

The Impact of Health Transformation on Rural Communities

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This brief outlines issues relating to the implementation and impact of the ‘health transformation’ policy in Northern Ireland. It draws on published research evidence and the discussion at a Roundtable event organised by ARK with the Rural Community Network, held on 6th Oct 2023. Participants at the Roundtable included officials from a number of H&SC Trusts, the Department of Health, academics and representatives from a range of NGOs.

Introduction

Since the 2011 publication of the *Transforming Your Care* report, there has been a vision and an imperative in Northern Ireland to reconfigure the health service, in particular by rationalising acute services. The 2016 Bengoa report found that “implementation was slow due to resistance to change and the absence of a strong strategic approach to transformation”. However, it also found that “much needed investment in community services development was hindered because of the high costs of maintaining the current configuration of hospitals, particularly for these vulnerable specialties where often expensive locum and agency staffing was the

only option for safe staffing,¹ thus preventing development of those services that would provide an effective alternative to hospital-based care – a vicious circle resulting in ever increasing pressure on all parts of our health and social care system and increasing concerns about the quality and safety of some services. As noted in the Bengoa report the choice is not whether to keep services as they are or change to a new model. Put bluntly, there is no meaningful choice to make. The alternatives are either planned change or change prompted by crisis”. (Bengoa, p.69).

Transformation by collapse

In recent years, we have seen transformation of the health service being effected not by planned change but by crisis and service collapse. The 2014 report from the King’s Fund on the evidence for reconfiguration, warned of this possibility arguing that a key factor determining the configuration of hospital services is the clinical co-dependency between different services. This can result in a domino effect whereby the loss of one service can go on to destabilise the whole acute service provision in a hospital.

¹ This relates to those specialised acute medical treatments which, because of difficulties with recruitment, require expensive locum and agency staff at all times to maintain safe staffing.

To date, it is hospitals outside Belfast and Derry cities that have seen the loss of services, with maternity services closed in Lagan Valley, Downe and Causeway hospitals since 2022. In spite of it being clear that it is services outside the main urban areas that are most threatened, the particular needs of rural communities do not seem to have been sufficiently foregrounded in the transformation project. Indeed, the 2021 *Health and Wellbeing 2026: Delivering Together Progress Report*, which runs to 140 pages mentioned rural issues only once – and that was in relation to primary care.

This is despite the fact that, under the terms of the Rural Needs Act NI 2016, a public authority must have due regard to rural needs when developing, adopting, implementing, or revising policies, strategies, and plans, and when designing and delivering public services.

The Rural Health and Social Care Toolkit for Northern Ireland, which was developed by a working group with representatives from HSCTs and Dept of Health and RCN - based on a Toolkit developed by the National Centre for Rural Health & Care in England, outlines a number of key considerations that need to be taken into account when health and care policies, strategies, plans and public services are being developed. They are:

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 .
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.
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.

These considerations are all supported by evidence.² And, while it is to be hoped that the proposed Integrated Care System will ensure that planning, management and delivery of services are more responsive to identified rural needs, such needs need to be addressed now, in light of the collapse of some services already.

² See <https://www.ruralcommunitynetwork.org/app/uploads/2022/10/NI-Rural-Health-and-Care-Toolkit-Final-version-1.pdf>

Evidence to Support Transformation?

For over a decade now, there has been agreement on every level in Northern Ireland that the only way that our Health Service can be put on a sustainable footing is through the centralisation of services in regional centres of excellence. However, studies of the impact of reconfiguration of specific critical services in England, such as emergency general surgery, intensive care and emergency medicine suggest that there is a poor evidence base to support those proposals. For example, The King's Fund study mentioned above found that "evidence to support the impact of large-scale reconfigurations of hospital services on finance is almost entirely lacking". It also found that evidence on "the impact on quality is mixed, being much stronger in relation to specialist services than other areas of care". However, the study did find strong evidence that senior medical and other clinical input to care is important, particularly for high-risk patients (Imison et al 2014).

The Republic of Ireland reconfigured its urgent and emergency care between 2006 and 2011, with safety and efficiency as the main drivers for the reconfiguration. However, the Study of the Impact of Reconfiguration on Emergency and Urgent Care Networks (SIREN) study found that reconfiguration was not associated with improvements in safety or efficiency. Further, it may have exacerbated capacity issues for regional acute hospitals. The SIREN study argued that "policy makers should recognise the potential harms of centralisation and end their narrow focus on safety concerns in the highest risk patients" (Browne, 2020)

The problems of workforce are very real across the UK, and the evidence review suggests a number of ways to mitigate these problems including incentivising particularly difficult to recruit groups or developing interdisciplinary teams that can meet the needs of the local community but which are better integrated into networks of specialist care, making it easier to access appropriate advice and arrange transfer where necessary.

Distance Matters.

When it comes to acute or urgent health care, distance and the time it takes to cover that distance, depending on the availability of ambulances, quality of roads, traffic levels etc. is crucial. The Kings Fund (2014) found several studies that suggest that greater distance to hospital is associated with an increased risk of mortality once illness severity has been taken into account. For example, Nicholl et al (2007) found a 1 per cent increase in mortality risk for each 10km increase in distance, an effect that was amplified in people with respiratory distress.

Other researchers have described a 'distance decay' effect under which distance from hospital services reduces patients' utilisation of them (services are taken less often or later). This impact is disproportionately felt by those with low incomes, poor access to transport, and by elderly people and people with disabilities (Mungall 2005).

The issue of transport to and from health services is a crucial one, given the poor public transport system in Northern Ireland. Taking health inequalities into account, the very people who most need to receive health advice and care are those least likely to be able to get to a hospital or healthcare hub which is any distance away. It is vital, therefore, that organizing transport – whether with Translink, community transport, or through H&SC Trust minibuses is part of any planning.

Maternity Services

The closure of maternity services at Causeway Hospital in particular raises real safety issues for patients who will have to travel 45-60 minutes, if traffic conditions are favourable, to get to Antrim Hospital. The Moray Maternity Services Review, otherwise known as the Roberts Report, explored maternity services in the Grampian area of Scotland, where there had been an outcry in the media when women were having to travel an hour or more to access consultant led services in Glasgow or Aberdeen. The Review recommended,

as an interim measure until consultants can be recruited, that a Midwife Led Unit be maintained in a small local hospital for low risk births. The Unit has access to planned consultant-led intrapartum care shared between Raigmore and Aberdeen as part of a “Network” with a choice of unit, dependent upon a clinical risk assessment, the woman’s personal choice and geographical location. Patients can apply in advance for travel costs to/from appointments and to give birth and, in particular circumstances, for example patients who arrive in poorly established labour, or who are having elective inductions or caesarians, are put up in nearby hotels.

Kwak et al (2019) aimed to establish the optimal hospital access time (OHAT) for pregnant women in South Korea. To do this, they used the data of 371,341 women who had experienced pregnancy in 2013. Access time to hospital was defined as the time required to travel from the patient’s home to the delivery unit. The incidence of obstetric complications was plotted against the access time to hospital. Change-point analysis was performed to identify the OHAT by determining a point wherein the incidence of obstetric complications changed significantly. Results, which had a high confidence level, showed that the OHAT for a range of obstetric complications ranged between 31 and 60 min and that pregnant women who lived outside the OHAT had significantly higher risk for obstetric complications than those who lived within the OHAT.

These findings are in line with a similar large-scale study in the Netherlands, which found that a travel time from home to hospital of 20 minutes or more by car is associated with an increased risk of mortality and adverse outcomes in women at term (Ravelli et al, 2011), while a population-based cohort study including 365,604 women in the Swedish Pregnancy Register, giving birth between 2014 and 2017 found that living more than 30 minutes from a delivery centre greatly increased the risk of out of hospital birth (ie in a car/ambulance) and concluded that increasing travel time to a delivery unit may increase the

risk of mortality. There is a large body of work from Canada which explores the impact of the distances rural women there have to travel to give birth which includes greater psychological stress/distress, as well as poorer maternal and infant outcomes eg Grzybowski et al, (2011). These findings need to be to the forefront when planning for maternity services is underway. But distance, and the ability to be able to start travel promptly, are issues in relation to most healthcare

Concluding Questions

The evidence above raises a number of questions that need to be addressed if Transformation of our Health Service is to ensure improved outcomes for the population across the region.

- What steps are being taken to increase capacity, staff and other resources in those hospitals which now have a larger population using them?
- What mitigations have been put in place to assist people in rural areas, especially those living in poverty and/or without access to a car, to travel to hospitals and other health settings that are not close to them?
- How can health care professionals be incentivised to work in more rural hospitals and healthcare centres.
- If the evidence indicates that apart from some specialist services, outcomes are not better in larger hospitals, do we need to rethink Transformation?
- How could proposed changes to services be better communicated with the public?
- How could service planners better engage with Section 75 groups when considering these changes?
- Given the success of the NW Cancer Centre, why are we not making greater use of cross-border health care facilities?

Issues Discussed at the Roundtable

A representative from the RCN introduced the main issues of concern to them. These focused on:

- A strong view that consultations regarding health service changes did not take account of S.75 requirements
- Events relating to the recent collapse of emergency general surgery at SWAH. This includes mitigations not being put in place by the WHSCT, despite suggestions to the contrary in WHSCT documents
- A view that the Regional Trauma Network does not provide safety for people living in Fermanagh and that there is nothing about patients in the Trauma planning documents.
- More generally a long standing failure to see geographical distance as a barrier to health care.

Age NI reported on findings of its survey of rural issues which showed that equal access to health and social care was the top issue for older people, including with regard to waiting times, diagnosis and access to care and the impact of delays on treatment. Access to GP services was a huge issue which “causes of lots of anger”. The point was made that older people feel they are being encouraged not to seek treatment and a perception that ageism is a factor. Some of the examples of this were older people saying they felt ‘talked down to’, that there had been a drop off in early intervention, a real feeling of not being taken seriously. Some older people felt they were expected to tolerate ill-health and pain and were told “what can you expect, you’re getting older?” Older people want a return to face to face appointments with GPs and “help me to look after myself” was a big thread in the survey. With regard to the latter reference was made to how, if better resourced, the community and voluntary sector was well placed to do this vital preventative work. Another strong theme emerging in the survey was the lack of integration of health and social care.

Workforce Crisis

There was consensus that there is a workforce crisis that has meant some services have been deemed unsafe and led to provision in some areas collapsing. Some participants argued that this crisis has been building for years because of lack of long term planning. With regards to how to address this there was a view that surgical hubs are the way forward, particularly as there are strong reasons to separate emergency from elective surgery. Participants agreed that surgical hubs make sense but concern was raised about how patients without access to a car are supposed to get themselves to these hubs. The question was asked about the provision made for such circumstances and whether people are signposted towards Trust-run transport or Community Transport where available? Another question was whether there has been any analysis of whether missed appointments are due to lack of transport? A major consideration is that transport infrastructure in NI remains poor which further disadvantages people in rural areas.

There was a robust discussion about the recruitment of surgeons for the SWAH with disagreements between participants. One such related to advertisements for Altnagelvin. The justification was given that surgeons would be expected to work across the Trust area - ie in the SWAH, but that it was only possible to have surgical trainees if there is a certain volume of surgery. There was some discussion of incentives used in Britain to recruit surgeons to under served areas included ‘golden handshakes’ but it was reported that such incentives are not regularly offered in NI.

Other obstacles to securing and maintaining a workforce were raised including that medical students in NI have to pay their own fees but in England these would be paid for them. The idea was floated of paying students’ fees in return for working in the NHS for a defined number of years.

It was reiterated several times in the course of the discussion that there are no plans to close hospitals. It was also pointed out that in England and Wales, it was accepted that emergency care needs to be centralized, but that this is not accepted by many in NI. It was agreed that more cross border cooperation would have clear benefits for people in both jurisdictions, given that there were areas of successful cooperation including with regard to emergency provision, children heart surgery and some other areas of work piloted through EU funding.

Community and Voluntary Sector

A frustration for some people is that these debates go back over two decades but have never been adequately addressed. This, it was argued, resulted in many people in rural areas feeling that the issues they have raised have not been taken seriously, either by the Department of Health or much of the media. Ultimately they argued, there has been a failure to see the importance of the issues raised or to acknowledge the consequences of many of the plans.

Community Transport, for example, provides mitigations to centralization on a voluntary basis and the model is proven to work. The roundtable heard that 35% of Rural Community Transport journeys are to health-related appointments. In spite of this, there has been no increase in funding for many years while the number of journeys has increased hugely. Government Departments need to work together on this. The Department for Health needs to engage with the Department for Infrastructure and to ensure a change in the rules re catchment areas for local community transport. For example, community transport is not funded for journeys from Newry to Dungannon or vice-versa because that brings them outside the area for which they are funded. Key transport infrastructure remains poor and this further disadvantages people in rural areas and is an obvious barrier to patients who don't have access to private transport travelling to centralised specialised health services.

It was agreed that Multi-Disciplinary Teams (MDTs) have, to some extent, the potential to stabilise the GP situation. There is a lot of evidence to support the establishment of MDTs but the model has not been rolled out across the region. MDTs have been shown to work well for older people, so not having them everywhere increases inequity and increases the pressure on GP and acute services. The view was expressed, however, that MDTs have weakened the community and voluntary sector's ability to do the preventative work they used to. For example, the community and voluntary sector had demonstrated its expertise with successful condition management programmes, but then lost funding for those programmes. Participants were reminded that when the MDTs were being consulted on, all agreed that the community and voluntary sector needed to be part of the MDTs. However, while the importance of collaborative work was acknowledged, the community and voluntary sector has never been seen as an equal partner, or even a partner that needs to be listened to.

As a result, there was both cynicism and optimism about the potential for the proposed Integrated Care System (ICS) model to make a difference. Some see the ICS model as having potential because it brings together a range of stakeholders. It was pointed out that the local Councils already do Community Planning and the Southern Area is already piloting an Integrated Area Partnership Board (IAPB). In addition, a system of Integrated Care Partnerships had been in place already. Also, of course, NI has had a structurally "integrated" system of health and social care since 1973. One factor is fatigue and frustration with the amount of changes, particularly at this level. The cynicism was addressed with assurances that the ICS will be set down in legislation and that carers and patients will be "at the table" and that representation will be very different than the ICPs were.

The failure to maintain and support the Social Prescribing Network in NI, even though it was viewed as a success, was given as an example of

how community and voluntary sector provision was not viewed as important. The Social Prescribing Network in NI and Scotland had five year funding from the National Lottery. The DoH was told it needed to plan for the end of that funding. However, while all agreed that social prescribing had helped immensely, it is being closed down because the Department did not act over the five years the Network was operating. As a result, twenty social prescribing groups, mostly in rural areas are closing down.

Inadequacy of services

The inadequacy of funding of GP services was argued to increase pressure on other areas and so addressing this is pivotal to tackling problems in other areas. As an example, it was reported that, funding for GP minor surgery has been cut in half. Among the impacts of this is that vasectomy is no longer available on the NHS in NI. It cost £330 to carry out a vasectomy in the GP surgery but £1300 in an acute hospital so this is very much a “penny wise, pound foolish” situation.

The lack of vasectomy services led to a discussion on maternity services – specifically where are they in the blueprint being developed? Where are maternity services within the ICS? It appears, at the time of the roundtable, that they are not there at all. It was noted that patient safety issues meant there was no choice but to close maternity services at Causeway. Staff were not happy about this but there was no option. Of note is the fact that maternity services received little attention in the Bengoa report although the point was made that when Bengoa was published, there was at least a Maternity Strategy for the region which is no longer the case. Key problems in maternity services do not seem to be being addressed including higher caesarian and induction rates.

Communication with patients

The discussion kept returning to the question of how, given the poor roads infrastructure and non-existent public transport in some areas, patients are to get to surgical hubs or maternity suites that are not within walking/taxi distance? It was pointed out that, even where there are public transport links, many of those dependent on social security would not be able to afford to pay upfront and then claim back the cost of travel. It was suggested that letters with appointment details should include details of how to get there – this seems not to be the case currently.

The question of poor communication with patients and communities was raised several times. Communication is key and clearly needs to be improved. For example, services that have to close for safety reasons are often seen as cuts but a decent communication strategy that engaged with local communities would go far to helping people understand that the problem is around the growing number of vacancies across all Trusts that threaten safe staffing levels.

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