"Community Hospitals – the under deployed resource in Rural Wales"

1. The National Health Service is a national institution! When it works well, it works very, very well, but when it underperforms it can cause much suffering.

2. The King's Fund publication entitled, 'The politics of health: what do the public think about the NHS?'[1] declared, "across a range of measures, pressures such as staffing levels, waiting times and access to services, appear to be having an impact both on people's experience of services and their overall perception of the NHS".

3. Unfortunately, in rural Wales at present there are many incidents of under-performance and patient dissatisfaction.

4. In his update[2] to the Welsh Assembly on the £100M NHS Wales transformation fund, Minister Vaughan Gething said, "The simple message is that our current system of health and social care is not fit for the future. Change is not simply desirable. Change is essential".

5. Minister Gething continued, "Change is not simply a financial equation. We have to deliver greater value in how each partner uses their resources to improve the quality of care. **Better outcomes and better experiences with and for our people are what drive this programme for change**."

6. This presentation is about how Community Hospitals can play a major role in contributing to that transformation.

The Problem

7. "The problem", many rural residents claim, "is that finance takes preference over people". Getting access to needed healthcare services is often difficult and rural residents in particular are discriminated against by having to travel long distances to receive help.

8. Neither of these challenges are new: "finance before people" and its effect of transferring local services to more remote locations, has been an issue since the first decade of the NHS.

9. I knew Nye Bevan personally. As a teenager I met him on several occasions. My father was an NUM official and my uncle was, for a couple of years, Mr Bevan's constituency secretary. I attended some of Mr Bevan's rallies and went to the house he used in Tredegar for more intimate discussions.

10. In 1955, Mr Bevan, then out of favour after disputes with Clement Attlee, was marshalling support for his attempts to become Labour Party Leader or Treasurer. At one meeting late in 1955, a man complained that "a neighbour from Cwm had been sent to Nantyglo hospital because there were not enough nurses in Ebbw Vale".

[1] 'The politics of health: what do the public think about the NHS?' King's Fund 3rd October 2019
[2] on February 19th 2019

11. Mr Bevan understood the root cause of the problem. Anthony Eden's new Government was trying to cash limit healthcare spending and managers were giving priority to budgets over patient's care.

The Level of Service

12. Some have said that the NHS was so much better than what came before, that a little inconvenience was to be expected. The man from Cwm at Mr Bevan's meeting would not have agreed. The local health services in South Wales built around worker funded, local community hospitals was meeting most people's needs.

13. For people from my generation in South Wales, it is fiction to suggest that the NHS made a huge difference. As Mr Bevan stated[3], in 1947 "All I am doing is extending to the entire population of Britain the benefits we had in Tredegar for a generation or more. We are going to Tredegar-ise you".

14. Nor was it only in South Wales that the pre-NHS service was as good, or better, than the later NHS has proven to be in these cash starved times. Last year, I met a 96 year old lady, who had started her career as a district nurse in Porthmadog before the NHS started. "Community care was better then than it is now" she told me, and gave me a book to prove it.

15. It was "The 27th Annual Report of the Madog Memorial Hospital for the year ending March 31st 1946". It makes interesting reading, especially in its anticipation of Mr Bevan's imposition of a National Health Service. The report reads,

> "The Madoc Memorial Hospital has made a real contribution to the health services of this district, and during this period the inhabitants have constantly shown their appreciation of the service by giving the institution their most loyal support. THIS IS AS IT SHOULD BE, FOR THIS HAS ALWAYS BEEN A HOSPITAL OWNED BY THE PEOPLE, MANAGED BY THE PEOPLE, AND RUN FOR THE PEOPLE"

Capacity to Deliver Quality Healthcare

16. The financial crash of 2008 introduced a "cost cutting first" ethos into publically funded services. I was still involved in Whitehall at that time and witnessed the Treasury drive at first hand.

17. The problems that this austerity drive was likely to cause were recognised at the time and highlighted for Wales. A World Health Organisation (WHO) report[4] of 2012 concluded:

> In the next few years, health policy in Wales will be powerfully shaped by significant financial challenges. The decision of the (Welsh) government to allow real health expenditure to decline faster than that in the rest of the United Kingdom – if maintained – will place LHBs and others under relentless pressure and may arouse political controversy.

18. In Wales an 8% population GROWTH was ignored with a 5% DROP in DGH beds and a 39% DROP in other care beds. The result, particularly in rural areas, was as the WHO feared, deep patient dis-satisfaction. Locally accessible services were removed from many rural areas.

[3] NHS 70: Aneurin Bevan Day celebrations in Tredegar". BBC News. 1 July 2018
[4] Health Systems in Transition Vol. 14 No. 11 2012 United Kingdom (Wales) Health system review

19. The latest beds per 100,000 statistics from the E.U. Commission Eurostat service updated to 2017 is

The latest disaggregated UK country figures places Wales on 295.

Impact on Rural Populations

20. There is an illusion that rural residents "have car", "have desire or willingness to travel to obtain healthcare" and even that "they will travel because they have no option". In practice, a sizeable number of rural residents show a marked resistance to travelling for healthcare advice and service[5].

21. In his review of rural health as long ago as 2003, Roger Strasser wrote "People in rural communities often value very highly self-sufficiency, self-reliance and independence. Unfortunately, urban-based policy makers and health service planners often seem to think that the country is just like the city but with a different population distribution, and that it is possible simply to transplant modified urban health services to rural areas"[6].

22. An academic paper on "distance decay[7]" stated:

> "There are trends towards centralising hospital care within the NHS, for many excellent clinical reasons. Yet this has a disproportionate impact upon those patients who live at greater distances from their hospitals".

23. This academic paper by Iain Mungall concludes that increasing centralisation and specialisation of hospital services has some adverse effects on access to care for rural and remote communities and that action must be taken to tackle this by for example, enhancement of primary care and community services.

> "This issue has not been well reported or researched though studies have demonstrated that utilisation of services is inversely related to the distance of patients from hospitals; so called ***distance decay***".

24. A study in Norfolk[8] showed that the number of visits to hospital (outpatients and inpatients) falls with increasing distance from the patient's home to hospital.

[5] Medicare & Medicaid Research Programme
[6] Rural health around the world: challenges and solutions*Roger Strasser, Northern Ontario
[7] Ensuring equitable access to health and social care for rural and remote communities. Iain J Mungall, January 2007

25. The American Journal of Public Health[9] has published many articles over time which advocate that attaining as much self-sufficiency as achievable within the rural area is the model of healthcare delivery that produces the better patient outcomes.

26. In Wales, despite propaganda to the contrary, in the "Care closer to Home" campaign, there has been a drift away from local service provision to more distant point of care, which has caused significant population dissatisfaction and not a little suffering.

27. The population dissatisfaction with the performance of the NHS in Wales is demonstrated in the Charity Commission files. Contributions by the public in Wales to "Friends of community hospitals" organisations, have reduced during the last 9 years. Historically, "Friends of community hospitals" had provided much charitable financial and physical support: Some 'Friends' organisations in Wales have even closed down[10,] and others seem close to closing.

28. It is true that the population in England has also demonstrated dissatisfaction[11] with the service from its NHS also, by a decline in collections by "Friends of community hospitals". In England, there has been some compensation in that Hospital Trusts have assigned some of their more substantial charitable funds for the benefit of community hospitals. There is less evidence in Wales of health board charitable funds being deployed to benefit community hospital services.

What Is Missing In Rural Wales?

29. Remember Minister Gething's aim[12], **"Better outcomes and better experiences with and for our people are what drive this programme for change."**

30. The largest consumers of NHS Wales's resource are older people. A significant 'bulge' in their consumption of healthcare resources is their need for unscheduled care. Yet other countries have shown that the volume of unscheduled care demand can be significantly reduced with effective monitoring of the elderly population and appropriate local healthcare resource.

31. But what measures does the Welsh NHS use to effectively monitor its "better outcomes" performance and hence the pace of improvement? Aneurin Bevan Health Board publish some measures from the International Consortium for Health Outcomes Measurement (ICHOM). These ICHOM Standard Sets are standardized outcomes, measurement tools and time points and risk adjustment factors for given conditions. But publication of their use, and the evidence they could provide, is not widespread elsewhere in Wales.

32. Cwm Taff have published an outcomes study conducted by WIHSC, but few consistent, comparable datasets are published in Wales.

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[8] Haynes and Bentham (1982) The effects of accessibility of general practitioner consultations, outpatient attendances and in-patient admissions in Norfolk. Social Science and Medicine 15. 561

[9] Example: Impact of the rural hospital on clinic self-sufficiency. McLaughlin CP, Ricketts TC, Freund DA, Sheps CG

[10] Example 'The Friends of South Pembrokeshire Hospital' removed from the Charity Commission Register on 9th May 2019.

[11] Mapping community-based financial charitable support for community hospitals in England and Wales: first findings Daiga Kamerāde, John Mohan, Third Sector Research Centre, University of Birmingham 2017

[12] Statement by the Minister of Health and Social Services: an update on the transformation fund 19 February 2019

33. For 50 years, various countries have used a Modified Barthel Index, or similar activity and participation level measures, as a measure of physical disability to assess behaviour relating to activities of daily living for patients with disabling conditions such as from stroke.

34. Much of England monitors older people through the 'Sunderland Community Scheme Score', or through two domains of the Therapy Outcome Measurement tool, i.e. Participation & Wellbeing. A simple measure applied in the Scottish Highlands provided some very useful information. Analysis of place of death by GP Cluster[13] has provided a valuable insight into the variation in End of Life Care currently delivered around the South and Mid Scottish Highlands Division.

35. Unfortunately, not only are statistics on outcome measures hard to find in Wales, meaning that evidence on quality of care management and patient progress is difficult to obtain, but most importantly, **Minister Gething does not have a strategy for providing effective healthcare in Rural Wales** that would "deliver better outcomes and better experiences for people".

36. The transformation fund he has established is, as he has said, "*a developmental one"*, which, Minister Gething makes clear, is "intended to act as a catalyst to speed up the scaling up of new models of care that have the potential to fundamentally change how we deliver healthcare and social care in Wales". Note he does not couple 'improving patient outcomes' as an essential characteristic within these new models.

37. Wales is not a country which possesses proven, more effective, models of care for rural areas. In exploring new models of care for rural residents, Wales lags behind other countries. In the absence of a Healthcare Delivery Strategy for Rural Wales, this presentation reviews some of the models that have been successful, or are being evaluated, for rural residents in other parts of the UK, building upon local community hospitals. Hence this presentation gives pointers to initiatives that might be included in a subsequent Welsh Rural Healthcare Delivery Strategy when one is produced.

Transformation Options

38. Transformation is a science not just a buzzword. In those healthcare models where flexible revenue generation is a significant item, such as Health Maintenance Organisations in the USA or BUPA in the UK, transformation strategies that improve margins are sought.

39. The NHS in Wales, devoid of any purchaser provider model, allows health boards little flexibility to generate significant new revenues. The Welsh NHS has aspirations to obtain 'cost – benefit optimization', but as a model, it predominantly repeats attempts at 'operational transformation'. Health Board meetings consider "forecast cost pressures" and then seek to cut operating costs in order to meet those cost pressures through minor process re-engineering of core activities.

40. Welsh Ministers have made frequent reference to "technology enabled" healthcare transformation, but have recently been forced to admit that this has not succeeded in Wales and have launched a new Strategic Health Authority for digital technologies to deliver a fresh start.

[13] Cluster A&E use and place of death, Scotland NHS Intranet http://intranet.nhsh.scot.nhs.uk/Org/HIP/Performance/Pages/Default.aspx 2018-19

41. Not for profit organisations, of which the NHS is an example, have adopted strategies in various parts of the world based upon "Agile Transformation". The basis of "Agile Transformation" is to extend the use of existing core assets. Throughout the UK, forward thinking healthcare organisations are using "Agile Transformation" approaches to develop their operational models around existing community hospital estate.

42. Community Hospitals are a resource waiting to be developed as part of a strategy of "Agile Transformation". E Pitchforth in her paper[14] "Community Hospitals and their services in the NHS" stated, "The Community Hospital presents a 'fluid' concept, with the greatest advantage perhaps being its flexibility to respond to local needs."

43. Today's health and care development models depend on health boards, GP practices, the Welsh Ambulance Service, local authorities, third party providers and private care home operators collaborating closely. Without such collaboration, even "Agile Transformation" fails.

Lessons From Rural Scotland

44. "Agile Transformation" is not new. In 2006 the eminent Professor Sir Lewis Ritchie wrote the "Developing Community Hospitals – A Strategy for Scotland", in which he encouraged agile transformation by requesting Boards to explore if more community casualty units could be based at community hospitals with Our of Hours (OoHs) centres collocated with them. He also said "NHS Boards should maximise the use of joint planning with local authorities in developing existing and new Community Hospitals according to service needs".

45. A recent review in 2019 by Dr Adrian Baker, rural healthcare specialist and Community Hospitals District Medical Lead, South and Mid Division, NHS Highland, of six community hospitals made several interesting points:

    - Over the last 12 years 2007-19 there has been a 17% reduction in bed availability in the six community hospitals reducing from 136 in 2007 to 112 in 2019. (This compares with a community hospital bed loss of twice this percentage (35%) in Wales.)
    - The Community Hospitals serving the Highland communities are not being fully utilised for End of Life Care. The importance of 'step up' admissions to community hospitals is evidenced by attendances at acute A&E centres since once elderly are admitted to an acute A&E, they often cannot be safely discharged home due to the lack of primary care and social care infrastructure in and out of hours.
    - The 2019 DRAFT NHS Highland Community Hospital Strategy has been written following a number of workshops and meetings in 2018-2019 and was published in May 2019.
    - Placing an out of area patient in the wrong Community Hospital, as can be seen from the qualitative data, results in an increase in length of stay by 2 – 4 times
    - The Scottish Government 2020 vision and Realistic Medicine both prioritise holistic care for people within their **local** communities. There is significant scope and opportunity to reinvigorate these local, cost effective community hospitals around the Inner Moray Firth.

46. The town of Nairn in the Scottish Highlands is one of rural Scotland's principal examples of the benefit of community health and care empowerment. Nairn Town and County Hospital and

[14] Pitchforth E, et al, Community Hospitals and their services in the NHS: Identifying transferable learning from international developments, Health Services and Delivery Research Vol 5; Issue 19, June 2017.

Primary Care Centre was opened in 2010. It is essentially a PFI build with 25 year leases to each of the bodies who use it to enhance the area's integrated care. These are Highland Council, Highland Health Board, Nairn Healthcare Group, Scottish Ambulance Service and the Town & County Dental Clinic.

47. The Nairn Healthcare Group (the Cluster) has commissioned the Out of Hours GP (OoH) service, an older people's visiting service to Care Homes and a minor surgery service, appropriate for the locality. It covers a cluster population of 15,000.

48. In Nairn Town and County Hospital the OoH services are run from the Minor Injury Unit. The MIU provides a Primary Care Emergency Centre service for patients registered with the practice and for temporary residents. The MIU is used by the ambulance services for appropriate patient deliveries.

49. The GPs are available for face to face, home visits and ward patients. This service is run by the local MIU nursing team and the local GPs.

The Story of Rothbury, Northumberland

50. Dr Iona Heath[15] wrote an article in the BMJ "Falling through the gaps in care". Her conclusion that "The gap between hospital and home is unsustainable, and for the sake of our frailest and most vulnerable patients it must be closed".

51. In 2016, a decision of Northumbria Healthcare to remove inpatient bed facilities from some valleys in rural Northumberland proved the accuracy of Dr Heath's prediction.

52. Rothbury Community Hospital serves the Coquet, Aln and Rede Valleys in rural North Northumberland. Due "to staff shortage" and "lack of use" in September 2016, the 12 bed inpatient ward was abruptly, 'temporarily' closed. The community reacted immediately with the formation of the Save Rothbury Community Hospital Campaign, which coordinated support from parish and county councillors, clinicians and staff working in the NHS, legal advisors, journalists, etc. Records were kept of the impact on the communities and the residents and some of the stories were very tragic.

53. In January 2017, the NHS Northumberland Clinical Commissioning Group (CCG) launched a three month public "consultation" announcing a permanent closure of inpatient beds in September 2017, intended to release an estimated £500,000 per annum for use elsewhere in the healthcare system. The justification published was not that the closure enhanced patient care but that as the "NHS Northumberland Clinical Commissioning Group (CCG) we must make sure that all of the resources available to us are used effectively, efficiently and economically".

54. At all times, a number of the elderly residents of the three valleys could not be safely treated at home and were 'out-posted' to community hospitals elsewhere. Their fate added to the volume of tragic unsatisfactory care stories.

55. Northumberland County Council's Scrutiny Committee, after hearing argument from the Save Rothbury Campaign Group and the Local Councillor, refused to accept the closure and referred

[15] 2012 Falling through the gaps in care – Iona Heath – BMJ 2012;345:e7863 doi:10.1136/bmj.e7863

the decision to the Secretary of State. The Secretary of State supported the community and required the CCG to "act in the best interests of the residents of North Northumberland".

56. Early in 2019, the CCG began collaboration with the Coquet, Aln and Rede Valley residents and "a flexible model of care" emerged for caring for patients in the community.

57. A 'virtual ward' is being created with a dedicated matron, nursing and medical team to care for all care in the community patients, either in their own homes or in the Rothbury inpatients' ward at local clinical discretion. Those patients deemed to be sub-acute, to need short term step-up beds surveillance or an interim step-down beds from acute hospital would be admitted to the inpatients' ward. Palliative care will also be available in the inpatients' ward. It will be "personalized healthcare in action".

58. The Northumbria Healthcare Five Year Strategy[16] defined their mission as "to transform the traditional hospital based model to ensure residents are true partners in determining their own healthcare provision". Amongst its declared aims are "maximising patient interaction locally" and "willingness to innovate and take measured risk"

An Agile Transformation Example From Wales

59. The 'salami slicing' cuts in the real healthcare expenditure in Wales over the past decade has impacted everyone, but affected residents of the more remote rural areas in particular. The Welsh Local Health Boards' (LHB's) policy of cutting services in the least populated areas first, has seen access to GP surgeries, pharmacies, and community hospital services made difficult for rural dwellers, even not possible for some.

60. A rural dweller who becomes faced with an episode of unscheduled care need, often has only one recourse, that is to call for the Wales Ambulance Service (WAST). Unfortunately, there has been a combination of developments: Higher numbers of 999 and 111 calls are being experienced, and difficulties are being encountered by Ambulance Service staff in transferring patients from an ambulance into a DGH Unscheduled Care Unit in a timely manner. These have tied up ambulances making them inactive and unavailable for long periods. These ambulances being unavailable have elongated significantly the response time between a rural patient's call for assistance and that assistance arriving.

61. In a new pilot scheme, the new WAST management in Wales has sought to address the challenge by transforming their approach to managing the less serious unscheduled care callout, by engaging a community hospital.

62. Ambulance pick up calls from patients in the intensely rural parliamentary constituency of Dwyfor Meirionnydd (2,100 Sq K) are regularly 35 miles plus from the Unscheduled Care Centre in Bangor. The Centre is invariably busy and the transfer of a patient after the ambulance arrives in Bangor can take more than an hour. WAST and the local health board (Betsi Cadwaladr) arranged for the Minor Injury Walk-in Centre (MIU) in the community hospital in Porthmadog to be staffed 24/7 supported by an 'Out of Hours' doctor service during nights and weekends.

63. By delivering the less seriously ill patients to the MIU in Ysbyty Alltwen in Porthmadog, the ambulance saves a 50 mile round trip to the DGH in Bangor and experiences a quick patient

[16] August 2019 Rothbury presentation 'Building a caring future

transfer. It is therefore available to accept the next call from rural Dwyfor Meirionnydd residents up to 2 hours sooner than if WAST had discharged the patient in Bangor.

64. The pilot scheme commenced in January 2019 with 50 referrals a month to the Ysbyty Alltwen MIU building, mostly by ambulance, with volumes rising towards 100 per month. In practice the transformation of using a community hospital MIU 24/7 would release some 140 ambulance shift hours extra per month to help reduce rural area amber/blue call response times. Unfortunately, despite funding having been announced, the Ysbyty Alltwen MIU is not always open overnight.

65. The county of Powys (5,200 Sq K) in rural Wales has two 24 hour MIUs and one 17 hour MIU which supports rural dwellers in a similar way to Ysbyty Alltwen. Collectively the four rural Wales community hospitals' unscheduled care services enable the Wales Ambulance Service to have on call the equivalent of an additional fully staffed ambulance.

66. Outside WAST, there were clear benefits for patients in obtaining earlier treatment and in being able to return to their own homes much sooner. There is a small reduction in the number of patients presenting at the Bangor DGH unscheduled care service centre. Although numerically small, the mathematics of queuing models is such that the small reduction can make disproportionately large material differences to waiting at peak times.

Rural Wales Priority Need

67. Many promises were made to the residents of Rural Wales in the Wales NHS 'Rural Health Plan' and the subsequent detailed papers. Sadly the promises were never delivered. The media in rural Wales contains in its archives substantial numbers of incidents where the population was let down by the Welsh NHS.

68. Unlike other countries, NHS Wales has not examined the health and care needs of rural Wales residents sufficiently meticulously to produce a strategy that would deliver real improvement. Neither the 'well-being plans' of the Gwynedd, Powys and Ceredigion communities nor the IMTP plans of the three health boards address how the needs of rural Wales will be met.

69. Wales' rural community hospitals perform well on the tasks entrusted to them. Minor Injury Units meet the 4 hour treatment target in 99% of cases. Inpatient beds, and the care they provide, perform positively in regular reviews undertaken by community health councils and in the few inspections conducted by Healthcare Inspectorate Wales.

70. More vigorous application of 'agile transformation' would guide management to explore how they could make even more use of the community hospital estate and expertise. As in Scotland, community hospitals could be deployed in strategies to reduce the number of elderly unscheduled admissions to acute hospitals. As in Northumberland, they could increase their capacity by operating a dedicated unified team 'virtual ward system' embracing both inpatient beds and beds in the community. They could enhance their level of care to embrace more sub-acute care by being led by a community hospitals consultant and their future could be made more secure by including a significant community hospital element in new doctors training experience, as in other parts of England.

71. A serious examination of agile transformation opportunities using community hospitals is needed in rural Wales to address the current care quality deficit in the area including:

- Addressing the backlog of some 7,000 persons in rural wales waiting over 6 months in the referral to treatment backlogs, which are impeding their quality of life. Many rural patients wait over 9 months for a referral to treatment appointment, some over a year. Financially the backlog translates into some £50m of intervention backlog underfunding at English national tariff prices;
- The scandal that, after enduring a long journey to reach an acute hospital A&E, one in five persons in rural wales who attends at an acute hospital A&E has to wait longer than the promised 4 hours for treatment, yet 99% of those treated at a minor injuries unit are seen within that time;
- That more than one in three persons for whom an ambulance is called in rural Wales find that if their request call has been triaged as orange, they have to wait for over half an hour for an ambulance, and too many patients in need have to wait for two hours or more;
- That life expectancy in some inland rural areas in Wales is four years less than life expectancy in many communities on the coast.

72. COMMUNITY HOSPITALS ARE INDEED, RURAL WALES UNDER DEPLOYED HEALTHCARE RESOURCE. A NEW STRATEGY FOR HEALTHCARE SERVICES IN RURAL WALES IS BADLY NEEDED.

DISCLAIMER: Opinions expressed in this paper are the opinions of the author and not necessarily those of the Community Hospitals Association.

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