



BRITISH-IRISH INTER-PARLIAMENTARY BODY
COMHLACHT IDIR-PIARLAIMINTEACH NA BREATAINE
AGUS NA ÉIREANN

30TH PLENARY SESSION
REPORT FROM COMMITTEE C ON DELIVERY OF HEALTH CARE TO RURAL
POPULATIONS
(Adopted 28th session)

OBSERVATIONS BY THE SCOTTISH EXECUTIVE



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Dear David

Thank you for your letter of 10 June to Jack McConnell enclosing a copy of the report adopted by the Body on the Delivery of Healthcare to Rural Populations. I am responding on the First Minister's behalf since the issues raised in the Report are very largely matters of health policy and delivery.

I was very interested to read the Body's report, and was pleased to see that Members felt that their visit to Caithness General Hospital in Wick had been productive and helpful. I was also interested to read the accounts of the visits to the Isle of Man and to Caerphilly Miners Hospital in Wales.

As the Report notes, there are a number of issues to be faced in maintaining safe, high quality healthcare services in remote and rural areas. These issues are of considerable concern to local populations, to the professional staff involved, and to the organisations responsible for planning and delivering health services. In Scotland, the unified NHS Boards.

As the Body's report brings out, hospital-based healthcare services in remote areas depend on a small number of key staff, for whom the decision to take up appointments in remote locations and to remain in post in hospitals such as Caithness General is a personal one. Such locations may involve a degree of professional isolation and constrained opportunities for specialist development, and can therefore be seen as bringing major challenges. The issues for clinical staff set out in paragraphs 44 and 45 of the Body's report is very clearly.

I was particularly interested to read the Body's conclusions and observations in paragraphs 51 and 52 of the report. I would offer the comment that the challenges facing healthcare organisations in providing hospital care for rural and remote populations are not driven primarily by considerations of policy and planning for health provision (see paragraph 51) but by developments in medical practice. In particular, there is persuasive clinical evidence that increased specialisation achieves better clinical outcomes, and that professional staff who deal with a particular condition only infrequently cannot in general achieve the same quality and consistency of treatment or level of results as those who see larger numbers of patients presenting with that condition. And it is difficult to sustain specialist services where they are used only infrequently – for example, an intensive care unit.

The question then becomes one of whether rural and remote populations should be provided with hospital-based services which are likely to be less clinically satisfactory – although more easily accessible – than services available to people in larger population centres. This is a difficult position to sustain, not only for healthcare organisations and for Ministers, but also for healthcare professionals. The question then arises as to how specialist services, which will tend to be provided only in larger centres, can be made as easily accessible as possible to remote and rural populations. These are the very issues that NHS Highland has been seeking to address and which were the subject of the report prepared by Professor Andrew Calder to which the report refers (see paragraphs 39 and 40).

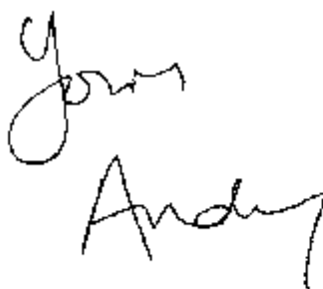
The report's conclusions and observations helpfully draw attention to some ways in which access can be improved, including integrated approaches and rotation of key clinical staff. The NHS in Scotland is pursuing a number of approaches, with specific support from the Scottish Executive. These include the development of Managed Clinical Networks, where clinicians plan and provide services in more than one location through joint training and support arrangements, and the development of telemedicine. Through telemedicine, some healthcare services (for example, dermatology, radiology) can be offered to patients locally while the clinicians providing the service are physically located in main population centres. There are examples of such services in the Highland and Islands of Scotland.

I also fully endorse the Body's observation that local populations should be closely involved and consulted about options for change. This builds understanding among patients and the public about the advantages and disadvantages, and the likely trade-offs, of potential models for organising healthcare services. Some of these issues are complex and sensitive. The Executive has issued guidance to NHS Boards which requires them to engage with, inform, and consult the public in their areas on NHS service issues, and to maintain a constructive dialogue. This helps lay the basis for effective consultation when service changes are in prospect. Consultation with staff is a key element of our guidance to Boards.

On maternity services, Scotland has had Community Maternity Units for many years and is fully supportive of the creation of further units to ensure continuity of service for women with normal pregnancies, where consultant led units may no longer be sustainable. It is clear that CMUs have to be well planned, with well trained staff and good identification procedures and back up in place. Units are supported nationally by the Scottish Multi-professional Maternity Development Unit for the professional development of all those involved in the delivery of these services. A CMU is one of the 8 options that NHS Highland are currently formally consulting with the public on for the future of the maternity service at the Caithness General Hospital in Wick.

The Body also comments on wider social policy issues relating to maintaining services to populations in rural areas. The Executive is committed to maintaining strong, prosperous and growing communities in rural Scotland. We recognise that an important ingredient in delivering this will be the provision of accessible and high quality services. Earlier in the summer we announced that one of our objectives in tackling disadvantage throughout Scotland will be to achieve improvement in the accessibility and quality of key services to the most disadvantaged rural communities. Depending on the views expressed by those communities, the services concerned may well include health care.

I hope that this is helpful, and demonstrates that the Scottish Executive is very much alive to the issues highlighted in the Body's Report and is working with the NHS in Scotland, professional groups, and the public to tackle them successfully.

A handwritten signature in black ink, appearing to read 'Andy Kerr', written in a cursive style.

ANDY KERR