REMOTE SERVICE FUTURES

Coll, Colonsay, Achiltibuie and Ardnamurchan

A Knowledge Transfer Partnership project

.

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1.Introduction

Remote Service Futures is a Knowledge Transfer Partnership (KTP) Project. It aims to produce a toolkit of good practice for working with communities and stakeholders on remote community service design. The project will work with communities over two years looking at methods of participation and generating ideas and sharing knowledge involved in designing remote services that are sustainable for the future.

Stakeholders in the project include local community members, health and social care professionals, the NHS, the Council, Argyll and Islands Enterprise, community planning, voluntary organisations, the Scottish Ambulance Service, education providers, politicians and any others with an interest in the local and wider community. The idea of the project is to identify methods to facilitate exchange of information within and between stakeholders to help ease decision-making about what services should be like in the future.

During the project, community members and stakeholders from four peripheral communities will be facilitated in: identifying their service requirements; identifying information needs; locating information; sharing information and using it to generate ideas for sustainable future services. The project focus is involving stakeholders in innovative ways. One outcome of the project should be potential sustainable service design ideas for the participating remote communities that have emerged from stakeholder's thinking and that are realistic and informed. The idea of the project is to find best practice in integrating stakeholders in the planning process. Ideas for service designs that emerge should be consensual and capable of being implemented. The major output of the project is a toolkit of good practice for involving remote communities and their stakeholders in service design decision-making.

2. What is a Knowledge Transfer Partnership?

Remote Service Futures is funded through the Knowledge Transfer Partnership (KTP) scheme.

"Knowledge Transfer Partnerships is Europe's leading programme helping businesses to improve their competitiveness and productivity through the better use of knowledge, technology and skills that reside within the UK knowledge base. Each partnership employs one or more high calibre Associates (recently qualified people) to work on a project, which is core to the strategic development of the business." [http://www.ktponline.org.uk/]

The objectives of the KTP programme are:

- Facilitating the transfer of knowledge and the spread of technical and business skills, through innovative projects undertaken by high calibre, recently qualified, people under the joint supervision of personnel from business and the knowledge base;
- Providing company-based training for graduates in order to enhance their business and specialist skills within the context of the project;
- Stimulating and enhancing business relevant education and research undertaken by the knowledge base;
- Increasing the extent of interactions by businesses with the knowledge base and their awareness of the contribution the knowledge base can make to business development and growth." [http://www.ktponline.org.uk/]

3. Project aims

This project aims to develop appropriate methods to explore local people's perceptions of:

- how current health services are used to meet current population needs;
- how services, other agencies and local people (health, council, voluntary sector, etc) work together to meet current population needs;
- what services will be needed in future and how these might best be provided by services, other agencies and local people;
- the role of health services in current and future community sustainability.

The project proposed here is a 6-18 month 'pilot' involving four communities to test methods of data gathering and exploring community empowerment in assessing and designing services to meet future needs. The Primary Health Care teams/communities identified are**, Coll, Colonsay, Achiltibuie and Ardnamurchan**.

Within Argyll and Bute the islands of Colonsay and Coll have been selected. Colonsay is an island situated a 2.5 hour ferry ride from Oban. The population of 126 residents are provided with health care services by one GP and a part time (15 hours a week) community nurse who are based on the island. The community nurse is linked in to a mainland community nursing team, based in Easdale for professional support and supervision. A health care assistant works variable hours, depending on the health needs of the community. Health services including podiatry, physiotherapy, occupational therapy and dental visit the island at regular intervals. Services including community childrens nurse, Macmillan nurse specialist, Marie Curie nurses and dietetics will visit on request. Residents requiring specialist health services are referred to specialist services based in Oban and/or Glasgow.

Coll is an island situated a three hour ferry ride from Oban. The population of 220 residents are provided with health care by one GP, one part time double duty community nurse/midwife (30 hours a week) and a health care assistant (15 hours a week). Health services including podiatry, Diabetes Specialist Nurse, physiotherapy, dietitian, dental and optometrist visit the island on a regular basis. A health visitor based on Tiree visits three monthly. The audiologist will visit the island as required. Residents requiring specialist health services are referred to specialist services based in Oban and/or Glasgow as appropriate.

The integrated equipment store provide a regular service to the islands as required, delivering equipment which assists individuals to remain in their own community.

Emergency health services are provided by the GP and nurses on both islands, supported by the Scottish Air Ambulance service who will mobilise an air ambulance to transfer patients to the mainland and specialist emergency units. If bad weather results in the air ambulance being unable to attend the island, the Ministry of Defence Sea King can be mobilized to assist local health care staff and transfer patients.

The project aims to develop within NHS Highland the knowledge, skills and understanding to devise and implement new methods of public engagement, with the ultimate goal of producing a toolkit to facilitate remote and peripheral service reconfiguration involving all stakeholders, particularly the public.

4. Project objectives

- Collate international information on rural community and stakeholder engagement.
- With communities and other stakeholders, devise community plans for public engagement.
- Devise community and stakeholder engagement plans that utilise new methods, processes and products.
- Implement engagement plans and formatively evaluate.
- Produce community service design ideas.
- Produce and test a toolkit for stakeholder engagement and dissemination strategy.
- Explore potential for commercialisation of the toolkit produced - provided through consultancy/ training.
- Produce a final report on best practice in rural stakeholder engagement around service design.

5. Project principles

- This project is about ensuring safe, sustainable health services for the future that meet the requirements of remote communities and that are developed in partnership with remote communities; the project is ***not*** part of a cost improvement plan.
- The endpoint of this project must not lead to 'cuts' in overall service provision. That is, people should still be able to obtain the appropriate quality/levels/types of care, close to home, that they require.
- That the study may lead to actual service provision improvement e.g. through fostering or supporting schemes or ideas for schemes to provide appropriate services to meet current and future needs.
- That those living in these remote locations can expect to have as much spent, per head, on their health services as the average Scottish resident or the average Scottish remote/ rural resident (whichever is greater amount).
- That service providers agree the principle of working in partnership to support the project and using its results.
- That all ideas are potentially 'on the table', that we can allow ourselves to 'think the unthinkable' (although there is no onus on actually doing that) and that we think 'outside of the box' about future service provision. All arrangements are subject to national contracts and workforce agreements.
- That we proceed collaboratively.

6. Project outputs

- Review document of international methods of rural stakeholder engagement.
- 4 x individual community plans for stakeholder engagement processes.
- 4 x community project plans that utilise new methods, processes and products for stakeholder engagement.
- Formative evaluative updates: the processes and methods used; when and where used; numbers of people involved; community and Associate feedback and reactions.
- 4 x briefings of community ideas for future healthcare (and other service) design in the participating communities.

- Toolkits for stakeholder engagement on healthcare design and training in remote and peripheral communities.
- Dissemination strategy.
- Report and business plan for commercialisation of toolkit of stakeholder engagement methods.
- Final report.

7. Implications for NHS Highland, the CHPs and community planning partners

The project opens up a number of potential opportunities and issues for NHS Highland, the CHPs and their partners. It provides a unique and focused opportunity to fully involve and engage with the public in shaping their future health service and needs.

It directly informs the wider issue of remote rural community sustainability and development and so directly relates to the CHPs' community planning partnership agenda and the socio-economic agenda of Highlands & Islands Enterprise.

The project directly challenges NHS Highland and the CHPs to be open and transparent regarding resource and health and activity information as detailed in the governing principles.

There is also a need for a concerted communication process throughout the length of the project not only with the community, but our staff, the local GP, visiting professionals, other stakeholders and local politicians. This will be supported by NHS Highland's Communications Team.

A robust project structure is required to ensure progress is maintained and outcomes are met. There will be an overarching steering group comprising the key project stakeholders and two operational groups, Oban Lorn and Isles Group, headed by Christina West Clinical Services Manager and John Lyon Clinical Director and a Mid Highland Group led by Alison Phimister, Locality Manager.

It will provide NHS Highland CHPs and partner organisations with a toolkit to progress community engagement in the future.

8. Duration

The general stages of the project are detailed in the project plan below with a start date of February 2008.

Project stage	***Project Months***								
	0	3	6	9	12	15	18	21	24
Knowledge Base & Company Induction	■								
Training & Development, MPhil registration	■					■			■
Completion of detailed action plan	*								
Holidays				■				■	
Information collation	*								
Community plans devised		*							
Project plans devised			*						
Public engagement plans implemented & evaluated				■	■	*			
Community design plans produced							*		
Public engagement toolkit produced								*	
MPhil thesis submitted									■
Final report									*

The project will last 24 months, starting from the point at which the KTP Associate commences work.

9. Start date

3rd March 2008.

10. Funding

RSF is funded, through the KTP scheme, by the Economic and Social Research Council (ESRC) and Scottish Executive. It is part-funded by NHS Highland, SEHD Remote and Rural Research Initiative and HIE Argyll & the Islands.

The total budget for the project over 2 years is £103,704 with funding from the following sources

KTP initiative	57,230
NHS Highland	25,000
HIE Argyll & Islands	10,000
UHI	11,474

Addendum – Project information and operation

11. The partners and their responsibilities

The company partner is NHS Highland. They are responsible for providing accommodation for the KTP Associate and workplace supervision. They are responsible for supporting the KTP Associate in the approved work of this project, in delivering the identified outputs and in publicising the work.

Centre for Rural Health, UHI are the knowledge base partner. They are responsible for knowledge, research and education-related work of the Associate. They are responsible for providing access to knowledge resources and a research environment, consisting of attendance at seminars, events and courses. They are responsible for identifying a programme of continued development and education with the KTP Associate and facilitating and supporting their access to this.

The KTP Associate is employed by the scheme to conduct the work of the project under the day to day supervision of the company partner and the educational and research supervision of the knowledge partner. The KTP Associate has specific outputs to produce in terms of the project and a programme of education and personal development is to be agreed with the KTP Associate that they must also fulfil.

12. Groups, their functions, membership and meeting

12.1 Local Management Committee: The role of the LMC is for the KTP Scheme to ensure that work on the KTP is progressing satisfactorily. On approval, at 3-monthly intervals, they can then approve release of finance into the project. LMC meetings are to check progress against agreed project milestones and discuss any issues arising. Minimum attendance at the LMC is Neil Duncan, Jane Farmer, Christina West – or their appointed representatives and the KTP Associate. Stephen Whiston will be Chair of this group with Secretarial support provided by the KTP scheme.

12.2 Steering Group: The Steering Group is to oversee management of the project operationally. The Steering Group will advise on dissemination and publicity and will advise on the strategic implications of the project. The Steering Group will review the financial report and review the risk management profile. The Steering Group will make operational decisions. The Steering Group will meet bi-monthly.

Steering Group members

Name	Organisation	Position in Partner organisation	Role in Steering Group
Jane Farmer	UHI Millennium Institute	Chair in Rural Health Policy & Management, Centre for Rural Health, UHI	Chair
Amy Nimegeer	NHS Highland	KTP Associate	KTP Associate
David Heaney	University of Aberdeen	Senior Lecturer, University of Aberdeen Centre for	Knowledge Base Mentor
Stephen Whiston	NHS Highland: Argyll & Bute CHP	Head of Planning Contracting & Performance	Company base lead (Argyll & Bute)
Stella Cockburn	NHS Highland	Management Accountant	Company base finance input (Argyll & Bute)
Christina West	NHS Highland	Clinical Service Manager, Argyll & Bute CHP	Company base operational lead
Alison Phimister	NHS Highland: Mid Highland CHP	Assistant General Manager Mid	Company base assistant lead
John Lyon	NHS Highland: Argyll & Bute CHP	Medical Director	Company base (medical input)
Community Representative			

13.3 Stakeholder Reference Groups:

Each participant community will have a reference group consisting of stakeholders. Groups will be established by the Associate once in post and their membership will vary according to which agencies are significant local stakeholders. Reference groups will: advise on community interaction, advise on strategic implications of information coming/going to communities and other stakeholders; act as a guide and sounding board for the project 'on the ground', act as a formal conduit for information into and out of the communities. Reference groups will meet formally at agreed intervals, but there will be significant interaction between the KTP Associate and the group members on an ongoing basis.

14. Budget and financial reporting

Budget and financial issues will be a standard agenda item reviewed at each LMC meeting and each Steering Group meeting.

15. Access to information

A key aspect of the project is informing stakeholders of each others' perspectives and gathering knowledge about the community and its service requirements. As part of this all stakeholders will be encouraged to ask questions; such as – how much is spent in providing primary health care to the community?; what is the 'cost' of a general practitioner or a community nurse?; how many emergency ambulance call-outs have their been to the community over the last 5 years?, etc. It is important that these questions are answered informatively and quickly. By adhering to this '*Terms of Reference'*, the stakeholders (including NHS Highland) are agreeing to: provide information where at all possible or say that they cannot provide it and give a reason why within 3 weeks of the question being asked. Without genuine exchange of information and co-operation, this project runs the risk of failure.

16. Contribution to NHS Corporate Objectives

The project is an objective of the CHPs Delivering for Health action plan regarding modernising services. The Chief Operating Officer is the executive lead for the project.

17. NHS Staff Governance

Staff in the project will have the opportunity for direct involvement and contribution to the development of outcomes.

18. NHS Patient Focus and Public Involvement

The project has at its core PFPI and will be in accordance with all relevant national guidance and SHC standards for public engagement.

19. NHS Clinical Governance

The project will inform the service issues considered and options developed.

20. NHS Equality Impact Assessment

The project will comply with equality and diversity standards and will be impact assessed accordingly.