You Can Hear the Whistle Blow

Following its opening in 1964, Portree Hospital had a lot to learn, to achieve, developments to embrace, staff to recruit, and a community both permanent and itinerant to serve. The manner in which it nearly lost its way, but subsequently came alive again, to advance into a new era by the mid 1990s needs to be looked at closely, especially in light of the calamitous changes that have taken place since the start of the redesign of health and social care services in Skye, Lochalsh and South West Ross (SLSWR). How was this turnaround in the 1990's achieved and why was it sustainable? This paper will attempt to analyse that, and then consider some of the relevant factors that brought about the current situation. Furthermore, some potential solutions are suggested for consideration.

The plan in 1995

Firstly, recruitment and retention and constant professional development of all levels and disciplines of staff lay at the root of any planned improvement and continued success for Skye health and social care in the 1990s. The Medical, Nursing, and Associated Health Professionals would, by default, have trained and qualified elsewhere, so something had to bring them to Skye. In most cases it was for personal or family reasons, a desire to be able to work in an enviable environment, enjoy a lifestyle not based solely on money, but also upon quality of life and job satisfaction. Professionally, typically, these staff would have gained a wide and varied experience in very large busy hospitals elsewhere and would be bringing a vast range of skills and knowledge with them, often extremely specialised, which could only be of benefit to a small rural community hospital with aspirations to achieve something of note, something exciting. Skye was benefitting from an influx of nurses with experience in A&E, ITU, CCU, Haematology, Acute Medical, High Dependency, Midwifery, Mental Health, and so much more. The irony of this should not be lost on any of us, as it is exactly the skill set that the recruitment drive for Advanced Nurse Practitioners (ANPs) required.

Some had worked for a year or two abroad, gaining yet more experience, broadening their horizons. In simple terms, recruitment and retention of a variety of players to "the Team" was essential. The Team, once assembled, had to work harmoniously and seamlessly for the benefit of the patients and each other and for their community.

Hierarchy was now less obvious than previously in the NHS of old as there was a positive move towards treating all staff equally. However, leadership had to be demonstrably apparent, decisive and supportive. Previously, Nursing assistants (NAs) had not even been included in the report/handover. In 1995 this seemed unbelievable, but "the times they were a changing", and for the better. Day to day care was to be delivered by a finely balanced skill mix; a ratio of 1 RN to 1 NA to around 6-7 patients throughout 24/7 ensured that the trained (but unqualified) staff not only learned from the fully qualified, but were able fulfil their obvious potential and to be recognised as an essential cog in the workforce wheel. They were actively encouraged to expand their knowledge, extend their skills and be included in decision making. Equally, the RNs would be encouraged to make clinical judgements, take more decisions, and

voice opinions, working in partnership with the medical staff, rather than being deferential, or in awe. All levels of staff could give and receive respect. Feeling valued and appreciated results in a good working environment, a positive atmosphere, which benefits all concerned and pushes standards of care ever upward. It is a natural process, an added bonus that is driven by job satisfaction, motivation, and a desire to always do the best that you can, to forge ahead and go that bit further for the people in your care and your colleagues. The reward is very simple; a reliable, cohesive, functional, and stable unit and team.

This was a period of positivity in NHSH and its remote and rural units. The lead came from a superb CEO, who was so in tune with the staff of all disciplines and levels throughout the region, that it is impossible not to appreciate even now, in 2022, how beneficial that was to everyone. NHS Highland had at its helm someone of integrity, upon whom we could rely, and in whom we knew we could trust. Little did we know how the management style was to change over the coming years.

Medical cover was always provided by the local GPs, and this meant that they too had to keep up their emergency skills as well as more routine care. In this respect, the GPs were the mainstay of medical care at the time. The expectations were high, but the delivery of care matched these. Liaison with Consultants further afield ensured that current approved protocols were not only followed, but newer ones developed that were achievable and sustainable within both Portree Hospital and tertiary units. An example of this was the Cardiac Protocol developed entirely at Portree, and seen as being so successful, that it was adopted by other units including Raigmore.

Naturally, treatments change and all things must evolve, but the hospital could evolve too and remain part of the advance. There was nothing to stop it. Medical regimes alter constantly, and a proactive unit, no matter how remote or rural, can make the necessary changes; can make a difference to its people.

It is pivotal to the enduring physical and psychological health and sustainability of a community. Tourists come and tourists go, but their immediate needs must be met too, whilst the permanent population must feel confident that their Health and Social Care needs are going to be met in the short, medium and long term. This, like education, employment, and housing are fundamental to the success and stability of generations to come.

Portree Hospital aspired to doing things a bit differently, to provide a service that went above and beyond that of most Community Hospitals at the time. The core belief was that the more comprehensive its range of staff, equipment, approach, and desire to move forward, the better the community would be served and kept safe. All staff were given plenty of opportunities to attend various courses and study days, appropriate to their roles and responsibilities. Advanced Life Support, Paediatric Advanced Life Support, Advanced Trauma Care, Pre-Hospital Care of Adults and Children, End of Life Care, Dementia Awareness & Care, Orthopaedic Injury Management, Infection Control, Major Incident Management, Mental Health & Well Being, Palliative Care, to name but a few. The list is actually very long and comprehensive. All approved study

was supported financially from the Hospital budget or endowments. It is worth noting that because the permanent staffing level of the unit was calculated accurately using a recognised formula, and with the correct level of contingencies built in, there was sufficient flexibility to allow for further study and training without it impacting upon patient care at all.

A New Phase

By the mid 2000s, as GP contracts changed, and a new concept in Rural Healthcare was introduced. This was through the team of Rural Practitioners. Initially some of us were sceptical, fearful that our nursing role on the front line would suddenly be eroded. Many of us did in fact feel a simmering resentment. However, the new RPs proved to be a revelation, highly skilled, extremely competent, and approachable, whilst encouraging us to continue as we had done previously and work alongside them, collecting more knowledge and skills all the while. These Doctors worked with the staff in both Casualty and the Wards. Some GPs continued to engage in OOH work thereby maintaining their skills and rapport with the hospital staff. Any concerns regarding the influx of new medics was soon quashed. This was a particularly safe, settled and satisfying period in the life of the hospital. All it required now, was expansion and redevelopment.

With the planned closure of Gesto, the redevelopment plan moved ahead and was completed in 2006. Despite the public misgivings, the patients and transferring staff made the move to Portree as seamlessly as possible. Every member of staff who wished to continue was able to do so. Virtually all staff made the transfer. Only those who actively declined or were ready to retire did not. There were no job losses or reassignment and the Gesto team was fully integrated into Portree successfully. Transferring staff were paid travel expenses in accordance with legislation. Whilst some in the community still believe that Gesto should not have closed, the building was by now in a dire state of repair and no longer able to meet many of the changing criteria for in-patient care.

Portree was now upgraded to do just that, and the transferring staff had already taken up opportunities to familiarise themselves with the range of care that they would expect to encounter in Portree. These were learning opportunities, and any staff taking advantage of these did so out of freedom of choice and were mentored by specific staff members in Portree. It proved to be very successful, raising their confidence, refreshing their acute skills and widening their knowledge. All this was achieved whilst remaining within budget and aided the transfer immensely when it took place. Meanwhile Portree staff, both qualified and unqualified, took it in turns to assist at Gesto to cover this training, or when any staff shortages occurred. This facilitated the amalgamation of all staff during the lead in period from 2000 to 2006. It is important to note that movement between the two hospitals was not enforced, but achieved by goodwill. Only those whose commute was not adversely affected were approached to assist. Compare this to the human resource management of Portree and Broadford.

During the lengthy redevelopment period, which was not without significant challenges, the hospital remained open with temporarily reduced in-patient beds, a comprehensive clinic service and no suspension of Casualty services.

In early 2006 as the new wing opened, to allow internal demolition and refurbishment of the original ward and 1st floor admin area, senior NHSH management paid us a visit. A plan was suggested and alarm bells rang. Apparently, the 6 new single rooms (Glamaig Ward) would make an ideal Rehabilitation Unit for CVA victims from across Highland. This was highly suspicious. Our firm but polite response informed the senior manager, that a return to the bad old days of patients being shunted out of their locality, far removed from the input and support of family and friends, during a period of rehab, was completely unacceptable. It was seriously suggested that these patients would come from over most of Highland, a huge geographical area. We argued that once they had been treated within the specialised Stroke Unit further afield, they should be assured of a return to either home or their local Community Hospital, not just Portree. Also, very significantly, it should be recognised that most recovering patients are in fact undergoing a form of rehabilitation, and it is not the preserve of one particular diagnosis or prognosis. The idea from on high was rebuffed, for the time being.

By September 2006 the extended hospital had 18 fully staffed and multi-functional beds, 8 of which were in single rooms, split over 2 wards, Glamaig & Marsco. Occupancy levels ran around 75-90%, which was the optimum for any hospital, allowing for emergency admissions and/or transfers from other hospitals, even out-with NHSH. The hospital could comprehensively monitor up to 4 patients simultaneously from any of the 18 beds, or the 2 Casualty rooms. The information could be viewed and analysed at both the bedside and at the central monitoring unit in the Nurses' Station. The system also allowed for retrospective analysis of any incident and each patient's details and vital recordings were saved. <u>This was unique to any other Community Hospital in NHSH</u>. The foresight that resulted in that level of constant medical assessment meant that Portree Hospital could remain a vital part of Remote & Rural Medicine. Near patient testing had already been introduced well ahead of other units, allowing rapid analysis of cardiac enzymes, and therefore immediate thrombolysis if required, a wide spectrum of blood and urinary analysis, negating the need to send numerous spurious samples to Inverness. Looking back at the Cardiac Treatment within the hospital, it was recognised that the life-saving "Door to Needle" time in Portree was second to none, a remarkable achievement for any hospital let alone a small community one.

Community Hospitals must be able to provide a local base for inpatients to free up beds in tertiary units. It is an essential part of bed management in any region. The new 1st floor incorporated an extensive range of well-equipped out-patient clinic rooms. This allowed for an increase in the number of specialised clinics that could be held locally, avoiding unnecessary travel and inconvenience for literally 1000s of patients every year, and therefore travel expense reimbursement. It also freed up ambulance time on the road. It's impossible to overestimate the importance of that. All of us deserve the right of access to care as close to home as possible, and during this time, that was being achieved for many, not all, but the vast majority.

In the original upstairs wing of the hospital were 2 en-suite on call rooms, a small staff sitting room and crucially a Relatives Suite, consisting of an en-suite bedroom, and use of the adjacent fully equipped kitchen and laundry facilities. These met the recommended standards of provision of care and accommodation for relatives/significant others, and staff at the time. In no time at all, by 2008, these rooms had been commandeered and no longer fulfilled their essential purpose. Items provided by the Friends of the Hospital specifically for relatives / carers in need whilst staying over in difficult, often traumatic circumstances, were removed and sent elsewhere. It was a take-over bid by the back door.

NHSH management had changed, morphed into another entity, and so too did their focus. The newer senior organisation, having mismanaged its finances, now sought to conceal the fact by changing the provision of health and social care across the board. All too soon, the essential Community Hospital structure spread throughout the region was to become less important, insignificant, depleted beyond all recognition, and beds reduced by stealth. This occurred literally overnight and unannounced in the case of Portree. Equipment was removed or disappeared without trace in some cases. Staff numbers were reduced surreptitiously as replacements were not sought. Skill mix was compromised. As the RPs drifted away, their numbers also fell meaning that Portree had to take a back seat in favour of Broadford. No one on the remaining staff at Portree felt confident enough to fight its corner with real determination or commitment. That was a perceived risk due to the management style that was now firmly established. Here lay a source of bullying that should have been eradicated long before the “shit hit the fan”. The staff of Portree had already, in 2009, experienced the very real threat of repercussions, when they as a group they made various complaints to the senior management team at the time. They asked for a meeting as they wished to voice their serious concerns in full over the general attitude of the C/N now in overall charge of the 2 units, and their fears for the future of the hospital. The threat was not even thinly veiled, but explicit. Most staff recognised that this was the beginning of the end for Portree, and they were the target of a campaign to make it as inefficient and ineffective as possible.

As all staff were living locally, it would be no easy decision to give up a position and seek alternative employment. There are and always will be limited opportunities on Skye, and many of the staff of all disciplines had made the move here seeking a secure and ultimately rewarding future in a great environment, away from the staffing crises that were already troubling larger units further afield.

Changes in Medical Provision & OOH Care

In this section we look more closely at the provision and management of Out of Hours care over the years.

Historically, the local GPs provided medical cover for the hospital and community 24/7. Calls came into the hospital rather than direct to the GPs home and the nurse in charge of the shift assessed the situation and took action accordingly. This was all well and good but had an impact upon the life/work balance of the doctors. Subsequently, a reluctance of many current practitioners and those now entering the medical profession, to be tied to onerous on-call work began to bite. With the change in GP contracts many simply opted out from OOH service cover, as was their right, and so

the concept of Rural Practitioners was introduced to Skye. This was an entirely new approach and quite revolutionary.

Initially an RP was on call within the hospital overnight, or one of the local GPs as some were continuing with OOH cover. This meant that the hospital still had 24/7 medical cover, but the first point of contact was the nurse, as it should be at its most practical application. There was already a camera and intercom at the old front door. It was routinely locked around midnight by the night staff and security checks carried out everywhere. The camera was to allow ease of contact with, and security assessment of, any attending person before letting them in, as the monitor was situated in the nurses station. It is safe say that the times that staff chose not to permit entrance could be counted on one hand and the Police would be called if required if they had concerns. The Police were often not available in any case due to the large area they had to cover. That was just the way of things, and probably remains a problem.

<u>Access was guaranteed in all but the most obviously threatening circumstances.</u>

Over the years any number of cases came through our doors, and we never knew what would arrive, but deal with it we did. Our equipment continued to improve and be upgraded steadily, and our ability to deal with whatever we were presented with was something of which we were proud. The monthly Casualty attendance figures of Portree were frequently higher than Broadford. It wasn't a competition, merely a fact driven by the town itself being the centre of most activity and population. Broadford's throughput of patients was significantly higher but this was inflated by the day cases they were seeing, not the number of inpatients. Out Patient Clinic attendance at Portree was much higher than Broadford.

When the hospital was redeveloped including a double set of automatic doors, an updated and more widespread camera system was required and subsequently installed covering 4 different areas and shown on a split screen in the new duty station. Despite this enhanced security system, around that time we were being instructed by NHSH not to see casualties after midnight and to refer everyone to NHS24 or Broadford even although the medic was often asleep upstairs.

We resisted this in very strong terms, and the team agreed that we had always served the community 24/7 and we would continue to do so. We did indeed continue to attend to all-comers and refused to insist that they phone NHS24. No one requiring care, however minor or significant, was to be denied it….ever. Yes we were rebels, but for all the right reasons. We had the ability and could assess a casualty fully within the Casualty Room with its essential equipment. We had been doing it safely, effectively and efficiently for years. With frequency comes expansion of knowledge, skills, confidence, and sound clinical judgement, all underpinned by care and compassion.

The RPs upstairs were now going to be classed as 2nd on call and we were to phone the duty doctor down in Broadford in the first instance, so that they could decide whether to alert the 2nd on call or not. What utter nonsense. It was a financial decision apparently. Yet there were sufficient medics to provide OOH cover for the north end. The gaps were infrequent so manageable. This was quite simply, another step in the reduction of unscheduled care at Portree.

Soon, this 2nd on call system of cover also disappeared and we had to seek medical input /advice from Broadford in every instance. The duty doctor may on occasions be driven up to Portree to review a patient, but in fact this was increasingly rare. Regularly, The RP, having carried out a telephone assessment, suggested that the patient be transferred down to Broadford, conveniently swelling both their Casualty and inpatient numbers; plus yet another ambulance journey that could have been avoided. All the while the service in Portree was being eroded, the data becoming skewed as the balance swung towards Broadford. The plan was working.

The distance from specialist care determines that a high standard of acute and emergency care must be immediately available at both ends of the island. This would ensure that resuscitation and stabilisation could be managed appropriately within a reasonable time frame in even the most extreme circumstances. Onward transfer of acute or critical cases should be attempted only when it is safe to do so, whether it be by air or road. It is neither safe nor acceptable to rush this inappropriately. The correct resources should be available in Portree. With the distance between ambulance bases and the likelihood of there being a shortage due to increasing numbers of patient transfers, the matter of safe provision of immediate care was now already seriously compromised.

An example of the need for a suitably staffed and equipped hospital may not be some of the key usual suspects, such as: cardiac, RTC, head injury, haemorrhage and trauma. With the demographic of Portree and North Skye it could also be this:

It was not unknown for youngsters to dump a drug and alcohol intoxicated pal at the front door of Portree hospital, and run away. In many instances he/she would be incoherent, unresponsive or unconscious, incontinent, covered in vomit, cold, and a bit battered and bruised. These very much under-age fun-seekers would have been very high risk indeed if not attended to immediately. That really would have been a tragedy of unforgivable proportions if the hospital staff had bowed down to the regime that was being thrust upon them. It was actually suggested at one point that we phone 999 if we had any casualty or in-patient emergency. Our reaction to that was defiant. The campaign of resistance stood firm but eventually the Casualty hours were reduced to midnight and then 11pm. This left staff feeling that they were no longer able to deliver care to casualties 24/7 and that the community was being denied an essential factor in its overall safety and sustainability.

It is just one example of what we were up against even back then, but also shows what a bit of dogged determination can achieve for the good of a community.

Finally, as the RPs played a reduced role at Portree, a plan was launched to introduce Advanced Nurse Practitioners (ANP). But where were they going to come from? A very small number of local staff (2) undertook and completed the lengthy course so naturally recruitment had to be gleaned from elsewhere, particularly during the interim. But where? Was there ever a genuine recruitment campaign, aimed at introducing new suitably qualified staff to the team. Was it attractive, and secure…..NO!

Meanwhile hours of access to the hospital's Casualty Department, as detailed above, had been severely curtailed quite deliberately by both local managers and those in Inverness. The objective was clear; to lower the public expectation of what would be available from now on and cause real and disturbing dissatisfaction with the hospital in some quarters. Equally, the bed capacity of the hospital was reduced to a ludicrous level so that even the scaled-down staff complement could no longer be justified. Rooms lay empty, devoid of any meaningful equipment; clinics became fewer, some medical equipment was "transferred out". It was suspected that their own Staff Fund (donations from the public) had been used, without their knowledge or any consultation, to replace items for patients. If that is true, then an investigation should follow.

Eventually amidst an embarrassing period of misinformation, frantic signage change and bewildering and poorly judged and ill-informed access instructions, emanating from the Head of Public Engagement at the time, the Urgent Care Centre was opened, but not to general approval. The configuration of the hospital was altered as the ANPs occupied an ever increasing space, a no-go area to other staff, and when the Covid Assessment Centre was established in Portree Hospital, that was the last straw. It is a glaring example of hypocrisy, given the ongoing attempts to centralise all community hospital beds and acute services in Broadford, that Portree was seen as being ideal for the Covid Assessment Centre, because it was the centre of population! This effectively split the hospital in two, not only structurally but professionally, as the different groups of staff were now entirely separate. Teamwork was but a distant memory.

The staff in the ward were subjected to poorer working conditions, with little opportunity for proper breaks or anywhere comfortable to take these. The ANPs on the other hand occupied one side of the hospital including the dayroom, and were supplied with additional comforts. This created tensions between the two groups of staff as the working atmosphere changed. The ANPs were certainly under-utilised, so perhaps it is no surprise that some resentment from the general hospital staff crept in. There now appeared to be separate factions within the hospital. How was this allowed to happen? Lack of professional supervision and a failure to recognise and prevent potential problems undoubtedly. The original nursing team were now devalued, and denied the opportunity to carry on their duties as they had previously. They had no supportive leadership, no one to reassure them, to bring cohesion or stability. This caused morale to fall yet further, as they felt unappreciated, disadvantaged, powerless and thoroughly disheartened. Despite this, they carry on, doing their best but are no longer allowed to treat any casualties, having no access to basic first aid equipment or what was previously a well-stocked and equipped Casualty Room. The keystone Duty of Care is reserved for in-patients as now even the Urgent Care Centre (UCC) is closed, which is a natural result of disingenuous recruitment campaigns.

As the permanent and tourist population of Portree, and Skye as a whole, multiplies exponentially year on year, the access to healthcare decreases at the same rate. Catastrophe cannot be far off. The public frequently say that "Lives will be lost" and it has been criticised for being over dramatic, sneered at, and dismissed out of hand by senior management locally. Cue rolling of eyes and snorts of derision at public

meetings by those whose PR skills are so lacking that they should never be wheeled out to represent the NHS. It demonstrates the level of contempt with which NHSH considers its population.

Any remaining ANPs on Skye may be struggling to maintain their skills and overall competence and confidence, so they too feel disadvantaged, discouraged and vulnerable. A familiar picture? Their intense period of study should have been consolidated by frequent patient interaction and treatment. As Portree was being by-passed generally, by order of management, their ANP practice time became less and less. This was the downward spiral designed to make the job unattractive, and worse, very daunting. Anyone who has chosen to take the plunge to achieve ANP qualification should be lauded, supported and encouraged to use their skills, to hone them constantly. That was not happening, and the reporting of some negative instances has not helped their confidence or morale. Some have left to take up employment out-with the NHS which is a terrible loss to the service. Every migration away from the NHS should be questioned. Could it be prevented? Was the cause normal or abnormal?

The strategy of divide and conquer has worked.

Here is a direct quote from the job advertisement for the Rural Support Team ANPs .

"*The benefits to living and working in the Highlands are significant, and very often underestimated! Good quality health social care services based on specific community needs are crucial to the viability and sustainability of remote and rural communities - to be part of this is exciting and rewarding. The contributions we make to our patients and their communities can often feel truly genuine and personal, it sometimes feels we are in the privileged position of being able to ensure first class care, without heavy consideration of targets or metrics! Though we are a relatively small team, we* have high aspirations" – Local NHSH manager.

We can only presume that this person is either deluded or having a laugh at Skye's expense, or perhaps the person has the same speech writer as a lead politician. Oddly, it is exactly the philosophy that we all believed in all those years ago. It meant something then, and it should mean something now. It shouldn't be a soundbite, but the foundation upon which the service is rebuilt.

In the meantime, any semblance of Portree Hospital at its most effective has gone. It is a mere shell, an edifice that will surely meet an ignominious end at the behest of a notable group of demolition experts. The perpetrators, some of whom have slithered off, some who jumped ship, and some who still remain, can be named and shamed but this is not the place. Anyone with any interest in renovating health and social care will know exactly who they are. They're not all part of NHSH either. Locally elected representatives both past and present who calculated that their own position was of more importance than the community should be "outed", and discredited. Because a relatively small but determined group of individuals were allowed to unpick and destroy the health and social care sector here in the Highlands, Portree is left without any meaningful service. It will be nigh on impossible to recruit and retain incoming staff with the necessary skills and enthusiasm when the future looks so bleak. How do you

sell a position to anyone thinking of moving to Skye and Lochalsh with the current problems? Even the new Broadford Hospital is struggling to recruit, so what chance Portree? Things must change drastically to attract incoming staff across the board.

During the 1990s and since the Millennium, Buzz Words aplenty have spewed from the mouths of those loving the sound of their own voice, with an intrinsic desire to trample over anyone and stomp upon ethically guided principles in pursuit of self-promotion and gain, leaving an enduringly negative impact in their wake. Fortunately, it is rare for the vast majority of Healthcare Professionals to choose that path. They do what they do out of a common desire to do good, to help others, and perhaps at the end of each day be able to look inwardly, and hope that they've made a difference. Those stalwarts are in short supply as are our hospital and care home beds. Carers in the community are so thin on the ground and poorly rewarded or recognised, that the system is broken. Can it be fixed? It is in need of resuscitation and stabilisation. That may need to come from the very top.

Who is responsible? Not NHSH alone, but every person who stood by and watched it happen.

"Disruptive innovation is not about pushing out the incumbent, it's about giving the consumer a choice."

Some Facts, The Bigger Picture and the Final Denouement of Portree Hospital

On 1 April 2006, NHS Highland took over responsibility for part of the former NHS Argyll and Clyde region (corresponding approximately to the Argyll and Bute council area), the other part of which was transferred to NHS Greater Glasgow and Clyde. It also inherited its debt.

The units within its responsibility are wide-spread and varied, bringing multiple challenges. The demographic and geographic features are difficult, remote and unique to not only Scotland, but the UK. NHSH is extraordinarily cumbersome resulting in constant battles between localities. Here was a no-win situation, but which units would survive?

As verified by Public Health Scotland Data, in the period between 2009/10 and 2018/19 NHS Highland has seen reduced availability of staffed beds across All Acute Specialties year on year. The area saw a 27% drop in availability of acute beds. That is second only to Western Isles, which is even worse at 30.7%. Grampian does not fair well, no surprise there, but at 21.4% loss, is still behind NHSH. All other regions have either much smaller reductions, have remained the same, or in 4 areas, actually increased.

Looking more closely at the number of Delayed Discharges across NHS Scotland reveals a worrying trend. In May 2022, there were 52,914 days spent in hospital by people whose discharge was delayed. This is an increase of 50% compared with the number of delayed days in May 2021 (35,348). The obvious reason for this is the failure of Community Based Care in general due to years of underfunding and reduction in the workforce. Unfortunately, the highly valued and caring "Home Help"

of old has all but disappeared, due mainly to worsening contracts, terms and conditions, and of course a feeling of being unable to fulfil their clients' needs due to unrealistic and unmanageable time pressures. It sounds familiar. It applies to healthcare staff too.

Questions are being asked and answers demanded regarding the current state of Portree Hospital and the community care bed crisis. There can be no doubt whatsoever that the tide that brought such steady improvement over several years, began to turn by the late 2000s. It was at that point that NHSH were looking at ways to ensure that the building of a new Skye Hospital would go ahead. The public were hoodwinked into thinking that this would be an all-singing all-dancing state of the art facility, reducing the need to travel to Inverness or Fort William for many clinical investigations and on-going treatment. Local councillors whose main interests lay in the southern end of Skye and Lochalsh, happily embraced the bigger picture that would involve the downgrading of Portree. Even some councillors representing the northern margins of Skye, particularly Portree, simply sat back, silently, with a blatant disregard of the risks to their community, whilst knowing only too well that Portree as the main centre should always have a fully functioning hospital with access to urgent care 24/7. Their inertia is nothing short of disgraceful, inexcusable and endangers the community they claim to serve.

Scottish Government put pressure upon NHSH to rein in the expenditure which appeared to many to be eaten up by Raigmore year on year. At the time of the introduction of Rural Practitioners to Skye and Lochalsh, the staffing costs will have increased very significantly indeed; several individuals on salaries in excess of £80-90K. However, the cost benefit analysis of this weighs heavily on the benefit side, as it provided very skilled and flexible cover across the 2 hospitals, allowing for the continuation of immediate, acute and on-going inpatient care on both sites. It should be noted that Portree Hospital routinely functioned within its annual budget. It was fully staffed, as mentioned above, with the correct ratios of all disciplines, all employed on permanent contracts. A very small number of bank staff were utilised but this was a core element which ensured stability, consistency, and continuity. This can be verified through Freedom of Information. Broadford on the other hand employed a smaller percentage of permanent staff, choosing to rely heavily upon a significant cohort of bank staff. This was done to appear "good on paper" but in fact is very poor practice. The Charge Nurse of Broadford constantly bemoaned the higher staffing complement afforded to Portree, whilst boasting how few staff Broadford required to function. NHSH's own locality accountant warned the management team that this was neither the way to calculate staffing levels nor arrive at a budget. It would result in a lower, unrealistic budget allocation. The reader should draw their own conclusions from this.

Something had to give, to suffer, be sacrificed, and what better place to start than around the edges? The nibbling was to begin. The sacrificial lambs would be Community Hospitals; seen as easy pickings. In 2007 there were around 16 Community Hospitals across Highland. What made Portree such an easy target? Since late 2007, its senior nurse was now to be the Charge Nurse from Broadford. The wolf was thrown in amongst the lambs. This could only ever mean one thing as she had voiced her intentions frequently; the demise of Portree. She may be gone, but

that legacy remains as others continue unabashed, unscrupulous, and lacking in any empathy for the fears of a community. Further enquiry may discover that the promise of a new hospital on Skye could only come at a cost, a sacrifice. The ethical argument would find that this decision was “Not for the Greater Good”, so should have been dismissed.

Several years ago, around 2004/5, a restructuring and amalgamation of locality management across Highland saw us lose a very strong voice and ally in favour of someone who did not have the interests of Skye, and specifically North Skye in mind at all. Many of us believed at the time, and still believe, that this was engineered categorically to the detriment of Portree and was one of many steps on the road to the demise of the hospital. Despite the redevelopment plans going ahead, there may well have been a different scenario in the making. NHSH were to spend over £1.3 million on improving the hospital to act as a “loss leader” and deflect attention from the longer game.

Within NHSH, the management structure, that was proven to be so toxic, has now altered to some extent, but understandably, mistrust lingers on. Many years of dishonest and calculating tactics, coupled with bullying behaviour have whittled away at staff, rendering them scarred and in many cases, utterly defeated.

The efforts to rebuild even an iota of trust will require a major change in attitude. The terms “Honesty & Transparency” have proved time and time again to be meaningless, as the only thing that was glaringly transparent, to anyone looking at events, was the complete and flagrant lack of honesty. It came from the very top, and that includes Scottish Government, who all the time were aware of the troubles looming large within NHSH and on Skye in particular.

In Sir Lewis Ritchie’s latest report he states

“I am deeply aware that there is a level of fatigue and frustration which was evident in the meeting from the community but also from NHS Highland staff. In my last update in October 2020, I said that the building and nurturing of relationships, between all those who receive and deliver services must be shared and clearly communicated. This is an ongoing imperative and significant momentum has been lost since October 2020, and that now needs to be remedied. I noted some changes in managerial leadership within NHS Highland, with immediate oversight of Implementation of the Review and this now must be accorded clear, urgent and sustained priority.”

He goes on to say

“It is essential that trust and effective communications are restored and further progress made. The final (15th) recommendation in my Report was entitled Making it Happen. As part of that, I expected an implementation plan, key milestones, and robust governance/scrutiny to be in place. That now indeed needs to happen and be fully evidenced by NHS Highland.

Yet only recently, the Hospital Signage was altered without reasonable communication. It is not and should not be a decision that is “sold” to the local councillors, some of whom have never supported the hospital in any shape or form,

and remain completely detached. This was an act of vandalism, and demonstrated yet again, the appallingly insensitive and dictatorial attitude of local management. An action of that nature speaks volumes about the disrespect for SLR's report. So much for effective communications, governance and scrutiny!

The diminishing of the hospital general nurse's role may well have been the first step on the road to failure. A workforce that was able to handle a wide range of presentations was already in place, whilst undertaking regular clinical updates and building up an expanding skills base. Yet, their skills were now going to be ignored, maligned and belittled. Opportunities to attend study days and clinical updates were becoming fewer and fewer, and staff were expected to attend in their own time. Staffing numbers had been reduced to a bare minimum, arguably to unsafe levels, so that resulted in a complete loss of flexibility, and any incentive to utilise one's off duty periods for anything related to NHSH. The lead in time from initial advertising, for acceptance and then training Advanced Nurse Practitioners was lengthy, yet that gap was not plugged in advance. The opposite approach was employed, almost certainly deliberately. As the access to all forms of unscheduled care in Portree was reduced constantly, the general hospital staff were in a hopeless and embarrassing position. Their role had changed and it was not of their making, or their decision; quite the opposite. It was thrust upon them without any consultation and minimal communication. This was a dictatorship.

The NHS as a whole knew that it was about to lose 1000s of highly skilled staff across multiple disciplines, as the data had screamed at them for years. In 1948, at the inception of the NHS, it was expected that a huge influx of staff would be required. By 1968 potential candidates would be on the threshold of their training. 40 years later in 2008-12……Retirement looms! And so it came to pass; the staffing crisis.
Workforce planning was not just abysmal, it was non-existent. Yet, despite the massive personnel gap that was opening up, the wholly unnecessary requirement for all nurses to attain a degree was running amok with a head of steam. The NHS must reconsider the future of nurse education and the merits of a university-based course versus vocational training. In the 1990s nurse training in the United Kingdom moved from an apprenticeship model to a university-based education. Around the same time, the two-tier structure of registered and enrolled nurses was being abandoned, resulting in resentment amongst many highly skilled enrolled nurses. Nursing leaders had decided that it was to become an all-graduate profession. Nursing is first and foremost a compassionate human activity, requiring interpersonal and technical skills as well as academic knowledge. It may be argued that the move into universities has served neither students nor patients as well as intended. Students today are financially worse off than their predecessors, have fewer practice opportunities, and often lack the sense of belonging that existed when training was hospital-based. The enforced academic environment is effectively preventing many excellent candidates from considering the training.

Students are no longer salaried, not employed as part of the team, but supernumerary, and frankly artificial. It is not the fault of the students, and those who succeed surely do so despite their university-based training, not because of it. Also, it should be noted that the drop-out rate In 2020 it was 25%. At the end of it all, they may not have a job to go to, and if they do it may be temporary, and all the while they may have

accumulated student loan debt. Every day may be a nightmare due to pressure of work, endless paperwork and little if any job satisfaction. Nursing wants to be classed as a profession, but it has shot itself in the foot. The NHS is a very poor example of professional competence as it does not look after its own, and it cannot do that, it almost certainly cannot expect to care for the public. Branch-specific courses have produced an inflexible workforce. The move from practice to universities was an adventurous approach, but it has failed. We need to return to a revised apprenticeship model, with university input and generic training.

The constant voice that blames everything on BREXIT is of little or no relevance whatsoever across the Skye Hospitals. The staff did not come from Europe, so there was no emigration back to their home countries. It is simply untrue, and whilst it has certainly left a gaping hole in many areas of the UK, and indeed some care homes across Highland, the same cannot be said of the NHS on Skye and other islands.

What is the Solution?

There is no one simple solution due to the amount of damage that has now been done. A safe level of service has vanished. Much that Community Hospitals stood for has been compromised, eroded, and destroyed in that order. It is impossible to determine how many beds have been removed from the system overall in the past 14 years, as the information on NHSH's website is so woefully inadequate, so blatantly inaccurate, that it is frankly not worth perusing. A cynic would view this as entirely deliberate.

Recruitment campaigns have been mostly pathetic, uninspiring and do little to tempt staff away from other areas. You can offer them a hospital with a fabulous view, but they need a permanent contract with sufficient hours available, and a guarantee that the work will be rewarding, stimulating, challenging and interesting.

Do the utmost to recruit to all disciplines to the two Skye Hospitals, with an openness about the problems and encourage staff with the foresight, energy, and enthusiasm to take up the challenge and turn that tide. They ARE out there, they always have been, and many will be willing to leave behind the constant pressure of larger hospitals or inner city communities, to settle on Skye, as they did before in significant numbers. This is a matter of desperate urgency, and the public need to see evidence of an imaginative upscaled, perhaps unique recruitment campaign, unencumbered by an inaccurate and outdated job descriptions.

Reinstate a Charge Nurse based entirely within Portree Hospital. Someone with proven leadership skills and sound clinical judgement must be present to demonstrate the desire to rebuild all that has been lost. Trust has been lost and it will take people of considerable interpersonal skills, integrity, and determination coupled with invention to re-establish it.

Incoming essential workers will always look at the infrastructure of an area before taking the plunge. Skye now offers less and less in the way of satisfactory infrastructure.

However, and this is contentious, lack of accommodation is a significant factor, as it is across so many rural areas in the UK. It is not reserved to Skye alone, and until the public in general wake up to the reality of this, there will be no improvement. The only real answer is to bring in some control over this. Highland Council's recent policy of buying private houses to convert into social / affordable housing may well make a significant difference. The vendor will benefit and avoid estate agency fees, whilst the area will gain affordable housing stock. Incomers get the blame for all ills, yet many of those migrants from other areas of the UK are able to bring the very skills that are so desperately needed. Everyone needs to look to themselves and ask what they can do to make a difference. Only agreement within communities to make a real transformation on this front, will perhaps bring about the necessary change. NHSH's lack of engagement regarding available housing is astonishing, given that they claim to have such serious recruitment issues.

Part of the solution lies in a complete rethink of how training is delivered, how all care, not just urgent care, is provided. As mentioned earlier, the geographic and demographic challenges are extreme, so require a unique approach. Today's students are not prepared for the reality of what the NHS has become. The dissatisfaction, concern and bewilderment amongst the Healthcare professions is obvious. No degree is ever going to quell the feeling of abject disappointment and dismay.

The NHS needs to take a step back, look inward and question its strategy over the last decade or more. Sadly many nurses and doctors etc do not actually make good managers. Those who rise meteorically may well be politicians in disguise, and the very fact that they whizz through the ranks at lightning speed should ring very loud alarm bells, especially when they have no knowledge of the basic principles, as contained in the Scottish Capital Investment Manual, needed to undertake a redesign of health and social care services as has occurred in SLSWR. Give me a good hard-working nurse with a clear cool head and genuine experience and compassion any day of the week when true insight and action is required. **These are the people who should be making decisions at a local level since they intuitively know what the basic principles are for a safe and sustainable health and social care redesign**. Let them have their say without fear of recrimination or, as happened on Skye, in fear of their hospital being closed if they didn't toe the line. **Talk to the local healthcare team at all levels.** Value their opinions. Trust their judgement. They were the future previously because they really cared and were personally invested in the system for the good of everyone. Those that remain are still the future and will have a fair idea what is manageable and deliverable, whilst understanding the foundations that need to be re-laid to achieve that. Bring all the facts to the table and start afresh with an entirely new local management team, made up of people who have earned trust and respect, and whose actions can be proven to be honest and free of hidden agendas. Involve only people who have a genuine and vested interest in the local perspective but let them think out of the box, as they may well find a solution that can cross borders into other Health Boards.

Return or renew all the equipment that was removed from Portree Hospital immediately. Enlist the assistance of Medical Physics with this. Reinstate the Casualty department to a useful assessment and treatment space complete with vital diagnostic

equipment and essential supplies, so that once again, the main entrance is the only entrance. Ensure that Telemedicine is fully functional. Ensure that a named GP is available all day 0800-1800 hrs, to cover the hospital, and assist the nursing staff with any unscheduled presentations. Do not take no for an answer. The GPs are under pressure, but they too must be part of the solution.

Reassess the role of the RPs. Recruit enthusiastically and as necessary. It's money well spent. Their expertise can be utilised far more widely, and will lend valuable support to the SAS and ANPs. All Paramedics and ANPs need to know that they have the support of the RPs to allow them to flourish, grow in confidence, and further develop their roles. Then and only then, can more ANPs be reintroduced as this will take time and development. The ANPs , if that is the route chosen, should work closely with the general staff as it requires team work, and mutual respect and support not separatism. The future depends upon having sufficient numbers of all personnel available and wishing to stay in post on Skye and Lochalsh. It must be attractive, future proofed, viable and robust enough to deal with whatever subsequent Governments throw at it. Recently, the SNP's Ian Blackford was courting NHSH's Senior Management, which demonstrates that he has not listened or heard anything at all of what his constituents have been telling him. Has he read the updated SLR report? Perhaps he is only hearing what he wants to hear from his First Minister.

Once the available staff are in post, rebuild all that was so good about the unscheduled care previously, and there was plenty. Forget all the stuff about insisting that people dial NHS24 or 111 until a much more stable and improved Urgent Care model is in place. The system isn't fit for purpose. There will always be some amount of inappropriate clientele, but surely the hospital can live with that, if only to **ensure that not one single person in need slips through the net**.

The NHS has a duty of Care. Every Healthcare Professional has a Duty of Care. It cannot be a matter of choice. It should be ingrained, the mantra by which they all abide.

Never again consider reducing staff and care to the lowest common denominator.

Aim High.
Aim Safe.
Aim for Excellence.
Aim for the future of a community.

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