NHS SCOTLAND

Agenda

NHS Scotland
Remote, Rural and Islands Overarching Task & Finish Group
Date: Wednesday 16th October 2024
Time: 15:00 – 16:00
Location: MS Teams

Chair(s):
Laura Skaife-Knight, NHS Orkney Chief Executive
Paula Speirs, NHS Scotland Deputy Chief Operating Officer

#	Agenda Item	Speaker	Start Time
1	Welcome & Apologies	LSK/PS	15:00
2	Action Log*	LSK	15:05
3	Core Services Development Progress	KB/KC/LB/DR	15:10
4	Finance Overview of RR&I aligned to Core Services	[redacted S.38(1)(b)]	15:30
5	Comms & Engagement Approach (Workforce / Population) Overview of guidance on national service changes	LSK/PS [redacted S.38(1)(b)]	15:40
Close			
6	Any other business	LSK/PS	15:55
7	Date of Next Meeting 20th November 2024, 10:30 – 12:00 *MS Teams*		

* Paper attached

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Attendees:

Kirsty Brightwell (KB)	SAMD Rep (Co-Chair Subgroup 3)	[redacted S.38(1)(b)]	Transport to Health (SG)
Kathleen Carolann (KC) Louise Bussell (LB)	SEND Rep (Co-Chairs Subgroup 3)	[redacted S.38(1)(b)]	Allied Health Professional (SG-CNOD)
[redacted S.38(1)(b)]	Mental Health Representative (SG)	[redacted S.38(1)(b)]	Workforce (SG)
Susan Laidlaw (SL)	Director of Public Health (NHS Shetland)	[redacted S.38(1)(b)]	NHS Scotland Finance Delivery Unit
William Findlay (WF)	Associate Chief Nursing Officer (SG)	Belinda Robertson (BR)	HIS
Nick Fayers (NF)	Chief Officer IJB Rep	David Rowland (DR)	Directors of Planning Rep
Lucy Flaws (LF)	Head of Planning NHS Shetland, Shetland Health and Social Care Partnership	[redacted S.38(1)(b)]	Centre for Workforce Supply – Remote and Rural
John Harden (JH)	Deputy National Clinical Director (SG)	Katherine Sutton (KS)	Chief Officer Acute Representative
[redacted S.38(1)(b)]	Deputies for Sarah Lowry, Primary Care (SG)	Jim Ward (JW) (Deputy [redacted S.38(1)(b)])	SAS Rep
Katy Kerr (KK)	Director of Finance Rep	[redacted S.38(1)(b)]	PgMS, NSS (Support)
Pam Nicoll (PN)	Medical Director, NES/National Centre for Remote and Rural Health Care	Clare Morrison (CM)	Director of Engagement and Change, HIS
Emma Watson (EW)	Medical Directorate NES	[redacted S.38(1)(b)]	Unit Head Diagnostics, Genomics and Participation, Healthcare Quality and Improvement (SG)
[redacted S.38(1)(b)]	Scottish Clinical Leadership Fellow, working with NES		

Apologies:

[redacted S.38(1)(b)]	Midwifery (SG-CNOD)	[redacted S.38(1)(b)]	Primary Care (SG)
Lorraine Cowie (LC)	Health Planning (SG)	[redacted S.38(1)(b)]	NHS Scotland Finance Delivery Unit
Colum Durkan (CD)	Director of Public Health (NHS Western Isles)		

Remote, Rural and Islands Overarching Task and Finish Group
DATE: 16th October 2024
TIME: 15:00 – 16:00
LOCATION: MS Teams

ATTENDEES:

Initials	Name & Organisation
LSK	Laura Skaife-Knight, CEO NHS Orkney (**Co-Chair**)
PS	Paula Speirs, Deputy Chief Operating Officer, Scottish Government (**Co-Chair)**
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], Scottish Clinical Leadership Fellow, working with NES
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], Workforce, Scottish Government
CM	Clare Morrison, Director of Engagement and Change, HIS
DR	David Rowland, NHS Dumfries and Galloway
EW	Emma Watson, NES
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], NHS Scotland Finance Delivery Unit
JH	John Harden, Deputy National Clinical Director, Scottish Government
KB	Kirsty Brightwell, NHS Shetland
KC	Kathleen Carolan, NHS Shetland
KK	Katy Kerr, NHS Dumfries and Galloway
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], Centre for Workforce Supply
KSu	Katherine Sutton, Chief Officer Acute Representative
LB	Louise Bussell, NHS Highland
LF	Lucy Flaws, NHS Shetland
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], Scottish Government
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], General Practice Policy Division, Primary Care, Scottish Government
PN	Pam Nicoll, NES
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], Secretariat, NSS PgMS
SL	Susan Laidlaw (NHS Shetland)
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], Mental Health Rep (SG)
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], Unit Head Diagnostics, Genomics and Participation, Healthcare Quality and Improvement (SG)
WF	William Findlay, Associate Chief Nursing Officer, Scottish Government

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NHS SCOTLAND

APOLOGIES:

Initials	Name & Organisation
BR	Belinda Robertson, HIS
CD	Colum Durkan, NHS Western Isles
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], CNOD, Scottish Government
LC	Lorraine Cowie, Health Planning, Scottish Government
LS	Lorraine Scott, NHS Grampian
NF	Nick Fayers, NHS Western Isles
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], Primary Care, Scottish Government
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], Finance, Scottish Government
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], CNOD, Scottish Government
DC	Debs Crohn, NHS Orkney
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], SAS (deputy for Jim Ward)
JW	Jim Ward, SAS
[redacted s.38(1)(b)]	[redacted S.38(1)(b)], Transport to Health (SG)

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1. Welcome, introductions & apologies

LSK welcomed the group.
CM, [redacted s.38(1)(b)] and [redacted s.38(1)(b)] are new members for matters relating to Communications and NES.
[redacted s.38(1)(b)] representing [redacted s.38(1)(b)] for Finance.
Declines received from BR, CD, [redacted s.38(1)(b)], LC, LS, NF, [redacted s.38(1)(b)], and [redacted s.38(1)(b)].

2. Action Log

Action 09-02.01 LSK to pick up with LC regarding the identification of a GP member for the group. LSK said it was good to have [redacted s.38(1)(b)] in attendance, working with NES join us.

Action 09-02-.02 [redacted s.38(1)(b)] action to be carried forward for update at next meeting.

Action 09-02.04 ownership to be updated to KB, LB, KC & DR. Subgroup 3 met on 30/09 to discuss the initial themes resulting from the Health Board questionnaire responses and to meet again 23/10 to review further data analysis. To be an agenda item at the next meeting. **(new action)**

Action 09-02.05 LB shared that Subgroup 3 is a tight knit group that is working well. The pace and frequency of meetings will be discussed again 23/10.

3. Core Services Development Progress

DR provided the background to the Core Services paper. In summary, [redacted S.38(1)(b)] created a template to send around the Health Boards to consistently gather the service issues and challenges they encounter.

From the submissions, [redacted s.38(1)(b)] set out the similarities and differences, the population differences, then themed the services in terms of what core currently looks like for each Board. This will be used to help develop what will be core services for all, what will be core services but with regional variations and those which will be supplementary services.

Questions and comments followed regarding how to ensure that all services are captured:

- KB said community nursing is not included currently. Labs are a specific piece of work and fell out of scope.
- LB said that depending on Board needs, there are differences in children's services offerings.
- EW shared that a lot of acute, child and mental health care services are delivered within a primary care and community model. Also, that radiology is captured, but none of the other diagnostics that RR&I Boards have in practice are included.
- LB said that there are different levels of services between cities and more rural locations given geography.
- WF asked if a decision tool had been used, or if there is a decision guide with criteria to help make decisions. LB confirmed not yet.
- KC raised that primary, secondary and tertiary pathway interfaces need to be defined.
- SL highlighted that Public Health is not included for example, screening and health improvement.
- DR agreed that was an important point however that extends the scope of Subgroup 3.
- [redacted s.38(1)(b)] asked about the social care capacity for the whole system. LB replied that this is out of scope for Subgroup 3 as NF is working on this specific work with the Chief Officers and that Subgroup 3 will link in with him on social care and this is why he is a member of this group so that there is a dotted line between these pieces of work.
- LB said that we are still gathering information and edits.

LSK summarised that the work completed so far captures the current state. It helps raise the questions to clarify the boundaries of what should be included going forward to move to a future sustainable model.

Next steps:

PS said that Oncology has already been developing their future state model on a tiered basis. Suggested that LC catches up with the other sustainable services workstreams that are further ahead to check where they are and to share their learnings with LSK. **(new action)**

KC said that the focus should be on describing a strategic direction of travel, to describe a set of principles to be used by Boards and to clearly re-define RGHs.

PS raised an action to pick up with LC on transport for RR&I following a conversation with the Cab Secretary about transport. Could another Working Group help to join things up? **(new action)**

LSK and LC to review the governance to be clear on the direction of travel and the working groups. The ToR may need to be updated for Subgroup 3 to reflect the end point we will produce which is a list of core services and re-defining the RGH's and developing a set of principles, capturing assets and pathways and the enablers to achieving this. **(new action)**

PN stated the importance of marrying up health population needs with existing data and to ensure the data is being measured accurately on these pockets. To demonstrate the impact on the population over time. LSK agreed and said that would be included within the next phase of this work.

PS shared that [redacted s.38(1)(b)] has been carrying out an initial interrogation of the PHS data. PN said she would recommend this to get really accurate data on inequalities and demonstrating the impact. PN said she would be willing to help with that work.

4. Finance Overview of RR&I aligned to Core Services

[redacted s.38(1)(b)] gave the update, highlighting the following:

- [redacted s.38(1)(b)] is continuing work to identify specialities that cost more to deliver in RR&I Boards.
- Analysis is being undertaken using PHS Cost book data and looking at specialities analysis across all patient types, split by Board, RR&I, island only and rural only.
- The work has identified outliers for investigation. However, it should be noted that the analysis is only as good as data quality and requires knowledge of services provided.
- [redacted s.38(1)(b)] has suggested running a detailed standalone session to go through in more detail.

LSK to ask [redacted s.38(1)(b)] to provide a paper for the next meeting and to have a spotlight on the agenda. **(new action)**

[redacted s.38(1)(b)] asked if a formula was being applied. Usually RR&I is overprovisioned as capacity, as it does not have constant demand.

PS responded that nothing in place for the costs of services. It was agreed that the cost book would be used as a baseline. [redacted s.38(1)(b)] is grouping the different Boards in his benchmarking.

[redacted s.38(1)(b)] raised the new Finance PLICS (Patient Level Information Costing System) system is being tested with NHS Highlands.

[redacted s.38(1)(b)] shared that PLICS is being implemented across all territorial Health Boards, on a phased basis, with implementation currently ongoing.

5. Comms & Engagement Approach (Workforce / Population)

LSK said that she would be keen to see a consistent approach being used across all the sustainable workstreams (Oncology, Vascular etc) to communicate and engage with the public and patients on the proposed service changes.

[redacted s.38(1)(b)] responded that she is developing consistency and coordination with LC.

JH shared that Oncology is reaching out to [redacted s.38(1)(b)] for advice and support as they scope out the feasibility of options.

LSK shared that a Staff Engagement short life working group has been established. That will help with creating a consistent approach.

[redacted s.38(1)(b)] gave an overview on the new National Service Changes Guidance and shared a few slides. The slides cannot be circulated as the guidance is due to be published imminently by SG.

- There were two main areas, those services that are planned and delivered by national NHS Board and those defined by SG to be delivered by NHS Boards.
- HIS will provide advice to SG Ministers.

6. AOB

None.

Date of Next Meeting:	20th November 2024, 10:30 – 12:00

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REMOTE, RURAL AND Islands (RR&I): Working Group 3
October 2024

Types of Service

1. **Core Services**

Core services are essential, non-negotiable healthcare services that must be present for any healthcare system to function in remote, rural, and island communities. These services are foundational and ensure the basic healthcare needs of the population are met, regardless of location. Without these services, a region's healthcare system would be unable to operate effectively, and the health of the community would be significantly compromised.

2. **Core Services with Regional Variations**

These services are critical for healthcare delivery but may vary based on regional factors such as population size, local needs, and resource availability. They are provided in a limited or modified capacity in some areas but are still considered necessary components of the healthcare system. While some regions may have fully functional versions of these services, others may offer scaled-down or partial services that still meet the community's basic needs.

3. **Supplementary Services**

Supplementary services are additional services that support and enhance the core healthcare infrastructure. These services offer significant benefits, improving care quality and patient outcomes, but they are not essential for the basic functioning of a healthcare system. They are more often regionally provided based on specific needs, resources, and demands, but are not fully necessary for sustaining healthcare operations in remote and rural communities.

Key Themes Defined

1. Workforce Challenges

This theme addresses the ongoing difficulties in recruiting, retaining, and supporting healthcare professionals in remote, rural, and island communities. It includes the unique challenges faced by healthcare providers in these areas, such as limited staff numbers, specialist shortages, and the need for multidisciplinary skills to cover a wide range of patient needs. The ability to maintain a sustainable and well-supported workforce is critical for the successful operation of the healthcare system.

2. Service Delivery
Service delivery refers to how healthcare services are organised, accessed, and provided to communities. It includes the logistics of operating and maintaining healthcare services in geographically dispersed and low-population areas. This theme focuses on ensuring that services are delivered efficiently and effectively, despite barriers such as distance, infrastructure limitations, or resource constraints.

3. Technology and Telemedicine
This theme highlights the role of digital solutions and telemedicine in improving access to care for rural populations. Technology and telemedicine help bridge the gaps caused by geographic isolation, allowing patients to receive remote consultations, diagnoses, and treatments. They enhance service capacity and reduce the need for long-distance travel, ensuring that patients can access specialist care when required.

4. Health Inequalities
Health inequalities address disparities in health outcomes and access to healthcare services between remote, rural, and island communities and more urban areas. This theme focuses on ensuring equitable access to healthcare and addressing socio-economic, geographic, and demographic factors that contribute to unequal healthcare experiences and results. Tackling these inequalities is essential to ensure that all communities receive comparable levels of care.

5. Sustainability and Infrastructure
This theme focuses on the long-term viability of healthcare services in rural and remote regions. Sustainability considers both financial resources and the availability of necessary infrastructure, such as medical facilities, transportation networks, and digital connectivity. Ensuring a robust infrastructure that can support healthcare needs in a sustainable manner is crucial for the ongoing delivery of services.

6. Access to Care (including Distance to Travel)
This theme emphasises the importance of ensuring that patients can access the healthcare services they need, despite the challenges of geographic distance and limited transportation options. For rural and remote communities, accessing care often involves significant travel. This theme focuses on reducing travel burdens and ensuring that patients receive timely care, whether through local services or through arrangements to transfer them to larger facilities.

SERVICE	SERVICE DEFINITION	KEY THEME
Core Services		
Acute Medical	Comprehensive emergency and inpatient medical care provided in hospitals	**Service Delivery; Access to Care**
General Practice	Primary Care services that provide health assessments, diagnoses, treatment and referrals	**Workforce Challenges; Access to Care**
Mental Health (inc. Community)	Comprehensive services focused on diagnosing, treating, and supporting individuals with mental health disorders	**Access to Care; Health Inequalities**
Inpatient Beds	Hospital beds available for patients requiring overnight care or more extended hospitalisation	**Service Delivery; Sustainability & Infrastructure**
Geriatric	Specialised healthcare services for older adults, focus on their unique and often complex health needs	**Service Delivery; Access to Care**
Dentistry	Oral health services including preventive care, diagnosis and treatment of dental issues	**Service Delivery; Workforce Challenges**
Radiology	Imaging services used for diagnosis and monitoring of various health conditions	**Service Delivery; Technology & Telehealth**
Out of Hours	Medical services available outwith normal working hours to provide urgent care	**Access to Care; Sustainability & Infrastructure**
Rehabilitation	Services focused on restoring function and improving quality of life after illness or injury	**Access to Care; Health Inequalities**
Palliative Care	Specialised medical care for people with serious life-limiting illnesses, focused on providing relief from symptoms and stress	**Service Delivery; Sustainability & Infrastructure**
Maternity	Comprehensive care provided to women pre, during and post pregnancy	**Access to Care; Health Inequalities**
Core Services with Regional Variations		

Emergency Department	Hospital department providing immediate treatment for acute illnesses and injuries	**Service Delivery; Access to Care**
Emergency Theatre	Surgical facilities available for emergency procedures that require immediate intervention	**Service Delivery; Access to Care**
Acute Surgical	Surgical services that address urgent medical conditions requiring surgical intervention	**Service Delivery; Sustainability & Infrastructure**
Intensive Care Unit (ICU)	Specialised care for critically ill patients requiring constant monitoring and support	**Service Delivery; Sustainability & Infrastructure**
Stroke	Services focused on the diagnosis and management of stroke patients (including rehabilitation)	**Service Delivery; Access to Care**
Children's	Paediatric healthcare services specially tailored for infants, children, and adolescents	**Access to Care; Health Inequalities**
Supplementary Services		
Medical Subspecialities	Specialised medical services focusing on areas of medicine (eg. Cardiology, neurology)	**Service Delivery; Workforce Challenges**
Other Specialised Services	Additional specialised healthcare services that may cater to unique of complex health needs	**Service Delivery; Access to Care**

Remote, Rural and Islands Overarching Task & Finish Group
OPEN ACTIONS LOG

Action Ref.	Action	Due Date	Revised Due Date	Owner
2024-09-02.01	LC to establish a suitable GP member for the group.	16/10/2024	20/11/2024	LC
2024-09-02.02	[redacted S.38(1)(b)] to get in touch with WF to invite to meeting with regards to Tele-medicine.	16/10/2024	20/11/2024	[redacted S.38(1)(b)]
2024-09-02.05	Subgroup 3 to look at frequencies of meetings and increase accordingly.	16/10/2024	20/11/2024	LC
2024-10-16.01	Subgroup 3 Target Operating Model/core services progress update	20/11/2024		KB, LB, KC & DR
2024-10-16.02	PS said that Oncology has already been developing their future state model on a tiered basis. Suggested that LC catches up with the other sustainable services workstreams that are further ahead to check where they are and to share their learnings with LSK.	20/11/2024		LC
2024-10-16.03	PS raised an action to pick up with LC on transport for RR&I following a conversation with the Cab Secretary about transport. Could another Working Group help to join things up?	20/11/2024		PS
2024-10-16.04	LSK and LC to review the governance to be clear on the direction of travel and the working groups. The ToR may need to be updated for Subgroup 3 to reflect the end point we will produce which is a list of core services and re-defining RGH's and developing a set of principles, capturing assets and pathways and the enablers to achieving this.	20/11/2024		LSK & LC
2024-10-16.05	LSK to ask [redacted S.38(1)(b)] to provide a paper for the next meeting and to have a spotlight on the agenda. (Costings of RR&I Core Services).	20/11/2024		LSK & [redacted S.38(1)(b)]

Version: xx (16/11/18)

Author: [redacted], Programme Management Services (PgMS)

Update
16/10 - LSK to pick up with LC regarding the identification of a GP member for the group. LSK said it was good to have [redacted S.38(1)(b)] in attendance, working with NES join us.
18/10 - [redacted S.38(1)(b)] emailed WF on this as [redacted S.38(1)(b)] not aware. 16/10 - [redacted S.38(1)(b)] action to be carried forward for update at next meeting.
LB shared that Subgroup 3 is a tight knit group that is working well. The pace and frequency of meetings will be discussed again 23/10.

Version: xx (16/11/18)

Author: [redacted] Programme Management Services (PgMS)

Remote, Rural and Islands Overarching Task & Finish Group
CLOSED ACTIONS LOG

Action Ref.	Action	Due Date	Revised Due Date	Owner
2024-09-02.003	Subgroup 2 to be paused (confirm whether meeting on 16th September to go ahead.	20/09/2024		[redacted S.38(1)(b)]
2024-09-02.04	KB to look into starting work on a gap analysis. Pre-meeting to be arranged to review the outputs of the questionnaire.	16/10/2024	20/11/2024	Kirsty Brightwell

Version: xx (16/11/18)

Author: [redacted], Programme Management Services (PgMS)

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Update
Closed. 10/09 all future meetings in diaries cancelled.
Closed 16/10 - ownership to be updated to KB, LB, KC & DR. Subgroup 3 met on 30/09 to discuss the initial themes resulting from the Health Board questionnaire responses and to meet again 23/10 to review further data analysis. To be an agenda item at the next meeting. (new action) 11/10 - Subgroup 3 met on 30/09 to discuss initial themes and meeting again 23/10 following further analysis.

Remote, Rural and Islands Overarching Task & Finish Group
DECISIONS LOG

Decision Ref.	Decision	Rationale

Made at	Agreed by	Date	Review date (if applicable)

Remote, Rural and Islands Task and Finish Group Terms of Reference

Context

The purpose of the Task and Finish Groups is to focus on supporting sustainability by planning on a population basis across Scotland to improve access to safe, quality services for our population. Other Task and Finish groups have been established to support sustainability within vascular, oncology, and diagnostic services. This Task and Finish Group will focus on remote, rural and islands (RR&I) healthcare.

Each of the Task and Finish Groups will be a collaborative and partnership arrangement involving representatives across NHS Scotland. Members of the group will offer each other peer expertise, support, and challenge to improve consistency where appropriate across NHS Scotland.

They will work at scale to develop a single plan and sustainable operating model for NHS Scotland to support effective decision-making arrangements to:

- **Reduce unwarranted variation and inequality in health outcomes.**
  Working together to develop new evidence-based models of care and standardised protocols. Consider opportunities to embed joint accountability, improve equity of outcomes and explore opportunities to better meet the needs of underserved communities whole pathways of care.

- **Improve equity of access to services and patient experience.**
  The review group should always consider what matters most to people who access or may access care and support, and people who work in services, communities, and partners. Review groups should share and build on the good practice that exists in their Boards, and adopt co-production approaches and partnerships with experts by experience (third sector). The review groups should use insight and feedback from patient surveys and complaints.

- **Improve resilience**
  Develop recommendations for sustaining the quality of care and developing combined capacity and capability. Strong leadership will be required to support sustainability and improve quality or navigate complex change. This may require workforce changes and working in partnership will be key so that staff may need to work more flexibly across a wider footprint of accountability through aligned contracts, processes, and cultures. This could reduce agency spend, improve patient experience, and make it easier to respond to demand changes in real time across Scotland. The review group may provide recommendations that specialisation and consolidation occur where this will provide better outcomes and value.

Purpose

FINAL DRAFT

This Group will determine a framework for the delivery of sustainable care for our RR&I communities from which specific local plans could be developed, which will consider the 2008 Delivering for Remote and Rural Healthcare Report, as the extant policy document for remote and rural healthcare in Scotland and associated 83 recommendations for the delivery of a sustainable model of healthcare for remote and rural Scotland, which were progressed through the Remote and Rural Implementation Group (RRIG). The Task and Finish group is responsible for:

- Developing a framework for R&I healthcare that allows consideration of core services to develop an understanding for all R&I Boards by late Summer/early Autumn 2024. This will also be coherent with the principles within the National Clinical Strategy and developing National Clinical Framework.
- Developing a R&I sustainable operating model that acknowledges the unique challenges of delivery and the rural credentials approach, in order to actively pursue a different approach by September 2024

The scope of the group extends to the delivery of all healthcare in RR&I communities. The definition of "rural" will be per the Scottish Government Urban Rural Classification 2020 definition of "Rural Areas" – i.e. settlements with populations less than 3,000.

Building and nurturing strong relationships among leaders, clinical teams and with system partners at all levels, based on honesty and transparency, is critical. This is a continuous process, requires hard work and commitment to a new way forward through this approach.

Clinicians throughout this need to be empowered and engaged, as they are best placed to accurately define problems and ensure a solution is evidence-based and meets patient needs.

This Task and Finish Group is one of a number of groups established to develop a more sustainable operating model across a number of fragile areas, identified through NHS Board returns on sustainable services. The other groups have been established to focus on delivery of oncology, vascular, and diagnostics services.

FINAL DRAFT

Background

Following fragility of services across rural and Island areas flagged in Board Sustainability Returns, a rapid review was commissioned, drawing on the extensive work and recommendations from a number of previous reviews. This concluded that:

- The RR&I model of care is expensive with key dependency on locums to deliver – which is at cripplingly high cost and significant cost pressure. As a result, many Boards delivering to RR&I communities have now had to drop to providing a minimum level of services.
- Health care planning and service delivery models must be adapted to meet the widely differing health needs of RR&I communities and overcome the challenges of geographic spread, low population density, limited

infrastructure and the development of an in-depth understanding of the significantly higher costs of rural and remote health care delivery.

The sustainability review identified several themes, set out in Annex 1.

In response, the DG-HSC approved that a Remote, Rural and Islands Task and Finish Group was established, reporting through the NHS Scotland Planning and Delivery Board.

Membership

Representation will be requested from across NHS Scotland for the Rural and Islands Task and Finish Group with a view to addressing the identified issues in the service area. Below is outlined the intended membership of the Task and Finish Group and the role/function and expertise each role is expected to provide as part of the Task and Finish Group.

Task and Finish Group Leadership
The Chairs, Laura Skaife-Knight CEO, NHS Orkney (Fiona Davies named deputy) and Paula Speirs Deputy Chief Operating Officer, NHS Scotland will provide the strategic leadership to the review.

Membership:

- NES to represent the National Centre for Remote and Rural Health and Care – Pam Nicoll (Emma Watson named deputy)
- SAMD representative - Kirsty Brightwell
- SEND representatives – Kathleen Carolan and Louise Bussell
- Nomination of Primary Care Lead - Katherine, NHS Highland Chief Officer Acute
- SG Primary Care - [redacted S.38(1)(b)]
- Primary Care to also cover:
    - 1) General Medical Practitioners
    - 2) Community Pharmacy
    - 3) Optometrists
    - 4) General Dental Services
- Mental Health representation noting work underway on forensic mental health services - [redacted S.38(1)(b)]
- Scottish Ambulance Service – reflecting their role in future workforce models – Jim Ward ([redacted S.38(1)(b)] named deputy)
- Director of Finance – Rural and Island Board - Katy Kerr (Dumfries & Galloway)
- Alignment of National Clinical Framework – John Harden and William Findlay
- HIS - Advise on redesign and improvement of services; and community engagement and also bring in HIS work on rural demonstrator sites – Belinda Robertson
- Strategic Planning Lead – Lorraine Cowie

FINAL DRAFT

- SG Nursing, Midwifery and AHP – [redacted S.38(1)(b)] and [redacted S.38(1)(b)],
- Directors of Planning – Lucy Flaws (NHS Shetland) and David Rowland (NHS Dumfries and Galloway)
- Director of Public Health – Colum Durkan, NHS Western Isles (Susan Laidlaw, NHS Shetlandnamed deputy)
- [redacted S.38(1)(b)] – Centre for Workforce Supply – Remote and Rural
- [redacted S.38(1)(b)] – NHS Scotland Finance Delivery Unit
- SG Workforce – [redacted S.38(1)(b)]

The Group will also look to engage with

- PHS on collaboration on data and intelligence to support decision making
- CMO Realistic Medicine Team in relation to value-based healthcare.
- Regional Transport Partnerships in relation to transport to health consideration: SG Transport to Health - [redacted S.38(1)(b)]
- Chief Officer is this Nick Fayers, NHS Western Isles
- Board Digital Lead
- Administrative support with meetings, minutes and actions will be provided by Scottish Government Health Planning staff.(NSS PgMS.)

Reporting and Escalation

Reporting Routes

The Task and Finish Group will report to the NHS Scotland Strategic Planning Board into the NHS Scotland Planning and Delivery Board. The Group will also provide regular updates to the Sustainability Steering Group to ensure coherence and consistency with the other service reviews under way.

Formal reporting updates are required at the Strategic Planning Board (bi-monthly).

Escalation Routes

An escalation process may be initiated to ensure a clear, consistent, and transparent process for the escalation of issues where:

- consensus is not reached and blockage to the Task and Finish Group's ability to function is identified.
- there is a significant lack of progress resulting in increased service issues causing media attention, or serious safety concerns.

Review

The Remote, Rural and Islands Task and Finish Group is set up to set up the explicit function to review, plan and create a new operating model for the service.

FINAL DRAFT

Once reporting indicates improvement over a sustained period the Task and Finish Group will produce a final progress report and lessons learned report. These will be presented to SPB and NHS Scotland Planning and Delivery Board.

SPB will consider the impacts of changes made to the service, evaluate whether more could be considered to make the service more sustainable.

SPB will evaluate the continuation of the Remote, Rural and Islands Task and Finish Group and stand the group down once final recommendations are delivered.

FINAL DRAFT

ANNEX 1

Rural and Island Health and Care Services

ESTABLISHMENT OF WORKING GROUP

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SITUATION

The rural and islands (R&I) model of care is expensive with key dependency on locums to deliver – which is at cripplingly high cost and significant cost pressure. For the past two decades, the ambition has been to deliver as much as possible on island and have visiting services to deliver. This is no longer viable or affordable.

Many Boards delivered to R&I communities have now had to drop to providing a minimum level of services, due to challenges with recruitment and associated need for extremely high cost locums. In parallel, these Boards are finding that their SLAs are increasingly unable to be delivered, leading to longer waiting times for patients in remote and rural areas.

In addition, R&I Boards are increasingly looking to larger Boards as the "provider of last resort" and whilst these Boards want to provide support, we have to recognise that they also have significant capacity issues and financial challenges.

A Sub-Group of Chief Officers have also recently convened to determine how to achieve sustainable health and care services within remote and rural areas noting the specific fragility of the care home sector within remote and rural areas.

The challenge of current GP contract for RRI has been raised by SGPC at its December 23 Conference, noting that the contract is constraining implementation of more care closer to home and requested SG to work with them on a more sustainable solution for remote and rural health.

BACKGROUND

There has been a significant amount of reviews, reports and recommendations over the past many years setting out the unique nature of service delivery in remote and rural communities.

- *Delivering for Remote and Rural Healthcare 2008* remains the extant policy document for remote and rural healthcare in Scotland. It focussed on improving patient experience of remote primary care and access to secondary care, the remote and rural workforce, including education and rural training pathways, infrastructure and emergency response and transport. The report set out 83 recommendations and forward issues for the delivery of a sustainable model of healthcare for remote and rural Scotland.

- The *Remote and Rural Implementation Group (RRIG)* was established to take this work forward with a role to oversee and monitor implementation across the system.

- In response, the *National Centre for Remote and Rural Health and Care* was established which is focusing initially on increasing recruitment of GPs but also established rural credentials. The Rural Credential established an

evidence-based framework for safe patient care, with significant input from RGH Leads and gained GMC approval. It set out how safe 24 hour care can be delivered in RGHs and that RGHs need to evolve from the current "mini DGH model" to one that delivered a defined set of core services.

- The focus of the next phase of work was to validate the RGH model and then transition RGHs into a safe and sustainable model, also considering future workforce, digital, transport requirements.
- In addition, the sustainability of primary care and GP Contract continues to be challenging, with Scottish LMC Conference in December 2023 passing a resolution that recognised the unique challenges of the GMS contract that are particularly amplified in remote and rural areas and that the needs of populations in remote and rural areas are not being fully met by the 2018 GMS contract

ASSESSMENT

Although some work of the RRIG progressed, the core actions remain undelivered. For example, RRIG recommendations on a **revised staffing model for the Rural General Hospital** (RGH) to ensure continued access to safe and sustainable services in remote and rural areas; the ongoing **requirement to develop Obligate Networks**; and the workforce issues that are needed around identifying skills and competencies to deliver **safe emergency care** and agree a common role cross RGHs.

While some change has resulted many of the challenges not only remain but have grown, not least the vast geography and sparsity of population, while the issues relating to education, training and support that have been a constant thread throughout, are cited by professionals working in rural areas today as considerations when they decide to apply for, or remain in remote and rural areas.

Critically, the planning, design, funding and delivery of quality health and care is now a complex and challenging task for RRI Boards - irrespective of setting, community and population characteristics, economic circumstances and individual health outcomes. In summary, RRI Boards are working to deliver a universal mainland model exacerbated with the way in which our clinical workforce are trained and how they are deployed across Scotland. The commitment to delivering as many services as close to home as possible is providing unsustainable in remote and rural areas.

At the same time, with the demographic profile in R&I, these Boards are experiencing now the challenges of an ageing population more acutely than in more urban Boards. As at mid-2021, the data showed:

- 12% of the population (660,901 people) lived in accessible rural areas
- 1.6% of the population (299,115 people) lived in remote and rural areas

In addition, the impact of the GP contract within RRI has resulted in more GPs wanting to work in hospitals rather than acute clinicians working within primary care.

It is clear that rural and islands Boards continue to have unique challenges within NHS Scotland and this has been further highlighted through the sustainable clinical

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services work and associated discussions with relevant Boards. In summary, the rapid review identified a number of themes:

- Delivery of 24/7 unscheduled care is leading to unsustainable on-call rotas (some 1:2 rotas) that are both difficult to recruit to and also resulting in crippling associated costs for permanent locums, provided through off rate card, with associated costs of travel and accommodation. From discussions, there is an opportunity for this to be delivered by an alternative model, ie GPs and Advanced Practitioners / Advanced Paramedics.
- Workforce planning. NES don't allocate junior doctors to smaller Boards, ie those R&I, which puts pressure on viability of models of care and increased pressure on on-call rota requirements. The system needs to increase generalism and multidisciplinary integrated teamworking, with practitioners able to hold risk and to enable people to live healthily in their communities. This will require pay and reward systems, workforce planning, education and training, and regulatory bodies to reflect the nature of this work.
- On planned care, it is noted that many theatres within RRI areas are not in use. At the same time, there are around 27 radiologists coming out of training with no jobs to go to as many Boards have outsourced their radiology activity. Is there a model of networking where staff can be hosted by one Board and work peripherally.
- From Board sustainability returns, all R&I Boards are seeing SLAs and visiting services are sporadic and not being delivered – need for fairer market, resilience plan, very person dependent. In addition, these are a high cost area to R&I Boards and presenting through all R&I Boards requiring brokerage.
- Model of care – R&I Boards challenged in delivering a number of speciality services ("ologies").
- The challenge of current GP contract for R&I is seen to be constraining implementation of more care closer to home. SGPC have offered that a different approach to funding for primary care might be more sustainable.
- Role of Rural General Hospitals – Current delivery model and workforce challenges.
- Impact of closure of care home sector in Highland and also provision across Island Boards.
- Population need – with an older population, this will drive the need to deliver increased levels of ophthalmology/cataracts but less so of childrens' services.
- A noted lack of coherence and duplication with work of HIS and NES on remote and rural workforce – need join up through sponsor teams and commissioning.

NEXT STEPS

The problems and indeed solutions are well understood and therefore, as part of the work of the National Clinical Framework and different way of planning for our population, a Working Group is being established to determine urgently a sustainable model of care for our remote and rural communities – otherwise these services will continue to not only attract very high costs but also increase risk of unsafe services.

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Health care planning and service delivery models must be adapted to meet the widely differing health needs of R&I communities and overcome the challenges of geographic spread, low population density, limited infrastructure and the develop an in-depth understanding of the significantly higher costs of rural and remote health care delivery.

A formal group is to be established to develop a single plan for delivery of rural and island health, which will build upon all of the work currently completed. This will build upon the work commenced by NES around remote and rural health and care in primary care and HIS work in Primary Care delivery along with the Chief Officers Group who are looking at the social care model.

The Group will:

- Develop a framework for rural and island healthcare that allows consideration of core services to develop an understanding for all R&I Boards by Summer 2024
- Develop a rural and island sustainable operating model that acknowledges the unique challenges of delivery and the rural credentials approach so we actively pursue a different approach by Winter 2024
- Bring together key partners so we are prioritising this approach through development of a task and finish group by May 2024 this will include SAS in terms of transportation for specialist services
- We reflect on the recommendations within the National Clinical Framework so we are considering the model in the context of rural and islands and clinical sustainability of specialist services by May 2024
- Active understanding of benchmarking of financial models as they are different to urban financial benchmarking by June 2024

The Group will report through the NCF work. A Terms of Reference will be established with membership proposed as:

- Chief Executive
- NES to represent the National Centre for Remote and Rural Health and Care
- Centre for Workforce Supply - remote/rural
- BMA / SGPC – nominating LMC representation
- Nomination of Primary Care Lead
- Chief Officer – Remote and Rural Group
- Transport –SAS and RTPs
- HIS – bringing in their work on the two rural Demonstrators
- DoF from R&I Board
- Mental Health representation noting work underway on forensic mental health services