Rural-Urban Outlooks: Unlocking Synergies (ROBUST)
*ROBUST receives funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 727988.**

August 2018
Aberystwyth University
Jesse Heley
eyh@aber.ac.uk

Snapshot: Expressions of Urban – Peri-Urban – Rural Relationships

The Mid Wales Healthcare Collaborative

Mid Wales

1. Brief Description

The Mid Wales Healthcare Collaborative (MWHC) Multi-institutional initiative was established in 2015 to focus on healthcare in a regional context, by connecting rural provision and service centres in urban areas in Mid Wales. The group is comprised of the: Betsi Cadwaladr University Health Board; Hywel Dda University Health Board; Powys Teaching Health Board; and the Welsh Ambulance Service (NHS Trust). In addition to these core members the MWHC engages with a range of other relevant bodies in Mid Wales including: Localities Authorities; Community Health Councils; Voluntary Sector Organizations; and assorted community groups and health forums in the region.

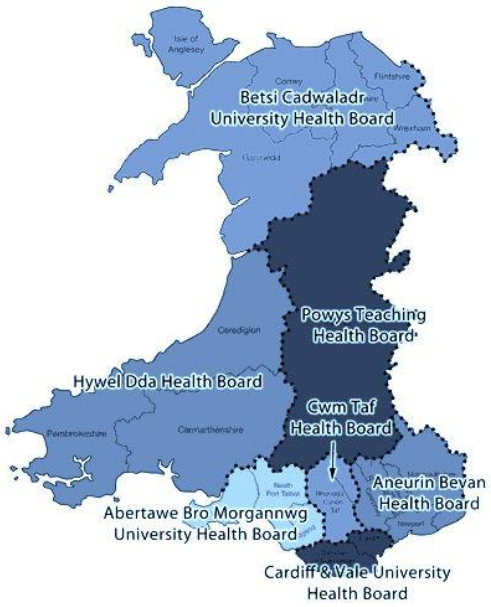

Figure 1: Healthboards in Wales. Source: NHS Wales http://www.wales.nhs.uk/nhswalesaboutus/structure

The work of the MWHC is overseen by a Collaborative Board which sets out a regional work programme - inclusive of priorities and delivery mechanisms - and is situated within a broader national strategy. This national strategy is informed, in part, through the work of Rural Health and Care Wales (RHCW) which pulls together Health Board and Local Authority representatives, as well as research expertise in healthcare (including Aberystwyth, Bangor, Cardiff, Swansea and Trinity St David Universities, and Coleg Cymraeg Cenedlaethol. The work of RHCW focuses on research, public and staff engagement, and workforce development.

The MWHC was established following the publication of the Mid Wales Healthcare Study in 2014. Commissioned by the Welsh Government and undertaken by the Welsh Institute for Health and Social Care (WIHSC), this study was carried out in light of longstanding concerns

regarding the (then) current delivery models to provide safe, accessible and sustainable healthcare in mid Wales. In summary, the report set out the need to institute a joint healthcare governance mechanism in the region (the MWHC) as a basis for addressing and overcoming a series of challenges set out in section 2.

2. Questions and/or Challenges

As set out in the Mid Wales Healthcare Study (MWHS) the delivery of healthcare provision in mid Wales faces a series of identifiable challenges, a number of which are allied (to a greater or lesser extent) to the rural character of the region, and the interrelationship between rural communities and urban centres in this context.

Delivery of care across multiple scales

The delivery of care in mid Wales, and particularly Primary Care (i.e. the first point contact of health care for individuals as normally provided by General Practitioners, but also pharmacists, opticians and dentists), is identified as facing considerable challenges and requiring a response that involves a coordinated response involving local and national agencies.

Governance

Following on from the above, the governance arrangements that characterize healthcare provision in Mid Wales are identified as complex, with no one body 'owning' the issue and able to fundamentally shape the overarching agenda. Notably, the MWHS notes that, currently, there is no fully effective mechanism for ensuring that the three Health Boards working across the region (coupled with ambulance services and NHS partners in England) co-ordinate planning and proficiently monitor comparative performance. The report also highlights current limitations in public- and staff-engagement, with a need for improvement in communications across and between these spheres. With implications for network and territorial relations, the MWHS calls attention to the further potential of civil society institutions as part of this agenda.

Improving access and interconnective relations

The MWHS states that the 'geography of Mid Wales speaks for itself' (MWHS, viii). Referring to comparative shortcomings in access and choice (number/density of transport links, physical distance to healthcare facilities, and capacity of patients to choose the location of care), as well as a need to make increased use of digital communications and telehealth. Outside of issues of patient care, this landscape also impacts on training and recruitment, as well as retaining and attracting staff.

3. Main Insights

3.1. Indications of the application of the new concept of 'New Localities'

The MWHS, and associated MWHC model following on from this publication, very clearly sets out an approach which aligns with the rhetoric of new localities. Specifically, the report identifies current shortcomings in healthcare governance in Mid Wales brought about by an approach which, at times, is overly focused on territorial platforms and does not adequately reflect the movements of people with different needs through and beyond the region. As such, an overly territorial approach adopted in practice by the three Health Boards does not correspond with the circumstances and expectations of the public. For example, in terms of where they expect or prefer to have treatment, and where they might more easily get to in terms of, for instance, appointment times and transport connections. As expected, issues of delivery in rural contexts is highlighted frequently in the MWHS and implicitly problematizes conflating distance, travel times and accessibility:

'[P]opulations in rural towns and villages are relatively small compared with the larger cities and towns of Wales and the road and rail links between them are sometimes difficult. This poses challenges both for those delivering services and for those accessing them in respect of the distances from fixed centres or the travel times to patients at home'

In more conceptual terms, Health Boards might historically maintain a degree of material coherence in the form of territorially defined units of administration, but lack imagined coherence for many of those people who reside inside of these prescribed boundaries; particularly those who might live and work in those liminal zones between two or more Health Board districts. As Jones and Woods (2013) argue, for localities to function well as social, economic and political edifices they require strong material and imagined coherence, and this is arguably not the case for Mid Wales as a space of healthcare delivery.

When considering urban-rural relations in this light, the lack of coterminous relations is very much in evidence in discussions of critical care and the role of hospitals. In total the MWHS identifies ten 'community' hospitals across Mid Wales; spread unevenly across the region and, accordingly, serving differing patient catchments. Moreover, these community healthcare hubs offer a different range of services in each locality, both in number and type. It follows that the 'nearest' hospital for any given resident may, or may not, offer a service they require. This is also the case for the two general hospitals which serve the Mid Wales region (Aberystwyth and Shrewsbury) which provide for the majority of – but not all – the secondary care needs of people in Mid Wales.

It follows that, for some services, patients may need to travel further afield to receive specialist care, both within and beyond the region as a whole, and this reflects the trend of increasing specialization adopted with the NHS over the past 20 years or so. This reflects the emergence of more discrete areas of expertise in line with clinical understandings and technological advancement. Examples given in the MWHS include the decline of general orthopaedic surgeons and the rise of more discrete knee, hip, shoulder, hand and spinal

experts, and the study refers to the well documented cumulative impact of concentrating proficiency in the form of better patient outcomes as measured by reduced morbidity and mortality rates. This transformation from generalist to specialist centres has obvious consequences for the spatial allocation of resources. Specifically, subspecialists are increasingly situated in clusters with commensurate equipment and expertise (e.g. anaesthetists) at a national level. Within Mid Wales, Bronglais retains specialists in a range of fields including gastroenterology and paediatrics, while other centres outside of the region have established expertise in such fields as plastic surgery (Morriston, Swansea) and major trauma (University Hospital Wales, Cardiff).

Hospital services are concentrated in fewer locations, usually in larger urban centres, and at an increased distance from many people in rural regions and localities. The MWHS identifies two overarching policy responses to this trend:

'One is to accept that rural populations, for specialist care, will have to travel greater distances to where that specialist care is based. Another is to explore whether those specialist skills can be retained in, or brought to, rural locations by a variety of changes in the way that medical staff are trained, deployed and refreshed professionally' (MWHS p. 14)

If these policy responses are taken as indicative of what has, is and will happen in healthcare delivery in Mid Wales, then this signifies a clear transformation in rural-urban connections, both in terms of relative and relational space. Most clearly, there is a shifting functional geography of 'travel-to-care' areas characterized by increased rural-to-urban flows within the region, but also flows of patients between rural and urban localities in Mid Wales to care centres in non-adjacent urban locations (Cardiff, Swansea, etc.).

The emergence of specialist care clusters at a national level - and predominately within the Cardiff and Swansea city-regions in the south – is part of an explicit hub-and-spoke narrative of development within the policy literature. However, the practical and political rhetoric of this shift as found within the policy-making environment has not necessarily been reflected in public knowledge of – and attitudes towards – the need and efficacy of this transformation:

'There are excellent examples of such networks working well for Mid Wales and Bronglais in particular; but there are also examples where the arrangements have struggled. There is a need for greater clarity about patient pathways, and on which hospitals are 'hubs' and which 'spokes', based on what is best for the patient rather than what is perceived by some as being an administrative convenience'. (MWHS p. vii)

If the hub and spoke delivery model is becoming embedded within (mid) Wales it is also clear that directions of travel are shifting and not always clear-cut; not only in regard to patient travel, but also in respect to the referral process itself. In this way the networks of healthcare professionals, the spatial reorganization of activities by Health Boards and the everyday geographies of patients (both in terms of physical interactions and imaginations) do not always marry-up and relate easily to each other.

3.2. Insights related to the broad area of 'Smart Development'

In its efforts to address and improve the healthcare, the MWHC is committed to identifying more efficient modes of care delivery that cross institutional and geographical boundaries. In so doing, the language of the group and associated texts is very much in line with the discourse of contemporary planning. As detailed in section 3.1, this includes the narrative-for-change provided by the MWHS and which is ably demonstrated in the following passage on clinical care:

'Clinical networks operate across geographical areas to allow health professionals to co-ordinate the way care is given to individuals … Networks seek to develop geographically specific pathways through which patients move at different times and stages of their care, accompanied by other processes that seek to ensure well-co-ordinated care… They have a major role to play in bringing together disparate hospitals and scattered staff, ensuring that patients can access the specialised care they need' (MWHS p. 88)

Evident in this passage is the need to maintain and enhance strong lines of communication between patients and staff, and between staff based in different geographic locations and professional spheres. This is credited with the capacity to establish trust and improve governance through increasing opportunities for shared decision-making, as well as better capitalize on the 'considerable resources of civil society' (Ibid, p. ix).

Through identifying a drive for locally-embedded care specialization situated within intra- and inter-regional scales, the recommendations of the MWHS clearly resonate with the notion of smart development. Referring to the importance of knowledge exchange, the role of communication and innovation is also foregrounded and particularly as a means to address some of those issues and barriers associated with care delivery in rural communities.

Particular importance is attached to telemedicine, and a lengthy account of the advancements bought about via - and further possibilities afforded by – telemedicine in the MWHS. Referring to the use of technology (including interactive audio, visual and data communications) as a means of delivering healthcare 'at a distance', this potentially encompasses all stages of the process including diagnosis, consultation and treatment, as well as health education and the transmission of medical data. This includes direct patient care where patient and doctor are geographically apart; teleconsultation, referring to the transmission of expert knowledge between health professionals and to non-specialists, and; distance learning, where up-to-date information is provided to doctors in less accessible locations, examples of these types of engagement include the use of sensors and alarms, and videoconferencing.

Taken holistically, telemedicine is identified as a dynamic and rapidly developing field, and the success and feasibility of associated projects is consequently variable – but largely successful. On this basis the Rural Health Implementation Group (RHIG) was established in 2010 by the Welsh Government in order to develop telemedicine and e-health services, with a particular emphasis on rural areas in Mid Wales. Over the period 2011-2013, 30

such initiatives were pioneered consultation with those Health Boards within the MWHC. 'Demonstrating how telemedicine can be used successfully within the NHS in Wales' (MWHS, p.92), the MWHC has been involved in subsequent efforts to identify 'telemedicine champions' able to establish these techniques and encourage greater buy-in, as well as acting as a lobbying force to address connectivity issues (particularly broadband provision) which act as barriers to the development of telemedicine initiatives in remote rural locations.

3.3. Other insights that could be relevant for further work

Healthcare delivery is a challenging agenda given broader social trends (particularly that of an ageing demographic) and the fact that delivery is increasingly centred on specialist centres in large areas of population. This is likely to have a disproportionate impact upon rural residents on logistical grounds, and particularly so where multiple services are coming together. As such, there are strong overlaps with broader infrastructural factors, including transport and broadband (notably in terms of telemedicine).

4. Data Sources and Indicators

Table 1 Data

Data / Indicator	Source
Mid Wales Healthcare Collaborative	http://www.midwalescollaborative.wales.nhs.uk/home
Mid Wales Healthcare Study	http://wihsc.southwales.ac.uk/media/files/documents/2014-10-23/MWHS_Report_-_WIHSC_for_Welsh_Government.pdf

5. Critical Appraisal of Data Use

Much of this data has been drawn from prior studies, reflecting broader trends in Wales. It follows that experiences of healthcare services in specific communities and cases cannot be assumed – especially where the types of services required differ. This extends to intra-rural and intra-urban dimensions, as well as differences across urban and rural localities within Wales.

6. References

European Commission (2010) Europe 2020: A Strategy for smart, sustainable and inclusive growth. http:7eur-lex.europa.eu/LexUriServ.do?uri=COM:2020:FIN:EN:PDF

Martin Jones & Michael Woods (2013) New Localities, Regional Studies, 47:1, 29-42, DOI: 10.1080/00343404.2012.709612