

# *Making it Work 2003*

## ***Recruitment and Retention in Remote Areas and Sustaining Health Services in Isolated Communities***

***A Conference Report***

***DRAFT January 2004***

By  
Ruth Cleland

## Foreword

If 'success is a journey, not a destination' you may answer the question of why it has taken sixteen months to stop the train and reflect on how far we have travelled since our memorable gathering – ***Making it Work*** in St Andrews 2003.

One of the main reasons is the currency of an event like 'Making it Work' is often better measured after the passage of time and we have been able to reflect on the very significant number of outcomes from the event.

The learning points, personal and collective outcomes, stimulus, both professional and cultural, that we all shared, will have different emphasis depending on which country or which part of the healthcare systems we came from or whether you were part of that unique experience of having patient representatives as an integral part of the event.

I would like you to take a little time to read this report and refresh your memory then reflect on the value that the time spent at St Andrews was to you as a patient representative or a healthcare professional, civil servant or politician. But more importantly, has the experience added some value to 'The journey of care' in the countries represented at St Andrews?

If the answer to that question is yes then the time may be right to continue the journey on the 'St Andrews Express'. If we have been able to demonstrate added value, we all know that we are still only scratching the surface of solving the problems of planning and delivering sustainable Health Service in Remote and Rural regions .

One thing is certain, we will not be able to find the solutions in isolation and the importance of a vibrant global Remote and Rural Healthcare Network grows by the day.

Our Norwegian colleagues would like to invite us to ***Making it Work2*** in Tromsø in September 2005. With the experience of St Andrews and other international events, we have a reservoir of knowledge that can allow us to plan for success and focus international Healthcare Professionals and Politicians on the problems and solutions for the delivery of healthcare to the more remote areas. BUT, and there is always a But! - in making an investment in the journey to whatever success may look like, the underpinning value must be the contribution that investment makes to 'The Journey of Care'.

It would be stimulating to resume the debate and I hope that we can continue this important work in Norway in September. 2005.

Jim Royan  
Chair  
NHS Grampian

## **Contents**

- 1. Summary**
- 2. The Germination of an Idea**
- 3. The Project Proposal**
- 4. The Planning Committee**
- 5. Acknowledgements**
- 6. The Conference**
- 7. The Programme – a description and analysis of presentations**
- 8. Public Involvement**
- 9. Culture**
- 10. Capturing the Learning**
- 11. Evaluation**
- 12. Subsequent Outcomes**
- 13. Overall Conclusions**
- 14. Summary of Key Learning Points**

## **Appendices**

## Summary Report

In September 2003, over 300 delegates from Norway, Australia, Russia, Canada, USA and Scotland gathered for the first International Conference in Scotland focussing on remote and rural health. This was a joint venture between NHS Scotland, sponsored by RARARI, and the Northern Norway Regional Health Authority (Helse Nord), based on close links which have been forged over the past few years through sharing similar healthcare challenges.

The conference saw a convergence of international expertise and allowed an important opportunity to share common experiences and good practice and explore innovative solutions.

The main conference themes were recruitment and retention and the sustainability of health services in isolated communities.

Key themes which emerged from the conference were:

- The importance of education and training for sustainability
- The need for appropriate measurement of quality and standards
- The value of community ownership and honest open dialogue with the public
- The need for support networks for all professionals

Conference delegates made it clear that they see a continuing need for a permanent voice for rural health issues with international dimensions.

Some of the learning points include:

- The need to plan for the impact of a growing elderly population in remote areas.
- Health Improvement is as important as health care provision.
- Identify and Strengthen the weak links in the chain of survival.
- Put local problems into a bigger global context.
- If you share skills and knowledge people will find local solutions.
- Things have changed and we need to respond to change positively.
- Rural health care is different.
- Focussed and structured education helps rural recruitment and retention.
- Rural practitioners need more support and skills.
- Values are social perceptions
- A new model for planning services could be public expectation plus health needs, refined by risk assessment and cost-benefit analysis.
- Re-design of services means more effective use of staff and new ways of providing service.
- A partnership project approach can find and apply practical solutions.
- An answer to recruitment and retention can be a “grow your own” policy.

## **2.The Germination of an Idea**

The Northern Regional Health Trust of Norway, (Helse Nord) shares strong similarities with the North of Scotland, including similar challenges in recruitment and retention of health care staff and sustainability of health services in remote and rural communities.

Helse Nord has sent delegations on a number of occasions to the Highlands to look at service delivery, organisational structures and the work of the Remote and Rural Areas Resource Initiative (RARARI). This continued interest and networking enabled a close working relationship to develop between key staff in both areas.

The idea of working together to organise an international conference to highlight worldwide remote and rural health care recruitment and retention came out of subsequent discussions and joint work began on a proposal.

To date, there had been no such event held anywhere in Scotland or Norway. Remote and rural areas have a tough competition to find and keep qualified and committed healthcare professionals. Sustainability of health services in remote communities and the need for public involvement and local authority partnership was also recognised as an early theme. The specific problems and challenges have been well documented. Professional isolation; increasing regulations; standards and directives; out of hours pressures; payment restrictions; expensive locum arrangements; difficult transport and infrastructure; facilities and housing; support for families; increasing specialism and competition with specialist centres; public, political and professional expectations.

An international event would present a forum to bring together health organisations from different regions and countries who share similar problems, and key stakeholders to share ideas and work together jointly to find solutions.

The advantages of joint collaboration with Norway will focus attention on the conference and demonstrate partnership working at international level. The benefits also included shared planning costs and shared creativity.

### **Dimensions**

Remote and rural healthcare issues affect 20% of Scotland's population. The Remote and Rural Areas Resource Initiative (RARARI) was a short-term initiative which will ceased on 31 March 2004. Key initiatives included:

- Providing treatment close to home through local chemotherapy
- Saving lives by early detection of Abdominal Aortic Aneurysms and planned surgery
- Sustaining community healthcare through managed clinical networks
- Training and equipping local staff for emergencies.

NHS Highland's catchment area comprises the largest and most sparsely populated part of the UK with all the attendant issues of a difficult terrain and a limited internal transport and communications infrastructure. The area covers almost 25,784 km<sup>2</sup>, which represents approximately one third of the Scottish land surface.

NHS Highland serves a population of some 208,000 residents and sees a proportion of its patients from the influx of tourists to the Highlands, which at certain times of the year can double or even triple the local population. The proportion of older people is above the Scottish average. However, levels of morbidity and levels of deprivation are well below the Scottish average.

Helse Nord, the Northern Norway Regional Health Authority, serves a population of almost half a million spread over 113,000km<sup>2</sup>.

Helse Nord has a sparse population, long distances and difficult transport conditions, especially in the wintertime. Recruitment and retention is difficult because of the onerous on-calls, long travelling distances and there is a high staff turn-over with huge locum-costs. Helse Nord is responsible for delivering all acute services, mental health (secondary care), ambulance services and rehabilitation. There are 12 acute hospitals and the biggest Ambulance service in Norway with 132 cars, 23 boats, 6 planes and 4 helicopters.

The geographical nature and dispersed population of both regions presents particular challenges for the efficient and effective delivery of health care services.

### **3. The Project Proposal**

A project proposal was developed and put to the Scottish Executive and the Remote and Rural Areas Resource Initiative (RARARI) and to Helse Nord and the University of Tromsø for support and sponsorship,

The proposal was to hold an international conference to highlight worldwide remote and rural health care issues such as recruitment and retention, as a joint venture with our Norwegian neighbours, the Northern Regional Health Trust of Norway (NRHTN), (latterly Helse-Nord). It should be designed to be a positive event, sharing good practice and proving solutions are possible.

#### **3.1 Project Proposers**

Ruth Rountree Carlton (now Cleland), Communications Manager, Highland Acute Hospitals NHS Trust

Trude Grønland, Strategic Service Planning Manager, (Helse Nord)

Inger Simonsen, Project Manager, Northern Regional Education programme, Norway

Keth Wohni, Administration Director, Dept of Child and Adolescent Institute of Medicine, Tromsø

### **3.2 Objectives**

Specific outcomes from an international conference would be desirable including the following:

- Highlighting the issue of remote and rural healthcare recruitment and retention, addressing political, professional, academic and public expectations
- Dissemination, researching and sharing of new and tested models of recruitment and retention in remote and rural areas. Examining projects and models of service, which have proven to be successful, sharing good practice and learning from transferable principles.
- Establish international recruitment and retention networking, in order to continue to address the issues.
- Scope the extent of the problem, varying methods of research and strategic ways of tackling issues.
- Wider involvement of and engagement with stakeholders: universities, local authorities, communities, government bodies responsible for infrastructure, enterprise, rural affairs etc
- Stimulation and investigation of new ideas, and generation of both short and long-term solutions
- To publish recommendations and conclusions from the conference to inform and develop central strategy and local policy.

### **3.3 Funding**

It was anticipated that the conference would be self-funding through delegate fees and sponsorships. A budget, to be shared by Scotland and Norway and backed up by extra sponsorship, would be necessary however to under write the planning costs, keynote speakers and publication and advertising materials. £22,500 was sponsored each by RARARI and Helse Nord.

### **3.4 The Venue**

Venues were investigated in both Norway and Scotland and it was decided that a large venue, with suitable breakout facilities, in Scotland, close to an international airport would be most suitable. (St Andrews)

### **3.5 Planning**

Norway and Scotland core planning committees were established and wider reference groups in both Norway and Scotland were established to help develop the themes and design of the programme and to determine the outcomes.

#### **4. The Planning Committee**

##### Norway Committee

Trude Grønland, Co-Chair, Strategic Service Planning Manager, NRHTN  
(Helse Nord)

Inger Simonsen, Project Manager, Northern Regional Education programme,  
Norway

Keth Wohni, Administration Director, Dept of Child and Adolescent Institute of  
medicine, Tromsø

Oddvar Larsen, Strategic Service Planner, Helse Nord

##### Scotland Committee

Ruth Rountree Carlton, Co-chair, Communications Manager, Highland Acute  
Hospitals NHS Trust (HAHT) and RARARI Steering Group Member

Jim Royan, Chair of Grampian Health Board and RARARI Steering Group  
Member

Jackie Sutherland, Medical Staffing Manager, (HAHT)

Danny Muschate, Primary Care Team (HAHT)

Malcolm Alexander, Director of RARARI

## 5. Acknowledgements

Our thanks in particular to the sponsors of this venture which was a joint venture between NHS Scotland, sponsored by The Remote and Rural Areas Resource Initiative (RARARI) and the Northern Norway Regional Health Authority (Helse Nord) and the University of Tromsø.

Key figures from these organisations gave tremendous support and commitment to the organising committee.

Our thanks to our excellent and highly professional Co-chairs and hosts during the Conference in St Andrews, Marit Eskland and Jim Royan.

Our thanks to our Scientific Advisory Committee led by Niels Bentzen, for their work in reviewing abstracts and providing advice to the committee, and for their part in planning and judging the Awards.

Our thanks to Robert Gordons University for their contribution in videoing the presentations, setting up and administration of conference material on the website and evaluation of the Public Involvement work.

Our thanks to the members of the public for their valuable contribution to the conference and to the Involving People Team at Scottish Executive Health Department for their part in this important exercise.

Our thanks to Price Waterhouse for their sponsorship and contribution to the workshop on Risk Management.

Our thanks to our other sponsors:

Nordland Fylkeskommune

Sosial- og Helsedirektoratet Directorate for Health and Social Affairs Norway

Universitetet i Tromsø, ABUP

Ressurskommuneprosjektet, University of Tromsø/ISM

Den Norske Legeforening, Regionsutvalget Nord

Inverness and Nairn Enterprise

The Scottish Ambulance Service

Bond Helicopters

Sparebank 1 Nord Norge

Our thanks to Highland Health Council for their participation in the conference and the provision and analysis of the "Opinionmetres".

Our thanks to Mac Armstrong for his participation and contribution to the event.

Our thanks also to our key note speakers notably:

Maclolm Chisholm

Richard Holloway

Mads Gilbert

Roger Strasser

Eivind Vestbø and Torgeir Gilde

Our thanks as well to all the wonderful speakers, presenters, helpers and scribes - each one played an important part in the quality and value of the conference.

Our thanks to Convention Management for their contribution to the organisation of the planning and booking arrangements.

Our thanks to all the committee members who all played important roles and whose imagination and enthusiasm made the conference such a successful and memorable event. Our thanks also to Jørn Stemland for his support and advice in the financial budgeting.

Our thanks to Sound and Vision who provided a very professional and responsive sound and vision system and were completely unfazed by all the many demands on their expertise.

Lastly, but by no means leastly, our heartfelt thanks to all the delegates who came and participated and contributed to the success of the event!

We apologise if we have left anyone out. As you can see, an enormous number of people contributed to making this conference unique and successful.

Ruth Cleland (formerly Rountree Carlton)  
Joint Chair of  
Committee

Trude Grønlund  
Joint Chair of  
Committee

## **6. The Conference**

Over 300 delegates from Norway, Australia, Russia, Canada, USA and Scotland gathered for the first International Conference in Scotland focussing on remote and rural health, which was a joint venture between NHS Scotland and the Northern Norway Regional Health Authority (Helse Nord), based on close links which have been forged over the past few years through sharing similar healthcare challenges.

The conference saw a convergence of international expertise and allowed an important opportunity to share common experiences. Conference delegates made it clear that they see a continuing need for a permanent voice for rural health issues with international dimensions.

Delegates heard keynote speakers including:

Dr Richard Holloway, writer and broadcaster, Dr Mads Gilbert, Professor of Emergency Medicine at University of Tromsø, and Dr Roger Strasser, Chair of WONCA Party on Rural Practice, and currently Professor of Rural Health and Founding Dean of Northern Ontario Medical School.

The programme lasted two and a half days and included a selection of parallel sessions and 20 workshops looking at issues such as, Professional Roles, Recruitment and retention, Tele-medicine, Planning for the Future, Risk management, Nursing and Maternity care and Rural Needs and Managed Clinical Networks.

A panel debate led by Professor John Temple was held on the final morning of the conference.

Members of the public from communities around rural Scotland were funded to attend the conference to add a valuable perspective to the debate.

Delegates were encouraged to contribute to a "Knowledge Bank" sponsored by Robert Gordon's University, which was set up to capture the learning and ideas from the conference.

### **6.1 Conference Aims**

- To present successful projects and good practice
- To stimulate and develop new methods and new strategies
- To publish solutions and conclusions for the development of new strategies for the short and long term.
- To explore what research has been done or is needed on the key issues
- To build networks for future collaboration
- To learn and investigate how other sectors like enterprise, transport and the service sector overcome recruitment and retention difficulties

## 7. The Programme

### 7.1 Plenary Sessions

Malcolm Chisholm, then Minister for Health and Community Care, Scotland, opened the conference. He welcomed international delegates to Scotland and described the valuable work of the Remote and Rural Areas Resource Initiative in rural health in Scotland. He also spoke of the importance of networking.

**7.1.1 “The Links”** - Setting the Scene – by Stewart Whiteford, Chairman of The Remote and Rural Areas Resource Initiative (RARARI) and Olav Helge Førde, Chairman of the Board Helse Nord RHF. This presentation described the background to the conference, the geographical and demographic similarities and the shared challenges for healthcare. They laid out the aims for the conference and challenged delegates to work together to find solutions.

#### **7.1.2 “Working out of Bounds?”**

by Eivind Vestbø and Torgeir Gilde

A reality check- Two Clinicians who choose to work in a remote and rural area, described the challenges of professional isolation, long hours and pressures of work, in a powerful monologue illustrated by photographs.

#### **7.1.3 “Rules of Engagement” -**

by Richard Holloway

Professor Holloway took a philosophical and humorous look at paradigm shifts in society. He began by quoting George Bernard Shaw who said, *“All professionals have a conspiracy against the layety!”*

He examined the development of plural moral cultures and the need to view moral values in different lights and accept other cultures and the potential for conflicting viewpoints. We now have to consider new innovations not thought possible before. The “Ethics Lag” arises when we have the capability of doing things before the debate on ethics about doing it.

The paradigm shift has produced “Generation X”, a generation who want a new way of living, placing high importance on a work/life balance. Professor Holloway emphasised the need to take the anger out of negotiations. Things have changed and how do we now fit needs around that new human actuality.

Professor led a lively discussion with the delegates on the “expropriation of health from doctors”. Communities and other professions want to have a say. One public delegate stated that communities are wanting better transport. Another delegate from Arizona stressed the need to engage communities in ownership of their own healthcare.

One delegate said he was a clinician, but also considered himself and his family as service users.

Professor Holloway pointed out that the public trust their clinicians and listen to them. Change therefore means convincing clinicians, raising public awareness and bringing the two together in change. Instead of needs fitting the model, the model should fit needs.

**Key Learning Points:**

***Things have changed and we need to respond to change positively.  
Value the viewpoints of others.***

**7.1.4 “Setting the Challenge”**

by Mac Armstrong, Chief Medical Officer, NHS Scotland

Dr Armstrong spoke about the rise of chronic diseases such as stroke, cancers, diabetes and mental illness and the threat of new 21<sup>st</sup> century diseases.

He also outlined the changing demography, the rise in the aging population, the lowest births recorded since 1850 and the impact on society and the health care system. One quarter of the Scottish population will be over 65 by 2031. The biggest growth of the older population is in rural areas.

He alluded to the changing expectations among patients and staff and the challenges of new biomedical technology, which impact on the delivery of our future health services.

The imperative is for health improvement as well as healthy care: tackling poverty, social exclusion, poor diet, smoking, alcohol, lack of exercise and promoting healthy ageing and maximising health potential.

***Key learning points: The need to plan for the impact of a growing elderly population in remote areas. Importance of Health Improvement.***

**7.1.5 “Out of the Rough”**

by Mads Gilbert, Professor, University of Tromsø, University Hospital of Northern Norway

Dr Gilbert described the challenges of delivering acute services in remote areas. He gave a thought-provoking presentation and put remote emergency medicine into context by recounting his experiences in Burma, where the evacuation time to hospital for a mine victim was 10 days.

Dr Gilbert also highlighted the global problem of poverty and inequality where millions die each year of preventable diseases. He reminded the audience that we are “*polishing a highly developed healthcare system in the west*”. He described how local medics had been trained in Burma and mortality rates have dropped from almost 50% to 10%. “*The challenge is to look globally and*

*think globally! .... If you share skills and knowledge people will find local solutions.”*

His illustrations underlined his point that **time** is a critical factor in the “**Chain of Survival**” of emergency medicine. Biology can give a “window of opportunity – the Golden Hour is critical”. Big challenges for medical systems are tough communication lines, distances and bad weather. Survival is determined by dynamic interaction and team work. The chain is as strong as its weakest link. You need to find the weakest link and strengthen it if you want to improve things.

Strengths include an informed and trained population, public access, improved telephone systems and equipment, correct protocols and better emergency training, maximising the benefit of local knowledge and upskilling of local medical staff. *“Lots of enthusiasts but a lack of systems.”*

Dr Gilbert questioned “What are the core services?” which should be provided in remote areas. Who should be allowed to deliver what level of care and of what quality? Who should pay and who should decide? He questioned the logistics of decision making.

***Key learning points: Strengthen the weak links in the chain of survival eg local skills and transport provision. Put local problems into a bigger global context.***

***If you share skills and knowledge, people will find local solutions.***

***Core services need to be defined in remote and rural areas.***

#### **7.1.6 “Long Drives...”**

Planning for the Future in Australia and Canada by Roger Strasser, Chair WONCA Party on Rural Practice

Dr Strasser focussed on his experience in Australia and Canada, but he made the point that rural realities are the same the world over: geography and demography, attitude and values, morbidity and mortality, communications and rural culture. These are reflected in the health status of remote communities which have more preventable deaths.

Access is the major issue. Rural health care is different from that in cities. Rural practitioners, doctors, nurses, physiotherapists, etc, by definition, require a wider area of knowledge base and skills.

Negative perceptions of rural practice start at pre-undergraduate level, within largely metropolitan institutions. Students pick up a sense that the ultimate failure is to become a rural practitioner. The teaching hospital view of medicine is highly specialised – Dr Strasser referred to it as the “hidden curriculum” of teaching hospitals!

He went on to describe the elements of positive facilitation of rural recruitment. A rural upbringing and positive rural clinical experiences are a strong foundation for attracting and keeping rural clinicians. He described a successful model in Australia which provides a framework for encouraging rural recruitment: rural student clubs, rural mentor schemes, networking support for students with a rural background, social supports, funding for rural travel (which has a higher cost for rural students), and early rural placements.

The Parallel Rural Community Curriculum developed in Australia by a colleague, enables students to spend 1 year in a general practice in a rural setting as an integrated clinical experience. This is a rural community based postgraduate training with high quality learning experiences and active community involvement, creating positive experiences. *“If well set up and well constructed the students will learn far more, connect with communities and get a sense that they could live their lives here..”*

Dr Strasser went on to look at retention issues. The most common reason of a GP not staying is a mismatch of expectations by the GP and the community. There can be better retention if both have a realistic and mutual expectation of the service and a growth of mutual confidence. Rural GPs need more support where they work a long way from hospitals. They have to be trained and equipped to deal with a higher emergency burden.

In looking for sustainable models of practice, money doesn't solve, but training and investment helps. He described a town in Canada where 50 doctors came and went within 2 years! New model with new funding arrangements and conditions helped to stabilise this service.

***Key learning points:***

***Rural health care is different.***

***Focussed and structured education helps rural recruitment and retention.***

***Rural practitioners need more support and skills.***

## 7.2 Parallel Sessions

### Day One Theme – “Hooking and Slicing!” *People & Communities*

**7.2.1 “Finding and Keeping** Inger Simonsen and Psychiatry Project Team  
Chaired by Mark Butler

#### **“15 New Child Psychiatrists by 2006”**

This session described an important “grow your own” project, which has solved the problems of recruitment and training of child and adolescent psychiatrists in Northern Norway.

The project team highlighted the principal success factors of the project, and also what issues must be addressed to sustain Child and Adolescent Mental Health Services in remote areas.

In 1998 the child and adolescent psychiatric services in Northern Norway had 8 consultant psychiatrists. This was a severe shortage, as there should be 23. The problem seemed to be connected to recruitment and training. The doctors in the region, the University of Tromsø and the health administration in the three northern counties decided that the problem could best be solved in collaboration by establishing a project.

The aim was to recruit and train 15 new doctors by providing training and supervision. “We wanted doctors with roots in Northern Norway who were prepared to do what it takes to do the training. We needed committed consultants who were prepared to travel and to do work for the project, health bureaucrats and county politicians who believed in the project and we also need funding from the Department of Health to implement the plan. Everybody was enthusiastic and the project manager started in January 2000.”

The project has so far been a success, and by the end of 2004 there will be 23 doctors working in the child and adolescent services. Establishing a medical network is one of the major factors in the success of the project.

#### **Key Learning Points:**

***A partnership project approach can find and apply practical solutions.***

***An answer to recruitment and retention can be a “grow your own” policy.***

**7.2.2 “Community Chest - Values, Expectation and Responsibility”** by Ivar Aaraas, Chairs: Fred Andersen

**“Healthfit”** – Mapping the Future with Communities  
by Laura Gray, Service planning Lead, Aberdeen City Collective  
chaired by Jim Royan

**7.2.3 “*The Professional Journey*”** Education and development for core NHS staff. Interchangeable and developing roles. NES  
Chairs: Malcolm Alexander

**7.2.4 “*Looking Outside Health*”** - Finding and Keeping in other sectors, Dag Sjong and Hege Stenhammer, Stat Oil  
Chair: Marit Eskland

**Day Two Theme – “Out of the Bunker!” - Securing the Future**

**7.2.5 “*Managed Clinical Networks*”** – Chris Baker and Rod Harvey, Consultant in Remote and Rural Health Chair: Malcolm Alexander, Strategic Director of RARARI

**7.2.6 “*New Roles and Models of Care*”** - strategies to tackle specialism v generalism by Daniel Haga and Leo Murray, Chair: Mac Armstrong

### **7.2.7 “Quality and Reality”**

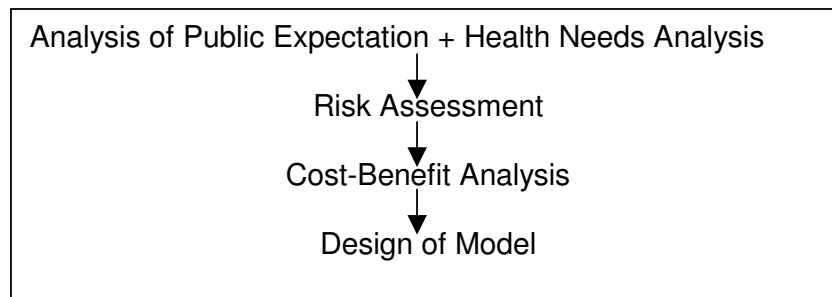
Defining Quality Core Services for Remote Areas  
Presentations by Geir Sverre Braut and Joe Owens  
Chaired by Richard Carey

#### **Presentation by Geir Sverre Braut, Deputy Director General, Norwegian Board of Health**

Dr Braut described the societal basis of a “White paper” on values in health care (1999-2000) – Strengthening autonomy, protecting the weak and vulnerable (through all aspects of life), sound professional practice, equity in the access to healthcare and predictable and transparent services. To some extent values and the concept of legal standards are set by society. Dr Braut posed the question of whether it is possible or acceptable to combine the concept of societies values and expectations with the possibilities of healthcare, using a risk analytical approach. Would society accept health care as determined by a set of random variables?

Dr Braut gave an account of his experience in the provision of healthcare to 30 to 500 residents in the small communities of an off-shore oil installation, provided by a nurse, emergency medic and an occupational health medic, with transport to specialist care on shore. There was a legal responsibility to plan the healthcare on the basis of documented risk assessment, which was recalculated regularly. He compared the parallel to the doubling of the population through tourism in small communities elsewhere.

Dr Braut posed a new model for health care redesign.



#### **Key Learning Points:**

***Values are social perceptions***

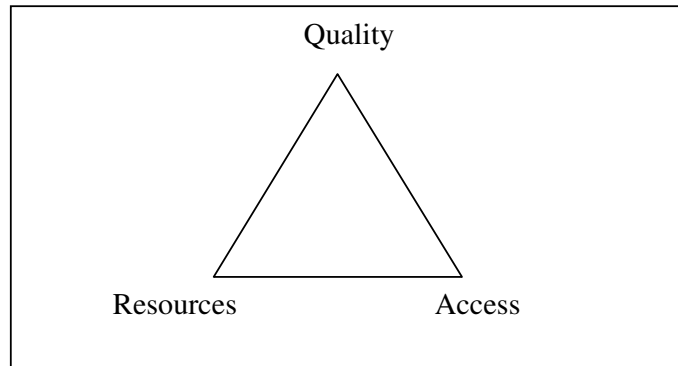
***A new model for planning services could be public expectation plus health needs, refined by risk assessment and cost-benefit analysis.***

#### **Presentation by Joe Owens, Chief Executive Lanarkshire Acute NHS Hospitals Trust**

Mr Owens described how the public perception of rural issues is different to clinical perceptions. The re-design of services means better, more effective use of staff and new ways of doing things, such as proactive chronic disease

management, preventing hospital admissions. Transport medicine is a major component. The future of multidisciplinary approach is based on the premise of nurses being available to take up increased roles and willing to do it for their pay.

Mr Owens described a model for re-design based on the equal weighting of Quality, Resources and Access.



***Key Learning Points:***

***Re-design of services means more effective use of staff and new ways of providing service.***

**7.2.8 “*The Disappearing General Surgeon*”** by Andrew Sim, General Surgeon, W Isles, and David Sedgewick, General Surgeon, NHS Highland  
Chairs: Olav Helge Førde and Ian Clark

## 7.3 Workshops

### **Appendix 1 (Abstract Book)**

#### **Finding and Keeping: staff are at the heart of good services (Workshop 2)**

(Workshop 2ii ) Chair: Hamish Johnston

2:iiA (Abstract 010) – A survey of Primary Care Health Professionals to provide a framework for future trends. Presented by Helen Richards and Jane Farmer.

2:iiB: (Abstract 025) - 70<sup>o</sup> North. Experiences from 10 years of recruitment and retention of doctors in primary health care services. Can the employer affect the development? Presented by Beate Lupton.

(Workshop 2:i):Karin Straum

2:iC (Abstract 029/37a) – Finnmark Training. The aim being to recruit young doctors into vacant positions in primary health care in northern Norway. Presented by Karin Straume.

2:iD (Abstract 037b/037c) – Recruit the Interns and Training and Network Building. Presented by Karin Straume and Mona Soedennaa.

Joint discussion of Workshops 1 & 2. Chair: H Johnston

#### **Finding and Keeping: Recruiting and training for the future (Workshop 3)**

Chair: Ken Proctor

3A: (Abstract 038) 15 new child psychiatrists by 2006 – a new model for training and keeping medical staff. Presented by Inger Simonsen and Project Group.

3B: ( Abstract 017) 8 Years Experience– A Program for Recruiting and Training Psychiatrists to Rural Psychiatry in Northern Norway. Presented by Jan Ove Holmen and Project Group

3C: (Abstract 001) Striving to Meet one`s own Needs – Outcomes of a 10 year “Experiment” in Training Family Physicians in Northern Ontario. Using data on demographic and geographic mobility of family Physicians to examine the extent of retention. Presented by Raymond Pong

#### **Sustaining Futures Services in the Western Isles (Workshop 4)**

Chair – Sheila Scott

Abstract 015 – Symposium – We will describe a range of service initiatives incorporating redesign, innovative models of partnership working and the use of policy initiatives such as Managed Clinical Networks and Personal Medical Services. These include:

- diabetic retinopathy screening
- children with special needs
- patients with cancer
- area wide learning disability services
- adults with mental health problems

Presented by Sheila Scott, Emelin Collier and Phil Tilley.

### **Education (Workshop 5)**

Chair: Professor Gillian Needham

5A: E-learning and NES – NHS Education for Scotland – learning in the 21st Century

Presented by Rose Marie Parr

5B: (Abstract 011) – European Network– Connecting Professionals – live presenting of the web promoting web technology as a positive dissemination and communication tool. Presented by Ian Dawson

### **Rural Health Nurse Training (Workshop 6)**

Chair: Nina Sjoevoll

6A: (Abstract 004) – Lifelong learning aspect for adult student nurses from districts where the lack of nursing-staff is critical. Presented by Edit Blasternes & Terje Arsvoll Olsen

6B: (Abstract 005) It Works – Recruitment & Retention of Health Professionals in Rural Areas in Northern Norway. Presented by Mari Wolff Skaalvik.

6C: (Abstract 012) – Learning and working to improve palliative care in rural Norway. Presented by Siri Gunn Simonsen

6D: (Abstract 016) – New Graduate Nurses in Western Norway– Yields in the labour market and job preferences. Presented by Oddvar Forland

### **The Locum Conundrum (Workshop 7)**

Chair: Alison Graham

7A: Presenting “Locum 123.com” . Presented by Robbie Coull

7B: The cost of locums to remote health. Presented by Fred Mürer

7C: (Abstract 035) A national best practice model for networking and recruiting in rural America. Presented by Alison Hughes

7D: “Are locum Agencies killing our work pool?” Panel debate: Participants: Robbie Coull, Hilde Gade, Fiona Thomson and Fred Mürer.

### **Maternity Care (Workshop 8)**

Chair: Fred Anderson

8A: (Abstract 030) Giving birth in a Northern Landscape. Traditional Saami-ways of birth and midwifery.

A film by Toril Hanson

8B: (Abstract 034) Lofotprosjektet – Child births in a modified midwife managed unit – an alternative to

centralisation of births. Presented by (to be confirmed)

8C: (Abstract 020) – Sustainable rural maternity services in Scotland– To scope required

multidisciplinary skills and innovative training methods.

Presented by Janet Tucker

8D: (Abstract 027) - Guidelines and Management of mild hypertensive conditions in pregnancy in rural general practices in Scotland– Issues of appropriateness and access. Presented by Janet Tucker & Jane Farmer

### **Supporting and Connecting People through Tele-healthcare (Workshop 9)**

Chair: Finn Henry Hansen

9A: (Abstract 042) Norwegian National Centre of Telemedicine – Project presentation by Sture Pettersen

9B: E-health Opportunities – Presented by Ray Newton

### **Looking & Learning from New Perspectives**

Chair: Inger Johanne Sivertsen

10A (Abstract 033) – Dancing in the Dust. Innovative strategies which have arisen out of incredible challenges. Presented by Sabina Knight, Australia

10B: (Abstract 028) Forming the reserve of health care managers in the remote region of North Russia -Using psycho physiological testing in recruitment of new leaders. Presented by Ioury Soumarokov, Arkangelsk

10C: (Abstract 043) New Model for Recruitment & Retention –looking outside healthcare at recruitment practice in other sectors. What lessons can we learn? Presented by Danny Muschate

### **Best Practice in Recruitment & Retention (Workshop 11)**

Chair: Steven Moore

11A: Parts of the Jigsaw – Recruitment and role development of Associated Health Professionals

Presented by Jacqui Lunday

11B: (Abstract 039) Running the remotest NHS dental surgery in a fragile Scottish mainland community.

Belief constructs of policy influences on macro attitudes combined with micro focus. Presented by Ken Gill and Colwyn Jones.

11C: (Abstract 007) How does the team work? - Understanding how rurality causes different workload patterns to emerge. Presented by Christine West.

### **Risk Management\* (Workshop 12)**

(Abstract 044) A session using Price Waterhouse group systems software which would seek to rank key issues impacting on recruitment and retention and capture best practice and solutions that have been implemented to address the identified issues. The workshop will also identify and inform future research or strategies.

Workshop by Price Waterhouse

### **Planning for the Future (Workshop 13)**

Chair: Mac Armstrong

(Abstract 041) A Comparison of 2 projects – Helse Nord Acute Services Project & The West Highland Health Services Project. Redesigning acute services in areas with historical models of provision – facing the challenges of public perception. Presented by Trude Groenlund & Gavin Brown.

### **Quality & Reality (Workshop 14)**

Chair: Richard Carey

14A (Abstract 032) – Clinical Practice Guidelines – Their Place in Remote Practice? – “Whilst the practice of imposing guidelines on to remote practitioners has been spectacularly unsuccessful, best practice has been influential in overcoming resistance”. Presented by Sabina Knight, Australia.  
14B A workshop on Standardisation – working within increasing standards & regulations. Presentation by Andrew Sim followed by debate and group discussion.

### **Training for rural needs (Workshop 15)**

Chair: Jim Douglas

15A Rural Colleges – training for rural needs, examples from Australia and Canada.

Presented by Roger Strasser

15B (Abstract 013) – Designing & Evaluating a Rural Clinical School.  
Presented by Professor J C Murdoch, Australia

### **Evolutionary Roles (Workshop 16)**

Chair: Einar Hannisdal

16A – (Abstract 008) The use of general practitioner beds in the municipality of North Cape – an analysis of one year admissions.  
Presented by Erik Langfeldt

16B (Abstract 002) – The Rural Practitioner, Skye – the new breed of doctor, the hospital GP. Presented by Leo Murray.

### **Core Services for Remote Areas (Workshop 17)**

**Workshop 17 i**– Chair: Stewart Whitsford

17A PreHospital Thrombolysis Project, Helse Nord. Presented by Mads Gilbert

(Abstract 036) – Strategies for Increasing the Uptake of Prehospital Thrombolysis – a Scottish model. Presented by Andrew Marsden

17B (Abstract 003) - Proposals for a Rural Ambulatory Diagnostic and Treatment Centre. Presented by Gerry Marr

**(Workshop 17ii)**

17C (Abstract 021) - Teaching ALS in Remote and Rural Areas: A Case for Teleconferencing. Presented by Julie Mardon.

17D: (Abstract 022) – A&E Medicine– Implementation of a Postgraduate Teaching Programme in A&E Medicine via Teleconferencing - One Years Experience. Presented by Julie Mardon

Joint Discussion on Core Services – chaired by Stewart Whiteford

### **15:00 – 17:00 Managed Clinical Networks (Workshop 18)**

Chair: Judy Welden

18A Developing Managed Clinical Networks. Presented by Rod Harvey & Chris Baker

18B (Abstract 014) – Orkney Evaluation by Professor David J Godden – A  
New Model for Consultant - Supported Intermediate Care  
in Remote Areas.

18C The Viking Surgeon. Presented by David Sedgewick

### **Free Papers**

Chair: Hasse Melbye

Abstract 006 – Dr John has gone: Health Professionals and remote rural  
community sustainability. Presented by Jane Farmer

Abstract 023 – Coming and Staying. Presented by Rhune Arild Larsen.

Abstract 040 - Recent changes to Scottish dentistry in rural & remote areas.  
Presented by Colwyn Jones and K Scoular .

### **Posters**

Abstract 009 A&B – Development of intermediate care as a discipline.

Educational activities ongoing within Argyll. Presented by Chris Downes.

Poster 024 – Results of local recruiting programme in a small Norwegian  
community by Anders Svensson.

Poster 031 – Resuscitation Training Service by Andy Matheson

Poster 044 – Open Univ/Paisley Univ open learning programme for Nursing  
Assistants by Simon Carr

## 7.4 The Panel Debate

“Challenging the Possibilities” – Panel Debate chaired by Professor John Temple

Panel Members: Naren Patel (QIS), Anne Markham (Chair, NES), Beathe Lupton, GP, University of Tromsø, Marit Eskland (Dr Med), Geir Sverre Braut (Clinical Standards Board, Norway), Ailsa Fraser (Teacher and Public Representative)

### Extracts from the debate:

- The public need a say in core services
- The question is what are **not** core services
- The service needs to be seen as fair ... most patients don't know what are core services or non core services
- The major mistake is to talk about them and us. we are all patients..
- We need to know what we are training people for
- People want the right intervention at the right time..
- There is a resistance of professional to interchangeable roles
- Perhaps we need to get rid of traditional names and spell out the team in a different way
- Public involvement – the earlier the better
- There is a perception that a doctor is the answer to everything
- Too little respect and too much hierarchy in the professional team
- Protocols are important in team work
- Clinicians are resistant to change as much as the public – change is perceived as threat
- Facilities might need to change if not appropriate
- It is about time we talked more about what we can do not what we can't do!
- We must build up trust
- There is a need to recognise up front funding – putting things in place before taking the old away

## 8. Public Involvement

The importance of involving patients and public delegates was identified very early on in the planning of the conference. This was a key part of highlighting awareness of the issues and achieving the following project objective:

- Wider involvement of and engagement with stakeholders: universities, local authorities, communities, government bodies responsible for infrastructure, enterprise, rural affairs etc

NHS Grampian took on the planning of this important work, achieved support and funding from the Involving People Team at SEHD and evaluation and research support from Robert Gordon's University (RGU). There has been limited consumer involvement in healthcare conferences to date and very little research hitherto.

A number of workshops and parallel sessions eg "Community Chest", were aimed at addressing the issue of public involvement in service planning and delivery. A public representative, Ailsa Fraser, teacher and NHS Highland Patients' Council member, also took an active part on the panel debate, chaired by Professor Temple.

The public delegates expressed a vast gain in their level of knowledge and understanding of health services and the challenges in providing these. They also said they were very impressed by listening to dedicated and enthusiastic rural practitioners.

A subsequent report was published by RGU on the Evaluation of User Involvement at the Making it Work Conference. The report discusses the value of public involvement, highlights the issue of the funding and research of this work and makes the following recommendations:

- When conference organisers decide that public involvement is appropriate, public representatives should be involved as early as possible in conference planning, design and delivery
- When patient/public delegates are to be involved...organisers explore as many routes as possible in order to find the most appropriate delegates
- Patient/public delegates should be given early notification of the event
- Those sponsoring delegates need to consider in dialogue with the patient/public representative, the main aims and objectives of attendance
- Those sponsoring delegates examine the financial costs of attendance for the delegates and ensure the timeously refund of expenses
- Attention be given to the training and development needs of representatives participating in the Patient Focus and Public Involvement Agenda
- Further research be undertaken into the role of conferences in the personal and professional development of NHS staff and patient/public representatives.

- The role of patient/public representatives in shaping national policy regarding the Patient Focus and Public Involvement be monitored and evaluated.

This report concludes “The conference in future years may well be regarded as a landmark in developing patient/public involvement. It is hoped that the organisers of the conference in 2005 will consider the recommendations of this report.”

As a result of this report, a public representative from the 2003 group will be involved in the planning of the next conference.

## **9. Culture**

The venue lent itself very well to social interaction between the delegates. The two evenings were designed to reflect cultural richness of the two hosting nations and maximise social interaction and networking between delegates. The Scottish evening began with the delivery and raising of the Norwegian and Scottish flags with the accompaniment of the Scottish Ambulance Service Pipe Band. A Scottish dinner was introduced by an address to a haggis and a local Highland Dance School provided dancing displays. A charity raffle raised over £2000 for charities in Korea and Finland. The evening was rounded off by a ceilidh dance.

The Norwegian evening began with a concert from the Norwegian violinist Susanne Lundeng, a wellknown “firework” from the North of Norway playing Norwegian folk music. A ceremonial Viking entertainment followed and a formal dance display by many of the Norwegian delegates in their national costumes. A Norwegian themed dinner was enjoyed and the evening ended with a band playing and delegates could dance until the wee hours.

## **10. Capturing the Learning**

### **10.1 Recording of the Event**

The plenary sessions and several of the parallel and workshop sessions were videoed by a team from Robert Gordon’s University, Aberdeen.

### **10.2 The Knowledge Bank**

The “Knowledge Bank” was a method of gathering in ideas and comments and learning points from all the parallel sessions and the workshop discussions. Delegates were invited to “post” their ideas and comments and workshop scribes deposited their notes. Dr Malcolm Alexander led the analysis of this data. He presented some of the outcomes at the final plenary session.

Key themes, which emerged from the knowledge bank were:

- The importance of education and training for sustainability
- The need for appropriate measurement of quality and standards
- The value of community ownership and honest open dialogue with the public

The need for support networks for all professionals

### **10.3 Website**

Material from the conference was posted on the Virtual Learning Website hosted by RGU. Access was opened to all after initially being open only to delegates. A discussion forum was actively used by delegates for some weeks after the conference. The Conference was hosted for a limited time period.

A website is an important facility for future networking, sharing of ideas, discussion fora and advertising of future events. As such, a dedicated website would be preferable for future work, with immediate access for uploading documents and direct on-line booking for conferences. This is currently under development with Norway.

## **11. Evaluation**

Various methods of evaluating the conference, the event, the evidence and the outcomes were used.

- Opinionmetres survey
- Report on Evaluation of the User Involvement (Ref: Health Services Research Group, Robert Gordon University, Aberdeen) (see section 10)
- Award Ceremony
- Event Evaluation Form in Delegate Pack
- Use of the VLS Website, posting materials and hosting a discussion forum
- Achievement of financial balance
- The Knowledge Bank – capturing random evidence and ideas from delegates (see section 9)
- The Price Waterhouse Risk Assessment Workshop (Ref: PWC)
- Measurement of subsequent Outcomes by a delegate questionnaire in November 2004. (see section 12)

## 11.1 Opinionmeters

Highland Health Council conducted a survey amongst conference delegates using “Opinionmeters”. The results revealed the following views amongst delegates:

- 91% agreed that working in remote and rural areas requires extra skills
- 86% agreed that remote and rural way of working is sufficiently different from urban working to need a special approach to education
- 92% agreed that working in multi-professional networks is of major importance in remote and rural areas
- 25% thought that criteria for measuring healthcare are the same in all health care sectors (53% thought they were not the same and 22% didn't know)
- 21% agreed that health policy in their country is helpful to working in a remote and rural area (64% disagreed, 15% don't know)
- 56% said that better support networks would be the most important factor to continue working in a remote and rural area (7% wanted better pay, 12% wanted better education and training, 12% wanted better systems of measuring quality)

## 11.2 The Eighteenth Hole: The Awards Ceremony

One of the most important parts of the Conference was appropriate recognition of the many excellent presentations, which had been carefully prepared and delivered throughout the programme. To try to do this justice, a scientific panel had been assembled by Professor Neils Bentsen from the University of Trondheim as chairman, joined by Mrs Inge Bentsen (Trondheim), Professor Ivar Arras (Tromso), Dr Fred Andersen (Tromso) and Prof Lewis Ritchie (Aberdeen). In the absence of the Professor Bentsen, Lewis Ritchie described the rationale of how the awards were determined and how difficult the process had been for the judges because of the high standard of presentations.

Three awards were presented for:

- Most innovative practice – presentation
- Excellence in practice - presentation
- Best poster or exhibit

The panel assessed all abstracts accepted – attending presentations, assessing posters and exhibits. They were each marked on a five-point scale for:

- Innovation
- Application / transferability

- Relevance for remote and rural areas
- Presentation quality

Mark Butler, Human Resources Director, Scottish Executive Health Department, kindly presented special prize quiches to the winners as follows:-

**Award for most innovative practice:** a split award, the judges felt that two separate prizes should be made:-

(1) Karin Straume, Finnmark, Norway for: *Finding and keeping – staff are at the heart of good services* [Abstracts 10, 25, 29 & 37].

(2) Julie Mardon, Royal Alexandra Hospital, Paisley, Scotland for: *Teaching advanced life support in remote and rural areas using video/teleconferencing*. [Abstract 21]

**Award for excellent practice:**

Janet Tucker, University of Aberdeen, Scotland for: *Sustainable rural maternity services in Scotland* [Abstract 20].

**Award for best poster:**

Anders Svennson, BØ, Norway for: *The results of a local doctor recruiting programme in a small northern Norwegian community* [Abstract 24].

Mark Butler concluded the Awards Ceremony by commending all of the presentations and presenters and by underlining the crucial role of the Conference in promoting progress for remote and rural health and healthcare issues.

*See appendix 4 for references to Abstracts*

### 11.3 Event Evaluation

An evaluation form was given to delegates as part of their conference packs. This asked delegates to score the event and venue. Of the 29 which were returned (approx 10 % response rate) the following conclusions have been drawn:

- The majority of respondents thought that there was enough time for discussion, although some felt there was not and would have liked to attend more of the workshops.
- The majority felt that the conference was the right length
- The exhibitions were found to be worthwhile, but the constraints of time were an issue.
- The majority found the conference venue and catering satisfactory
- The plenary speakers were all graded highly for content and enjoyment.

Some comments included:

- So much was viewed from the medical manpower perspective – the answer seemed to be teamwork.
- Most informative and stimulating
- Excellent. Beyond expectations
- More microphones would have been helpful
- Great content and presentation styles.
- Comparison of health, social work and local/central government responsibilities would have been helpful to compare
- More analysis was required in workshops
- Worthwhile meeting.

Two delegates complained about the provision of some named tables for committee members and key speakers. However, this was arranged as a courtesy to host key speakers and to facilitate event management between the organisers.

## 12. Subsequent Outcomes and Analysis

A letter and questionnaire (appendix 2) was sent to a large number of delegates in November 2004, asking if delegates had continued to network or made changes as a result of the conference. This analysis was prepared from the responses received.

We are currently gathering evidence of shared working and change of practice which has come about as a result of the 2003 Making it Work Conference. For example, NHS Shetland have since visited Norway to explore Out of Hours GP arrangements.

### **Analysis to Date:**

(appendix 3)

21 responses received. Questionnaires were emailed to around 150 previous delegates.

### **2003 Delegate Questionnaire**

#### ***1. Have you made changes, or put into practice any learning as a result of the 2003 Conference?***

The majority of the respondents replied Yes.

Examples of practice:

- The Involving People Team at SEHD have carefully considered “how we engage with patients in national events and how we use their experiences to develop service re-design and find creative solutions to problems in remote and rural areas “
- NHS Shetland visited Norway to look at how they organise, deliver and provide services out of hours. “This was to inform our thinking in the development of out of hours solutions for Shetland in light of changes happening within both primary and secondary care.”
- Dr Kerr (NHS Ayrshire and Arran) tells how the conference informed ongoing research into clinical decision making and use of air ambulance
- Norway have tried out several experiences from Scottish projects such as the Skye model, managed clinical networks and we have had several delegations to Scotland to study the scottish way of partnership between communities and health services, public involvement etc
- NHS Highland is looking at new ways of emergency care and access to training schemes and have considered varying recruitment methods
- A delegate from Tromso University has put in to practice ideas and experiences made by others into own distance learning programme
- Dr Kim Hobbs from Australia gained certain insights into management and ongoing professional development of remote personnel has been actioned

- Patsy Brodie (NHS Tayside) “I have communicated to others the issues which affect service delivery arising from the conference and we are looking at different ways of working.”
- The Scottish Ambulance Service replied that they are in the process of putting the learning into action
- A Rural Practitioner from Skye said he had been “motivated by the conference to soldier on remotely!!”

## ***2. Have you continued to network with others as a result of the 2003 Conference?***

Most respondents gave examples of continued networking

Some examples:

- A delegate from Arizona experienced 3 follow-ups: One from a physician wishing to strengthen telemedicine technology in Scotland. I was able to connect him with vendors who might help. I also had a visit from a conference participant interested in technology applications for health care. I hosted her at my home and took her to a meeting in Phoenix to introduce her to the leading players in the state of Arizona. A third encounter was from a Norwegian delegate who wrote asking for information about the U.S. and Canadian rural health care infrastructure support systems
- NHS Highland have been in dialogue with Bergen University regarding exchange nurse training
- Members of the public involved in conference have continued to be involved in shaping strategies and planning at national level by The Involving People Team at Scottish Executive
- NHS Argyll and Clyde and NHS Highland have made contact with Norway regarding Maternity Services

## ***3. What themes would you like to be covered at the 2005 Conference in Norway?***

Maternity Services

Mental Health

Education

General Surgery

Health Improvement

Telemedicine

Economic Aspects of Health Service

Public Involvement in Re-design of Services

Medical licensure and Legal practice

Diabetes and other chronic disease management in rural areas

Access

Models of Service Planning and Sustainability

Unscheduled care

Cooperations between primary and secondary health care  
Korelia

**4. Are there aspects of local authority partnership working, which could be developed by international working?**

Not everyone expressed a view on this question, however, one respondent felt that this is valuable if there is a commitment to trying out proven solutions. Another delegate asserted that our local authority partners are crucial to delivery of services appropriate to the community and any international experiences would be of interest and value to them.

An American delegate gave an example of joint working on the border of Mexico and USA to reduce illness through education, nutrition and exercise programmes.

**5. Did Involvement of the Public add value? How could this be improved?**

Several respondents felt that this was important.

Comments:

- Involvement of the public is crucial and must only add value. More creative ways of involvement need to emerge to allow maximum participation by the public
- Recommendations from the RGU report need to be taken into account (These include involvement in the planning and early involvement in service change.)
- It was impressive to hear delegates ' viewpoints

*(The planning committee has involved a public representative in the planning of the 2005 conference.)*

**6. What do you think was most successful about the 2003 Conference?**

- Finding solutions to similar problems
- Wide range of disciplines represented
- Programme content was impressive, logistics efficient
- Cultural enrichment
- Learning from presentations and posters
- Inspiring remote clinicians
- Technically well organised
- Wide variety of workshops
- Sharing of solutions
- Networking
- Outstanding venue conducive to mixing of delegates
- Remote and rural areas need an international network for health because rural health issues need other solutions than central health

**7. What would you do differently?**

- Engaging the public in the planning process at an earlier stage
- Less expensive venue
- More time for discussions
- Need people who can make changes
- Fewer workshops and more time to discuss actions

**8. Have you visited the website <http://itlearningspace-scot.ac.uk> and did you find it useful?**

A number of delegates had visited the website, but several found it difficult to access.

**9. Would you or someone from your organisation attend the next conference in 2005 in Norway?**

All respondents, bar one, said yes, however funding was an issue for some.

**10. Any other comments?**

- an important forum which we should seek to continue
- could we also have some more research reports towards informing evidence-based policy development?
- debates provide ideas for creative solutions that can be worked on once the meeting has ended
- The idea of such conferences is good and it is important to have follow ups
- This kind of forum is essential; we need to look outside of our own little areas and apply already proven solutions from elsewhere.

**Organisations**

Replies ranged from

Scotland	13
Norway	7
Australia	1
USA	1

### 13. Overall Conclusions

#### **Measuring the Outcomes:**

Did the conference achieve the aims outlined in the proposal?

- To present successful projects and good practice – A wealth of knowledge was indeed presented and demonstrated
- To stimulate and develop new methods and new strategies – A number of delegates who responded to the delegate questionnaire have been inspired to explore and develop local solutions, based on learning from the conference
- To publish solutions and conclusions for the development of new strategies for the short and long term – The RARARI Report and the Public Involvement Evaluation Report sought to draw some conclusions. This report and the planning of the 2005 conference is the next stage in taking the work from the conference forward and realising potential outcomes.
- To explore what research has been done or is needed on the key issues – The conference demonstrated that far more research is needed in this area and that policy should be evidence based.
- To build networks for future collaboration – a great deal of networking has gone on informally between delegates, but the demand for a more formal network to be established requires further development
- To learn and investigate how other sectors like enterprise, transport and the service sector overcome recruitment and retention difficulties – There were some valuable learning points from an oil company, but far more remains to be learned from other non-health sectors.

#### **The Conference as a method of working:**

The conference provided an opportunity for professionals and patients, from a wide background of roles and experience as well as international boundaries, across health service provision, to share good practice, ideas, and thinking around solutions. The continued networking and development of local policy as a result of the conference, as detailed in “Evaluation of the Outcomes”, undoubtedly underlines the value of this event.

### 14. Summary of Key Learning Points:

- The need to plan for the impact of a growing elderly population in remote areas.
- Health Improvement is as important as health care provision.
- Identify and Strengthen the weak links in the chain of survival.
- Put local problems into a bigger global context.
- If you share skills and knowledge people will find local solutions.

- Things have changed and we need to respond to change positively.
- Rural health care is different.
- Focussed and structured education is proven to help rural recruitment and retention.
- Rural practitioners need more support and skills.
- Values are social perceptions
- A new model for planning services could be public expectation plus health needs, refined by risk assessment and cost-benefit analysis.
- Re-design of services means more effective use of staff and new ways of providing service.
- A partnership project approach can develop and apply practical solutions.
- An answer to recruitment and retention can be a “grow your own” policy.

**Appendices:**

1. Abstract Book
2. Questionnaire to Delegates
3. Analysis of Delegate Responses