RGPAS MANIFESTO Final draft, 15/05/2023

Rural general practice is approaching a crisis: urgent action is needed to ensure that people living in remote and rural Scotland will continue to have access to medical care. The rural population rarely has a choice of practice or access to hospital emergency departments, so the survival of rural general practice is essential.

There has been a steady decline in the rural medical workforce over the past 10 years and many rural GPs are approaching retirement, so inaction will quickly lead to crisis. Several (sometimes well-intentioned) policy initiatives have stoked this fire, particularly the 2018 GP contract which poured new resources into urban practices but virtually nothing into rural areas. This has led to a huge loss of morale among rural GPs. Many previously thriving practices have now been handed back to Health Board control, often leading to replacement of established GPs by expensive temporary locum doctors. Patient satisfaction with rural general practice has plunged.

On 16th January 2020 the Scottish Government Primary Care Directorate published ***Shaping the Future Together: Remote and Rural GP Working Group Report.***

https://www.gov.scot/publications/shaping-future-together-report-remote-rural-general-practice-working-group/pages/0

The report made twelve recommendations (see Appendix) which were accepted for implementation by the ***Cabinet Secretary for Health and Wellbeing***. We are very concerned that these recommendations will not be delivered.

One central recommendation was the creation of a *National Centre for Rural and Remote Health and Social Care*. The Centre was to be launched in April 2023, but this was postponed in November 2022. Since then, there have been no further announcements about when it will be launched. Two organisations created to support rural practice were dissolved with the intention of the functions being incorporated into the National Centre:

- ***The Remote and Rural General Practice Working Group*** was created by the Scottish Government to try and resolve some of the rural problems created by the 2018 GP contract.
- ***The Scottish Rural Medicine Collaborative (SRMC)***, designed to improve recruitment and retention of Rural GPs was dissolved in March 2023.

It seems that key mechanisms created to support rural practice have disappeared.

In addition a Public Petition to create an Agency or Commissioner for Rural Health, aiming to ensure equity for rural residents, has recently been rejected by the Holyrood Health and Sport Committee in favour of yet another enquiry of unknown scope and start date.

A call to action

In response to this calamitous situation, the Rural GP Association of Scotland (RGPAS) proposes the following actions:

1) Creation of a more favourable political and management culture

- The crucial generalist role of rural GPs must be supported. To counteract the seemingly inevitable move towards medical specialisation, there is a need for government to encourage and support rural generalism.
- The Rural Working Group needs to be re-activated, with active participation of working rural clinicians, to propose solutions to the problems currently facing rural practice.
- Small independent practices should be supported rather than be allowed to fail or prepared for takeover by larger organisations.

2) Appointment of a Rural Health Commissioner

- This role, successfully implemented in Australia, should allow appraisal of the impact of all government and Health Board policies on rural health. In line with the role of the Children's Commissioner, a rural health commissioner would have the right of early access to all policy initiatives to examine and report on their impact on rural health. The commissioner would have an advisory but not policymaking role.

3) Ensuring continuity of care

- There is a need to recruit and retain more GPs in permanent positions – partnerships or salaried posts: Balance between remuneration for GPs with permanent contracts and temporary locums is needed to encourage doctors to take permanent posts. At present, there is little incentive to become a GP partner because it is possible to make more as a locum working 6-7 half days per week.

4) Ensuring equity of funding and support for rural practice

- The 2018 GP contract was a kick in the teeth for rural practices that received none of the extra funding that was awarded almost exclusively to central belt GPs. This was because the "Scottish Workload Allocation Formula" (SWAF) awarded funding based on a historical survey of the number of consultations offered by practices. This led to the formula allocating funds based on a flawed definition of deprivation (which doesn't work in rural areas) and the age of patients. This in turn led to relatively well-resourced practices in urban areas receiving almost all the additional funding allocated by the contract. Notably, even urban practices in the most deprived areas were disadvantaged by this formula because the life expectancy of their patients was less than that in wealthier areas. The GP Workload Allocation Formula needs to be redesigned.
- Rural GPs provide a much broader range of care than urban GPs. Frail and unwell patients find it difficult to travel long distances to central urban locations for secondary care. Rural GPs therefore often provide extended care either using additional skills and knowledge or through liaison with specialists. This significantly extends the length of

consultations with patients as well as increasing the time required to liaise with specialists including setting up bespoke shared care arrangements. Rural practices also deliver other services such a palliative care and "Hospital at Home" services, which require significant time to both plan and deliver. In urban areas this care is delivered by specialist services.

- Rural practices also deliver life-saving Pre-Hospital Emergency Care which frequently means postponing a full surgery. In addition, they also deliver urgent, non-life-threatening care that in an urban area would be provided by Emergency Departments.
- Rural practices also generally have fewer patients, an inevitability in remote communities, which further reduces income.
- A revised Workload Allocation Formula needs to incorporate these factors, which were included in the previous funding allocation system. A root-and-branch exercise to ensure fair implementation of funding is required.
- Support services promised in the 2018 GP contract have barely materialised for rural practices, and those implemented have often been inadequate, inconvenient, and expensive.
    - Immunisation services are a good example. Rural practices generally want to continue providing immunisations, and their patients want this too. Health Boards are required by the contract to deliver these services but have failed to deliver in a way that suits patients. Practices should be offered a choice to deliver these services and receive the funding that would otherwise be spent by Boards.
    - Community treatment centres have not been commissioned in all areas, and where this has taken place, continuity of care, accountability for test requests, and co-ordination of appointments have all reduced safety, and added travel costs for patients.

5) Supporting remote and rural GPs to have guaranteed time off

- GPs in independent remote and rural GMS practices find it difficult to get time off for holidays, professional education and to participate in health board or national planning meetings. A system to provide reliable GP cover is required. The *GP Associate Scheme* was very successful before 2004 – one GP provided cover for two or three practices over the course of year. There is a strong case to develop a similar system.
- Remote and rural GPs also require time off in case of personal or family illness. A pool of GP colleagues to provide cover in these circumstances is required.

6) Retaining older GPs

- There is a need to reduce the bureaucratic load, particularly that associated with appraisal and revalidation.
- Opportunities for part-time and flexible working should be developed and supported.

7) Encouraging career diversity, broadening interest/experience and strengthening sustainability

- Rural GPs generally want to expand services available to their patients. Rural access to point-of-care testing, such as blood tests and ultrasound (now used by most rural GPs in Norway) could improve patient experience, reduce travel and save money for the NHS.
- More joined-up thinking to increase sustainability and encourage combined GP, hospital and academic posts is required.
- Funded sabbaticals and practical support for swaps with urban or rural colleagues are likely to benefit both patients and GPs.

8) The "Rural Pipeline"

- We need to ensure that medical students and trainees can experience remote and rural practice. Student funding bureaucracy continues to hinder student access to rural placements. This needs to be streamlined. A fund to allow rural student electives and placements would be valuable.
- Rural GPs should be supported to act as medical student career mentors.
- We recognise that Rural Fellowships are a critical component of the rural pipeline. We want to ensure that the fellowships are protected and enhanced in the future.
- Scotland needs a national strategy that enables and empowers a 'rural pipeline' approach to recruitment AND retention. Canada's blueprint for rural health would be a good starting point https://srpc.ca/Rural_Road_Map_Directions). One key driver of recruitment is retention. If there are happy, satisfied, empowered rural clinicians then young doctors will want to join them.
- In the current climate, the pull to Australia, New Zealand and Canada, or to humanitarian work seems strong for young doctors. All these opportunities demonstrate an appetite for generalist and interesting work among medical graduates. We need to find ways to attract these emigrant doctors, and potential future emigrant doctor, into Scottish rural practice.

Appendix

The twelve recommendations from ***Shaping the Future Together: Remote and Rural GP Working Group Report, 2020.***

The Scottish Government and the British Medical Association should:

1. Continue to state their unequivocal *commitment to maintaining the Income and Expenses Guarantee, under current contractual and funding arrangements.*

2. Ensure that new terms and conditions arrangements, developed as part of Phase 2 or any further iteration of the GP Contract, clearly recognises the diversity of remote and rural general practice.

This seeks to provide a long-term sustainable footing for rural practices and their local communities. A comprehensive plan for consulting with remote and rural stakeholders on any wider contractual changes should be agreed. This must include and embrace the views of the public and the communities served.

3. Develop a set of criteria for the use of the Rural Fund, recognising and supporting the distinct role of rural GPs and multidisciplinary team members (MDTs).

4. Continue to develop a package of support for dispensing practices through the Dispensing Working Group that will protect and enhance the sustainability of Scotland's dispensing practices.

Refining Rural Enablers

The Scottish Government in concert with all stakeholders should:

5. Establish a National Centre for Remote and Rural Health and Social Care, to foster and promote innovation and excellence within Scotland and internationally.

6. Renew efforts to make maximum use of information technology and digital connectivity in the provision of remote and rural primary care.

7. Continue to improve pressing physical infrastructure issues across remote, rural and island general practice to better support multidisciplinary working, training and education.

8. Work closely with HSCPs, territorial and national (special) Health Boards and Bodies to establish change management support and capacity for remote, rural and island communities. In turn, these endeavours should also help non-rural areas across Scotland.

9. Work together with the Scottish Rural Medicine Collaborative, to develop innovative solutions to support recruitment and retention of remote and rural GPs and broadening multi-disciplinary team workforce, at all career stages.

10. Further promotion of the recruitment of medical, nursing, pharmacy and allied health professional (AHP) students is required. This includes more opportunities for student rural replacements and support for the expansion of training practices and training opportunities in remote, rural and island areas.

11. Review the method of funding allocations to territorial Boards with significant remote and rural areas, including Island Boards, in the light of changing demographics, care needs and evolving models of care provision.

12. Ensure that there are proportionate mechanisms in place to assess and evaluate new models of care provision in remote, rural and island areas and to assimilate and disseminate best practice.