CONSIDERING A FUTURE RURAL HEALTH ECOSYSTEM FOR THE SOUTH WEST REGION OF NORTHERN IRELAND

AN ADVOCACY PAPER

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Abbreviations

AI	Artificial Intelligence
ANP	Advanced Nurse Practitioner
BBC	British Broadcasting Authority
CAMHS	Child and Adolescent Mental Health Services
CAWT	Cooperation and Working Together
COPD	Chronic Obstructive Pulmonary Disease
CSU	Commissioning Support Unit
CVS	Community and Voluntary Sector
DfC	Department for Communities
DFLE	Disability Free Life Expectancies
DOH	Department of Health
ECCH	East Coast Community Healthcare
ED	Emergency Department
EGS	Emergency General Surgery
EU	European Union
FODC	Fermanagh and Omagh District Council
GDHI	Gross Domestic Household Income
GDP	Gross Domestic Product
GP	General Practitioner
GYW	Great Yarmouth and Waveney
HiAP	Health in All Policies
HLE	Healthy Life Expectancies
HSC	Health and Social Care
HSE	Health Service Executive
IAPB	Integrated Area Partnership Board
ICBs	Integrated Care Boards
ICLRD	International Centre for Local and Regional Development

ICS	Integrated Care System
ISO	Interreg Specific Objectives
IVI	Innovation Value Institute
JPUH	James Paget University Hospital
LCGs	Local Commissioning Groups
LGD	Local Government District
MaPS	Money and Pensions Service
MDT	Multi-Disciplinary Teams
NGO	Non-Governmental Organisation
NHS	National Health Service
NI	Northern Ireland
NIMDM	Northern Ireland Multiple Deprivation Measure
NISRA	Northern Ireland Statistics and Research Agency
OECD	Organisation for Economic Co-operation and Development
OPALS	Older Person's Assessment and Liaison Service
OUNHCHR	Office of the United Nations High Commissioner for Human Rights
PHA	Public Health Agency
PCI	Percutaneous Coronary Intervention
RPA	Review of Public Administration
SAs	Small Areas
SDG	Strategic Development Group
SEN	Special Educational Needs
SEUPB	Special EU Programmes Body
SOA	Super Output Area
SOAS	Save Our Acute Services
SWAH	South West Acute Hospital
U.K.	United Kingdom
UN	United Nations

UTC	Urgent Treatment Centre
UU	Ulster University
WHAZ	Western Health Action Zone
WHO	World Health Organisation
WHSCT	Western Health and Social Care Trust
WRAP	Western Response and Action on Poverty

Foreword

To be inserted

1-pager

By Chief Executive & Council Chair

Executive Summary: Abridged Advocacy Paper

A cornerstone of building resilient rural communities is ensuring that they have access to high quality, safe and effective healthcare – irrespective of whether they live in small towns, villages or remote regions. Healthcare in rural areas faces numerous challenges, including ageing populations (in terms of both patients and health workforce), declining demographics, reconfiguration and rationalisation of services and shortages of healthcare professionals. Yet, access to healthcare services plays a pivotal role in shaping health outcomes among various populations – from elderly to children – and across both physical and mental illnesses. Both the World Health Organisation (WHO) and the Organisation for Economic Co-operation and Development (OECD) have been arguing of the need to develop approaches to healthcare provision that ensure that rural contexts are reflected across health policy and programme cycles, involving both health and rural development authorities. Evidence points to the importance of secure infrastructure in building communities that are health resilient; with healthcare provision increasingly included among a list of services noted as being fundamental to community life.

Providing healthcare within and between rural areas presents unique challenges. These range from (i) geographic and transportation barriers where those living at greatest distance from healthcare services are faced with longer emergency response times and are at highest risk of unmet needs, especially where public transport is poor or unaffordable; (ii) workforce shortages, both in terms of recruitment and retainment, and funding challenges; (iii) infrastructure and resource limitations, ranging from fewer beds to limited diagnostic equipment; (iv) an ageing and/or declining population resulting in demand being highest in those areas most likely to experience clinic closures; (v) social isolation resulting in the healthcare needs of some 'falling through the cracks'; and (vi) socio-economic and hidden deprivation whereby rural poverty and deprivation are often masked or hidden, all of which impacts health outcomes. Together, these contribute to health inequalities which current financing models of (rural) health systems fail to reflect.

Why this Paper?

In the South West region of Northern Ireland, the South West Acute Hospital (SWAH) has been facing significant challenges recently; the most notable issue of which has been the suspension of emergency general surgery (EGS) services. Additionally, other services have also been affected including cessation of the preventative cardiology service, known as the "Our Hearts Our Minds" programme and the Older Person's Assessment and Liaison Service (OPALS). While a state-of-the-art primary care centre at Omagh was established as part of an attempt to address the gap left by the closure of the Tyrone County Hospital, a fuller approach could be taken to the creation of access to services at this hub. These challenges are in addition to wider issues facing health service provision in the South West – including loss of GP services. As of 31 March 2025, there were 305 GP practices in Northern Ireland. This figure represents a reduction of 45 practices (12.9%) since 2014. This change in the number of practices is as a result of closures, as well as mergers (where practices have combined). The

WHSCT, which includes the Fermanagh and Omagh District Council area, recorded the largest proportionate decrease in GP practices across all Trust areas between 2014 and 2025 at 17.5%. In the Fermanagh and Omagh District Council area, the figures show a drop from 27 practices in 2014 to 19 practices in 2025. This represents a decrease of 29.6%, significantly above both the regional and Trust average.

Whilst local government does not have a formal role in health service provision, there is a direct connectedness between the achievement of health and community well-being outcomes and other key activities of Council including, for example, spatial planning. The WHO specifically identifies the role of integrative spatial planning in influencing the social determinants of both physical and mental health – in terms of spatial quality (how the built environment is planned, designed, constructed and managed and their resulting accessibility, connectedness and safety) and spatial equity (access to green spaces, facilities for play and access to healthy food). Importantly, local councils in Northern Ireland do have a specific legal competency for community planning under the *Local Government Act 2014;* with community planning operating to the quadruple helix model of stakeholder collaboration to improve the social, economic, and environmental well-being of districts and their residents. In addition, councils have a critical role in rural development – in which shrinkage or loss of any services, including across healthcare, is a core issue.

As the future offering of the SWAH is under review, the development of this advocacy paper is timely as it considers what a sustainable model of healthcare provision for the South West region of Northern Ireland might look like (including its cross-border functional area). This advocacy paper has been prepared in direct response to an approved motion set down at a meeting of the Council which, in light of the crisis in healthcare in the South West region, called for all relevant bodies that deal with health provision in the Fermanagh and Omagh Council area, as well as civic society, trade unions and community representatives to come up with a plan and/or recommendations on how a resilient healthcare ecosystem for this geo-spatial region could be sustained so that citizens of the area can have the confidence that a free, safe and modern healthcare will be provided to surrounding rural communities.

What the Data tells Us?

Fermanagh and Omagh is a uniquely rural district, representing 20% of Northern Ireland's landmass and 6% of its population. Its dispersed settlement pattern, extensive waterways, and the longest share of the Northern Ireland-Ireland border create both opportunities and significant structural challenges that directly shape health needs, service accessibility, and long-term system sustainability.

Demographic Pressures

The district faces slow population growth, a declining working-age population, and rapid ageing. By 2040, one in four residents will be over 65. At the same time, healthy life expectancy lags far behind overall life expectancy—by nearly two decades—implying long periods of chronic illness and increasing demand on already-pressured services.

Poverty, Inequality and Health Risk

Poverty is deeply entrenched. Nearly one-quarter of residents have lived in relative poverty for six years, with child poverty estimated at 23–27% and older-age poverty above the Northern Ireland average. Fuel, food and transport poverty cluster in rural and border areas, with over 150 small areas categorised as high-risk. These conditions directly worsen physical, mental and emotional health, limit health-seeking behaviour, and compound inequalities in access to care.

Accessibility and Transport Barriers

Fermanagh and Omagh suffers from profound transport deficits: no motorway, dual carriageway, rail service, or airport. Public transport is limited and often impractical—only 29% of residents can reach the South West Acute Hospital (SWAH) within two hours during key times, and just 8% can return home in the same window. With 70% of residents living outside main towns and some areas showing more than 25% of households without vehicle access, inaccessible transport translates directly into inaccessible healthcare.

Economic and Workforce Challenges

The rural economy is experiencing significant labour shortages in hospitality and healthcare. These trends mirror national patterns but have disproportionate impact in a district already struggling to recruit and retain healthcare professionals. Demographic decline, rising care complexity, and workforce shortages threaten the viability of local health services, contributing to longer travel times, delayed diagnoses, poorer outcomes and escalating costs.

Deprivation and Health Inequalities

Multiple deprivation measures place several areas in the top 10% of most deprived areas in Northern Ireland. Gross Disposable Household Income (GDHI) is below the Northern Ireland average, and food availability and affordability are notably worse in rural communities. Border areas carry the highest risk of income poverty.

Community Planning, Spatial Equity and Opportunity

Local strategies – including the FODC Anti-Poverty Strategy and the Fermanagh Omagh 2030 Community Plan – recognise health and well-being as core priorities, emphasising spatial planning, place-shaping, digital connectivity, and integrated public services. Progress has been made in areas such as physical activity, reduced male life expectancy gaps, improved broadband and job creation. However, worrying trends remain: declining female life expectancy in deprived areas, rising falls among older people, increased child poverty, decreasing economic activity, and dwindling public/active transport options.

A Cross-Border, Integrated Approach is not Optional – It's Necessary

The district is deeply interconnected with its neighbouring Irish border counties in terms of trade, labour mobility and more broadly, daily life via familial and cultural connections. Health co-operation can improve the range of service availability, reduce travel burdens, and support shared workforce planning.

Implications for a Sustainable Rural Health Ecosystem

The evidence is clear: without coordinated action, the district's health system will become increasingly unsustainable. Taken together, the evidence shows a district experiencing interlinked demographic, socio-economic, and infrastructural pressures that threaten the sustainability of its healthcare system. A peripheral rural and ageing population – facing growing rates of poverty, growing healthcare needs, poor mobility/transport infrastructure and limited access to services – requires a fundamentally different model of care. Strategic intervention now can transform the district into a model of rural health resilience and sustainability.

What Has Gone Before: The Learnings

Over the past decade, experiences across local government, statutory health bodies, and civil society demonstrates that the region possesses the foundations of a resilient, collaborative, and innovative rural health ecosystem – one capable of delivering better health outcomes, stronger communities, and more sustainable services. Previous initiatives reveal 'part' of a path forward: the need for a coordinated, multi-level, community-driven approach that recognises the unique needs and assets of rural populations, backed by robust governance and resourced delivery.

Local Government Leadership: WRAP and the Health Impact of Tackling Poverty

The Fermanagh and Omagh District Council's Western Response and Action on Poverty (WRAP) Programme represents a practical and evidence-based model of community-anchored intervention. Emerging from regional welfare reform mitigation policy, the programme mobilised local government, the Public Health Agency (PHA), the community/voluntary sector, and financial guidance services to support the District's most vulnerable households. Key outcomes and insights from this programme include:

- 140 households (411 individuals) supported, with over 800 wraparound referrals and £45,000 in direct aid, followed by an expanded 2024 tender to reach 200 households with £64,000 in aid;
- 80% of participating households included a person with a disability or long-term condition, despite health status not being a selection criterion – underscoring the strong link between chronic health need and household financial stress; and
- 68% of participants reported positive change in health and well-being, demonstrating the measurable health return on social investment.

Substantial challenges were documented around cost of living, low-income employment, private rental pressures, fuel poverty, homelessness, and the disproportionate financial burden facing people with disabilities or long-term conditions. In terms of implications for a sustainable rural health system, WRAP clearly demonstrates that health outcomes cannot be improved without addressing poverty, housing, energy insecurity, and the wider determinants of health. It also proves that the South West has both the community capacity and the inter-organisational relationships needed for scaled, collaborative interventions. Local government

has shown its ability to act as a convenor and catalyst for health improvement – an essential component of any future rural health ecosystem.

Statutory Health System Learning: WHSCT's Pathfinder Initiative

The Western Trust's Pathfinder Initiative (2018–19) constitutes one of the region's most substantial health engagement exercises, with over 2,200 stakeholders involved across 62 engagement events. Although not implemented – largely due to the onset of the COVID-19 pandemic – the initiative produced a rich evidence base that remains directly relevant to the challenges facing the District. Key Pathfinder findings include:

- Rurality significantly affects travel times, access to GP services, recruitment, diagnostics, and post-acute care;
- GP services were already retracting before the pandemic; per capita investment and provision lagged behind other regions; and
- Communities identified major opportunities in social prescribing, home care innovation, diagnostics closer to home, and rural-tailored workforce models.

The Trust committed to a Connected Communities model, emphasising (i) outcomes-based well-being; (ii) compassionate and cohesive communities; (iii) expanded community health partnerships; and (iv) a structured locality-planning and community-connector infrastructure.

Pathfinder still matters and shows that the statutory system recognised the rural challenges early, mapped solutions aligned to national transformation policy, and built wide community trust and expectation. Its non-implementation represents a lost opportunity – but also an opportunity to reset. A modernised Pathfinder, post-pandemic and informed by today's service pressures, could be the backbone of a renewed rural health strategy for the South West region

Civil Society Leadership: Save Our Acute Services (SOAS)

Community action has been a defining force in rural health advocacy. The SOAS movement, formed in 2022, reflects a data-driven, rights-based, citizen-led demand for equitable access to acute and emergency care, particularly following the withdrawal of emergency general surgery (EGS) from the South West Acute Hospital (SWAH). Key contributions of SOAS to date include:

- Developing a comprehensive roadmap for rebuilding sustainable surgical capacity at SWAH;
- Aligning proposals with regional Department of Health policy on urgent/emergency care and general surgery;
- Highlighting SWAH's under-utilised infrastructure, including 97 uncommissioned beds, and its potential role in cross-border emergency and elective care networks; and
- Appling rigorous analysis to equality and rural-needs assessments, arguing for better consideration of age, disability, gender, and dependents, and of geographical equity.

The SOAS Roadmap rests on three levels of action: (i) Local Level – focused on the restoration of EGS, reopening of beds, and ensuring trauma stabilisation; (ii) Regional level – with an

emphasis on base elective specialties at SWAH, accelerating elective commitments and integrating SWAH clinicians with Omagh; and (iii) North-South Level – aimed at positioning SWAH within a cross-border service network for trauma and elective care. SOAS amplifies the essential principle that rural citizens are entitled to the same access to timely emergency and elective care as urban citizens.

While the South West region possesses critical assets that are essential for a sustainable rural health ecosystem, it is cleat that the region needs a new, ambitious, whole-system approach that does not accept existing constraints as immovable. Lessons from WRAP, Pathfinder, and SOAS point to a clear set of guiding principles whereby a sustainable rural health ecosystem must:

- Address the root causes of health inequity, including poverty, housing, transport, and energy insecurity;
- Leverage existing physical and community assets, maximising use of Omagh Primary Care Centre and SWAH;
- Build integrated care pathways that reflect rural geography and travel times;
- Adopt rural-tailored workforce solutions, including apprenticeships, new career pathways, and community-embedded roles;
- Enable local government and civil society as core partners, not peripheral stakeholders;
- Re-establish trust through transparent implementation of previously generated evidence (e.g., Pathfinder);
- Adopt a multilevel governance framework aligned to the Northern Ireland Programme for Government; and
- Embrace co-design, ensuring residents and patients shape the system that serves them.

The Stakeholder Perspectives – 4 June 2025

In developing this advocacy paper, the ICLRD, together with Fermanagh and Omagh District Council, organised a one-day focus group on 4 June 2025 in Enniskillen. A diverse grouping of stakeholders took part including elected representatives, departmental officials, local government officials, health agencies, community representatives and various organisations dedicated to addressing health and social care issues in the region. Key takeaways included that a sustainable rural health ecosystem is an interconnected web of resources including local authorities, government departments, statutory agencies, health and social care services (incl. GPs, hospitals and health practitioners), educational institutions, business and crucially, the community and voluntary sector – all working together to plan and deliver healthcare that meets the needs and circumstances of the population across the different life stages. The workshop discussions focused on Primary Care, Secondary Care, Domiciliary Care and end-of life environments as well as touching upon children and young peoples services. Across each of these services, discussions centred on accessibility to the services (or not), increasing pressures on the services, workforce shortages and challenges in recruitment and retention, under-resourcing and funding of services, poor messaging and communication with patients,

lack of wider supports and integrated care mechanisms and failings in considering geography when making decisions. While policymakers face critical decisions, the current 'one-size-fits-all' approach is ineffective, and incremental changes will be insufficient. At a time when a transformative paradigm shift is required, stakeholders identified a broad range of actions which address both immediate needs and long-term sustainability. The path ahead requires coordinated action, robust partnerships and an unwavering focus on equity, of partnership, perseverance and purpose, ultimately ensuring that rural populations in the South West region have timely and affordable access to quality healthcare. The moral case for equality in service provision stands tall and the investment focus should be on keeping care close to home, even in sparsely populated rural areas in the South West.

Good Practices in Rural Healthcare Provision

Rural health systems across the U.K. and internationally are experiencing universal challenges such as those noted in the South West region. Despite these many challenges, international experiences have identified innovations and key strategies that are leading to resilient and sustainable healthcare ecosystems. Many of these strategies align with the WHO's recommendations for rural health equity, which emphasise strengthening primary care, investing in rural health workforce, and leveraging digital health. These range from (i) community health programmes which as community-directed interventions are leveraging local knowledge to enhance basic health education, outreach and connections to services; (ii) school-based services including immunisations, screenings and health education programmes for children and adolescents; (iii) mobile clinics and outreach whereby medical teams travel to more rural and isolated settlements, bringing 'care to the doorstep'; (iv) family health programmes that ensure every household is assigned a primary care team as required; (v) telemedicine and digital health to overcome distance barriers; (vi) digital information and mapping whereby better data is resulting in improved planning and delivery of health services; and (vii) faith-based and local non-profit partnerships with rural healthcare providers resulting in better outreach, education and service access.

The following is a number of case studies that have been rolled-out by the NHS across rural communities in the U.K.; each contributing to a sustainable model of rural healthcare provision while also improving the lives of the citizens within their catchments by offering choice and improved health outcomes.

Case Study: Forming An Acute Hospital Group

This case study examines the emerging Acute Hospital Group model in Norfolk and Waveney, where three acute Trusts are exploring a unified governance and strategic partnership to address rising demand driven by an ageing population, high prevalence of long-term conditions, significant health inequalities, and substantial financial and clinical pressures. The Group model aims to standardise care, improve efficiency, and enhance outcomes through shared leadership, coordinated planning, and consistent clinical practices, with eleven collaboration opportunities identified across transforming services, improving quality, and achieving sustainability at scale. Key learning outcomes include understanding how demographic pressures shape system redesign; recognising the value of unified governance

in delivering consistent, high-quality specialised services; appreciating the benefits of a shared workforce, digital, and estate strategies; and identifying the cultural, financial, and strategic risks that require mitigation, such as maintaining Trust identities, ensuring equity of access, and fostering a shared vision. The case also highlights potential relevance for the South West region of Northern Ireland, where similar site-based or hub-and-spoke clinical models—including cross-border options—may offer opportunities for specialised service delivery.

Case Study: Neighbourhood Health Implementation Programme

This case study explores the Neighbourhood Health Implementation Programme, using the Great Yarmouth and Waveney pilot to illustrate how shifting care from acute hospitals into integrated, community-based models can improve outcomes for people with complex, long-term conditions while reducing system pressures. Built around prevention, community-centred delivery and digital innovation, the neighbourhood model coordinates multidisciplinary teams around individuals – particularly high-frequency service users – to provide personalised, proactive support that reduces fragmentation and unplanned activity. Key learning outcomes include understanding how neighbourhood health can rebalance care systems, the value of integrated case management in improving patient experience and efficiency, the importance of prevention and self-management, and the potential applicability of this model to regions such as the South West of Northern Ireland seeking more accessible, sustainable, community-focused healthcare.

Case study: Developing Urgent Treatment Centres to Better Serve Local Populations

This case study outlines how developing an Urgent Treatment Centre (UTC), as demonstrated in Great Yarmouth and Waveney, can significantly reduce pressure on Emergency Departments (EDs) by diverting patients with lower-acuity needs to a dedicated, GP-led service equipped for minor illnesses, injuries, and essential diagnostics. With rising demand driven by an ageing population and increased chronic conditions, UTCs offer faster access, improved patient experience, and cost-effective care, while enabling ED staff to focus on more complex cases and improving ambulance handovers. Key health outcomes include shorter waiting times, higher patient satisfaction, reduced iatrogenic risk, and more efficient allocation of clinical resources, making UTCs a valuable model for meeting future urgent care demand, including at SWAH.

Case Study: Managing Frailty through a Neighbourhood Health Model

This case study describes how Great Yarmouth and Waveney are developing a neighbourhood health model to manage rising levels of frailty, particularly in a rural context where isolation and an ageing population intensify health risks and service demand. By shifting from fragmented, referral-driven care to a proactive, partnership-based approach involving community, voluntary, social care, and NHS organisations, this programme aims to reduce hospital demand, improve quality of life, and deliver more coordinated support across the frailty life course. Key health outcomes include enabling people with frailty to live well at home, preventing deterioration through earlier intervention, reducing high-intensity service use, improving patient experience, and creating a more sustainable system that also enhances professional collaboration and workforce wellbeing.

Case Study: Digitalisation of Health Services

This case study highlights how digitalisation – through telehealth, remote monitoring, mobile health tools, and community-based digital hubs – is improving healthcare access and outcomes for rural populations, particularly in areas like Wales and North Norfolk where isolation, ageing demographics, chronic disease, and limited transport create significant barriers to care. Key opportunities include reduced travel, earlier intervention, better chronic disease management, enhanced continuity of care, and more personalised support, while challenges such as poor connectivity, low digital literacy, and concerns around equity and privacy must be addressed to ensure inclusive, effective adoption.

The digital transformation programmes described have demonstrated measurable health benefits: reduced emergency admissions (up to 22–25% in monitored groups), improved medication adherence, increased mental health referrals, higher patient satisfaction, fewer missed appointments, and improved access for older and disabled residents. Additional system-level outcomes include cost savings, better coordination across health and social care, more efficient use of staff time, and strengthened preventative care. Sustaining these gains requires tailored rural digital strategies, investment in infrastructure and skills, and ongoing co-design with local communities.

Case Study: A Co-Produced Model of Care for Acute Services

This case study shows how Cheshire East transformed unsustainable acute services by redesigning pathways toward community-based care, supported by virtual acute hubs, flexible multidisciplinary staffing, and data-driven planning – an approach that improved access for rural residents while easing pressure on hospitals. The model delivered substantial health gains, including an 18% reduction in emergency admissions, shorter ED waits, improved continuity of care for frail and elderly patients, higher patient satisfaction, and reduced staff burnout, alongside significant financial savings. By strengthening integration between acute, community, and primary care and expanding remote and locally delivered specialist services, the programme demonstrates a scalable approach to tackling rural health inequalities and enhancing outcomes.

Case Study: Virtual Wards in Meeting Healthcare Needs

This case study highlights how the South East of England is using Virtual Wards to deliver acute-level care at home, easing hospital pressures while improving equity and outcomes for a diverse 9.4 million population. Virtual Wards – staffed by multidisciplinary teams and enabled by remote monitoring – have reduced admissions, prevented hospital-acquired harm, improved medication management, and enhanced patient experience by supporting recovery in familiar home settings. Evidence shows substantial financial benefits alongside strong health outcomes, including high admission-avoidance rates, fewer infections and episodes of deconditioning, and greater autonomy for frail and chronically ill patients. As data quality and digital access improve, Virtual Wards are expected to further strengthen system integration and scalability across the U.K., including potentially in Northern Ireland.

The Case for a New Approach

Health systems – particularly in rural areas – face persistent challenges in delivering equitable, accessible, and high-quality care. The evidence presented highlights how geography, demographics, workforce shortages, and service reconfiguration have contributed to widening health inequalities, poorer outcomes, and barriers to timely care in the South West region of Northern Ireland. While international human-rights principles affirm the right to accessible, acceptable and good-quality healthcare, the current system falls short of these standards, especially in emergency, maternity, mental health, and primary care access for rural communities. A paradigm shift is therefore required: one that mobilises data, strengthens integrated care, restores community-based capacity, and reconsiders service configurations through the lens of equality, geography, and patient experience.

The South West region stands at a pivotal moment. The combined learning from WRAP, the dormant but valuable Pathfinder Initiative, and the SOAS movement shows that transformative change is possible when local government, statutory bodies, and community actors work collectively. This is more than a call to restore services – it is a call to build a modern, integrated, rural-proofed health ecosystem that capitalises on the region's assets, tackles inequalities at their source, and delivers safe, timely, high-quality care for all rural residents.

The region has proven community capacity, a clear evidence of need, and a history of collaboration. What is required now is political will, sustained investment, and a commitment to co-design. The South West can become a model for sustainable rural health – not only for Northern Ireland, but for rural regions across the U.K. and Ireland. The case for a new approach to rural healthcare provision is clear:

- Health services must be geographically flexible, digitally enabled, and integrated across the Northern Ireland-Ireland border;
- Investment in transport, digital infrastructure, and preventative health is a precondition for health equity;
- The system must shift from episodic acute care to proactive, community-based, multidisciplinary support; and
- Tackling poverty, transport inequality and workforce shortages is essential to delivering sustainable care.

This paper highlights a strong regional consensus on the need for a policy-driven, place-based transformation of health and social care in the South West of Northern Ireland. Stakeholders recognise that rurality, population health needs, and persistent inequalities require solutions that integrate contemporary innovations such as community planning, area-based partnerships, territorial cooperation, and data-driven decision-making. The analysis argues that meaningful change must extend beyond the health system itself, drawing on Northern Ireland's wider governance assets (e.g., Section 75 equality duties, spatial planning powers, co-design culture) and addressing structural challenges like primary-care underinvestment,

workforce shortages, and the enduring effects of the Inverse Care Law. Strengthening primary care, restoring upstream interventions, and ensuring equitable access – particularly in rural communities – are essential to improving outcomes.

There are significant opportunities to rebuild a more resilient, equitable system in the post-pandemic period through hybrid digital–in-person models, renewed workforce planning, and cross-border cooperation leveraging Northern Ireland's long-standing collaboration with Ireland. With SWAH strategically positioned as an underutilised 21st-century asset, the analysis highlights potential for shared acute, elective, and primary-care services across the border, drawing on European models of cross-border hospitals and the EU's "living laboratories" approach to border regions. Ultimately, the paper concludes that coordinated territorial cooperation, integrated care, and whole-of-government governance reforms are required to address long-standing access barriers and deliver sustainable, high-quality healthcare for rural populations.

The data paints a compelling case for transforming Fermanagh and Omagh into a model of rural health sustainability – one that addresses deep-rooted inequities and leverages cross-border collaboration, spatial planning and community-centred innovation to secure long-term well-being for its people.

Recommendations

Six key recommendations are put forward by this Advocacy Paper:

1. To establish a Ministerially mandated Interagency Task Force to drive a multi-year, cross-system transformation of the region's health ecosystem.
2. To explore SWAH as part of a North–South shared services network for acute, elective and emergency care.
3. To prioritise cross-border shared primary care services to address rural workforce and access challenges.
4. To pursue short-term advocacy actions including strengthening primary care MDTs, restoring key community services, and reviewing evidence from existing initiatives.
5. To renew the community planning model to better integrate health, spatial planning and population-based approaches.
6. To establish a Biennial International Symposium on rural and population health to bring global expertise to the region and embed long-term innovation. These recommendations collectively aim to secure equitable access, improved outcomes, and a resilient rural health ecosystem.

KEY ADVOCACY POINTS	
1	**A uniquely rural district with uniquely rural health needs** • Fermanagh and Omagh covers one-fifth of NI's landmass but only 6% of its population—creating major access and service delivery challenges. • By 2040, one in four residents will be over 65. • Healthy life expectancy lags by nearly 20 years, increasing long-term pressure on health and social care. • A shrinking working-age population threatens staffing, economic sustainability, and care capacity. • 70% of residents live outside main towns; many cannot reach essential services without a car.
2	**Rural poverty is deepening—and it directly harms health** • Around 23% of residents face long-term poverty; up to one in four children live in poverty. • The district has Northern Ireland's highest risk of fuel poverty and one of the highest risks of food poverty. • Poverty clusters in rural and border areas compound health inequalities.
3	**Health inequalities are widening** • Life expectancy gaps persist, with declining outcomes for women in deprived areas. • Chronic conditions, falls among older people, and delayed diagnoses are rising. • A growing mismatch between population need and service capacity threatens system sustainability.
4	**Transport poverty is one of the biggest barriers to healthcare access** • The region is not served by a rail service; there is no motorway or dual carriageway, and no airport. • Public transport is limited and often ineffective – only 29% can reach SWAH within two hours during key times; only 8% can get home. • Up to 25% of households in some areas have no car. **Result:** Health services may exist, but many cannot actually reach them.
5	**Workforce shortages put local services at risk** • Recruitment and retention difficulties in health and social care are well-documented and worsening. • Rural, border regions face additional challenges in attracting skilled staff. • Without targeted strategies, service rationalisation will continue—further increasing travel times and reducing outcomes.
6	**A cross-border, integrated approach is not optional—it's necessary** • The region is deeply interconnected with Irish border counties in trade, labour and daily life. • Health cooperation can improve service availability, reduce travel burdens, and support shared workforce planning.

7	**Spatial planning and community engagement offer real solutions** • The *Fermanagh Omagh 2030 Community Plan* emphasises place-shaping and integrated planning. • Investments in digital connectivity, community health hubs, outreach services and localised prevention can significantly improve wellbeing. • Leadership from councils, the Western Trust and community organisations is key.
8	**A sustainable rural health ecosystem requires system redesign** We must move from an urban-centric, acute-care model to one that fits rural realities; this entails: • More prevention, early intervention and home-based care. • Better transport and digital access as health equity priorities. • Integrated public, community and cross-border services. • Targeted action on poverty as a health determinant
9	**The evidence is clear: without coordinated action, the South West region's health system will become increasingly unsustainable** • Rising need + shrinking workforce + deepening poverty + poor transport infrastructure = a system under severe strain. • Strategic intervention now can transform the region into a model of rural health sustainability.

1 Introduction

A cornerstone of building resilient rural communities is ensuring that they have access to high quality, safe and effective health care - irrespective of whether they live in small towns, villages or remote regions. Healthcare in rural areas faces numerous challenges, including ageing populations (in terms of both patients and health workforce), declining demographics, reconfiguration and rationalisation of services and shortages of healthcare professionals. According to the World Health Organisation (2021), the shortages in health care professionals are felt most acutely in rural and remote regions. Together, these challenges impact the accessibility (including equitable access) and sustainability of healthcare services, raising concerns among citizens and policymakers alike. Access to healthcare services plays a pivotal role in shaping health outcomes among various populations – from elderly to children – and across both physical and mental illnesses. Studies consistently show that disparities in access to healthcare contribute to higher rates of chronic conditions, increased healthcare costs, and poorer health outcomes among various populations (Hofer, 2024). As Hofer notes in a recent paper in the *European Journal of Health Sciences*,

> "individuals living in rural or underserved areas may face challenges in accessing healthcare due to long travel distances to healthcare facilities, resulting in delayed diagnosis and treatment, which can exacerbate health disparities" (2024, 18).

Despite advancements in healthcare infrastructure and policies aimed at improving access, disparities continue to exist, posing significant challenges to the health and well-being of populations. In rural and peripheral areas, there are growing instances of General Practitioner (GP) and other health services closing or operating at reduced capacity due to both cost-related issues and a reduction in the number of health professionals who live and work in remote communities. This is leading to a wider policy (and political) debate on the need to remodel service provision, often "with little consideration of the wider social and economic impacts of change" (Farmer et al, 2003).

Both the World Health Organisation (WHO) and the Organisation for Economic Co-operation and Development (OECD) have been arguing of the need to develop approaches to health care provision that ensure that rural contexts are reflected across health policy and programme cycles, involving both health and rural development authorities. Evidence points to the importance of secure infrastructure in building communities that are health resilient; with health care provision increasingly included among a list of services noted as being fundamental to community life.

As argued by Farmer et al (2023), while change is not necessarily wrong and communities and service provision should not be in stasis, there are important issues at stake. Critically, health services, "embodied in GPs, nurses and allied health staff, are part of the important underpinning for community and not simply because of their direct (curative, preventive and palliative care) contributions to patient health", particularly in rural, ageing communities, but

also, because of their role and status in rural communities, "health professionals are often deeply embedded in the social networks that make up the 'fabric' of rural life".

1.1 Improving Healthcare Access in Rural Areas

Providing healthcare in rural locations presents unique challenges as rural communities tend to be geographically dispersed, with lower population density and often limited health infrastructure. Despite people in rural settings sometimes enjoying longer life expectancy on average, significant access barriers and inequities persist within and between rural areas.

1.1.1 Challenges in rural healthcare access

- **Geographic and Transportation Barriers:** Rural residents may live far from the nearest hospitals or clinics. Those living at greatest distance from healthcare services in rural and coastal areas are at highest risk of unmet needs, especially where public transport is poor or unaffordable[1];
- **Workforce Shortages:** Rural health systems often struggle to recruit and retain healthcare professionals. Fewer doctors, nurses, and specialists choose to practice in isolated areas. In England, small rural hospitals have been described as "unavoidably small" due to remoteness and face chronic staffing and funding challenges[2]. Workforce recruitment and retention is a core challenge in rural locations, requiring priority attention;
- **Infrastructure and Resource Limitations:** Rural clinics may have limited diagnostic equipment, fewer beds etc. Medicines and specialist services might not be readily available locally. Emergency response times can be longer in remote regions. Also, rural populations are on average older, which increases demand for healthcare while these areas simultaneously experience population decline and clinic closures in some cases;
- **Socio-economic and Hidden Deprivation:** While many rural areas can appear affluent on average, pockets of deprivation may be hidden within overall averages. Rural poverty, farming communities under financial stress, and lower minority representation can all impact health outcomes; and
- **Social Isolation:** Lack of anonymity and stigma in small communities can also be a barrier – e.g. individuals may be reluctant to seek mental health or substance abuse services. Isolation and loneliness are more common in sparsely populated areas, impacting mental and physical health of rural residents (especially the elderly). Traditional support networks might be stronger in some communities, but where they are absent, vulnerable people can "fall through the cracks".

These challenges contribute to rural health inequalities – differences in health outcomes between rural and urban populations, and among rural communities themselves. Those remote from services, with poor transport and lower incomes, experience worse health outcomes. Moreover, financing models haven't always accounted for the higher costs of

[1] Health and wellbeing in rural areas - Local Government Association
[2] As above

delivering care in sparsely populated areas – a study found that a handful of small rural hospital trusts in England made up 23% of the total deficit of all trusts, reflecting systemic underfunding of rural healthcare[3].

1.1.2 Strategies to enhance access in rural areas

Despite the obstacles, many innovative approaches are improving rural healthcare access. International experiences identifies key strategies that have been effective in rural healthcare delivery:

- **Community Health Programmes:** Engaging community health workers or volunteers to provide basic health education, outreach, and linkage to services. These community-directed interventions leverage local knowledge and trust to extend the reach of healthcare into remote villages;
- **School-Based Services:** Providing health services in schools (immunisations, screenings, health education) to reach children and adolescents in rural areas. This tactic uses schools as accessible hubs for healthcare delivery in communities that may lack a clinic;
- **Mobile Clinics & Outreach:** Regularly sending medical teams on outreach visits or using mobile clinic vans to travel to isolated settlements. These bring care "to the doorstep" of rural residents;
- **Family Health Programmes:** Structuring services so that each family or household is assigned to a primary care provider or team. This ensures continuity and proactive care;
- **Telemedicine and Digital Health:** Using telehealth technology to overcome distance barriers. Telemedicine connects rural patients with remote specialists via video, phone, or remote monitoring. This extends to the use of remote controlled robotic surgery – this is becoming more prevalent to deliver specialist surgery in areas where clinical skills are not available;
- **Partnerships with Local Non-Profits and Faith-based Organisations:** Rural healthcare providers often collaborate with non-governmental organisations (NGOs), charities, and religious organisations already active in the community. These partners can help with health education, transportation for patients, or running outreach programmes;
- **Digital Information and Mapping:** In addition to telemedicine, better data on rural health needs is improving planning. For instance, in England the development of a specialised Rural Deprivation Index by researchers has given a clearer picture of hidden rural poverty, enabling more equitable resource allocation.

Many of these strategies align with the WHO's recommendations for rural health equity, which emphasise strengthening primary care, investing in rural health workforce, and leveraging digital health[4]. It is also crucial to involve rural communities in designing solutions – a participatory approach fosters local ownership and sustainability.

[3] See Footnote 1.

[4] Early discharge hospital at home as alternative to routine hospital ...

1.2 Healthcare in the South West Region of Northern Ireland

The South West Acute Hospital (SWAH) in County Fermanagh has been facing significant challenges recently; the most notable issue of which has been the suspension of emergency general surgery (EGS) services. Additionally, other services have also been affected. This includes, for example, the preventative cardiology service, known as the "Our Hearts Our Minds" programme, which was recently discontinued after its funding ended. This follows on from the cessation of the Older Person's Assessment and Liaison Service (OPALS) programme due to staffing challenges. While the establishment of a Strategic Development Group (SDG) in response to the loss of services is to be welcomed, it is clear from a review of minutes of meetings held by the South West Acute Hospital SDG that maintaining existing services, re-instating cancelled services and developing new services is beset with a complex set of challenges, not lease budgetary constraints (across the wider health service), staffing recruitment and retention and cultural behaviours. More recently, a public consultation process was approved in early July 2025 by the Western Health and Social Care Trust (WHSCT) – also referred to as the Western Trust – on a permanent change to EGS at the SWAH. This, however, was subsequently paused at the recommendation of the Minister for Health who instead called for the Trust to produce "a vision plan emphasising how the South West Acute Hospital will be supported to meet both the needs of its current and future population" (BBC, 16 July 2025)

While a state-of-the-art primary care centre at Omagh was established as part of an attempt to address the gap left by the closure of the Tyrone County Hospital, a fuller approach could be taken to the creation of access to services at this hub. The primary care centre at Omagh remains a significant asset; with this paper also setting out recommendations that relate to the future of primary care in the wider Fermanagh and Omagh District and to which the centre at Omagh should be seen as an important component (but not a substitution for access for remoter rural communities who need effective primary care access in their own areas).

These challenges are in addition to wider issues facing health service provision in the South West – including loss of GP services. As of 31 March 2025, there were 305 GP practices in Northern Ireland. This figure represents a reduction of 45 practices (12.9%) since 2014. This change in the number of practices is as a result of closures, as well as mergers (where practices have combined). The WHSCT, which includes the Fermanagh and Omagh District Council area, recorded the largest proportionate decrease in GP practices across all Trust areas between 2014 and 2025 at 17.5%. In the Fermanagh and Omagh District Council area, the figures show a drop from 27 practices in 2014 to 19 practices in 2025. This represents a decrease of 29.6%[5], significantly above both the regional and Trust average.

The combined implications of this for effective and accessible health services, and community well-being, are of growing concern to Fermanagh and Omagh District Council (FODC). The WHO Regional Office for Europe's 2014 Report on the Social Determinants of Health clearly identifies a recommended role for local authorities in determining and influencing the health

[5] https://datavis.nisra.gov.uk/bso/general-medical-statistics-2024-2025.html#

outcomes of the communities which they serve. The report, which links the wider socio-economic conditions of populations to the need for co-ordinated action across policy-making and implementational work, argues that in addition to social injustices, as they relate to health, leading to unnecessary suffering and sometimes death, there are also strong economic arguments for heightened investment in health services because:

> *The cost of health inequities to health services, lost productivity and lost government revenue is such that no society can afford inaction. Tackling inequities in the social determinants of health also brings other improvements in societal well-being, such as greater social cohesion, greater efforts for climate change mitigation and better education* (WHO, 2014, p.17).

Whilst local government does not have a formal role in health service provision, there is a direct connectedness between the achievement of health and community well-being outcomes and other key activities of Council including, for example, spatial planning. The WHO 2014 report specifically identifies the role of integrative spatial planning in influencing the social determinants of both physical and mental health – in terms of spatial quality (how the built environment is planned, designed, constructed and managed and their resulting accessibility, connectedness and safety) and spatial equity (access to green spaces, facilities for play and access to healthy food). Importantly, local councils in Northern Ireland do have a specific legal competency for community planning under the *Local Government Act 2014*; with community planning operating to the quadruple helix model of stakeholder collaboration to improve the social, economic, and environmental well-being of districts and their residents. In addition, councils have a critical role in rural development – in which shrinkage or loss of any services is a core issue.

The COVID-19 Pandemic has emphasised the relevance of the social determinants of health for population health outcomes. It has also emphasised the relevance of local authorities in responding to the health needs of their communities. Whilst the focus for policy-makers, including local government, is now on building resilience to future pandemics and both global and national crisis, the COVID-19 Pandemic has created the conditions for innovations in policy and service delivery and emphasised the interdependencies between economic, social, and physical/environmental factors, both locally and at the level of a cross-border territory, to respond to population health needs.

1.3 The Purpose and Scope of this Report

This paper is an advocacy paper commissioned by Fermanagh and Omagh District Council (FODC), with a view to exercising its role in democratic governance in favour of improving the health and well-being and access to services of its constituent population, who are citizens and service users. This population includes citizens and service users who are also members of the health and social care workforce. As the future offering of the SWAH is under review, the development of this advocacy paper is timely as it considers what a sustainable model of health care provision for the South West region of Northern Ireland might look like (including its cross-border functional area). This advocacy paper has been prepared in direct response to the approved motion set down at a meeting of the Council, namely:

Focusing on the crisis in health care in our Council area with the announcement of services being withdrawn from the SWAH and the continued threat to all our GP surgeries, especially Maple Healthcare Lisnaskea, at present; this Council will convene a series of meetings and invites all relevant bodies that deal with health provision in the Fermanagh & Omagh Council area, as well as civic society, trade unions and community representatives to come up with a plan and/or recommendations on how rural communities in the Fermanagh & Omagh Area and indeed West of the Bann can attract and keep health care professionals in this area so that our citizens can have the confidence that a free, safe and modern health care will be provided to our rural people.
In the meantime, this Council also calls on the Department of Health and the Western Health and Social Care Trust to work collaboratively to ensure the future sustainability of GP services in Lisnaskea and the surrounding areas.

The research methodology has been designed to capture and document existing policy and practice with respect to rural healthcare service provision in the South West region of Northern Ireland. A mixed-methods approach was adopted to primary data collection, entailing the collection of qualitative data, consisting of an expert focus group and informal one-to-one interviews, in addition to desk-based approaches that involved a review of academic literature, a review of legislation and policy as it pertains to effective, equitable and safe health service provision, and drawing on international best practice. This suite of methods allowed for deeper insights into real-world experiences. The expert focus group involved an appropriately diverse range of stakeholders in the area of primary and secondary health care provision as well as advocacy groups and concerned citizens. The focus group considered. The analysis of sectoral, professional and community perspectives comprised a focus group and a series of semi-structured interviews.

This research has been undertaken by the International Centre for Local and Regional Development (ICLRD), a North-South-U.S. academic partnership established in 2006 to explore and expand the contribution that planning and the development of physical, social and economic infrastructures can make to improve the lives of people on the island of Ireland and elsewhere. For further details on the multidisciplinary ICLRD Research Team involved in this study, see Appendix A.

2. The Healthcare Ecosystem of the South West Region of Northern Ireland: A Geographical Context

The Fermanagh and Omagh District Council (FODC) area makes up one-fifth of Northern Ireland's landmass and is home to 6% of its people. The area shares the longest stretch of border with Ireland – 192 kms or 39% of the total border corridor. The District shares many natural co-dependencies with its cross-border neighbours, including in the areas of trade, tourism and labour. Increasingly, there is a case to be made for this co-dependency to extend into integrated healthcare service provision.

2.1 What the Data Tells Us

The geographic position of Fermanagh and Omagh brings both major benefits and economic challenges. While it is a highly attractive place to live and work, its rural nature, settlement pattern and natural landscape (including a vast network of lakes and waterways) poses unique challenges with respect to demographics, economic infrastructure, sectoral composition and broader connectivity and accessibility.

Highlighting the rurality of the District, the area is home to almost one-third of all farms and 20% of farmed land in Northern Ireland. The area accounts for more than 19% of Northern Ireland employment in agriculture, forestry and fishing, and 12% in mining and quarrying.

Recent research by Perspective Economics (2023) highlighted increased recruitment challenges and potential labour shortages in certain industries, such as hospitality and health care – both of which are key industries to Fermanagh and Omagh. This is reflective of trends evident across Northern Ireland as a whole, but also across the United Kingdom (U.K.).

With a current population of 116,812, the District is experiencing slow population growth and a declining working-age population (see Figure 2.1); both of which have socio-economic and health needs implications. In terms of an ageing population, 18% of current population is aged 65 years and older. Population projections suggest this could increase to 22% of the population by 2030 and 25% by 2040 – representing a quarter of the population in 15 years time.

The region is experiencing a growing divergence between life expectancy rates and healthy living expectancy. Healthily life expectancy for males in Fermanagh and Omagh is 63.3 years and 61.7 years for females. The average life expectancy is 79.2 years for males and 83.2 years for females. Thus, it can be surmised that the average person could have almost 20 years of life during which they are in poor health. Coupled with a decline in those of working age population, this is likely to put a very significant strain on health and social care services locally. This highlights the need for a greater emphasis to be placed on increasing healthy life expectancy, as opposed to overall life expectancy.

Fermanagh and Omagh District Council's *Anti Poverty Strategy 2024-2034*, published in December 2024, sets an important socio-economic context for analysing the adequacy of current healthcare provision in the region. The research underpinning the Anti Poverty Strategy found that 23% of the population in the District Council area have been living in relative poverty for 6 years prior to the strategy's publication, with certain groups and geographical areas within the District at particular risk and more vulnerable to poverty. The strategy also refers to work done by Action for Children in extrapolating from U.K.-wide and regional research, which suggests that 23-27% of children in the District could be living in poverty (2024, 10) – so approximately 1 in 4 children. Similar rates were identified in research undertaken by Perspective Economics (2023). The implications of child poverty are complex and potentially lifelong, including risk to children's emotional and social development arising from adverse childhood experiences relating to poverty and the conditions of poverty. Turning to the other end of the lifecycle, Perspective Economics (2023) noted that the area has an average ageing poverty rate of 8.4%. Bot the child poverty and ageing poverty rates for the Council area are above the Northern Ireland average.

Figure 2.1 Population Profile of Fermanagh and Omagh Vis-à-Vis Neighbouring Counties

In terms of levels of deprivation within the FODC area, measured using the Northern Ireland Multiple Deprivation Measure (NIMDM)[6], 3 Super Output Areas (SOAs) across the District (representing 6%) fall within the top !0% most deprived areas of Northern Ireland (see Figure 2.2) (Perspective Economics, 2023, 7). A review of Gross Disposable Household Income (GDHI), as a measure of living standards, shows that Fermanagh and Omagh was 5% points below the average level of GDHI in Northern Ireland.

The Council's Anti-Poverty Strategy further emphasises that the cost-of-living crisis continues to affect many with an increasing issue of debt as a result of rising costs. This has implications

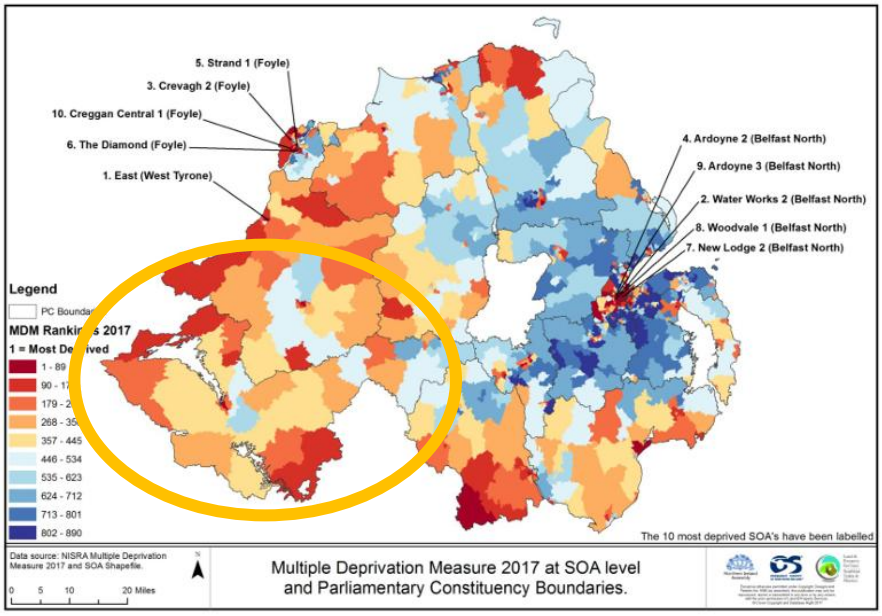
[6] The Measure is constructed from 38 indicators relating to seven different types of deprivation – income deprivation, employment deprivation, health deprivation, education deprivation, access to services, living environment deprivation and crime.

for health outcomes as food and fuel poverty have particular and direct implications for physical health, while overall poverty increases overall risks to mental, emotional and physical health in individuals, families and communities. The strategy also refers to recent research carried out by University of Ulster which found that Fermanagh and Omagh District had the third highest average risk score for food poverty across Northern Ireland councils, with rural areas at greatest risk of such poverty (2024, 9). Food items were on average more expensive and less available from rural outlets in Fermanagh and Omagh. The level of household access to food is therefore not equitable across the District.

The Anti-Poverty Strategy describes the issue of fuel poverty in the District:

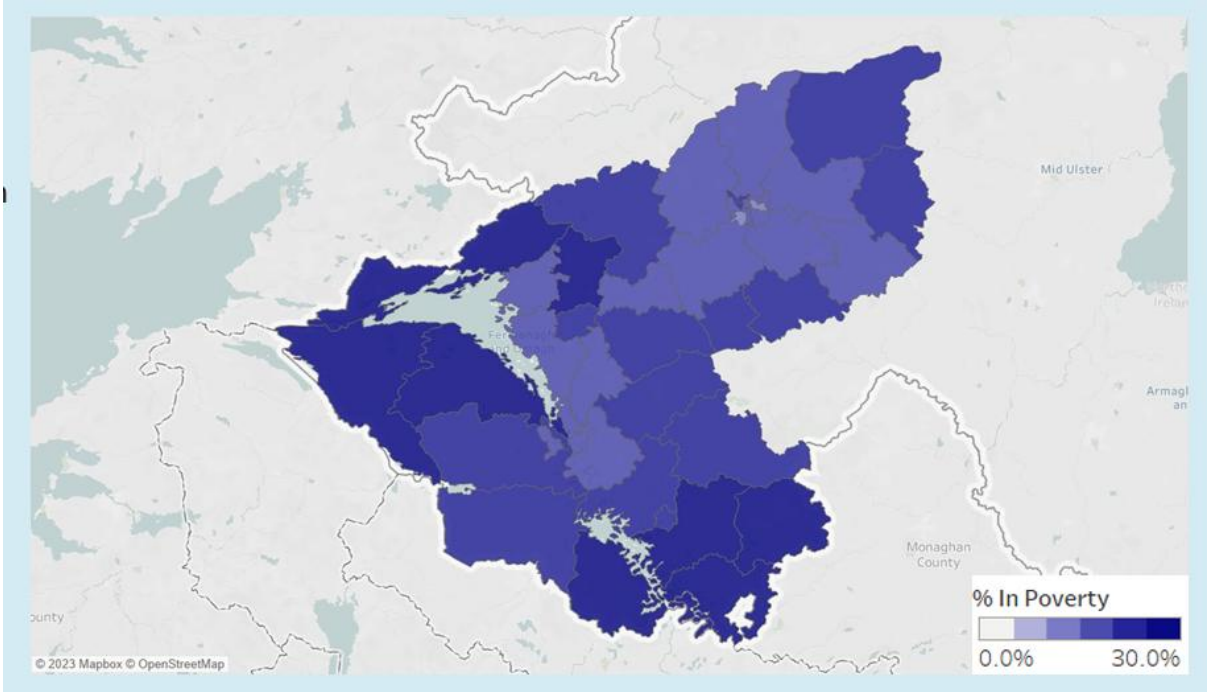
> *The research further found that Fermanagh and Omagh district has the highest at-risk rate of fuel poverty of all 11 councils in Northern Ireland. Rural areas are at higher risk of fuel poverty within the district. This is particularly true for small areas (SAs) bordering with Leitrim, Cavan and Monaghan. As regards transport, the researchers found that more than one in three of domestic properties in the district are more than a 10-minute walk from an existing bus stop. There are SAs with 25% or more households with no vehicle ownership. A combined transport poverty risk score concluded that intermediate sized settlements and villages have the highest average combined risk score. Across the board, there were 157 Small Areas in Fermanagh and Omagh classified as high risk clusters for either fuel, transport or food poverty, 52 Small Areas (33%) experience two of the three issues, and 4 Small Areas (containing over 900 domestic properties) had high risk clusters for fuel, transport and food poverty together.*

Figure 2.2 Northern Ireland Multiple Deprivation Measure, 2017



As noted also in the Anti-Poverty Strategy, the Department for Communities (DfC) has recently released administrative data to demonstrate the risk and depth of income poverty for households in Northern Ireland. The DfC data indicates that the proportion of households in poverty within Fermanagh and Omagh ranges from 13% to 33% (2024, 10) – between one in ten and one in three, with border areas suffering the most, as illustrated in Figure 2.3 below.

Figure 2.3 Percentage of Households in Poverty in Fermanagh and Omagh



(Source: Fermanagh and Omagh District Council, 2024, 10)

2.1.1 Challenges and implications for the healthcare system

As outlined in Chapter 1, the healthcare system in the South West region of Northern Ireland is facing into significant challenges as a result of such trends as:

- Declining demographics;
- Ageing population;
- Reconfiguration and rationalisation of health services;
- Shortages in healthcare professionals; and
- Recruitment and retention of staff in the healthcare sector.

Taken together, these lead to challenges surrounding (i) accessibility to services (incl. equitable access); (ii) the need to deliver more complex healthcare to increasing numbers; and (iii) sustainability and viability of health care services. These, in turn, lead to

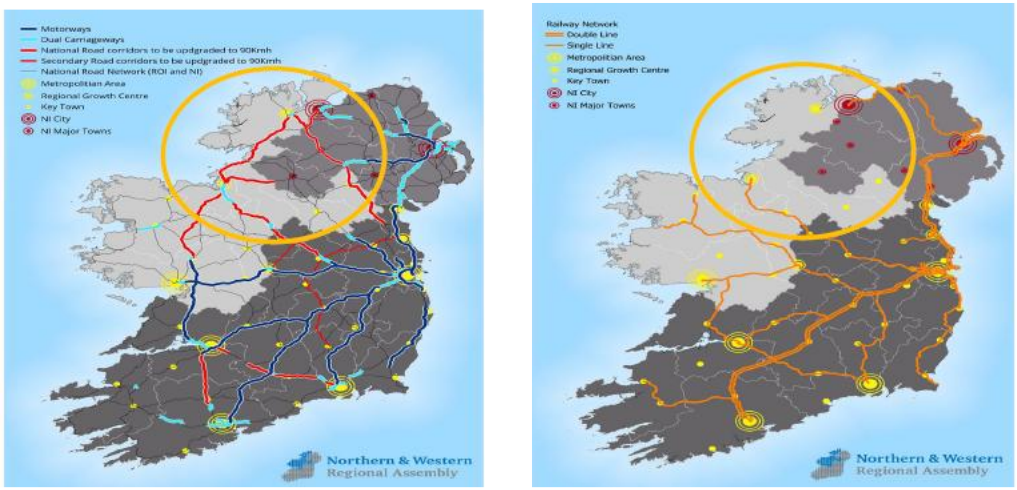
- Longer wait times/longer distances to travel;
- Higher rates of chronic conditions;

- Declining health outcomes, due to delays in diagnosis and treatment; and
- Higher healthcare costs.

2.2 Ongoing Challenges to Services

Road infrastructure across the FODC area is least well developed due to a distinct absence of motorways or dual carriageways. The more rural areas of the District are poorly served by bus services and the area as a whole is devoid of rail infrastructure and an airport (see Figures 2.4). As home to more than 10% of Northern Ireland's businesses, major agricultural producers and a number of world-leading export businesses, the area needs access to a high-quality transport. While investment in infrastructure is essential for economic growth, it is also critical for population health and well-being.

Figure 2.4 Road and Rail Infrastructure Deficits in Fermanagh and Omagh



(Source: Northern and Western Regional Assembly)

Transport poverty is recognised as a longstanding issue in Fermanagh and Omagh, particularly for several socio-economic groups such as young renters, pensioners with disabilities or long-term ill-health and people on low incomes (Furey et al, 2023). Through the Community Planning process, the Council engaged in a comprehensive analysis of transport poverty over 2022 in partnership with community transport providers. The analysis included a focus on public transport travel times (incl. Translink and Bus Eireann timetables) to health facilities. This mapping work was undertaken by Basemap Ltd. Results show, for example, that between 11am – 1p.m., 29% of residents within the District can travel to the South West Acute Hospital (SWAH) in Enniskillen within 2 hours using only public transport and walking. For those trying to get home during this same time period, the possibility of doing so, using public transport and walking, falls to 8% (see Figure 2.5). This, together with other findings as highlighted in the Figure below, clearly demonstrates that public transport provision is a challenge for rural dwellers analysis

Figure 2.5 Public Transport Travel Times to Health Destinations, Selected Time Periods, September 2022

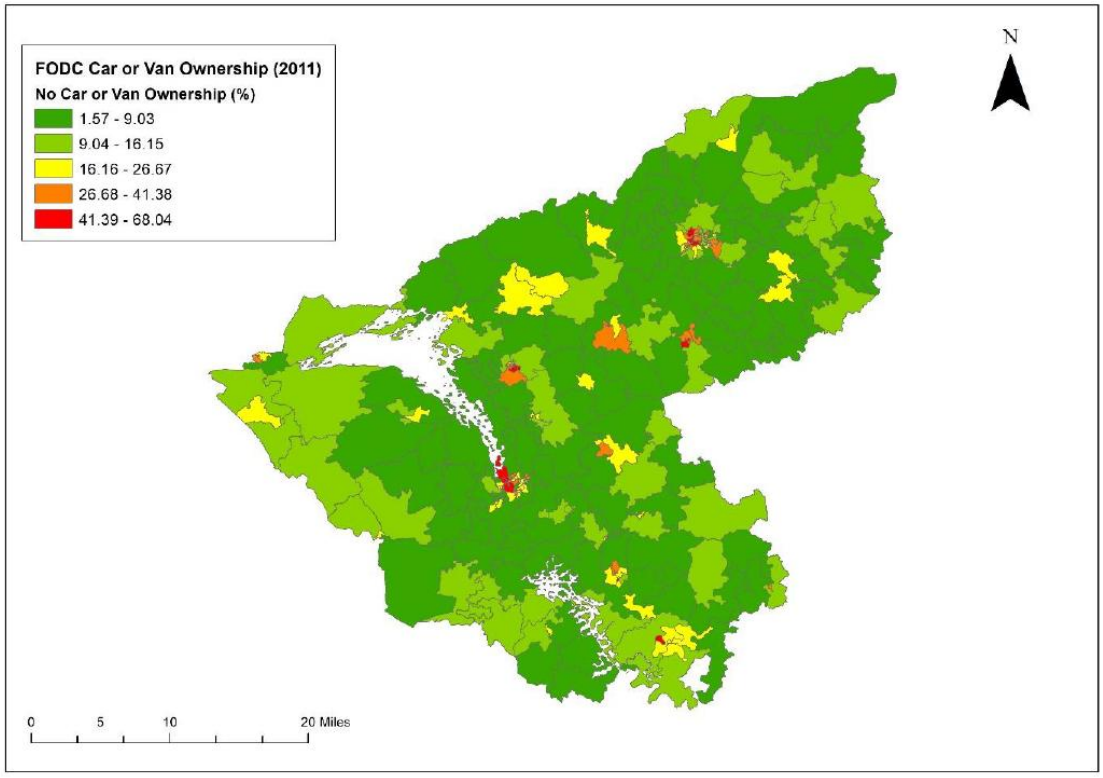
% of the population who can travel to the destination by public transport within 2 hours

Destination	Location	Weekday				Weekend	
		7am-9am Outbound	11am-1pm Inbound	11am-1pm Outbound	4pm-6pm Inbound	7am-9am Outbound	4pm-6pm Inbound
Hospitals							
Altnagelvin Hospital	Derry~Londonderry	0%	0%	0%	0%	0%	0%
Belfast City Hospital	Belfast	0%	0%	0%	0%	0%	0%
Craigavon Area Hospital	Craigavon	0%	0%	0%	0%	0%	0%
Musgrave Hospital	Belfast	0%	0%	0%	0%	0%	0%
Omagh Hospital	Omagh	12%	11%	8%	11%	6%	9%
Royal Victoria Hospital	Belfast	0%	0%	0%	0%	0%	0%
South Tyrone Hospital	Dungannon	10%	7%	11%	15%	12%	13%
South West Area Hospital	Enniskillen	26%	29%	8%	22%	1%	11%
Ulster Hospital	Belfast	0%	0%	0%	0%	0%	0%
GPs							
Enniskillen Grouped	Enniskillen	93%	76%	76%	91%	47%	73%
Omagh Grouped	Omagh	42%	40%	36%	40%	27%	37%
Dr Porteous & Partner	Lisnaskea	57%	47%	47%	61%	56%	56%
Dr McCaw & Partner	Irvinestown	50%	72%	61%	51%	37%	42%
Derrygonnelly Practice	Derrygonnelly	46%	25%	25%	46%	25%	25%
Derrylin Practice	Derrylin	37%	21%	21%	58%	37%	21%
Dr Corry & Partner	Carrickmore	19%	16%	25%	27%	12%	23%
Dr Cromie and Partner	Brookeborough	47%	47%	47%	52%	44%	47%
Tempo Practice	Tempo	35%	25%	25%	56%	25%	25%
Dr Cunningham & Partner	Florencecourt	24%	6%	6%	6%	6%	6%
Dr Herdman & Partner	Belleek	37%	28%	41%	37%	28%	28%
Dr Monaghan & Partner	Fintona	36%	35%	36%	36%	36%	35%
Dr Reilly	Dromore	70%	60%	64%	69%	39%	37%
Trillick Practice	Trillick	45%	28%	45%	46%	23%	23%
Dr Ritchie& Partner	Drumquin	38%	38%	46%	55%	32%	32%
Dr Scully	Drumquin	41%	41%	49%	56%	41%	41%
Ederney Practice	Ederney	15%	15%	15%	15%	15%	15%
Gortin Practice	Gortin	19%	19%	19%	19%	19%	19%
Newtownbutler Practice	Newtownbutler	27%	23%	23%	36%	23%	35%
Dr Boyd & Partner	Fivemiletown	3%	3%	3%	33%	3%	3%
Dr Hicks & Partner	Plumbridge	0%	0%	0%	0%	0%	0%

Source: Basemap and Fermanagh and Omagh District Council analysis of Translink data (September 2022 timetable)

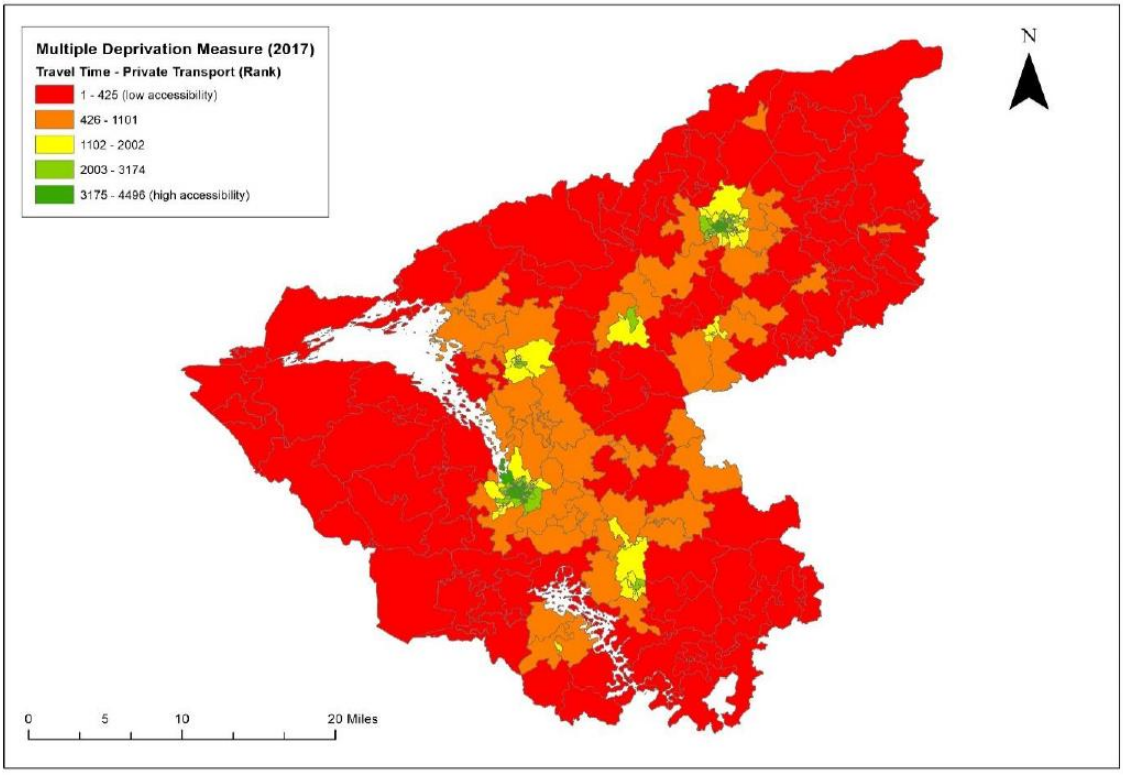
Across the District, it is estimated that 70% of the population live outside of Enniskillen and Omagh, thus are rural-based. At the same time, there are Small Areas (SAs) where 25% or more of households have no access to a car or van. This, together with access to public transport and frequency of public transport services significantly impacts on a person's ability – or not – to access key services. Figures 2.6 to 2.9 below highlight the scale of challenge being faced by residents of the District (Furey et al, 2023).

Figure 2.6 Percentage of Households with No Car or Van Ownership (2011 Census)



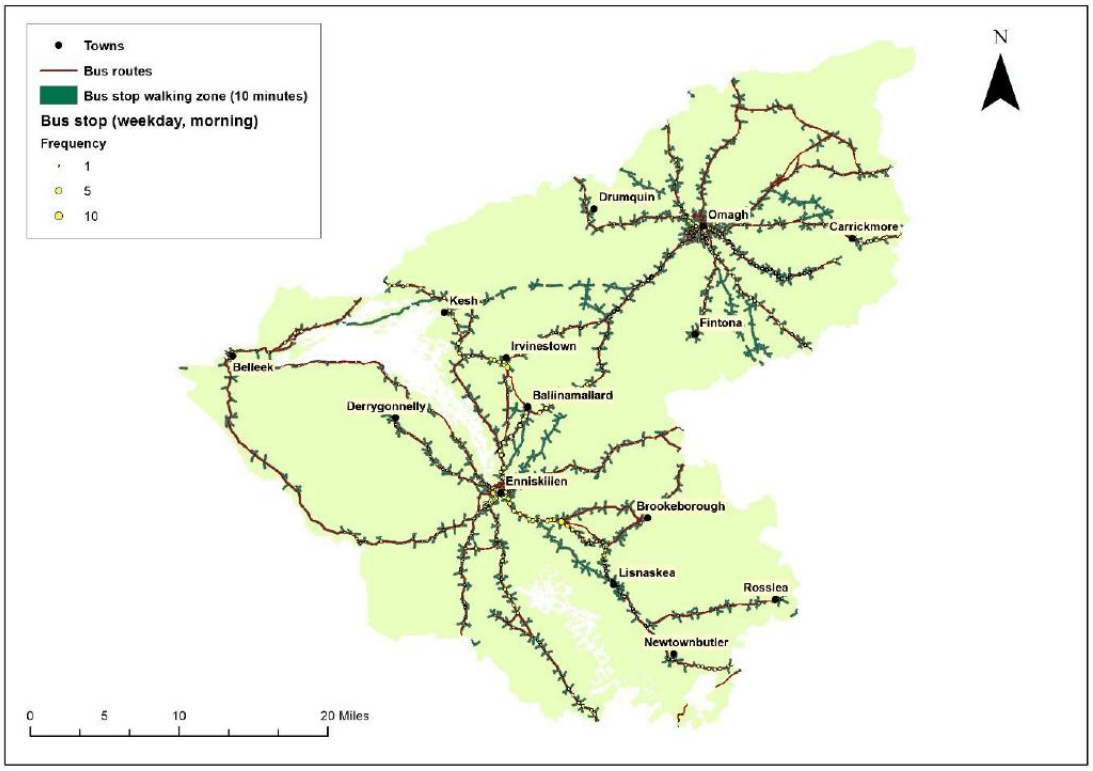
(Source: Furey et al, 2023, 37)

Figure 2.7 Ranked Private Travel Time to a Range of Key Services (NISRA, 2017)



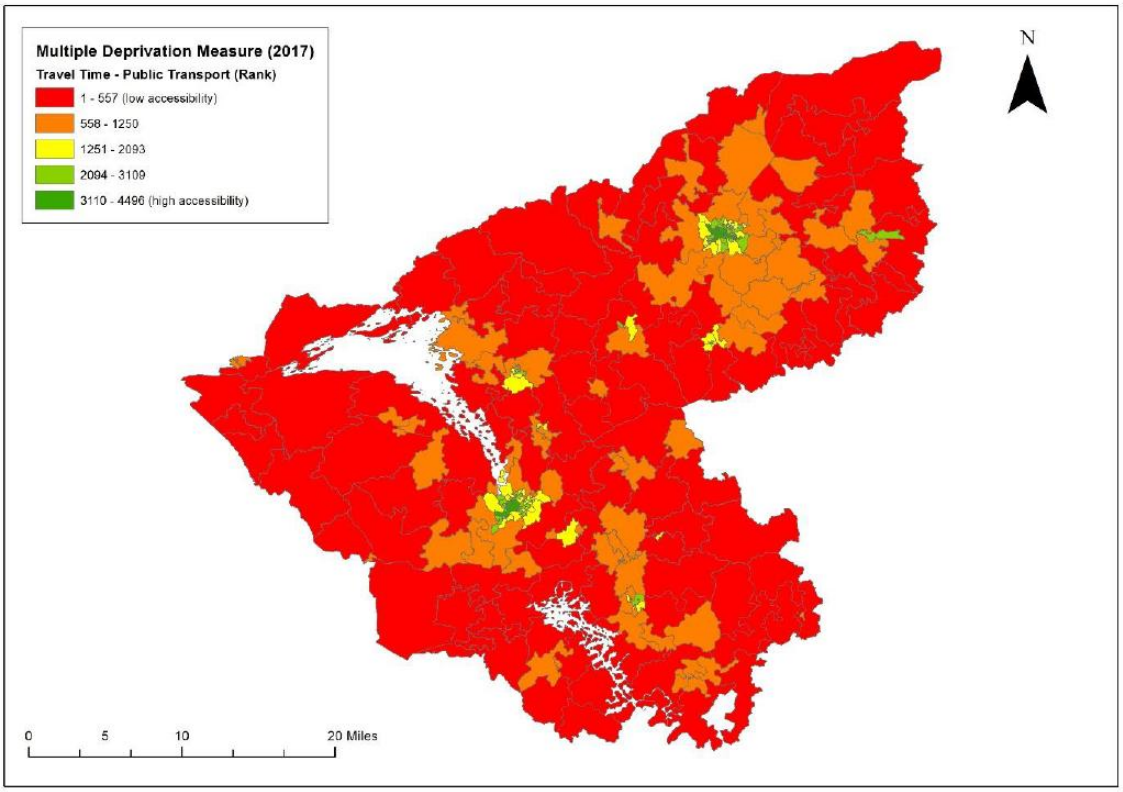
(Source: Furey et al, 2023, 39)

Figure 2.8 Frequency of Weekday Morning Bus Services



(Source: Furey et al, 2023, 31).

Figure 2.9 Ranked Public Travel Time to a Range of Key Services (NISRA, 2017)



(Source: Furey et al, 2023, 40)

2.3 Taking a Functional Territory Approach – The Spatial Complimentary

It is internationally recognised that there is a direct correlation between the achievement of health/community well-being outcomes and other key activities of local government – including integrative spatial planning and associated access to spatial quality and spatial equity. The *Fermanagh Omagh 2030 Community Plan,* produced by Fermanagh and Omagh District Council and updated in 2020, places a core focus on the achievement of healthy people and places across the District; its vision being of

> *a welcoming, shared and inclusive Fermanagh and Omagh district, where people and places are healthy, safe connected and prosperous, and where our outstanding natural, built and cultural heritage is cherished and sustainably managed* (p.4)

This is to be achieved through strong partnership working; and in terms of people, the focus being on physical, emotional and mental health. The Plan's 6 priority outcomes are outlined in Figure 2.10; and in the context of this paper, four of the six have a strong focus on overall health and well-being and will be discussed further in Chapters 3 and 6. Notably, the Council has a core role to play in achieving these outcomes - through Community Health and Leisure Services, Environmental Health Services, the Health Improvement Team and Economic Development.

Figure 2.10 Priority Outcomes of the Fermanagh Omagh 2030 Community Plan

(Source: Fermanagh and Omagh District Council, 2020, 16)

These priorities were further reflected and elaborated on during the public consultations held as part of the process to develop community well-being plans, a joint initiative of the Western Trust and the Council. During these consultations in 2022, priorities highlighted were:

- Access to Services;
- Health Literacy/Education and Well-being;
- Physical Health, Mental and Emotional Well-being;
- Family Support, and
- Poverty (Fermanagh and Omagh District Council, 2023, 12).

The latest *Statement of Progress* on the roll-out and delivery of the Community Plan, for the year 2023, highlights the role of spatial planning in building healthy communities. For its two main towns, Enniskillen and Omagh, the Council have embedded the Place Shaping approach, "bringing together land use planning and community planning and the creative use of powers and influence, to promote the general well-being of communities and residents" (Fermanagh and Omagh District Council, 2023, 5). In terms of measuring progress, 38 population indicators have been identified and some key highlights flagged in the latest *Statement of Progress* include:

Positive

- Reduction in the gap in life expectancy in males in deprived areas;
- Reduction in the admittance rate due to drugs and alcohol;
- Increase in physical activity of residents;
- More older people using the internet;
- Decrease in recorded crimes against older people;
- Good health of people 65 and over improved;
- Improved GCSE Attainment;
- Increase in the number of jobs;
- Increase in wage levels; and
- Improved broadband access availability in the District.

Negative

- Increase in the gap in life expectancy in females in deprived areas;
- Increase in falls of people over age of 75;
- Decrease in older people who feel they can get to all the places in their local area that they want;
- Increase in the number of people living in relative poverty;
- Reduction in the number of people that believe their cultural identity is respected by society;
- Life satisfaction of people with disabilities;
- Increase in the number of children living in poverty;
- Decrease in economic activity rate; and
- Decrease in public transport – active travel.

Undoubtedly, progress has been impact by COVID-19, and its aftermath, and ongoing financial uncertainty in the public sector.

3. Population Health Needs of the South West Region of Northern Ireland

This section looks first at selected highlights from existing sources which demonstrate the needs of the population in the South West region of Northern Ireland. Secondly, it indicates activity or initiatives of various stakeholders in the region or whose activity impacts on the region, which constitute a baseline of capacity and understanding of the challenge. These initiatives are important because they represent the response of various stakeholders to the challenge, and are indicative of a latent social capital of commitment to addressing the problem, which can be mobilised in an ecosystems approach involving collaborative action, codesign and evidence-based intervention aligned with key trends for best practice in development of systems and approaches which can positively impact population health in the region.

3.1 Previous Analysis of Needs

3.1.1 Northern Ireland Health Inequalities Reports for 2024 and 2025

The **2024 Report on Health Inequalities** published by the Northern Ireland Department of Health (DoH) and Northern Ireland Statistics and Research Agency (NISRA) had the following key findings for Northern Ireland as a whole:

- Deprivation gaps for male and female life expectancies at birth saw no change since 2016-18; with the most-least deprivation gaps stood at 7.2 years for males and 4.8 years for females in 2020-22. While female life expectancy at birth remained similar in all areas over the last five years, male life expectancy decreased in 2020-22 in Northern Ireland and across the most and least deprived areas;
- Inequality gaps narrowed for both male and female disability-free life expectancies (DFLE) following improvements in the most deprived areas. The most-least deprived gaps in healthy life expectancies (HLE) stood at 12.2 years for males and 14.2 years for females in 2020-22. This represents no changes in inequality gaps observed for male or female HLE since 2016-18;
- Large inequality gaps continue to highlight markedly higher rates of premature mortality in the most deprived areas, with none of the gaps showing a notable change over the analysed period, with the exception of preventable mortality where the gap widened as the rate in the most deprived areas increased to now treble the rate in the least deprived areas;
- Large inequality gaps continue to exist for mental health indicators. Prescription rates for mood and anxiety disorders increased regionally and for the most and least deprived areas between 2018 and 2022, with the rate in the most deprived areas 66% higher than in the least deprived areas. In 2020-22, the suicide mortality rate in the most deprived areas was more than two and a half times the rate observed in the least deprived areas;

- Alcohol and drug related indicators continue to show some of the largest health inequalities monitored in Northern Ireland. The deprivation gap for drug misuse deaths widened over the analysed period and showed the largest inequality gap, where mortality in the most deprived areas was almost six times that of the least deprived;
- While improvements were observed regionally and in the most and least deprived areas with the under 20 teenage birth rate, in addition to regionally and in the most deprived areas for the proportion of mothers reporting smoking, the relative inequality gaps remain very large; with rates in the most deprived areas being over five times that in the least deprived in 2022; and
- In 2022/23 the percentage of primary 1 pupils in the most deprived areas affected by obesity was more than double the proportion in the least deprived areas. The inequality gap in year 8 pupils affected by obesity was slightly lower, with the proportion in the most deprived areas 94% higher than in the least deprived areas.

Of the 34 health outcome indicators analysed for Western Trust residents, six were worse than the Northern Ireland average, 27 were similar to the Northern Ireland average, and one of the health outcomes analysed was better than the Northern Ireland average. Overall, the health outcomes for the Western Trust area against the Northern Ireland average were largely similar to the regional average. However, the report indicated that there were some significant differences involving poorer health outcomes for the most deprived areas of the Western Trust area than the Western Trust average.

The report, for example, highlighted inequality gaps between the Western Trust overall rate and the Western Trust most deprived areas rate, in the area of life expectancy. Male life expectancy is on average 78.2 years in the Western Trust area, but in the most deprived areas within the Trust area, it is 73.2 years. Female life expectancy is on average 82.0 years in the Western Trust area, but in the most deprived areas of the West it is 79.3 years.

Across the 53 indicators analysed, the majority of outcomes were significantly worse for those residing in the 20% most deprived areas of the Western Trust when compared with the Western Trust average. Exceptions to this included deaths attributed to COVID-19 (lower in more deprived areas), infant birthweight and childhood obesity figures. The largest gap in health outcomes for the Western Area overall, where outcomes were worse than the Northern Ireland average, was in the following areas:

- Standardised Death Rate – Alcohol Specific deaths;
- Standardised Prescription Rate – Statin;
- Breastfeeding on discharge;
- Standardised Death Rate – Lung Cancer;
- Standardised Prescription Rate – Mood and Anxiety; and
- Standardised Death Rate – Smoking Attributable causes.

At Local Government District (LGD) level, Fermanagh and Omagh had the largest health inequality gaps between the most deprived areas of the District and the area as a whole – as shown below in Figures 3.1 and 3.2.

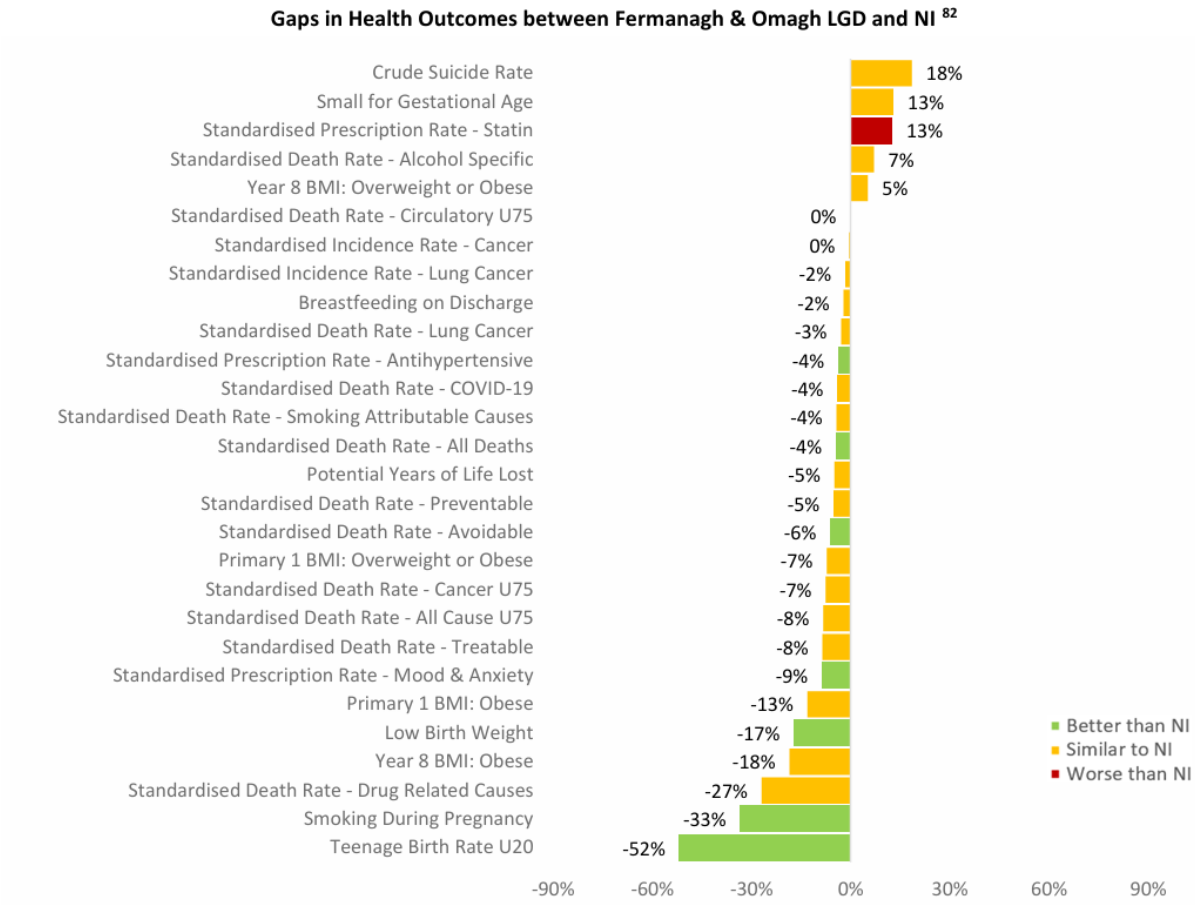
Figure 3.1 Largest Deprivation Inequality Gaps in each LGD Area

The table below indicates the five largest deprivation inequality gaps in each Local Government District (LGD) between the LGD's 20% most deprived areas and the LGD average. [55, 56]

Antrim & Newtownabbey LGD	Drug Related Death Rate (114%)	Alcohol Specific Death Rate (111%)	Self-Harm Admission Rate (93%)	Smoking during Pregnancy (85%)	Drug Related Admission Rate (76%)
Ards & North Down LGD	Drug Related Admission Rate (97%)	Smoking during Pregnancy (81%)	Alcohol Related Admission Rate (75%)	Preventable Death Rate (67%)	Self-Harm Admission Rate (64%)
Armagh City, Banbridge & Craigavon LGD	Under 20 Teenage Birth Rate (134%)	Smoking During Pregnancy (111%)	Drug Related Admission Rate (100%)	Alcohol Related Admission Rate (96%)	Alcohol Specific Death Rate (96%)
Belfast LGD	Drug Related Death Rate (96%)	Under 20 Teenage Birth Rate (91%)	Alcohol Related Admission Rate (90%)	Alcohol Specific Death Rate (83%)	Preventable Death Rate (80%)
Causeway Coast & Glens LGD	Alcohol Specific Death Rate (111%)	Drug Related Admission Rate (99%)	Smoking During Pregnancy (96%)	Alcohol Related Admission Rate (88%)	Under 20 Teenage Birth Rate (85%)
Derry City & Strabane LGD	Drug Related Death Rate (168%)	Alcohol Specific Death Rate (149%)	Alcohol Related Admission Rate (116%)	Drug Related Admission Rate (103%)	Lung Cancer Incidence Rate (92%)
Fermanagh & Omagh LGD	Self-Harm Admission Rate (67%)	Alcohol Related Admission Rate (64%)	Drug Related Admission Rate (61%)	Lung Cancer Death Rate (48%)	Lung Cancer Incidence Rate (46%)
Lisburn & Castlereagh LGD	Under 20 Teenage Birth Rate (155%)	Alcohol Specific Death Rate (139%)	Smoking During Pregnancy (101%)	Alcohol Related Admission Rate (95%)	Drug Related Admission Rate (92%)
Mid & East Antrim LGD	Drug Related Death Rate (220%)	Drug Related Admission Rate (157%)	Self-Harm Admission Rate (145%)	Smoking During Pregnancy (137%)	Alcohol Related Admission Rate (120%)
Mid Ulster LGD	Alcohol Related Admission Rate (59%)	Drug Related Admission Rate (43%)	Under 75 Death Rate – All Causes (26%)	Potential Years of Life Lost (24%)	Avoidable Death Rate (23%)
Newry, Mourne & Down LGD	Alcohol Specific Death Rate (68%)	Self-Harm Admission Rate (48%)	Alcohol Related Admission Rate (48%)	Drug Related Admission Rate (40%)	Preventable Mortality Rate (27%)

(Source: Department of Health/NISRA, 2024)

Figure 3.2: Gaps in Health Outcomes between Fermanagh and Omagh LGD and Northern Ireland



(Source: Department of Health Northern Ireland/NISRA, 2024)

The largest health inequality gaps observed in the FODC area, between the District average and the District's most deprived areas, were the following:

Self-Harm Admission Rate (67%)	Alcohol Related Admission Rate (64%)	Drug Related Admission Rate (61%)	Lung Cancer Death Rate (48%)	Lung Cancer Incidence Rate (46%)

The **2025 Health Inequalities Annual Report,** published as this paper was being finalised, found that of the 34 health inequalities indicators applied regionally to each Trust, 11 of these in the Western Trust were below the Northern Ireland average. The only Trust which had more than this was the Belfast Trust area (which had 26 worse than the Northern Ireland average). Both the Western and Belfast Trust areas contrast sharply with other Trust areas which had no, or just one, indicator worse than the Northern Ireland average.

Additionally, the 2025 Annual Health Inequalities Report highlighted the following data (Figure 3.3.) which indicates alarming statistics for the Western Trust area, including those which suggest that further investment is needed in earlier and risk-based intervention in the areas of mental health, drugs and alcohol misuse. Furthermore, the Western Trust area has the highest teenage births rate (under 20) in Northern Ireland.

Figure 3.3 Largest Deprivation Inequality Gaps in each HSC Trust Area 2025

Belfast HSCT	Drug Misuse Death Rate (132%)	Drug Related Death Rate (123%)	Under 75 Respiratory Death Rate (108%)	Drug Related Admissions (105%)	Under 20 Teenage Birth Rate (103%)
Northern HSCT	Drug Misuse Death Rate (124%)	Drug Related Death Rate (123%)	Drug Related Admissions (115%)	Smoking during Pregnancy (101%)	Self-Harm Admission Rate (96%)
South Eastern HSCT	Under 20 Teenage Birth Rate (109%)	Alcohol Specific Death Rate (109%)	Drug Misuse Death Rate (105%)	Drug Related Admission Rate (99%)	Smoking during Pregnancy (99%)
Southern HSCT	Alcohol Specific Death Rate (102%)	Drug Related Admission Rate (97%)	Alcohol Related Admission Rate (96%)	Under 20 Teenage Birth Rate (95%)	Smoking During Pregnancy (82%)
Western HSCT	Drug Misuse Death Rate (130%)	Drug Related Death Rate (115%)	Alcohol Related Admission Rate (112%)	Under 20 Teenage Birth Rate (107%)	Alcohol Specific Death Rate (107%)

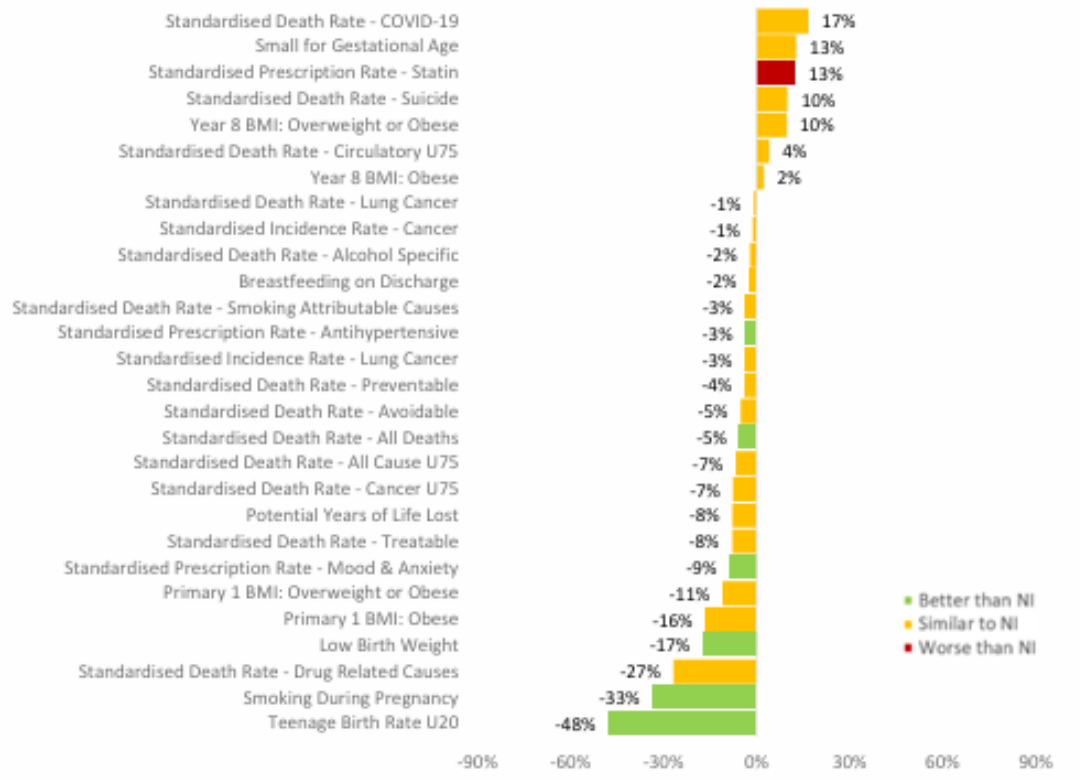
(Source: Department of Health/NISRA, 2024)

The 2025 report indicates that in the Western Trust area, male life expectancy (78.4 years) is similar to the Northern Ireland average (78.8 years) and female life expectancy (82.0 years) is 0.5 years less than the average (82.5 years).

Across the 34 health outcome indicators analysed, the majority of outcomes were significantly worse for those residing in the 20% most deprived areas of the Western Trust, when compared with the Western Trust average. Exceptions include deaths due to covid, low birth weight, suicide death rate, babies born small for gestational age, and primary 1 and year 8 overweight and/or affected by obesity, where differences were not statistically significant. In addition, rates were higher in the 20% most deprived areas of the Western Trust for all 19 service-based indicators when compared with the Western Trust average, apart from the under 18 dental extraction rate.

The reports statistics for LGDs indicate that in Fermanagh and Omagh, male life expectancy (79.6 years) was 0.9 years higher than the Northern Ireland average (78.8 years) and female life expectancy (83.1 years) was similar to the average (82.5 years). See Figure 3.4 for deeper comparison of gaps in health outcomes.

Figure 3.4 Gaps in Health Outcomes between Fermanagh and Omagh LGD and Northern Ireland average



(Source: Department of Health/NISRA, 2024)

Across the 32 health outcome indicators analysed in the report, the majority of outcomes were significantly worse for those residing in the 20% most deprived areas of Fermanagh and Omagh LGD when compared with the Fermanagh and Omagh LGD average. Exceptions include:

- Female life expectancy at birth;
- Male and female life expectancies at age 65;
- Treatable mortality;
- Under 75 circulatory and cancer mortality;
- Deaths due to COVID;
- Suicide rate;
- Smoking attributable death rate;
- Lung cancer death rate;
- Alcohol specific deaths;
- Drug related deaths;
- Smoking during pregnancy;
- Under 20 teenage birth rate;
- Breastfeeding on discharge;

- Low birth weight;
- Babies born small for gestational age; and
- Primary 1 & year 8 overweight and/or affected by obesity,

where differences were not statistically significant.

In addition, rates were higher in the 20% most deprived areas of Fermanagh and Omagh LGD for all 19 service-based indicators when compared with the Fermanagh and Omagh LGD average, apart from the all age dental registration rate, all age and under 75 circulatory admission rates, elective inpatient and day case admission rates, under 18 dental filling and extraction rates, and the under 18 dental registration rate.

The largest inequality rates observed in the last year for Fermanagh and Omagh LGD are set out below:

Alcohol Related Admission Rate (70%)	Drug Related Admission Rate (60%)	Self-Harm Admission Rate (58%)	Lung Cancer Incidence Rate (50%)	Potential Years of Life Lost (36%)

While the statistics for 2025 show certain improvements in health outcomes for the Fermanagh and Omagh District, a number of issues remain as to the experience of the most deprived areas within the District. These are illustrated in statistics reported such as the differences in life expectancy between the least and most deprived areas of the LGD, which are 3.1 years for men and 1.7 years for women. Certainly, further analysis would be of interest as to the possible causation of a change in statistics such as self-harm admission rates which dropped 10% in 12 months in the District – if this is due to targeted interventions then evidence on the success of such interventions should be reviewed in considering future investments in health services and access for people in the Fermanagh and Omagh LGD.

3.2 Eliciting and responding to rural health gaps in the South West Region of Northern Ireland – Examples of Initiatives to Date

The purpose of this section is not to provide an exhaustive list of initiatives which have been aimed at tackling health gaps in the region but to provide examples of where action has been taken which shows potential for future multifactoral interventions involving a collaborative approach between elected decision-makers (including local government), policy-makers (local, regional and national), statutory delivery bodies in the healthcare and other sectors, and civil society organisations (including patient and citizen advocacy groups). For a future health ecosystem to fully function involves the recognition by all actors of the importance of a collaborative approach within a multilevel governance framework such as that which exists in implementing and delivering on the ambitions of the Northern Ireland Programme for Government.

3.2.1 Local Government implementing National/Regional policy-driven responses: Western Response and Action on Poverty Programme (WRAP)

As outlined in Chapter 2, poverty has direct implications for health outcomes, and social deprivation can have a lifelong impact on health outcomes. Working within a regional framework driven by the Department for Communities response to the 2016 *Welfare Reform Mitigations Report*[7], Fermanagh and Omagh District Council (FODC) has undertaken active measures to alleviate poverty indicators in an evidence-based support programme to the most deprived households in the LGD. FODC's action in the area of tackling poverty – insofar as local government can intervene to ameliorate the symptoms of poverty on the ground – has included delivery of the WRAP Programme, and leverage of additional support from the Public Health Agency (PHA) for action on fuel poverty, as well as support for the Money and Pensions Service (MaPS) Money Guiders programme.

Launched in Autumn 2023 following the coming together of a consortium of local community and voluntary sector organisations, led by FODC, the WRAP Programme has supported 140 households in Fermanagh and Omagh, comprising 411 individuals. More than 800 referrals were made for wraparound support and £45,000 in financial aid was distributed by way of shopping vouchers. Given the success of the programme and additional funding being made available from the DfC Social Supermarket Fund, FODC offered a further tender for an external delivery body (single organisation or consortia) in Autumn 2024 to provide a single point of contact, on a district-wide basis, to support 200 households requiring poverty support. This included £64,000 in financial aid to be distributed to participating households by way of shopping vouchers.

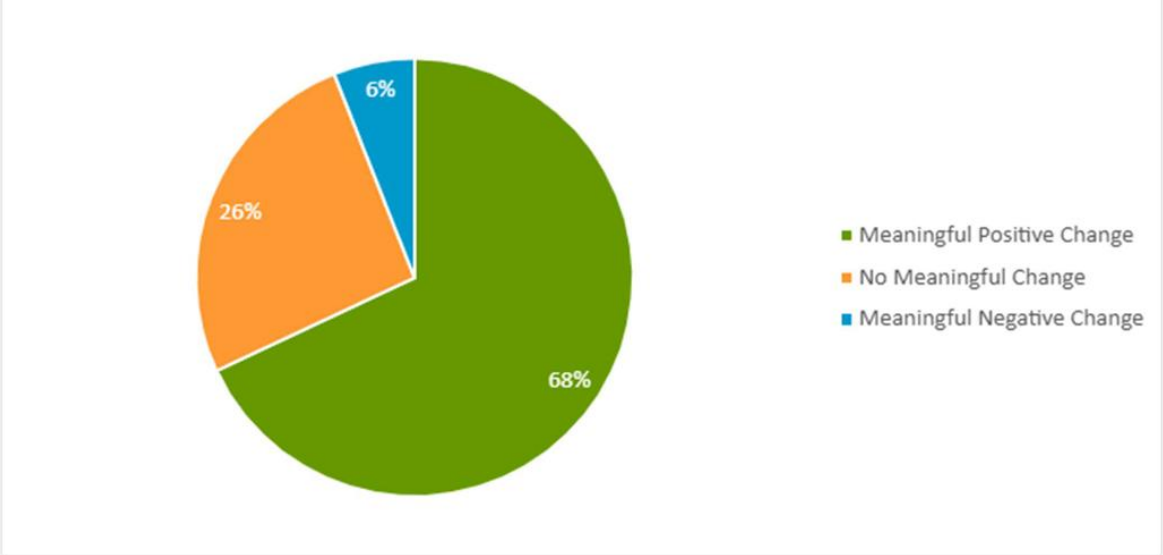
While the WRAP scheme did not involve targeting of households according to health status indicators, it is noted as significant that

> *80% of the participant households disclosed that there were one or more people within the household who had a disability or a medical condition that has an effect on the persons' ability to carry out normal day to day activities.*

Furthermore, WRAP as part of its evaluation framework monitored fourteen indicators regarding self-reported levels of health and well-being at pre- and post-access of the programme by interviewees. Importantly, 68% of programme participants reported meaningful positive change as regards their health and well-being at the end of the programme as highlighted in the Figure below.

[7] https://www.executiveoffice-ni.gov.uk/sites/default/files/publications/ofmdfm/welfare-reform-mitigations-working-group-report.pdf

Figure 3.5 WRAP Programme – Measures of Meaningful Change in Health and Well-being at End of Engagement



(Source: Fermanagh and Omagh District Council)

In terms of learnings and conclusions emanating from the WRAP Programme, the format and delivery consortium has proven the capacity for stakeholder organisations in the South West region of Northern Ireland to work together effectively for the better well-being of the most vulnerable residents in the Fermanagh and Omagh District. The conclusions and learning from the WRAP Programme[8] should help to inform future collaboration in relation to the wider issue of health and well-being, and point to the potential for a community-based approach to complement improvements in access to health services and for health outcomes in the population. This involves learning from what worked well, and what requires further investment and/or a rework, including:

- All consortium partners were operating significant waiting lists for support through the WRAP Programme. Many of those on waiting lists were provided with other support (outside WRAP) as it became available and as staff resources within the consortium would allow;
- Households are continuing to struggle due to the cost of living and wages and/or benefits do not appear to have kept pace and do not appear to cover many households' essential needs;
- Households in which there is a disability/long-term medical condition appear to be finding themselves with disproportionately higher financial challenges as witnessed with 80% of programme participants identifying as such despite this not being a target demographic. Since the WRAP Programme participant households were all identified as experiencing poverty, the data would indicate that limiting medical conditions and/or disabilities have a negative impact on household finances to the extent that meeting essential needs is a challenge. At a time of potential change in Government

[8] WRAP Programme Report (2025)

policy around reduction of allowances that support people with disabilities/long-term medical conditions, it would be expected that these challenges would increase for these and other households with similar experiences unless there was a significant reduction in the cost of living and/or other interventions;

- In 52% of households, there was income coming in to the household from some form of paid employment. This data would support anecdotal information that working households are struggling to meet essential needs due to poverty;
- Households in the private rental sector, having made up 36% of the programme participants, indicates that there is significant pressure on household budgets and that rents may be a contributory factor for many households;
- There are a significant number of people in the District living in temporary/emergency housing, including 12% of participant households, i.e. homeless. This does not take into account hidden homelessness and households which had been served eviction notices. Some of the households reported that they were no longer able to afford to pay rising rent and/or bills and many were finding it difficult to find alternative rental property at affordable cost that was suitable for their needs. This suggests that demand is outstripping supply in the District and there is a lack of affordable housing available[9];
- It was noted that private landlords own many of the temporary/emergency accommodation properties, that rents (largely at cost to ratepayers) were generally high, that tenants often did not have access to (or control over) energy supply/use in their homes (so could not, for example, join the oil buying network or adjust thermostats to manage costs), and properties were often very poorly insulated which inevitably had a negative impact on those already in precarious financial situations;
- 12% of households on the WRAP Programme identified as being of minority ethnicity. Challenges and barriers cited by these households included delays around settlement status and lack of fixed address (particularly for members of the Traveller Community) which both limit or prevent access to public funding support;
- The 'Cost of Living' was the most common reason (48% of participants) cited for financial challenges with many households expressing difficulty ordinarily affording energy, food, and fuel for vehicles and/or transport; and
- Many Programme participants reported that financial challenges were having a significant impact on the mental health and well-being of people within the household, including on children. Figures suggest that 23% of the population of Fermanagh and Omagh District Council area are living in relative poverty (circa 26,877 people / 8399 households on the basis of Census 2021 population figures and WRAP average household size of 3.2 people). Therefore, it is expected that the potential for mental health and well-being impacts of poverty on this scale across the District are significant in terms of how the WRAP Programme was delivered and support provided to households.

[9] 24 April 2025 WRAP Programme Report

3.2.2 Statutory Delivery Body: Western Health & Social Care Trust Pathfinder Initiative[10]

In 2018, the WHSCT launched its Pathfinder Initiative, in response to its declared commitment to take a detailed focussed look at Health and Social Care Services provision in Fermanagh and West Tyrone.

While the Pathfinder Initiative was not implemented and appears no longer to be within the corporate priorities of the Western Trust (if implementation had been prioritised to a greater extent, it is arguable that the Council may not have felt the need to commission this advocacy paper), it is worth including some analysis of it here. This is done to illustrate, first, that considerable resource and effort were deployed in the design of Pathfinder by the Trust, and secondly to demonstrate that the Trust, precisely because of its work in the initial stages of the Pathfinder Initiative, collected and holds extensive evidence on the issues for Fermanagh and Omagh which remain the subject of concern for the population and its representatives. Furthermore, it is a material issue relevant to resolution of current levels of generalised trust in healthcare delivery for the people of Fermanagh and Omagh that the Pathfinder initiative raised public and community expectations and was not then advanced to delivery. Had this situation been different, it is arguable that many of the current issues around service access in the District would be different or, at least, less chronic in terms of the needs and service gaps they reflect.

With regards to Pathfinder, the Trust stated that the programme

> *involves looking at the population's needs, creating ways to improve what we do, look at ways to anticipate care better, ways we can improve access to diagnostics and treatment, look at post-acute Health & Social Care, best practice in recruiting and retaining an appropriate workforce and ultimately providing the delivery of affordable Health and Social Care services for the area*.

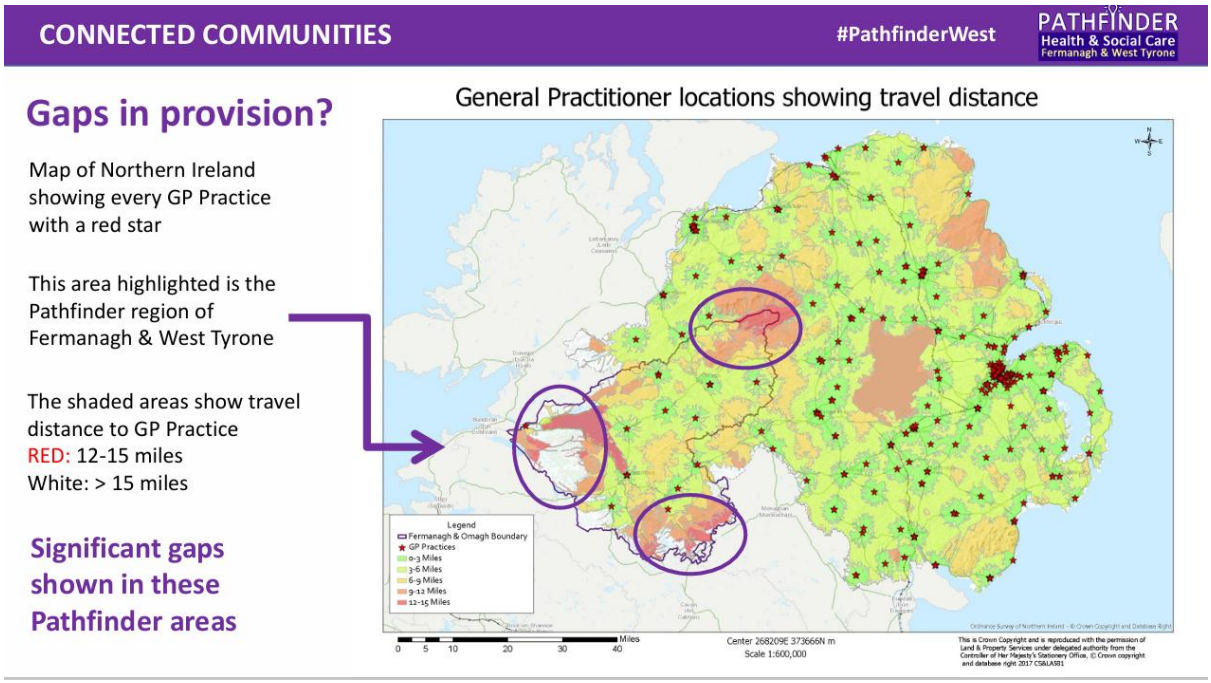
Pathfinder involved a pre-engagement phase from August to November 2018, comprising of 17 large events taking place at venues across the region to outline the programme and its goals. The second phase, viewed by the Western Trust as integral in achieving the overall aims of the project, was the 'Engagement Phase'. In one of the most comprehensive community engagement initiatives ever undertaken by the Trust, the Pathfinder team attended 62 Engagement Sessions and had wide ranging discussions on the future planning and delivery of services in the area with over 2,200 stakeholders, attending venues all across Fermanagh and West Tyrone. This involved patients, community and voluntary groups, carers, action groups, staff, schools, public representatives and other stakeholders.

With the PHA leading a recalibration of the population health needs analysis, the next phase in the process involved seven appointed independent 'Experts by Experience' (Personal and Public Involvement) joining a number of influential stakeholders across four work streams, influenced by the *Health and Wellbeing 2026 Delivering Together* report, to look at designing and developing plans for the delivery of services going forward.

[10] All materials taken from Western Trust Website and final report of Pathfinder Initiative published 2019: Pathfinder Update Report – June 2019 | Western Health & Social Care Trust

Pathfinder identified a range of opportunities and gaps in care and specifically recognised that GP services in the Fermanagh and Tyrone area were already retracting. Some key infographics emerging from these phases – relating to gaps in GP provision, travel time, and relative per capita investment in GPs across Northern Ireland – are presented below.

Figure 3.6 Gaps in GP Provision and Travel Distance to GP Practice[11]



The Pathfinder report involves a detailed look at the demographic needs and rural nature of the region – also the focus of this paper – and specifically stated the importance of quality of life within the rural nature of the area. It further noted the vital importance of voluntary and community provision networks as a component of health and well-being of the population.

Through these extensive consultation and engagement phases in 2018/19, Pathfinder identified emerging themes as follows:

- Workforce;
- Career progression;
- Access to diagnostics;
- New ways of working to meet demand;
- Importance of generating networks of service; and
- Timescales for change[12].

[11] Drawn from Western Trust published material on Pathfinder Health Summit and Western Trust Pathfinder Full Report (2019), P31.
[12] Western Trust Pathfinder Full Report (2019), p8.

Figure 3.7 GP Locations in Northern Ireland and Per Capita Investment in GPs across Northern Ireland[13]

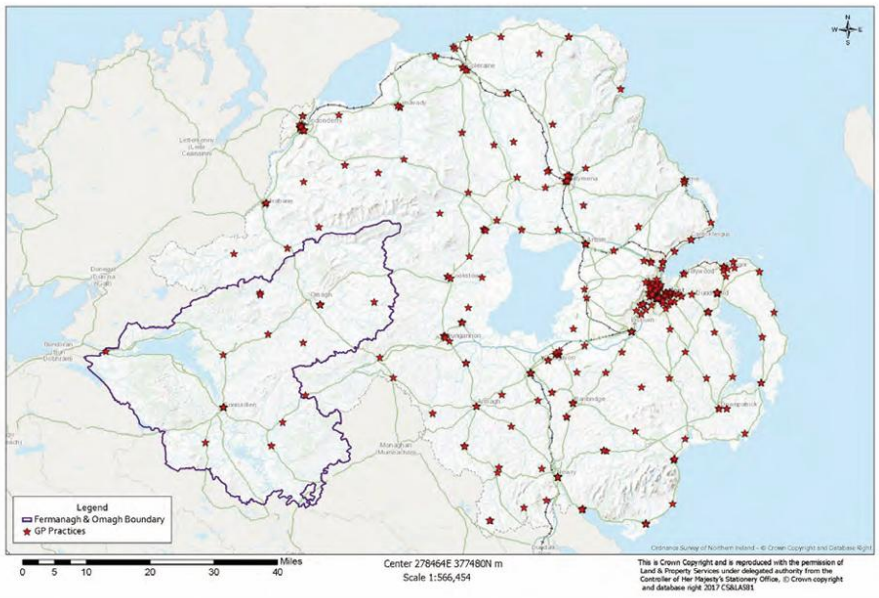
The Pathfinder area has 82 GPs in 21 practices, who have 140,764 registered patients
0.58 per 1,000 patients

The rest of Northern Ireland has 1,232 GPs for 1,843,013 patients
0.67 per 1,000 patients

11,300 patients are registered at 3 practices each with 1 permanent GP in the Pathfinder area

Map showing GP Locations in Northern Ireland.

The area drawn out with a purple border shows the Pathfinder Area for Fermanagh and West Tyrone



(Not accounting for less than full-time working)

(Source: Western Trust/Pathfinder)

The Pathfinder report details in depth the responses and the issues discussed at a range of local engagement sessions; examples of issues arising included the need for more emphasis and investment on social prescribing, the overall issue of home care, and the opportunity to look at a healthcare apprenticeship scheme to deal with workforce shortages (being experienced in many rural regions of Europe and which are the subject of ongoing collaborations between healthcare bodies, education and training bodies, professional and local communities). A full read of the report reveals the richness of the engagement which took place as part of this pre-pandemic initiative by the Western Trust, published just over six months before the Pandemic was declared, and over whose implementation a response to the Pandemic had to be prioritised. It is worth revisiting this work and examining how Pathfinder could be updated and adapted as a basis for addressing many of the improvements which have been cited in the course of the FODC/ICLRD engagement.

Pathfinder and the Connected Communities Model: Pathfinder committed to a senior leadership oversight group for the implementation of the priorities identified in the engagement period. These priorities were to ensure alignment with Northern Ireland regional healthcare transformation themes, to ensure co-creation (through the involvement of experts by experience), to mobilise the Connected Communities model as a vehicle for delivery on the ground.

[13] Western Trust Pathfinder Full Report (2019), p19.

The final report states that:

> *Connected Communities will be a main feature of the Pathfinder work and will determine the focus of the work undertaken, whether in pharmacies, virtual clinics, domiciliary care, business case development and the Drumclay transition unit. The Connected Communities theme underpins many of the issues and concerns stemming from the Pathfinder engagement phase and will nurture:*
>
> - *Embedding well-being in Fermanagh and West Tyrone;*
> - *Measuring well-being using an outcomes based population health approach;*
> - *Creating communities that are compassionate and where kindness becomes the underpinning philosophy; and*
> - *Rebuilding community cohesiveness at three different levels Community Health; and How we organise?*[14]*.*

Pathfinder and Community Health Partnerships: In addition, the Western Trust in the Pathfinder Full Report indicated a commitment towards identifying appropriate models for developing community health partnerships (essentially a type of community planning model focused on the delivery and support of health and social care services and the ecosystems required to sustain them). The Trust recognised that working differently and involving other actors such as local government, the Housing Executive, transport providers and the community and voluntary sector was desirable. It also acknowledged that resourcing of such models would be required in order to achieve the desired functionality which was identified as follows[15]:

- Development of locality planning networks;
- Creation of a database of specific support in the community;
- Provision of a phone/digital service to signpost patients to support;
- Identification of gaps in service provision;
- Provision of support to individuals and groups to fill these gaps in service provision;
- Supporting of support organisations and services to network and work together;
- Setting up information-giving events, and development and training of members of the community to become Community Connectors;
- Working with individuals in the most appropriate way for the individual; this might be one-to one in GP practices, in the community, on the phone, in hospitals, care homes or in patients' homes;
- Focussing on 'What is Important' to the patient and supporting them to set goals or access the support that they want;
- Working with groups to support people to better self-manage their health and well-being by providing self-management courses, group education sessions and peer support groups; and

[14] Western Trust Pathfinder Full Report (2019), p31.
[15] Western Trust Pathfinder Full Report (2019), p32.

- Working with complex patients, their families and support network who are highlighted through Multi-Disciplinary Team (MDT) meetings

Many of these issues were echoed again at the 2025 event as part of FODC/ICLRD engagement process (see Chapter 4). While the Western Trust did not progress the commitments it made in the final report of Pathfinder, post-pandemic would have been an opportunity to do so, basing the reform on the lessons from the pandemic and improving access on an equitable basis. While workforce has been a universal challenge in healthcare systems, innovation to address workforce shortages and ability to appoint beyond non-recurrent funding are urgent needs. It is important also to note that not all of these issues lie with Healthcare Commissioners to resolve, particularly when commissioned resources are in place for Trusts to use.

3.2.3 Civil Society – Advocacy Group: Save Our Acute Services (SOAS)

While this study relates to the overall issue of a health ecosystem for the Fermanagh and Omagh area and the South West of Northern Ireland as a whole, and while detailed consideration needs to be given to the matter of preventative primary and community care systems which meet patient needs earlier in the patient journey and lifecycle, it remains that any functional healthcare ecosystem needs secondary and acute hospital services within reach for patients in a way which does not jeopardise the patient outcomes of those who require urgent care. Save Our Acute Services – better known as SOAS – is a data- and evidence-driven grassroots citizen and patient advocacy initiative formed in 2022 in response to the threatened and temporary withdrawal by the WHSCT of emergency general surgery (EGS) at SWAH. SOAS is driven by healthcare service users, citizens and constituents in the South West region of Northern Ireland, and its aim and vision are as follows:

> *We strive to represent the voices of the community by advocating for fair and sustainable healthcare solutions. Our commitment includes providing evidence-based arguments, engaging with policymakers, and fostering public participation in the fight to secure essential medical services. We envision a **sustainable and robust South West Acute Hospital**, where all residents have timely access to critical healthcare services. Together, we can ensure Fermanagh is never forgotten and that our community receives the care it deserves*.

A specific focus has been maintained by SOAS on the issue of surgical service levels and point of emergency care at SWAH**.** Acknowledging that the historical under-utilisation of SWAH presents a rare opportunity for both the population and the health system, the group has led an evidence-based campaign for co-designed approaches to restoring EGS services at the hospital. The group's work highlights the opportunity presented by the hospital as a modern healthcare facility run by the Western Trust which is designed for infection control and which has been historically under-utilised (97 beds remaining uncommissioned i.e. not used for the delivery of publicly-funded services other than non-recurrently funded 'waiting list' initiatives designed to reduce the numbers of patients waiting for elective procedures). SOAS have also highlighted the opportunity for SWAH to be considered as a shared service point in a cross-

border context. ICLRD elaborate further on this issue in our analysis and recommendations in the final sections of this report.

The SOAS Roadmap: In January 2025, following several years of careful research and building a consensus advocacy platform, SOAS launched a roadmap for SWAH. In the creation of the roadmap, SOAS ensured that the suggested roadmap aligned with regional policy priorities relating to the regional *Review of Urgent and Emergency Care* and *Review of General Surgery* which were both published by the Department of Health (Northern Ireland) in 2022. The roadmap aims to ensure a critical mass of activity which will make SWAH attractive to key clinical staff at three levels:

1. **Local:** − Return of emergency surgery to SWAH, surgical beds reopened − Major Trauma stabilisation available;
2. **Regional:** − New elective specialities based in SWAH − Accelerated elective activity in line with Elective Care Framework − SWAH-based consultants will do sessional work in Omagh Hospital and Primary Care Complex; and
3. **North-South:** − SWAH to be used for emergency cases along North-South corridor − SWAH as receiving trauma centre for gaps in the Health Service Executive (HSE) trauma network − Build elective capacity for agreed shared specialities - Integration of the above: − Designation of SWAH as a 'Rural Area Hospital' − The creation of an integrated surgical network for the Western Trust[16].

This roadmap also aligns with the stated goal of the Elective Care Framework from the Department of Health to reduce the dependence on the Independent Sector. SOAS has meant an evidence-informed citizen voice has been audible in relation to the discussion of healthcare facility configuration and resourcing. The campaign has strongly emphasised the overall issue of the rights of rural dwellers as equal citizens to those in urban areas. Additional work by SOAS most recently has included scrutinising the Equality and Rural Needs impact assessments carried out within the Health and Social Care system for the Department of Health full public consultation entitled *Hospitals - Creating A Network for Better Outcomes* (published in October 2024). In the context of the SOAS organisational response, SOAS drew on the human rights framework embedded in legislation in Section 75 of the *Northern Ireland Act*, and has suggested that there is room for improvement in the granularity of data used in equality and rural needs impact assessments, to focus more specifically on impact on the Section 75 groups of decisions being made around location of services in particular (geographical locations rather than other locations). SOAS has argued further consideration needs to be given to equality impact on the specific Section 75 grounds of age, gender, disability and dependents.

SOAS ultimately highlight the need and benefit of restoration of EGS at SWAH, even on a partial basis initially, in the context of the reutilisation and development of SWAH as a high standard inpatient facility for the delivery of elective care serving the needs of the Northern Ireland elective care system, offering collaborative capacity for Ireland's elective care

[16] SOAS – CIC #NI694537 Discussion Paper – SWAH Roadmap SOAS – CIC #NI694537 Discussion Paper – SWAH Roadmap Page 5 5

demands, and which can also offer timely access to EGS for patients on both sides of the border.

3.3 The Evolving Context for Improving a Rural Health Ecosystem in the South West Region of Northern Ireland

Fermanagh and Omagh has a shared history of adaptation to healthcare system changes. Since the early 2000s, the District has seen the closure of the Erne Hospital, the closure of the Tyrone County Hospital (loss of two former acute hospitals with major experience in trauma management) and the initial establishment of SWAH as a fully-functioning general acute hospital with superior facilities and design. The District has also experienced the establishment of a major primary care centre at Omagh, which provides a range of services for patients from across the region and has superior design and fit-out. Omagh Primary Care, while also a state-of-the-art centre needs to be better utilised for the District and assigned a greater range of services (including community-based diagnostics services for which it was designed).

While the next section (Chapter 4) sets out considerable detail on potential for an optimal health ecosystem for the area in focus, and Chapter 5 looks at contemporary and emerging best practices from within the NHS in meeting rural health needs through whole-systems approaches, the discussions which are reflected in Chapter 4 can be set in the context of the following principles.

3.3.1 Building on the strengths of the region

There is acknowledgement across all sectors relevant to the issue of sustainable and resilient health-care provision that the region has particular strengths in terms of models of community-based and community-driven approaches to health and well-being, including the healthy living centres and all the organisations which assisted with the WRAP Programme planning and delivery as outlined above. In this sense, there is a strong element of social and cultural capital in the region, not least derived from its rurality and influenced by the culture of mutual support which allows rural communities and economies to function and become resilient in the face of shocks and challenges.

The region has a strong community sector which is not funded sufficiently to do what it already does, much less do more. However, the tools are there and the issue is policymaking and resourcing.

The region has a state-of-the-art primary care centre at Omagh which was designed to ‘shift left’ many services which otherwise would be delivered in a hospital setting for want of appropriate alternative clinical facilities. The region also has a state-of-the-art acute hospital, underutilised.

In the prelude to a paradigm shift that is addressed in the next chapter, it is vital that a prevailing and legitimate sense of the constrained resources, and the limited possibilities within the existing context in which facilities like SWAH have been under-utilised, and

Multidisciplinary Primary Care Team recruitment delayed, are not allowed to limit people's sense of what might be possible. Continuing to work on the assumptions that limit a current sense of what might be possible is not a solution for the current or future population and their health needs. Neither is it a solution for healthcare systems at policy, commissioning or delivery level to under-reach in terms of ambition for service levels, quality and access, when it is clear that things can and should be done differently – and are in fact being done differently elsewhere within the NHS – an inspiration which may be drawn from some of the examples provided in Chapter 5.

3.3.2 Policy and legislation – finding inspiration from work in progress

Devolution as an opportunity to design a healthcare systems model fit for Northern Ireland's unique needs: The local government system in Northern Ireland sits in a wider context of devolved regional governance which the United Kingdom (U.K.) adopted in 1998, in three separate Acts of Parliament (for Northern Ireland[17], Scotland and Wales respectively)[18]. While the U.K. Parliament remains sovereign, devolution meant that certain powers, statutory functions and a corresponding funding envelope (know as the 'block grant') were transferred from Westminster/Whitehall to regional assemblies (in this case the Northern Ireland Assembly) supported by regional executive administrations.

Health and social care are one such devolved matter which - notwithstanding the issue of the block grant and overall U.K. austerity issues – lie completely within the control and are subject to the agency of the Northern Ireland Executive and its Minister for Health. This presents an opportunity for a policy-driven, solution-focused approach to meeting the needs of the entire population of Northern Ireland to the best of the resources and options which are available to the Executive because the NHS in Northern Ireland operates within a wider U.K. context and can avail of inspiration and evidence-based modelling, professional exchange and the opportunity to improve how it responds to population changes within a wider U.K. benchmarking context[19]. It also presents an opportunity to draw on the inspirational reservoir of intellectual capital which is the NHS agenda for quality, safety and value – supported by such leadership resources as those available through NHS Horizons which are inspired by the

[17] Link to the Northern Ireland Act of 1998: Northern Ireland Act 1998 (legislation.gov.uk)

[18] Devolution was a process which evolved during the course of the 1990s and was strongly linked to the emergence of the Europe of the Regions agenda and the U.K. Government's embracing of this policy agenda in the context of modernising democratic governance in the U.K. as a whole. Devolution was enacted following separate plebiscites in Scotland, Wales and Northern Ireland. The plebiscite in Northern Ireland was on the terms of the 1998 Peace Agreement (referred to variously as the Good Friday Agreement or the Belfast Agreement but in fact titled 'The Agreement, 1998'). The effect of adoption of the terms of the 1998 Agreement was to allow for devolution to happen for Northern Ireland in the same way as Scotland and Wales. Regional Assemblies were established in the three regions of the U.K., elected by proportional representation/single transferable vote. The U.K. central government retains overall responsibility for certain functions including legislative competency, some of which can be transferred to devolved regional administrations over time. These are known as 'reserved functions'. A list of these is contained in Schedule 3 of the *Northern Ireland Act, 1998;* see Northern Ireland Act 1998 (legislation.gov.uk)

[19] The Northern Ireland Secretary of State, in a speech delivered on 19th September 2024 to the annual conference of the Centre for Cross Border Cooperation, referenced the issue of the Northern Ireland healthcare system's performance and the opportunity to improve value for investments, in view of the performance of systems in England, Scotland and Wales.

strategic insights of NHS Horizons, whose programmes are available to all working within the NHS and often beyond[20].

The interdependent issues of quality, safety and performance have been actively and consistently debated in the wider arena of the NHS and in healthcare policy in a recognisable way for almost two decades. These have been largely informed by the principles of the Triple Aim, Quadruple Aim[21] and now the Quintuple Aim (see Figure 3.8). These are axioms developed by the U.S. Institute of Healthcare Management[22] and which have evolved through a global debate on healthcare quality and systems management. While the *Healthcare Act (England) 2022* introduced the Triple Aim into a legislative framework for NHS England to operate within, the Institute of Healthcare Management at international level has now updated the aim to include five domains.

Figure 3.8 The Quintuple Aim

(Source: Institute for Healthcare Improvement)

The ongoing debate on healthcare improvement, population health and the ongoing focus on quality and safety in the healthcare system in Northern Ireland is consistent with global patterns in which health systems across the world have sought to adapt to significant

[20] NHS Horizons
[21] untitled BMJ Editorial June 2015: Sikka, Morath, Leape: The Quadruple Aim: care, health, cost and meaning in work – correspondence to Dr Rishi Sikka, Advocate Health Care, 3075 Highland Avenue, Suite 600, Downers Grove, Il 60515, USA; rishi.sikka@advocatehealth.com
[22] Improvement Topic: Triple Aim | Institute for Healthcare Improvement

differences in demographics between the early 21st Century and the demographics of the post-World War II era from the 1950s to the 1990s.

This is not to mention the significant acknowledgement that many initiatives and commissioning frameworks in Northern Ireland since 1999 have made of the additional population health inequalities which arise from adverse childhood experiences, which themselves relate to a range of factors from socio-economic neglect to conflict-related trauma. This is a commendable achievement by all of those working in the development of health and social care in Northern Ireland who have chosen to increase understanding of the needs of the population as a society emerging from conflict. This trend of open dialogue and increasing awareness of the link between mental and physical health, and the destigmatisation and removal of taboos in discussing the impact of the conflict on the health of the population is to be welcomed (Miller, 2021). This openness in Northern Ireland Health and Social Care about the benefits of trauma-informed approaches has copper fastened a process by which Northern Ireland's acknowledgement of its past can provide inspiration not only for services which meet the physical and mental health needs of the children of the conflict as they enter later life, but also can inspire other societies internationally, particularly those which are either on or will go on a similar journey towards post-conflict recovery.

It is important that in planning for lifelong health services the health system continues to develop responses that recognise that, based on evidence of need including the Northern Ireland Study of Health and Stress (Bunting et al, 2013), a particular response is required given Northern Ireland's history of conflict and the internationally-evidenced direct relationship between childhood experience, intergenerational and individual lifelong physical and mental health outcomes[23]. This is particularly so because of historical cautiousness about acknowledging the conflict as an identifiable factor in the physical and mental health of people in Northern Ireland. There is a real long-term social and economic cost to conflict-related trauma which extends into subsequent generations. It is essential to consider more generally the health needs of the population of the South West region of Northern Ireland which, largely rural in nature, experienced specific impacts of the conflict associated with the region's geophysical character and its location close to the border.

In the last two decades since devolution, a number of key whole-system initiatives have formed part of a regional government-led attempt to ensure Northern Ireland has a health and social care system that is fit for purpose. Northern Ireland already has a governance advantage in the fact that social care and healthcare are managed under the same structures and not delivered by different sectors (as, for example, in England where Local Government is responsible for social care and the NHS is responsible for health care). This reduces the structural potential, if not the actual incidence, of silo working between the two components of services which are fundamental to the well-being of the population and to communities and families.

[23] Further evidence is widely available on the link between Adverse Childhood Experiences and Lifelong Health Outcomes and can be found in analysis such as the following: Kaitlyn Petruccelli, Joshua Davis,Tara Berman: 'Adverse childhood experiences and associated health outcomes: A systematic review and meta-analysis' in Child Abuse & Neglect Vol. 97, November 2019, 104127.

Addressing Structural and Administrative Blockages: The Donaldson Report In the wake of challenges presented by health and social care systems governance to the effective delivery of the original vision and redistributive ambitions of Transforming Your Care (combining service redesign, integrated care models for earlier and 'upstream' interventions and ultimately optimising healthcare costs to best value and better population health), the then Northern Ireland Minister for Health, Edwin Poots, commissioned the *Donaldson Report* (published December 2014).

The *Donaldson Report* aimed, amongst other things, to examine what the structural and administrative blockages were to achieving the gradual reinvestment of existing health and social care resources (in terms of indicators both financial and non-financial/productivity-related) from secondary care into primary and community-based preventative healthcare systems. The approach to Transforming Your Care had been envisaged (perhaps hopefully) as being focused on enabling clinical best practice to lead the introduction of integrated care and the principles underlying it. In practice, Transforming Your Care delivery functioned more like an efficiency savings initiative, with a high focus on recurrent savings rather than whether cuts at one point on the continuum of care were enabling reinvestments and interventions earlier in the patient journey or closer to home for patients.

In acknowledging that, by 2014, while there was a good deal of work already under way in Northern Ireland in the areas of quality and safety in healthcare, the *Donaldson Report* did remark the following:

> *The way in which central bodies seek to achieve compliance with their policies and make broader improvement changes is based on a very traditional and quite bureaucratic management model. There is much detailed specification of what to do, how to do it, and then extensive and detailed checking of whether it has been done. This has strengths in enabling the central bodies and the government to demonstrate their accountability and give public assurances, but it can greatly disempower those at the local level. It can cause those managing locally to look up, rather than looking out to the needs of their populations. The alternative is a style of leadership based on inspiration, motivation and trust that those closer to the front line will make good judgments and innovate if they are encouraged to do so. Perhaps the relationship needs a lighter touch, to liberate freer thinking on how to make services better for the future*[24].

The recommendations for addressing the structural changes needed in how health and social care in Northern Ireland were governed in terms of policy and budgeting (as distinct from actual operational delivery, for which the Health and Social Care Trusts are accountable), culminated in the *Health and Social Care Act (Northern Ireland) 2022*. This made changes which were aimed at eliminating unnecessary bureaucracy and administration within the

[24] Donaldson Report (2014): p4.

healthcare management and commissioning system, and in facilitating that element of the 'local' referred to by Donaldson, and made provision for the Integrated Area Partnership Boards (IAPBs) for each of the subregional commissioning areas in Northern Ireland, to replace and evolve the function previously filled by the subregional Local Commissioning Groups (LCGs).

There is a role for the Western and Southern Area IAPBs in what comes next for the South West region of Northern Ireland. How commissioning and service delivery bodies work with IAPBs, the professions, and the voluntary and community sector as equal partners will be key to the quality of healthcare in Northern Ireland as a whole and particularly for those areas of population outside of the urban agglomerations centred on Belfast and Derry/Londonderry. Investment and support need to be an ongoing commitment in resourcing terms, for the capacity, skills, culture and behaviour which can animate these structures to optimal effect for the common good, for population outcomes, and to boost the health innovation potential of each area.

There is also a role for permanent commissioning structures as they stand, and for the Trusts, in grasping the opportunity for innovation in the 2020s which was so ably demonstrated by some of the health and social care innovations that were pioneered post-devolution by health and social care leadership particularly in the West of Northern Ireland, and which have a continuing legacy. These include initiatives such as the Western Health Action Zone[25], the Healthy Living Centres, and the Family Support Hubs.

Relevant for Fermanagh and Omagh, credit should also be given to those Commissioners, Trusts and Clinicians in the Western Trust Area who managed to avail of windows of opportunity created by Transforming Your Care and subsequent initiatives, to innovate and in some cases achieve permanent integrated care components in specialties such as Cardiology, Diabetes, and Older People's Medicine.

Integrated Care: Too often what is an international best practice model of care becomes misinterpreted and associated with specific administrative and governance experiments in a local context. It is incumbent on those involved in policy advocacy, including elected representatives at all levels, to understand the origins of concepts which are supposed to be driving improvement in our health and social care system. Very often, a term becomes shorthand for something else. In the current context, for example, the term 'Bengoa' may have become perceived shorthand for proposed changes in the configuration of acute hospital services in Northern Ireland. In the same way, the term 'Integrated Care' as commonly used

[25] The Western Health Action Zone (WHAZ) in the mid-to-late 2000s had a range of initiatives, one of the most influential and cost-neutral being a professional cross-sectoral professional exchange scheme which allowed public sector employees across health, social care, education and local government to access secondments and periodic release to be embedded in the work of community and voluntary organisations focused on health and social well-being. This scheme led to considerable and lasting innovations in the areas of community health, and design of health-promoting environments beyond health and social care settings. It also supported the development of an interagency community of practice which has contributed to intersectoral leadership capacity and strong collaborative working relationships between stakeholders within different organisations over the last two decades.

in Northern Ireland would benefit from a refreshed awareness of the global best practice standards in the design and delivery of integrated care systems, the Nine Pillars of Integrated Care[26].

One of the key points of moving towards systems and away from structures is that there must be systems to compensate for the dismantling of centralised points of contact for key services. It is not sufficient to redesign without equally investing in compensatory models of access to care and this is what the Basque Region health system has achieved under the leadership of Professor Rafael Bengoa before and since his role as Health Minister for the Basque Country.

Professor Bengoa's research and expertise has provided inspiration for the Northern Ireland Health and Social Care system in considering its challenges for almost two decades. This is partly due also to the evidence base of success created by the Basque Region's health service approach to the integrated care of long-term conditions (which included extensive funding for community based Advanced Nurse Practitioners - ANPs) and creating accessible rural healthcare systems based on the principle of universal access in a peripheral and often challenging geophysical landscape.

The International Foundation for Integrated Care (IFIC) sets out the nine pillars of integrated care which health systems need to commit to and demonstrate at all levels for integrated care systems and pathways to be designed to best effect for those who need them and for best value. The Nine Pillars of Integrated Care which are 'essential for creating effective integrated care systems that enhance health outcomes and patient experiences'[27] are;

1. Resilient Communities and New Alliances;
2. Workforce Capacity and Capability;
3. People as Partners in Care;
4. Transparency of Programme Results and Impact;
5. Population Health and Well-being;
6. Aligned Payment and Systems;
7. System Wide Governance and Leadership;
8. Shared Values and Vision; and
9. Digital Solutions.

Patient Mobility: Other areas of positive progress which have been the result of policy-driven approaches to health and social care include the ongoing bilateral arrangements for patient mobility between Northern Ireland and Ireland, in the areas of both elective and unscheduled/emergency point-of-care access for individual citizens. As the current policy debate and cross-border health cooperation landscape in Europe has shown during and since the COVID-19 Pandemic, facilitating the mobility of individual patients on a personal

[26] https://integratedcarefoundation.org/nine-pillars-of-integrated-care
[27] Ibid

transactional basis is only one way in which neighbouring states can exercise the opportunities of cross-border health for their citizens. Health systems can also draw on existing arrangements and possibilities for patient mobility, as a key enabling component in smart approaches to territorial complementarity and mutuality as regards health facilities, clinical specialties, health system capacity needs and overall resilience of health systems that mobilises geography as an asset when shared services can be developed on a transboundary basis.

4. What People Said – Overview of Focus Group, June 2025

To inform the development of this paper, ICLRD together with Fermanagh and Omagh District Council, organised a one-day focus group on 4th June 2025 in the Manor House County Hotel, Enniskillen. The purpose of this event was to build a picture of the ideal rural health ecosystem for the South West region of Northern Ireland. The focus of the conversation centred on how the health ecosystem can be developed to reflect the rurality of the region, exploring how the inherent challenges that this presents can be overcome to better meet the healthcare needs of the local population into the future.

A diverse grouping of stakeholders took part including elected representatives, departmental officials, local government officials, health agencies, community representatives and various organisations dedicated to addressing health and social care issues in the region.

This section aims to capture the conversations from the Workshop, offering insights into the 'enablers' needed to build a strong and resilient ecosystem for the rural South West region.

4.1 Understanding the Rural Health Ecosystem

In framing the discussion, a rural healthcare ecosystem was identified as being much more than a network of hospitals, GP surgeries and health practitioners. Rather, it is an interconnected web of resources including local authorities, government departments, statutory agencies, health and social care services, educational institutions, businesses and crucially the community and voluntary sector (CVS) that work together to plan and deliver healthcare services. This holistic view recognises that health is shaped by social, economic, cultural and environmental determinants – as reflected in the *Fermanagh and Omagh 2030 Community Plan* – as much as by medical interventions, and it is the interaction of these factors that influence the health of individuals living in an area.

4.2 The Healthcare Landscape in the South West Region

Healthcare services are provided across a spectrum of environments, each tailored to meet specific needs and circumstances of individuals at different stages of life or illness. From the first point of contact in the community to specialised support in hospital settings, care environments play a crucial role in promoting well-being, managing acute and chronic conditions, supporting recovery and providing comfort at the end of life. During this 1-day event, workshop participants focused their discussions on Primary Care, Secondary Care, Domiciliary Care and End-of-life environments, as well as touching upon Children and Young People's Services.

4.2.1 Primary Care

Workshop participants engaged in an in-depth discussion about the current issues faced by local people in accessing primary care services in the South West region. Primary care is considered the 'cornerstone' of the rural health ecosystem in the area. GPs and pharmacies

are recognised as the first point of contact for most health concerns. These services are vital, given access to hospitals and specialists is limited.

It was noted that the Region has a proud history of community-based care, but identified that this is now being tested by a range of pressures, both old and new including: workforce shortages and recruitment difficulties; changing demographics and patient needs; access and managing pathways to care; infrastructure; funding and contractual issues; mental health; social care; as well as community expectations and frustrations. These reflect broader issues seen right across Northern Ireland, but also distinct characteristics of the South West region marked by rurality, demographic change and underinvestment.

Key Points

- The current system for accessing primary care services in the South West region is inconsistent and challenging for patients;
- Workforce shortages and recruitment issues are critical problems that need immediate attention;
- Effective communication and patient navigation are essential for improving access to healthcare services;
- Focused funding and resource allocation are necessary to address regional disparities and support healthcare initiatives;
- Women's health services and mental health services need to be more accessible;
- Community pharmacies are a vital part of the ecosystem but require more support and resources; and
- Improving health literacy is crucial for better patient outcomes and understanding of healthcare pathways.

4.2.2 Secondary Care (including Emergency Care)

Workshop participants viewed secondary and emergency care as ‘pillars’ of the health ecosystem. They explored the core difficulties facing delivery of and access to secondary and emergency care considering factors such as geography, workforce, infrastructure, patient needs and broader systemic pressures.

Key issues identified in secondary care ranged from long waiting times to see consultants or attend outpatient appointments which can lead to delays in diagnosis and treatment, potentially worsening health outcomes; accessing ambulance services, including long response times which can be critical in emergency situations where timely intervention is crucial; ‘Out of Hours’ confusion in terms of when to go to the Emergency Department (ED), potentially leading to unnecessary visits and associated strains on the system; and bed blocking which is impacting the overall efficiency of hospitals.

Key Points

- ED overload as a result of patients presenting to hospital instead of going to their GP due to lack of access, causing system-wide blockages. This overload is leading to longer waiting times, increased pressure on healthcare staff and a strain on resources;

- Significant delays in surgical waiting lists since COVID-19, with urgent surgeries taking up most of the time and resources available. This has resulted in non-urgent surgeries being postponed, causing prolonged patient suffering and potential deterioration of conditions;
- Service reductions which have been felt more acutely in rural areas compared to urban settings;
- Minor Injuries Units/Treatment Centres need proper resourcing;
- Access to Rapid Response Teams needs to be improved to enable timely intervention for patients in need of urgent care;
- Early access to 'next step' care by accessing private consultants is leading to health inequalities. Ensuring fair access to services for all patients is crucial;
- The ED is often the single point of entry to the hospital system, creating challenges for Eds, and tension between GPs and hospital staff. Alternative access routes to secondary care need to be considered;
- Questions were raised as to whether significant service changes have been accompanied by adequate risk assessments; with such oversights leading to unintended consequences, such as increased patient risk, staff burnout, and inefficiencies in the healthcare system; and
- The current negative narrative around healthcare provision is deemed ‘unhealthy’ and is impacting patients and recruitment. Negative media coverage and public perception can deter individuals from seeking necessary care and discourage potential healthcare professionals from joining the workforce;

4.2.3 Care at Home (Domiciliary Care)

Focus group participants acknowledged that over the past two decades, the landscape of domiciliary services has undergone significant changes. One of the most notable differences is the shift towards Care in the Community. The number of people cared for in nursing homes has drastically reduced, with many individuals now receiving care at home in familiar surroundings. There is a growing emphasis on creating a care system that is local and place-based, ensuring that care services are tailored to the specific needs of the community. This approach has highlighted the importance of local knowledge and the role of carers as the 'eyes and ears' of the community. However, despite these positive developments, participants reported that the sector continues to face challenges related to recruitment, retention, scheduling and logistics, as well as appropriate financing of independent providers.

Key Points

- In terms of improved access to homecare, there is a need for timely homecare packages to be put in place. Currently, response times are problematic leading to longer hospital stays and bed blocking in secondary care. This is impacted by the shortage of district nurses, social workers and occupational therapists to arrange care packages and complete the required risk assessments;
- The sector struggles with recruiting and retaining carers due to low pay and working conditions. This is a region-wide problem but is felt most acutely in the peripheral, isolated parts of the South West region. Carers often feel undervalued and face

burnout due to full rotas with no flexibility. The current system lacks the built-in capacity to adapt to the changing daily needs of service users, which exacerbates the issue;

- Patients leaving acute hospital often require further support and rehabilitation before they can safely return home, placing pressure on hospital resources. In addition, there is a pressing need to enhance the infrastructure of community care services, including expanding 'hospital at home' and reablement capacities;
- The current brokerage system is hindered by a lack of local knowledge, which compromises its effectiveness. It often fails to take account of geographical challenges leading to inefficiencies in the delivery of care and frustrations in the workforce;
- Family carers experience burnout and stress, which impacts their health and the health services; and
- Training is needed to equip carers with the skills to meet the changing needs of service users, particularly complex needs and multi-morbidities.

4.2.4 Children and Young People's Services

The well-being of children and young people is crucial for the development of a healthy and thriving society. Focus group participants highlighted the importance of early intervention and support systems to ensure the mental and physical health of children and young people in the rural South West region.

Key Points

- To enhance Early Years Play Programmes, there must be greater emphasise on play in the curriculum in addition to the promotion of early intervention and prevention strategies;
- Need to recognise the importance of supporting those who care for young children to catch conditions early; and provide resources and training for those who 'hold the baby' to ensure early detection of conditions and necessary support;
- Need to allocate more resources to mental health services for infants and young children;
- To increase the reach and capacity of the Family Nurse Partnership programme to support more families;
- Develop strategies to make services more accessible to the 18-25 year age group;
- Implement measures to reduce the backlog in Special Educational Needs (SEN) assessments and provide interim support for children on waiting lists;
- Boost funding for Adolescent Mental Health Services (CAMHS) Funding to better support young people up to age 18;
- Need to tackle school disengagement by developing programmes to re-engage young people in education;
- Improve access to sports for young people in disadvantaged and rural areas by developing and implementing initiatives that focus on a lifecycle approach; and
- Establish mechanisms to capture the voice of young people in service planning and decision-making, to ensure their needs and perspectives are considered.

4.3 Policy Choices and the Path Forward

All stakeholders in attendance at the 4th June workshop agreed that there is an urgent need to address the unique healthcare challenges faced by the rural South West region. The current 'one-size-fits-all approach' is ineffective, necessitating a tailored understanding and adjustment to the distinct health needs of this rural area.

The community should be regarded as 'active' participants in their healthcare, rather than 'passive' recipients. This involves constructing a people-centred health system that emphasises resilience rather than merely addressing problems. There is an opportunity to establish such a system in the South West region, balancing realism with optimism.

Looking ahead, incremental changes are insufficient. The situation demands a transformative, paradigm shift in the entire health system planning and service delivery. This includes transitioning to a preventative model to keep people out of hospitals and adopting a whole-systems approach that involves elevated community planning. Investing in systems thinking and co-designing prototypes for effective access and service provision through community planning is essential. An annual symposium on health in the ecosystem could facilitate this process. The mindset should shift from 'us and them' to 'in this together,' addressing power imbalances and fostering mutual respect.

One proposal tabled called for a scenario plan to be developed to envision the ideal state of future health needs and outline the steps to achieve it. It is crucial to optimise the use of existing resources and understand what integrated services look like. Reflecting on the growing divergence between life expectancy rates and healthy living expectancy as discussed in Chapter 2, workshop participants contended that conducting a comprehensive economic analysis of the costs of inaction, including healthy years lost, was necessary. Analysing demographic trends, infrastructure deficits and funding deficits will aid in future planning. Financial analysis and economic forecasting on 'Invest to Save' initiatives, can – and should – inform investment decisions. In addition, big-picture thinking and movement towards a more integrated system, such as coordinated appointment scheduling and transport services, are needed.

Advocating for a complete paradigm shift in policy, planning and delivery of healthcare for the region is essential. To this end,

- Recognising the role of 'Health in All Policies' (HiAP) across government sectors like education, transportation, agriculture, environment, and rural development is crucial.
- Place-based policies can help reduce inequalities and improve primary care in areas with low accessibility;
- Exploring how rural proofing is implemented within health and coordinated across government is necessary; and
- An equity-based funding model that adjusts for the costs of providing healthcare in the South West region is needed.

In summary, reshaping the health ecosystem for the South West of Northern Ireland requires a multifaceted approach, involving community participation, preventative models, systems thinking, economic analysis and a paradigm shift in policy and planning.

4.4 Looking to the Future

The South West region deserves a rural healthcare ecosystem as dynamic as its people. Emerging from the workshop was a vision of an integrated, patient-centred system that bridges distances and overcomes barriers, harnessing innovative technology, local expertise and strong community networks. By fostering collaboration among healthcare providers, social services and CVS organisations, the region aspires for accessible, quality care tailored to local needs. This future-focused approach aims to promote wellness, prevent illness, empower individuals to manage their health and ensure no one is left behind.

As individuals, communities and health care professionals navigate the challenges of the healthcare system in the South West region, policymakers face critical decisions. The workshop identified a broad range of actions which address both immediate needs and long-term sustainability. The path ahead requires coordinated action, robust partnerships and an unwavering focus on equity, of partnership, perseverance and purpose, ultimately ensuring that rural populations in the South West region have timely and affordable access to quality healthcare.

The moral case for equality in service provision stands tall and the investment focus should be on keeping care close to home, even in sparsely populated rural areas in the South West.

The stakes could not be higher and the wrong choices risk exacerbating inequalities and undermining the very foundation of community and individual health. Yet, with strategic investment, imaginative thinking and a steadfast commitment to serving local people, the South West region can seize this moment of change to build a more resilient, responsive and sustainable rural healthcare ecosystem.

Fermanagh Omagh's history of community spirit and innovation offers hope that, with the right approach, the healthcare ecosystem can evolve to provide high-quality, accessible and compassionate care for all and be poised to meet the health needs of the future. Local authorities, such as FODC, play a key role in enabling this.

5. Harnessing the Strengths: Current Good Practices in Rural Healthcare Provision

This chapter presents a range of emerging and evidence-based successful models of healthcare provision which have been developed elsewhere in the U.K., with the objective of illustrating good practice which is already deemed to be feasible for delivery in a National Health service (NHS) context. It is also worth acknowledging the degree to which the U.K. health system has, traditionally and prior to Brexit, been deeply influenced by and has influenced the European context for healthcare systems development. This is particularly true of the NHS in the wake of World War II and the fact that it became a beacon model of inspiration for the reconstruction of health systems in post-war Europe.

Within the EU, population health inequalities, improved access to health services, and improvement of mental health services are key priorities in the post-pandemic era. These issues are being explored in detail not only by DG SANTE but also by DG REGIO and in particular through the Interreg programmes. In recent years, all have focused on the sharing of collaborative good practice in how health systems can contribute to territorial cohesion in border areas, improving the lives of citizens, and ensuring that citizens can choose to remain in rural areas rather than having their choices and health outcomes limited by gaps and inequalities in access to services.

Over 137 million EU citizens (30% of the entire EU population) live in rural regions[28]. The importance of sustainable rural regions is further heightened in the context of the Draghi Report (2024) on European competitiveness and the need – determined by cohesion policy and remaining important for the post-2027 period – for territorially-balanced competitiveness. Competitiveness is measured in many different ways but adequate population health service provision is one key factor in competitiveness and in regional attractiveness as defined by the OECD (i.e. regions as places that are attractive to live in, work in, invest in, and to visit). Rural health systems experience universal challenges such as those experienced in Fermanagh Omagh which is why concerted and focused, policy-driven action is required and necessary to address them. 'No action' should not be an option.

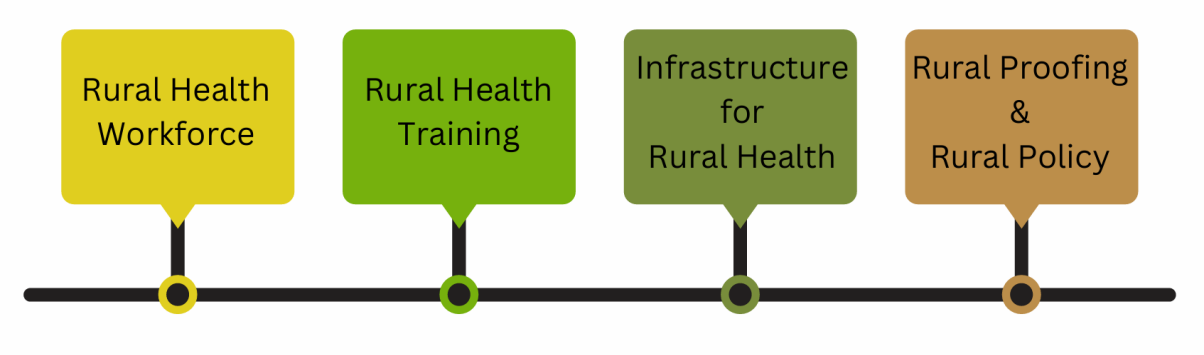
Rural Health Compass, a policy and collaboration platform formed to address the EU's need for sustainable rural health systems as an essential counterbalance to cities and urban health systems, identifies the challenges experienced by rural regional healthcare systems as:

- Recruitment and retention;
- Workload;
- Burnout;
- Medical Deserts;
- An ageing health workforce; and
- Lack of investment and resources.

[28] See Rural Health Compass for a range of resources on rural health Rural Health Compass – Navigating rural health and policy.

The EU has long held a strong track record in supporting progressive rural development through LEADER and the European Rural Development Programmes and it is, therefore, no surprise that rural health policy and debate are a vibrant sector of the EU dialogue on health outcomes for citizens. Key principles espoused by Rural Health Compass for rural health systems, and drawn from a presentation made by its Director Dr Veronika Rasic in June 2024 to the Interreg programmes (which have an ongoing focus on best practice in healthcare in border regions) are summarised as follows

Figure 5.1 Rural Health Compass – Key Principles for Rural Health Systems



(Source: Rural Health Compass/Dr. Veronika Rasic)

Rural Health Compass highlight examples of how these components should work; these include:

Primary Healthcare teams should be at the heart of the community, with the following features:

- Multi-faceted and community oriented;
- Are a valuable resource for their community;
- Interdisciplinary teams - doctors, nurses, and allied health professionals; and
- Fit for purpose - able to meet the needs of the community that it serves.

Creating a homegrown workforce:

- Recruitment of students with a rural background;
- Early exposure to rural health;
- Longitudinal rural clinical placements;
- Decentralising medical education - rural focused medical schools; and
- Rural training opportunities in undergraduate and postgraduate training - 'rural career pathways'.

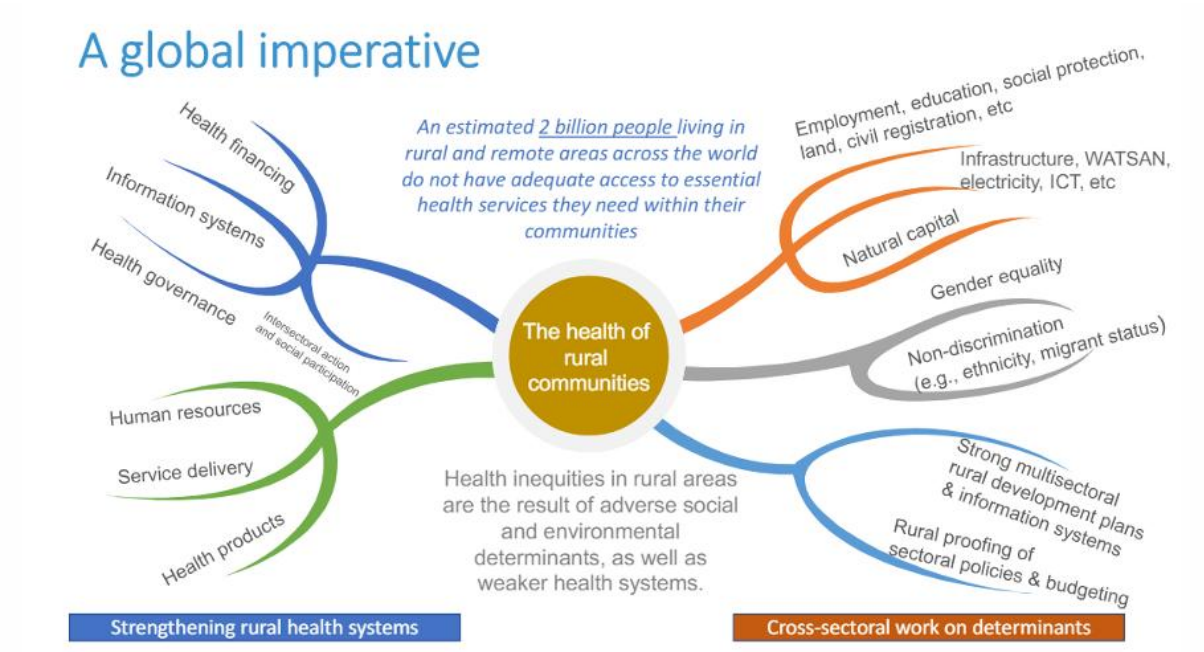
The importance of medical training approaches and pathways, with teachers and mentors being crucial for nurturing a rural healthcare workforce:

(a topic which should be taken up in discussion with both the Ulster Medical School and Queen's University School of Medicine in the context of the recommendations of this report):

- The importance of good rural role models;
- Supporting development of rural research and academia;
- Recognition of rural expertise;
- Partnering with rural communities for positive rural experiences;
- Curricula which includes rural health, rural scenarios and rural placements; and
- Modelling and investing in appropriate services and practice for rural healthcare systems: "You can't be what you can't see".

Rural Health Compass emphasises the relevance of the OECD recommendations on policy-proofing for rural health – an issue which has arisen in the context of discussions on the current situation in Fermanagh and Omagh. The global imperative for rural health illustrated below in Figure 5.2 indicates that a progressive and innovative healthcare system should embrace the matter of rural health in recognition that this connects the issues faced by countries such as Northern Ireland to a wider external context of how rural regions across the world can be sustainably developed. Rural health in Fermanagh and Omagh and the wider South West region is not a minority issue unless the behaviour, assumptions and choices of policymakers and those who fund and design services insist on maintaining a position of isolation and insularity.

Figure 5.2 The OECD Global Imperative on the Health of Rural Communities



(Source: OECD/Rural Health Compass/Interreg)

The adoption of the models detailed in the remainder of this chapter, from Norfolk, Great Yarmouth and Waveney, Cheshire, and the wider South East region of England are, if effect, case studies of European good practice which have been tested in an NHS context and are, therefore, highly relevant for Northern Ireland.

5.1 Case Study: Forming an Acute Hospital Group, Norfolk U.K.

This case study, focused on Norfolk and Waveney, could support the Trust and other key stakeholders, including FODC, in both integrated healthcare and community health, when considering options to develop a robust strategic partnership between two or more hospitals when developing, for example, site-based clinical specialty delivery for the broader population (e.g. some specialised services either offered from one of the hospitals or, clinically led and delivered across the two sites). As this is currently a 'live' project, this case does not reflect the outcomes of forming a strategic partnership; that will be reported at a later stage. Should, however, this model be considered an option for the South West region, there are other established partnerships which could be reviewed to ascertain impact.

5.1.1 Introduction and context

Norfolk and Waveney are home to a population of around 1.2 million people, with a significant proportion of its residents being elderly. One in four people living in Norfolk and Waveney are aged 65 and over, with the elderly population set to grow more than any other group over the next 10 years (see Figure 5.3). By 2033, there will have been a growth of 17% in the population aged 65-84 and 46% in the population aged 85+, which substantially outstrips growth in any other population group, and the national growth rates for those age groups. The demand for healthcare is at its highest in the older age groups so this demographic picture, without substantial changes to preventative measures, will lead to a marked increase in demand. The region faces a high prevalence of long-term conditions and significant health inequalities, which are further complicated by social determinants of health, rurality, and deprivation. Despite people in Norfolk and Waveney living longer than the national average, they spend more years of life in ill health than the average nationally. The total allocation in 2023/24 for Norfolk and Waveney was £2.3bn and over half of this was spent on delivery of acute services. There is a high prevalence of long-term conditions amongst the population with higher rates of Asthma, COPD, Hypertension, Rheumatoid Arthritis and Stroke than the national average. Prevalence of long-term conditions is closely correlated with age; therefore, with an ageing population, long term conditions would be expected to increase in line with this.

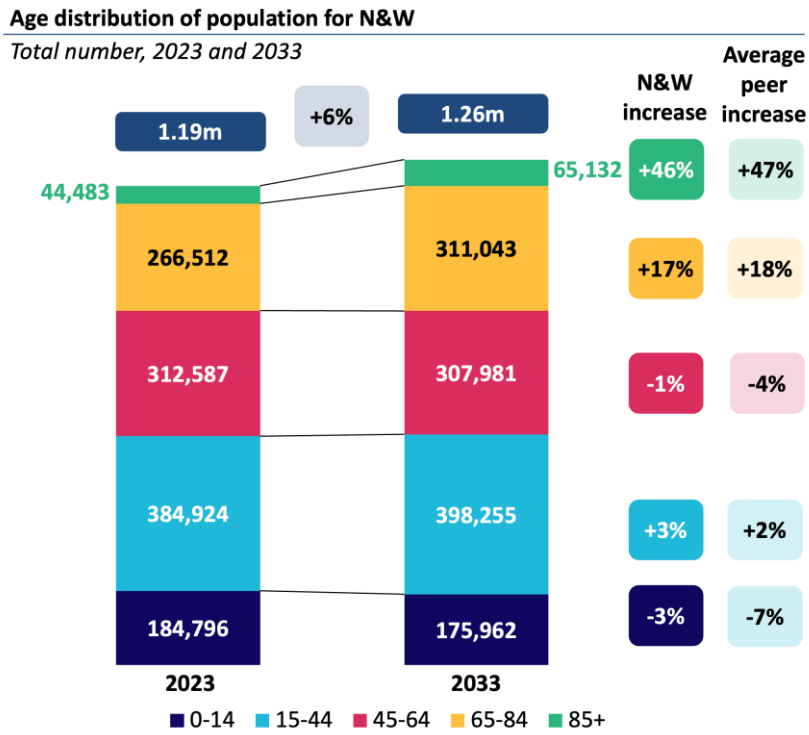
Currently, there are three acute Trusts which undertake the majority of acute patient activity across Norfolk and Waveney. The pursuit of the Group model is part of the response to the aforementioned collective challenges, with financial and clinical pressures being compounded by an ageing and growing population.

In the South West region of Northern Ireland, there may be the opportunity to consider options for developing the delivery of specialised services across two or more hospitals – i.e. site delivery or 'hub and spoke' delivery of clinical services – including on a cross-border basis (albeit it is noted that a partnership on a cross-border basis could bring additional strategic challenges).

5.1.2 Case for becoming a Group

A Group Model is an organisational structure where multiple healthcare providers work together under a unified governance framework. It aims to improve efficiency, standardise practices, and enhance patient care. It features central leadership responsible for strategic direction and governance, while local units maintain operational management. The model offers flexibility, advantages, and opportunities for collaboration, enabling the delivery of consistent care quality and outcomes by emphasising standardised systems, policies and procedures to ensure consistency and improve the quality of care. In this case, working across three Trusts, it supports the development of a common care model, coordinated planning, and provides unified leadership to address the challenges faced by the region.

Figure 5.3 Age Distribution of Population for Norfolk & Waveney



Across Norfolk and Waveney, eleven opportunity areas for collaboration across three broad themes were identified. These have the potential to transform clinical care and deliver consistent access to high quality services through the adoption of best practice. The 3 broad themes are:

1. **Transform health and care services based on the needs of patients and population**
   - Address growing demand for health and care by playing an active system role in preventative and proactive healthcare for people with long-term conditions;
   - Deliver a consistent best practice model of urgent and emergency care with a particular focus on frailty;
2. **Deliver high quality outcomes building on combined knowledge, skills and experience**

- Implement safe and sustainable care models initially in maternity and stroke care with development of models for other specialties to follow to deliver clinical, financial and environmental sustainability;
- Level up outcomes and access by optimising elective care pathways, making best use of collective capacity, improving access to services, reducing waiting times and enhancing patient care;
- Deliver better outcomes for people with cancer at all stages of the pathway, starting with earlier diagnosis;

3. **Achieve greater sustainability by working at scale**
    - Make most effective use of workforce capacity and allowing the easier movement of staff to improve service resilience and staff development opportunities;
    - Improve the offer for staff to train and develop, leading to the retainment of healthier and happier staff;
    - Create a University Hospital System to enhance potential for research, training and innovation;
    - Use collective assets to leverage joint negotiation, purchasing and investment power of the three Trusts;
    - Realise the benefits of system-wide service transformation that are possible through enabling programmes such as estates and digital; and
    - Have an aligned approach to strategy, transformation and planning functions.

5.1.3 Risks associated with a group model and their mitigations

Transitioning to a group model presents several potential risks that must be carefully considered. Identifying these risks effectively is crucial to outline and implement strategies that will mitigate them. From a ***credibility and financial perspective***, the integration could exacerbate existing financial deficits and undermine stakeholder confidence if not managed effectively. Proactive measures will enhance the resilience and sustainability of the proposed group model. ***Culturally and operationally,*** working with diverse organisational cultures and operational practices across multiples sites may lead to resistance and inefficiencies, potentially impacting staff morale and patient care. Fostering a shared vision and values is essential in alignment of the Trust identities. Externally and strategically, the ***geographic diversity and distinct identities*** of each hospital pose challenges in standardising services and maintaining the unique strength of each Trust. This could affect the overall strategic goals and external partnerships, and could also risk increasing inequality in care; thus the importance of investment, quality and equality impact assessments with measurable outcomes. Strategies that ***promote collaboration*** will aid in optimising resource utilisation and service delivery, thereby achieving strategic objectives and facilitating the smooth integration of the group model.

5.2 Case Study: Neighbourhood Health Implementation Programme – A Focus on Great Yarmouth & Waveney Pilot in the East of England

This case study explore the potential of the Neighbourhood Health Implementation Programme that NHS England is currently rolling out. This programme offers a real opportunity to instigate a shift of activity from the acute site into community and primary care delivery models – or in the case of the South West region of Northern Ireland, to achieve a better balance in accessible, integrated health care.

5.2.1 Neighbour Health – An Overview

In the U.K., 'neighbourhood health' refers to a transformative approach to delivering health and social care that is community-based, integrated, and person-centred. It is a central pillar of the U.K. Government's 10 Year Health Plan, aiming to shift care away from hospitals and into local communities, especially for people with complex needs and long-term conditions. As such, neighbourhood health is a place-based model of care that (i) brings services closer to people's homes, reducing reliance on hospitals; (ii) integrates health, social care, and voluntary services to provide coordinated support; (iii) empowers individuals and communities to manage their own health and well-being; and (iv) focuses on prevention, early intervention, and digital innovation.

It is designed to improve access, outcomes, and experience for patients, while also addressing health inequalities and making the system more sustainable. The neighbourhood health model is built around three major shifts:

- From hospital to community – prioritising care at home or in local centres;
- From treatment to prevention – promoting health literacy and early support; and
- From analogue to digital – using digital tools to enhance care delivery.

In terms of neighbourhood health, the U.K. Government's 10 Year Health Plan includes commitment to the roll-out of:

- Neighbourhood Health Centres: One-stop hubs for diagnostics, rehab, mental health, and social care;
- Multidisciplinary care teams: GPs, nurses, social workers, pharmacists, and community volunteers working together;
- Neighbourhood Provider Contracts: New commissioning models to support integrated care at local levels; and
- Community engagement: Services tailored to local needs and identities, not just administrative boundaries.

Target Populations include adults with frailty or multiple long-term conditions, children and young people with complex needs, and people requiring palliative care or frequent emergency services.

5.2.2 Neighbourhood Health in Great Yarmouth and Waveney (GYW)

Whilst working to support a specific cohort of individuals, the programme is about longer-term sustainable change and how a GYW health and care system can be coordinated around an individual. The proposed cohort will be identified from the High Frequency Users (those over 18 including frailty and long-term conditions) which account for 466,360 contacts. The current cost to the system is estimated at £101m over a 12-month period including primary, community, acute, urgent and emergency care, mental health and adult social care. High frequency users on average access 4.8 services annually compared to the average person who will need 2.9 service contacts.

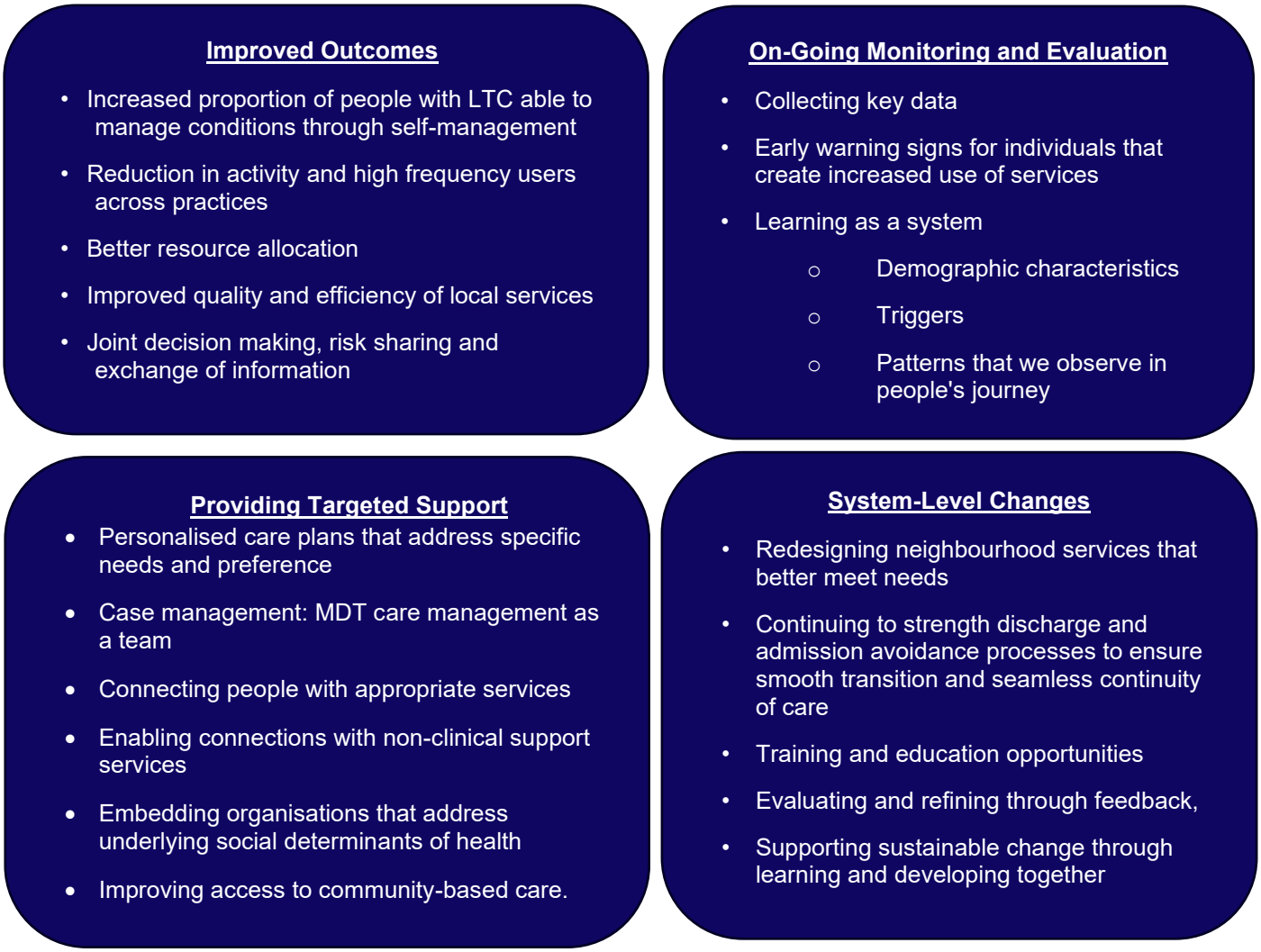
This case management model supports adults with multiple long-term conditions by integrating clinical and non-clinical professionals around the patient, enabling proactive care coordination, personalised self-management support, and reducing fragmentation across the system. It moves away from a 'one size fits all' approach to deliver care that is responsive to the individual and population health needs. The purpose of the neighbourhood health pilot will is:

- Coordinate proactive, personalised care for people with complex, long-term conditions;
- Reduce unplanned activity and care duplication;
- Act as a single point of contact for the person;
- Maximise prevention opportunities focussing on wider determinants of health; and
- Support self-management and person-defined goals.

The ethos of the case management approach will be 'no decision about me without me' with case workers in place to support person centred care, having direct involvement with the individual and making every contact count.

Figure 5.4 outlines the expected outcomes from this emerging approach.

Figure 5.4 Expected Outcomes of the Neighbourhood Health Implementation Programme



5.3 Case Study: Developing Urgent Treatment Centres to Better Serve the Local Population

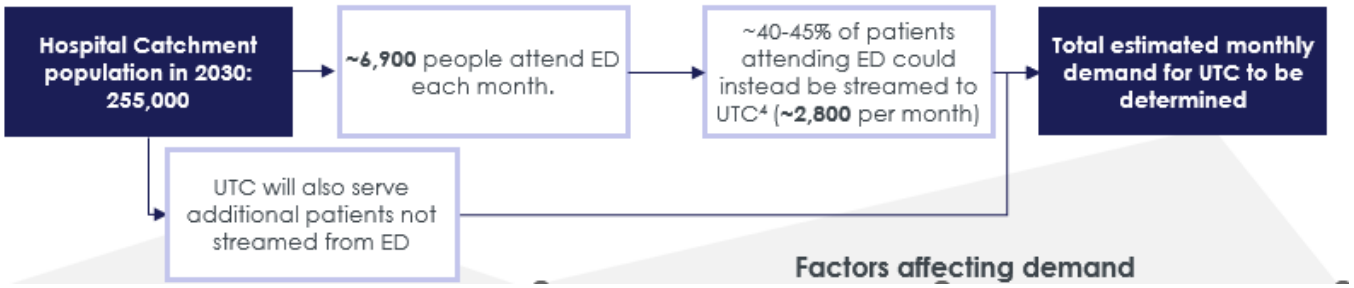
This case study highlights the increasing use of urgent treatment centres to reduce the activity through a hospital's Emergency Department (ED). This is an option to either develop, or maximise, in terms of activity at SWAH.

5.3.1 The Great Yarmouth & Waveney Urgent Treatment Centre

In Great Yarmouth and Waveney, an Urgent Treatment Centre (UTC) is being developed to support the local population and improve the response times in the hospital's ED. UTCs are increasingly being used to manage a considerable proportion of the activity handled by EDs See Figure 5.5 for an overview of the indicative demand for UTC services in hospital by 2030. There are national requirements for UTCs including;

- **Access & hours:** open ≥12h/day, 7 days/week (often longer if co-located with an ED); booked patients (111/online/GP/ambulance) and walk-in;
- **Clinical scope:** minor injury and illness across all ages (incl. <2); accept appropriate ambulance conveyance ("fit to sit"); and
- **Diagnostics: bedside tests including ECG**; plain X-ray available during opening hours alongside basic patient pathology tests.

Figure 5.5 Indicative Demand for UTC Services at Hospital in 2030



The factors affecting demand, demonstrating the need for a UTC, are outlined in Table 5.1 below.

Table 5.1 The Factors Affecting Demand and Demonstrating Need for a UTC

Changes affecting population (+)	Seasonal variation (+/-)	Utility of UTC vs ED (+/-)

• (+) A rapidly ageing population across the region will drive increasing need per capita.
• (+) Population growth will increasingly be driven by the >65s.
• (+) Greater prevalence of chronic conditions across the region leading to increased service utilisation (to be substantiated)
• (-) A shift to neighbourhood models of care could reduce demand for acute services.
	• Patient case characteristics may vary significantly per month.
	• If certain disease types (e.g. respiratory illness) are more suitable for UTC triage than others, this could lead to peaks and troughs in patient numbers.
		• The proportion of patients that can be seen in UTC will depend on:
		  • Physical asset size
		  • Staff capacity
		  • Integration with hospital with hospital diagnostics
		  • Access to care in the community

5.3.2 Target Benefits/ Value Proposition for a UTC

The target quantifiable benefits based on similar programmes are outlined in Table 5.2, while the target qualitative benefits based on similar programmes are noted in Table 5.3 below.

Table 5.2 Target Quantifiable Benefits based on Similar Programmes

	Lower unit costs for low-acuity care	Better front-door flow – improved 4-hour performance and ambulance	Reduced time in department for lower-acuity patients
Primary benefit for:	**Hospital**	**Hospital Emergency Department and Ambulance Service**	**Patients in UTC**
How the benefit is realised:	Patients with lower acuity needs seen in settings with less intensive staffing and monitoring	The filtering of low acuity patients allows more staff resource focussed on remaining ED patients. Ambulance handovers could be improved through a separate streamlined handover process for UTC/ ED. A booking system for UTC could help regulate peaks in daily demand.	For patients in UTC, dedicated staff prevent low acuity patients being deprioritised.
Existing quantifiable evidence on impact	~40% reduction in cost (£67 for a Type 3 A&E vs £114 for a non admitted ED attendance in 2018)	Limited evidence given the recent trend towards collocated UTCs integrated into ED screening.	Evidence of shorter time in department, however UTC has less unwell patients.

Table 5.3: Target Qualitative Benefits based on Similar Programmes

	Better outcomes through workforce optimisation	System alignment and standardisation	User experience – quality of experience
Primary benefit for:	Hospital	Hospital/ Primary / community care	Patients
How the benefit is realised:	By creating a dedicated GP-led service in UTC, acute specialists can be reserved for more acute cases	UTC can be integrated with NHS 111, GP, social care and community care to enable improved wraparound services for patients.	Patients in UTC are not subjected to the often-traumatic experience of A&E, as well as reducing iatrogenic harm such as infection and long sedentary periods.

The tables above outline the evidence-based rationale to have an UTC alongside an acute ED to support the local population's demand for treatment for less serious conditions. Interestingly, recent NHS surveys comparing public satisfaction between UTCs and EDs reveal notable differences in patient experience; for example:

- Overall Satisfaction

    - UTCs consistently receive higher satisfaction ratings than Accident and Emergency/ED; and
    - In 2024, UTC patients reported more positive experiences across nearly all areas of care, including communication, waiting times, and emotional support;
- Waiting Times
    - 64% of Accident and Emergency patients waited over 4 hours for their visit to be completed, compared to much shorter waits at UTCs; and
    - 28% of Accident and Emergency patients waited over an hour for initial assessment, versus 10–15% at UTCs.

5.4 Case Study: Managing Frailty through a Neighbourhood Health Model in Great Yarmouth & Waveney

This case study focuses on a coordinated approach to tackling frailty in the local community. In a rural setting, frailty issues are compounded with issues of geographical isolation. Due to the increasingly pressures resulting from the higher prevalence of frailty in an ageing population, new approaches are being developed to tackle associated health issues via a neighbourhood health model. Within Great Yarmouth and Waveney (GYW), a high proportion of the population live with frailty conditions. As a result of this, new approaches are being developed, covering short, medium- and long-term plans.

5.4.1 Frailty and neighbourhood health

Frailty is a big challenge for GYW as the number of people living with associated health risks is growing due to a combination of ageing population, lifestyle factors, and missed opportunities for prevention. On current trajectories, there will be circa. 12,700 people with moderate and severe frailty by 2040. This has important implications in terms of (i) low quality of life and well-being for a growing proportion of the population; (ii) significant cost for the health and care system and high-intensity use of other services; and (iii) higher demand for hospital beds, with cost implications for the construction of a new hospital. While the system is responding to this challenge in a number of ways, **there is an opportunity to address the significant gap in proactive care** which currently remains too reliant on referral and is fragmented and incomplete. For example, East Coast Community Healthcare CIC (ECCH) and James Paget University Hospital (JPUH) have made progress to develop a desired future model and can demonstrate the value this would create.

However, mobilising a proactive care programme is complicated because there is not currently a local delivery vehicle for transformation, system governance and leadership is changing rapidly, making it difficult to build a mandate, national policy is developing rapidly and there are urgent operational performance challenges and a lack of funding.

Looking to the short- to medium-term future, Table 5.4 outlines key identified goals and delivery tools for managing frailty through neighbourhood health models.

Table 5.4 Managing Frailty through Neighbourhood Health

	Winter 25/26	Winter 26/27	Future
Goal(s)	• **Reduce rate of admissions with 1+ day LoS for patients with frailty at JPUH front-door.** • **Reduce reattendance rate for people with frailty.**	• **Further reduce rate of UEC admissions for patients with frailty at the hospital front door.** • **Reduce rate of attendances for people with frailty.**	**Reduce undiagnosed frailty and improve % patients with care plan.** **Continue to reduce rates of attendance for people with frailty.**

Ideas	• Introduce frailty-attuned triage at front door, triaging patients to the right level of acuity:
	  • For higher-acuity patients – frailty-attuned SDEC
	  • For lower-acuity patients with frailty, constitute a Frailty Front Door team – with links to community services including UCR and Virtual Ward
	• Direct admissions from ED front door to community beds for patients requiring therapies to reduce the rate of admission to hospital beds for these patients
	• Form a frailty acute/community MDT to track high-intensity users and coordinate support
	• Create a bookable hot clinic that the Front Door Frailty team can book into.
		• Improving proactive use of virtual wards (see separate case study) to act on primary care referrals in a step up capacity, shifting the balance from more reactive care focused on discharge
		• More proactive outreach to care home patients at risk of crisis
		• Continuing to develop the bookable hot clinic model to increase patient volumes, referral pathways, and a more integrated offer.
			• Any qualified care practitioner role development to tackle the workforce issues associated with delivering frailty services.
			• Closer alignment to neighbourhood health and neighbourhood health centres – more proactive case finding to identify cases before contact with services

5.4.2 Frailty – mapping interventions and opportunities

As outlined in Figure 5.6 below, there are 4 Goals of a successful frailty life course model. However, no single organisation can achieve these goals in their own right. Rather, success depends on a partnership model that would include such stakeholders as:

- Local authorities – public health, adult social care, housing and adaptations;
- Community and Voluntary sector – charities, carers' support, leisure and transport providers;
- Specialist services – mental health, palliative and hospice care, faith and spiritual support; and
- NHS Partners – Integrated Care Boards (ICBs), community services, acute trusts, ambulance services, primary care.

Figure 5.7 outlines a system-enabled Neighbourhood Care-Framework and Roadmap, enabling a neighbourhood to thrive as the cornerstone of a healthier, sustainable future.

Figure 5.6 The Four Goals of a Successful Frailty Life Course Model

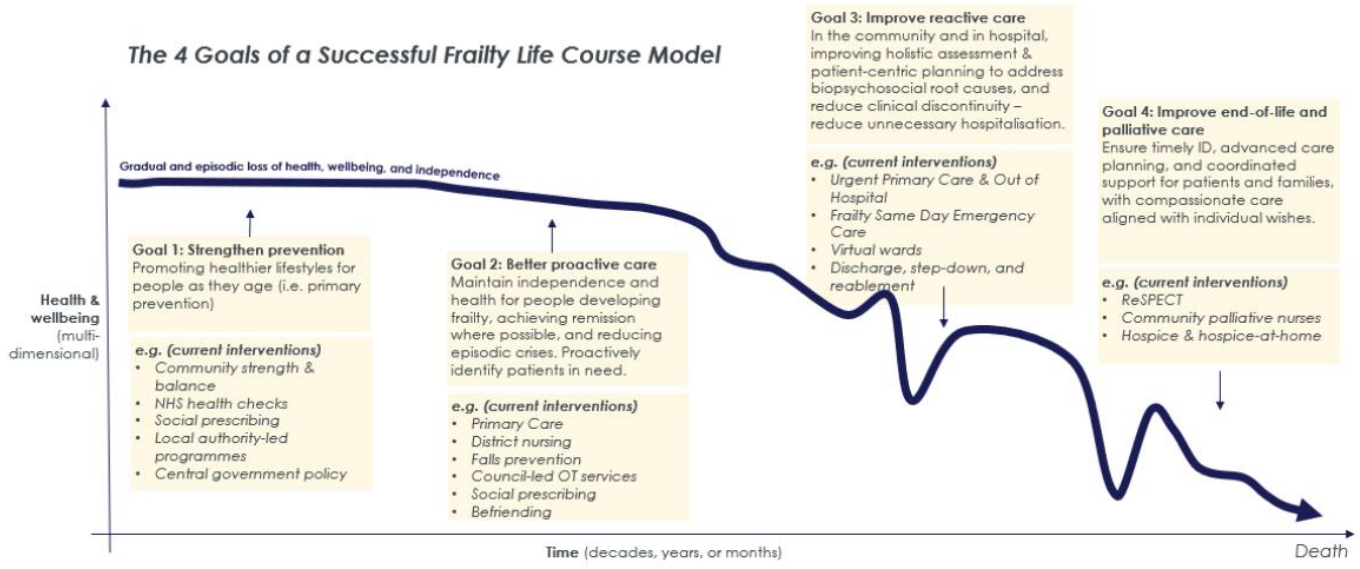
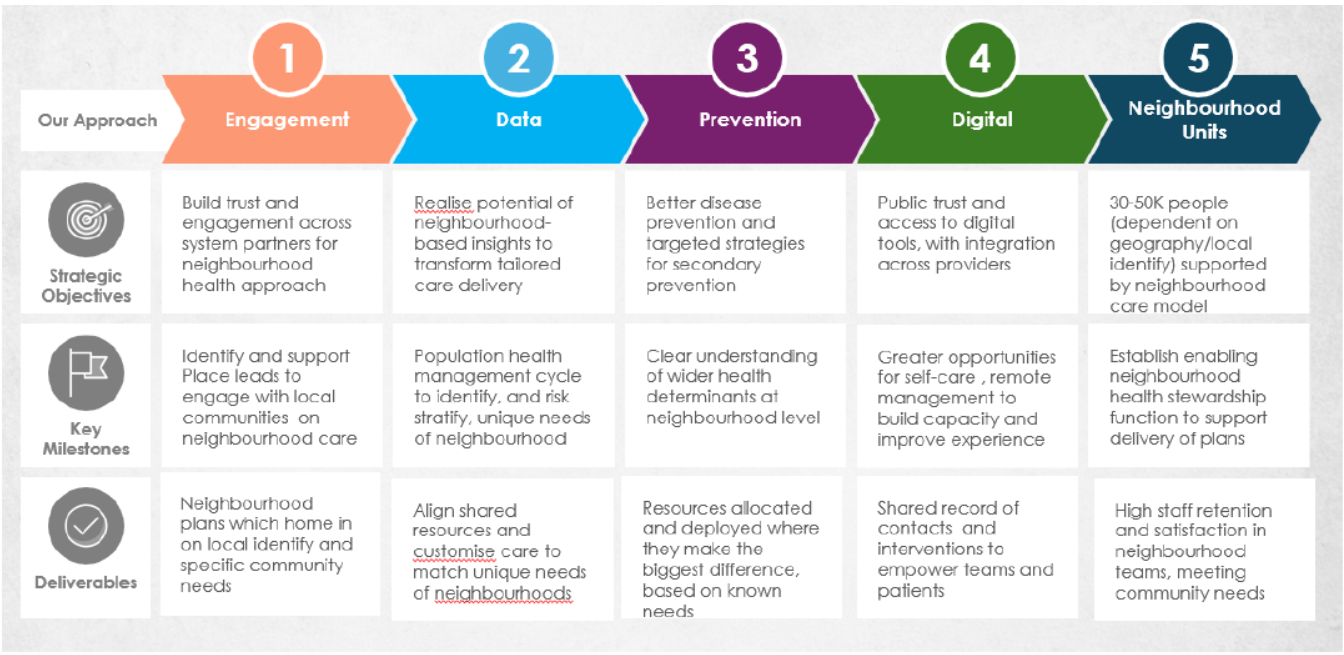


Figure 5.7 A System Enabled Neighbourhood Care Framework and Roadmap



Key benefits of such a programme include supporting people to live well in their communities, improving population health and enhancing the patients experience of care while also providing value from finite resources. From the service providers perspective, such programmes build collegiality and bring joy and meaning to professionals working together across services and sectors in neighbourhood units.

5.5 Case Study: Digitalisation of Health Services

There are increasing examples of the digitalisation of health services to support local populations, especially those in rural locations. This case study considers the benefits accruing from two initiatives; the deployment of a Video Consulting (VC) service by NHS Wales and the roll-out of telehealth innovations across a number of rural communities in the U.K. With rapid advancements in digitalisation and a growing commitment across governments to invest in advancing digital services and build digital skills, there are growing possibilities around how digital can play a greater role in improved access to care and enhanced patient experiences.

5.5.1 Key opportunities and challenges for digital health in rural areas

There is a growing evidence-base pointing to the many opportunities for the utilisation of digital services in healthcare provision – and with technological advances, this number is increasing all the time. Examples include:

1. Telehealth & Telecare

- Enables remote consultations, reducing the need for travel;
- Supports chronic condition monitoring and mental health care; and
- Offers personalised feedback and self-management tools.

2. Mobile Health (mHealth)

- Uses mobile devices to improve communication between patients and carers;
- Real-time health tracking and alerts; and
- Helps reduce isolation, especially for older adults.

3. Data Analytics & Predictive Care

- Electronic health records can be analysed to predict hospital readmissions; and
- Enables targeted interventions and resource allocation.

4. Inclusive Design & Co-Production

- Engaging rural communities in designing digital services ensures relevance and trust; and
- Co-design approaches (e.g. citizen assemblies, lived experience advisory groups) improve uptake and satisfaction.

Innovative technologies, such as artificial intelligence (AI), virtual reality, and miniaturised diagnostics offer new ways to deliver care remotely and is going some way to increasing the potential for such tools to deliver on personalised treatments and improved diagnostics. In terms of access points to digital health services, there are growing instances of community-based Digital Hubs as well as libraries, village halls, and community centres being used. This helps bridge the gap for those without personal devices or internet access. Bring able to maximise the potential of digitalisation requires an ongoing investment in digital literacy and support services. This includes providing training programmes for older adults and low-income groups; provision of devices and connectivity support; and tailored assistance for those with disabilities or cognitive impairments. Digitalisation can result in reduced

emergency admissions through early intervention, enhanced access for isolated populations, especially elderly and disabled, by removing the need to physically travel to a hospital or healthcare setting, and contribute to cost savings for both the NHS and patients.

While the opportunities are numerous, so too are the challenges. Again, these diverse in nature and include (i) poor broadband infrastructure, mobile coverage and higher costs in rural areas hindering service delivery; (ii) low digital literacy among older and socioeconomically disadvantaged groups which could, in turn, lead to digital exclusion, especially for those aged 65+; (iii) equity and privacy concerns and lack of trust in digital systems; (iv) fragmented digital services and lack of integration across platforms; and (v) workforce readiness whereby rural health professionals may lack training in the relevant digital tools.

Despite these, digitalisation of health services has the potential to significantly improve health outcomes for rural residents, with its success depending on addressing infrastructure, literacy, and equity challenges.

5.5.2 Digitalising health services for rural communities

There are many models of telehealth innovations across the U.K. These range from remote monitoring, virtual GP consultations and mobile diagnostic units. In NHS Wales, a National Video Consulting (VC) Service has been established to support virtual attendance across primary, secondary, and community care. To date, the service has improved patient experiences as a result of reduced travel, increased convenience, and better continuity of care, with over 50,000 patients and staff using the service and demonstrating that the service has worked across age, income, location, and disability groups – confirming equity of access. From a staff perspective, the VC service has improved efficiencies, with clinicians reporting improved time management and reduced missed appointments.

North Norfolk, served by the Norfolk and Waveney Integrated Care System (ICS), has prioritised digital transformation to address rural health inequalities. This rural district in East England, encompassing coastal towns like Cromer and Sheringham, and inland villages such as Holt and Fakenham, is characterised by a dispersed population of circa. 105,000 residents, with a high proportion of older adults (30% aged 65+), many living alone. In healthcare provision terms, the area has a limited transport infrastructure, with many communities over 30 minutes from the nearest hospital and suffers from poor digital connectivity, with patchy broadband and mobile coverage.

With an ageing population, key health concerns in the catchment area include:

- Chronic disease burden with high rates of COPD, diabetes, hypertension, and arthritis;
- Mental health with rising cases of depression and anxiety, particularly among older adults and carers;

- Access barriers with long travel times to GPs and hospitals, limited public transport, and workforce shortages;
- Health inequalities with lower life expectancy and poorer outcomes in deprived coastal communities; and
- Digital exclusion with many residents having no internet access or lacking the confidence to use digital tools.

These issues contribute to higher emergency admission rates, lower engagement with preventative care, and fragmented care pathways.

Through a digitalisation transformation initiative the ICS aims to tackle geographic isolation by reducing the need for travel through remote care and workforce constraints by enabling clinicians to work more efficiently and flexibly. Through a programme of digital services, co-ordination between health, social care, and voluntary sectors will be improved, and it will be possible to reach underserved and vulnerable groups. As part of the programme, patients will be supported to engage confidently with digital tools. The digital health model as implemented included:

1. **Telehealth Services**
    - Video and phone consultations across primary, secondary, and mental health care; and
    - Used platforms like *Attend Anywhere*.
2. **Remote Monitoring**
    - Devices for tracking blood pressure, glucose, and oxygen saturation; and
    - Data shared with GPs and community nurses for proactive care.
3. **Digital Health Hubs**
    - Libraries, village halls, and community centres equipped with Wi-Fi, tablets, and trained staff; and
    - Offered drop-in support and scheduled digital health clinics.
4. **Digital Literacy Programmes**
    - Workshops for older adults, carers, and people with disabilities; and
    - Delivered by Age U.K., local councils, and voluntary groups.
5. **Integrated Care Records**
    - Shared digital records across GPs, hospitals, social care, and mental health teams; and
    - Enabled real-time access to patient information.
6. **Virtual MDTs**
    - Online multidisciplinary team meetings to coordinate care for complex patients; and
    - Included GPs, nurses, social workers, pharmacists, and mental health professionals.

The following table provides an illustrative cost/benefit analysis over a 3 year time horizon on the programme

Table 5.5 Cost/Benefit Analysis of the Digitalisation Transformation Programme in North Norfolk

Category	Estimated Investment	Benefits Secured
Digital Infrastructure (devices, hubs, platforms)	£2.5M	Access for 20,000+ residents
Training & Literacy Support	£500K	6,000+ residents trained
Remote Monitoring Programme	£1.2M	25% reduction in emergency admissions
Staff Time Savings	—	Equivalent to 12 FTEs reallocated to direct care
Reduced Travel Costs (patients)	—	~£1.1M saved in travel expenses
Avoided Hospital Admissions	—	~£2.8M saved over 3 years

Net benefit estimates include £6.5m in savings over 3 years, improved patient experience and outcomes, and enhanced workforce efficiency and retention. In terms of documented health outcomes, the ICS have recorded a reduction in emergency admissions by 22% among patients using remote monitoring; a 40% drop in GP appointment no-show rates due to telehealth; an increase of 18% in mental health referrals, indicating improved access; a rise in patient satisfaction by 35%, especially among older adults and carers; and an improvement in medication adherence by 20% in digitally supported patients. As the roll-out continues to be monitored, emerging outcomes include better coordination of care for patients with multiple long-term conditions, increased uptake of preventative services, including flu vaccinations and cancer screenings, and improved digital confidence among older adults and digitally excluded groups.

Achieving successful health outcomes is dependent on a number of factors; from having localised digital strategies tailored to rural contexts, investing in connectivity, devices, and digital literacy; having access to facilities such as community hubs, village halls and libraries and committing to a process of ongoing consultation and co-design with rural residents to ensure telehealth services continue to meet their needs.

5.6 Case Study: Transforming Acute Healthcare in Rural U.K. Communities

In this case study, increasingly unsustainable acute services were positively impacted by redesigning patient pathways to provide more in the community setting, including through the use of virtual hubs and flexible staffing models. Significant financial savings resulted, and the patient experience/outcomes improved through real transformation of service provision.

This case study focuses on Cheshire East Place, a rural and semi-rural area in North West England with a population of approximately 378,000. The region includes market towns, farming villages, and remote communities, many of which face challenges accessing acute healthcare services due to geographic isolation and poor transport links; limited hospital infrastructure, with long travel times to acute care centres; seasonal demand fluctuations, especially in tourist areas; and workforce shortages, particularly in emergency and specialist care. The area is served by two acute trusts, community providers, mental health services, and primary care networks working under the Cheshire East Health and Care Partnership.

Key health concerns in Cheshire East and similar rural areas include (i) an ageing population, with high prevalence of frailty, dementia, and multi-morbidity; (ii) chronic conditions such as COPD, diabetes, cardiovascular disease; (iii) increased demand for crisis and urgent support in the area of mental health; (iv) emergency care pressures with long ambulance response times and ED overcrowding; and (v) health inequalities with disparities in access and outcomes between rural and urban populations. These issues are compounded by fragmented service delivery, digital exclusion, and limited continuity of care.

5.6.1 The innovation

The Cheshire East Partnership, supported by NHS Midlands and Lancashire Commissioning Support Unit (CSU), developed a co-produced Model of Care for acute services, aligned with six integrated care principles; namely:

1. Integrated Acute and Community Pathways

- Redesigned referral and discharge processes; and
- Same Day Emergency Care units to reduce admissions.

2. Virtual Acute Hubs

- Remote triage and consultation for urgent cases; and
- Use of telemedicine and digital diagnostics.

3. Workforce Redesign

- Multidisciplinary teams including paramedics, ANPs, and social care staff; and
- Flexible staffing models to cover rural demand.

4. Data-Driven Planning

- Population health analytics to identify high-risk groups; and
- Dashboards for service utilisation and outcomes.

5. Community Engagement

- Participatory design with residents and frontline staff; and
- Localised service planning based on community needs.

6. Fly-In, Fly-Out Services

- Rotational specialist clinics supported by video conferencing; and
- Used in remote areas of NHS Highland and replicated in England.

This transformation programme via a co-produced model of care aimed to address unsustainable acute service models due to workforce and financial pressures, poor coordination between acute, community, and primary care, limited access to urgent and emergency care in rural settings, inadequate data sharing and population health intelligence, and low patient satisfaction and staff morale.

5.6.2 Cost/Benefit analysis

The following table provides an illustrative cost/benefit analysis over a 3 year time horizon on the programme

Table 5.6 Cost/Benefit Analysis of the Model of Care for Acute Services in Cheshire East

Category	Estimated Investment	Benefits Secured
Acute Service Redesign (staffing, IT, Training)	£3.2M	Reduced ED admissions by 18%
Virtual Hub Infrastructure	£1.5M	Improved access for 25,000+ rural residents
Workforce Flexibility Model	£800k	Increased staff retention by 12%
Community Engagement and Co-Design	£300k	Higher patient satisfaction and trust
Avoided Hospital Stays	--	~£4.5M saved over 3 years
Reduced Ambulance Transfers	—	~£1.2M saved in transport costs

In terms of net benefits, it is estimated that £6M+ in savings have been made over 3 years. There is an improved patient flow and reduced pressure on acute trusts; and an enhanced workforce morale and sustainability. In terms of documented health outcomes, the Health and Care Partnership note a reduction by 18% in emergency admissions in the pilot areas, a decrease in average ED waiting times by 22 minutes; an improvement of 30% in patient satisfaction scores, improved continuity of care, especially for frail and elderly patients, and reductions in staff burnout rates, with improved retention. As monitoring of the programme continues, emerging outcomes include better integration of acute and community services, improved triage accuracy through digital tools, and increased uptake of preventative care due to better access.

As this programme continues to support a reduction in rural health inequalities, there is every reason to believe that it is a scalable model for other ICSs and rural regions, including the South West region of Northern Ireland.

5.7 Case Study: Virtual Wards in the U.K. – Addressing Health Inequalities and Meeting Healthcare Needs

The Southeast region of England, encompassing counties such as Kent, Sussex, Surrey, Hampshire, and Berkshire, serves a population of approximately 9.4 million. This region includes six Integrated Care Systems (ICSs) and 32 NHS Trusts delivering acute, community, and ambulance services. In response to increasing hospital pressures and health inequalities, NHS England launched a national 'Virtual Ward' programme in April 2022. The goal was to provide 40–50 virtual ward beds per 100,000 people, enabling acute-level care at home for patients who would otherwise require hospitalisation. The use of 'virtual wards' is increasingly becoming the norm in the U.K. health ecosystem. In addition to improved financial sustainability, this model brings considerable benefits to the patient.

The South East region faces several population health challenges, including (i) within an ageing population, a high prevalence of frailty and chronic conditions; (ii) health inequalities with disparities in access and outcomes across ethnic and socioeconomic groups; (iii) hospital capacity strain as a result of high bed occupancy rates and delayed discharges; and (iv) underrepresentation of black and minority ethnic groups in virtual ward cohorts, indicating potential access barriers. These issues are compounded by workforce shortages and increasing demand for urgent and emergency care services.

5.7.1 The innovation

Virtual Wards are defined as short-stay, acute-only services delivered at home. Key features include:

- Step-up and step-down care: Admission avoidance and early discharge;
- Multidisciplinary teams (MDTs): Including consultants, nurses, pharmacists, and allied health professionals;
- Technology-enabled care: Remote monitoring via apps, wearables, and dashboards;
- Daily clinical oversight: Board rounds, diagnostics, and interventions equivalent to hospital care; and
- Pathway diversity: Covering frailty, respiratory illness, heart failure, and paediatrics.

Virtual Wards are now active in every ICS, with over 11,800 beds nationally and 73% occupancy as of December 2023. They aim to tackle several systemic challenges such as hospital overcrowding by enabling early discharge and admission avoidance, access inequality through remote care delivery, reducing geographic and mobility barriers, workforce efficiency as a result of technology-enabled monitoring which reduces burden on frontline staff, and

better patient experience whereby care at home, for example, improves comfort, autonomy, and family engagement.

However, challenges remain, including digital exclusion, inconsistent service models, and gaps in ethnicity data collection.

5.7.2 Illustrative Cost/Benefit analysis

The following key figures, drawn from a number of evaluation reports, provide an insight into the cost/benefit of the virtual ward programme

South East Region Evaluation (2024):

- Virtual wards analysed: 29;
- Admissions avoided annually: 9,165;
- Gross benefit: £24.5 million;
- Gross cost: £14.2 million; and
- Net benefit: £10.4 million.

Frimley Health Foundation Trust:

- Frailty virtual ward: 96% admission avoidance;
- Annual savings: £631,000; and
- Primary care visits avoided: ~70/month, saving £95 each.

Croydon Model:

- Cost saving per patient: £742.44 compared to rapid response control group.

5.7.3 Health outcomes

In terms of documented outcomes to date, the Virtual Ward has reduced hospital admissions with mature virtual wards showing a 1:1 ratio of virtual ward to avoided admission; improved patient experience with patients reporting higher satisfaction and autonomy; reduced risk of harm with lower recorded incidences of hospital-acquired infections and deconditioning, and improved medication management with embedded pharmacy teams optimising treatment. As monitoring continues, an emerging outcome centres on system integration with improved collaboration across primary, secondary, and community care.

As virtual wards mature, per-admission costs are expected to decline. Enhanced data collection and interoperability will support better evaluation and targeting. Together, these make a strong case for continued scalability.

6. Analysis – A Future Sustainable Rural Health Ecosystem for the South West Region of Northern Ireland

This analysis is divided into two sections: first, it recaps on the conclusions drawn from the multi-stakeholder dialogue conducted as part of the process of preparing this advocacy paper; and secondly, in acknowledging the key structural challenges experienced by the health system as a whole, it explores some arguments for bravely pushing on with innovating components and elements of the health ecosystem on a model which recognises and works with the potential strengths offered by the geographical location of the region under study.

6.1 Place-based Conclusions Drawn from Stakeholder Perspectives

The conclusions drawn from the stakeholder engagement as part of this process are the product of robust and experience-driven evidence-based expertise and knowledge of the stakeholders who gave generously of their time and their thinking in the course of ICLRD's research for this advocacy paper. As such, they are relevant and material to what happens next. Most striking about the stakeholder engagement was the fact that the issue of access to basic health services and social care supports dominated so much of the discussions it was clear that further examination of specific patient group needs within the population remains a requirement of implementation beyond the current state of things. That all stakeholders were so engaged and exercised about basic access issues and equity of access, and so clearly understood the implications of doing nothing to address these barriers, indicates a broad consensus in the region that the current state is unacceptable and needs to change.

The workshop highlighted a combination of systemic and contextual issues impacting healthcare delivery in the South West region now and in the future. Some of the headline messages crucial for developing a sustainable rural health ecosystem in the region are noted below:

1. **Acknowledge the Problem:** The number one priority for health leaders and decision-makers is to (i) acknowledge that there is a problem at the 'heart' of the healthcare system and (ii) better understand the scale/scope of the problem in the South West region;
2. **Regional Disparities:** No regional parity in investment per head has resulted in years of infrastructural underinvestment and service inequities. The 'voice' of the region needs to be heard, in that this cannot continue and there is a 'duty' to care for everyone equally;
3. **Demographics:** Seismic demographic change is fast approaching with the ageing population set to increase from 20% to 25% by 2040 – the region needs to prepare itself;
4. **Paradigm Shifts:** Tinkering at the edges will not work, wholescale transformative change is needed involving paradigm shifts in policy, decision making and implementation. Across the board, the ways of 'thinking' and 'doing' things in respect of health need to be radically different. We need to move past good intention, and honour the people of this region with services that meet their needs;

5. **Governance:** There is a 'call' for accountability by government and public bodies concerning health policies, standards, investment and service delivery decisions. Deep concern was expressed about the withdrawal of emergency surgery in SWAH; and
6. **Funding:** Advocate for a revision of the funding formula for health in the South West region, which takes account of rurality and provides the basis for health equity, incentivising integrated, preventative and patient-centred care.

6.1.1 Key elements of the vision for an 'ideal' rural health ecosystem

As noted in Chapter 4, the 4 June workshop considered what an 'ideal' rural health ecosystem would look like; with key elements highlighted including:

1. **Accessibility:** People receive the care they need, when they need it;
2. **Integrated Care:** A healthcare system that connects patients with the right services at the right time. More fluid collaboration between primary and secondary care services is crucial;
3. **An Enabling System**: A healthcare system that empowers patients by providing them with the information and support they need to make informed decisions about their health;
4. **Patient-Centric**: Patients must be the focus of the ecosystem, with their needs influencing design and delivery of services;
5. **Community-Centred:** Communities must be at the centre of public health. Engaged communities are those who are resilient and health literate, and are critical to ensuring communities are front and centre in policy design and policy decisions reflecting local needs;
6. **Improved Pathways to Care:** Clear pathways to care must be established involving a series of interconnected touchpoints, with improved public understanding, confidence and user-friendly navigation;
7. **Prevention and Early Intervention:** Root causes of long waiting lists must be tackled, backlogs addressed and early access to healthcare services provided; with a focus on prevention rather than late intervention and crisis management;
8. **SWAH Rethink:** A rethink in the purpose of SWAH is necessary, including its potential in a cross-border context;
9. **Cradle to Grave:** Universal access to care through all life stages is critical; with seamless integration between different parts of the healthcare system;
10. **Evidence-based Decision Making:** Data sources and research must be used to their full potential and combined with Clinician and Patient input to support decision-making;
11. **Innovation:** Use of technology advancements will bring healthcare services closer to the patient; and
12. **A Learning Health System:** Partners/stakeholders must continuously self-study to generate knowledge, engage stakeholders and implement behaviour change to transform practice.

6.1.2 The way forward

To date, lots of worthy concepts and initiatives have been introduced to enhance health service delivery. However, their vision has not been fully realised due to piecemeal

implementation, leading to a diluted impact. Workshop participants proposed a holistic solution, rejecting siloed and fragmented thinking and instead 'centring' the voices and assets of local people, which are seen as essential for long-term success and resilience:

- 'Health in All Policies' (HiAP) as the overarching framework to focus attention on rurally orientated policy solutions;
- Whole Systems Thinking to identify the most effective ways to implement HiAP at the local level;
- Local and place-based healthcare to ensure that HiAP initiatives are rooted in the local reality, levelling-up inequality in the South West;
- 'Real' Rural Proofing to accommodate the specific needs of rural communities and address associated health inequities; and
- A 'Hub and Spoke' Model as a practical delivery solution, working across health trust boundaries and across the border.

By embracing these linked principles, with genuine engagement and sustained commitment, the rural health landscape can be re-shaped and healthcare services attuned to the needs of the South West region.

6.1.3 Place-based Partnerships in healthcare delivery

Reflecting on the emphasis placed by Fermanagh and Omagh on the Place Shaping approach to promote well-being (see Chapter 2), and recognising that many health determinants and services are rooted in local communities, it is important to note that many health systems have increasingly turned to place-based partnerships as a way to integrate care and improve population health in a given locality. In England, "place" typically refers to an area within an Integrated Care System that often aligns with a local authority (for example, a city or county). The place-based partnership model in England is seen as a foundational element of Integrated Care Systems (ICSs) and tends to bring together the NHS (hospitals, community services, primary care), local government (which oversees social care, public health, housing, etc.), and community/voluntary organisations to plan and deliver services collaboratively for that area .

The idea is that by working together, partners can address issues that no one organisation can solve alone. Key aims often include improving prevention, tackling the root causes of health inequalities, and redesigning services to be more person-centered and efficient across the care continuum. For instance, a place-based partnership might focus on a goal like reducing obesity in a local population. The NHS acute trust in that area can't achieve this alone – it requires input from public health (council-led initiatives on diet and exercise), schools (healthy meals, physical education), local charities (running weight management groups), and primary care (identifying and counselling at-risk patients). The partnership provides a forum to align these efforts and share resources.

One notable aspect of place-based partnerships in the NHS context is the delegation of budgets and decision-making to the place level. Recent policy encourages ICSs to delegate some functions and funding down to place, to empower these local partnerships. In practice,

some ICSs have given their place partnerships a pooled budget (NHS + council money) to manage certain services. Where this has happened, partners report it helps them act more flexibly and innovatively. A King's Fund study of three place partnerships found that the one with no delegated funding faced significant challenges in making progress. This suggests that having the authority and resource at place level can accelerate integrated initiatives.

6.1.4 Key components of the processes

Based on the policy and literature review and stakeholder engagement via semi-structured interviews and a stakeholder engagement workshop, there is a consistency is messaging emerging around what are the key components of a resilient and sustainable health care ecosystem; namely:

- **Championing Prevention over Cure:** Preventing health problems before they arise, addressing the root causes rather than treating the symptoms;
- **Community Engagement and Provision:** Leveraging the local knowledge of the Community and Voluntary Sector (CVS) to inform policy and decision-making. Partnering with the vibrant CVS to address the social determinants of health and deliver outreach services;
- **Integrating care**: Co-ordinating primary and secondary care provision creating clearly understood pathways and user-friendly navigation; Advocating for the full and consistent roll-out of initiatives including Hospital @ Home, Multidisciplinary Teams (MDTs) and Social Prescribing for better patient outcomes;
- **Connected Health:** Connecting all aspects of technology use in healthcare (telemedicine, telehealth, mHealth, eHealth, digital health, AI, robotics etc.) to improve access and reshape services; and
- **Cross Border Collaboration:** Leveraging proximity to the border to enhance provision and share resources.

6.1.5 Resource inputs

There is widespread agreement as to what are the resource inputs required to deliver a fit for-purpose rural healthcare system; namely:

- **Strengthening Infrastructure:** Investing in roads, transportation and internet connectivity;
- **Workforce Development:** Developing the health workforce to address critical shortages; Creating incentives to attract and retain healthcare practitioners;
- **Data Informed Decision-Making:** Collecting and using local health, demographic, infrastructure and investment data to set priorities and measures outcomes;
- **Technological Innovation:** Investing and using technology as a tool to bridge the urban/rural divide; and
- **Funding Reform:** Equitable resource allocation, seeking regional parity in investment.

6.1.6 South West Acute Hospital (SWAH)

SWAH is a state-of-the-art, purpose-built facility with significant physical capacity for increased service provision. It is considered an asset not only for the local area but also for

the entire region ("the roads go both ways"), with the potential to serve both local, regional and cross-border needs. It was noted that the hospital was built on the potential of cross-border cooperation and is seen as a flagship hospital in Europe.

Following the stakeholder engagement workshop, and a specific discussion centred on the future of SWAH and the need for a 'rethink', key points emerging are:

- **Underutilisation and Potential**: Despite being a flagship hospital, SWAH is currently underutilised. There is a deep frustration among the community due to the inadequacies in service provision and a need to stabilise current service provision with no further downgrading. The hospital has the potential to become an 'epic' centre if its acute facilities are fully utilised;
- **Emergency and Elective Surgeries**: There is a need to restore emergency general surgery (EGS) services at SWAH. The hospital has the capacity to handle overflow elective surgeries from across Northern Ireland, which could help build up emergency surgery capabilities;
- **Investment Needs**: Significant investment is required to meet the specialised standards for EGS. The hospital needs upwards of £100 million to return EGS services, which were removed in 2021;
- **Increasing Provision in Geriatric and Palliative Care Wards**: There is a need to increase the provision in geriatric and palliative care wards. Enhancing these services can help address the growing demand for specialised care for the elderly and those with life-limiting illnesses, ensuring that patients receive the appropriate care and support locally; and
- **Exploring Options**: The discussion highlighted the importance of exploring various options to fully utilise SWAH's facilities. This includes considering different models of care, partnerships and innovative approaches to service delivery to ensure the hospital meets the healthcare needs of the community.

Despite these challenges, some of which are persistent and will not be addressed in the short-term, the very existence of SWAH in the region, presents a number of opportunities; namely:

- **Utilising Physical Assets**: SWAH has physical assets available that can be used to service local, regional, and cross-border needs. This includes the possibility of using its theatres for elective surgeries and building up emergency surgery capabilities;
- **Cross-Border Cooperation**: The hospital's potential for cross-border cooperation could be a significant opportunity. This includes exploring partnerships with surgeons from nearby border counties to utilise SWAH's theatre space;
- **Addressing Community Frustrations**: By fully utilising SWAH's facilities and restoring essential services, the hospital can address the community's frustrations;
- **Attract Specialists**: Develop strategies to attract specialists to travel to SWAH to provide local access. This could include offering incentives, creating a supportive work environment and promoting the benefits of working at SWAH;
- **Protected Status**: It was noted that a small number of rural hospitals in England have been given 'protected' status, which ensures they receive the necessary support and resources to serve the needs of their rural catchments. It would be useful to explore this concept in relation to SWAH; and

- **Explore Innovative Models**: Consider different models of care, partnerships and innovative approaches to service delivery, to ensure SWAH meets the healthcare needs of the community into the future.

These points highlight the potential of SWAH to become a central hub for healthcare services in the region, provided it receives the necessary support and investment.

6.1.7 The role of key stakeholder groupings

The Community and Voluntary Sector (CVS) is a key element in building a sustainable and resilient rural health ecosystem for the South West region. Its value needs to be fully recognised and embraced by the public health system if universal healthcare is the goal. The CVS has the capacity to amplify the voice of rural residents and act as intermediaries between communities and decision-makers, ensuring that rural health issues are central to the conversation in health and social care planning. While the impact of the CVS is profound, workshop participants noted that its continued contribution is not without challenges. These include, but are not limited to (i) funding instability and an (over)reliance on grants, donations or short-term contracts which can make long-term planning difficult; (ii) volunteer recruitment and retention and the acknowledged risk that an ageing volunteer base is a threat to sustainability; (iii) lack of integration whereby barriers to collaboration between statutory and the CVS can result in gaps in service provision; and (iv) recognition and influence where the value of community-led initiatives can be overlooked or be given peripheral importance by policy- and decision-makers.

Building on the strengths of the CVS offers significant opportunities for the rural health ecosystem in the South West region. This includes:

- **Strengthening Partnerships:** Closer integration and collaboration between statutory health services and the CVS can enhance service delivery and reduce fragmentation;
- **Policy Recognition:** Mainstreaming the role of the CVS in rural health policy will ensure sustained funding, strategic support and alignment with broader health priorities;
- **Digital Innovation:** Embracing digital tools (e.g. telehealth platforms, online support groups) can extend the reach of community initiatives, whilst they can also address digital exclusion through digital literacy training and supports; and
- **Asset-based Approach:** Recognising that communities are the 'core' asset in building a sustainable and resilient rural health ecosystem (have knowledge, networks and delivery capacity). Cultural change is needed within the ecosystem to fully value the role of the CVS.

The CVS is the 'glue' that binds the ecosystem together. It needs to be fed (with multi-year funding and contracts), valued (voice, vision, delivery and impact) and crucially raised to an equal partner, placed in the centre of policy and decision-making frameworks. As the rural health ecosystem continues to evolve in the face of demographic, economic and technological change, supporting and empowering the CVS must be a central priority for policy-makers, funders and leaders alike. Only then can an ecosystem be built that is healthy, vibrant, connected and resilient for the future.

Another key actor is local government. By acting as both advocates and connectors, local representatives can help ensure that health care is grounded in the realities of the communities they serve and is responsive to local priorities in the South West region. Strong, focused leadership involving council and community must drive the rural health agenda of the South West forward, to ensure it is no longer overlooked.

6.2 Overall Analysis Towards a Way Forward

It is clear from a review of sources, including efforts across the system in the immediate pre-pandemic period, such as the Western Trust Pathfinder initiative, that a consensus has emerged on the need to address the nature of population health needs and the rurality of the region, and that this must be done in a way that can deploy contemporary innovations in healthcare transformation. These include area-based partnerships, community planning techniques and models, and smart territorial approaches to optimising available resources for positive population health outcomes. It is clear that, despite institutional and organisational differences, a will for change has existed, and been collectively expressed, in the region, based on evidence and engagement. Despite the massive disruptive effect of the Pandemic, there is a clear understanding of what the direction of health and social care systems needs to be for the South West region, perhaps cemented and reinforced by experiences arising from the Pandemic and post-Pandemic recovery period, at community grassroots, and health system level. There is an appetite for renewal and change which involves picking up the threads of good evidence-based work and seeing how these can help to create a better future for the population and the health of the people of Fermanagh and Omagh, and surrounding hinterlands.

The change cannot be achieved by the health system alone, either at commissioning or delivery level, or both. The change requires a policy-driven approach which differentiates from a one-size-fits-all approach at the level of the Northern Ireland Region and which instead works with the specific nature of Northern Ireland and its population, its interdependencies between rural and urban, and its geophysical location on an island with a neighbouring state with whom it has a long history of cross-border health cooperation. The opportunity in this policy-driven approach is to draw together all the elements of good practice which Northern Ireland has developed in public governance over the last two decades since devolution – things like community planning, the power of well-being, the agency of local government, bespoke specialist agency-led housing provision, spatial planning, outcomes-based programmes for government and the intersectionality of high-level outcomes, the special legislative commitment to protection of the Section 75 equality categories (making Northern Ireland unique in Europe), the culture of evidence and data-driven decision-making, and co-creation and co-design: all of these things go to create possibilities of offering a solution-focused future.

In healthcare policy terms, the aim of this analysis is not to re-rehearse what are well-evidenced arguments for the primacy of a global move to integrated care systems and their relevance to addressing the future needs of the population of the region under focus. Nor it

is to make any incursion on the area of research and discussion that is the expert reserve of healthcare systems academics and policymakers. Rather, the aim is to draw together and identify steps that can feasibly be taken to advance a policy-driven, place-based approach to improving rural health access and outcomes in the South West region of Northern Ireland that has a whole of government support model. In doing so, ICLRD brings the benefit of a position slightly outside and independent of the healthcare system, but drawing on the experience and knowledge inherent among those who have operated either delivering or using services, or both, within the health ecosystem.

Prior to the pandemic, the Northern Ireland Health and Social Care System had partly adopted the principles of moving to a system of integrated care. It had also developed a whole-systems culture of data-driven decision making. In the Western Trust area, in initiating the Pathfinder initiative, the Trust had undertaken a highly participative deliberative dialogue with service users and citizens across Tyrone and Fermanagh which was rooted in the acknowledgement that there were particular population health and service access needs which needed to be designed on a co-created basis.

This paper has sought to identify key actions which draw on existing work, assets and intellectual capital which different stakeholders in the healthcare ecosystem have contributed in recent years: such as the work done by FODC in delivery of the WRAP programme; the work done by SOAS in identifying solutions for the future sustainable delivery of acute hospital services to the population previously served by SWAH; and the work done by the Western Trust prior to the COVID-19 Pandemic through its Pathfinder initiative. This analysis, therefore, explores and seeks to interconnect and identify opportunities for collaborative action on issues which have already been acknowledged as problematic by the health and social care system itself, by local and central government, and by civil society in the region. It does not seek to duplicate or displace any existing or previous work done by those working with quality assured healthcare systems and performance data, nor to dismiss work done by those outside of the formal healthcare institutions. It merely seeks to survey some key ethical and structural themes which apply to healthcare access globally, to acknowledge the considerable efforts made across the system in a fractured way to address part of all of the problem, and to suggest ways in which those resources and energy could be mobilised in a co-ordinated approach for best future outcomes.

6.2.1 The Inverse Care Law

The Inverse Care Law was identified in 1971 by a United Kingdom GP, Julian Tudor Hart, in a seminal article published in the Lancet. Tudor Hart was based at Glyncorrwg Health Centre, Port Talbot, Glamorgan in Wales. Since its identification by Tudor Hart, the Inverse Care Law has been invoked not as a standard for delivery but as a provocateur and driver for greater equity of access and remedial actions to ensure that the inequalities created by the conditions detailed by Tudor Hart in 1971 are the subject of vigilance and commitment not to let the law define, but rather inspire, how healthcare is delivered to those most in need. In summary, the Inverse Care Law is as follows:

> *The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced. The market distribution of medical care is a primitive and historically outdated social form, and any return to it would further exaggerate the maldistribution of medical resources*[29].

In 2021, The Lancet published an editorial on the topic of 50 years of the Inverse Care Law[30]. A 2022 Health Foundation Report analysing policies to tackle the Inverse Care Law since the 1990s concluded that the Law 'is not an inevitable or irreversible feature of general practice' and that without policy-driven action to improve funding for primary care and GPs, and a stronger centralised approach to workforce supply for General Practice, health inequalities in England were likely to become more exacerbated (Fisher et al, 2022).

From all of the public evidence of pressures on the GP sector most ably communicated by the Northern Ireland GP Professional Community (members of whom also gave generously of their time and thought processes to engage with the ICLRD process in Fermanagh Omagh), it is clear that greater consideration needs to be given to how Northern Ireland funds its primary care systems overall, and how primary care needs to not continue to be seen or treated simply as a facility that is there to alleviate pressure on secondary care facilities. Personalised, patient centred concepts need to balance a tendency to see healthcare systems as the subject of need - prioritising the needs of the system over the needs of patients - and in this already losing focus of the *raison d'etre* of a nationally-insured health system. Patients and citizens are the subject of need in healthcare. Healthcare systems are the object of agency and the means by which patient and citizens healthcare needs ought to be met. It is important to recognise that real healthcare systems transformation involves treating primary care as a component of the healthcare system equal in importance to secondary care, in all aspects – workforce, collaboration, innovation capacity, and care closer to patients.

If primary care is seen fully as a field of investment, and acknowledging that Omagh has a state-of-the-art community-based medical primary care facility which should form part of a solution for the region, many kinds of innovation are possible. These include greater investment in special interest GP training and funded places (e.g. for specialty support for long-term conditions in a primary care setting); and greater opportunities for specialist and consultant clinicians to work in a primary care setting, delivering upstream interventions, rather than within the constraints of a secondary care system receiving patients who could have had earlier and more timely interventions closer to home, thus relieving the pressure for specialist and acute care.

While some of Northern Ireland's most complex health inequalities continue to be mapped in urban areas, the issue of equity of access for rural healthcare service users is of itself a human rights issue and continues to provoke debate and concern in the region. Therefore this advocacy paper has sought to provide an overview and synthesis of issues which, while they

[29] Ibid

[30] The Lancet: Editorial – '50 Years of the Inverse Care Law' in Volume 397, Issue 10276 P767 February 27, 2021

are not new to those working in or with the health and social care system, can now be the focus of a place-based policy advocacy intervention by Fermanagh and Omagh District Council. In this, the Council is exercising its role as a local government body with a specific role in influencing the determinants of health, as is recognised by the WHO.

The WHO, in its definition of health systems governance, makes the following statement:

> *Effective health systems governance is essential for ensuring that healthcare services are accessible, equitable, efficient, affordable and of high quality for all. This requires efficient and equitable allocation of healthcare resources, the presence of policies and regulations guiding healthcare delivery, and mechanisms for monitoring, evaluating and reviewing the healthcare system's performance.*
>
> *Moreover, health systems governance plays a crucial role in promoting equity and social justice in healthcare. It strives to ensure that the healthcare system is responsive to the needs of all members of society, regardless of their socioeconomic status, ethnicity, culture, gender or other factors*[31].

The challenges experienced by patients and citizens in the South West region of Northern Ireland, with regard to access to primary, intermediate and secondary care, and mental healthcare, indicate that there is more that can be done to improve health systems governance beyond the current state of access in the region. As a step towards solutions for a more effective healthcare ecosystem in the South West, it is important first to recognise and discuss some of the challenges faced by the health system. Some of these are faced by, but not made by, the health system. Some of these are challenges faced by all public health systems in a post-pandemic era. Some of these are exacerbated by geography. Some – as key health authorities in other parts of Europe have recognised and invested in (e.g. Romania-Hungary) – can be improved by innovation deriving from that precise geography, such as cross-border institutional approaches which have a specific territorial focus and for which, in this case, the health services have the asset of long-standing collaborative infrastructure through CAWT and interdepartmental cooperation on a North-South basis.

It is fair to say that many of the challenges referred to below were recognised challenges before the COVID-19 Pandemic and remain challenges, exacerbated by the legacy of the pandemic as it affected population health and social care needs, and also of the legacy impact of pandemic response on the health and social care systems themselves, both in terms of workforce and systems of organisation.

6.2.2 Post-Pandemic healthcare transformation

It has been clear since early in the onset of the COVID-19 Pandemic that pre-existing challenges experienced by health systems were going to be compounded by the challenges resulting from the pandemic. Early analysis during the Pandemic proves interesting reading, particularly literature which demonstrated the on-the-spot analysis of future learning from the crisis management which all health systems and professionals had to do in order to

[31] Health Systems Governance

respond to the Pandemic. It is clear that while responding, systems and analysts were already recognising that out of this crisis needed to come change (Jazieh and Koziakidis, 2020).

Some of these challenges, in the post-pandemic era, point to opportunities for transformative action which not only embeds the learning from the pandemic but also creates increased resilience for future shocks. The digitalisation forced by the global pandemic is now an opportunity to explore how physical barriers to accessing healthcare can be overcome with technology-based solutions that are balanced with the need to ensure face-to-face patient access is not delayed or overlooked at the risk of missing diagnoses and other issues (Jazieh and Koziakidis, 2020).

In a spatial sense, rural and remote areas could become pilot areas for the delivery of hybrid models of care which involve digitalised and communications technology-based solutions (such as Project Echo and video-based clinical consultations) where it improves access for the patient and clinical response time. In physical terms, and with the right innovations in workforce, skill mix, and diagnostics support services (such as pre-transport stabilisation for haematology samples and decentralised outreach service points for non-emergency medical imaging, for example) access could be improved for a range of issues that arose during discussions with stakeholders and which are part of the primary care ecosystems supports required.

At the same time as tackling workforce planning needs for the future, health systems have to contend with populations adversely affected by the long legacy of the virus itself, of which not everything is yet known, and also planning for future responses should a similar scenario arise. The need for country-based healthcare asset systems to be able to conduct virus surveillance and facilitate early infection control actions (these are dependent on facilities which are appropriately designed and can be stood up as isolation facilities, for example) is clear. The pandemic also proved that pre-existing health status is a direct factor in health outcomes from infectious diseases. As already discussed, socio-economic deprivation and poor health status are linked.

By necessity, many in-country health systems which operated on decentralised models experienced a degree of re-centralisation of command and control structures. Many peripatetic services were pulled back into delivery from centralised locations. Recovery of workforce capacity and new recruitment in the post-pandemic era has been challenging across all sectors. Every organisation in every sector made changes to procedures and custom and practice in order to be able to respond to best effect to the pandemic with the resources they had available to them.

It is now for suggestion as to whether, from a systems management and leadership perspective, public service organisations should review any service model changes made for the pandemic which remain in place in the post- pandemic era, with a view to determining their relevance or necessity in the current and future phases. Similarly, there exists the opportunity for organisations to revisit planned innovations and longer-term strategic or

quality improvement initiatives which had to be placed on hold by necessity in order to respond to the Pandemic.

6.2.3 Healthcare workforce challenges

Services as operated by the healthcare system are configured to optimise patient safety from the point of care onwards. Health services are constrained in relation to budgeting and workforce issues – the remedies to these issues require innovation and territorial co-operation. An example of such innovation in recent years was the establishment of the Ulster Medical School at Ulster University (UU) Derry/Londonderry with its focus on graduate entry and producing doctors specially trained in primary care and community medicine, with a view to addressing shortages in GP workforces on both sides of the border. Nevertheless, recruitment and workforce planning continue to be an issue for both the NHS and the HSE in the border region across a full range of workforce skills and professional groups.

As regards medical training and retention, the question remains as to what the longer-term planning of primary care medical workforce needs to involve, in order to optimise resources such as the UU Medical School for areas like the South West region of Northern Ireland. As regards doctors, the NHS in Northern Ireland continues to face a particular challenge of a 'brain drain' both overseas and relating to the difference between Northern Ireland and Ireland in remuneration rates for clinical professionals in all categories.

Evidence-based models such as the Advanced Nurse Practitioner (ANP) model from the globally-celebrated Basque health system which inspires the expertise of international figures such as Professor Rafael Bengoa, require further investment not just in training of ANPs but in commissioned places. The gaps in primary care provision and the further shrinkage of secondary care services in the region under focus carries its own safety concerns for patients and citizens as regards implications, for their condition and health, of travel time and transport to point of care. This concern extends to the potential implications for patient outcomes as regards both early intervention and prevention, and access to urgent care within specific time windows including those which relate to specific clinical best practice and intervention windows for specific conditions.

6.2.4 Institutional collaboration and culture for placemaking

Place-making is everyone's responsibility and health is too important for the health system alone. The health service is a repository of considerable information derived from its data-rich operational and planning culture. As a data-driven society, there is a need to get better at drawing intelligence for the future from our current operations and from models of place-making which are translational – initiatives which transform data into information that can be used for the good of all cannot be underestimated. The Northern Ireland Health and Social Care System is an outstanding example of a sector which has driven innovation and pioneered its own internal data and performance culture. Many sectors could learn from this culture and there is much information from data which, while the health service itself may not need it, could form useful evidence bases for the response of other actors in the wider healthcare ecosystem to challenges, in ways that could ultimately alleviate both the pressures and the weight of expectation which our health service experiences on an ongoing basis.

This requires agency. While the health service is not accountable for the provision of transportation or regional accessibility infrastructure such as roads and public modes of transport, there is a role for every public service delivery body in contributing to evidence for community planning which can help to generate a responsive model of territorial cooperation for services and infrastructure. This includes and requires a clear understanding within the health service of the power it can have as a driver for community planning and joined-up approaches to optimising infrastructure investments such as new primary care centres. David Maguire, writing in 2023 for the King's Fund on the topic of the cost and causal factors for delayed discharges (social care, discharge planning, non-NHS factors such as housing), states:

> *The NHS normally thinks of issues related to housing and other wider determinants of health as problems for other partners, especially at times where performance is under extreme pressure. Can the NHS work with partners in local government, housing associations and voluntary and community sector organisations to make a significant difference to operational pressures and financial bottom lines? Short-term actions might offer a chance to forge connections with valuable partners that could pay off even more in the long-term*[32].

In 2015, the Review of Public Administration (RPA) in Northern Ireland afforded coordination of community planning functions to local councils. There remains much opportunity for the community planning process in Northern Ireland to act as a dynamic platform for joined-up service planning aimed at enabling optimal access to services for citizens, regardless of where they live. There is a moral responsibility for the public sector in all areas to consider the barriers to access experienced by communities, families and individuals living with complex deprivation.

At the core of this matter is the issue of high quality communication, investment in relationships, and mechanisms for collaborative working between and within public sector bodies responsible for the resourcing, planning, delivery of services, and those who make policy which governs these processes. Northern Ireland cannot afford for any agency to work in silos, and collaborative working must reach beyond strategy planning and information sharing, to actual implementation and ongoing monitoring in a data-driven culture which strives to provide the best possible outcomes for citizens. An enabling culture of self-efficacy and pro-active innovation is required across the entire public sector, a horizontal ecosystem that allows for joined-up working to be delivered at every level, even the most simple local collaborations.

The challenges experienced by patients and citizens in the South West region of Northern Ireland, with regard to access to primary, intermediate and secondary care, and mental healthcare, indicate that there is more that can be done to improve health systems governance beyond the current state of access in the region. From a local government

[32] The Hidden Problems Behind Delayed Discharges | The King's Fund

perspective, it is increasingly acknowledged that planners, designers and developers all have responsibility for promoting healthy settlements. In addition to community planning, the process of RPA also resulted in the devolution of spatial planning to local government in Northern Ireland. In 2023, Fermanagh and Omagh District Council adopted its Local Development Plan (LDP); and two of its core planning principles focus on improving health and well-being and supporting good design and positive place-making. The local plan is a critical component of the spatial planning process in relation to improving health and well-being but "building an understanding of the planning and public health systems and their alignment opportunity has been a steep learning curve for most policy-makers and practitioners" (Chang and Hobbs, 2024). Research highlights that while healthy place-making can be a clear objective or priority of local government, this vision does not always translate into tangible actions (Chang and Hobbs, 2024). In Northern Ireland, the limited functions of local government go some way to explaining this discrepancy; and to reiterating the necessity of both the Local Development Plan and Community Plan being closely aligned.

6.2.5 Territorial cooperation for healthcare – opportunities from Northern Ireland's track record in cross-border cooperation

Northern Ireland and Ireland have a history of healthcare-based cooperation which reaches back to at least the second half of the Twentieth Century. Cross-border emergency care protocols have been in place for decades. Since the Ballyconnell Agreement in 1998 and the foundation of Cooperation and Working Together (CAWT - The Cross Border Partnership of the Health Services in Ireland/Northern Ireland), the health service delivery bodies responsible for services to the population of Northern Ireland and Ireland border counties have been jointly planning and delivering health services, usually piloted with European funds. Many of these models have made their way into mainstream provision. Many more innovations have inspired countless waves of healthcare professionals and managers in smart, evidence-based approaches to meeting the needs of patients in border regions and to transboundary professional collaborations which have endured in the areas of knowledge exchange, clinical research and care quality improvement.

In the context of an integrated care agenda, there are additional opportunities for intermediate and primary care ecosystems in the South West of Northern Ireland which could have a cross-border dimension. There have been advances in primary care-led cross-border enhancement of care in the areas of diabetes and cardiology, including those led by newcomers to the healthcare ecosystem such as the Ulster University Medical School in partnership with the GP profession and primary care services in Northern Ireland and the border counties. CAWT also continues its long history of pioneering scaled-up approaches to improving access to health and care in the border region, albeit more strictly in relation to the allocation of EU funds for cross-border co-operation than mainstream re-engineering of service configurations. As regards mainstream shared services already established as precedent by the Departments of Health, North and South, the North West Cancer Centre, the Primary Percutaneous Coronary Intervention (PCI) Service at Altnagelvin, and the All-Island Paediatric Cardiology Network are noted across Europe as examples of models of efficient shared services jointly commissioned by two neighbouring governments. Cross-

border care from Northern Ireland and the Irish border counties has inspired health systems across Europe. This pioneering spirit should be continued with pride.

In 2025, and for the remainder of the current EU Cohesion Programming Period (2020-27) Northern Ireland continues to be a beneficiary of European Structural Funds through the special facility of Peace Plus. In this, it is also able to avail of support for Interreg Specific Objectives (ISO) relating to boosting cohesion in border regions and it is noteworthy that its' impact can also be in the area of health. The EU has acknowledged the benefits for GDP of good population health. The Special EU Programmes Body (SEUPB) has already awarded funding to a number of strategically-important cross-border health projects which have potential implications and benefits for the South West region of Northern Ireland and these should be taken into account in any response to this paper and its recommendations.

The direction of travel for European health priorities post-pandemic (mental health, good lifelong health, and more accessible and resilient health systems – including workforce planning[33]) remains relevant to both Ireland and the U.K. and, in this context, the fact that Northern Ireland is host to a significant modern, under-utilised hospital asset in a border region should not be ignored.

The impact of resilient healthcare ecosystems across greater portions of a country's territory is increasingly seen in many EU member states as a strong factor in improving competitiveness of national economies. There is obvious potential in taking a courageous, ambitious and evidence-based approach to the future viability of SWAH that takes into account the totality of the potential of its geographical location and the quality offering as an NHS hospital built for the 21st Century.

The European Commission has since 2021 declared Border Regions to be living laboratories for innovation and territorial cooperation, and as such important to how central governments can enhance outcomes for greater numbers of their citizens (European Commission, 2021). With the 2021 declaration and subsequently the Bridge for EU Regulation, the European Institutions have formally recognised the importance of cross-border cooperation for competitiveness. 30% of the EU's population lives in a border region and 40% of its territory is classified as border region. The EU also recognises the importance of development cooperation on external borders.

Cross border primary care shared services are a key issue which should be explored in tandem with the role of hospitals in the border region.

[33] The 2024 edition of *Health at a Glance: Europe* examines key health challenges and how to develop stronger, more resilient health systems against a rapidly changing health landscape. The report includes a special focus on the interconnected topics of health workforce shortages and healthy longevity (good physical and mental health). The dual demographic challenge of an ageing population and an ageing health workforce reflects the urgent need to take actions to increase training and retention in health sector jobs. The report highlights the importance of enhancing prevention throughout the life course, supporting mental health at all ages and empowering individuals to manage their own health.

In reviewing the evidence as part of this process, it is ICLRD's view, as an expert body in the field of transboundary spatial planning and regional territorial cooperation, that it may be opportune to revisit the original ambition with which investment was made in the building of SWAH as what was termed 'A Hospital for the South West of Northern Ireland'. The opportunities that its unique geographic location provides for future viability – based on spatial complementarity of trauma services available across Northern Ireland and Ireland's border region, based on need of the population particularly in Cavan/Monaghan/Leitrim, and taking into account the complementarity which could be achieved with services already in place such as those at Cavan General Hospital, should be explored. Consideration should also be given to the potential for strategic hospital cooperation with Sligo and Galway and on the potential for SWAH having a role in elective care recovery for both Northern Ireland and Ireland. At a time when hospitals on Europe's eastern borders are being destroyed it seems like an extraordinary privilege to have one which has state-of-the-art patient facilities which are not currently being fully utilised for the common good or in the enhanced delivery of the right to health of the catchment population.

SWAH's location (and original feasibility) offers consideration of cross-border catchment options when considering future viability. The European cross-border hospitals of Cerdanya (Spain/France), Valga-Valka (Latvia/Estonia), Gmünd (Austria/Slovakia/Czechia) and the cross-border networks of hospitals and specialist care provision in regions like Gorizia/Nova Gorica (Italy/Slovenia) and the Romania-Hungary border region, are examples of best practice in this field. These are globally-renowned as transboundary innovations in health systems and interjurisdictional shared services models through which neighbouring health systems lever much added value beyond that which they can offer alone. Northern Ireland does not have to overcome a language border to work with a neighbouring health system. While all health systems have a duty of care to ensure a patient can communicate and be heard in the language that they are comfortable in (because language is also a quality and safety issue in clinical care), there are many cross-border regions which have established shared services and cross-border healthcare facilities on a multilingual model, sometimes involving three or more operating languages.

A further potential opportunity for the Northern Ireland health system to work in strategic cooperation with the health system of Ireland for mutual benefit – and particularly in addressing challenges such as harmonised approaches to healthcare ecosystems in border areas, cross-border regulatory issues including accreditation for diagnostics provision, patient mobility, and future healthcare workforces - arises from the new Bridge for EU Regulation. Whether the Ireland/Northern Ireland border can benefit from equivalent arrangements to create a systematic approach to identifying and tackling cross-border obstacles is fully dependent on how Ireland chooses to implement this in relation to the Ireland/Northern Ireland border region. The regulation, in the first instance, allows for neighbouring EU Member states to establish cross-border coordination points to systematically gather evidence and jointly examine solutions to obstacles which hinder the growth and development of border regions. While the regulation applies primarily to internal EU borders, the regulation specifically states that it should be possible for Member States to establish

equivalent arrangements with a third country[34], on the assumption that there will be cases where an individual Member State may determine that to do so is desirable and beneficial.

The opportunity to focus a Bridge for EU-type mechanism on addressing administrative and legal obstacles to creating more resilient health systems on a cross-border basis exists but is subject to a political decision to take this approach. This may be an option in pursuit of a complementary network of healthcare system assets between Ireland and Northern Ireland and could potentially offer innovative solution-finding in the establishment of healthcare ecosystems for the South West of Northern Ireland and indeed across the entire border corridor.[35] Ultimately, such an approach would strengthen the healthcare offering on the island for the benefit of the population of both states on the island.

[34] 'While this Regulation does not apply to cross-border obstacles in border regions between Member States and third countries, it should be possible for Member States to set up equivalent procedural frameworks under national law to identify and resolve legal and administrative cross-border obstacles in their cooperation with third countries'.

[35] REGULATION (EU) 2025/… OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of … on a Border Regions' instrument for development and growth (BRIDGEforEU) L_202500925EN.000101.fmx.xml

7. Conclusion and Recommendations

Health systems face significant challenges in ensuring equitable access to healthcare and improving outcomes for the communities served (Chapter 3). In particular, rural communities often struggle with the challenges in providing the breadth of sustainable services required to meet increasingly complex population health needs. Whether impacted by geography, changing demographics or socio-economic classification, rural communities often experience worse health outcomes – in many instances, manifesting as health inequalities (Chapter 4). Innovations are happening, and in England there is a shift to neighbourhood health services, place-based partnerships, and shifting care from hospitals to community settings to address these gaps (Chapter 5). Meaningful improvement in health outcomes and equity will depend on empowering local communities, strengthening the role of the CVS and local government, reforming funding, and building a coherent, connected, and resilient rural health ecosystem (Chapter 6).

7.1 Conclusions

The Office of the United Nations High Commissioner for Human Rights (OUNHCHR) and the World Health Organisation (WHO) together state the following, of the right to health[36]:

> *The right to health is a fundamental part of our human rights and of our understanding of a life in dignity. The right to the enjoyment of the highest attainable standard of physical and mental health, to give it its full name, is not new. Internationally, it was first articulated in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The preamble further states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition"*[37] [38].

Most striking also in this joint description of the right to health are the entitlements which make up this right. These include (i) the right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health; (ii) the right to prevention, treatment and control of diseases; (iii) access to essential medicines; (iv)

[36] Office of the United Nations High Commissioner for Human Rights & World Health Organisation: Fact Sheet no. 31 on The Right to Health: Factsheet31.pdf

[37] Ibid, p1.

[38] The right to health was further emphasised in the 1948 Universal Declaration of Human Rights and the 1966 International Covenant on Economic, Social and Cultural – noting health as part of the right to an adequate standard of living and as a human right respectively. Since then, other international human rights treaties have recognized or referred to the right to health or to elements of it, such as the right to medical care. The right to health is relevant to all States: every State has ratified at least one international human rights treaty recognizing the right to health. Moreover, States have committed themselves to protecting this right through international declarations, domestic legislation and policies, and at international conferences.

maternal, child and reproductive health; (v) equal and timely access to basic health services; (vi) the provision of health-related education and information; and (vii) participation of the population in health-related decision making at the national and community levels[39].
The right to health also covers the governance and standards of service and access offered by healthcare services, goods and facilities[40], and include:

- The provision of health services, goods and facilities to all without any discrimination[41].
- All services, goods and facilities must be available, accessible, acceptable and of good quality;
- Functioning public health and health-care facilities, goods and services must be available in sufficient quantity within a State. They must be accessible physically (in safe reach for all sections of the population, including children, adolescents, older persons, persons with disabilities and other vulnerable groups) as well as financially and, as previously mentioned, on the basis of non-discrimination. Accessibility also implies the right to seek, receive and impart health-related information in an accessible format (for all, including persons with disabilities), but does not impair the right to have personal health data treated confidentially;
- The facilities, goods and services should also respect medical ethics, and be gender-sensitive and culturally appropriate. In other words, they should be medically and culturally acceptable; and
- Finally, they must be scientifically and medically appropriate and of good quality. This requires, in particular, trained health professionals, scientifically approved and unexpired drugs and hospital equipment, adequate sanitation and safe drinking water.

These conclusions and associated recommendations are aligned with the above principles which are derived from various international conventions to which the U.K. is a signatory and which are relevant for inspiring a required re-shaping of the health ecosystem for the South West region of Northern Ireland. They also support a re-engineering of the sense of what is possible and engendering creativity (the 'art of the possible') in the quest for solutions which data and other forms of evidence, as outlined in Chapters 2-6, already indicate are needed.

The Health and Social Care (HSC) System in Northern Ireland has committed itself some years ago to a data-driven culture of decision-making which is operated to extremely high standards in key areas such as performance management of existing commissioned activities. The NHS in Northern Ireland is familiar with many studies and debates over decades, which have focused on the potential and actual burden of cost to the health system and wider economies of delayed access to care and of complex health inequalities (incl. long-term conditions, and psychological and emotional health impact on lifelong physical health). The HSC system in Northern Ireland has been home to many worthy examples of pioneering practice designed to tackle these issues and, in doing so, provide international exemplars. This paper does not

[39] Ibid, p3-4.
[40] Ibid, p4.
[41] Non-discrimination is a key principle in human rights and is crucial to the enjoyment of the right to the highest attainable standard of health.

need to re-rehearse these arguments. There is a responsibility on the system to ensure that avoidable and preventable barriers to accessing care are not put in place, and to ensure that there is always a challenge function and critical analysis of what is determined to be possible at any given time, to ensure that ambitions are reaching the level which the population needs and deserves.

Primary care needs as much attention in the South West region of Northern Ireland as secondary care, and they should be addressed on an ecosystems basis with careful attention to what can be done to strengthen the various components of this continuum of care. The issue of integrated care in key clinical specialties should be revisited and supported to grow.

Strong community-based social care and carer support capacity are an investment in the reduction of unnecessary burdens (incl. cost burden) on the NHS at a time when it is dealing with the cost of delayed discharged and elective care waiting lists. Not to invest in these systems and capacities is counter-intuitive and shortsighted. There is a strong community and voluntary sector, which holds a great deal of intellectual capital as well as knowing the needs of the community and how networks can help to deliver for these needs, who are willing and ready to help. This should be respected and the sector regarded as, and resourced to deliver as, full partners to the well-being of the population. There are area-based carer shortages in the South West region of Northern Ireland which could be addressed through community and third sector action which the market and private sector have failed to address.

While wishing to avoid any comment on the issue of whether patients have been detrimentally affected by the withdrawal and shrinkage of services in Fermanagh and Omagh, the fact remains that primary, emergency healthcare and specialised secondary care access in the region is not equitable. There are serious concerns about the impact of travel times on patients who need quick interventions. The experience of the patient pathway needs to be improved. Services may be designed and resourced to be safe from the point of care onwards. However, there remains the ethical question, for consideration by the strategic leadership and corporate governance structures of healthcare organisations, of whether resource-driven decisions to reduce or relocate emergency health services, to a point of care further away from rural citizens of the South West, are either a defence or an indicator of commitment to equality of outcome for all of the population served in the region. The question remains if such decisions are acceptable for healthcare bodies to make without considering how these decisions interact with equality legislation, health impact assessments, the wider duty of care (and stated commitments) for the health of the population, and whether there are alternatives which may not have been explored. Consideration must also be given to whether an accountability focus on rurality and innovation for accessible care ecosystems would help to move the needle on the issues documented in this paper.

Mental healthcare and mental health access for children and young people requires scrutiny in the region to ensure that equitable levels of intervention and preventative supports are available and accessible to those who need them. There is a duty to the next generation as they are the most important investment we will ever make as a society.

Workforce to support the NHS is crucial and it will be necessary to look closely at innovative workforce solutions to support an optimised health ecosystem for the South West of Northern Ireland. In this, there are models within the wider NHS across the U.K. which can be explored, as can shared approaches with the HSE to developing workforce capacity and resilience for the border region and Northern Ireland.

In line with the OUNHCHR and WHO guidance on the right to health, maternity and perinatal care for women and infants in rural areas deserves further support in the Western Area, in tandem with the current process for review of the Northern Ireland Regional Maternity Strategy. While Northern Ireland as a whole is struggling with recruitment of midwives, and this will be key to addressing the challenges for maternity care at the moment, the potential for improved experience of care, which a future resumption of emergency obstetrics at SWAH would deliver for women in the region and potentially on both sides of the border, should not be lost. It is acknowledged that this that this is a medical workforce issue, and would require the necessary senior clinical cover and decision making at SWAH. The maternity suite at SWAH was designed with service users, and represents state of the art supports for the normalisation of birth and midwife-led care. Geographically-accessible emergency maternity services are essential to women everywhere; with the service operating to the best international practice and standards of maternity care (incl. avoidance of preventable increases in Caesarean section or C-section rates) and centred on women being able to access the same levels of care at the right time. Community midwifery needs to be supported to resume post-natal home visiting, especially for women in rural areas who have had C-sections with the resultant higher health risk and limited mobility in the postnatal period.

It is incumbent on a health system with an asset like SWAH to ensure the local population's emergency care needs are not neglected. In pursuit of the development of SWAH as a high standard inpatient facility for the delivery of elective care, consideration should be given to the following additional areas of potential: (i) offering collaborative capacity for Ireland's elective care demands, (ii) area-based secondary care needs in the wider cross-border central border region, and (iii) offering timely access to emergency general surgery (EGS) for patients on both sides of the border.

As the engagement workshop on 4th June concluded, a paradigm shift is needed. This reaches to governance, culture and behaviour which can enable and model the flexibility and creativity needed to best mobilise the excellent data-driven culture which is firmly established within the NHS. The means exit to understand the problem; what is now needed is the courage and the conviction to believe that it can be addressed in ways that deliver positive outcomes for those most in need – rather than taking a minimalist approach to access. Current access levels for key care such as EGS should not be seen as a standard or a limit, but rather a baseline from which improvement can be driven.

7.2 Recommendations

This paper puts forward six key recommendations that can support and inform better services and an improved rural health ecosystem for the South West region of Northern Ireland. These are set out below.

As regards dissemination of this paper, the authors recommend (i) briefing of all elected members on this document; (ii) briefing of partners via health and well-being fora for the FODC area; (iii) sharing of the final paper in full by FODC with the Minister for Health and their team; with all representatives for the South West region of Northern Ireland at Assembly and Parliamentary level (both houses), with a request that the recommendations be considered for action and direction by the Minister and his Officials; and (iv) sharing of this paper in full with the Northern Ireland regional professional representative associations and trade unions for all healthcare professions (medical including General Practice (GP), allied health professionals, nursing, health and social care workers).

7.2.1 Six Key Strategic Actions

This paper puts forward 6 key strategic actions as follows:

1. **Establishing an Interagency Task Force with Ministerial Mandate**

Recommendation: That an interagency, multi-stakeholder task force is formally mandated at Ministerial level, and established, chaired and resourced by the Northern Ireland Department of Health (DoH) for the development and improvement of healthcare ecosystems in the South West region of Northern Ireland.

Established initially for two years with review and possible extension to five years, this should have a governance structure which allows for a challenge function in the pursuit of key objectives for the region, and a high-level commitment from the Department of Health to take the position of the task force into account on key central planning issues affecting the region. It should have suitably-experienced professional managerial co-ordination with a mandate to liaise with senior leadership across all relevant institutions. The task force should include mandated representation from multiple levels of the healthcare system – from delivery bodies (Trusts) and Commissioning, local government, higher and further education, the clinical professions and trade unions, key government programming areas such as spatial planning and infrastructure, as well as representation from the community and voluntary sector (CVS) and from patients and carers based in the region. It should have a direct link with the Trusts and the IAPBs for the Western and Southern Areas of Northern Ireland and with the Health and Well-being Forum established by Fermanagh and Omagh District Council (FODC). The task force should develop a concise vision for health outcomes for the population of the South West region, including specifically those relating to the Section 75 categories (in acknowledgement of the exacerbatory factor that is the inverse care law on top of barriers because of rurality). It should include a multiannual roadmap for the monitoring of improved configuration of existing resources across the primary and secondary care spectrum and taking in community partners. The Task Force should also have input to the consideration of cross-border shared services models which can benefit the overall health system of Northern Ireland as well as improving access to care for people on the ground in the South West region.

The Task Force should have fact finding and consultative input on workforce planning and skills innovation and should have the function of elevating issues being experienced at any level of the HSC delivery system which are blocking the progression of a roadmap. It should also have a role in providing feedback to DoH in how the 'Health In All Policies' model can be more widely implemented at different levels of the public system – including the use of the Health Impact Assessment Tool to inform decision-making and resource allocation.

Specifically, the Task Force should include a focus on the following issues:

- Improving primary care in the rural South West region of Northern Ireland; including configuration and resources for community-based models of assistance and access that involve mobilising the assets and recommendations of Chapter 4, and the commitments of the Western Trust Pathfinder Initiative;
- Further exploration of how women's medicine, perinatal care, child and adolescent mental health services and services for people with disabilities and complex needs need to be made accessible for the population of the South West region;
- A mechanism for stakeholders, in particular health and social care delivery stakeholders from primary and secondary care, to explore how alignment of existing resources and programming can help to mobilise all available assets towards improved accessibility of services in Fermanagh Omagh, on the basis of both geography and patient group/service user group;
- Ensuring that population access mapping, remote and on-site access issues, and transportation/infrastructure planning and health service decentralisation are viewed with a connected approach that optimises technology while also ensuring that physical access barriers to care are addressed in the region;
- Exploration of innovative models to deliver workforce planning and skill-mix in health and care, involving higher and further education providers (including working with the GP Federation and the North West Tertiary Education Cluster[42]). This should include exploring skills pathways for health and social care workforce specifically serving the Fermanagh and Omagh District) and community and voluntary organisations in the field of health, social care and community health and well-being. Consideration should be given to joint approaches and cross-border training pathways involving the HSE workforce planning functions and education and training providers on both sides of the border; and
- Consider restoration of full emergency surgical services (both general and obstetric) at SWAH in the context of:
    a) a human rights-driven approach to geographical accessibility of acute healthcare services for rural dwellers;
    b) a cross-border patient catchment and demand/need for key elective and emergency surgical services accessible at SWAH as a component of the offering available to service users of both health systems in the border corridor; and

[42] Formal partnership of Ulster University, Atlantic Technological University, the Open University and Further Education Providers on both sides of the border and focusing on driving skills and educational responses to cross-border educational needs in the wider North West region of the island of Ireland.

c) A contemporary best practice shared services model that utilises all options available to the healthcare system in Northern Ireland (as per the quintuple aim) through taking account of the additional opportunities presented by geography, transboundary co-operation, a cross-border population in need of a response, and the resilience of the Northern Ireland system through the ability to stabilise consultant presence and senior clinical decision-making at SWAH.

2. <u>Considering SWAH as a special North South Strategic project for Shared Health Services within a wider border regional hospitals network</u>

Recommendation: That a mapping of functionality and complementarity across medical and surgical services within a wider cross-border/regional border network of acute general hospitals be undertaken

The border areas of Northern Ireland and the border counties of Ireland, particularly those bordering Fermanagh and Omagh, experience similar population health challenges to those of the South West region of Northern Ireland. They also face the challenge of ensuring that services are sustained in the region ahead of projected rises in the over 65 age group in the next 10-15 years. It is recommended that both the Northern Ireland and Ireland Departments of Health are encouraged to work in close liaison with the Task Force to firstly, jointly commission a detailed feasibility work on a border region hospitals ecosystem that operates to mutual benefit and which assumes a role for SWAH; and secondly, commission detailed feasibility work in the context of a full surgical and acute hospital services centre at SWAH, meeting a) the cross-border catchment's need for geographically-accessible elective and unscheduled care including emergency care and b) the collective need in Northern Ireland and Ireland for elective care services in the context of elective recovery of both systems post-pandemic.

This would include undertaking, first, a mapping of functionality and complementarity within a wider cross-border/border regional network of acute general hospitals including those at Fermanagh, Cavan and Sligo. It should expressly not involve any threat to the feasibility of any existing border region acute hospital in Ireland – but rather be part of an exercise to understand how the population of the border region on both sides can be best served by removing the 'border effect'. It should explore how, in geospatial terms, and in terms of the principle of proximity in healthcare delivery, existing assets and hospitals could work with each other in a complementary fashion across medical and surgical services. For example, can reciprocal service access be provided for women in the border areas of Fermanagh accessing maternity services in Cavan or Sligo, rather than travelling to Derry? The exercise would then involve, secondly, a North-South feasibility study and associated budget for the operation of SWAH as a facility serving patient catchments from both sides of the border in both elective and unscheduled care programmes, using quality assured data from both health systems and other relevant territorial data. Such a feasibility study should also explore the role of SWAH as a diagnostics provision centre for hospitals in Ireland and examine what obstacles have prevented this potentiality from being fully developed to date. The exploration of the potential significance of SWAH as an infection control/isolation hospital in the context of future pandemic preparedness on a North-South basis might also be considered, given the

design of SWAH, with wards involving individual rooms. It is also recommended that, subsequently, the running of SWAH at corporate level would involve protection of resources, collaborative transboundary inter-institutional governance at senior corporate level, and accountability for maintaining delivery of envisioned mission.

Where it is not possible for a cross-border North-South strategic shared services initiative to be explored in relation to optimising the future viability of SWAH as a facility and centre of excellence serving a cross-border population, then it is recommended as an alternative that consideration be given to exploring the feasibility of SWAH as a protected rural hospital within Northern Ireland, under devolved legislation and funded on a protected basis by the Northern Ireland Executive. This option would be entirely dependent on resourcing from within Northern Ireland and, therefore, possibly higher risk than the cross-border shared services option.

3. Northern Ireland and Ireland to explore shared services in the area of rural primary healthcare and pilot best practice models in Fermanagh and neighbouring Irish border counties of Cavan, Monaghan and Leitrim

Recommendation: That shared services in primary care are made a policy priority alongside the issue of shared secondary care services across the Fermanagh and Omagh area. The flagship model of the primary care centre at Omagh should be a focus for the Northern Ireland Department of Health in exploring options for cross-border primary care and GP shared services, including taking account of primary care hubs which already exist in border locations on either side.

Northern Ireland and Ireland have already established robust precedents for shared cross-border health services in terms of cancer and cardiac care. Post-pandemic, there is a global challenge to reinforce primary care systems and this paper has documented a number of issues which require a response that focuses on viable primary care infrastructure in rural areas. The need for continuing to support rural areas as sustainable places for people to live and access healthcare services appropriate to all stages of life is an issue experienced on both sides of the border. More remote outlying areas in Cavan, Monaghan, Leitrim and Fermanagh, and Tyrone and Donegal, would benefit from exploration of how shared primary care services in these areas could improve access for citizens on both sides of the border and also form platforms for addressing common issues such as rural healthcare workforce shortages.

4. Short Term Actions for Advocacy

In terms of short-term actions for advocacy, this recommendation includes:

- Advocacy for the continued exploration at multiple levels of public governance in Northern Ireland of the 'Health In All Policies' Approach which has already been adopted by the Northern Ireland Department of Health[43];
- Support to Western Trust for a review of evidence and the measures committed to for implementation in the Pathfinder initiative which may not have been progressed due

[43] Health in all policies | Department of Health

to the COVID-19 Pandemic. This includes creation of a delivery plan for the measures subject to update and review, as well as engagement with commissioning structures and the IAPB for the Western Area;

- Re-examination of what services are currently being provided at Omagh Primary Care Centre and what additional services could be provided there, including community-based diagnostics;
- Full establishment of Primary Care Multidisciplinary Teams in the Southern Sector of the Western Trust Area; including further exploration of how the Nine Principles of Integrated Care are being – or can be – used in relation to the development of healthcare ecosystems affecting the South West region of Northern Ireland;
- Review of evidence and full establishment of all existing commissioned care posts for the Southern Sector of the Western Trust Area and the prevention of any periodic or scheduled recruitment freezes now or in the future for any commissioned posts, whether recurrently or non-recurrently funded;
- Revisiting of level of peripatetic community healthcare services operating in the Southern Sector of the Western Trust area including restoration of full-reach post-natal home visits;
- Interim restoration of EGS at SWAH pending development of a North-South feasibility study and budget for the operation of SWAH within a cross-border spatial network of hospitals as outlined in Recommendation 2 above;
- Consideration by Western Trust and Commissioners of the findings from the engagement event held by Fermanagh and Omagh District Council in partnership with ICLRD on 4 June 2025 (see Chapter 4); and
- Ensuring the GP Federation have an opportunity to discuss innovation in skills and workforce for primary care GP services with training and education providers serving the South West region of Northern Ireland (including South West Regional College).

5. Review of the Community Planning Model and Processes for Fermanagh Omagh District Council area

Recommendation: Consider a renewed focus on capacity building for joined-up planning on health, social care and community access issues; and offer training and development to health and social care stakeholders in the theory and practice of placemaking and best practice in interagency approaches to spatial planning.

The community planning process has, to date, played a significant role in improving the connections between all tiers of Government and wider society in the identification of long-term priorities for improving the social, economic and environmental well-being of districts and the people who live there. However, risks of duplication of service are beginning to emerge through Area Integrated Partnerships Boards (AIPBs) and the recently announced Neighbourhood Health Models. Given the focus of community plans already on population health needs, there is no reason why the envisaged health and wellbeing plans being produced by the AIPBs could not be embedded within the community planning process. Indeed, given community planning's close relationship to spatial planning and the Councils' Local Development Plans, it is recommended that community plans place a stronger emphasis

on place-based initiatives that improve health and wellbeing, and support health equality between different communities.

6. Development of a Biennial International Symposium on Rural and Population Health

Recommendation: That Fermanagh and Omagh District Council would host a Biennial International Symposium on rural and population health. It is proposed that the initial biennial be held in late 2026 – to coincide with the Irish Presidency of the EU in the second half of 2026 and to avoid the elections of 2027. Work should commence on the organisation of this immediately, with the first step being to secure funding for this international event.

As the interdependencies between health, well-being and spatial planning and urban design becomes better understood, there is an internationally recognised need to hold fora which bring together key stakeholders and actors concerned with place-based population health, and who seek to understand health inequalities in rural and remote communities and develop time-critical solutions for inclusive primary and secondary care practices. It is proposed that such an event bring together leading medics, health practitioners, academic scientists, advocates and researchers to exchange and share their experiences and research results on all aspects of rural health service provision. Key themes that could be considered during such fora, from a transnational and multi-disciplinary perspective, include workforce capacity, training and development, changing population health needs, community/patient engagement, rural proofing, the role of design and the built environment in health outcomes, and digital technology and remote solutions for primary healthcare.

Appendix A: The ICLRD Research Team

Ms. Caitriona Mullan

Caitriona Mullan is a specialist in cross border policy, development cooperation and territorial governance working across the EU and EEA. Her technical background includes decades of public service in the areas of local government, regional development, EU Funds, health systems, tertiary research and education, She is a senior external expert for the European Commission and also for the Congress of Local and Regional Authorities Centre of Expertise in Multilevel Governance. She is an advisor and facilitator for the AEBR/DG REGIO B Solutions initiative across the EU and on external borders. She is a senior research associate with ICLRD and with the Centre for Cross Border Co-operation. She is also North-South advisor to the Astronomical Observatories of Ireland.

Ms. Caroline Creamer

Caroline is Director of the International Centre for Local and Regional Development (ICLRD) and a Research Fellow with the Social Sciences Institute (MUSSI) and the Innovation Value Institute (IVI) at Maynooth University. She is Facilitator of the All-Ireland Smart Cities Forum and ESPON Contact Point for Ireland. She has worked in a research and management capacity on a number of funded projects and action research programmes - at various scales - for over 25 years. A qualified town planner, Caroline's research interests include spatial planning practice and policy, leadership in placemaking and place shaping, regional and local development and regeneration, collaborative and participative decision-making and inter-territorial and cross-border development.

Ms. Lynda Collins

Lynda is an economist, specialising in local and regional development with over 25 years' experience across Northern Ireland and the Border Counties of Ireland. She has led multi-sectoral partnership projects addressing complex social, economic and environmental challenges and is skilled in integrating diverse stakeholder perspectives. Lynda's research interests include rural development, community health and resilience and cross-border cooperation. Lynda is also an experienced leadership and management consultant, advising on matters related to health economics, strategic and corporate planning, good governance and policy advocacy. Lynda's professional practice is guided by a commitment to equity, inclusivity and sustainability.

Mr. Jonathan Barber

Jon is a Deputy Chief Executive, and executive lead for strategy and transformation, at in the Norfolk & Waveney University Hospitals Group that serves a population of over 1 million people. He is the Acute Partner on the Norfolk & Waveney Integrated Care Board that

commissions services across all health care partners, with an annual budget of circa £3billion. Jon is Chair of the Gt Yarmouth & Waveney Place Board, one of 5 place boards in the Norfolk and Waveney ICS, which brings local partners from across all sectors to focus on new ways of delivering services in the locality. He is working on one of the NHS England Neighbourhood Health pilots. Jon has held a number of non-executive positions, including with central government departments, and works as a consultant with the Council of Europe. He previously held senior management roles in both local and central government and holds an MBA in public sector management.

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