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Remote and Rural Healthcare - The Scottish Experience

North Yorkshire Health and Wellbeing Board
25th July

Dr Roger Gibbins

Purpose and Objectives

Share Scottish Experience:

- Commission into Future of Public Services
- National Framework for Service Change in NHS Scotland
- Delivering for Remote and Rural Healthcare
- Enable the Board to reflect on your strategies, priorities, plans, approaches

Roger Gibbins

- Chief Executive of NHS Highland 2000 - 2010
- Executive Coach and Leadership Consultant
- Member of Christie Commission into Future of Public Services in Scotland
- Member of NHS National Framework Advisory Group
- Chair Remote and Rural Steering Group
- Supporting Scottish Government health and social care integration

Scottish Context

- Integrated Health System:
- 14 Health Boards reporting directly to Ministers and Parliament
- 32 Unitary Local Authorities
- 9 and moving to Single National Police and Fire Authorities
- Single Outcome Agreements and Community Planning Partnerships based on LAs

NATIONAL PERFORMANCE FRAMEWORK

THE GOVERNMENT'S PURPOSE

TO FOCUS GOVERNMENT AND PUBLIC SERVICES ON CREATING A MORE SUCCESSFUL COUNTRY, WITH OPPORTUNITIES FOR ALL OF SCOTLAND TO FLOURISH, THROUGH INCREASING SUSTAINABLE ECONOMIC GROWTH

HIGH LEVEL TARGETS RELATING TO THE PURPOSE

GROWTH PRODUCTIVITY PARTICIPATION POPULATION SOLIDARITY COHESION SUSTAINABILITY

STRATEGIC OBJECTIVES

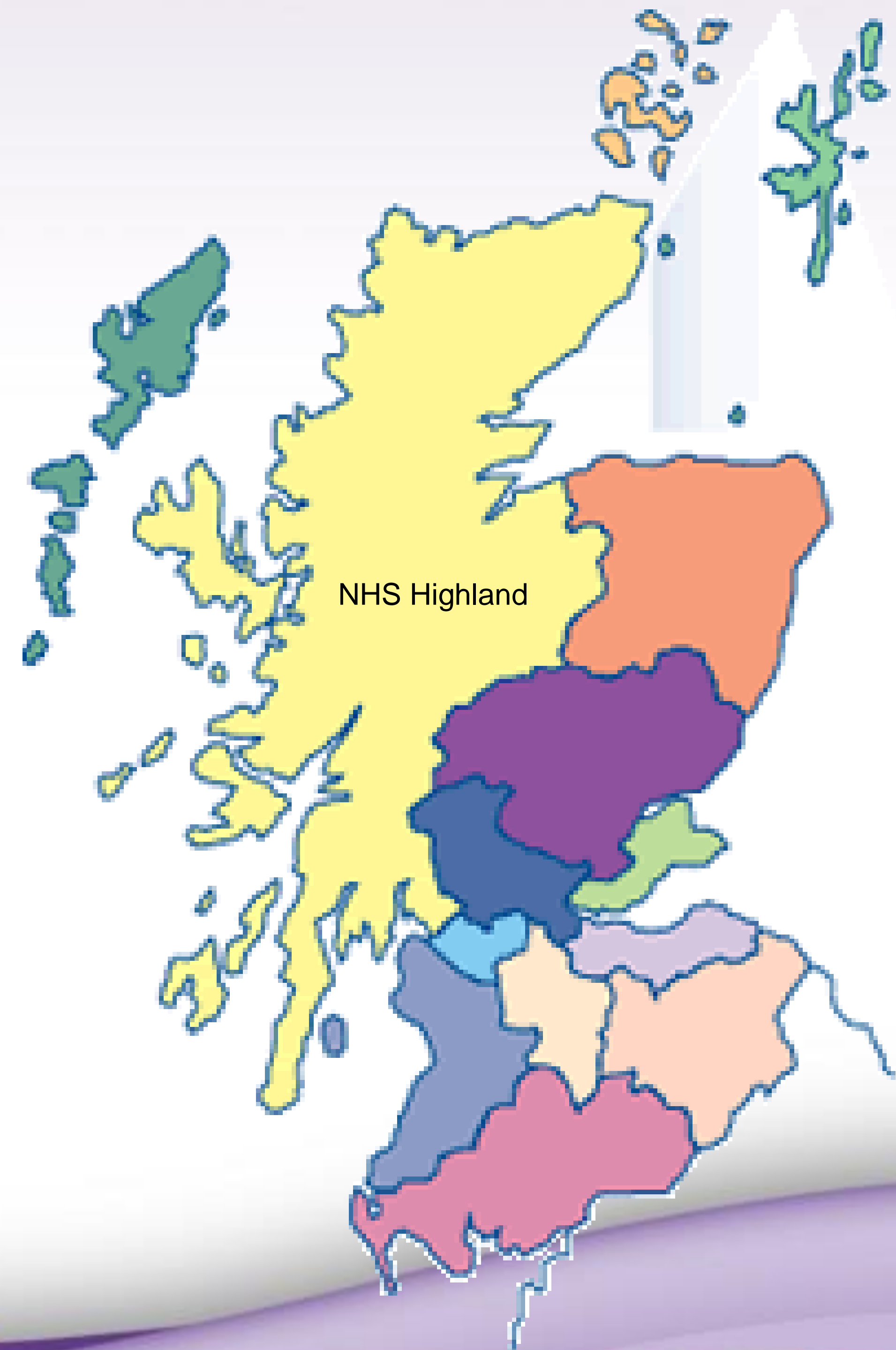
WEALTHIER & FAIRER	SMARTER	HEALTHIER	SAFER & STRONGER	GREENER

NATIONAL OUTCOMES

- We live in a Scotland that is the most attractive place for doing business in Europe
- We realise our full economic potential with more and better employment opportunities for our people
- We are better educated, more skilled and more successful, renowned for our research and innovation
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens
- Our children have the best start in life and are ready to succeed
- We live longer, healthier lives
- We have tackled the significant inequalities in Scottish society
- We have improved the life chances for children, young people and families at risk
- We live our lives safe from crime, disorder and danger
- We live in well-designed, sustainable places where we are able to access the amenities and services we need
- We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others
- We value and enjoy our built and natural environment and protect it and enhance it for future generations
- We take pride in a strong, fair and inclusive national identity
- We reduce the local and global environmental impact of our consumption and production
- Our public services are high quality, continually improving, efficient and responsive to local people's needs

NHS Highland

- 41% of Scotland
- 33,000 sq km
- 300,000 population
- 10,000 staff
- Two LAs - Highland and Argyll and Bute
- One DGH, three Rural General Hospitals

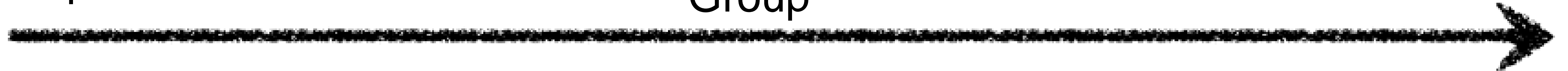


Chronology

May 2005
Building a Health Service Fit for the Future
published

October 2010
Final Report Remote and Rural Implementation Group

May 2012
SG Consultation on Health and Care Integration



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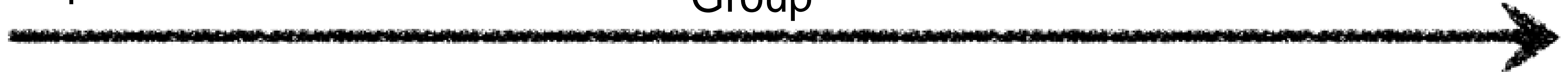

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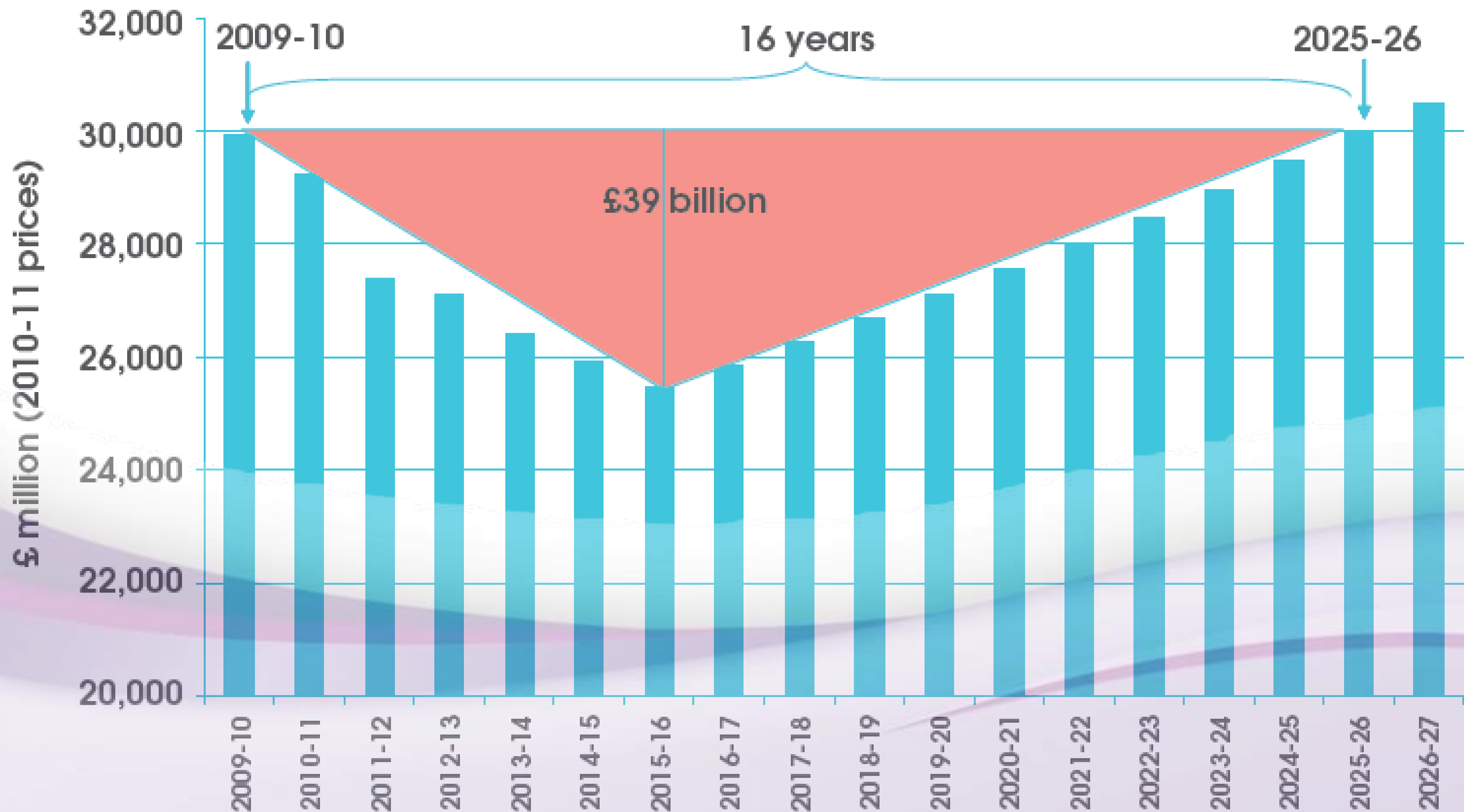
COMMISSION ON THE FUTURE DELIVERY OF PUBLIC SERVICES

Commission Context

Long-term Fiscal Outlook (source: Scottish Government)



Prevention

- Given the financial environment, all public services need to take action to reduce demand
- Focus on prevention and persistent inequalities is key to tackling the root causes of problems
- Huge weight of evidence makes a persuasive case for preventive approaches
- Should also prioritise activities with greatest impact – early years, employability, regeneration

Services Built Around People

- Much greater emphasis on working with people and communities in the design and delivery of public services
- Engaging with service users to better understand their circumstances, needs and aspirations
- Empowering individuals and communities – enhancing their autonomy and resilience
- Building on the talents, assets and potential of the individual, the family and the community

Working Together

- Public services have been unduly fragmented and complex – leading to ‘failure demand’
- Need much better co-ordination and integration between services to achieve better outcomes
- Want stronger drivers and incentives to promote collaboration between public bodies
- Focus accountability on outcomes - for example, through common powers and duties

Reflections

- Happening already in limited number of places
- Need to break down the organisational barriers that stop people doing the right things
- The answers lie in how services are organised and delivered and in culture change
- Need to develop forms of local (community) engagement and accountability across services
- Most importantly, new forms of leadership

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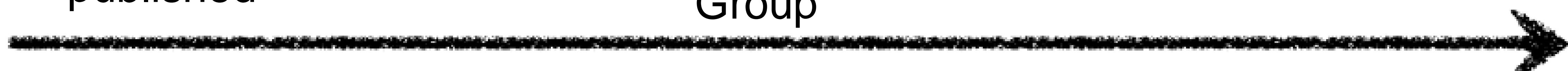

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Integration of Adult Health and Social Care

What is the Problem we are trying to solve?

- Too much variability of health and social care in different parts of Scotland, particularly for older people.
- No incentive to help get people out of hospital quickly and back into a homely setting.
- Much easier to get people admitted to hospital than to arrange services that would keep them at home.

Framework for Improvement

- Consistency of outcomes across Scotland;
- Applies in every council and health board area;
- Statutory underpinning;
- Integrated budget to deliver some acute, community and social care services;
- Someone clearly accountable for delivering agreed outcomes;
- Professionally led by clinicians and social workers;
- Simplifies rather than complicates existing bodies and structures
- Minimal disruption to staff and services.

What does the evidence tell us?

- Planning for populations, not delivery structures
- Pooling resources – money and people
- Embedding GPs, other clinicians and care professionals in the processes of service planning, investment and provision
- Very strong local leadership

Proposals for Reform

- Nationally agreed outcomes across health and social care, first on improvements in outcomes for older people
- Joint accountability via the Chief Executives of the Health Board and Local Authority to Ministers, NHS Chairs, Council Leaders and the public for delivery of outcomes
- CHP committees taken off the statute book and replaced by Health and Social Care Partnerships – joint and equal responsibility of the NHS and Local Authority
- Jointly appointed accountable officer will report to the Chief Executives of the NHS and Local Authority
- Integrated budgets for community health and social care, and for some acute hospital services
- Strong clinical and professional leadership, and engagement of the third sector, in commissioning and planning of services through locality service planning groups

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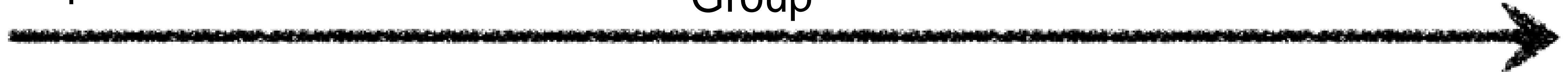

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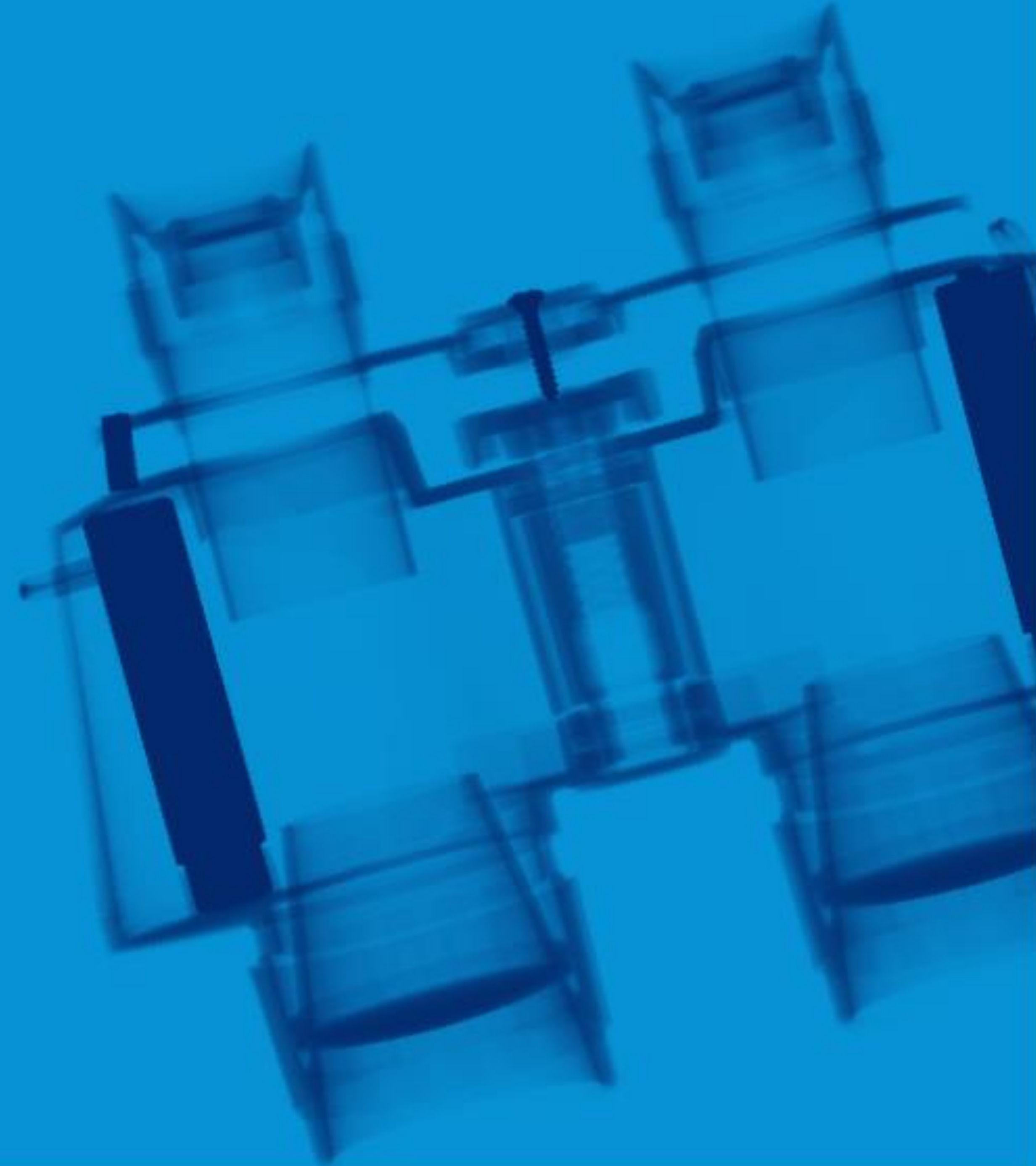
A National Framework for Service Change in the **NHS in Scotland**

BUILDING A HEALTH SERVICE **FIT FOR THE FUTURE**



Key Messages

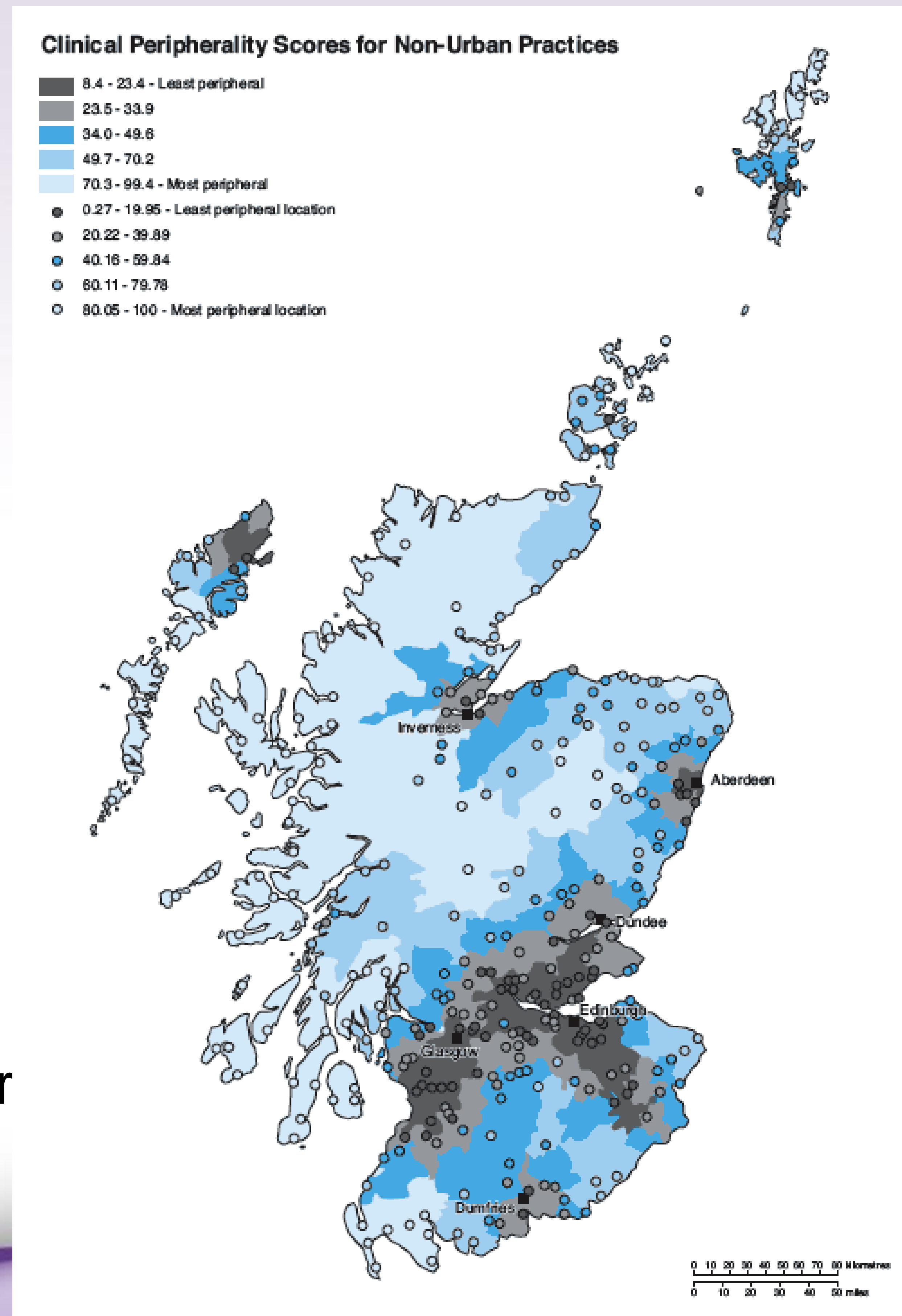
- Change emphasis from Hospital to Community (90%)
- Preventative and anticipatory, rather than reactive
- Local as possible, specialised as necessary
- Systemic approach to most vulnerable/those with long term conditions
- More fully integrated / Galvanise the whole system

New health care model

Current View	Evolving Model
Geared towards acute conditions	Towards Long-term conditions
Hospital Centred	Embedded in Communities
Doctor Dependent	Team Based
Episodic care	Continuous care
Disjointed care	Integrated care
Reactive care	Preventative care
Patient as passive recipient	Patient as partner
Self care infrequent	Self care encouraged and facilitated
Carers undervalued	Carers supported as partners
Low tech	High tech

Safe and Sustainable Rural Care

- Recognition - one in five
- Enhanced primary care
- The Rural General Hospital
- A resilient system of urgent care
- Formalised arrangements for training and development



REMOTE AND RURAL
STEERING GROUP

DELIVERING FOR REMOTE AND RURAL HEALTHCARE

THE FINAL REPORT OF THE REMOTE AND RURAL WORKSTREAM

30th November 2007

Topics

- Model of Care
- Emergency and Urgent Response
- Extended Community Hospital
- Rural General Hospital
- Workforce Development and Training Pathway for Doctors

The then Current Reality

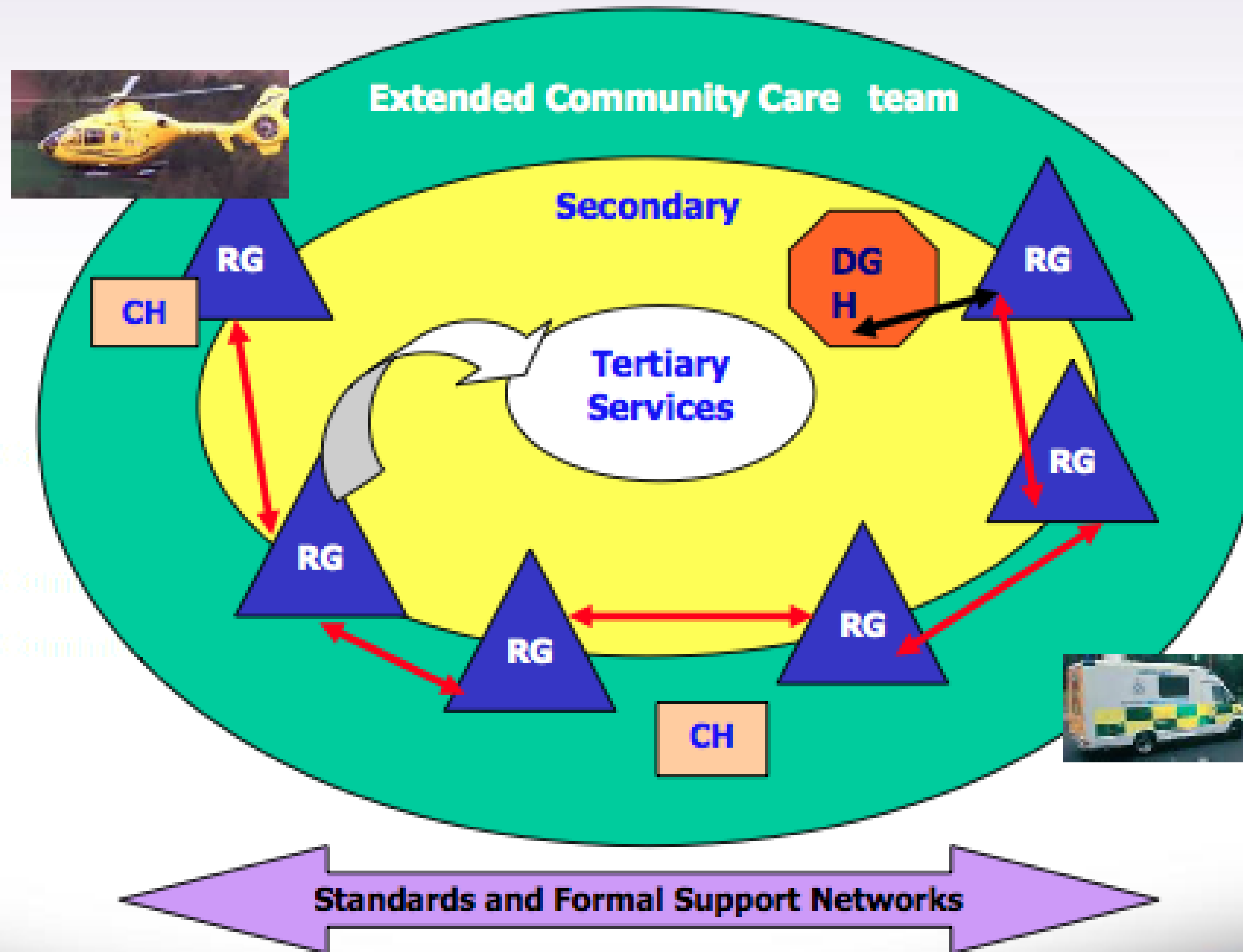
- Hugh variation in models of care, availability of services
- Few standards, little evidence of effectiveness, quality
- Low staff morale, no recognised training and development in R&R healthcare
- Suspicion regarding downgrading and closure
- Poor engagement with communities, local issues easily escalated
- Despite variation and variable quality, significant commitment to current provision - very strong “loss aversion/endowment factor”

Attempts to Modernise met with suspicion

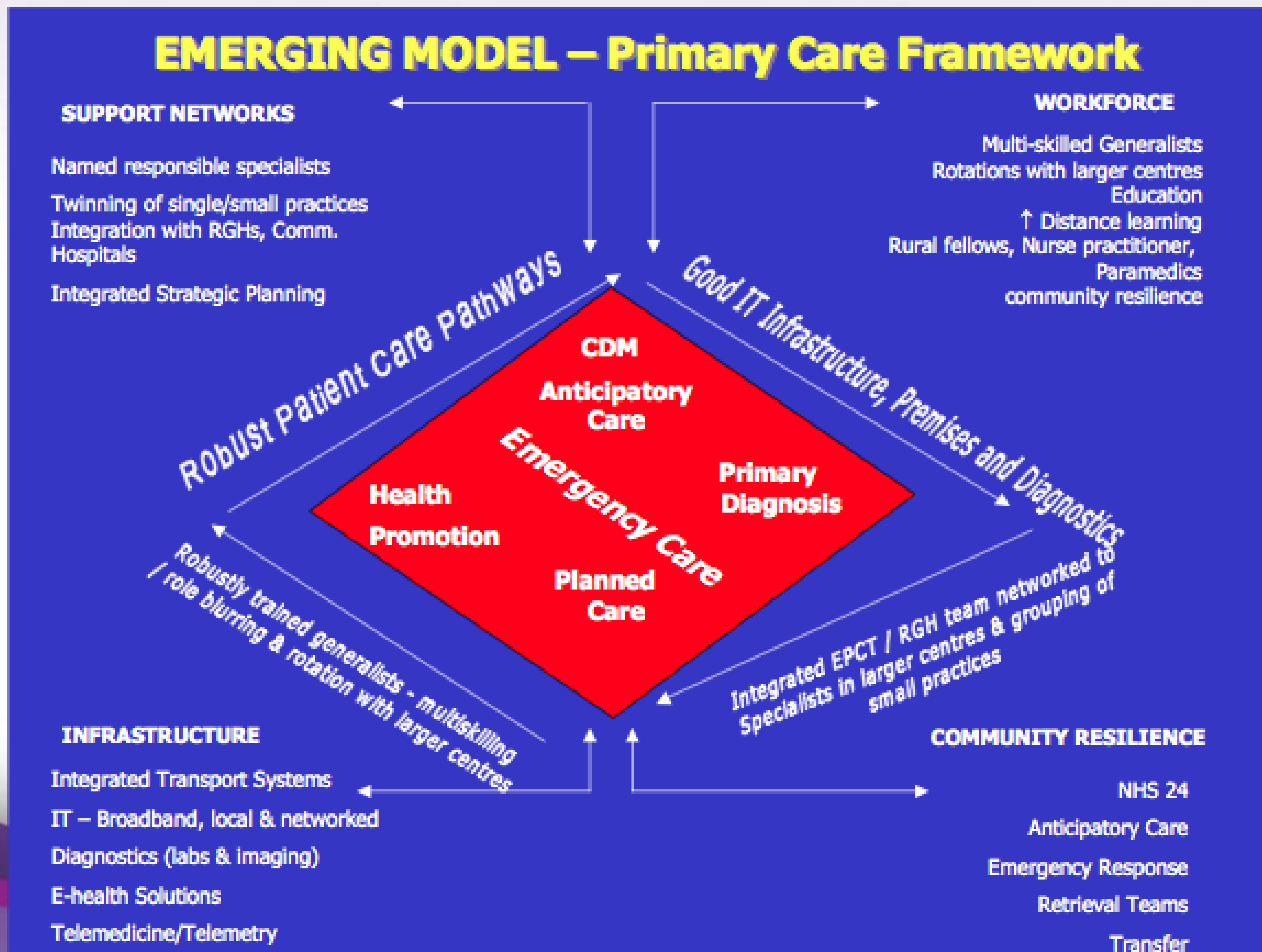
Model of Care

- A framework to build a measure of consistency, but also confidence and security
- From which: workforce planning, care pathways, networks, standards and quality
- Community resilience and supported self care
- Responsive and robust urgent care
- Develop the wider health and care team
- Extended role for GPs/practitioners - GPs with a special interest
- Core role and functions of facilitates - Community Hospital, Rural General Hospital

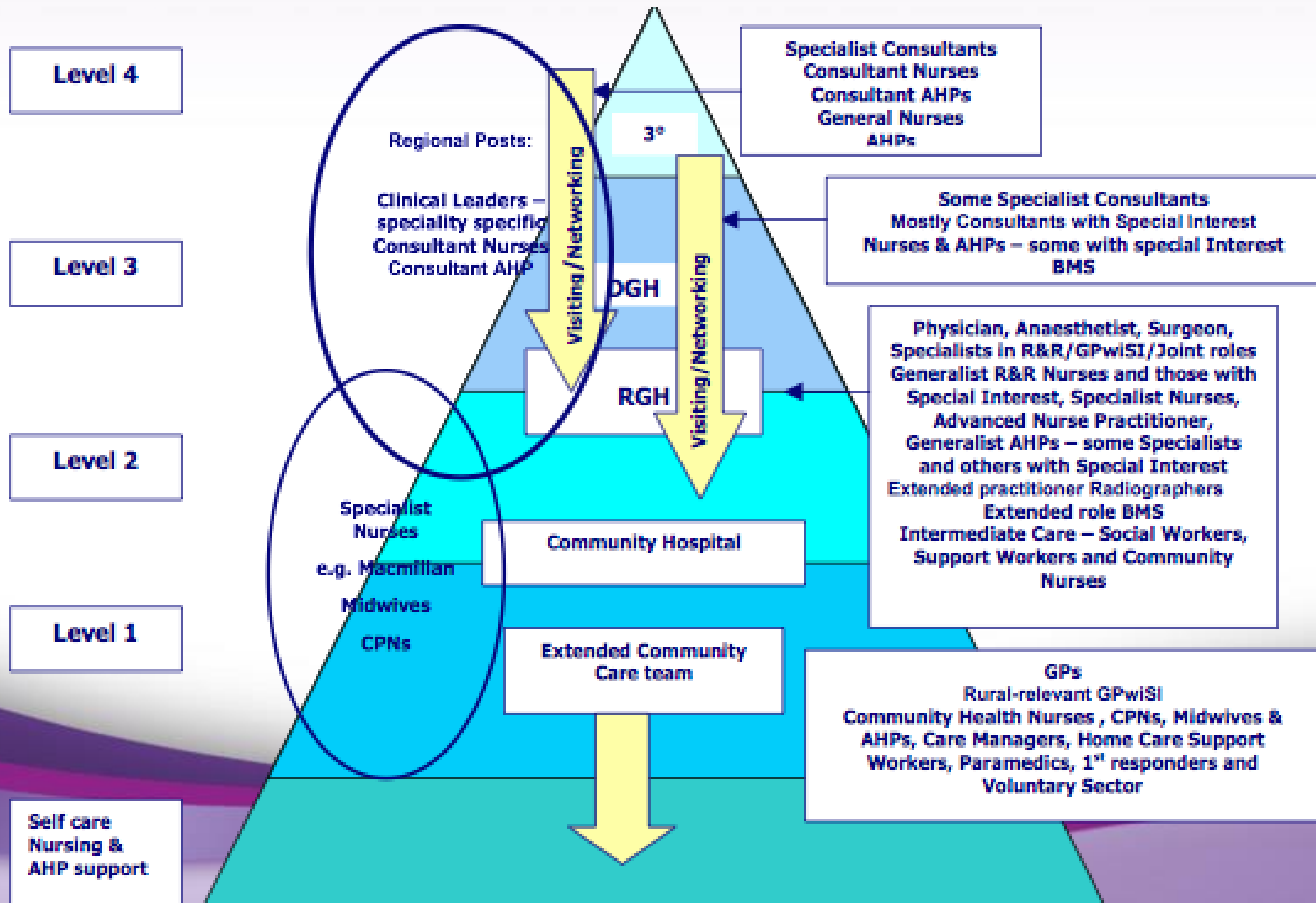
Model of Care



Model of Primary Care



Model of Care - Workforce



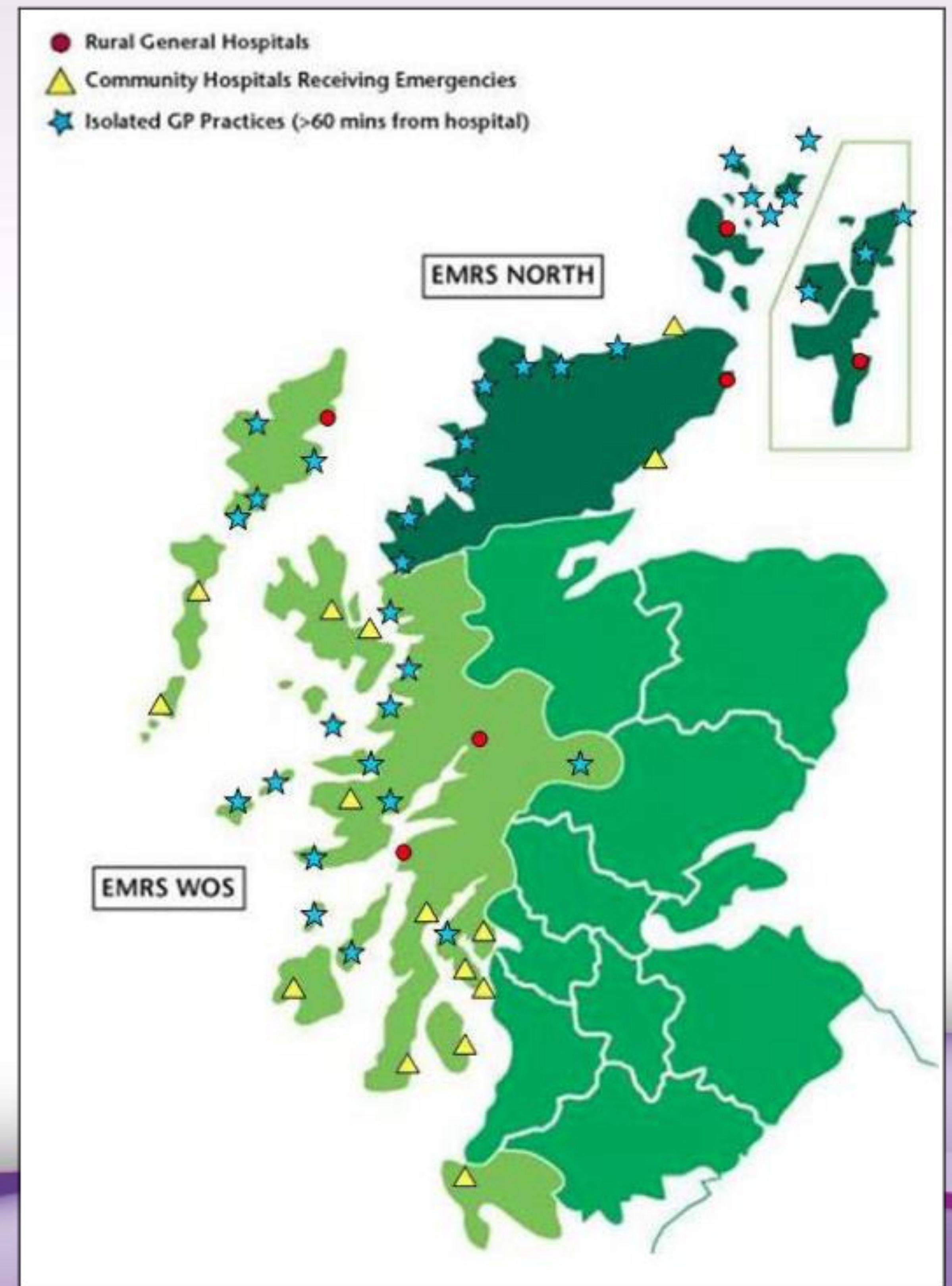
Emergency and Urgent Response

- Appropriate response in emergency, robust and responsive to local need, seen as a universal right
- Pilot and evaluation of aero-medical Emergency Medical Retrieval Service
- Strategic Options Framework for Emergency and Urgent response for Remote and Rural Communities

Emergency Medical Retrieval Service

Emergency Medical Retrieval Service

- A&E/Intensive care doctors to R&R acutely ill/trauma patients
- Air Ambulance/RAF
- Treat and Stabilise
- Transfer to definitive care
- £costly



Map of EMRS Coverage from October 2010

Policy Framework for Emergency and Urgent Response

- Clarification of roles - Scottish Ambulance Service (SAS) and Territorial Boards
- SAS has strategic responsibility for emergency and urgent response
- Appropriate Standards for R&R response, to supplement national standards
- Range of types of responses that would be appropriate
- Process and timetable for SAS and Boards to map areas and introduce areas plans and new arrangements

Urgent Response Standards, eg

- Patients will receive a timely response that is appropriate to their clinical need
- Patients should not normally have to wait longer than 30 minutes for the arrival of a member of the community emergency response team, although it is recognised that there will be exceptional circumstances where this may occur and there should be a system for recording these (eg extreme weather conditions).
- Systems are in place to ensure that a trained person will always be available to be deployed in accordance with the clinical needs of the patient.
- A trained individual from the graded community emergency response team will be immediately deployed. If this is a First Responder, then a healthcare professional will be deployed at the same time, where the patient's clinical need dictates this.

Graded Community Response Team

- Skills and training which must be available at each level of the graded community response team are:
- Level 1 First Responder.
- Level 2 Retained SAS/ Technician/Allied Health Professional (AHP), Community Pharmacist/Generic Health Care Support Worker (GHCSW).
- Level 3 Accident and Emergency (A&E) Paramedic, or General Practitioner (GP), or Community Nurse, Mental Health Teams.
- Level 4 Secondary transfer by specialist Retrieval/Transfer Team (eg Mental Health Team, Neonatal Transport Team, Transfer of Critically Ill or Injured Child Service, Emergency Medical Retrieval Service (EMRS) Team.

Urgent Response Example:

- ***Very Remote Rural (eg includes peninsulas, and mainland remote settings)***
  Defined as settlements of less than 3,000 people and with a drive time of over 60 minutes to a settlement of 10,000 or more.
- Community CPR training
- Community First Responders (Trained to Intermediate Level FPOS with additional skills as defined in the standards document)
- Retained Driver
- Retained Ambulance Service
- Community Practitioner Response Level 2 (eg Generic Health Care Support Worker GHCSW)
- Level 3 Community Practitioner Response
- Level 3 Extended Community Practitioner Response

Extended Community Hospital

Extended Community Hospital

- Hub for Out of Hours unscheduled care integrated with practitioner led minor injury/illness units
- First line resuscitation, triage, transfer or admission
- Diagnostic services;   Centre for Tele-health
- Outpatient clinics by visiting specialists; Role in pre-operative assessment
- Intermediate care beds; Midwifery service; Palliative care
- Designated place of safety for mental health crisis

Rural General Hospital

- Six in Scotland - Highland and 3 Islands
- Between a Community Hospital and DGH
- Rationale - respond to acute medical emergencies and maximise use of resource to provide appropriate local care
- Medical Consultant/Specialist GP staffing model
- Emergency medical care: triage, diagnosis, resuscitation and stabilisation
- Treat where possible, transfer when necessary
- Routine elective care, surgical and medical

RGH Core Services

Unscheduled Care:	*Planned Care*
•Nurse led urgent care/minor injury •Resuscitation, acute medical and surgical admissions •Initial fracture management •Midwifery led maternity •Neonatal resuscitation •Diagnosis/initial mgt acutely ill child •High dependency management before transfer •Retrieval and transfer arrangements	•Management of Stroke Patients •Rehabilitation and step down •Post-op step down, rehab, follow up •Management of patients with long term conditions •Haemodialysis; cancer care as part of network •Ambulatory care for children •Routine elective general surgery •Visiting services
Support •Clinical decision making support via e-health links to other centres •Pharmacy	***Diagnostic etc Services*** •Diagnostic capability - imaging; digitised image capture; ultrasound and CT scanning •Laboratories - limited range biochemistry, haematology and cross match blood •Surgical intervention, e.g. biopsy of legion •Cardiac investigation - stress testing and echocardiography

Workforce Development / Training Pathways

- Demoralised, undervalued, isolated
- Variable, fragmented, disparate in terms of care provided
- Single handed GPs;   Ageing workforce, no succession
- No recognised pathway for ‘specialist generic’ roles
- Team development - Extended Primary/community care teams; co-location
- Blurring of distinctions - generic support worker; between primary and secondary care

Concluding Remarks

- Reframe focus and approach:
- Prevention, manage demand, reduce failure demand
- Build community and individual capacity and resilience; assets based approach
- Strategies that reconcile service/clinical prerequisites with community/local priorities
- New forms of community engagement - sharing responsibility and decision making
- New forms of organisational arrangements - collaborations around communities focused on outcomes
- New forms of leadership based on partnership and co-creation

Resources/References

- Report on the Future Delivery of Public Services (Christie Commission): http://www.scotland.gov.uk/Resource/Doc/352649/0118638.pdf
- Government's response to Christie Commission: http://www.scotland.gov.uk/Resource/Doc/358359/0121131.pdf
- Health and Social Care Integration - Consultation on proposals: http://www.scotland.gov.uk/Resource/0039/00392579.pdf
- National Framework for Service Change in NHS in Scotland: http://www.scotland.gov.uk/Resource/Doc/924/0012113.pdf
- Delivering for Remote and Rural Healthcare: http://www.scotland.gov.uk/Resource/Doc/222087/0059735.pdf
- Emergency and Urgent Response Strategic Options Framework: http://www.sehd.scot.nhs.uk/mels/CEL2010_21.pdf
- Final Report of Remote and Rural Implementation Group: http://www.nospg.nhsscotland.com/wp-content/3.-Final_Report_RRIG_Oct10.pdf
- Community Hospital Strategy Refresh http://www.scotland.gov.uk/Resource/0039/00391837.pdf

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DISCUSSION

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