

**A Review of Service Development and
Innovation in the Delivery of
Joint Health and Social Care and
Support Services
in
Rural and Remote Areas

Main Report**

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1. EXECUTIVE SUMMARY

Introduction

- 1.1. This review was commissioned by the Joint Improvement Team (JIT) in conjunction with the Remote and Rural Health Improvement Group (RRHIG) 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.
- 1.2. 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.
- 1.3. 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.
- 1.4. 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.
- 1.5. 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.

Key Challenges

- 1.6. 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.
- 1.7. 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.
- 1.8. There were widely acknowledged tensions between providing local, easily accessible services and having access to specialist services that may be further away from home.

- 1.9. 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.
- 1.10. 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.
- 1.11. 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.
- 1.12. 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.
- 1.13. 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.
- 1.14. 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.

Addressing the Challenges

Partnerships and Joint Working

- 1.15. The development of partnerships and joint working is again, by no means a unique arrangement for rural and remote areas, but there are both greater imperatives and opportunities to support this approach.
- 1.16. Professional isolation is recognised to be a barrier to recruitment and retention and in this context, and in order to drive up standards, obligate networks are emerging as an important development that supports better co-ordinated working across existing professional and Health Board boundaries. For social care services, voluntary sector partnerships are increasingly recognised as offering significant potential for delivering greater service flexibility and innovation.

Community Based Services

- 1.17. Many areas reported operating service hubs that had grown up over many years and which had come to play a central role in the delivery of local services. Many provided opportunities for service co-location and in some cases, service integration.
- 1.18. The development of integrated community care teams, in different forms and at different stages of maturity, was evident across all areas reviewed.
- 1.19. The provision of routine night-time care was significantly impacted by the geography and population distribution in different rural areas but most now provide short-term, responsive night-time care services which are often associated with the prevention of admission / supported discharge arrangements.
- 1.20. Care at home services were increasingly incorporating Telecare in order to better support vulnerable people at home. Areas reflected different investment choices between low level preventative services that address long term conditions and intensive home care with a focus upon preventing hospital admissions and re-admissions.
- 1.21. Considerable change was reported concerning care at home commissioning arrangements with the introduction of guaranteed service levels and reduced costs through revised contractual arrangements being widespread.

Integrated Services and Equipment

- 1.22. The development of intermediate care protocols and resources in rural areas was widely reported and was seen as being an important means by which to reduce the otherwise greater likelihood of admission to hospital for assessment, as opposed to full assessment at home. These services reportedly reduced the risk of patients admitted for assessment remaining longer than necessary.
- 1.23. There is mixed practice overall in the integration of Occupational Therapy services. In the areas where the NHS Board covers more than one local authority, the services retained their separate identity and responsibilities, although increasingly being brought strategically and managerially closer through the CHP arrangements. Joint Equipment Stores have been developed in all areas.
- 1.24. With one exception, the areas reviewed have developed community alarm services which rely on a variety of technology suppliers but which have initial response calls to registered voluntary key-holders. There are reported tensions between a desire to draw Telecare more closely into the assessment and care management process and the

use of call centres as a broader base for access to council services as a whole. The adequacy of key-holder arrangements as a foundation for the extension of Telecare was also the subject of considerable debate.

Residential Care and Specialist Care Housing

- 1.25. The areas reviewed reflected differences in the balance of resources by which care away from home was organised and delivered, but moves to establish financially sustainable, locally accessible, small-scale services reflected a general direction of travel which was towards housing-based models.
- 1.26. The development of some very small facilities highlighted the challenge of providing for a mix of needs in such settings, most notably their limited ability to provide effective care for people with dementia, and the required sensitivity when bringing people with a mix of needs together in a small intimate building.
- 1.27. However, there were examples of residential care being developed across health and social care boundaries to provide for a broad range of needs.

Workforce Strategies

- 1.28. A key issue for rural areas is how to match the social care workforce to needs that in any one locality can change significantly over a short period of time. Annualised hours within contracts, guaranteeing a regular level of income but permitting hours worked to be varied to match varying levels of demand, were reportedly being increasingly adopted.
- 1.29. Good progress was reported on integrated team-working, but there was less evidence of the development of an integrated workforce in the area of personal care, where the overlaps between the work of home carers and community nursing assistants has long been recognised.

Community Resilience

- 1.30. 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.

Summary of Key Issues

The Nature of Rural and Remote Areas

- 1.31. Any analysis or understanding of what works in rural and remote areas needs to be related to relatively local geographical and population profiles and one approach cannot be assumed to apply across all rural areas or indeed, localities
- 1.32. The nature of rural society, with its multiple and over-lapping professional and personal relationships, is such that individuals working or living in key positions or locations can have a disproportionate influence upon how change is perceived and its impact represented.
- 1.33. To be successful in seeing through the approval and implementation of change, additional time and energy has to be committed to community and staff engagement in order to make sure that the positive case for change, based on sustainable services and employment arrangements, is presented to these stakeholders in ways that are balanced and persuasive.

Aspects of the Change Agenda

- 1.34. Many service changes appear to be opportunistic (eg. tying in with staff turnover) rather than planned and strategic. For example, the trade-off between local, very accessible services and those services that require specialist knowledge and expertise and therefore need to be more centralised, is a complicated balance the outcome of which is not always obvious. Decisions are often significantly influenced by the level of public acceptance rather than purely professional views.
- 1.35. Expectations of delivered services vary considerably between rural communities that appear to be very similar, reflecting a complex mix of what has historically been provided in a locality, what local residents have experienced elsewhere, and a growing awareness of what a 'reasonable' level of service means.
- 1.36. Workforce considerations, in particular those regarding integrated and aligned roles, are fundamental to delivering successful service development and innovation as well as sustainability, in rural and remote areas.
- 1.37. Service hub models help develop critical mass, and are widely seen as offering a viable and sustainable model with enhanced potential for integration. Supported housing developments can be viable where residential care could not, but they need to fulfil a flexible role to meet changing local needs.

- 1.38. The perceived viability of routine and responsive mobile care at home services varies significantly, with the level of additional current revenue costs rather than a longer-term cost benefit analysis, appearing to be the key consideration.
- 1.39. Evidence of community resilience is apparent in the role played by the voluntary sector and yet the potential contribution of informal carers in rural and remote areas may require further sustained investment if it is to be realised.

Areas for Future Study

- 1.40. Two issues arising from this review of development and innovation in rural and remote areas seemed particularly important yet challenging as regards their impact upon delivering the best possible outcomes for service users.
- 1.41. 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. Further details of the proposed focus of the work are set out in Chapter 6 of the main report.

1. INTRODUCTION

Background

- 1.42. This review takes place at a time of considerable change and development in the national policy agenda that is shaping the type of services that are being developed across Scotland. Within the context of Single Outcome Agreements (SOAs) between the Scottish Government and local authorities, NHS Health Boards, Local Authorities and other public bodies have to compile an agreed set of priority local outcomes and related indicators, which support the National Outcomes in SOAs and in so doing, ensure that all organisations are clear about their respective contribution.
- 1.43. Underpinning the outcomes agenda are a number of themes in national health and social care policy which help to explain the objectives that local statutory agencies, including Community Health Partnerships (CHPs), are required to address in delivering their priority outcomes. The principal ones are:

- (a) Shifting the balance of care towards independent living for older people in order to develop sustainable responses to the

growing demographic pressure associated with the steadily increasing older population.

- (b) Increasing personalisation of services in order to deliver more person-centred provision and greater opportunities for users to arrange their own preferred care and support package.
- (c) More focussed response to long term conditions through enhancing the nature and scope of preventative and anticipatory care so that more people can remain in their own homes for longer and avoid unnecessary moves into a care home or hospital.
- (d) Developing interim services which help to avoid unnecessary admissions and re-admissions to or delayed discharge from hospital.
- (e) Greater recognition of the role of informal carers and more effective approaches to embedding their contribution in the planning and delivery of health and social care services.
- (f) Developing a more sustainable and better integrated health and social care workforce in order to deliver a seamless response that better meets the needs of older people.

1.44. Many of these policy drivers present particular challenges in rural and remote areas. This review was commissioned by the Joint Improvement Team (JIT) in conjunction with the RRHIG to consider how different local partnerships have approached the task of addressing this policy agenda.. It sought to identify examples of good practice and innovation in service delivery with a particular focus upon the delivery of services to people at home or in their local communities, including approaches to community capacity building.

1.45. The review was undertaken as a contribution to the work of NHS Scotland's Remote and Rural Implementation Group (RRIG) associated workplan. It was significantly informed by the recent report by Professor Bob Hudson of the University of Durham, also commissioned by the Joint Improvement Team, *Supporting People in Remote and Rural Areas: A Framework for Analysis*.

1.46. Some of the key issues highlighted in Professor Hudson's report are set out for reference in Appendix One.

Methodology

- 1.47. The method adopted for this project ensured that the areas of service covered in the JIT / RRIG Joint Project Work Plan were addressed including; housing, Telecare, transport, joint governance and management structures, managed care networks, carers and care at home.
- 1.48. The scale of the review was however limited and whilst developments concerning most areas of service have contributed to the overall picture of change that is reported upon below, it has not been possible to consider in detail specifically what impact the rural and remote agenda has had upon the development process and the final characteristics of each particular service.
- 1.49. The first phase of the project, involved gathering information on health and social care policy and practice from a range of mainland and island rural areas. Some of the local authorities were co-terminus with their local NHS board, others were not.
- 1.50. 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 participating areas were:
 - Angus
 - Argyll & Bute
 - Highland
 - Moray
 - Orkney
 - Scottish Borders
 - Shetland
 - Western Isles
- 1.51. For anyone who is interested in finding out more about work in the particular areas referred to below, contact details for each of the 8 local partnerships and lead agencies are set out in Appendix Two.
- 1.52. These areas include some of the most sparsely populated areas in Scotland, as demonstrated in the table set out in Appendix Three.
- 1.53. A questionnaire was sent separately to identified local authority, NHS, and where appropriate CHP managers in each area, for completion. In some cases managers collaborated to complete a single return whilst in others separate returns were received from each agency. In other cases, only one agency submitted a completed return.

- 1.54. The scope of the questionnaire included:
- how universal services fit into the delivery of health and care services
 - an overview of the range of practices in service delivery
 - information on inter-agency and interdisciplinary working arrangements
 - workforce planning, recruitment, training and retention of staff
 - the role of informal carers and the voluntary sector
 - key issues for service users
 - approaches to budget management and shared resources
- 1.55. Phase Two of the project involved face-to-face or video conference interviews. Questionnaire returns from Phase One, varied significantly regarding the level of detail that respondents included and the areas of service that were referred to in their responses. As a result careful consideration was given to how the Phase Two interviews should be focused in order to ensure greater consistency in the information provided and that interviews focused upon those aspects of local practice that have the greatest impact upon the achievement of key targets and outcomes.
- 1.56. Second phase interviews focused initially upon integrated working, supporting more people at home and out-of-hours community health and social care services. This enabled consideration of 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. In addition, interviews ranged widely across a number of local service areas and issues, in particular how short term interventions linked with longer term care and support services. Local on-call arrangements and response arrangements for community alarm service users were also covered in some detail, whilst issues relating to accident & emergency services and NHS24 calls, less so.
- 1.57. This report describes some of the key challenges that were identified in the interviews, and then examines some of the responses being developed to address the challenges. Finally it summarises some of the key issues affecting service development and innovation in rural and remote areas.

2. KEY CHALLENGES

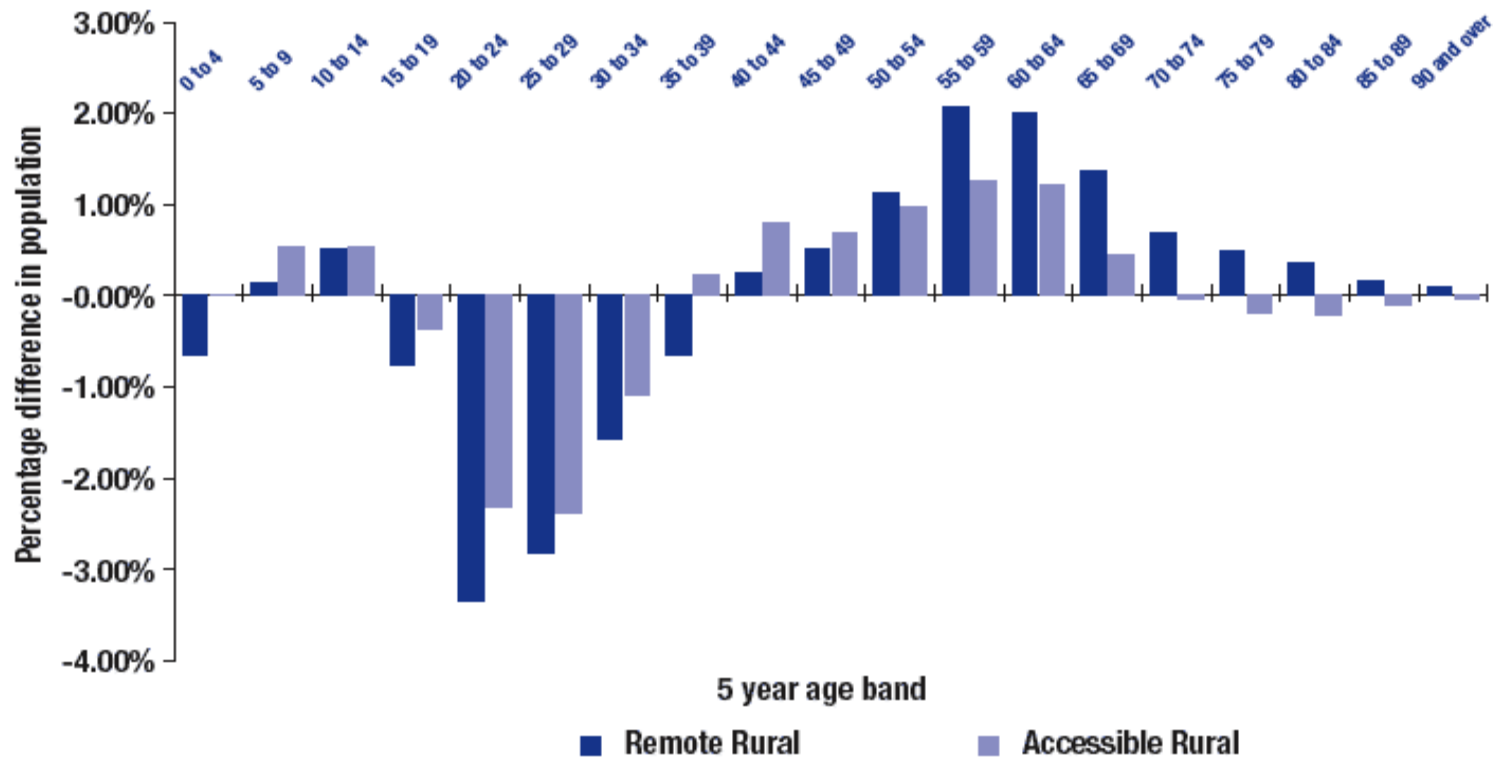
Population Distribution and Trends

- 1.58. It quickly became apparent that 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.
- 1.59. The Scottish Government's current definition of remote and rural communities is, 'Settlements of less than 3,000 people and with a drive time of over 30 minutes to a settlement of 10,000 or more. (Scottish Government Urban Rural Classification 2007 – 08).
- 1.60. In seeking to better understand the significance of different local geographies and population profiles the categorisation below emerged from discussions with local partners and was found to offer a more useful basis from which to begin to better understand the impact of geography and population spread upon local services in the areas reviewed.
- Areas with a distribution of burgh towns, which form the hub of general community health and social care service delivery (Angus, Scottish Borders).
 - Areas with one or two centres of population, from which similar service hubs operate, but with distant areas of very low pockets of population (Moray, Highland).
 - Areas with islands which have a population level that can sustain a range, but not necessarily full range, of services (Parts of Western Isles, Argyll & Bute, Shetland, Orkney).
 - Areas with small islands, low population, insufficient volume to sustain a broad range of direct services (parts of Western Isles, Argyll & Bute, Shetland, Orkney).
- 1.61. Of the three island areas, Orkney has a compact mainland area, with the challenge of delivering services to small islands; Shetland has a larger mainland mass, with similar small island populations; whilst Western Isles has two larger land masses on its mainland, a wide spread of small pockets of population, but with most former small islands now with causeway connections. As a predominantly mainland area, Argyll and Bute had the additional challenge of supporting predominantly small islands with low populations.
- 1.62. In some cases, particular models of service were unsustainable due to the absence of a 'critical mass' of clients with resulting high costs and spasmodic demand for services. In others, population centres of a few hundred people provided a sufficient level of demand for services to be structured around a 'hub' or core facility with outreach being offered into a more dispersed hinterland.

- 1.63. 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 rural areas. As a result the experience of this review suggests that any analysis or understanding of what works in rural and remote areas needs to be related to relatively local geographical and population profiles and one approach cannot be assumed to apply across all rural areas or indeed, localities.
- 1.64. The review has been able to confirm a clear set of issues as directly affecting local partner's capacity to deliver community health and social care services in ways that deliver the outcomes that users want, are cost effective, and take account of the demographic features of remote and rural areas.
- 1.65. One of the more important demographic issues concerns the age balance within rural areas which generally shows fewer people in the age bands from 20 to 35 and more people in the age bands of 50 to 70, as illustrated in Figure 1 below.
- 1.66. Other issues that were identified included the costs of service delivery to people at home, including transport and the time committed to travel and the challenges of developing and maintaining skills to meet the general range of care needs that arise in remote and rural areas.

Figure 1: Differences in Age Distribution of Population of Rural Areas, Relative to the Rest of Scotland, 2006.

Source: General Register Office for Scotland, 2007 (2006 mid-year estimates on data zones) Based on Scottish Executive Urban Rural Classification, 2005-2006.



Access to Services

- 1.67. 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 across to equality in the delivered service that people received. All of the areas reviewed acknowledged that service users receive a different level of access to services depending upon where they live. As we have seen above, not only is access likely to vary but the very nature of the services that are provided in different types of area, are also likely to be substantially different, in response to local needs and circumstances.
- 1.68. Within the context of the geographical and population issues detailed above, a number of important factors appeared to impact upon access to or take-up of services and the level and type of available provision.
- 1.69. There were widely acknowledged tensions between providing local, easily accessible services and having access to specialist services that may be further away from home. The more specialised a service is, the further away it is likely to be located from the home of the recipient. This means, for example, that there is a proportionately greater demand for palliative care at home, due to most provision being delivered in distant specialist centres.
- 1.70. The need for specialist support is probably more evident to the user of medical services, and therefore there appears to be a greater acceptance of the need to have some procedures undertaken out of the patient's home area. In fact, there are examples of resistance to having some services brought closer to home, even when objectively assessed as being safe, possible because of the feeling that having the procedure undertaken locally is in some way compromising the quality of the service. This issue arose, for example, in public consultation on maternity services in Orkney.
- 1.71. Although by no means an exclusively remote and rural issue, there was some evidence that rural communities identify more closely with long established services and facilities (there are fewer of them per square mile) such as GP practice locations, existing residential homes and community hospitals, and are more cautious about accepting substitute service developments.
- 1.72. Some examples include:
 - Continuing pressure from service users to base a GP, nurses and social care staff on an island of less than 160 people when the arrangement is no longer sustainable.
 - Some island populations have traditionally expected and received a very modest level of service – their attitude reflects a self

reliance and independence that dampens expectations but can also make discussions about change and new service models a little strained.

- Other island populations, perhaps with different experiences of available services from elsewhere, reflect a higher level of expectation of statutory services and in these cases can lead to resistance to change or demands for higher levels of service than can be delivered sustainably for what are often tiny communities.
- 1.73. There is often particular pressure to resist change in the pattern of use of community hospitals, driven by concerns that altering their role will threaten their viability. Medical services to community hospitals are GP led, but often not by the GPs of those patients who are in a unit at a particular time. It was reported by some that this resulted in a particularly cautious approach which further delayed discharge. Despite this, in a number of areas, they were used for step-down support, providing a halfway base between the main hospital where the patient had been treated and the patient's home.
- 1.74. Small-scale residential care homes incur high unit costs, and also raise issues about the appropriateness of bringing different user services together in order to achieve 'critical mass'. It was acknowledged in areas that retained small-scale residential care, that the potential exists for local residential care units to be viable but only at a cost, for instance the absence of specialist care, such as dementia support.
- 1.75. The extent to which it has been possible to retain low level / preventative services that address issues such as social isolation, and practical support in the home in the face of high needs system pressures was a widely discussed issue amongst respondents.
- 1.76. The particular challenges that have to be addressed in organising home based care in remote and rural areas, such as transport arrangements, distance and travel logistics and the availability of local carers to undertake the work were recognized as having the potential to make it harder to justify and maintain low level home care provision. However, the available home care statistics (*Source: Scottish Government Statistics Division*) do not provide clear evidence of rural areas delivering proportionately fewer low-level home care arrangements. It is possible that the statistics mask real differences for rural areas, such as the impact on the demand for home care generated by the absence of easily accessible day care.
- 1.77. In some areas the adaptations policy is clear but there is little co-ordination between housing adaptations approvals and work scheduling and the assessment and care management process or with hospital discharge planning. This can make it difficult for users to benefit from the adaptations they need in time to avoid a lengthy hospital stay, or intermediate or long term placements in care homes.

- 1.78. Although many rural areas have a network of community halls and other publicly accessible buildings, almost all supported financially in some way by local authorities and drawing on central government funding for redevelopment, there was limited evidence of significant levels of their use for the delivery of statutory social care services. They were however used extensively by local voluntary organizations for activities such as lunch clubs.
- 1.79. In Argyll & Bute, as one example amongst many, transport infrastructure weaknesses are a major issue in determining service responses and the pattern of delivery arrangements that is developed in different areas. Perversely, the extreme nature of these difficulties is said to act as a spur to health and social care to develop joint solutions to delivery problems.

Resources – critical mass and opportunity costs

- 1.80. Small populations and the lack of critical mass are basic features of rural and remote areas and as such are an ever-present challenge in designing affordable and sustainable services.
- 1.81. Overnight care was cited as perhaps the most obvious area where lack of sufficient demand can render a service prohibitively expensive. In many cases, such a service was seen as non viable and was not considered, despite the only alternative being admission to a care home. Some areas, such as Moray, offer pre-planned overnight sleep-in cover, but this is for a limited period of time and has a high threshold for qualification. In this case, some of the overnight care is provided directly, some by agency contracts, and some through direct payments.
- 1.82. Areas responded in a variety of ways to requests for urgent assistance. Thus a community nurse or NHS24 doctor might decide to have the ambulance bring the patient to a local hospital, whilst elsewhere someone presenting the same needs might receive a home visit, in the first instance. These different responses were based upon a rational consideration of the relevant factors; in the one case a call might require a 40 mile round trip and could result in an unacceptable delay in responding to several other calls that might arise closer to the hub from which the service is delivered. In the other, responding to a caller living close to a community 'hub' would involve only minimal delay in responding to other demands.
- 1.83. Providing a guaranteed visiting service in any locality would require an increase in the number of doctors or nurses on call, more financial resources but would also result in more down-time in the services provided, i.e. the proportion of service time which would be devoted to responding to irregular demand, rather than being actively engaged in service delivery would be greater.

- 1.84. Respondents acknowledged that this approach could result in different outcomes for the patient since bringing patients to an assessment point at a local hospital increased the chances of admission to hospital, with the consequent likelihood of a period of hospital care that in other circumstances could have been avoided.
- 1.85. Strategies being adopted to minimise the risk of unnecessarily prolonged admission included the designation of short-stay assessment areas in the receiving hospital to clearly distinguish between patients brought in for further assessment, and full in-patients. This approach was established in some areas such as Argyll & Bute, while in others, such as Shetland, there was a move away from designated places within the local hospital to a focus upon developing more robust home support services in the community.
- 1.86. Access to initial assessment was generally restricted to designated localities, so in Moray, the 'Home from Hospital' scheme operated in Elgin and Lossiemouth, but is being developed to cover the Buckie area. Bringing together the comprehensive intensive support and rehabilitation resources needed to make a scheme such as this work across the whole area would present major challenges in terms of finance or recruitment and deployment of limited skill resources such as physiotherapy.
- 1.87. In the Keith & Speyside Locality which contains some of the most rural and remote parts of Morayshire, enablement training is being piloted for home care staff to be completed by November 2009. This is to enable home care staff in more remote areas to develop key skills in encouraging and facilitating service-users to maximise their own self-care skills, by supporting service-users to be as independent as practicable, developing local support networks and supporting unpaid carers to continue in their caring role.
- 1.88. In Borders a specialist Dementia day service operated in Berwickshire only and in the Western Isles, the Mobile Overnight Support Service covered only 70% of the population in the more outlying areas. Extending it to the remaining 30% could only be done at unacceptable opportunity cost to other demands on services.
- 1.89. Also in the Borders, an Intermediate Care Unit had recently been set up in a central care home to provide step up/step down care. It was clear that not all service users were happy to take up the offer of this service when it was not in their own area, thereby highlighting the need to establish more local services, despite the cost implications of doing so.
- 1.90. Care homes located in rural areas reflected varying levels of provision for people with more specialist needs depending upon their proximity to centres of population. The European Working Time directive was cited as having undermined the viability of some small scale services,

including care homes, because of restrictions on the time that staff can work over a given period.

- 1.91. Those close to population centres tended to have either larger units that could cater for diverse needs such as specialised care for people with dementia, or a variety of separate units including ones providing for special needs. Smaller residential units that tended to serve smaller local populations, had neither the staffing levels, skills nor the physical design to adequately meet the full diversity of needs. (Care Centres in Shetland; Care Units in Western Isles).
- 1.92. However, where a good level of service already exists, particularly in an island setting, it is very difficult to re-design a service or reduce service levels without causing significant public unrest and in these circumstances change is usually incremental and slow to happen.

Workforce Issues

Local Job Markets and Retention

- 1.93. A key issue identified in most of the survey areas concerned the recruitment and deployment of front-line care staff. The skewing of the age distribution among the population in remote and rural areas, with fewer people in the 20 to 40 age band and more people in the 50 to 70 age band and above, compared to the Scottish average age distribution (Source: *Poverty and Social Exclusion in Rural Areas* [UHI website]), is an important factor in determining the extent of this challenge for service providers and commissioners.
- 1.94. In Shetland, with very low unemployment levels (0.7%), there is particular pressure to make social care work competitive in the jobs market, not just with wage levels but also flexible working conditions.
- 1.95. Workforce issues were acknowledged in Argyll and Bute to be one of the main barriers to developing new models of care. One particular issue of concern referred to here and echoed elsewhere, was that Council home care staff have 'bank contracts' which do not provide any security by way of a guaranteed number of hours. This leads to people taking seasonal work – often in the tourism industry – with resulting pressure on care services ability to respond to fluctuations in demand.
- 1.96. Moray identified the demographic imbalance as a serious concern for future sustainability of nursing and related services, where there is a significant number of staff in the 40s and 50s age band. It was less of an issue for social worker recruitment at present.
- 1.97. Matching supply of appropriately skilled staff to what can be rapidly changing service demand levels in areas of low population holds particular challenges for remote and rural areas, in particular:

- Finding available applicants.
 - Organising formal induction programmes and ongoing training.
 - Having enough staff to cope with unplanned staff sickness and other absences.
- 1.98. A general feature across all services is the greater capacity for disruption to service arising from staff turnover. Rural services, such as area social work teams, GP practices, community nursing teams, OT, usually operate on a smaller scale to their urban counterparts. A single staff resignation can result in service disruption in a situation where in a more populated setting the departure of a team member from a larger team will be of lesser consequence. Not only does the departure disproportionately affect the viability of a team, but the opportunities for the short-term deployment of agency staffing are fewer.
- 1.99. Examples of this from the areas reviewed were discontinuity of service within a single-staffed GP practice, community night-nursing team, and locality community care team. There was however little evidence of specific strategies to address this problem. In most cases the potential for service disruption from a single unplanned resignation could be easily identified, but there were no contingency arrangements, such as planned temporary transfers from other teams, in place before the event.

Recruitment

- 1.100. These issues can be broken into two distinct categories:
- Recruitment of specialist professional staff, likely to be found outside the locality where the service is based
 - Recruitment of care staff within the locality
- 1.101. For professional staff in remote and rural areas, there is often little choice but to relocate partners and/or families as part of the new job arrangements. For a professional, whether doctor, nurse or social worker, based in the Central Belt, there are a range of job application choices across a number of NHS Boards or local authorities which do not require relocation. There is also a more active independent jobs market, through the independent sector and agency work.
- 1.102. Professional staff recruitment, quite logically, seems to place greater emphasis on lifestyle choices and benefits. A recent, well-publicised – and successful - recruitment of a GP in the Highlands had involved advertisements focused on out-door magazines rather than professional journals. But in general terms a job decision that necessarily involves changes for all the family, where there is one, presents a significant barrier to successful recruitment.

- 1.103. This factor was identified in Moray as also a consideration for unpaid carers who may wish to relocate to a rural area to care for a relative but who are discouraged or are unable to do so due to the limited job market in such areas, i.e. scarcity of employment, low requirement for higher grade skills, less flexible working patterns, difficulties with travel particularly in the winter months, and low pay.
- 1.104. Local recruitment of staff is much more subject to the elements which contribute to a competitive jobs market. The absence of guaranteed weekly hours for home care staff is still a feature in a number of employing authorities despite this having been shown to be a strong barrier to recruitment and retention. Only the fragility of some other rural employment opportunities such as fish processing and the less positive prospects that they offer, enables social care work to retain some of its attractiveness.
- 1.105. The demographic weighting away from young adults and towards older people in remote and rural areas, set out earlier, is an obvious contributing factor to local recruitment, creating an additional barrier to matching care providers to care service users.

Training and Continuous Professional Development (CPD)

- 1.106. For staff with professional status regulated by statute, nurses, doctors, social workers and increasingly, social care staff, professional registration conditions require demonstrated levels of training and CPD. Providing staff with the necessary amount of time away from their post to ensure sufficient learning opportunities requires backfilling which can be difficult to arrange and expensive for the more specialised training requirements.

3. ADDRESSING THE CHALLENGES

Partnerships and Joint Working

- 1.107. The development of partnerships and joint working is by no means a unique arrangement for remote areas, but there are both greater imperatives and opportunities to support this approach.
- 1.108. *Supporting People in Remote and Rural Areas: A Framework for Analysis* identified some of the reasons why partnership arrangements have particular relevance in remote and rural areas. Professional isolation is shown to be a barrier to recruitment; strategies that reduce isolation will mitigate that. Organising social care services can be a problem and yet voluntary sector partnerships can support care arrangements through their greater agility.

- 1.109. The concept of Managed Clinical Networks has been developed into more formal structures termed Obligate Networks, which are "...linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional or Health Board boundaries, to ensure equitable provision of high quality clinically effective services throughout Scotland." The development and evaluation of outcomes for this work is being undertaken through the Joint Improvement Team.
- 1.110. One example involves **Orkney and Shetland** Health and Social Care Partnerships which are engaged in joint work with NHS Grampian, supported by the Joint Improvement Team, to develop an Obligate Network to support integrated working and positive outcomes for people with mental health support needs. This approach reflects the formal partnerships that are increasingly being put in place between island NHS Boards and specified mainland Boards.
- 1.111. Delivering for Remote and Rural Healthcare highlighted that:
- "Services must be planned and co-ordinated with a greater focus on more collective and collaborative responses within and across communities. This will include the formalisation of networks to ensure that larger centres are obligated to support and sustain healthcare services in remote and rural areas."*¹
- 1.112. This imperative is evident in a recent initiative in **Argyll and Bute** which has trialled a consumer-led budget allocation approach. This is a corporate initiative to consult local members of the public about their views on the available service options and what resource investment they think would be best for their community. This approach is being initiated with the very small island communities on Coll and Colonsay, but may be rolled out if it proves to be successful in achieving a sustainable and attractive service profile that meets the expressed needs and wishes of local residents.

Community Based Services

Service Hubs

- 1.113. Many areas reported operating service hubs that had grown up over many years and which had come to play a central role in the delivery of local services. Covering a radius that was appropriate for each locality but which could vary considerably in size from one to another, it was proving possible to deliver relatively similar service levels to the population, particularly in relation to services such as; home care, day care, night care, GP home visits, local hospital rehabilitation services and community rehabilitation services.

¹

- 1.114. Areas with a relatively even spread of burgh towns such as Angus, Moray and the Scottish Borders, Inverness & Nairn within Highland, Lerwick, Stornoway, and Kirkwall featured particularly prominently in this regard. In the case of Argyll and Bute, this feature was apparent in its larger mainland population centres and island based GP practices had fulfilled a similar role too.
- 1.115. **Highland**, in reviewing its callout arrangements for emergency alarms and Telecare is examining in detail the option of a structured integration within the NHS Hub at Raigmore Hospital, tied in with remote health monitoring initiatives, GP callout, 24/7 care at home, community nursing and Scottish Ambulance Service – everything but fire and police emergency calls. This example highlights the potential to link a number of different delivery arrangements in order to maximise efficiencies and promote access to people across a variety of more or less remote areas.
- 1.116. There appeared to be no ideal area that was covered by these ‘hubs’, rather, the area covered was determined by a combination of factors including the type of service concerned, historical delivery patterns and the population profile and spread. It was often reported for instance to be possible to provide equal access to day-time services over a greater geographical area than can be achieved by night-time services. This could make it more likely that someone with night-time care needs would be admitted to residential care. It was also reported to be possible to provide better access to planned services than it was responsive services; making it more likely, for example, that a patient would be brought to hospital for assessment than be assessed at home.
- 1.117. Where historical hubs like burgh towns do not exist, some areas were planning initiatives to create service groupings that would serve a similar purpose; Shetland, with its pattern of local care centres has an incrementally increasing co-located range of services, residential, day care, clinical care.

Integrated Community Care Teams

- 1.118. The development of Integrated, or in some cases ‘Extended’, Community Care Teams, in different forms and at different stages of maturity, was evident across all areas reviewed. In some cases, they were long-established and formed the basis of support to prevent admission to hospital, assist rehabilitation and early supported discharge, and in a number of areas to support strategies focused on anticipatory care.
- 1.119. Integrated Care Teams operate across all areas of **Argyll & Bute**. They provide short term, flexible, integrated health and social care services with joint responses planned through Single Shared Assessment and the case review system. Funding to establish the

teams was a key challenge but closure of local NHS wards ultimately enabled all areas to be resourced in this way. The new arrangements have had a particularly positive impact upon the number of delayed discharges in Oban and Helensburgh.

- 1.120. **Angus** has a well-developed and defined joint team structure aimed at prevention of admission to hospital and facilitating early supported discharge. While all areas reviewed had taken steps along this route, Angus was further advanced in the operation of four 'virtual' teams covering the whole area, including social care, district nursing, OT and physiotherapy, with a focus on intensive support, very strong rehabilitation support and regular review. The social care staff in this service are primarily employed for the scheme, although they may also work elsewhere within the general social care service. This is coupled with an extensive range of extra-care housing.
- 1.121. The capacity to cater for unanticipated need, especially out-of-hours, is an important factor in any strategy to support independence. The absence of access to alternative services out-of-hours often leads to hospital admission which could otherwise be avoided.
- 1.122. In 2007, **Orkney** extended its management and operational capacity for the home care service by having it fully functioning from 8am to 10pm seven days a week. As well as helping organisers to deal with some routine work more effectively in the evening, it also gives a longer time window when home care service that was often accessible only 8am to 5pm Monday to Friday can be organised in response to unanticipated needs that arise evenings and weekends.
- 1.123. However, even areas adopting more integrated approaches face growing demands upon their limited resources. Senior managers in **Argyll & Bute** and **Borders** are increasingly scrutinising initial assessments that indicate that a care home placement is required. Similarly, an assessed need for overnight care is closely scrutinised to see if a novel approach or combinations of other practical and technological supports could bring the same benefit. In both of these types of cases, significant progress is reported in encouraging assessors to design new and imaginative responses, many of which involve developing a much more detailed understanding of people's daily routines, interaction with family and neighbours and local community resources that may be able to contribute to meeting the assessed needs.

Routine Night-Time Care

- 1.124. The clearest impact that the geography and population distribution in rural areas has on the nature of health and social care services is in the provision of routine night-time care. Most areas now provide short-term, responsive night-time care services which are often associated with the prevention of admission / supported discharge arrangements.

The voluntary sector also often works in partnership with statutory services to a partner in accessing short-term care.

- 1.125. Providing routine night-time care was an apparently insurmountable barrier in some remote and rural areas. If assessment identified regular, but not continuous, personal care during the night as a requirement, this could not be provided and triggered admission to residential care. Angus, with a favourable population distribution, has well-developed night time services for both emergency and routine care; but the challenge is to find ways in which these can be developed to cover sparsely populated areas in ways that are economically sustainable.
- 1.126. One problem is that the financial framework within which the viability of night time and evening care at home is usually assessed is based on the current costs and structures, rather than the long-term financial picture. Therefore, especially if there is current capacity within the residential care sector, or sometimes in the hospital sector despite the constraints placed on delayed discharges, the cost of having home-based night time care is measured as the net additional cost of the service, with no identifiable saving from the non-use of the residential resource. Whilst this is what influences the current budget outturn, the real evaluation of the home-based option should be over a long-term cost comparison including the cost of capital.
- 1.127. It is likely, therefore, that the financial barriers to providing regular care at unsocial hours in more rural areas are perceived as being higher than they actually are in the long-term.
- 1.128. The **Western Isles** has a Mobile Overnight Support Service, three teams of two social care staff delivering personal care services throughout the night to 70% of the population. The introduction of the service, over three phases, had a marked impact on reducing delayed discharges from hospital. It is almost entirely focused on planned care delivery, the aim now being to restructure the service to include more capacity for unplanned care, closer integration with the overnight nursing service and capacity to act as a response service to enhanced Telecare provision.
- 1.129. Similarly in **Borders** a mobile night support service is provided by 5 teams based in two major towns, each comprising two Social Care staff who provide a service to particularly vulnerable individuals who need support during the night. In some cases the teams are located in the local community hospitals to aid joint working. This has offered a viable alternative to care home provision and is well received by service users and carers.
- 1.130. Within **Highland**, a service has been developed in Nairn that gives access to emergency night-sitting and emergency home care as part of an anticipatory care programme covering 500 patients within one GP

practice. This operates via a private care agency, based on direct referral by the community nurse or GP.

- 1.131. All the components that play into making complex care at home possible support the personalisation of services. At this stage, self directed support, principally through direct payments, seems on the evidence of this small scale review to be peripheral to the care agenda in remote and rural areas. In addition to the practical service delivery and workforce challenges faced by statutory providers, the most obvious hurdles to developing this approach to commissioning services is the absence of independent care providers in most rural areas.

Care At Home

- 1.132. Providing realistic options for care at home involves a mix which includes domestic support, help with meals, personal care, nursing care, day care, emergency response services. Telecare is becoming an increasingly important aspect of the services that are targeted at supporting more people to remain in their own home.
- 1.133. **Angus** benefits from a distinctive pattern of care services which reflect a high commitment to low-level domestic support and the important role played by the emergency response teams. At first sight, the operation of the response teams – noting that the geography and population distribution make it easier than in other areas – seem to be a relatively expensive service.
- 1.134. However, along with a range of other peripatetic services that are delivered into people's homes, it appears to reduce the need for high level home care and servicing of sheltered and very sheltered housing. It appears to be particularly effective in supporting a shift in the balance of care from residential homes to housing-based services and for areas with a similar population distribution may offer some useful lessons.
- 1.135. It is worth noting the different profile of home supports available in Angus compared with the other areas looked at in this study (refer to Graphs 1 and 2 in Appendix 4). In particular the small number of service users who have 10 hours or more home care service per week, while considering this in the context of its high level of emergency response services, extensive hot meal delivery service, and wide range of supported accommodation. A comprehensive user satisfaction survey undertaken last year in Angus showed, for older people's services, that 97% of service users were satisfied with the service they received, and a similar percentage felt that their needs were met by the services provided.
- 1.136. **Angus** also had the most advanced arrangements for home-based emergency support, with users of their community alarm system having access to a formal, employed, emergency response team 24 hours a day. The geography of the area makes this type of service more viable

than in some of the more scattered communities. This sits alongside the home care service that has a delivered service profile that is significantly different to the typical service in the rest of Scotland, referred to above. In the provision of personal care, for example, service is available until 10pm, based around 4 teams covering areas as needed, but not contained within the service referred to in the home care statistical returns.

- 1.137. In **Argyll & Bute** the block purchasing of home care services has been used to provide guaranteed access to a home care service at an agreed rate. This arrangement reduces the cost impact of spot purchasing at higher prices and if the block is set carefully on the basis of historical patterns of demand, cost risks are minimised.
- 1.138. For access to home care services out-of-hours, **Moray** has a combination of directly provided and contracted services, coupled with direct payment arrangements.
- 1.139. **Shetland** is in the process of developing an Intensive Support Team, to provide services for both long and short term needs. A Dementia Care Manager had been appointed, a post which carries a caseload as well as having an advisory function for both care at home and day care; a new senior care worker appointment had also just been made, aimed at focussing on providing a sustained programme of short intervention sessions with the prospect of adding OT and physiotherapy support to the team later.

Integrated Services and Equipment

Intermediate Care

- 1.140. The greater likelihood of admission to hospital for assessment for people in rural areas as opposed to full assessment at home brings with it an increased risk of the patient admitted for assessment remaining longer than necessary. **Orkney** is developing a receiving area in the hospital, specifically designated for triage, not accommodation, as part of a strategy to reduce avoidable admissions. It is also soon to introduce a community based joint intermediate care service.
- 1.141. **Borders** run a seven bed intermediate care resource operating from a Council run care home in the centre of the Borders in Galashiels. The focus of the service is on providing continual assessment and achieving positive outcomes for service users. Referrals to the service are made from Social Work (45%) and NHS (55%) staff. The average length of stay is 30 days and the strength of the emphasis upon rehabilitation has meant that the return to home rate from this facility is currently running at 87%.

- 1.142. **Moray's** 'Home from Hospital' scheme, which covers Elgin and Forres only, as explained earlier, is based on assessments led by the social worker and discharge liaison nurse, drawing on others such as OT, physiotherapist, dietician as necessary. One of the options, instead of a direct return home, can be transfer to one of the community hospitals. Depending on the service available and the needs of the patient, the intermediate hospital placement may be out-of area.
- 1.143. **Argyll & Bute** have introduced a short term assessment bed in Dunoon Community Hospital for use by GPs for people who cannot remain in their own home but for whom a long term stay in hospital is not required. Social care staff members are responsible for instigating an immediate review and care planning process in order to ensure swift move-on and access to required equipment, support and longer term adaptations in the home.
- 1.144. In **Angus**, there is a very specific and clearly defined intermediate care service, jointly operated by Council and NHS which includes social care, district nursing, OT, physiotherapy in 4 'virtual teams' covering all of the county.
- 1.145. Referral to the service (discharge) is usually from the Discharge Co-ordinator (Angus) at Ninewells Hospital, but can also be from one of the community hospitals. The assessment, done in coordination with ward staff and others, is transferred by e-care to the co-ordinator for social care based in Kirriemuir who will mobilise service as appropriate. Similar referral will be made from hospital to OT, physiotherapy, and to district nursing as appropriate.
- 1.146. The focus is on intensive support and regular review. Social care staff members are dedicated to this scheme although may also work elsewhere. The service operates within a time constraint of 14 days, sometimes extended to 28 days for those with orthopaedic aftercare. There is a very strong rehabilitation focus, through OT, physiotherapy, and social care staff working on agreed rehabilitation programmes.
- 1.147. There are community hospitals at Arbroath (medically led by a Trust Practitioner), Montrose, Brechin and Forfar (led by GPs). Step-down planning via community hospital is mostly through Arbroath from Ninewells. Community hospitals may typically cover issues like pain management, carer not coping, COPD assessment, chest infection, Urinary Tract Infection (UTI). 'See and Treat', the emergency nursing service, may also admit to community hospitals.
- 1.148. Prevention of Admission (POA) involves the same staff. Referral is typically from a GP or district nurse, with the same focus on intensive support across services, rehabilitation and review and operating within the same parameters as Early Supported Discharge (ESD).

- 1.149. Six beds are block purchased by the NHS in Arbroath Nursing Home which are time limited in their use and have the same focus on rehabilitation and support as with the rest of the ESD and POA programme.
- 1.150. The smaller and more dispersed areas appeared to face a greater challenge in structuring and maintaining defined intermediate care services. It is certainly less possible to retain a dedicated workforce for the purpose of short intensive support and this appears to point to services that are organised on a more *ad hoc* basis.

Integrated Occupational Therapy Services

- 1.151. In **Argyll & Bute** a joint NHS/Council OT service is hosted by the CHP. This arrangement is designed to introduce greater consistency in practice and approach amongst all OTs, in particular it is also seen as providing a solid basis for developing a case management approach in all settings.
- 1.152. **Argyll & Bute** has extended the use of its service prioritisation framework to include OT and podiatry services to ensure better access in line with other services identified through the Single Shared Assessment (SSA). This initiative further ensures greater consistency with a particularly positive impact being seen upon people in the most remote areas.
- 1.153. There is mixed practice overall in the integration of Occupational Therapy services. In the areas where the NHS Board covers more than one local authority, the services retain their separate identity and responsibilities, although increasingly being brought strategically and managerially closer through the CHP arrangements. In the areas with coterminous boundaries, **Western Isles** and **Orkney** have integrated OT service, while **Shetland** retains separate services, but moving towards joint management.

Equipment Stores and Referral Arrangements

- 1.154. Joint Equipment Stores have been developed in all areas, for instance **Orkney** opened one last year, and the inclusion of OT within the Early Discharge / Prevention of Admission teamwork is recognised as pivotal to the effectiveness of these arrangements. **Angus** included an on-line referral form for its Joint Equipment Loans Service.
- 1.155. **Argyll and Bute** operate an integrated equipment hub with satellite spokes. An overall manager was introduced to ensure co-ordination and equity of access across the county. Part-time store managers are employed at each satellite centre to manage allocations and professional access to equipment. They are currently looking at how to incorporate access to Telecare into this system.

- 1.156. **Moray** uses the mobile library service when required for the delivery of equipment to outlying areas.
- 1.157. **Borders** operate a 'clinic' system throughout dispersed localities to encourage straight forward assessments of small items of equipment. This has enabled faster assessments and the quicker delivery of equipment.

Tele-health and Telecare

- 1.158. With the exception of Angus, which has its 24 hour response teams, all other areas have developed community alarm services which rely on a variety of technology suppliers but which have initial response calls to registered voluntary key-holders.
- 1.159. Call Centre arrangements varied, from being coupled with the local hospital switchboard (**Orkney**), to being provided centrally by a private company (**Shetland**), being part of a consortium based in Aberdeen (**Moray & Highland**) to being directly provided locally (**Western Isles**).
- 1.160. There were concerns expressed in Orkney about a system that competes for attention with the normal flow of incoming telephone calls to the hospital. Most areas seemed to be at some stage of reviewing their arrangements, principally driven by the extension of Telecare from basic alarm services.
- 1.161. From this overview, two broad themes emerge:
- Tensions between a desire to draw Telecare more closely into the assessment and care management processes against the use of call centres as a broader base for access to council services as a whole.
 - The adequacy of key-holder arrangements as a foundation for extension of Telecare.
- 1.162. One view presented was that integrating call response arrangements into Council-wide service access runs the risk of drawing Telecare away from being integrated into assessment and care management. This could have the consequence of making it more difficult to co-ordinate the consideration of and response to users' comprehensive Telecare and social care needs. An alternative approach which was being examined in detail in Highland, was the greater integration of Telecare with the existing NHS24 hub at Raigmore Hospital, thereby gaining efficiencies and drawing Telecare closer to integrated assessment.
- 1.163. The second theme, on voluntary key-holders, has particular relevance to remote and rural areas. In most areas, it is unrealistic to consider having any kind of first response based upon a formal paid service, with the exception of calls diverted to blue-light services because of the

nature of the information available. There were wide variations in practice from either no key-holder being available or circumstances where the nature of the call required a different response, for example, when a person had fallen.

- 1.164. The absence of a formal employed response team to deal with Telecare emergency alerts has been seen in most areas as a seriously limiting factor in extending Telecare to second and third generation phases. **Highland** has continued to progress to second generation provision, based on informal key-holders as first responders. Their experience is that close working with family members and key-holders, with a strong focus on initial reviews of how the service is working, can enable second generation development – environmental sensors etc - to proceed successfully in most cases.
- 1.165. A number of technological initiatives were described in **Angus**, which together represent a comprehensive set of measures to support people living independently in their own homes. They are described below.
- 1.166. Letham, had always been considered too small to support a dedicated GP practice, based about 5 miles from Forfar and 10 from Arbroath. For the last 14 years it has had a clinic with video-link to Forfar, which is now well-established and well-used. This is now being developed with further links to diagnostic equipment.
- 1.167. There is tentative work around links into vital signs monitoring equipment, but these are at an early stage and are not yet operational. The observation made was that there are signs it will be resisted as an alternative to hospital admission, since it is viewed as being less desirable, less reassuring.
- 1.168. There are well established practices with lower level monitoring equipment such as pressure mats, enuresis checks, door contacts (popular) and smoke detectors. The assessment is undertaken through care management.
- 1.169. At the time of information gathering, there was a new initiative on community safety, with the capacity for alarm users to have doorstep conversations recorded and transmitted to the call centre as protection against being subject to ‘roof repairers’ etc. The service is called ‘Doorstoppers’.
- 1.170. The general view appeared to be that Tele-health will have to be developed incrementally, since there is a high degree of resistance to change, especially where the initiative is being used to replace existing service. Any new service must offer tangible added-value to the user.

Residential Care and Specialist Care Housing

- 1.171. The areas reviewed reflected differences in the balance of resources by which care away from home was organised and delivered, although all had some kind of mix between residential care and supported housing. Moves to establish a financially sustainable, locally accessible, small-scale service, are reflected in a general direction of travel which is towards housing-based models.
- 1.172. **Highland** is one of three partnerships which were awarded additional Telecare Development Programme funding of £150,000 each for “demonstrator projects” – innovative approaches to shifting the balance of care through housing-based solutions which include Telecare.
- 1.173. In **Argyll & Bute** the Council has developed a Progressive Care Housing Unit on Jura along with a number of other housing initiatives. It operates as ‘extra care housing’, taking people with higher level needs thereby avoiding off-island placements. The unit has managed to support faster hospital discharges and is available to support measures to avoid hospital admissions. Currently the Council is reviewing how other accessible housing can be used to support faster hospital discharges in the Campbeltown and Oban areas. An extension of the Progressive Care Unit model is also seen as a viable alternative to care home placements and is to be developed in other areas.
- 1.174. **Orkney** has a well established very sheltered housing scheme on one of its islands, Westray, as well as a similar mainland facility, in addition to its range of residential care homes. Local health and social care partners are now embarking upon the development of an integrated health and social care campus in Kirkwall which will comprise a residential, continuing care and intermediate care facility as well as extra care housing. A small extra care housing scheme is also planned for St Margaret’s Hope.
- 1.175. In the **Western Isles**, a number of the previously designated ‘Care Units’, small residential homes without 24 hour staffed cover, are being converted into supported accommodation, with the remaining Care units being staffed up to provide 24 hour cover.
- 1.176. **Angus** has a wide range of sheltered and very sheltered housing, with a strong tie-in to the 24 hour emergency response teams for the alarm service. The area’s specialist housing also provides an important focus for it’s distinctive pattern of care services which was referred to earlier.
- 1.177. **Moray** has two Very Sheltered Housing complexes, and in recent years has achieved a significant shift in it’s balance of care from residential to very sheltered facilities.

- 1.178. Within the more traditional residential care models, developments are taking place which reflect the need to find appropriate mixes of care provision and skills that can be brought together to keep localised residential care relevant and viable. The very small facilities in **Shetland** and the **Western Isles** highlight the challenges of trying to provide for a mix of care in such settings, most notably their limited ability to provide effective care for people with dementia, and the general sensitivity that has to be applied in bringing people with a mix of needs together in a small intimate building.
- 1.179. However, in these same areas there are examples of residential care being developed across health and social care boundaries to provide for a broad range of needs. **Orkney** has no nursing homes in its area, but in fact its residential homes provide for a wide range of needs up to the point where people require continuous hospital care. Its latest planned development is being taken forward as a joint local authority / NHS facility.
- 1.180. The **Western Isles** has developed specialist dementia care units within its two larger homes, capital and revenue funded jointly with the NHS. The areas most recently built home has a dementia unit and also two beds funded by the NHS as a 'step-down' facility from the local hospital, coupled with clinical facilities for visiting medical staff and clinics for physiotherapy and podiatry, for residential and community use.
- 1.181. The **Borders** has a dispersed range of sheltered and very sheltered housing provision (total of 33 developments) and in conjunction with its ownership by the Registered Social Landlords; is prioritising the re-development and re-modelling of those suitable opportunities in each of the areas of the Borders to support the re-balancing of care e.g. new development in Peebles to provide Extra Care Housing.

Workforce Strategies

- 1.182. An important aspect of the RRIG agenda concerns workforce strategies and in particular the development of an integrated rural resource worker role with the potential to deliver joint health and social care staffing arrangements, more effective joint working and enhanced recruitment and retention of staff.
- 1.183. In this context it was notable that every area reviewed identified challenges around workforce recruitment, retention and training. One of the particular issues noted was the capacity to match the social care workforce to needs that in any one locality can change significantly over a short period of time.
- 1.184. Annualised hours within contracts, guaranteeing a regular level of income but permitting hours worked to be varied to match varying levels of demand, seemed to be being increasingly adopted. **Moray**

has a basic home care contract that guarantees 16 hours per week; **Western Isles** are in the process of introducing annualised hours, but as yet in pilot areas only. **Shetland** operates annualised hour contracts for staff from the Care Centres. Understandably, this approach seems most effective in areas that are remote and sparsely populated. In more accessible and densely populated areas, it is possible to move workers on fixed contracts from one work location to another, based on traditional non-flexible contracted hours.

- 1.185. In some remote and rural areas, home care staffing has long operated on a semi-casual basis where staff are recruited, hours increased / reduced, laid off, depending on the demand for home support in a particular area. This type of staff policy has some clear disadvantages and yet from the perspective of both employee and employer the introduction of guaranteed hours coupled with annualised hours is not universally popular. Features identified as being problematic include the continuing insecurity of income; inability to use contract for bank borrowing and disincentives to provide good quality training.
- 1.186. Those who are not guaranteed weekly hours can 'pick and choose' what work they do; contracts place a much greater onus on the staff member to agree to undertake requested work. On the other hand, for some the annualised hours contract has advantages over a fixed working week, allowing staff to develop a shift pattern that, for example, might be a better fit with a partner who also works offshore and is at home two weeks out of every five or six weeks.
- 1.187. Additional, or sometimes alternative, flexibility can be introduced through contracts that operate across residential and community care work. There is a greater imperative for this approach where the residential home is small and staffing levels may need to be varied to match the needs of the current cohort of residents. In larger residential homes, the staffing levels are more constant.
- 1.188. **Shetland** has developed a policy of flexible contracts within its Care Centres, which not only have annualised hours but also have flexibility for deploying staff within either community or residential care settings. This contributes to levelling out some of the peaks and troughs that occur in matching supply of care staff to demand, and provides flexibility for employment that adds to the attractiveness of this kind of work in a competitive jobs market. This approach, coupled with increased autonomy for budgets at the Care Centres, allows services to be developed in ways that more closely match local community needs.
- 1.189. **Shetland** is also working within a national framework, on the development and accreditation of a generic health care assistant post, focused on activities including supporting rehabilitation, health promotion, better management of chronic conditions, supporting

domestic and parenting skills. This post is particularly aimed at the enhancement of services on 'non-doctor' islands.

- 1.190. **Moray** has challenged the view that the pool of potential recruits for its home care service in rural areas had been fully accessed, a view based upon the experience of service managers who had considered on the basis of local knowledge and general community awareness, that the home care service in rural areas, was unlikely to benefit from further significant recruitment. They have undertaken an active recruitment drive in specific areas and held local public meetings to explain and promote the opportunities for work in home care. The result has been additional successful recruitment to the service.
- 1.191. There was generally good progress on integrated team-working, but less evidence of the development of an integrated workforce in the area of personal care, where the overlaps between the home care service and community nursing assistants has long been recognised. In most areas full integration had been established within Occupational Therapy but even this had met some considerable staff resistance, although the aggregate numbers of staff between health and local authority were in each case relatively small.
- 1.192. There were good outcomes from some joint training initiatives, with joint programmes for SVQ in place across social work and NHS staff. This approach is well regarded because it makes economic sense especially in rural scattered areas, but also because it supports the process of team-building and joint working.

Community Resilience

- 1.193. We have already seen that the more remote an area is, the more challenges exist to delivering services that are similar in type to those in more populated areas. A good example is local day care, where its operation in more remote areas is different from in urban centres. There are alternative opportunities within small communities, an example given in *Delivering for Rural and Remote Health Care*, and evidenced in responses to this review, being the development of 'First Responders' as a support mechanism for emergency medical response in rural areas.
- 1.194. In a number of remote areas in **Moray** there has been a move to enable service-users to have more self-determination over social care services. In Tomintoul, for example, the lunch club (supported by the Partnership) in order to continue had to become self-funding. The development worker for the Partnership facilitated lunch club members in developing an alternative that would be self-sustaining and also provide a more inclusive quality service. The outcome was the development of a "lunch social group" which provides for greater inclusiveness, more choice, is sustainable and social group members

manage the club themselves, albeit at increased cost to the individual service-user.

- 1.195. A number of other initiatives are underway in Moray with objectives that include; improving the health and well-being of older people by fostering companionship, improving confidence and self-esteem, raising activity levels and offering sustainability by community capacity building; a rural therapeutic service which enables service-users in rural areas to access support mental health services within their own locality and providing information on a wide variety of topics particularly focussed on teenagers and young adults as well as the development of dedicated Information Points.
- 1.196. More generally, the absence of reference to the use of local village facilities to support local service delivery suggests that there is potential for their use to be increased and for such as mobile day hospitals or rehabilitation services to operate closer to people's homes.
- 1.197. Community strength was evident in the ways in which palliative care services are delivered. Most areas, for example, followed a different protocol for community nursing than for palliative care. Where the standard arrangement was for emergency and routine community nursing service to transfer to on-call or specialist evening service, it is often the case that the local community nurse will provide service for palliative care in evenings, and at other times. There are also various partnership arrangements in place for this service, with Marie Curie nurses providing direct nursing care, and with Macmillan Crossroads providing personal care.
- 1.198. 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, can be more nimble-footed in providing short-term responses whilst still retaining their ability to provide longer-term services. Private sector agencies for community-based health and social care are thin on the ground in rural areas, for obvious reasons of viability, and the voluntary sector is a substitute resource.
- 1.199. In **Angus**, Sue Ryder has been contracted by NHS and Social Work to provide some palliative care (not end of life), which can deal with routine medication, and social care, although longer-term social care is provided through direct services. The use of the Sue Ryder service supplements an existing directly provided service which offers a short-break scheme including home based respite.
- 1.200. There are a number of other peripheral services which are not contracted, such as a befriending scheme in Monifeith. Eighty percent of day care is provided by the voluntary sector, mostly local agencies rather than branches of national organisations, with the remaining 20%

being concentrated on dementia care and provided directly by social work.

- 1.201. In **Moray**, Crossroads Care is active in Speyside and there are no substantial issues about differential availability in more remote areas. Quarriers are contracted for some carer support services, and Red Cross run a befriending scheme in Keith & Dufftown.
- 1.202. Marie Curie nursing is available for home support and is regarded as being a very effective and responsive service with a local organiser employed to cover the needs of the Grampian area. As well as nursing, it can provide supplementary services for social care cover and relief for relatives.
- 1.203. **Shetland** has a voluntary sector that has traditionally been well-supported through the Council and the Charitable Trust, but not the Health Board. A number of organisations focused on idiosyncratic areas and also on acting as advocates for particular interest groups, but there was also an array of service providers within the sector.
 - WRVS – now getting to be re-established after period of problem recruitment, their main activity being in the meals-on-wheels service.
 - CAB – has a focus on carer support and neighbour mediation and is well-regarded as a high quality service provider.
 - ‘Moving-on’ – good mental health support service.
 - Crossroads – engages in a positive partnership with the statutory sector, but faces the same problem as statutory section in recruiting staff.
 - Befriending scheme
- 1.204. Meals-on-wheels are well established and the **Shetland** Isles Council has a commitment to ensure that this service is universal across the area. WRVS are involved in the organisation of this service. Meals are provided from care centres, school kitchens and other sources, with delivery by a range of means including local taxis. A reported downside of this commitment to a universal approach to the service can lead to, for example, a taxi fare of £28 to deliver one meal.
- 1.205. In the **Western Isles**, two principal partner agencies in the delivery of care services are Alzheimers Scotland and Crossroads Care. Crossroads Lewis has a substantial role in carer support, including a service focused on terminal care funded through Macmillan. Alzheimers Lewis and Harris provides carer support and day centres. Crossroads Harris, the longest established of these services, is well regarded and well supported by the small population there.

- 1.206. With support and funding from the Council and NHS Board, two distinct local services were separately developed in Uist and in Barra, uniquely drawing together joint overall leadership from Alzheimers Scotland and Crossroads Care, known as Tagasa Uibhist and Cobhair Bharraigh, each providing a combination of outreach and day care support focused mainly on carers' needs.
- 1.207. **Borders** support a community capacity building service through the voluntary sector. Two neighbourhood link workers are employed and a further four members of staff are being considered to expand the services. Each older person referred is put in contact with a suitable activity and/or service in accordance with their needs and interests.
- 1.208. **Orkney** has a partnership with Age Concern, which is very active locally and provides a general support service. Age Concern has a specific function in the installation and maintenance of equipment for the community alarm service, a function that transferred to them from being a direct council service 7 or 8 years ago. Previously, the demands of the service, which are irregular, had from time to time intruded into the other duties of the OT technician. Age Concern has a full-time administrator and access to two retained technicians who are employed on a sessional basis. It also undertakes an active morning schedule of calls to certain clients.

Looking Forward – Plans and Aspirations

- 1.209. Most areas identified some or all of the aspects outlined below as being work in progress or something that they intend to address in due course.
- 1.210. *Accommodation with Care*: The development of Extra Care Housing and work to ensure that all future care home provision is of sufficient quality to meet the complex and higher level needs of an increasingly older resident group.
- 1.211. *Sheltered housing warden services*: Reviews of warden services for Sheltered Housing, are examining the potential for community warden support to include other types of housing tenure rather than being confined to defined sheltered housing schemes.
- 1.212. *Home Care re-design*: Looking to develop the role of intensive home carer as distinct from carers providing less intensive, non personal care. This new role will be supported by plans to introduce a higher rate of pay for home carers providing personal care compared to those undertaking domestic tasks. There are plans to integrate with district nursing as part of a wider review of nursing in the community. In many local communities, health and social care workers have pre-existing working relationships and when this feature is combined with the traditionally low turnover of staff in rural areas this provides a positive basis for re-designing service models and working practices.

- 1.213. *Development of Carers strategy*: This is to include training for carers, involvement in the commissioning process and using Talking Points as the basis for delivering information/engagement. The NHS Carers Information Strategy supplements the funding that is available from the Local Authority for local Carers support organisations and to develop outreach support away from the larger population centres.
- 1.214. *Intermediate Care and Rehabilitation Services*: Developing a range of short-term services to promote early discharge or prevent inappropriate admission to hospital and/or a care home.
- 1.215. *Preventative Services*: Development of low level services to support older people in the Community.
- 1.216. *Shared Services*: An area of substantial discussion between health and social care but little progress has been achieved to-date except for some progress in discussions with NHS Highland regarding audiology services.
- 1.217. *Joint day services review*: This will look at bringing together NHS and social care day provision to enable a rationalisation of building use and integration of roles and service models.
- 1.218. As a footnote to this section, it was notable that despite their acknowledged significance in supporting speedy and appropriate access to services, developments in assessment and care management arrangements did not feature highly in responses from partnerships which described recent or ongoing service improvement activity. All areas were engaged in implementing the roll-out of the electronic Single Shared Assessment (SSA) and related E care programme and whilst this in itself was said to be a major development, its impact was as yet unclear.
- 1.219. Feedback on the development of community resilience focussed primarily upon the role of voluntary sector agencies. Developments in the way that informal carers were supported and measures to better incorporate their role into service planning and delivery arrangements were rarely commented upon.

4. SUMMARY OF KEY ISSUES

The Nature of Rural and Remote Areas

Definition of Rural and Remote

- 1.220. The shape of care services, especially supported housing, residential and home care, may be determined by some very specific features of population distribution and geography that the working definitions of remote rural do not adequately capture.

- 1.221. It is important to assess the influence of the development of rural transport infrastructure - causeway, bridge, road - on the delivery of care services.
- 1.222. Does the potential for change in care services play a part in decisions on infrastructure, or are they dependent on harder economic factors?
- 1.223. Would a more detailed categorisation for defining 'remote and rural' assist in better understanding of key drivers for change and service delivery arrangements?

Change and Decision Making in Rural and Remote Areas

- 1.224. In many cases the basis upon which services were designed or developed was not principally driven by current national policy and strategic agendas around outcomes, shifting the balance of care and service modernisation.
- 1.225. Often decisions to change services did not reflect what local professionals considered to be the most appropriate and/or cost effective way of achieving the desired objective for service users.
- 1.226. This feature of the changes that were reviewed therefore begs the question of why this should be the case?
- 1.227. It is often the case that in rural and remote areas economic and infrastructure considerations are often the key drivers for change because of the particularly fragile nature of their economic and business environment. This change, often presented in terms of enabling people in rural areas to benefit from facilities already enjoyed by city-dwellers, can however result in unintended consequences for people's lives and the other services they depend upon.
- 1.228. In many situations even relatively small changes can have a large impact – both added value for service users but also loss of income or altered focus of investment into larger towns and villages thereby affecting staff, suppliers and small local businesses.
- 1.229. This is often particularly the case when change is wrought upon residential care facilities or long established GP or community health services, including closure or substantial re-modelling. Not only will there often be the visual impact and community resistance to having a vacant building in their midst and/or the uncertainty associated with a new-build scheme, but there is the potential impact upon livelihoods, where few other alternatives are likely to exist.
- 1.230. Such changes often bring substantial changes for people living in towns and cities as well as rural areas but the nature of rural society, with its multiple and over-lapping professional and personal relationships, is such that individuals working or living in key positions

or locations can have a disproportionate influence upon how change is perceived and its impact represented.

- 1.231. The description of a 'goldfish bowl' is often applied to the visibility of professional people in small rural settings, but the more important influencing factor seems not just to be visibility but the multiple relationships that people have within a localised community.
- 1.232. This means for example that a change programme, with a key objective of providing an improved, more cost effective care service, which requires renegotiated working conditions, is much more likely to have impediments placed in the way of implementation if the change is judged not to be in the best interests of the current workforce. A similar dynamic also often arises in the representation of local interests around physical planning issues.
- 1.233. In an urban setting, workforce interests are likely to be expressed through whatever formal union engagement is built into the process; in a typical rural community, some of the workforce, or persons close to them, are likely to have additional relationships with some of the key players in the decision-making process. Consequently, the opportunities for representation of the staff viewpoint are multiplied.
- 1.234. In some instances the roles and related skill sets of care staff need to change as a result of proposed service changes. In many rural areas, such a prospect generates significant resistance from amongst the staff involved, which goes beyond what might be expected elsewhere. Residential care work seems to have a status that is not afforded to it in cities, where residential staffing is often characterised by low wages and high turnover. Home care work, on the contrary, does not carry the same status in rural areas. So any suggestion that residential staff move towards also providing home care is likely to face resistance.
- 1.235. Whilst it cannot be said that staff have an effective veto on change; to be successful in seeing through the approval and implementation of change, requires additional time and energy to be committed to community and staff engagement in order to make sure that the positive case for change, based on sustainable services and employment arrangements, is presented to these stakeholders in ways that are balanced and persuasive.
- 1.236. It is therefore true to say that there is a different overall power balance between 'the authorities' and the community when it comes to presenting a positive case for change. Whilst some developments may have unintended consequences many will lead to some disruption for the interests of others and it is these groups and individuals who are, by virtue of their community networks and perceived authority, able to exert substantial and widespread influence over key stakeholders in rural and remote areas.

Aspects of the Change Agenda

Shifting the Balance of Care

- 1.237. Positive community engagement is especially important in rural areas to support change in service delivery, because the nature of community networks increases their power.
- 1.238. Many service changes appear to be based on opportunities (eg. tying in with staff turnover) rather than being more wide-ranging and strategic. Changes from hospital / residential home beds to home-based / supported accommodation services are challenging and often, on balance, the outcome is viewed as a loss of service.
- 1.239. There are examples of modernising the use of community hospitals to support localised services but these hospitals tend to be very protected by their local communities.

Access

- 1.240. The trade-off between local, very accessible services and those services that require specialist knowledge and expertise and therefore are more centralised, is a complicated balance but one that has a general level of public acceptance. Non-local services may also play a part where confidentiality is of special importance.
- 1.241. Expectations can vary considerably between rural communities that appear to be very similar. These expectations are often based upon a complex mix of what has historically been provided in that locality, what local residents have experienced elsewhere (and that is influenced by the number of 'incomers'), and a growing awareness of what a 'reasonable' level of service means.
- 1.242. Travel time and cost is a key factor in shaping services for rural areas. There would be benefit in modelling the costs & benefits of the range of mobile services in Angus against the more traditional pattern in many other areas.
- 1.243. Low-level maintenance home care services appear to be more difficult to sustain in remote areas, although the practice in Angus contrasts with the general trend.
- 1.244. The different emergency response systems which apply within some regions, often because of varying levels of remoteness, need to be accompanied by approaches that support undifferentiated outcomes. Where it is not possible to have a full medical assessment of a patient at home because of where the patient lives, the creation of a designated assessment unit may help to counterbalance the risk of avoidable lengthy admission.

- 1.245. Assessment and care management arrangements did not feature highly as an area for development other than as regards the roll-out of the electronic SSA.

Critical Mass and Service Viability

- 1.246. Care centres and other service hub models help develop critical mass.
- 1.247. The criteria by which the viability of routine and responsive mobile care services, such as the overnight support service in the Western Isles, are assessed need clearer analysis
- 1.248. 'Viability' may sometimes be judged on additional current revenue costs, rather than longer-term cost benefit analysis
- 1.249. Supported housing developments – e.g. Orkney / Jura – can be viable where residential care could not, but they need to fulfil a flexible role to meet changing local needs
- 1.250. The process of service redesign needs to take account of the likelihood that there will be resistance to change which may otherwise represent an appropriate and proportionate response to factors such as population drop in certain areas – e.g. location of GP practice areas.

Community Resilience

- 1.251. The voluntary sector appears to have an expanded role in many rural areas, filling a gap that is not as readily taken up by private sector agencies. It also seems able to provide services that are better able to operate flexibly and respond more quickly to changes in user needs, possibly because they are less constrained by bureaucratic structures.
- 1.252. Some elements of community resilience create ambivalent feelings in the community. A 'First Responder' system is used as an example of positive community resilience, supporting fragile local communities; it is in some cases however cast in a less positive light because of the absence of adequate statutory provision that it implies, and the disincentive that it represents for authorities to deliver that provision.
- 1.253. Locally informed budget setting processes such as in Argyll & Bute are an example of innovative community engagement.
- 1.254. There are some examples of substitution by the voluntary sector to sustain the viability of a fragile service, such as the community alarm service in Orkney.
- 1.255. There was little reference to developments in the way that informal carers were supported and the means by which their views inform service planning and delivery.

5. AREAS FOR FUTURE STUDY

- 1.256. Three issues presented particular challenges to joint working and the introduction of integrated services in rural and remote areas in most of the areas involved in this review.
- 1.257. The issues were:
- access to responsive, joined up health and social care services out-of-hours.
 - the further development of joint front-line care and support posts across health and social care.
 - the development of integrated working practices and delivery arrangements across a variety of services and agency boundaries.
- 1.258. It is proposed that the next phase of this study should look in more detail at how the first two of these important issues can be addressed in two different rural and remote areas. The third issue - that of integrated working practices will of course, be considered in the context of both out-of-hours services and joint worker roles. More widely, Quality Improvement Scotland (QIS) is understood to be considering how best to identify and promote good integrated practice across Scotland.

Overnight Care Services

- 1.259. This work will take place in Argyll & Bute and in the Western Isles both of which have population clusters and very remote areas, resulting in differential access to overnight care. The work will focus in particular upon the joint working and integration aspects of overnight care services and will take account of work that is being undertaken in a number of other areas to develop this aspect of local services. It will look at what currently impedes access to overnight care and compare practice across the two areas.
- 1.260. It will start with an overview of the arrangements currently in place for planned and responsive access to overnight care services, including the interaction between on-call assessment and care provision for community nursing and social work, and the relationship with NHS24 (or other GP on-call), with the Tele-care arrangements and with any independent sector care services.
- 1.261. An initial stage of this work will examine the care outcomes for people referred for overnight support who are unable to be provided with care at home.
- 1.262. The approach taken will be to examine ways in which a more integrated approach to health and social care services out-of-hours could improve the opportunities for care arrangements being put in

place, where infrequency of demand, absence of readily available staff or other issues currently present barriers to planned or responsive overnight care at home services.

Rural Workforce

- 1.263. This work will begin with a review of current rural resource worker / integrated care worker development activity, with particular reference to the work being led by the Rural Health Research Centre and also, the recently completed SSSC/NES commissioned research to scope the skill sets and qualification requirements of similar health and social care posts.
- 1.264. The review will be look at work being undertaken in 2 partnership areas, but will keep an eye on any other current initiatives across Scotland. It will:
 - Focus upon practical aspects of the development of joint posts and the related implementation process, including HR, legal and governance aspects.
 - Consider the potential interface of progress on joint posts with other aspects of the rural and remote workforce agenda and review in case study sites.
 - Compare and contrast key issues, what works and what does not, within the 2 areas.
 - Identify possible routes to develop/innovate around the implementation process.

APPENDIX ONE – SUMMARY OF KEY ISSUES FROM ‘SUPPORTING PEOPLE IN REMOTE AND RURAL AREAS’

Supporting People in Remote and Rural Areas: A Framework for Analysis.
Professor Bob Hudson of the University of Durham

Population distribution and trends

- The problems of definition of ‘remote and rural’, in terms of a clear distinctive line between remote rural and non-remote rural.
- The demographic trends of increasing numbers of older people, fewer adults of working age

Access and Resources

- Meeting service standards for low population numbers
- Dealing with fluctuating levels of population
- Less provision of lower-level services, such as basic domestic assistance through home care
- Transport problems
- Likelihood of longer hospital admission because of the difficulties of delivering complex home support

Workforce Issues

- Recruitment and retention of professional staff
- Professional isolation – fewer ancillary services
- Lack of service user choice
- High visibility of professional staff

The report moves on to examine specific strategies for addressing the challenges presented in remote and rural areas

Strategies

- Tele-health / tele-care
- First generation: key-holder alert
- Second generation: environment sensors, vital signs monitoring
- Third generation: tele-consultation through broadband or wireless technologies

Workforce strategies

- Third generation: tele-consultation through broadband or wireless technologies
- Recruitment and retention
- Embedded practitioners
- Generalist practitioners
- Integrated teamwork (Extended Community Care Teams)

Strategies to support independence

- Extra care Housing
- Personal budgets

Community Development

- Developing social networks
- Building community resilience
- Local Area Coordination

Partnership Strategies

- Horizontal and vertical integration
- Between service sectors
- Between professions
- Between institutions and the community
- Between statutory, private and voluntary
- Between types of care (such as acute and long-term)

APPENDIX TWO - STUDY AREA CONTACTS

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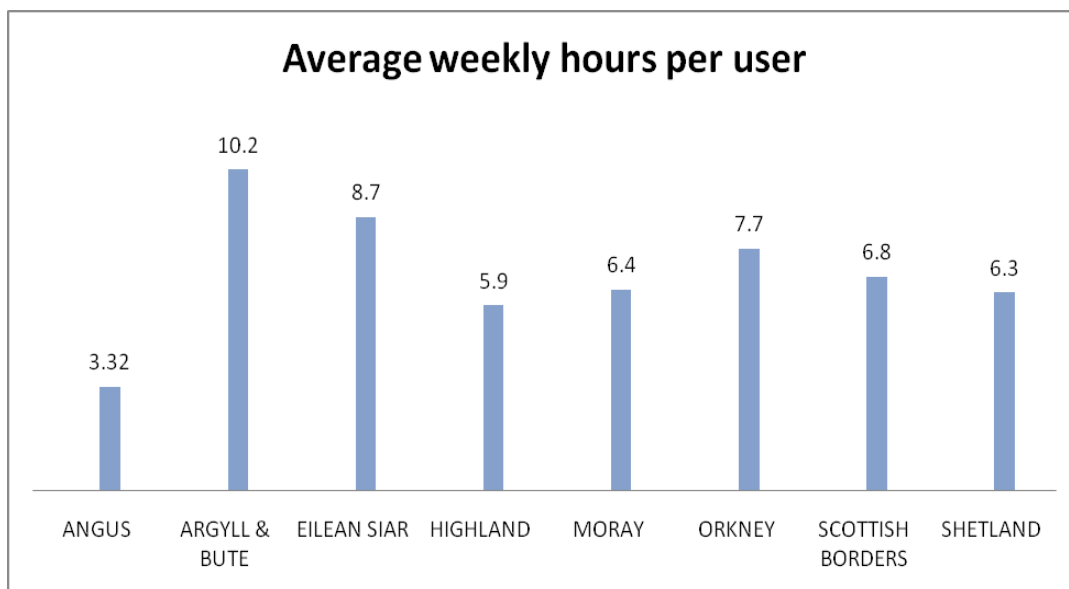
APPENDIX THREE – POPULATION DENSITY BY COUNCIL AREA

Population density by Council Area, 2001 Census			
	2001 Census Population	Area (hectares)	2001 Density (number of people per hectare)
Aberdeen City	212,125	18,576	11.42
Aberdeenshire	226,871	631,259	0.36
Angus	108,400	218,178	0.50
Argyll & Bute	91,306	690,899	0.13
Clackmannanshire	48,077	15,864	3.03
Dumfries & Galloway	147,765	642,601	0.23
Dundee City	145,663	5,983	24.35
East Ayrshire	120,235	126,216	0.95
East Dunbartonshire	108,243	17,461	6.20
East Lothian	90,088	67,918	1.33
East Renfrewshire	89,311	17,379	5.14
Edinburgh, City of	448,624	26,373	17.01
Eilean Siar	26,502	307,094	0.09
Falkirk	145,191	29,737	4.88
Fife	349,429	132,486	2.64
Glasgow City	577,869	17,549	32.93
Highland	208,914	2,565,934	0.08
Inverclyde	84,203	16,046	5.25
Midlothian	80,941	35,369	2.29
Moray	86,940	223,756	0.39
North Ayrshire	135,817	88,539	1.53
North Lanarkshire	321,067	46,981	6.83

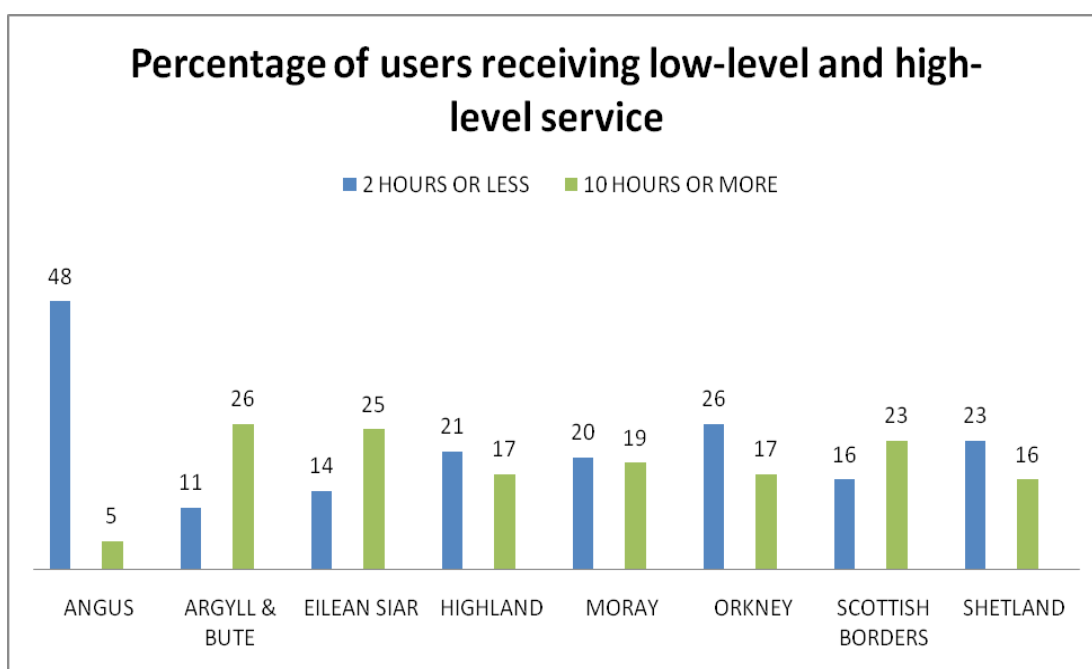
Orkney Islands	19,245	98,990	0.19
Perth & Kinross	134,949	528,581	0.26
Renfrewshire	172,867	26,109	6.62
Scottish Borders	106,764	473,176	0.23
Shetland Islands	21,988	146,648	0.15
South Ayrshire	112,097	122,199	0.92
South Lanarkshire	302,216	177,193	1.71
Stirling	86,212	218,735	0.39
West Dunbartonshire	93,378	15,890	5.88
West Lothian	158,714	42,733	3.71
Scotland	5,062,011	7,792,452	0.65

Source: General Register Office for Scotland

APPENDIX FOUR – COMPARATIVE HOME CARE INFORMATION



Data from 2008



Data from 2006

Source for comparative statistics:

<http://www.scotland.gov.uk/Publications/2008/08/27154843/2>

<http://www.scotland.gov.uk/Resource/Doc/1095/0042211.xls>