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Remote & Rural

Steering Group

Challenges for Scotland's Rural General Hospitals

Professor Andrew Sim, Clinical Lead,
Rural General Hospital Project

Making it Work 3 Conference 13th May 2008



The Challenges

- Staffing
- Healthcare Delivery
- Patient transportation
- Education and Training
- Public
- Political

The Challenges

- **Staffing**
- Healthcare Delivery
- Patient transportation
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The Staffing Challenge

- Permanent staff
 - Recruitment
 - Retention
- Locums
- Trainees

The Locum Challenge



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Reasons to employ locums:

Annual and Study leave

Sick Leave

Special Leave

Vacancies

Other

‘testing the water’

Not appointable to a permanent post

The Locum Challenge



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Problems with locums:

- Expense
- Availability
- Skills and experience
- Commitment to the employing authority
- Work practice
- Continuity of care
- Continuity of educational experience

The Locum Challenge



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Problems locums have:

- Remuneration (long term locums)
- CPD/CME
- New environments
- Differing work practices
- Discontinuity of experience
- Social disruption

The Locum Challenge

Western Isles Hospital 2002 – 2007



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212 Consultants (16 – 17 substantive posts)

Permanent Consultants	21
Long term locums	25
Short term locums	166

Locum periods

Long term	33
Short term	466

Locum days

Long term	12,250 (2042/yr)
Short term	5,620 (937/yr)

The Locum Challenge

Western Isles Hospital 2002 – 2007



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The Locum Challenge



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To devise staffing systems which remove the need for locums (particularly short term locums) for all predictable leaves of absence.

Trainees



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- European Working Time Regulations
- Modernising Medical Careers
- Locums
- Interest in Remote and Rural Healthcare

The Challenges

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Health Delivery Challenges



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Core services

- Emergencies
- Common conditions
- Chronic disease
- Diagnostics

Additional services

- Available expertise
- Local need

Health Delivery Challenges



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Cancer Care

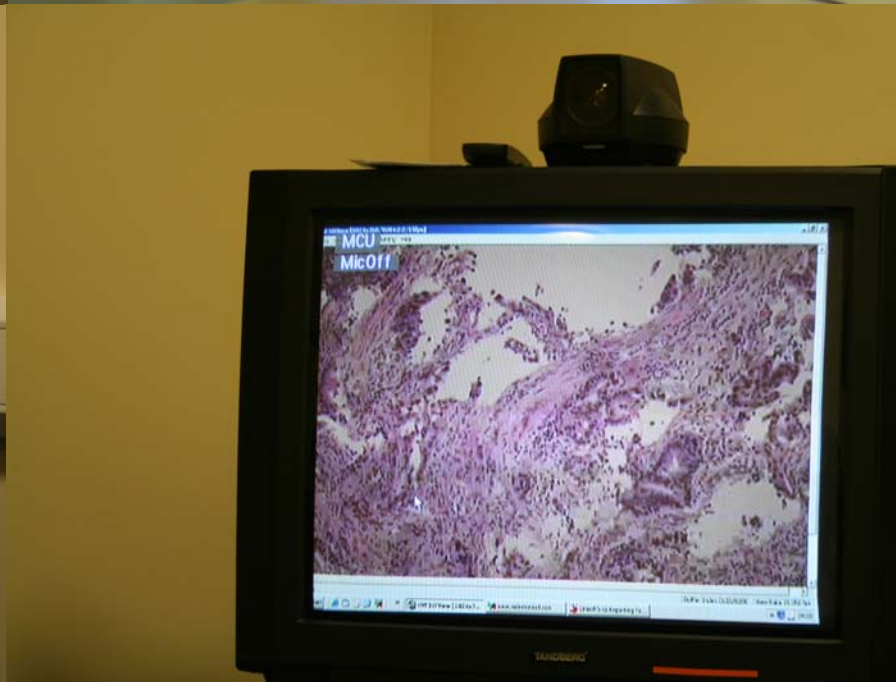
Numbers of patients and skill maintenance

Specialist facilities - diagnostic and
therapeutic

Patient and healthcare worker choice



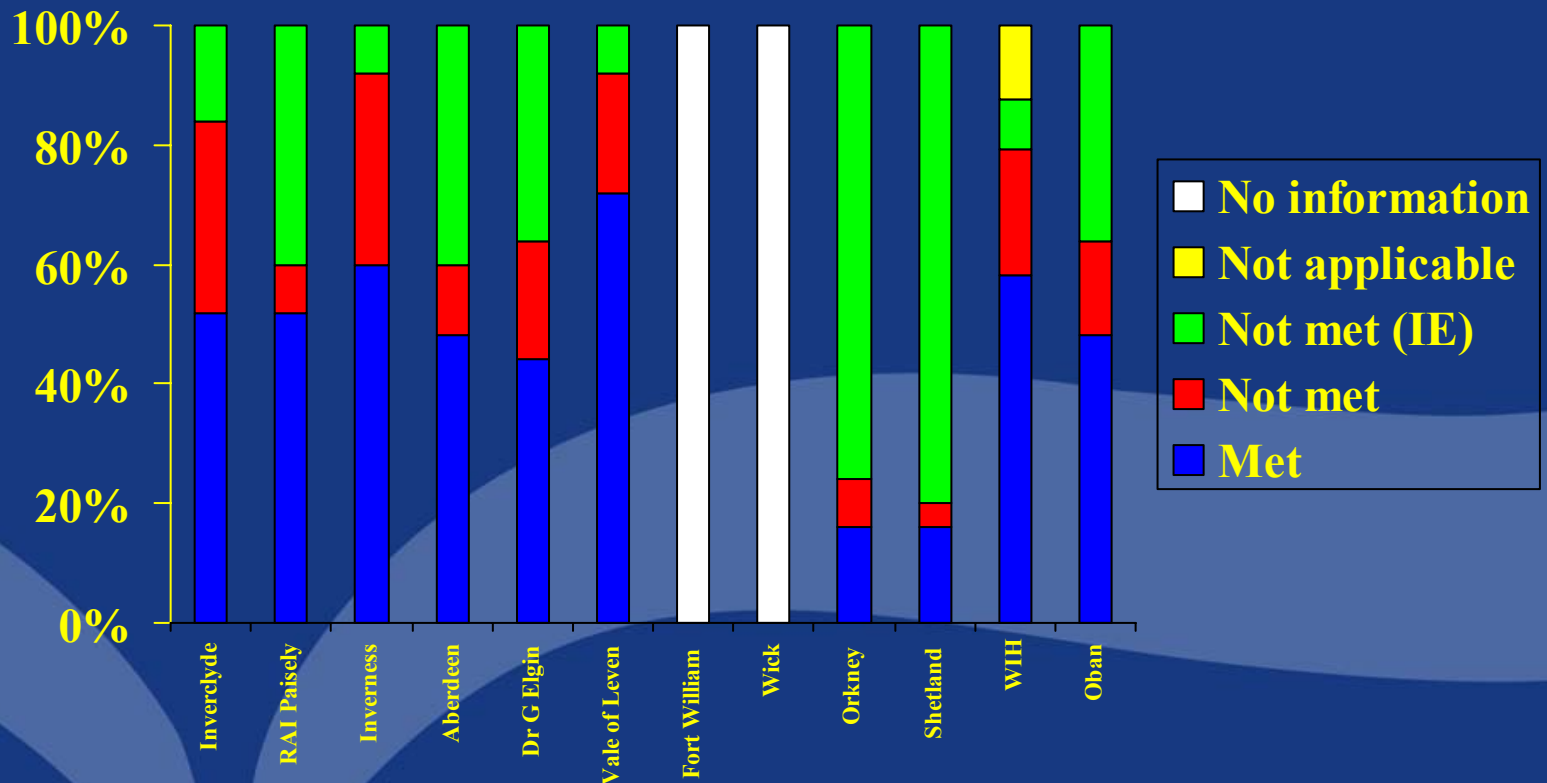
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Colorectal Cancer Clinical Standards Board of Scotland Achievements in Meeting Standards



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Healthcare Delivery Challenge



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To ensure that patients in remote and rural areas get their healthcare as near to where they live as possible but not at the cost of receiving treatment less good than what might be available in another centre.

The Challenges

- Staffing
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- Education and Training
- Public
- Political



Bettyhill

Thurso
Wick

Lochinver

Inner Seas

Scotland

Glasgow

Newton Stewart

Stranraer

Gatehouse of Fleet
Whithorn

Isle of Man
Douglas

Leeds

Irish Sea

Scottish Ambulance Service Call Targets



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- Category A Calls (life threatening emergencies):
63% of calls should be responded to within 8 minutes
- Category B Calls (other emergencies):
95% calls are responded to within 14, 19 or 21 minutes depending on population density.
All rural areas have a 21 minute response target.
- GP Urgent Calls:
95% of GP calls should have a crew in attendance within 15 minutes of the agreed timescale.



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Some remote areas do experience longer
Scottish Ambulance Service response times
but not to the extent feared by anecdotal
accounts.

Fiona Grant

Remote and Rural Project Manager



WoS pilot implementation

Progress has been excellent in implementing the WoS EMRS pilot. We are still on target for a June 1st start date. Consultant recruitment is complete and recruitment of support staff is well underway. The service's new base at the Bond heliport in Glasgow will be delivered in mid-May.

Visits to the new hospitals served by the service will be complete by the pilot start date. Plans for education and training for rural health care staff to be delivered by the EMRS are in development.



EMRS Website

www.emrs.scot.nhs.uk

The SGHD are working with EMRS to develop the team's website. It is intended the website will act as a clinical and training resource for the team and for rural hospitals. The teams comprehensive set of standard operating procedures can be accessed via password on the site by rural practitioners. For a password please contact Alasdair Corfield.

EMRS Pilot Evaluation

As part of the EMRS pilot, funding has been identified to allow a rigorous, external evaluation of the EMRS pilot over the 18 months from June 2008. Several bids were received from external organisations to undertake this important piece of work. Following two rounds of interviews, the tender has been awarded to a collaborative bid from DTZ and the Centre for Rural Health. The DTZ/ CRH team will hopefully commence work on the evaluation before June 2008 in order to build a complete picture of EMRS activity and outcomes, including interviews with rural healthcare practitioners.



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The Patient Transportation Challenge

To endeavour to find ways to improve on an already good service by identifying new methods of transporting patients safely and rapidly.

The Challenges

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The Education and Training Challenge



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- Remote and Rural Healthcare Educational Alliance (RRHEAL)
- Remote and Rural Training Pathways
- University Degrees and other qualifications in Remote and Rural Healthcare

The Education and Training Challenge



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To make sure that necessary learning opportunities are available to all who work in remote and rural healthcare

To train staff specifically for their roles and responsibilities in remote and rural healthcare

To ensure that education and training in remote and rural healthcare is at the same level as that available for those working in urban areas

The Challenges

- Staffing
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- **Public**
- Political



The Public Challenge



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How best to use the immense interest and enthusiasm the public has for its local remote and rural health services.

The Challenges

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**BETTER HEALTH,
BETTER CARE:**
ACTION PLAN

“Help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care”

Remote and Rural Health Care

Building a Health Service: Fit for the Future recognised that a one size fits all approach can not meet the challenges of providing health care in remote and rural areas and established a national steering group to develop a framework for the provision of services in those areas. A further group was established to develop specific training for doctors working in remote and rural areas. Both groups have now reported and we will issue guidance on how we expect their recommendations to be implemented early in 2008.

NHS

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The Committee believes that smaller and more remote NHS boards have an inherent difficulty in attracting and retaining staff and board members with the appropriate skills and experience.

Scottish Parliament Audit Committee Report
on the
2006/07 Audit of the Western Isles Health Board
May 2008

The Political Challenge



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To ensure that politicians and the government are properly informed of issues, problems and successes in remote and rural healthcare.

This will allow the politicians to provide the directives and resources necessary to ensure that NHS Scotland provides safe, effective and modern healthcare to its remote and rural inhabitants.

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“It is common knowledge that small hospitals are relatively more costly than establishments with 200-500 beds.”

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“...in patient care in the rural hospital meets with obstacles, such as disproportionate running costs due to the small number of beds occupied....”

The Rural Hospital
RF Bridgman
1955

Net Operating Expenditure per Head

April 2006 – March 2007

ISD November 2007

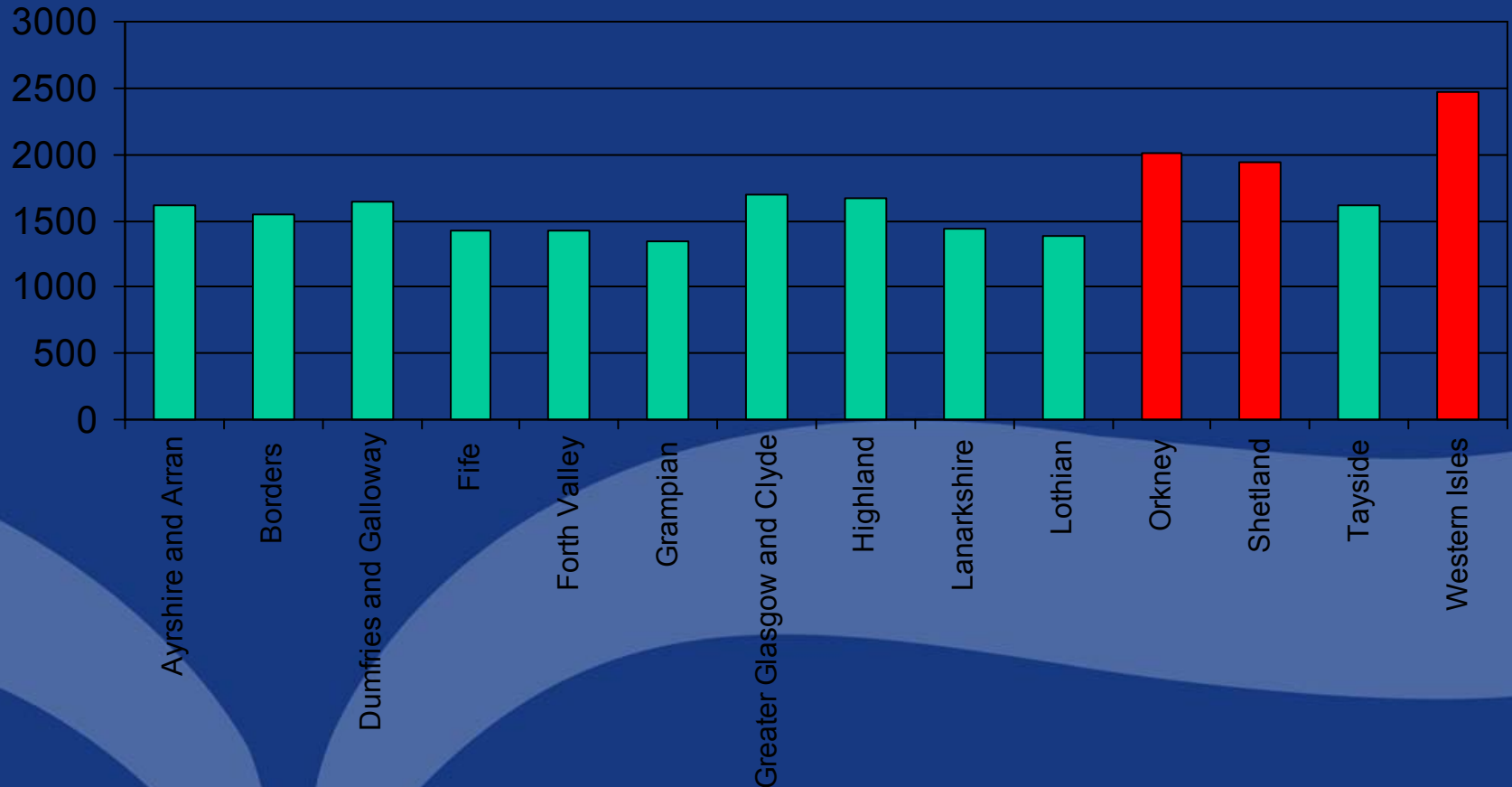


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per head



Hospital Running Costs

April 2006 – March 2007

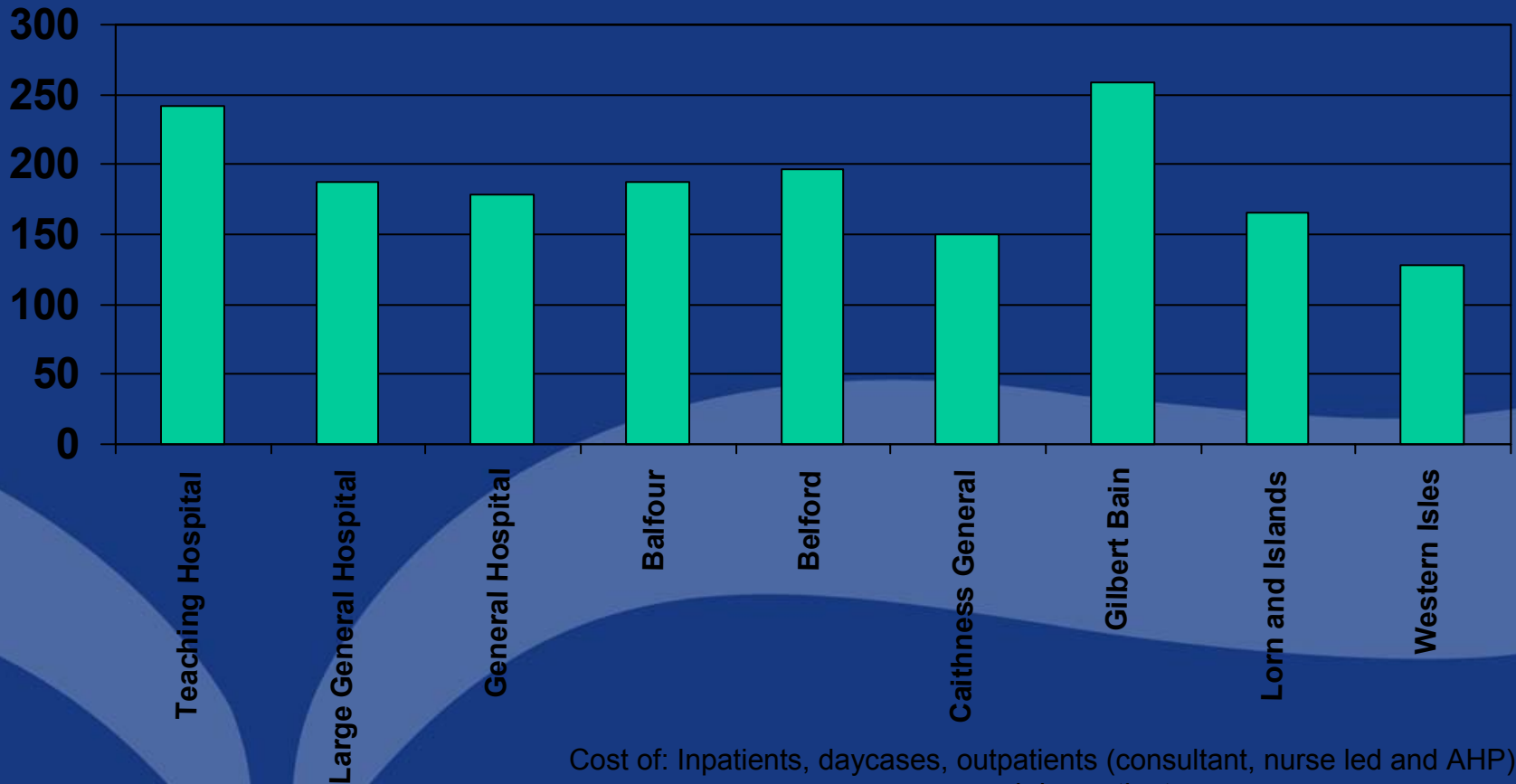
ISD November 2007



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000s/hospital bed



Cost of: Inpatients, daycases, outpatients (consultant, nurse led and AHP), A&E

Colorectal Cancer in Rural Areas



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Rural patients tended to have more advanced disease

(Liff, USA ,1991)

Rural population cancers were diagnosed more frequently at the stage of severe clinical symptoms

(Launoy,France 1992)

Increasing distance from cancer centre associated with poorer survival

(Campbell, Scotland 2000)

Patients remote from cities have poorer lung and colorectal cancer survival

(Campbell, Scotland 2001)

Colorectal cancer time to treatment was similar in rural and urban areas

(Robertson, Scotland 2004)

Urban rather than rural residence associated with later presentation of lung and colorectal cancer (129,811 patients)

(Paquette, USA 2007)

Increase in distance from primary care provider associated with later stage of colorectal cancer

(Parsons, USA 2007)



Newton Stewart Cat A 54.5%, Cat B 82.7%, GP 87%

Stranraer Cat A 76.3%, Cat B 93.7%, GP 88%

Gatehouse of Fleet Cat A 33%, Cat B 77.7%, GP 90%

Whithorn Cat A 80%, Cat B 88.9%, GP 75%

Image NASA
Image © 2008 DigitalGlobe
Image © 2008 TerraMetrics
© 2008 Infoterra Ltd & Bluesky

nter 54°50'49.83" N 4°48'28.12" W

Streaming | | 30%

Eye alt



Thurso Cat A 54.6%, Cat B 88.5%, GP 97.1%

Bettyhill Cat A 1%, Cat B 76.2%, GP 94.3%

Wick Cat A 60.3%, Cat B 89.6%, GP 97.3%

Shinarua Cat A 16.7%, Cat B 53.6%, GP 97.5%

Image NASA
Image © 2008 DigitalGlobe
Image © 2008 TerraMetrics

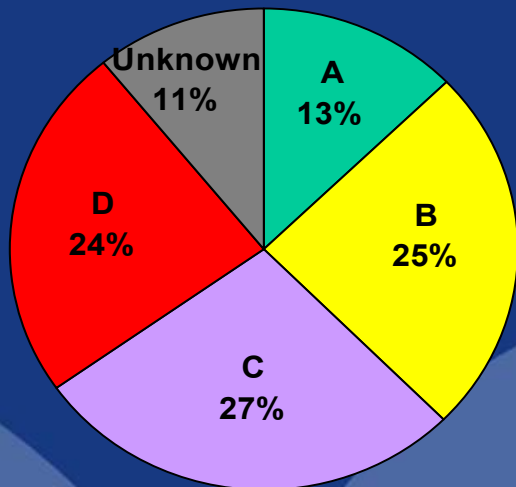
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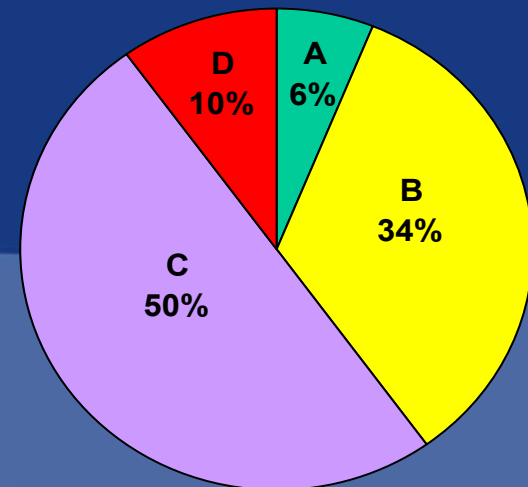
Streaming 1%

Eye alt 2

Colorectal Cancer Dukes' Stage at Presentation



Scotland
2000/2001



Western Isles
2006/2007

Colorectal Surgery in Rural Australia

Birks et al 2001



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69 rural surgeons - 62 of whom contributed 877 patients over a 12 month period

675 anastomoses with 3.3% leak rate

Perioperative mortality 4.6%

The Locum Challenge

Western Isles Hospital 2002 – 2007



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2002 and 2003

75% permanent

10% long term locums

15% short term locums

2004 to 2007

50% (40 – 62) permanent

35% (26 – 48) long term locums

15% (11 – 21) short term locums