Inquiry into out-of-hours Health Care Provision in Rural Areas

Centre for Rural Health

Introduction

There is little robust academic evidence, either from the UK, or from other countries, which directly addresses any of the four questions posed by the inquiry. They are, without doubt, difficult questions which require to be addressed in Scotland. Most of the relevant publications identify the difficulty of addressing the issue of out of hours healthcare provision in rural areas, involve descriptive accounts of service delivery, and suggest potential solutions. Analytical work has tended to focus on the views of stakeholders rather than assessment of outcomes. There is little rigorous evidence in favour of any one particular model.

I present my evidence in six sections. I have summarised the recent work of the Remote and Rural Implementation Group, summarised a report on out of hours services produced by the Centre for Rural Health, outlined some recent and ongoing evaluation on the role of community first responders, provided some personal views on the delivery of out of hours services in remote and rural area, and attached a brief description of the role of the Centre for Rural Health.

Remote and Rural Implementation Group

The Remote and Rural Implementation Group has recently produced a strategic options framework on emergency and urgent response to remote and rural communities which is of relevance to this inquiry. This was designed as a tool to be used by the Scottish Ambulance Service, in partnership with NHS Boards, Community Health Partnerships and local communities, to establish, over time, a response appropriate to local circumstances. Work involved in developing the framework included a literature review, a mapping of the current emergency and urgent service provision, development of Standards for Emergency and Urgent Response, supported by a Framework of possible response models for remote and rural communities, and an analysis of the costs of implementing and not implementing models. The responsibilities of various organisations are described and supported by standards that service responses will be expected to achieve. Seven recommendations were made about standards, service delivery and community engagement in remote and rural areas. Parallel to the framework, an evaluation of Emergency Medical Retrieval Service for Remote and Rural Scotland Pilot was commissioned, results of which are now available, which are also of interest.

The literature review conducted as part of development of the strategic outcomes framework identified UK and international models of remote and rural acute and emergency care, and evidence to support these models:
Volunteers are used extensively internationally in emergency care delivery in remote and rural areas. Community engagement is a key element of this. First responders have the ability to deliver defibrillation and life saving first aid measures to the seriously ill and injured.

The community practitioner response is described as a primary response; a tiered response and a response to provide an increased skill level to patients.

Retrieval systems are usually clinician led and activated. The use of telemedicine allows specialists to assist remote and rural clinicians while the retrieval team is in transit. Additional boat and air infrastructure is discussed.

The literature describes relevant emergency and urgent models of care but there is a lack of rigorous analytical research. Because of this, the review concludes that any service changes require careful monitoring and proper evaluation from the outset.

Out of Hours Care in Remote and Rural Scotland 2005 Report

The most relevant piece of work that CRH has conducted was a report completed in 2005. While some of the results have been superseded by events, the report remains relevant, as many issues remain unresolved.

The key findings of the study were as follows:

- The structure of OOH services in remote and rural areas prior to the introduction of the new General Medical Services contract had evolved according to local circumstances. GP co-operatives had been an important development where geography allowed, but delivery in remote and island areas remained practice based.
- Difficulties relating to access were identified as the primary barriers to change in remote and rural areas.
- Across the Health Boards proposed changes had many similar features - centralisation of care with patients encouraged to travel, patient transport systems, fewer doctors on call, the creation of multi-disciplinary integrated teams, and with NHS 24 as first point of contact.
- These major changes in service delivery were being introduced within a short time scale and were causing much uncertainty, exacerbated by a lack of detail of the new service structure and organisation.
- Uncertainty was reflected in the wide range of opinions expressed by rural GPs about their contribution to the new services, the viability and safety of new services, and the future role of rural general practice.

At the time of the study, OOH service redesign in remote and rural areas was a contentious and complex subject, and this remains the case today. One respondent likened it to “wrestling with an octopus”. Geography, weather, transport infrastructure, population distribution and structure, and recruitment and retention of health care personnel all conspire to make it more difficult to
modernise services in these areas. All these factors combine to produce a set of constraints, resources, attitudes and demands for services that shape the re-design process. Farmer et al (2003) proposed that existing services may, however, represent a successful model of care. Rural areas are diverse and services are likely to have evolved in ways that fit the local environment, culture and geography, resulting in a delicate balance of what is possible, given the circumstances.

The study concluded that other workable solutions were needed in the most remote areas. Major redesign had been possible in urban parts of Scotland but localised appropriate solutions for relatively small populations were identified as time consuming, expensive and requiring flexibility, imagination and political will.

Community First Responder Schemes

CRH is in the process of evaluating the introduction of the community first responder scheme in Rannoch and Tummel. Also, CSO have just confirmed the award of a grant to CRH to assess the role of CFRs across Scotland during 2010. This study also aims to contribute to our understanding of public participation in healthcare services. The concept of community resilience will be explored, and the study will examine social and cultural impact of public involvement in healthcare delivery. International evidence suggests a trained community response during a healthcare emergency can have an impact on patient survival rates, particular evidence relates to cardiac arrests. However, to date the role of community first responders has been unevaluated in Scotland.

We are able to report some early interim findings from the study in Rannoch. A survey was conducted in Rannoch & Tummel prior to the introduction of the CFR scheme. A total of 266 of 606 questionnaires were returned, a 44% response rate. In the last year, 72% of respondents had been seen or had been visited by a GP, 46% by a nurse, 15% had called NHS 24. Respondents made a total of nine 999 calls in the last year. Of responses received, 6 people had volunteered to join the scheme, and a further 27 indicated they may do in the future. A range of views were expressed about the scheme:

- 36% of respondents agreed the scheme would be good as an addition to service, 18% were neutral and 46% disagreed.
- 65% agreed that they would have concerns about the safety of the scheme, 18% were neutral and 17% disagreed.
- 68% agreed that in a life-threatening emergency, they would be satisfied to be seen by anyone who is appropriately trained and skilled, 15% were neutral, and 17% disagreed.
- 24% agreed that current arrangements for healthcare emergencies were satisfactory, 11% were neutral and 65% disagreed.
- 73% agreed that GPs from the local practice should be available 24 hrs, 14% were neutral and 13% disagreed.
This survey will be repeated once the scheme is fully established and in operation. We are also conducting interviews with local stakeholders and early evidence shows there is confusion in the community over the role of a first responder scheme.

**Personal views on out of hours healthcare provision in rural areas**

My impression is that since the 2005 report has been produced, little progress has been made in resolving the difficult issue of the delivery of out of hours services in remote and rural areas – hence the need for this inquiry. Often the current configuration of services is expensive, unsustainable and inefficient. My view is that the most sustainable and cost effective way to deliver adequate out-of-hours services in rural areas is to focus on the emergency and urgent response, as my perception is that this is the element which causes concern in communities. Non-urgent primary care cases should be triaged where possible to adequate day time services. Solutions need to be tailored to rural communities, as there are many different sets of circumstances, and existing resources should be used to deliver a team-based approach including general practitioners, nurses, paramedics, ambulance technicians, pharmacists and community first responders. There is potential for more communities to contribute to improving the accessibility of service delivery through first responder schemes, but it is important that volunteers are used appropriately and supported in their role, and not seen as a replacement for services. At the moment, it is my perception that rural areas are not best served by the number of different agencies involved in the delivery of out of hours care, and communities are confused by the different roles each organisation plays. Better co-ordination is required between Scottish Ambulance Service, NHS 24 and GP out of hours services, with co-location or integration of these services as future possibilities. This has been identified by the services themselves. Exploration of the use of technology to support remote models of care should be continued and supported as this has the potential to transform the quality of care delivered. The proposed standards for different levels of response recommended by the Remote and Rural Implementation Group should be introduced with support from the Scottish Government, and changes in service delivery required to meet these standards carefully monitored.

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The Centre for Rural Health is a collaborative venture between the University of Aberdeen and the UHI Millennium Institute. The CRH mission is “to advance knowledge of health and health services in rural and remote communities”. Those communities currently face a number of important challenges including: changes in demography; changes in the nature of health care provision; and increased expectations of the community. CRH is developing the evidence base for rural health care by carrying out relevant primary research; developing collaborative research; and bringing the
international perspective through appropriate collaborations. David Heaney is a senior research fellow at the Centre. It is also worth noting that he lives in the remote Wester Ross village of Achiltibuie, and while he is a member of a community first responder scheme there, he remains neutral in academic exploration of the role of CFRs in the provision of care.

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References

1. Emergency and Urgent Response To Remote and Rural Communities Strategic Options Framework October 2009 Accessible at http://www.nospg.nhsscotland.com/?page_id=292