



Scoping Paper for NHS Western Isles Clinical Strategy

Getting Fit for The Future

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1 Executive Summary

1.1 OBJECTIVES

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1. Executive Summary

This scoping document was commissioned in October 2006 and will be finalised by end December 2006. The document identifies those areas of work currently underway as well as describing further areas of work required to align services with the recommendations in *Delivering for Health*. The Scoping Document is the first phase in producing a final Clinical Strategy.

1.1 Objectives of the Scoping Document

To identify and collate the work of the:

- § Service redesign groups
- § Multi-agency partnerships (such as Mental Health Partnership)
- § Managed Clinical Networks (MCNs) (such as Chronic Heart Disease/Stroke)
- § Delivering for Health (D4H) work streams
- § Other areas where change in service are anticipated (such as Community Health Partnerships (CHP))

This scoping exercise does not encompass all the work of the Board in relation to operational routine planning and other ongoing service planning groups such as waiting times, infection control and cancer steering group. It is envisaged that such groups will continue as currently.

1.2 Drivers for Change

These are outlined in section two. Important drivers include:

- § Delivery for Health – the Scottish Executive response to the Kerr Report
- § Changing demography – an aging population
- § Advances in medical science
- § Shifting the balance of care from hospital settings to community settings
- § Enhanced roles for staff

1.3 Methodology

Sections two to five record the key objectives and actions for change under the headings incorporated in *Delivering for Health*.

For each section key informants have been interviewed to identify what is happening locally, regionally or nationally. This has been done with the agreement of the Area Partnership Forum; however the views of the key informants have not been widely consulted on due to time constraints.

1.4 Key Findings

Much excellent and relevant work is being undertaken, however, it is now imperative to set this in the context of:

- § An overarching clinical strategy
- § Enabling safe and sustainable services to be delivered as locally as possible
- § When clinically necessary, provided at a distance by our partners in strategic health alliances
- § Within a financial envelope that is affordable

1.5 Service Redesign

In particular many of the service redesign groups are nearing completion and being implemented. These are:

- Renal Services
- Paediatrics
- Radiology
- Mental Health
- Public Health

We also need to build on the work already undertaken in:

- Community Redesign
- Primary Care Out of Hours
- Medical Redesign
- Uists and Barra Redesign

The areas that require further detailed and focussed work as a priority are:

- Maternity
- Surgical (including Orthopaedics and Gynaecology)

2 Recommendations

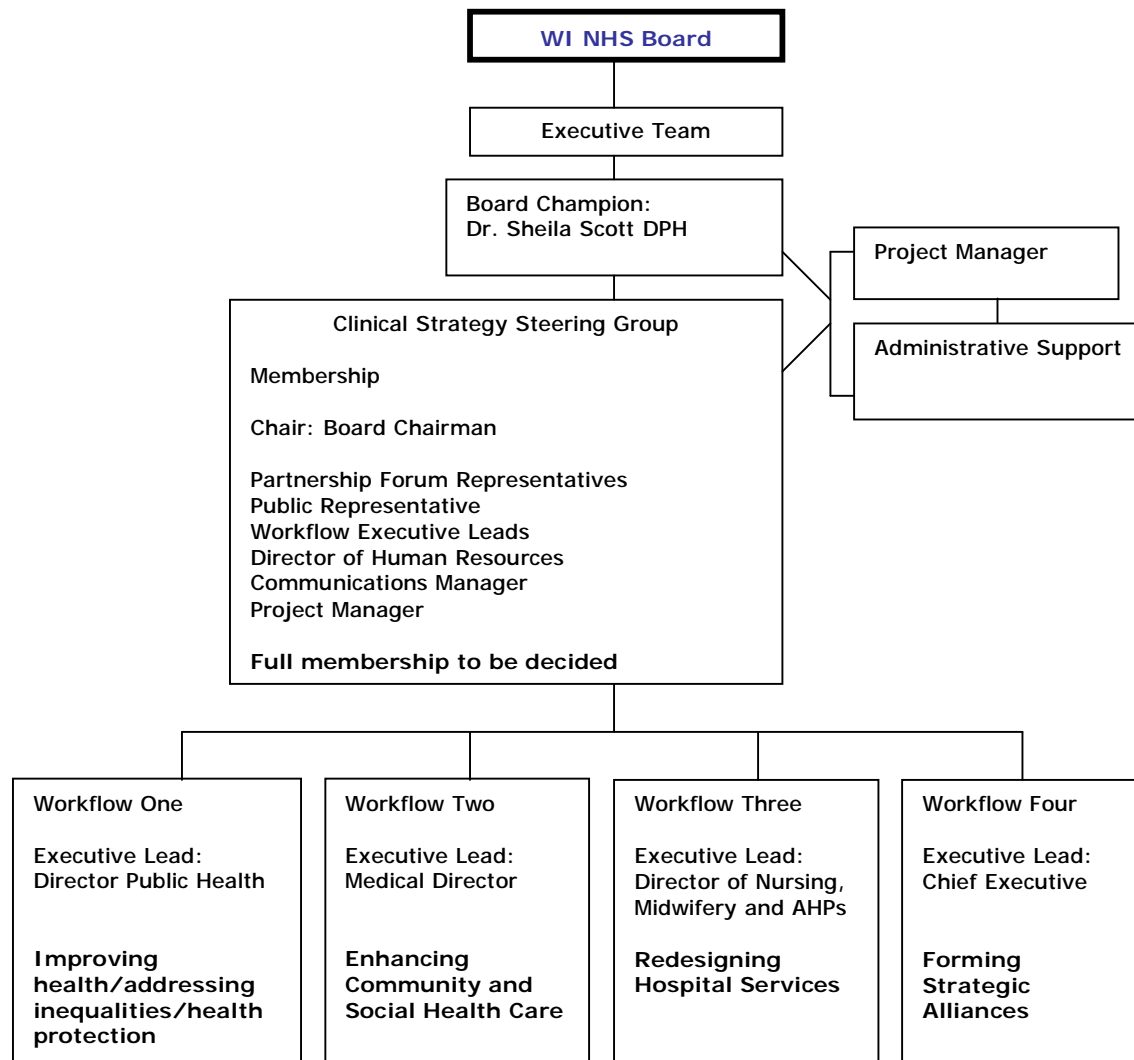
2.1 Recommendation 1: Structures

All changes initiated or proposed by Service Redesign or other planning groups should be allocated and taken forward under the four following work streams. Each stream will be led by an Executive Director.

Work stream	Lead director	Priorities	Key themes
Improving health/addressing inequalities/health protection	Director of Public Health	<ul style="list-style-type: none"> § Smoking § Alcohol § Gender inequalities § Obesity 	<ul style="list-style-type: none"> § Anticipatory care § Men's health § Working with CHP/acute settings § Community Planning Partners.
Enhancing community and social health care	Medical Director	<ul style="list-style-type: none"> § CHP/CHaSP, § Referral guidelines/protocols § Uist & Barra Hospital redesign § Establishment of alternative diagnostic and treatment centres in Primary Care 	<ul style="list-style-type: none"> § Chronic Disease Management § Care as local as possible § GPs with special interests § Enhanced roles § Interface with hospital.
Redesigning Hospital Services	Director of Nursing, Midwifery and Allied Health Professionals (AHPs)	<ul style="list-style-type: none"> § Bed usage § Pre-assessment § Maternity § Orthopaedics § Waiting times § Maintaining volumes § Hospital Acquired Infection 	<ul style="list-style-type: none"> § Separation of planned and unplanned care § Diagnostics § e-health § Enhanced roles § Remote and Rural General Hospitals
Forming strategic alliances	Chief Executive	<ul style="list-style-type: none"> § North/West or both § Establish Commissioning Team § Review Service Level Agreements/UNPACS 	<ul style="list-style-type: none"> § Reports § MCNs § Joint appointments

Each lead director will be supported by other members of the Executive Team, 'Stream' manager and administrative support.

Structure



2.2 Recommendation 2: Establishment of Steering Group

There should be a Clinical Strategy/Getting Fit for The Future 'GFTF' Steering Group chaired by the Board Chairman. The Lead Director will be supported by a dedicated project manager. Administrative support will be appointed to co-ordinate, update and collate actions. Dedicated financial support will also be required. The work of the service redesign committee should be subsumed/merged into this group and include appropriate membership.

2.3 Recommendation 3: Key Components to Underpin Work Streams and the Steering Group

These include:

- § Patient focus and public involvement
- § Partnership working

- § Community planning partners
- § Clinical effectiveness and governance
- § Manpower planning
- § Education and training
- § e-health/telemedicine
- § Information services
- § Input from MCNs/D4H service redesign working groups
- § Financial modelling/option appraisal
- § Risk assessment and management

2.4 Recommendation 4: Financial Parameters

The Director of Finance to clarify what financial resources will be available in the short, medium and longer term in the light of:

- § the current financial positions
- § likely future levels of funding
- § determine from benchmarking the desirable shift of resources from hospital settings to primary and community care settings

2.5 Recommendation 5: Financial Planning

Any service change must be fully costed and affordable within indicative resources and fit the shift in the balance of care target as laid out by the Director of Finance.

2.6 Recommendation 6: Population Needs

The Director of Public Health should further clarify what the future needs for patients with chronic diseases and acute hospital care are likely to be, using combination of epidemiology and demography and building on the work outlined in appendix one.

2.7 Recommendation 7: Workforce Planning

A strategic overview of workforce availability to be undertaken based on detailed analysis by age cohort of the current workforce and the local demography, to assess whether assumptions about the availability of different types of staff are correct. This should be reflected in the Pay Modernisation Benefits Plan.

2.8 Recommendation 8: Timescales and Deliverables

The next phases to completing the clinical strategy will be:

- Completion of this scoping document by end December 2006
- Allocation of ongoing work as detailed in Scoping Paper sections two to five to indicative work streams January 2007
- Development Day 22nd January 2007
- Drafting the outline of the Clinical Strategy and Implementation Plan for the four work streams for March 2007.
- Consultation and refinement for April 2007.

2.9 Risk Assessment

What has been outlined in this summary and in sections two to five represents the key strategic directions for NHS Western Isles. There are risks in taking forward this process in terms of delivery to set timescales:

- § capacity
- § current financial position
- § resilience

§ manpower availability

2.10 Clinical Governance

The future development and implementation of the Board's clinical strategy will have to be under-pinned by robust clinical governance and clinical effectiveness structures and systems.

2.11 Resources

Further discussion will take place at the development day in January and a task will be to identify the resources required to complete and produce a clinical strategy, including project management and administrative support.

2.12 Commitment and Priorities

Central to the success of this exercise is a clear understanding of the level of priority this work is to be afforded and Board and Executive support for those charged with its delivery.

3. Introduction

3.1 Overview

This document sets out outline proposals to Western Isles NHS Board concerning clinical strategic direction and the re-design of a number of services over the next decade. This document is intended to identify key areas where more detailed work should be carried out in describing the clinical strategic direction that services will take and identifying priorities in finance, investment, partnership working and key strategic alliances. And, it makes recommendations for the structures and processes to take this work plan forward.

Options are presented for changing and improving the delivery of care, 'because now, more than ever, we can prevent people becoming unwell, treat them faster and better if they do, and more often than not, treat them close to their home rather than in a hospital.' [D4H]

This document takes account of Getting Fit for the Future. It also takes into account wider strategic challenges such as the need to ensure a robust response to Scottish Executive policy, as described in Delivering for Health.

In pulling together an over-arching strategic framework, this document weaves together a number of key themes and presents a range of proposals around which a clinical strategy can be formed. The document also highlights on-going work and progress in a number of priority areas.

We describe our outline proposals for:

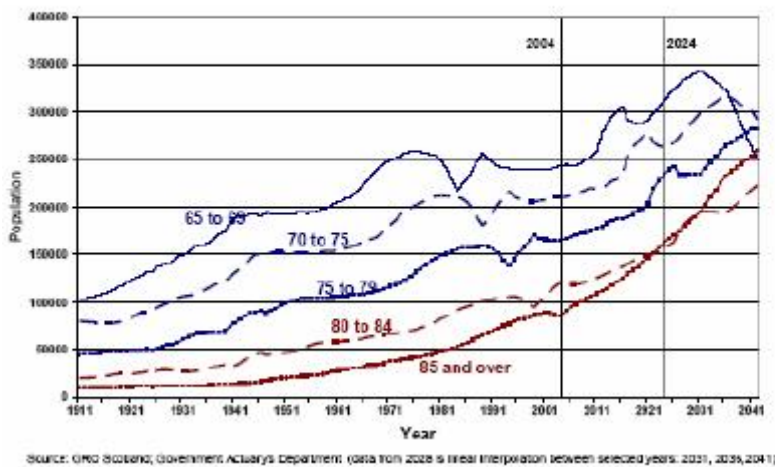
Scottish Executive, Delivering for Health (November 2005)

Scottish Executive, Fit for the Future (May 2005)

3.2 Drivers for Change

Continuing to make the progress expected of us means we have to take action to meet the challenges facing us head-on. These are not challenges to be encountered at some distant point in the future – they are already here. Delivering for Health has laid down a 'road map' for health services over the next 20 years, but it also explains why the NHS needs to change. In developing Getting Fit for the Future, we have taken into account the key messages set out in Delivering for Health about the future design of services. Figure 2.2 below sets out why and how the system of healthcare needs to change.

Figure 2.2: Scotland's Older Population by 5 year Age Group, Trends (1911–2002) and Projections (2003–2042)



The next twenty years will see an ageing population, a continuing shift in the pattern of disease towards long term conditions (or chronic diseases as some people call them) and

growing numbers of older people with multiple conditions and complex needs. These changes in themselves will make the current model of health care delivery unsustainable. We will no longer be able to afford a health care system which more often than not waits for a health crisis before providing care. This reactive approach often results in an unnecessary, damaging, expensive and prolonged hospital admission. We need a health care system with an emphasis on Health Improvement providing continuous preventative care for people with long term conditions to balance our ability to react quickly and safely to medical emergencies.

The projected changes in the population will impact on demands for health care. The population of Scotland is changing dramatically. Most significant, of course, 'in terms of implications for healthcare is the growing proportion of older groups in the population. In 1911, people aged over 65 made up 5.4% of the population; in 1951, 10.0%; in 2001 15.9% and in 2031 they are projected to constitute 26.6% of the population. The growth of the over 80s is proportionately even more rapid. In 1911, 0.6% of the population was aged 80 and over. In 1951 the figure was 1.3%; in 2001, 3.8% and by 2031 8.2% of the population will be aged 80 and over.' These changes are at the most extreme in the Western Isles. See Appendix 1 where the total population is projected to drop by about 15% by 2024 and the working population by about 20%. The population aged >65 is due to increase by 32% by 2024.

Between 2000 and 2031 the number of people over 65 is expected to increase from 787,000 to 1,200,000; and those over 85 from 84,000 to 150,000.8 Figure 2.2 shows graphically the trend in the population over the next thirty years.

Figure 2.2: Scotland's Older Population by 5 year Age Group, Trends (1911-2002) and Projections (2003-2042)

The population changes anticipated above require us to review our health and social care service provision. The extension of life expectancy and the accompanying rise in chronic diseases in the community will have an impact on our services. In order to address this we need to assist our population to make healthy choices about their lifestyle and behaviours. These anticipated population changes reinforce our continuing support for the vital health improvement work already underway in the Western Isles.

These demographic changes also emphasise the need to have a modern, fit for purpose Western Isles Emergency Care at the heart of a robust secondary care service, which will be able to support the immediate and follow-up acute hospital care needs of the Western Isles population.

See Appendix 1 for detailed data on demographic changes and predictions.

Fewer older people now reside in institutional care than in previous decades. Around 95% of the over 65s live at home, many of whom make no greater demands on health and social care services than do younger members of the community. However, the likelihood of care being required increases significantly with age, particularly in the over 80s age group. As the absolute number within this age group is growing and will continue to grow in coming decades there will be increased pressure placed on health and social care services.

Alongside our demography, there are significant changes facing the workforce over the next five to ten years. These include:

- declining birth rate
- changes in work patterns that sit more easily with family and life-style commitments, coupled with European Working Time Directive restricting hours of work
- delivery of the benefits of the modernisation of terms of condition of employment such as the new consultant contract and the new GMS Contract, alongside wider reform of the workforce through Agenda for Change
- shorter working hours and a stronger educational focus for doctors in training (ie Modernising Medical Careers) – a shift to a service delivered by trained doctors rather than doctors in training

□ increased specialisation of consultants leading to a fundamental redesign of services and shift to larger multi-disciplinary teams

Anticipating these changes and modernising NHS pay systems is fundamental to the modernisation of the service itself. If NHS Western Isles is to deliver modern, responsive services, 24 hours a day, 365 days a year, those who provide services need to be encouraged to broaden their skills, embrace new working methods and maximise their contribution to NHS priorities, in return for a fairer system of rewards and modern working practices. Realising the benefits of pay modernisation is not solely an issue for human resources alone, but is integral to the redesign of our services. The labour market increasingly consists of an ageing population and this has implications for the demands on Health Services in the type of treatment required.

There is already a reduced pool of younger workers both nationally/locally from which to recruit and there are currently chronic staff shortages in many key disciplines. Shortages in supply have been particularly highlighted in doctors, nurses and midwives and Allied Health Professions and this has major implications on examining the way we work and redesign of new roles. This involves staff working across traditional "boundaries" towards integrated multi-disciplinary and multi-agency teams covering a variety of new roles that go beyond the reliance on doctors and nurses. There is also a need to developing an organisation recruitment strategy, which is not only innovative but addresses future supply and demand issues and NHS Western Isles needs to set up a Workforce Development process to address these issues which links closely with our neighbouring Health Boards and to the National Workforce Plan.

To assist these changes in patterns of modern healthcare the NHS has embarked on a huge change management programme in Pay Modernisation, the aim of which is to improve delivery through redesign and better team working. This has significant human resource and financial implications in working practices, for example reductions in working hours in some disciplines and increases in annual leave entitlements and this ultimately influences the way healthcare is delivered.

Given the national and local backdrop NHS Western Isles needs to utilise its existing workforce to its full potential. As demands change and therefore roles and practice, there should not be the need for redundancy, but there is the need for a number of strategies to 'design' a workforce to meet changing patterns; retraining programmes, role redesign, vacancy management and secondments. There is a need to fully recognise the considerable dedication and expertise of our current staff and adopt an approach to build on this.

To date NHS Western Isles has been very successful in managing significant organisational change developed in partnership with staff organisations/Trades Union colleagues. The 'goodwill' that exists should be further developed with a formal policy based on a number of principles such as proactive planning, meaningful consultation, fair and equitable treatment and ensuring that support for staff is consistent with the national template for good practice.

The changing workforce allied to increasing expectations and new technologies make it impossible to sustain the current configuration of local services, without taking radical action.

3.3 Our Strategic Objectives

In framing these proposals, we have been guided by the Kerr Report and the Scottish Executive response to that report: Delivering for Health. In Delivering for Health, there is a clear statement of the new services that patients can expect in future.

Figure 2.3: from Delivering for Health (2005)

The changes patients will see:

- More of their health care will be provided locally in GP practices, in community pharmacies or in Community Health Centres, with greater use of day case treatment.

- If they stay in a less well-off area, their local primary care team will have dedicated resources to reach out and help people with higher risks of ill-health.
- If they have a long-term condition, help and support will be available so they can play an increasing role in managing the condition themselves.
- If they are older, frail or liable to frequent hospital admission, they will get co-ordinated care provided locally.
- Carers will be treated as partners in the provision of care.
- Patients will have access to their own Electronic Health Record and so will all the clinical staff involved in their treatment.
- If they need specialist treatment in hospital they will get access to a good, safe service provided by the right person, even if that means they have to travel.
- 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.
- If patients require care urgently, they will be able to see the right person, with the right skills, at the right time.
- Patients will experience fewer cancelled appointments or procedures because of an emergency or because tests are not available.
- If they stay in remote and rural areas, the NHS will provide them with a core set of services.

Section 4

Making Improvement Happen

NHS Western Isles Clinical Strategy					
Key Objective 4.1		An NHS as local as possible			
	Strategic Objectives	National Situation	Local Position	Comment	Resources
4.1.1	CHP	<p>Deliver Health Improvement in Local Areas</p> <p>Locality Planning</p>	<p>Mapping of health improvement activities against public health competencies. (Cross ref: PH Health Promotion). Scheme of establishment has been submitted to SM but is being revised to include stronger partnership links.</p> <p>Five locality planning groups are being created across the WI, two still to be established. These groups will report to the CHP committee.</p> <p>Area Health & Care Teams are being developed around general practices. These include multi agency teams delivering services direct to the patient.</p> <p>The Joint Future functions, partnership working, are to be assumed by the CHP.</p>	<p>Already been undertaken and an action plan is to be developed once there is clarity about the CHP structure.</p> <p>It is not possible at this time to begin to identify the possible resource implications or the timeframe for development and implementation.</p>	
4.1.2	Managed Clinical Network Development	<p>Scottish Executive Guidance</p> <p>To role out the MCN model of managing service and care to new areas including 'long term conditions' and partnership working, particularly those areas of work involving partnerships with the local authority.</p>	<p>The MCN model is key to sustainability in remote and rural areas and there are many areas where this model will enhance and promote good practice.</p> <p>D f H: Key objective to maintain people with long term conditions in the community: Health Promotion activity.</p>		
4.1.3	Regional Planning	<i>To be added</i>			

	Redesign				
4.1.4	Paediatrics	<p>Core competences have recently been published for people working with children and young people. NES are soon to provide funding for training of local staff.</p> <p>Regional: A strategic alliance has been established with Yorkhill Hospital in developing these services locally.</p>	<p>WI NHS designing a leading model for paediatric services with the consultant community paediatrician supported out of hours by a team of GPs and Physicians with paediatric training who are linked to a tertiary children's hospital for advice.</p> <p>Consultant appointment is a joint appointment with Yorkhill Hospital Glasgow (1 week in 8 at Yorkhill).</p>	<p>There are local GPs who have already undertaken training at Yorkhill Hospital, Glasgow in preparation for their role in Enhanced Services and there are plans for rotation to the WI for Yorkhill-based staff.</p> <p>A children's on-call team is being developed with 6 GPs and 2 Adult Consultant Physicians having completed Yorkhill training for extended roles and certified paediatric / neonatal courses.</p>	<p>A team which extends to Anaesthetists, GPs, Midwives, RGNs, RSCNs and AHPs will have access to on-going training in partnership with Yorkhill and supported by in-house training.</p> <p>50% of costs of GP training is being met by NES</p> <p>The Redesign recommendations are being implemented as a staggered development. No timeframe has been agreed for full implementation this needs to be rectified. The full costs of this development have been identified and agreement has to be reached with Finance on a timeframe that is affordable.</p>
4.1.5	Our of Hours Service	<p>Redesign Group have submitted their report to the Exec Team. The Consultants Committee have asked for the report to receive further consideration.</p>	<p>The model for out of hours ensures practitioner level nurses and paramedics can be the first point of contact. This allows the on-call GP to carry out more of the traditional hospital based medicine.</p>	<p>Lewis Model: This allows the GP based at A&E, WI Hospital to also provide medical cover at the hospital.</p> <p>Scottish Ambulance Service are very supportive of the report's recommendations and would like to see further development of the role of paramedics.</p> <p>Harris Model: is still working</p>	

				<p>with the established model and this will need review within the context of the clinical strategy.</p> <p>Uists and Barra: The opportunity for change is limited because of geography and availability of medical staff. There is the opportunity to base paramedics at U&B Hospital</p>	
4.1.6	Maternity & Gynaecology	<p>Baby Friendly Strategy (UNICEF)</p> <p>North of Scotland Planning Group</p> <p>Birthrate Plus</p> <p>Expert Group Maternity Services (EGAMS)</p>	<p>Redesign: Project Board have requested a further report from Cathy Macdonald and Cathy Carnell reconsidering the options for this service.</p>	<p>Report pending and will inform the clinical strategy.</p> <p>Further information from Cathy Macdonald to complete this information. Unavailable at this time.</p>	
4.1.7	General Surgery & Orthopaedic Surgery		<p>A planned 2 year development starting 2006 was approved by the Board and will complete in 2008.</p> <p>Approved model for four consultant Anaesthetists and four consultant Surgeons.</p> <p>Appointments have been made.</p>	<p>In line with the changed recommended for other services under 'Managed Hospital Care & Day Surgery' ought to be considered in association with any future redirection of these services for strategic alignment with 'Delivering for Health'.</p>	
4.1.8	General Medical		<p>The Board have approved the implementation of a three consultant physician model.</p>	<p>The service is half way through a two year development plan. They are identifying multi-disciplinary training needs. A model integrating primary and secondary care is also under consideration.</p> <p>Under consideration is the development of enhanced roles for AHPs, Nurses and GPs.</p>	<p>The group are still meeting and at this time there is no formal plan. This will have to be completed and the group should take direction from the Clinical Strategy.</p>

4.1.9	Radiology		Approval has been given for the service to move towards a Radiographer led service with support from a mainland centre.	A draft service specification has been sent to three Boards. Responses expected early December.	
4.1.10	Renal Dialysis	The implementation of the Renal Dialysis Service development was approved by the Board and is one of the key developments identified by the Minister.	A RD Unit is being implemented at WIH. With satellite unit at Uist and Barra Hospital.		
4.1.11	Review of locally provided Hospital Services	Delivering for Health	A detailed review of what services and procedures that are provided at WIH, U&BH and St. Brendan's is required, taking into account the opportunities in the consultant, GP and agenda for change contracts to align services with cost effectiveness and sustainable models. This exercise should recognise that some services and procedures will transfer to GP surgeries or Health Centres and other, more specialised, to mainland centres.	The WI Clinical Strategy should address the need to design a hospital model that is sustainable into the future with an emphasis on diagnostic and ambulatory care, the opportunity for enhanced GP involvement and the role of other professions in expanded scope of practice for nurse and AHPs. This exercise will take some time to complete, should be evidence based and will require to be supported by a detailed 'Workforce Plan'.	A dedicated team should be identified to undertake the data collection and analysis and to research the evidence base for decision making. A planning forum should be identified for setting out the strategic direction that services should take and informing the WI Clinical Strategy.

NHS Western Isles Clinical Strategy					
Key Objective 4.2		Systematic help for people with long-term conditions			
	Strategic Objectives	National Situation	Local Position	Comment	Resources
4.2.1	Managed Clinical Networks Cross Ref: 4.1.2	Scottish Executive Guidance	There are currently four MCN's for Diabetes, CHD, Stroke, Cancer.	The MCN model is now well established in the area of four long term conditions. There is the potential to further develop this model to enhance the management of other areas of clinical services.	
4.2.2	Community Services		<p>A Community Services Redesign group is reporting in Nov 2006. This clinical strategy will have to take recognition of this report. The first draft addresses some long term conditions but there is the opportunity to expand this section into a broader strategy for managing all long term conditions.</p> <p>The report recommends the formation of a group to review the services provided by the Day Hospital and opportunities for moving some services currently provided in hospitals, into the community.</p> <p>The report identifies the opportunity for GPs, Nurses and AHPs to develop enhanced roles and areas of special interest. This should be revisited in more detail and aligned with a manpower strategy and training strategy to take advantage of these opportunities.</p>	<p>There is a need for a local WI strategy which links Primary Care, Community Care Services and allied professions such as housing, social work, education (in the case of young people) and voluntary organisations.</p> <p>A general strategic policy position needs to be adopted by the Board to recognise and drive this topic forward.</p> <p>The development of future plans will have to be linked to hospital services planning to ensure that there are clear pathways of care and seamless services for patients. An example being the treatment and management of Asthma, and for the management of newly diagnosed patients.</p>	Given the level of importance of the management of long term conditions in the paper 'Delivering for Health' and that the effective clinical management of long term conditions is critical to avoid unnecessary hospital admission; a separate group should be formed to plan the future management of long term conditions in the community.

4.2.3	Primary Care Services		There needs to be a full review of which services can be provided from health centres and practices and in the patient's home. Many of these services will have traditionally been delivered from hospital wards or out-patient clinics.	Locally there is the opportunity to develop the role of all members of the Primary Health Care team using the opportunities in GP contract and Agenda for Change.	
4.2.4	GP Enhanced Roles		Currently there are GPs with special interest in cardiology, palliative care, paediatrics (Cross Ref:4.1.4) and dermatology. There is an active community hospital in the Southern Isles this model could be adopted to deliver care in remote and rural areas in Lewis and Harris.	There are further opportunities to develop the role of GP with special interest and for the development of enhanced roles in key clinical services. A review of the opportunities possible under the new GP contract should be undertaken and aligned to the development of the clinical strategy.	
4.2.5	Management of Osteoporosis	Delivering for Health, Innovation and R&D	A locally proposed trial for a peripatetic diagnostic service for people with Osteoporosis to identify and needs assess the incidence of this condition in the population of WI, Shetland and Orkney.	There is potential if the condition is identified early enough to manage through lifestyle and diet change and avoid the longer term active treatments.	
4.2.6	Neurological Conditions Respiratory Disease Dermatology Rheumatology		The Community Redesign group have reported and the report established initial arguments for community based services however there is scope to increase these service and prevent patients travelling to Glasgow and other mainland centres and prevent admissions to hospital.	A full needs assessment and review based on need has to be undertaken to inform the Clinical Strategy and work force planning to develop these services.	
4.2.7	Chemotherapy		Another example of a service which can be brought back to the Islands. Data is being collected and a business case will be made in early 2007.		

NHS Western Isles Clinical Strategy					
Key Objective 4.3		Reducing the inequalities gap			
	Strategic Objectives	National Situation	Local Position	Comments	Resources
4.3.1	Develop a 2010 Strategy for Western Isles	<p>2010 Pilots are being developed in Lothian, Glasgow & Tayside including review of evidence by the national Public Health Network.</p> <p>Regional Level the northern Public Health Network are currently developing a remote and rural model.</p>	<p>NHS WI is participating in NoSPHN model.</p> <p>A working group is looking at the opportunity for standard CHD assessment and screening across Western Isles. This work involves Health Promotion and the CHD MCN. Identified risk factors to be addressed through a range of interventions provided locally.</p>	<p>Indicators of deprivation used nationally do not highlight NHS WI as having any significant areas of deprivation. Through local intelligence and work done in Shetland we know there are more qualitative ways of assessing deprivation. The pilot anticipatory care project will be developed to target areas/ households of people living in deprived conditions.</p>	Not yet known
4.3.2	Increase Health Care Delivered to Disadvantaged Communities		<p>Men's Health Initiative Healthy Outer Hebridean Initiative Scottish Health at Work (SHAW) Healthy Working Lives Pathways to Work</p> <p>Health Risk Factor interventions (Health Promotion), a Western Isles specific mapping exercise based on inequalities, identifying communities with particular health risk factors is being matched to targeted interventions on smoking, alcohol, CHD and cancer.</p>	<p>These initiatives are short term funded bids and need a co-ordinated strategic approach and long term funding. There is a need to ensure effective evaluation which is absent at this time.</p>	
4.3.3	Other areas of work			<p>See Local Health Plan Local Deliver Plan DPH Annual Report Health Improvement Strategy</p>	
4.3.4	Implementation of Hall 4	Health for All Children Fourth Edition.	<p>Child Health Screen is now Hall 4 compliant. Child Health system is Hall 4 compliant. Potential in the future to use data</p>	<p>National programme for reducing inequalities for children. This is cross referenced to 5.6 Children's services.</p>	

			for planning and needs assessment.		
4.3.5	Community Regeneration / Community Planning	All Community Planning Partnerships have developed Regeneration Outcome Agreements (ROA) with Communities Scotland. For period 05-08 based on the governments strategy for 'Closing the Opportunities Gap' (CtOG) Joint Health Improvement Plan	Local ROA in place and first annual report published last June. Four CtOG priorities are: 1 Improving employment opportunities for people of all ages particularly for disadvantaged groups and individuals. 2 Improving adult education and literacy 3 Youth outreach 4 Community empowerment and development. Joint Health Improvement plan published 2004-07 is needs to be updated, especially following the publication of 'Delivering for Health'	A component of the ROA is a community needs assessment in the South Uist area, which is intended as a pilot for the development of local community planning partnerships. The expected outcome of the needs assessment is the development of strong community partnerships across the islands and there will be implications for community health staff and opportunities for health improvement.	(Lucy Macleod)
4.3.6	Health Improvement Strategy (HIS)	NHS Strategy	Work is ongoing to complete a local HIS the outcome of which will inform a local Clinical Strategy. Due to be completed by Dec 2006	This strategy is being developed in partnership with Health Improvement CnES, and WI NHS Divisions.	
4.3.7	Pathways to Health	Welfare Reform Bill 2006	This programme is at a very early stage but it is anticipated that WI NHS will enter into an agreement with Job Centre Plus to deliver the 'Condition Management Programme' element of this legislation.		Fully funded, including management costs, by Job Centre Plus (Dept. of Work and Pensions). Staff: required to be identified and be trained to deliver and manage the programme.
4.3.8	Health and Homelessness (H&H)	Scottish Exec H&H Standards	H&H needs assessment due to be reported to the Board in early 2007. This will set out the local measures required for WI NHS to	There will be implications for community and public health staff particularly in preventative work. This commitment has	The standards imply the need for the Board to recognise and respond to the health needs of

			<p>be compliant with the national standards.</p> <p>Cross reference: Mental Health, Alcohol Abuse and Domestic Abuse Integrated Children's Services Strategy.</p>	<p>the potential to lead to a health gain and health improvement for disadvantaged people.</p>	<p>homeless people and to lead partnership planning in this area. There will be a need to expand on this issue in a full Clinical Strategy.</p>
4.3.9	Community Health Partnership	Community Planning	<p>There will be a substantial role for the involvement of the CHP in reducing the Health Inequalities Gap.</p> <p>At this time, without clarity around what the breadth of services the CHP structure will absorb, it is not possible to be specific about the priorities the CHP will identify. It will be a priority for the CHP to publish a strategy to clarify how it will align services and workforce to the Clinical Strategy.</p>		
4.3.10	Community Projects		<p>A number of new community involvement projects, such as Cearns Project, Newton and Sandwick, have been piloted and which provide the opportunity for healthy living initiatives, activity, diet and exercise. A key element is the development of social / community companies offering employment and skills development. These projects have been held as exemplary models for community regeneration and there is a need to role the model out to other communities in the WI.</p>		

NHS Western Isles Clinical Strategy					
Key Objective 4.4		Actively managing hospital admissions			
	Strategic Objectives	National Situation	Local Position	Comment	Resources
Unplanned Admissions					
4.4.1	Admission Planning	<p>Delivering for Health</p> <p>Decide to Admit Not Admit to Decide, National Waiting times Unit</p>	<p>The current systems and practice for admitting patients to WI Hospital required to be reviewed and brought into line with national recommendations and active management. Not all admissions to hospital are the most appropriate decision. It is necessary to implement a formal protocol to ensure that the most appropriate clinician is deciding to admit on agreed criteria. A clear policy for A&E ENPs should be developed ensuring that appropriate training and practice is in line with national standards.</p>	<p>Many admissions to hospital are avoidable and with restructuring services more appropriate use of hospital admissions could be made, with next day follow-up for assessment and diagnosis many admissions would not be necessary.</p>	
4.4.2	Admission Planning Infrastructure	<p>Delivering for Health</p>	<p>Rapid response. The development of rapid response teams to support urgent care in the home would avert the need for some admissions to hospital. This service will need to be developed in partnership with community services and Social Services.</p>	<p>Many local services are operating on outdated practices and not organised to match the needs of patients. This is exaggerated at certain times, weekends and holidays. A more responsive whole service, multi-agency response is needed.</p>	
4.4.3	Admission Planning Transport	<p>Delivering for Health</p>	<p>Local transport systems are often inadequate to support the discharge of patients from A&E or on routine discharge from wards. Transport cannot be arranged at short notice for patients who have been delivered to A&E who require transport to return home. For example wheelchair bound.</p>	<p>A review of transport arrangements is required to ensure that suitable transport is available 24/7 to facilitate the discharge of patients either from A&E or from hospital beds.</p>	

Planned Admissions					
4.4.4	Design and review systems for planning elective admissions	Delivering for Health	<p>A whole systems design is necessary to ensure that there is the most efficient use made of bed capacity. In particular elective procedures are organised to ensure that there is synchronised with patient discharge and there is alignment with theatre utilisation and out-patient clinics.</p> <p>The implementation of preoperative assessment needs to plan patient discharge to prevent over-night stay.</p> <p>For Medical patients better use must be made of Day Hospital facilities.</p>	<p>Capacity management and maximised usage of beds is currently a problem due to the management lists and consultant work schedules. With adjustment a more streamlined and efficient system will minimise the need for delayed discharge and over-night stay.</p> <p>Benchmarking length of stay, variation of discharge through the week and between consultants.</p> <p>A review to ensure that Consultant's lengths of stay are in line with national benchmarking is needed.</p>	
4.4.5	Day Surgery	Delivering for Health 70% of surgery to be provided as day cases.	<p>Change of practice. WIH has to benchmark themselves with their colleagues and other centres. Practice has to be evidence based and procedures are relevant to day surgery practice.</p>	<p>A review of systems and processes has to be undertaken. Scope for the expansion of the roles of AHPs and Dermatology Nurses for minor surgery.</p>	Ensure that training is provided to targeted staff members.
4.4.6	Hospital, Clinical Accommodation and Facilities Review		<p>WIH has very limited day surgery facilities and there is not the most efficient use being made of the facilities that are available.</p> <p>The hospital was designed around different needs than exist today. A full review of the facilities that are needed to match modern practice.</p> <p>Planning hospital accommodation based on need should result in the opportunity to reduce significantly the number of in-patient beds.</p>	<p>Examples are the absence of A&E assessment, endoscopy suite and minor operation facilities. A recommendation is made that a full review of the hospital facilities and usage is undertaken. The WIH currently provides in-patient long term continuing care and a review of the most appropriate setting for these services should also be undertaken and alternative provision planned where appropriate.</p>	

4.4.7	Non-clinical accommodation		Currently there are personnel who are not directly involved in hospital or clinical services using accommodation in WIH, while there are personnel who ought to be based in the hospital 'farmed out' to accommodation elsewhere.	A review of the location of personnel needs to be undertaken so that the right people are in the right place participating as full members of the hospital team.	
4.4.8	Roles		There are major issues in the roles that employees have traditionally adopted. There is a need to adjust the roles of staff under the opportunities in the GP, Consultant and Agenda for Change contracts to amend the scope and areas of diversity in which ALL staff groups participate. There is the opportunity for a wider scope of practice for medical staff too and in order to ensure that WI services are making full use of staff time it may be necessary to negotiate 'scope of practice' at an individual level.	Clinical services and outcomes has to be the priority for the personnel occupying clinical posts and the focus of their time should be directed to activities supporting these clinical roles. There is scope to diversify roles and direct activity to clinical governance, clinical effectiveness and to supporting training and education. The future of locally provided education and training opportunities is in providing multi-professional workshops including General Practitioners.	
4.4.9	Visiting Consultant Services		The absence of a commissioning team who have direct responsibility for the monitoring and control of SLAs and services means that there is a lack of a framework for control of contracts and costs. The commissioning of visiting consultant services should be reviewed in line with the changing needs of the local population and demand.	Recommendation is the appointment of a commissioning manager / team responsible for the management and control of services provided by mainland services. There are some services that could be repatriated while others that might be contracted out to visiting consultants. A key part of the clinical strategy must determine the level of services that NHS WI needs to commission from mainland providers and what services can be provided locally by other	

				means.	
4.4.10	Nurse led discharges	Delivering for Health	Following a recommendation of Delivering for Health a new approach using 'nurse led discharges' should be implemented.	Two nurses have attended national conferences and there will be a review of the systems for nurse led discharges.	
4.4.11	Clinical Decision Unit		Introduce a fast-track laboratory services to support the clinicians to make quick decisions on diagnosis and clinical care, and consequently admission.		

Section 5

An integrated NHS for the whole of Scotland

NHS Western Isles Clinical Strategy					
Key Objective 5.1		eHealth Strategy			
	Strategic Objectives	National Situation	Local Position	Comment	Resources
	eHealth				
5.1.1	Telemedicine	Scottish Centre for Tele Health launched October 2006. The centre will act as the national policy unit to take this initiative forward.	Several telemedicine projects in hand: Paediatrics, out of hours (Yorkhill) Mentor, stroke assessment (Raigmore) X-rays diagnostic service for thoracic care (Raigmore) Stobhill SLA (under review)	There is a need, in the short term , for a Telemedicine Steering Group to ensure continuity of planning and commissioning of telemedicine services.	
5.1.2	Electronic Health Record	Core components being provided nationally.	Picture Archiving and Communication System (PACS) Emergency Care Summary A&E System SCI Store SCI Gateway	National System migrating onto the system April 2007 Implemented Implemented Implemented Partially implemented	
5.1.3	eCare	National programme linking Social Services and Health Care. National framework targets to be implemented locally.	A programmed implementation is planned and a local Project Manager is being appointed (SE funded). A development strategy will be a priority.	Local eCare strategy to be developed and will inform WI NHS Clinical Strategy.	
5.1.4	Community Health Index (CHI)	National target to implement universal usage of CHI numbers as patient identifiers. Compliance critical the whole eHealth agenda.	At June 2006 = 100% compliant. At Dec 2006 = 96% compliant.		
5.1.5	Electronic Discharge	National product: SCI Discharge National situation: A variety of locally implemented systems producing discharges, but all must meet nationally defined standards and be transmitted via SCI Gateway.	Partially implemented. SCI Discharge in use in Acute Psychiatry and currently in implementation planning for Surgical and Medical Specialties for inpatient discharges.	Does not meet the requirements of every discharge scenario and therefore there is a national review of the product. Local and National solutions to be developed for other types of discharges scenario.	

5.1.6	New Ways Waiting Times Definitions	Nationally provided module for 'Compass PAS' to meet reporting requirements.	Implemented		
5.1.7	Diabetes Retinopathy	National DRS Programme SOARIAN	Health Boards across Scotland have been finding problems with this system and it is still being developed. WI NHS will be in a position to implement the system in Dec. provided the difficulties have been resolved.	Business case presented to the Executive Team July 2006.	
5.1.8	Primary Care Systems	Target: Must be Scottish Enhanced Functionality (SEF) compliant to support new GMS contract	Implemented		
5.1.9	Enhanced IT Networks	Target: To enable all NHS sectors to exchange data securely and efficiently.	Achieved using 'Connected Communities'.		
5.1.10	Information Governance	Target: Boards to comply with national legislation, standards and processes: freedom of information and data protection, corporate governance.	Formal systems and processes need to be described and implemented.	NHS WI requires to take action to ensure there is a short term response to developing these systems.	
5.1.11	FAIRE Development	CnES Social Work Dept.	Community Alarm Scheme with the potential for the scheme to be extended to health monitoring systems for people who have chronic conditions, post discharge, and others. This could be provided on a short or long term basis.	The scope of this technology offers potential to complement community services for example District Nursing by provided additional links and monitoring of physically compromised people living in the community.	
5.1.12	Learning Together	NES Pilot	Programme is being developed in building expertise in island health care using electronic opportunities and accessing eLibrary, especially the Remote and Rural Portal.		
5.1.13	Health Information Project (HI)		The HI project has been operating for two years and provides health information to the public on conditions and local services and is accessible from a number of locations across the Western Isles	The project is locally managed and this system will have to be continued and expanded upon as services change under the Clinical Strategy and Service Redesign implementation programmes.	

NHS Western Isles Clinical Strategy					
Key Objective 5.2		Hospital services: planned and unscheduled care			
	Strategic Objectives	National Situation	Local Position	Comment	Resources
5.2.1	Waiting times Targets	Achieve a 4 hour maximum wait in A&E	Achieving target		
5.2.2	Reduce likelihood for episodes of unscheduled events.		Improve anticipatory care and long term condition management. Cross reference 4.2		
5.2.3	Anticipatory Care	Delivering for Health	Local application for Scottish prediction tool SPARRA Identifying patients at risk of admission or re-admission to hospital and targeting care. Developing services and responses in Primary Care and community services. (Reference: 4.1)	The real outlier is Coronary Obstructive Pulmonary Disease. COPD. Other conditions: diabetes, cardiovascular disease. Other major contributing factor is deprivation.	
5.2.4	Improve management of unscheduled events.		Redesign of Primary Care Out of Hours Review of the Emergency Care Centres and integrating Primary Care Out of Hours, Ambulance Services, A&E and Secondary Care. Need to Plan and Develop effective process for the management of the acutely ill. Assessment monitoring intervention and the decisions affecting patient pathways.	There is a need for robust and efficient systems for transferring patients to the next level of care. Need for an integrated plan for these services if NHS WI is to meet Delivering for Health objectives. A detailed plan should be developed.	To be Identified. These plans and developments will directly impact on Workforce Planning and taking full advantage of national contracts for Primary Care, Consultant Contract and Agenda for Change. (Cross Reference 5.8)
5.2.5	eHealth Cross Reference 5.1	Delivering for Health. National eHealth Network being established based in Aberdeen	Telemedicine should be incorporated into A&E and Out of Hours Services.	WI NHS will need to link with the national network and develop a local plan for implementing and maximising	

				the opportunities of eHealth. Evidence shows that this initiative will help to reduce admissions and unnecessary transfers.	
5.2.6	<p>Planned Care</p> <ol style="list-style-type: none"> 1. Improve referral and diagnostic pathways. 2. Treat Day surgery as the Norm 3. Actively manage admissions 4. Actively manage discharge and length of stay. 5. Actively manage follow-up 	<p>Delivering for Health</p> <p>'10 high Impact Changes', Modernisation Agency, Dept of Health.</p> <p>Target: Maximum 18 week waiting time for commencement of treatment.</p>	<p>NHS WI is required to have a three year Improvement Plan</p> <p>incorporating:</p> <p>Develop Protocol Based Referral</p> <p>Electronic Referral and Direct Booking</p> <p>Patient Focussed Booking</p> <p>Avoid unnecessary follow-up and providing necessary follow-up in the right care environment.</p> <p>nb. There is an opportunity to develop GP and video-link follow-up with perhaps video-link follow-up becoming the norm where follow-up is required. (Challenge issue at Unscheduled Care Programme Conference 2006)</p>	<p>Planned Care Programme under development. Stephen Moore</p> <p>Issues for WI NHS Board: Planned and unscheduled care should be managed as a whole and not as competing aspects of health care.</p> <p>Requirement for referral management systems, single point of contact, pooled lists, better capacity and demand management.</p> <p>There is a need to establish effective telemedicine links with these initiatives (example: National Paediatric Telemedicine Network).</p> <p>Targets for Day surgery will shortly be set and there is a need to ensure that services are planned and fit for purpose anticipating that event. The target is likely to be 75% of procedures performed as 'day cases'. Reference: British Association of Day Surgery, Basket of Procedures'.</p>	<p>Implication for NHS WI:</p> <p>There will be a need to have pre-planned and robust contracts in place with mainland service providers to cope with the volume and skills maintenance required.</p> <p>Major workforce implication:</p> <p>The need to have adequate skilled personnel specifically trained in Day Surgery procedures.</p>
5.2.7	<p>National Diagnostic Programme</p> <p>Eight specific tests: MRI, CT, Barium, Endoscopy, Cystoscopy, Sigmoidoscopy, Ultrasound</p>	<p>National target of maximum 9 weeks wait.</p> <p>National Cancer Target: Max 62 day wait referral to treatment.</p>	<p>WI NHS needs to design systems and processes that ensure rapid access to key diagnostic tests. This target is linked to 'Planned Care Target' and for some assessment procedures the timeframe will have to be</p>	<p>WI NHS is hitting target for CT, Barium and Ultrasound.</p> <p>Planned investment for a new multi-slice CT scanner and barium suite will bring the service into line with other</p>	

			significantly shorter than 9 weeks to achieve PC target of 18 weeks.	centres. Work is ongoing to meet the 9 week target for endoscopy. Business plan being submitted to Centre for Change and Innovation who will fund purchase of new endoscopes.	
5.2.8	Osteoporosis Cross Ref: 4.2		Business case being developed for a trial shared screening / scanning service with Orkney and Shetland for the peripatetic screening for osteoporosis and low bone density conditions.		

NHS Western Isles Clinical Strategy					
Key Objective 5.3		Hospital services: as specialised as necessary			
	Strategic Objectives	National Situation	Local Position	Comment	Resources
5.3.1	Note: Wide discussion is required to explore appropriateness of locally provided specialties, or whether these are provided from elsewhere. Also what networks and strategic alliances are required (cross ref: 1.4				
5.3.2	Whatever decisions are reached they will have to take cognisance of regional planning for North and West of Scotland				
5.3.3	Current outreach for out-patient and elective cases is provided by:	North (Visiting Consultants)	ENT Rheumatology Ophthalmology Respiratory Audiometry Optometrist Oral Surgery Orthodontics Urology		
		Glasgow (Visiting Consultants)	Neurology		
5.3.4	Contracted Services		There are numerous services contracted under SLA's that will have to be considered in more detail for the full Clinical Strategy		

NHS Western Isles Clinical Strategy					
Key Objective 5.4		Rural Health Services			
	Strategic Objectives	National Situation	Local Position	Comment	Resources
5.4.1	Dental Services	Scottish Executive Dental Action Plan (DAP) (Year 2)	<p>Delivering on the DAP:</p> <p>Increase access to general dental services</p> <p>Improve oral health</p>	<p>The WI NHS purchased the only independent general dental practice in the Western Isles in 2005, to ensure continued delivery of general dental services in Stornoway.</p> <p>The oral health measured by the national dental inspection programme continues to show children of the WI continue to have poor dental health.</p>	
5.4.2	Dental Workforce		<p>Continuing to develop a sustainable workforce by attracting a 'younger workforce' encouraging students and dental professionals in training to the islands.</p>	<p>This initiative will require partnership working with organisations such as NHS Education for Scotland (NES)</p>	
5.4.3	Dental Premises		<p>There is a need to review dental accommodation to ensure that there are adequate facilities to provide access to dental services and training.</p>	<p>There is an opportunity to rationalise the number of clinics (currently 10) to four. Thus ensuring dental professionals have peer contact. There would be a cost saving by rationalising and centralising services into four locality bases.</p>	
5.4.4	Dental Premises 2		<p>Plans are being brought forward for a purpose built dental clinic in the Stornoway area.</p>	<p>Business case being presented to the Board in early 2007. Clinical Strategy will have to take account of this plan.</p>	
5.4.5	Dental Workforce Development		<p>Ensure that dental professionals can develop their clinical skills and provide services locally. Dental therapy services is an example recently introduced.</p>	<p>To decrease reliance on visiting consultants there is the opportunity to develop dentists with special interests. This would ensure that services are provided locally, provide dentists with career opportunities and ensure that local services are continuing to</p>	

				offer an enhanced service.	
5.4.6	Rural and Remote Dental Fellows		Two Remote and Rural Dental Fellows are employed by the health Board and NES to provide access to general dental services and postgraduate training.	It is important to maintain this initiative to support dentist, gaining skills and providing services in remote areas.	
5.4.7		The work of the Remote and Rural Steering Group to develop a framework of care for the 1 in 5 people in Scotland who live in remote or rural communities is progressing through the work of 4 sub-projects and the linked project which are detailed below. <ol style="list-style-type: none"> 1. Rural General Hospital 2. Primary Care Group 3. Community Health Strategy 4. Education 	The Remote and Rural Steering Group will publish recommendations for Rural Health in the next two to three months and should be taken into account in the development of a NHS WI Clinical Strategy		
5.4.8	Medical Education	Rural Health Education Alliance (RHEAL)	Working to produce recommendations on education for medical staff specialising in rural health.		
5.4.9	Recruitment and Retention	Fifth Work Stream Group	Is currently considering immediate issues with recruitment.		
5.4.10	Transport	Emergency Medical Retrieval Service	Reviewing transport and patient transport strategy and considering future options for the Ambulance Service. WI Clinical Strategy will have to take account of Northern Periphery Programme, the ambulance transport services in remote and rural areas. This is being developed in partnership with Iceland and Sweden.		
5.4.11	Northern Periphery Programme eHealth	Four partners; Scotland, Sweden, Norway and Finland are reviewing eHealth solutions and the use of eHealth in sustainable health networks.		Information should be published in the near future and will inform the WI Clinical Strategy	

5.4.12	Research Hebrides	WI NHS / UHI Initiative Lews Castle College, WIE, NHS WI	Under the auspices of the Community Planning Partnership the initiative is seeking to provide facilities for Research & Development for: Arts and Culture Renewable Energy Health and Social Care		
5.4.13	Modernising Medical Careers (MMC)	Moving towards junior doctors being more involved	Currently 2FY1, to increased 2FY2 to 4FY2		
5.4.14	General Practice Vocational Training Scheme.		Decrease from 5GP VTS to 3 GP Specialist Training Posts 2 National posts in medicine and surgery will go to ST1		
5.4.15	Ambulance Transport and Services in Rural Areas (ATSRuAr)		This is combined activity with the Ambulance service. Partners are Iceland and Sweden. Particular areas of interest: Documenting rural ambulance services Exploring education and training issues Involvement of electronic communications Transport issues with thrombolysis How patients travel to hospital and GP practice premises		

NHS Western Isles Clinical Strategy					
Key Objective 5.5		Mental Health Services			
	Strategic Objectives	National Situation	Local Position	Comment	Resources
5.5.1	Child and Adolescent Mental Health (CAHMs)	Children and Young People's Mental Health: A Framework for Promotion, Prevention and Care (December 2005)	A scoping exercise for compliance with the framework has been completed. The development of a Child Mental Health Strategy for the Western Isles followed on from this and is nearing completion.	A local strategy will be presented to the Board in early 2007. This is a significant service development and will require investment if the local service is to comply with national standards.	A review of the staff and financial resources to support the development of this service will be made with the presentation of the strategy.
5.5.2	Dementia Strategy	A report has been made as part of the Mental Health Redesign Group report and reflects the guidance from SIGN Guideline No. 86	A Dementia Strategy (2005) was developed in partnership with CnES and local voluntary sector, under the auspices of the Mental Health Partnership. The Mental Health Redesign Group report details recommendations for services supporting dementia care and identifies hospital in-patient care and community services as well as more specialised service developments that are necessary to comply with national guidelines.	The strategy was submitted to WINHS Board and CnES Social Work Committee in 2005. There is an opportunity to link with Dementia Unit at Stirling University and to have their involvement in planning the redesign of dementia services. A cost of £2,500 has been identified for this work to be taken forward.	There are implications for the CPN team and the wider elderly team in regard to training costs associated with the recommendations and there are capital costs associated with alterations to in-patient facilities.
5.5.3	Mental Health Redesign		Redesign report due to be presented to the Board December 2006	At this time Option 3 is the preferred option: See the report for details.	

5.5.4	National Integrated Care Pathway	Mental Health Delivery Plan 2006 Target: Five ICPs to be in place by end of 2007	ICPs are a development of national standards and are targets mentioned in the new Mental Health Delivery Plan 2006.	Local ICPs have to be accredited by NHS QIS. ICPs are linked to Clinical Effectiveness and Clinical Governance. The Board is advised to have develop an ICP strategy by December 2006. However this is dependent upon the Board's Clinical Governance Strategy and having working structures for clinical effectiveness and clinical governance.	An ICP Co-ordinator post is required. Operational staff will have to identify dedicated time for the development and implementation of ICPs. There will be a requirement to back-fill time for staff to be released.
5.5.5	Developing Nurse Led Services and enhanced roles for AHPs.		Within the Preferred Option 3 of the local Mental Health Redesign report and CAHMS Strategy are recommendations for adopting enhanced roles for nurses and AHPs. Work has already begun on developing the 'Specialist Nurse / Nurse Consultant' roles.	There is the potential to develop the roles of local staff to address the needs of the service through Agenda for Change and the development of enhanced roles.	Funding for training for local staff to prepare for new roles will have to be identified and funding for the posts that are to be created. There may be an additional need for bridging finance to support service change.
5.5.6	Learning Disabilities	Same as You	A review of the level of local provision of this service is required to take into account national recommendations and standards for staffing levels and caseload. There is a need for all staff to be adequately trained in managing challenging behaviour. The needs of people with LD should be identified in ALL Board strategies and plans irrespective of the subject. This remains a short-coming in Board papers and ought to be addressed so that the specific needs of people with LD are being planned for in all Community, Primary Care and hospital care services. There is also a requirement to ensure that there is training of the general workforce in recognising and	Because our services are Primary Care led service WI NHS is a national leader in the Rural delivery of LD services. Sign 52 Guideline compliance. Inspection due Feb 2007 and there is a need to review the current status of services in line with the guideline. Requirement for a local needs assessment for autism. There is anecdotal evidence that WI has an unusually high incidence.	There will be investment required in developing and matching the LD team to national standards and local need.

			meeting the needs of people with LD.		
5.5.7	Occupational Therapy (OT)		Review of this service is currently underway as part of a review of all AHP services. A scoping exercise is being undertaken to determine the immediate future needs of this service.	This report will be available early 2007.	
5.5.8	Psychological Therapies		Review of the resource available, the creation of a local register of people with qualifications and skills in the broader psychological therapies. Cognitive Behavioural Therapy training was provided to four staff.	Within the Mental Health Redesign report are recommendations for significant development and provision of Psychological services. Clinical Psychology is required for Adult Mental Health Services, Adult General Services, CAHMS, Children's General Services and Learning Disabilities.	
5.5.9	Mental Health Delivery Plan (2006)	A new national Mental Health Delivery Plan is being officially launched in December 2006.	Local developments in mental health will have to come into line with this guidance and the Clinical Strategy will have to take cognisance of these recommendations.	Review required early 2007	

NHS Western Isles Clinical Strategy					
Key Objective 5.6		Child Health Services			
	Strategic Objectives	National Situation	Local Position	Comment	Resources
5.6.1	Hall 4		Cross Ref: 4.3.4		
5.6.2	Improving Health for School Age Children	Framework for Nursing in Schools	Being implemented in partnership with the Education Dept.	Two Public Health Nurses (Schools) in appointed and undergoing training.	
5.6.3	Child and Adolescent Mental Health Services (CAHMs)	Cross Ref: Mental Health 5.5			
5.6.4	Paediatric Service Cross Ref: 4.1.4	Community and Acute			
5.6.5	Additional Support for Learning	Additional Support for Learning Act (Scotland) 2005	WI NHS must be in a position to meet the requests for assessment of special needs children from Education Department or from parents to ensure that the child's special need does not impede their ability to access education and learning opportunities.	The main services this will impact upon will be Speech and Language Therapy and Occupational Therapy. The Lead Officer for ASL compliance is the Head of Speech and Language Therapy, who also requires administrative support to assist with the administration and co-ordination of the service.	Prime funding (non-recurring) was provided for two years. One year of this funding was not allocated to the project. New revenue funding will have to be identified.
5.6.6	Integrated Children's Services Plan	Lead by the Local Authority.	NHS has a responsibility to take a partnership role in the production and delivery of agreed plan.	Requires strategic commitment from Child Health Commissioner.	

5.6.7	Child Health Commissioner	Mandatory for all NHS Boards	NHS WI has an obligation to comply with the national requirements for this role.	Within the Paediatric Redesign Report it is recommended that this post is full time and reports to WI NHS Board.	Funding for the post, accommodation and administrative support needs to be identified.
5.6.8	Child Protection	Scottish Executive Guidelines	To address the national priorities of 'Looked After Children' (LAC) and children whose parents are substance mis-users. There is no identified budget for child protection.	Need to review the roles of Health Visitors and Community Nurses and to undertake a needs analysis to determine level of resources required.	Budget to be identified

NHS Western Isles Clinical Strategy					
Key Objective 5.7		Neurosurgery and neuroscience			
	Strategic Objectives	National Situation	Local Position	Comment	Resources
	It is assumed that the current arrangements will remain in place				

NHS Western Isles Clinical Strategy					
Key Objective 5.8		Service change and the NHS workforce			
	Strategic Objectives	National Situation	Local Position	Comment	Resources
5.8.1	Health Promotion	Health Issues in the Community, NHS Health, CHEX	To deliver health issues in the community, training for primary care and acute services staff.	The benefit of this training will prepare staff for adjusting skills from working with patients to working with communities.	To be identified.
5.8.2	Career Pathway Initiative	Workforce Planning Unit	First planning session to develop a training and education model based on 9 levels and linked to position and roles held in the organisation, has been held.	A planned programme using in-house expertise and external facilitators will be available to all staff. There is potential in this initiative to link training and development to the clinical	

				strategy ensuring that training is supporting the aims of the strategy and the Board's clinical governance objectives.	
5.8.3	Personal Development	KSF and Appraisal	There is a local learning network and directory and learning events calendar. This is an on-going area of work.	This initiative is aimed at all staff and all levels in the organisation.	

6 Timelines for Action

Delivering for Health identifies a timeline for action for national, regional and local development of the targets and recommendations and against which progress will be measured. NHS Western Isles is making progress towards some of these targets but will be required to produce a clinical strategy that reflects the national agenda.

While it is important that time is taken for proper consideration of the strategic direction the Board will take, the production of a clinical strategy should be timely so that a programme of change can be fully brought to bear and ensure that that programme is in step with regional and national programmes.

7. Financial Plan

NHS Western Isles receives a total allocation of just under £60 million, including ring fenced monies, GDS, GMS, GOS and GPS.

The Director of Finance as indicated in the Executive Summary will produce detailed planning assumptions about future funding of services.

Section 8

Appendix 1

Demographic Factors

Western Isles

1. Demographics dynamic for a new Sustainable health model

1.0.1 Population Profile:

In table below is a small geographic area breakdown of the latest population estimate of the Western Isles by broad age groups using the Scottish Neighborhood Statistics 'Intermediate Datazone' boundaries that seek to represent communities approximating to between 2,500-6,000 people.

Table 1: 2004 Population Profile of Western Isles by Intermediate Datazone area

Western Isles Intermediate Geography Population Estimates 2004							
Intermediate Geography Area	Number				Percentage		
	All Ages	0-15	16 – 64	65 plus	0-15	16 - 64	65 plus
South Lewis	2296	369	1,405	522	16%	61%	23%
Northwest Lewis	3914	681	2,354	879	17%	60%	22%
Broadbay	3071	661	1,918	492	22%	62%	16%
Barra and South Uist	3047	609	1,892	546	20%	62%	18%
Point	2710	504	1,738	468	19%	64%	17%
Harris	2037	342	1,153	542	17%	57%	27%
Stornoway East	3179	518	1,936	725	16%	61%	23%
Stornoway West	3213	589	1,994	630	18%	62%	20%
Benbecula and North Uist	2793	540	1,778	475	19%	64%	17%
Total	26260	4,813	16,168	5,279	18%	62%	20%

Source: GRO(S)

The above table indicates that approximately over one third of the population is of non-working age with majority being in the older age bracket. Within the islands there are variances in the proportions of elderly and children with Harris having the largest elderly group at 27% and among the smallest proportion of children at 17% while at the other end of the spectrum Broadbay has the lowest proportion of elderly at 16% while the largest level of children at 22%.

1.0.2 Population Projections:

Below are the latest available projected populations for health board areas which shows Western Isles as predicted to have the largest decline both overall and for those of working age to 2024.

Figure 1 Projected percentage change (2004-based), NHS board area, 2004 - 2024

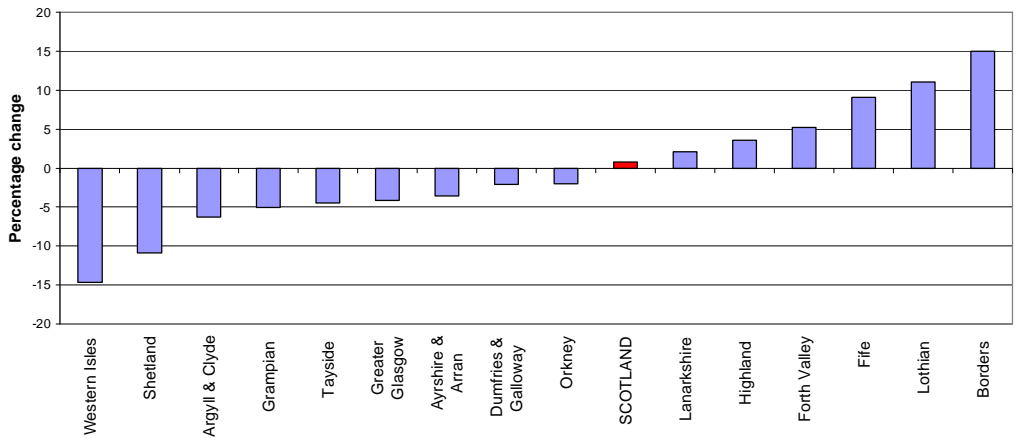
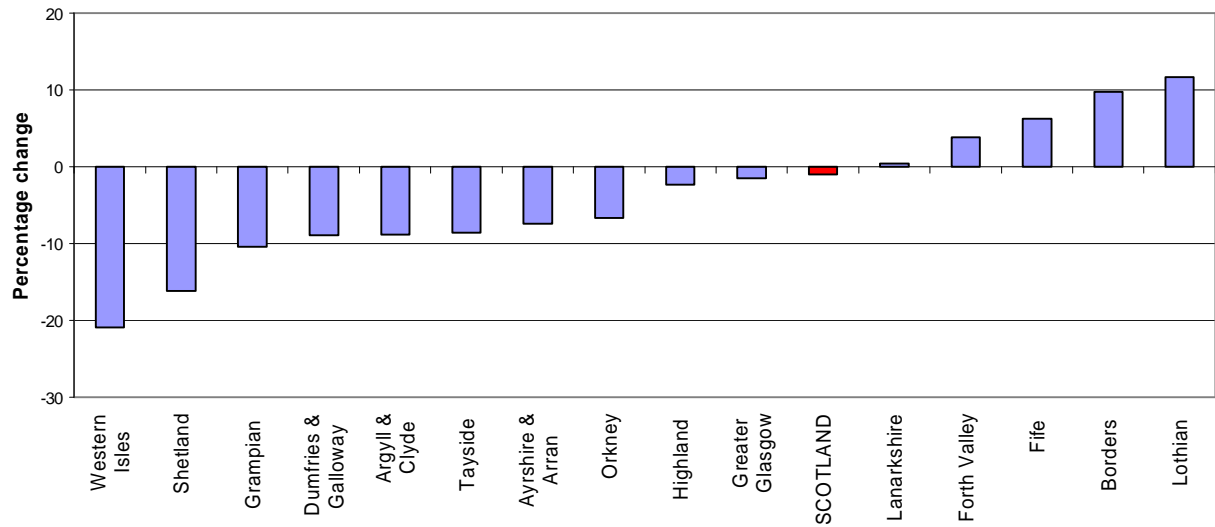


Figure 2: Projected percentage change in population of working age 16-59/64¹ (2004-based), by NHS board area, 2004 - 2024



¹Includes change in women's state pension age from 60 to 65 between 2010 and 2020

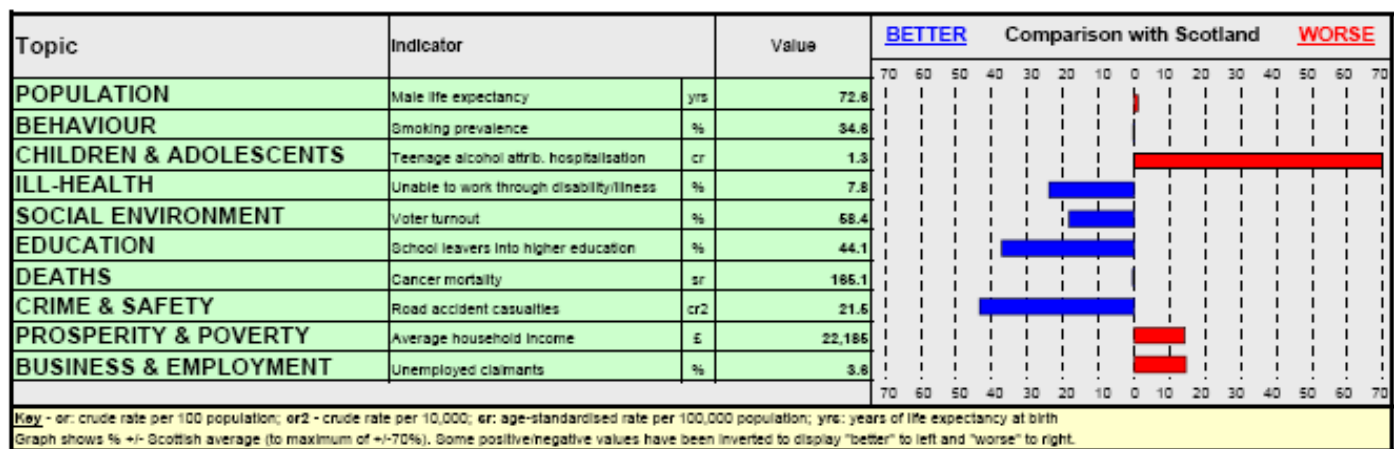
2.0 Western Isles Health Status

2.1 National Comparative Profile of Population Health Determinants and Health Inequalities:

Health Scotland produced Constituency Profiles in 2001 and 2004 which provided a selection of representative indicators of health and health determinants across a number of domains. This provides comparative indications of how the Western Isles fares against the Scottish national average in these indicators. Below are provided a summary of indicator highlights and a selection of those domains that relate specifically to health and behaviours while there are others in the Profiles that provide further data on the wider health determinants.

Figure 3: Western Isles Constituency Profile 2004 for Indicator highlights from Profile Domains.

Indicator Highlights



The above summary table presents a highlight indicator from each topic area and compares the Western Isles position relative to Scotland as a whole. It can be seen clearly here that the Western Isles fares badly for level of teenage alcohol hospitalizations and again unfavourably for economic topics measured by income and unemployment levels while positively for crime, education, social environment and incapacity levels. Further more detailed comparisons from the profiles within the more directly health-related topics are given below in figure 4:

Figure 4: Western Isles Constituency Profile 2004 Indicators from ill-health, behaviour, children & adolescents and deaths domains with Scottish Comparisons.

BEHAVIOUR (NB Some measures at regional/council level)	Year	Number	Measure	% +/- Scottish Measure	% Change over time
Estimated Smokers	2001	6,600	34.6 %	-0.1	
Overweight & Obese - Males ¹	1998		66.4 %	6.8	
Overweight & Obese - Females ¹	1998		55.5 %	2.4	
Regular Exercisers - Males ¹	1998		41.0 %	7.9	
Regular Exercisers - Females ¹	1998		30.0 %	11.1	
Daily Fruit Consumption - Males ¹	1998		51.0 %	10.9	
Daily Fruit Consumption - Females ¹	1998		63.0 %	6.8	
Alcohol (% drinking over recommended weekly limit) Males ^{1,a}	1998		25.0 %	-24.2	-26.5
Alcohol (% drinking over recommended weekly limit) Females ^{1,a}	1998		12.0 %	-20.0	9.1
Travel to Work/Study by Public Transport, Bicycle or On Foot	2001	5,741	38.5 %	-16.3	
Drugs Misuse - new patients/clients ^{2,b}	02/03	13	76.1 sr	-67.9	29.5

1. These data are only available at a regional level and in this case relate to: *Highlands and Islands*
 2. These data are only available at a council level and in this case relate to: *Eilean Siar*
 Change over time measured against: a - 1995 (Scottish Health Survey); b - 1999/00

CHILDREN & ADOLESCENTS	Year	Number	Measure	% +/- Scottish Measure	% Change over time
Infant Mortality (total deaths over 5 years) ^a	97/01	7	5.7 cr4	5.1	-3.3
Smoking During Pregnancy ^{1,b}	00/02	40	18.2 %	-32.8	-24.1
Breastfeeding at 6-8 weeks ²	2001	n/a	n/a %	n/a	
Teenage Pregnancy (13-19 year olds) ^{1,c}	00/02	23	2.2 cr	-48.8	-25.4
Teenage Abortions (13-19 year olds) ^{1,d}	00/02	7	0.6 cr	-52.5	12.8
Teenage Alcohol Attributable/Related Hospitalisations ^{1,e}	99/01	29	1.3 cr	77.9	99.6
Low Birth-weight Babies (<2500g) ^{1,e}	00/02	11	5.2 %	-8.9	9.6
Immunisation Uptake (excluding MMR) ^f	2002		96.2 %	-0.3	1.5
MMR Immunisation Uptake ^f	2002		82.1 %	-6.7	-11.6
Pre-School Overweight and Obese Children ²	2001	n/a	n/a %	n/a	
Looked After Children ^{3,f}	2001	48	86.3 cr2	-16.7	33.2
Children Referred to "Reporter" ^{3,f}	2001	182	339.8 cr2	-4.6	34.8

1. Average annual numbers and rates. Change measured against: a - 1987/91; b - 1994/96; c - 1990/92; d 1993/95; e - 1989/91; f - 1997
 2. Data are only available for 10 out of 13 of the NHS Boards across Scotland. (No data from Grampian, Highland and Island Boards)
 3. These data are only available at a council level and in this case relate to: *Eilean Siar*

DEATHS	Year	Number	Measure		% +/- Scottish Measure	% Change over time
Heart Disease ¹	99/01	90	130.6	sr	4.7	-36.5
Stroke ¹	99/01	43	55.3	sr	-8.0	-33.2
All Cancers ¹	99/01	100	165.1	sr	-0.4	0.7
Lung Cancer ¹	99/01	17	30.6	sr	-30.3	-14.4
Accidents ¹	99/01	9	23.2	sr	33.4	12.2
Drug-related Mortality (total deaths over 5 years)	97/01	<5	n/a	cr3	n/a	
Smoking Attributable Mortality (35 year-olds & over) ¹	95/01	67	414.9	cr3	3.6	

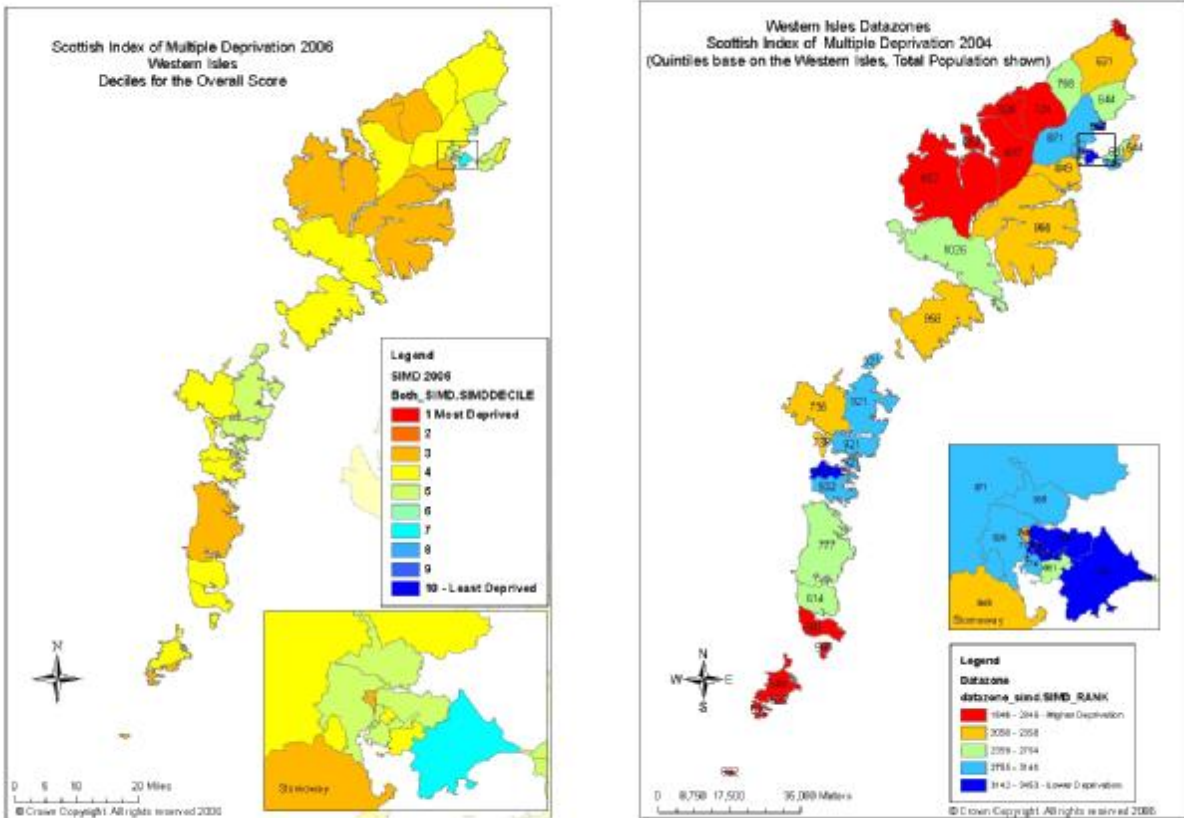
*1. Average annual numbers and rates.
Change over time measured against 1989/91*

ILL-HEALTH	Year	Number	Measure		% +/- Scottish Measure	% Change over time
Suicide/Deliberate Self Harm Hospital Admissions ¹	99/01	51	227.9	sr	-25.1	
Alcohol Attributable Related Hospital Admissions ^{1,2*}	99/01	546	1645.8	sr	56.7	74.7
Long-term Limiting Illness	2001	5,431	20.5	%	0.9	62.6
Self Assessed Health (classified as "Not Good")	2001	2,338	8.8	%	-13.1	
Prescriptions (DDDs) ³ for Anti-depressant related drugs	2001	421,981	1533.7	cr	-14.7	
Prescriptions (DDDs) ³ for Cardiovascular related drugs	2001	6,237,440	22670.1	cr	22.1	
Adults Unable to Work due to Disability ^b	2003	1,200	7.8	%	-23.9	0.0
Attendance Allowance Claimants	2001	975	18.6	%	1.6	

*1. Average annual numbers and rates. 2. Trends for alcohol attributable related hospital admissions not available for constituencies in Fife
3. DDDs³ = defined daily doses. Note that prescriptions data relate to GP Practice populations within each constituency.
Change over time measured against 1991 except for: a - 1989/91; b - 1999*

2.2 Western Isles and comparative levels of multiple deprivation:

Figures 5a: and 5b: Scottish Index of Multiple Deprivation 2006 (Scottish deciles - based) and 2004 (WI Quintiles-based)



The above maps show the distribution of multiple deprivation across the Western Isles by the Scottish Neighborhood Statistics datazone, which is a small population area of between 500 and 1,000. This deprivation is measured across a number of domains including income, employment, education, health, housing, geographic access and crime in 2006 measure. Figure 5a shows the Western Isles level of multiple deprivation relative to the Scottish scores, which shows the Western Isles at neither extremes of most or least deprivation. When looking at deprivation levels relative to the Western Isles as a whole the most deprived communities appear to lie in West Lewis, Barra and to a lesser extent in South Lochs, South Harris and South Uist while the least deprived areas include areas around Stornoway and parts of Benbecula.

3. Morbidity Information

3.1 Primary Care Morbidity:

Table 2: Quality & Outcomes Framework (QOF) for April 2005 - March 2006, Western Isles and Scotland Prevalence rates for 10 Clinical Domains

Clinical Domain	No. of Practices ¹	Total disease register size ¹	Raw prevalence (per 100 people) ²	
			WI	Scotland
Asthma	11	1444	5.4	5.4
CHD	11	1488	5.5	4.5
COPD	11	284	1.1	1.8
Mental Health	11	145	0.5	0.6
Hypertension	11	3936	14.6	12.1
Cancer	11	184	0.7	0.7
Stroke TIAs	11	560	2.1	1.9
Hypothyroidism	11	1095	4.1	3
Epilepsy	11	200	0.7	0.7
Diabetes	11	801	3	3.4

Data Source: QMAS database, as at 9th August 2006, plus further notifications of adjustments from NHS Boards

¹This is the total number of all practices participating in the QOF, across all contract/agreement types. Apparent achievement and prevalence may vary by CHP in part due to mixture of practice contract types

²This is the number of patients recorded by practices as being on their disease registers for this condition

³Prevalence = number of patients on the disease register for this condition, divided by list size, multiplied by 100.

There is no centrally available information on primary care morbidity levels including consultation rates. However, there are as part of the new Quality Outcomes Framework does provide some comparative data across Scotland although not all practices are participating and there are a number of issues around the appropriateness of this data for epidemiological comparisons at present. Nonetheless it gives a useful indication of where the Western Isles shows apparent variance with Scotland in prevalent levels for main conditions eg. Hypertension, Stroke&TIAs, & hypothyroidism appear above Scottish levels.

3.2 Community Prescribing Information:

Table 3: Total Costs and Items Dispensed by British National Formulary (BNF) Chapter in Western Isles for 2005 ranked by Cost together with ranked comparison with Scottish Health Boards

BNF Chapter Description	Dispensed			Per 1000 patients			Rank within individual board expenditure			Rank out of Health	
	GIC	Items	Quantity	Cost GIC	Items	Quantity	Rank GIC	Rank Items	Rank Quantity	Rank Cost (GIC)	Rank Items
CARDIOVASCULAR SYSTEM	1,361,135.25	180108	7209275	50,107.34	6630	265394	1	1	1	1	1
CENTRAL NERVOUS SYSTEM	1,006,468.73	82641	6074051	37,051.64	3042	223607	2	2	2	8	5
GASTRO-INTESTINAL SYSTEM	584,719.42	44077	5753021	21,524.42	1623	211778	3	3	3	2	2
ENDOCRINE SYSTEM	532,764.06	40661	1705167	19,610.57	1497	62766	4	4	5	1	1
RESPIRATORY SYSTEM	425,463.10	29298	721463	15,659.65	1078	26554	5	5	9	11	7
NUTRITION AND BLOOD	180,715.26	14718	734544	6,651.23	542	27035	6	9	8	4	3
INFECTIONS	172,911.27	24922	1019635	6,361.11	917	37511	7	6	7	1	2
MUSCULOSKELETAL & JOINT DISEASES	156,933.01	19938	1408416	5,777.64	734	51852	8	8	6	4	2
SKIN	153,772.94	21703	3565818	5,655.63	798	131148	9	7	4	1	3
DRESSINGS	152,462.91	14158	145492	5,611.76	521	5355	10	10	12	1	1
MALIGNANT DISEASE & IMMUNOSUPPRESSION	151,012.95	1906	96742	5,553.75	70	3558	11	16	15	4	4
OBSTETRICS,GYNAE+URINARY TRACT DISORDERS	136,207.57	7967	461984	5,013.93	293	17006	12	12	10	14	13
STOMA APPLIANCES	99,929.67	1461	50588	3,682.20	54	1864	13	17	18	4	5
DUMMY CHAPTER	60,418.76	4598	139805	2,232.52	170	5166	14	15	14	6	1
APPLIANCES	57,758.37	6278	320255	2,127.54	231	11797	15	13	11	6	1
EYE	55,566.81	9536	95930.5	2,045.82	351	3532	16	11	16	2	1
EAR, NOSE AND OROPHARYNX	31,860.78	5276	142552.5	1,172.26	194	5245	17	14	13	8	10
INCONTINENCE APPLIANCES	23,374.04	1089	21656	860.55	40	797	18	18	19	10	10
IMMUNOLOGICAL PRODUCTS & VACCINES	20,676.22	961	1251	761.20	35	46	19	19	21	13	4
ANAESTHESIA	2,522.83	529	3153	92.74	19	116	20	20	20	5	1
OTHER DRUGS AND PREPARATIONS	1,494.31	309	57845.65	55.08	11	2132	21	21	17	14	12

GIC = Gross Ingredient Cost

Source: PRISMS

The most common type of prescribing in the Western Isles is for cardiovascular drugs as in Scotland as a whole, although it is higher (both in cost and volume) in the Western Isles than any other health board in Scotland. Other areas where the Western Isles appears as the highest prescribing Board in Scotland include prescriptions for the endocrine system, eye, anaesthetics, dressings and appliances. The most common drugs prescribed within these BNF chapters in the Western Isles are shown below in table 4.

Table 4: Top 20 prescribed drugs by Volume for Western Isles Health Board 2005/06

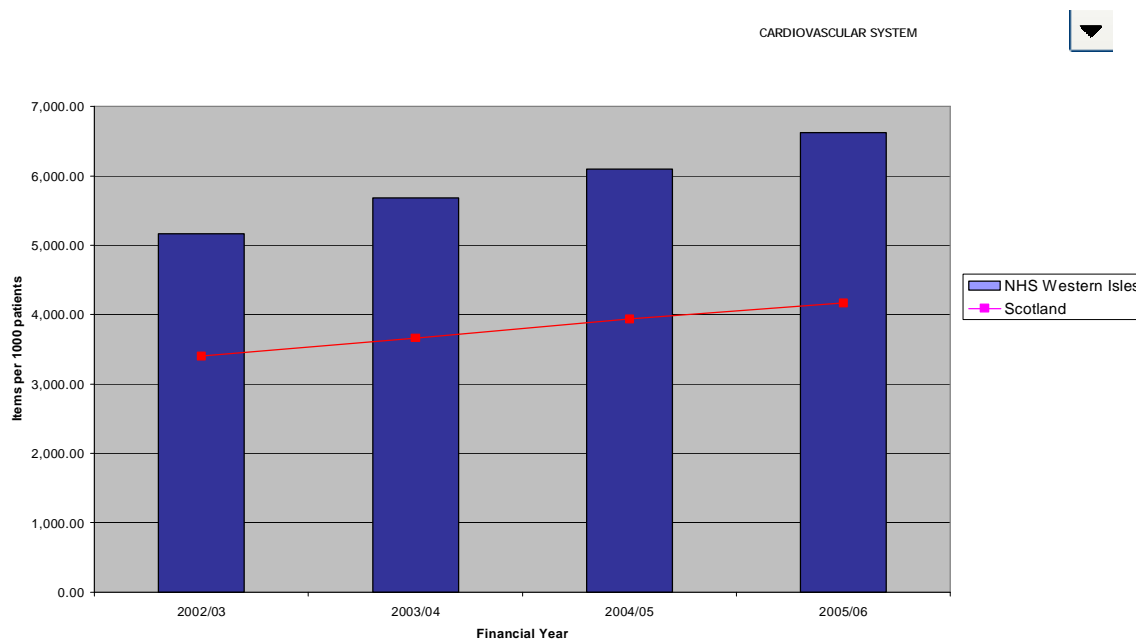
Approved Drug Name	Total GIC	GIC per item	Total Items for	Items Rank	Scotland Items Rank
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ASPIRIN	30,081	1.23	24372	1	1
BENDROFLUMETHIAZIDE	20,200	1.04	19347	2	2
OMEPRAZOLE	287,532	17.24	16676	3	8
ATENOLOL	18,329	1.12	16418	4	5
LEVOTHYROXINE SODIUM	20,337	1.34	15173	5	7
SIMVASTATIN	121,152	8.97	13501	6	4
LISINOPRIL	58,685	5.38	10904	7	20
SALBUTAMOL	49,041	4.72	10395	8	6
FUROSEMIDE	12,655	1.39	9121	9	14
AMLODIPINE	109,573	13.12	8350	10	15
CO-CODAMOL	49,887	5.98	8343	11	3
DICLOFENAC	55,078	7.65	7201	12	17
PARACETAMOL	12,444	1.79	6942	13	9
ATORVASTATIN	173,295	29.18	5938	14	13
DIAZEPAM	5,923	1.13	5247	15	18
EMOLLIENTS	28,257	5.43	5202	16	12
AMOXICILLIN	8,762	1.73	5067	17	11
ISOSORBIDE MONONITRATE	47,137	9.64	4888	18	Not in top 20
WARFARIN SODIUM	10,137	2.10	4817	19	Not in top 20
RAMIPRIL	45,015	9.73	4626	20	16

Source: PRISMS

3.2.1 Cardiovascular drug prescribing:

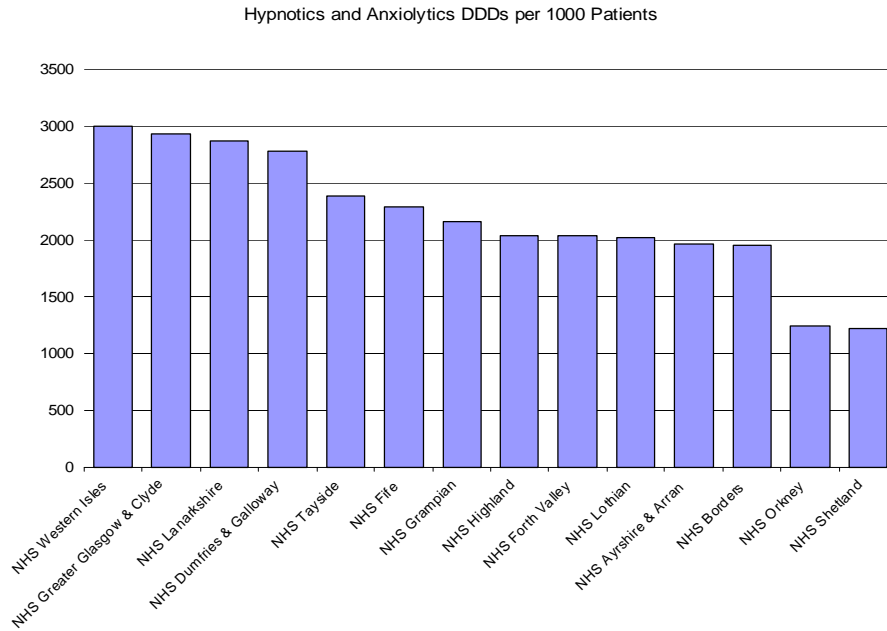
Figure 6:: Comparison of Cardiovascular drug prescribing for Western Isles and Scotland



Source: PRISMS

3.2.2 Audit Scotland Prescribing Indicators:

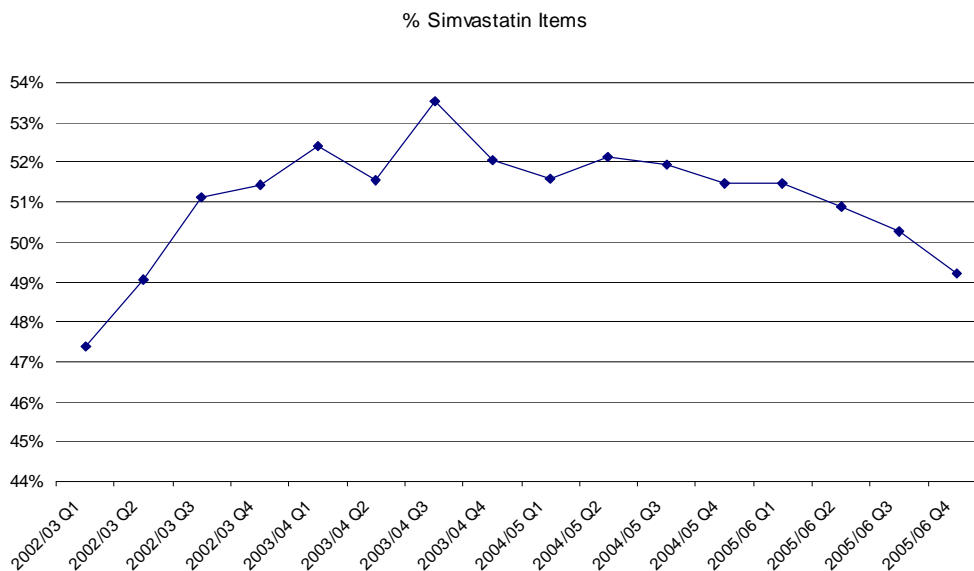
Figure 7: Audit Scotland Prescribing indicator A07- Hypnotics and Anxiolytics DDDs per 1000 patients for each NHS Board



Source: PRISMS

The Western Isles has the highest level of prescribing of hypnotics and anxiolytics within Scotland for the most recent period. Although it is believed that such drugs are often over-prescribed it may be that in the Western Isles such prescribing reflects the high levels of alcohol dependence in the population, particularly those seen in secondary care services where such drugs are often first prescribed.

Figure 8: Audit Scotland Prescribing Indicator M03 - Simvastatin as a % of all Statin drugs and Items/1000 Patients of Simvastatin in Western Isles.



Using Simvastatin as the drug of first choice in lipid lowering has merits supported by significant evidence. The availability and price of generic Simvastatin provides extremely good value for money whilst providing the ability to achieve target cholesterol levels. The Western Isles is below Scottish levels of Simvastatin prescribing and moreover as seen in figure 8 they have been declining in recent years.

3.3 Hospital Morbidity

3.3.1 Western Isles Hospital inpatient/day case service utilization:

Table 5: Main Disease Conditions at Western Isles Hospital ranked by Total Occupied Bed Days

Broad Diagnostic Group	Data	2003/04	2004/05	2005/06	Grand Total
Diseases of the respiratory system	Sum of los	4176	6870	3853	14899
	Count of No.	341	290	352	983
Heart disease	Sum of los	4304	5034	2651	11989
	Count of No.	426	330	320	1076
Symptoms signs & abnormal clinical & laboratory findings not elsewhere classified	Sum of los	3553	3691	4042	11286
	Count of No.	741	759	856	2356
Injury poisoning & certain other consequences of external causes	Sum of los	3204	3333	3873	10410
	Count of No.	493	508	407	1408
Diseases of the digestive system	Sum of los	4046	2740	2839	9625
	Count of No.	762	729	727	2218
Cerebrovascular diseases	Sum of los	1957	1105	2687	5749
	Count of No.	62	30	50	142
Malignant neoplasms	Sum of los	2352	1729	1505	5586
	Count of No.	290	254	246	790
Diseases of the musculoskeletal system & connective tissue	Sum of los	1504	1793	1595	4892
	Count of No.	262	263	199	724
Diseases of urinary system	Sum of los	1075	1087	1952	4114
	Count of No.	140	108	108	356
Diseases of nervous system	Sum of los	1477	1195	1302	3974
	Count of No.	185	189	155	529
Factors influencing health status & contact with health services	Sum of los	949	2144	790	3883
	Count of No.	342	462	300	1104
Other diseases of the circulatory system	Sum of los	558	1482	857	2897
	Count of No.	110	133	113	356
Mental & behavioural disorders	Sum of los	711	684	814	2209
	Count of No.	147	127	140	414
Diseases of the skin & subcutaneous tissue	Sum of los	1055	628	348	2031
	Count of No.	273	264	313	850
Endocrine nutritional & metabolic diseases	Sum of los	534	617	549	1700
	Count of No.	90	83	74	247
Diseases of the blood & blood forming organs & certain disorders involving the immune mechanism	Sum of los	626	531	538	1695
	Count of No.	74	73	63	210
Diseases of genital organs & breast	Sum of los	487	582	517	1586
	Count of No.	214	226	201	641
Certain infectious & parasitic diseases	Sum of los	827	418	275	1520
	Count of No.	52	45	38	135
In situ or benign neoplasms of uncertain or unknown behaviour	Sum of los	746	208	122	1076
	Count of No.	200	136	130	466
Diseases of the eye & adnexa	Sum of los	129	135	119	383
	Count of No.	293	279	292	864

Congenital malformations deformations & chromosomal abnormalities	Sum of los	68	167	46	281
	Count of No.	15	17	10	42
Diseases of the ear & mastoid process	Sum of los	7	46	31	84
	Count of No.	11	16	18	45
Pregnancy childbirth & the puerperium	Sum of los	35	28	16	79
	Count of No.	42	37	12	91
Certain conditions originating in the perinatal period	Sum of los		9		9
	Count of No.		1		1
Total Sum of los		34380	36256	31321	101957
Total Count of No.		5565	5359	5124	16048

Source: SMR01

3.3.2 Uist & Barra Hospital inpatient/day case service utilization:

Table 6: Main Disease Conditions at Western Isles Hospital ranked by Total Occupied Bed Days

Broad Diagnostic Group	Data	2003/04	2004/05	2005/06	Grand Total
Symptoms signs & abnormal clinical & laboratory findings not elsewhere classified	Sum of los	646	585	613	1844
	Count of No.	149	98	147	394
Mental & behavioural disorders	Sum of los	323	441	908	1672
	Count of No.	50	55	58	163
Diseases of nervous system	Sum of los	164	437	963	1564
	Count of No.	20	27	25	72
Injury poisoning & certain other consequences of external causes	Sum of los	620	562	362	1544
	Count of No.	68	61	64	193
Factors influencing health status & contact with health services	Sum of los	270	514	352	1136
	Count of No.	46	48	42	136
Heart disease	Sum of los	376	140	508	1024
	Count of No.	32	33	24	89
Diseases of the digestive system	Sum of los	203	437	299	939
	Count of No.	90	100	72	262
Malignant neoplasms	Sum of los	403	201	326	930
	Count of No.	22	18	21	61
Diseases of the musculoskeletal system & connective tissue	Sum of los	156	235	440	831
	Count of No.	32	24	36	92
Cerebrovascular diseases	Sum of los	269	200	248	717
	Count of No.	5	8	10	23
Other diseases of the circulatory system	Sum of los	74	143	426	643
	Count of No.	10	8	9	27
Diseases of the respiratory system	Sum of los	289	175	137	601
	Count of No.	35	25	22	82
Diseases of urinary system	Sum of los	305	94	186	585
	Count of No.	25	11	14	50
Diseases of the skin & subcutaneous tissue	Sum of los	134	64	40	238
	Count of No.	51	43	53	147
Diseases of the blood & blood forming organs & certain disorders involving immune mechanism	Sum of los	26	20	92	138
	Count of No.	11	10	15	36
Endocrine nutritional & metabolic diseases	Sum of los	27	52	43	122
	Count of No.	9	16	7	32

Certain infectious & parasitic diseases	Sum of los Count of No.	37 6	72 4	8 6	11 10
Diseases of genital organs & breast	Sum of los Count of No.	36 5	4 2	0 3	4 10
In situ or benign neoplasms of uncertain or unknown behaviour	Sum of los Count of No.	0 10	11 11	4 12	1 3
Pregnancy childbirth & the puerperium	Sum of los Count of No.	3 1	3 1	2 1	1 1
Diseases of the eye & adnexa	Sum of los Count of No.	0 1	1 1		
Diseases of the ear & mastoid process	Sum of los Count of No.		1 1		
Total Sum of los		4361	4392	5957	14710
Total Count of No.		678	605	641	1920

Source: SMR01

The main conditions currently taking up hospital provision within the Western Isles are respiratory and heart conditions especially in the Western Isles Hospital. Cerebrovascular conditions including strokes account for comparatively high level of hospital utilization relative to the actual nos. of patients which is as result of long lengths of stay for rehabilitation of patients. Mental and behavioural conditions account for much hospital time in the Uist & Barra Hospital under GP care. This does not feature in the Western Isles Hospital table so highly but this is because the data here only relates to acute specialties and if we include patients in the psychiatric specialties then the WIH is likely to feature similarly high proportions of such patients as in Uist & Barra Hospital.

3.4 Cross Border Flow Hospital Activity:

Table 7: Cross Border Flow activity – Inpatients/Day Cases according to where treated by Health Board of Residence

NHS Board	Total Activity in 3 year period	% own Board	% NOS Boards	% rest of Scotland	% other
Grampian	316,145	97.1	1.8	1.0	0.1
Tayside	154,585	94.8	1.2	3.9	0.1
Highland	150,483	93.4	3.3	3.2	0.1
Western Isles	18,658	77.8	9.4	12.5	0.3
Shetland	10,917	69.6	28.8	1.5	0.1
Orkney	9,022	63.9	34.5	1.5	0.1

Source: SMR01, SMR02, SMR04

Table 8: Cross Border Flow activity – Outpatients according to where treated by Health Board of Residence

NHS Board	Total Activity in 3	% own Board	% NOS Boards	% rest of Scotland
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	year period			
Grampian	1142228	98.3	1.3	0.4
Highland	540330	98.0	0.9	1.1
Tayside	688428	96.9	2.6	0.5
Shetland	21266	77.5	20.7	1.8
Western Isles	28945	74.0	9.1	16.9
Orkney	13806	70.5	27.8	1.7

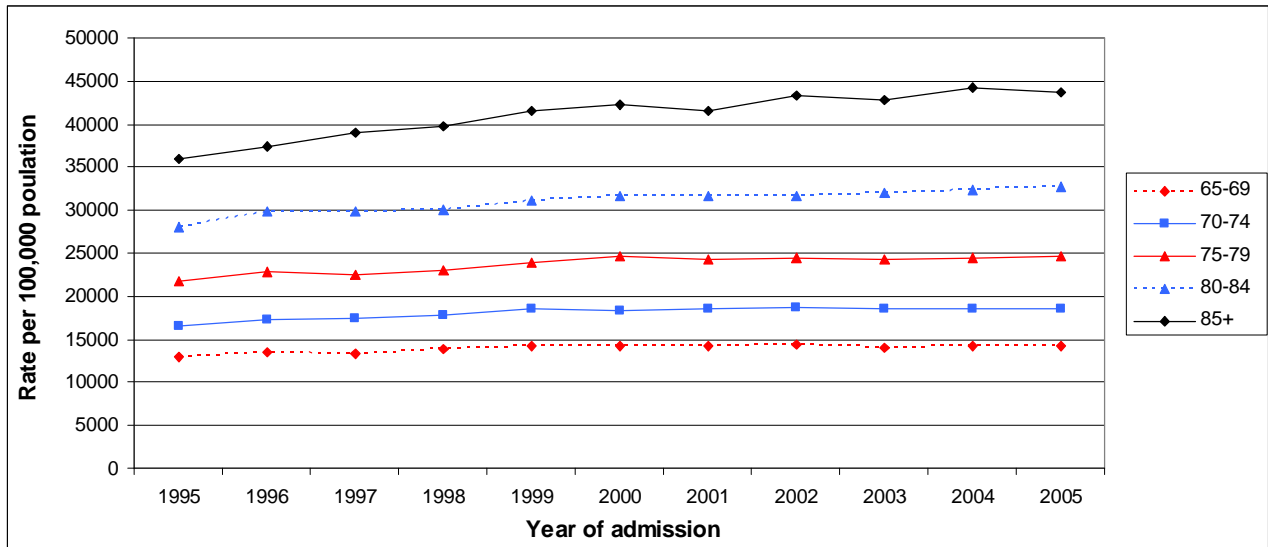
The above tables 6 & 7 show that the Western Isles in common with the other island boards treats relatively less of its residents within its own hospitals although it does treat more than the other island boards as inpatients/day cases. However, the Western Isles unlike the other island boards and the remaining boards within the North of Scotland is unique in sending significant levels of patients outwith the North of Scotland – 12.5% for inpatient/day case treatment and 16.9% for outpatient appointments.

3.5 Delivering For Health and Indicators supporting the move from Secondary to Primary care settings: towards near-home care

The policy background for recent developments in monitoring hospital patient activity is towards a move from secondary to primary care settings. Thus monitoring to reverse the rising emergency and multiple admissions in older people together with the development of improved programmes of management of long-term conditions in the community and other programmes for those conditions appropriately cared for in such a setting such as ambulatory sensitive care conditions. Therefore the identification and monitoring of those patients at risk of hospital admission and those patients where hospital admission is avoidable is a key part of national and local health intelligence to support the delivery of the objectives of the ‘Delivering for Health’ agenda.

3.5.1 Emergency Admissions in the over 65s

Figure 9::Rates per 100,000 population of emergency continuous inpatient stays by age group; years ending 31st March 1995 to 2005

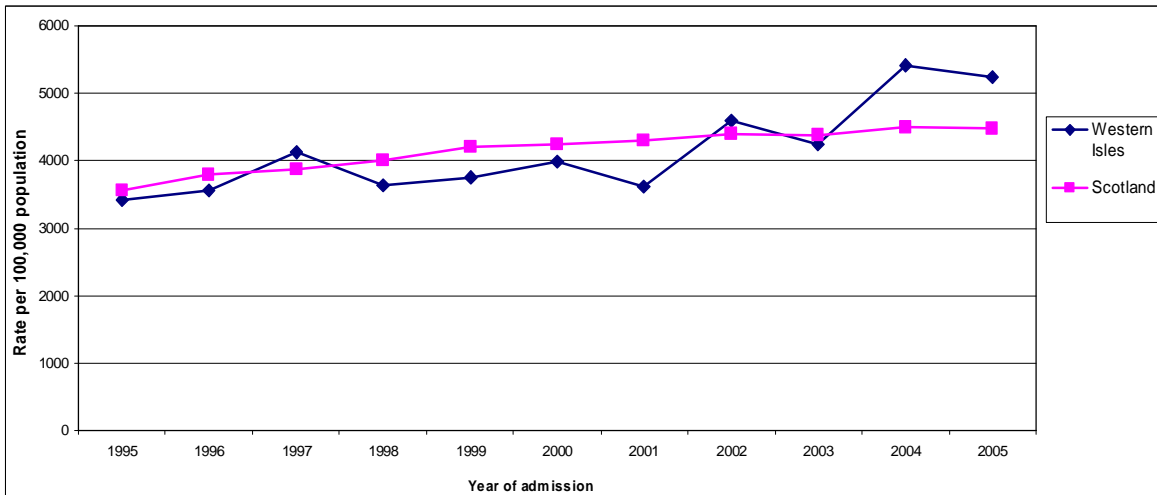


Source: SMR linked dataset

It is seen in figure 9 that the Western Isles has an increasing trend of emergency admissions among the over 65s but particularly as the more elderly the patient becomes.

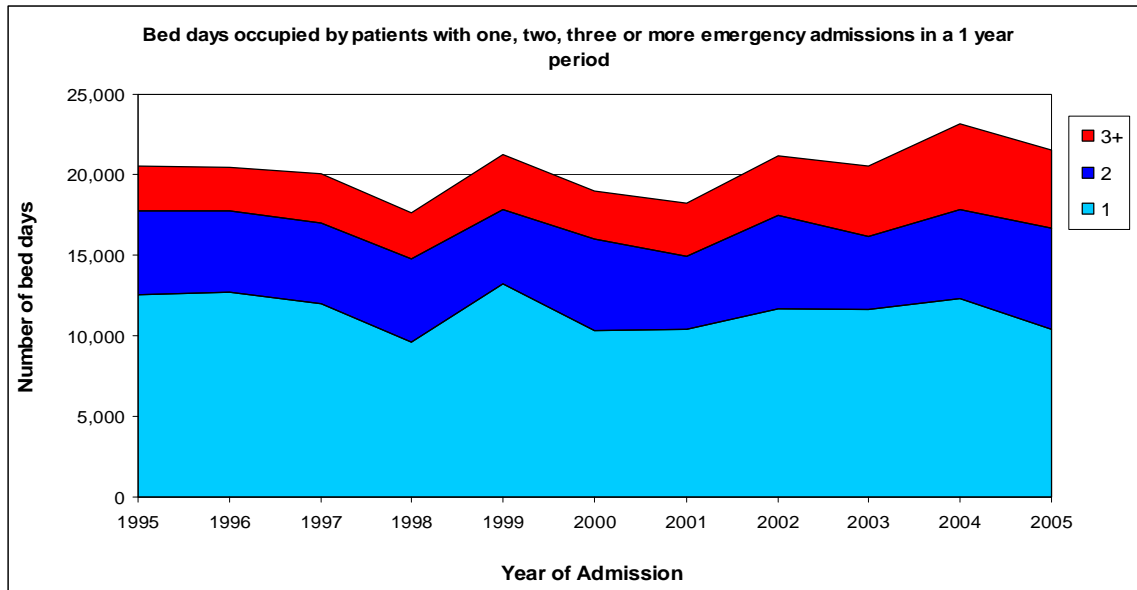
3.5.2 Multiple emergency admissions over 65s

Figure 10: Western Isles comparative to Scottish patients aged 65+ with 2+ emergency admissions within 1 year by NHS Board of Residence, years ending 31st March 1995 to 2005



Source: SMR linked dataset

Figure 11: Number of bed days occupied by Western Isles patients aged 65+ with 1, 2 or 3+ emergency admissions within a 1 year period for years ending 31st March 1995 to 2005.

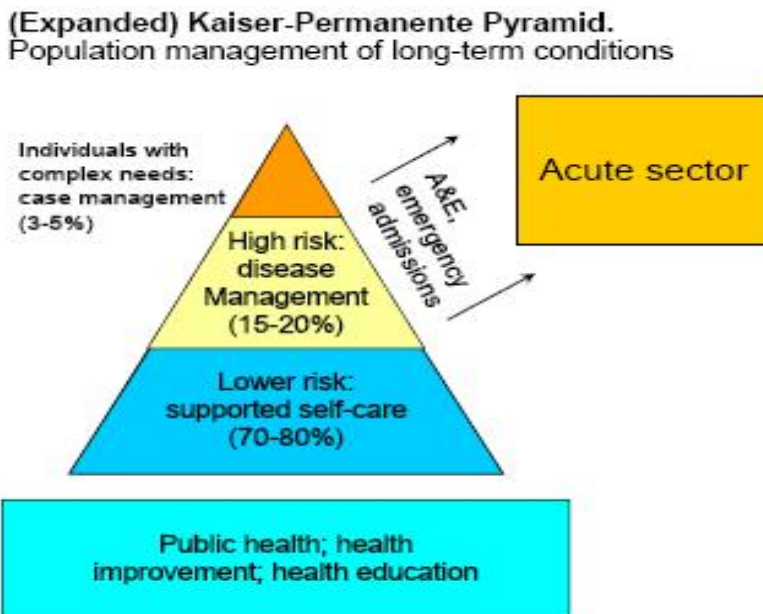


Source: SMR linked dataset

It is evident from above tables that there has been an increasing trend in both the number of multiple admissions among the 65+ age group and the bed days occupied by these elderly patients which in most recent years has risen above national averages. This together with the rise in all emergency admissions among the elderly age group is unsustainable particularly with aging population predictions which are even more marked within the Western Isles. Therefore alternative models for the management of long-term conditions and avoiding hospitalization are required.

3.5.3 Management of Long-term conditions:

Figure 12: Population management of long-term conditions – Kaiser-Permanente Pyramid



Source: ISD Delivering for Health programme

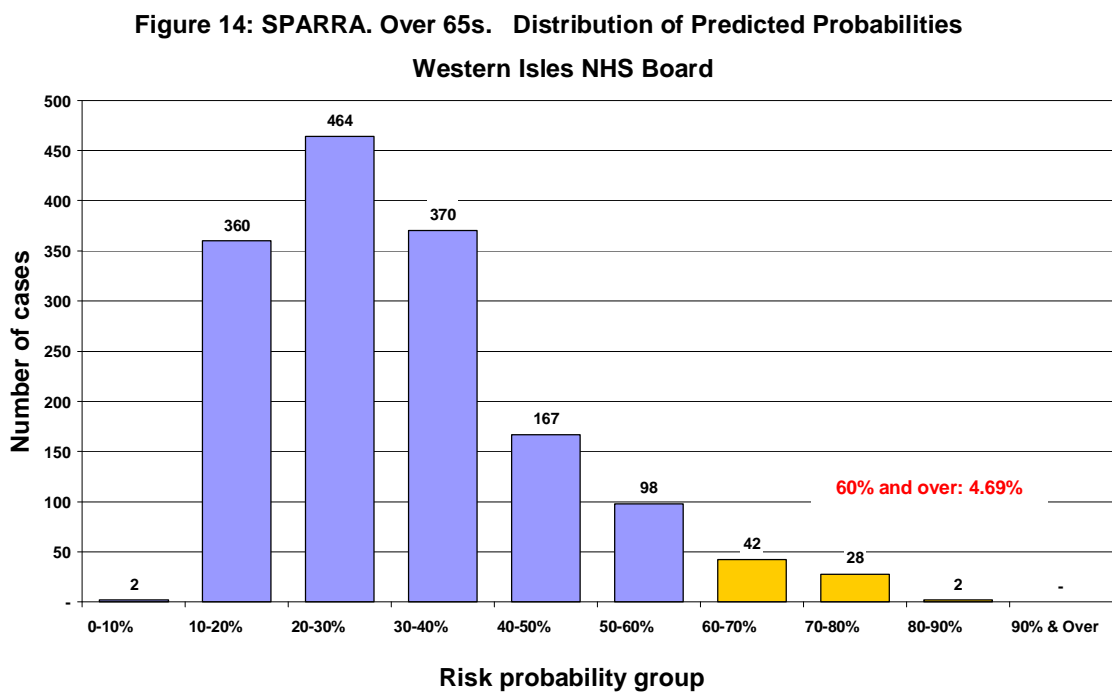
The core message from this model is that between 70-80% of people with long-term conditions can be managed through supported self-care while the higher risk category of

between 15-10% that often present in the hospital as emergency admissions would benefit from disease management programmes while more specific case management delivery would be needed for those with individual complex needs. But development of such care management programmes for all groups should assist avoidable pressure on hospital systems that has been developing for a number of years. Key to the above model of care for long-term conditions in the Western Isles as elsewhere in Scotland is:

- 1) Identification of patients at risk of hospital admission using the National SPARRA modeling tool
- 2) Introduction of local models of care to manage patients more effectively in the community and avoiding hospitalizations where possible.

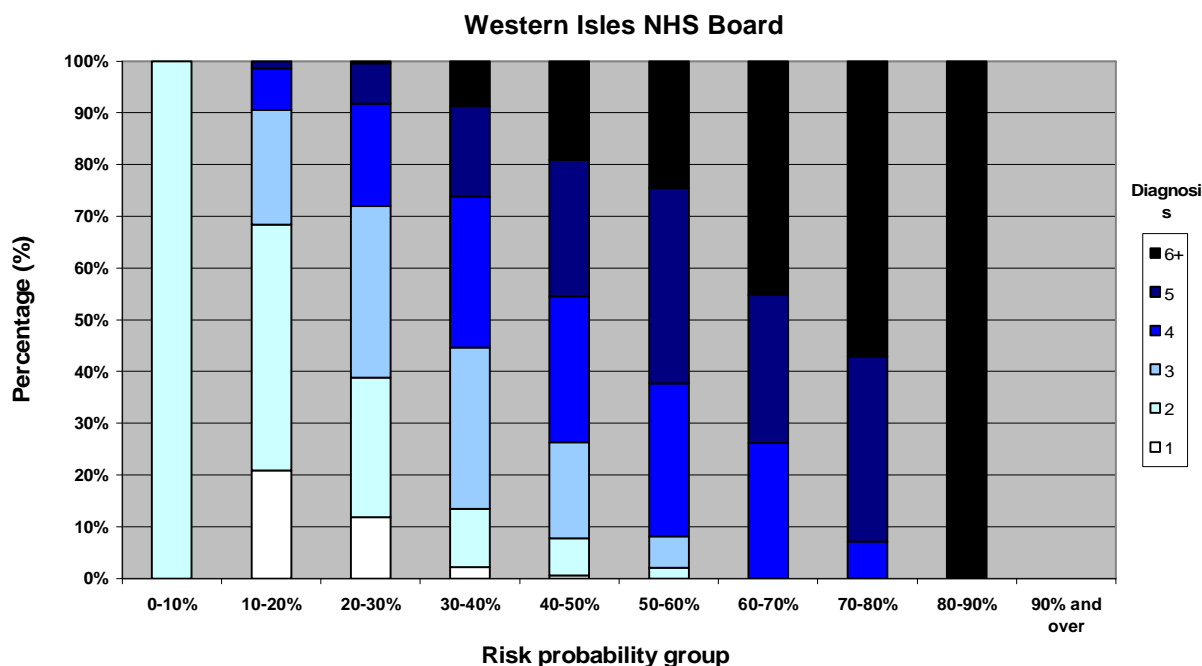
Therefore, both the identification of patients at risk of hospitalization and the monitoring of those patients with conditions where hospitalization is likely to have been avoidable such as in ambulatory sensitive care conditions will be a key aspect for delivering on this challenge.

3.5.4 – SPARRA – Western Isles patients at risk of hospitalization



Source: ISD SPARRA data for Western Isles

Figure 15: Diagnosis group make up of SPARRA risk categories



Source: ISD SPARRA data for Western Isles

The above figures 14 and 15 show the distribution of risk within Western Isles from SPARRA model which indicates for the period 1st April 2006 – 31st March 2007 the no. of patients at high risk (p>60%) of further hospital admission are 72 and of these the greater the risk the greater is the no. of broad diagnostic groups the patients have been admitted for over previous 3 years.

3.5.5 Avoidable Hospitalisations in the Western Isles – Ambulatory Sensitive Care Conditions:

Table 9: Age/Sex Standardised rates/10,000 population for Ambulatory Sensitive Care Condition Hospitalisations

Diagnosis	2003		2004	
	Scotland	Western Isles	Scotland	Western Isles
Angina	260.6	319.5	244.5	235.0
Asthma	145.5	274.2	174.6	237.9
Cellulitis	126.5	158.7	139.8	134.8
Chronic obstructive pulmonary disease	0.1	-	0.2	-
Congestive heart failure	160.8	137.7	157.9	123.8
Convulsions and Epilepsy	213.7	294.9	224.1	264.6
Dehydration and Gastroenteritis	157.8	215.4	182.0	284.0
Dental Conditions	340.0	231.8	319.2	213.2
Diabetes complications	136.6	243.0	158.5	207.9
Ear Nose and Throat Infections	225.5	293.3	230.3	197.6
Gangrene	20.8	13.9	24.9	43.4
Hypertension	19.5	89.1	19.6	56.6
Influenza and pneumonia	157.1	259.3	166.0	105.6
Iron Deficiency Anaemia	54.9	32.8	70.5	18.4
Nutritional Deficiencies	0.1	0.0	0.3	0.0

Other vaccine preventable	9.8	0.0	13.3	3.1
Pelvic Inflammatory Disease	17.6	16.8	19.2	10.9
Perforated / Bleeding Ulcer	44.1	21.4	44.0	21.2
Pyelonephritis	15.5	15.4	18.0	16.5
Ruptured Appendix	21.8	0.0	22.8	0.0

The above table gives a measure of the possible levels of avoidable hospitalizations using ambulatory sensitive care conditions as a proxy for such a measure. These conditions are well recognized as being indicative of how effective primary care provision is operating. It is seen above that there are number of such conditions (eg. Asthma, Hypertension, Gastroenteritis, Epilepsy & Diabetes complications) where the Western Isles appears above the national average level although with small numbers sizeable annual fluctuations can occur.

4.0 Mortality Information

Table 10 below shows the numbers of deaths in the Western Isles for 2005 which show as for Scotland in the main that the largest causes of death are cancers, diseases of circulatory system including strokes & CHD, respiratory diseases as well as deaths resulting from mental disorders and external injury and poisonings.

Table 10: Numbers of Annual deaths in Western Isles for EUROSTAT cause of death groupings

Causes of Death	W Isles 2005	Scotland 2005
I. Certain infectious and Parasitic Diseases	3	719
<i>Tuberculosis</i>	2	49
<i>Meningococcal infection</i>	0	4
<i>Viral hepatitis</i>	0	16
<i>Human immunodeficiency virus (HIV) Disease</i>	0	31
II. Neoplasms	108	15,408
<i>Malignant neoplasms</i>	105	15,135
<i>Malignant neoplasms of lip, oral cavity and oharynx</i>	3	242
<i>Malignant neoplasm of oseophagus</i>	8	798
<i>Malignant neoplasm of stomach</i>	1	590
<i>Malignant neoplasm of colon</i>	15	966
<i>Malignant neoplasm of rectum and anus</i>	2	609
<i>Malignant neoplasm of liver and intrahaepatic bile ducts</i>	1	320
<i>Malignant neoplasm of pancreas</i>	5	603
<i>Malignant neoplasm of larynx</i>	2	106
<i>Malignant neoplasm of trachea, brOnchus and lung</i>	24	4,009
<i>Malignant melanoma of skin</i>	2	158
<i>Malignant neoplasm of breast</i>	11	1,151
<i>Malignant neoplasm of cervix uteri</i>	1	127
<i>Malignant neoplasm of other parts of the uterus</i>	1	136
<i>Malignant neoplasm of ovary</i>	1	366
<i>Malignant neoplasm of prostate</i>	3	765
<i>Malignant neoplasm of kidney, except renal pelvis</i>	1	341
<i>Malignant neoplasm of bladder</i>	2	457
<i>Malignant neoplasm of lymphoid, haematopoietic and related tissue</i>	5	1,012
III. Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism	0	118
IV. Endocrine, nutritional and metabolic diseases	11	988
<i>Diabetes mellitus</i>	10	745
V. Mental and behavioural disorders	25	2,454
<i>Mental and behavioural disorders due to use of alcohol</i>	10	343
<i>Mental and behavioural disorders due to use of drugs</i>	1	217
VI-VIII Diseases of the nervous system and the sense organs	4	1,306
<i>Meningitis</i>	0	18
IX. Diseases of the circulatory system	145	20,060
<i>Ischaemic heart diseases</i>	68	10,331
<i>Other heart diseases</i>	29	1,457
<i>Cerebrovascular diseases</i>	33	5,789
X. Diseases of the respiratory system	44	7,093
<i>Influenza</i>	0	11

<i>Pneumonia</i>	16	2,483
<i>Chronic lower respiratory diseases</i>	12	3,027
<i>Asthma</i>	1	100
XI. Diseases of the digestive system	13	3,221
<i>Ulcer of the stomach, duodenum and jejunum</i>	0	232
<i>Chronic liver disease</i>	4	1,152
XII. Diseases of the skin and subcutaneous tissue	1	127
XIII. Diseases of the musculoskeletal system and connective tissue	6	326
<i>Rheumatoid arthritis and osteoarthritis</i>	3	134
XIV. Diseases of the genitourinary system	8	1,063
<i>Diseases of the kidney and ureter</i>	6	617
XV. Pregnancy, childbirth and the puerperium	0	4
XVI. Certain conditions originating in the perinatal period	0	164
XVIII. Congenital malformations, deformations and chromosomal abnormalities	1	159
<i>Congenital malformations of the nervous system</i>	0	15
<i>Congenital malformations of the circulatory system</i>	1	58
XVIII. Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	1	325
<i>Sudden infant death syndrome</i>	0	20
<i>Other ill-defined and unknown causes</i>	0	85
XX. External causes of morbidity and mortality	20	2,212
<i>Accidents</i>	13	1,284
<i>Transport accidents</i>	3	301
<i>Falls</i>	4	676
<i>Poisonings</i>	0	48
<i>Intentional self-harm</i>	5	547
<i>Assault</i>	0	80
<i>Event of undetermined intent</i>	2	216
Total:	390	55,747

4.1 Comparative mortality rates:

Table 11 below compares the mortality rates for the main diseases causing deaths in Scotland adjusted for age and sex structures for all the health board areas. The Western Isles is below the Scottish level for mortality rates for all these conditions with the exception of pneumonia but the numbers here are very small that this is not likely to be significantly above the national rate.

Table 11: Standardised mortality ratios ¹ (based on Scotland experience) for selected causes, by administrative area, Scotland, 2004

Area	All deaths	Malignant neoplasms					Isch-aemic heart diseases (I20-25)	Cerebro-vascular diseases (I60-69)	Pneumonia (J12-18)
		All sites (C00-97)	Stomach (C16)	Large intestine (C18)	Trachea, bronchus & lung (C33-34)	Breast (female) (C50)			
SCOTLAND	100	100	100	100	100	100	100	100	100
Health board areas									
Argyll & Clyde	108	104	112	116	99	130	113	118	107
Ayrshire & Arran	101	99	108	103	101	98	106	109	103

Borders	91	88	73	133	64	69	97	84	119
Dumfries & Galloway	93	97	64	109	85	122	86	98	81
Fife	95	93	98	105	92	94	98	102	102
Forth Valley	101	101	112	100	108	103	101	102	124
Grampian	91	96	105	97	82	91	90	87	88
Greater Glasgow	113	116	115	92	133	98	106	98	117
Highland	94	91	74	107	85	96	84	98	86
Lanarkshire	109	103	120	102	110	112	119	110	116
Lothian	92	95	83	85	97	79	86	96	71
Orkney	89	80	33	50	71	125	117	68	140
Shetland	87	81	50	150	50	50	83	64	100
Tayside	95	95	91	105	85	118	101	100	94
Western Isles	97	96	75	50	96	86	100	67	124

¹ Rates may vary significantly from year to year, particularly those based on small numbers. Rates based on fewer than 20 deaths are shown in *italics*.

5.0 Future Population Health Burden

5.1 Hospital Services Forecast

Table 12: Forecast of Western Isles Residents Hospital Morbidity based on existing linear trend 1997/98-2005/06 and projected age/sex distribution of population to 2016.

Diagnostic Group	Current	Projected				
	2005/06	2008	2010	2012	2014	2016
Symptoms signs & abnormal clinical & laboratory findings not elsewhere classified	1144	1371	1504	1645	1794	1936
Diseases of the digestive system	977	1119	1163	1217	1278	1335
Injury poisoning & certain other consequences of external causes	629	816	869	925	980	1035
Malignant neoplasms	703	763	813	871	933	987
Diseases of the eye & adnexa	319	399	447	501	561	625
Heart disease	504	571	574	582	595	606
Diseases of the skin & subcutaneous tissue	384	450	486	524	560	595
Diseases of the respiratory system	443	461	485	513	543	573
Factors influencing health status & contact with health services	463	522	517	514	512	502
Diseases of the musculoskeletal system & connective tissue	367	422	432	444	457	468
Other diseases of the circulatory system	228	270	290	312	336	357
Diseases of nervous system	254	303	316	328	335	343
In situ or benign neoplasms of uncertain or unknown behaviour	186	259	276	297	319	339
Diseases of urinary system	202	245	261	278	297	314
Mental & behavioural disorders	217	251	269	286	300	314
Endocrine nutritional & metabolic diseases	114	148	156	163	170	176
Diseases of the blood & blood forming organs & certain disorders involving the immune mechanism	96	123	133	143	155	166
Diseases of genital organs & breast	238	216	197	179	164	147
Cerebrovascular diseases	96	93	89	85	82	77
Congenital malformations deformations & chromosomal abnormalities	45	52	55	56	58	60
Certain infectious & parasitic diseases	57	58	56	54	54	54

Pregnancy childbirth & the puerperium	28	43	40	38	35	32
Diseases of the ear & mastoid process	28	25	22	20	18	16
Certain conditions originating in the perinatal period	0	3	3	3	3	3
Grand Total	7722	8983	9453	9978	10539	11060

The above is a worst case scenario predicting hospital morbidity levels for Western Isles residents based on the previous 9 year linear trend to 2005/06, which saw large increases across almost all diagnostic groups. This coupled with the dramatic ageing population that is projected to 2016 produces possible large increases in hospital morbidity. However, the challenge for the Western Isles in common with health systems across Scotland is to cater for this ageing population with a redesigned health service that is focused on near-home care. This would see much of the long-term conditions managed in community settings avoiding such high hospital morbidity levels that have been the trend till now.

5.2 Cancer Burden

Cancer is among the largest conditions in the Western Isles as elsewhere in terms of both the rise in incidence as early detection programmes and techniques improve and in terms of the numbers of persons living with the disease. This higher prevalent burden is combination both of increased incidence and increased survival times from earlier detection and improved treatments. Below is provided predictions based on previous trends and expected developments in the detection and treatment for cancers.

Table 13: Future Predictions on Cancer Burden, incidence and prevalence to 2010-14, Western Isles

	New Cases		Prevalent Cases	
	2000-2004	2010-2014	2000-2004	2010-2014
Males	97	110	370	445
Females	104	115	611	696
Total	201	225	81	1141

Source: Scottish Executive Health Department (2001). *Cancer Scenarios: An aid to planning cancer services in Scotland in the next decade*. Edinburgh: The Scottish Executive

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Comments

Comments on this paper are welcomed and will be put forward to be incorporated into the Clinical Strategy. However further amendments to this document cannot be made as it is now finalised.