



# Understanding perspectives on major system change: A comparative case study of public engagement and the implementation of urgent and emergency care system reconfiguration



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## ABSTRACT

**Objectives:** Major changes have been made to how emergency care services are configured in several regions in the Republic of Ireland. This study investigated the hypothesis that engagement activities undertaken prior to these changes influenced stakeholder perspectives on the proposed changes and impacted on the success of implementation.

**Methods:** A comparative case-study approach was used to explore the changes in three regions. These regions were chosen for the case study as the nature of the proposals to reconfigure care provision were broadly similar but implementation outcomes varied considerably. Documentary analysis of reconfiguration planning reports was used to identify planned public engagement activities. Semi-structured interviews with 74 purposively-sampled stakeholders explored their perspectives on reconfiguration, engagement activities and public responses to reconfiguration. Framework analysis was used, integrating inductive and deductive approaches.

**Results:** Approaches to public engagement and success of implementation differed considerably across the three cases. Regions that presented the public with the reconfiguration plan alone reported greater public opposition and difficulty in implementing changes. Engagement activities that included a range of stakeholders and continued throughout the reconfiguration process appeared to largely address public concerns, contributing to smoother implementation.

**Conclusions:** The presentation of reconfiguration reports alone is not enough to convince communities of the case for change. Genuine, ongoing and inclusive engagement offers the best opportunity to address community concerns about reconfiguration.

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## 1. Introduction

Healthcare systems have been described as ‘complex adaptive systems’, consisting of the combination of organisations, resources and management required to provide health services to a population [1,2]. Such systems involve numerous actors operating at various levels and are subject to continuous change and adaptation, through formal and informal processes [3]. As the health needs of populations have changed and medical technology has advanced, health systems have faced pressure to adapt [4]. In the acute hos-

pital sector, the policy response in many countries has focused on reconfiguration of services to a more centralised and specialised model, particularly for complex care conditions [5,6].

Reconfiguration may be defined as “a deliberately induced change of some significance in the distribution of medical, surgical, diagnostic and ancillary specialties that are available in each hospital or other secondary or tertiary acute care unit in a locality, region or health care administrative area” [4]. A synonymous term ‘major system change’ is also commonly used, defined as “interventions aimed at coordinated, system-wide change affecting multiple organisations and care providers” [7,8].

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### 1.1. Arguments for reconfiguration and opposing perspectives

Although reconfiguration is often presented as an ‘evidence-based’ approach to improving system efficiency and outcomes, a number of studies have characterised it as an inherently political and contentious process [5,9]. Proposals to reconfigure emergency care services have been found to be particularly controversial, often subject to strong community resistance [5]. Public opposition to the reconfiguration of emergency care has affected its implementation and revealed divergent priorities for healthcare provision across different stakeholder groups [10,11]. Research evidence on volume–outcome relationships has been employed to justify centralising care at large specialist hospitals [11]. However, this is contested and it has been argued that centralisation can actually hamper patient outcomes in certain circumstances and is detrimental to other aspects of the core mission of healthcare systems such as access and experience [4,9]. Critics have further argued that the centralisation approach is primarily motivated by a desire to reduce costs [12,13].

Jones and Exworthy explored ‘framing’ in the communication of arguments for changes to hospital services in the UK [14]. The policy of centralising hospital services was initially framed in terms of improving access and experience. However, over time there has been a shift towards portraying centralisation as a clinical necessity to address risks to patient safety which outweighs other concerns about access and experience. It is suggested that this was aimed at overcoming community opposition to changes, as was the co-opting of influential figures from the medical profession to ‘champion’ the changes.

### 1.2. Public engagement

The highly ‘pluralistic’ nature of public-sector healthcare bodies has been described in the organisational literature. Such bodies typically have multiple objectives, diffuse power structures and knowledge-based work processes, and these characteristics present a number of challenges to the implementation of strategic change [15]. Implementation depends on numerous interrelated contextual factors such as the nature of the change itself, relationships between key local actors, the presence of key change leaders and environmental pressures [16]. Denis and colleagues suggest that bringing about change in pluralistic organisations requires power, legitimacy and knowledge, as multiple interests must be satisfied. Thus, attention must be paid to the requirements of actors within and outside of the organisation in order to garner their support [15].

As a response to these pressures, formal engagement processes have been developed to involve stakeholders such as staff, patients and the public in planning around healthcare. Guidelines have also been developed to advise policy-makers and managers on how best to engage communities around reconfiguration [17]. A three-stage process has been employed in the UK, involving information-sharing, public meetings and final decision-making informed by public feedback [5,17,18]. In Ireland, a recently-produced guidance document has called for increased public participation in policy-making in order to improve public understanding of how policy is developed and enhance the ‘legitimacy’ of decision-making [19]. Within the Irish healthcare arena, there is a growing trend towards formal public and patient involvement in designing new policies and programmes [20].

Several authors have criticised current approaches to public engagement in healthcare [18,21], highlighting the lack of consistency in methods employed and poor measurement of their impact [22]. Barratt and colleagues explored public responses to emergency care reconfiguration programmes carried out in the UK [18], finding that the public felt their concerns were ignored despite the

extensive engagement process conducted. The authors challenged the apparent belief among policy-makers that local communities can be convinced of the need for change if presented with the ‘right’ evidence, and it is argued that more effort must be made to address the range of community concerns around planned changes.

It has been suggested that the purpose of public engagement has not generally been well-defined, which has contributed to the lack of evidence regarding its direct impact on the success or failure of reconfiguration [22]. Jones suggests that public engagement in its current form is not a democratic and egalitarian sharing of views in order to reach a consensus, but is instead influenced by a positivist, rational and technocratic ideology which values abstract ‘expert’ knowledge over and above the experiential ‘non-expert’ knowledge of the public and patients [23]. It is argued that clinicians have been co-opted by policymakers to reinforce the framing of centralisation as a clinical necessity. In essence then, public engagement is characterised as providing a veneer of democratic involvement in decisions that are in fact made based on the views of an elite minority.

Terms such as ‘consultation’, ‘engagement’ and ‘involvement’ have been used interchangeably in the literature, with little consistency in definitions and methods associated with each term. In order to address this issue, the International Association for Public Participation [24,25] has created a descriptive public participation spectrum (Fig. 1) which outlines different levels of public engagement in planning, and typical methods associated with each category. Under this conceptualisation, public participation ranges from merely being informed of plans, to empowerment in decision-making. We have adopted the definitions outlined in the spectrum in our descriptions of public engagement activities.

The current study explores stakeholder perspectives on the public engagement undertaken during the reconfiguration of urgent and emergency care systems in the Republic of Ireland. Specifically, this study investigates the hypothesis that engagement activities undertaken prior to urgent and emergency care service reconfiguration influence stakeholder perspectives, and impact on implementation outcomes.

## 2. Methods

### 2.1. Setting

The Health Service Executive (HSE) is the public sector body responsible for the delivery of health care in the Republic of Ireland. It is responsible for the delivery of most urgent and emergency care in Ireland through acute hospital emergency departments, acute assessment units and minor injury units. A small number of private urgent care facilities also operate in Dublin, Cork and Galway. Public ambulance services are delivered by the National Ambulance Service and Dublin Fire Brigade. Primary care is largely delivered by private general practices. Privately-run out of hours primary care is also available in most of the country. Urgent and emergency care services are not universally free at the point of contact. Patients who attend a public emergency department without referral from primary care are liable for a charge (currently €100) unless they fall beneath an income threshold or into a set of clinical categories.

In 2006 the HSE introduced a programme designed to ‘transform’ healthcare provision, with the overall aim of improving system coordination, quality and efficiency [26]. One aspect of this programme involved region-level reconfiguration of acute hospital services, including urgent and emergency care. The implementation of reconfiguration has differed across Ireland; several regions have made changes to the configuration of services while others have made few changes. The changes have largely consisted of closing or downgrading the function of smaller emergency depart-

INCREASING LEVEL OF PUBLIC IMPACT				
INFORM	CONSULT	INVOLVE	COLLABORATE	EMPOWER
<b>Public Participation Goal:</b>	<b>Public Participation Goal:</b>	<b>Public Participation Goal:</b>	<b>Public Participation Goal:</b>	<b>Public Participation Goal:</b>
To provide the public with balanced and objective information to assist them in understanding the problem, alternatives, opportunities and/or solutions.	To obtain public feedback on analysis, alternatives and/or decisions.	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered.	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution.	To place final decision-making in the hands of the public.
<b>Promise to the Public:</b>	<b>Promise to the Public:</b>	<b>Promise to the Public:</b>	<b>Promise to the Public:</b>	<b>Promise to the Public:</b>
We will keep you informed.	We will keep you informed, listen to and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision.	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision.	We will look to you for direct advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to the maximum extent possible.	We will implement what you decide.
<b>Example Techniques to Consider:</b>	<b>Example Techniques to Consider:</b>	<b>Example Techniques to Consider:</b>	<b>Example Techniques to Consider:</b>	<b>Example Techniques to Consider:</b>
<ul style="list-style-type: none"> <li>• Fact sheets</li> <li>• Web sites</li> <li>• Open houses</li> </ul>	<ul style="list-style-type: none"> <li>• Public comment</li> <li>• Focus groups</li> <li>• Surveys</li> <li>• Public meetings</li> </ul>	<ul style="list-style-type: none"> <li>• Workshops</li> <li>• Deliberate polling</li> </ul>	<ul style="list-style-type: none"> <li>• Citizen Advisory Committees</li> <li>• Consensus-building</li> <li>• Participatory decision-making</li> </ul>	<ul style="list-style-type: none"> <li>• Citizen juries</li> <li>• Ballots</li> <li>• Delegated decisions</li> </ul>

Fig. 1. Spectrum of approaches to public participation, typical methods and their impact [24].

ments in rural parts of the country and centralising complex care services to larger tertiary hospitals. Further information on urgent and emergency care provision in Ireland is contained in a supplementary file. A description of care provision in each of the case-study regions is provided in Table 1.

## 2.2. Design

This study employed a comparative case study design. Comparative case studies are particularly suitable for studies seeking to understand and explain the influence of context on the successful implementation of an intervention [27,28]. The current analysis focuses on three regions: North East, Mid-West and South, where large-scale reconfiguration was planned and implemented by the HSE. Region-specific reconfiguration planning documents were commissioned for each of these regions [29–32]. These regions

were chosen for the case study as the nature of the proposals to reconfigure care provision were broadly similar but implementation outcomes varied considerably. The characteristics of these regions and changes to the configuration of services are described in Table 1. In the North East and Mid-West, reconfiguration of urgent and emergency care services commenced in 2009, with the South commencing in 2012.

### 2.2.1. Documentary analysis

Documentary analysis of reconfiguration planning documents for the three regions was conducted in order to examine the planned public engagement processes. Published regional planning documents were identified by a member of the study team working within the health service. This team member was not involved in collection or analysis of interview data.

**Table 1**  
Regional characteristics and summary of reconfiguration undertaken.

Region (Constituent counties)	Population	Area (km <sup>2</sup> )	Urban population <sup>a</sup>	Pre-Reconfiguration Care Provision	Recommended Changes	Implementation
North East (Meath, Louth, Cavan, Monaghan)	440,211	6395	0.51	Five acute hospitals accepting undifferentiated emergency patients. No identified regional hub hospital for specialist care.	Construction of new regional hospital to become hub for emergency care. Existing emergency departments to be reconfigured to minor injury units [29].	Partial Implementation. New regional hospital not constructed. Two emergency departments reconfigured to minor injury units. Some centralisation of trauma, coronary and stroke care.
Mid-West (Clare, Limerick, North Tipperary)	378,210	8252	0.47	Four acute hospitals accepting undifferentiated emergency patients. Regional hub hospital in Limerick city providing specialist care.	Transfer of all emergency care to hub in Limerick. Three existing emergency departments to be reconfigured to minor injury units [30].	Full but delayed implementation
South (Cork, Kerry)	663,176	12,161	0.56	Six acute hospitals accepting undifferentiated emergency patients. Regional hub hospital in Cork city providing specialist care.	Most emergency care to be transferred to hub in Cork, emergency department to be retained in Kerry, two existing emergency departments to become minor injury units, one ED to close [31,32].	Full implementation

<sup>a</sup> Proportion of population living in urban area [34].

### 2.2.2. Interviews

Semi-structured interviews were conducted with a range of stakeholders to explore their perspectives on the public engagements that took place and community responses to planned changes. Participants were sampled using purposive and snowball sampling methods [33]. An initial ‘core set’ of potential participants who were centrally involved in the reconfiguration process were identified by the research team. These participants were then asked to suggest other individuals they believed could assist with the study.

Stakeholders were categorised according to their role in relation to the health service. The term ‘internal stakeholders’ refers to a heterogeneous group. It includes those directly working within the regional HSE management structures and involved in reconfiguration planning and implementation. It also includes ‘internal outsiders’ for example HSE clinicians whose views and interests will not necessarily coincide with HSE management. The term ‘external stakeholders’ refers to those working outside the HSE and also covers a heterogeneous group, including general practitioners, politicians, hospital campaigners, journalists and others.

The interview topic guide explored stakeholder views on public engagement and perspectives on the impact of reconfiguration. Interviews were recorded and transcribed by the study team.

### 2.2.3. Analysis

Framework analysis was used [35], employing an adapted version of a framework developed by Spurgeon and colleagues [9]. The coding framework is available as a supplementary file. Initially, documentary and interview data were analysed separately by independent researchers using NVivo software for data management. There were three major stages in the analysis process: (1) Familiarisation with the data and identification of key issues; (2) Charting the relationship between issues/sub-issues and individual interview charts; and (3) Summarising the content from individual interviews to map to the relevant issue/sub-issue. To ensure consistency in application of the coding framework, researchers met regularly to compare coding. Where inconsistencies occurred, researchers consulted with a senior colleague in order to reach con-

**Table 2**  
Number of stakeholders interviewed, by region and position.

Position	Region		
	North East	Mid-West	South
Internal	8	13	21
Clinician	3	5	7
Management	3	5	10
Nursing	2	4	4
External	9	8	15
Ambulance personnel	0	2	3
General practitioner	3	2	4
Hospital campaigner	2	1	4
Media representative	1	1	2
Politician	3	2	2
Total	17	21	36

sensus and modifications to the coding framework were made if necessary.

In line with the approach recommended by Yin, data for each case were initially analysed separately [28]. Individual case summaries were developed from documentary evidence and initial readings of interviews, describing the planned engagement activities and stakeholder responses to reconfiguration. This was followed by a cross-case analysis using Yin’s ‘pattern matching’ approach [28].

## 3. Results

In total 74 stakeholders were recruited for interview across the regions, and four regional reconfiguration documents were analysed. A breakdown of stakeholders by region and position is provided in Table 2.

### 3.1. North East

The North East was the first region for which a reconfiguration plan was produced [29]. The reconfiguration planning document emphasised several “disturbing aspects” of existing urgent and

emergency care provision. Guidelines from Canada, Australia, New Zealand and the UK were cited in recommending that a new-build regional hospital providing emergency care would be most suitable to provide safe, effective care for the population.

In relation to engagement, the report described visits to hospital sites in the North East to meet with staff as part of the investigation into service provision in the region. However, there was no reference to planned engagement with the local community in the report, with just a single mention of potential community interest in the report's content:

“The Health Service Executive has indicated to us that we should anticipate subsequent wide circulation of this report to the general public, patients, clinicians, staff, trade unions, local hospital groups, professional, academic and regulatory bodies, local and national politicians and governmental organisations, and private sector organisations with interests in healthcare reflecting widespread interest in improving healthcare in the North East” [29]

During our interviews, regional stakeholders referred to some public meetings that had taken place at a local level around changes in provision at specific facilities. The purpose of these meetings was apparently to share information with various groups.

“we did a whole communication plan. We went out to the public. We had public consultation with politicians every month, with any group that wanted to meet us, the Women's Institute, you name it, clerical groups, the bishop. We met everybody when [NE hospital] was going off call.” Internal management stakeholder.

This point was contradicted somewhat by two external stakeholders. It was noted by a member of a protest group that health service management had refused to meet with the group as they had not been elected and thus had no “mandate” to represent the people. A general practitioner also noted a lack of clarity regarding planned changes, stating that “we just heard rumours”.

A management stakeholder involved in communication at region-level noted a reluctance amongst planners to engage with the public on service changes:

“I suppose we seem to shy away from that a little bit because it's the people who oppose these are generally the ones that are going to turn up”. Internal HSE management stakeholder.

Stakeholders gave a mixed response to the changes, with some in favour and others opposed to the changes. In general, internal stakeholders appeared to endorse the reconfiguration plan, though some expressed reservations around how it was implemented and explained to the public.

Hospital campaigners and general practitioners generally rejected the case for change, questioning the evidence provided and motivations behind the plan.

“They can't show us the research for, the international best practice for removing all emergency services from a local hospital” External stakeholder, hospital campaigner.

Protest groups were organised in three towns where emergency facilities were to be replaced by minor injury units. Participants described how large-scale protest marches and media campaigns were separately launched by these groups, which received widespread coverage in national and local media [36–38]. The groups were organised around their ‘local’ hospital and did not coalesce or coordinate their activities despite expressing very similar views. Stakeholders representing these groups rejected the argument that centralising care at a single site would improve quality and safety, instead emphasising the safety of care provision in their

local hospital, as well as its importance to their local community's sense of worth and security.

### 3.2. Mid-West

The Mid-West was the second region to implement reconfiguration of acute hospital services. The reconfiguration planning document for the region was produced by external management consultants [30], and explicitly acknowledged the influence of the approach taken to reconfiguring services in the North East. The report concluded that acute resources were “diluted” across hospital sites, with no site having sufficient patient volumes or resources to provide safe and sustainable care. It was suggested that emergency care be centralised to a single hospital in Limerick, the region's major population centre.

The Mid-West report included a chapter on implementing the plan, which made specific reference to public engagement. It was recommended that a “professional media awareness and information programme” be developed in order to inform the public of the planned changes and the reasoning behind them [30].

It was evident from the stakeholder interviews that some engagement had taken place at regional and local levels, though it was apparently intended to inform relevant groups of the planned changes rather than seek their opinions. An internal stakeholder involved in implementing the regional plan noted that meetings with GPs in the region were particularly ill-tempered, describing them as “very aggressive”. GP stakeholders expressed concern at the loss of access to services at several hospitals and indicated dissatisfaction with their interactions with reconfiguration planners.

“There wasn't consultation, it was decided that ‘we're doing this and that's it’ and the level of consultation, that's a very important thing. Consultation means ‘evacuate your bases in Crimea, we're moving in’, that's consultation from the HSE” External stakeholder, GP.

A management stakeholder based at a hospital due to lose its accident and emergency department noted that they had avoided engaging with the public due to the expected negative response.

“we probably didn't include our public in consultation around what we were doing because we wouldn't have got agreement anyway” internal stakeholder, management

As in the North East, public reaction to the planned changes was generally quite negative. Protest campaigns were organised around two hospitals in the towns of Ennis and Nenagh, both of which were due to have their emergency departments reconfigured to minor injury units [39]. Stakeholders representing these groups opposed the idea of centralising emergency services to Limerick on the grounds that patients would have to travel longer distances, and perceived lack of capacity at Limerick to deal with the influx of new patients. It was suggested that the changes were instead motivated by ill-conceived cost-saving and centralisation agendas.

“The admin people inherently believe that bigger is cheaper. They think you get what's called economies of scale but it's not true. You might if you're doing endoscopies get economies . . . but not if you get a cardiac arrest.” Internal stakeholder, hospital clinician.”

Implementing reconfiguration proved a difficult and lengthy process, with long delays in transferring emergency services from Ennis and Nenagh.

“That got pushed back, that didn’t actually happen until 2012, it was meant to happen in 2010.” Internal stakeholder, hospital clinician.

Several stakeholders attributed these delays to political interference and opposition, including amongst hospital staff.

“There was fierce protests against it so therefore it was delayed.” External stakeholder, hospital campaigner.

“To some degree we got resistance from staff as well.” Internal stakeholder, management.

### 3.3. South

External management consultants were commissioned to review acute services in the region [31], producing recommendations that were consistent with those in the Mid-West and North East. It was recommended that emergency care be centralised to a single hospital site in Cork city. Subsequently, health service management for the South produced a ‘Reconfiguration Roadmap’ document for the region, described as “the HSE’s response” to the original review [32]. The recommendations of the ‘Roadmap’ document differ somewhat to those of the management consultants, calling for the retention of an emergency department at Kerry General Hospital and defining a clear role for all acute hospitals in the region.

The ‘Roadmap’ document provided a significant level of detail on engagement, including a section outlining the communication strategy for addressing the public. Public events were to be held to explain and showcase service changes, with advanced paramedics meeting community groups in areas where emergency departments were to close. The report also named stakeholders from a broad range of backgrounds including public representatives, business people and general practitioners who were formally consulted with during the reconfiguration planning process.

It was evident from the stakeholder interviews that extensive public engagement had taken place around reconfiguration. An internal stakeholder involved in the reconfiguration programme suggested that the public meetings, press releases and media campaigns helped to inform the public and assuage fears and misunderstandings around the changes.

“10,000 people won’t march on the streets unless they believe there’s something fundamentally wrong, and if you are doing the right thing and they are still marching there only two things, only two things that would explain that. One is you’re doing the wrong thing, or you’re not spending enough time explaining to them. If you spend enough time explaining to them and you are doing the right thing they won’t march. You’ve got to give time to those issues” Internal clinical stakeholder

Several stakeholders expressed doubts about the plan, with stakeholders representing community protest groups highlighting a loss of access to local services, lengthened travel distances and ambulance response times. It was evident that there was extensive formal and informal interaction between community groups and the reconfiguration implementation team, even after implementation had taken place.

“We’re meeting with [HSE representative] on a very regular basis now and we’re bringing up questions for him” External stakeholders, hospital campaigner

Despite this, one stakeholder felt that the public did not fully appreciate the implications of the planned changes.

“local people had little influence and many still do not fully understand the changes” External stakeholder, hospital campaigner.

As in the other regions, some stakeholders felt that the engagement was merely a box-ticking exercise, with little chance of making meaningful changes to the plan.

“I always got the impression that it was a fait accompli anyway, that it was never [going to change the plan]” External stakeholder, media.

Nevertheless, stakeholders in the South generally appeared to be comparatively accepting of the reconfiguration, and public opposition was less vociferous than in other regions.

### 3.4. Cross-case analysis

Implementation of planned reconfiguration differed considerably across regions, both in the fidelity to the original plan and the methods of public engagement employed. Public opposition was notable in each case but tended to be localised in character. Findings are summarised in Table 3. It was apparent from the documentary analysis that reconfiguration of services was justified on the basis of quality and safety concerns, along with a drive towards creating what was described as a more efficient and effective model of care [29–32].

#### 3.4.1. Nature of public engagement carried out

With the exception of the South region, planning documents provided little detail on public engagement. The available evidence suggests an ad-hoc approach to public engagement was taken, with little consistency across regions. However, there was some evidence that regions learned from the experience of those who had begun the reconfiguration process before them. For example, while engagement in the North East was largely localised, it was apparent that in the Mid-West a mix of region-level and local engagements had taken place. In the South, engagement activities were more extensive again, with representatives from various backgrounds and areas invited to join planning and implementation groups. In general, engagement was focused on the implementation of plans, however in the South there was evidence that stakeholders outside of the health service had a role in planning the changes prior to their implementation. The purpose of conducting public engagement was not clearly articulated in either documentary or interview sources.

#### 3.4.2. Stakeholder positions and perspectives

Stakeholder perspectives on the case for reconfiguration were largely related to their position in the health service. Internal stakeholders typically endorsed the promised efficiency and safety gains, though there were some exceptions in this cohort. External stakeholders expressed a range of perspectives. GP stakeholders ranged from giving guarded support for planned changes to outright rejection and campaigning against them.

The position of politicians appeared to heavily depend on whether their party was in power or not. Stakeholders affiliated with government parties tended to support reconfiguration, while those affiliated with opposition parties generally rejected reconfiguration and were in many cases involved in campaigning against it.

For some stakeholders the engagement process appeared to harden positions they had already adopted. For example, GP stakeholders in the Mid-West reported that they grew increasingly convinced that reconfiguration was being pushed through to save money, based on the perceived one-sided engagements they had with regional health service management. It was also notable

**Table 3**  
Summary of reconfiguration planning and public engagement undertaken in each region.

	North East	Mid-West	South
Reconfiguration planning	External management consultants met with national-level senior management and clinicians before producing report. No evidence of public involvement.	External management consultants overseen by project steering group, composed of regional and national level clinicians and managers. No evidence of public involvement	Regional group set up to respond to management consultant report. Representatives from across health service, as well as business, public and patient representatives involved.
Leadership	Plan apparently directed from central HSE in Dublin, no local clinical leadership.	Implementation team led by local clinician included academic representatives, clinicians, nurses and management representatives.	Implementation team led by local clinician. Report outlines defined roles and time commitments for named individuals.
Planned public engagement	Report acknowledges expected public interest in plans but no engagement plan is outlined.	“Media awareness and information programme” called for to inform staff and public of benefits of planned changes.	Public events planned to showcase enhanced ambulance provision. Detailed public engagement plan included in planning document.
Engagement methods	Staff briefings, newsletters, media campaigns and internet announcements used. Local-level engagement around changes at specific hospitals.	Region-wide public meetings held with GPs. Local-level engagement around changes at specific hospitals. Limited formal public engagement beyond media awareness campaigns.	Public presentations, newsletters, road-shows and web tools used to engage with public and other stakeholders at regional and local levels.
Response to changes	Protest groups organised around hospitals due to ‘lose’ ED. Mixed buy-in to reconfiguration among clinicians and GPs, and some were active in protest groups. Some high-profile politicians involved in opposing changes in the region.	Protest groups organised around hospitals due to ‘lose’ ED. GPs generally opposed plan, some hospital consultants publicly withdrew support for reconfiguration. Some clinicians were active in protest groups, as were a number of high-profile politicians.	Protest groups organised around hospitals due to ‘lose’ ED. Several GPs and politicians offered guarded support for reconfiguration and were not involved in protests.

that public opposition to changes did not appear to change the perspectives of those already in favour of reconfiguration. Several internal stakeholders involved in planning and implementing reconfiguration attributed opposition to public misunderstanding, or unwillingness to understand the arguments advocating the changes in service provision.

#### 3.4.3. Engagement, opposition and implementation

Organised opposition to reconfiguration was evident in each region but engagement activities appeared to have some influence on the magnitude of opposition. In the South for example, the ongoing nature of engagement between regional management and stakeholders appeared to mollify dissent to a greater degree than was observed in other regions. This appeared to facilitate the implementation process, as reconfiguration in other regions was delayed by vociferous community opposition.

Campaign groups opposed to reconfiguration typically argued that reconfiguration would result in increased risks for populations due to longer distances of travel to receive emergency care, particularly for rural populations. It was also generally suggested by representatives of these groups that the government and Health Service Executive valued saving money over the health and safety of the population. Despite common concerns, campaign groups tended to remain localised, and efforts to develop a national protest movement did not come to fruition. The politicised nature of protest campaign groups may have hampered their cooperation, and several stakeholders noted rivalries between groups with different party affiliations.

## 4. Discussion

This study investigated the hypothesis that public engagement activities influence perspectives on reconfiguration and implementation outcomes. The case studies we present offer support for the assertion that public engagement can influence perspectives and responses to reconfiguration. Public engagement led to small changes to the implementation of reconfiguration plans in the

South region but there was little evidence of impact in the other two regions studied.

It is apparent that public participation in decision-making around reconfiguration was generally quite limited. However, the South region engaged in a more inclusive engagement process than other regions, with a broad range of stakeholders apparently involved in designing the final reconfiguration plan. In addition, there was an open channel of communication between community groups opposed to the changes and those managing the change process throughout its duration. While protests did take place in the South, there did not appear to be the same degree of animosity towards reconfiguration as encountered in the other two regions, and several stakeholders attributed this to the extensive and interactive engagement undertaken. By contrast, in the North East and Mid-West, where engagement was typically characterised as little more than information-sharing, opposition among the public and other external stakeholders was a notable feature. Despite the shared concerns of communities across the country, organised opposition to reconfiguration remained localised, thwarting several attempts to form a national coalition. It was apparent that groups affiliated with rival political parties (or groups that were expressly apolitical) tended to view each other with suspicion.

Previous studies on community resistance to reconfiguration have emphasised the importance of hospitals to local identity and the sense of ownership that communities have over these facilities. The local political context, the actors involved and the tactics employed have also been identified as having an influence on community resistance [40]. Researchers have drawn on theoretical frameworks from sociology and political science to explain the gap between expert and public perspectives [41,42]. This disparity has been attributed to fundamental differences in how the public and ‘experts’ process and perceive information about risks, described as the ‘expert-lay divide’ [41]. Recent research has demonstrated that merely presenting communities with evidence to justify planned changes is not enough to persuade them to support reconfiguration [4,18] and may in fact contribute to public opposition by reinforcing the notion that ‘expert’ opinion is more valuable than the views of the public [18]. Arnstein has argued that information-sharing

approaches may be viewed as tokenistic or manipulative by the public, serving only to demonstrate the power imbalance between decision-makers and citizens [43]

While it is unlikely that a 'perfect' engagement strategy exists, Dalton and colleagues identified several factors associated with positive public engagement [22]. The best outcomes were found in cases where the engagement process started at the early stages of planning, the public were offered opportunities for genuine interaction, the process was led by clinicians involved in delivering the service in question, and public representatives were engaged with. The approach taken in the South generally aligned with these recommendations, and it was clear that opposition to reconfiguration was low in comparison to the other regions. However, care must be taken to avoid conflating negligible protest with support for changes, as protests may be influenced by a variety of factors beyond engagement activities including the nature of the planned changes and local context [21]. There is also a potential danger of developing an engagement process that is designed to overcome opposition rather than to actually integrate the public into the decision-making process.

In Ireland, guidelines for public consultation on decision-making have portrayed public involvement as complementing the democratic process, allowing the public to understand the process and adding legitimacy to decisions [19,44]. Reference has previously been made to involving the public as healthcare 'service users' or 'consumers' whose input is required to improve their experience with the system [45,46]. It is thus apparent that the approach in Ireland reflects international moves towards greater public and patient involvement in decision-making around healthcare. Gibson and colleagues offered a critique of approaches to this involvement in the United Kingdom, suggesting that the government and other state apparatus retain a deep mistrust of the public which undermines their power to influence decision-making in a meaningful way [47].

In a demonstration of the ongoing and international nature of problems with public engagement, a recent King's Fund review highlighted a lack of public and patient involvement in developing NHS sustainability and transformation plans [48]. This is despite the establishment of public engagement guidelines in the UK and the potentially considerable changes in healthcare configuration that these plans will bring about. It is evident that there is a considerable gulf between the official rhetoric around public and patient involvement in decision-making and the reality on the ground. There is a need to further explore how, and to what extent, the public wish to be involved in decision-making in order to move beyond current approaches which largely appear to be conducted on terms developed to meet the requirements of policymakers. Through the development of a shared understanding of what public and patient involvement actually means, it should be possible to narrow the 'lay-expert divide' in decision-making.

The study was limited by its retrospective nature and variation in the number of stakeholders interviewed in each region, with more in the South than other regions. This may be partially attributed to the fact that reconfiguration was implemented later in this region and a larger sample frame was available and willing to participate. Nevertheless, the diverse range of stakeholders interviewed in each region, as well as the availability of planning documents helped create a rich picture of the engagement activities that took place, and the various narratives that developed around reconfiguration. The categorisation of stakeholders as 'internal' and 'external' presented some issues as neither set was monolithic in endorsing or opposing reconfiguration. This was evidenced by the fact that a number of internal stakeholders including clinicians and nurses did not agree with the case for reconfiguration, while management stakeholders unanimously endorsed the case for change. It is also important to note that the three case-study regions actu-

ally implemented reconfiguration to some degree. The majority of regions in Ireland have seen little or no change of the type implemented in the three study regions, despite sharing many of the same characteristics and issues. Finally, other issues beyond the scope of the current study may have had an impact on implementation, for example the funding available to implement changes.

## 5. Conclusion

This study supports the assertion that the presentation of 'expert' evidence alone is not enough to convince communities of the benefits of reconfiguration, finding instead that the public are not passive consumers of what is 'right' but instead actively question and oppose plans to change healthcare services in their area. The need to develop effective public engagement strategies is particularly pressing in the 'post-truth' world, where authority and expertise are coming under increasing public scrutiny [49]. Our findings accord with previous research in suggesting that engagement which is led by local clinicians, includes a range of stakeholders from an early stage, and offers genuine and ongoing public interaction, is most likely to be effective.

## Conflict of interest statement

The authors of this study declare that they have no competing interests.

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## Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <http://dx.doi.org/10.1016/j.healthpol.2017.05.009>.

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