Being Here:

An Approach to Building Sustainability of Health and Care Services in Remote and Rural Areas
Being Here
On December 11th 2012 NHS Highland received a letter from the Cabinet Secretary for Health and Social Care inviting it to develop and test models for remote health and care services in Scotland, with outline estimates of:

- Governance arrangements
- Resource requirements
- Expected timelines

It was also agreed that any recommendations resulting from this work would be expected to:

- Have relevance to all remote areas of Scotland
- Reflect the new context of integrated health and social care
- Be suitable for testing in rural and urban areas of Scotland

The proposals developed and submitted for consideration by NHS Highland take account of the historical context in establishing and providing services, the extensive research and work undertaken to date regarding:

- Policy and principles informing and guiding service provision
- Rural community viability, resilience, participation and ownership
- Partnership arrangements across the public and voluntary sector
- Current status of service – issues, resourcing, challenges and solutions
- Service proposals with resource implications and timelines
- Evaluation methodology and reporting process
- Governance arrangements
It must be stressed that there will be no single model of service. The proposals for consistency will set out principles and key elements for success, rather than a blueprint, as successful solutions will be grown from local need and local resilience.

The proposals are underpinned by NHS Highland Quality Approach\(^1\) principles and combine a mixture of NHS Highland funded and non recurring funding.

**Why**

The challenges of delivering safe and sustainable services in remote and rural areas have long been recognised, and there is a plethora of reports going back to the Dewar Report\(^2\) of 1912 and, more recently, Delivering for Remote and Rural Healthcare\(^3\) in 2007. A fifth of the Scottish population live in a rural area, and of these a significant number live in very remote areas, which necessitate different models of service delivery at a higher proportionate cost to those in more populated areas.

Highland has seventy percent of communities deemed to be part of ‘rural’ Scotland and since 1912 has been the subject of much interest due to the enormity of the challenge of providing public services in a safe and equitable way. Given the history and experience Highland is therefore a good place to explore options for future sustainability. In many
respects there has been tremendous success through the Highlands and Islands Medical Service, but that success has brought with it its own challenges in that communities and individuals have become reliant on their very local service, be it doctor, nurse, police, fire and rescue, small school or post office. A dependency has therefore been created, and it is little wonder that some of these communities find change difficult.

Expectations of communities that have been in receipt of these local services, specifically those delivered through the NHS, are understandably high but for many reasons recruitment and retention is challenging (reasons include training, revalidation, governance, and importantly, personal).

Even where recruitment is possible, single handed, isolated practice is no longer deemed to be desirable or safe.

**How**

Different parts of Highland are at different stages, and it is also clear that there are similar challenges in other remote and rural areas, and so the proposal set out an action research approach to developing a menu of possible solutions that will be tested as the opportunities arise. Action Research is described by Hart and Bond⁴ as “A method of understanding a system while simultaneously trying to change it.” By adopting this approach, changes can be made as and when necessary but within an evaluation framework that promotes learning and transferability. It is clear that there will be no single successful model and that this needs to take a partnership route to include all public services working in the area and the communities themselves. The work needs to build on that already happening on community resilience, the definition of which in this context is a ‘collective and
The map below shows the immense geographical challenges and the lack of opportunity through economies of scale, to provide services at reduced cost. A Home Carer, for example, in a town may be able to support up to eight clients in a small radius. In a remote and rural area the clients can be spread over many miles, and the same level of care can only be delivered to one or two clients. In Rural General Hospitals, if a key member of staff in a one in two or three rota is off, it is necessary to employ locums at a very high cost in order to sustain the service. Absence can often be absorbed in busier areas but that is not possible when teams are already very small. Sustaining this level of care has excess costs attached.

**Location of Isolated GP practices and Non-Bypass 999 RGH & Community hospitals**

The map below shows the immense geographical challenges and the lack of opportunity through economies of scale, to provide services at reduced cost. A Home Carer, for example, in a town may be able to support up to eight clients in a small radius. In a remote and rural area the clients can be spread over many miles, and the same level of care can only be delivered to one or two clients. In Rural General Hospitals, if a key member of staff in a one in two or three rota is off, it is necessary to employ locums at a very high cost in order to sustain the service. Absence can often be absorbed in busier areas but that is not possible when teams are already very small. Sustaining this level of care has excess costs attached.
The key essential principles are:

In order for any models to be successful, there requires to be meaningful and extensive community engagement, hearing all the voices, ownership and participation, also involving all key public and voluntary agencies working with and in the community in an integrated and collaborative way and the facilitation of community development approaches to enhance community resilience.

Any model will require to be multidisciplinary team based to ensure best use of all available skills, talents and resources. The team will require clear coordination and clear lines of accountability and must have access to ongoing and relevant continuing professional development with opportunities for team members to work in busier areas to maintain skills and competencies. Single handed Practice and long periods of lone working should be phased out as the opportunity arises.

Transport and travel are often barriers to change, from routine daily journeys to emergency and urgent response, and these aspects are an essential part of any new model of service. Consideration needs to be given particularly to fast access in emergency situations and may in future involve ambulance boats as well as helicopters.
1. Small Isles and Acharacle

Three GPs from the Broadford practice on The Isle of Skye provide the service to the Small Isles of Eigg, Muck, Rum and Canna with one GP visiting by charter boat twice a week. Outside these times, telephone and Video Conferencing (VC) consultations can be arranged via the Practice Manager based in the Eigg surgery.

There are four rural community health and social care support workers who are residents on Eigg and Muck contracted for two hours per week and are being trained and managed by the Area Integrated Team Lead in Mallaig.

In Acharacle, the Rural Support Team provide a multidisciplinary service aiming to prevent professional isolation and minimise reliance on GPs with the deployment of Advanced Nurse Practitioners and Unscheduled Care Practitioners. As well as providing daytime primary care services, they can also cover annual leave and sickness
In Mid-Argyll one GP practice now runs the out-of-hours service, the community hospital in-patient service and A&E in Lochgilphead. In 2015 three new GPs were recruited in Lochgilphead. The Lochgilphead practice also took over GP services for Furnace and Inveraray, including out-of-hours cover in June 2015.

The proposal for Mid Argyll is to establish a single GP out of hours service for Mid Argyll integrated with the Lochgilphead Medical Practice community hospital inpatient and A&E service. Lochgilphead Medical Practice was awarded the contract to provide medical services for the Inveraray practice. Merger of the two practices will enhance local service delivery and provide a larger pool of GP workforce to provide the service. The remote and rural OOHs service is in place and working well. Day time primary care service to Inveraray embedded as normal practice. A Clinical challenge was discovered in Inveraray, there was no structured chronic disease management prior to Lochgilphead taking over at all - many patients were being treated for a chronic disease that was not READ coded. Patient’s records have had to be reviewed and summarised in order to record which patients had particular chronic diseases. The Practice had been clear that a two year period to review and introduce service comparable to the high standards in Lochgilphead was likely. Consideration has been given to chronic disease management and weekly clinic introduced.
3. Kintyre

The proposal for Kintyre is to establish a single GP out of hours service and a single GP practice led community hospital inpatient and A&E service. Day time GP services will continue to be provided across the 3 practice sites: Campbeltown, Carradale and Kintyre Medical Group (KMG) Campbeltown Medical Practice (CMP) commenced responsibility for in-patient care and out of hours services for the entire peninsula, while maintaining their own in-hours GMS work on the 20th July 2015.

Campbeltown Practice has identified GP input equivalent to 12 sessions from start date. Existing GP 4 sessions and locum/new recruitment GPs 8 sessions (new GP in place – started October 2015) to support this model.

KMG GP vacancy – discussions are on going with Campbeltown practice to take over KMG practice. April 2016 – Delayed due to concerns over GMS contract changes, dispensing practice service and value of GMS contract.

Since July 2016, the Campbeltown practice has been responsible for in-patient care and out-of-hours services for all patients in Kintyre. In September 2016 it had six full-time partners and 1.5 WTE salaried GPs. In March 2016 a GP left the KMG which is now operating with one part-time GP and locums across its surgeries in Muasdale, Gigha and Southend. A patient focus group was established in the face of the GP’s departure. Initially, it was proposed that Campbeltown take over the practice, but this was put on hold. It is understood that the latest proposal involves the takeover of Southend by Campbeltown with Muasdale and Gigha potentially merging at a later date. There is no change at the moment to pharmacy services.
4. Islay

The Scottish Government were keen to include any learning from Islay. Islay medical services operate independently of the Being Here programme. The practices have not received any Being Here funding and their changes have been introduced independently of the project. All three practices continue to be managed centrally by one GP partnership. They have been very successful recruiting the full complement of five GPs and a Rural Fellow. Establishing itself as a teaching practice was seen as a key development. In order to enhance skills, they have also introduced a training system whereby all the GPs will work in Glasgow secondary care for up to two weeks a year. The Health Implementation Board has now been replaced by the Locality Planning Group (LPG) which includes health and social care professionals, third sector representatives and community residents.
The steering group has been able to form a collaborative partnership to ensure aspects of the proposal were actively reviewed and disseminated. Each work-stream was sponsored by a member of the group who was responsible for raising matters of strategic importance and providing both a national and local perspective.

**Activities**

Additional activities to support the programme work streams included:

- Commissioning an independent report on marketing and GP recruitment: [http://www.orchid.je/work/nhs-highland#.WMFekLXvT2Y](http://www.orchid.je/work/nhs-highland#.WMFekLXvT2Y)
- Use of social media to promote vacancies: [https://twitter.com/nhshighlanDRec](https://twitter.com/nhshighlanDRec)
- Hi-profile advertising campaign between November 2014 and January 2015

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**Governance**

The Being Here Steering Group has met on a quarterly basis between May 2014 and May 2017. Representatives on the group came from the Scottish Government (Health, Quality and Strategy Directorate); NHS Education Scotland; NHSH Board members; GPs; North of Scotland Planning Group; NHSH Senior Management; Scottish Fire and Rescue Service; Scottish Ambulance Service.

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Exhibitor at Royal College of GPs annual conference 2014 - 2016

Support for GP refresher training course developed and delivered by Lochgilphead Medical Practice. (Accredited through NHS Education for Scotland)

Co-sponsorship of The Belford Hospital International rural medical conference: http://www.belford-hospital-150.co.uk/

Support for the Small Isles Health fair in 2016

Linkage with South central Foundation ‘NUKA’ model of Healthcare: https://www.southcentralfoundation.com/

Newsletters:

Thematic seminar in Oban, “How can education support service change?”

Attendance at the inaugural Scottish Rural Parliament, Oban in October 2014

Support for the development of a ‘rural school’ and the role it has in providing a social responsibility for rural healthcare: http://www.rrheal.scot.nhs.uk/what-we-do/scottish-rural-health-partnership.aspx

Support for the inaugural “Rethinking Remote” conference at Eden Court, Inverness May 2016: http://www.invernesscampus.co.uk/news/2016/rethinking-remote/
Evaluation

Over 10% of the £1.5M budget has been allocated to research and evaluation work – this is being managed by NHS Highland Research and Development Department, with the University of the Highlands and Islands (UHI) subcontracted to carry out some of the activities. An action learning methodology has been adopted to enable changes to be implemented as the project moves forward. The full evaluation report is expected by late 2017 and an interim report is currently available.

The Research and Evaluation work comprises five work-packages:

1. Project Management
2. Baseline Stakeholder Review
3. Programme Reviews and Engagement
4. Reports, Evaluations and Recommendations
5. Health Economics / cost flow analysis
Some results to date...

- At least 12 GPs have been recruited into the test site areas since the campaign began.

- The Rural Support Team model is being rolled out in other areas of North / West Highland.

- Four members of the community on the Small Isles are now fully trained / employed as Rural Community Health Support Workers.

- Scottish Government is supportive of our ideas for recruitment and retention of rural posts.

- Field work for the evaluation is showing very encouraging results for rural community resilience.

References

NHS Highland Quality Approach¹  
http://www.nhshighland.scot.nhs.uk/AboutUs/HQA/Pages/Welcome.aspx

Dewar Report² – Sir John Dewar 1912  


Action Research for Health & Social Care: A Guide to Practice.

Christie Commission Report on the delivery of public services⁵  