Se Ur Beatha

Developing a Plan for Improving Health and Health Services for the people of the Western Isles

2009 to 2014

NHS Western Isles will work with partners to improve the communities’ health and wellbeing, to tackle inequalities, and to deliver high quality clinical services and pro-active health care and advice.¹

¹ Mission Statement – Corporate Plan 2008-2009
CONTENTS

CONTENTS ............................................................................................................................................. 2
TABLE .................................................................................................................................................. 3
LIST OF FIGURES ............................................................................................................................... 3
BACKGROUND ...................................................................................................................................... 4
INTRODUCTION ................................................................................................................................... 5
STRATEGIC ASSUMPTIONS/THEMES ............................................................................................. 6
CONTEXT FOR CHANGE ................................................................................................................... 7
Policy.................................................................................................................................................. 7
Health status of the Western Isles population.................................................................................... 10
Remoteness and rurality..................................................................................................................... 16
Socio-economic challenges ............................................................................................................. 17
Work force challenges...................................................................................................................... 17
CONTENT OF CHANGE .................................................................................................................. 19
Propositions......................................................................................................................................... 19
  Specialist Services ......................................................................................................................... 20
  Options for Primary and Community-Based Care ........................................................................ 21
    Extended Community Care Teams ............................................................................................. 21
    Community Resource Hubs ....................................................................................................... 22
    The Uists and Benbecula ............................................................................................................ 22
    Barra ........................................................................................................................................... 23
  Options for Secondary Care ........................................................................................................ 23
    Medicine....................................................................................................................................... 24
    Surgery ......................................................................................................................................... 26
    Child Health Services ................................................................................................................ 27
    Maternity Services ...................................................................................................................... 29
    Mental Health Services .............................................................................................................. 31
What This Means for Patients ......................................................................................................... 32
  Potential changes that patients will see: ....................................................................................... 32
Early Deliverables ............................................................................................................................. 33
Resource Implications ...................................................................................................................... 34
PROCESS FOR CHANGE ................................................................................................................ 35
  Project and Change Management ............................................................................................... 35
  Criteria for Decision Making ....................................................................................................... 35
  Comparison of Options ................................................................................................................ 36
  Current Evidence Base .................................................................................................................. 36
  Impacts on population’s health of demographic challenges ...................................................... 37
Long Term Conditions Population Prevalence .............................................................................. 37
SUMMARY OF EVIDENCE .............................................................................................................. 40
  Primary and community care services ........................................................................................ 40
  Hospital Services .......................................................................................................................... 40
NEXT STEPS ....................................................................................................................................... 41
TABLE
Table 1: NHS Western Isles’ values

LIST OF FIGURES
Figure 1: Percentage change in population, NHS Board areas (1997-2007)
Figure 2: Birth, deaths and migration
Figure 3: 2006 Proportion of pensionable age, working age and children for administrative areas
Figure 4: 2031 Proportion of pensionable age, working age and children for administrative areas
Figure 5: GRO Population pyramids
Figure 6: Percentage population change in sustainable community areas
Figure 7: Maps showing current locality areas and sustainable communities
Figure 8: 2007/08 Long term conditions prevalence rates
Figure 9: 2007/08 Total persons on GP disease registers for all long term conditions
BACKGROUND

1. The Cabinet Secretary’s Annual Review of NHS Western Isles on 10 November 2008 directed the Board to have a firmly shaped clinical strategy underpinned by sound financial, estates, IT and workforce plans.

2. The development of the Health Board’s first whole-system clinical strategy gives the opportunity for a fresh approach to delivering healthcare for the people of the Western Isles. There is both real challenge and tremendous opportunity for the Board to provide direction and leadership to its staff to continue to develop and improve relationships and partnership working, refresh the culture and pull together to improve the health of the people it serves.

3. “Se Ur Beatha – Health in the Hebrides” was the name originally given to one of the most important documents that NHS Western Isles has produced. Although never formally approved by the Health Board, it was published in 2007, following a planning process led by the Board’s Director of Public Health and outlined a number of options in relation to a strategic direction for health services over the coming months and years. Se Ur Beatha is the name now given to the clinical strategy rather than any one document.

4. Since February 2008, the current project has drawn heavily on that original planning work and the opportunity has also been taken to review and refresh a number of reports from previous clinically led service redesign groups. This has contributed to the development of this framework to deliver one of NHS WI’s Corporate Objectives for 2008/2009 “To develop and deliver a Clinical Strategy for NHS Western Isles (in line with the “Next Steps” document, processes and timescales) which will describe the future pattern of health services available to the Western Isles population”.

5. Previous service redesign work will contribute to the process of service improvement through the work of the Service Improvement Programmes for mental health, 18 week referral to treatment waiting time target and long term conditions, all of which were formally launched in the Western Isles on 17 December 2008.

6. Widespread involvement of people who may be affected by service changes is essential in shaping the way ahead. A record of discussions, comments and views noted during staff and public meetings between February and October 2008 has been captured and these have been given careful consideration in shaping the proposals and context for change.

7. The report which follows documents the context for change and presents propositions and options for the future structure and delivery of services. The structure of the report adopts, in part, the three dimensions of strategic change:

   - CONTEXT (internal and external) - the why;
   - CONTENT – the what, and
   - PROCESS – the how.

---

2 Pettigrew and Whipp, Three dimensions of Strategic Change
INTRODUCTION

8. A critical consideration of the work to develop this plan is the requirement for strengthening primary and community service resources that promote and improve health and provide appropriate access to and provision of services for people living at home. This will, in time, strengthen the resilience of local communities and reduce the need for people to be admitted to hospitals.

9. Consideration is also given to the services which will be delivered from Western Isles Hospital, which has been designated by the Cabinet Secretary as one of six Rural General Hospitals in Scotland. Each of these hospitals will provide core medicine, surgical and anaesthetic services. However, because of the historical and geographical differences between each of these hospitals, the configuration of other services may differ.

10. Providing services in a remote area presents particular challenges. There are balances that need to be achieved; providing cover for the less predictable, emergency and unscheduled care services versus the more predictable and planned work all of which should reflect population needs; identifying which services can be provided locally and safely and those which can only be provided at a mainland unit; identifying which specialist services are provided locally and whether they are provided by visiting or resident clinicians.
STRATEGIC ASSUMPTIONS/THEMES

11. A number of key strategic assumptions underpin this framework for the finalisation of a clinical strategy. These will help in formulating options as well as making decisions that will avoid planning blight and prevent potential gaps in current service occurring. They include:-

   a) This work is wider than purely a clinical services review. The planning to implement the changes required to deliver the final strategy will require separate and significant programme management and continued engagement of staff, patients and other partners.

   b) Confirmation of the designated status of the Western Isles Hospital as a Rural General Hospital as defined in the Remote and Rural Report.

   c) Review of existing patient pathways to ensure changes are subject to systematic clinical governance arrangements i.e. clinical effectiveness, audit and evaluation.

   d) Emphasis on professional intervention to help deliver anticipatory care, population health promotion and wellbeing to maintain good health and to continue to reduce ill health

   e) The essential hospital services that must be provided here fall into the broad categories of acute care, diagnostics, elective care and rehabilitation.

   f) Services will be delivered wherever possible by substantive, rather than temporary staff.

   g) Modernisation of health care will be based on the principle of mutuality, supported by evidence, ensuring patient safety and improving patient experience;

   h) Targeted investment to deliver strategic changes through innovative education, training and learning opportunities for staff so that they can provide improved patient pathways and recognised service standards;

   i) An organisation and team development approach is planned and delivered to achieve an environment in which people are required to share and solve problems as part of a team;

   j) Management skills and capacity are explicitly developed to deliver integrated financial and service plans and performance management arrangements are geared towards the long term strategy and the delivery of national and local performance targets.

   k) Health services will be efficient, affordable and able to be sustained through the Board’s Financial Plans.

   l) Selection of preferred partners for obligate networks should be based on service and patient need and on the ability to prevent unnecessary travel to the mainland or for additional journey/referral from secondary to tertiary facilities

   m) Rationalisation of general practice premises as part of options for community services and the development of extended community care teams in a shared hub.
CONTEXT FOR CHANGE

Policy

12. The Scottish Government Better Health Better Care Action Plan was launched by the Cabinet Secretary for Health and Wellbeing on 12 December 2007. Better Health Better Care builds upon previous NHS in Scotland Health Policy and seeks to accelerate improvements in health and health services in Scotland.

13. The document highlights the importance and aspiration of:
   a) communication, participation and partnership;
   b) being valued
   c) having clarity about priorities and providing a stable environment
   d) shifting resources for care into communities
   e) raising quality
   f) reducing inequality
   g) the concept of a mutual NHS

14. NHS Western Isles has excellent examples of good practice and innovative working that align with the direction set by Better Health, Better Care. Moreover, in some areas NHS WI is acknowledged as having been at the leading edge of service development: for example in the area of emergency nurse practitioners and the role of its A&E department team, blurring the distinction between primary and secondary care services focusing on the appropriate response to an emergency situation. NHS WI is in a strong position to deliver the aspirations set out in Better Health, Better Care Action Plan.

15. The continued efforts of staff to provide quality healthcare services must be recognised and acknowledged. It is this legacy of systems, goodwill and continued commitment of dedicated staff that provide a solid foundation to develop a plan and ensure its delivery and sustainability.

16. The clinical strategy must be based on NHS Western Isles' values (Table 1 below) and set out a clear direction for planning and delivering healthcare which improves people’s health and wellbeing. In setting the direction for improvements in the health and health services for the people of the Western Isles, this strategy must generate affordable plans for services which are accessible, safe and sustainable. Additionally, services should consistently reflect the same standards of good practice available to people living elsewhere in Scotland.

3 Better Health, Better Care – SGHD 2007
Table 1: NHS Western Isles’ values

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accountability</strong></td>
<td>We will be transparent, honest and open in our decision making processes</td>
</tr>
<tr>
<td><strong>Diligence</strong></td>
<td>We will discharge our statutory duties ensuring the highest levels of clinical, corporate, financial and staff governance</td>
</tr>
<tr>
<td><strong>Dignity</strong></td>
<td>We will respect the individuality of patients, their needs, rights, beliefs and choices</td>
</tr>
<tr>
<td><strong>Justice</strong></td>
<td>We will make judgments that are based on merit and free from discrimination</td>
</tr>
<tr>
<td><strong>Excellence</strong></td>
<td>We will ensure that what we decide is based on evidence of the best quality</td>
</tr>
<tr>
<td><strong>Realism</strong></td>
<td>We will be honest about what is and is not possible to be achieved in any decision</td>
</tr>
<tr>
<td><strong>Engagement</strong></td>
<td>We will involve the public, staff and partners fully in our decision making processes</td>
</tr>
<tr>
<td><strong>Diversity</strong></td>
<td>We will recognise the particular needs of individuals and communities</td>
</tr>
<tr>
<td><strong>Contribution</strong></td>
<td>We will ensure that we make our contribution to the sustainability of the Western Isles, as an employer and service provider</td>
</tr>
</tbody>
</table>

Source: 2008/2009 Corporate Plan

17. It should be openly acknowledged that, in common with other Health Boards in Scotland NHS Western Isles is facing a financially challenging situation. However, population size is a key determinant of health board funding levels and with NHS Western Isles having one of the smallest populations of any health boards and one that has declined to the greatest extent (see figure 1) the challenge to NHS WI should not be underestimated. In terms of affordability and value for money, it is currently unable to sustain the present model of care and range of services within its budget. Recurring financial pressures highlight the need for rigour in its resource management and performance management controls.

18. The improvements required over the next 3-5 years will mean changes in the way some services are organised and accessed. In deciding on which changes should be made to deliver healthcare to the most modern standards, a number of factors (or decision criteria) will be taken into account, namely:

- Changing demography – a population which is ageing, and at a faster rate than elsewhere in Scotland with a reduction in working age population
- Advances in medical science, IT and telemedicine – huge potential to embrace new technologies to improve patient care
- Shifting the emphasis to care at home and in community settings – evidence of levels of hospital admissions considerably lower elsewhere and of services increasingly available within communities elsewhere
- Affordability, value for money – the board is currently overspending and benchmarking indicates opportunities to improve efficiency and value for money.
• Sustainability – specialist and certain other services are currently dependant on high levels of temporary locum cover which is expensive, fragile and affects the quality of service
• Remote and Rural Healthcare Report – Western Isles profile does not conform to the recommendations of this report
• Workforce challenges - new medical training requirements, legislative changes relating to working hours and opportunities to enhance roles for staff
• National NHS performance targets, principally HEAT targets (i.e. Health Improvement, Efficiency, Access and Treatment – as specified in the Local Delivery Plan)
• Limited ability to specialise locally – small populations generate little demand for treatment of certain conditions which makes specialisation locally unviable, unattractive to clinicians and may provide poorer outcomes for patients
• Capacity – the importance of a partnership approach to ensure any impact of change is within the collective resources of partner organisations

19. At the outset of the clinical strategy project a number of risks were identified. These included the acknowledgement that, as a small Health Board, NHS Western Isles has limited capacity or capability to undertake a project of this scope from within its own staffing resources.

20. The engagement of all clinicians in the project is critical to its success and while change brings opportunities, it can also be challenging. New systems of clinical leadership are required and inclusion, engagement and commitment need to be strengthened to ensure the right models of care are identified and agreed.

21. The continued engagement and support of the mainland Health Boards is also critical to the development of as wide a range of viable options as possible. A review of existing service level agreements with mainland health boards is underway, with monitoring and performance management of existing service level agreements also being critically examined. Partnership links are also being explored at corporate/executive level and clinical links are developing in line with the expectations of the new ‘obligate networks’. In addition, close involvement is being maintained with The Remote and Rural Implementation Team and North of Scotland Regional Planning Group that are tasked with translating the national remote and rural policy into practical guidelines for implementation.

22. A number of key policy areas highlighted in the remote and rural report are being locally reviewed in order to help NHS WI orientate services towards the changing needs of its communities and to make the best use of available resources;
  • obligate networks
  • defining the role and function of a Rural General Hospital,
  • developing a framework of generic principles of service delivery for primary care in remote settings;
  • develop a rural education strategy, in support of the national agenda, including development of a proposal to establish a virtual school of rural healthcare;

4 Modernising Medical Careers
5 European Working Time Directive
• review the role of the Helicopter Emergency Medical Retrieval Services to determine the appropriateness of this service in supporting unscheduled care in remote and rural areas;
• develop workforce planning arrangements to support the remote and rural agenda

23. The importance of wise leadership and an open and honest management ethos is critical to the success of this strategy. Without robust policy frameworks and operational procedures supported by consistent performance management systems, none of the changes will succeed or be sustained and people’s health and health services will not improve in the longer term.

Health status of the Western Isles population

24. The Western Isles face a number of challenges in both the delivery of health services and in maintaining and improving the health and well-being of its population. Recognising these challenges and the responses required forms the basis of much of the underpinning evidence for the development of the clinical strategy.

25. A long recognised challenge to all services in the islands has been the demographic and geographic challenge faced from both overall declining and ageing population and the impacts from its remoteness and rurality. The overall trend in the Western Isles continues to show the greatest proportionate decline over the previous 10 years among all health board areas as seen in figure 1 below.

Figure 1: Percentage change in population, NHS Board areas (1997-2007)

<table>
<thead>
<tr>
<th>NHS board area</th>
<th>1996 Population</th>
<th>2006 Population</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Isles</td>
<td>27,910</td>
<td>26,300</td>
<td>-5.8</td>
</tr>
<tr>
<td>Shetland</td>
<td>22,830</td>
<td>21,950</td>
<td>-3.9</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>1,215,700</td>
<td>1,192,419</td>
<td>-1.9</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>372,750</td>
<td>367,020</td>
<td>-1.5</td>
</tr>
<tr>
<td>Tayside</td>
<td>395,330</td>
<td>394,134</td>
<td>-0.3</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>148,520</td>
<td>148,300</td>
<td>-0.1</td>
</tr>
<tr>
<td>Orkney</td>
<td>19,770</td>
<td>19,860</td>
<td>0.5</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>556,540</td>
<td>560,042</td>
<td>0.6</td>
</tr>
<tr>
<td>Grampian</td>
<td>530,480</td>
<td>535,290</td>
<td>0.9</td>
</tr>
<tr>
<td><strong>Scotland</strong></td>
<td><strong>5,083,340</strong></td>
<td><strong>5,144,200</strong></td>
<td><strong>1.2</strong></td>
</tr>
<tr>
<td>Highland</td>
<td>300,280</td>
<td>308,790</td>
<td>2.8</td>
</tr>
<tr>
<td>Fife</td>
<td>346,540</td>
<td>360,428</td>
<td>4.0</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>275,950</td>
<td>288,473</td>
<td>4.5</td>
</tr>
<tr>
<td>Borders</td>
<td>105,960</td>
<td>111,430</td>
<td>5.2</td>
</tr>
<tr>
<td>Lothian</td>
<td>764,780</td>
<td>809,764</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Source: GRO(S) 1997, 2007 Mid-Year Population Estimates
26. In recent years there had been some positive trends with slight net population increases in 2004 (+250 persons) and 2005 (+110 persons) arising from in-migration particularly from East European migrant workers. However, the latest 2006 population estimates for the Western Isles gave a slight decrease of 0.1% (20 persons) on 2005 estimate. The main component resulting in this decrease has been a slowing down of recent gains in net migration to 110 persons from 245 persons in 2005 and 315 in 2006 while birth and death rates have continued at similar recent levels.

Figure 2: Birth, deaths and migration

![Births, Deaths and Net Migration for Western Isles 1997-2007 (Mid Year Estimates)](image)

Source: General Register Office for Scotland - Mid Year Estimates

27. The demographic imperative continues for services from an ageing population and its greater health and social care needs. Latest population projections show that declines in both children and working aged population are set to continue with the proportions of elderly (pensionable age) in the population expected to make up 31% of the total population by 2031 from around a quarter in 2006 which is the second highest proportion among all council areas in Scotland.
Figure 3: 2006 Proportion of Pensionable age, working age and children for administrative areas.

Source: GRO(S)
Figure 4: 2031 Proportion of Pensionable age, working age and children for administrative areas

Source: GRO(S)

28. The trend towards an increasingly ageing population within the Western Isles can be represented in the population pyramid graphs Figure 5 below.
29. The figures above show in 2006 a classic hourglass-shape indicative of burgeoning numbers of elderly together with significant numbers of young people at the bottom but with a squeezed middle group of younger working age population (20-mid-30s). In the projections shown in the hour glass shape for 2031 it is seen that the hour-glass shape is projected to develop further...
towards an almost mushroom shape indicative of a population in decline with a further reducing working age population and declining younger ages as birth cohorts decline.

30. Another aspect of the demographic trends on the islands is the geographic variation such that the more remote areas of the islands have been bearing the brunt of the population decline while the main urban area of Stornoway and surrounding environs has actually seen net gains of migration from surrounding areas.

**Figure 6: Percentage population change in sustainable community areas**

![Figure 6: Percentage population change in sustainable community areas](chart)

*Source: based on GRO Small area datazone population estimates, 2001-06 aggregated to local SCAs by Public Health Intelligence Department.*
Remoteness and rurality

31. Inextricably linked to the islands population decline in its effects on both service delivery and many aspects of health and well-being of the population, are the areas geographic challenges both in terms of its remote islands status and the overwhelmingly rural nature of its communities.

32. 78.9% of the Western Isles population live in areas classified as very remote-rural compared to 3.0% in Scotland as a whole, which is the largest proportion of any health board area. Similarly, the Western Isles has second lowest population density at 8.5 persons/square km of all Scottish health boards while Scottish average is 65.2 persons/sq. km.

---

7 Scottish Executive Urban-Rural Classification, 2005-06
8 General Registrars Office Scotland
33. These remoteness and sparsity factors of the Western Isles population place obvious challenges in delivering health services particularly where the focus of government policy is to provide care as near to the patient as possible.⁹,¹⁰ The implications of such factors for the population’s health are not only felt in terms of accessibility of services but in other direct impacts on a person’s health arising from the economic vulnerability and social isolation of their remote/rural situation.

34. On the positive side, infrastructure and improvements within the Western Isles, particularly in terms of road, ferry and public transport developments and increased car ownership have reduced travel times, and with a higher number of GPs per population than any other health board in Scotland primary care is reasonable accessible.

**Socio-economic challenges**

35. The Western Isles face undoubted socio-economic challenges such that resource deprivation is a very real aspect of life for some of the islands population. This can include low household income and access to affordable and good quality housing. Hence, Western Isles has 3rd lowest average household income in UK at just £23,400 out of total of 121 areas¹¹ while over 10% homes in Western Isles are ‘below tolerable standard’ compared to 0.5% for Scotland as a whole.¹²

36. The Scottish Index of Multiple Deprivation is the preferred method for measuring deprivation and inequalities but this area-based deprivation measure is insensitive to the dispersed nature of rural deprivation. Research is underway as parts of the Well North Cardio Vascular Disease (CVD) screening project to better understand the impacts of deprivation on health in a rural context.

37. The clinical strategy will take into account such challenges of tackling health inequalities in remote and rural communities and will therefore require models of care to be sensitive to impacts of rural deprivation particularly in the role of anticipatory care and wellbeing within health delivery.

**Work force challenges**

38. Closely related to the challenges above are the pressures placed upon a sustainable workforce in the Western Isles. When looking at provision of services it is important to look at the skills and tasks that make up the service and decide who can provide the clinical skills needed. Is it a Nurse, an Allied Health Professional or a Doctor? One of the main challenges will be leading the workforce through a period of change. Often there is a lack of willingness to change as people move from their comfort zones and into unknown or less known territory. There may even be some degree of protectionism of the current configuration.

39. New types of clinician are coming along. Work is well underway for the development of the rural general surgeon and the hybrid GP-physician. A hybrid GP-physician model is working in

---

⁹ Delivering For Health, Scottish Executive Health Department, 2005
¹⁰ Better Health, Better Care, Scottish Executive Health Department, 2007
¹¹ Wealth of Nation Report, 2003
¹² 2002 Scottish House Condition Survey, 2004
some areas. Nurse and paramedic practitioners have been developed, particularly in regard to
the out of hour’s service/unscheduled care. New ways of working that extend the hospital at
night concept to cover a much wider part of the care provided out of hours, and indeed in-
hours, is needed. For example with co-ordination of the ambulance service, the community
nursing service, the out of hours GP service and the services supporting A&E, a completely
different model could be developed using the entire clinical workforce to provide emergency
care in the out of hours period. This would need the development of many groups of clinicians
including paramedics, out of hours nurses, emergency nurse practitioners, GPs and consultant
medical staff. Examples could include the management of trauma which could be done at
different levels by nurse or paramedic practitioners, emergency nurse practitioners, GPs or
general surgeons. Telehealth will play an important role linking to specialists who are on call in
larger centres to give advice. Again the specialist at a remote centre could advise on whether or
not the patient needed to be transported and if so with what degree of urgency.

40. The implementation of new medical training requirements, legislative changes relating to
working hours, continued professional development, professional re-validation, and
regulation and enhanced roles for staff all need to help shape the kinds of services which it is
possible to provide within the boundaries of best practice and legal constraints. The impact of
these should not be underestimated.

---

13 Modernising Medical Careers
14 European Working Time Directive
15 Regulation of Health Care Support Workers
CONTENT OF CHANGE

Propositions

41. One of the prime aims of a clinical strategy is to maintain a range of services which can be delivered locally, where it is safe to do so, and a health and social services review which improves the health and wellbeing of the people of the Western Isles. Allied to this is the need for services to represent best value and demonstrate improved efficiency in the use of all resources to maximise the health gain from investment in staff and the estate. This means:-

- Redesign for flexible use of Western Isles Hospital to reflect more efficient use of patient and other areas;
- Rationalise properties to reflect future use and opportunities to collocate staff and services, or redevelop services to deliver new ways of working;
- Develop obligate networks to create sustainable clinical services which reflect standards consistent with Scotland;

42. The Western Isles Hospital in Stornoway is, and will always be, a focal point for health service provision which brings together specialist and non-specialist services. However, the ways in which a number of the hospital beds and some other facilities are used is becoming increasingly out of step with developments elsewhere in Scotland.

43. It is essential that, until there is evidence of primary and community-based services managing more patients at home and no longer requiring some people to come into hospital (or to be in hospital for as long), services in the hospital must be maintained. Nonetheless, there are significant improvements that could and should be made to the way the WIH is currently used that would improve its efficiency and would lessen the disruption for patients and their families without reducing access for patients who needed hospital admission.

44. Using benchmarking data from across Scotland, including other remote and rural locations, and reflecting comments by respondents, it is believed that the overall number of beds required now could be reduced by as much as a third, by improving care planning and discharge arrangements. Even future requirements taking demographic changes into account and based on current activity projected over the next 20 years are likely to indicate fewer beds will be needed than are currently available. These estimates take little if any account of potential reductions in patient admissions which may result from developing more appropriate services in the community.

45. Such efficiency improvements should be delivered by improving the patients’ journey through the hospital, which, in turn would address criticisms of some patients who wait long times for tests, treatment and discharge home. The prime motive would therefore be service improvement, rather than reducing costs.
Specialist Services

46. There are good facilities in Western Isles Hospital and it is important that as much elective work as can be managed safely and effectively by our workforce, and visiting specialists both medical and non medical, is carried out at this facility. This also extends to the Uist and Barra Hospital, again a modern facility which should be used to provide services as close to patients as is reasonably possible.

47. Developing clinicians locally to take on a wider range of general services will require the support of specialists in mainland centres. Essentially there are three types of networks in Scotland, the managed service network, the managed clinical network and the newly developing obligate networks.

48. An obligate network is a formalised arrangement between two or more healthcare organisations which secures access to sustainable service for the whole population serviced by these organisations. These networks can run at various levels from clinical decision support to visiting services up to a full virtual department and it will be for each area to decide which type of network is suitable. Four areas in “Delivering for Remote and Rural Healthcare” have been identified for the early development of networks: child health, mental health, radiology and laboratories and others will be considered, driven by the needs of the Western Isles.

49. Obligate networks are seen as important for all specialties, regardless of whether they are delivered by resident or visiting specialists within the Western Isles. Even resident specialists will be expected to play a key part in the wider network, with rotas, continued professional development (CPD), teaching and cover for absences in the future being designed and operated network-wide. While resources will be needed to establish them, obligate networks are seen as a way of safeguarding the continued provision of specialist services locally, thereby reducing unnecessary trips by patients and others to distant hospitals.

50. It is important to understand the health needs of people and the prevalence of disease in the WIs, as well as the extent of current services, and the ways these are used. To this end, the Board’s Public Health Department has produced service profiles to inform the Strategy. Further service modelling of options is nearing completion, and the completed data set will be used as part of the evidence pack for the formal option appraisal.

51. A critical element of any network model is the efficiency and effectiveness of communication tools. For many decades the telephone has provided the main telehealth service between professionals and the value of this simple means of communication must not be underestimated. However there are many wider applications that can be used in the context of the rural general hospital including videoconferencing, other telehealth, data transfer, image transfer (such as PACS) and remote monitoring.

52. The potential implications of the clinical strategy on medical teaching and training have been set out in a report which emphasises that the education and learning needs of all staff in the context of remote and rural working need to be reviewed.
Options for Primary and Community-Based Care

53. The options for primary and community-based care relate to the scale of GP, and other local health and social, care and specifically the number and content of Extended Community Care Teams (ECCTs) and, where there is hospital provision, Community Resource Hubs (CRH).

Extended Community Care Teams

54. General Practice is a cornerstone of ECCTs, and opportunities should be taken to review branch surgeries and dispensing arrangements to reduce unnecessary journeys by both patients and staff, to reduce the high cost of medicines where necessary and improve efficiency. This review remains to be explored in the current work, with any subsequent changes needing to be sensitive to concerns about the potential to impact adversely on practice income.

55. A range of options has emerged for the number of ECCTs required for the WIs:-
- four, as set out in the July discussion paper (Lewis, Uists/Benbecula, Barra and Tarbert) provoked alternative suggestions of
- five from one public group (splitting Lewis into east and west), principally on the basis of travel distances, and
- seven from one staff group (Habost, Uig/Bernera/Lochs, Group, Broadbay, Harris, Uists/Benbecula and Barra) reflecting more closely current General Practice and nursing team profiles [there are currently 12 practice-attached community nursing teams]. Further work by the CHaSCP suggested that there could be
- six ECCTs, each bringing together the newly developing Health and Social Care Teams within their area, as follows:-
  - Westside – Habost + Borve + Carloway
  - Stornoway – BroadBay + Group covering Tolsta to Point.
  - Lochs – South Lochs + North Lochs + Uig/Bernera
  - Harris – North Harris + South Harris
  - Uist – North Uist + Benbecula + South Uist
  - Barra

56. ECCTs will develop and provide services to suit the needs of their population and available clinical capacities; they may therefore differ from area to area and over time as health needs change with population changes. Services could therefore include any number of the following:
- Older people’s services and intermediate care
- Falls prevention (early education & prevention)
- Chronic disease management/long term conditions management
- Anticipatory care and prevention of admission to hospital
- Pre-operative pre-admission assessment and preparation
- Treatment at home for acute illness e.g. intravenous antibiotics.
- Development of advisor posts and better integration of home care organisers who would:
  - Train staff
  - Treat patients
  - Audit & monitor the quality of services
  - Improve links between carers and professionals
• Special Interest Community Nursing services to suit local need and compliment existing Macmillan nursing resources (e.g. heart failure, tissue viability, palliative care, continence)
• Development of the role of the Home Care Assessor

Community Resource Hubs
57. Community Resource Hubs (CRH) are proposed for the WI's, enabling ECCTs and services to be integrated and properties to be rationalised:-
• Community Resource Hubs settle naturally round the 3 inpatient facilities of Uist and Barra Hospital, St Brendan’s and WI Hospital, with an increased availability of community based services, over time, reducing the number of hospital beds required
• A main hub would be at OUaB (Uist & Barra Hospital) with Barra developing further as a hub when St Brendan’s is redeveloped, enabling co-location of services.
• Whilst designated as a Rural General Hospital, WIH could be redeveloped to serve as both a RGH for the Western Isles and a Hub for Lewis & Harris; a further option, in view of distance and population, is to develop a smaller hub in Tarbert to serve Harris.

The Uists and Benbecula
58. A Community Resource Hub could be developed in and around the Uist and Barra Hospital site, offering the following services in addition to the existing hospital and other local provision:-
• GP services
• De-Toxification
• Chemotherapy
• Local post-operative care
• Nurse/AHP led pain clinic
• Endoscopic examination
• Increased use of telehealth

59. Through co-location of services and developing sufficient scale to offer a wider range of local provision, community service developments in the Uists could include the following:-

• Developing joint health and social care roles to work across disciplines and organisations
• Further developing the Mobile Overnight Support Service (MOSS)
• Further developing services for people requiring terminal care
• Specialist care for older people (gerontology nurses)
• Increasing knowledge and focus on anticipatory care
• Health promotion, especially to teens regarding alcohol
• Home intravenous therapies
• Developing an appropriate escort policy for mental health patient transfers
• Joint training and learning across health, social and voluntary sector
• Further developing nurses to work in both hospital and community settings.
Barra

60. By co-locating services on the site of a replacement for St Brendan’s, a Community Resource Hub could be developed to offer the following services:-

- GP services
- Social day care
- Day care therapies
- In patient palliative care
- Properly equipped and resourced emergency room
- A clinic room for visiting consultant
- Some radiology services
- Increased use of telehealth
- Local provision of other services based on population needs (e.g. alcohol treatment, patient transfer, community psychiatric nursing, physiotherapy)

Options for Secondary Care

61. The Scottish Government has already determined that Western Isles Hospital, Stornoway will be one of six Rural General Hospitals (RGH) in Scotland which should have a common range of core services and should excel in assessment and diagnosis, before transferring patients to larger centres where required. The definition of a Rural General Hospital (RGH) is as follows:

“The RGH undertakes management of acute medical and surgical emergencies and is the emergency centre for the community, including the place of safety for mental health emergencies. It is characterised by more advanced levels of diagnostic services than a Community Hospital and will provide a range of outpatient, day-case, inpatient and rehabilitation services.”

62. The RGH is described as being a level 2\(^{16}\)+ facility which means it should provide local assessment, diagnosis and treatment; it will be the emergency centre for the community providing treatment of minor injuries and minor illness with the majority of patients being admitted locally and a proportion transferred. Level 3 facilities are identified as the core admitting services, with locally available 24/7 receiving in general surgery, general medicine, and orthopaedics; with anaesthetic and radiology support.

63. Rural General Hospitals should network with each other and with the larger centres to develop agreed, evidence-based protocols. This will ensure that the clinical standards are similar across Scotland. RGHs will also be part of local networks linking with the locally based Extended Community Care Team, with the principle that the RGH is retained to manage the more complicated conditions that cannot be cared for at home, or within a community hospital setting.

\(^{16}\) National Framework for Service Change
64. For the specialist RGH functions, there are a number of potential service configurations. The principal differences common to most specialties can be summarised thus:

**Option 1**
This represents the current configuration and, although unsustainable in the longer term, is used as the baseline against which other options are compared (also a technical requirement of formal economic appraisal);

**Option 2**
This is an interpretation of the national policy position set out in “Delivering for Remote and Rural Healthcare”. In essence, it enables a range of treatments to be provided by the three core specialties of General Medicine, General Surgery and Anaesthetics within Western Isles Hospital with cover 24/7 and for all other specialist services to be provided on a planned basis by visiting specialists or by referring patients for treatment off island. It also introduces the concept of a new group of consultants who will be specially trained to meet the needs of remote and rural communities e.g. Rural General Surgeon.

**Option 3**
This option is a hybrid, recognising that Western Isles Hospital currently provides a wider range of local specialist services than other RGHs and much of which may be able to continue safely with the right obligate network support from other Health Boards.

65. Amongst the options for specialist services is a choice of which Health Boards to look to for obligate network support; should the links developing through MCNs be the guide, as in the case of coronary heart disease with Glasgow? To what extent should short term pricing and capacity determine future links e.g. with elective orthopaedics and the Golden Jubilee National Waiting Times Centre? Should regional considerations dictate links, as in the case of Inverness and a wide range of visiting specialist services? Are there other natural partners?

**Medicine**

66. Activity in primary care accounts for about 90% of patient contact with the health service. Of the proportion of patients that require specialist referral or treatment, medical activity is a large proportion of in-patient work (accounting for some 60% of total in-patient admissions) and there is therefore a clear role for acute medicine and secondary care support for the management of long-term conditions within a hospital setting, including a wide range of outpatient clinics.

67. It is not possible to be prescriptive about which patients should and should not be admitted to WIH as this very much depends on the skills of the particular team and individual clinical decision making. Increasing visiting medical services should be considered in support of locally-based consultants and the development and involvement of interested general practitioners to provide cross cover of staff between the hospital and community services.
68. There is still a need for continued exploration of the effectiveness of the current ‘Hospital at Night’/Out of Hours multi-professional team and the Community Night Nursing Services model in the context of increased visiting services and involvement of general practitioners.

69. In the context of an appropriate mix of locally-based/visiting consultant and general practitioner arrangements, there are a number of services (e.g. respiratory medicine, diabetes and coronary heart disease) that are appropriate for specialist nurse leadership rather than always consultant led provision. Enhanced telehealth is envisaged to support nurse led services to deliver an anticipatory and preventative model of care to reduce hospital admissions.

70. Agreement needs to be reached that the WIH should undertake the initial assessment of acute patients and ensure a clinically safe transfer for some patients, where appropriate. Formal arrangements for accessing support from mainland centres should include specialist laboratory medicine and radiology. The impact on the working patterns of partner boards is part of the consideration for designing service configuration, as is the stage of development of local Managed Clinical Networks, such as those covering Diabetes, Coronary Heart Disease and Stroke.

71. The WIH is an essential and valuable resource within the community providing local access to a range of emergency, diagnostic and planned treatment services and with the potential to be part of a Community Resource Hub providing some community services too. While it is not viable as a district general hospital able to offer intensive care facilities, it may be capable of providing high dependency care.

72. Experience of a relatively wide range, but low volume case-mix of patients has led to the development of multi-skilled generalist nurses. The ability to focus skills to ensure competence and confidence in emergency or unpredictable situations is crucial to the sustainability of safe and effective local services. Evidence suggests that nursing care could be clustered around specific patients needs to ensure more frequent use and therefore maintenance of acute knowledge and skill. Examples sited are for patients requiring acute, emergency or high dependency care. This clustering approach could be developed for other types of patient needs, for example, nurses with intermediate skills would care for patients requiring rehabilitative care and support them towards self and independent care.

73. The need for more highly specialised nursing care needs to be better assessed. Patients with long term conditions, children, and people with diabetes or renal disease may be best served through the development to of a practitioner nurse working in an integrated way with extended community care teams. Good examples already exist within the A&E department. Consideration of formal obligate networks needs to consider the broader team and take account of the need to support nurses at the general or specialist level.

74. The role of Allied Health Professionals should be at the level of generalist practitioners to match the needs of patients across the range of therapeutic care. Special interest roles should be in areas of defined and agreed healthcare need. Workforce and workload planning tools should be adopted to inform the future shape of the AHP workforce in the context of a rural general hospital and community resource hubs.

---

17 National Framework for Change and Remote and Rural Needs assessment annexe
75. Other areas for further consideration and detailed work are that of the radiography and medical scientist teams. The recent appointment of a radiologist working locally will allow the development of a flexible and generalist range of radiographers. Formalised networks should also be considered for laboratory professions.

**Surgery**

76. Surgical services need to be integrated across the proposed Community Resource Hubs (Uist and Barra and St Brendan’s), WI Hospital, a mainland District General Hospital and a mainland tertiary centre as part of a formal, specified obligate network arrangement so that they can either provide themselves, or refer patients to services which can offer a standard of care comparable with other parts of Scotland.

77. Arrangements to provide local surgery should be formalised and include the demonstration of health need (to support viability), team competences (to ensure quality), and outcomes demonstrated to be at least as good as other centres and approved by the local NHS Board and the surgical service network. This will ensure that local surgical services are underpinned by robust clinical governance systems, availability of competent multi-professional teams, the ability to provide high dependency care for patients, agreed care pathways and protocols, and access to advice from specialists within larger or tertiary centres’.

78. WI Hospital should provide elective outpatient, in-patient and day case services and a 24 hour emergency service, acting as part of a regional network of surgical services within assessed and agreed boundaries. The broad provision of general surgery will be planned, mostly on a day case basis, either in the WI Hospital or on an outreach day case basis in Community Hubs. There will be a list of surgical procedures agreed by the obligate network that will be undertaken locally.

79. In relation to local 24 hour surgical services, these should provide assessment, triage, resuscitation and stabilisation of emergency surgical and trauma patients with admission and surgical intervention where appropriate followed by transfer when necessary in collaboration with the relevant receiving hospital. An agreed list of emergency workload that would be undertaken locally will be agreed by the obligate network. In addition, core clinical competency requirements of the broader surgical support team should be assessed.

80. There are a number of areas, (e.g. breast surgery) where local surgical intervention requires further debate, informed by independent evidence, and agreement on the extent to which certain procedures and in what circumstances should be carried out locally and whether workload should be concentrated with one individual who is an integrated member of a wider specialist team in association with a larger or tertiary centre.

81. A number of surgical sub-specialties that should be provided on a visiting basis for planned treatments include ophthalmology, ear nose and throat and urology. Gynaecology needs to be considered alongside maternity services given the combined nature of the obstetrician and gynaecologist consultant post. Proposals for orthopaedics are also currently being developed.
82. Evidence\(^{18}\) states that the following surgical services are more successfully undertaken in specialist centres and should not be provided locally:
- surgery on children under the age of 5 years,
- neurosurgery (such as emergency Burr Holes),
- operations on the neck and chest (other than emergency tracheotomy),
- stomach and rectum operations,
- liver, vascular, ovarian, vaginal or penile operative procedures (with the exception of circumcision).

83. The services outlined in this section require a team-based competency approach and the introduction of extended or new roles for nursing, allied health professionals and other clinical support staff. The medical workforce requirement is for three general surgeons with support from anaesthetics and acute physician colleagues as outlined in the relevant paragraphs below. Consideration of the extent to which nurse led services can be further expanded or developed is required as part of local team-based competency requirements. Nurse led services may include urological assessment, clinics, pre-operative assessment and post-operative support, accident and emergency, tissue viability, minor surgical procedures, chemotherapy, renal dialysis, and colorectal screening.

84. The need to have available the necessary skills to provide local high dependency care for short term periods (post operative care or pre-transfer stabilisation) is being assessed in accordance with Scottish Intercollegiate Guidelines (SIGN) - with consideration of specific needs of the Uists and Barra localities and overall transport challenges. A review group chaired by the Chief Executive is expected to make recommendations in this matter shortly.

**Child Health Services**

85. There should be a consultant led acute and community child health service serving the community of the Western Isles that incorporates neonatology. Evidence\(^{19}\) suggests that, in addition to there being no formal network of professional support, there are gaps in community paediatric services within NHS Western Isles.

86. Unscheduled (medical) care of children and neonates is currently provided by a single handed locum consultant paediatrician with children’s nursing cover for some inpatient ‘shifts’. Although there are good working relationships with secondary and tertiary centres (principally RHSC, Yorkhill, Glasgow); there is no formal network of support in place leaving the service vulnerable in the long term.

87. Services need to become part of either a managed clinical network with Yorkhill or an obligate network again with Yorkhill. Either way, remote and rural child health services such as those covering the Western Isles should be firmly embedded in a formal network with Yorkhill. The establishment of the network should incorporate the formalisation of a named specialist consultant responsible for the support of the remote area. Responsibility would include outreach support to the remote area to maximise local care, development of robust protocols for the

---

\(^{18}\) Remote and Rural Report; Surgical Annex
\(^{19}\) RARARI (remote and rural areas resource initiative) Paediatric project (Western Isles, Orkney, Shetland and rural Highland) 2004
management of common conditions and a commitment to deliver education and training. The network should also ensure full exploration of e-health solutions.

88. The service should be consultant led, either based locally and spending time in Yorkhill Hospital to maintain skills, or based at the Yorkhill Hospital and providing a comprehensive outreach service. The paediatrician should be supported locally by appropriately trained GPs or, if developed in the future, a remote and rural hospital practitioner with skills covering the secondary care of children, babies and adults. Child health nursing should be based on specialist staff rotating between hospital and community duties. The training and ongoing support for nurses, midwives and allied health professionals should also be part of a managed clinical network.

89. A separate children’s ward should be created within WIH by designating a 6-bed bay and having flexible use of other single rooms as required, for both medical paediatric patients and children admitted for elective surgery. Views are expressed in the Remote and Rural Report (Child Health Technical Annex) that “any child requiring intravenous medication support and/or requiring admission over 24 hours were not appropriate to be cared for in a Rural General Hospital.” However, this would not allow for the care of the terminally ill child.

90. Difficulties are also experienced in the management of neonates in RGHs. For example if a neonate requires to be readmitted and they are over 28 days old, in many instances they cannot now be cared for by midwives because of the direct entry training and issues around retaining skills and competences in order to retain current first level nurse registration.

91. Guidance on future service delivery has been sought from policy direction. The Action Framework suggests that there is a need to balance access, quality and sustainability and that the achievement of such can only be addressed by the existence of a robust and well organised planning framework working in a collaborative manner at regional, inter-regional and national level. The Emergency Care Framework for Children and Young People in Scotland (ECF) determines levels of care delivery RGHs should provide Level 2 Care as defined by the ECF. It has to be recognised, however, that due to their geographical isolation, the RGH may at times be forced to work at Level 3. Where this situation arises the child or young person’s care must be supported by a formalised paediatric network, perhaps by use of e-health technology.

“Level 2 (i.e. general hospitals with an Accident and Emergency Department but without a Paediatric Inpatient Unit) may have facilities for assessing and observing children and young people over a period of time prior to making a decision about whether to discharge or not”.

“Level 3 Emergency Care should be available from a general hospital with a paediatric inpatient unit which will have significant more capacity to manage the unwell child or young person than a hospital without such facilities”.

Karen Tarn, Interim Project Manager – Clinical Strategy
92. The Action Framework and the Emergency Care Framework for children and young people indicates that the way forward is for the establishment of a formal paediatric clinical network and to negotiate it as part of what is the most appropriate local service delivery model for the WI based upon local health needs and resources and incorporating the needs of children with long term conditions. Such arrangements would also apply evidence of best practice to determine the most appropriate age limits for local surgical interventions.

93. The majority of child health care will be delivered in the community, concentrating on health promotion, anticipatory care, care of long term conditions and those with special needs and ensuring the provision of robust child protection arrangements.

**Maternity Services**

94. In terms of the national policy guidance (Remote and Rural Healthcare Report) a Rural General Hospital provides midwifery-led maternity services, but does not provide for a local consultant-led obstetric service. Whether this is appropriate for the WIH, as an RGH, remains a matter for consideration by the Board. However, it is clear from local discussion and debate that such a model for the Western Isles would be seen as problematic on grounds of safety. The Board’s professional advisory machinery should be further consulted to ensure full consideration of all issues are taken into account as part of a formal decision making process.

95. Since the condition of the mother (or baby, in utero) can change rapidly, safety is paramount and another vital element of a safe maternity service is the support and emergency backup provided by the Scottish Ambulance Service and Neonatal Transfer Service. Further detailed work is required in this area.

96. The SGHD’s Keeping Childbirth Natural and Dynamic (KCND) programme has been developed to support the multi-professional team to implement the principles outlined in the 2001 Framework for Maternity Services in Scotland document. Boards’ implementation of the national framework document is monitored through the review of the NHS QIS National Clinical Guidelines for maternity services.

97. The pathway for normal maternity care is a strand of the KCND programme to facilitate ongoing risk assessment and to ensure evidence based care by the appropriate professional for all women accessing maternity care across Scotland. The ethos of the pathway is that pregnancy and childbirth are normal physiological processes and unnecessary intervention should be avoided.
98. Local guidance should augment the pathway in relation to indications for and the process of transfer from midwife led to maternity team care appropriate to the geographical area. Levels of care are defined as:

**Green:** midwife-led care – healthy women with uncomplicated pregnancies should be offered a midwife as their lead professional, being the first point of contact to confirm, book, assess and plan care, although it should be acknowledged that women may still choose to see their GP and/or obstetrician.

**Amber:** assessment required – Women with any potential risk factors should be further assessed or referred to the appropriate health professional for further assessment or support. Following this assessment women may return to the green midwife led part of the pathway or be referred to the red maternity team part of the pathway for further specialist advice and care. A number of the amber criteria will require clear local guidelines with appropriate education and audit in place.

**Red:** maternity team care – women with significant medical/obstetric or social risks factors should have a consultant obstetrician as the lead professional, sharing care with midwives, GPs and other care providers as appropriate e.g. diabetologists, cardiologists, neonatologists, psychiatrists and allied health professionals.

99. To be consistent with professional and policy guidance and reflecting developments elsewhere across Scotland, opportunities for further development of midwifery-led maternity services across the Western Isles might usefully be explored. Provision of services at the moment to the Southern Isles is extremely resource intensive and requires considerable operational management to ensure levels of care. The Board should consider the development of a service which is geared to responding to the majority of activity and have in place safe and effective contingency arrangements for exceptional occurrences.

100. Currently, the local presence of consultants means that someone is on hand when there are complications and when delivery by caesarean section is required. Whether or not the NHSWI service continues to have a local consultant presence, an obligate network for Obstetrics is seen as essential for the future maternity service and the new role of the rural general surgeon in time presents opportunities to strengthen out of hours cover and could be built into future service arrangements.

101. The local specialist gynaecology service is clearly linked with the consultant input required for the maternity service and assessment of current activity needs to be concluded in this area.
Mental Health Services

102. Mental Health is one of the support services listed as part of the Rural General Hospital definition. It is a key service where a partnership approach, through the CHaSCP, must ensure that strategies and plans are timeously reviewed to ensure targeted and appropriate use of health and social care resources can be aligned; particularly in relation to the provision of care units, care homes and residential care facilities. The relationship with the public health division and the single operating division (CHaSCP specifically) is an area for clarification to ensure cohesive planning and delivery of services and prevent fragmentation.

103. There is significant support and progress with existing work to improve mental health services for the people of the Western Isles. Work being taken forward is recognising policy and practice shifts elsewhere towards community-based psychiatry. This includes consideration of shifting resources out of the hospital by adapting the existing Acute Psychiatric Unit as a “place of safety”, focussing the medical provision on community based work and strengthening community psychiatric nursing and other non-medical resources.

104. It is anticipated that further development and full implementation of existing work will lead to a considerable reduction in hospitalisation, and the movement of elderly continuing care from a clinical to a social care setting.

105. Current service improvement work taking place will also lead to improvements in the integrated care pathway for people with dementia and propose a dedicated mental health team for older adults. In so doing, the service will become more responsive, able to support more people at home and reduce the need for hospital admission.

106. Continued improvement of mental health services must involve our NHS mainland partners as part of the local mental health service improvement programme; specific policies are required in relation to children and adolescents, older adults, people with learning disability. The development of an obligate network should be considered as a matter of urgency as should the status of the Board’s Psychiatric Emergency Plan.

107. The focus of mental health services within remote and rural communities must be on the early detection of disease, with efforts targeted at difficult to reach people and those in need, the aim of which is to prevent relapse and escalation of disease.

108. There will inevitably be situations where individuals will experience a mental health crisis and require management, sometimes by generalist practitioners and sometimes by generally trained physicians. Services must be organized as part of a formal network, with a specialist centre and there should be appropriate retrieval arrangements to allow access to inpatient care.

109. The Board needs to consider its local provision of services in the context of:

- Specific arrangements for the management of mental health crisis in remote and rural areas to be included in NHS Boards’ Psychiatric Emergency Plans (PEPs);

---

20 NHS WI Child and Adolescent Mental Health Strategy 2007 and the Clisham Project
• The requirement to review the need for the extension of current mental health service provision to cover out of hours;
• The development of formal obligatory networks with specialist psychiatric centres, including communication across the system involving case management and critical incident reviews;
• Responsive retrieval systems for patients experiencing mental health crisis;
• The need to establish robust e-health links between remote and rural healthcare settings and psychiatric centres.
• The necessary skills and competencies to appropriately manage an individual experiencing mental health crisis, there is an urgent need for the development of a pre-hospital psychiatric care course, delivered utilising a ‘BASICS’ type approach
• Development of a cohesive mental health service for older adults which is equitable and accessible.
• Planning for a Cognitive Care Centre and developing Day Hospital Assessments which would combine brief admissions to facilitate patients from Uist & Barra
• Establishment of a robust Carers Group
• Re-design of the facilities within the Western Isles Hospital (both internal and external)
• Development of the Dementia ICP and other systems and protocols around dementia care
• Developing innovative rural models of care
• Development of research proposals e.g.
  - The use of technology and patient interaction, particularly aggression.
  - The effect of ‘bi-lingualism’ on cognition.

What This Means for Patients

110. It is essential that the ways in which different service options may affect patients, staff and communities is described clearly and in language which is easily understood. Work is underway to examine a range of common presentations or diagnoses and to describe the current patient pathway and how that might change for a typical patient under each of the options.

111. Principal changes are likely to focus on the balance of care between supported self-care, primary and community based care while people remain at home, and hospital care, both within the Western Isles and the mainland. They are also likely to highlight shorter wait times, more efficient use of service elements such as in-patient bed stays in hospital and increasing reliance on new technologies such as ehealth and telemedicine.

Potential changes that patients will see:
• More of their health care will be provided locally in the community either at home or in community resource hubs with greater use of day case treatment, rather than in hospital as inpatients.
• Local health and social care teams will work more closely to support people who are at higher risks of ill-health.
• If they have a long-term condition (e.g. heart failure, diabetes, or asthma) help and support will be available for monitoring and assessment and, where appropriate, to help them manage the condition themselves, thus avoiding admission to hospital, except when necessary.
• If they are older, frail or liable to frequent hospital admission, they will get more systematic, coordinated care provided locally.
• Carers will be treated more as partners in the provision of care.
• Personal access, along with the clinical staff that treat them, to their own Electronic Health Record.
• If they need specialist treatment in hospital they will get access to a good, safe service provided by the right clinician, even if that means they have to travel.
• Key medical resources will be concentrated to allow specialists to deal with complex cases and so provide the best possible outcome for patients.
• If they need to go to hospital, they will have quicker access; more tests will be done locally, and their length of stay will be planned and shorter.
• Patients will experience shorter waiting times for appointments or operations, with fewer appointments or procedures being cancelled because of an emergency or because test results are not available.

Early Deliverables

112. To introduce the most modern systems of working across the whole range of health and care services is a huge undertaking and will involve many people in a wide range of changes and improvements over a number of years to come. These will be further detailed in the Strategy as it develops and in the associated Implementation Plans, which will be prepared following approval of a preferred option in the summer of 2009. In the meantime a number of specific improvements are being progressed over the coming months, which demonstrate the Board’s commitment to improving services and achieving benefits for the people it serves. Amongst these are the following:-

• Local Chemotherapy for people in the Southern Isles – a new service to be based at Uist and Barra Hospital, for people with malignant disease who would otherwise have to travel routinely to mainland centres for specialist treatment;
• Dental Services – the provision of additional dental surgeries in Stornoway to better serve demand and attract additional dentists to work on the Islands
• Stroke Care – to develop an action plan to improve standards of care for people who suffer stroke, to reflect best practice
• Breast Cancer – to introduce new evidence-based protocols for people to be referred to the type of rapid testing/diagnosis/treatment arrangements provided in ‘on-stop shop’ specialist clinics
• Heart Failure Service – to introduce improvements, including purchase of modern equipment, to enable high quality care for people suffering from heart failure
• Diabetes – to introduce improvements in the patients’ pathway of care as recommended by the Managed Clinical Network and further develop a ‘demonstration’ obligate network with mainland specialists
• Rehabilitation – to appoint the WI’s first Rehabilitation Co-ordinator
• Orthopaedics – to develop proposals in partnership with mainland specialist centres for a sustainable specialist orthopaedic service with optimum provision of patient services being maintained locally
• Clinical Communications – improvements in speed and quality of letters to GPs on patient discharge and to Consultants on referral
• Property – improvements in the efficiency of the estate, through a new strategy, freeing up funds for direct patient care
• Barra – review of proposal for replacement of St Brendan’s Hospital and discussion with CnES over creation of a hub and timescale for its development

Resource Implications

113. Further clarity is still required on the main cost drivers and on the detail of options in order to measure affordability and differentials. Comparative workforce and cost information for the options will be presented, albeit recognising that they will be based on broad assumptions. It is obviously important that any cost assumption is reasonably accurate and analysed as required for planning purposes to allow alternative scenarios to be considered and tested for safe, effective and sustainable care.

114. A key issue to be clarified is the level of shift from traditional service level agreements to reliance on obligate networks. It should not be assumed that obligate networks will be on the same financial footing as service level agreements; rotation of staff for purposes of supervision, education, training and continued professional development, peaks and troughs in throughput may change the components of cost.

115. A clinical group should be tasked to identify and agree specific reasons for admission and procedures that will be undertaken in the hospital in Stornoway and undertaken on the mainland against each of the options. Resource implications can then be assessed and presented.
PROCESS FOR CHANGE

Project and Change Management

116. We are wholly reliant on our staff for our success and the modernisation of our services. This will mean ensuring we have staff that embrace the values and behaviours required to deliver our ambitious plans, and who understand how they contribute both individually and as a team member, to improving systems of patient care, whatever role they are in.

117. The original Programme Management Plan (PMP) was approved in March 2008 and included the reporting and management arrangements. These included a Project Steering Group, Clinical Reference Group and Project Team. The PMP has been complemented by an associated Communication and Engagement Plan which has been the subject of discussion with staff and the Scottish Health Council in order to ensure that it meets required standards.

118. A revised programme, presented as part of a Progress Report to the Board in August 2008 incorporated the impact of a number of significant events and changes that could not have been taken into account at the outset of the project. These are the additional but essential time taken to engage stakeholders, the loss of the project manager and advice received from the Scottish Government Health Department (SGHD) in relation to both independent scrutiny (which may be required) and the Cabinet Secretary’s endorsement of the Remote and Rural Healthcare Report. The outcome of critical work of the Remote and Rural Implementation Group and its key sub groups is not yet available. It was envisaged therefore that the second phase leading to formal decision on options will be summer 2009.

119. As a result of the August progress report the project management arrangements were reviewed and in September 2008 a proposal was developed to stand down the Clinical Strategy Steering Group and introduce a Clinical Programmes Board to integrate the governance, leadership and performance management of the Clinical Strategy Project, Service Improvement Programmes, Patient Safety and Patient Experience Programmes.

120. We are required to follow a statutory public consultation process that must comply with the requirements of HDL (2002) 42, the National Standards for Community Engagement and the emerging Independent Scrutiny requirements. NHS WI has had further advice from the SGHD augmenting this guidance in relation to the time at which Independent Scrutiny will take place, if it is confirmed as necessary by Ministers.

Criteria for Decision Making

121. As a strategic body accountable to the Scottish Government Health Directorates and to the Cabinet Secretary for Health & Wellbeing, there are a variety of directives, standards and guidelines (the “givens”) that we must comply with and, moreover, we must be able to demonstrate that we comply with.
122. Taking account of these “givens”, experience elsewhere and the views of our staff and local people, a clinical strategy for the people of the Western Isles will need to demonstrate that the following criteria are met i.e. that a preferred option is:

- Safe (complies with national/international law, facilitates the delivery of best practice, risk-assessed, quality assurance is systematised)
- Affordable (within budget, value for money)
- Sustainable (has longer term viability, robust, realistic)
- Effective (quality care, good clinical outcomes for patients, exploits new technology)
- Efficient & accessible (makes best use of staff, buildings and equipment, minimises wasted capacity, readily available, protocol-based)
- People focused and designed to meet their needs (designed around the ‘best’ patient journey, available/accessible when the patient needs it)
- Consistent with national policy/standards/regulation (e.g. “Delivering for Remote and Rural Healthcare\(^{21}\))

**Comparison of Options**

123. There are additional and vital elements to the process of identifying workable options. These include the need to compare options against the above criteria; complete resource identification and full engagement with mainland board partners to assure the Board that its clinical strategy does not destabilise capacity planning of other NHSScotland partners.

124. Infrastructure of technology and transportation will be critical to the delivery of a clinical strategy. These components, based on activity assumptions for each option, need to be considered in terms of capacity and capability.

125. The outcome of the local Working Group assessing the implications of implementation of modernising medical careers and European Working Time Directive is also an important part of the comparison process.

**Current Evidence Base**

126. The Public Health Intelligence (PHI) department are working on a range of health intelligence measures that will inform the evidence base around the options. A key component of this will be the assessment of current and projected morbidity trends in the Western Isles population which will focus in particular on the impacts from the ageing population across a range of long term conditions.

127. Work is underway in collaboration with the Long Term Conditions Programme at Information & Statistics Division (ISD) of National Services Scotland to assess the future impacts for such conditions in the Western Isles based on national prevalence estimates.

128. The second main component of the health intelligence evidence base will focus on a range of indicators describing the model of healthcare delivery in the Western Isles. Work thus far confirms the view that this model continues to be a predominately secondary care-based and interventionist rather than a preventative model, which is at odds with the demographic and policy imperative of shifting the balance of care towards anticipatory care and community provision.

129. The public health intelligence department are compiling a number of whole system indicators identified below (i.e. emergency admission trends, avoidable hospitalisation rates, levels of patients at risk of hospital admission – SPARRA, hospitalisation levels of older people, comparative activity and intervention rates) that help illustrate the increasing hospital-based model. More detailed evidence on hospital services has already been provided in specialty profiles which will inform decisions around the particular range of appropriate hospital provision.

130. The third component of the health intelligence evidence base will examine the likely future impacts in terms of sustainability/un-sustainability of both the existing model based on projections from current activity trends and of the remote and rural model. This will cover both local and mainland activity.

131. A key component of this will be an assessment by an agreed clinical group of the detailed core treatments appropriate for hospital services under the proposed remote & rural and remote/rural + options. Consideration is being given to methods for both identifying what core treatments will be in R&R options and in conducting a review of hospital bed usage at present in light of such an assessment together with the emerging options for primary care/community services to enable quantification and configuration of future possible hospital provision.

132. The final component of the evidence base will be an appraisal of the formal research base around remote and rural healthcare and more widely around shifting the balance of care towards community provision as it relates to the delivery of healthcare in the Western Isles.

**Impacts on population’s health of demographic challenges**

133. These challenges are perhaps most manifest within the population's health in terms of the increasing health needs of older people arising from the demographic trends. A combination of increased numbers of older people and longer life expectancy means that greater prevalence of a range of conditions among older people will become an increasing feature of healthcare. Many of these conditions in turn will be greatly susceptible to the challenges of the islands geography for their successful anticipation and early management. In particular the management of long term conditions will be a key feature in determining how the Western Isles in common with other areas across Scotland will shape their health services.

**Long Term Conditions Population Prevalence**

134. One of the principal areas of increasing health burden where demographic and healthcare trends are expected to impact are in the rising prevalence of long term conditions (LTC).
135. There are many definitions of what comprises long term conditions. Recent work by ISD as part of its programme to provide intelligence to support this area summarised the key aspects as including “Conditions which require ongoing medical care, limit what a person can do for a year or more and have a clear diagnosis are generally included (e.g. coronary heart disease, diabetes).”

136. ISD advised though that care needs to be taken in interpreting data since “this definition also includes many conditions which, although long-term and life-limiting in some cases, can also be acute or easily managed in others (e.g. back pain, skin disorders).”

137. Therefore, estimates for the number of people with a long-term condition vary widely depending on the definitions and data sources used. Within the Western Isles there are currently only the Quality Outcome Framework (QOF) disease registers in primary care that contain population data on the prevalence of Long term conditions. These contain figures on particular diseases types which account for the most significant long term conditions such as hypertension, coronary heart disease, obesity, asthma, depression, etc.

138. This may be an underestimate compared to other national data sources but these are not available within the Western Isles. Below is provided a chart showing the latest LTC Western Isles and Scottish prevalence figures for those conditions recorded as part of the QOF disease registers.

Figure 8: 2007/08 Long term conditions prevalence rates
Figure 9: 2007/2008 Total persons on GP disease registers for all long term conditions

Source: QOF Disease Registers
SUMMARY OF EVIDENCE

139. It is evident from the existing trends described above that the current hospital-based model of health delivery is not best placed to meet the challenges facing the Western Isles population both in terms of sustainability of the acute-based care model and the appropriateness of such a model in managing the changing pattern of care needs of an ageing population.

140. Allied to the need for alternative healthcare models suggested by the data is a substantial body of researched evidence pointing to a more devolved form of healthcare delivery which focuses on the greater need for shifting the balance of care nearer the patient where possible. This is particularly relevant for remote and rural healthcare systems such as the Western Isles where issues around sustainability and specialisation become particularly pressing.

141. A high level review of evidence suggests that there are a number of interventions that could contribute to shifting the balance of care through shifting the focus of care, for example rehabilitation in the community for a range of conditions, and location of care, for example in community and day hospitals. Changing roles and shifting responsibilities are other interventions sited in the evidence for example substitution of roles and telephone consultation.

Primary and community care services

142. There is information available in relation to numbers of staff, list sizes, enhanced and additional services. There is still work to be done to identify primary care activity data that can contribute to whole system capacity planning exercises. The development of an overview primary care anonymous activity report based on disease register information, referral activity and the QOF should be considered.

Hospital Services

143. Patient activity data for the Western Isles hospital inpatient, day case and out patient has been collated for 2007/2008 to enable identification of workforce and cost baseline for current service provision.

144. We still need to collate off island activity for the same period. Our mainland board partners will need early notification and involvement in further work; they will also need to undertake similar capacity planning exercises to ensure that options take account of their ability to manage and sustain the impacts of our choice. Clarity therefore about the requirement for repatriating activity offset by desired increase in activity and indeed mode of provision.

145. There are descriptions available to us for core activities that it is intended to take place in a Rural General Hospital. However, these are broad (e.g. excision of lesion) and do not allow immediate identification of correct procedure codes that is need to identify activity levels (using a mix of current service provision and population needs assessment) for identification of resource implication purposes.
NEXT STEPS

146. The progress with and scale of the project should be noted in the context of a whole system review of healthcare with the acknowledgement that there is substantial further work to be undertaken.

147. Approval of the direction of travel described in this framework is required in order that it is used as the basis for further development.

148. Clinical Programmes Board, specifically Executive Team, need Board authorisation to ensure comprehensive involvement and engagement of all staff, general practitioners and the public.

149. Options must be further developed in conjunction with all clinical staff utilising existing mechanisms or, where there is specific need, specialty based multi-disciplinary workshops should be run.

150. This document should be distributed to staff and general practice with a request for departmental, team or locality group consideration and comment. The document should be shared with the general public through planned open meetings to take place in January in the form of round table discussion groups.

---

i Clinical Strategy Project Risk Register

ii Review specific elements of Remote and Rural Report to determine local perspective/requirements

iii Analysis of service profiles for modeling service options

v Public Health prevalence indicator work

vi To be identified and work undertaken on this and remote and rural procedures

vii Consider development of primary care activity report for capacity planning purposes
Document and version control history

Drafting process:

<table>
<thead>
<tr>
<th>Name of Individual/Group</th>
<th>Date of issue</th>
<th>Version</th>
<th>Updated By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline to Clinical Strategy Project Team</td>
<td>07 October 2008</td>
<td>V01Draft1</td>
<td></td>
</tr>
<tr>
<td>Consultant Clinical Strategy Project Director</td>
<td>12 October 2008</td>
<td>V02Draft1</td>
<td>Karen Tarn</td>
</tr>
<tr>
<td>Clinical Programmes Board</td>
<td>20 October 2008</td>
<td>V03Draft1</td>
<td>Karen Tarn</td>
</tr>
<tr>
<td>Clinical Strategy Project Team</td>
<td>20 October 2008</td>
<td>V03Draft1</td>
<td>Karen Tarn</td>
</tr>
<tr>
<td>NHS WI Board Workshop</td>
<td>29 October 2008</td>
<td>V04Draft2</td>
<td>Karen Tarn</td>
</tr>
<tr>
<td>Clinical Strategy Project Team</td>
<td>29 October 2008</td>
<td>V04Draft2</td>
<td>Karen Tarn</td>
</tr>
<tr>
<td>Consultant Clinical Strategy Project Director. Interim Project Manager</td>
<td>28 November 2008</td>
<td>V05Draft1</td>
<td>Martin Hill and Karen Tarn</td>
</tr>
<tr>
<td>Consultant Clinical Strategy Project Director. Interim Project Manager</td>
<td>10 December 2008</td>
<td>V05Draft2</td>
<td>Martin Hill and Karen Tarn</td>
</tr>
<tr>
<td>Clinical Programmes Board</td>
<td>11 December 2008</td>
<td>V05Draft2</td>
<td>Martin Hill and Karen Tarn</td>
</tr>
<tr>
<td>NHS WI Board</td>
<td>11 December 2008</td>
<td>V05Draft2</td>
<td>Martin Hill and Karen Tarn</td>
</tr>
</tbody>
</table>

Authors: Martin Hill, Consultant Project Director and Karen Tarn, Interim Project Manager

Contributors: Project Team, Clinical Programmes Board, Clinical Reference Group

Final Approval Date:

Review Date: