



**Remote and Rural
Implementation
Group**

**Final Report of the Remote and Rural Implementation Group
October 2010**

Forward

The Remote and Rural Implementation Group was established to oversee the implementation of the recommendations of Delivering for Remote and Rural Healthcare¹, published by Scottish Government, in May 2008. This Report is the final report of a two-year programme, led by the Remote and Rural Implementation Group (RRIG), prepared for Scottish Government and NHS Boards across Scotland and summarises the significant progress taken to ensure that healthcare in remote and rural Scotland is sustainable for the long term.

The report begins with a summary of the key achievements of RRIG, which are not inconsiderable, before moving on to a report on our activities, particularly in relation to the workstreams that RRIG led on behalf of NHS Scotland. Whilst the programme was time-limited, the work to sustain services in all Boards and particularly in remote and rural Boards is an ongoing exercise that extends beyond the life of a time-limited programme. Each section of the report, therefore, highlights work that we know will continue and where appropriate, make recommendations to review the current policy direction, in light of changing circumstances. Those recommendations are made in the context of the NHS Scotland Quality Strategy for person centred, safe, effective and sustainable healthcare.

I commend the Report to you and strongly urge NHS Scotland to adopt these recommendations and urge colleagues across Scotland to work collaboratively to take forward our recommendations.

Dr R Gibbins
Chair
Remote and Rural Implementation Group

October 2010

¹ (2008) – 1: (2008) "Delivering for Remote and Rural Healthcare" May 2008, Scottish Government, Edinburgh. RR Donnelley B 56045 05/08

Key Achievements of the Remote and Rural Implementation Group

- Ensured that the 63 Commitments and 20 Forward Issues identified by Delivering for Remote and Rural Healthcare were delivered.
- Developed an Education and Performance Management Framework that will ensure that services within remote Community Hospitals can deliver the Quality Ambitions of NHS Scotland.
- Defined what conditions will be treated and cared for in a Rural General Hospital, including by a visiting specialist and those which will be transferred to another hospitals, ensuring that these are available to clinical staff, managers and the public.
- Described a sustainable model of care within an RGH, including how that can be sustained for the future.
- Developed and launched the Strategic Options Framework for Emergency and Urgent Response that people living within remote and rural communities can expect. This Framework is standards based, clarifies who is responsible for what and describes the different types of response that may be available.
- Established an aero-medical Emergency Medical Retrieval Service for remote and rural Scotland.
- Defined what an Obligate Network is and identified areas where these should be introduced.
- Established new Specialist Training programmes for specialty training in remote and rural General Surgery; Remote and Rural Anaesthesia and established a new training programme for general practitioners to train for additional competency in General and Internal Medicine.
- Implemented the development of Practitioners with a Special Interest (PwiSI) within Nursing and AHP professions. Two nursing programmes were established: PwiSI in Dementia Care and a PwiSI in children's care.
- Ensured the establishment and ongoing need for the Remote and Rural Healthcare Alliance (RRHEAL).
- RRHREAL have ensured that appropriate, accessible education has been developed or is available for remote and rural Learners. Early successes include Mental Health Crisis Intervention Courses; Core level paediatric Emergency Care for remote and rural areas; generic support worker education programmes and advanced education for radiographers to support the roll-out of a multi-skilled radiographer.

This Report is the final report of the Remote and Rural Implementation Group, prepared for Scottish Government and NHS Boards across Scotland and summarises the significant progress taken to ensure that healthcare in remote and rural Scotland is sustainable for the long term.

Background

In 2008, following an extensive period of consultation, the Cabinet Secretary for Health and Wellbeing launched 'Delivering for Remote and Rural Healthcare' as the Framework for delivery of a sustainable model of healthcare for remote and rural Scotland. Scottish Government subsequently promulgated this framework as Scottish Government Policy by Chief Executive Letter, CEL 23 (2008)².

The Framework extended across the continuum of care, from the need for community resilience and integration between health and social care within local systems, through the role of hospitals, including remote Community Hospitals and the newly established category of Rural General Hospitals, to the workforce, transport and technological solutions required to sustain appropriate local access to care.

CEL 23 (2008) established the Remote and Rural Implementation Group, under the auspices of the North of Scotland Planning Group (NoSPG) to oversee and report to Government on the implementation of the 63 commitments and 20 forward issues, identified in the report as necessary to sustain local services within remote and rural services for the future. These commitments were aimed at a variety of stakeholders, including NHS Boards and their Community Health Partnerships (33 commitments); NHS Education for Scotland (NES); the Scottish Ambulance Service; NHS Quality Improvement Scotland (NHS QIS); RRIG (20 commitments); NHS Scotland as a corporate whole and Scottish Government Health Department. The Joint Improvement Team (JIT), which is jointly sponsored by COSLA, the Scottish Government and the NHS works directly with Community Health Partnerships (CHPs) to promote and support effective partnership working. The JIT joined the RRIG shortly after its inception in order to ensure effective links with the partnership aspects of service planning and delivery in remote and rural areas.

The Implementation plan was projected to take two years and was due to end in July 2010.

² (2008) – 2: CEL 23 (2008) "Delivering for Remote and Rural Healthcare" May 2008, Scottish Government, Edinburgh
The Remote & Rural Implementation Group

Remote and Rural Implementation Group

The Remote and Rural Implementation Group (RRIG) was established by NoSPG in April 2008, chaired by Dr Roger Gibbins, Chief Executive of NHS Highland. Dr Annie Ingram, Director of Regional Planning and Workforce Development was identified as the Project Director and Mrs Fiona Grant was appointed as the National Programme Manager. Continuity from the development stage was seen as important, with all three individuals, along with a number of other RRIG members who had been key to the development of the Framework, populating this national group. Membership of RRIG is attached at Appendix 1.

RRIG has met quarterly since April 2008, with four meetings during 2008 and four meetings in 2009. In 2010, there have been two meetings, including a final meeting of the group on 16th September 2010. In September 2009, RRIG also hosted a Sharing and Learning Exchange event in Nairn.

The role of RRIG was two-fold: to oversee implementation of the Framework, with the majority of actions to be progressed by Boards; and to progress a number of cross-cutting actions, where RRIG was identified as responsible for developing the response to the Commitments and Forward Issues to the point of decision and implementation. RRIG established five workstreams to progress these Commitments, as follows:

- Service Models and Care Pathways
- Emergency Response and Transport
- Obligate Networks
- Workforce and Education
- EHealth and Infrastructure.

RRIG was not directly accountable for the individual national or NHS Board actions but provided overall direction, support and performance management to Scottish Government Health Department on the project in its entirety.

Delivering the Commitments

Delivering the 83 recommendations, identified in Delivering for Remote and Rural Healthcare as 63 commitments and 20 forward issues, as identified above, has been the responsibility of a number of different stakeholders. In addition to leading the RRIG workstreams, through sub-groups, RRIG also was charged with monitoring implementation of the recommendations across the health system in Scotland. As part of that process, RRIG was required to collect information from a range of sources on a six monthly basis and submit this to the Health Management Board of Scottish Government as a performance management report. Performance Management returns have been sought from the 14 territorial NHS boards, Scottish Ambulance Service, NHS QIS, RRIG workstreams and RRHEAL and provide evidence of achievement.

The performance management reports have been collected and reported in sections with actions appropriate to the responsible stakeholder, with the RRIG actions, national and Scottish Government actions and Board/CHP actions each reported in different sections. Whilst this was appropriate for that process, it was agreed that for this final report, it would be important to consider the Commitments and Forward actions, as they appear in Delivering for Remote and Rural Healthcare, to ensure that all of the commitments have been met and there is action to address the Forward Issues.

The Commitments and Forward Issues, as each appears in the text of Delivering for Remote and Rural Healthcare are reproduced in Appendix 2. This Appendix also identifies those responsible for progress and a brief summary of evidence of progress, gathered from the performance management returns, submitted to RRIG.

These Performance Management returns were reviewed to determine what evidence was available to confirm that a given commitment was being met. The evidence was categorised as no evidence, limited evidence, evidence and significant evidence³ and a summary of progress overall against each Commitment and Forward Issue was reported.

Some Boards, particularly those with a largely urban catchment, intimated that the work was not relevant to their Board, although in some cases these Boards did provide some evidence of action to the specific Commitment or Forward Issue. There was also concern, expressed early in the project that the RRIG performance management returns duplicated some required by other areas of Government and therefore

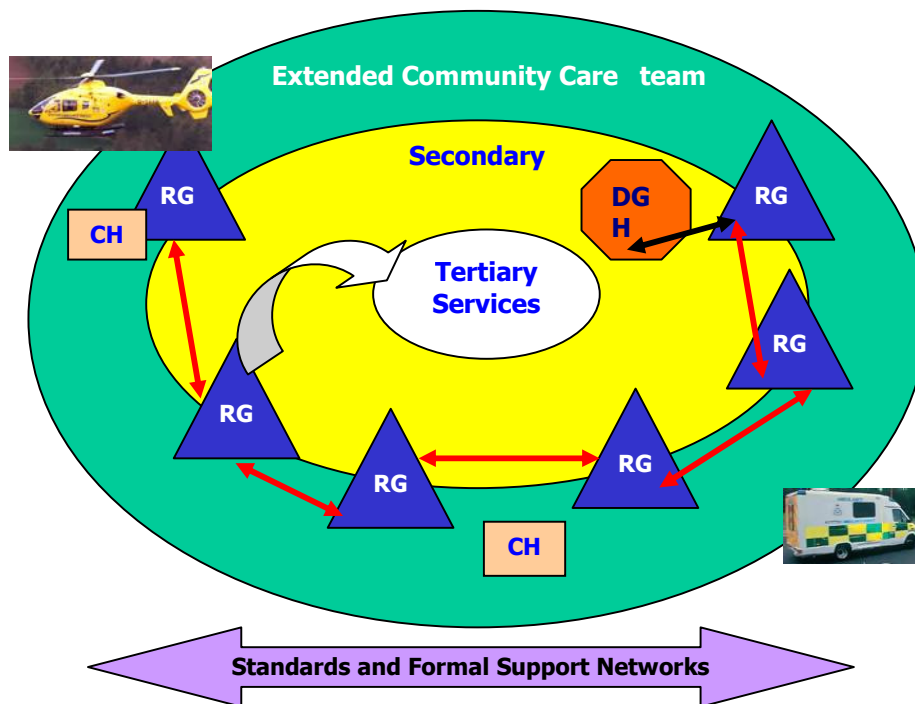
some Boards did not complete, or only partially completed the returns. Where no evidence is reported, therefore, this does not imply that no action has been taken, simply that no evidence was provided to judge this.

RRIG Workstreams

A brief summary of the actions taken and progress towards achievement of the objectives of each RRIG workstream is described below. Detailed progress against individual Commitments or Forward Issues is described within Appendix 2.

Service Models and Care Pathways

Delivering for Remote and Rural Healthcare clearly described a framework for sustainable healthcare in remote and rural communities, which was system wide. The pictorial model used to describe the requirements is reproduced below:



³ Limited evidence was used when a respondent, when asked a question answered yes or no and provided no further information. Evidence was used where some text was used but did not give detail; significant evidence was used where there was lengthy explanation.

The work to establish this approach was mainly directed at Boards, working through Community Health Partnerships and with wider public sector partners and evidence has been produced that would suggest that many of the identified actions have been progressed.

Support for this work was also provided by the JIT, which commissioned Professor Bob Hudson of the University of Durham, to produce a report which summarised and explored current approaches to addressing the health and wellbeing needs of people in remote and rural areas and to develop a framework for further policy analysis and exploration.

There is significant evidence, within the Board returns that the system of care in remote and rural communities is based on fostering community resilience, with integrated teams supporting self-care and anticipating health needs to avoid crisis in long term conditions. Both territorial NHS Boards and SAS report local access to emergency care systems within communities and the Strategic Options Framework, developed by the Emergency Response and Transport Workstream of RRIG, reported later, will further progress this.

Further work by the JIT involved a study of service development and innovation in the delivery of joint health and social care and support services in remote and rural areas, which was reported to the RRIG in May 2009. Through this study the importance of Out of Hours arrangements for Care at Home services in helping to avoid unnecessary hospital admissions was highlighted and further work was undertaken to scope current arrangements and to identify the key challenges faced by providers. An initial report was provided to the RRIG in March 2010.

Remote Community Hospitals

The importance of the Remote Community Hospital in supporting the changing needs of local communities was recognised by Delivering for Remote and Rural Healthcare⁴, and a number of core services were recommended. Evidence suggests that a number of Boards have reviewed the current model, in line with the recommendations.

The spectrum of care provided by Community Hospitals varies with population density and health need, the physical facility and the skills of the workforce. In remote areas, a number of the Community Hospitals provide acute care and an extensive range of services for their local population. At the September 2009 event, sustainability of these acute care facilities, was highlighted and a number of

⁴ (2008) -1:p17-19

issues that related to the workforce, particularly the general practitioners who undertake extended roles within these facilities, in some places working exclusively in a hospital setting. A separate focussed piece of work was therefore taken forward during the first half of 2010 to develop a better understanding of the role of such facilities and what was required to ensure the ongoing sustainability of local services, particularly ensuring that the doctors who work in these facilities have access to the right type of training and education on an ongoing basis, and work within a robust clinical governance structure that demonstrates both quality and safety of services.

Work had been taken forward, as part of Delivering for Remote and Rural Healthcare to develop what was described as Intermediate Care Competencies⁵, however, validation of this approach has been challenging. Changes to the regulation of Medical Staff and the introduction of licensing and revalidation⁶ have caused concern, particularly amongst those doctors who are registered with the General Medical Council, as a general practitioner but work exclusively in a hospital facility.

During 2010 two workshops were held that aimed to clarify the service and workforce requirements facing the General Practitioners and agree a way forward.

Initially, the work concentrated on three remote Community Hospitals described as having similar workloads and patterns of care, including the Balfour Hospital in Orkney, which is defined as an RGH but unlike in other RGHs, acute medical care is provided by GPs; the New Galloway Hospital in Stranraer; and Broadford Hospital in Skye⁷. In addition, the work also included three other smaller remote community Hospitals, Uist and Barra Hospital in Benbecula; Islay Hospital and Nairn Town and County Hospital, where the care is also GP led but is linked to a GP practice. The work sought to clarify the commonalities and differences between the Hospitals, define the skills required to work in these environments and design a system of appraisal and revalidation that would satisfy the regulator.

The outcome of the work is a Framework that:

- Describes the role of each hospital;
- Defines the additional skills and competencies required of GPs to provide care within these hospitals;
- Provides a matrix of educational requirements;

⁵ (2008) -1: p69

⁶ www.gmc-uk.org/doctors/revalidation

⁷ It should be noted that there are other Community Hospitals that provide a similar range of services to those already included within this work, notably Campbeltown Hospital and the Mid-Argyll Hospital in Lochgilphead.

- Describes a range of performance measures that practitioners have agreed will be used to benchmark performance; and
- A proposed approach for appraisal and revalidation.

Work is underway by RRHEAL to match the educational requirements to pre-existing programmes and identify where additional programmes are required. A Remote Community Hospital Obligate Network has been proposed that will provide peer support, co-ordinate and support education, develop and benchmark for these hospitals. This work has been supported by a number of the Medical Directors from these remote areas.

Confirmation is being sought from the RCGP that revalidation for this group of doctors will be through the Royal College of General Practitioners.

One issue that has been identified but has yet to be resolved are remuneration arrangements and the need for a consistent approach across Scotland.

Continuing Actions

- NoSPG will provide continued support to ensure completion of the Framework and work with Remote and Rural Boards to test the approach within the identified Hospitals.
- RRHEAL will complete the review of educational requirements and develop and agreed Education pathway for Remote Community Hospitals.
- NoSPG will work with the Association of Community Hospitals, NES and other stakeholders to ensure that an appropriate Framework is available to other Remote Community Hospitals.

Recommendations for the Future

- The Medical Directors of Remote and Rural Boards should ensure that there is agreement between the Boards and the Regulator on revalidation arrangements for non-standard roles.
- Remote and Rural Boards should establish a Remote Community Hospital Network.
- NoS Workforce Planning and Development Group should review of terms and conditions for GPs working in Community Hospitals and seek a consistent approach across Scotland.

Rural General Hospitals

Delivering for Remote and Rural Healthcare defined the Rural General Hospital (RGH) as a specific category of hospital within remote and rural Scotland and described the role and function of those hospitals and the workforce required to staff the RGH. Most of the actions required were aimed at the four Boards, NHS Highland, NHS Orkney, NHS Shetland and NHS Western Isles, that have RGHs and there is evidence from all four that action has been taken to review the role of the RGH in line with the model.

Acute Hospital Care Pathways

Whilst the majority of care is carried out in primary care, without the need for referral or admission to hospital, there remains a need for delivery of acute care, within a hospital environment for some patients. The need for hospital care will depend on the circumstances of the individual, however, Delivering for Remote and Rural Healthcare recognised that the public and those working within healthcare, needed to better understand what a Rural General Hospital would do, what patients would be treated within the RGH and when a patient would be transferred to another facility, or discharged back into the community.

RRIG therefore established a workstream, led by Professor Andrew Sim, Consultant Surgeon, NHS Western Isles and Professor of Remote and Rural Medicine, with the University of the Highlands and Islands, to develop an understanding across the six RGHs on the pathways of care for those patients where a hospital referral was considered necessary. Acute Hospital Care Pathways have been developed that describe what conditions will be treated and cared for within an RGH, those that may be treated by a visiting specialist and those which will be transferred to another hospital. These condition specific pathways have been agreed by a group of RGH clinicians and were launched September 2010.

It is intended that these pathways will be a living document, updated as required, available to support doctors in training, General Practitioners, managers, planners and the public. The main publication route will be through the Remote and Rural pages of the North of Scotland Planning Group website and can be accessed through the following link: www.nospg.nhsscotland.com/index.php/remote-rural-healthcare/rr-implementation-group-rrig/care-pathways with links to NHS Board sites and to the Remote and Rural Healthcare portal of the Knowledge Network www.knowledge.scot.nhs.uk.

Sustainability of the Rural General Hospital

The defining characteristic of the RGH is the ability to provide emergency surgery and each RGH must therefore have the workforce capability to provide this. Acute medicine was recognised as the largest proportion of activity undertaken within the RGH and this also had implications for the required medical workforce.

Despite the evidence from Boards that the Model described in Delivering for Remote and Rural Healthcare had been implemented, there were significant concerns across of all of the rural Boards regarding the sustainability of the model, as a result of workforce pressures, and an event was planned for July 2010 to understand the implications for the sustainability of the agreed RGH model and how this might need to change to protect this fragile but extremely important resource.

The event aimed to provide a safe environment to debate the challenges to the sustainability of services within the RGHs and describe alternative models of care, including the supporting workforce models that will be required to deliver sustainable local services appropriate to patient need. Stakeholders from all of the Remote and Rural Boards that have RGHs were represented and initial agreement on the future workforce model and steps that will need to be taken to put this into place was sought.

Between September 2009 and the event in July 2010, a series of conversations with different stakeholders were begun and a range of separate actions identified to be progressed ahead of, or in tandem with the event, including: An observation study of medical, nursing and midwifery staff in one RGH; a review⁸ of the original needs assessment; validation of the workforce profile for each RGH and an update of the population profiles. Boards were also encouraged to host local discussions aimed at determining how, in the absence of a doctor in training workforce, the core functionality of the RGH could be sustained. A full report of the event can be accessed at www.nospgh.nhsscotland.com/index.php/remote-rural-healthcare/rr-implementation-group-rrig/event-2010, however, a new model emerged from the event, which requires to be further developed and is described below.

⁸ In June 2010, RRIG commissioned NoSPHN⁸ to assess the degree to which the findings of the RGH Needs Assessment had been used by RGHs to implement the proposed model and assess whether and in what ways, the sustainability of fragile services due to workforce issues is relevant.

RGH – a Revised Model

A team based approach, built around a graded system of practitioner is required in the RGH to provide the care appropriate to the requirements of the community and ensure that a safe system of emergency care was available at all times. This local system of care is embedded within a matrix of support to ensure a safe system of care locally and includes Obligate Networks with other centres, clinical decision support, telehealth and education appropriate to need.

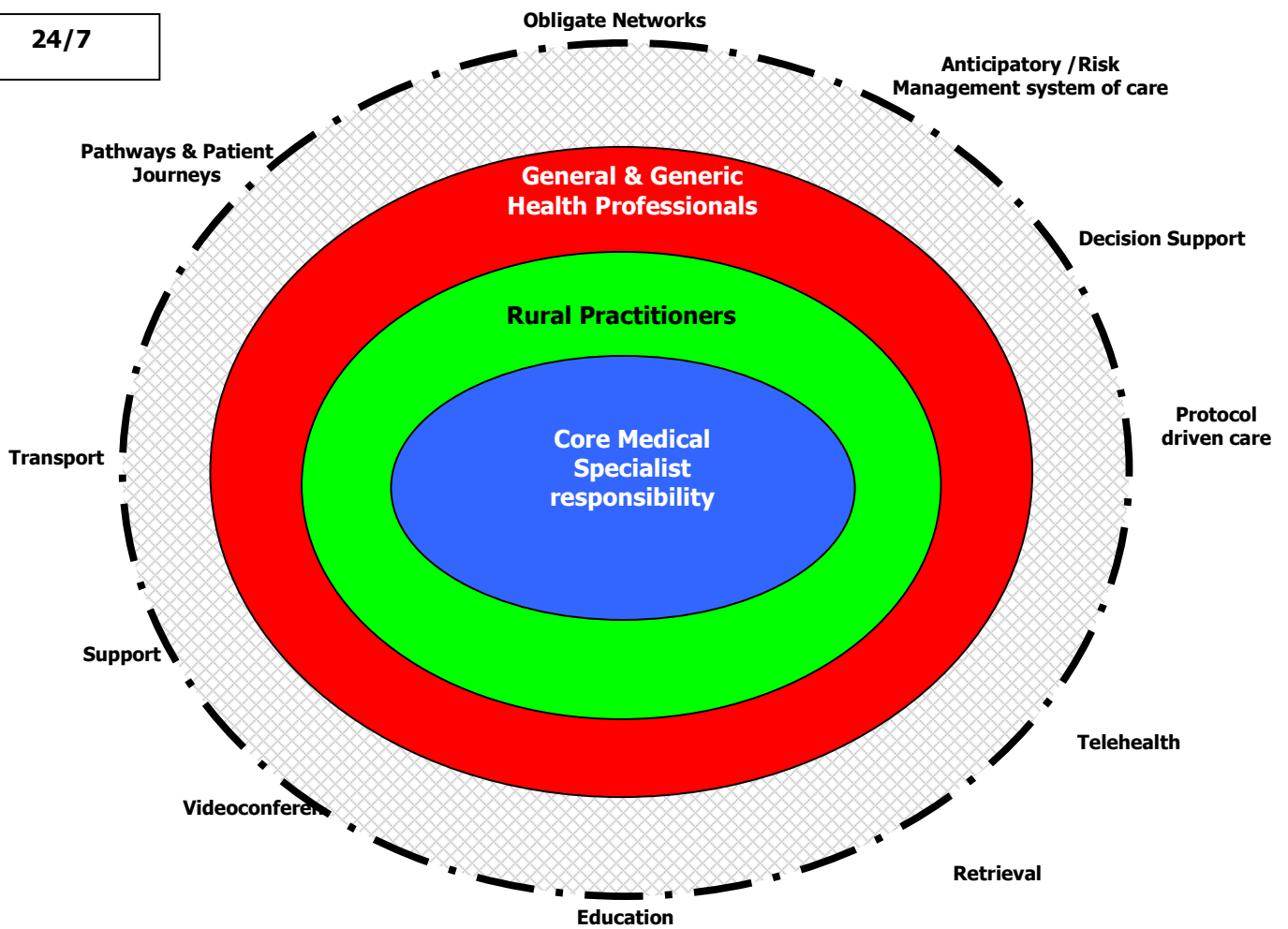
The revised model, as described pictorially below, is built around senior medical staff providing the **Core Medical Specialist Responsibility** in the core disciplines of medicine, surgery and anaesthesia, supported by competent **Rural Practitioners**, who have the skills necessary to deal with emergency admissions. The Core Medical Responsibility Role will provide clinical leadership ensuring a safe system of governance and providing training, education and supervision. In addition, these leaders will provide much of the routine elective care within the facility in-hours⁹. These senior clinicians will be supported by Rural Practitioners, with a defined set of skills and competencies required to ensure a safe system of emergency care. The skills and competency requirement need to be further defined but will include the diagnostic, assessment and decision making skills necessary to deal with emergency admissions. The use of doctors, from general practice or specialty doctors, extended role nurses, physicians assistants, or extended role paramedics may have the right experience, or with training, be able to deliver the agreed level of competency, under the supervision of the Core Medical Responsibility Role.

Support should be provided by the general and generic staff, including nurses, AHPs, multi-skilled biomedical scientists and multi-skilled radiographers, as described in Delivering for Remote and Rural Healthcare, and generic support workers, working in teams.

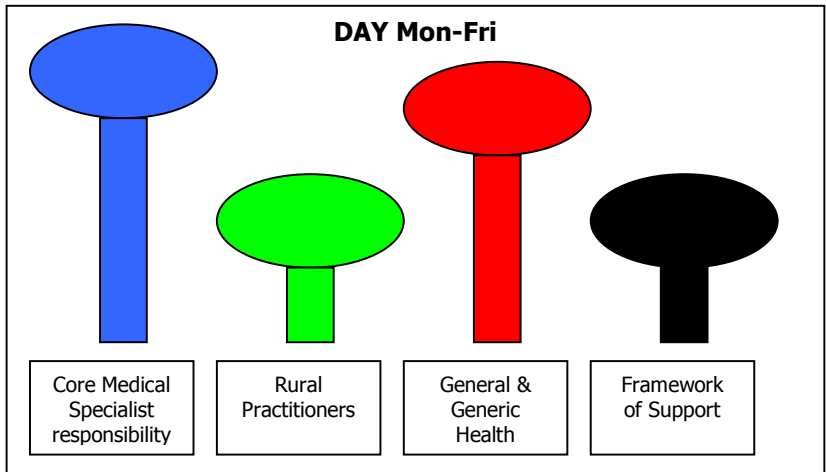
The RGH would still have a role in the training of doctors but the system of emergency care, particularly out of hours would not be reliant on these doctors.

⁹ In-hours is defined as Monday – Friday, 8am-6pm

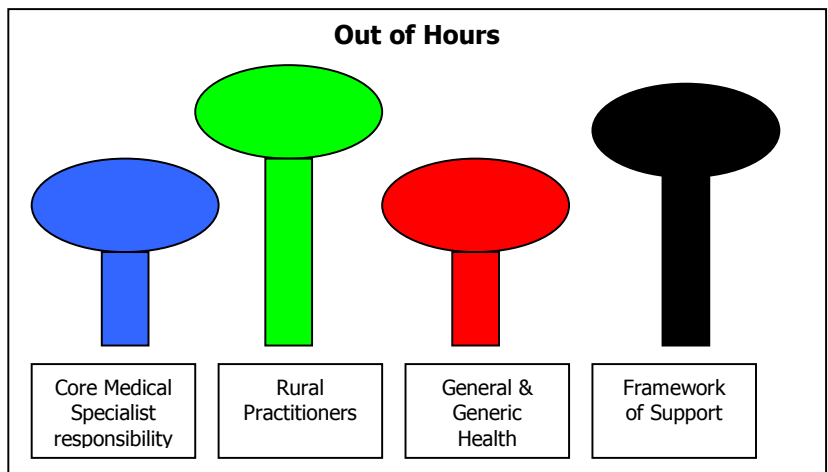
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Describing the difference between the in hours and out of hours period, it is suggested that Monday to Friday, 9-5, the majority of the workload was covered by the Specialist with Core Medical Responsibility and the generic staff, supported by the Rural Practitioners and through a network of support mechanisms but that the focus was more on local self-sustainability for the majority of activity. This is described pictorially below:



Out of Hours, however, the balance between the roles changes with greater reliance on the Rural Practitioners and a framework of support for emergency care and only limited reliance on the Core Medical Responsibility role. The Framework of support will include a network approach to care and include an **Emergency Care Obligate Network**, protocol driven care, telehealth, together with emergency retrieval. An anticipatory/Risk management systems and Clinical Decision Support, linked to an agreed larger centre will be a crucial requirement. This is also demonstrated pictorially.



Agreed Actions

- Boards with RGHs will compare current RGH model with the role and function defined within Delivering for Remote and Rural Healthcare to determine whether the service model is consistent with the recommended model and address inconsistencies.
- A review of the Needs Assessment by NoSPHN has been commissioned and will be shared with Remote and Rural Boards with RGHs to support local redesign.
- RGH Boards will identify skills and competencies required to deliver safe emergency care and agree a common role across RGHs, supported by an agreed competency framework.
- NoS Workforce Planning & Development Group, working with key stakeholders within the RGH Boards, will scope the Rural Practitioner roles required, agree role description and seek common description and banding for role.
- NoS Workforce Planning & Development Group, working with RRHEAL, will compare the role requirements with the curriculum for the Physicians Assistant and the Rural Practitioners for Remote Community Hospitals to develop pathways into required training.
- RGH Boards will undertake Training Needs Analysis within local systems.
- RGH Boards will investigate integration of GP out of hours and hospital out of hours requirements.
- RGH Boards, working with larger centres, will identify where other Obligate Networks can support care and use Obligate Network guidance to ensure that networks are established.

Recommendations for the Future

- RGH Boards should undertake Observation Study to better understand the service requirements, if a model that does not rely on doctors in training is introduced.
- The policy commitment for sustainable models of care within Rural General Hospitals should be reviewed and NHS Boards should be encouraged to implement this revised model of care to ensure the sustainability of locally available services.
- RGH Boards should design a safe system of emergency care within the RGH that is consistent across all RGHs, underpinned by a robust system of governance. The system of care will be supported by an Emergency Care Obligate Network, with identified larger centre(s) that adopts an anticipatory approach to risk management and emergency care and is supported by a clear

governance structure, agreed pathways of care and clinical decision support requirements.

- RGH Boards should establish a team based approach to care within the RGH that includes Core Medical Responsibility role, Rural Practitioners, generic and general staff and a matrix of support.
- RRHEAL should develop an education and training pathway for Rural Practitioner and commission educational programme, with educational objectives appropriate to need.
- NoS Workforce Planning & Development Group, working with RRHEAL, should establish a Career Framework, to support implementation of new roles.
- RGH Boards should review the role of the Consultant to establish clear leadership and governance role.
- RGH Boards should review the roles that general and generic staff could provide if roles were extended, as recommended in Delivering for Remote and Rural Healthcare and implement these across remote and rural Scotland.
- RGH Boards, working in collaboration with SAS and EMRS should define the additional transport requirements to support Emergency System of Care and ensure that transfer rates are routinely monitored.
- Remote and Rural Boards should develop a peer review system between RGHs and Acute Care Remote Community Hospitals.

Emergency Response and Transport

Ensuring that there is an appropriate response in an emergency, that is seen as robust and responsive to local need is seen as a universal right¹⁰. Indeed research¹¹ suggests that effective emergency and urgent response systems have the added benefit of making communities 'feel safer'. This was confirmed by an audit¹², carried out as part of the development process for Delivering for Remote and Rural Healthcare, which showed that:

"Results showed that in geographical locations where there is a higher density of population and locally based SAS crews, response times generally mirror or better those of urban areas. However,

¹⁰ Lopez-Aubin JM et al (2005) "Conference Report: Proposals for Improvement of Emergency Rural Healthcare" March 2005, The International Journal of Rural and Remote Healthcare Research, Education Practice and Policy

¹¹ Wisborg T et al (2008) "Life or death. The Social Impact of paramedics and first responders in landmine infested villages in Northern Iraq" Remote and Rural Health 9, 2008:816. www.rrh.org.au

¹² (2007) "Delivering for Remote and Rural Healthcare: Technical Annex7: Remote Scottish Ambulance Service Response Audit" Nov 2007, www.elib.scot.nhs.uk

results also demonstrated that as the more rural the area, the longer the response time is likely to be ... This however is more reflective of geography and road network than base resources.” p4

Within the Emergency Response and Transport Workstream of RRIIG, therefore, two independent projects have been progressed: a pilot and independent evaluation of an aero-medical Emergency Medical Retrieval Service; and a project to develop a Strategic Options Framework for Emergency and Urgent response for Remote and Rural Communities.

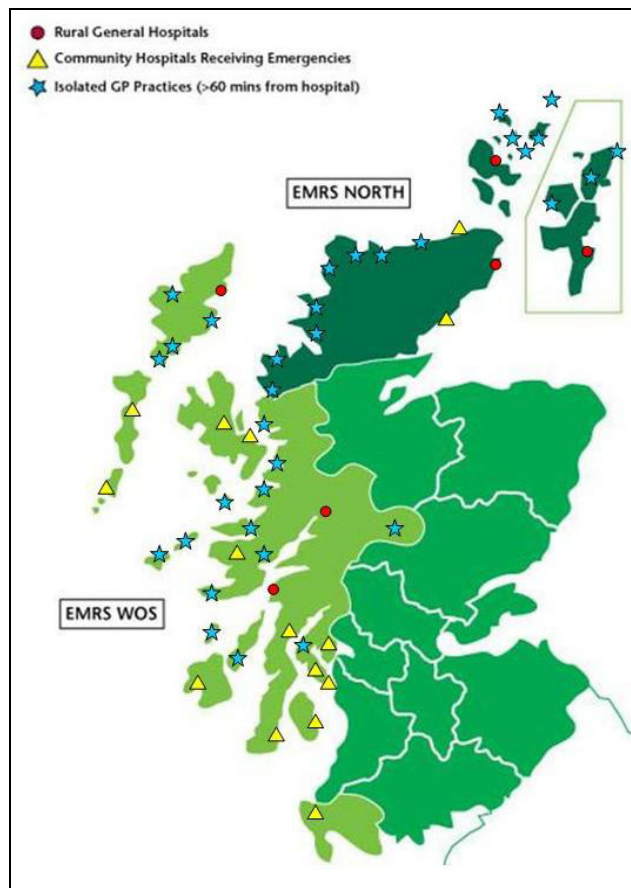
Emergency Medical Retrieval Service

The Emergency Medical Retrieval Service, or EMRS, is designed to bring consultant grade doctors, who are either A&E or intensive care doctors to acutely ill or trauma patients within remote and rural communities. The team are brought by air ambulance and will treat and stabilise patient, within the local community, before arranging for and escorting the patient to definitive care. The service also provides a consultant manned telephone advisory service.

Following publication of Delivering for Remote and Rural Healthcare, an independent pilot, funded by Scottish Government, was established to assess the clinical and cost effectiveness of the pilot service operating across the west coast of Scotland, from Stranraer in the south, to Wester Ross in the North and including the Western Isles, Arran and the many islands that make up Argyll and Bute and to consider the requirements and feasibility of a national EMRS covering the whole of remote and rural Scotland. The evaluation also considered options for delivery and made recommendations on the most efficient and cost effective way of providing a national remote and rural EMRS. The evaluation took place between June 2008 and June 2009, with a final report submitted to Scottish Government in January 2010.

In March 2010, the Cabinet Secretary for Health and Wellbeing announced her intention to establish an Emergency Medical Retrieval Service for all of Scotland, provided by two teams, operating from one centre, in Glasgow, from October 2010. In the interim period the service would continue to operate across the pilot area and plans for roll out would be established. The cost of the new service will in excess of £2.3m per annum and represents an important investment in addressing the tyranny of geography experienced by those living in remote and rural areas.

The map below outlines the areas that will be covered by EMRS.



Map of EMRS Coverage from October 2010

Emergency and Urgent Response in Remote and Rural Communities

The provision of an EMRS is designed to address specific requirements when there is trauma or a patient is acutely unwell. It is extremely important to have access to that specialist resource within remote and rural communities but it was recognised by RRIg that the role undertaken by EMRS was only one aspect of a robust and responsive local community emergency response system. RRIg therefore established an Emergency Response and Transport workstream to address the wider needs of remote and rural communities.

The multi-disciplinary group recognised that the geographical challenges faced across remote and rural Scotland and the existing service configurations would suggest that one size would not fit all and following an review of the literature, an audit of current practice and extensive consultation, the group developed a matrix approach, which combined standards for emergency and urgent response provision, supported by

a Framework of possible response models for remote and rural communities; which provided the basis for the Strategic Options Framework.

This **Strategic Options Framework (SOF) for Emergency and Urgent Response** to remote and rural communities is designed as a tool to be used by the SAS, in partnership with NHS Boards, CHPs and local communities, to establish, over time, a response appropriate to local circumstances. The SOF includes:

- A Memorandum of Understanding which clarifies the statutory responsibilities and the role of both the SAS and Territorial Boards in relation to this, with particular emphasis on the strategic responsibility of the SAS in relation to emergency and urgent response.
- A set of specific standards for emergency and urgent response, for use in remote and rural communities and in addition to, the national SAS response targets.
- A range of types of response to emergency and urgent response, ranging from community response, including first responders to the full A&E response, which may be used to achieve the standards. Some of the proposed models currently exist and others may need to be developed.

The SOF is supported by a Technical Annex, which includes details on the process of how the SOF was developed and the evidence in support of the Framework. These documents have been uploaded on to the North of Scotland Planning Group website and are accessible at www.nospkg.nhsscotland.com/index.php/remote-rural-healthcare/rr-implementation-group-rrig/strategic-options-framework.

SAS have been asked to work with Boards to develop implementation plans and both SAS and a number of territorial NHS Boards have provided some evidence of initial action to scope requirements, although there was no evidence provided by some of the most remote areas.

Implementation of the SOF has been identified as one of the early activities in support of the Healthcare Quality Strategy for NHSScotland¹³ and the Quality Alliance will be expected to seek assurance that progress is being made. In addition, Scottish Government issued a letter to Chief Executives¹⁴ in June 2010, with a requirement to submit detailed implementation plans by October 2010. A workshop hosted by SAS, with key Board leads is planned for the autumn. A copy of the SOF is available at from the

¹³ (2010) "The Healthcare Quality Strategy for NHSScotland" 10 May 2010, The Scottish Government, Edinburgh. ISBN:978-0-7559-9323-9 (web only)

¹⁴ CEL 21 (2010) "Strategic Options Framework for Emergency and urgent Response in Remote and Rural Communities" 7th June 2010, Scottish Government, Edinburgh.

following link: <http://www.nospg.nhsscotland.com/index.php/remote-rural-healthcare/rr-implementation-group-rrig/strategic-options-framework>.

Agreed Actions

- Scottish Ambulance Service, working with territorial NHS Boards should produce detailed Strategic Options Framework Implementation Plans, linked to Board plans to implement the NHS Scotland Quality Strategy.
- SAS will host an event in late 2010.

Obligate Networks

The concept of the obligate network was a new concept, introduced by Delivering for Remote and Rural Healthcare. Like the forerunner Managed Clinical Network (MCN), introduced following the Acute Services Review¹⁵, in 1998, these networks aimed to link professionals together and improve and sustain standards of care, but unlike the MCNs, which had no responsibility for delivering services to patients, the Obligate Networks were required to sustain and improve access to services. Additionally, the Obligate Network created a corporate obligation for all providers of healthcare across NHS Scotland to ensure access to patients from other boards.

Whilst Delivering for Remote and Rural Healthcare had introduced the concept, further definition and guidance was required. Following further research to clarify the requirements of remote and rural systems; an analysis of the current guidance for MCNs and an understanding of the requirements of the emerging model for the National Managed Service Network for Neurosurgery, guidance was developed. The JIT supported the development of the guidance, through engaging interested stakeholders focussed on mental health services, on how existing work on Managed Care Networks could inform the development of obligate networks. The Obligate Network Guidance was promulgated through a letter from the Chair of RRIIG and the Director of Healthcare Policy and Strategy from SGHD to Board Chief Executives in March 2009. This guidance is attached at Appendix 3.

An Obligate Network is defined in the guidance as:

¹⁵ (1998) "Acute Services Review" May 1998, Scottish Office, HMSO

“... a formalised arrangement between two or more healthcare organisations that secures access to sustainable services for the whole population served by these organisations. Obligate Networks may be strategic between NHS Boards, who will agree a basket of services to be provided within that arrangement, or they may be at an operational service level between a specialist service and a more generally based service. These networks will provide:

- Access to expert opinion to inform and support local decision making, which may be 24/7;
- Development of shared protocols and pathways;
- Improved discharge planning;
- Transfer Debriefs;
- Peer Group support, training and education; and
- Rotation for Skills update and maintenance, this may include joint appointments.

Whilst aimed at clinical service sustainability, obligate networks may also provide benefits for non-clinical services.”¹⁶

Recognising that the obligation arrangements might differ between services, the guidance described three types of Obligate Network:

- Clinical Decision Support where the obligation may be limited to ensuring clear pathways of care;
- Clinical Decision Support and Visiting Services where the obligation includes both clear pathways of care, supported by a visiting service; or more far reaching with the
- Creation of a Virtual Department, with joint appointments.

The guidance recognised that specific arrangements would need to be agreed on a speciality specific basis and may require larger departments to make significant changes to current working arrangements.

Delivering for Remote and Rural Healthcare identified the importance of a network approach to sustain core services within the Rural General Hospitals and recommended the establishment of Obligate Networks to support locally available medicine, surgery and anaesthesia. Four other specialist areas for the development of networks were also identified as a priority, including: Child Health, Mental Health, Radiology, Laboratories. It was also recognised that Boards may also want to use this approach for other services.

¹⁶ (2009) “Framework for Obligate Networks” 4th March 2009, p4, Scottish Government, Edinburgh.

Whilst the guidance was issued to Board Chief Executives, it was not promulgated as formal policy direction and access to the guidance on an ongoing basis has been an issue. This has been perceived as an issue.

The needs for formalised networks was identified as one of the key building blocks, identified by those from across the continuum of healthcare who participated in the pre-Delivering for Remote and Rural Healthcare consultation, as necessary to sustain local services and to ensure access to more specialist services that are not available locally.

Formal establishment of Obligate Networks has, however, been slow. There is evidence that a mental health obligate Network has been established between NHS Orkney, NHS Grampian and NHS Shetland, covering all aspects of mental health and learning disability. This Obligate Network has included joint appointments and, through the support of the JIT, has been evaluated independently. This evaluation is available in a separate report. NHS Western Isles have established two Obligate Networks, one with NHS Borders for radiology and one with NHS Greater Glasgow and Clyde for diabetes. There are also ongoing discussions with Glasgow regarding the potential to establish an Obligate Network for Mental Health.

A number of other Boards report working towards establishment of other Obligate Networks. There is only limited evidence of the use of Obligate Networks to support the services described as Core Services within Delivering for Remote and Rural Healthcare, although some Boards report that discussions are underway. Clinical governance and defining clinical accountability has been a particular barrier and this remains to be resolved. The pressures currently facing the RGHS, described elsewhere in this report, requires that this gap now needs to be addressed and a new requirement to establish an Emergency Care Obligate Network, was identified.

At the RGH workshop, held in July 2010 and reported above, delegates identified a need for an Emergency Care Network, rather than obligate networks to support Core services, as initially identified.

Lateral network

“Lateral networks between RGHS should also be established” Commitment 48¹⁷

It was envisaged that a lateral network between RGHS should be established to develop agreed standards, protocols, training and development, support and share good practice in a manner that is

broadly consistent with a traditional MCN but that there should be an obligation between the RGHs to work in this way. There is no evidence that this has happened and indeed at the Learning Exchange, hosted by RRIG in September 2009, delegates in a workshop dedicated to this suggested that:

“A ‘virtual’ remote and rural network should be created which is accessible by all involved across the continuum of care. Existing resources such as the Association of Community Hospitals should be pulled on and a single electronic point of access developed to a Directory/information portal. This could be achieved using the methodology approach to the Patient Safety Programme Model.”¹⁸

A number of electronic resources currently exist. RRIG has a dedicated web page as part of the North of Scotland Planning group website www.nospg.nhsscotland.com/index.php/remote-rural-healthcare/rr-implementation-group-rrig; there is a remote and rural portal within the Knowledge network www.knowledge.scot.nhs.uk and RRHEAL also has a dedicated website www.nes.scot.nhs.uk/rrheal. No single point of access has been established. A number of individual groups also have established arrangements for networking, for example, the Viking Surgeons.

There remains a question on whether a network is actually required. A number of the groups that have come together across remote and rural Scotland, including those working in remote Community Hospitals, the Biomedical Scientists within the RGHs have suggested that they do need an obligate network, mainly to undertake the functions originally envisaged. This was also highlighted as a priority at the recent RGH event, held in July 2010.

Agreed Actions

- The guidance for Obligate Networks should be re-published and readily available to NHS Scotland through the SHOW website.
- NHS Boards should review their need for Obligate Networks, through their clinical governance structures, to ensure that remote and rural practitioners and services are adequately supported and resourced.
- NoSPG will convene a meeting of Remote and Rural Boards should reconsider whether the establishment of an R&R Network, would provide additional support to improve the overall system of care.

¹⁷ (2008) -1: p76

¹⁸ (2009) “Delivering for Remote and Rural Healthcare – One Year On: Sharing and learning Exchange” p55, 1&2 September 2009. www.nospg.nhsscotland.com/index.php/remote-rural-healthcare/rr-implementation-group-rrig/event-one-year-on

Recommendations for the Future

- An Emergency Care Obligate Network should be established between all RGHs and agreed centres to ensure clear pathways of care, supported by clinical decision support and an anticipatory system of care for at risk patients.
- Obligate Networks for Laboratory Services, Radiology, Child Health and Mental Health should be established.
- A clear system of governance to support these Obligate Networks is required that defines lines of accountability and leadership.
- Active engagement by the larger centres and obligation of individual clinical departments to support remote and rural centres is required.
- Remote and Rural Boards which host an RGH should ensure that a safe system of care is developed that is consistent across all RGHs and Acute Care Community Hospitals.

Workforce and Education

“Team working, integration and shared competencies are key to the future staffing of services within remote and rural healthcare. Many of the solutions to the development of sustainable and affordable services will need to involve a range of doctors, nurses, midwives, AHPs and healthcare scientists and their support staff, working creatively to deliver new models of skill mix and interventions that are safe, effective and patient centred.”¹⁹

Delivering for Remote and Rural Healthcare identified an ageing workforce, organised in a fragmented way and suggested that robust workforce planning, supported by fit for purpose education was required for the future. A significant number of both the Commitments (29 of 63) and Forward issues (11 of 20) were directed at Workforce or Education and often both. Many of the Workforce specific issues were directed at Boards to be progressed, with only a small number being progressed by the RRIG workstream. The Education requirements were progressed mainly by the Remote and Rural Healthcare Educational Alliance (RRHEAL), established by NHS Education for Scotland, to address the needs of remote and rural systems and learners within these systems. Workforce and education issues are inextricably linked, however, for the purposes of this report, are reported separately.

¹⁹ (2008) -1: p39

Workforce

Primary and Community Care Teams

Evidence provided from Boards reports action to establish, or are progressing towards establishment of integrated and co-located Extended Community Care Teams (ECCT), although some Boards have intimated that further definition of the ECCT role, in particular, is required. There is also confirmation that community teams have a skill mix appropriate to the needs of the community, including the skills required to manage mental health crises and that locally based teams within the community, community hospital or RGH have the skills required to manage the care of acutely ill or injured child.

General Practice Those Boards which still have single handed general practitioners have all reported as working towards reducing professional isolation and co-locating services, although some of this will be managed over time through turnover of staff.

Training, including of general practitioners, within remote and rural areas continues to be an important feature of medical education both within practice and in the hospital services, although recruitment to training programmes has been challenging, particularly in the North, and this is recognised as an issue that needs to be addressed going forward. NHS Education for Scotland, North Deanery are committed to a review training in Remote and Rural settings including of the contribution these environments make to Foundation Programme design and general practice programmes in the North.

Secondary Care

“Competence in the management of acute medical, surgical (including initial fracture management and manipulation of joints), delivery of anaesthesia and mental health emergencies are core skills/competencies required within the RGH. Other competencies include management of low risk births, neonatal resuscitation, endoscopy, rehabilitation and management of chronic conditions. These competencies must be available and sustained within the multi-disciplinary team.”²⁰

The workforce models identified as required within secondary care, particularly within the RGH, have been reported as progressing in the performance management returns.

²⁰ (2008) -1: p45

Nurses: Evidence has been provided to confirm that the nursing skill mix within the RGHs has been reviewed in line with the model and pilot education programmes to establish Nurse Practitioners with a Special Interest (PwiSI), funded by NES, will be implemented in two NHS Boards.

- In NHS Shetland, a PwiSI in Mental Health, with a specific interest in dementia care has been established and recruitment into post is planned for August 2010.
- In NHS Western Isles, the PwiSI role in children's care has been developed and has been integrated into that Board's redesign of children's services, working across primary and secondary care. Recruitment was also planned for August 2010.
- NHS Dumfries and Galloway were initially involved in the development of the PwiSI role and whilst recognising the benefits of this type of development in maximising the optimal use of the nursing role, have decided to incorporate the principles of the PwiSI within current role developments locally.

Allied Health Professions (AHP) The role of the AHP as multi-skilled generalists within remote teams was highlighted within Delivering for Remote and Rural Healthcare and the potential to develop PwiSI roles from within these professions was also recognised. Following launch of the Framework for Remote and Rural Healthcare, guidance was developed to support Boards, however, most of the focus was expected to be within NHS Boards. Two NHS Boards, both Island Boards have provided evidence of the use of multi-skilled AHP generalists and only one NHS Board has provided evidence of the development of AHP PwiSIs. Ten Boards reported that this was not relevant and the others did not provide any evidence.

The development of multi-skilled **Biomedical Scientists (BMS)** was seen as key to the retention of a limited range of laboratory services within the RGH, working within a Laboratory Obligate Network. Whilst there is no evidence that any Board has established a service network for laboratories, the BMS from across remote and rural Scotland have established a group to review the requirements for BMS roles and, in particular, the education requirements for these staff recruitment and retention is an issue, as is the space to develop training.

This group has completed a scoping exercise of the workforce, service and education challenges and considered potential solutions which include the development of an Obligate Network. The group has linked closely with Dr Robert Farley, Clinical Scientist, Programme Director for Healthcare Science, NES,

on the implementation of the national agenda²¹ and with RRHEAL to consider and develop appropriate educational solutions for remote and rural laboratories. Remote and rural issues have been included in the discussions of the new NES/SGHD partnership pilot cohort of Healthcare Science Development Leads across Scotland. In particular, the need to produce education to develop a more generalist role, using a more attractive approach of recognition such as a specialist track programme, with clear opportunities to influence the development of a Masters level programme, with a flexible set of education units, which can be undertaken within local areas and a different approach to supervision have been proposed. The discussions on this potential development are in the early stages as there are a number of factors to consider however, there is scope to influence how it may be developed.

Similarly, multi-skilled **Radiographers** were also seen as key to the retention of locally based imaging services. Evidence has been provided by at least one Board that confirms that the vision that radiology services would be organised as Obligate Networks has been implemented and there is evidence that some other Boards are working towards this. A review of the requirements was progressed as an early project by RRIIG and the output from this has informed further work by RRHEAL to ensure that the programmes are available for radiographers to ensure that they have the right skills and competencies to deliver the range of skills defined.

Medical Workforce

Seven specific commitments were made in relation to the medical staffing of hospital services within remote and rural communities, including a number relating to the training of doctors with the skills required to work in remote and rural areas.

The senior medical cover within the RGH was to be provided by a team of at least three doctors in each of the core specialty areas of medicine, surgery and anaesthesia; supported by doctors in training.

Delivering for Remote and Rural Healthcare recommended that the importance of remote and rural areas as a training resource for doctors in training should be recognised and appropriate training opportunities should be established, through new Speciality Training posts if necessary, to ensure the supply of remote and rural physicians, surgeons, anaesthetists and GPs.

²¹ (2007), Safe, Accurate and Effective: an action plan for Healthcare Science in Scotland, The Scottish Government, Edinburgh 2007

NHS Scotland has a history of supporting remote and rural education and has a number of 'rural-track' programmes, including rural-track options and programmes for remote and rural physicians and Rural GP programmes, including R&R GP fellowships, for post CCT doctors who wish to gain further experience for remote practice. Three areas were identified that needed to be addressed and Scottish Government have now agreed to establish two R&R General Surgery Fellowship posts and one Anaesthesia Fellowship post on a substantive basis.

The role of general practice within the RGH was also acknowledged and NHS Education for Scotland was charged with establishing a pilot to test a hybrid acute medicine/general practitioner training approach, in collaboration with the Academy of Royal Colleges. In 2010, NES offered two programmes, developed through collaboration between the Specialty Training Board for Medicine and the Specialty Training Board for General Practice that will offer trainees the opportunity to undertake specialist training in General Internal medicine, in addition to attaining a Certificate of Completion of Training (CCT) in general practice. One programme has been offered through the West deanery and one through the North.

Recommendations for the Future

- Remote and Rural Boards should work with local authority partners to define the role of the Extended Community Care team (ECCT) that reflects the population need.
- RGH Boards should identify skills and competencies required to deliver safe emergency care and agree a common role across RGHs, supported by an agreed competency framework.
- RGH Boards should support the establishment of a network to support laboratory services.

Doctors in Training

- NHS Education for Scotland, North Deanery will review the R&R Foundation placements and its GP training programmes.
- NHS Education for Scotland, working with R&R Board Medical Directors and Directors of Medical Education, should use established educational quality metrics to ensure that within RGHs trainees get high quality experience and that service continuity has reduced the reliance for out of hours care on these doctors.
- NHS Education for Scotland – North Deanery working collaboratively with Board Directors of Medical Education ensure that suitable outcome data is available to identify what currently works well in remote and rural training and what does not.

Education

“Access, rural specific content and support for remote and rural learners were the key issues to be addressed. ...The concept of a Remote and Rural Healthcare Education Alliance (RRHEAL) supported by a remote and rural Managed Education Network emerged through an extensive consultative process. The RRHEAL would provide a linking role between the service and educational providers and be a sustainable structure supporting rural education for the NHS Scotland for the future.”²²

The majority of the Commitments and Forward Issues that identified an education requirement have been progressed by RRHEAL and evidence has been provided to confirm that all of these objectives have been progressed by RRHEAL and are either complete, or where there is an ongoing requirement are in a maintenance phase. The following is a brief summary of the progress achieved by RRHEAL.

- **Mental Health:** a Mental Health Pre-hospital Crisis Intervention course specifically for remote and rural practitioners has been developed. It is delivered locally and in a blended format making it accessible and cost effective. In addition, RRHEAL has also developed a distance delivered 'Safetalk' programme providing increased access to suicide awareness training for remote and rural healthcare staff.
- **Radiography:** RRHEAL has identified competences required by remote and rural radiography teams who require multi-skilled practitioners and identified available education at advanced levels in the UK to meet this need. Work is continuing to adapt or rural-proof the format of delivery in order that these programmes are more accessible and cost effective for remote and rural practitioners.
- **Paediatric Teams:** A Rural-proofed core level paediatric emergency care programme has been completed and over 2500 healthcare staff across Scotland have undertaken this programme. RRHEAL is also working with NES Child Health to rural-proof the Intermediate Paediatric Emergency Care programme to increase access for remote and rural staff. RRHEAL will build on this work in conjunction with the Obligate Network for Child Health.
- **Generic Rural Support Worker Education:** RRHEAL has established a working alliance between education providers, rural health boards, Scottish Funding Council, Scottish Social Services

²² (2008) – 1: p64

Council and Scotland's Colleges to progress this work. The education programme is expected to be run as a pilot across three remote and rural boards towards the end of this year.

The second phase of the JIT's work, following on from its report to RRIG in May 2009, looked at the introduction of Generic Rural Support Worker posts by local partnerships and in light of the work by RRHEAL to prepare the learning and qualification framework for such posts, sought to identify possible barriers to their introduction across remote and rural areas..

- **Biomedical Scientists:** RRHEAL has completed scoping of the delivery methodology of the institutions which provide the appropriate level of education required in the UK. A portfolio approach to the rural specific skill set has been developed in consultation with stakeholders. The final report provides a portfolio education solution and identifies all available education and gaps. Report will be submitted to Scottish Government in 2010.

RRHEAL was also required to work with the remote and rural health boards using their learning and development plans to prioritise education and training needs and has established an ongoing programme of structured engagement with each of the remote and rural boards, working actively in partnership to support current and emerging education and training needs. In this way, RRHEAL has established an educational mapping system that is providing a coordinated national approach to the development of remote and rural specific education across Scotland.

Through this process of structured engagement and mapping of priority needs RRHEAL has begun work in a number of key areas of priority in response to the needs of the remote and rural workforce.

- **GPs working in Community Hospitals and Rural General Hospitals:** RRHEAL is working with the wider Community Hospitals project, reported above, to identify the core competences required by rural practitioners who provide care across acute settings. This work will produce a remote and rural specific education pathway which is cost effective and accessible. In this way assisting boards to make the required changes and adaptations to their workforce as required.
- **Remote, rural and Island Nursing:** RRHEAL are responding to priority needs across a number of boards to identify more appropriate training to support new and emerging roles for nurses in remote and rural practice. This work will provide the remote, rural and Island nurse education input to the National Review of Nursing in the Community.

RRHEAL are leading the development of a "Distributed Education System and Platform for Remote and Rural Workforce". This will provide a coordinated and managed approach to increasing the range of education programmes delivered at distance. RRHEAL have also developed the Remote and Rural Education Platform, this is a practical easily accessed "one stop shop" for remote and rural learners. Learners will be able to remotely access tailored learning programmes and record their learning. This represents a significant change in the way education will be accessed in the future and provides the sustainable cost effective solutions required. The platform will be operational in October 2010.

RRHEAL has begun to and will continue to work with Educational Providers to ensure the development of appropriate accessible and viable training programmes. Currently, RRHEAL is working with a wide range of education providers across Scotland to increase availability of remote and rural proofed education programmes and has produced Quality Standards Guides for Distance education and Distance Mentoring and Supervision. These guides and resources will be available from September 2010 enabling more education providers to be able to produce high quality education and training programmes at distance while meeting a requisite standard.

Agreed Actions

RRHEAL will continue to:

- Work with the R&R NHS Boards, using their learning and development plans to prioritise education and training needs.
- Develop "Distributed Education System and Platform for Remote and Rural Workforce".
- Work with Educational providers to ensure that programmes are appropriate to need, accessible and viable for the long term.

EHealth and Infrastructure

"The concept of utilising eHealth in a remote and rural situation is not an addition or an add-on, it is more of a developing philosophy which should permeate every aspect of the remote and rural agenda."²³

²³ (2008) -1: p82

The seven commitments identified in Delivering for Remote and Rural Healthcare relating to eHealth ranged from the practical, roll out of PACS imaging systems, to the aspirational, ensuring that Scotland becomes a digital economy.

Evidence is available to demonstrate that there has been progress in each area identified but it is also recognised that this will remain an emerging and developing agenda. Scottish Government launched the eHealth Strategy for NHSScotland in 2008. This strategy supports the vision described but also recognised that the approach will be incremental. A number of infrastructure challenges have been addressed, particularly ensuring that all Boards and practitioners have access to broadband that operates at speed appropriate for a modern healthcare economy, however, bandwidth demands continue to grow and this is an area that will require further investment in remote and rural areas, beyond health, to ensure that the level of connectivity across Scotland is maintained.

As implementation has progressed, the use of video-conferencing to support clinical decision making has improved. Evidence submitted on the role of video-conferencing to support a multi-disciplinary team (MDT) approach to care has highlighted the success of the Gastro-Intestinal (GI) Cancer MDT, established between Raigmore Hospital, the Belford Hospital and Caithness General Hospital in NHS Highland and the Western Isles hospitals. The group have met weekly since 2005, support live discussion of imaging and histology to design patient management plans. Such approaches have an important service delivery and educational role.

Articulation of the new eHealth requirements has been difficult, particularly in relation to the services that this would support. There are only limited examples of the clinical decision support arrangements envisaged in Delivering for Remote and Rural Healthcare and these are usually specialty or condition specific e.g. acutely unwell child, stroke. One reason for this might be the need to convince local clinicians that the infrastructure is robust and in order to address some of these concerns, Scottish Government, have funded a pilot to establish standards for videoconferencing across the North of Scotland. There may also be an issue however, within some Boards that the clinical decision support arrangements are seen as not required, as the staffing model, particularly in the RGHs remains consultant led. The vulnerability of services, particularly out of hours has been identified at the RGH event, where the need for robust clinical decision support was highlighted for small hospitals, including RGHs.

Recommendations for the Future

- The National Video-Conferencing Pilot should be completed and proposals and for roll-out across Scotland should be submitted to the EHealth Programme Board and the Board Chief Executives.

- NHS Boards should develop eHealth plans to support the roll-out of Obligate Networks in collaboration with the Scottish Centre for Telehealth and the IT Leads group.

Fair Shares Allocation for of Remote and Rural Services

Delivering for Remote and Rural Healthcare recognised that to effect the changes identified, NHS Boards would require to commit resources to redesign of services and there is considerable evidence that this has been achieved. The final Forward Issue recognised that part of this was beyond the control of NHS Boards and asked for reassurance that the new method of allocation of NHS resources being developed by Scottish Government, the NHS Scotland Resource Allocation Formula, which had been developed by the NHSScotland Resource Allocation Committee (NRAC) would take into account the ability of remote and rural NHS Board to maintain and develop remote and rural services.

Scottish Government accepted the proposals made by NRAC in February 2008 and a Technical Advisory Group on Resource Allocation (TAGRA) was established in 2008 to maintain and develop the formula. This group was asked in June 2008, following a debate in the Scottish Parliament to undertake a review of the Impact of the NRAC formula on remote and rural areas and the final Report of that group has recently been submitted to the Cabinet Secretary.

The TAGRA review was limited in scope and has concluded that 'in general the current treatment of remote and rural areas in the NRAC formula is appropriate'²⁴, although the group did recommend that the formula could be improved in the treatment of GP out of Hours services and suggested further work on the allocation of resources for rural general hospitals, GP dispensing and the cost of agenda for change.

RRIG were not involved in the technical review but were given the opportunity to comment on the final conclusions at the last meeting of the group and whilst welcoming the proposal to review the method of allocation for RGHS, particularly when the adjustment under the NRAC for hospital services has had the effect of reducing the contribution for these essential services. RRIG remains to be convinced on the efficacy of the TAGRA review, which appears to have reinforced the structural bias that exists in the allocation of resources to remote and rural Boards.

²⁴ (2010) "The Impact of the NHSScotland Resource Allocation Committee (NRAC) Formula on Remote and Rural Areas of Scotland: The Report of the Technical Advisory Group on Resource Allocation (TAGRA)" September 2010.

Recommendation for the Future

- In taking forward the next stages of its work in this area, TAGRA should work more closely with the relevant remote and rural Boards to ensure that any system of funding can be demonstrated to be fair in an open and transparent manner.
- Scottish Government should review the way in which services are funded with consideration given to a base allocation to all Boards that reimburses the costs of the minimum level of service, before any weighted capitation approach is adopted.

Delivering for Remote and Rural Healthcare -Outstanding Commitments

Whilst much has been achieved by RRIIG, working with NHS Boards across Scotland, there remain a small number of outstanding actions. Most of those will be addressed by the progressing the next steps outlined through-out this paper. There will remain, however, a small number of commitments to be addressed. There is evidence that some action has been taken to address some of the issues but for a sustainable framework to be in place this needs to be addressed more holistically across Scotland.

The following table highlights these Commitments and makes proposals on how these should be progressed.

Commitment		Recommendations for the Future
17	Responsive retrieval systems for patients experiencing mental health crisis	The Review of Specialist Transport established by SGHD should be invited to consider the needs of these patients.
Forward Issue		
7	Innovative solutions to provision of pharmacy services	NHS Boards should review pharmacy services within the wider context of redesign.
15	Whole patient pathways	NHS Boards should review whole patient pathways within the wider context of redesign.

Summary of Agreed Actions

The following table is a summary of the actions already agreed to be taken forward and presented elsewhere in this report.

Remote Community Hospitals

- NoSPG will provide continued support to ensure completion of the Framework and work with Remote and Rural Boards to test the approach within the identified Hospitals.
- RRHEAL will complete the review of educational requirements and develop and agreed Education pathway for Remote Community Hospitals.
- NoSPG will work with the Association of Community Hospitals, NES and other stakeholders to ensure that an appropriate Framework is available to other Remote Community Hospitals.

Rural General Hospitals

- Boards with RGHs will compare current RGH model with the role and function defined within Delivering for Remote and Rural Healthcare to determine whether the service model is consistent with the recommended model and address inconsistencies.
- A review of the Needs Assessment by NoSPHN has been commissioned and will be shared with Remote and Rural Boards with RGHs to support local redesign.
- RGH Boards will identify skills and competencies required to deliver safe emergency care and agree a common role across RGHs, supported by an agreed competency framework.
- NoS Workforce Planning & Development Group, working with key stakeholders within the RGH Boards, will scope the Rural Practitioner roles required, agree role description and seek common description and banding for role.
- NoS Workforce Planning & Development Group, working with RRHEAL, will compare the role requirements with the curriculum for the Physicians Assistant and the Rural Practitioners for Remote Community Hospitals to develop pathways into required training.
- RGH Boards will undertake Training Needs Analysis within local systems.
- RGH Boards will investigate integration of GP out of hours and hospital out of hours requirements.
- RGH Boards, working with larger centres, will identify where other Obligate Networks can support care and use Obligate Network guidance to ensure that networks are established.

Emergency Response & Transport

- Scottish Ambulance Service, working with territorial NHS Boards should produce detailed Strategic Options Framework Implementation Plans, linked to Board plans to implement the NHS Scotland

Quality Strategy.

- SAS will host an event in late 2010.

Obligate Networks

- The guidance for Obligate Networks should be re-published and readily available to NHS Scotland through the SHOW website.
- NHS Boards should review their need for Obligate Networks, through their clinical governance structures, to ensure that remote and rural practitioners and services are adequately supported and resourced.
- NoSPG will convene a meeting of Remote and Rural Boards should reconsider whether the establishment of an R&R Network, would provide additional support to improve the overall system of care.

Workforce & Education

RRHEAL will continue to:

- Work with the R&R NHS Boards, using their learning and development plans to prioritise education and training needs.
- Develop "Distributed Education System and Platform for Remote and Rural Workforce".
- Work with Educational providers to ensure that programmes are appropriate to need, accessible and viable for the long term.

Recommendations for the Future

The work of RRIG has concluded, but as identified in the foreword to this report, there remain a number challenges that have emerged throughout the project, or as circumstances have changed have required that the recommendations in Delivering for Health be revisited. These have been presented in each of the relevant sections of this Report but are reproduced in full in the table below.

Remote Community Hospitals

- The Medical Directors of Remote and Rural Boards should ensure that there is agreement between the Boards and the Regulator on revalidation arrangements for non-standard roles.
- Remote and Rural Boards should establish a Remote Community Hospital Network.
- NoS Workforce Planning and Development Group should review of terms and conditions for GPs working in Community Hospitals and seek a consistent approach across Scotland.

Rural General Hospitals

- RGH Boards should undertake Observation Study to better understand the service requirements, if a model that does not rely on doctors in training is introduced.
- The policy commitment for sustainable models of care within Rural General Hospitals should be reviewed and NHS Boards should be encouraged to implement this revised model of care to ensure the sustainability of locally available services.
- RGH Boards should design a safe system of emergency care within the RGH that is consistent across all RGHs, underpinned by a robust system of governance. The system of care will be supported by an Emergency Care Obligate Network, with identified larger centre(s) that adopts an anticipatory approach to risk management and emergency care and is supported by a clear governance structure, agreed pathways of care and clinical decision support requirements.
- RGH Boards should establish a team based approach to care within the RGH that includes Core Medical Responsibility role, Rural Practitioners, generic and general staff and a matrix of support.
- RRHEAL should develop an education and training pathway for Rural Practitioner and commission educational programme, with educational objectives appropriate to need.
- NoS Workforce Planning & Development Group, working with RRHEAL, should establish a Career Framework, to support implementation of new roles.
- RGH Boards should review the role of the Consultant to establish clear leadership and governance role.
- RGH Boards should review the roles that general and generic staff could provide if roles were extended, as recommended in Delivering for Remote and Rural Healthcare and implement these across remote and rural Scotland.
- RGH Boards, working in collaboration with SAS and EMRS should define the additional transport requirements to support Emergency System of Care and ensure that transfer rates are routinely monitored.
- Remote and Rural Boards should develop a peer review system between RGHs and Acute Care

Remote Community Hospitals.

Obligate Networks

- An Emergency Care Obligate Network should be established between all RGHs and agreed centres to ensure clear pathways of care, supported by clinical decision support and an anticipatory system of care for at risk patients.
- Obligate Networks for Laboratory Services, Radiology, Child Health and Mental Health should be established.
- A clear system of governance to support these Obligate Networks is required that defines lines of accountability and leadership.
- Active engagement by the larger centres and obligation of individual clinical departments to support remote and rural centres is required.
- Remote and Rural Boards which host an RGH should ensure that a safe system of care is developed that is consistent across all RGHs and Acute Care Community Hospitals.

Workforce & Education

- Remote and Rural Boards should work with local authority partners to define the role of the Extended Community Care team (ECCT) that reflects the population need.
- RGH Boards should identify skills and competencies required to deliver safe emergency care and agree a common role across RGHs, supported by an agreed competency framework.
- RGH Boards should support the establishment of a network to support laboratory services.

Doctors in Training

- NHS Education for Scotland, North Deanery will review the R&R Foundation placements and its GP training programmes.
- NHS Education for Scotland, working with R&R Board Medical Directors and Directors of Medical Education, should use established educational quality metrics to ensure that within RGHs trainees get high quality experience and that service continuity has reduced the reliance for out of hours care on these doctors.
- NHS Education for Scotland – North Deanery working collaboratively with Board Directors of Medical Education ensure that suitable outcome data is available to identify what currently works well in remote and rural training and what does not.

EHealth & Infrastructure

- The National Video-Conferencing Pilot should be completed and proposals and for roll-out across Scotland should be submitted to the EHealth Programme Board and the Board Chief Executives.
- NHS Boards should develop eHealth plans to support the roll-out of Obligate Networks in collaboration with the Scottish Centre for Telehealth and the IT Leads group.

Fair shares of Funding

- In taking forward the next stages of its work in this area, TAGRA should work more closely with the relevant remote and rural Boards to ensure that any system of funding can be demonstrated to be fair in an open and transparent manner.
- Scottish Government should review the way in which services are funded with consideration given to a base allocation to all Boards that reimburses the costs of the minimum level of service, before any weighted capitation approach is adopted.

Outstanding Commitments

- The Review of Specialist Transport established by SGHD should be invited to consider the needs of patients suffering mental health crisis who need to be urgently transferred to a different care provider.
- NHS Boards should review pharmacy services within the wider context of redesign.
- NHS Boards should review whole patient pathways within the wider context of redesign.

Conclusions

Delivering for Remote and Rural Healthcare established the policy direction and set out a framework through which sustainable remote and rural healthcare would be achieved. It also provided the Remote and Rural Implementation Group and NHS Boards with some extremely challenging targets and a relatively short time frame in which to deliver. This Report shows that the majority of those targets have been met or are well on the way to being met. This benefits those who live and work in remote and rural Scotland. The formal project is now complete but as can be seen from this report, the work will and needs to continue to respond to the changing demands that modern healthcare presents.

On behalf of RRIIG, we would like to take this final opportunity to thank all of those who work in remote and rural Scotland and those who may be in more urban locations that provide services to remote and rural areas for all of the hard work, passion and enthusiasm that you have shown in taking forward this agenda.

Dr Roger Gibbins
Chair
Remote and Rural Implementation Group

Dr. Annie K Ingram
Project Director
Remote and Rural Implementation Group

11 October 2010

Appendix 1

Membership of RRIIG

Name	Title	Organisation
Sharon Adamson	Head of Acute Services Planning & Redesign	NHS Greater Glasgow & Clyde
Paul Ardin	Director of Primary Care Development	NHS Ayrshire & Arran
Eric Baijal	Director of Public Health	NHS Borders
Peter Baxter	Associate Medical Director – North	NHS 24
Gavin Brown	Director of Corporate Services	NHS Fife
Alison Burns	Locality Manager – Stranraer	NHS Dumfries & Galloway
Kathy Collins	Nursing & Quality Adviser	National Services Division
Alasdair Corfield	EMRS	NHS Greater Glasgow & Clyde
Robin Creelman	Chair- Patient & Public Involvement Group	Argyll & Bute
George Crooks	Chief Operating Officer / Clinical Lead	NHS 24
Ros Derham	Scottish Partnership Forum	RCN
Roelf Dijkhuizen	Medical Director	NHS Grampian
Neil Douglas	Chair	Academy and Faculty of Royal Colleges
Jane Farmer	Co-Director, Policy and Research	Centre for Rural Health
Derek Feeley	Director of Healthcare Policy & Strategy	Scottish Government
Betty Flynn	Regional Workforce Programme Manager	NoSPG
Julieann Flynn	Head of Primary Care	NHS Tayside
Andrew Fowle	General Manager, Moray CHSCP	NHS Grampian
Anne Gent	Director of Human Resources	NHS Highland
Roger Gibbins	Chief Executive	NHS Highland
Dremot Gorman	Consultant in Public Health Medicine	NHS Lothian
Ken Graham	Medical Director	NHS Shetland
Fiona Grant	Remote & Rural Programme Manager	NoSPG
Mike Hall	Clinical Director, Argyll & Bute CHP	NHS Highland
Stephen Hearn	EMRS Lead Clinician	NHS Greater Glasgow & Clyde
Nigel Hobson	Nurse Director	NHS Western Isles
Iain Hunter	General Manager	Scottish Centre for Telehealth
Annie Ingram	Director of Regional Planning & Workforce Development	NoSPG
Gordon Jamieson	Chief Executive	NHS Western Isles
Alison Keir	Project Lead, Rural North West Forth Valley partner	NHS Forth Valley
Heather Knox	Director of Regional Planning	West of Scotland Regional Planning Group
Ian Leslie	Dean of Faculty of Health	University of Highlands & Islands
Iain Macaulay	Acting Director of Social Work	Western Isles Council

Eddie Macdonald	General Manager, Stirling CHP	NHS Forth Valley
Ron Macdonald	e-Health Programme	NHS National Services Scotland
Sandra Mair	Director of Performance Management	NHS Lothian
Sandra Dee Masson		Unison
Jan McClean	Regional Planner	South East Regional Planning Group
Bill McKerrow	ENT Consultant / RRIIG Clinical Lead	NHS Highland
Gill McVicar	General Manager, Mid Highland CHP	NHS Highland
Eileen Moir	Director of Nursing & Practice Development	NHS Quality Improvement Scotland
Gillian Needham	Postgraduate Dean (North)	NHS Education for Scotland
Bill Nicoll	General Manager – Perth & Kinross CHP	NHS Tayside
Pam Nicoll	Programme Director	Remote & Rural Healthcare Education Alliance (RRHEAL)
Marthinus Roos	Medical Director	NHS Orkney
Shirley Rogers	Director of Human Resources	Scottish Ambulance Service
Laura Ryan	Unscheduled Care Clinical Lead (Primary Care)	NHS Borders
Sheila Scott	Director of Public Health & Planning	NHS Western Isles
Andrew Sim	Consultant Surgeon	NHS Western Isles
Jacqui Simpson	Acting Director of Regional Planning	South East Regional Planning Group
Gill Stillie	Director of Service Delivery	NHS 24
Sarah Taylor	Director of Public Health & Planning	NHS Shetland
Jill Vickerman	Assistant Director of Healthcare Strategy and Policy	Scottish Government
Rhoda Walker	Director of Nursing & AHP	NHS Orkney
Iain Wallace	Associate Medical Director	NHS Greater Glasgow & Clyde
James Ward	Medical Director	NHS Western Isles

Delivering for Remote & Rural Healthcare – Delivering the Commitments and Forward Issues

The following table identifies firstly the Commitment, as it appears in the text of Delivering for Remote and Rural Healthcare, followed by the Forward Issue, who was identified as responsible for progress and a brief summary of evidence of progress, gathered from the performance management returns, submitted to RRIG. Performance Management returns are submitted by the 14 territorial NHS boards, Scottish Ambulance Service, NHS QIS, RRIG workstreams and RRHEAL.

The returns were reviewed to determine whether there was any evidence that the commitment was being met, categorised by no evidence, limited evidence, evidence and significant evidence²⁵. Some Boards, particularly those with a largely urban catchment, intimated that the work was not relevant to their Board, although in some cases these Boards did provide some evidence of action to the specific commitments or forward issues. There was also concern, expressed early in the project that the RRIG performance management returns duplicated some required by other areas of government and therefore some Boards did not complete, or only partially completed the returns. Where no evidence is reported, therefore, this does not imply that no action has been taken simply that no evidence was provided to judge this.

	Commitment	By whom	Progress
1.	This model of care for remote and rural communities, incorporating formal working links between remote and rural areas and those in larger centres, should be introduced.	Govt	Adopted as Government Policy and promulgated through CEL 23 (2008). Evidence suggests that 3 territorial NHS Boards did not see this as applicable in their Board, two other boards provided no evidence and in all other territorial Boards work was being progressed to implement this policy directive.
2.	Patients should receive the same standards of care for common procedures irrespective of where they live.	NHS QIS RRIG Boards	RRIG was established to progress this and can demonstrate evidence that this has underpinned all of the work progressed by RRIG workstreams. In particular, the Emergency Response and Treatment Workstream of RRIG developed a Strategic Options Framework (SOF) that introduced standards for emergency and urgent response in remote and rural areas and the Healthcare Quality Strategy for NHS Scotland ²⁶ have confirmed that this will be implemented. In addition, the launch of the Emergency Medical Retrieval Service will seek to improve outcomes for those from remote and rural areas by providing earlier access to skilled A&E and Intensive Care doctors. In 10 of the 14 territorial NHS Boards reviewed (71%) no evidence was presented to confirm that this was being addressed as a specific workstream, however 14% of organisations provided some evidence of action and 2 Boards stated this was not

²⁵ Limited evidence was used when a respondent, when asked a question answered yes or no and provided no further information. Evidence was used where some text was used but did not give detail; significant evidence was used where there was lengthy explanation.

²⁶ (2010) "The Healthcare Quality Strategy for NHS Scotland" p11, May 2010, The Scottish Government, Edinburgh. ISBN 978-0-7559-9323-9 (web only)

			relevant. There is evidence that the Scottish Ambulance Service (SAS) had taken action to address this but no evidence that NHS QIS have arrangements in place.
3.	The system of care within remote and rural communities should support self-care, anticipate health needs to avoid crises in chronic diseases and have the capability to respond to emergency situations. CHPs should ensure that: <ul style="list-style-type: none"> Teams are integrated and co-located including health and other relevant organisations; ECCTs support individuals to self-manage their own care; Priority is given to anticipatory care and the prevention of disease escalation; Action plans are developed for implementing long-term condition management; There is local access to an emergency care service and that there is collaboration with the SAS to develop robust community emergency response systems. 	Boards & CHPs	Significant evidence that a system of care that supports self care, anticipates health needs to avoid crises in those with a chronic disease is available. 3 Boards reported that this was not applicable. Evidence was presented by a number of territorial Boards and by SAS that there were collaborative approaches developed in relation to emergency care and the launch of the SOF will progress this collaborative approach further.
4.	The system of care should build community resilience to ensure that local people can be cared for as close to home as possible.	Boards & CHPs	Evidence that most Boards have or are working towards a system that supports community resilience and this was also identified by SAS. Again 3 Boards reported this as not relevant and two Boards provided no evidence.
5.	Remote primary care should have common methods of data collection and data set.	RRIG ISD	Whilst there was some limited evidence that Boards are working towards improved data sets within primary care, there was no evidence that this issue had been progressed. RRIG has not progressed this, however, ISD have developed and introduced Navigator, which is a web based information tool that provides access to comparative information over nine indicators including: patients at high risk of admission to hospital, potentially preventable admissions; readmissions within 7 or 28 days; QOF prevalence; prescribing; Hospital admission rates for 6 key conditions; length of stay; day case activity and consultant activity.
6.	CHPs should review their Community Hospitals to determine which, if any, should be enhanced and develop plans to implement this model.	Boards CHPs	Not all Boards have Community Hospitals, however of those who do, 3 reported this as not relevant and the remainder confirmed that the Community Hospitals had been or were being reviewed in light of this model. The level of evidence available varied between Boards.
7.	Remote Community Hospitals, acting as Community Resource hubs, should provide an agreed range of services, including enhanced diagnostics. CHPs should be responsible for reviewing the services provided within their Community Hospital and that these include: <ul style="list-style-type: none"> Acting as a resource hub to the community, integrating and co- 	Boards CHPs	6 territorial NHS Boards reported this as not relevant, 2 provided no evidence and the remaining 6 provided significant evidence that action to meet this commitment is being taken forward. SAS also presented evidence of progress.

	<p>locating services provided by health and other related organisations;</p> <ul style="list-style-type: none"> • Provision of a first line emergency service and a minor illness/injury service including acting as the Place of Safety for mental health crisis; • Provision of a range of diagnostic services, as described later; • Undertaking a role in pre-operative assessment; • Provision of a range of outpatient visiting services appropriate to the health needs of the local population; • The provision of an intermediate care service that is accessible by all practitioners; • The provision of a palliative care service. 		
8.	NHS Boards should seek to maximise the provision of appropriate secondary care undertaken locally.	Boards	9 territorial NHS Boards provided evidence of action to maximise the provision of appropriate secondary care undertaken locally; 4 Boards reported this as not relevant and 2 Boards provided no evidence.
9.	Through further analysis of the population-based activity, NHS Boards should identify the reasons for variations between RGHS, in terms of surgical profiles, patient pathways, practitioner or patient preferences and differences in patient management. NHS Boards should also use collaborative analysis of the key features of the local work to understand and develop a rationale to inform the detail of the service modelling.	Boards	9 Boards provided limited evidence of some analysis of variation, although no evidence was available to confirm that the differences highlighted by Delivering for Remote and Rural Healthcare had been addressed. 5 Boards reported this as not relevant.
10.	The North of Scotland Public Health Network should support NHS Boards to further investigate the variations in population intervention rates, ensuring that further work is framed within wider contexts such as the impact on receiving hospitals, community hospitals, other small urban general hospitals and primary care.	NoSPHN	Further review was undertaken by NoSPHN for the Medical workshop in Feb 2008, however, no Board reported having worked with NoSPHN. A review of the needs assessment was conducted during July/August 2010 by issuing a questionnaire to each RGH through the Directors of Public Health in each of the relevant Boards. Responses were received from each of the 6 RGHS (4 NHS Boards). Final details of the review have still to be gathered. Once complete the full findings of the review will be shared with each of the Boards / RGHS to support ongoing local discussions and work as appropriate.
11.	Through a network of RGHS, common protocols and standards should be developed for appropriate local intervention.	Service Models & Care Pathways Workstream	Condition Specific care pathways for RGHS have been developed and agreed by the Service Models and Care Pathways workstream and approved by representatives of the RGHS clinicians. Protocols for the Acute Community Hospitals were partially developed as part of the early work but require further development and this is being progressed by a small sub-group.
12.	The RGH should be defined as a Level 2+ facility.	NHS Boards	There are four Boards that have RGHS and all confirmed that action had been taken

	<p>NHS Boards should review the service provided within their RGH to ensure that the services provided are consistent with the model described, specifically including:</p> <ul style="list-style-type: none"> • A nurse led urgent care service; • The provision of a first-line emergency care service; • The management of acute medical and surgical emergencies; • A midwife led maternity service should be developed as a minimum, which should seek to maximise local deliveries; • The management of patients with stroke, step-down, rehabilitation and follow-up of a range of patients conditions; • The management of long term conditions; • The provision of an ambulatory care service for children; • Elective and emergency surgery as prescribed above; • Visiting services appropriate to the health needs of the population; • The provision of the prescribed range of diagnostics and clinical decision support; • The provision of a pharmacy service. 		<p>or was being taken to review the role of the RGH in line with the model. Additionally, 1 NHS Board that has a remote Community hospital that undertakes all functions of an RGHS, except emergency surgery, also confirmed reviewing the model against the proposed RGH model.</p>
13.	Where additional services are provided, a clear governance framework should be developed.	NHS Boards	Four Boards confirmed that this was in place. One Board that has an RGH provided no evidence, however that Board also reported that the model proposed was largely in place prior to the policy requirement.
14.	The focus of mental health services in remote and rural communities must be upon early detection and prevention of disease escalation.	NHS Boards	11 Boards confirmed action to meet this commitment. 3 Boards reported not relevant because of urban nature of the Board.
15.	The extended community care team must have the ability to manage mental health crisis 24/7.	NHS Boards CHPs	10 Boards confirmed this to be in place and provided evidence to confirm this. 2 Boards provided no evidence and 3 Boards advised not relevant.
16.	Formal support networks should be developed with psychiatric centres.	RRIG NHS Boards	RRIG developed guidance on Obligate Networks, which was sent to all Board Chief Executives in March 2009. 9 Boards reported formal support networks between centres and three Boards Grampian, Shetland & Orkney reported a formal Obligate Network for mental health, established with NHS Grampian. 5 Boards provided no evidence.
17.	There must be responsive retrieval systems for patients experiencing mental health crisis.	SAS	No evidence was presented by any respondent on the establishment of responsive retrieval systems for patients experiencing a mental health crisis.
18.	The Remote and Rural Healthcare Educational Alliance (RRHEAL) should urgently address the training needs of remote and rural practitioners through	RRHEAL	Three part programme developed by RRHEAL and this is with educational providers for commissioning.

	the development of a Pre-hospital Psychiatric Emergency Care Course which should be delivered utilising a 'BASICS' type approach.		
19.	An ambulatory care service should be provided for children. This service should be part of a formalised network with a paediatric centre.	Boards	11 Boards confirmed this to be in place, 3 provided no evidence and no Board identified as not relevant.
20.	Paediatric teams within RGHs should be identified and CHPs should ensure that these teams have the skills required to manage the care of an acutely ill or injured child 24/7.	Boards	NES have provided training and support to embed the Emergency Care Framework in all Boards. This was identified as the core requirement for R&R Boards and has been delivered. 7 Boards provided evidence that this commitment is being met, 4 provided no evidence and 3 reported this as not relevant.
21.	There must be responsive retrieval systems for the acutely ill or injured child or young person.	Neonatal Transport, paediatric Retrieval Service, EMRS	Scotland has a Neonatal Transport Service and a Paediatric Retrieval Service, North Boards report however, that there is a need to ensure that children requiring High Dependency care are admitted to the appropriate unit and this is not necessarily the Intensive care units in Edinburgh or Glasgow. The HDU audit undertaken by SAS confirmed this and action will be required to address.
22.	Health and social care within remote and rural areas should be organised as integrated teams, known as Extended Community Care Teams (ECCT). Current organisational barriers should not stand in the way of efficient service alignment.	Boards	10 NHS Boards provided evidence to confirm progress towards implementation, however, the degree of integration varies between Boards. 1 Board provided no evidence and 3 reported not relevant.
23.	The ECCT should be co-located when possible with other services, both within normal working hours and out of hours.	Boards	10 Boards reported co-location was either in place, partially in place, or planned.
24.	NHS Boards should consider opportunities to link single handed practices to reduce professional isolation and enhance the range of services available to the Community.	Boards	This was not relevant for 7 NHS Boards and the other 7 provided evidence of action or plans to address. Some plans depend on current staff retiring.
25.	Community Resource Hubs should have a skill mix appropriate to the health needs of the community.	Boards	8 Boards provided evidence of action, 3 provided no evidence and was reported as not relevant for the remainder.
26.	The RGH will have a medical workforce which is predominantly consultant led in the area of anaesthetics, medicine and surgery, supported by GPwSI and doctors in training.	SGHD MDs Boards	Workforce is under significant pressure and hospital models are not all sustainable. RRIG has commissioned work to review the models. The four Boards that have RGHs provided evidence of having or working towards this model despite the known difficulties and 1 Board, with an extended Community Hospital also reported some action.
27.	Nurses in RGHs should be multi-skilled, generalist practitioners.	RRIG Boards RRHEAL	NoS Nurse Directors progressing with the four Boards across the North that have RGHs. RRHEAL are also working with Boards. The remaining Boards reported not relevant.
28.	The Nurse with a Special Interest (NwSI) in Acute and in Enabling Care will be developed.	RRIG Boards RRHEAL	3 PwSI programmes in nursing established by the Workforce & Education workstream of RRIG in Shetland, Western Isles & D&G.
29.	AHPs should be multi-skilled generalised practitioners, to meet the therapeutic	RRIG	Work undertake by RRIG early provided guidance for Boards and also RRHEAL.

	needs of patients across the spectrum of care.	Boards RRHEAL	RRHEAL have developed appropriate programmes where a need has been identified.
30.	AHPs should develop special interest roles (AHPwISI) where there is a defined healthcare need.	RRIG Boards RRHEAL	Developing in Boards. No specific AHP models identified through this work
31.	The radiography team within the RGH will be flexible and consist largely of generalist practitioners.	RRIG Boards RRHEAL	Review undertaken by RRIG. RRHEAL developed education packages & NES assistant practitioner programme has been rolled out.
32.	A team of multi-skilled generalist Biomedical Scientists who are part of a formalised network will be developed.	RRIG Boards RRHEAL	RRIG have established a group and this group is working towards the establishment of an Obligate Network. Links have also been made with RRHEAL to identify education needs.
33.	A generic support worker will be developed to support the work of Nurses, AHP and Social Care professionals.	RRIG Boards RRHEAL	Programme developed by NHS Shetland, with the support of the RRIG Workforce and education Workstream. An educational provider being sought.
34.	There should be robust systems established to allow for proleptic appointment of professionals to remote and rural areas.	SGHD	SGHD Scheme withdrawn – NES funding can be available for appointments if at end of training.
35.	The Remote and Rural environment should be recognised as a rich source for training opportunities.	NHS Scotland	RRIG have continued to support the need for training as an integral role for Remote and rural services. Other National policy directives are undermining the ability to deliver this.
36.	A Practice Education Network for remote and rural healthcare should be established.	RRHEAL	RRHEAL have established this.
37.	Education programmes which are specific and responsive to the needs of remote and rural practitioners should be introduced.	RRHEAL Boards RRIG	RRHEAL is now established as the focal point for addressing the educational requirements in remote and rural areas and have delivered across a number of initiatives. This will be an ongoing requirement and RRHEAL are now part of the NES strategic engagement process with NHS Boards. A gap for GPs in acute hospitals being addressed by separate sub-group that includes RRHEAL representation.
38.	RRHEAL should introduce Educational Programmes which are specific and responsive to the needs of remote and rural practitioners.	RRHEAL	Ongoing.
39.	RRHEAL should ensure that Educational Programmes, wherever possible, are accredited.	RRHEAL	Ongoing.
40.	RRHEAL should develop robust systems that establish a critical mass of remote and rural learners that secures viable investment for learners.	RRHEAL	Ongoing.
41.	NHS Boards should consider proleptic appointments, either on an individual NHS Board or regional basis, to Consultant posts in order to allow for time for	Boards	SGHD removed funding.

	appointees to undertake site specific training prior to taking up the substantive post.		
42.	The Academy of Royal Colleges should commission research into the attractiveness of the GPwSI role within remote and rural areas.	RRHEAL	RRHEAL research project completed.
43.	The importance of remote and rural areas as a training resource for doctors in training should be recognised and appropriate training opportunities should be established, through new Speciality Training posts if necessary, to ensure the supply of remote and rural physicians, surgeons, anaesthetists and GPs.	SGHD	Training posts for surgery & Anaesthesia now established and funded. Issue with recruitment and attractiveness of programmes and this is undermining both the training in remote and rural areas and the sustainability of the workforce model.
44.	The proposed training curricula, developed by the Remote & Rural Training Pathways Group, should be adopted.	NES	Complete
45.	Remote and rural systems should not be destabilised, as a result of the full implementation of MMC.	SGHD	At significant risk. Issue with recruitment and attractiveness of programmes.
46.	NHS Education for Scotland should, in collaboration with the Academy of Royal Colleges establish a pilot to test the hybrid acute medicine/general practitioner role.	RRHEAL STB Medicine & STB GP	Two programmes advertised for Aug 2010.
47.	Vertical obligatory networks between RGHS and larger centres should be established.	RRIG Boards	RRIG developed guidance, which was circulated to all Board Chief executives in March 2009. There has been limited success with Obligate networks reported as established between Orkney, Shetland and Grampian for Mental Health; Western isles report 2 Obligate networks, with Glasgow for Diabetes and with Borders for radiology; plan is emerging for a mental Health ON. Delivering for Remote and Rural Healthcare required Obligate Networks to be established to support the Core specialities, Laboratories, radiology, child health and mental health. There is some limited evidence of discussion between some Boards but these have not routinely been established yet. There was evidence of discussions between boards on networks for other specialities.
48.	Lateral networks between RGHS should also be established.	RRIG	No appetite for a remote and rural network, post RRIG at Sept 2009 event and no evidence of action to address. There are emerging plans for an Obligate Network between acute community hospital practitioners.
49.	Remote and Rural healthcare should be judged using the same standards adopted throughout Scotland.	RRIG Boards	NHS QIS have confirmed to RRIG that they will establish a Remote and Rural Advisory Network. There was no evidence provided by Boards of any engagement in such a network. The SOF introduced standards for emergency and urgent response in remote and rural areas.
50.	NHS Boards should review their primary care premises and prioritise their capital plans to include purpose built premises, working in collaboration with Local Authorities and other Agencies to facilitate the co-location of teams.	Boards	10 Boards reported progress towards meeting this commitment, 1 provided no evidence and 3 reported not relevant.

51.	NHS Boards should ensure that the fabric of RGHS is fit for purpose and ensure that, where necessary, this is addressed in their capital plans.	Boards	All four Boards with RGHS reported action to address this.
52.	Patients should not have to travel needlessly for those diagnostic tests that can either be provided and accessed locally or provided locally and reported within the larger centre.	RRIG Boards	9 Boards reported action to address this and 5 reported not relevant.
53.	A remote and rural diagnostics network should be established to ensure local access, consistent standards of care, support of services and professionals in remote and rural areas and make best use of scarce resource.	RRIG Boards	Initially RRIG sought to establish one network between the RGHS, however, it became apparent that this was unlikely to deliver and it was agreed that NHS Highland would seek to develop a network with between the 3 RGHS in Highland and Raigmore; whilst NHS Grampian were asked to work with the Northern Isles to develop such an arrangement and Western isles were asked to identify a partner from a mainland Board. 6 Boards reported emerging or established networks in place, 1 Board provided no evidence and 7 Boards reported not relevant.
54.	The roll out of digitised imaging (PACS) should prioritise remote and rural areas.	SGHD	National PACS is now live to all planned sites in Western Isles, Highland, Tayside, Grampian and Orkney. Shetland will feed in existing data from their existing PACS service into Grampian and they will receive new equipment c. July 2011.
55.	The eHealth Strategy Board should review their investment plans to ensure that the level and quality of connectivity should be the same across Scotland.	SGHD RRIG eHealth	The eHealth Strategy was launched in Sept 2008. This strategy supported the direction articulated in Delivering for Remote and Rural Healthcare, but recognised that an incremental approach would be adopted. In January 2009, the eHealth Directorate allocated funding for investment in primary and community care (£8m recurring), to improve information and data (£15m over 3 yrs), to support change and add benefit (£16.2m over 2 yrs); and Infrastructure funding (£20m supported capital over two years – to be agreed regionally). There were significant infrastructure challenges faced by some Boards to upgrade broadband networks to N3, however, the issues in Orkney and Shetland will be addressed in late autumn 2010 and a solution has been implemented that improves the level of connectivity to the remaining GP practices in Highland, who did not have broadband access. NHS Scotland has also funded a national VC pilot to improve the standards and quality of video-conferencing across Scotland and the six North Boards have agreed to pilot this. This will include ensuring the quality and reliability of services for differential uses, including clinical uses.
56.	Remote and Rural Communities in Scotland should not expect anything less than a first class IT infrastructure to support local delivery of care. The IT infrastructure must therefore be robust across the whole of Scotland to allow	Govt	RRIG have through reports to Government and the Convention of Highlands and Islands continued to identify this as an issue for UK and Scottish Governments to

	for rapid and safe communication and reduce the need for patient and staff travel.		address.
57.	The concept of utilising e-health in the remote and rural setting must permeate every aspect of service planning and delivery in remote and rural healthcare to maximise local access and reduce the need for patient travel.	Govt SGHD RRIG EHealth Boards	Ongoing but requires infrastructure investment beyond health and the level of robustness being sought, as described above.
58.	NHS Boards should review their existing premises and ensure any new premises have access to a range of modern communication tools including broadband access, video-conferencing and tele-medicine as a minimum.	Boards	10 Boards report that action to address this is included within strategic plans within the Board. 4 boards report this as not relevant. The broadband bandwidth demands continue to grow and this is an area that will require further investment in remote and rural areas, beyond health, to ensure that the level of connectivity across Scotland is maintained.
59.	An integrated transport strategy that is responsive to remote and rural patients' needs must be developed.	Strategic Transport Partnership s & Boards	Scottish Government publish an integrated Transport Framework in 2009, however, only 1 board provided any evidence to support this approach. Other Boards either provided no evidence (8 Boards) or did not see this as relevant.
60.	The SAS should be responsible for ensuring that robust and responsive local community emergency response models are developed.	ER&T SAS	SAS working as an integral part of the Emergency Response and Treatment Workstream of RRIG developed a Strategic Options Framework (SOF) that introduced standards for emergency and urgent response in remote and rural areas and the Healthcare Quality Strategy for NHS Scotland ²⁷ have confirmed that this will be implemented. In addition, SAS provided significant evidence of collaborative approaches within individual NHS Boards.
61.	The Emergency Medical Retrieval Service (EMRS) Pilot should be established as soon as possible.	EMRS SGHD	The Cabinet Secretary launched the Emergency Medical Retrieval Service in March 2010, with roll out to all of remote and rural Scotland by October 2010. Implementation plans are progressing well and arrangements for the ongoing funding and management of this service are being established for the long term.
62.	The EMRS pilot should be supported by an independent evaluation including a prospective study which identifies the needs of the northern Highlands and the northern islands of Scotland.	SGHD	This was completed by December 2009 and preceded the decision by the cabinet Secretary. The evaluation demonstrated clinical efficacy, improved outcomes, improved access, cost effectiveness and value for money.
63.	Within the Equalities legislative framework it is expected that each NHS Board will, when progressing local implementation of the models presented in the report, conduct and report on Equality and Diversity Impact Assessments	NHS Scotland	This is an ongoing requirement for all NHS Boards and organisations.

²⁷ (2010) "The Healthcare Quality Strategy for NHS Scotland" p11, May 2010, The Scottish Government, Edinburgh. ISBN 978-0-7559-9323-9 (web only)

	according to locally agreed guidelines.		
	Forward Issues	By whom	Progress
1.	Explore the use of the wider healthcare team to develop resilience within the community, including the use of NHS 24 skills and technology and a pilot to test the role which Ambulance technicians and paramedics can play in anticipatory care and chronic disease management.	Boards	The majority of territorial NHS Boards and the SAS reported progress towards achieving this.
2.	Obligatory Networks should developed and should determine the exact range of local and visiting services that should be provided on the basis of population need within the framework of the core services.	ONS	Whilst recognised by Boards as an approach, there is limited evidence of this being achieved to date. Whilst guidance was developed, accessing this is an issue and there remain a number of organisational issues to be addressed within Boards to give effect to the concept as envisaged. The fragility of some services, within RGHs and Community Hospitals suggest that the need remains, however, Boards have not yet looked to this as an approach to sustain local access.
3.	Working patterns within larger centres need to be reviewed to support the needs of the RGH.	Boards in partnership	3 Boards report action, however none of these Boards would be defined as larger centres. Many of the larger Boards consistently report that Delivering for Remote and Rural Healthcare is not relevant to their Board, despite the requirement for larger centres to support remote services. This, together with forward issue 2 above, and the reported fragility of the staffing model in the RGHs suggests that there remains work to be done, to ensure that all Boards recognise the corporate responsibilities to sustain services across Scotland.
4.	Research into the acceptability and attractiveness of the GPwSI within remote and rural communities is required.	RRHEAL	2 Boards report pilot projects in place and RRHEAL have undertaken a research project due to report in summer 2010.
5.	An audit should be commissioned to undertake an evaluation of the effect on service delivery of a Consultant-led medical service as compared to a GPwSI led medical service as part of an obligate network.	RRIG	Approach to acute community hospitals suggests that this work is no longer required.
6.	A pilot should be established to test the hybrid acute medicine/general practitioner role.	NES Boards	Post in place in Fort William & the STB for medicine and STB for GP agreed to advertise 2 programmes for Aug 2010.
7.	NHS Boards are encouraged to develop innovative solutions to providing access to community pharmacy services in remote and rural areas in the Pharmaceutical Care Service Plans.	Boards	No action is reported by any Board, however, the question does not appear on the performance management returns.
8.	The Scottish Government should review the proleptic appointment scheme to support sustainability of R&R services.	SGHD	Scheme withdrawn 2009.
9.	The Remote and Rural Training Pathways Group should seek to establish	STBs	Complete where required.

	approval for the new curricula through the relevant medical training accreditation bodies.		
10.	The Training Pathways Group will progress the work in the areas of acute resuscitative care and airways management, and treatment of the acutely ill child.		No evidence provided, although there is no clear reference in the performance management return. This will be addressed however, by the Emergency Care framework and the majority of Boards reported progress towards implementation of this.
11.	NES, in collaboration with Remote and Rural NHS Boards, through the Deanery structure must continue to ensure adequate training opportunities for doctors in Remote and rural practice.	NES	Programmes in place, however, recruitment and attractiveness of programmes is an issue, which the deanery have flagged needs to be addressed.
12.	NES, through the deanery structure must ensure that a commitment is made to fund replacement posts for backfill of the 18 month GP training, and that these posts are supported by the necessary educational approval, to ensure that we can continue both to deliver a sustainable service and to attract junior doctors to these posts.	NES	This issue was addressed at the time, however there remain issues as outlined in relation to issue 11 above.
13.	NHS Boards should undertake a review of the current medical workforce to provide NES with clear forward projections for training numbers.	Boards NES SGHD	CEL 28 (2009) overtaken this and there is a projected reduction in junior doctors. Boards have completed returns for the workforce directorate of SGHD and the National Medical Reshaping Board. Fill rates in RGHs has been consistently poor over the last two years and RRIG has arranged an event to review the RGH staffing model. The Deanery have also intimated that the training programmes need to be reviewed in light of changes.
14.	Directors of Planning and Board Medical Directors should agree the nature and form of lateral and vertical networks.	Boards	No evidence of any action has been provided.
15.	Robust Care Pathways should be developed for the most common patient conditions.	RRIG	Condition specific, acute care pathways have been developed by the Service Models and Care Pathways workstream that describe what will be provided within an RGH, which conditions can be treated locally but by a visiting specialist and which conditions will require transfer to another centre. These are due for launch in summer 2010. The Emergency Response and Transport workstream have developed standards of response and provided a menu of types of response that SAS and Boards will use to engage with remote and rural communities to develop an appropriate response for the emergency and urgent requirements. These will inform patient pathways. Whole patient pathways have not been developed by RRIG or the RRIG workstreams. 7 Boards provided evidence of local review of patient pathways.
16.	NHS Quality Improvement Scotland (QIS) should appoint a Remote and Rural	NHS QIS	Complete: R&R Advisory Network to be established by QIS, however, no evidence

	Clinical Advisor to ensure an understanding of remote and rural issues sought in the development of its standards. This Clinical Advisor should establish a Remote and Rural Reference Group to support him/her in this work.		provided by Boards of awareness or engagement with this.
17.	The Scottish Government should consider the development of an integrated transport strategy, including health.	SGHD	Integrated Transport Framework and guidance promulgated to service by SGHD in 2009.
18.	Consider how closer integrated working arrangements between the SAS and NHS Boards can be achieved.	ER&T	RRIG has developed the SOF, implementation of which will underpin closer working between SAS and territorial NHS Boards. 10 territorial NHS Boards and SAS provided evidence of improved integration, however, this will be an evolving and ongoing process, responding to the changing needs of local populations.
19.	The Scottish Government should consider providing funding for the appointment of a National Programme Manager with appropriate administrative assistance in order to ensure capacity is built to support the implementation of the remote and rural framework.	SGHD	Complete
20.	The Scottish Government should consider the impact of the NRAC review on NHS Boards' ability to maintain and develop remote and rural services.	SGHD	SGHD introduced NRAC in 2009/10. Following debate in Scottish parliament, Cabinet Secretary agreed that a technical group (TAGRA) established to maintain and develop the NRAC formula should review the impact on remote and rural Boards. TAGRA review completed and submitted to cabinet Secretary confirming the view of TAGRA that the adjustment is fair, appropriate and robust. Report has 4 recommendations for further work including GP out of hours allocations; cost of dispensing pharmacies; review of service restrictions including RGHs and Agenda for Change. RRIG remain to be convinced of the efficacy of the formula and have submitted concerns.

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NHS Chief Executives

4 March 2009

Dear Colleague

FRAMEWORK FOR OBLIGATE NETWORKS

This letter provides guidance to NHS Boards in the establishment of Obligate Networks.

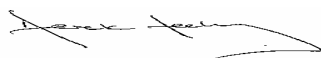
In May 2008, following an extensive and inclusive review, 'Delivering for Remote and Rural Healthcare' was published by the Cabinet Secretary, as Scottish Government policy. Within the detailed report the establishment of 'Obligate Networks' was identified as one of the key building blocks required to sustain local services and to ensure access to more specialist services that are not available locally. This concept builds on the well-established MCN approach that Scotland has pioneered but takes this a bit further and was identified as crucial to the sustaining access for those living in remote and rural communities by the Cabinet Secretary, when Delivering for Remote and Rural healthcare was published.

The term is used in Delivering for Remote and Rural Healthcare but is not defined in any detail and Annex 1 to this letter has been developed, by the Remote and Rural Implementation Group, to define the concept and provide guidance on where Obligate Networks will be required and, how these should be agreed between NHS Boards.

Obligate Networks should be established between NHS Boards to sustain core services and ensure access to four key specialist services not routinely available in Rural General Hospitals (RGHs), including Child Health, Mental Health, Radiology and Laboratories.

NHS Boards are asked to consider the proposed framework and report on plans, either in place or intended, on establishment of the proposed Obligate Networks and to identify other or future priorities to RRIIG by email to nospg.rr@nhs.net no later than **31 March 2009**.

Yours sincerely



Derek Feeley
Director
Healthcare Policy and Strategy Directorate



Roger Gibbins
Chair,
Remote and Rural Implementation Group

A Framework for Obligate Networks

This paper explores the concept of Obligate Networks and makes recommendations on the way forward. Consultation of the proposed framework has been wide and has included all Boards and regions across NHS Scotland.

Background

Throughout the engagement process, which preceded the publication of 'Delivering for Remote and Rural Healthcare'²⁸, a number of common requirements were identified by those working in remote and rural locations as necessary building blocks to ensure sustainability of local services and appropriate access to more specialist care for their communities. These common requirements included clinical decision support, education and training, quality assurance and standards, transport and formal support networks. Networks were seen clearly as the way forward but it was highlighted by a number of different practitioners, working in different areas of care, that a more formal approach would be required, agreed collectively between the remote and rural health system and those in the larger centres with access to more specialist services, if local access to was to be sustained. 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.**"²⁹

Two types of networks were envisaged: vertically, between specialist centres and remote and rural communities to support access to services and clinical expertise not available within the community; and lateral networks, between remote practices and RGHS to ensure common standards, protocols, training and development and to share good practice.

Networks within NHS Scotland

The network concept within NHS Scotland is not new. Although in existence as a model, before the Acute Services Review in 1998³⁰, this far-reaching strategy identified clinical networks 'as arguably its most important recommendation'³¹ of the Review, with Managed Clinical Networks seen as offering:

"...the best prospect for delivering high quality services which make optimal use of resources and offer more uniform access to patients... Development of networks is not the same as centralisation and any need to concentrate high technology services will be balanced by increased outreach services for the population served."³²

The concept of Managed Clinical Networks was accepted as extant health policy and the first guidance was issued in February 1999³³, defining MCNs as:

²⁸ (2008) "Delivering for Remote and Rural Healthcare" May 2008, Scottish Government, Edinburgh. RR Donnelly B56045 05/08

²⁹ Ibid, p5 emphasis added.

³⁰ (1998) "Acute Services Review" May 1998, Scottish Office, HMSO

³¹ Ibid, p135

³² Ibid, p135

³³ NHS MEL (1999) 10 "Introduction of Managed Clinical Networks within NHS in Scotland" 9th February 1999, Scottish Office.

"...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."³⁴

This initial guidance identified a role for MCNs in supporting remote and rural communities 'concerned with a number of specialities rather than one single speciality or disease' (para 4), and established a number of core principles for MCNs (Appendix 1). These principles have remained largely unchanged in later guidance^{35 36}, although the most recent guidance has removed the reference to the role of networks in development of the intermediate specialist, referring instead to the development of new or extended roles^{37 38 39}, which perhaps reflects the evolving nature of healthcare over the last decade. The support for remote and rural health services has been seen but has tended concentrate on speciality specific support.

One of the identified strengths of MCNs is their flexibility, built on a democratic consensual style⁴⁰, and the concentration on clinical outcome and service improvement, with achievement of standardisation through the development of shared protocols, but without direct accountability for service delivery. In terms of delivering for remote and rural areas, the attendant lack of formality can also be a weakness.

HDL (2007) 21 also provided guidance on regional and national MCNs. This reproduced at Appendix 2, for ease of reference, however the role envisaged for these MCNs:

"1. ...to clarify and support the development of patient pathways across Board areas when the service cannot be provided in one Board area alone. They are therefore **focused on common protocols, training and audit**⁴¹."

"4. It is important to emphasise, particularly in the regional and national contexts, that MCNs should not be viewed as a means of filling a funding gap in existing services. However, they **can** exert influence through their integration into regional planning processes and through their role as vehicles for developing an evidence base to support quality improvement and service developments."

and perhaps more importantly the role that they are excluded from highlights the gap that the obligate network will need to resolve.

'Better Health, Better Care'⁴², published in December 2007, reaffirmed the importance of networks within NHS Scotland, positioning them as an organisational expression of the values of cooperation and collaboration that lie at the heart of Scotland's mutual approach to health services. It went on to identify the need for the traditional MCN model to be strengthened in some circumstances, to address particular service planning challenges, such as, in the provision of neurosurgery and specialist children's services. Work has been taking place on both these issues since the publication of Better Health Better Care and a proposal to establish a Managed Service Network for Neurosurgery was accepted by the Cabinet Secretary for Health and Wellbeing in January 2008.⁴³

At the National Directors of Planning Business Meeting on 5th August 2008, a paper⁴⁴ was presented which outlined a number of overarching principles, identified by the Neurosciences Working Group, as necessary for the establishment of an MSN. Whilst clearly developed for a different purpose, these

³⁴ Ibid, para 3

³⁵ NHS HDL (2002)69 "Promoting the development of MCNs in the NHS In Scotland" 18th Sept 2002, Scottish Executive

³⁶ NHS HDL (2007) 21 "Strengthening the Role of Managed Clinical Networks" 27th March 2007, Scottish Executive

³⁷ MEL (1999)10 para 8.9

³⁸ HDL (2002) 69 para 11.9

³⁹ HDL (2007) 21 para 10.5

⁴⁰ Ibid, para 23

⁴¹ Emphasis added

⁴² (2007) "Better Health, Better Care" December 2007, Scottish Government, Edinburgh. RR Donnelley B53881 12/07

⁴³ (2008) "Neuroscience Implementation Group: Report to Cabinet Secretary for Health and Wellbeing" Jan 2008. unpublished

⁴⁴ Feeley D (2008) 'Managed Service Networks (MSNs)' BP 27 (08), unpublished

overarching principles of coherence, consistency, sustainability and redesign are helpful in refining the obligatory network concept further. It is suggested however, that whilst the seven key criteria may have applicability for obligate networks, the underpinning detail may be different.

Delivering for Remote and Rural Healthcare

Delivering for Remote and Rural Healthcare, the final report of the remote and rural work stream established following the publication of the 'National Framework for Service Change'⁴⁵ was accepted by the Scottish Government in spring 2008. The Report identified the importance of a network approach to sustain **core services** in **medicine, surgery** and **anaesthesia** and identified **four** more specialist areas for the development of networks as a priority, including: **Child Health, Mental Health, Radiology, Laboratories**. Since publication, work has been ongoing to further determine the detail in respect of both the core services and these specialty areas.

The service models and care pathways group are developing care pathways for the most common conditions and these pathways are built on a clear expectation that whilst many of the services will be available locally, these services will, for some patients, network with another centre, where a wider range of diagnostics and treatments are available. These relationships require to be defined.

Within the more specialist service networks, perhaps the furthest advanced work is in relation to the development of a Managed Care Network for Mental Health between NHS Grampian and NHS Orkney and NHS Shetland. This network will not be a single entity but a collaboration of the four main sub-specialty areas that make up main stream mental health services, including adult mental health, older people (mental health), Learning disability, and Child and Adolescent Mental Health Services, coming together under the umbrella of one obligate network.

It is intended that some specialist services for children may also be sustained through a networking approach. In relation to children's cancer, a permissive network⁴⁶, has been proposed. No further guidance is currently available, although work is ongoing at this time.

Obligate Networks

The aim of 'Delivering for Remote and Rural Healthcare' is to provide a framework to ensure sustainability of, or access to, services. Obligate Networks were identified by that report as key building blocks of this framework. These may be Vertical Obligate Networks to support access to services and specialist expertise; or they may be Lateral Obligate Networks that ensure common standards of care.

It is likely that Vertical Obligate Networks that sustain clinical services will be the most prevalent type of Obligate Network. Delivering for Remote and Rural Healthcare identified only one Lateral Obligate Network that needed to be established, a network between the RGHS. It is recommended that RRIG should undertake this function in the initial stages of implementation and ensure that there are robust ongoing arrangements for the future, once the role of RRIG is concluded.

Obligate networks will require a degree of formality, often missing from the traditional MCN approach, if services in remote and rural areas are to be sustained for the long term. The way in which this will be achieved is summarised in the Framework below. A comparison of the requirements from the different networking vehicles and the additional requirements from Obligate Networks is provided at Appendix 4.

Defining an Obligate Network

⁴⁵ (2005) "National Framework for Service Change" May 2005, Scottish Executive (2005) "Delivering for Health" November 2005, Scottish Executive

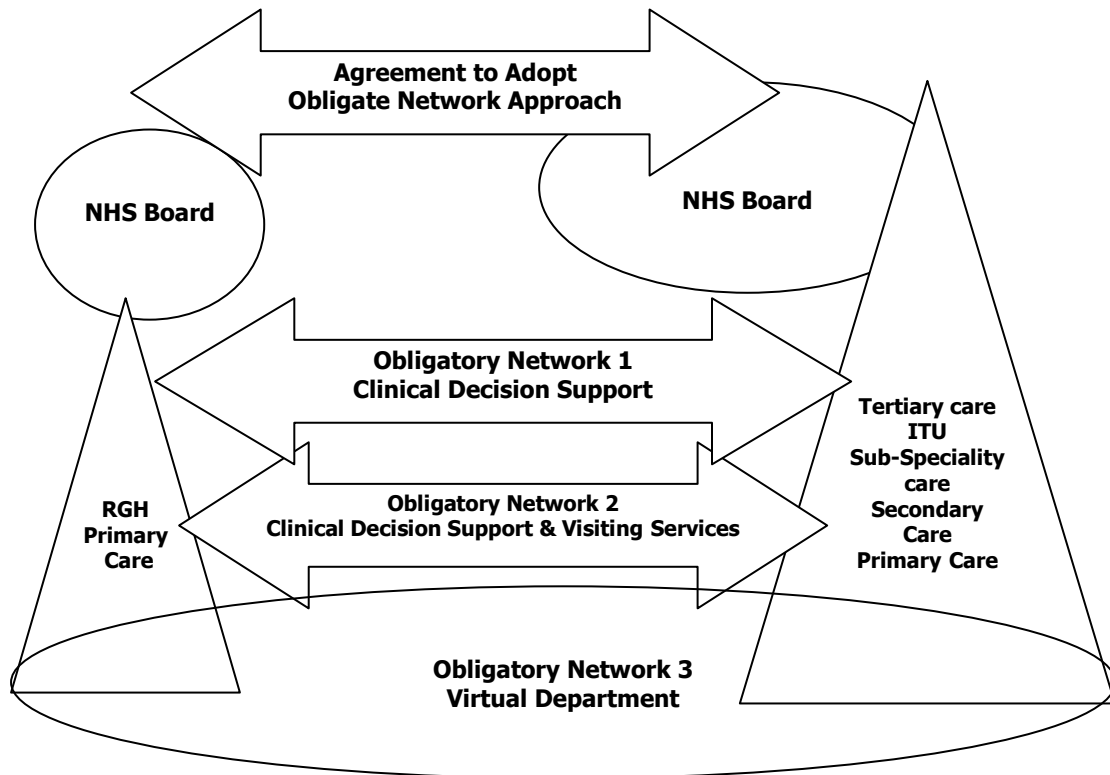
⁴⁶ (2007) "National Steering Group for Specialist Children's Services: Report on Children's Cancer Services in Scotland: Option Appraisal – Children's Cancer" p 7, Nov 2007, Scottish Government.

An Obligate Network is a formalised arrangement between two or more healthcare organisations that secures access to sustainable services for the whole population served by these organisations. Obligate Networks may be strategic between NHS Boards, who will agree a basket of services to be provided within that arrangement, or they may be at an operational service level between a specialist service and a more generally based service. These networks will provide:

- Access to expert opinion to inform and support local decision making, which may be 24/7;
- Development of shared protocols and pathways;
- Improved discharge planning;
- Transfer Debriefs;
- Peer Group support, training and education; and
- Rotation for Skills update and maintenance, this may include joint appointments.

Whilst aimed at clinical service sustainability, obligate networks may also provide benefits for non-clinical services.

The obligation arrangements may differ between services, the obligation may be limited to ensuring clear pathways of care, where more specialist diagnostics or treatments are not locally available, this may be supported by a visiting service and limited clinical decision support, or it may be more far reaching, with the creation of a virtual department, with joint appointments. The specific arrangements will need to be agreed on a speciality specific basis and may require larger departments to make significant changes to current working arrangements. The following graphic describes the model:



It is recognised that whilst there may be existing arrangements between NHS Boards, in order to maximise the available capacity across Scotland, Obligate Networks, particularly, although not exclusively, for clinical decision-making, could be provided by an NHS Board, not normally linked with the more remote Board.

It has also been recognised that obligate networks for clinical support services may differ for individual clinical pathways. For example, patients from the Western Isles are currently transferred to Raigmore for ENT surgery. NHS Western Isles could enter into an obligate network with NHS Greater Glasgow & Clyde for radiology services. This should not be seen as a reason to change the definitive patient pathway, but, there will need to be arrangements in place to ensure that this does not add to the steps within the pathway and arrangements between clinicians will be required to ensure appropriate communication.

Framework to Develop Obligate Networks

The comparison of the different network vehicles provides a number of steps towards the establishment of Obligate Networks.

1. Establish heads of agreement at regional or Board level to the principle of an obligate approach to service delivery and sustainability. This must be written and must clearly define the nature of the obligation. Whilst many boards will currently have agreements in place, in relation to a number of services, through Service Level Agreements, the underpinning philosophy of an Obligate Network is different, based on partnership and mutuality of responsibility, rather than buying of a service. It is about dual responsibility and accountability for the service.
2. Ensure Chief Executive Leadership, supported by appropriate Medical Director and functional Executive support. The appropriate Regional Planning Group may undertake this function for arrangements between NHS Boards.

3. Agree a work programme for the services to be included within the Obligate network and identify priorities for development.

For each Specialist Service where an Obligate Network is to be established:

4. Define the range of service provision required/included (e.g. specialist input - visiting or telemedicine clinics, MHO cover etc). This must be written and clearly define the nature of the obligation.
5. Structural arrangements for the Obligatory network should be clear, with clear identification of the Lead Clinician and Lead Service Manager at specialist service level. Arrangements for administrative and data collection support must also be clear.
6. A Network steering group should be established with multi-professional/multi-disciplinary representation from each participating service/organisation. In some areas it may be possible to combine this role across disciplines e.g. between an RGH and a centre that has sub-specialist surgical services, one Steering group may be more appropriate.
7. The network may consider that a co-chairing arrangement or joint clinical leads is an appropriate model to cover boundaries. These posts should be from different organisations.
8. Service users and/or carers and representatives of the voluntary sector should be members of the obligate network. In some circumstances, it may be more appropriate to engage with service users and carers in a different way, it is important however, that their views can influence the design of services.
9. Map current service provision by specialist service and identify the gap between current and future services. This should include ensuring meeting NHS targets and improvement to services and may require redesign.
10. Agreement in principle establishment of network and formal Board sign-off in each Board will be required.
11. Develop a Project Plan for development of Network to include key elements, including:
 - Identified range of service provision;
 - Common care pathways, protocols and standards;
 - Established e-health links, including tele-health opportunities and web design;
 - Integrated approach to workforce planning;
 - Programme of training and education;
 - Plan for communication and stakeholder engagement;
 - Data Collection/Analysis, including ensuring that services are supported by an appropriate evidential base;
 - Agreement of key performance indicators and plan to implement and monitor these;
 - Arrangements for the management of risk;
 - Programme of audit and framework for clinical governance and quality improvement; and
 - Service user and carer input.
12. Establish appropriate governance arrangements for the Obligate Network. Where the Network expands beyond Board boundaries specific arrangements will be required to ensure that each Board is assured that appropriate standards of clinical, corporate and staff governance are met. These arrangements should link with the governance arrangements in place at regional level.
13. All workplans should be approved by the accountable body(ies). This may be a Board or may be through the Regional Planning Structures established by Boards. Each network should provide an annual report on progress and service improvement.

Appendix 5 provides a standard template for use when proposing the establishment of an Obligate Network.

Conclusions

An Obligate Network, as envisaged by Delivering for Remote and Rural Healthcare is something more than the traditional MCN approach in place in Scotland. It will require a degree of formality, excluded from these arrangements and it may be required to fill a gap in service delivery. This is particularly relevant for the vertical networks identified in the report.

RRIG will establish arrangements to establish a lateral Obligate Network between the Rural General Hospitals and the relevant NHS Boards.

To sustain services in remote and rural areas there will need to be a formal agreement between Boards, in the North this may be part of the recently announced Island Partnership approach⁴⁷, part of the regional planning structures, or it may be something more than that. It will also, however, require agreement at speciality level. In terms of speciality level, there is an urgent need to establish obligate networks to sustain core services and to address the four specialist service priorities identified: Child Health, Mental Health, Laboratories and Diagnostics.

Agreement of a definition is however only the first step. This paper identifies a process to progress the development of this concept, both between organisations and at speciality specific level. To date, there has been an 'in principle' acceptance of this approach as a vehicle to sustain services, it is now time to test the approach and move from concept to reality.

Next Steps

As noted above, the priority areas for action have been identified as: sustaining core services and developing networks to ensure access to four key specialist services not routinely available in RGHS, including Child Health, Mental Health, Radiology and Laboratories. These priority areas are not an exhaustive list, however, further priorities will be for NHS Boards to determine.

NHS Boards should consider the Framework for Obligate Networks and report on plans, either in place or intended, on establishment of the proposed networks. RRIG will offer to facilitate and support the establishment of Obligate Networks, where Boards request this support.

⁴⁷ (2008) Letter from Colin Cook to Chairs and Chief Executives of NHS Grampian, Highland, Orkney, Shetland & Western Isles. 8th July 2008

Extract from HDL (2007) 21: Strengthening the Role of Managed Clinical Networks

“Core Principles

10. The core principles of MCN development are re-stated here, with some modifications based on practical experience:

10.1 Each MCN must have clarity about its management arrangements, including the appointment of a person, usually known as the ‘Lead Clinician’ (or ‘Lead Officer’ if it is a multi-agency Network), who is recognised as having overall responsibility for the functioning of the Network. Each Network must also produce an annual report to the body or bodies to which it is accountable, and that annual report must also be available to the public.

10.2 Each Network must have a defined structure which sets out the points at which the service is to be delivered, and the connections between them. This will usually be achieved by mapping the journey of care. The structure must indicate clearly the ways in which the Network relates to the planning function of the body or bodies to which it is accountable.

10.3 Each Network must have an annual work plan, setting out, with the agreement of those responsible for delivering services, the intended service improvements, and, where possible, quantifying the benefits to service users and their families.

10.4 Each Network must use a documented evidence base, such as SIGN Guidelines where these are available, and should draw on expansions of the evidence base arising through audit and relevant research and development. All the professionals who work in the Network must practice in accordance with the evidence base and the general principles governing Networks.

10.5 Each Network must be multi-disciplinary and multi-professional, in keeping with the nature of the Network. Multi-agency Networks will cover NHS and local authority/social care services. There must be clarity about the role of each professional in the Network, particularly where new or extended roles are being developed to achieve the Network’s aims.

10.6 Each Network should include representation by service users and the voluntary sector in its management arrangements, and must provide them with suitable support in discharging that function. Each Network should develop mechanisms for capturing service users’ and carers’ views, and have clear policies on improving access to services, the dissemination of information to service users and carers, and on the nature of that information.

10.7 Each Network must have a quality assurance programme which has been developed in accordance with the arrangements set out by NHS Quality Improvement Scotland. The social work Performance Improvement Framework (PIF) and developing work on joint inspection will be relevant to multi-agency Managed Care Networks.

10.8 Networks’ educational and training potential should be used to the full, in particular through exchanges between those working in the community and primary care and those working in hospitals or specialist centres. All Networks should ensure that professionals involved in the Network are participating in appropriate appraisal systems which assess competence to carry out functions delivered on behalf of the Network, and that the participating clinicians are involved in a programme of continuous professional development.

10.9 There must be evidence that the potential for Networks to generate better value for money has been explored.”

Extract from Annex to HDL (2007) 21: Strengthening the Role of Managed Clinical Networks

Regional MCNs

1. The aim of all Regional Networks is to clarify and support the development of patient pathways across Board areas when the service cannot be provided in one Board area alone. They are therefore focused on common protocols, training and audit.
2. Generally, the arrangements which are being put in place by the 3 Regional Planning Groups relate to the assessment of applications to become a regional MCN to ensure that there is clarity about the benefits to be gained through the development of the Network, as well as clarity about the management and clinical lead arrangements, and any costs involved.
3. There is also an important role for inter-regional MCNs. These may cover 2 or more regions, and in some cases which would not meet the criteria for designation as a national MCN, may need a Scotland-wide scope through a co-ordinated approach by all 3 Regional Planning Groups.
4. It is important to emphasise, particularly in the regional and national contexts, that MCNs should not be viewed as a means of filling a funding gap in existing services. However, they **can** exert influence through their integration into regional planning processes and through their role as vehicles for developing an evidence base to support quality improvement and service developments.
5. Each MCN must have clarity about its accountability and governance arrangements, and differentiate between governance, accountability, performance management and accreditation. The core principles set out in paragraph 10 of the main HDL apply to regional MCNs.

MANAGED SERVICE NETWORKS (MSNs)

The following is a summary of the paper presented to the National Directors of Planning Group in August 2008.

1. Overarching principles

MSNs should enable:

- Coherence
- Consistency
- Sustainability
- Redesign

2. Any proposal to develop an MSN should be tested against **seven key criteria**:

(a) Ownership/Leadership

MSNs must be owned by Boards. They should be chaired by 'honest broker' at CEO (by CEO who was not from 'provider' Board). It was recognised that Clinical Leadership was vital and should be provided by a Medical Director. MSNs also need a Director who would be a senior person from a Board. The CEO, Medical Director and Director should each come from a different Board.

(b) Commissioner/Provider Relationship

The underpinning philosophy was to keep things together as much as possible; i.e.

- MCN a subset of the MSN
- Links to National Planning Forum would be important
- Standards and transparency should guide the design and specification of services

(c) Infrastructure

A number of key infrastructure requirements were identified:

- eHealth should prioritise MSN requirements, including telehealth
- ISD to form data consultancy
- a managerial infrastructure would be necessary
- audit/data infrastructure would be crucial

(d) Governance/Accountability Authority

The governing principle should be that MSNs needed to work within existing governance and accountability arrangements. It was recognised that:

- an escalation process was required
- IST & QIS might have a role

(e) Funding

There was a strong preference that resources should be **pooled** not top-sliced and vested in statutory authorities.

(f) Quality Improvement

It was agreed that MSNs should be vehicles for improvement and should pursue sustainability and redesign through standards.

(g) Workforce/Staffing

Key requirements include:

- clarity about roles
- job planning important
- workforce planning and development sitting alongside service
- planning in the MSN

3. In comparing the outline models against the above criteria, the clear preference was for a **consortium approach** with the following key features:

- A single Consortium (i.e. including providers and purchasers)
- Chaired by Non-Provider
- Large and small boards involved
- All provider boards as members
- Service Leaders at the table (and linking to the MCN)
- Patient/public reps important
- National Planning read across to be considered as this work develops

Comparison of the Requirements from Different Networking Vehicles

MCN Criteria	MSN Criteria	Underlying Principle	Obligate Network
		Aim	Sustain service delivery either through local access or clinical decision support
Management Arrangements Lead clinician/officer Accountability Network manager Annual Report	Ownership/Leadership CEO/MD/Lead Director Managerial infrastructure Governance and accountability	Management Arrangements	Once structure (next) agreed, clear management arrangements to: Progress individual service agreements, within context of wider agreement. Must involve local lead clinicians, managers, with finance and planning support
Defined structure Relations to planning functions	Commissioner/provider relationship Infrastructure to support, including eHealth	Structure	Services included agreed strategically between Boards, involving Chief Executive, Director of Finance and/or Planning and MD. May be convened regionally. Clear identification of services to be included. Detail agreed at service level.
Workplan for Service Improvement		Performance management	Agreed workplan within strategic context to agree which services. Each service produce a workplan with KPIs. Priority to standards & protocols
Documented evidence base & agreement to practice in accordance with evidence. Audit	Audit	Standards/Evidence base	Services should be planned and delivered in accordance with the evidence base. Audit support should be provided.
Multi-disciplinary/multi-professional New roles	Workforce/staffing	workforce	Multi-disciplinary/multi-professional engagement in network. Engagement of wider community partners necessary in some networks e.g. mental health Detailed workforce planning for the multi-professional/multi-disciplinary team undertake within context of network.
Service user/voluntary sector involvement	Patient/public reps	PFPI	PFPI engagement in speciality specific networks.
Quality Assurance Programmes	Quality Improvement	Quality Assurance	Quality Assurance Programmes
Education and		Education &	Key aspect of obligate network.

Training Appraisal & CPD		training	Training & education plans to be developed within workplan.
Value for money	Funding should be pooled	Performance management	Service meets key NHSS targets including 18 week RTT.

Obligate Network – Standard Assessment Framework

This paper outlines in a standard proforma the basic information that should be expected to be described before approval to establish an Obligate Network is made by NHS Boards. NHS Boards may also require additional information.

It is accepted that some of the elements may not be available at an early stage but will be required to be addressed over time by the Obligate Network and would provide, in the early stages a reporting template.

Obligate Network Criteria	Obligate Network Response
Proposed Obligate Network	[Insert overall service title]
Participating NHS Boards	[insert names of all participating NHS Boards]
Aim of Network	[insert brief description of the aims of the network including detailed explanation of services to be included]
Organisation: Management Arrangements and Accountability	Identify lead executive in each NHS Board overseeing obligate network
Lead Clinician	Insert name Note: it may be appropriate to have joint clinical leads.
Lead Service Manager(s)	Insert name and designation
Identified lead in each participating NHS Board	Insert names and designation
Network Steering Group	Explain organisational arrangements in place to oversee network between NHS Boards, including accountabilities
Chair of Steering Group	Insert name and designation. Note: it may be appropriate to have co-chairs. These should come from different organisations.
Members of Steering Group	List names of others not identified above.
Service User, Carer, Voluntary sector representatives	List names/organisations
Evidence to support	Brief description of population need, service deficits.

establishment of network	
Expected outcomes	Brief description of improvements sought by approach.
Resource Requirements	Identify capital and revenue resource requirements and funding sources.
Project Plan (may include one or more of these elements)	<ul style="list-style-type: none"> • Identified range of service provision; • Common care pathways, protocols and standards; • Established e-health links, including tele-health opportunities and web design; • Integrated approach to workforce planning; • Programme of training and education; • Plan for communication and stakeholder engagement; • Data Collection/Analysis, including ensuring that services are supported by an appropriate evidential base; • Agreement of key performance indicators and plan to implement and monitor these; • Programme of audit and framework for clinical governance and quality improvement; and • Service user and carer input.
Governance and Risk Arrangements	Identify Governance arrangements: corporate, clinical and staff and identify reporting arrangements to each participating NHS Board. Management of risk should be explicit, including where the risk is carried when the service is unavailable.
Diversity & Equality Assessment	
Other Information	

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