RCGP SCOTLAND

Health, Social Care and Sport Committee - Healthcare in Remote and Rural Areas consultation
RCGP Scotland response

1. Are there any immediate issues unique to remote and rural communities which the National Centre will need to focus on to improve primary and community care in these areas?

RCGP Scotland welcomes the opportunity to respond to this consultation. As the membership body for general practitioners in Scotland, we exist to promote and maintain the highest standards of patient care.

The most prominent healthcare issues faced by remote and rural communities relate to access to appropriate and necessary services. For many, access to secondary and tertiary care is much more difficult than for their urban counterparts, and thus rural transport networks and adverse weather can have disproportionate effects on health outcomes among the population of these areas. Teams in general practice can also end up being faced with patients who have a much wider range of needs.

As we noted in our response to the call for views for this consultation, recruitment of a wider range of health care professionals- often described as the Multi-Disciplinary Team (MDT) model has continued to face a variety of challenges in rural and remote practices. In Scotland, the introduction of the MDT workforce into primary care was intended to help relieve the workload pressures on GPs. An effectively resourced MDT also enables patients to access appropriate care in an environment capable of providing it through better use of healthcare professionals and their skills sets, located within the general practice teams. However, the MDT structures that can work well in urban centres cannot always be deployed in sparsely populated areas. Recruitment and staffing of MDTs within remote and rural practices continues to pose significant challenges, and this has led some remote and rural GPs to feel their practices and patients face a significant disadvantage when compared to their urban areas. As one of the intended benefits of the MDT is the relief of workforce pressure on GPs, this has been a frustrating situation for these practices.

It would be beneficial for the MDT model to be a focus of the National Centre, with special focus given to what model for delivery and resourcing would best support them in line with the experience of remote and rural clinicians and patients. Further insight related to the experience to date of MDT team members might allow for a more effective and efficient deployment of the resources and workforce in these regions.

Another immediate issue which the Centre could focus on would be the matter of childhood vaccinations, and how to ensure that recommended schedules are adhered to, and that uptake rates are at the level needed to confer protection. Investigations into strategies to catch up children who have missed their vaccinations would be welcome.

2. Are there any issues which the National Centre will be unable to address, which may require further policy action from the Government?

Major issues related to structural or financial considerations, including workforce and infrastructure, are unlikely to be able to be addressed by the centre. Workforce recruitment, which was previously supported by Scottish Rural Medicine Collaborative (SRMC), continues to pose a significant challenge. Unfortunately, it is these high-level issues which are at the root of many of the difficulties facing remote and rural healthcare, and general practice in particular.

Many remote and rural general practices do not have appropriate infrastructure, both physical and digital. The impacts of inadequate premises are well known, and with many GPs having to work within ageing facilities without the capital for energy efficiency improvements. Some rural practices have reported difficulties in treating their patient population within the confines of their current practices. Urgent investment in digital infrastructure is required to improve interoperability, accessibility and the reliability of clinical systems. Capital investment is required, but the allocation of this by boards too often prioritises larger population areas and secondary care to the detriment of remote and rural primary care.

The difficulties regarding workforce across Scotland are well known, however the complexity of recruiting and retaining GPs to work in rural and remote practices is a real risk. These issues can lead to rural practices not being able to continue as independent contractors and becoming board administered 2C practices. Despite Braemar practice being rated highly for care it provided to patients, it handed back its contract to the board triggered by a GP retirement. Also this year another large practice in Inverurie had given notice of handing back its contract citing there being not enough GPs to recruit, although within the notice period it had managed to find a way to continue to hold this NHS contract.

3. What would you like to see included in the Scottish Government's forthcoming Remote and Rural Workforce Strategy?

In regard to primary care outcomes, the single most impactful outcome would be a boost to GP numbers, as measured by whole time equivalence and not headcount. This is needed to describe the current primary care capacity across remote and rural Scotland, as well as to be used in planning of fully staffed services.

Proactive steps such as support for students who wish to experience rural working environments may lead to enhanced recruitment outcomes as well.

For the incoming workforce, additional training in areas such as prehospital care is necessary, and rapid access to such training would also ensure the workforce is imbued with the relevant skills to treat remote and rural populations. Support for maintaining the broad extended skillset of the present workforce is critical for achieving positive outcomes in these areas.

The reintroduction of Protected Learning Time (PLT) would be a critical step to increasing retention outcomes in general practice. The effectiveness of the delivery of PLT for all practices, including those in remote and rural areas, within the current arrangements set out by the Scottish Government should be monitored, with a view to considering utilising NHS24 as the national call handling service in the future to provide cover.

4. What specific workforce related issues should the strategy look to resolve?

As previously noted, it would be worthwhile to consider what models of multi-disciplinary team working are possible in a remote or rural context, and how best they can be deployed to meet the needs of the population in these areas. MDT models of working will be different in rural

areas and reasons for this might include that some staff group's days of work in an area or shift patterns will not overlap, for example.

The challenge of providing cover for unscheduled and urgent care would be a specific issue that the strategy might seek to resolve. Due to the aforementioned staffing issues and the remote and rural workforce, healthcare provision is more inelastic than in urban settings, and so investigation into how to best improve this could be beneficial.

In regard to the workforce itself, the strategy should look into ways to minimise or avoid professional isolation to improve satisfaction and mental health amongst clinicians.

5. Are there any workforce-related issues which the creation of a Remote and Rural Workforce Strategy alone will not address. If so, what are these issues and what additional action may be required to address them?

The workforce strategy is unlikely to impact upon broader issues regarding living in remote and rural areas which impact upon staff.

For example, accommodation for those who wish to relocate to new areas and similar issues are beyond the reach of a workforce strategy but are issues which have material impacts on the ability of healthcare services to recruit and retain an appropriate workforce.