



**REMOTE AND RURAL
STEERING GROUP**

**Remote and Rural Workstream
Interim Summary Report**

16th April 2007



Foreword

The Remote and Rural Steering Group was formally established in December 2005, following the publication of the “National Framework For Service Change”¹, which made recommendations on the future design of the NHS in Scotland and “Delivering for Health”², the Scottish Executive’s response.

The Remote and Rural Steering Group established four sub-groups to consider: the role and function of a Rural General Hospital; the requirements of Remote Primary Care; the development of a remote and rural education strategy, including the establishment of a Virtual School; and the need for an emergency medical retrieval service. In addition, a linked group to review the implications for the training of doctors in remote and rural practice was established between the Academy of Royal Colleges, NHS Education for Scotland and the R&R Steering Group.

The project groups have progressed considerably and at the December 2006 meeting of the Steering Group it was agreed that an Interim Report should be prepared, which captures progress so far, including proposals that the Steering Group are minded to recommend and outlines in detail the next steps in the project.

This Interim Report is quite detailed and will be the subject of further discussion and debate with the Rural NHS Boards during April 2007, however, it has been agreed that a short summary should be submitted to the Health Department Delivering for Health Implementation Board, which provides a high-level overview of progress and the emerging out-puts. This is the Summary report.

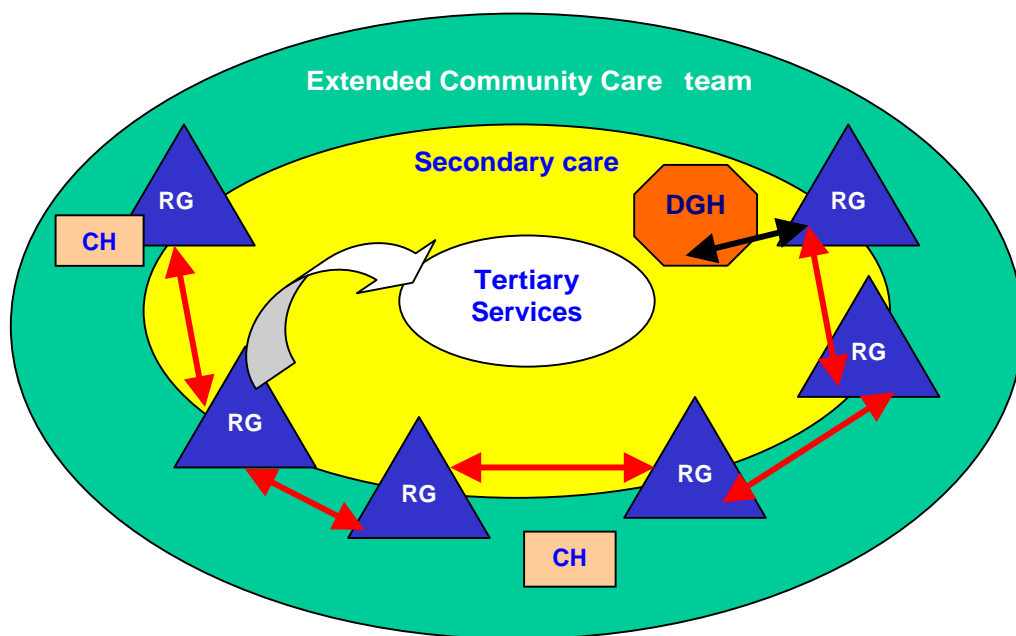
¹ (2005) “National Framework for Service Change” May 2005, Scottish Executive

² (2005) “Delivering for Health” November 2005, Scottish Executive

Remote and Rural Healthcare - The Emerging Model

This project was established to develop a strategy for sustainable healthcare within remote and rural Scotland. This Report considers a number of aspects of Remote and Rural healthcare, including the integration between different aspects of care and the following model summarises the system of care that will need to be developed, where it does not already exist.

Figure 1: Model of remote and Rural Healthcare



Delivering for Health identified that the majority of care can be provided within local communities, with only a minority of cases requiring further referral outwith that community. Within the remote and rural communities of Scotland, there are only a limited number of health and social care professionals, whose skills and expertise need to be shared if these communities are to have local access to the widest spectrum of care. The development of Extended Community Care Teams (ECCT) will ensure that a sustainable, robust system of services is available locally.

All remote and rural areas will also have access to intermediate care services, some within a Community Hospital (CH) and others delivered within a patient's home. Some communities will also have a Community Hospital and others will have a Rural General Hospital (RGH), which may fulfil the Community Hospital role.

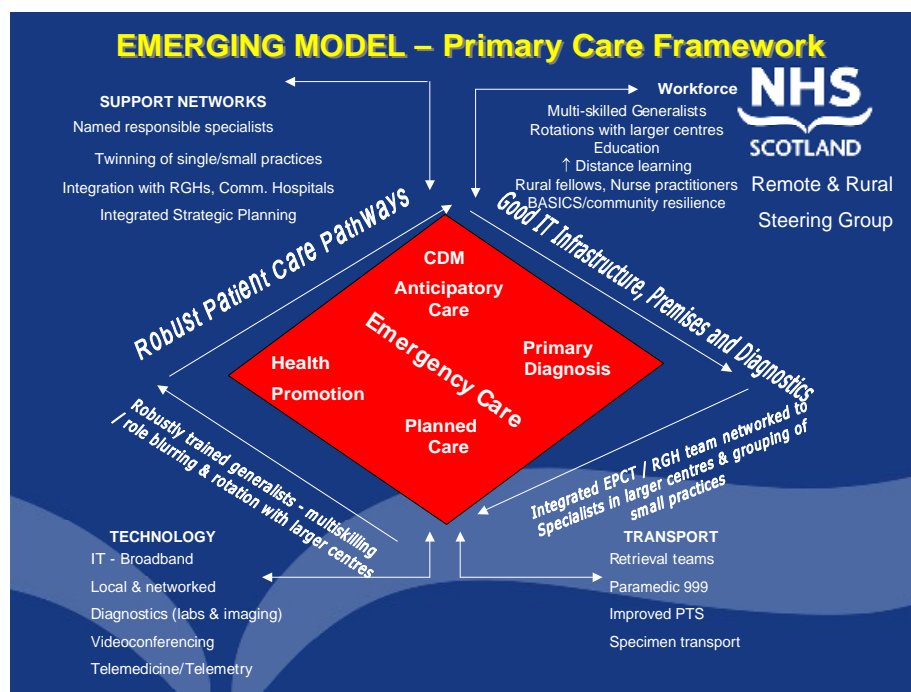
Remote Primary Care - Model of Care

The predicted demographic changes within Scotland suggest that we need to redesign how we provide care within remote and rural communities in order to ensure the sustainability of services. Current models of care tend to be reactive, with little or no anticipatory care, a wide variation in care pathways and multiple unnecessary visits to secondary care. Emerging models need to move towards encouraging self-care and providing anticipatory care; underpinned by robust care pathways with the balance of care shifting to local provision where it is safe and appropriate to do so.

The table below provides a summary of current and emergent models for remote primary care.

Current Model of Care	Emerging Model of Care
<ul style="list-style-type: none"> • Self care infrequent • Reactive care • Variation in care pathways • Multiple visits to secondary care • Fragmented teams • Education not fit for purpose • Poor infrastructure 	<ul style="list-style-type: none"> • Self care encouraged • Anticipatory care • Robust negotiated care pathways • Shifting the balance of care to locally based care • Integrated competency based teams • Rurally effective education • E-health based infrastructure

A diagrammatic representation of the emerging model for remote primary care is detailed in Figure 2 below.



Rural General Hospital

Six Rural General Hospitals have been identified:

- Gilbert Bain Hospital, Lerwick;
- Balfour Hospital, Kirkwall;
- Western Isles Hospital, Stornoway;
- Caithness General Hospital, Wick;
- Belford Hospital, Fort William; and
- Lorn and the Isles Hospital, Oban.

The Rural General Hospital (RGH) has been defined by the group as a level 2+ facility and is described as follows:

“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.”

Remote and Rural communities should have access to immediate emergency triage, resuscitation, stabilisation, treatment when appropriate and transfer when necessary. They must have appropriate diagnostic facilities, visiting specialists and networks with others. As a minimum an RGH should support the following services:

Unscheduled	Planned
<ul style="list-style-type: none"> • Practitioner led A&E service managing minor injury and minor illness; • Ability to resuscitate patients; • Ability to manage acute surgical and medical admissions; • Simple Fracture management and manipulation of joints; • Midwifery led maternity service; • Neonatal Resuscitation; • Capability to diagnose and initially manage acutely ill child; • Capability to manage patients requiring a higher dependency of care before transfer; • Clear and appropriate retrieval and transfer arrangements. 	<ul style="list-style-type: none"> • Management of patients with stroke; • Rehabilitation and step-down; • Post-op step down, rehabilitation and follow-up; • Management of patients with Chronic and long term conditions, including haemodialysis, cancer care as part of a network; • Provide ambulatory care for children within the locality; • Routine elective surgery; • Visiting services.
Diagnostic	Support
<ul style="list-style-type: none"> • Diagnostic capability, including: <ul style="list-style-type: none"> Imaging: Digitised image capture, Ultrasound and CT; Laboratories: Biochemistry, Haematology and cross match blood; Endoscopy: Upper and lower GI; Cystoscopy Echocardiography; 	<ul style="list-style-type: none"> • Clinical decision support via Ehealth links to other centres; • Pharmacy support.

Remote and Rural Staffing model

Healthcare is currently delivered by a range of professionals, often working in isolation and sometimes working in teams. The emerging models for healthcare in remote and rural areas are based on integrated teams, demonstrated by a range of competencies, based on patient need. These competencies often overlap between traditional professional roles, which is to the benefit of holistic care and utilises scarce resources to best effect. The majority of this team will be based within the remote and rural community, in primary or social care, within the hospital service or between any combination. Some members of the team will be based in the larger centre, with responsibility for supporting local delivery including provision of a visiting service, where appropriate.

Emerging Staffing Model

The following models (Figures 3 and 4³) describe a stratified workforce, highlighting those roles and competencies that should be within the remote and rural community and those in other agencies or levels of healthcare.

In order to sustain the competent workforce, appropriate training and education is required. This workforce must be supported in a variety of ways including formal networks and mentoring arrangements with larger centres, up to date equipment, modern IT and technological links and robust transport systems.

The models are discussed in further detail in the Interim report.

Key to sustainability of the emerging model is the development of formal networks, including links at specialty level e.g. cancer care, clinical decision support e.g. paediatrics and networks between RGHs e.g. RGH surgeons.

³ The model is stratified by the levels of emergency care described in the (2005) "National Framework for Service Change" Vol. 2, p98-103, Scottish Executive. Astron ^{B40206 05/05}

Figure 3: Emerging Remote & Rural Staffing Model

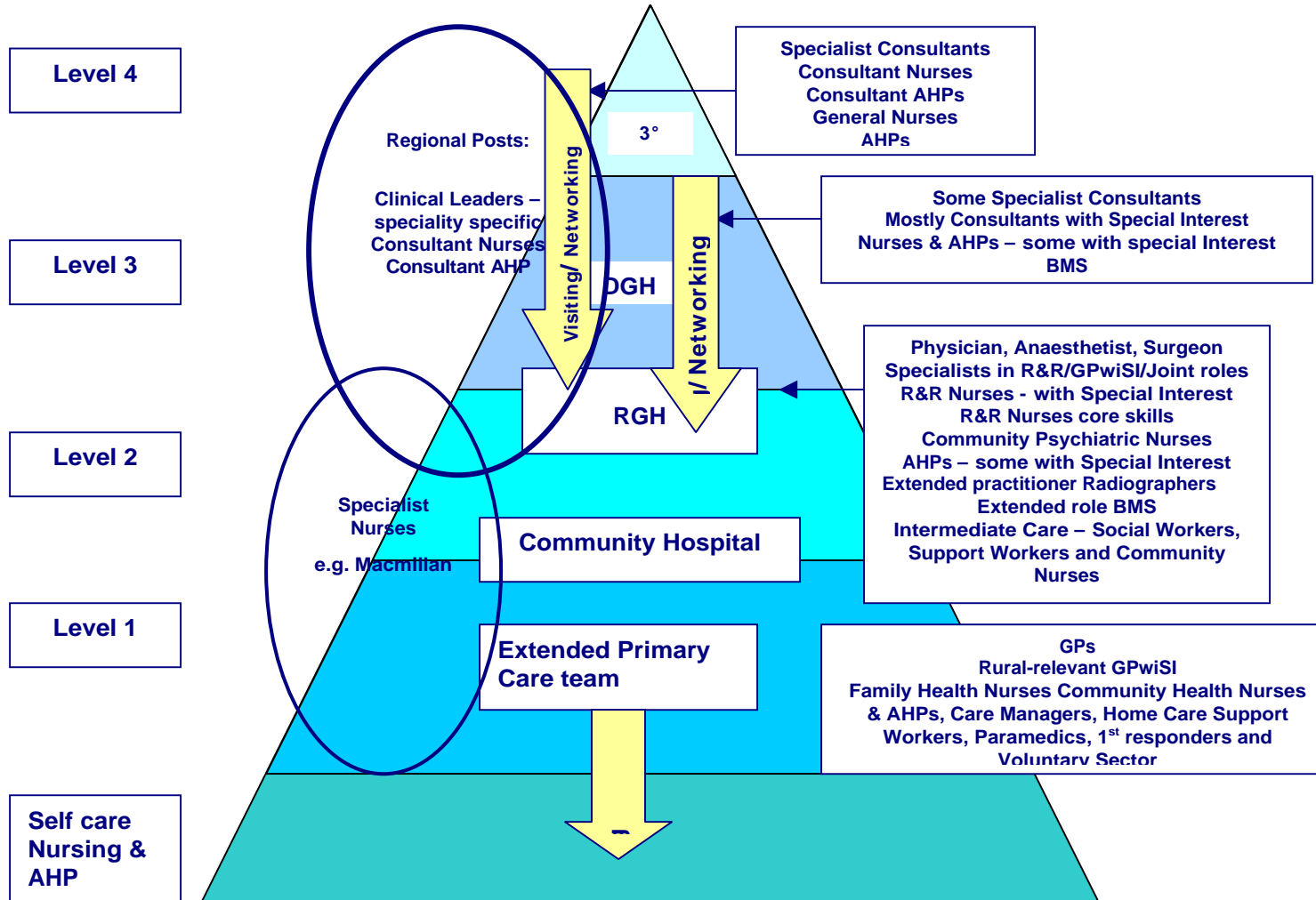
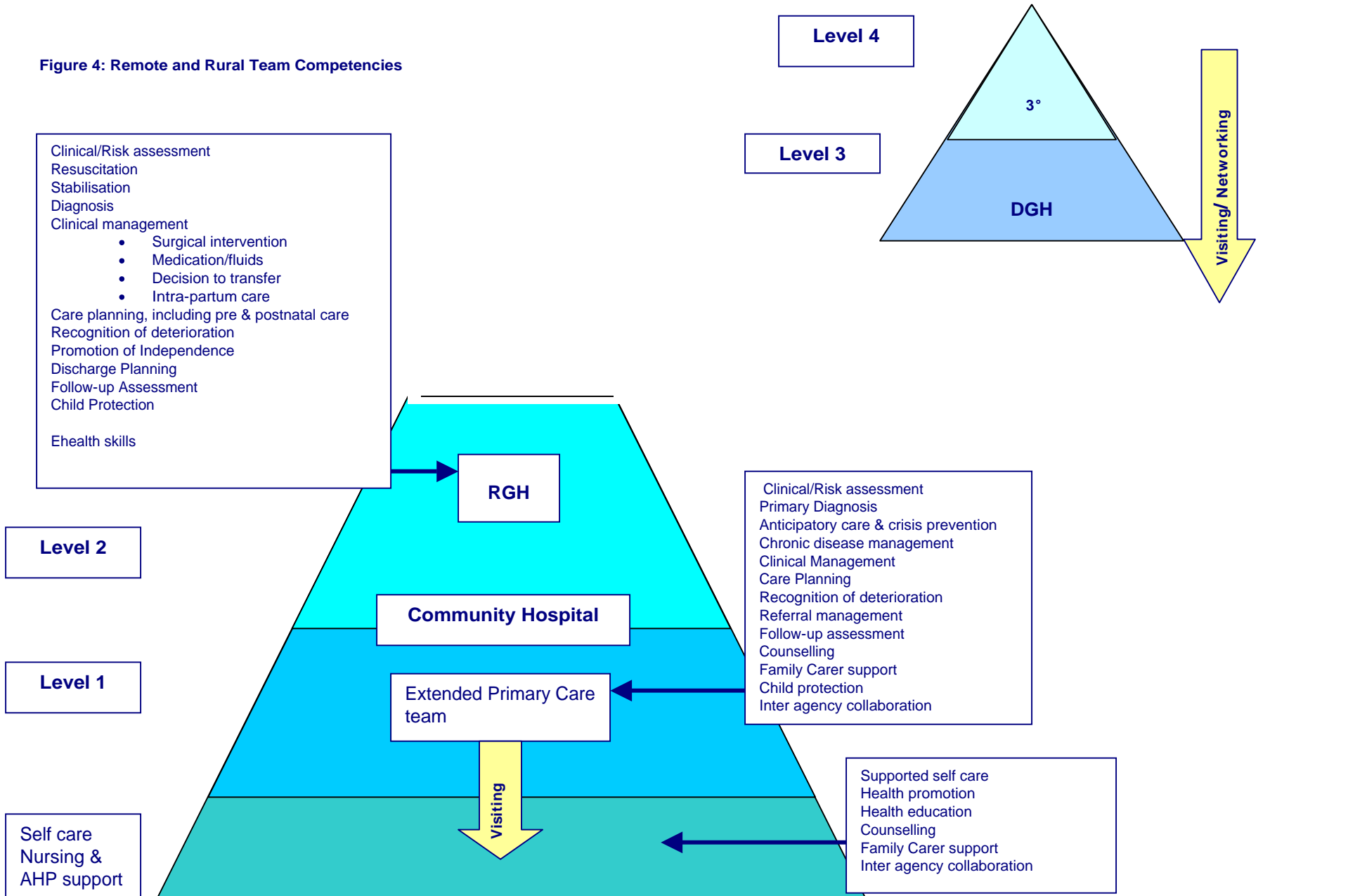


Figure 4: Remote and Rural Team Competencies



The Remote and Rural Steering Group

Emergency Medical Retrieval Service

Delivering for Health requires that: “The role of HEMS⁴ should be reviewed and, if necessary, enhanced in remote and rural Scotland.” A project board with representatives from across NHS Scotland was established in late 2005 to examine the potential role of an air based Emergency Medical Retrieval Service for Scotland (EMRS) in supporting rural healthcare in Scotland and, if appropriate, to plan the development of the service. A report was submitted to SEHD in May 2006.

The project board recommended the introduction of an Emergency Medical Retrieval Service supporting the care of seriously ill and injured patients covering all remote and rural Scotland. A pilot is planned, commencing with a Glasgow based service serving all rural hospitals on the West Coast. During the pilot the needs of the North Highlands and Northern Isles will be evaluated and recommendations made. If the evaluation proves the service to be a success the wider service may be through expansion of a single Glasgow centre or the establishment of a second centre in either Inverness or Aberdeen. The pilot is likely to commence in September 2007.

⁴ HEMS is an acronym for Helicopter Emergency Medical Service

Rural Training Pathways Project

The Rural Training Pathways (RTP) Project is a tripartite collaboration between the Academy of Medical Royal Colleges and Faculties in Scotland (The Academy), NHS Education for Scotland (NES) and the Remote and Rural Steering Group and is chaired by Professor Sir Graham Teasdale. Four objectives were identified for this project:

1. To develop an appropriate training pathway for doctors in remote and rural areas.
2. Define skills and competencies required.
3. Scope educational requirements, including appropriate curricula.
4. Identify infrastructure for Continuing Medical Education/Continuing Professional Development.

This work has been based around four key medical specialties: Medicine, Surgery, Anaesthetics and Accident and Emergency Medicine and General Practice. A fifth group is currently looking at more generic immediate service delivery needs, and will report early in 2007.

The work of the groups so far has been based upon the assumption that Rural General Hospitals will continue to operate with some form of consultant led or protected service.

All groups agreed that proleptic appointments were necessary where possible, and understand that the Scottish Executive Health Department is currently looking at ways to support these appointments. It is understood that SEHD operate a scheme to support Health Boards to cope with the double-running aspect of proleptic appointments.

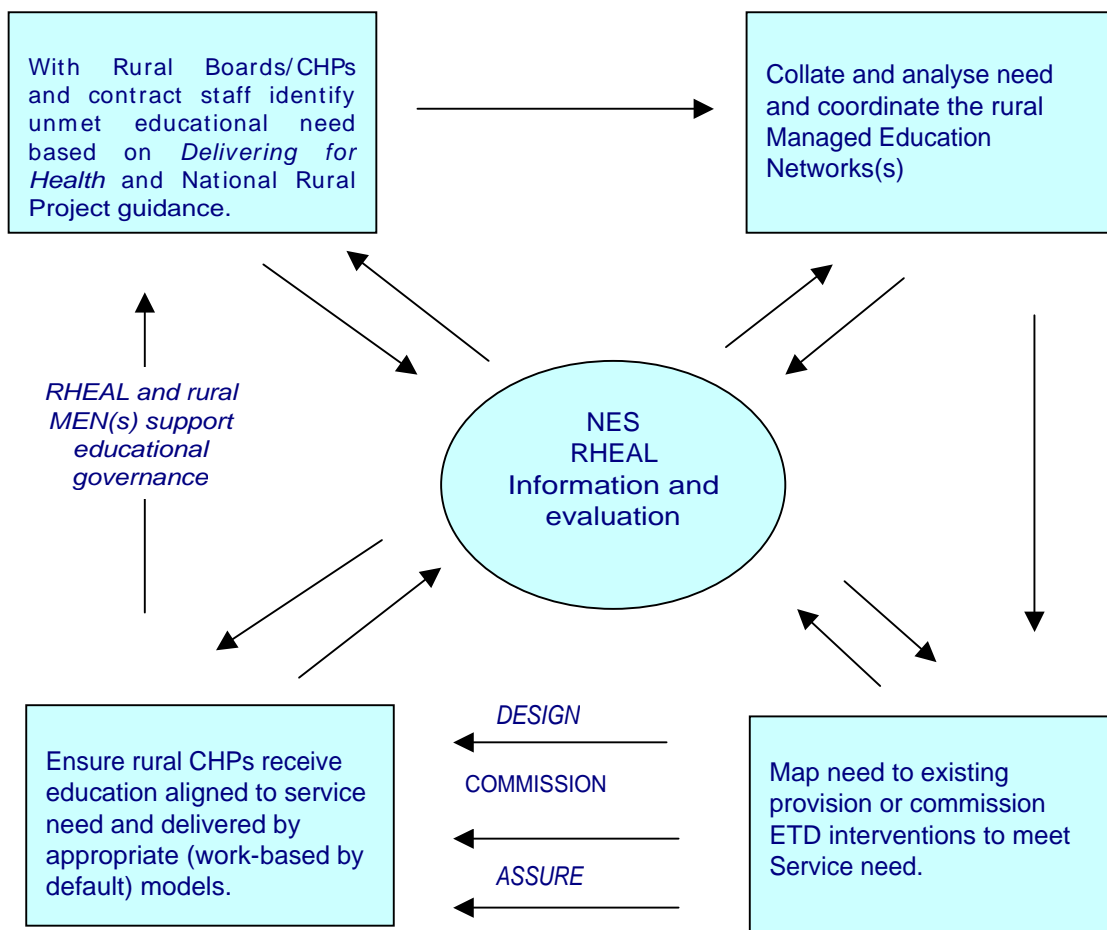
The groups feel that the models they have produced will allow a 'two-way' route for clinicians wishing to practice in remote and rural areas but who may also decide to do so for only a limited period before returning to urban practice.

Rural Healthcare Educational Strategy

Professor Gillian Needham, Postgraduate Medical Dean, NES North of Scotland Deanery led the project to develop a Rural Healthcare Educational Strategy, including exploring the concept of a Virtual School of Rural Healthcare to develop practical proposals to support rural education.

A Rural Healthcare Educational Alliance (RHEAL) to support a programme of work and a rural Managed Education Network has been proposed and approved by NHS Education for Scotland Board. The RHEAL network will make links between existing staff, resources and institutions more effective and facilitate the identification of effective rural education solutions for Rural Boards.

The functional relationships for RHEAL are described below:



Emerging Commitments

The full Interim report includes a number of emerging commitments and identifies next steps or further work to complete the report. There are listed below, together with a timetable for completion.

- The vast majority patients (around 90%) should be cared for in a community setting by the extended primary care team.
- The system of care within Remote and rural communities should support self-care, anticipate health needs to avoid crises in chronic diseases and have the capability to respond to emergency situations.
- The system of care should build community resilience to ensure that local people can be cared for as close to home as possible.
- Health and social care within remote and rural areas should be organised as integrated teams, known as Extended Community Care Teams (ECCT). Current organisational barriers should not stand in the way of efficient service alignment.
- The Community Hospital or RGH should be the hub for the ECCT both within normal working hours and out of hours.
- Patients should not have to travel needlessly for those diagnostic tests that can either be provided and accessed locally or provided locally and reported within the larger centre.
- The ECCT should exploit the opportunities to utilise e-health solutions to deliver care locally. This will include access to a range of modern communication tools including broadband access, video-conferencing and tele-medicine as a minimum.
- The Rural General Hospital should be classified as a Level 2+ facility.
- The RGH will provide a defined core range of services, including the management of acute medical and surgical emergencies and will provide a range of outpatient, day-case, inpatient and rehabilitation services.
- The RGH will be the emergency centre for the community and the place of safety for mental health emergencies.
- The RGH will provide access to an advanced level of diagnostic services, including CT in addition to basic imaging, endoscopy and a limited range of laboratory services.

- There is a clear need for a 24/7 medical service within the RGH.
- RGHs should have Community Midwife Units staffed by interventional midwife practitioners. These Units should be part of a formal regional network with a maternity hospital or tertiary centre.
- RGH medical staffing will be based on the consultant led model in anaesthesia, and a consultant protected model in general and internal medicine and, possibly general surgery; supported by other trained doctors, including dual trained roles (physician and GP) and GPwSI.
- Visiting specialists will enhance locally based services.
- Nurses in RGHs should be multi-skilled generalists.
- The Nurse with a Special Interest in acute care or enabling care will be developed to support nurses with general skills.
- AHPs and/or Social Care Workers should take the lead professional role when the patient requires intermediate care.
- New roles will require formal networks providing education, training, support and guidance.
- Formal networks with larger centres should be established to support remote services.
- Lateral networks between RGHs should also be established.
- Education programmes specific to remote and rural practice should be introduced.
- Remote and Rural healthcare should be judged using the same standards as throughout Scotland.
- Robust systems for the transfer of patients within remote and rural areas should be established.
- An Emergency Medical Retrieval Service is crucial to the development of the emerging models.
- NHS Boards should consider proleptic appointments, either on an individual NHS Board or regional basis, to Consultant posts in order to allow for time for appointees to undertake site specific training prior to taking up the substantive post.
- RGHs should move towards the Consultant-protected staffing model and consider filling vacant consultant medicine posts with a 'mixed economy' of Consultant in Internal Medicine supported by GP/General Physicians as described above.
- Training programmes for those wishing to practice anaesthesia in RGHs should include work placements in RGHs.

Next Steps

- Explore the use of the wider healthcare team to develop resilience within the community, including a pilot to test the role which Ambulance technicians and paramedics can play in anticipatory care and chronic disease management.
- Explore patient care pathways for common conditions to demonstrate how these can be adapted to support local access to care.
- Further work to refine the nursing model in line with the Strategy for Community Nursing across all aspect of the Extended primary care team is required.
- Determine the range of diagnostic tests, which patients in remote areas should reasonably expect to be provided locally, either directly or through use of technology.
- This range should be defined in collaboration with the Diagnostics, Unscheduled Care and Shifting the Balance of Care workstreams.
- The classification of the RGH as a level 2+ facility should be aligned with the output of the unscheduled care group.
- The precise role for surgery within all RGHs needs to be further analysed and debated. It is proposed that the profession, NHS Rural Board representatives and selected members of the Remote and Rural Steering Group meet to undertake a risk assessment on the future shape of surgery utilising a number of descriptors concurrently such as: analysis of health needs, volumes and outcome data, travel times and weather conditions with a view to gaining consensus on this issue.
- The debate regarding the role of surgery needs also to consider whether caesarean sections should be available within the RGH.
- If these are to be available, the impact on the required skills and competencies of the surgical and midwifery teams needs to be addressed.
- If Caesarean sections are not available, the impact on the role and competency of the midwife, particularly in assessing risk needs to be defined. In addition, the additional transport requirements must be identified.
- Regional networks should determine which visiting services should be provided on the basis of population need.
- The requirements for healthcare for children and young people in a remote or island setting need to be established to ensure that formal networks with paediatric centres are established.

- A senior clinician should be identified as responsible for supporting the remote area and that staff within this setting are adequately trained in paediatric care and follow agreed protocols of care.
- The exact role for paediatric surgery will be debated in collaboration with the national Specialist Services for Children workstream.
- The requirements for the management of patients who live in a remote or island setting and are experiencing a crisis in their mental health will be established.
- Formal networks with secondary care will be established, and a responsive system of transport or retrieval will be in place.
- Diagnostics and Laboratory networks will be established.
- Working patterns within larger centres will need to be reviewed to support the needs of the RGH.
- Further work to link the role of the nurse to the required patient outcome should be progressed.
- An appropriate competency framework should support this.
- The role and competencies of midwives within the remote and rural healthcare needs to be defined.
- The role of the generic support worker needs to be explored.
- Further analysis of the role of the AHP with a Special interest is required.
- The extended radiographer and BMS roles should be discussed with appropriate professional bodies.
- NES, in particular the Deanery structure must continue to ensure adequate training opportunities in Remote and rural practice. The current implementation process for MMC must not sacrifice the future needs of the RGH.
- Directors of Planning and Board Medical Directors should agree the nature and form of lateral and horizontal networks.

- NHS Quality Improvement Scotland (QIS) should appoint a Remote and Rural Clinical Advisor to ensure an understanding of remote and rural issues sought in the development of its standards. This Clinical Advisor should establish a Remote and Rural Reference Group to support him/her in this work.
- The Emergency Medical Retrieval Service Pilot should be established as soon as possible.
- This pilot should be supported by clear evaluation and outcome measures.
- The SAS should continue to work on integrated transport system that supports and is responsive to the needs of remote and rural healthcare.
- NHS Ambulance Liaison Committees should foster positive relationships through regular dialogue and reporting of performance with remote and rural colleagues.
- SAS should reissue the current guidance on access to the PTS and should work with remote and rural practitioners to train R&R teams on the SAS on-line booking service.
- SAS should ensure that ambulances in remote areas are appropriately staffed.
- There should be clear agreed definitions of the type of situation that constitutes an emergency transfer, including inter-hospital transfer and the response to a mental health emergency.
- The precise role and shape of surgery within RGHs need to be fully defined before the training programme can be ratified.
- The Anaesthetic Training Pathways Group should address the anaesthetic skills training for practitioners who work in remote settings outwith the RGH.
- The Training Pathways Group should explore the model of “Super-generalists”.
- The RHEAL should make sure ensure that they have robust systems to support training that is flexible enough to meet the changing needs of practitioners and meets the expectations of those practitioners.
- The possibility of developing a specialist degree for practitioners working in remote areas should be explored.
- The Rural healthcare Educational Alliance Network (RHEAL) should define the educational priorities for Remote & Rural areas and ensure that arrangements are in place to address these.

Timetable for Achieving 'Next Steps' of Remote and Rural Project

Delivering for Health Objective	Sub-Project	Next Step	Lead	Target Date
Develop model for extended primary care in remote areas	Remote Primary Care (RPC)	Evaluate Community Resilience in two sites	Mrs Fiona Grant Remote and Rural Project Manager	End May 2007
		Refine the community nursing model in line with the Strategy for Community Nursing.	Mrs Fiona Grant Remote and Rural Project Manager	End May 2007
As above and links with Shifting the Balance of Care Workstream		Evaluate the shifting the balance of care model in two areas.	Mrs Fiona Grant Remote and Rural Project Manager	End May 2007
Identify Transport requirements to support remote primary care		Evaluate the responsiveness of SAS in two remote areas.	Mrs Fiona Grant Remote and Rural Project Manager	End May 2007
Define the Core Model for RGH	Rural General Hospital (RGH)	The classification of the RGH as a level 2+ facility should be aligned with the output of the unscheduled care group.	Mrs Fiona Grant Remote and Rural Project Manager	End May 2007
Define the Core Model for RGH		Define the precise role for surgery within all RGHS.	Dr Annie Ingram, Project Director/ Mrs Fiona Grant Remote and Rural Project Manager	End May 2007
Develop workforce model for RGH		Examine the impact of the availability of a local caesarean section service on the required competencies midwifery team.	Dr Annie Ingram, Project Director/ Mrs Fiona Grant Remote and Rural Project Manager	End May 2007
Develop Strategic Networks to Support RGH		Regional networks should determine which visiting services should be provided on the basis of population need.	Dr Annie Ingram, Project Director/ Mrs Fiona Grant Remote and Rural Project Manager	End March 2008
Develop Strategic Networks for RGH		The requirements for the management of patients who live in a remote or island setting and are experiencing a crisis in their mental health will be established.	Mrs Fiona Grant Remote and Rural Project Manager	End December 2007

Develop Workforce Model for RGH	Nursing, Midwifery and AHPs	<p>The role of the nurse in the RGH should be linked to patient outcome.</p> <p>An appropriate competency framework should be developed to support this.</p> <p>The role and competencies of midwives within the remote and rural healthcare needs to be defined.</p> <p>Explore the role of the generic support worker.</p> <p>Analyse the role of the AHP with a Special Interest.</p> <p>Discuss the extended radiographer and BMS roles with the appropriate professional bodies.</p>	<p>Mrs Fiona Grant, Remote and Rural Project Manager/Mrs Betty Flynn, Regional Nursing Workforce and Workload Advisor</p> <p>Mrs Elinor Smith, Chair, NoS Maternity Services Group</p> <p>Mrs Fiona Grant/Mrs Betty Flynn</p> <p>Mrs Judith Catherwood, NoS Regional AHP Workload Advisor</p> <p>Mrs Judith Catherwood, NoS Regional AHP Workload Advisor</p>	<p>End May 2007</p> <p>End May 2007</p>
Develop core model for RGH and	Next Steps common to both RPC and RGH sub-projects	Complete Health Needs Analysis	Dr Eric Baijal, Clinical Lead, NoS Public Health Network.	End March 2007
Stakeholder Engagement		Undertake awareness workshops/consultation with rural NHS Boards	Dr Roger Gibbins, Chair RRSO/Dr Annie Ingram, Project Director/Mrs Fiona Grant, Remote and Rural Project Manager	End April 2007
Develop Strategic Networks to Support RGH		Diagnostics and Laboratory networks will be established.	Dr Annie Ingram, Project Director/Mrs Fiona Grant, Remote and Rural Project Manager	
Develop Strategic Networks to Support RGHs		Establish formal networks with Paediatric Centres.	Mrs Fiona Grant, Remote and Rural Project Manager	
Define Core Model for RGH		Determine the range of diagnostic tests to be provided locally.	Mrs Fiona Grant, Remote and Rural Project Manager	
Define Core model for RGH and Remote Primary Care Framework		Robust Care Pathways should be developed for the most common patient conditions.	Mrs Fiona Grant, Remote and Rural Project Manager	End December 2007
Develop Strategic Networks for support of RGHs		A Remote and Rural Clinical Advisor should be appointed to QIS.	Dr Michael Bews, Director, QIS	End May 2007

<p>Identify transport requirements necessary for the support of remote and rural healthcare</p>	<p>Transport</p>	<p>An integrated transport system that supports and is responsive to the needs of remote and rural healthcare should be established.</p> <p>NHS Ambulance Liaison Committees should foster positive relationships through regular dialogue and reporting of performance with remote and rural colleagues.</p> <p>SAS should reissue the current guidance on access to the PTS and should work with remote and rural practitioners to train R&R teams on the SAS on-line booking service.</p> <p>SAS should ensure that ambulances in remote areas are appropriately staffed.</p> <p>There should be clear agreed definitions of the type of situation that constitutes an emergency transfer, including inter-hospital transfer and the response to a mental health emergency.</p>	<p>Mr Adrian Lucas, Chief Executive, SAS</p>	<p>End December 2007</p>
<p>Review and if necessary enhance ERMS</p>	<p>Emergency Medical Retrieval Service</p>	<p>The EMRS Pilot should be established and formally evaluated utilising outcome measures.</p>	<p>Dr Stephen Hearn</p>	<p>End May 2007</p>
<p>Develop Educational Strategy to support remote and rural practitioners</p>	<p>Educational Steering Group</p>	<p>Ensure adequate training opportunities in remote and rural practice.</p>	<p>Professor Gillian Needham, Post Graduate Dean</p>	<p>Ongoing</p>
		<p>The RHEAL should make sure ensure that they have robust systems to ensure that the training provided is flexible enough.</p>	<p>Professor Gillian Needham, Post Graduate Dean</p>	<p>Ongoing</p>

		The possibility of developing a specialist degree for practitioners working in remote areas should be explored.	Professor Gillian Needham, Post Graduate Dean	End December 2007
		The RHEAL should define the educational priorities for remote & rural areas and ensure that arrangements are in place to address these.	Professor Gillian Needham, Post Graduate Dean	End Dec 2007
Develop Medical Training Pathways to support the development of remote medical practitioners of the future	Rural Training Pathways	The Anaesthetic Training Pathways Group should address the anaesthetic skills training for practitioners other than consultants.	Prof. Neil Douglas, President or Royal College of Physicians and Surgeons of Glasgow	End May 2007
		The Training Pathways Group should explore the model of "Super-generalists".	Prof. Neil Douglas, President or Royal College of Physicians and Surgeons of Glasgow	End May 2007