Dilemmas in reconfiguring the National Health Service in Rural Wales (2013)

Gaye Heathcote

Dedication

I dedicate this paper to my friend and colleague, Professor Dr. Zsuzsanna Benkő.

Zsuzsanna laid the foundational stones in the development of Health Education as theory and practice in Hungary in the late 1980s. Her seminal work, initially in Hungarian universities (formerly Medical Universities) set out the parameters of Health Education as a respected academic discipline which attracted fellow academics from across the social, physical and medical sciences. Her inspired leadership, her vision, her creativity, her tireless energy and her understanding of the essential role of health education, health promotion, and equality and diversity in public health provision and life-style choices were, and still are, unequalled in Hungary. She has already established a conception and delivery of a sustainable field of research, teaching and professional application which is enviably multi-disciplinary, multi-agency and multi-sectoral. Zsuzsa is a credit to the profession, to her country and to the network of European colleagues in the field in which she works and to which she so actively contributes. I have been honoured to be her friend and colleague for the past 25 years.

The National Health Service (NHS) in the United Kingdom (UK) is facing an unprecedented challenge: how to maintain its excellence in services free at the point of delivery in the context of a shrinking financial 'envelope' and a challenging socio-economic climate. The NHS is internationally renowned but is under enormous pressure. There is, in all parts of the UK (which sees regional variation in funding, resource distribution and patient outcomes) an acknowledgement that further transformation of health care services is essential to better meet the needs of an ageing population, optimise the use of healthcare technology, reduce childhood mortality and ensure that the NHS lives within its financial means. There is a consensus that 'there are too many services in the wrong place; this means that, currently, care is not as effective as it could be, and that it is increasingly unaffordable' (Letter to *The Guardian* 25.1.13). Implicated in these imperatives is a requirement for a robust 'integrated' system of health *and* social care which offers the patient 'seamless' pathways from acute (hospital-based) intervention to community (local and/or home-based) care.

The 'recipe' for achieving these objectives is similar across broad areas of the countries and regions that make up the UK, notwithstanding more specific, localised differences on the remote rural - dense urban continuum of service provision. There is general agreement that the ingredients are: to provide good care closer to people's homes; to help patients keep out of hospital (or at least substantially decrease the time they stay there); to implement safe and sustainable services across primary, community, secondary and social care; to make better use of technology; to build community-based infrastructure and capacity and to extend public health, health promotion and self-care initiatives. In short, the aim is to

drastically reduce the pressure on the acute services and meet people's needs more effectively through localised, integrated health and social care systems. In rural areas More use of technology (telemedicine, telesurgery and telemonitoring) is also being discussed.

The rhetoric which supports the mantra 'care closer to home' is compelling. There is much available research to show that many patients admitted to hospital remain, for a variety of reasons, for too long a period after their acute episode, with all the attendant problems of being separated from friends and family and the comfort of their homes and prey to hospital-generated infections. Moreover, the immediate post-acute phase can effectively be delivered by specialist nurses rather than by doctors and clinicians while, post discharge, the necessary health and social care facilities can appropriately be provided within local communities and by networks of primary care providers working closely with families, social care volunteers and professionals. In this way, acute care is now diffused into localised multidisciplinary, multi-agency units.

Conversely, some hospital services, both in the planned and emergency 'acute' contexts need to be centralised, concentrated into centres of excellence. This applies to the majority of specialisms where surgery is reliant on highly specialised clinicians and complex technologies. It makes more sense here to travel further to be treated by high quality specialists rather than being treated locally by staff who do not see enough patients with a particular condition or illness to become appropriately and sustainably skilled.

Although, since the inception of the NHS in 1946, change has been integral to the service and the rate and direction of change particularly

accelerated in the last 30 years, the drivers for the wave of current reconfigurations across the UK (see *Health and Social Care Act 2012)* are: to further enhance the quality of care following rigorous standards set by e.g., the European Directive, the UK's medical Royal Colleges, the Academy and the NHS Confederation; to create 'centres of excellence' which deliver optimal care for acute patients and which will attract top calibre clinicians and high tech. investment; to correct an over-enthusiastic market led approach to the market which has witnessed bankrupted hospitals/hospital trusts, unfairness and inequity of access and service delivery and some high profile law suits and public enquiries into instances of woeful patient neglect (such as that at the Mid-Staffordshire Hospital) or an unusually high incidence of infant mortality (following infant cardiac surgery at the Bristol Royal Infirmary); the need to rebalance increasingly scarce resources into the treatment and care of the chronically sick or debilitated, in line with the weighting of the demographics of a large and growing elderly population.

The current reconfigurations across the UK, at a general level, accepted and even welcomed. The public, the clinicians and the politicians pretty well all accept that 'no change is not an option' and that service reshaping should put patient need rather than the interests of organisations at its heart. There is agreement that patients themselves, communities and local political representatives need to be fully included in decision-making from the outset and to be part of the solution, not seen as the problem. Changes ought to be driven by staffing, demographics and associated health and social care 'pathways'. Reconfigurations should be justified by quality improvements and enhanced patient outcomes. Patient concerns

about safety, access to services (including transport issues) should be properly addressed by comprehensive cross-sectoral co-operation.

But suspicion persists. Patient communities need a great deal of convincing that reconfiguration is not simply about financial cuts and a drive to save money as budgets shrink and economic gloom deepens. The rhetoric of enhanced quality improvement rings hollow when trust in politicians, policy-makers and service provision is at an all-time low and when morale among health and social care professionals is challenged and the pressure on them greatly increased. Clinicians are in a particularly difficult position, torn between, on the one hand, professional aspirations attached to working in a 'centre of excellence' with a critical mass of patients to maintain and hone their skills, and, on the other, fulfilling their duty of equitable care to ageing populations with predominantly chronic (rather than acute) needs in community settings. Crudely, decision makers are having to juggle with large numbers of imperatives against a context of shrinking resources. These are: specialisation skills concentration, improved patient outcomes, more exacting professional standards and minimisation of patients' hospital stay, balanced with demands to treat more patients in home or community settings, a commensurate need to retrain doctors, nurses and clinicians to adapt to new roles and new work patterns and increased pressure to break down the administrative and financial barriers that currently exist between 'health' care and 'social' care.

In practice, the problems of balancing and implementing these changed patterns of care are, arguably, particularly difficult in more rural areas such as major (geographical) parts of Wales and Scotland. Scotland

has greater devolved powers from London than has Wales, and a greater say and more financial control. A number of examples of excellence in delivering health care are emerging from Scotland (which, in turn, has studied successful and sustainable rural health care delivery in other countries such as Australia, Canada, Scandinavia etc. In Wales, where I am currently working on behalf of patient-led organisations to implement a workable and sustainable rural health model, these problems are more intractable.

Here, our Health Boards are facing the same challenges as elsewhere. Currently, our acute services are inappropriately weighted to meet the needs of our (mainly) elderly and geographically scattered communities. There has, for example, been a neglect of adequate screening, public health initiatives, community care, anticipatory health issues and chronic disease management. There are variations and inequalities relating to services, treatment and access, depending upon whether you live in one of the small towns, or in a village or in isolation in remote mountainous locations. There is considerable strain on policy decision-makers and health practitioners who have to comply with strict professional guide-lines and standards issued by the various regulating and accreditations bodies. They also have to negotiate vocal local opposition arising from a public perception of inequity and discrimination in health and social care. Adherence to bilingualism (English and Welsh) in service provision and delivery is a legal and human rights requirement. In short, Health Boards currently need to confront problems which, historically, have arisen from a combination of increased expectations, poor management, and a previous failure to achieve quality, compliance, equitable resource distribution,

efficiency, safety and balance. They also need to negotiate cultural, geographical, linguistic and demographic differences.

In 2011 the (Welsh) Minister for Health and Social Services, in launching the reconfiguration proposals, stated that 'no change is not an option' and that public debate around the proposals should not be about 'service change' but 'health processes', predicated on a 'much more transparent approach to performance reporting and a 'more open relationship with the people of Wales.' The 'health processes' can be summarised as:

- protecting positive health
- improving standards of care
- 'creating a new attitude and momentum, including a new relationship with the public'
- greater involvement in public health initiatives
- continuous improvement of services and patient experience
- addressing inequalities and inconsistencies
- embracing new technological processes
- (increased) multidisciplinarity and cross-agency activity
- creating partnerships (a 'compact') between Government, the NHS and its partner organisations, and the public/users of services.

Following the publication of these proposals, the Health Board for Mid-Wales (other Welsh Health Boards followed) launched a 'consultation process' which sought to 'listen to and engage' the public and having 'listened', develop affordable, feasible and sustainable proposals for high-

quality and equitable health care for the communities it serves (across three counties spanning a geographical area of between a third and a half of the country of Wales). Now, more than a year later, this process, which amassed vast amount of data on the public's and health care professionals' views and where appropriate, alternative proposals (collected through surveys, questionnaires, focus groups, individual and corporate submissions, open meetings in-depth individual interviews etc.) has had the opposite effect of leaving people feeling frustrated, disempowered and unheeded. The predominant view is that a huge amount of money (which could have been spent on patient care and improved services) has been wasted on an appearance of democracy; that the whole exercise has been a charade; public opinion has not been listened to; that the Health Board was, from the outset, engaged in a cost cutting exercise, the results of which can only further compromise a system that already was not coping with the challenges of rurality. There is, therefore, widespread distrust in the Health Board and its ability or willingness to provide a service which is fit for purpose for its rural populations.

So what are the particular challenges for health care delivery in Wales and similar predominantly rural or remote areas?

Four years ago, the then Welsh Assembly (now Government) put forward its *Rural Health Plan for Wales*(2009). This Plan made a number of important points about rural services:

- rural health awareness and planning cannot be considered in isolation from social, economic, transport, housing and social care considerations

- the elderly population in Wales is increasing proportionally at a sharper rate in rural areas compared with urban ones. This is compounded by the outward migration of young people and the falling number of births (although now in 2013 there are some signs of increase)
- this ageing population places proportionally greater demands on the chronic illness and social services than on the acute health services. This has a significant impact on the demands for local services and support systems across the health, well-being and social care spectrum
- accessing services in rural areas is a major issue and should be considered alongside the need for effective transport systems and arrangements. This, in turn, impacts on integration, community cohesion and engagement in rural settings and requires an effective and integrated response at planning and delivery levels.

If the move to 'care in the community' is to be a meaningful response (rather than a cost-cutting measure that entails Health Boards abdicating responsibility for health, redefining it as 'social care' and passing costs on to special services), then any action to close local community and district hospitals that provide e.g. accident and emergency care, lower level acute care and (in collaboration with GPs' practices) primary care, is to be resisted. Commensurately, there will be a continued need for more specialised hospital care offering complex surgical procedures and specialisation in some locations. This, however, requires a particularly robust transport system and effective arrangements that overcome a poor

infrastructure of roads in often inhospitable terrain and climatic conditions (where it is impossible to get a mobile phone signal and where the air ambulance service cover is scant and dependent upon public subscription).

A greater emphasis on community and primary care requires a number of safeguards:

- a safe, sustainable and accessible system of localised health and social care based on an integrated, networked arrangement of General Practitioners, highly trained community nurses and assistants, and very efficient and high quality co-ordination across the public, private and voluntary sectors
- more public health initiatives, greater emphasis on capacity building in communities, enhanced transport arrangements, increased use of technology for screening, monitoring and delivery and greater resourcing and support for patients in their own homes and for their informal carers
- more investment in training/retraining as the focus of care shifts from hospital to community, from acute to chronic conditions and at the same time there is a decrease in the number of hospitals in Wales' few urban areas and a move towards a very small number of highly specialised 'centres of excellence'.

To achieve these different and seemingly incompatible goals in a way that ensures optimal patient outcomes within a greatly reduced resource 'envelope' is a formidable challenge for management. At the time of writing, there is widespread fear in Wales that this challenge will not, even possibly cannot, be met in an effective or sustainable manner, and

that the mid-Wales Health Board, like other Health Boards throughout the UK, is fixated on centralisation at all costs, financial expediency and a ‘one size fits all’ delivery model. To live in rural Wales should not be seen as a ’lifestyle ‘choice’ where one chooses to inhabit a wild and beautiful country but at the same time sacrifices one of the founding principles of the NHS, that of equity of healthcare which is free at the point of delivery and available to all, irrespective of individual circumstance.