Notes on Rurality

HEALTHCARE IN SHROPSHIRE

Shropshire Defend Our NHS

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Rurality: an introduction

There are two contradictions at the heart of the crisis in our local NHS.

Firstly, our local NHS leaders say that centralising emergency services is good for patients – but the national experts say this is completely the wrong approach for rural areas.

Secondly, NHS England says that healthcare in rural areas costs more to provide, and has promised to develop a funding solution – but instead of doing this, NHS England is insisting on the rapid implementation of £25 million cuts in NHS spending in our own overwhelmingly rural area.

In Shropshire Defend Our NHS, we believe these are fundamentally important questions that should not be ignored.

What's happening to our NHS?

Shropshire is one of the most sparsely populated counties in England. Powys, also served by the two hospitals, is the most sparsely populated area of Wales. The Wrekin is also predominantly rural. The only two urban centres are Telford and Shrewsbury; the rest of the catchment area for the hospitals – including our market towns – is classified as rural. We have an ageing population with increasing health needs; public transport is poor; many of us travel long distances to access healthcare; and our ambulance service struggles to provide an adequate emergency service. All of these factors are relevant and must be taken into account before cuts to local NHS services are implemented.

We have two local A&Es and District General Hospitals: the Royal Shrewsbury and Telford's Princess Royal. The hospitals provide services to a population of more than 550,000 people and a 90% rural area of over 2000 square miles. Local health leaders plan to close one of the A&Es and all the 'acute' services at one of these. The hospital will be sharply downgraded, offering only routine planned care (hip and knee replacements, cataract surgery etc.).

The leaders of the local Future Fit project say that centralisation of services is a good thing, as this leads to more specialist care. The expert body for urgent and emergency care is the Royal College of Emergency Medicine. The RCEM states very strongly that the benefits of centralisation do **not** apply in rural areas because of the long distances travelled to access care. Of course, distance matters. You can have the best healthcare in the world – but it is of no use to you if you're dead by the time you get there. One study found 'dead on arrival' rates at A&Es to vary between 23% and 74%. The lowest rates were at metropolitan hospitals; the highest rates at hospitals in rural towns.

Future Fit was always about cuts, but as Future Fit slides into chaos, the proposed cuts are becoming deeper. NHS England has instructed local NHS leaders to make £25 million cuts in health spending, to be followed by further Future Fit cuts later on. Saving money is being put ahead of patient needs. The threats here are real and immediate. We learned this month of firm plans to close one of the two A&Es as part of 'winter pressures' planning; a 'quick and dirty' approach to closure that would be extraordinarily risky for local people. This is without question financially driven. We may have lobbied hard enough to force a retreat; sadly, we are confident the threat will return soon.

Why are NHS leaders trying to cut our healthcare?

The biggest problem is that there just isn't enough money going into the local NHS. It costs more to provide healthcare in rural areas. Many staff have to travel long distances between visits, for example, and it's much harder to achieve economies of scale for equipment and staff.

In December 2014, NHS England recognised this, and committed to a funding solution for rural areas. Instead, in October 2015, NHS England is insisting that our two local hospitals make cuts of £23 million. NHS England also wants Shropshire Clinical Commissioning Group – the organisation that buys a lot of our healthcare for us – to make additional cuts of £2 million, on top of the deep cuts it is already making. This means cuts to community NHS services such as district nursing and physiotherapy, and more rationing of surgery such as hip and knee replacements.

Of course, there are severe funding problems affecting many hospitals in England. There are some complex policy issues here, because the NHS as a whole remains completely affordable. The way funding works, though, is that a challenge in the city becomes a crisis in the countryside. Funding arrangements are inequitable. There is a very strong case for a 'rural premium' to offset some of the extra costs in Shropshire and other rural areas.

A separate issue is that national funding arrangements for A&E care and unplanned hospital admissions are poor, meaning that most hospitals make a loss on these core services. This is a particularly serious problem for smaller hospitals – like the Royal Shrewsbury and the Princess Royal – because it is harder for them to offset the loss against more profitable services, as larger specialist hospitals can.

These are the factors that lie behind local NHS deficits. Funding arrangements are unfair and are leading to inequitable healthcare for people in rural areas. There is not 'too much healthcare' locally. Rather, there is just not enough funding coming into the local NHS to enable the NHS to keep going. The unfair funding for the countryside means we now face cuts that will – almost without question – kill people. Because we have a local 'health economy', covering our urban centres of Telford and Shrewsbury as well as more rural areas, **all** of us who depend on the local NHS will lose out.

There's another problem as well. The Board of the two local hospitals is setting the agenda on this – and they are about as wrong as they could be. They find it hard to recruit staff – reflecting national problems, as well as local problems that they could and should have dealt with. They are adopting a backward and protectionist attitude, saying that if they can't offer services, then patients can't have them. This is completely outdated. Good practice now is for different organisations to work together to provide care. If our hospital trust can't provide services, they need to work with other hospitals that can.

What will happen if an A&E closes?

We know that this will kill people because this is what the research shows. When ambulances have to travel further, mortality rates increase. Although the impact is different for different conditions, the overall impact of longer journeys to A&E is demonstrably negative, with an increased risk of death.

Whichever A&E closes down, there will be life-threatening journeys for an increased number of patients. Some of the figures are genuinely shocking. For example, if the Royal Shrewsbury closes, 14% of South Shropshire patients would spend an hour or more in an ambulance before they reached A&E – an increase of almost 10%. For Powys, more than 50% will travel for over an hour (up from 6%). Unnecessary deaths are an inevitable consequence.

We think it's completely unacceptable for this to be turned into a 'Shrewsbury versus Telford' contest, with an argument about whose lives matter most, or which closure would lead to more deaths. The reality is that we need both our A&Es and both our hospitals in an area of this size.

Is there an alternative?

We have to insist on an alternative – because the consequences are so disastrous if these cuts go ahead.

Most importantly, we need a 'rural premium' for Shropshire, and for The Wrekin too. Without extra funding for our area, we face deep NHS cuts and NHS services that cannot possibly meet our needs. We will not have equitable healthcare without extra funding. Ultimately, this is a political question. We need our local MPs to be steadfast in lobbying for adequate funding for our area.

It has become clear that local health leaders are trying to impose an urban model of healthcare on our largely rural area. Centralisation is not the answer for rural areas; the national experts are clear about this. We need the appointment of a senior 'Rural Lead' in Shropshire Clinical Commissioning Group, and a careful review of the overall health needs of our area before damaging centralisation and closure take place.

Healthcare in Shropshire cannot be dictated by the short-term organisational needs of our local hospital trust. Good practice is for hospitals to work together to assemble 'clinical networks' – so that patients can have the care we need. It is really not good enough for our local trust to use recruitment difficulties in some clinical areas as an excuse for closing down a whole acute hospital.

We need 'joined up' care. Currently, services are fragmented and different NHS organisations do not always work together well. We would like to see pooled budgets for community NHS services, hospital services and social care. We think it is probably time for these organisations to merge, too. This could create opportunities for better care built around the needs of patients.

'Telehealth' solutions are not a panacea, but are a part of the solution for increasing access to specialist care. There are also mobile diagnostic imaging techniques and point of care testing solutions that could greatly reduce the need for long journeys to hospital. Investment and positive innovation, rather than cuts and closures, offer a way forward for rural areas.

'Bottom up' change is far safer for patients than a 'big bang' of closing an A&E and a hospital. We have excellent GPs, a strong network of community hospitals, and skilled and hardworking NHS workers locally. Change in Shropshire needs to start with building on these strengths.

This paper is written as a contribution to the debate by members of Shropshire Defend Our NHS. This is an organisation of local people, including health workers and social care

practitioners, all of us desperately concerned by what is happening to our NHS. The coming months will be decisive in determining the future direction of local NHS services. These introductory pages are a summary of the more detailed notes that follow. We are very happy to provide further information on anything we raise here, and, if you wish, to attend a meeting of any local organisation to explain our case. The NHS is too important to lose.

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Notes on Rurality

Two contradictions

There are two contradictions at the heart of the crisis in our local NHS.

Firstly, our local NHS leaders say that centralising emergency services is good for patients – but the national experts say this is completely the wrong approach for rural areas.

Secondly, NHS England says that healthcare in rural areas costs more to provide, and has promised to develop a funding solution – but instead of doing this, is insisting on the rapid implementation of £25 million cuts in NHS spending in our own overwhelmingly rural area.

This is not a coherent or rational approach to redesigning NHS services. In this paper, we explore these contradictions more fully. We also offer the beginnings of an alternative approach, evidence based and drawing upon recognised good practice.

What the experts say

The Royal College of Emergency Medicine is the professional body representing specialist doctors in Emergency Care, and seeking to maintain clinical standards in A&E and Emergency and Urgent Care settings. The CEM has this to say on the centralisation of emergency services:

Urban areas are most suitable for centralisation of services. Clinicians can work in more than one unit thus retaining skills, patients are not geographically or psychosocially disadvantaged and economies of scale are maximised. ***In rural areas, significant clinical benefit is lost as a result of increased transport times and none of the advantages stated for urban areas pertain[1].***

(Written evidence to the Health Select Committee, May 2013; our emphasis).

Duplication?

We currently have two A&Es attached to two District General Hospitals: the Royal Shrewsbury Hospital, and Telford's Princess Royal Hospital. Both hospitals offer acute services. The Board of the Hospital Trust, and the Boards of our two local Clinical Commissioning Groups (Shropshire CCG and Telford and Wrekin CCG) perceive two hospitals as 'duplication'.

They argue that centralising services will be of benefit to patients, stating for example that there will be: *Better clinical outcomes through bringing specialists together, treating a higher volume of cases routinely so as to maintain and grow skills[2].* It's a message that has been repeated again and again at public engagement events.

Their plan is to move to a single 'Emergency Centre' – a combined A&E and acute hospital – either at the Princess Royal Hospital or the Royal Shrewsbury. The other A&E and acute hospital will be lost; replaced with a lower level Urgent Care Centre and a sharply downgraded hospital offering only routine planned care.

They can't both be right

There are two opposing positions here. The national experts in emergency care say that centralisation is not in the interests of rural areas. Our local NHS leaders say that centralisation is

best for Shropshire because it leads to more specialist care, and having two A&Es and two hospitals is just unnecessary 'duplication'.

The outcome matters for Shropshire, because peoples' lives depend on getting this decision right.

The Royal College of Emergency Medicine is not alone in believing that the needs of urban and rural areas are different.

For example, a comprehensive 2014 review of rural healthcare needs notes:
Accessing services is the foundation of health. Distance from services and support can have a great impact on rural health… In terms of getting timely services to people and getting people to services across primary, community, secondary/specialist and social care, access needs to be improved across the spectrum, from emergency survival to the convenient delivery of routine services[3].

'Access needs to be improved' – yet the proposals for Shropshire and Telford and Wrekin will make access for our majority rural population far, far worse.

A 2011 Welsh report, written to support the implementation of the Welsh Rural Health Plan, highlights the current trend towards the centralisation of specialist services, and comments:
However, this centralisation of hospital services has a disproportionate disadvantage upon those patients who live at a distance from their hospital[4].

One literature review of healthcare in rural areas comments:
The trend towards centralisation of hospital services pays too much attention to the advantages of centralisation and not enough to the extent to which delays in reaching hospital contribute to preventable death. More research is needed into the wide variation in dead on arrival statistics seen at different hospitals, and in the extent to which delays in reaching hospital contribute to preventable deaths[5].

While another describes the circular trend of centralisation reinforcing specialisation, which in turn reinforces further centralisation, and states:
What is the impact of these trends on remote and rural communities?
There is an impact of centralisation and specialisation on access to care; services are taken up less often or later. This negative impact is disproportionately felt by those people who have low incomes, poor access to transport, and by elderly and disabled people[6].

A consensus emerges from the experts around the health needs of rural communities. There is a widely recognised phenomenon known as 'distance decay'. The further people have to travel to access healthcare, the less likely they are to utilise that care – to the detriment of their health, and – for some – with a very real risk to life.

We think our local health leaders have looked at the quality of care solely in terms of what happens to patients once they arrive at the hospital. From that perspective, the centralisation of care may be justifiable. This is not a holistic approach, though, and it can lead clinicians to reach conclusions that are at odds with the best available research on the health needs of rural communities. Putting it simply, our local health leaders have got it wrong. One size does **not** fit all, and the national experts on rural healthcare needs are very clear about this. What is happening in Shropshire is an attempt to impose an urban solution on a predominantly rural area. For our rural communities, worse access means worse healthcare.

Our catchment area and population

The local hospital trust is SaTH (Shrewsbury and Telford Hospital NHS Trust). It serves the populations of Shropshire, Telford and Wrekin, and parts of Powys (over the border in Wales). The provision of services to Wales may seem like an anomaly, but is an established reality based on patient need. Powys would not readily justify an acute hospital of its own, Shrewsbury is the historically established major town for the Eastern areas of mid-Wales, and the geography of Wales (the Cambrian Mountains, together with long distances) makes access to Bronglais Hospital in Aberystwyth particularly difficult for many people living in the Welsh borders. The hospitals also serve smaller numbers of people in Herefordshire and other neighbouring counties.

The two urban centres are Telford, with a population of around 155,000, and Shrewsbury, with an estimated 71,715 people. Together they account for around 40% of the overall catchment populations for the two hospitals. The remainder of the area is classified as rural by the ONS, and is split between relatively small market towns and very sparsely populated rural areas. The total population of Shropshire is 306,100 people, while Telford and Wrekin has a population of around 172,000. The Powys catchment population is a little harder to define. The population of the historical area of Montgomeryshire, currently 63,779, certainly depends on access to the Royal Shrewsbury Hospital. The hospital trust uses a larger number in calculating its own estimate. The total population of Powys is around 132,700.

The population density of Shropshire is 97 people per square kilometre (compared to an English average of 413), making this one of the most sparsely populated local authority areas in England. Powys, with its population density of 26 people per square kilometre, is the most sparsely populated authority in Wales. Both Shropshire and Powys have populations much older than the national average, with all the issues around health needs that follow from this. The older population is increasing faster in Shropshire and Powys than most of the UK (a pattern typical of the UK's rural areas). People in Shropshire and Powys encounter the problems common to many rural areas: poor access to essential services (including GP access), poor road networks, and exceptionally poor public transport. Social exclusion is a very real issue. In surprisingly large parts of Shropshire and Powys, broadband is poor or even non-existent, as are reliable mobile phone signals.

The local authority area of Telford and Wrekin has different characteristics. The population density, at 580 per square kilometre, exceeds the average for England. The population is younger. Social deprivation is higher than in Shropshire and Powys. The local authority is dominated by the urban centre of Telford. The areas around Telford, however, remain predominantly rural.

The two hospitals in total cover a population estimated at 556,812 people. Around 60% of these people live in rural areas. Geographically, the catchment area for the hospitals – a vast area of more than 5000 square kilometres – is 90% rural. (It is worth noting that the average [mean] catchment population for an A&E and acute hospital in England is currently a little below 293,000 people. Many acute hospitals will obviously serve smaller populations than this. In our own area, with the additional consideration of rurality, two A&Es and hospitals can readily be justified).

The data here are primarily from ONS reports and census data; the Telford and Wrekin population estimate is that of the local authority; the total catchment population for the hospitals is taken from the draft Future Fit Strategic Outline Case.

If we lose local hospital facilities, what does this mean for people in our rural areas?

Ambulance conveyance times for patients with 'time critical' conditions

Recent Future Fit data analysis took actual patient journeys by ambulance occurring over the course of a year, and re-modelled this data by different Future Fit outcomes (i.e. the consequences of patients being transported by ambulance to a single Emergency Centre in either Shrewsbury or Telford)[7]. The analysis is not confidential, but has not been widely shared with the public. The data underline the very real risk to patients if emergency services and acute care are centralised.

If the single Emergency Centre were to be based at Telford's Princess Royal Hospital, an outcome long thought to be the most likely, ambulance journey times would increase very sharply indeed for residents of rural Powys and the rural areas of South, South West and North West Shropshire.

Currently, around 6% of Powys residents with a 'time critical' condition face an ambulance journey of an hour or more to reach A&E. If the A&E at Shrewsbury were to close, and patients travel instead to Telford, this percentage would increase to over 50%. More than half of these dangerously ill patients, needing time critical medical care, would spend over an hour in the back of an ambulance before they reach A&E. These journey times would apply to an estimated 458 Powys residents each year. The number facing journeys of 45 minutes or more would be a shocking 734. These times are of course additional to the time spent waiting for an ambulance to arrive in the first place.

For the large rural area of South Shropshire, currently around 4% of residents with a 'time critical' condition face an ambulance journey of 60 minutes or more to reach A&E. With a Telford Emergency Centre, this would increase to 14% (around 120 people in a year). Again, the ambulance response times would be added to this.

In the local authority district of Oswestry (the town and the surrounding rural area), ambulance journey times would increase by an average of 19.2 minutes. This would give an average journey duration of just over 45 minutes. With current emergency provision, only 14 'time critical' patients (in Oswestry and North Shropshire districts combined) face an ambulance conveyance time of 60 minutes or more. With a single Emergency Centre at Telford, the number of 'time critical' patients having to endure these very long journeys would increase from 14 to 53. As before, ambulance response times are additional.

There can be no question that these longer ambulance journey times will cause an increased risk of mortality for a significant number of patients.

If the A&E at the Princess Royal Hospital were to close, the number of patients with very long ambulance journey times would be less – but the pattern of increased times would be the same. Longer journeys would apply particularly to patients living in the rural areas to the north of Telford.

We stress that there is no suggestion in this paper that services should be taken away from the Princess Royal Hospital and given to Shrewsbury instead. Our purpose is to highlight the particular difficulties facing rural areas (including The Wrekin), not to call for worse healthcare for the residents of Telford and Wrekin. We regard attempts to set up a 'beauty contest' between the

Princess Royal Hospital and the Royal Shrewsbury Hospital as divisive and counter-productive. The need of local people is for equitable access to healthcare wherever we happen to live.

Ambulance response times in Powys and Shropshire are already poor. In Shropshire, the CCG chose last year to respond to repeated failure to meet national targets by opting out of them altogether! The closure of an A&E would result in longer journeys, increasing the pressure on response times because ambulances would, on average, spend a longer time with each patient. There are no plans within Future Fit to increase funding for the ambulance service when emergency care is centralised.

Research evidence from the UK shows very clearly indeed that mortality rates rise as the length of ambulance journeys to emergency care increases[8]. Although the impact is different for different conditions, the overall impact of longer journeys to A&E is demonstrably negative, with an increased risk of death. The data from Future Fit modelling should cause local NHS policy makers to stop and think again.

Interestingly, the most senior clinician involved with Future Fit recently admitted that some patients locally will have an increased risk of mortality if they have to travel further to a single Emergency Centre. He acknowledged this in a small meeting of Future Fit decision makers. The following week, he was asked about this same issue in the more public setting of a Board meeting – and would not answer the question.

What else does the research show?

Several recent literature reviews effectively summarise the unique health issues facing rural populations[9, 10, 11]. There is evidence that the number of visits to hospital (for outpatient and inpatient episodes) falls with increasing distance from the patient's home to the hospital. Distance from home to an A&E department is a major factor in reducing utilisation rates. For people suffering from asthma, rural dwellers have both lower rates of hospital admission and higher mortality rates. Prognosis and survival rates for some cancers are inversely related to distance from a GP. Diabetic patients living in rural areas experience worse outcomes than their urban counterparts, with higher rates of diabetic retinopathy. Evidence from several studies shows that trauma deaths are higher in more rural areas, and at their highest when there is no major A&E department in the district. 'Dead on arrival' rates vary hugely, and are lowest in urban areas and highest in rural areas. There are also inequalities in access to 'gold standard' treatments. Patients living more than 20 km from a centre offering coronary angiography and revascularisation are less likely to receive this care. Treatment delays in accessing early CT scans for acute stroke and early percutaneous coronary intervention for acute myocardial infarction may reduce the advantages of the approach.

The pattern of disadvantage in terms of access to healthcare seems to be a consistent one. In most areas of rural England, patients have worse access to high quality healthcare, and therefore experience outcomes – sometimes including death – that are unnecessarily poor.

There is nothing here that should be surprising. This is about access and mobility. People who have to travel long distances to healthcare are less likely to use it, and – when they do – are more likely to experience a delay in accessing appropriate care. Public transport is poor or absent in many rural areas. Older people, people living in poverty, disabled people and people with the greatest health needs are the least likely to have independent access to a car, compounding the

difficulties they will experience in accessing care. Friends and relatives will often find it harder to provide support, for the same reasons.

Of course these things will impact on health outcomes. This will be true in Shropshire just as it is true elsewhere.

The role of specialist care

This is not an argument against specialist care. Patients with multiple injuries are best treated in a major trauma centre. Patients with severe brain injury require specialist neurological care. Where it is in patients' interests, it is of course appropriate to transfer patients to the unit where they will receive the very best care – or to take them straight there if their condition allows this. The need for specialist care, however, should not be used as a justification for closing down local hospital facilities in the full knowledge that patients will die as a result. Two very different issues are being deliberately confused to provide clinical cover for cuts.

There are some time critical conditions where time to treatment is the single most important factor. This applies, for example, to patients with acute respiratory distress, severe blood loss, anaphylactic shock, status epilepticus or poisoning. The condition of sick children may deteriorate very rapidly. Placental abruption is a time critical emergency, with delay threatening the lives of the baby and his/her mother. Other conditions again are somewhere in between. In urban areas, stroke outcomes have been improved through the establishment of specialist stroke centres, seeing large numbers of patients. Benefits *may* apply in rural areas, but there is also a trade-off between quality and time. There is a need for more research into this. Care of cardiac patients has improved greatly in recent years, with far better outcomes than in the past. However, for myocardial infarction, 'time is muscle', and delay in reaching care may result in morbidity or mortality. A slightly unfunny local joke is 'You only have one heart attack in Ludlow'.

It is too simplistic to simply argue that specialist care is a good thing if this means patients die on their way to that care; time critical conditions need *timely* care. One size does **not** fit all. The unthinking application of an urban model to rural emergency care is not in the interests of patients. For commonly occurring time critical conditions, it is a reasonable objective to provide high quality care at *enough* locations that access and outcomes are not unreasonably compromised. This is about the lives of local people, and we fear this has been forgotten by decision makers. The Royal College of Emergency Medicine view is worth reiterating: *Urban areas are most suitable for centralisation of service…. **In rural areas, significant clinical benefit is lost as a result of increased transport times and none of the advantages stated for urban areas pertain.***

Thinking it through

Although access to emergency care has caused most public disquiet, other aspects of healthcare will be affected. Very obviously, family members will find it more difficult to visit loved ones who are critically ill or dying. This is a very real issue. The partners of those who are seriously ill are often older, less likely to drive (or unconfident about driving longer distances), and often in poor health themselves. It is worth pausing to think this through. It is not a trivial matter for a frail 85 year old woman to travel for several hours by public transport to visit her sick husband in hospital – and then travel several hours back home. She would not meet criteria for patient transport as she is not a patient.

The same problems will arise for planned care, as many diagnostic and elective procedures are intended to be centralised at a single Diagnostic and Treatment Centre. Wherever this is sited, a significant proportion of users will face longer journeys to attend appointments. The same will apply for accessing follow up care. Even for patients, criteria for accessing patient transport in Shropshire are restrictive. If someone is theoretically able to use public transport, they are not entitled to use patient transport – even if there is no public transport available between their home and the site of their appointment. Taxis may be prohibitively expensive for longer journeys.

Access is not a detail. Our NHS leaders in Shropshire pay lip service to rurality and access – and then ignore all the issues that arise from these things. Access is **fundamental** to the provision of healthcare in a rural area.

Acute healthcare cannot be seen as something that starts and ends at the entrance to the hospital. Centralisation of acute care reduces access for people living in rural areas. This is about the loss of equitable care. A model of care that may work well in an urban area can have unintended consequences in a rural area. There is a clear and evident risk of creating barriers to access through the cost and time of travelling to essential healthcare. This will apply particularly to older people, people with disabilities, and poorer people – and, ironically, to people with the greatest health needs.

The unfulfilled promises of Future Fit

Future Fit – the NHS centralisation plan for Shropshire and Telford and Wrekin – is in chaos now. After nearly two years of work, and the wasted expenditure of over £2 million, Future Fit has all but collapsed. Future Fit was always intended as a cuts package, but the original proposals included some positive strands too. The project has fallen apart because Future Fit spending cuts were not deep enough or fast enough to satisfy NHS England or hospital regulator the Trust Development Authority (TDA). Local NHS leaders are attempting to salvage the Future Fit name and brand, but much of the clinical content of Future Fit has disappeared. Future Fit's positive aspects would have been costly, and we are therefore unlikely to see these implemented.

NHS bosses met on 1st October to decide which A&E and hospital to close down. They ducked the decision, and agreed to put Future Fit on hold while they progress deep spending cuts instead. The current position is that the local NHS has been instructed by external agencies to resolve underlying deficits: an anticipated 2015/16 deficit of £23 million at the two hospitals, and a £2 million deficit at Shropshire CCG. We also know of prior cuts plans for Shropshire CCG: for £9.4 million this year, to be followed by £7.4 million a year for the next 5 years[12]. These are very deep cuts. Because the CCG is the 'commissioning' body, cuts to CCG spending impact directly on provider organisations, including the hospital trust, Shropshire Community NHS Trust, and the Robert Jones and Agnes Hunt Hospital.

In the short to medium term, if these spending cuts are progressed, we therefore face deep cuts also to NHS care in Shropshire and Telford and Wrekin. We know from the Chief Executive of Telford and Wrekin CCG that the intention is still to close an A&E and an acute hospital. We also know that the hospital trust is very likely indeed to move quickly to close one of its A&Es, to be followed by beds being juggled around as the trust more gradually progresses the closure of one of its acute hospitals. A&E closure could happen in 'weeks or months', according to one SaTH Director.

The more positive aspects of Future Fit are worth noting. There were bold promises of care closer to home and community alternatives to hospital care, of joined up care, of proactive management of long-term conditions. We whole-heartedly supported these ideas – and we wish to go a good deal further, towards the idea of hospitals at the heart of fully integrated care as outlined in the Royal College of Practitioners' Future Hospital programme[13].

Unfortunately, there were no meaningful attempts to progress the positive aspects of Future Fit. The only areas of Future Fit to be taken seriously were the plans to close one of the two A&Es, and to centralise acute care at one hospital site, and planned care at the other. Other options for hospital care were ruled out as 'unaffordable'. There were never coherent plans for the community alternatives to hospital that were promised, and proposed investment in community services was very small indeed. The fate of Rural Urgent Care Centres, intended to compensate for reduced access to emergency care, is instructive. Rural Urgent Care Centres were 'kicked into touch' – separated from the plans to close an A&E and acute hospital, required – if they ever happen - to conform to a model that would make them unviable, and with no protected budget or timescale for implementation. With Future Fit now falling apart, it seems increasingly unlikely that Rural Urgent Care Centres will be established. Even Urban Urgent Care Centres received little attention from Future Fit leaders, beyond an extraordinarily bold assertion on the numbers of patients they will treat.

Future Fit has (or had) become a two-fold programme: centralisation of services in order to make financial savings, and a narrow vision of hospital care that starts and ends at the hospital entrance. Although the Future Fit brand has been retained, the project has now been largely overtaken by something even worse – a crude cuts package intended to achieve £25 million savings, probably at speed, in an unmanaged way, and with little or no attempt to replace lost hospital services with community alternatives. The agenda is in practice driven by the catastrophic lack of NHS funding for Shropshire, and within that context by SaTH's funding squeeze and short-term organisational needs. This is not patient-centred care, and is very far removed from the evolving models that are increasingly recognised as best practice at national level.

One driver for change: the money isn't there

In December 2014, the Board of NHS England clearly acknowledged the additional costs of providing healthcare in rural areas, and committed to making it a priority to develop a 'more comprehensive approach to adjusting for rurality/sparsity'. This is important. At Board level, NHS England understands that it costs more to provide healthcare in rural areas, and has taken responsibility for identifying a funding solution for this – although it has not done so. Instead, NHS England has made it clear that £25 million short-term savings must be made from local healthcare, including £23 million from the Royal Shrewsbury and Princess Royal Hospitals.

Because of the importance of this, the decision made by the NHS England Board is included here:

*As previously agreed, we are also reviewing potential methodologies for addressing the **additional costs faced by rural areas**. Whilst rural deprivation issues are picked up in the CCG formula through the adjustment for unmet need based on the Standardised Mortality Rate under the age of 75 and there is a specific adjustment to the ambulance funding formula to reflect the challenges of rural geographies, **there is a prima facie case for a more comprehensive approach to adjusting for rurality/sparsity, and we***

will therefore make this a priority within our development programme over the coming year[14] (our emphasis).

This is quite explicit. There is no rational justification for the continued shortfall in funding to our local health service, and no rational justification for NHS England's role in demanding the implementation of deeper cuts to local healthcare. There is an imbalance of funding that means that a challenge in a city becomes a crisis in the countryside. Structural problems in the English NHS funding policy penalise rural areas very severely indeed. Because we have a 'local health economy' that covers Shropshire, Telford and Wrekin, and parts of Powys, these inequitable funding arrangements affect *all* of us locally, irrespective of whether we live in a rural area or in Shrewsbury or Telford. The overall character of the area is overwhelmingly rural; the underfunding of rural healthcare is therefore a real and damaging issue for our towns as well.

At the time of writing (October 2015), there is also an escalating crisis in the English NHS. Interestingly, there is emerging evidence that this is a *manufactured* crisis. The Department of Health as a whole is underspent, but the money allocated to provider organisations has been progressively squeezed since 2010[15]. NHS commentator Roy Lilley suggests, *'Keeping the Trusts short of money is a policy choice and piles on extra pressure which exacerbates the problems of day-to-day running; special measures palaver, impact on quality and good people leaving their jobs'*[16]. This sums things up quite well.

After £20 billion of 'efficiency savings' under the last government, the NHS has now been told it has to find a further £22 billion savings by 2020. Most knowledgeable commentators agree this is unachievable without deep cuts to patient care. Around 80% of hospitals are currently in deficit, because they cannot provide adequate patient care *and* balance the books at the same time. Deficits are spiralling. The BMA describes this situation as 'a funding crisis'. NHS regulators describe this as the worst financial position in a generation. This winter is likely to be an exceptionally challenging one for the NHS. This is without question an England-wide problem, and the problems are deep enough to raise significant concerns for the future of the NHS. It is worth reiterating, though: this is an unnecessary crisis, caused by the withholding of funds from the organisations providing NHS care, even though this money is currently available within the NHS. The idea that the NHS is unaffordable is not substantiated. The money is there.

It is these national problems – an England-wide funding crisis **and** a funding bias against rural areas – that are creating our local situation of deep NHS deficits.

The funding crisis being experienced by SaTH, the hospital trust, is very real. The trust had aimed to use Future Fit to make recurrent savings of at least £12 million a year, simply to remain viable. We are now being told of a short term requirement by NHS England and the TDA that SaTH achieves a further £23 million cuts, its predicted deficit next year. We also now know of Shropshire CCG's £2 million deficit, and this apparently must also be cut from local healthcare spending.

The question is, however, whether it is appropriate for deficits to be the driver for reduced access to healthcare for over half a million people. These deficits have not occurred because local health organisations are somehow being reckless, or spending too much money on healthcare. The underlying problem is that there is not enough money going into the NHS in Shropshire or other rural areas in the first place.

The case for a rural premium

There is a compelling case for the allocation of a 'rural premium' to the organisations commissioning or providing healthcare in rural areas[17]. Most importantly, it costs *more* to provide healthcare in rural areas. Health professionals who travel between appointments are less productive. It is harder to achieve economies of scale, with a requirement for higher spending on staff and equipment. In the current era of staff shortages, there may be additional costs incurred through the use of locum or agency staff. There is broad agreement amongst commentators, in the UK and internationally, that there are significant excess costs in delivering healthcare to rural communities. There have been fewer attempts to quantify these costs. Evidence from the Scottish mainland shows that health boards covering rural areas require up to 10% of additional resources per head to cover the additional costs of hospital services, and up to 23% for General Medical Services (GMS) costs[18].

NHS England is the only UK country to make no financial recognition of the increased costs of healthcare delivery in rural settings (other than a payment for increased emergency ambulance costs). Scotland, Wales and Northern Ireland all use funding formulae that make a significant adjustment for rurality.

The 'weighted capitation formula' in use in England has taken NHS funding policy in an opposite direction, with a strong bias *against* rural areas. Allocations policies have come and gone, but the pattern has been a consistent one of inadequate levels of per capita funding to rural areas, and – surprisingly - to those areas with older populations[19] [20]. In 2009/10, Ministerial intervention prevented a significant transfer of NHS funds to rural areas. This inequity was slightly reduced in 2011/12. In 2013/14, there was to have been a new allocations policy – one that would have given additional funds to areas with older populations, and indirectly to rural areas. It was cancelled by NHS England. In 2014/15, this was replaced by a policy that reversed the (cancelled) policy – maintaining an arrangement that continues to result in inadequate NHS funding for rural areas. The history is outlined by Asthana and colleagues[21]. The reality is that rural areas in practice subsidise the NHS in metropolitan areas. This is a clear anomaly, given that rural areas – typically with older populations with more health problems – have a greater level of need.

There is effectively a 'double whammy' for Shropshire and other rural areas. There is no additional NHS funding available to meet the additional rurality costs incurred by health providers in our area. Also, the NHS funding arrangements introduced in 2014 reduce the 'weighting' given to age. This is extraordinary, given the sharply increased health needs of older people and our ageing population – but areas with older populations receive *less* funding support than in the past. Shropshire, dealing with rurality and an older population, loses out twice. NHS funding is a complex area – but a member of the BMA Council has argued that patients in the countryside are left at a 'severe disadvantage', with rural areas under-funded by hundreds of millions of pounds[22]. We are not receiving equitable healthcare.

There are three other problems:

The 'national tariff' for NHS care means that hospitals make a loss on providing emergency care and unplanned hospital admissions. This is a major problem for small hospitals, often those in rural areas. Big teaching hospitals can offset those losses against other work, but for hospitals like the Royal Shrewsbury and the Princess Royal, this is their 'bread and butter'. They make a loss on the day-to-day work that we require them to do – patching us up or saving our lives in an emergency.

The system is rigged against them. They're set up to fail. Next year's predicted £23 billion deficit in our two hospitals comes from them treating us when we're sick, and doing it really very efficiently.

The removal of the 'Minimum Practice Income Guarantee' (MPIG) has caused great anger amongst GPs. It will result in reduced funding for GP practices in the most sparsely populated areas, and there is a risk of reduced GP coverage as a direct consequence of this[23].

And finally, rural councils receive less money per head of the population than urban councils - and that means there is less money going into social care. It is the same pattern as the NHS - an overall funding cut (albeit deeper in local government), but affecting rural areas particularly badly[24].

When our two hospitals and Shropshire CCG go into deficit, this is not the fault of NHS managers. The local financial crisis arises from the way NHS funding works. The current NHS funding formula has been a disaster for Shropshire, with our rural and relatively old population. There is now insufficient money going into our local NHS to fund routine NHS care. Our hospitals are in crisis, and our CCG is making cuts in areas such as hip and knee replacements and spinal injections for people in very severe pain. Budgets for provider organisations are being hugely squeezed across the NHS, which is why we are starting to see cuts and closures across the country – but many rural areas are being tipped into even greater crisis. An argument for equitable healthcare is surely not unreasonable. This is absolutely **not** an argument to cut NHS spending in urban areas; rather, we need to see adequate funding for healthcare provision across England as a whole.

The solution to systemic funding problems cannot be to drive through £25 million cuts in local NHS care. We need a political solution: a recognition by the government and by NHS England that the provision of healthcare in rural areas incurs additional costs, and a more realistic financial recognition that older people –even when in relatively good health – still tend to have health needs that are greater than those of younger adults. NHS England has made a firm commitment, almost a year ago, to address the issue of rural funding. This now needs to be taken forward. If the work has not yet been done, there is an urgent need for interim arrangements to stop the collapse of local healthcare. We also ask our MPs to lobby hard for the funding that Shropshire needs. This is now urgent. **A rural premium is an absolute necessity.**

Another driver for change: "staff shortages"

The underfunding of the NHS in rural areas affects the number of staff employed, and therefore the stress levels of those staff (particularly in high pressure areas such as A&E). Smaller rural hospitals often need to work harder to attract staff, and are more dependent on retaining the staff they have.

In some ways this section on staffing may appear to be a digression. We are including it here because we are confident that 'a staffing crisis' will be used to justify A&E closure and other financially driven NHS cuts.

We have been told repeatedly by SaTH's senior managers that it is essential to implement A&E closure because of a difficulty recruiting A&E Consultants. Sometimes the argument is broader; for example, the draft Future Fit Strategic Outline Case[25] reports a difficulty in recruiting Critical Care specialists as well. In a recent statement in which the hospital denies plans to close an A&E as part of 'winter pressures' planning, there is a broad comment on staffing: *'We face immense challenges in*

recruiting the skilled medical staff needed for the vital and highly skilled work that takes place in A&E departments and the other hospital teams that work alongside them'[26].

There is an alternative perspective here. One nurse said to us, *'This sudden patient safety crisis is just a cynical excuse. They haven't cared before so why should they care now? They just want to save money, that's all. Closing either of the A&Es would be a complete nightmare, the worst thing possible for patient safety'.*

We've been told that there *are* some risks to patient safety in our local A&Es, despite the professionalism and hard work of highly skilled doctors and nurses. The risks apply particularly at the Royal Shrewsbury. This is not through any fault of staff, but because systemic problems are more apparent in a hospital that takes a greater number of 'Majors' (reflecting its status as trauma centre and the hospital serving an older population with the greater health needs that accompany age).

The people who have approached us do not believe that closing an A&E will solve the problems, and are strongly opposed to the loss of either of our A&Es. They say that this is about cost cutting, that closure would allow senior managers to duck their responsibilities around safe staffing levels and support for staff, and that closure of either A&E would increase mortality because of the extra distances travelled by patients. Our informants aren't able to go on the record. We would like them to, but we understand their concerns. The reasons behind staff shortages at our local hospitals, however, are worth exploring.

A national recruitment crisis

There are undoubtedly recruitment and retention problems at our local hospitals, as there are at the overwhelming majority of hospitals in the UK. The problem is not unique to the Royal Shrewsbury and the Princess Royal Hospitals. A recent report showed that 85% of NHS trusts are finding recruitment 'fairly or very difficult', while 89% are reliant on agency or temporary staff to meet staff shortages[27]. Clifford Mann, President of the Royal College of Emergency Medicine, recently stated that retention of staff continues to be *'the greatest resource challenge facing every UK emergency department'*[28]. There have been hopes of this being a resolving crisis, with most trainee posts in emergency medicine now filled[29] (although imposed contractual changes for junior doctors could destabilise this).

Most hospital trusts are struggling with recruitment. Most of them do **not** imagine that closing A&Es and hospitals is in any way a solution. The Royal College of Emergency Medicine has worked hard to publicise the medical staffing crisis in A&E, raising political and public awareness, and establishing a national campaign (STEP) to address the difficulties. Nowhere does the RCEM call for A&E departments to be closed down as a response to recruitment problems. There are potential solutions to these national staffing difficulties through workforce and contractual changes, and through changed funding arrangements for unplanned care.

There are also initiatives in other parts of the country that are being successfully used to ease the pressure on A&E Consultants; we would like to see SaTH be more innovative in its approach. Additionally, it makes little sense that the two SaTH A&Es are effectively run as 'islands', with minimal attempts made to foster joint working and a sharing of expertise.

Finance determines local A&E nurse levels

Locally, is it cost or safety that determines staff numbers in our two A&Es? At least where nurses are concerned, cost seems to be a significant factor. The budget for 2015/16, put before the SaTH Board on 26th March 2015, identified one of many cost savings:

Nurse staffing levels Accident and Emergency department *– Whilst it is acknowledged that additional nursing staff are required to support the performance of the Accident and Emergency Department revised templates were not constructed as part of the skill mix review and commissioners have not expressed an interest in supporting the cost of achieving safer staffing levels. A decision to not progress with the revised staffing levels generates savings of £305,000*[30]*.*

It's an interesting one. The nurses are 'required', and would achieve 'safer staffing' – but achieving savings takes priority. The Board's discussion of these cost savings followed a report on Emergency Activity, in the same meeting, during which *'The members were informed of surges in activity over the past month which was challenging at times. The Trust had been at Level 4 Escalation on a number of occasions…*[31]*'.*

It is also worth noting that this decision took place two months after inspection reports from the Care Quality Commission recommended *increasing* A&E nursing levels at both sites[32] [33]. SaTH's decision is cost-driven.

Some deep-seated cultural problems

Our hospitals are also remarkably unhappy places to work. The Care Quality Commission assessed the quality of care at SaTH last year, with its January report noting the culture of 'permafrost'[34] between the senior management team and frontline clinical leaders, and commenting *'There was an obvious disconnect between the senior team, and the ward or department managers and their staff. All staff, both senior and junior, within the trust, were aware of this disconnect. We could not see any plans, at this time, for the trust in resolving this disconnect'*[35]. This is concerning.

There is an annual staff survey in the NHS. The most recent results for the Royal Shrewsbury and Princess Royal Hospitals[36], from the 2014 survey, show that only 22% of Medical and Dental staff report good communication between the senior management team and staff. For Adult and General Nurses, only 18% believe there is good communication between the senior management team and staff. The staff survey also shows that SaTH is in the lowest 20% in the country for staff who feel secure in raising concerns about unsafe clinical practice, and less than a half of staff are confident that their concerns would be acted upon. A staggering 67% - two thirds of staff at the Royal Shrewsbury and Princess Royal – do not believe that senior managers in their organisation are committed to patient care. These results are genuinely shocking. Something is going very wrong at our local hospitals.

These more formal finding correspond with the information we have been given by individuals. We have been told of A&E nurses raising safety concerns since 2007 and not being heard. This has primarily not been about recruitment difficulties, but around not enough staff being employed. A few years ago, A&E nurses raised their concerns about understaffing and a consequent risk to patients. They were reportedly told *'You have to take ownership of the problem'*, an answer that did not help them deal with the problem of too many patients and not enough nurses. Subsequently, there was a reorganisation in which some nurses lost their jobs. The belief of nurses is that those

who had raised clinical concerns were the ones to find themselves without a role in the new structure.

We have been told of A&E Consultants who have resigned in support of their nurses. We have been told also of a series of senior nurses in A&E who believe that they have been driven out of their jobs, through a quiet policy decision to remove them. We have been told of a climate of fear and unhappiness. We have been told that twelve A&E nurses have left the Royal Shrewsbury in the last year; that a similar pattern applies in ITU; that three senior paediatric trained nurses have left. There is a certainly a problem that needs to be addressed – but closing an A&E won't solve it.

There is a more mundane reason for recruitment and retention difficulties. SaTH has been trying to close down one of its A&Es and hospitals since 2009. The Senior Management Team has become extremely focused on this, perhaps to the detriment of more important concerns. These repeated threats of closure are very likely indeed to have hindered recruitment, and have certainly led to very low morale (particularly at the Royal Shrewsbury, the hospital that many staff have regarded as most likely to close). The phrase 'self-fulfilling prophecy' springs to mind when SaTH managers say it is hard to recruit so they will have to close services.

There is genuinely no reason at all to suppose that SaTH will resolve its staffing difficulties by closing down one or other of our A&Es and hospitals. Part of the solution is for SaTH to engage more proactively with the national initiatives around A&E staffing, to relieve the pressure on existing Consultants. There is surely potential for enhanced working practices across the two A&Es; perhaps consideration could even be given to getting the telemedicine equipment out of the cupboards where it now languishes, enabling staff at the Royal Shrewsbury and Princess Royal to talk to one another and to take joint decisions on patient care. Another and very important strand is for senior managers to act decisively to end a culture of bullying, and to create a working environment in which staff feel supported. This would help to resolve the problems with recruitment and retention on a long-term basis.

And back to finance

There is an alternative analysis. We have seen a recent estimate that SaTH intends to make a saving of up to £13 million through 'workforce efficiencies' as a result of implementing Future Fit[37]. Based on SaTH's average staff costs, this £13 million would equate to the loss of around 335 jobs. NHS England now expects further savings of £23 million from our hospitals. The bulk of these savings would necessarily come from staff cuts, as staffing is the major expense for NHS organisations. SaTH currently spends 64% of its budget on staff. On this basis, the extra savings required by NHS England would equate to the loss of a further 379 jobs. A realistic estimate, based on the data available to us, is that around 700 jobs of hospital workers will be lost if these cuts go ahead. This is one route to dealing with staff shortages – but it does very little for patient care or staff morale. Job loss on this scale would also be damaging to the local economy.

Senior managers have the wrong solution

Rather than address the underlying reasons for staff shortages, SaTH's senior managers have drifted into a protectionist and ultimately reactionary response. In practice, their default position has become one of putting the perceived organisational needs of SaTH ahead of patient care. The approach is essentially one of *'We can't offer these services with as many Consultants as we'd like, so*

we're going to close them down'. This is simply wrong – and the additional imperative of saving money does not justify their stance. In a recent paper for NHS England, examining models for providing NHS care, Sir David Dalton comments *'Boards should not pursue self-protectionist strategies, using the 'interests of patients' as camouflage'*[38] – yet this is exactly what SaTH's Board is trying to do. This is not in line with the models of good practice that are now recognised and promoted by the Royal College of Physicians and increasingly by NHS England.

We also fear that there may be an exaggeration of local difficulties to justify closure of one of the A&Es and acute hospitals. There are risks in our A&Es; there have been for a considerable time; SaTH senior managers need to address them. However, when the Chair of SaTH tells a meeting of the Health and Wellbeing Board of *'the immediate fragility of the system, it's the IMMEDIATE fragility of the system, this is scary fragility'*[39], this is primarily for effect, and is said with the intention of justifying rapid A&E closure. Our hospitals have a *financial* crisis – but not a clinical one. The CQC found no evidence of clinical crisis in A&E. Our A&Es are currently doing much better around meeting A&E targets than the trusts running neighbouring hospitals in Hereford, Worcester and Stoke, for example. When the national 4-hour target is not met locally, this typically reflects a lack of beds at the hospital preventing patient admission, rather than any failure of the A&E department – and this in turn reflects a lack of money for beds and staff (together with a misguided Community NHS Trust policy of closing community hospital beds to save money). The care offered at the Royal Shrewsbury Hospital and the Princess Royal Hospital remains in general very good, and local NHS leaders risk doing staff a disservice when they suggest that services are on the brink of collapse.

This document is being written a short time after Shropshire Defend Our NHS was approached by an extremely reliable informant, with detailed knowledge of what was happening at our hospitals. Sadly, this person felt they had to remain anonymous. We were informed that the intention is to close one of our two A&Es as part of 'winter pressures' planning. This would mean imminent closure of one of the A&Es. This came as no surprise. We have known for several months - from attendance at Board meetings, from three SaTH Directors, and from SaTH documents, including the annual plan - that SaTH's senior managers have already decided to close down one of the A&Es as soon as they can.

Although the Chief Executive currently denies that there is a *plan* to close A&E, he has made no commitment that an A&E will not close; our expectation is that SaTH will make an attempt to close an A&E in the coming months. The real driver will be financial. The public, however, will be told of an immediate patient safety crisis. We would not be surprised at all to see a quiet decision to reduce locum and agency staff in A&E, followed almost immediately by announcements of a staffing crisis, risks to patient safety– and A&E closure. 'Temporary' closure will quickly become permanent. A similar mechanism was recently used by managers of Shropshire's Community NHS Trust to justify ward closure at Ludlow Hospital. We hope that the non-Executive members of SaTH's Board would not allow the implementation of a decision as cynical as this.

It has been an interesting experience attending SaTH Board meetings over a long period. The Board of two years ago was principled and courageous in putting patients first. That Board would not have sanctioned the decisions that it is now taking. We are now in an era where cost savings and the preservation of the organisation are being put ahead of patient care, and the public is being deceived through half-truths and obfuscation. It really is time to pause and think again.

An alternative model of care

Shropshire and Telford and Wrekin are living in the past. Locally we have an outdated model of healthcare, characterised by the Future Fit drive to ever-larger and more specialist sites for the provision of hospital care. The NHS is beginning to move on. Our local health leaders have not yet caught up.

There are alternative models of care – some of them emerging just over the border in Wales. Others are proposed by the Royal College of Physicians in its 'Future Hospital' programme. Simon Stevens, as Chief Executive of NHS England, is supportive of smaller hospitals. Current planning guidance for CCGs encourages the commissioning of viable smaller hospitals[40].

What, then, are the options? The 2014 Dalton Review[41] proposed a number of innovative models of care. The one that most directly applies locally is perhaps the simplest: *'One provider delivers a service or specialty from premises owned by another provider'*. If SaTH cannot deliver a service, that is not a good reason for the service to end. This is not a patient-centred approach. The model can work well. Locally, we have a cancer service at Hereford Hospital that is provided from Gloucester. It may well be that there are some clinical areas where SaTH excels and can provide support or services to other trusts. It is time, though, to transcend artificial organisational boundaries.

There are variations on this broad approach. Professor Marcus Longley's excellent 2014 study of the health needs of rural mid-Wales[42] is highly relevant, given the similarities between rural Shropshire and rural Powys, and that many mid-Wales residents access healthcare provided by SaTH. The paper is a strong one, recognising the central importance of access in the provision of healthcare in a rural area. One of the recommendations of Professor Longley is the development of clinical networks around pathways, put together *across* organisational boundaries. Shared staffing and shared services across organisations potentially offer a patient centred and cost effective route for offering a range of specialist services in a rural area.

The Royal College of Physicians explores similar themes, suggesting hub and spoke models of care, for example. The RCP powerfully redefines the definition of 'hospital', emphasising that a hospital is not necessarily based on a single physical site, and should not be constrained by organisational barriers such as trust boundaries.

The Royal College of Physicians also takes its model further. The RCP outlines a fully integrated model of healthcare, where hospital specialists work across a wide range of community settings. Expert help can become more readily available to GPs and within Community hospitals.

Most recently (September 2015), Simon Stevens has outlined a programme of support from larger or more specialist hospitals to smaller ones that is intended to ensure access to specialist care for older people in rural areas[43] [44]. Simon Stevens is clear that the era of 'go it alone' hospitals is over.

The beginnings of a solution lie in these initiatives. Healthcare in rural Shropshire, mid-Wales and The Wrekin cannot be defined by the financial or organisational needs of SaTH. Patient-centred care demands starting from patient needs and then looking at how those needs may be met, transcending organisational boundaries where necessary.

The potential is there, in a local transformation of healthcare, to look meaningfully at support for primary care and community services (NHS and social care), to ensure continued access to acute and

hospital-based planned care, and to redesign our services based on the needs of patients in a largely rural area. We are not calling for 'no change'. We are calling for change that is in the interests of patients. We support clinical integration as part of that change – and our belief is that organisational integration would support this process. The 'not our problem' culture that has grown up between the different organisations in our local health economy is not in the interests of patients.

We need a clear plan for rural areas

The Future Fit proposals are in chaos now; this can no longer be disputed. Implementation of much of Future Fit is now delayed. The only aspects of local NHS change that will be progressed soon will be a deep cuts package: £25 million cuts, hundreds of NHS staff to lose their jobs, an A&E and acute hospital to close, and progressive cuts to community NHS services.

We do not pretend to have the whole of a solution but we know that the current direction of travel is a disaster. We are therefore offering some initial thoughts on necessary components of an alternative:

1. We need to ensure adequate NHS funding for our local area. Healthcare planning has to start from patient needs, not a desperate scrabble to make cost savings. This is urgent now, and there are no long-term solutions without the local funding crisis being resolved. Shropshire is one of the most sparsely populated areas in England, with all the additional costs of providing NHS care that go with this. This is not currently recognised by NHS England, and will need to be addressed at a political level. We believe there is an urgent need for a 'rural premium' to be introduced as part of NHS England's allocations policy.

2. We do not believe that our CCGs or hospital trust understand the challenges faced by people living in rural areas. They are seeking to apply an inappropriate model of healthcare that is designed for an urban area with a highly concentrated population. Issues of rurality and access have been almost entirely overlooked. We therefore propose that Shropshire CCG appoints a Rural Lead – perhaps at Board level, or a staff member of sufficient seniority and knowledge to influence the commissioning of services. The awareness of the needs of rural populations has been extremely poor in the planning of local healthcare, and this must be addressed.

3. We strongly suggest an independent study or review of local health needs and appropriate models of service delivery, similar to last year's excellent review led by Professor Longley of the health needs of rural mid-Wales. This should precede any closure of emergency or acute facilities, but should not stand in the way of development of community services and progress towards integration of services. If possible, this should be a whole system review – taking in acute care, but looking beyond this to community NHS services, primary care, and social care. If Professor Longley were available, we suggest his leadership of this exercise would be ideal.

4. We need a modern 'best practice' picture of hospitals. It's essential to go beyond the protectionist argument from hospital leaders: *'We struggle to recruit so you can't have this service any more'*. Best practice, recognised now by NHS England and by professional bodies such as the Royal College of Physicians, is about building clinical networks across different organisations in order to meet patient needs. Hereford Hospital's cancer care is provided from Gloucester. The world didn't end. We need our local health leaders to start from what patients need - and to look at how to provide that even when that means crossing the artificial

organisational or administrative boundaries that exist across Shropshire, Telford and Wrekin, and Powys.

5. 'Joined up care' is long overdue. Small moves towards joint working between community NHS services and social care are a start, but not enough. At the moment, we have fragmentation built into the system, with community and acute organisations fighting with one another about who takes responsibility. One example: at the time of writing, 100 patients at the Royal Shrewsbury Hospital are well enough to be discharged, but there is nowhere for them to go[45]. This creates a shortage of beds, meaning that patients cannot be admitted to the hospital from A&E. This in turn creates enormous pressure on A&E staff and services. The Community NHS Trust, rather than expanding its community bed base, is pursuing a strategy of closing beds in community hospitals. SaTH and the Community NHS Trust have different financial interests, and are therefore pursuing different strategies. We'd like to see pooled budgets and a shared agenda. It may be time to go further: to join together the *organisations* providing hospital care and community NHS care, and ask them to take on responsibility for social care too.

6. 'Telehealth' is not a panacea – but will be a part of the solution when it comes to increasing access to specialist care. SaTH has complained that its Consultants can't be in four places at once. Potentially, they can – when it is clinically valid to do so virtually. Ward rounds can take place across sites. Clinical advice can be given remotely. Consultations can – where appropriate and where this meets the needs of patients – take place by video link. Two A&E departments might actually talk to one another! We are well aware of slow broadband speeds in rural areas, and poor mobile phone coverage too. We wholly reject the glib 'It'll all be done by Skype' reassurances that we have heard from the proponents of hospital closure. Nevertheless, there is without question scope for a serious review of linking SaTH sites together, linking SaTH with other acute hospitals as necessary, and linking SaTH with local community hospitals or even with GP surgeries. These are not insurmountable problems. We know this has not been a priority for SaTH – but it should be.

7. There are other technological developments that potentially offer a very great benefit to rural areas such as our own. Recent years have seen the development of mobile diagnostic imaging services, including X-Ray, CT, MRI and DXA services. It is likely that the cost of these will continue to fall in coming years. NHS England reports on its backing for 'Lab in a Bag' technology that holds out the promise of laboratory standard testing in community settings[46]. Meeting patient needs in a rural area requires innovation and investment in order to offer equitable services.

8. Finally, change to our local healthcare systems should be created 'bottom up'. We have to build on our strong GP service, on our network of community hospitals, and on the hard work of our immensely talented and committed local NHS workers. Starting with what we have and making incremental changes is a more positive and far less dangerous approach than the 'big bang' of closing an A&E and an acute hospital.

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