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INTER-PARLIAMENTARY BODY

COMHLACHT IDIR-PHARLAIMINTEACH
NA BREATAINE AGUS NA hÉIREANN

REPORT

from

COMMITTEE C (Economic & Social Affairs)

on

DELIVERY OF HEALTH SERVICES TO RURAL POPULATIONS

Doc No. 97 **April 2004**

Background to the Enquiry

1. At its meeting during the 26th Plenary Session of the Body in Kilkenny in March 2003, the Committee decided to examine the delivery of health services to rural populations and people living in peripheral areas. Committee Members were aware that this was an issue which was of major interest and concern for many citizens in Britain and Ireland. They felt therefore that it would be valuable to look at examples of how this issue was addressed in different regions.

2. The Committee decided to visit three different locations, the Isle of Man, Wales, and Scotland. The Isle of Man location was deemed appropriate to the remit of the enquiry as it provided a model of delivery of a range of health services for a defined population area, both urban and rural. Services provided ranged from a new state of the art acute hospital facility based in Douglas to geriatric and outpatient care facilities in outlying areas.

3. The Committee visit to Wales focused on a model of a self-standing midwifery led maternity unit servicing a rural catchment area in the Rudry valley in South Wales. The unit, although located a half hours drive from Cardiff, was seen by its management as a model which could be developed and operated in outlying peripheral areas.

4. To complete the range of issues examined by the Committee, it decided to visit a health service delivery location in a remote area of Northern Scotland, - the Caithness General Hospital at Wick in the northern highlands. This visit allowed the Committee Members to assess not only the problems associated with health service provision for a remote population but also the social impact on sectors within this community of constraints on access to the full range of hospital services normally available to an urban population.

5. The Committee would like to record its thanks to those who assisted the organisation of these visits. Mr. Donald Gelling CBE MLC organised the visit to the Isle of Man and arranged a meeting with the Hon Clare Christian MLC. Mr. John Marek AM and Mr. David Melding AM, and the Welsh Assembly secretariat were most helpful with the visit to Wales. Finally the Committee would like to express its thanks to the Scottish Parliament staff ,the management and medical personnel of Caithness General Hospital, and the group of local GP's at Wick who facilitated the visit to northern Scotland.

ISLE OF MAN

NEW ACUTE HOSPITAL

6. The building of the new acute hospital outside Douglas came about following a long period of investigation as to the best way in which to update the existing hospital facilities in the centre of Douglas. Initially, beginning in the very first years of the 1990s, the plan had been to redevelop the existing Nobles hospital site in

Douglas, which dates from 1912. Upon further examination, however, it became clear that the Nobles site could not be properly redeveloped and was too constrained. By 1997 it was therefore instead proposed to use the site of an old Victorian mental hospital outside Douglas for the building of a new acute hospital: this met with some opposition, both from those emotionally attached to the old site and by those who felt that moving the hospital from Douglas to a more rural area was a practical mistake. However, the new proposed hospital was to be no more than 20 miles from anywhere on the island, and after a lengthy planning process the decision was agreed upon.

7. The redevelopment of this site outside Douglas necessarily led to the closure of the old mental hospital there: this had in fact been agreed earlier in 1991 when it had been decided to care for all mental patients in the community. This mental hospital, with a capacity for about 300 patients, had in fact been falling into a state of disrepair for a number of years. Mental patients were instead put in housing in ordinary streets, in some 22-3 sites scattered around the island, four persons to each house, all with 24 hour staffing.

8. Work on the acute hospital began in 1997: the hospital was not yet open when we visited in May 2003 - it was due to open a few months later and move gradually to capacity over the following months. It was stressed that this site was not the only major health care site on the island. There were in fact three other community health care sites: one in the north, in Ramsey (an old cottage hospital site), one in Douglas (on the old Nobles hospital site) and one in the south (the new Southlands site, which we will touch upon later). All GPs were based in groups: their general 24 hour responsibility had been given up and a special contract drawn up for night-time care.

9. The new acute hospital would, it was hoped, deal with almost every area of medical care needed. One principle exception was neuro-surgery: those needing that sort of medical treatment were taken by helicopter to Liverpool (a 45minute journey). For some specialisms, consultants would visit rather than be based permanently on the island: it was not possible for a permanent staff to cater for all medical areas as in some of these speciality disciplines the throughput of patients, in number and in diversity of condition, was insufficient to maintain the necessary levels of expertise and training.

10. The new hospital was equipped with 314 beds (only a few more than had been the case in the old Nobles hospital) and was hoping to have a substantially increased throughput of patients, compared to the old hospital, due to greater general efficiency, and particularly due to more day-surgery and a shorter length of stay for those kept in. It was expected to be able to care for the health needs of the assumed 2021 population of 85,000. The hospital also had 6 IT beds and a separate coronary care unit, as well as 15 beds in a private wing. In addition there were 6 operating theatres (and 1 in maternity), an increase in 50% over what had been the case in the old Nobles hospital. Some theatre lights would come from the old hospital, some would be new, in order to moderate costs. The hospital was manned by 24

consultants, 5 or 6 of whom would at any one time be "passing through". Nurse training had originally been phased out on the island in 1994, but had been re-stared in 2000 and, as there were problems recruiting specialist nurses, attempts were being made to recruit some nurses who had left the profession with requisite skills some years before. These were also cheaper than agency nurses. In total the hospital had 1700 staff.

11. The design of the hospital was modern. It possessed a lot of light walls, no radiators, and its U shape allowed it to maximise natural light. It was also decentralised. There were community-sponsored courtyards. The children's ward was separated into young and adolescent sections, and was then further split up into 4 bed bays. The hope was to maintain single-sex wards where possible. Although the floor space was similar to that of the old hospital it was more efficiently used. In order to allow for staff to get away from their work for a time there was segregation in the catering facilities: a voucher system catered for inpatient needs. Concerns about security (especially with regard to maternity care) meant that there was only one public entrance into the hospital building and 88 CCTV cameras were deployed about the site. There had been a decline in standards of behaviour (principally by patients) over recent years and a worrying increase in violence towards staff.

12. The authorities had hoped to have stringent control over MRSA at the hospital. Adult and child waiting areas would be separate, but both were close to the digital radiology facility (the most expensive part of the new hospital). Day surgery would be furthest from the public entrance but nearest to the theatres. It had always been planned to include a private wing in the hospital (there had been one at the Nobles hospital). At present, Manx law did not permit such private beds to generate profit: charges could only cover costs. That could change in the near future, however. Consultants had the option of doing some private work: thought was also being given to the possibility of having one theatre dedicated to private work. Aside from the main hospital building there were separate buildings housing a diabetic care centre, an acute mental heath centre, and an education and training centre.

13. It had been difficult to keep costs under very tight control. Construction work had run over budget due to some problems with some contractors going bankrupt. In all, some 25% of the work had been done by local companies - it had been broken down into packages, some of which had come in under cost and some over. Too many discrete packages had undoubtedly added to overall costs and the over-run on the initial budget. The original budget had been c£80 million, but so far Tynwald had voted £111.7 million. The loan required to pay for the hospital would be paid off by 2020 - the only cost then on the Manx tax-payer would be for the running of the hospital - roughly the same amount (for a greater throughput) as the old Nobles hospital, although it would of course rise over time.

14. The demographic on the island was shifting. The population was growing younger and more active - and was growing in size. In each year it was expected that the hospital would deal with 55,000 outpatients. 15% of these each year would be new outpatients - the others repeat outpatients. There was a target for all patients

to see a consultant within 13 weeks, and also for all patients to receive the appropriate hospital treatment in 13 weeks. That second target was not currently being met. A&E had a throughput of 30,000 cases each year.

SOUTHLANDS CLINIC

15. The Southlands clinic site is a residential care home which also deals with mental illness and disability: an existing old persons' home turned into a community health centre. There were 86 beds in all: six rooms with 12 beds each, and a larger room of 14 beds. There were also a number of treatment rooms. Four GPs were based next door and were contracted to work at the clinic in addition there were weekly visiting consultants. 12.5 care staff manned the clinic. The care staff/patient ratio was 1/8, although the staff establishment/patient ratio was almost 1/1. The clinic had cost £7 million to build.

16. People were on the whole referred to the clinic by social services staff or by GPs. A multi-disciplinary case conference decided which mental patients to send there. A selection of more acute mental patients was still at one of the new acute hospital outbuildings: some of those could be sent to Southlands for rehabilitation. There were also convalescent beds for re-enablement treatment. It was expected that there would be 95% occupancy at the clinic (62% occupancy at the hospital). The cost per patient per week at Southlands was £400 - but the charge would only be £270 (these were the costs for long stay). It was difficult to cost beds at the acute hospital, although private beds had been coasted at £350 per night.

17. Patients for geriatric care at the clinic were of course over 65, except for a few individuals who were there with advanced cases of senile dementia. There were, of course, also private nursing and elderly care homes in the Isle of Man which could cater for patients with these problems. Sheltered housing was available which could often be afforded by renting out one's own house. Guidelines for charging for geriatric care were a difficult and sensitive area. Overall health spending on the Isle of Man was £307 million per annum, which represented over 50% of total annual state expenditure.

18. Some other problems challenging the Manx health system were: an increasing problem with autism spectrum disorder, and an increasing drug and alcohol problem. There had been massive seizures of drugs recently. There was no good centre for treatment of alcoholism on the island: there were plans for a dedicated deter unit, and private incursions were also being made into this area of care. The only current public resource for dealing with this area was in the usually inappropriate acute mental service.

WALES

BIRTHING CENTRE

CAERPHILLY MINERS Hospital

19. The Birthing Centre located in the Caerphilly Miners Hospital, which is 20 miles north of Cardiff , became fully operational in 2002. Although located in the hospital, the Centre is self-standing as regards management and services. It is led and staffed fully by a team of midwives and operates without a consultant or paediatric unit component.

Transition To Midwife led service

20. Prior to this, the maternity unit service together with a paediatric service was run from within the hospital by junior doctors. This service also included a team of midwives working within the unit since 1992. A Health Authority review of services at Caerphilly Hospital led to a decision to withdraw the paediatric service. A general finding of the review was that low-risk pregnancy cases were over-medicalised whilst high risk pregnancy cases were under-medicalised. In addition to this finding the review also noted that a full and efficient midwifery service had been operating in the hospital since 1992.

21. The combination of these two perceptions led the review team to suggest that the group of midwives at Caerphilly draw up proposals for a midwifery-led maternity service which would combine a professional public health care service with and efficient and safe maternity delivery service for the local population.

22. The midwife team drew up proposals for such a service which were then converted into a business plan for the new birthing centre. The plan was benchmarked with similar other types of unit in England, and members of the Caerphilly midwife team visited some of these units to study practice and lessons learned. The transition from a consultant led service to a full midwife led service at Caerphilly took place over a five year period.

Birthing Centre-Services and Facilities

23. The Centre offers the following services:

- Midwife-led service for delivery
- Water Bath delivery option
- Pre- and post natal services
- Breast feeding support and baby massage service
- Early pregnancy testing
- Emergency contraception service

24. The Centre is a self-standing unit located at Caerphilly Miners hospital but not part of the hospital administration or services. The unit comprises a birthing room, birthing bedroom, birthing pool, and small resuscitation room, together with six post natal bedrooms fully en suite.

25. There is a team of 21 midwives based in the Centre, who have been in operation in the area since 1992 and are well known to the local population. As well as the

services provided at the Centre they also provide a home birth service for those opting for this.

26. There is no post-natal paediatric unit attached to the Centre.

27. There is a neo-natal GP care service available. The Centre has no fixed policy on length of post natal stay for patients in the Centre and this is left to the patient to decide. Experience has shown that normally the period is five days although often patients opt to leave earlier.

Patient Options and Choices

28. Patients in the area covered by the Centre have the option of a midwife led birth in the Centre or a consultant led birth in hospital in Cardiff- normally at the Royal Gwent or Cardiff University Hospital. There are approximately 1350 births annually in the area. At present the Centre deals on average with a quarter of these, and of this quarter around 17% are referred or transferred to the two above hospitals. 95% of the users of the Birthing Centre service are local, and 5% from outside the area. An audit on Centre use for the period January 2002-September 2003, the first nine months of the full operation of the Centre, indicated that the midwife team dealt with 435 births, in addition to 55 home births and 41 post-natal returns.

Advantages of Birthing Centre service

29. In discussion with Committee members, the Centre management indicated that despite understandable initial concern among the local population at the withdrawal of a consultant led maternity and paediatric unit from Caerphilly Hospital, the services offered by the Centre were increasingly being taken up as an option by the local community. It had the advantage of offering the water birth option which was not available in the hospital option. The profile of the Centre was one of a service led both by midwives and by the women patients themselves in terms of services. Its objective was to give mothers a choice in regard to maternity services. Proximity was an advantage, as in addition to the service and facilities for pre and post natal care available to the local community, support services were also available locally at the Centre, as well as the midwife service for home births.

30. In response to Members questions, some further information on use of maternity services at the Centre was provided. The water birth option showed an increase from 9% to 14 % of patients dealt with. In 72% of delivery cases handled ,72% were without sutures, 11% without painkiller, and 16% with anaesthetic. The experience of the midwife led approach at the Centre was that in the majority of cases only minimal pain relief was required for patients. In regard to home births in the area served by the Centre, 3% of total births were at home. The national target set for Wales was 10% by the year 2007.The question of post-natal testing was also raised. The Committee was informed that testing for hearing defects was universal in Wales and that there is regular testing in paediatric care for sight defects.

Role of Centre in Overall Health Service Provision

31. Committee Members discussed with the management of the Centre its role in the overall provision of maternity services within the region covered by the local Health Authority. The midwife-led service aimed to give mothers a choice and is seen as an import part of a health service responsive to patient need and choice. It was recognised as providing a balance between safety and choice, but the safety factor remained uppermost in their approach. In their experience, selection in deciding which cases would be dealt with by the Centre was very important. Essentially it dealt with low-risk cases. The number of critical cases which were actually handled by the Centre was very small compared to the overall level of births in the area. Another very important factor was that the Centre had a close and planned linkage with neo-natal service providers in the area. For example it had a rapid reaction unit to deal with emergency and critical cases.

32. It was noted by Members that although the midwife service was stand alone, without consultant service or paediatric service, it was located within a half-hour drive from Cardiff and its referral hospitals which could provide the full range of service to both critical and low-risk patients. In response the Centre management suggested that the model embodied by the Birthing Centre operation could operate effectively in outlying regions without this close access. What was important was the case selection process and the planned linkage with back-up services. In regard to risk factors which could arise for patients, the Committee was told that no maternity service delivery system could eliminate risk completely. The risk factor was about 1 in 2000 for births with complications. This applied also to hospital based services with high technical units and equipment. Children delivered in these locations can still have difficulties on birth.

SCOTLAND

Caithness General Hospital at Wick

33. The Committee visited the Caithness General Hospital at Wick, as well as a local group GP practice, also in Wick. This location provided an opportunity to assess health service provision for a community living in a remote rural area of Scotland. Wick in Caithness is some 14 miles from John O'Groats, the northernmost point of the mainland. It is 108 miles from the nearest urban centre, Inverness. Caithness General Hospital serves a catchment area in Caithness and Sutherland with a total population of around 35,000 people. The population is largely rural, living in small villages, hamlet or isolated crofts, but also includes the towns of Wick (8500) and Thurso (9000). Among the features of the local geography of the area pointed out to the Committee Members were that it was the largest bogland in Europe and had the lowest population density in western Europe. There was no dual carriageway in Caithness or Sutherland and the nearest motorway to Wick was 210 miles. Traffic light density in Caithness was six sets and in Sutherland one set!

Range of Services

34. Caithness Hospital has approximate a 90 bed capacity which includes;

- 23 general medical and 3 HDU beds
- an 18 bed surgical and 10 bed day case area
- 25 rehab and elderly care beds which includes a 4/5 bed stroke unit and attached Gym and OT department,
- 11 bed maternity unit
- 4 renal dialysis bays.

35. In addition the hospital facilities include a laboratory, pharmacy, a radiographer run XR and U/S services, an endoscopy suite with theatre and anaesthetics and also palliative care.

36. Hospital staffing was 3 physicians with general and special interests, 5 SHO's , 3 surgeons and 5 SHO's, 3 obsteticians/gynaecologists,1 OT and assistant, 1 whole time and 1 part time dieticians.

37. In addition to these services, the hospital also provides outpatient clinics run by consultants for general medicine and surgery, diabetic gynaecology obstetrics and mental illness, usually on a weekly basis, and clinics on a range of other areas usually on a monthly or bi-monthly basis. Support services for patients are also provided in physiotherapy, speech and language, occupational therapy, dietetics, and chiropody.

38. A major constraint for the hospital was the lack of a resident paediatrician and there was no paediatric back-up. Major surgery is performed at the hospital but there is no intensive care unit. Dentistry which requires general anaesthetic is not performed but done in Inverness.

Issues Facing Satisfactory Delivery of Health Services in Caithness

39. The visit of the Committee Members to Caithness was timely in respect of the issues the Committee was examining as it took place on the eve of publication of a review of the delivery of maternity services in Caithness. The review, an independent one conducted on behalf of the Highland Acute Hospitals Trust, raised certain issues and problems in relation to the provision of maternity services at Caithness. As Committee Members learnt during the course of their visit, the same problematic also applied to the provision of other areas of health care and specialist treatment at the hospital. The discussion of these problems at Caithness provided therefore a concrete context for the Committee's enquiry into the delivery of health services to rural and peripheral populations. Another linkage to the Committee's visit to Wales was the review's overall conclusion that the consultant led maternity service at Caithness General Hospital should be reconfigured to provide a midwife-led normal delivery facility at the hospital.

40. The review conclusion was based on the finding that the provision of specialist obstetric care at the hospital was unsatisfactory to the point of being unsafe in the view of obstetricians working in the region. This situation was due to the low birth

numbers and very low work intensity, the serious difficulty in recruitment of specialist obstetricians, and the practice of specialist obstetrics in the absence of any conventional neo-natal care service. In the view of the consultant staff who met with the Committee, these core problems of recruiting and retaining staff, maintenance and development of clinical skills and professional career development for existing staff, raised serious issues regarding the safety and sustainability of providing other areas of care and treatment for patients who present at Caithness General.

Location

41. These problems exist for other hospitals in the highlands and in Scotland, but are particularly aggravated for Caithness Hospital due to its remote location. Conversely, it is the remote location and logistics problems involved which make the withdrawal or reconfiguration of health care provision for acute and general patients an issue of major concern for the local population. The Committee heard that already, despite a wide range of facilities, a substantial number of cases presenting for A+E, cardiovascular and paediatric care were transferred to Raigmore Hospital in Inverness, usually by road, although a helicopter service was available for extreme emergency cases. The transfers are made on the grounds of safety and best care for the patient.

42. As the Committee heard from the hospital management, although the review itself acknowledged the difficulties for the local population posed by its recommendations, a major protest from within the local population at the proposal to withdraw consultant -led maternity services was to be expected. However as the review conclusion was primarily based on safety concerns, and supported by obstetricians themselves, they saw no real alternative to carrying it through.

Recruitment

43. The geographical location of Wick is a major constraint on recruitment of staff, as the Committee heard both from management and from staff at the hospital who recounted their own difficulties with their decision to locate in Wick, both from the professional as well as the domestic perspective. On the latter, the employment prospects for spouses within the region are very limited, and in regard to facilities such as schools, leisure, outward travel, these are also limited within the local area. Several medical personnel who met Committee Members made the point that moving to Wick was in fact a lifestyle choice with major implications which involved balancing some positive factors with significant lifestyle constraints.

Professional Skills Development and Safety Issues

44. Even for those medical personnel who opt to work in Caithness General Hospital, there are serious constraints on their opportunity to develop their clinical skills across a range of treatments and procedures. This ultimately has consequences for safety of patient care and treatment. Within the health service, an increasing number of specialists are now required to operate a continuous rota, and the level

required is set to increase in the future. In the case of the maternity unit at Caithness for example the low workload offered by the small number of obstetric cases (around 80 a year) is not adequate to enable the specialists in place to maintain and expand their clinical skills. This dilemma also applies to other areas of treatment in the hospital.

45. Medical staff who met with the Committee as well as management, clearly recognised this problem and the clear implications it had for safety and for their ability to confidently offer a wide range of services to the local population. The converse of safety is concern over liability which was naturally also a factor contributing to transfers of patients presenting to Raigmore Hospital in Inverness. In the view of one consultant this situation was particularly unsatisfactory , but unavoidable, in regard to paediatric cases. Caithness Hospital had no resident paediatrician and no paediatric back-up.

Social Dimension of Rural Health Service Delivery

46. The Committee heard views on the social dimension of the delivery of rural health services , both from medical personnel at Caithness Hospital and from a group of local GP's who operated two practices in a medical centre in Wick serving some 10,000 patients in all.

47. The population in the Caithness/Sutherland region is an ageing one and the 18-40 age groups within the population continues to decline. The pattern is that young people from the area who leave do not generally return. Hospital Management and staff recognised that although Caithness General offered a wide range of services, the need for transfer to Inverness for some services placed a difficult and disruptive burden for an ageing population and their families living in remote locations. They would not regard it as a satisfactory situation and if consultant led maternity services were withdrawn, the situation would worsen. They expected young professionals in the area to opt for delivery in Inverness, even for low-risk births, at least initially.

48. However for Hospital staff, safety and quality of care was paramount and they had to accept that this meant that Caithness hospital would not be able to provide the range of services it would wish. The point was made by a member of staff that as a matter of fact, however unsatisfactory, people who lived in remote areas such as Caithness/Sutherland had to accept that they would not have access to the range of health services available to an urban population.

49. In discussion at the GP practice, there was a similar view that the range of services at Caithness General was not fully satisfactory for an aging rural population. The absence of full paediatric,orthopaedic and vascular service was referred to in particular, as was the present difficult logistic situation with transfer to Inverness for patients and families. This involved serious social disruption and cost. The population served by the practice were almost exclusively NHS patients, with only about 1% using private care. The population generally in the area was low income. Preventative medicine was difficult to promote, as this would require a significant

change in local culture and attitude. There were abuse problems, alcohol and drugs , mainly among the middle aged male population.

50. One GP was strongly of the view that what was lacking was a specific social policy on the part of government which would be applied to remote districts such as Caithness/Sutherland. Such a policy would involve government recognising that it was committed to having rural populations, and consequently accepting that their particular needs be supported, not just the provision of satisfactory of health services but also other services and infrastructure. Initiatives such as low tax incentives for local residents, and also salary weightings for workers residing or wishing to move to the area were required. As regards the provision of health and over public services, it was clear that taxpayers in the region did not get the same return for their taxes as did people in urban or semi-urban areas.

Conclusions and Observations

51. Rural populations, particularly those in remote areas, do not have the same proximity of access to the range of clinical and health services as populations in urban areas. This disadvantage, which also applies in respect of other social services and opportunities, is a matter of concern to these communities. This concern has been increased as a result of health provision policy and planning and reorganisation measures being introduced, both in Britain and Ireland, either at local, regional and national level. Many rural communities foresee the outcome of such measures leading to a further reduction in their already disadvantaged level of access within their locality to the range of health provision services they feel they are entitled to expect.

52. Programmes of major reconfiguration or relocation of health service facilities also have impact on urban communities, particularly smaller ones. But there are a range of problems specific to rural communities in regard to the provision of an adequate and acceptable level of health care provision across a range of services. The following observations are offered by way of general conclusions of the enquiry based on the information received and discussion held during the visits to the Isle of Man , to Caerphilly, and to Wick.

a. health authorities and service providers proposing reconfiguration or relocation of services must involved the affected population in an open consultation process. This consultation should seek to recognise and where possible accommodate the specific concerns of these communities and address issues in relation to their particular needs across age and social groups. This process is important also for securing the confidence and acceptance by the communities that any relocation or reconfiguration of services implemented is related to safety and best care standards of health service provision

b. There should also be a consultation with the existing health service personnel

managing and delivering health care to these communities. Whilst the primary concern of such personnel is to provide safe care and treatment to a high professional standard, they are also well placed to understand the particular needs and health profile of the community they serve.

c. planned reconfiguration and relocation measures should take into account a range of factors. As well as safety, maintenance of professional standards, and related issues of professional liability, and the area of cost and efficiency factors, issues such as the social impact of such measures on communities, the particular needs of certain age groups, problems with proximity, also need to be recognised and given due consideration.

d. there is considerable merit in the view expressed to the Committee by the Wick GP group that the issue of provision of health services to rural populations needs to be put in a wider framework of a specific policy approach for urban populations, covering all services and special needs. This would require an explicit government commitment to having and maintaining a rural community and accompanying integrated programmes of investment and incentive measures aimed at providing the necessary range of services and infrastructure necessary to sustain a rural population across a range of services.

e. The recruitment and retention of professional medical personnel in remote rural health facilities is a serious problem It could be helped by such a wider social policy, as it would address their social, rather than merely professional needs.

f. The skills retention and professional development problem in regard to staff who have chosen to work in rural areas is of concern, and it also has a follow-through effect on safety and hence relocation issues. Health planners and management could seek to develop an integrated regional wide programme of outpatient and day services between hospitals and care facilities in the region which involved rotation of clinical and professional staff between facilities. This could assist with maintenance and development of professional skill. These types of service are available in locations visited by the Committee and could be further expanded on a region wide basis.

g. An overall social policy approach to rural population needs should also address the proximity and access issue in regard to provision of health and other services. Improved transport infrastructure, both road and rail, is a clears necessity particularly as reconfiguration/relocation will often mean increased distance for access to certain services and treatments.

h. The model of mid-wife led maternity facilities for low risk patients is an interesting and effective one which could be replicated in many rural and

remote areas. As the Committee heard in Caerphilly, such units needs to be well planned, to have good identification procedures and effective back-up services for risk cases, and a full post-natal care programme for mothers using such facilities.

i. the provision of health services in the Isle of Man is a well integrated model of health care provision for both urban and rural population in a specific geographic area. The new acute hospital facility, complemented by smaller cottage hospitals and other day and residential care facilities for specific groups in outlying regions provides a useful perspective for delivery of an inclusive health care programme on a regional basis in Britain and Ireland. It has to be noted however that the isle of Man population have the advantage of being within not more than 20 miles of the new hospital. It is also the case that the financial resources committed to the service, both capital and running costs, are probably in excess of the resources available to most regional health boards and authorities.

APPENDIX 1

Isle of Man Visit -11/12 May 2003

Members attending

William O'Brien MP Co-Chairman
Harry Barnes MP
Seymour Crawford TD
Jerry Cowley TD
Jimmy Devins TD
John Ellis TD

Isle of Man Delegate accompanying visit
Hon. Donald Gelling CBE MLC

Persons giving evidence to Committee

Hon Clare Christian BSc MLC Minister for Health
Hon Tony Brown SHK Speaker of House of Keys
Mr. Malachy Cornwell-Kelly LLB ,Clerk of Tynwald
Mrs. Jackie Bairstow Manager Southlands Complex

Caerphilly Visit - 25/26 January 2004

Members Attending

William O'Brien MP Co-Chairman
Harry Barnes MP
Joe Benton MP
Jerry Cowley TD
Seymour Crawford TD
Jimmy Devins TD
Cecilia Keaveney TD
Dr. John Marek AM
Mr. David Melding AM

Persons giving evidence to Committee
Ms. Maggie Davis Senior Midwife

Wick Scotland visit - 14/16 March 2004

Members attending

William O'Brien MP Co-Chairman
Joe Benton MP
Seymour Crawford TD
John Ellis TD
Cecilia Keaveney TD

Persons giving evidence to Committee

Caithness Hospital
Mrs. Pauline Craw Nurse Manager/Lecturer
Ms Kay Oswald Directorate Assistant
Ms. Alison Phimister Local Services Manager
Mr. Paul Fisher Clinical Director
Sister Julie Munro Maternity Unit
Staff Nurse Alison Geddes A&E unit
Staff Nurse Ruth Griffith. Rehab Unit

Mr. George Bruce Caithness and North Sutherland Health Forum
Mr. David Flear Highland Region Area Covenor

GP Practice- Wick
Dr. Emily Cobb
Dr. Carol Leeuwenberg
Dr. Derek Kelly
Dr. Ewan Pearson