Inquiry into out-of-hours Health Care Provision in Rural Areas

Scotland Patients Association (SPA)

SPA would like to thank the Health & Sport Committee for inviting SPA to comment.

Introduction

Health Care provision, whether it is remote Malawi or Scotland, requires the appropriate skill mix of experienced health professionals to promote and prevent illness as well as treat medical and surgical emergencies. Health professional to be effective need to be able to access the population as well as the population being able to access primary and secondary health care centres close to their homes and to families.

Scotland’s geography will always be a challenge to providing Health Care but this challenge was met and overcome many years ago. Scotland should be proud to have designed a very successful Health Service fit for this purpose 96 years ago.

SPA would remind the H&S committee that Scotland addressed the issues of Health Care in the remote and rural areas, such as the Highlands and Islands, prior to the NHS being designed and implemented. The Highlands and Islands Medical Service (HIMS) were launched in 1913.

HIMS covered approximately half of Scotland’s landmass before the NHS took over in 1948 and it was no doubt a blue print for the latter. An American pioneer called Mary Breckenridge visited Scotland in 1924 and on her return built the Frontier Nursing Service in Kentucky built on the HIMS model.

Perhaps it would be useful for the committee to consider the model of HIMS to see how they achieved excellent health cover for the remote and rural areas. HIMS could be improved by the addition of modern technology, but should not be replaced by the latter.

(Before 1913 Medical and Nursing services were poor or non-existent in many areas and Crofters did not qualify for services under the new National Insurance Scheme.)

HIMS was built on the combination of doctors and nurses working together and was set up by a treasury grant of £42,000 pounds. The service was extended to hospitals in the 1930s with extra treasury funding.

Stornoway had its first surgeon in 1924, Wick gained theirs by 1931 with the support of Aberdeen University, and Shetland and Orkney followed in 1934. Close links were established with other Universities and in 1935 the first air ambulance service was operational.
What do patients need?

Generally speaking sick people are relieved to see a highly trained and experienced health professional walk through their door. Fear and anxiety are instantly diminished but would escalate instantly if it became obvious to them if a person sent in an emergency to help and diagnose their condition, lacked experience and knowledge.

Whatever system is set up to deal with Health Care and medical and surgical emergencies in any part of Scotland it is essential that competence matches confidence of all NHS professionals according to the position they hold. Passing exams and book knowledge is more useful to NHS professionals and their patients when experience is added and improved upon over years. Experience is particularly useful in remote areas because hospitals are not down the road and severe weather can isolate patients and their health care professional. This kind of situation is not for the faint hearted or those lacking in experience of working remotely.

Scotland cannot change its geography and yet 96 years later it is again faced with the dilemma of how to care for its population, many of whom live in remote and rural areas. Some areas have lost, or may lose their traditional General Practitioner (G P) as designed all these years ago for the HIMS, and which they had previously enjoyed.

Can Scotland afford the cost of Health Care in remote parts of Scotland?

SPA would argue it would be too costly for Scotland not to provide more GPs, district nurses, health visitors and other allied health professionals trained to work in remote and rural Scotland and not to do so should not be an option.

At present the changes in NHS services vary across Scotland and are not equitable. If this situation were to progress it would become difficult to sustain communities and would mean that many would not wish to live in remote and rural areas. People would not wish to put themselves, or their family, at risk by living in a remote or rural area and many would have to consider a move into the urban and city developments, where most NHS services are now concentrated. If this happened there would be an impact on the sale and value of property especially in the present financial climate?

It would be difficult to sustain communities if there was no reliable 24 hour NHS cover and it was for that reason the HIMS was designed, to sustain remote and rural communities.

- The retired, elderly aging population, which is living longer with more complex conditions, could not stay in remote and rural areas without appropriate professional health care. Few would consider retirement to the country and would have to reconsider their options. How would they get to the nearest GP surgery and be looked after when they became house bound? Transport access and patient and ambulance
Transport is an issue to consider. How far away is the nearest district hospital?

- The decision to centralise medical services has caused people in remote and rural areas to travel more for health care. At one point the hospital in Fort William was nearly closed but thankfully commonsense prevailed and it continues to provide an excellent standard of care and service and SPA think this model needs to be expanded to take the pressure of city hospitals for straight forward surgery, by highly qualified general surgeons, who link with University Teaching Hospitals.

- Who would wish to set up a business and live with a young family in a remote part of Scotland if NHS cover were sparse or at a great distance from home? What young woman would consider a pregnancy without easy access to professional cover by experienced midwives and obstetricians?

- What tourist would like to visit our most beautiful and remote countryside if medical cover was sparse and not well organised? Populations increase dramatically during the summer months. It should be remembered that heart attacks and strokes can happen anywhere anytime and in all age groups and people need a speedy diagnosis and treatment to have best outcomes.

- SPA is aware of patients in the city who have easier access to teaching hospitals who have been turned away having presented with symptoms and signs of a stroke and only have managed to get the most appropriate treatment because it was easier to access by repeatedly presenting themselves to A&E to see a doctor or a general practitioner (GP).

- What chance would people have to do this in the remote and rural areas if they do not have easy access to an emergency GP service in or out-of-hours, or and A&E department?

- It is more costly to the patient, the NHS and the country to fail to diagnose a heart attack, stroke or cancer.

If NHS services become diminished in more remote communities it would appear to SPA that Scotland is going backwards towards a time in which we required to invent the HIMS. Telemedicine and NHS 24 advice on the end of a phone should be an extra, not a substitute, for patients receiving the most appropriate care by the most appropriate NHS health professional face to face.

( http://www.60yearsofnhsscotland.co.uk/history/birth-of-the-nhsscotland/highlands-and-islands-medical-service.html.)

What is required to provide a safe NHS service which covers 24 hours?

- To be fair to people who live in remote and rural areas they would need to have experienced doctors, nurses and allied health professions to care for them so that they would not be disadvantaged more than they are, by living at a distance from specialist NHS centres.

- In addition communication by IT services, including broadband services and mobile phone access, in all remote areas, to allow the best use of
telemedicine to connect to qualified and experienced NHS staff. It should be remembered that all technology needs a professional person at the end of it and extra staff would be required to hold clinics and give advice even out of hours.

(Anecdotal evidence from people who have had occasion to need medical services in Norway seems to be a combination of the best use of telemedicine and face to face contact with an emergency doctor on call, who can turn up at an emergency allocated centres to see the patient by appointment.)

- Patients need to have a speedy diagnosis in order to be treated well to have the best outcomes. For this we need more GPs, District nurses and health visitors trained to work in rural areas. Delay in a diagnosis due to inexperience or the lack of easy accessible back up facilities with qualified help, can produce very poor outcomes for patients and cost the patient and the NHS more.
- Some remote and rural areas still have GPs covering the out of hours services by arrangement with other practices and that may work very well for those communities until doctors become ill, or retire or need cover for holidays and study leave. We should be encouraging young Health professionals to work in remote areas as part of their general training and then they would appreciate the value of living and working in such a setting.

Areas such as Kinloch Rannoch, Mull of Kintyre are essentially on the mainland of Scotland but are as isolated as islands surrounded by water. This geography and severe weather conditions, which only Sea King Helicopters might manage, demands experienced health professionals to work in remote areas. Patients in and near to cities have the advantage to be able to present themselves to the A&E of their choice or a Minor Injury Unit. Patients in remote areas cannot do this due to the lack of transport access and distance from the nearest A&E or Minor injuries unit.

If a doctor can examine a patient face to face rather than on the end of a phone that is always better for patient and the doctor and may prevent and unnecessary visit to hospital with the associated long journeys to and from.

**Ambulance Service**

- When an ambulance responds to an emergency call it is most important for the patient to receive the most appropriate care, from the most appropriate person, in the fastest possible time to produce the best outcome for that patient.
- SPA has been made aware that an emergency ambulance call can provide a “first response ambulance service” which arrives quickly but is not able to cope with the immediate needs of the patient in an emergency, due to the fact that the first response ambulance may be accompanied by a technician or two, or someone known as a first responder who is neither a technician or a paramedic.
SPA knows of a young adult who was fitting and had to wait outside their house with the “first response ambulance”, which had two technicians on board, who had to wait about half an hour for the paramedic to arrive because they could not cope with this type of emergency. This was an exceedingly frightening experience for the patient, their family and I assume the technicians. This was a very costly exercise all round because of the lack of matching competence and confidence with the most appropriate person and vehicle. This event did not take place in a remote or rural setting but imagine if it had. It would be a great worry for those who do live remotely if this happened to them.

There is no good in arriving quickly to provide a service as an emergency only to find out that a more senior paramedic needs to come with another vehicle to take the patient to hospital. This is true no matter where a patient lives in Scotland.

Likewise we have heard of patients discharged from hospital who require four people to lift when the patient arrives at the house which requires two ambulance crews. If this is not co-ordinated well the patient may have to wait over an hour in the ambulance until the other crew are available. This may not seem important but it is for the patient who is very sick and may be terminally ill. This lack of communication happens in the cities and would result in very poor outcomes for patients if it were to happen in the remote areas of Scotland.

We need the most appropriately trained person and the most appropriate vehicle to respond to 999 calls for best outcomes

Patients who have to travel back and forward to hospital for dialysis may not always be that ill to require a two man ambulance and other transport could be provided to free up two man emergency ambulances. I have been told that there is about a 6% yearly increase in demand for this kind of transport and that the ambulance service is stretched to cover this service. A review of the type of vehicles required to provide a patient service should be looked at urgently because patients should not need to wait an inordinate time to go back and forward to hospital from their home when they feel ill because their time on this earth is precious.

Morale of staff relates to being valued by management as well as being treated with respect and dignity and is essential for patients to have an excellent service which treats them with respect and dignity

- If any NHS service is stretched then the morale of highly trained personnel falls because they know what they should be providing but cannot. In order to recruit and keep people in post, management need to listen to what all NHS staff require doing their job, to a high standard to which they have been professionally trained.
- For example, if well meaning members of the population are recruited by NHS management to provide a first response ambulance service because it is a cheaper way of filling the gaps in a service, this could
lower the morale of the highly trained paramedics who take great pride in their work. Likewise if lay people are trained to do simple dressings take blood pressures and take blood samples. When does the simple dressing become recognised by the non nurse to need referral on to a more senior health professional, because the situation has changed?

There is nothing worse than a person who is confident in their abilities but is unaware they lack the required competence. This is a dangerous combination and could at best; cause a delay of a diagnosis or worst scenario, a death which may have been avoided. If a poor outcome is a result after a not so highly trained person deals with an emergency then it leaves family wondering if the outcome could have been better and could lead to a formal complaint.

It is not fair of management to put the less qualified or inexperienced person in a role beyond their competence. It may be the cheaper option in the short term but it is likely to reduce the morale of the person and they may give up and leave. Inexperienced staff do not produce good outcomes for patients.

SPA does not think that the best value for money and best outcomes for patients needs can ever be achieved by substituting doctors with nurses, nurses with care assistants and allied health professionals by well meaning people who have been led to believe they have training enough to provide adequate care.

**NHS Continuing Health Care**

The Scottish Government is encouraging all Health Boards to review all patients who receive NHS Continuing Health Care and to transfer these patients into the community. This is important situation for all patients but is especially important for those who live in remote areas of Scotland because there are fewer suitable options for patients in the community. It is possible for a patient who requires full nursing care, including help with eating and drinking and who is bed bound and who can do nothing for themselves to be discharged from a rural hospital into a Care Home with nursing which is Grade 3 (adequate) by the Care Commission. There may be no suitable Care Homes with Nursing close to a person’s home and this can cause added hardship for spouses and their relatives visiting. Many Care Homes with nursing are only Grade 3.

**Living and Dying Well**

We are aware that patients at present have difficulty in accessing hospice care in the more populated areas of Scotland when they require it and therefore this will become a serious problem with the lack of hospital beds and lack of hospice beds all over Scotland. To receive the most appropriate care for NHS Continuing Care and Palliative Care experienced and highly trained nurses and doctors are required to produce the best end of life experience for patients and to provide pain relief. If Scotland cannot provide the nurses and doctors for the populated areas what kind of experience will people have in a remote area?
More and more patients are discharged into the community but without the appropriate staffing levels and experienced doctors and nurses, care in the community will diminish.

We will need more trained district nurses and health visitors to look after those who are ill and to prevent illness. Health visitors are particularly important to help young families and to work closely with General Practices. They are accepted in all households, without stigma, and can help young families with young babies and are skilled at looking out for postnatal depression and child abuse.

Health Visitors are essential to the health and wellbeing of all communities whether they be in the cities or remote or rural.

The basics of good NHS care are the same in any community, urban or rural. Elderly people who are housebound are vulnerable wherever they live. Everyone at some time will need to have access to a team of NHS staff who knows the patient such as a GP or consultant, qualified specialist nurses, such as district nurses, health visitors and specialist practice nurses, in addition to all allied health professionals and trained care assistants to work within the health team.

Diagnostic Scanners should be able to be staffed into the evenings and at weekends and also more staff should be trained to offer appointments and to offer prompt reports. SPA is aware that some scan results can lie around for weeks waiting for people to return from holidays to report. We are aware of one patient who had to wait 5 weeks to get a report which was 18 weeks from the injury and was still to be treated. If scans take so long to be reported the Government will not be able to achieve the new targets for cancer diagnoses.

Transport

Public transport needs to be available in addition to dedicated transport, to aid patients from home to GP Surgery and General Hospitals as well to the more Specialist Hospitals. People do not expect their own hospital at the end of each road but for the less specialised cases the old system which developed under HIMS was to have local district hospitals with competent general surgeons.

To provide the best service to Scotland’s population we need to expand the training of more general surgeons and hospital services such as the Belford at Fortwilliam. We need to look to the future. General surgeons could work alongside more specialised surgeons in training and specialist surgeons could visit the general hospitals when required; when a patient could not be moved to the city hospital. Specialist surgeons and physicians could travel to the patients more than they do at present. Competent teams could go out and perform surgery near to the patient as well as giving assistance with telemedicine. The latter to work well needs the well trained specialists to be free to hold telemedicine/surgical clinics in addition to their normal work load.
so more trained staff will be required and the costs will rise in salaries but patients would have better outcomes nearer to home and it would relieve the strain on the teaching hospitals.

**Staffing and training**

No NHS service can work without having the appropriate trained staff in more than adequate numbers, to allow study leave, holidays, sick leave and maternity leave. (The majority of medical graduates are woman nowadays it should be remembered)

If we expanded the numbers of trained staff we could more that cover out of hours services throughout Scotland as well as expanding our hospital service throughout Scotland. We could cover our own population of 5 million plus and offer services to people in English Primary Care Trusts who need NHS care if we had spare capacity and the expertise.

Many of our Scottish patients have to go south to the London area for specialist care. Why should we not aspire to providing specialist care in Scotland for the North of the UK as the London Hospitals do for the South of the UK?

Scottish patients who should be able to get services on the NHS often have to go privately because time is not on their side or our surgeons do not have the competence. Patients often find they have to seek medical or surgical care privately in Scotland, Europe or in England.

We train enough doctors in our universities and we could do our best to keep them in Scotland if we had training links with other specialist centres in the UK and Europe so that our patients do not need to travel far from home.

Scotland is a beautiful country in which people wish to live, even in the more remote areas and it essential that they are provided with as equable care as people who live in the more populated areas. We all expect to drive out into the country and stop for lunch or dinner but if people do not feel safe to live and bring up their families, as well as growing old in an area, that community will die and so will tourism.

I urge the Health and Sport committee to read how Sir John Dewar and his committee assessed the provision of the need for Health Care in the remote areas in Scotland and the speed in which the Highlands and islands (Medical Service) Grant Act of 1913 came to be. It would be so sad if we slid back in time and did not learn from the past.

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