



SCOTLAND

Remote & Rural

Steering Group

Detailed Rural General Hospital Model

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Rural General Hospital Project

Making it Work 3 Conference 13th May 2008

Delivering for Remote and Rural Healthcare



The Final Report of the Remote and Rural Workstream

30th November 2007

Rural General Hospitals



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Delivering for Health states that patients can expect that:

“If they stay in remote and rural areas, the NHS will provide them with a core set of services in Rural General Hospitals”



Rural General Hospitals



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Definition

“The RGH undertakes management of acute medical and surgical emergencies and is the emergency centre for the community, including the place of safety for mental health emergencies. It is characterised by more advanced levels of diagnostic services than a Community Hospital and will provide a range of outpatient, day-case, inpatient and rehabilitation services.”

Rural General Hospitals



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- Needs Assessment

Lack of Intensive Care, low risk pregnancies, diagnostic capability, cancer care with specialised units, recruitment and retention

- Rapid appraisal

Variation in intervention rates, wide spectrum of activity, variation in emergency and elective intervention rates, day case activity variations, elective intervention rates for patients with cancer

Rural General Hospitals



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- Unscheduled Care
- Planned Care
- Diagnostics
- Support

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- **Core Medical Services** - Anaesthesia, General Medicine, General Surgery
- **Maternity** - Midwife run
- **Networked Medical Staff** - Radiologists, psychiatrists and laboratory medicine specialists
- **Visiting Services**
- **Other Services** - Child health, mental health, endoscopy, imaging and laboratories

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- A nurse led urgent care service;
- The provision of a first-line emergency care service;
- The management of acute medical and surgical emergencies;
- A midwife led maternity service should be developed as a minimum, which should seek to maximise local deliveries;
- The management of patients with stroke, step-down, rehabilitation and follow-up of a range of patients conditions;
- The management of long term conditions;
- The provision of an ambulatory care service for children;
- Elective and emergency surgery as prescribed above;
- Visiting services appropriate to the health needs of the population;
- The provision of the prescribed range of diagnostics and clinical decision support;
- The provision of a pharmacy service.

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- Will have a medical workforce which is predominantly consultant led
- Is regarded as a level 2+ facility
- Must be part of a network with larger centres – this will include the development of obligate networks
- Will network with each other to develop agreed evidence based protocols
- A core range of services will be provided in all RGHs

Rural General Hospital



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Core Surgical Procedures

Emergency Surgical Workload	Planned Surgery
<ul style="list-style-type: none">• Appendicectomy;• Caesarean Section;• Endoscopy (including injection of varices);• Evacuation of retained products of conception;• Lacerations;• Initial fracture management and joint dislocations;• Repair of perforated ulcer;• Control of haemorrhage (including splenectomy);• Resection and anastomosis of bowel;• Ruptured ectopic pregnancy surgery;• Chest drain;• Drainage of pericardium injury (for cardiac tamponade) plus suturing of penetrating injury.	<ul style="list-style-type: none">• Biopsy of lesions;• Cholecystectomy and/or exploration of common bile duct;• Circumcision;• Endoscopy;• Nail bed procedures;• Peri-anal procedures;• Resection and anastomosis of bowel;• Simple undescended testes repair;• Scrotal surgery including vasectomy;• Varicose veins surgery.

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Diagnostics

- Imaging: digitised image capture, ultrasound and CT scanning
- Laboratory medicine: biochemistry, haematology, blood transfusion and microbiology (where agreed)
- Endoscopy: upper and lower GI and cystoscopy
- Surgical intervention/investigation e.g. biopsy
- Cardiac testing: exercise stress testing and echocardiography

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Allied Health Profession Services

Locally Based - Physiotherapy, occupational therapy, diagnostic radiography, dietetics, podiatry, speech and language therapy

Visiting - Orthoptics and orthotics

Travel to Access - Prosthetics, art therapy and therapeutic radiology

Infrastructure to Support Remote and Rural Practice



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Support networks

- Obligate – these will include formally agreed specialist clinical links, with an obligation to support local delivery of care and local decision making within the RGH. This should be available in all core specialities on a 24/7 basis
- Lateral - between remote practices or RGHSs to develop agreed standards, protocols, training and development to support and share good practice
- Vertical – with larger more specialised centres to deliver specific aspects of healthcare

Infrastructure to Support Remote and Rural Practice



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Quality Assurance and Governance

- Remote and rural healthcare should be judged on the basis of standards developed for NHS Scotland
- Remote and Rural Clinical Advisor
- Remote and Rural Reference Group

Infrastructure to Support Remote and Rural Practice

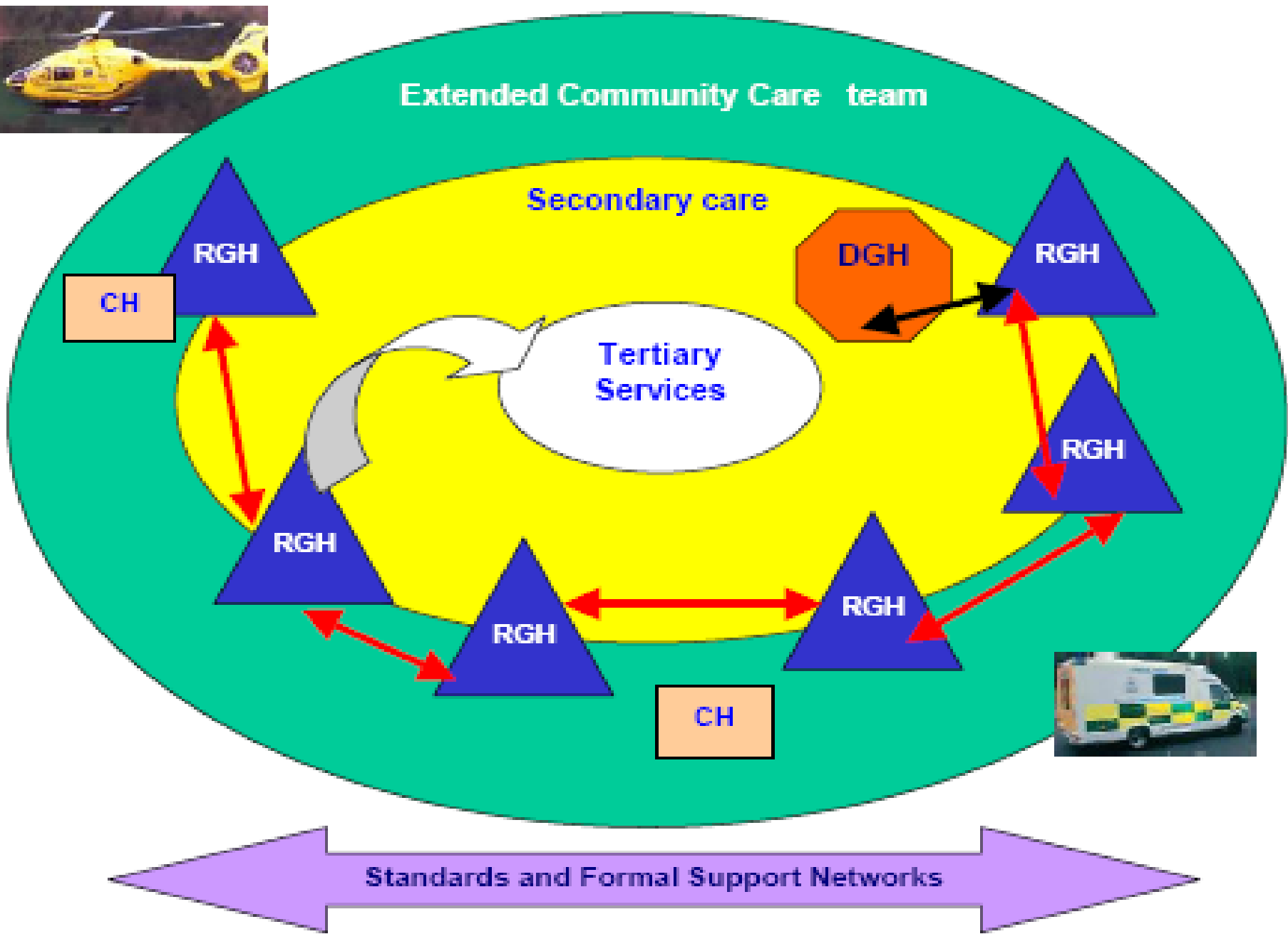


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E-health

The concept of utilising e-health in the remote and rural setting must permeate every aspect of service planning and delivery

Figure 1: Model of remote and Rural Healthcare



The Herald

FOUNDED ON MONDAY JANUARY 27, 1783

Saving rural hospitals

Remote communities deserve equal treatment

AFTER years of uncertainty and a gradual but seemingly unstoppable process of downgrading services, the prospect for Scotland's rural general hospitals now looks promising. The report from the working group on the future of the six hospitals has recognised that the needs of their communities cannot be met by the policy of providing centres of excellence backed by community facilities offering a restricted range of expertise. Whenever a local hospital is threatened with closure or a diminution of the services it offers, there is an inevitable reaction against the idea and in recent years we have seen campaigns to save services in Wick, Oban and Fort William. The hospitals there, along with those in Stornoway, Lerwick and Kirkwall, will be given a new lease of life by the plans to train doctors in a wider range of skills to become more general consultants. It is a welcome recognition that in a country as diverse as Scotland, a single model will not fit all.

In rural areas, emergencies include injured people who have been rescued from the mountains or the sea, as well as accidents at work or on the roads. It is often vital that they get appropriate medical treatment fast. In many cases the additional risks of being transported long distances by ambulance outweigh the benefit of being treated in a specialist centre. The same argument is made by mothers campaigning to retain maternity services in the rural hospitals: they want to be able to give birth in their local hospital, knowing there is medical back-up if necessary, rather than risk the baby being born on the way to hospital.

The recommendation that services at these hospitals must be consultant-led is the most far-reaching one. The

least nine specialists will be needed to offer the full range of general services in each hospital: three consultant surgeons, three anaesthetists (led by a consultant) and three medical specialists. That in itself is a welcome indication of a new era. Some of the hospitals have experienced difficulty in recruiting suitable staff in recent years due to the uncertainty over their future, but the shortage of staff has itself compounded the problem. If these hospitals are now to have general surgeons, who can deal equally well with fractures, emergency caesarean sections and removing an appendix, backed up by equally versatile anaesthetists, both staff and patients can have a new confidence in the service they provide. To achieve that, however, will require a new training regime, which will require to be properly resourced.

The new blueprint will be seen in some quarters as a reversal of the recommendations by Professor David Kerr for centres of excellence in the major teaching hospitals, backed by networks of district hospitals. There is no argument that some very complex conditions require specialist care, but these proposals will not remove that option where it is necessary or desirable. The vision which informed the Kerr model was of the NHS in Scotland working as an integrated entity. Since the furthest flung hospitals have always transferred patients to all parts of Scotland, it is no threat to the general principle if they also provide round-the-clock medical and surgical care for their own communities.

If we want a National Health Service that lives up to its name, it must provide a level of service that is equal (although not necessarily the same) for patients in the far north and west and in the islands as for those in the

Decision on wind farm is best left to islanders

IT WAS most enlightening to read the comments on the proposed Lewis wind farm from an alliance of environmental agencies (Letters, February 8). It was instructive that none of the signatories had anything to say about the future of the Outer Hebrides, the people, the economic circumstances we face in the islands or the demographic challenges.

Their only point seems to be to prevent development in the islands, to prevent business development, to prevent new skills coming and to prevent communities benefiting from industry. Their approach seems to be the most miserable form of "environmental colonialism" – sitting in the central belt lecturing the natives.

If these organisations believe the environment of the Outer Hebrides is of such quality, why don't they seek to put their money where their mouths are and invest here? Why does the RSPB only have one person employed in Lewis and Harris, but dozens employed in the central belt? At least the RSPB has sent one person here; the others have no presence at all.

That we have a special environment it is due to the efforts of generations of crofters who have toiled on these wind-swept moorlands; it has nothing to do with environmental bodies, and for them to now present themselves as the guardians of our environment is offensive.

These same crofters worked under uncaring landlords. It is ironic, in the era of community ownership, that our prospects for development may be stifled more effectively by the RSPB and its ilk than any landlord managed.

Can we be clear that we support the development of renewable energy in the Outer Hebrides and the Lewis Wind Power project, in particular, as it will bring more than 400 jobs. It will put 100mW of power generation into the control of the community and will bring up to £10m of benefit annually. We have recommended almost 50 conditions on any planning



permission to effects to the mitigated and

The economic benefit deliver is increased reasons the proposed, support the Stornoway land on which of the Outer Hebrides democratic know more about Lewis and the islands than the or FoE will eu

It is a pity to raise the development islands to the Given the challenge for many years failure of national government

When Will Highlands and Board in 196 be judged on Hebrides and Given the on population decline of our there has been policy. If the moves from a formal rejection Power project wrong for the

Go Ape proposal

Are our