

“Disentangling the knots”

Making effective use of funding for Rural and Remote General Practitioners in Scotland.

A joint report by the Rural GP Association of Scotland
(RGPAS) and BASICS Scotland.

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Introduction

For too long, resource set aside for the benefit of supporting rural and remote GPs has been hosted through NHS organisations who are unable to deliver sustainable impact where it is needed most. We describe this as having “too many knots” constraining overall capability which need to be disentangled.

Rural GPs have been involved in well-intended programmes of work to improve access to rural healthcare for at least two decades. Scottish Government has supported the development of high value programmes of work which have, in some cases, resulted in significant progress, only to be halted after two or three years because of a funding review, lack of ownership following a change in a senior responsible officer, or another organisational transformation. This pattern has created uncertainty, loss of momentum and loss of valuable expertise. Over time the profound cumulative loss has undermined the ability to make lasting change.

Having experienced such a repetitive pattern of shelved projects it is understandable that rural GPs can feel demoralised and cynical. These experiences highlight the reality, and those working within it often describe a sense of overwhelm or even despair at the thought of further challenges as they try to respond professionally to the latest review or organisational change.

One of the biggest barriers rural GPs face is the increasing demand placed on them to deliver safe and efficient healthcare with fewer staff. While GPs are delivering more than ever they are working under increasing strain due to workforce shortages and increased demand.¹ This is further exacerbated by promising initiatives designed to ease the long-term burden but which, for a range of reasons, never seem to reach full potential before being closed. A long legacy of evidence and proposed solutions exists which describe the persistent issues faced by remote and rural healthcare; this now demands serious attention.²

Rural GPs, as represented by the [Rural GP Association of Scotland \(RGPAS\)](#), feel strongly that it is time for a reset. This is why we are launching this campaign: to make effective use of funding for rural and remote general practice in Scotland to support lasting change. The time has come for Scottish Government to support rural GPs to form a “Far End” collective, akin to the successful “Deep End” initiative, to definitively address rural health inequalities.

Rural GPs should be recognised as equal co-design partners with genuine input into policy development and service planning, and work within a professional framework of shared learning and mutual support.

The charity [BASICS Scotland](#)¹¹ exists to give healthcare practitioners across remote and rural Scotland the skills, competency and support to provide high-quality pre-hospital emergency care, thus improving patient outcomes and reducing rural health inequalities. The provision of a comprehensive, co-ordinated network of highly skilled and well-equipped BASICS Scotland responders and fixed resources results in more resilient remote and rural communities. Despite their life-saving input, BASICS Scotland does not benefit from stable funding.

We believe meaningful change will only be possible if there is clear commitment to allocate funding directly to the organisations responsible for delivering the work, such as BASICS Scotland and RGPAS, alongside existing improvement mechanisms. We are asking decision



makers to make this commitment in 2026, supporting rural GPs and the communities they serve.

We want to make our case constructively by using examples showing what has happened in the past and setting out some recommendations for the future.

Background

Since 2005 there have been no fewer than twenty healthcare policy and evidence developments relating to remote and rural healthcare. Prior to this, the most significant body of evidence came in 1912 with the Dewar report.³ This report resulted in the Highlands and Islands Medical Service.

Despite huge improvements in population health and the introduction of the NHS, the core, residual challenges remain largely unchanged:

“Items for special consideration” – taken from the [1912 Dewar report](#)³:

~ proximity to services

~ difficulties of travel and rugged geography

~ circumstances of people

~ rural depopulation

~ security of tenure

~ the doctor’s income

~ means of communication

~ the doctor’s dwelling house

~ holidays

~ the scope of general practice

~ continuity of care

One hundred and fourteen years later in 2026, the rural and remote population of Scotland is experiencing an increase in geographically related inequality. Despite best efforts, funded interventions and well-informed clinical evidence, the lessons learnt have not been effectively implemented across the system and are in danger of being lost. Tackling these age-old challenges will require sustained commitment and close partnership with rural professionals and organisations.



Key Policy and Evidence Documents – (full list titles in Appendix 1)

Timeline of Key Policy and Evidence Documents Relating to Remote and Rural Healthcare in Scotland





Examples of funded interventions:

We have observed that most funded interventions were led by host organisations. Typically, they were sub-units of NHS boards with limited internal ownership of programme delivery, clinical buy-in or continuity. We believe this structural flaw resulted in poor strategic integration of recommendations and avoidable inefficiency.

Reports from RCGP Scotland, NHS boards, Scottish GP Committee, Scottish Government Primary Care Division and a recent Scottish Parliament Inquiry make recommendations on previous findings and can be found as references at the end of this document.

We don't need any more evidence.

We need to consolidate what is already there to understand what we already know and then implement it.

We also observe that many successful projects have integrally involved rural clinicians and managers working closely together using their deep understanding of the day-to-day delivery of rural healthcare in their specific geographical areas to address specific issues.

Below are details of some significant initiatives and investments:

The Remote and Rural Areas Resource Initiative (RARARI)⁴: 1999 – 2003
Scottish Executive Health Department ~ £8.0M

This programme of research produced a wealth of evidence which under the guidance of the Remote and Rural Implementation Group culminated in the landmark policy document Delivering for Remote and Rural Healthcare (2007/2008). At the heart of this work was the concept of delivering care as close to the patient as possible and resulted in:

- The Rural General Hospitals supported by larger urban health boards within a legislated Obligate Network of Care.
- Community Hospitals delivering enhanced intermediate care alongside the use of technology to support augmented home care.
- Rural Support Teams utilised the developing Advanced Nurse Practitioner and Paramedic roles.
- An important recognition of the value of generalists in a healthcare system that was increasingly reliant on specialists.
- The Emergency Medical Retrieval Service that not only transports critically ill patients to specialist centres but also provides expert advice to rural generalists managing critically unwell patients in rural hospitals and remote communities.
- This pivotal change in the delivery of rural healthcare with an increased emphasis on the value of the generalist and the multidisciplinary team was supported by the Remote and Rural Healthcare Educational Alliance (RRHEAL) which has overseen a groundbreaking programme of rural healthcare education.



ISLES NETWORK OF CARE (INOC) 2010 to date.
NHS Orkney

A service redesign project that integrally involved the different outer isles communities in how their individual service should be delivered and involved the communities in the recruitment process. The project investigated the barriers preventing health professionals taking up remote island posts and addressed the problems. Specifically, INOC addressed pre-hospital emergency care provision through training and the provision of standardised equipment, alongside the problem of professional isolation by creating a weekly videoconference meeting. These interventions transformed recruitment to the outer isles of Orkney.

“BEING HERE” 2014 – 2017⁵
NHS Highland £1.4 million

A trial and evaluation of alternative models of primary healthcare recruitment and retention of GPs in NHS Highland across four test sites, based on the Alaskan NUKA model of care. Services from South Skye to the Small Isles continue to operate. A successful recruitment campaign and a [qualitative evaluation](#) was commissioned over 2 years 2015 – 2017 costing £250k total.

MAKING IT WORK:
Remote and Rural Healthcare Education Alliance (RRHEAL) 2019⁶

A framework for remote and rural workforce stability. Part of an INTERREG (EU funded) Project⁷ following on from “Recruit & Retain”; “Being Here” and several other smaller projects in NHS Highland. This framework summarised the lessons learnt from different projects to help guide future recruitment work.

THE SCOTTISH RURAL MEDICINE COLLABORATIVE (SRMC): 2017 – 2023⁸
Scottish Government~ £1.0 million over 6 years

Set up to address rural GP recruitment and retention challenges, this programme was the natural successor to previous projects. It functioned as a collaboration of 10 rural health boards and other key stakeholders, hosted firstly by NHS Tayside / North of Scotland Planning Group (NoSPG); then NHS Highland using fixed term contracts and the Chief Executive of NHS Borders / Highland as the functional Senior Responsible Officer (SRO).

Central to the working of SRMC was bringing together geographically dispersed individuals with in-depth experience to focus on specific issues and develop jointly owned strategies to address workforce recruitment and retention.

The SRMC website was integral to this work. Since the website was deactivated in 2026 there is currently no accessible record of the substantial resources developed.

The work of SRMC was subsumed into the National Centre for Remote and Rural Health and Social Care following recommendations 5 and 9 in the “[Shaping the Future Together: Remote and Rural General Practice Working Group Report](#)”



REDISCOVER the JOY of GENERAL PRACTICE (RtJ)⁹: 2019 – present
Collaborative recruitment programme between NHS Shetland, Orkney, Western Isles and Highland. Funded by Scottish Government.

Building on the lessons learnt from the Orkney Isles Network of Care, RtJ has a strong values-based philosophy recruiting highly motivated GPs to a peripatetic team providing cover to rural practices. NHS Shetland places team members into rural practices looking for GP support. All team members receive BASICS Scotland prehospital emergency care training and are joined together in a community of practice through an active WhatsApp group and videoconference meetings. The project was developed by senior managers and the Associate Medical Directors from each board who had developed strong working relationships through SRMC.

NATIONAL CENTRE for REMOTE and RURAL HEALTH and SOCIAL CARE
2023 – March 2026¹⁰ Funded by Scottish Government .~£3M

Recommendation 5 from the [“Shaping the Future Together: Remote and Rural General Practice Working Group Report”](#) saw the formation of the National Centre for Remote and Rural Health and Social Care under the former NHS Education for Scotland – now Public Service Delivery Scotland (PSDS).

Several priorities for the centre were identified:

- ***To be a multiplier for rural innovation***
- ***To spread and contribute to Scotland’s Rural Healthcare story using data to show that our rural clinicians and service providers are exemplars***
- ***To lead on promoting Scotland’s Rural Healthcare on a national and global stage***

Since March 2026 the National Centre is undergoing a workforce and activity review and the work is paused. It is understood that the funding is secured to continue under a new target operating model which is currently in design.

The above list is not a comprehensive list of previous rural initiatives, but rather a brief overview of projects that RGPAS committee members have a good understanding about, there is undoubtedly other work of which we are unaware or about which we have less intimate knowledge. These examples are used to illustrate some of the breadth and depth of work that has been done. This work should not be lost but should be used to inform future work.



Our recommendations

These recommendations describe the immediate action that RGPAS and BASICS Scotland feel Scottish Government must take.	
1	Key organisations should not have to rely on hand-outs, underspends or payment significantly in arrears to deliver vital support to rural Primary Care • Scottish Government should provide direct annual funding, under the principles and terms of Fairer Funding, to BASICS Scotland and RGPAS to continue their work in supporting the extended roles of rural GPs. • Rural GPs must be equal partners in co-designing policies which concern the design and delivery of rural services, along with the educational needs of rural GPs and students.
2	Collaborative partners should be equally involved in tackling rural inequity • Scottish Government should support the establishment of a permanent organisation in line with the Scottish “Deep End”¹² to help understand and address rural health inequalities and deprivation. • Significant long-term investment with the involvement of relevant organisations as equal partners in the co-design of the new structure is essential for success. • Rural-proofing policies should be considered as a key responsibility of this structure to, amongst other issues, tackle root causes of recruitment and retention issues.
3	Rural GPs and collaborative partners should be enabled to develop not-for-profit solutions to recruitment and retention problems • Innovative models such as in-house, not-for-profit locum solutions which allow Scottish GPs to manage their own requirements should be supported and developed to avoid reliance on commercial agencies. • Similarly for medical student elective placements, a matching service would alleviate an inefficient and convoluted process.
4	A repository of legacy information must be established to ensure that knowledge and heritage is preserved. • It is very difficult to find a complete record of the huge body of evidence relating to remote and rural medicine in Scotland and there is an increasing risk that it will become permanently lost unless action is taken to collect and properly store it in an appropriate accessible archive.



In more detail

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Key organisations should not have to rely on hand-outs, underspends or payment significantly in arrears to deliver vital support to rural Primary Care

Scottish Government to provide guaranteed direct annual funding, under the principles and terms of Scottish Government Third Sector Fairer Funding, to BASICS Scotland and RGPAS to continue the work they do to support the extended roles of GPs in providing clinical expertise in rural settings.

Too often, established organisations receive only minimal year-on-year funding allocations that fail to support effective forward planning, resulting in last-minute funding bids with no assurance of future support. This creates unacceptable uncertainty, risks wasting previous investment, and may have a significant adverse impact on the continuity and quality of services if these organisations are unable to plan and operate effectively over the longer term. BASICS Scotland¹¹ and RGPAS should be provided with guaranteed funding within the same financial year for at least three consecutive years supported by an appropriate annual supplier process.

Pre-hospital emergency and immediate care services have been delivered successfully by GPs for many years and are now a standard, integral part of a strong network of rural emergency response.

The importance of effective pre-hospital emergency care (PHEC) cannot be overstated. PHEC is a source of significant anxiety for both rural communities and the practitioners serving them. Concerns about the provision of PHEC are frequently given as reasons for not applying for rural and remote positions. Conversely, when PHEC training is provided to successful applicants and emergency equipment standardised, rural recruitment has been transformed.

The provision of PHEC services are essential in rural areas without consistent paramedic ambulance cover or a local A&E. Rural practices depend on GPs with up-to-date PHEC training. If training course availability is limited (as it was after the pandemic) both the provision of PHEC by established GPs and recruitment to rural areas are severely impacted. The provision of PHEC services is not part of the GMS GP contract and most rural practices provide these services voluntarily.

Scottish rural healthcare providers have standardised PHEC services around training delivered by the charity BASICS Scotland and the Sandpiper Bag. The Sandpiper Bag contains all the equipment required to deliver effective PHEC and is provided by BASICS Scotland's sister charity, The Sandpiper Trust. The Sandpiper Trust replaces all equipment used from the Sandpiper Bag for GPs delivering PHEC to patients, as well as replacing all out-of-date equipment.

Regular funding will enable BASICS Scotland to reliably provide training and resources for rural clinicians responding to pre-hospital emergencies; this includes timely post incident welfare support.

	GP Practices providing these lifesaving services must be paid and BASICS Scotland previously undertook significant work on this with Scottish Government. RGPAS provides advocacy, essential mutual support and educational opportunities to rural GPs. Stable funding would allow rural GPs to contribute meaningfully to policy development, liaise with organisations supporting the recruitment pipeline, support recruitment and retention in rural practice, and create educational resources and events for rural GPs, such as its popular annual conference.
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2	Collaborative partners should be equally involved in tackling rural inequity. Provide recurring funding for a collaborative framework between rural organisations and policy makers to tackle rural inequity through the formation of a “Far End” group. The equity health gap in remote and rural communities appears to be widening. RGPAS feels strongly that a permanent organisation to tackle rural health inequalities is required. It proposes that the “Far End” should be created around the four “WEAR” principles used by the Deep End: Workforce, Education, Advocacy and Research. Lessons from the Deep End should inform the development of the Far End model, with both organisations working collaboratively to understand and address health inequalities across Scotland. Geographically inclusive models should be adopted to ensure equitable care based on need, regardless of income or location. This would provide a significantly different approach to co-ordinating rural healthcare initiatives. A peer-to-peer network of multi-disciplinary clinicians, academics, policy makers and operational delivery mechanisms could achieve so much more if they are enabled to work collaboratively. The Deep End model in Scotland is an effective, comparable blueprint for tackling health inequalities. Rural and remote communities in Scotland would benefit from the same focus.
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Rural GPs and collaborative partners should be enabled to develop not-for-profit solutions to recruitment and retention problems

- **A “one-stop” website providing a road map for Scottish rural recruitment and retention, along with links to the many different organisations providing expertise and support to rural health providers should be developed.**
- **Innovative models such as in-house, not-for-profit locum solutions which allow Scottish GPs to manage their own requirements should be developed, including vetting and matching to avoid reliance on commercial agencies. This should be supported until they can achieve self-supporting status.**
- **A similar matching service for medical student elective placements would alleviate an inefficient and convoluted process.**

The extended role of remote and rural GPs requires additional training to that needed for urban practice. To ensure adequate workforce numbers, it is important to consider the different career stages when individuals might decide to take up remote and rural working and build support mechanisms to assist them with the transition.

The concept of a “rural pipeline” identifies the different training stages or entry points to a rural career. Significant work has been undertaken in Scotland to encourage and support individuals develop a rural career. Such initiatives include: ScotGEM Medical School, rural student selected placements and electives, GPST Rural Track Programme, GP Rural Fellowship, Rural Clinical Fellows Teaching Programme, Rural Grand Rounds, the GMC Remote and Rural Credential and Rediscover the Joy of General Practice. The rural healthcare landscape is vibrant and can be confusing for individuals considering a rural career. Conversely, rural GP practices and health boards wishing to recruit can struggle to target interested individuals.

A comprehensive “one-stop” Scottish rural website designed to assist individuals navigate the rural landscape should be developed, alongside an active social media programme to maintain a high online profile. The website should showcase individuals working in rural areas, relevant conferences, courses, training programmes, organisations and individual opportunities. The Scottish Rural Medical Collaborative (SRMC) website was designed to provide this function, alongside an archive of rural activity and research. Following the closure of SRMC, the website was not maintained and has recently been removed.

RGPAS members were integrally involved in setting up and maintaining the SRMC website and have an intimate knowledge of its design. RGPAS is interested in re-branding, updating and launching the website as a Scottish rural healthcare resource and a critical component for successful recruitment and retention to rural practice.

Innovative models for recruitment and retention have been successfully piloted in some of the most fragile and remote areas of Scotland. Best practice confirms that this involves both the communities and healthcare professionals themselves.

	Rural GPs know their practices best. If you have seen one remote and rural GP practice, you have seen ONE remote and rural GP practice. It is virtually impossible to standardise and centralise recruitment and backfill for leave. One solution could be to establish a dedicated internal (peer to peer) locum supply chain of GPs who wish to work in rural areas. This would exist as a not-for-profit autonomous social enterprise model for the benefit of rural GP practices and the communities they serve. As an OSCR registered charity, RGPAS is interested in exploring the creation of such an organisation. As an independent charity, it would have access to wider sources of external funding to support such work.
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4	A repository of legacy information must be established to ensure that knowledge and heritage is preserved. It is very difficult to find a complete record of the huge body of evidence relating to remote and rural medicine in Scotland and there is an increasing risk that it will become permanently lost unless action is taken to collect and properly store it in an appropriate accessible archive. More than 20 years of extremely valuable evidence from at least 10 projects, including lengthy academic evaluations, has been compiled. However, much of it is now inaccessible because of restricted access or broken source links, preventing the material from being viewed, referenced or published for wider benefit. Scotland has a long and important heritage in rural primary care, but the current scattered evidence base does not reflect its significance. As holder of the intellectual property, the Scottish Government has a responsibility to preserve this strong legacy and rich body of knowledge for the future. RGPAS is interested in developing a repository of Scottish rural healthcare research alongside an archive of oral histories from rural healthcare providers from both the past and the present. We see this as an important element in creating a strong Scottish rural brand, which in turn will help support future recruitment.
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Appendix 1

Key policies summaries

- 1912 – Dewar Report ³
- 2007 – Delivering for Remote and Rural Healthcare
- 2013 – RCGP 2022 Vision
- 2013 – Supporting Remote and Rural Healthcare (NES) ¹³
- 2014–15 – Realistic Medicine ⁹
- 2016 – Primary Care Workforce Survey
- 2016 – Rural Health (Government & BMA)
- 2016 – Scottish Rural Medicine Collaborative (SRMC)
- 2017 – Workforce Plan Part 1 ¹⁴
- 2017 – Workforce Plan Part 2 ¹⁵
- 2017 – Delivering the new GMS Contract - MOU ¹⁶
- 2018 – GMS Contract Reform ¹⁷
- 2018 – RCGP Workforce Paper
- 2019 – Audit Scotland Workforce Planning Review ¹⁸
- 2019 – Undergraduate Medical
- 2019 – Remote and Rural GP Sustainability Survey
- 2020 – Shaping the Future Together ¹⁹
- 2021 – Memorandum of Understanding (Implementation)
- 2022 – RCGP 2022 – Building the Future: Delivering Primary Care
- 2023 – Finding Our Workforce (RCGP Scotland) ²⁰
- 2024 – Scottish Parliament Remote and Rural Healthcare Inquiry²¹



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