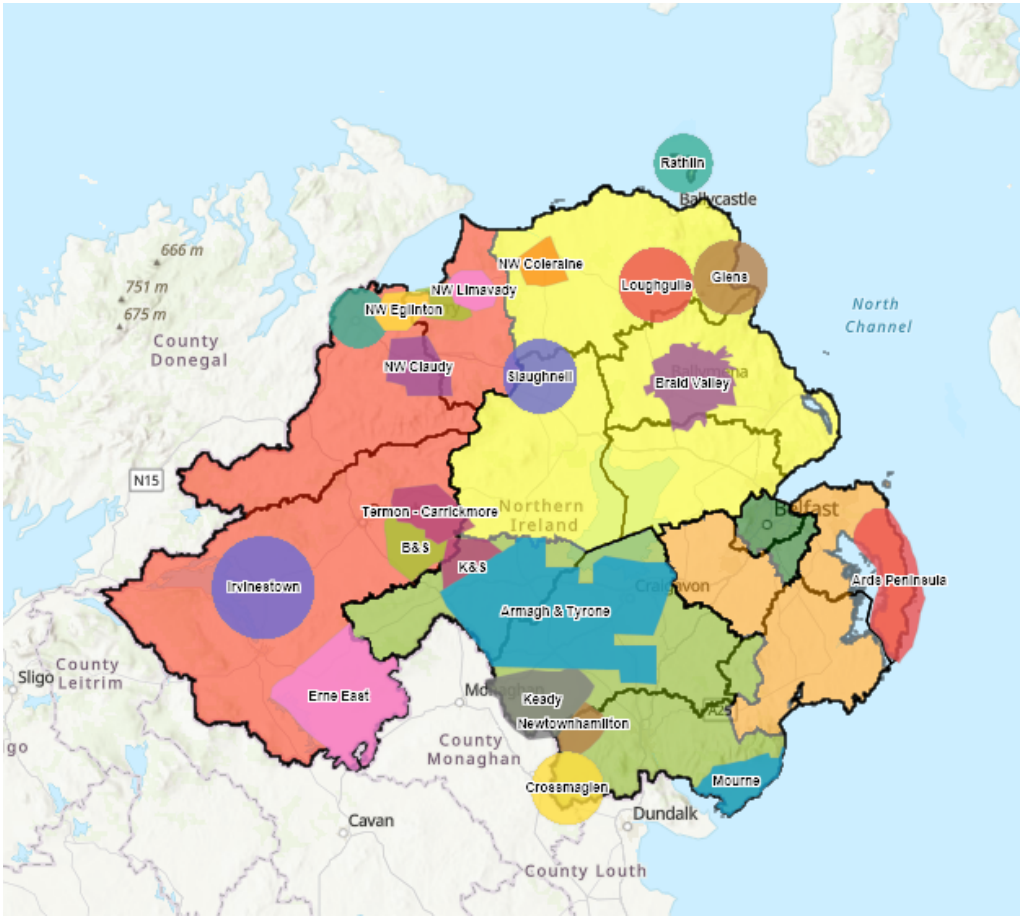
Fit:
This case study provides good practice in terms of considering rural needs:
Ref 1: extending services based at acute hospitals
Ref 4: enhancing the capacity of rural service delivery through collaboration
Ref 6: extending rural workforce through engagement of the VCS sector

Introduction
Community First Responder Schemes are made up of volunteers who live within their local community. Community First Responders are alerted to specific 999 emergency calls in their area

by the Northern Ireland Ambulance Service Health and Social Care Trust, and are complementary to the emergency services provided by the Trust. Their aim is to reach a potentially life-threatening emergency in the vital first few minutes before the arrival of an ambulance crew. They are able to provide basic emergency life support and use a defibrillator if required. Community First Responders are a complementary service and are alerted in addition to an ambulance.

Context

There are 18 Community First Responder Schemes with over 300 volunteers in Northern Ireland, many of which are based in the most rural communities such as the Mournes, the Ards Peninsula, and the Glens of Antrim.



Locations of Community First Responder Schemes

The chance of surviving an out of hospital cardiac arrest (when a person's heart stops and they stop breathing normally) decreases by approximately 10% for every minute that passes without cardiopulmonary resuscitation (CPR). There are around 1500 out of hospital cardiac arrests in Northern Ireland per year where resuscitation is attempted. Of these, 84% happen in the home where there may not be someone who knows how to provide CPR or have a defibrillator close by. In

these circumstances it is vital to get basic emergency life support to the patient as quickly as possible. Community First Responders who live in the area can be on scene within minutes and make a real difference before the ambulance arrives.

Due to the geography of Northern Ireland, people who live in rural areas can experience longer ambulance response times, and in these areas there is a need for local responders to provide early assessment and intervention until advanced care arrives. Community First Responders can improve the patient's chance of survival, using their skills to play a vital role within their communities, and sometimes can be the difference between life and death.

Practice

Community First Responders are usually alerted to incidents that are considered to be potentially life-threatening medical emergencies. Examples of calls Community First Responders are alerted to include people:

- in cardiac arrest—unconscious and not breathing;
- with chest pain who may be having a heart attack;
- who are choking;
- who are unconscious for an unknown reason but are breathing normally; or
- who are potentially suffering from a stroke.

Members of some Community First Responder Schemes also attend people who are experiencing a seizure or breathing problems. Community First Responders are not knowingly alerted to:

- calls where the patient is under 12 years old;
- trauma-related incidents, i.e. road traffic collision;
- calls that present possible hazards such as those involving alcohol, drugs or potential violence; or
- calls where the patient is suffering mental health issues.

Community First Responders use their own vehicles to respond and they must follow the rules of the road with no exemptions. They do not use blue lights or audible/visual warning devices of any description, as it is illegal to do so. Alongside emergency life support, Community First Responders also play a vital role in the provision of much needed reassurance and support to patients and relatives during very difficult circumstances, which can prove invaluable.

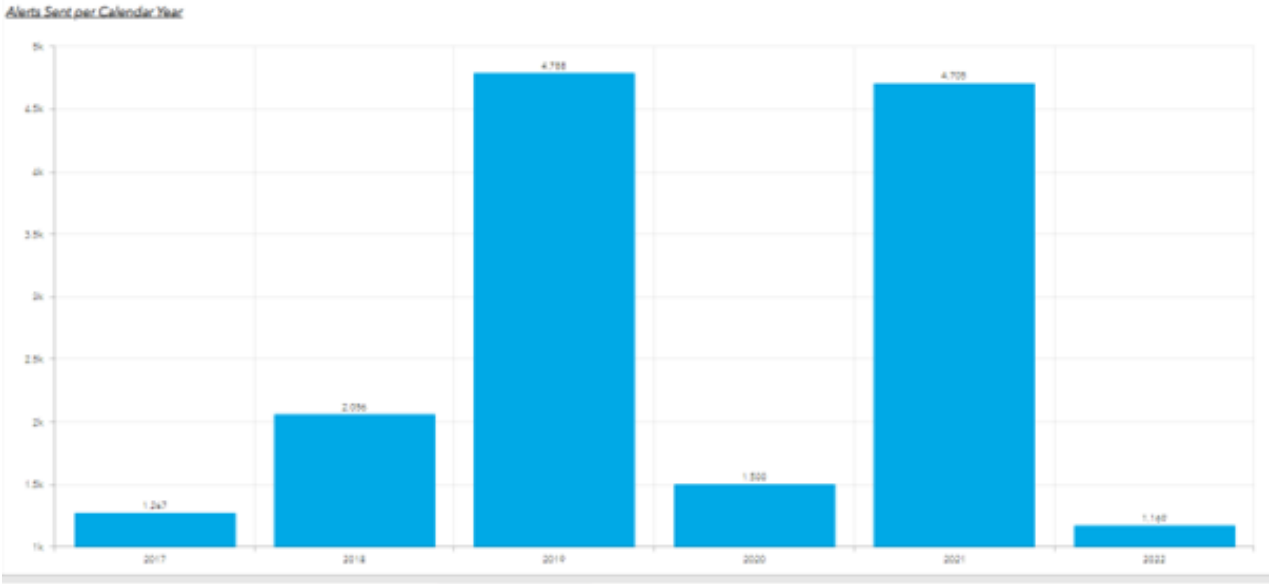
The Trust does not govern or fund Community First Responder Schemes, but provides:

- clinical guidance and training;
- support to set up and maintain a scheme;
- support to alert volunteers and troubleshoot; and
- emotional support (post-incident).

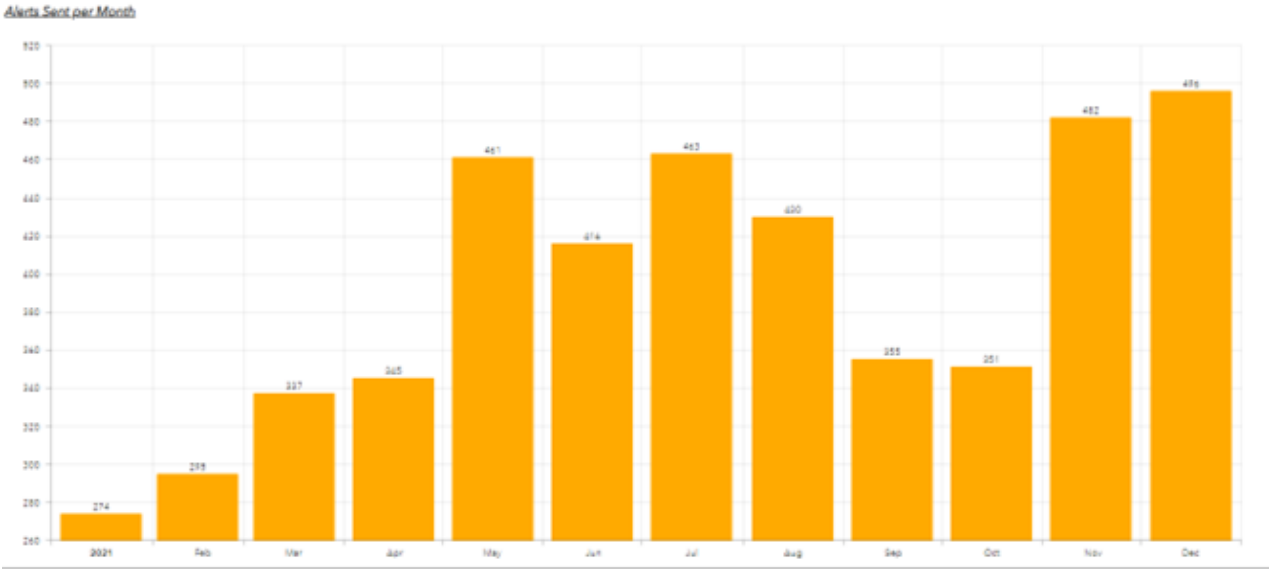
Community First Responder Schemes are set up as independent community groups or charities. An independent charity or community group co-ordinates the Schemes. Community First Responder Schemes are required to have a Co-ordinator as a point of contact for the volunteers, and to act as a liaison with the Ambulance Service. Stephanie Leckey, Community Resuscitation lead with NIAS, said 'Community First Responders are a vital link in the Chain of Survival and can be quite literally the difference between life and death'.

Impact

CFR alerts sent per calendar Year (note in 2020 CFRs were all stood down in March and not reactivated until Mid Oct 2020)



Total number of alerts per month for ALL Schemes in 2021



“The CFR team who had arrived on scene (Paul, Janine & Cathy) were all pro-actively carrying out CPR and gaining a good history of what had happened on my arrival. This allowed me valuable time to prepare my PPE, but also grab most needed equipment from the Rapid Response Vehicle (RRV). They did a fantastic job, not only at rotation of CPR, but also in assisting me with airway equipment, and undoubtedly securing a good airway on the patient- including bringing more equipment to the scene from the RRV. Assistance was also given to allow efficient administration of fluids.

Having the team there to continue the CPR allowed me to then gain IV access and begin Advanced Life Support (ALS) protocol. Return of spontaneous circulation (ROSC) was achieved on a number of

occasions, and I have no doubt that the patient achieved this ROSC through the great effort of CPR from the team, and therefore allowing free hands for some other procedures to be carried out. CPR was only part of their valuable presence, as they also provided great scene safety/control with by-standers and family who turned up. I am unfortunately unsure of the outcome at the moment, but I have no doubt that due to the actions taken by the CFR team, every chance was offered to the patient at the time." (Rapid Response Vehicle Paramedic)

Farm Families Health Checks

Fit:

This case study provides good practice in terms of considering rural needs:

Ref 2: making non-acute services more directly accessible to rural residents

Ref 4: enhancing the capacity of rural service delivery through collaboration

Ref 5: preventive initiatives which encourage healthy lifestyles and wellbeing

Introduction

Farm Families Health Check Programme (FFHCP) is a joint initiative between the Public Health Agency (PHA) & the Department of Agriculture, Environment and Rural Affairs (DAERA) with the overall aim being "to improve the health and social wellbeing of rural farmers and farm families in Northern Ireland by increasing local access to health screening services by providing health related advice and information, and to signpost to existing services for further advice and support". This is achieved through promotion and advertisement of the service to farming/rural communities for the provision of health checks and advice; onward referral and sign-posting to relevant services and engagement with agri-food sector, community, voluntary and statutory organisations.

Context

The programme is now in its eleventh year of service provision, initiated in 2012, and is embedded within the rural and farming communities. It is an accessible and necessary service which aims to alleviate health inequalities experienced by those living in rural/hard to reach areas. This service is specifically targeted to rural dwellers in order to address the health needs of the wider farming community who are recognised as particularly susceptible to poor health and wellbeing. The Health check provided by Farm Families offers a holistic overview of client's health.

Hazards associated with farm work include: accidents[14]; stress and mental health problems[15], and musculoskeletal disorders[16]. Many of these conditions affect farmers and farm workers to a greater

[14] Northern Ireland Farm Safety Partnership survey 2019 (hseni.gov.uk) ; The Farm Safety Partnership | Health and Safety Executive Northern Ireland (hseni.gov.uk

[15] Farmers and mental health - Research Matters (assemblyresearchmatters.org)

[16] [Musculoskeletal disorders in farmers] - PubMed (nih.gov)

extent than the general population (Brumby, 2006). This includes occupational diseases caused by, aggravated or exacerbated by workforce exposure. Farmers working long and anti-social hours and face greater isolation exacerbated by the rural setting as their presence is often less visible in rural communities. People in rural areas tend to come from a culture of self-sufficiency and there is a reluctance to seek outside help. Social factors around fear over confidentiality in small communities can also prevent individuals from making use of services. Stresses are magnified by isolation, single worker situations (farmers), a lack of knowledge about services and difficulty accessing them.[17]

The availability and range of services are limited in rural areas in comparison to those provided in towns and cities. A change in the nature of healthcare provision has also occurred, and recent policy developments have led to the centralisation of healthcare services. Rural communities have witnessed closures of acute hospitals as a result of resource constraints and the need to provide safe, high-quality care. This has reduced access to numerous types of care such as the availability of primary care services; pharmacies, G.P. and dental practices and community-based services

Practice

Health checks are delivered by trained nurses in a bespoke van with two private treatment rooms and a waiting area. The van attends farmers' marts and rural community events, bringing the service to the target clientele. The incidence of Type 2 Diabetes is on the increase and could be delayed or prevented through screening, such risk is assessed along with cholesterol, blood pressure, weight, height and waist circumference and advice tailored to needs of the client, given accordingly, by highly training nursing staff. There is also an opportunity to discuss any worries or concerns about stress or mental health. With farmer's working outdoors, often for long hours and without skin protection, they are exposed to high levels of UV, increasing their risk of skin cancer, clients are given advice on how to protect themselves. Clients are also reminded of any screening available to them according to their age and gender. Guidance around alcohol misuse and smoking cessation is given alongside other areas of concern as arises.

As a result of these health checks, clients may be advised to see their GP or signposted to other services (including Rural Support, Farmsafe training, smoking cessation services etc.). Nurses also provide lifestyle advice tailored to the client's needs as are assessed at visit. A follow up phone call (within 3 months) is provided to all clients who have been asked to see their GP to encourage those who haven't made an appointment to do so, or to reinforce health messages given.

Impact

FFHCP is delivered by the Northern Health and Social Care Trust (NHSCT) staff on a regional basis. To date over 21,000 clients have accessed the programme. FFHCP has been extensively evaluated in 2016 & 2019. Evaluation reports were positive in terms of confirming that the objectives of the

[17] Institute of Health Research and Innovation - Rural Health and Wellbeing (uhi.ac.uk)).

original business case were either met or surpassed. The 2019 evaluation showed that of clients seen by the Programme at that time:

- 52% were farmers
- 15% were farm family members
- 34% were Rural dwellers

To date of 21435 clients who have accessed the Programme, 9365 were referred to their GP. "When I attended the FFHCP, a health issue was identified and I was referred to my GP. The health check prevented me from developing a more serious health condition and I will be forever grateful." FFHCP client

"We all know farmers work long hours, often isolated and lonely not taking time to look after themselves- we at Farm Families Health Checks can reach these farmers and provide them with health screening with onward signposting and referral through the mobile clinic" Christina Faulkner FFHCP Co-ordinator

Early and timely interventions provided by FFHCP are critical in identifying clients who are pre-diabetic, have high cholesterol or those with high blood pressure. By doing so, this gives the client the opportunity to make lifestyle changes and obtain further medical interventions. This prevents more serious long-term health issues and complications which would negate the need for more aggressive and costly health care. FFHCP allows for personal connections and signposting between rural dwellers and service providers, both of which are very important.

Community Support Hub Pilot

Fit:
This case study provides good practice in terms of considering rural needs:
Ref 2: making non-acute services more directly accessible to rural residents
Ref 4: enhancing the capacity of rural service delivery through collaboration
Ref 5: preventive initiatives which encourage healthy lifestyles and wellbeing

Introduction

The Fermanagh and West Tyrone Pathfinder was established in 2018 to consider how sustainable health and social care services could be provided for people in the Fermanagh and West Tyrone area in light of ongoing workforce challenges in the rural geography. The Pathfinder programme placed strong emphasis on ensuring the user's voice is heard because users need to play a key role in developing and implementing new service and care pathways.

Context

At the community engagement events attended by the community, health professionals, delivery organisations, the WHSCT, PHA and FODC the following issues were common in each DEA:

- Access to Services,
- Health Literacy/Education and Wellbeing,
- Physical Health, Mental and Emotional Wellbeing,
- Family Support and
- Poverty.

One of the actions from the consultation exercise was to develop the concept of Hubs. At both the workshops and during the Covid meetings there was continued request to integrate, connect and enhance community hubs. This would encompass all sectors involved in service provision and provide ease of access to information avoiding duplication.

Practice

The Community Support Hub pilot is being co-produced with service users and providers. We will build on our existing good practice in co-production and partnership working to establish a hub impacting on a population challenged by the negative health impact of having some of the most deprived areas in the UK. We are involving as partners those who are already working with some success to address challenges relating to population health, both the preventative side and those at risk of developing multi-morbidities.

The hub will be piloted in two areas, Omagh and Erne East which will build on our: regional identity; integrated Health and Social Care (H&SC) system; less competitive health economy and the fact that co-production and collaboration is at the heart of all our best work.

This pilot project aims to enhance the collaboration in service provision, and to learn from the experience to enable district wide provision in a way which meets the ever demanding needs of the community.

The Community Support Hub is a central point of contact providing co-ordinators to:

- Develop community infrastructure to enhance health and social wellbeing and support those with or at risk of developing multi-morbidities.
- Work alongside existing services to co-ordinate, integrate and provide quality services to adults aged 18 plus who are in need of advice and support and do not meet the criteria for statutory social services provided through the Western Health and Social Care Trust (WHSCT).

Co-ordinators will be employed to ensure the most efficient service delivery model in terms of referrals to and from the Hub. The Co-ordinator will work alongside the service user and existing services to ensure an integrated and co-ordinated approach to support plans.

Impact
The aims and objectives of the hub:

- Increase knowledge of current services available in these areas
- Engage partners - actively involve Communities working together on Prevention & Intervention locally
- Locally owned Action plans for the 2 pilot areas (Omagh/Erne East)
- Map current services and gather information on unmet need
- Develop a coordinated and strategic approach to existing health and wellbeing provision
- Promote equity and equality of services
- Increase access to multidisciplinary teams
- Increase knowledge of and provision of Community based education, awareness and activity programmes
- Collaborative approach to data intelligence for planning of future services

Community Cardiac Service Project

Fit:
This case study provides good practice in terms of considering rural needs:
Ref 1: extending services based at acute hospitals
Ref 4: enhancing the capacity of rural service delivery through collaboration

Introduction
Community Cardiac Services:
There has been a 67% increase in requests for cardiac investigations in the past decade.
This is set to continue as several hospital departments such as The Emergency Department (ED) and Acute Assessment Unit (AAU) seek faster turn-around times.
Open access GP referrals minimise unnecessary emergency referrals. The GP can commence management of Heart Failure patients' earlier thus avoiding hospital admission.

Context
As a result the EU Acute INTERREG VA Project funded a Community Cardiac Investigations Service in Sligo and South Fermanagh which was introduced in November 2018. This project resulted in the setting up of a Community based Cardiac Investigation Service on four sites. To date this project has completed diagnostics on 778 unique patients (13 months of 24-month project complete).

The project targeted the elderly frail patient in remote areas who either was unable or had difficulty in travelling to the acute hospital. It focused on patient flow, to improve access for patients through the Emergency Department (ED) and Acute Assessment Unit (AAU).
It aimed to reduce bed days and facilitate earlier treatment to improve outcomes for patients. It was hoped that this would then lead to a reduction in Did Not Attend / Could not Attend rates

Practice
The EU INTERREG VA funding stream has provided an opportunity to create a Community Cardiac Investigative Service in both NI and RoI. The demand for these investigations is increasing year on year yet capacity within the hospitals remains the same. In order to address this growing problem the project has introduced a structure to allow these investigations to be carried out in an appropriate community setting for low risk patients. This will enable more capacity for complex testing in an Acute site and enhance the ability to carry out tests in a much more timely way for inpatients (3 day wait reduced to 1 day waiting time). This, in turn, will improve the availability of beds in hospitals as patients can be discharged earlier as all tests will have been completed and clinical decisions made. It is envisaged this service will improve the efficiency of this stage of the patients' pathway through the hospital impacting on the overall efficiency of the hospital.

Impact
The project has funded one Senior Cardiac Physiologist and an administrative support. In addition it has funded a portable scanner and a number of Holster monitors. To date attendance rates at these community-based clinics has been 98% compared to 84% when patients have to travel to an Acute Hospital. The service will be monitored monthly to ensure all the key performance indicators are achieved.

- Improved access and waiting times for GPs in community based cardiac investigations. Echo waiting list reduced from 16 weeks to 4 weeks.
- Reduction in time waiting for inpatients in accessing Cardiac Investigations from 3 day wait time to one day wait.
- Reduction in waiting times from ED/AAU in accessing investigation procedures by prioritising these patients for same day discharge.
- Reduction in hospital LOS
- Reduction in numbers of inpatients who have been discharged without receiving investigation procedure.
- Increase in overall activity levels in accordance with plan 30% OPD, 70% inpatients

Patient Flow Outcomes
- Prior to this project an average of 8 inpatients had to wait more than 3 days for an echocardiogram.

- Bed-day saving of 24 bed days per week-86 per month and 1032 days per year.
- Costing at €922 per bed day... Potential saving of >€950K per year
- Reduced numbers of patients accommodated on Trolleys

Regional Workforce Wellbeing Website

Fit:
This case study provides good practice in terms of considering rural needs:
Ref 5: preventive initiatives which encourage healthy lifestyles and wellbeing
And specifically addresses the key area of workforce

Introduction
This is a partnership project between the Regional Workforce Wellbeing Network, which has representation from the majority of the 16 Health and Social Care (HSC) organisations in Northern Ireland organisations and the wider health sector in Northern Ireland, and the HSC Healthier Workplaces Network with the outcome being the development of a Regional HSC Staff Wellbeing Resource website that was launched in April 2022.

Staff wellbeing is a key priority within the HSC Workforce Strategy. COVID has placed significant added stressors for the HSC workforce and ongoing stressors and challenges exist for staff working across the wider Health and Social Care sector in the day-to-day delivery of health and care services. The website offers the opportunity to share members' expertise and resources. Use of the website as a means of hosting and providing health and wellbeing resources ensures the wellbeing of professionals who work in rural and more isolated settings. Remote delivery also ensures that support is accessible as required by the staff group regardless of their home location.

Context
The importance of HSC staff health and wellbeing has long been noted – it is implicated in issues of recruitment, retention, absenteeism and presenteeism. Both staff safety and staff wellbeing also have clear implications for patient care and patient experience.

The Regional Workforce Wellbeing Network was set up in April 2020 with a mandate to maintain a focus on supporting the wellbeing of Health and Social Care (HSC) staff, during the COVID-19 pandemic response and beyond.

Work challenges include, working in PPE, working in new environments due to redeployment and workload pressures affecting their care of patients. Restrictions on family contact for patients and concern for patients not able to access their normal care has added to the pressure on staff. In

addition, frontline staff have faced major concerns for their personal safety and that of their families.

HSC is trying to resume access to normal services, whilst still dealing with the pandemic and this places substantial additional burdens on staff. Rebuilding and restarting services is important for population wellbeing, but alongside this task there is an imperative to ensure that HSC staff are given opportunities, time and resources to recover from the challenges of dealing with the pandemic.

Practice
The website hosts a library of resources, including distance learning opportunities, easily accessed using a search tool. HSC Staff and their families can search for publications, websites links and videos relating to support for example, mental health, grief and bereavement, self-care, dealing with stress and anxiety, domestic abuse, children and young people, families, healthy eating, home working, learning and much more. A Recovery Toolkit for staff has also been developed to ensure this is prioritised within organisations and also to help teams to have conversations about their needs moving forward post pandemic.

Impact
This is a newly launched website in 2022.

Using the internet as a mechanism for information delivery is a particularly appropriate choice in Northern Ireland where 38% (Census 2011) of the population live in rural locations. In Northern Ireland, for the latest dataset available on NISRA (2018), 16% of households had no home broadband and 15% had no home internet access. These households will not be able to avail of services being delivered remotely using this website. In addition. the OFCOM Connected Nations report (2019) acknowledges that more work is needed to improve services in rural areas where some customers who do have access to broadband experience slower speeds that in towns or cities and, further, that 19% of rural dwellers are unable to receive decent broadband. As mitigation, staff can choose to access this website either at home or at work. Accessing the website while at work minimises potential accessibility issues in respect of broadband availability or connectivity that could be a challenge for staff living in rural locations across Northern Ireland.
Currently the resource library contains 176 separate resources covering articles, short courses, video information and links to relevant websites.

There is a dedicated feedback mechanism via email to enable staff to provide any comments on the website or ways it can be improved or to request more information.

Staff retention should be maximised and absence from work minimised if staff health and wellbeing is positively addressed by this resource.

Homecare Optimization Programme

Fit: This case study provides good practice in terms of considering rural needs:

Ref 2: making non-acute services more directly accessible to rural residents
Ref 3: That services which deliver care to people in their own homes need to be designed so they work for people in outlying or harder-to-reach locations (whilst retaining the care time made available).
Ref 7: That workforce planning needs to be alive to issues arising in rural locations, including at smaller hospitals, such as recruitment or retention issues and access to professional training.

Introduction

Homecare Optimization commenced in 2018/19 as part of the Trust's Delivering Value strategic priority. The key objectives of the programme are;

- To increase accessibility of safe, effective, affordable homecare services across the Trust in both urban and rural areas.
- To ensure sustainability of homecare services across the Trust particularly in rural areas.
- Realignment of services, reducing overall mileage undertaken each day by staff, additional time used to provide service user care rather than undertaking travel.
- To ensure Homecare services are deployed in a cost effective manner

Context

Initial progress was made in 2018 / 19 unfortunately the programme was interrupted due to Covid-19. However it has since recommenced with significant progress being made this year with a planned completion during 2023.

Practice

The Western Trust's Homecare services are delivered via a mixed economy, 75% independent sector and 25% in-house. The service delivery model is made up 65% guaranteed Block contracts supplemented by 35% spot purchase. The service is delivered to individuals across all community Directorates. The objective of this programme is to optimise the use of the Block contracts, in doing so this will increase care contacts, reduce overall spend and increase available capacity.

It is important to emphasise that this is NOT about reducing service provision but reconfiguring and maintaining the delivery arrangements for existing services whilst increasing capacity and delivering financial savings. This is achieved by;

- Consolidation of the Service within a locality
- Reconstructing service delivery to eliminate inefficiency
- Clustered Provision to Reduce Travel

- Matching Planned Activity to Actual Activity – Evidence Based
- Natural efficiencies without reducing care for any individual
- Partnership working with Homecare providers

Impact
The programme has been fully implemented in the Enniskillen and Irvinestown localities as at May 2022, as well as being partially implemented in the Cityside, Waterside and Strabane localities.

A review of the outcomes from Enniskillen and Irvinestown indicate that the key objectives listed above have been achieved. Some of the key performance indicators include;

- 122 new Homecare referrals accommodated from within existing resources
- 1141 additional weekly hours of care accommodated
- Reduction of 332 weekly Spot hours
- Improved retention of care staff reported by Homecare providers, realignment of services significantly decreased overall mileage undertaken by staff especially evident in rural areas.
- Additional capacity generated to accommodate future care demand. This additional capacity could now be used to target difficult to source care packages for service users in rural areas where previously, due to limited care capacity, the full care package may not have been sourced to meet assessed needs.
- Reduction in the numbers of patients from Enniskillen & Irvinestown localities delayed in hospital due to inability to access homecare [as at June 2022]

Quotes from partners

Social work manager – "the success of the Homecare Optimization programme has meant we have been able to secure care for a large number of individuals, many of them with complex needs to enable them to be supported at home"

Homecare Provider –"the reform in Enniskillen and Irvinestown went better than I imagined. It has helped to address many of our operational challenges. I now look forward to it being extended across the rest of Fermanagh"

Service User's family member – "mum has been in a nursing home in Omagh for the past 10 months because we couldn't get a homecare package for her. She has been really anxious to get home but I was giving up hope. I am crying tears of happiness now that I have been told that care has been sourced for her"

Homecare Worker – "these changes make a lot of sense. My work is centred on a smaller area which means I don't have to travel as much"

WIDER UK CASE STUDIES

Supporting high intensity users of NHS services in Cornwall

In common with many areas, NHS Kernow – which covers the mainly rural geography of Cornwall and the Isles of Scilly – is aware that a small number of service users account for a disproportionate number of avoidable, unscheduled contacts, such as visits to A&E and 999 calls. This scheme seeks to explore and address the underlying reasons behind this high intensity use, by using a whole person approach.

In late 2018 Volunteer Cornwall was commissioned by Kernow Clinical Commissioning Group to deliver support for high frequency users of ambulance services, emergency departments and other NHS resources, in order to reduce pressures on the NHS in Cornwall and to improve individual wellbeing.

The scheme became operational in January 2019, initially with a single co-ordinator post. Two additional co-ordinators joined in early 2020 and a further co-ordinator appointment is planned (in 2020) with service partners Portreath, who are a mental health charity.

Through the High Intensity User service (HIU) co-ordinators work one-to-one with frequent users of NHS services to help them access alternative support. Clients are typically very vulnerable and can sometimes be quite challenging. Although many have little faith in statutory services, individuals are often more willing to trust the voluntary sector.

"Coordinators listen to the needs of the service users with a friendly approach, supporting them into finding solutions to their issues, aiming to reconnect them back to a better life, to their families, to their communities and often helping them to access the appropriate services in a less chaotic style."1

The county-wide scheme sought to identify the top 50 users of health resources and it works "down from the top of the list". Initially, referrals came mostly from South West Ambulance Trust, but difficulties in obtaining timely information led to a change of approach.

Now the focus has switched to the most frequent attenders at hospital emergency departments. To enable this to work an honorary NHS contract allows HIU staff to access appropriate data. The scheme is now in discussion with Clinical Directors at the area's Primary Care Networks so it can engage more widely with GPs.

The large geographical area of Cornwall presented another challenge to the scheme. Initially, based on similar schemes in more urban locations, it had been hoped to engage with up to 50 clients in the first year. However, it soon became apparent that this was unrealistic given the considerable distances and travel times between clients. To minimise this constraint the scheme now operates with co-ordinators who each cover a specific part of the county.

Typically, co-ordinators work intensively with clients and their families for around 6 weeks and then seek to gradually withdraw support. During the first year of the service, the scheme supported people into volunteering, clubs, gym-on-prescription, social prescribing, detox, new accommodation, debt support, court support, house clearing, walking groups, growing clubs and more.

The financial benefits of the scheme have been substantial. Between January 2019 and February 2020 the scheme had engaged with 37 clients at a total cost of £49,000. Savings generated totalled £295,000 and the client usage costs of health services were reduced by 58%. Those savings comprised:

- 276 fewer ambulance trips;
- 212 fewer emergency hospital attendances;
- 103 fewer non-elective admissions; and
- 192 fewer hospital bed days.

Clients have also reported huge benefits to their personal wellbeing.

> "If I never had Nat to help me, I would not have come this far. My boys are also receiving support and it has helped them a great deal. Since Nat I've joined Tae Kwando, that Nat got funding for, I also do more with the boys and am less anxious and engaging with people a lot more. I go out more and am meeting new people."1

Appointing the right people as co-ordinators has been crucial to the success of the scheme. They need the right balance of empathy, strength and determination or "a cross between an angel and a Rottweiler" as one client described the co-ordinator who helped him.

As well as expanding the current scheme, work is underway to collaborate more closely with GPs in the hope that working with high intensity users of primary care may help address clients' problems at an earlier stage.

Source:
1. https://volunteercornwall.org.uk/how-we-help/health-social-care/integrated-care-system/hiu-service

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'Near Me' delivering remote care in NHS Highland, Scotland

'Near Me' video consulting is transforming the way that people are accessing health and care services in Scotland. It is now used in every NHS Board area in Scotland and is being expanded to care services. In 2019 it received the Institute for Healthcare Improvement (IHI) Lucian Leape Institute Medtronic Safety and Culture Technology Innovator Award for improving patient safety through the successful implementation of technology and culture change.

Prior to the 'Near Me' scheme being introduced, many patients, particularly those in the most rural parts of the country, faced long, inconvenient and sometimes challenging journeys to attend hospital outpatient appointments. For example, a patient otherwise having to travel from Caithness to hospital in Inverness would face a round trip of over 200 miles. The project addresses such access issues by delivering convenient person-centred care, with outpatient consultations being delivered either at a patient's home or at a local clinic. Other benefits include the ability of clinicians to work remotely and a reduced carbon footprint.

'Near Me' is powered by the 'Attend Anywhere' platform, which the Scottish Government procured for use across Scotland. Early use was largely limited to rural areas, especially in the north of Scotland in NHS Highland and NHS Grampian.

'Near Me' was the service name picked by patients in the Highlands, where the first test clinic opened in January 2018. It was then rolled out across the health board area through 2018 and 2019. Funding came from NHS Highland (for salary costs) and from the Scottish Government Technology Enabled Care Programme (for equipment and estates). There was also a small grant from the Health Foundation towards the co-design work.

In order to use the 'Near Me' service at home patients must have internet access and an appropriate device for making a video call. Not all patients have this and the constraint was addressed in Highland by the provision of a network of 15 clinic rooms located in rural areas, where people can use health service devices. In some cases, the clinic rooms are supported by a local health worker who can offer checks, such as those for blood pressure or blood tests.

Such was the success of the scheme that, by November 2019, the service was said to have provided 2,700 video consultations across 31 clinical specialties. This equated to a saving of an estimated 350,000 travel miles a year for patients and clinicians across Highland.[1]

The Covid-19 pandemic gave a major impetus to expansion of the service. As part of the response, 'Near Me' was adopted as the service name across Scotland, a supported scale-up programme was put in place and 'Near Me' was made available at nearly every hospital and GP practice. Prior to March 2020, there were around 300 'Near Me' consultations a week across Scotland, but by June 2020 it was nearly 17,000 a week.[2] Satisfaction rates with the service are high, with 98% of patients giving feedback saying that they would be happy to use the scheme again.

The Project Lead emphasises the importance of co-designing the service with participation from everyone involved, including not only patients and clinicians, but every staff group involved in the outpatient process. Indeed, co-design has been at the heart of the project since the earliest, pre-launch design stage and has led to numerous beneficial changes. 'Near Me' also had to be fully embedded into the ways that outpatient appointments are provided, which necessitated a whole-system approach.

> "The main hurdle to overcome is that people think of this as a technology project: it isn't. The main issue is how to embed a new method of consulting into existing processes and care pathways, so that it is as easy for both patient and clinician to have a video consultation as it is a face-to-face consultation. So it's really a process change project."
>
> "Effectively implementing telehealth is about more than just technology. It's about co-design, using a whole-system approach, and ultimately about delivering person-centred care."
> **(Project Lead)[3]**

Looking to the future, it is hoped that use of the 'Near Me' service will continue to grow across the whole of Scotland, in urban as well as rural areas. Its wider use in care and nursing home environments is also identified as a significant opportunity.

Sources:
1. https://www.recruitnorthhighlands.com/2019/11/27/award-winning-healthcare-in-the-north-highlands/
2. https://www.nearme.scot/wp-content/uploads/2020/06/near-me-vision-public-june-20.pdf
3. http://www.ihi.org/communities/blogs/technology-isnt-enough-co-designing-patient-centered-telehealth

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Guildford and Waverley Community Gynaecology Service in Surrey

The Guildford and Waverley Community Gynaecology Service (GWCGS) has been running since 2014 and it won a Women's Health Award in 2018. Following a successful three-year pilot project, the service is now fully integrated with the Royal Surrey County Hospital. The aim of the service is to improve access for women with gynaecological needs and to provide them with the care they need without having to attend the main hospital.

Prior to this service the only option for women living in Guildford and Waverley who needed gynaecological care, beyond the remit of their GP, was to go to hospital. The concept of starting the Community Gynaecology Service (CGS) arose from the drive to bring some services out of a hospital setting and into primary or community care, thereby improving access for patients, including those living in rural areas. It was an innovation led by the GPs involved.

The service is accessible to all patients registered with a GP in Guildford and Waverley. The gynaecology clinics, based at St Luke's surgery in Guildford and at the rural surgery in the village of Shere, are provided by a team of expert GPs with a special interest in women's health. The rural

location is very beneficial for those living outside of the city. It has the advantage of plenty of parking and a tranquil setting, whilst the city centre location has good access by public transport.

The pilot was commissioned and funded directly by Guildford and Waverley Clinical Commissioning Group (CCG). Now the service is fully integrated with the Royal Surrey County Hospital whose contract with the CCG states that they must provide a primary care-led, community-based, tier 2 gynaecology service. The CCG, in turn, subcontracts that service to the CGS (as part of Shere surgery).

There are typically 3 to 4 clinics held each week, seeing a total of 20 to 25 patients, offering a range of services which include 3D ultrasound diagnostics. Approximately half of the patients attend at each of the centres. Patient satisfaction ratings are outstanding and local GP involvement is good. Part of the offer to involved GPs is training, which is both practical and part of the CCG's GP education programme.

There is some cost saving for the CCG as the CGS tariff is lower than the standard hospital outpatient appointment tariff. Keeping costs down is helped by the CGS adopting a one-stop model for visiting patients wherever possible. If the project did not exist all of its patients would have to be seen in a main hospital.

A key benefit for patients is good access. Not having to be seen in hospital means not having to spend time finding a parking space and negotiating busy hospital environments. The service also offers holistic care, as the GPs are passionate about women's wider health and wellbeing. Being in a GP surgery, with longer opening hours than a hospital outpatient department, also enables the team to provide clinics earlier and later in the day.

The service is very responsive, having changed its remit since the initial pilot to adapt to changes in other local services (such as a reduction in local complex family planning services) and evolving NICE guidance.

> "It [the CGS] could certainly be replicated, but it depends on the availability of GPs with the appropriate specialist skills and interest. The way our service is set up means we, as GPs with Special Interest, are very autonomous: we have oversight and governance from the hospital, but if it involved significant consultant time for supervision it would most likely not be financially viable as this would increase costs. Therefore, the level of skill and accreditation of the GPSIs involved does define the service model."

> "Commissioning this model definitely requires the CCG/STP to have an appetite to commission tier 2 services and for them to be able to negotiate with the secondary care stake holders to ensure support for governance."

(Lead GPSI, Guildford and Waverley Community Gynaecology Service)

Two further factors are said to be key to the success of this service:

- The ability, and contract, to 'triage' all gynaecology referrals made by Guildford and Waverley GPs means that patients are seen in the most appropriate clinic to meet their needs, based on their medical problem. It also ensures that the service only sees patients who are within its remit, which minimises the risk of needing to make onward referrals to secondary care (these being costly and a less satisfying journey for patients);
- Good relationships with the hospital consultants are also vital. The GPSIs have agreed shared pathways and they can take referrals from the consultants for things that fit their remit better than the hospital team.

The GPSIs would like to expand the GWCGS service and hope to discuss this further with the Royal Surrey County Hospital and the area's Sustainability and Transformation Partnership. Potentially, activity could be increased if the area covered was to be expanded.

Sources:
Guildford and Waverley gynaecology http://www.gwcgs.co.uk/?page_id=25

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Enhanced primary care in Frome, Somerset

In 2013 Health Connections Mendip (HCM) was set up as a social prescribing, community development service, formed through a collaboration between the eleven GP practices that are based in the district of Mendip, Somerset. At around the same time the GP practices also set up their unplanned admissions teams.

These two initiatives first came together in Frome, a hub town in Mendip, and together they form the core of the Frome Model for Enhanced Primary Care. This innovative approach, therefore,

combines a programme of community development, social prescribing and unplanned admissions work, which runs alongside routine medical care. It helps to connect patients with support and activities in the community that will have a positive impact on their health. It is rooted in an understanding that health is heavily influenced by social factors and that whole population health is improved by working together across organisations and communities.

> "The aim is to break a familiar cycle of illness reducing people's ability to socialise, which leads in turn to isolation and loneliness, which then exacerbates illness."
> **(Dr Helen Kingston, Frome medical practice)[1]**

The project uses principles of personalised care planning. Its offer is not limited to those with long-term conditions or to older people, and anyone who gives cause for clinical concern, who is at risk of hospital admission or is discharged from hospital can be referred into the unplanned admissions team. Carers are also supported. Furthermore, anyone can choose to become involved with HCM by self-referring or simply making contact to find out how to be involved with the service.

Fundamental to the success of the model is its whole system approach. A multi-disciplinary approach within the surgeries is combined with strong support from individuals and organisations within the area's communities. Key elements of this model are: regular multi-disciplinary meetings which facilitate easy interaction between the GPs and other medical or care professionals; and the Health Connector (from HCM) who provides the social prescribing. A social worker also visits the Frome surgery on a regular, weekly basis.

Initially, through HCM's work, there was a single Health Connector post based in the Frome surgery, which covered the whole of the mainly rural Mendip area. However, the success of the scheme rapidly led to that service being expanded. From 2015 the area's Clinical Commissioning Group has funded Health Connectors in each of the eleven GP practices in Mendip. (They are all employed by the Frome surgery on behalf of the other practices.)

Support from the local community is essential in enabling the model to work effectively. In this context, HCM plays a key role in helping to grow social capital. It achieves this by:

- Mapping community assets and identifying gaps: there is now a readily available directory, which lists over 400 services in the local community;
- Helping local people to fill gaps: it helps people to create valuable new services and activities in a sustainable way, providing support with aspects of establishing a new group. Groups that HCM has supported are numerous, but they include Macular Degeneration, Stroke and Diabetes Support Groups;

- Providing effective signposting: to ensure people can access and benefit from the many community services and activities. This signposting is achieved in many ways, including:
  - Through active citizens, who act as Community Connectors to signpost family, friends and neighbours to services that may be helpful. There are now around 1,500 of these active citizens;

  - Through social prescribing by the Health Connectors, who focus on what will prove most important to the individual patient;
  - By writing out to suitable patients that have been identified from practice registers;
  - By promoting services on the Health Connections Mendip website;
  - At Talking Cafes, which are physical places where people can discover community support; and
  - Via a monthly local radio slot, on social media and in a monthly newsletter.

The project's headline achievement, according to a paper in the British Journal of General Practice, has been a "highly significant reduction in unplanned admissions to hospital", over a period when admissions rose elsewhere in Somerset. Cost reduction was not the main objective when establishing the model. However, a reduction in emergency admissions to secondary and tertiary health care has reduced costs to the NHS.

> "The results of this project show that doing the right thing isn't more costly and that we can offer better care, better medicine. For every £1 put into our scheme, we saved £6 in emergency admissions."
> **(Dr Helen Kingston, Frome medical practice)[1]**

Frome has had many enquiries about its approach from elsewhere and those involved have been working with various locations around the UK and abroad. They have also created a website template for the approach, which is available at a modest cost.

> "The model can happen anywhere, but you do need the right people. It is really important to allow things to happen organically, as success is so easily stifled by bureaucracy."
> **(Health Connector, Frome Surgery)**

Sources:
1. http://www.frometimes.co.uk/2018/02/27/frome-leads-the-way-in-easing-the-nhs%E2%80%88crisis/
Also:
https://www.compassionate-communitiesuk.co.uk/projects
https://bjgp.org/content/68/676/e803
https://www.pointsoflight.gov.uk/compassionate-frome/

https://shiftdesign.org/case-study-compassionate-frome/
https://healthconnectionsmendip.org/

Community Front Room in Bridport, Dorset

Responding to concerns that the previous service was not supporting people as well as it could do, the Dorset Clinical Commissioning Group (CCG) undertook a thorough review of its Mental Health Acute Care Pathway (MHACP). That review was co-produced along with Dorset HealthCare, Dorset Mental Health Forum, users of the service and their carers, plus a range of external partners such as local authorities. An extensive formal public consultation also formed part of the process which led to the presentation of the final business case in September 2017.

Central to the proposed changes was a desire to make services more locally accessible to everyone, including those living in rural areas, and part of that initiative involved the creation of Community Front Rooms in the three market towns of Bridport, Shaftsbury and Wareham. Mirroring a successful pilot drop-in facility in (urban) Bournemouth, the CCG commissioned three rural Community Front Rooms which opened in 2019. All of them are run by local charities.

The Bridport Community Front Room is run by the Burrough Harmony Centre, a small mental health charity that already operated in the town. The facility is open between 3.00 pm and 11.00 pm from Thursday to Sunday (when other facilities are typically closed). It is operated by two members of staff, one with a mental health qualification and the other with direct specialist knowledge of mental health issues.

Located close to the town centre, the Community Front Room provides a safe, welcoming and understanding environment for adults who are in or are heading towards a crisis. It is a place where people can talk things through, be listened to or just sit quietly. Quite deliberately the ambience is homely rather than clinical.

The rules are relaxed and people can just turn up without any need for an appointment or referral – they just ring the doorbell. Staff cannot admit anyone showing too much aggression or severely intoxicated, who would generally be asked to come back at another time. Ambulance and police services often bring people along, which avoids a trip to hospital A&E or the unnecessary use of

cells. However, the Community Front Room is not a formal Place of Safety and sometimes, if the person cannot be kept safe, there is a need to escalate things for an assessment in Dorchester.

Since opening in July 2019 this Community Front Room has received between 78 and 100 visits each month. Some have been by first time contacts who are not known to mental health services. The benefits from the service have been both financial and personal.

Whilst no formal evaluation of savings to the NHS was available at the time of writing this case study, an approximation based on the much larger Bournemouth scheme (and divided pro-rata by the number of visits) suggests potential savings in the order of £45,000 per annum.

As for the benefit to service users, feedback has been extremely positive.

> "I don't know what I would do without the Community Front Room now; it is an oasis of calm, a beacon of hope, and no matter how you are feeling, you will be welcome here.
>
> Sometimes, just having a cup of tea with someone is all you need – a chat with people who have 'been there'; or just space to sit quietly, knowing you are safe.
>
> But it's there for the times of crisis too. Hands reach out to hold you when you feel as if you are falling.
>
> Hope, acceptance, safety, and empathy sum up the Community Front Room ... "
> **(Service user)**

The service manager believes that the scheme could be replicated in many rural market towns. In her own words, her advice would be:

"Stay true to the model and maintain compassion and humanity in all delivery;
Develop a strong team, with high quality training;

Ensure consistent and compassionate support for all staff, as it is a challenging role;

Ensure the buy-in of local agencies and emergency services and that they understand the ethos and values of the service, which are very different to traditional clinical services."

The service is looking to offer more digital or virtual support in future, to supplement, though not replace, the existing provision. It is hoped that this will enable those living in more outlying rural areas to access support when they can't physically travel to the Community Front Room. It may also make the service feel more accessible to young adults.

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services often bring people along, which avoids a trip to hospital A&E or the unnecessary use of cells. However, the Community Front Room is not a formal Place of Safety and sometimes, if the person cannot be kept safe, there is a need to escalate things for an assessment in Dorchester.

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Whilst no formal evaluation of savings to the NHS was available at the time of writing this case study, an approximation based on the much larger Bournemouth scheme (and divided pro-rata by the number of visits) suggests potential savings in the order of £45,000 per annum.

As for the benefit to service users, feedback has been extremely positive.

> ‘‘I don't know what I would do without the Community Front Room now; it is an oasis of calm, a beacon of hope, and no matter how you are feeling, you will be welcome here.
> Sometimes, just having a cup of tea with someone is all you need – a chat with people who have 'been there'; or just space to sit quietly, knowing you are safe.
> But it's there for the times of crisis too. Hands reach out to hold you when you feel as if you are falling.
> Hope, acceptance, safety, and empathy sum up the Community Front Room ... ‘‘
> **(Service user)**

The service manager believes that the scheme could be replicated in many rural market towns. In her own words, her advice would be:

“Stay true to the model and maintain compassion and humanity in all delivery;
Develop a strong team, with high quality training;

Ensure consistent and compassionate support for all staff, as it is a challenging role;

Ensure the buy-in of local agencies and emergency services and that they understand the ethos and values of the service, which are very different to traditional clinical services.”

The service is looking to offer more digital or virtual support in future, to supplement, though not replace, the existing provision. It is hoped that this will enable those living in more outlying rural areas to access support when they can't physically travel to the Community Front Room. It may also make the service feel more accessible to young adults.

The case studies included in this toolkit have been selected as examples of good rural practice. Their inclusion does not infer that they have necessarily been developed as a result of a systematic rural proofing process.

MensCraft suicide prevention project in Norfolk

Suicide rates are above the national average in Norfolk and particularly high in the Norwich area (where they were 75% above the national average in 2018).[1] Three quarters of those who die by suicide are male.

In response a multi-agency project, led by MensCraft, appointed a Prevention and Positive Activities Co-ordinator [the co-ordinator] in January 2019 to work with vulnerable men in the greater Norwich area. That area extends well beyond the city and covers a rural area within approximately a ten mile radius. The project was enabled by a successful bid for national suicide prevention funding, which was made by the Norfolk and Waveney Sustainability and Transformation Partnership and was managed by Norfolk County Council Public Health.

Based in Norwich, MensCraft is a Community Interest Company which aims to provide 'activity, identity and meaning' via a range of different programmes for men and boys. As their website notes, "men tend to be affected by the indirect consequences of enforced under-employment and significant life events … leading to substantial negative effects on their wellbeing ... Typically men do not access mainstream health, community information and advice services for support." [2]

The co-ordinator works alongside a mental health nurse and offers initial support within 48 hours, until the patient is seen by the Community Mental Health Team which, in emergency cases, must take place within 120 hours. Initially, referrals came via a single point of access from GPs or from the Norfolk and Suffolk NHS Foundation Trust (NSFT) Escalation and Avoidance Team. However, to optimise use of the service this was changed in September 2019 so that referrals can now come from a variety of local organisations and with self-referrals also welcome.

The project gives men the chance to talk about how they are feeling, as well as providing opportunities to take part in groups or social activities. Where appropriate, they will be signposted to other sources of support, such as organisations which can help with debt, homelessness and drug or alcohol problems.

> "Men can find it really hard to communicate. I'm not a clinician so am not there to help them find solutions, but instead offer them the space to talk about how they are feeling so that they can feel understood and heard. Just being there can be massive and can make a real difference, especially to someone who is feeling isolated and alone."

> "When I first meet the patient, I'll ask him to tell me his story and we work together to develop a safety plan. I will also do what I can to alleviate his stress in the short term, to make him safer while opening up other sources of support which could benefit him."
> (Prevention and Positive Activities Co-ordinator, MensCraft)[3]

The co-ordinator has provided non-judgemental support by phone and often by home visits to over 40 men, of all adult ages, in the 18 months that he has been in post. Each client is unique but, on average, he estimates that he spends around 10 hours with each one over a six week period.

Participants' reactions are very positive:

> "I was in a right state, I was thinking about suicide a lot. Just being able to speak with someone was good. It really helped me understand where I was and helped me focus on what my next steps should be. I wasn't used to talking about myself and what I needed, so it helped to have that extra support."

> "The other activities MensCraft offer are good. People don't label you as someone that's worked with you (the Co-ordinator) they just let you be you. It's good to be a part of something and build relationships with people on your own terms and at your own speed."
> **(Project client)**

Notably, the Covid-19 lockdown caused additional pressures on the service, as many clients experienced additional stress and anxiety and home visits had to be suspended temporarily. However, great care was taken to ensure that connections were maintained virtually through a mixture of video meetings, phone calls and via a talking group.
When asked why the project was so successful, the co-ordinator emphasised the support of MensCraft as an organisation.

> "Working for an amazing organisation is key to the success of this role. They work hard to promote the scheme and to support men's needs, more generally, and they back it up with action … They also care for my wellbeing".
> **(Prevention and Positive Activities Co-ordinator, Menscraft)**

Such has been the success of the project that four additional co-ordinator posts are being created which, from September 2020, will cover the whole of Norfolk, much of which is very rural in character.

Sources:
1 .https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority
2. https://www.menscraft.org.uk
3. https://www.nsft.nhs.uk/Pages/Additional-support-for-men-at-risk-of-suicide.aspx

E-enabled social prescribing in Lincolnshire

Social prescribing is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of locally based, non-clinical services, when medical intervention is not getting to the root of an individual's problem. Participants might have a number of needs, including long term medical conditions, mental health issues, loneliness, debt concerns or complex social needs.

GPs, nurses, emergency services, housing providers, social care teams and family members can make referrals to the organisations providing social prescribing in Lincolnshire. They are Voluntary Centre Services (covering west Lincolnshire) and Lincolnshire Community and Voluntary Service (covering the remainder of the county). Depending on the level of need, the individual may be assigned a link worker who will support them to think about their goals and how they can move towards achieving them. The link worker can also provide or signpost to the help they will need.

Social prescribers offer three levels of support, depending on need. These are:

1. Where the person knows what help they need, but would like advice on where to access relevant local activities;
2. Where the person needs guidance to know what help they might need and where to find it; and
3. Where the person would like help to think about their goals and someone to support them as they start moving towards those goals.[1]

The large area and rural character of the county, combined with often poor public transport links, present particular problems and can compound issues with social isolation. Many people, estimated at around 20% of those in the 45-54 age group, would prefer to have a digital option to access social prescribing so good connectivity is considered a priority.

The context is a very successful scheme developed by the Digital Health Team at Lincolnshire Community Health Services NHS Trust, which has been taken up by some 4,000 students at the University of Lincoln. That scheme, combining information, health, and wellbeing services, was first offered in September 2019. It is accessed via the Vitucare system, comprising an online platform with separate tiles for different services. Importantly, students can use Vitucare from either home or university. This has proven to be beneficial to students wanting to find services and activities, to self-care and to access e-consultations. It is also an effective channel for urgent health messaging, such as how to check for signs of meningitis when a case was discovered on campus.

During the Covid-19 lockdown Social Prescribing Link Workers have video-called a number of their clients, which has been well received by participants.

An online social prescribing platform for wider public use, has since been created in its test format in conjunction with a group of co-producers who have lived experience of the approach. This again uses Vitucare and provides a bespoke, individualised digital offer which includes:

- Information tiles for an online advice library, for 'One You Lincolnshire' and for social prescribing;
- Tiles for staying in contact, which offers secure messaging, care documents and video calls with a therapist; and
- Self-care tiles which relate to personal goals, how clients are feeling and their lifestyles.

The team is currently developing some additional tiles, which will include a health tracker (self-tracking sleep, exercise and hydration), a 'meet the team' function and a wellbeing area (with hints and tips on how to stay happy and healthy). The platform is expected to be brought properly into use in late summer or early autumn 2020.

The scheme aims to optimise its relevance by customising to an individual's characteristics (such as their age, gender, interests, health conditions and residential location). If the user agrees, information in Virtucare can be shared with local GPs or other clinicians, to alert them to any concerns. For example, a patient using psychological services might be offered specialist tracker tiles for their needs, such as depression or psychosis. To facilitate this, the scheme has been carefully designed so that the coding used fits with existing GP systems.

"By providing a digital social prescription we hope to empower people to feel more in control and manage their own health and wellbeing. This will be achieved by connecting people with their

communities thereby reducing isolation, encouraging opportunities to participate in activities and impacting positively on physical health. Resources will be available to support people to manage practical issues such as debt, housing and relationships, and digital campaigns will be used to 'nudge and nurture'. This can all be delivered from the comfort of the citizen's home and negate time and expense travelling."
(Project Support Officer)

As a further development the Digital Health Team at Lincolnshire Community Health Services NHS Trust has started work with 'Active Lincs', with the intention of being able to connect citizens up to their local leisure centres.

Sources:
1. http://www.lincolnshirecvs.org.uk/social-prescribing-home/ also
https://lincolnshire.nhs.uk/latest-news/social-prescribing-proving-success-lincolnshire
https://voluntarycentreservices.org.uk/wp-content/uploads/2019/11/2019-SP-Leaflet-Practitioners.pdf

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Farming Health Hub providing health and wellbeing services in Cornwall

The Farming Health Hub is committed to creating opportunities that engage with a wide range of partners across the public, private and voluntary sectors to enhance and develop support for the Cornish farming community.

It is widely recognised that farmers can face particular health related challenges. These range from physical safety issues in their working environment to mental health concerns exacerbated by isolation, by long hours and often by financial challenges over which they may have little control.

For a variety of reasons farmers often fail to engage with health services at an early stage.

"Both male and female farmers don't tend to seek health care as often as they should. It is hard for them to take the time out of the farm and they also tend to be a bit stoical, so will soldier on. We see people for all sorts of issues, including bad backs and joint and hip problems."
(Rural physiotherapist)[1]

Farmers from Cornwall are especially likely to face challenges for several reasons, including:

- Farms in the county are typically smaller and many have issues with financial viability;
- Livestock farms predominate and external market forces, with fluctuating prices, cause concerns;
- Many are family farms where there is increased pressure to keep them going.

Sadly, suicides in the agricultural sector are significantly higher than the average for England[2]. Whilst there is no available statistical breakdown by occupation for Cornwall, it is notable that the county suicide rate for males is 49% above the national average.[3]

The Farming Health Hub Cornwall was set up in 2019 and it aims to offer a range of support within three main areas:

- General physical health checks, such as eye and hearing tests, diabetes, cholesterol levels and dental health;
- Mental health support, including managing stress, anxiety and depression, plus coping with rural isolation and loneliness;
- Support to develop the farm businesses, including financial and legal advice, help accessing education or training, and applications for grant funding or welfare.

As a new organisation it is still shaping its operational model. However, it intends to create a better connection between farmers and existing resources, signposting rather providing services directly. Ideas include making health checks available at local livestock markets and offering drop-in opportunities at locations where farmers naturally gather, thus avoiding the need to make special trips to more formal settings.

Starting out as an idea shared by three volunteers, all with close ties to farming communities, the hub has already succeeded in establishing a strong partnership board. That board brings together representatives from public, private, voluntary and educational sectors including the National Farmers Union, Young Farmers, Cornwall Health Watch, the Police, Exeter University, auctioneers, Citizens Advice, Cornwall Council and the Royal Agricultural and Benevolent Institute.

The hub has already had a presence at local agricultural shows and it held two events partnering with Mole Valley Farmers (a local farm supplies retailer) where health checks were made available. Another notable success has been the production of a leaflet, drawn up during the Covid-19

pandemic, which provides contact details for sources of help and advice on business issues, physical health and mental health. This has been widely distributed through partnership board members.

A recent grant (in 2020) has enabled the recruitment of the Farming Health Hub's Manager, who comes with a wide range of experience, to help the Hub develop to its full potential. She said,

"I am delighted to be part of this journey. We hope to bring the Farming Health Hub into the heart of the farming community as a valued resource and a go-to place."

Jon James, a founding volunteer, emphasised the significance of the work underway.

"The importance of this approach and need to collaborate has been further highlighted by Covid-19, and throughout 2020 we are building a programme of work that will further develop our offer for the farming community."

Sources:
1. https://www.fwi.co.uk/business/business-management/health-and-safety/farmers-offered-nhs-check-ups-bakewell-market
2. ONS suicide by occupation in England
3. PHE Suicide prevention profile Cornwall 2016-2018

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Commissioning local micro-providers of care in Somerset

The Somerset Community Micro-enterprise Project helps local people to set up micro businesses of nine or fewer people that provide local services for people who need some help and support at home.

The scheme, which became operational in 2015, was commissioned by Somerset County Council in response to acute challenges in providing quality care to clients in rural parts of the county.

The scheme, which has received financial support from a variety of funders, initially operated in partnership within Community Catalysts CIC. However, since 2019 it has been managed by the Council directly.

Its main objectives are twofold:

1. To support the development of very small, community-based care and support services that:
   - Provide personal, flexible and responsive support and care;
   - Give local people more choice and control over the support they get;
   - Offer an alternative to more traditional services; and
   - Provide employment opportunities to local people.

2. To provide an accessible directory of information for people who are seeking care or support.

"We want people, wherever they live in Somerset, to have a great choice of local, responsive, high quality support to live their lives. Micro-providers offer what people value most … Continuity, flexibility and the ability to build a trusting relationship with a local person."
(Scheme manager)

The current directory lists over 440 providers and it is estimated that, in total, they support some 2,000 local residents and provide around 11,000 hours of support and care each week.

Inclusion in the directory means that providers have completed a development journey and have offered evidence that they have set up according to best practice. In February 2020 a new accreditation scheme was launched enabling Somerset to officially endorse micro-providers and their local peer networks.

Because of their small scale and the way they operate, providers do not fit the criteria for being regulated by the Care Quality Commission (CQC). However, the approach offers confidence to families and professionals in Somerset, through a shared "doing it right" quality commitment. A quality assurance process is in place, where providers may be removed if their conduct is incompatible with the standards of the scheme. This approach is said to work well with many local networks in Somerset being effectively self-monitoring.

This increased capacity from developing local, responsive support services has meant that:
- People are well-supported at home or in the community by people from their own neighbourhood;
- Support is co-designed, with creative people on both sides of the care equation finding ways to do things differently;
- Clients of the services can be offered an effective choice;

- People can work locally, with hours that suit their family circumstances, earning an income and making a positive difference;
- People and families know that good support is available and, as a result, many come home earlier from hospital and delayed discharges can be avoided;
- People stay connected to their community, contributing to it and avoiding loneliness;
- Lower overheads, compared to larger care businesses, mean that costs to the client are typically lower, yet the carers can still earn a better hourly rate; and
- The scheme is inherently more resilient than relying on larger providers, as the impact arising from the loss of one small business can more readily be absorbed by others.

In summary, the project is considered a win-win, with good work being provided at a fair cost. The scheme is, however, best suited to clients who are self-funding or who hold personal budgets. Lack of CQC accreditation and administrative complexity, unfortunately, make it unsuitable for the Council to use for direct commissioning.

The scheme manager considers that the model could operate well in any rural area. However, key to the particular success of the Somerset scheme has been the high level of support and responsiveness from Somerset County Council and the strong network of more than 100 'community connectors', many called Village Agents, that operate in the county.

The scheme continues to grow as positive feedback from existing providers and clients encourages more people to participate.

For more details see:
https://www.facebook.com/somersetmicroproviders/

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South West Care Collaborative improving care home provision in Devon

There are over 500 care homes located in the Devon, Plymouth and Torbay area and many of these are in rural locations. Compared to the rest of England a much higher percentage are owned by small operators, each running one or two homes. Individual homes also tend to have fewer residents than the national average. These smaller businesses can face greater challenges retaining staff and achieving or maintaining excellence across the many aspects of their care provision.

The organisation now known as the South West Care Collaborative (SWCC) – formally the Devon Care Home Kite Mark initiative – was set up in 2012 by George Coxon, the owner of two care homes. He recognised a role for a proactive, provider led coalition to promote best practice and to provide a stronger voice for the (often maligned) care home sector. His diverse work background, which included various roles within the NHS, also helped him to plug into relevant networks.

Members opt into the collaborative based on a consensus of supporting one another. There are some core features, which include:

- Sharing to Learn, with members learning from each other;
- Peer Review, as a credible way to drive up standards, using an empowering approach that is based on cooperation rather than competition in a sector that faces increasing challenges; and
- Embedding strong values in the initiative, such as pride, sound evidence, positive atmospheres or environments for those needing 24/7 care and a culture of improvement, with enthusiastic and skilled staff looking after happy residents.[1]

It receives no external funding and members each pay a small subscription.

"SWCC emphasises the importance of co-operation and collaboration. If you share a piece of work, someone will share back. This helps everyone to improve."
(George Coxon)

The SWCC has grown steadily and in 2020 has some 100 participating members. These are generally providers and managers, mostly from care homes, but also including some nursing homes. It is supported by a steering group of 7 members who collectively represent 18 homes, just over 600 beds and over 725 staff from across Devon.

Members receive a number of benefits, which include:

- Skills Academy workshops with specialist expert speakers and discussions about what members do well and how they can improve. These have covered key care areas such as fall prevention, diabetes, stroke prevention, dementia, skin care, end of life care, nutrition and hydration, and guidance on safeguarding;

- An opportunity to participate in Peer Review. Members agree a reciprocal visit to each other's homes to conduct an "appreciative inquiry". The topic chosen for review is usually drawn from the latest Skills Academy master class. Members find these reviews a useful part of their quality assurance and good evidence when completing CQC Provider Information Returns;

- A bi-annual Masterclass Programme for managers and their deputies focused around leadership and improving lives of those in their care; and

- An annual event which has a diverse range of speakers and workshops.

The SWCC also emphasises the importance of establishing strong, trustful and effective external networks and so it works closely with other organisations. Examples include:

- The Care Quality Commission - looking at their key lines of enquiry questions (namely safe, effective, caring, responsive and well led);

- The area's NHS Sustainability and Transformation Partnership on policy matters;

- Devon County Council, Torbay Council, and Plymouth City Council as commissioners;

- The South West Academic Science Health Network, particularly to share workshop provision; and

- The Royal Devon and Exeter NHS Foundation Trust, seeking to help avoid preventable admissions and delayed transfers of onward care.[1]

South West Care Collective aims to continue to grow its membership of care providers who share a genuine commitment to continuous improvement.

"When the time is right, we should all be able to look forward to wrap-around care in a safe and caring environment."
(George Coxon)

Source:
1. https://www.swahsn.com/south-west-care-collaborative/#:~:text=The%20South%20West%20Care%20Collaborative,sharing%20best%20practice%20and%20innovation

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Training GPs for rural practice in Northumberland

"Recruitment and retention of the GP workforce is becoming a serious issue for the profession as a whole, but it is nearing crisis point in many rural areas across the UK."[1]

Health Education England (HEE) statistics[2] indicate that there has been a significant improvement in the fill rate for GP training posts in recent years, but the majority of areas cited on the HEE list of 'hard to recruit areas' are still rural or coastal.

Although there are various contributory factors, such as rural practice funding and limited employment opportunities for spouses, many of the factors that discourage trainee GPs from selecting rural areas relate to workload characteristics and concerns about professional isolation.

After they have completed a medical degree and two years of foundation training, doctors that wish to become an independent GP must complete at least three years of specialty training. This normally comprises 18 months in an approved training practice and 18 months in an approved hospital setting.

Two particular challenges that face GPs in rural Northumberland are the local demographic and the dispersed pattern of secondary care. A higher than average proportion of the population is over retirement age, so chronic diseases – such as heart disease, cancer and diabetes – are more prevalent and are often identified at a late stage. Accidents amongst those in high risk occupations,

such as agriculture and forestry, occur more frequently and mental health issues, often related to isolation, are common across the age range.

Access to hospitals can be difficult, particularly for the elderly, leading to GPs providing more intermediate care. These issues are compounded by generally poor connectivity, with internet and mobile signals not always available or reliable, which presented a significant problem during the COVID-19 pandemic.

In response to local challenges, Dr Lambourn at the Cheviot Medical Group set up a bespoke GP training programme, drawing from experience in rural Scotland. This scheme, which lasts for 42 months (and is 6 months longer than usual) appointed its first trainee GP in 2017. It aims to enable the trainee GP to develop additional, rural-specific skills and to gain confidence in areas of work which, in more urban areas, might be less commonly encountered or treated in other settings. Examples include community hospital work, community outpatients, minor surgery, emergency accidents and rescues, and dealing with a range of mental health problems.

It is hoped that by providing a quality and bespoke training course suited to the needs and interests of the particular individual, and supported by a number of GPs that offer specialist expertise, trainees will feel confident and will enjoy working in a rural context. Furthermore, that they will choose to continue their careers in rural practice.

Whilst it is too early to evaluate the success of this initiative in that respect, there is some evidence of success from schemes in Scotland, where "those trainees that do come [to less popular locations] usually stay on after training, as they discover these locations' hidden attractions"[3].
However, it must be acknowledged that salary supplements of £20,000 which apply to Rural Track training in Scotland and to designated hard to fill areas in England may well be a major incentive. Northumberland is not currently eligible for such a supplement.

The recruitment process is underway to take on another trainee in 2020. The scheme is constantly being refined and, whilst no decisions have yet been made, it is possible it will move to a model more similar to the Rural Track GP Specialty Training programme developed by NHS Education Scotland or to a 3 year GP specialist qualification with a supplementary 1 year of further professional development to enhance rural focused skills.

Sources:
1 Royal College of GPs Rural Forum, February 2014.
2.Specialty recruitment: round 1 - acceptance and fill rate
3. Enhanced recruitment scheme

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Refugee doctors project in Lincolnshire

There is a shortage of doctors in Lincolnshire and that shortage is most acute in the rural areas, outside the city of Lincoln. It is estimated that over the whole county there are perhaps 150 vacancies for hospital doctors and 100 for GPs. Although this scheme cannot solve that issue, it is hoped it will nonetheless make a positive contribution.

It is notable that all other refugee doctor schemes currently operating in the UK are based in large urban centres. This project, based in Grimsby, is a pioneering one serving a rural area.

Learning from the earlier successes of those urban projects, the Lincolnshire Refugee Doctor Project (LRDP) set up as a Community Interest Company in 2016, with a Board of Directors that comprised 3 people from the health sector and 4 others, including representation from the business sector.

At the end of 2016 a funding request was made to Health Education England - East Midlands for a project covering the central and southern parts of the county. Although this had a positive scoping report and despite strong stakeholder support, funding was not forthcoming at that time. However, a subsequent approach to Health Education England - Yorkshire and Humber did receive a positive response. This resulted in the project being based further north in Grimsby.

The scheme, supporting doctors who are refugees back into medical practice in the UK, includes not only clinical training to meet the standards of the General Medical Council, but also clinically focused English language training, which must be satisfactorily completed. It also offers wider help to settle doctors with their families into Lincolnshire. That help can address issues such as finding accommodation, accessing benefits and understanding public transport.

Between August and October 2019 eight doctors were recruited. Two of them, who were already part way through their studies, have so far successfully completed the course. Most are at a much

earlier stage, but it is hoped that when the scheme is fully established it will generate around four new NHS doctors each year.

Costs vary considerably depending on the individual doctor's starting point, but on average it is likely to be around £12,000 for each doctor satisfactorily completing the course to foundation 2 level (so the stage immediately prior to specialist training). This is a fraction of the estimated £350,000 cost for a doctor qualifying via the traditional route.[1]

"The scheme is a clear win-win. It provides a refugee doctor with the hope of working in the NHS in future and provides our NHS with the hope of having doctors to work locally in future."
(LRDP Director)

This early success has led Health Education England - East Midlands to review its position and funding has been offered for an additional scheme, to be based in Lincoln and commencing in 2020. Once both schemes are fully established it is likely that there will be 20 to 30 refugee doctors in training at any one time.

The project has however faced some challenges along the way, including:

- Disappointment that the initial project application for funding was not successful;
- Transport difficulties in rural Lincolnshire necessitating much virtual teaching (especially during the pandemic lockdown); and
- Strict definitions applied to Universal Credit eligibility, which has led to the course running over 3 days per week to allow an opportunity for participants to find paid work.

The project Directors consider that it could be replicated in other rural areas. It is their ambition to put together a package which explains how to set up a Company, as well as outlining both the language training and the clinical curriculum. They advise that considerable determination and commitment are needed as experience from this scheme indicates that,

"there is an awful lot of effort at the beginning for little visible result". However, "success comes at unexpected times." **(LRDP Director)**

Looking to the future, in addition to establishing the Lincoln-based project, it is hoped to extend the scope of the scheme in 2021 or 2022 to include some other professional health roles.

Source:

1. Department for Health and Social Care, 2017