

**Delivering for Remote and Rural Healthcare – One Year On  
Sharing and Learning Exchange  
1<sup>st</sup> and 2<sup>nd</sup> September 2009**



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## Introduction

Delivering for Remote and Rural Healthcare (DFRRHC)<sup>1</sup> was launched by the Cabinet Secretary for Health and Well Being in May of 2008 as Scottish Government policy for sustainable healthcare to remote and rural communities. A Chief Executive's Letter (CEL)<sup>2</sup> identified a lead from the Health Directorate of Scottish Government and an NHS Board Chief Executive for the workstream and instructed the North of Scotland Planning Group (NoSPG) to lead this national programme over a two year period. The Remote and Rural Implementation Group (RRIG) was therefore established as a sub-group of NoSPG to bring together the representatives of remote and rural Boards within other regions and key stakeholders to provide leadership and direction to implement those recommendations that need to be taken forward in a co-ordinated way. RRIG is also tasked with providing regular performance management reports to the Scottish Government Health Department (SGHD) on progress against implementation.

The programme has now been ongoing for one year and the RRIG proposed that an event be organised to share learning between Boards and to re-energise the Implementation Programme.

The purpose of this paper is to provide a report of 'Delivering for Remote and Rural Healthcare – One Year On, Sharing and Learning Event' which was held on the 1<sup>st</sup> and 2<sup>nd</sup> of September in the Newton Hotel and Conference Centre, Nairn. A total of 120 people attended the event from across Scotland, including colleagues from NHS Shetland, linking via video-conference, for all or at least part of the day and the keynote speaker presented via video link from British Columbia, Canada. A list of delegates can be seen in Appendix 1

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<sup>1</sup> (2007) Delivering for Remote and Rural Healthcare, The Final Report of the Remote and Rural Steering Group Nov 2007 SGHD ISBN B56045 05/0

<sup>2</sup> (2008) CEL 23 (2008) " Implementation of Delivering for Remote and Rural Healthcare Care" Scottish Government, Edinburgh

## **Setting the Scene**

The Chair of the event was Dr Roger Gibbins, Chair of the RRIG and Chief Executive of NHS Highland. Dr Gibbins explained that the Cabinet Secretary for Health and Well Being had showed strong support for DFRRHC by launching the policy in May of 2008. He stressed that there is now a strong framework and vision for healthcare in remote and rural areas including primary care, extended community care teams, Community Hospitals, Rural General Hospitals (RGHs) and Obligate Networks. Dr Gibbins said that implementation of policy is always more challenging than development but was to be expected given the tight resources that are available, the potential for other policies impacting on where the agenda for remote and rural healthcare might want to be, such as the reduction in doctors in training numbers, the referral to Treatment Targets, pandemic flu and efficiency savings to name but a few. Any change in practice is easy to talk about, not so easy to implement. Dr Gibbins set a challenge for how the momentum might be maintained and how systems identify that they are on the right track and also how RRIG can support Boards.

Dr Gibbins informed delegates that there is a different focus for this event, the emphasis is on using collective resources of experience to share and learn about the good practice that is happening and identify what the priorities are for the remaining year of the programme. Dr Gibbins stressed that a conclusion could be reached on what impact DFRRHC had made on how services are delivered to those in remote and rural communities.

## Policy Overview

Dr Ingram Project Director of the Remote and Rural Programme provided delegates with a brief overview of the development of Delivering for Remote and Rural Healthcare, which was launched by the Cabinet Secretary in May 2008, as Scottish Government policy<sup>3</sup>.

Dr Ingram reminded delegates of the need for the development of the policy framework. She outlined a number of issues which affected the sustainability of healthcare service in remote and rural areas such as the fragility of the current model, uncoordinated and fragmented care, variation between centres with limited support from larger centres, career limiting perceptions, an aging workforce and the lack of remote and rural specific training programmes. Whilst there were passionate views on sustainable services, these views were often opposing. Dr Ingram reiterated that the aim of the policy was to provide a framework for sustainable healthcare within remote and rural Scotland, providing standardisation and consistency across areas to provide high quality care as locally as possible based on Needs Assessment and to attract an appropriately trained workforce.

The changing nature of care and the increasing complexity of needs were highlighted as just some of the challenges that must be met to ensure accessible healthcare in remote and rural Scotland. The overall model of care recognises the interdependence of individual services and focuses on the integration between different aspects across what is described as the 'continuum of care'. This is defined as self care and preventative care within the local community through the different levels of supported care up to that which requires the resources provided by a tertiary centre. Underpinning this model are national standards, supporting networks and the need for a robust transport infrastructure.

Delivering for Remote and Rural Healthcare makes 62 commitments and include actions for NHS Boards, for Regional Planning Groups and for the Scottish Government. RRIG has been established to lead the cross cutting actions and has 5 overarching workstreams of Obligate Networks, Service Models and Care Pathways, Emergency Response and Transport , Workforce and Education and e-Health and Infrastructure. The workshops will cover the work to date of the majority of the RRIG workstreams along with other key issues and will seek views on future priorities.

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<sup>3</sup> Delivering for Remote and Rural Healthcare is accessible via [www.nospg.nhsscotland.com](http://www.nospg.nhsscotland.com)

## **Training the Remote and Rural Workforce: the British Columbia Experience**

Mr Bill McKerrow, Clinical Lead of the Remote and Rural Programme introduced a biography of the keynote speaker<sup>4</sup>, Professor Dave Snadden, Vice Provost of the Medical School of the University of British Columbia (UBC).

Professor Snadden presented via video link from Canada and commenced by giving the historical context of the Northern Regional Campus in British Columbia. In 2007, 7,000 northern British Columbia (BC) residents and physicians held a protest around physician shortage. In response to this, six months later agreement was reached for distributed medical education between University of British Columbia (UBC), University of Northern British Columbia (UNBC) and University of Victoria (UVIC). In August 2004 the Northern Healthcare Student Campus (NHSC) was completed, in September 2004 the first class enrolled and in May 2008, the first class graduated. The UNBC is situated in the City of Prince George which was founded in 1915 and has a population of 70,000. Prince George is situated in Northern British Columbia which has a total population of 300,000. The UNBC was founded in 1991 has 4,276 students and 178 faculty. Professor Snadden explained some of the drivers for the medical school development had been: longstanding misdistribution of physicians in Canada to rural areas; current evidence on rural recruitment and retention of physicians suggest local origin and/or locally trained doctors are more likely to settle locally; Northern BC has the worst healthcare statistics in the province; and the expansion of medical school places in Canada requires new opportunities for clinical learning. These drivers also applied to other trainee healthcare professionals.

An overview of the Northern Medical Programme (NMP) was presented. The NMP is a distributed campus of the UBC which admits 32 students per year to a 4 year graduate entry programme. The students spend semester 1 in Vancouver and the remainder at NMP. Years 3 and 4 are totally clinically based in hospital and community healthcare settings. After graduation post graduate education (residency) of between 2-6 years is undertaken before trainees are ready for independent practice. The NMP uses the UBC curriculum which is distributed to all sites of instruction using an extensive videoconference infrastructure. Clinical education uses new smaller sites for year long integrated clinical training. Northern Ontario School of Medicine (NOSM) uses Distributed Community Engaged Learning: an instructional

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<sup>4</sup> Full biography available in Appendix 3

model that allows widely distributed human and instructional resources to be utilised independent of time and place in community partner locations across the North. The Saguenay medical education campus of Université de Sherbrooke uses the Practice Based Learning Sherbrooke curriculum with specifically trained local resources and interactive videoconferencing for large group activities. Clerkship is offered in regional sites.

Professor Snadden highlighted some of the characteristics of Rural/Northern Regional Campuses stating that the majority of education is in a rural/northern context, the admissions processes are weighted to rural applicants, the distances to partner sites can be large (1000km), community support is high and there are robust links to partner sites by audio visual technology for educational delivery. There are 3 Faculty of Medicine Campus locations within university campus, 25 additional sites in 6 health authorities across the province and approximately 25 more sites planned by 2010. In terms of student selection the NMP uses an evaluation instrument; Rural and Remote Suitability Score (RRSS) to identify and select candidates most likely to fit the culture of the educational setting; and students express a site preference. Students enter the standardised UBC admissions process and the RRSS is applied to the admissible pool to identify those with a profile more suitable for education in the NMP. The RRSS seeks to identify: experience in Rural and Northern environments; recreational pursuits compatible with rural/northern life and/or rural/northern ties. The class profile of the NMP for the past 5 years shows a high number of students of rural/northern origin and the destination of the first two residency matches shows the majority have ended up in either Family Medicine or Family Medicine Rural environments.

Professor Snadden stressed that the NMP is not just about educating students, but is also interlinked with the sustainability of rural communities. He concluded his presentation by outlining the findings of the NMP Impact Study by Hanlon et al, Community Development Institute UNBC 2008. This study showed that the NMP has created social learning environments that can produce change, has an impact on recruitment, that medical education has a contribution to make to quality improvement and enhancement of patient care, but that it is essential for the programme to be accompanied with resources commensurate to the task.

Questions by delegates revealed the similarities of issues in remote and rural Scotland with those of northern BC and these included recruitment and retention challenges, the fact that practitioners need to have the skills to manage emergencies until help can arrive with the range being from 4 hours to 3 days for help to arrive in BC. The Ambulance Service in BC provides a Medivac Service which has rotary and fixed wing aircraft, but the adverse weather

conditions such as snow and temperatures of minus 30 degrees centigrade can mean that it can be up to 3 days before a patient can be evacuated.

## **Workshops – Converting Policy into Practice**

### **Obligate Network Workshop**

The Obligate Network workshop aimed to provide participants with an understanding of the concept of the Obligate Networks and provided an operational perspective from the emerging Mental Health and Learning Disabilities Obligate Network, established between NHS Orkney, NHS Shetland and NHS Grampian, covering general adult psychiatry, psychiatry of old age and learning disabilities. This included early information from the formal evaluation of that network, funded by the Joint Improvement Team (JIT), and the practical challenges experienced in establishing the Learning Disability Obligate Network.

#### **What is an Obligate Network?**

Dr Annie Ingram explained that the need for formalised networks was a key theme repeated by practitioners across remote and rural areas during the development of Delivering for Remote and Rural Healthcare. What such a network might be required, however, to be further defined. In March 2009, guidance was issued by Derek Feeley, Director of Healthcare Strategy and Dr Roger Gibbins, Chair of RRIG that defined an obligate network as:

“A formalised arrangement between two or more healthcare organisation’s that secures access to sustainable services for the whole population...”<sup>5</sup>

Three different types of Network, of varying degrees of sophistication are identified in the guidance: An Obligate Network (ON) that provides clinical decision support, an ON that provides both Clinical Decision Support and a visiting service; or an ON that operates as a virtual department and includes joint appointments. Obligate Networks are more formalised

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<sup>5</sup> (2009) “Framework for Obligate Networks” letter of 4<sup>th</sup> March 2009 to NHS Chief Executives from Derek Feeley, Director of Healthcare Strategy and Dr Roger Gibbins, Chair of RRIG

arrangements than the more traditional Managed Clinical Network, which concentrate on clinical outcomes and service improvement without direct accountability for service delivery. Obligate Networks exist to ensure continued service delivery.

Obligate Networks provide a range of clinical benefits, to clinicians, to patients, for education and ensuring the overall governance of the clinical system. Some of the benefits identified are detailed in the table below.

<b>Support to Clinicians</b>	<b>Patient and Access benefits</b>
<ul style="list-style-type: none"> <li>• Clinical decision making</li> <li>• Emergency management</li> <li>• Skill sharing</li> <li>• Inclusivity</li> </ul>	<ul style="list-style-type: none"> <li>• More rapid access</li> <li>• Less travel to expertise</li> <li>• Better distribution and utilisation of service</li> <li>• Shorter waiting times</li> </ul>
<b>Educational Benefits</b>	<b>Governance</b>
<ul style="list-style-type: none"> <li>• Shared learning</li> <li>• Common learning pathways</li> <li>• Development and maintenance of skills</li> <li>• Inclusivity and sense of belonging to a wider network</li> </ul>	<ul style="list-style-type: none"> <li>• Setting standards</li> <li>• Audit</li> <li>• Improving and adjusting Standards</li> </ul>

There are however a number of challenges to delivery including agreement between Boards, the engagement of clinical staff and the recognition of need for such an approach. Money is also an issue.

### **Setting Up an Obligate Network**

Dr Harriet Mowat of Mowat Research Ltd has been funded by the Joint Improvement Team (JIT) of Scottish Government, in partnership with RRIIG, to undertake a process evaluation of the establishment of the Mental Health and Learning Disabilities Obligate Network between NHS Orkney, NHS Shetland and NHS Grampian and presented emerging findings to the group.

This Obligate Network was the first Obligate Network to be established and both JIT and RRIIG recognised the importance of learning from the process. Using an action research approach, Dr Mowat intended that the process of evaluation would to facilitate the generation

of new knowledge, changes to practice, solve problems and provide a safe environment through which the managers from each NHS system could learn and improve the service overall.

She reported initial resistance to the formalised process of setting up an Obligate Network group, but through the goal orientated and action focussed approach, the managers involved from across each health system had begun to recognise the value of relationships and working together to improve the services. Early findings suggest that relationships are important for the approach to be successful; the current approach of Service Level Agreements (SLAs) are insufficient for the purposes of the Obligate Network and will need attention; and that both the underlying principles and the impact on practice needs to be understood.

The word obligation was seen by members of the group as particularly powerful, with the concept of obligation providing a moral responsibility, that prevents partners from walking away, goes further and was seen as better than the traditional MCN approach.

In practice, the Obligate Network has delivered training, exchanges and shadowing, has improved communication and identified a range of agreed actions, particularly to improve patient pathways and develop a more patient centred approach. The evaluation is still ongoing and a final report will be available in early 2010.

### **Improvements to Learning Disability Services**

Susan Carr, Service Manager for Learning Disabilities with NHS Grampian shared with delegates the approach and successes of the Obligate Network approach for all three Boards for Learning Disability services.

Shared understanding, including visits to each area within the network for all was seen as vital preparatory work to ensure shared knowledge of the issues facing each service and identification of shared challenges and priorities for action. The listening and learning process, reviewing and agreeing the way forward was important in building relationships.

Key agreements include:

- Partnership approach to identification of health needs for people with a learning disability to promote appropriate access to specialist staff in particular;
- Shared communication training to promote a common approach to supporting clients with challenging behaviour;

- Joint needs assessment for clients with challenging behaviours;
- Development of a Dementia pathway for clients with a learning disability;
- Development of the special interest roles for Learning Disability Nurses, for the benefit of the whole network; and
- Potential to widen the scope of the network and engage the wider healthcare team.

## Discussion

Discussion focussed on the cultural shift necessary to embed the concept of Obligate Networks within the structures of Boards, as a normal way of doing business. This included recognition that whilst services in one Board may be working well, in another Board that may not be the case. There was recognition that the corporate Scotland approach required partnerships between Boards to deliver care for the benefit of patients. The group recognised that Obligate Networks can exist between Boards but also might be required within Boards.

It was stressed that the guidance applied equally to all Boards but there was concern that the guidance was not easily accessible on the SHOW website.

The group recognised that there were a number of practical issues to be resolved in the establishment of an Obligate Network and some of these were quite complex.

- Clinical leadership, potentially from a distance and possibly across Board boundaries;
- Governance, particularly clinical governance;
- Accountability, especially if something goes wrong;
- Protectionism – making sure everyone plays in;
- Defining the exact nature of the obligation;
- Formalising agreements on the responsibilities of partners;
- Ensuring it is a 14 NHS Board issue.

Delegates were asked what RRIG could do to unblock any potential issues and it was suggested that RRIG should:

1. Ensure that the importance of the Obligate Network approach is reinforced to all Boards;
2. Support the notion that the Obligate Network approach is the way to do business in the future;
3. Remind Boards of the Obligate Networks required as necessary by Delivering for Remote and Rural Healthcare. These are defined as required to support the core

services of surgery, medicine and anaesthesia within the RGHS; and to support radiology, laboratory services, Child Health and Mental Health services in remote and rural areas.

## Care Pathways Workshop

Professor Andrew Sim, Consultant General Surgeon in the Western Isles is the Clinical Lead of the Service Models and Care Pathways Group and has undertaken a huge amount of work on drafting high level pathways for the acute hospital in the remote and rural setting. Professor Sim was unfortunately unable to attend the event and so Dr Charlie Siderfin, Lead General Practitioner (GP) in acute Medicine for the Balfour Hospital in Orkney and also a member of the Care Pathways workstream presented this session. He began by reminding delegates of the recommendation made in DFRRHC that:

*"Patients should receive the same standards of care  
for common conditions irrespective of where they live"*

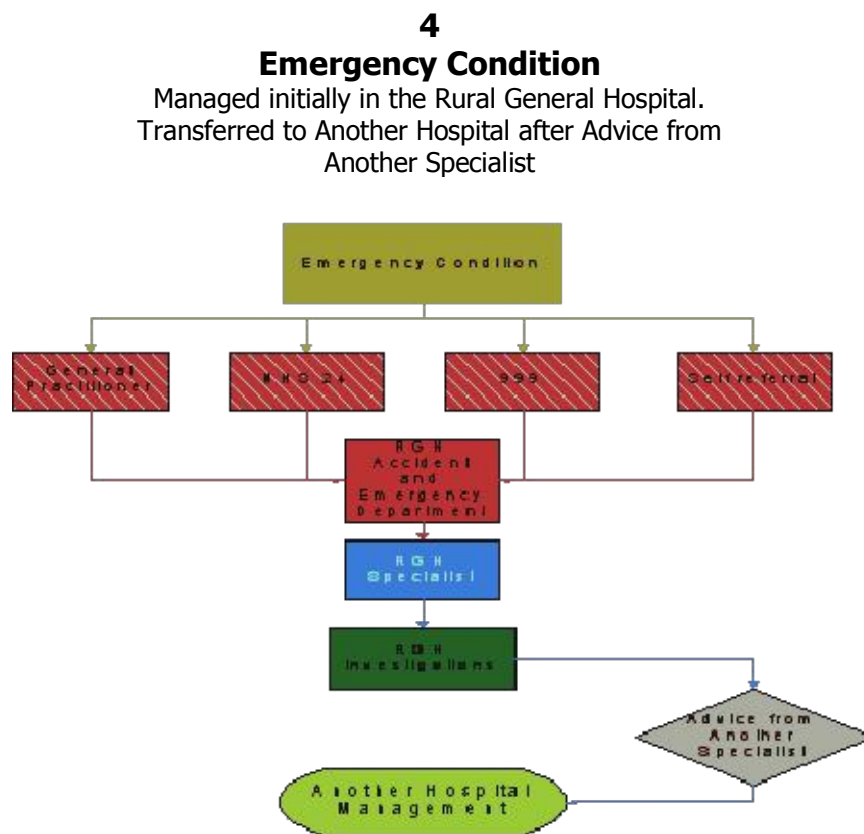
The recommendations of Delivering for Remote and Rural Healthcare required RRIG to take a lead role in the development of care pathways for common conditions, generally referred to RGHS. In response, the Care Pathways workstream was established and a small group of professionals supported Professor Sim in the development of draft pathways. Dr Siderfin explained that the High level Pathways for the Acute Hospital are aimed at a specific audience which includes the SGHD, health service managers, trainee doctors and other healthcare professionals, particularly those new in post, patients and members of the public. Dr Siderfin questioned whether these pathways may also have a role in helping Community Hospitals define what conditions they are able to treat locally.

He highlighted that the Pathways are still very much a work in progress, are set at a very high level and designed to be underpinned by protocols which would be developed in local systems. The Pathways are split into 3 Referral Pathway Groups of: Urgent or Non-urgent pathways (7 in total); Emergency pathways (4); and Malignant pathways (6).

Dr Siderfin expanded on the detail to show the elements used in the design of the High level Pathways. These are:

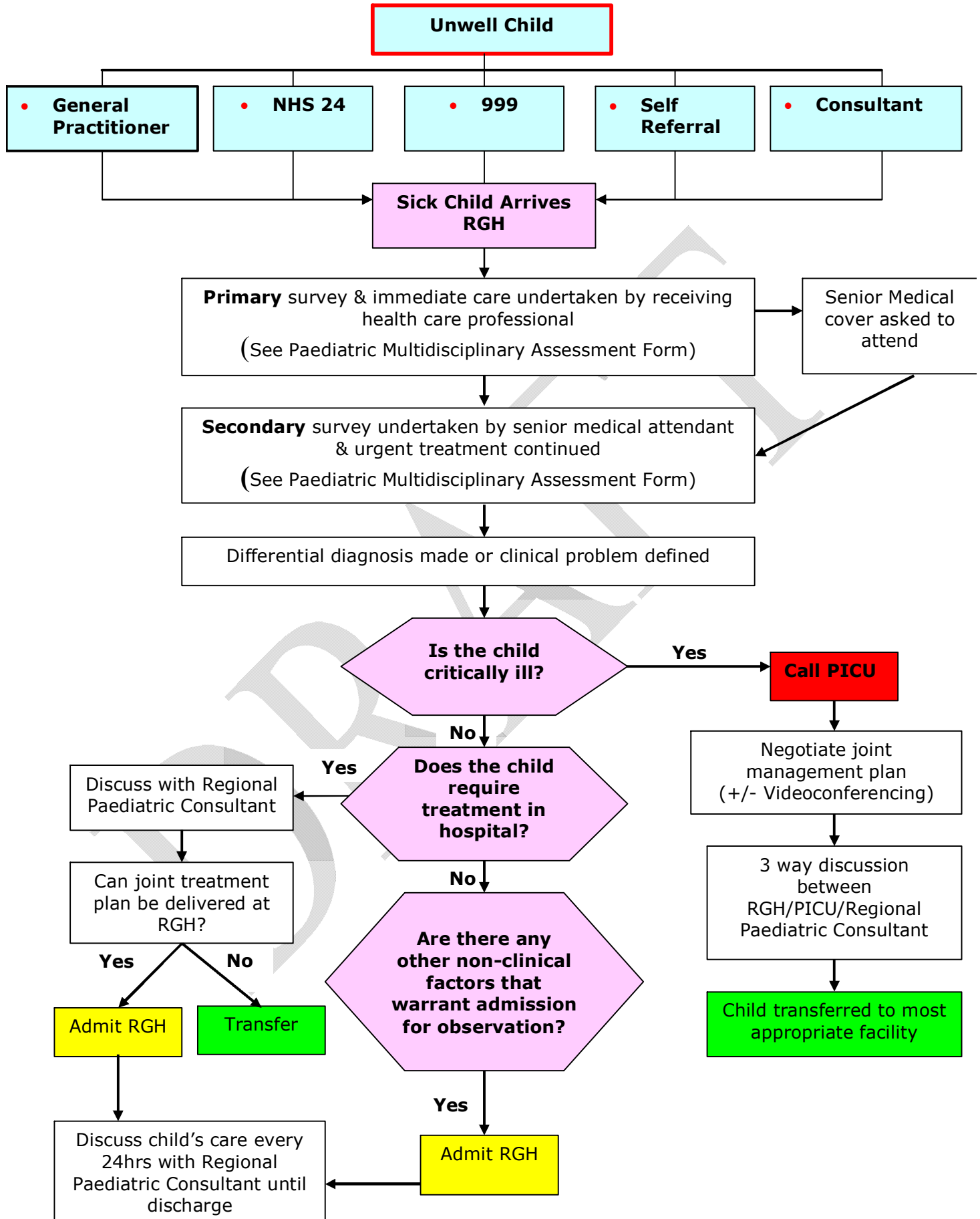
- **Presenting condition** - Urgent/Non urgent, Emergency and Malignant
- **First point of access to healthcare services** – primary care practitioner, NHS 24, 999, A&E
- **Initial specialist referral** - RGH specialist, visiting specialist, another specialist
- **Subsequent advice/referral** - visiting specialist, another specialist
- **Investigation** - Rural General Hospital or Another hospital
- **Management** - Rural General Hospital or Another Hospital.

An example of a high level pathway for an emergency condition is shown below:



Dr Siderfin then explained that the purpose of these Pathways is to provide clarity of care pathway between the rural hospital and tertiary (obligate) centre, provide uniformity across RGHS and Community Hospitals, provide clear guidance to clinicians and provide a degree of protection to clinicians providing services outside the normal remit of their speciality. Dr Siderfin used the example of paediatrics and a protocol for care of the unwell child which is illustrated below.

# Emergency Child Admission Protocol



Dr Siderfin described how the high level Pathway might be supported by more detailed Care protocols. The purpose of the detailed protocols is, by regular joint reviews of the protocols with specialist consultants in the relevant fields, this will ensure that treatment remains up to date with current evidence. The protocols will act as an aide memoir for clinicians, can be used in teaching and service delivery by juniors, provide guidance and a degree of protection to clinicians providing care outside the normal remit of their speciality, provide clarity of care pathway between rural hospital and tertiary (obligate) centre, and help provide the same standard of care irrespective of where patients live. Dr Siderfin stressed that the protocols should be modified to reflect local situations. He suggested that a central repository of protocols should be made available for adoption and adaptation by rural hospitals.

Dr Siderfin concluded his presentation by demonstrating how a Protocol had been developed jointly between GPs in Orkney and Cardiologists in Aberdeen for the management of Acute Coronary Syndrome (NSTEMI).

Mr Bill McKerrow, RRIIG Clinical Lead facilitated the discussion, inviting attendees to consider the following questions and the general discussion has been summarised under the question headings:

**Are the care pathways useful to: the SGHD, Managers, New Junior Doctors, Patients and the Public?**

While the facilitator did not focus on any one of the above groups in particular the following general comments were made which could apply to all or any:

- In the context of developing an underpinning principle in terms of access to care, the general concept of clinical pathways appears to be appealing and amenable to the process of implementation.
- The consistency of approach and content (common sections) was seen to be of value whereby each pathway was developed by focusing on: condition; first point of access; first clinician attending to the patient (do they have suitable experience, knowledge and skills?); subsequent advice and referral; management of condition. However, it was appreciated that conditions may be managed in different ways depending on the path of their presentation.
- Using pathways, protocols **AND** the experience of appropriate practitioners is very helpful in determining what the right decision is with respect to appropriate admission.
- It is essential to know the "system" without becoming overwhelmed or "bogged down" by the detail i.e. valuable to know where to go, who to contact, what to do

etc. It is important to know what services are where and this is sometimes as important as the clinical information contained within care pathways and protocols.. Therefore, the value of pathways and protocols lie in their ability to present the "system" in a clear and consistent manner.

- Pathways and protocols are very relevant to non-specialist staff/new staff/inexperienced staff who, on occasion, are required to provide a service that would routinely be provided by specialists.
- The benefit of developing care pathways and protocols is that the process defines appropriate interventions and aims to ensure that the same level and quality of care is delivered irrespective of location and setting.
- The practical experience of using care pathways is poor with factors of accessibility, use-ability of flow charts, and the perception that they demean and de-professionalize practitioners/clinicians being viewed as barriers to implementation. When developing care pathways, promoting engagement, ownership and agreement across and within professions is perhaps one way to overcome these barriers (linked to Question 2).
- Care pathways satisfy managerial and clinical agendas as they have the potential to provide the common denominator to join up the whole of the NHS. They have the potential to minimise/remove: duplication; waste of resources; and time if using appropriately and correctly. However, there is an assumption that by developing a pathway/protocol it will automatically work, which is not necessarily true and it is the benefit of working through this developmental process, in a dynamic way, that will provide the opportunity to engage with and involve clinicians and managers and improve the system overall.
- Detailed pathways are useful in terms of both promoting confidence amongst clinicians and ensuring aspects of clinical governance, safety and professional protection.
- Engagement with clinicians in the development and implementation of pathways and protocols could be through a revalidation/training process. Taking responsibility for, and ownership of, the part of the pathway they work in will also aid clinician engagement.
- Patient and Public empowerment is important and thus pathways and protocols can also serve as a useful and enabling tool to engage with the public and patients by providing information on where an individual can expect to be in their care pathway and what to expect in terms of service delivery and standard of care.
- Many community general surgical cases require straightforward procedures and a significant number of such procedures could be carried out as day cases. Therefore, by developing appropriate and relevant care pathways and protocols, many day cases

could be carried out confidently as part of routine practice within a Primary Care/GP surgery setting. This would also provide the opportunity to increase the skill-mix of Primary Care Practitioners and the confidence of their patients by providing this type of service as close to the patient's home as possible and within surroundings that the patient is familiar and feels comfortable and confident with (linked to Question 2).

- It is important to consider two particular components of care pathways: timing of the pathways/protocols and how each fits into each care setting along the continuum of the patient pathway and experience and clinical treatment of patients.

A general question was raised in terms of the involvement of the Scottish Ambulance Service (SAS) and NHS24, and the joint clinical assessment being developed. The question was, will the RGH always be in the loop of access or could the first point of access be in the form of going direct to, for example, a District General Hospital (DGH) or tertiary centre? The response to this question was that this will be dependent on geography and location.

### **Do the pathways have a role in helping Community Hospitals define what conditions they are able to treat locally?**

- It is important to know what services are where and this is sometimes as important as the clinical information contained within care pathways and protocols. Developing pathways that clearly specify where to go, who to contact and what should be treated where should help to define the conditions that can be treated locally within and across specific health care settings

### **What changes (if any) are required to the care pathways?**

- There are currently 3 types of Referral Pathway Groups (RPGs) - "urgent" or "non-urgent"; "emergency"; and "malignant" - with differing levels of detail, form and function i.e. (1) high level pathways; (2) more detailed pathways/protocols of care; and (3) detailed local clinical protocols. It may be more appropriate to have only 2 types of RPGs i.e. "planned" and "emergency", or "urgent" and "non-urgent" depending on preferred terminology. Having only 2 RPGs may avoid any inference and potential confusion that it is acceptable to care for patients outside specified target times if they present with any conditions/categories falling outside of the above RPGs (especially in the case of the "malignant" RPG). This comment is linked to Question 1 in terms of the potential for revised RPGs and pathways to assist the Gatekeepers of the Pathway in deciding the most appropriate care pathway whether that be within the Community setting or at the hospital door.

### **How would you use the care pathways in your area?**

- To identify where to go, who to contact, what to do etc. and the appropriate interventions relating to each stage of care..
- To provide relevant and key information to all types of clinician i.e. specialist/non-specialist staff; experienced/inexperienced staff.
- To promote a consistency of approach and ensure that the same level and quality of care is delivered irrespective of location and setting.

### **Have you developed local protocols in your area and if so, for what conditions?**

- Subject not discussed in great detail.
- Some examples were provided of protocols which were used in the acute sector including a protocol of triage assessment within an A&E department of a large teaching hospital; and another used by the Scottish Centre for Telehealth.

### **How can RRIG help in sharing pathways or protocols which have been developed?**

- A key issue is the accessibility of protocols. Electronic access was the preferred method of access and dissemination. Therefore, the efficiency and reliability of associated IT systems is critical to the successful sharing of pathways and/or protocols. A potential role for RRIG would be to act as a repository of pathways and protocols whereby an up-to-date version of each could be held centrally.
- There may be a risk of developing pathways and protocols in isolation. Hence, the value of RRIG would be in working with services in a supportive and conjoined manner to guide the process of pathway development in a timely, appropriate and effective manner.

### **Are there other ways that RRIG could support work in your area and if so what are they?**

- RRIG could support the process of engagement, ownership and responsibility by highlighting the part of the care pathway for which each professional/specialty is most directly involved. This support could be provided in the form of RRIG giving strategic direction and guidance on the role, importance and need for the implementation of integrated care pathways and protocols across care settings in remote and rural areas.

## **Emergency Response and Transport Workshop**

Mrs Fiona Grant, Remote and Rural Programme Manager and Mr Ian Donald presented the work of RRIg's Emergency Response and Transport's (ER&T) workstream. The background to the work was explained in that Delivering for Remote and Rural Healthcare<sup>6</sup> was developed using a consultative approach, involving practitioners and representatives of the public. One common theme that emerged, for more detailed study, was the capacity of the NHS to respond in emergency or urgent situations and there was concern that this had the potential to impact on the outcomes for patients. It was recognised, however, that response in an emergency situation presented significant challenges to territorial NHS Boards and in particular, to the Scottish Ambulance Service (SAS) as a Special Health Board to provide an appropriate accident and emergency response, when presented with such diverse geography.

An audit was commissioned as part of the development process for Delivering for Remote & Rural Healthcare, in collaboration with SAS, the results of which showed delays in responses to patients with conditions requiring an emergency or urgent response, in the remote and rural areas studied, and the potential for an adverse impact on clinical outcome. It was subsequently recommended that 'robust and responsive local community emergency response systems should be developed' and this recommendation was accepted.

The Remote and Rural Implementation Group (RRIG) established an Emergency Response and Transport (ER&T) workstream to progress the implementation of these recommendations. The RRIG ER&T workstream was a multi-disciplinary group of health professionals and lay people, including patient representatives, General Practitioners (GPs), representatives from the Scottish Ambulance Service (SAS), NHS Boards and Community Health Partnerships (CHPs), Scottish Government Health Department (SGHD), Senior NHS Management, the Centre for Rural Health and other stakeholders.

Around the same time, the then Chairman of the Scottish Ambulance Service, Bill Brackenridge, identified that there was variation in the response to the emergency and urgent care needs in Scotland's islands and asked that RRIG include a review of island services and develop options for new models. This proposal was endorsed by the Government's Healthcare Policy and Strategy Directorate and included within the project plan for the workstream. RRIG approved the proposal of the Group to extend this further to review

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<sup>6</sup> (2007) Delivering for Remote and Rural Healthcare, The Final Report of the Remote and Rural Steering Group Nov 2007  
SGHD ISBN B56045 05/0

models of emergency and urgent response across remote and rural Scotland due to the synergies between remote and rural mainland communities with island settings.

Following agreement of the Project Plan, the group, commissioned a Literature Review of the Types of Emergency and Urgent Response available within the UK and in other countries; mapped the current emergency and urgent service provision across remote and rural Scotland; developed Standards for Emergency and Urgent Response, supported by a Framework of possible response models for remote and rural communities; which provided the basis for the Strategic Options Framework.

This Strategic Options Framework (SOF) for Emergency and Urgent Response to remote and rural communities is designed for use as a tool to be used by the SAS, in partnership with NHS Boards, CHPs and local communities, to establish, over time, a response appropriate to local circumstances. The Framework includes guidance on how to use the Framework and more detailed information on the defined responsibilities of NHS organisations, the standards to be achieved and the types of response that might be introduced.

A full report of how the SOF was developed, including the mapping of the current service, the literature review, the drafting process for the standards and types of response; an overview of the engagement feedback, costs of implementing and not implementing models and full recommendations is shown in what is being described as the Strategic Options Framework Technical Annex can be accessed at [www.nospg.nhsscotland.com](http://www.nospg.nhsscotland.com).

Mrs Grant introduced Mrs Julie Ann Flynn, Head of Primary Care, Perth and Kinross CHP, explaining that Mrs Flynn would present an example of where policy had been converted into practice using the example of the introduction of First Responders into the Kinloch Rannoch area.

Mrs Flynn began her presentation by giving an overview of the Perth and Kinross CHP including its geographical context, demography, location of provision of clinical services in the area and emergency and urgent response activity. The historical context of Kinloch Rannoch was provided. Until April 2004, General Practitioners (GPs) in Scotland had 24 hour responsibility for the care of their own patients which, outside normal hours, the GPs delivered themselves or delegated this to another doctor through collaborative arrangements such as out of hours co-operatives. Since the 1<sup>st</sup> of April 2004, the Primary Medical Services (Scotland) Act 2004 placed a duty of NHS Boards to provide 'primary medical services' for their populations either through direct provision or by contract or agreement with a range of providers through indirect provision involving specific arrangements. Integral to these new

arrangements was the ability of GPs to continue to provide services during the out of hours period or to 'opt out' of such provision where acceptable alternative services can be provided. Where GP practices exercise their right to opt out they give up their personal responsibility for out of hours services for the population. In so doing the NHS Board has a duty to meet the standards established by NHS QIS. In response, NHS Tayside consulted GP Practices across their area to establish their intentions with regard to provision of 24 hour care for their patients. Consistent with the rest of Scotland, the vast majority of practices in Tayside decided to 'opt out' of the provision of out of hours care and this responsibility passed to NHS Tayside. One exception was the Kinloch Rannoch Practice, a single handed practice covering a population of around 595 patients which continued to provide out of hours services as a level 1 provider under locally negotiated General Medical Services (GMS) contract arrangements, an arrangement was made at this time with the practice and NHS Tayside to defer the 'opt out' for 12 months.

In 2007, the GP in Kinloch Rannoch decided to retire. The post was advertised and some applications were received but with only limited out of hour service provision proposals. The application was awarded to the existing Aberfeldy Practice. Some members of the local community were unhappy since the original decision to allow GPs to 'opt out' was taken in 2006 and the new 'merged' arrangements of Aberfeldy and Kinloch Rannoch and continuation of out of ours provision from NHS Tayside escalated the concerns of some of the community. The CHP responded by undertaking a consultation exercise with the local community of Kinloch Rannoch. An initial meeting was held with contractors, service providers and stakeholders; three public open spaced events were also held with the community, councillors and providers. It emerged that the community's main concerns were not with day to day healthcare provision, but concerns focussed around feeling safe and not having, in their view a responsive emergency service. The CHP presented a number of options to the community in 2008:

- the status quo;
- provision of GP out of hours service 24/7 located in Kinloch Rannoch;
- provision of community paramedic for out of hours, located in Kinloch Rannoch; and
- support to establish a First Responder Scheme for out of hours emergency response (whilst awaiting the attendance of an emergency ambulance).

These options were assessed against three key criteria: safe, sustainable and economically supportable. Measures for Improvement were also examined and these were: to improve ease of access to local responsive emergency services; to reduce potential risks to patients awaiting emergency response; and to compliment safe and effective out of hours services. A community event was held in October of 2007 at which the Chairman of the NHS Tayside Board concluded that the Board would consider the options discussed together with the public

comments in March of 2008. The NHS Board paper of March stated that "the business case seeks to recommend to the NHS Board that safe, sustainable and economical supportable solutions to improve emergency response within the community of Kinloch Rannoch. Any proposals to be taken forward will be done in collaboration with a reference group as part of a one year pilot to test the change". The outcome of this was that Option 4 was selected (First Responders Scheme) and a multi-agency reference group established to take forward the preferred option which would include community representatives and that an independent evaluation was to be part of the process.

This Evaluation is to be undertaken by the Centre for Rural Health (CRH) and would take the form of a desk based review of existing literature in the United Kingdom and beyond on First Responder Schemes, methods of engaging rural communities and innovation in the delivery of services. Resource to fund this Evaluation was provided from RRIG, the SAS and NHS Tayside.

Mrs Flynn reported that a number of challenges were experienced throughout the whole process including: the dependency on other agencies/stakeholders; elements of the Public/community /council; Members of Scottish Parliament Letters and enquiries; misconceptions, misinterpretations, misrepresentations, request via the Freedom of Information Act; media attention and resulting press releases. It was Mrs Flynn's view, that the SOF may have taken the 'sting' out of the Kinloch Rannoch situation had it been developed at that time, as it could have been a useful tool, having been developed nationally and based on what evidence is available. The current situation is that a reference group has been established and have met 6 times since December 2008 and regular community updates are circulated to every household in Kinloch Rannoch. The community First Responder Scheme was established and commenced with eight volunteers in August 2009. A full and comprehensive Evaluation is being undertaken by the CRH. There is also support being provided by the British Association of Immediate Care (BASICs) Scotland provision within Aberfeldy and Kinloch Rannoch Practice areas, within normal working hours.

The workshop then moved into the discussion session, with the main focus being on the First Responders Scheme and the problems experienced in engaging with communities. Common themes which emerged were that there is support for creating resilience within communities. Support was also shown for the Emergency Medical Retrieval Service (EMRS) but that this has to be balanced with the need to retain some skills locally. Members supported the SOF with expressions of the need to have the Standards formalised in some way and for progress on implementation to be closely monitored. Concerns were raised on the funding implications for new models, training and skills maintenance.

## Workforce Workshop

Mrs Anne Gent, Lead of the RRIg Workforce workstream and Director of Human Resources NHS Highland Chaired the Workforce workshop and introduced Mrs Betty Flynn, Regional Nursing Workforce and Workload Advisor, Workforce Programme Manager for the NoSPG, who has been providing project support to the workstream. Mrs Flynn opened her presentation with a quote from DFRRHC:

*'Team working, integration and shared competencies  
are key to the future of staffing of services  
within remote and rural healthcare.'*

She continued by stating that the development of a sustainable and affordable workforce will involve working creatively to deliver new models of skill mix and interventions that are safe, effective and patient centred. Multi-professional initiatives will be required across all the professions. DFRRHC made a number of commitments including: the development and co-location of integrated health and social care teams, known as Extended Community Care Teams (ECCTs); reviewing of skill mix in Community Resource Hubs and RGHs; the development of generalists, role expansion and Practitioners with a Specialist Interest (PwSI) working within a network and where there is a defined health need.

Mrs Flynn outlined a number of forward issues which were highlighted in DFRRHC such as the reviewing of working patterns within larger centres so that the needs of the RGH can be supported and some formal evaluation of new roles. The range of practitioners who should be available within remote and rural healthcare systems was explained by Mrs Flynn using the Remote and Rural Staffing Model from DFRRHC and its related Levels of competences detailed.

The presentation concluded by stressing the importance of having a sustainable workforce that is capable of delivering services to meet the needs of patients and that patients are cared for in an appropriate environment by a workforce that provides safe and effective care.

Mrs Gent thanked Mrs Flynn for here workforce policy presentation and introduced Mrs Gill McVicar who is the General Manager for the North Community Health Partnership of NHS Highland and would talk about how the new role of Rural Physician had been introduced in the Belford Hospital, which is an RGH in Fort William.

The background to the development of the Rural Physician role was summarised by Mrs McVicar in that the Remote and Rural Steering Group had a tri-partite arrangement with the Academy of Royal Colleges and NHS Education for Scotland to establish a Rural Training Pathways Group whose remit was to ensure that bespoke medical training pathways were developed. However, there were some 'here and now' issues and what was described as the 5<sup>th</sup> Workstream was established to address these issues. This workstream applied for proleptic appointment funding from the Scottish Government to test some innovative approaches to the development of a sustainable medical workforce in RGHs and Community Hospitals.

Mrs McVicar described three initiatives with similar outcomes, but different ways of achieving this. The first was in NHS Orkney where it had been decided to focus on increasing service provision, knowledge and skills of GPs working in the acute hospital, linking with NHS Grampian for supervision, mentoring and appraisal. The second of the initiatives was in the mid Argyll Hospital in Lochgilphead who choose to concentrate on the development of competences for General Practitioners (GPs) working in intermediate care. The last initiative was in the Belford Hospital where the role of GP/Physician was to be developed and this is the subject of today's presentation. The rationale for introducing a Rural Physician, Mrs McVicar explained included the following:

- 75% in patient and 87% emergency activity in the RGH is of medical origin;
- Better anticipatory care;
- Better and more coordinated management of long term conditions;
- Better integration;
- Patient centred case management and pathways;
- Minimum of 3 Consultants for rota;
- Insufficient work; and
- There is a change in emphasis in medical training which is producing fewer generalists.

The vision of creating a Rural Physician role was outlined by Mrs McVicar. It is to build sustainability, protect standards and quality, develop a consultant protected model supported by a team based competency approach which utilises the ECCTs and works across the traditional primary/ secondary care boundaries to improve unscheduled care. The key aims of the service are to train a GP with MRCP in post by a combination of in house and placements to Level 2 in acute/general medicine; to ensure that future requirements of the area are met by encouraging a wider than normal approach to recruitment; to design a post that is a good fit with local needs; to ensure the sustainability of the medical service within the RGH; to make strong links with the wider health and social care teams; to strengthen the

rehabilitation/ re enablement potential at local level; to develop a career pathway; facilitation of a formal network approach to skills maintenance and finally to exploit the potential for integrated workforce planning.

Mrs McVicar summarised her presentation stating that the 'GP Plus' physician can function at advanced medicine level and provide a greater range of services in a hospital than the acute physician alone. Training is possible after final certification CCT/CCTGP and modular credentialing is the way forward to provide the future workforce with the ability and recognition to adapt to the needs of their particular rural hospital. She stressed that time in job planning must be allowed for real development of careers for physicians and GPs in rural areas to cover as many bases as possible at national standards. Finally, Mrs McVicar concluded that the deliverer of care must be nationally recognised as no different from another provider in a major conurbation, through skills acquisition and credentialing, peer review, audit and managed clinical networks.

Mrs Gent then opened discussion to delegates by asking them how much they were aware of the RRIg workstream and of the issues raised within the two presentations they had heard. Attendees responded that they know something about parts of the agenda. One person commented that there are a few GPs with MRCP but it is unlikely that others will choose this as a career path. However others responded that they knew GPs who were either working towards this or were willing to work towards it. Discussions continued to include that whilst the model is being tested currently, it also needs to evolve. A 'shopping list' of necessary skills and competences is required based on the health needs of that community before the role is developed locally.

Perth and Kinross CHP reported that NHS Tayside has a bespoke training programme for GPs in Community Hospitals, the first year of which is currently being evaluated. The outcome of this evaluation will be used to negotiate a SLA with the GP practice (instead of a contract with individual GP) and the Local Negotiating Committee is involved in this. NHS Tayside's aspiration is to have a physician linked to each community hospital. Responses to this information demonstrated that a national contract would be helpful.

The discussion then revolved around the RGH workforce and in particular the impact of the reduction in availability of doctors in training to service delivery and that this is driving the agenda to move towards different models of service delivery. Challenges and opportunities which this situation presents are that it highlights the fragility and vulnerability of services in the RGH, but presents opportunities to introduce new models of service delivery. These could include the service being delivered wholly by trained doctors, or for different

practitioners to deliver, supported by trained doctors – an option which is being described as the 'consultant protected model'. Mrs Flynn explained the workforce tool which can be used to predict the impact on service delivery if there is a 25% and 40% reduction of doctors in training. She added that there is a need to plan how these numbers are replaced; for example, is there a need to replace all of the numbers or just some of them and if so what do we replace them with? Mrs Flynn cautioned that it may not be as simple as just replacing them with Nurse Practitioners, as there are also recruitment issues within the nursing profession. The general view was that it will take 5-10 years before any new workforce is available and therefore how do we deliver the service in the short term? This view was reinforced with comments that it will not be possible to train others to do what doctors do in the timeframe that is available.

NES explained that they are looking at what programmes people want and that this will be done at a local basis; it is not a national piece of work. However, NES proposed that what is really being created is a specialist generalist, who will have transferrable skills and that this would need to incorporate all professional groups who will also need to be able and willing. A concern was raised that these people will be trained up and perhaps in 10 years' time doctors will again become available – what happens then? Mrs Gent raised the issue that some new workforce models will require extra resource. A suggestion was made that NES should ring fence some funding to resource remote and rural training. However there were opposing views that this would not be possible as the whole country will be struggling to sustain services let alone change workforce.

Attendees stressed the urgent need to identify what needs to be done and who can therefore do it; with a caution that newly trained nurses cannot be left to be in charge of wards/departments in order to release senior staff to work on this. Telehealth links provide opportunities, however proleptic appointments seem like far away Disney Land.

One potential solution is to extend the current Night Nurse Practitioners model to a 24/7 service. In addition, further integration of secondary and primary care presents opportunities. In effect the RGH was described as a mini DGH with one front door providing a combined assessment unit and therefore does not need juniors in each speciality.

Mrs Alison Burns, Locality Manager, Stranraer CHP explained that the new Galloway Hospital is in a particularly difficult situation being neither an RGH nor a DGH. Its Hospital Practitioners need a higher level of skill than GP training, but there is no bespoke training out there. Out of Hours doctors currently look after the hospital; however this is not sustainable due to working time intensity. They are looking at introducing an Advanced Nurse

Practitioner and that these individuals can manage a more acute case mix if the right clinical decision support is available, for example through telemedicine.

## **Emergency Medical Retrieval Service Workshop**

Dr Alasdair Corfield, Consultant in Emergency and Retrieval Medicine commenced his presentation by explaining that the Emergency Medical Retrieval Service (EMRS) is an 18 month pilot covering the west coast of Scotland and is subject to a formal Evaluation which has been commissioned by the Scottish Government to examine the clinical and cost effectiveness of the service, to present a preferred option for a possible future service which incorporates the needs of the whole of remote and rural Scotland.

The 'chain of survival' was shown by Dr Corfield to be sequential, including good quality pre-hospital and intermediate care, timely stabilisation and critical care interventions, direct triage and safe transfer. This 'chain of survival' can be affected by the interventions of a number of practitioners who may not have the appropriate skills or their skills may be atrophied due to low exposure to such situations. The result of this can be delayed stabilisation of the patient, sub-optimal triage to definitive care and therefore possible deterioration during transfer. Dr Corfield went on to explain the retrieval process which consist of a referral from any rural healthcare practitioner which could be a doctor, nurse or paramedic to a Retrieval Consultant which may result in advice only or in the patient being retrieved and taken to definitive care.

Dr Corfield provided examples of on site interventions which could be provided by the EMRS team as follows:

- Emergency anaesthesia;
- Ventilation (invasive & NIV);
- Chest injury management;
- Cardiac pacing;
- Invasive monitoring;
- Inotropic /vasopressor support;
- Near patient testing;
- Emergency surgical procedures; and
- Therapeutic hypothermia.

A clinical governance structure is in place within the EMRS which was outlined by Dr Corfield to include the provision of personal protective equipment, general equipment management,

training, debriefs, adverse incident reporting, standard operating procedures, audit, clinical governance meetings and clinical risk management.

Dr Corfield gave practical examples from patients on how the EMRS had impacted on their clinical outcomes and subsequent quality of life. In terms of general support for rural practitioners Dr Corfield covered the service that EMRS provides:

- Equity of access to critical care provision;
- Improved safety and standard of transfer of critically ill;
- Optimal triage;
- Critical Care Network;
- Improvement in survival and functional outcome;
- Improved training and empowerment for rural healthcare professionals; and
- Major incident management.

Dr Corfield then gave an outline of the formal West coast EMRS Pilot stating that in one year there had been 409 patient contacts of which 222 were patient retrievals and 187 detailed advice calls. All of those patients were of a high level of clinical acuity and there had been very positive feedback on the EMRS received from rural practitioners. Over relatively small time period the EMRS has moved from an ad hoc service into a voluntary service covering Argyll and Bute which then received partial funding. The Scottish Government then funded an 18 month pilot for the west coast of Scotland and during that time the team have expanded into primary retrieval where that service has been requested. The report of the formal Evaluation of EMRS is due at the end of November and a decision will be taken thereafter by the Scottish Government regarding the future of the service and of possible funding models for this should the service be continued.

Dr Corfield concluded by outlining some challenges and opportunities faced by the EMRS and these were:

### **Challenges**

Fiscal constraints  
Matching EMRS to local work patterns  
Complex geography and weather  
Scotland  
Expensive solution to an unrecognised problem  
Multi-agency working

### **Opportunities**

Expansion to cover all of remote and rural Scotland  
Added value for the wider NHS  
Enhanced primary retrieval service  
Links with national services such as Spinal Injuries

Dr Corfield introduced Dr Mike Hall, Clinical Director in Argyll and Bute and GP in Campbeltown Hospital who would present his experience as a referring practitioner to the EMRS using one specific real example. Dr Hall began by explaining the geographical situation of Campbeltown; it is 138 miles from its tertiary centre in Glasgow, a journey which takes 3 hours and 15 minutes by road in normal weather conditions. Campbeltown Hospital provides GP delivered care, has 39 beds of which 19 are designated as acute beds, has a new Accident and Emergency Department which opened in 2008 and the hospital has imaging facilities and near patient testing on site. Transfers from the hospital are undertaken by road, fixed wing and helicopter. 90% of these transfers are well enough for a paramedics to escort them, however 10% of them require the more specialised skills of a retrieval team. Dr Hall then covered the detail of the specific clinical situation he was faced with one Christmas Eve which occurred during the voluntary phase of the EMRS. A 32 year old fire fighter had been cycling to work at 6.15 in the morning and because of the icy road condition, went head first through the windscreen of a parked car. Initial assessment of the patient showed a wound on the right side of his neck which was bleeding profusely, his hear rate was 160 beats per minute and his blood pressure was very low, all of which pointed to the patient being in a state of severe shock. He was resuscitated by the GP and nursing staff and fluids and a blood transfusion commenced. The EMRS was contacted and advice provided on how to administer hypotensive resuscitation, whilst a consultant, registrar and paramedic were deployed by helicopter. When the EMRS Team arrived on the scene the patient was distressed and they were unable to asses the wound. An emergency general anaesthetic (GA) was therefore administered to control pain, reduce anxiety and control the patient's blood pressure and allow management of the bleeding. After the patient was under GA, examination of the wound revealed that the jugular vein had been transected. The wound was packed and sutured by the EMRS Team which controlled the bleeding; 8 units of blood were transfused and an arterial line inserted. Dr Hall explained that paramedics do not have the skill to carry out any of the interventions detailed as undertaken by the EMRS team. Thereafter the patient was retrieved, bypassing the normal referral centre (Southern General Hospital) and taken directly from Campbeltown to the operating theatre in the Western Infirmary in Glasgow. This journey directly to definitive care was possible because the EMRS Team had assessed the patient, recognised the need for specialist surgery and discussed the patient directly with a consultant cardiothoracic surgeon and a consultant vascular surgeon at the Western Infirmary. The outcome is that this patient has now made a full recovery and has returned to work. Dr hall concluded his presentation by reporting that Campbeltown had to

date experienced 55 retrievals from the EMRS, 22 of which have been in the past year. In addition 36 advice only call have been made, 19 of which occurred in the past year.

Dr Corfield then facilitated a discussion structured around specific questions. Responses from delegates have been captured in the bulleted points noted below each question.

**To what extent is there a need for a service like EMRS in remote and rural Scotland generally?**

- Big benefit – one person to organise all the necessary care and equipment etc.
- Training and support of rural doctors is very important.
- Losing resources – can lose staff for 4 to 5 hours in an emergency/when escorting patients. With an EMRS transfer this is avoided.
- Don't have a feel for every alternative means of providing the service – will only have a feel for cost effectiveness of the service to balance with alternative means of providing the service, e.g. different responses for different areas.
- Major challenges around financing the service.
- No alternative in rural areas but to airlift – many alternatives in urban areas.

**What is your view of the Service? In terms of:**

- **Process – advice service, dispatch times, availability, etc?**
- **Outcomes – short term and longer term?**
- **Value for Money – any views on this?**
  
- Outcome measures tend to be in terms of crude mortality measures. EMRS patients have had better survival outcomes than would be expected for that cohort of patients.
- Evaluation – how do we link the benefits of this service with models that are evolving throughout RGHS – needs to be built into evaluation.
- Questions around how one captures the financial benefits of the service – being grappled with at present.
- Significant advantages in looking at all retrieval services together, e.g. EMRS, paed, neonatal, etc.
- Different to air ambulance service in England which isn't totally integrated into NHS.
- Can we explore different means of financing, e.g. charitable donations? Would this be politically correct?

**What should be used as performance measures for the Service? How can the data for these be effectively collated (possible prompts – patient outcomes, survival rates, improve QuALY and relative value for money intervention).**

- Issues around how you react to demand.
- How appropriate are the calls?
- How many calls received?
- Impact of training in the communities?

**What effect would funding this service have on existing services in the receiving or referring hospitals?**

*This question wasn't addressed in the discussion*

**What is the best way to resource this Service?**

- NRAC basis for the percentage of people who live more than an hour from a DGH with ITU.
- Centrally – from the SGHD
- Fly M&S packages to Campbeltown when retrieving there!!

**EMRS is currently being piloted in the west coast of Scotland and is based in Glasgow. How would you like to see the Service develop?**

- The existing service should be developed and expanded so that it can be provided to all areas that are outwith an hour from a DGH with ITU.

**What added value do you think a national Service could deliver outwith remote and rural Scotland?**

- Redesign OOH services as a result of EMRS being further developed.
- Social return on investment – cost benefits.
- Rural regeneration and resilience.

**Is there any potential for integration with other specialist transfer Services?**

- Yes. Would make it more cost effective.

## Other Comments:

- There should be synergy between the DTZ review and the outcome of the other retrieval service reviews.

## Exploring the Remote and Rural Network Workshop

Mrs Fiona Grant, Remote and Rural Programme Manager and Mr Bill McKerrow, RRIG Clinical Lead jointly presented the workshop on 'Exploring the Remote and rural Network'. Mrs Grant commenced the presentation with a definition of an Obligate Network:

*A formalised arrangement, between two or more healthcare organisations that secures access to sustainable services for the whole population....*

*Obligate Networks – letter 4 March 2009*

Obligation arrangements may differ between services and are described in 3 levels. Level 1 is where the obligation may be limited to ensuring clear pathways of care, where more specialist diagnostics or treatments are not locally available and access to clinical decision support. Level 2 build on Level 1 arrangements by the provision of a visiting service alongside access to clinical decision support and Level 3 is more far reaching, with the creation of a virtual department, including joint appointments. These Levels are not prescriptive and the specific arrangements will need to be agreed on a speciality specific basis and may require larger departments to make significant changes to current working arrangements. Mrs Grant highlighted the differences between MCNs and ONs stating that MCNs concentrate on clinical outcome and service improvement, without direct accountability for service delivery, whereas Obligate Networks exist to ensure continued service delivery. She added that ONs can be vertical between different levels of service or lateral, for example between Rural RGHS.

The clinical benefits of ONs were listed by Mr McKerrow to include: support to clinicians, decision-making, emergency management, skill sharing and inclusivity. Improvements to access to care and benefits to patients are: less travel to access expertise, more rapid access, better distribution and utilisation of resource and shorter waiting times. There are also educational benefits including shared learning, common learning pathways, development and

maintenance of skills and inclusivity and a sense of belonging to a wider network. Obligate Networks also underpin governance in that they facilitate the setting of standards, audit and improving and adjusting standards

Mrs Grant continued the presentation posing the question as to whether the development of a Remote and Rural Network, as a legacy of RRIG may potentially have some additional benefits including peer support for local clinicians, sharing of good practice and the development of a central repository for information which would also prevent duplication of effort.

Ms Grant facilitated a discussion, inviting attendees to consider the following questions and the general discussion has been summarised under the question headings:

- **Do you see the need to develop a Remote and Rural Network and if so why?**

The general view was that some form of network would be useful, but that this may take the form of an electronic repository, with the ability to communicate through this medium with peers. Ideally a form of search engine for the 'Network site' would be useful so that practitioners or managers can find out whether an issue they are addressing has been implemented elsewhere, or indeed information on why it was not implemented. In other words the Network could be used for Action Learning and to share knowledge. The Patient Safety Programme Model was quoted as a good example to replicate. Attendees expressed the view that such a resource would be invaluable, but would need to be managed in order to make it useable and up to date. The consensus view is that RRIG should have a role in brokering such a Network.

There was, however, a real concern to avoid the creation of more bureaucracy through the development of yet another Network and so strong support for the 'virtual network' model described above.

- **What would the Remote and Rural Network look like?**

A 'Virtual Network' as described above should incorporate the whole spectrum of care to remote and rural communities, for example, community care, primary care, community hospitals and RGHS.

- **If you were going to develop a Remote and Rural Network – how would you go about it?**

Attendees suggested that resources and knowledge available through existing structures should be used such as the Association of Community Hospitals and adoption of the Patient Safety Programme Model as the methodology for developing the Virtual Network.

- **Who would need to be involved?**

Delegates expressed a wish that if this Network is to be developed, it should be done so on a multi-agency basis and include practitioners from across the whole continuum of care.

## **Education Workshop**

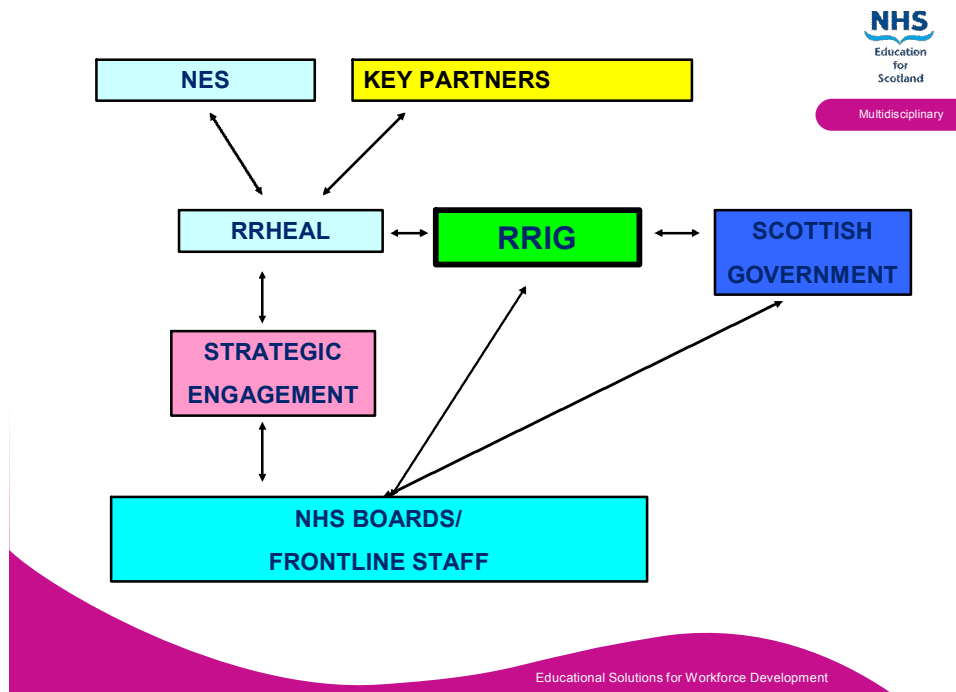
Mrs Pam Nicoll, Programme Director of the Remote and Rural Healthcare Educational Alliance (RRHEAL) began her presentation by explaining that the RRIG Workforce and Education Subgroup is jointly Chaired by herself and Mrs Betty Flynn, Regional Nursing Workforce and Workload Advisor, Workforce Programme Manager for the NoSPG and described the group's collaboration with NHS Education for Scotland (NES) as a Special Health Board. Mrs Nicoll gave the historical context of the development of RRHEAL, explaining that its establishment was driven by the following policies: The 'Kerr Report' in 2005, which stated "how can we provide safe and sustainable services that will support rural communities?"; Kerr was adopted as government policy as Delivering for Health in 2005 which made a proposal for a 'Virtual School of Rural Healthcare'. However NES consultation with stakeholders across Scotland in 2006 showed the requirement instead for the creation of what was called the RRHEAL which should be supported by a Rural Managed Educational Network and sit within NES. The requirement for RRHEAL was further endorsed in Delivering for Remote and Rural Healthcare 2007 and thereafter in Better Health, Better Care in 2007.

Mrs Nicoll continued by explaining that RRHEAL is designed:

- to provide a linking role between services and educational providers;
- to build on NES current work streams;
- to address the need for a coordinated approach to the development of NES Remote and Rural activity; and

- be a sustainable structure supporting rural education for the NHS in Scotland for the future.

RRHEAL would achieve its aims by addressing educational solutions in a multi-profession way, using a national approach and by working alongside mainstream NES. Mrs Nicoll described the structural relationships of RRHEAL as outlined in the diagram below.



Mrs Nicoll explained that the commitments of RRHEAL which were made in DFRRHC's Implementation Plan have been adopted by RRHEAL and NES and these are that education programmes will be responsive and specific to needs of remote and rural practitioners and where possible, accredited. RRHEAL will establish a collective system to gather remote and rural priority needs and assist education providers to provide accessible and appropriate education programmes. The main initial priorities for RRHEAL to address were also set out in DFRRHC's Implementation plan, namely to support education for remote and rural practitioners working in Radiography, Child Health and in particular Emergency Care, Laboratories, Mental Health Crisis, to support Allied Health Professionals (AHPs) and Nurses with Special Interest, evaluate the GP Hybrid /Acute Medicine role and support the development of the Generic/Rural Support Worker who will work across health and social care.

There are a large number of stakeholders, Mrs Nicoll explained, that RRHEAL have to work with including RRIG, NES leads, NHS Boards, Educational providers, Skills for Health and many others and the mix of these stakeholders will change depending upon which educational programme is to be developed. Mrs Nicoll introduced Mrs Gillian Swan, Educational Projects Manager, RRHEAL who proceeded to provide an example of where RRHEAL is supporting an NHS Board to implement a new role; NHS Shetland and the development of the Generic Support Worker (GSW). This project has been supported through NES resource to identify the characteristics, attributes and competencies of a GSW. RRHEAL has represented the North of Scotland NHS Boards in this endeavour. Competences were mapped using a Skills for Health toolkit and matched to the Career Framework. Discussions were held on the dimensions of the role the challenges in terms and conditions identified. Opportunities were also highlighted and a vision formed and a report drafted on the findings. A consensus event was held in March 2009 and the actions which fell out of this were as follows:

- RRHEAL to identify education packages;
- RRIG to scope remote and rural areas to check/confirm the understanding of what is required is up to date; and
- RRHEAL to identify the education programme/ model that represents a national accredited route, linked into the National Framework, a partnership approach with SSSC, COLEG and SQA.

Mrs Swan stated that in addition RRHEAL/NES/GSW Group had to establish ways of the GSW keeping up to date with supervision, undertake a structured discussion between NHS Boards and the JIT. There was also a requirement to communicate relevant reports for example CRH/SfH 'Care for older people'; 'SGHD Regulation report'; and SQA document on mentorship to the majority of the stakeholders listed previously.

Mrs Swan concluded by saying that the development of the GSW will produce the following benefits:

- Patient benefits: locally delivered care fit for setting increased continuity of care.
- Service benefits: efficient use of available workforce and skills, training budgets, more flexible workforce to meet changing demands and demography.
- Staff benefits: locally relevant contribution to the community, training at national standard, mapped to both Career and Knowledge and Skills Frameworks.

Mrs Nicoll invited attendees at the workshop to comments on a number of specific questions and the responses to these are listed below.

## **NES Remote and Rural Action plans:**

**Is RRHEAL responsive to NHS remote and rural needs for education?** Delegates expressed the view that it is clear that RRHEAL are regarding education needs priorities of NHS Boards, but that they could be more responsive. There is a need for a Medical workforce Summit to include people working in RGHS, Community Hospitals and rural GPs. This Summit is required to identify solutions/training/education. Its purpose would be to capture rural GP needs and actions, look at skills mix including education to support more generalist physician assistant roles where required.

**Is NES/RRHEAL pro-active?** Comments stressed the need for RRHEAL to assist with raising remote and rural issues around rural GP specific education needs and related revalidation issues. They added that the Obligate Network structure should be used to support for education needs to ensure sustainable services. Delegates requested that RRHEAL keep RRIG informed of (Remote Education for Communities Health) RE4CH progress. This is a RRHEAL led proposal to develop a "distributed Education system for Scotland", enabling increased access to a greater range of high quality education for remote and rural practitioners on a permanent basis.

**General Issues** which were identified via discussions were:

- problems recruiting to junior doctor training slots within Rural Hospitals. There were specific requests from NHS Highland and NHS Grampian to work closely with NES (with RRHEAL input) on resolving the vacancy problem and looking at how these posts could be designed to be more attractive;
- the IT infrastructure to support videoconferencing (VC) and remote learning is not good enough, particularly in relation to bandwidth. NES's own VC facilities and their 'ad-hoc' management also needs to be improved and a more professional 'joined up' IT infrastructure put in place;
- remote and Rural Boards need options to be able to move away from total reliance on GP led rural services and the education for new/extended/enhanced roles needs to be 'rural proofed' to ensure they are fit for purpose within the context of rural services that in future may or may not be led by doctors; and
- education for Healthcare Support Workers also needs to be 'rural proofed'.

## Remote and Rural Board priorities and themes:

- **Re-shaping the medical workforce:** current junior doctor roles within Rural General Hospitals are unsustainable and there is a recruitment 'crisis' e.g. for hospitals in Wick and Elgin. These posts need to be re-designed (or re-configured into different posts) which fit into the 'sustainable workforce' with 'generalist' skills in order to deliver a core set of services identified through the re-design process. Rural general and community hospitals can be consultant led with training grades or GP led with GP trainees.
- **Developing a sustainable workforce:** reshaping the medical workforce needs to happen as part of the wider workforce development in support of service re-design. Remote and rural Boards need to be able to decide the best make-up of the workforce e.g. for Rural General and Community hospitals, in terms of delivering a core set of agreed services. NES (with RRHEAL input) can then support service re-design and a re-shape of the workforce through development of education for new, enhanced and extended 'generalist' roles.
- **A single NES 'Distributed learning platform':** NES could support a single point of entry or 'shared learning platform' for our learning resources. This should be a 'Distributed Education System'(RE4CH) providing high quality blended learning; work based learning, e-learning and formal educational programmes in partnership with local further and higher education in a 'UHI' type model where NHS staff can attend college or University and access their learning resources through a NES portal. A potential integrated 'single point of entry' makes use of the NES e-Library/Knowledge Services portal.

## Education Workshop General Discussion Points:

- **Dementia Specialists:** a question was raised about what they are allowed to do, how we address this. The response was that this could be achieved through partnerships and their expertise and matched to regulation/registration/A4C KSF.
- **Rehabilitation Specialists:** NHS Borders asked about delivery on the Rehabilitation agenda in remote and rural area and commented on satisfaction with RRHEAL work on development of Rural Support worker.
- **HEI Scotland's Colleges:** comments on lack of perceived connect with national health policy. RRHEAL working with Scotland's Colleges, COLEG and individual HEIs to assist with connection with remote and rural NHS workforce needs and policy drivers.

- **Rural Health Practitioner:** a question raised as to whether this role was still being developed. It was explained that this would be a multi-professional worker across the organisations to teach/follow client to meet general needs from both health social care. Discussed focus on education to support more generalist roles within specific professions overall but highlighted the similarities with multi professional /multi agency Rural Support Worker developments.
- **Education Objectives for Doctors:** concerns were raised around lack of education to support or produce doctors who can then cope with remote and rural practice. The GP/ Hybrid role was used as an example and how strategic engagement is required to work out how we make these people fit for purpose. Other concerns were raised including validation for GPs so that they do not fall off the career perch and that this is fundamental to recruitment. A comment was made that new recruits find practice daunting. Clinical Decision support resource was raised as a requirement for Arran and Galloway.
- **GP Hybrid/Acute Medicine:** It was emphasised that this is a national education objective. RRHEAL has been asked to describe and evaluate current GP education and training underway to support local service needs in remote and rural areas. This study will assist in illustrating needs for an accredited education route with PMETB and demonstrate range and variety of training currently in place. Challenges are to achieve education before placing practitioner in the remote and rural setting.

## **Integrated Out of Hours Health and Social Care Services Workshop**

Dr Margaret Whoriskey, Assistant director of the JIT and Mr Tony Homer, JIT Associate, presented the results of the 'Review of Service Development and Innovation in the Delivery of Joint Health and Social Care and Support Services in Remote and rural Areas' which had been undertaken in May of this year. Dr Whoriskey stated that there are geographic, financial and demographic challenges which have implications for models of care. She illustrated the demographic context to the Review in some charts, the first of which showed the Health Improvement Efficiency and Access Targets (HEAT) one of which is to reduce emergency admission bed day rates for people aged 65+ by 10% by 2011. She challenged delegates to 'think the unthinkable', for example what if these trends continue unabated into the future, spurred on exclusively as a consequence of Scotland's increasingly ageing population? Specifically, what would happen if emergency admission rates by age group remained constant - and the historic trend in reducing average lengths of stay faltered? Dr Whoriskey

theorised that the consequence of this would be an 84% increase in demand for in patient beds. She continued to present data on people aged 65 years and over according to three care approaches; NHS Continuing Care, Care Home residents and people living at home receiving Home Care and how if this same data is detailed by age band, it illustrates the far greater proportion of people aged 85 and over who are receiving these services.

Dr Whoriskey explained some of the work that the JIT are involved in which includes supporting local health and social care partnerships, national development programmes, the reshaping older people programme, shifting the balance of care programme and have recently had the opportunity to support the RRIG programme and engage stakeholders across health and social care.

Dr Whoriskey explained that this Review was commissioned by the JIT in conjunction with the RRIG to consider how different local partnerships are addressing the principal themes within the national health and social care policy agenda, with particular reference to joint working and integration in service delivery in rural and remote areas. It sought to identify examples of good practice and innovation in service delivery with a focus upon services that are delivered to people at home or in their local communities, including approaches to community capacity building. A total of 12 areas were invited to participate in the study, 8 of which were able to contribute to the 2 stage fieldwork phase. The first phase of the project, involved gathering information on health and social care policy and practice from the 8 partnerships which included mainland and island rural areas. Second phase interviews focused upon integrated working, supporting more people at home and out-of-hours community health and social care services, and the extent to which they enabled local partners to address current policy priorities regarding reducing hospital admissions, delayed discharges and more generally, shifting the balance of care.

Dr Whoriskey outlined the key challenges which were highlighted in the Review. In every area, the structure of population distribution had a significant bearing on the capacity of local health and social care agencies to deliver community based services. However, whilst issues relating to geography and population spread were an inimitable feature of remote and rural areas, their impact varied hugely both within and between different areas. Delivering greater equality of outcome for all service users was a key objective for all of the statutory partners across the areas included in this review. However, this did not translate into equality in the delivered service that people received. There were widely acknowledged tensions between providing local, easily accessible services and having access to specialist services that may be further away from home. Although by no means an exclusively remote and rural issue, rural communities seemed to identify more closely with long established services and facilities such as GP practice locations, even to the extent of resisting having services brought closer to their

homes in some instances. Small populations and the lack of critical mass were another common feature of rural and remote areas and as such were an ever-present challenge in designing affordable and sustainable services. Overnight care was an example where lack of sufficient demand was considered to render a service prohibitively expensive and thereby non viable, resulting in the service not being developed. The provision of urgent assistance also posed difficulties relating to the cost of delays in responding to other calls whilst dealing with the urgent call. The recruitment and deployment of front-line care staff was a key issue in all of the study areas. The shifting age distribution in remote and rural areas, with fewer younger people and more older people, was adding to service demand on the one hand, whilst creating additional challenges for staffing on the other. A widely reported issue for all services was the greater capacity for disruption to services in rural areas arising from staff turnover, where a single staff resignation can result in significant service disruption. A significant barrier to recruitment for professional staff was that there is often little choice but to relocate partners and/or families to take up a new job. Providing sufficient learning opportunities for skill retention and to meet mandatory Chronic Obstructive Pulmonary Disease (COPD) requirements can be difficult to arrange and expensive to deliver.

Strategies to address the challenges were suggested and these included:

- **Partnership and joint working:** including the provision of more effective services and better outcomes, looking at how to prevent potential professional isolation through Obligate Networks and maximising the role of voluntary organisations.
- **Increasing community services:** the development of co-location and integrated community care teams, the provision of routine night-time care, the importance of telecare and changes concerning care at home commissioning arrangements with the introduction of guaranteed service levels and reduced costs through revised contractual arrangements were all posed as enabling strategies.
- **Integrated services and equipment:** the development of intermediate care teams and resources in rural areas including integrated Occupational Therapy (OT) services and joint equipment stores were widely reported as reducing potential admissions as were Telecare links to assessment and care management and key-holder responder arrangements.
- **Care Homes and specialist housing:** the availability of small scale, financially sustainable and locally accessible schemes are key. The direction of travel is towards housing based solutions. Joint health and social care facilities are emerging in response to difficulties of meeting a sufficient spectrum of needs in care homes.
- **Workforce strategies:** Workforce was a widespread challenge due to demographics and skills/learning requirements. Solutions included annualised hours,

integrated team working and integration around personal care and healthcare roles and the Generic Support Worker (GSW) working across health and social care.

- **Community resilience:** all the areas reviewed had a range of services that had been developed through the voluntary sector. The overall picture is that the voluntary sector, working alongside statutory agencies, are better able to respond at short notice to changed demands whilst still retaining their ability to provide longer-term services. Little reference was made to significant developments and innovation in user and care engagement.

The key issues were summarised. One size does not fit all in rural and remote areas, there is a huge challenge in achieving change and in joining up the service, employment, infrastructure and social benefits. There are varying expectations in what constitutes a 'reasonable level of service'. Workforce integration is the key to delivering better services in many situations and service hubs offer potential revenue savings and integration benefits but may be limited by short term capital considerations. Developing community resilience could be the key to sustainable services and robust communities – substantial development activity is thin on the ground.

Dr Whoriskey concluded the presentation by outlining areas for future study. The issues are firstly, access to responsive, joined up health and social care services out-of-hours and secondly, the further development of joint front-line posts across health and social care. It is proposed that the next phase of this study should look in more detail at how these important issues can be addressed in two different rural and remote areas.

Discussion in this workshop revealed a strong message that an Out of Hours response is required for social care. Attendees acknowledged that urban models cannot be delivered in remote and rural communities, but that community hospitals (where there is one) could be used to support social care out of hours. Delegates expressed the view that the integration of health and social care is not progressing as well as it could.

### **Board Discussion Feedback – Day 1**

The Event had been structured to allow time for NHS Board delegates to discuss what they had learned from the Event Workshops and from that which of the examples could be implemented in their Board area. Boards were also asked to begin thinking about their

priorities and which of those cut across Board boundaries and would require assistance from RRIG.

Dr Gibbins Chaired the session and set the scene by stating that this is the last year of implementation of the recommendations from DFRRHC and that there is a need to use the policy to best effect. He invited a few Boards to feedback their key priorities from their discussions and these are summarised below.

**NHS Highland:** to focus on workforce planning and education, take a radical rethink of pathway redesign, be more adventurous and to look at competencies and not posts.

**Scottish Ambulance Service (SAS):** to implement the RRIG SOF in a prioritised manner including the development of local monitoring performance plans and to continue the 'health family' engagement process.

**NHS Orkney:** to implement the new emergency and urgent response models and to address the pressing issue of the lack of a local CT scanner.

The above Boards were also asked to identify what might be the priorities for RRIG in the last year of the programme. Responses included:

- RRIG should build a database of Obligate Networks and promote the accessibility of guidance on networks (perhaps through a Chief Executive's Letter);
- to evidence what the issues are for e-health in remote and rural areas and to make the case centrally and to ensure that retrieval services were available for very remote areas;
- to facilitate discussion on creating a sustainable workforce and specifically around the current challenges of reduction of doctors in training numbers, GP validation and how to redesign services.
- to influence the centre to support broader remote and rural sustainability by encouraging a joined up public sector approach to creating community resilience;
- to work more closely with the JIT to develop community services; and
- to create an exit strategy without unnecessary bureaucracy which should include a monitoring umbrella to measure progress on implementation of the SOF.

## Summary of Day 1

Dr Ingram explained that there were some common themes emerging and these are categorised under: Workforce and Education; Obligate Networks, Care Pathways; Emergency Response and Transport and e-Health and Infrastructure. Dr Ingram summarised the key issues emerging under each of the categories.

**Workforce** There is an imperative for robust workforce planning to be undertaken which is competency and not post driven. Doctors are still required as part of the workforce in remote and rural services and this will require sustainable training programmes and skills maintenance. The integration of Community Care Teams needs to be progressed. Building of resilience within communities is essential which will include 'growing our own' professionals. There is a need to be brave when redesigning services; 'think the unthinkable'.

**Education** Responsive solutions which are competency based and deliver the service requirement must be developed. It is acknowledged that it is not all about medics, but that they are an important component of the workforce therefore the previous points around sustainable training programmes and skills maintenance are reinforced. The Rural Fellowship Programme may need to be reviewed to ensure that it is fit for purpose following any redesign.

**Obligate Networks** There is a need for clarity around the resources required for the establishment of an Obligate Network. Formalisation of the status of Obligate Networks by the issuing of a Chief Executive's Letter would be helpful. Obligate Networks are a different way of doing business but should be viewed as the way forward. They are not just an issue for rural Boards, all 14 NHS Boards must engage. The e-health infrastructure connectivity needs to improve in order to support these Networks.

**Care Pathways** Care Pathways and Networks are a fundamental requirement to sustaining services; they play a vital role in business continuity. A balance is required to maintain local services and access specialist care. Care Pathways must extend to incorporate a multi-professional approach. The development of high level pathways into local protocols will require ownership and discussion. Patients should be involved in the development of Care Pathways as this helps them to understand the complexities of issues.

**Emergency Response and Transport** Community resilience needs to be retained. There is strong support for the EMRS, but a balance is required so that local services are not deskilled. There was general support for the SOF, with acknowledgement of the affordability issues; however there are needs to performance manage the implementation of the SOF. The standards for emergency and urgent response need to be formalised.

**E-Health and Infrastructure** The fundamental issue is that whatever form of e-health is being utilised – it **must** work. This means that the IT infrastructure needs to be sufficient to deliver the clinical needs.

### Reflection and Horizon Scanning

Professor Jane Farmer, Co-Director of the Centre for Rural Health, Research and Policy had been asked to reflect on the Event presentations and workshops and consider where the Implementation Programme of DFRRHC had reached and to undertake some horizon scanning in terms of where the evidence may suggest what the future priorities for Boards and RRIG should be.

Firstly, Professor Farmer asked the question 'what has been achieved?' She responded to this by stating that there were numerous examples of good practice which are happening, evidenced by the workshops and the storyboards; that there seems to be a 'buzz about the place'. Professor Farmer stated that when DFRRHC came out, she wondered what the term 'community resilience meant', however that term is now embedded in everyday use. Flexible working and competency based teams are the norm, but registration and regulation can be obstacles to such ways of working. In addition, when it comes to implementing such concepts within communities, it is more difficult. Professor Farmer suggested that although a new language had permeated into the consciousness of healthcare professionals, it has not yet reached communities. Good communication is required and tangible examples are needed to take to the community of how new ways of working do work in other areas. Professor Farmer reinforced a point made earlier in the Event, in that implementation is tough.

Integrated transport is an essential component to sustaining remote communities, asserted Professor Farmer. She gave the example of Colonsay who needed a post bus, an ambulance and hearse and asked why this could not be one vehicle for multiple use?

Professor Farmer expressed the view that there were some very interesting things happening, one of which had been illustrated in the presentation by Professor Snadden in Canada. She observed that the changes which had occurred there had been initiated by the power of 7,000 people protesting and that it would be great to get a similar level of public interest in healthcare in this country. Professor Farmer explained that such a vibrant University as was evident in British Columbia not only fulfilled the role of educating health professionals, but brought social and economic benefits when situated in rural areas. She added that it was interesting that Professor Snadden's Line Manager is the community, and that the community raises money to support the University. There are lessons to be learned from this model including 'growing our own' and the recognition of tensions between government policy and rural areas/professional guidance etc.

Reflecting again on why implementation is tough, Professor Farmer suggested that health professionals and managers are looking at things from a rational perspective, for example why did we not implement ONs years ago? Her experience in working with communities is that perceptions and personalities are different, there are emotive issues which have been built through experience and there is a need to work with communities, to sell to them what needs to be done.

Professor Farmer said there were major issues about to hit us, such as the huge reduction in numbers of doctors in training which will lead to operational delivery challenges, the lack of resources to place people in care homes leading to bed blocking. She expanded, there are 'elephants in the room' that must be addressed: the need to shift from a secondary to a primary care focus; the power of medics generally as a barrier to change; revalidation of GPs and the huge issue of lack of a robust IT infrastructure including limited broadband and mobile phone coverage undermining the possibilities of technological solutions.

On reviewing the Literature, Professor Farmer highlighted a number of pertinent issues including the need to build community resilience as small communities are struggling; she suggested that governance should be devolved to communities to allow them to make choices on the use of resources and to create social enterprise; the requirement for strong leadership; and asked how we cover gaps in communities, using the example of replacing GPs in the future with other multi-agency generalists. Professor Farmer reported that coming from the communities themselves is a will to build resilience, to support themselves through health improvement initiatives, improvement of self management, walking clubs etc. However, Professor Farmer cautioned that communities are not aware of policy that the Welfare State is withdrawing and communities need to understand that.

Professor Farmer explained the areas that the Centre for Rural Health, Research and Policy will be concentrating their research on as follows:

- e-Health.
- International Rural Health Observatory.
- Rights, entitlements, costs, taxes, 'equity'.
- Rural health economics.
- Models for small community resilience.
- New 'staffing'/transport, etc models.
- Exercise, nutrition, wellbeing.

In Professor Farmer's view, the next steps for RRIg should be to inform the public of the political realities, to raise the profile of remote and rural issues again with the Cabinet Secretary and to develop an exit strategy from RRIg which perhaps should include remote and rural issues in the HEAT targets. She suggested there is an urgency to 'just get on with it'; introducing adventurous new roles; developing people in communities and influencing the central agenda in terms of transport and IT infrastructure.

Delegates were asked whether they had any comments or questions about Professor Farmer's presentation. Professor Dave Godden, Co-Director of the Centre for Rural Health, Research and Policy reinforced the need to engage with the wider community because it is important for these communities to receive joined up services. He added that there needs to be a government framework for integrating the public sector and suggested that influencing the government on this could be a future role for RRIg. Dr Sarah Taylor, Director of Public Health and Planning in NHS Shetland asserted that the environment described by Professor Farmer is not a world that she recognises. She explained that in Shetland there are Community Councils where people living in these communities are shaping their services and that there is something about tapping into what is already there in terms of community movements and to promote and share the good practice that is happening across the patch. Professor Farmer responded by saying that where the Centre for Rural Health has been involved, it is usually because there is a problem around service delivery and that the approach has been too paternalistic and rather should be pro-active.

Dr Charlie Siderfin, Lead GP for Acute Medicine in NHS Orkney said he was struck by how Professor Snadden had informed us that he is accountable to the community, whereas in this country we have a Welfare State. He explained that it is also the case in Australia that communities pay for their own doctor, including his/her house etc. He suggested that there is a need to exploit the energy in community movements such as The Belford Action Group (TBAG) to be proactive in using that resource to shape services for the future. Dr Gibbins

raised the west Highland experience and how to turn that protest movement into a support movement. Professor Farmer responded by suggesting that there should be more sharing of issues with the community, explaining the complexities and that there are trade-offs, that it is not possible for them to have everything that they wish.

## **The Market Place**

The purpose of the Market Place was to allow delegates to share and learn good practice that is happening in territorial Boards, the SAS, the Scottish Centre for Telehealth, JIT and within the RRIG workstreams. Boards and the other organisations were asked to present a Storyboard highlighting good practice which had either directly been developed through implementation of the recommendations of DFRRHC, or were directly relevant to the policy. 20 Storyboards were received and electronic versions of these can be accessed via [www.nospg.nhsscotland.com](http://www.nospg.nhsscotland.com).

Boards were asked to identify one person to present their Storyboard and spread their other delegates around the Market Place. The presentations were repeated approximately 9 times, allowing time for most delegates to attend all of the Storyboards. Boards were then given time for discussion and to build on their discussions of the previous day, and to firm up their priorities in the form of an Action Plan, and to identify priorities for RRIG for the remaining year of the Implementation programme.

## **Board Discussions Feedback – Day 2**

Dr Gibbins invited Boards to feedback their key priorities from their discussions and these are summarised below.

**NHS Tayside:** Mr Bill Nicoll, General Manager, Perth and Kinross, CHP explained that before this Event, his CHP had not recognised the significance of the remote and rural agenda for their CHP and this needs to be raised with colleagues and formally with the Board. He added that Tayside was not really thinking of ONs and the opportunities that these present. Perth

and Kinross CHP wish to explore the concept of an ON for emergency response with the SAS. There is potential for Tayside to work across boundaries with North West Forth Valley and with Angus CHP. Mr Nicoll highlighted other priorities such as utilising DFRRHC policy to advance integrated concepts such as virtual wards, and reviewing Perth and Kinross' community hospital redesign to explore new roles from DFRRHC and also to review the range of diagnostic provision.

Dr Gibbins asked whether RRIG could support Perth and Kinross in any way and Mr Nicoll responded by saying he would reflect upon whether RRIG could help with raising the remote and rural agenda with Tayside Board, and stressed that the CHP wished to remain part of the remote and rural network.

**Forth Valley:** Alison Keir, North West Project Manager reported similar issues to those raised by Tayside in terms of not previously recognising the significance of the remote and rural agenda for their CHP and also the cross boundary issues. Mrs Keir explained that she would be making links with Orkney as they are developing services in a similar manner to themselves and could learn from one another. She added that RRIG's support in progressing the e-health infrastructure agenda would be appreciated and that RRIG could have a role in signposting good practice.

**Borders:** Mr Robbie Pennington, Team Leader, Dementia Services reported on behalf of NHS Borders, saying that the issues which had been raised by Boards previously were also applicable to Borders. He highlighted that Borders have a Strategic Change Programme which is looking at a range of issues including the integration of teams, the use of Care Homes as intermediate care resource and the review of community hospitals. RRHEAL would be approached to support in any workforce education issues arising from this. Mr Pennington stated that RRIG could help by acting as a single point of access for sharing good practice, as had been achieved at this Event and that closer working between JIT and RRIG would also be useful.

**Highland:** Mrs Gill McVicar, General Manager, Mid Highland CHP said that the ON sessions had been useful and that these would continue to be developed within Highland. Mrs McVicar reported having enjoyed the shared learning at the Event, but queried whether many of these examples of good practice would have occurred without the support of DFRRHC policy. She went on to say that in Highland it feels like CHPs are 'chipping at the edges'; there is a shelf in place, but there is now a need to take a radical approach based on Needs Assessment. Services need to be reviewed; "what do we need to do and where do we need to do it, think the unthinkable"; review the workforce and consider what skills and competences are

required rather than posts in order to ensure that services are sustainable for the future. Mrs McVicar's view is that current education systems are not fit for purpose and that they need to change. Modernising Medical Careers (MMC) is driving change and the solution is not doctors. Clarity is required between the roles of the NoSPG and RRIG and that duplication between them should be avoided. RRIG has a role in influencing the government to allow more flexibility, especially in the area of workforce contracts. Mrs McVicar proposed that RRIG should host a follow up conference nearing the end of the Implementation Programme. She also explained that a workforce that is fit for purpose is required and that there is an urgency to get stakeholders around this agenda. Mrs McVicar proposed that a summit be held on the core staffing needs for RGHS and Community Hospitals, suggesting that Day 1 could look at what do we need, and Day 2 could pull in other stakeholders such as SGHD/NES/RRHEAL to explore how we deliver this core workforce.

**Shetland:** Dr Taylor reported that Shetland has similar priorities to those already listed, but added that they have particular IT Infrastructure and transport challenges which RRIG could assist with by lobbying central government. She stressed that the different aspects of the public sector need to pull together to sustain small communities, and again RRIG could have a role in influencing this. Dr Taylor stated that this Event had been useful in sharing and learning about the good practice that is around and how some of the 'tricky issues' can be addressed, but made a plea for equitable involvement in events such as this. She agreed that there is a need for a summit to resolve some of the workforce issues and threats present in implementation of MMC.

**Orkney:** Mr Marthinus Roos, Medical Director, NHS Orkney reinforced Orkney congruence with issues raised previously. He added his support to the proposal to hold a Summit on workforce, explaining that in Orkney whilst staffing of the RGH is a challenge, the redesign of care in the northern isles into a network of care will include the need for extended roles. The establishment of an Emergency Response Network and integration of SAS staff into the Balfour Hospital are also priorities for Orkney. Dr Siderfin raised the issue that there are a number of GP led 'community hospitals plus' in remote and rural areas that need a forum to get together to debate a staffing model. He suggested that whilst this could be in the same event as RGH discussions, initial discussions need to be separate in order to avoid the 'head to head' situations which have occurred in the past between GPs and consultants.

**Western Isles:** Mrs Karen Tarn, Clinical Services Redesign Project Manager, NHS Western Isles welcomed the idea of having a Workforce Summit. She explained that the Western Isles' Clinical and Property Strategy was currently considering 3 options: the first was maintaining the status quo; the second was to move to the models outlined in DFRRHC and

the third was to extend the consultant led service. Mrs Tarn stated that there were plenty of examples of good practice which had been showcased at this Event and that she would take these back to the Board for further exploration. Current new ways of working locally included the impact of stroke thrombolysis in Barra, Lewis and Benbecula and the possibility of an outreach stroke ward in the Uist and Barra Hospital; the creation of an 'emergency' bed in a care home; work on the development of ONs in Diabetes and Radiology, but that she was unaware of what other Networks RRIG were asking to be developed..

Dr Gibbins explained that there was not a specific agenda for ONs, it was an evolutionary process for Boards and urban partners to use and explore what might be developed although as a minimum the core services of the RGH should be part of a lateral ON with a larger centre.

**D&G:** Mrs Alison Burns, Locality Manger, Stranraer, NHS Dumfries and Galloway faced similar issues to those raised. Specific priorities for them are a sustainable workforce for the New Galloway Community Hospital and this is not just about medics, but also includes nursing, Allied Health professionals (AHPs) and Biomedical Scientists. Support was therefore added for a Workforce Summit to be held. Mrs Burns explained that Stranraer is partnering with NHS Ayrshire and Arran to look at a Stroke ON. Dr Gordon Baird, GP, Stranraer expressed his view on the possible medical staffing models. These are either a consultant led model, or the use of GPs with added skills and that in his view the latter was more sustainable. He added that Stranraer, Orkney and Lochgilphead all face similar medical workforce issues.

**Lanarkshire:** Ms Marilyn Aitken, CHP General Manager, Clydesdale Locality, NHS Lanarkshire reported that they face similar issues to those raised by other NHS boards and that their CHP had to remember to 'fly the flag' as a rural area. She added that the local community hospital is looking at their admission criteria and will consider expanding on the RRIG care pathways work. Ms Aitken echoed views that RRIG has a role in brokering access to good practice across remote and rural areas.

**NES/RRHEAL:** Mrs Pam Nicoll, Programme Director, RRHEAL explained that the NES/RRHEAL Action Plan had to reflect the priorities of remote and rural Boards and those raised through RRIG and the Plan must be responsible and responsive. She added her wholehearted support for a Workforce Summit as there are a number of issues to be addressed, particularly around the medical workforce and GP re-validation. Mrs Nicoll reported an eagerness to use the ON structure to ensure that educational solutions are sustainable, for example ongoing competence and fitness to practice and increased use of the

education delivery models used in Canada which were demonstrated at the is Event. She suggested that the Managed Knowledge Network (MKN) could be used as a vehicle to share good practice, however that it would need to be adapted to build a single platform which would be accessible not only to healthcare professionals but also to social care professionals and those in the 3<sup>rd</sup> sector.

**Scottish Centre for Telehealth (SCT):** Mr Hunter, General Manager, SCT expressed the view that reflecting on the changes in service, there is a pressing need to do something about the IT infrastructure as there are still variations across remote and rural Scotland. He added that there is a need to build on what is already there and maximise its use.

**SAS:** Mr Sam Kennedy, General Manger, North, SAS expressed the view that as an organisation, the SAS needs to be more pro-active and when the SOF is signed off they can begin to practically implement this. This will involve a process of working with Boards and CHPs to prioritise what has to be implemented and will also require an increased capacity within the SAS to undertake this.

Dr Gibbins responded saying that there is a huge willingness within Boards and CHPs to collaborate with SAS colleagues and to implement the changes required.

**Greater Glasgow and Clyde and Lothian:** Ms Heather Knox, Regional Director of Planning, West of Scotland Planning Group (WoSPG) reported on behalf of colleagues. She said that it had been a very good event and that the Market Place session had worked particularly well. WoSPG and the South East and Tayside Planning Group (SEAT) which include the larger urban Boards will continue to work with rural Boards to support them and in particular around the development of ONs. Ms Knox suggested that RRIG's role was to support the national agenda and therefore RRIG should take on the workforce debate. She proposed that RRIG should address other national issues such as transport, retrieval and through EMRS and the Emergency Response and Transport workstreams explore the issue of providing clinical advice to the Emergency Medical Dispatch Centre (EMDC) in the SAS.

**Grampian:** Mr David Sullivan, Director of Planning reported that NHS Grampian recognises its' rural responsibility both internally as a Board and to work with other Boards as equal partners. Particular priorities are to use the RRIG Implementation Plan to progress ONs for Radiology, Laboratories, Surgery and Morbid Obesity services. Mr Sullivan suggested that there is still some ambiguity around ONs and that a solution might be to hold a 'one off' discussion to clarify these issues and then to stimulate the issue of a CEL on ONs.

Dr Gibbins requested that in order to facilitate that discuss Mr Sullivan provide detail to RRIG on exactly where the ambiguity is around ONs.

## **Next Steps**

Dr Ingram reflected on the outcomes of the Event and what the priorities are for taking forward. Her view is that people have valued the opportunity that the Event has provided to network with colleagues from other areas. She acknowledged the huge amount of work going on locally in redesigning services, enhancing of local services and repatriation of care into the community. Dr Ingram said that feedback had proposed a number of priorities for RRIG and had reinforced that RRIG's main role is to influence policy. She outlined the main priorities which had been highlighted:

### **Policy Influence:**

- promote remote and rural issues at policy level;
- influence the centre to support broader remote and rural sustainability by encouraging a joined up public sector approach to creating community resilience; and
- influence workforce policies.

### **Obligate Networks:**

- ensure that the importance of the Obligate Network approach is reinforced to all Boards;
- support the notion that the Obligate Network approach is the way to do business in the future;
- remind Boards of the Obligate Networks required as necessary by Delivering for Remote and Rural Healthcare. These are defined as required to support the core services of surgery, medicine and anaesthesia within the RGHS; and to support radiology, laboratory services, Child Health and Mental Health services in remote and rural areas;
- build a database of Obligate Networks; and
- stimulate a CEL.

### **Service Models and Care Pathways:**

- work more closely with JIT to integrate teams and services to sustain local care;

- encourage integration with Local Authorities, particularly in the area of out of hours health and social care service;
- ensure that models of care are integrated across traditional primary and secondary care boundaries and across community care;
- finalise High Level Care Pathways;
- encourage the development of local protocols, and
- co-ordinate the development of protocols through the creation of an electronic Directory of the Pathways and protocols which is accessible by all.

#### **Emergency Response and Transport:**

- support the implementation of the outcomes from the Evaluation of EMRS;
- encourage the building of community resilience;
- ensure the SOF is signed off;
- influence the formalisation of the SOF; and
- clarify the performance management arrangements for the implementation of SOF.

#### **Workforce and Education:**

- Encourage robust workforce planning based on competences not posts;
- host a Workforce Summit to establish core models;
- use outcomes of Summit to influence national policy
- ensure sustainable remote and rural medical training programmes are in place which reflect the needs of service;
- ensure educational solutions are developed to support the outcomes of the workforce summit;
- ensure that proleptic funding continues to be available to ensure sustainability of services in remote and rural areas;
- address the revalidation issue for GPs who are working over and above their GMS contracts;
- NES/RRHEAL to continue to pursue the accreditation of Level 2 in Acute Medicine and GP Intermediate Care competencies;
- creation of a single NES 'Distributed learning Platform'; and
- RRHEAL to work more closely with Higher Education Providers to ensure connect with National Health Service policy.

#### **e-Health and Infrastructure:**

- evidence the issue in relation to the IT infrastructure and it's limitations on practice;
- lobby the case for enhancing the IT infrastructure;

- influence the centre to support joint working with other aspects of the public sector and others to explore possible funding solutions for enhancing the IT infrastructure; and
- ensure that Scottish Government develop an integrated transport strategy.

#### **Remote and Rural Network:**

- A 'virtual' remote and rural network should be created which is accessible by all involved across the continuum of care. Existing resources such as the Association of Community Hospitals should be pulled on and a single electronic point of access developed to a Directory/information portal. This could be achieved using the methodology approach to the Patient Safety Programme Model.

#### **Exit Strategy**

- develop an exit strategy from RRIG which is not unnecessarily bureaucratic; and
- repeat this Event near the end of Implementation Programme.

### **Closing Remarks**

Dr Gibbins closed the Event with the following remarks. He stated that the next RRIG meeting is on the 24<sup>th</sup> of September and that RRIG can only be effective as a group if people attend and engage. He added that a summary note of business is drafted and distributed to Chief Executives after each meeting and asked members to reflect on how this summary note should be best used and to consider their Board's representation on RRIG. A draft report of the Event will be available at the September meeting and will be posted on the SHOW website at [www.nospg.nhsscotland.com](http://www.nospg.nhsscotland.com).

Dr Gibbins thanked delegates for their contributions and stated that he hoped the Event had re-energised the remote and rural Implementation Programme in their Boards. He concluded by stating that there are common themes emerging and RRIG will build on these.

## Appendix 1

### Delegate List

Forename	Surname	Title	Organisation
Jane	Farmer	Co Director	Centre for Rural Health
David	Godden	Research Fellow	Centre for Rural Health
Harriet	Mowat	Researcher	Mowat Research Ltd
Donald	Cameron	Head of Planning & Performance	NES
Pam	Nicoll	RRHEAL	NES
Jack	Rae	Board Member	NES
Gillian	Swan	Educational Projects Manager	NES
Peter	Baxter	Associate Medical Director	NHS 24
Malcolm	Kerr	GP	NHS Ayrshire & Arran
Bruce	McMaster	GP	NHS Ayrshire & Arran
Peter	Lerpiniere	Dementia Specialist Nurse	NHS Borders
Angie	Lloyd Jones	Rehabilitation Co-ordinator	NHS Borders
Robbie	Pennington	Team Leader - Dementia Services	NHS Borders
Gordon	Baird	GP	NHS Dumfries & Galloway
		General Manager - Wigtownshire & Stewartry Local Health Partnerships and D&G Out of Hours	
Alison	Burns		NHS Dumfries & Galloway
Mhairi	Hastings	Nurse Manager, Wigtownshire	NHS Dumfries & Galloway
Ken	McFadzean	Ambulance Manager	NHS Dumfries & Galloway
Joan	Pollard	Superintendent Physiotherapist	NHS Dumfries & Galloway
Ann	Alison	Tele-health Project Manager	NHS Forth Valley
Mary	Cameron	eHealth Manager	NHS Forth Valley
Pamela	Dimberline	Telecare Co-ordinator - Stirling Council	NHS Forth Valley
Charles	Jardine	GP	NHS Forth Valley
Alison	Keir	Project Manager	NHS Forth Valley NHS North West Forth Valley
Connie	Smith	District Nurse, Callander Health Centre	
Dave	Anderson	Head of Communications	NHS Grampian
Susan	Carr	Service Manager - Learning Disabilities	NHS Grampian
Alisdair	Chisholm	General Manager - Acute	NHS Grampian
Roelf	Dijkhuizen	Medical Director	NHS Grampian
Andrew	Fowlie	General Manager - Moray CHP	NHS Grampian
Karen	Gunn	Service Manager - Specialisms	NHS Grampian
Jamie	Hogg	Clinical Director	NHS Grampian
George	King	Unit Operational Manager	NHS Grampian
Aileen	MacVinish	Project Manager - BCWD	NHS Grampian
Mark	Sinclair	Director of HR & Strategic Change	NHS Grampian
Pauline	Strachan	Deputy Medical Director	NHS Grampian
David	Sullivan	Director of Planning	NHS Grampian
Ali	Walker	Service Manager, Adult Mental Health	NHS Grampian
Lesley	Wilkie	Director of Public Health	NHS Grampian
Sam	Wilson	Consultant Psychiatrist	NHS Grampian
Sharon	Adamson	Head of Acute Services Planning	NHS Greater Glasgow & Clyde
Alasdair	Corfield	EMRS Consultant	NHS Greater Glasgow & Clyde
Andrew	Gallagher	EMRS Consultant, Victoria Hospital	NHS North West Glasgow NHS Greater Glasgow & Clyde
Stephen	Hearns	Lead Clinician, EMRS	
Melanie	McColgan	Service Manager - Emergency Medicine	NHS Greater Glasgow & Clyde

			Clyde
Cath	McFarlane	General Manager Emergency Care & Medical Services	NHS North West Glasgow
Sally	Amor	Child Health Commissioner	NHS Highland
Doreen	Bell	Lead Nurse, North Highland CHP	NHS Highland
Lorraine	Coe	Clinical Nurse Manager	NHS Highland
Anne	Gent	Director of Human Resources	NHS Highland
Roger	Gibbins	Chief Executive	NHS Highland
Mike	Hall	Clinical Director - Argyll & Bute CHP	NHS Highland
John	Herrick	Director - Dental Services, Argyll	NHS Highland
Derek	Leslie	General Manager - A&B CHP	NHS Highland
William	McKerrow	Consultant / R&R Clinical Lead	NHS Highland
Gill	McVicar	CHP General Manager	NHS Highland
Noelle	O'Neill	Public Health Scientist	NHS Highland
Ian	Scott	Clinical Director - SE CHP	NHS Highland
Nigel	Small	General Manager - SE CHP	NHS Highland
Donna	Smith	Service Performance & Partnership Manager	NHS Highland
Roseanne	Urquhart	Head of Healthcare Strategy	NHS Highland
Jo	Veasey	Directorate General Manager - Women & Child	NHS Highland
Stephen	Whiston	Head of Planning	NHS Highland
David	Whiteoak	Locality Manager - Oban	NHS Highland
Claire	Wood	Lead AHP, North Highland CHP Area Representative Mid CHP Staff Side Representative for Union based at Rose Memorial Hospital, Dingwall	NHS Highland
Lyn	Wormald		NHS Highland
Marilyn	Aitken	CHP General Manager Service Development Manager for Long Term conditions, Clydesdale	NHS Lanarkshire
Maureen	Taggart		NHS Lanarkshire
Sandra	Mair	Head of Performance	NHS Lothian
Ron	MacDonald	Head of National Telecommunications Services	NHS NSS
Keith	Farrer	Long Term Conditions & Cancer Lead	NHS Orkney
Peter	Gent	Interim Acute Services Manager	NHS Orkney
Marthinus	Roos	Medical Director	NHS Orkney
Charles	Siderfin	GP / Acute Medicine Lead	NHS Orkney
Milne	Weir	Acting Chief Operating Officer	NHS Orkney
Simon	Bokor-Ingram	Operational Services Manager	NHS Shetland
Ian	Kinniburgh	Chairman	NHS Shetland
Sandra	Laurenson	Chief Executive	NHS Shetland
Sarah	Taylor	Director of Public Health & Planning	NHS Shetland
Evelyn	Campbell	Head of Older People's Services	NHS Tayside
Jim	Dreghorn	Retired GP - Kinloch Rannoch	NHS Tayside
Julie	Flynn	Head of Primary Care	NHS Tayside
Bob	Lister	Acting Lead Nurse Service Manager - Community Hospitals & Psychiatry of old age	NHS Tayside
Jim	McGuinness		NHS Tayside
Bill	Nicoll	CHP General Manager	NHS Tayside
Audrey	Ryman	Project Manager - Older People's Strategy	NHS Tayside
Chris Anne	Campbell	Hospital Lead	NHS Western Isles
Karen	Tarn	Clinical Strategy Project Manager	NHS Western Isles
Pip	Farman	Co-ordinator NOSPHN	NoSPG
Betty	Flynn	Regional Workforce Programme Manager	NoSPG
Fiona	Grant	Programme Manager - Remote & Rural	NoSPG
Sandra	Hay	Corporate Services Manager	NoSPG
Annie	Ingram	Director of Regional Planning & Workforce	NoSPG

Development			
Fiona	MacDonald	Cardiac Service Improvement Manager	NoSPG
Helen	Strachan	Regional Manager - Oral Health & Dentistry	NoSPG
Neil	Strachan	Project Manager - CAMHS Network	NoSPG
Robin	Creelman	Chair Argyll and Bute PPF	NHS Highland
Ian	Donald	Regional Redesign Manager	Scottish Ambulance Service
Sharon	Hammell	Head of Communications	Scottish Ambulance Service
Sam	Kennedy	General Manager	Scottish Ambulance Service
Calum	Kerr	National Service Redesign Manager	Scottish Ambulance Service
Rod	Moore	Team Leader A&E	Scottish Ambulance Service
Cathy	Dorian	Service Development Manager	Scottish Centre for Telehealth
Iain	Hunter	General Manager	Scottish Centre for Telehealth
Tony	Homer	Associate - Joint Improvement Team	Scottish Government
Hannah	Keates	Policy Manager	Scottish Government
Margaret	Whoriskey	Assistant Director, Joint Improvement Team	Scottish Government
Emma	Ashman	Regional Officer	Scottish Health Council
Ian	Leslie	Dean of Faculty of Health	UHI
Fiona	Skinner	Academic Leader - Faculty of Health	UHI
David	Snadden	Vice Provost Medicine	University of British Columbia
Heather	Knox	Director of Regional Planning	WoSPG

### Evaluation

Participants were invited to complete a short evaluation form at the end of the Event, to help planning for future events. A total of 120 people attended the Event, including colleagues from NHS Shetland, linking via video-conference, for all or at least part of the day. 52 questionnaires were returned, representing a response rate of 43%. The aim of the Event was to highlight progress with implementation of Delivering for Remote and Rural Healthcare. Respondents were asked if the event achieved this aim and 48 (92%) agreed or strongly agreed that it had.

A full report of the Evaluation can be accessed via the SHOW website at [www.nospg.nhsscotland.com](http://www.nospg.nhsscotland.com).

### Biography of Keynote Speaker

Professor Snadden earned his MB ChB from the University of Dundee in Scotland in 1977 and completed family residency training in Inverness. His connection to the north continued in the Highlands where he worked as a family resident trainer while maintaining a full-time rural-based general practice. This 11 year stint included front line volunteer mountain rescue work. Professor Snadden began his academic career with the Department of Family Medicine at the University of Western Ontario where he earned a MCISc in 1991. After returning to Scotland, he became Senior Lecturer at the Department of General Practice, University of Dundee. He completed his doctorate (MD) in 1998. He has supported investigations into re-validation methods for general practitioners and appraisal methods for graduates. He is a Fellow of both the Royal College of General Practitioners and the Royal College of Physicians of Edinburgh. Professor Snadden has been the Director of Postgraduate General Practice Education and Acting Postgraduate Dean at the University of Dundee in Scotland and in 2003 moved to the UBC where he is the Vice Provost for the Northern Regional Programme of Medical Education.