Being Rural: exploring sustainable solutions for remote and rural healthcare

RCGP Scotland Policy Paper written by the Rural Strategy Group Scotland

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Executive summary

Remote and rural healthcare in Scotland has reached a crisis with problems with recruitment and retention for GP practices from Stranraer in Wigtownshire to Whalsay in the Shetland Islands. The causes of the crisis are complex and multi-factorial and have the potential to adversely impact on safe and effective patient care. When brought together, as is the case, these issues (listed below) constitute a particularly challenging environment in which to recruit and retain both GPs and other healthcare professionals to remote and rural environments.

- Connectivity (mobile phone/broadband)
- Transport
- Fragility of support services
- Workload (including the 24 hour commitment)
- Professional development
- Education and Training
- Professional and social isolation, including
- Adverse effects on family life

To effectively support remote and rural practice, RCGP Scotland is committed to working constructively with Scottish Government, health boards, NHS Education for Scotland (NES), and other stakeholders to:

- Help eradicate current inequalities in access to good primary healthcare provision in rural areas.

- Increase recruitment and retention for rural practitioners through actions at school, undergraduate, GP training and continuing postgraduate development levels.

- Promote rural general practice in Scotland as the exciting and rewarding career that it is.

- Achieve better mobile and broadband coverage throughout remote and rural areas of Scotland to better manage patient care.

Introduction

Remote and rural healthcare in Scotland is experiencing a deepening crisis and is in urgent need of review and reshaping. RCGP Scotland sees general practice services in remote and rural areas to be founded upon the same generalist and community-based principals as general practice everywhere; the approach epitomises the 'essence of general practice'.[1]

The growing recognition of the need for generalism in healthcare is a welcome development. This means that in rural areas, the GP often has to undertake a much wider role in acute illness and trauma than his/her urban colleagues, often with limited backup and support. Experience shows that innovations in rural areas can be rolled out to the benefit of the wider NHS and translates well to non-rural settings.

In the past, the focus has tended to be on the Highlands and Islands, however, we recognise now that this is an issue across both Highland and Lowland Scotland, affecting all rural Health Board areas.

Background

GP recruitment and retention is increasingly difficult throughout the country, but has reached crisis point in remote and rural areas.

There are currently a wide variety of groups looking at different aspects of the problems, including Scottish Government, NHS Education for Scotland, NHS Highland, RCGP Rural Forum, the Centre for Rural Health[2] and the Dewar Group which recently held a conference in Fort William[3] to mark the centenary of the 1912 Dewar Report.[4]

During July 2013, an RCGP delegation led by UK President, Dr Mike Pringle visited practices in the Western Isles to seek further insight into the particular problems experienced in these practices (Appendix 1).

Historical context

Providing health care in rural areas of Scotland has always been a challenge. The clan system had a well developed medical system[5] in the Highlands informed by European Universities, but this disintegrated in the aftermath of the Jacobite rebellions. In the 1850s, attention was drawn to the inadequacy of medical care, but it was not until the Dewar Report of 1912[4] that sufficient political will existed to tackle this problem. The resulting Highlands and Islands Medical Service was the first state-funded comprehensive health system and was the sole model for the NHS white paper 30 years later.[6] Soon after the formation of the NHS continuing problems were noted, particularly in the Birsay Report of 1967.[7]

More recently, Professor Sir David Carter's 'Acute Services Review' (1998)[8] raised the problems of healthcare in remote communities. This led to a recommendation that both a 'task force'[9] to consider the needs of remote communities and a resource centre should be set up. Partly as a consequence of this, the Scottish Executive Health Department invested £8 million in the Remote and Rural Area Resource Initiative (RARARI), a 3-year project (2000–2003) which gave workers in remote and rural areas the opportunity to explore aspects of healthcare delivery. This project achieved much, including supporting BASICS Education, that currently provides an

important resource to continue to support emergency pre-hospital care across Scotland. However, since 2003, it has proved more difficult to fund specific remote and rural initiatives.

Recent events

Recruitment and retention of GPs is difficult across Scotland and the UK. In rural areas of Scotland, increasing numbers of practices are now being run at considerable cost by locums or directly by Health Boards under “2c contracts”. These arrangements come at a higher cost and may have an adverse effect on continuity of care. High profile recruitment campaigns such as in West Lochaber have been unable to recruit doctors[10] and NHS Greater Glasgow & Clyde has been unable to recruit to the Isle of Cumbrae despite 3 attempts.[11]

Pharmaceutical services, resilience of general practice and dispensing

GPs and patients are currently very concerned about loss of GP dispensing services in remote and rural areas. For example, on the Isle of Cumbrae the loss of dispensing led to the resignation of the incumbent GPs who felt that the practice was no longer viable. Following this, the Health Board has continued, for over a year, to provide locum cover whilst seeking a variety of options for more permanent staffing. A comprehensive view of this issue is contained in the paper prepared by Dr Kate Dawson in response to the pharmacy application in Benbecula . In May 2014, Drymen has experienced a loss of GP services for the same reasons, and Aberfoyle is currently under threat. This is a critical issue that has been recognised by Scottish Government who are planning changes in legislation to ensure the needs of patients are not prioritised above the commercial interests of pharmacy service providers[12].

In line with the implementation of new government policy on Prescription for Excellence[13], Scottish Government has introduced new regulations on the control of entry for new pharmacies in rural areas. This will require health boards to designate some areas as remote and rural and empower them to refuse an application if it would adversely affect the provision of other medical services in that area.

These regulations came into place on 28 June 2014. http://news.scotland.gov.uk/News/News-scrutiny-for-pharmacy-applications-cfa.aspx)

Improving Infrastructure, Patient Care and Professional Development for GPs

1. Connectivity Mobile Phone and Broadband Coverage

Lack of investment has resulted in poor mobile phone signal and poor broadband internet connections. The decision to allow mobile reception providers to cover a percentage of population rather than land area has been detrimental to rural populations. The rollout of 4G ultra-fast mobile networks has begun and yet many rural areas of Scotland have no mobile signal at all. For example, the Applecross, in Wester Ross community now has a fast broadband link from Broadford on Skye, but no mobile reception. This is causing a digital version of the 'inverse care law' that needs to be recognised at a national level.[14] Rural areas - which have the most to gain from telehealth - have the poorest connections. Rural practices which often operate from a number of branch surgeries, are often limited in services provided by having inadequate or unreliable connectivity.

The Scottish Government has recognised the importance of fast internet links to remote and rural areas. BT is at an early stage of a rollout of fast broadband with the target of 97% coverage by 2017. It is hoped this will provide opportunities for technology to improve healthcare in remote areas and will also be important for community resilience.[15 & 16]

2. Geography/Transport

In the Dewar Report[4] (1912) the Highlands and Islands were described as follows:

"The country is rugged, roadless, and mountainous, and where not composed of islands is very largely peninsular on the seaboard, and inland is broken up by lakes and rivers. The weather conditions, too, and particularly in the winter-time, add enormously to the difficulties of travel."[4]

Much has changed, but the basic description of the area remains valid. Many roads, even some main roads, remain single track. Public transport options are scarce and where they exist, are often interrupted by the weather.

The care of seriously injured or ill patients becomes both challenging and prolonged for the rural GP who relies on a generalist approach to make difficult decisions in a resource-poor environment. The Emergency Medical Retrieval Service (EMRS) [17] has developed into an essential link to bring consultant-led critical care to rural communities, and optimise the retrieval journey to larger centres of expertise. However, there are specific implications in the care of the psychiatrically unwell with transfer off the islands requiring air transport and trained CPN escorts resulting in delay in transfer for definitive treatment and considerable strain on GP services.[18]

Patient transport generally is difficult in many rural communities with perceptions that the ambulance service is relatively underfunded in rural areas leading to delays in transport.

3. Fragility of Support Services

There is an interdependence between services especially given the shared, extended roles and if one service fails it has a marked knock on effect on the others: such as loss of palliative care trained nurses and loss of radiography services.

For example, “The recently introduced National On-Call Agreement has had the effect that on-call periods for radiographers attract a much smaller retainer fee than previous contracts allowed. No rural-proofing has been considered for this national change, and this has introduced a significant pay cut to all radiographers accepting a new contract; particularly those who are moving to or wishing to accept a permanent contract in rural areas.

There are further difficulties in implementing compensatory rest periods and other conditions of employment, with the effect that expectations remain for these components to be waived by rural staff. The effects of this on provision of radiography services are starting to be seen in areas that have required to recruit new radiography staff, however the full ramifications are yet to become apparent. Indeed, as well as radiography staff, this also has had an impact on emergency and retrieval services, community nursing and other support services which are vital to rural healthcare.”[19]

4. Managerial Priorities/Professional Representation

Managerial Priorities
We recognise that many managers of health services for remote and rural areas work extremely hard to provide resilient and high quality heath care. However, there are perceptions in some areas that geographical distance from managerial support and decision making at Health Board level causes difficulties. The reality is that remote and rural issues do take up an inordinate amount of management time. Service models are hard to change and recruitment and retention is time consuming and costly.

In the Western Isles, great progress has been made in Lewis around the Western Isles Hospital in the range and sustainability of services available, including that for OOH, but this has been perceived by some of the more remote GP practices to be at the detriment of primary care services in other locations.

Clinics in the Uist and Barra Hospital are staffed by consultants who come from Stornoway, but as patient transport is centrally funded by Scottish Government and staff transport is funded by the Health Board then there is inevitably Health Board pressure to centralise clinics.

Professional Representation
An example of issues around professional support and representation is seen in areas like Campbeltown and Lochgilphead. These areas are remote and isolated, the hospitals are staffed by GPs and provide a highly effective ‘blue light’ emergency receiving response. The model of care is one which is entirely compatible with the direction of travel of Scottish Government’s 2020 vision, bridging the primary/

secondary care divide. However, supporting the model may need different forms of professional representation to those that currently exist.

5. Workload

The nature of rural practice is different from urban areas. Whilst the numbers of patient contacts tends to be less in rural practice, other factors contribute to different pressures on rural GPs.

These include:

- 24 hour commitment - many remote and rural areas have been unable to opt out of the out of hours (OOH) provision or where, as in Lewis and Harris, some have opted out, the burden of provision has fallen on the remaining GPs. An informal poll at the 2013 Remote Practitioners' Association of Scotland (RPAS) meeting suggested that 60% of RPAS members were involved in covering OOH. In these areas, some innovative solutions have been developed (see Appendix 1) with close working with nurse and ambulance extended role practitioners, but these models need further thought and investment to work across different geographical areas. The fact remains that many GPs continue to carry full responsibility for 24 hour care, and despite moves to shift workload to other professionals, GPs remain ultimately responsible for much of the clinical care in rural areas.

- Increased pressure during the OOH period – rising patient expectations, particularly from patients who have moved from central locations to rural locations, combined with rising prevalence of multiple morbidities, is creating a more complex and frequent workload on OOH and community hospital services.

- Scope of work - in many of the remote practices the GP also provides a variety of other services, e.g. GP led specialist clinics in areas like dermatology and paediatrics, immediate (BASICS) care, medical support to search and rescue services. Some of this work is not contractually recognised despite requiring specific training.

- Professional isolation exacerbated by poor access to broadband, difficulty in hiring/funding locums, and the inevitable impact of geographical distance on increased travel times. This can result in stressed doctors. Recent tragedies including suicide[20] are testament to the great pressures faced by rural GPs.

- Shift of care from secondary to primary care – a national drive[21] as described in the Routemap to the 2020 Vision. The aim is to look after more patients at home rather than hospital, including swifter discharge from hospital, and has resulted in an inequitable pressure on rural areas where there are already challenges in providing multidisciplinary input. Specific examples include home dialysis, management of post-operative infection and community-based chemotherapy. It also includes the presentation of temporary residents where access to notes and previous investigations is limited. Increased prevalence

of comorbidity makes clinical judgements for acute presentations far more challenging, and again this is even more of an issue when treating tourists and other visitors.

- The General Medical Services (GMS) contract – negotiations between the Scottish General Practice Committee (SGPC) and the Scottish Government are ongoing at present with a stated aim of encouraging longer term stability and a greater focus on quality outcomes. This may well allow the opportunity for greater flexibility to support service development, better control of workload and a more stable income base for GP practices thus aiding recruitment. However, these negotiations are at an early stage and there is a need to ensure that new contractual developments will support rural models of health provision. RCGP Scotland supports a greater focus on quality and community based care. Contract negotiations in the rest of the UK are following a different focus and are less certain as to impact on workload, especially in rural areas.

6. Education and Training

The WHO Global Policy Recommendations[22]–'Increasing access to health workers in remote and rural areas through improved retention' - makes five clear, evidence-based recommendations in regard to education. We have added a sixth on premises and the estate for rural general practice:

- *Get the 'right' students*

Cochrane Review[23] states that recruiting from a rural background increases the chance of graduates returning to practise in rural communities. The Highland Schools Medical Mentor Scheme[24] is run by the RCGP North of Scotland Faculty. It aims to redress the perceived imbalance rural students' face to get into medical school. It is a successful scheme, but limited by the burden that is placed on the volunteer GP mentors. Raigmore Hospital also has a successful 'Doctors at Work Scheme'[25] run annually to enable students to get structured work experience. Unfortunately, there is little or no community work experience involved.

- *Train students closer to rural communities and bring students to rural communities*

Undergraduate rural placements
It is important for students to have positive experiences of rural health early in their career, but only a limited number of Universities encourage and actively facilitate their students being attached to remote or even rural practice. Aberdeen and Dundee Universities are good examples of best practice given the effort they make to facilitate and encourage rural student placements.

Electives and special study modules (SSMs/SSCs) are important gateways for students to access rural practice, and there are many examples of where this has been effective in stimulating interest in rural practice as a career. However, these

programmes need to be funded adequately, with the increased costs to students recognised. Dundee and Aberdeen have achieved an effective means of covering these costs, and the means of doing so should be made available to other Scottish universities – in medical schools as well as placements for other members of the healthcare team. Consideration should also be given by Health Boards to provide 'Dewar Bursaries' to assist undergraduates financially to gain rural work experience, ideally open to students from across the country.

Other countries, notably Australia and Canada, have situated major teaching and research units in rural areas, not in cities, a policy which has had success in increasing recruitment.[26] Academic rural research both into educational requirements and into clinical and health policy is important and needs to be encouraged and better resourced in Scotland.

- *Foundation Year exposure to rural practice*

There are limited examples of where this has been possible. There are many opportunities for stimulating and challenging FY2 attachments in rural areas. This is a significant opportunity for people to experience life in rural practice and also an excellent opportunity to learn generalist medical skills.

- *GP specialty training schemes*

The recently established 'Rural Track GP Training' by the Scottish Deanery is growing in popularity. There is an opportunity to increase input to the scheme and extend to other parts of rural Scotland. However, there are currently limited opportunities for trainees to join other rural-focussed GP training schemes. Many rural placements are bundled with other, less rural placements because of geographical boundaries and the constraints of training posts currently available. Current trainees could be offered opportunities to select specific rural placements, which will offer a range of practice including community hospital and pre-hospital work, as part of the core RCGP Training Curriculum. Development of this could be modelled on the current 'rural track' training programme[27], which is currently limited to practices within the North of Scotland Region.

Current training regulations are perceived as problematic for small practices with low list sizes to achieve adequate throughput of patients for GP training. Imaginative solutions could be sought for this, including rural GP trainees spending some time in urban practices, possibly on an exchange basis.

It is also important to stimulate interest in rural practice for GP trainees on non-rural track schemes. This would be facilitated by taster weeks or visits to rural practice, or allowing GP placements to be undertaken in areas remote from the hospital component. Thus, hospital jobs in inner city areas could be combined with GP placements in remote and rural areas.

- *Match curricula with rural health needs*

On a broader front, there could be considerable benefit in revising undergraduate and postgraduate curricula to include rural health topics so as to enhance the

competencies of health professionals working in rural areas, and thereby increase their job satisfaction and retention.

GP training is currently shorter than all other UK medical or surgical specialities, and less than half the duration of some of the specialities, but while the length of training has stayed the same, general practice continues to evolve.

General practice in all geographical settings is facing the dual challenge of an ageing population with complex, multiple co-morbidities. The structural changes that the NHS is undergoing will demand much more of your average GP in terms of clinical, managerial and leadership skills. More and more patients will be treated outside of hospital, in their homes and communities.

RCGP recommended in 2012 enhanced and extended training for general practice. Central to this is a minimum training time in all general practice programmes of four years with at least 24 months spent in primary care. This is not to question current training or the skills of existing trainees and recently qualified GPs: it's about ensuring that GP training keeps up with the demands of an increasingly challenging and complex environment, including that of remote and rural practice.

http://www.rcgp.org.uk/policy/rcgp-policy-areas/enhanced-and-extended-speciality-training-in-general-practice.aspx.

David Greenaway's 'The Shape of Training Review'[28] stressed the importance of generalist skills in the NHS of the future. These are exactly the skills that are required to function competently in remote and rural areas. In addition the current GP Specialty Curriculum includes the competency of 'community orientation' – a prerequisite for rural practice. These skills will also be needed for the forthcoming 'Integration of Health and Social Care in Scotland'[28] a key Scottish Government policy.

- *Facilitate professional development*

To design continuing education and professional development programmes that meet the needs of rural health workers and that are accessible from where they live and work, so as to support their retention. In order to do this effectively, all rural health workers must have good connectivity to broadband and mobile phone services.

NHS Education Scotland (NES) has developed post-CCT Rural Fellowships[29] providing high quality work experience and training for GPs who have completed specialty training. Places are limited to 12 per year and the posts are jointly funded by NES and the territorial health boards. These posts are well funded and are an attractive opportunity to develop remote and rural skills. They have a good track record of recruitment into remote and rural GP posts, and the scheme could usefully be expanded.

BASICS Scotland[30] provides a wide range of extended skills training, suited to the needs of a rural clinician with support from NES.[31]

Rural practice also benefits from experienced GPs moving to remote and rural areas mid-career. Progress is being made to facilitate this with specific training opportunities to prepare doctors for the different challenges involved. The RCGP Rural Forum has developed a proposal for an educational package along these lines. (see Appendix 3).

Various options exist to support "at distance educational engagement" such as the NES RRHEAL Education Platform.[32] Such platforms host content and links to material that is specifically relevant for remote, rural and island healthcare teams. This is another good reason to ensure that rural areas have adequate broadband connectivity.

- *Ensure surgery premises are adequate for GP training and undergraduate teaching*

In some rural areas, surgery premises are also not fit for purpose for training or teaching. Lack of consulting room capacity is a barrier to a practice moving toward training practice status. Investment in estate for rural general practice should be seen as a priority by rural health boards.

7. Family Life

Housing
One of the big attractions to working in remote and rural Scotland is the chance to live in areas of outstanding national beauty. Unfortunately, the reality can mean a housing shortage because of the demand for holiday homes and lack of available land to build on.

Employment for Spouses/Partners
Doctors spouses/partners may well be in the same profession or employed in support services. As highlighted by the Dewar report, lack of opportunities for spouse employment acts as a disincentive for doctor recruitment.

Education
Access to good schools is challenging due to lack of availability of good schools and travel distance between home and school.

Mobile Phone/Broadband Coverage
Connectivity in some rural areas can be very poor and this has implications for families to stay in touch with relatives. Lack of good internet provision causes great frustration and can interfere with the families' ability to engage with services as well as childrens' educational access to the benefits of social media that their urban counterparts take for granted.

8. Social Isolation

Isolation may not be just professional, but also social. Whilst the outdoors lifestyle is a winning factor, the remoteness of island and rural communities is also off-putting. Other parts of Scotland have similar lifestyle opportunities yet do not suffer from the same distance issues.

9. Remote and Rural Profile and Branding

One unfortunate result of the crisis in recruitment has been the development of negative perceptions of the remote and rural careers. RCGP Scotland believes that remote and rural practice offers exciting and rewarding opportunities to provide high quality, community based care. There is a need for these opportunities to be built on and how this is portrayed will be important. Examples such as the Youtube videos for the salaried GP vacancy on Arran [33] or experiences of GP rural-track trainees need to continue[34]. There is also a need to work with rural communities to change perceptions to more positive ones.

The Deep End project and associated meetings have been successful in capturing the experiences of inner-city GPs. The RCGP Scotland "Time to Care Remote and Rural Deprivation Project"[35] recognises that deprivation is not only an urban issue.

The website RuralGP.com which is supported by the Remote Practitioners Association for Scotland (RPAS) has been a successful mechanism for raising the profile of remote and rural practice, creating a clear identity for remote and rural practice and providing a forum for debate on rural issues.

It is encouraging that a major outcome of the European Union Recruit and Retain Project [36] has been the proposal for specific funding for a "Why Rural?" brand and media campaign to support recruitment to rural areas across Europe. This will be closely aligned to NES Strategy for Attracting and Retaining Trainees in Scotland (StART). [31]

In addition the Remote and Rural Healthcare Educational Alliance (RRHEAL)[37] is currently hosting the website of the developing Scottish School of Rural Health and Wellbeing. This currently has an advisory board of Universities and NHS organisations[i47].It aims to provide high quality remote and rural education, training and research programmes that support the current and future remote and rural health and social care workforce to improve the health and wellbeing of people living in remote and rural communities in Scotland.

Improving the Patient Experience

The main priorities of this paper are laid out in order to address the over-arching principle of improving patient care. All of the issues highlighted, if not addressed reasonably and without unnecessary delay, have the potential to adversely impact on the quality of patient care.

For GPs the world over, their first priority is to their patients. It is an indication of the level of commitment and care that general practice in remote and rural areas, despite the challenges and pressures that they face daily, continue to provide high standards of care within this challenging environment. However, it is evident that lack of connectivity in scattered communities, transport issues, GP training opportunities, the fragility of support services, increasing workload, social isolation and family life are all affected by the lack of proper infrastructure which is taken for granted in urban areas.

The present and the future of providing quality patient care is currently not sustainable for remote and rural communities. RCGP Scotland is committed to being a key partner in developing sustainable solutions. We welcome engagement with Scottish Government, NES, Health Boards and partners in a constructive dialogue to help resolve the issues currently adversely affecting remote and rural communities.

Recommendations and Actions Matrix

Policy area	Recommendations and Actions	Notes/Comments
1. Connectivity - Mobile Phone and Broadband Coverage	To ensure rural areas have effective digital links for health care delivery, learning, commerce and leisure	Scottish Government is investing in rural broadband. RCGP Scotland met with Scottish Government representatives in May 2014 to discuss the challenges. Throughout 2014/15, RCGP Scotland will continue to meet with Scottish Government and their agencies to develop strategies to resolve this issue throughout remote and rural areas.
2. Transport	To ensure transport infrastructure is adequate to support patient and lab services	The Rural Parliament[38] will be an important opportunity to ensure the healthcare impacts of transport are acknowledged. RCGP Scotland will seek an opportunity to ensure this is recognized and to lobby for continued investment in rural transport infrastructure.
3. Isolation and Fragility of Support Services	Rural proofing of health care workers contracts	RCGP Scotland will raise the rural proofing of NHS health workers' contracts with Scottish Government.
4. Workload and Contractual Issues	a. A new GMS contract needs to ensure resilience and the continued financial viability of practices that are providing essential care to remote and rural areas	RCGP Scotland will seek further meetings with SGPC to discuss how remote and rural factors are recognised in the GMS contract negotiations.
	b. Recognition of the role of dispensing GPs in remote and rural areas	Scottish Government consulted and reported on this issue in June 2014. The report stressed that pharmacy applications will be more transparent to local communities and will give patients a stronger voice; that Health Boards will be required to apply new tests when considering pharmacy applications in clearly designated and clearly identified remote and rural areas and importantly, that Boards will be given powers to refuse a pharmacy application if it was deemed that it "would adversely affect the security and

		sustainable provision of existing NHS primary medical and pharmaceutical services in the area." http://news.scotland.gov.uk/News/News-scrutiny-for-pharmacy-applications-cfa.aspx) The Rural Strategy Group continue to monitor the implementation of the new regulations and report to members on progress, where appropriate.
5. Education, Training and Professional Development	Get the 'right' students – facilitating recruitment of medical students from rural areas	RCGP Scotland will use existing academic links to ensure selection procedures do not discriminate against applications from rural areas where opportunities to meet entrance requirements may be limited. A paper on this issue will be brought to the Scottish Academic Forum in September. RCGP Scotland supports mentoring and work experience schemes, particularly those that include rural generalist work exposure.
	Train students closer to rural communities and bring students to rural communities	RCGP Scotland will use existing academic links, including the Scottish Academic Forum to promote the use of rural student attachments in all medical schools in Scotland. RCGP Scotland will consider how a 'Dewar Bursary' scheme could be encouraged, funded and administered to encourage student attachments to rural GP practices.
	Foundation Year exposure to rural practice	RCGP Scotland will use existing deanery links to promote rural 'foundation year' attachments across Scotland.
	GP specialty training schemes	RCGP Scotland supports the continuation and extension of the current GP Rural Track training This may require exploration of how perceived barriers to small remote practices being actively involved in specialty training could be overcome. RCGP Scotland encourages taster week or visits to rural practice for GP specialty trainees on non-rural track schemes.

	Match curricula with rural health needs	RCGP Scotland will use existing RCGP, academic and deanery links to encourage a focus on rural generalist skills in undergraduate and postgraduate curricula to help ensure future doctors have sufficient skills to work in rural areas.
	Facilitate professional development	RCGP Scotland supports and encourages the further development and growth of the NHS Education Scotland (NES) Rural Fellowships. RCGP Scotland supports the RCGP Rural Forum proposal for training opportunities for established doctors who are seeking to move to rural areas.
	General Practice Premises	RCGP Scotland will work with SGPC (Scottish General Practice Committee) to ensure surgery premises are adequate for GP consulting, training and undergraduate teaching
6. Remote and Rural Profile and Branding	To ensure career opportunities in rural healthcare are seen as exciting, rewarding and to be aspired to	The “Recruit and Retain” project is initiating a “Why Rural?” media campaign to provide a consistent positive brand. This needs to be built on and include an historical perspective to ensure health care workers are aware of the opportunities and achievements. RCGP Scotland will support this project, making use of its media and communications tools.

Appendix 1

Royal College of General Practitioners

President's visit to Western Isles 10-15 July 2013

Attendees

- Professor Mike Pringle
- Mrs Nickie Pringle
- Dr John Gillies
- Dr Hal Maxwell (RCGP Scotland Remote and Rural lead)
- Dr Jane Bruce (Executive Officer for Membership)
- Julianne Reddin (Services to Members Co-ordinator)
- Professor Sir Lewis Ritchie

Itinerary

Wednesday 10 July: Isle of Lewis

- Health Centre Stornoway
- Western Isles Hospital
- Search and Rescue Helicopter base, Stornoway Airport
- Evening Reception for Local GPs and AiTs at the Education Unit, Western Isles Hospital.

Thursday 11 July – North Uist

- Travel from Isle of Lewis to North Uist
- Visit to Lochmaddy Surgery; North Uist GPs

Friday 12 July – Uist

- Uist and Barra Hospital
- Meeting with Benbecula based GPs.
- Reception with local GPs from Southern Isles.

Saturday 13 July - Uist

Coffee morning with a local group raising money for a memorial for the MacLeod family's contribution to general practice in Lochmaddy.

Monday 15 July - Uist

Visit to Carloway Health Centre and local GP

10 July 2013

Group Medical Practice, Stornoway

Attendees arrived at the airport on schedule at 8am and were met by Dr Bob Dickie, Chair of the North Scotland Faculty. After picking up hire cars we travelled to the Group Medical Practice Stornoway to visit the practice and spend time with practice partners Dr Bob Dickie and Dr Brian Michie.

Over coffee at the practice Dr John Gillies gave an overview of the purposes of the visit which were primarily:

- To meet and engage with RCGP members based in the Western Isles.
- To find out more about the pressures of delivering high quality patient care in remote and rural areas and the innovative solutions that have been developed in each area to maintain continuity of care.
- To raise the profile of remote and rural issues at UK level through the President and at a Scottish level through the Chair of RCGP Scotland.
- To further understand issues pertaining to recruitment and retention of GPs in remote and rural areas.

Dr Bob Dickie and Dr Brian Michie then gave an overview of healthcare provision on the Isle of Lewis. In the 1990s a Scottish working group was formed with the purpose of reviewing healthcare provision in remote and island communities. Dr Bob Dickie was involved in this work which identified that a one size fits all solution would not be an appropriate model across all communities.

There was an emphasis at this time (on the Isles of Lewis and Harris) to build up secondary care provision and the two original hospitals on the island were merged to form the Western Isles Hospital which is based in Stornoway. The hospital has 17 consultants and it was noted that rotation is not feasible in the Western Isles due to travel pressures. Many patients have to travel to the mainland for surgery. Within the community there has been a historical lack of desire to travel off the island and, until several years ago, it was extremely common for older residents to be suffering from untreated cataracts as there was no cataract surgery available on the island.

Currently the Isle of Lewis has a population of around 20,000 which rises by another 2000 at peak times. As such the number of temporary residents is low. It takes a day to travel to Edinburgh. Inter island travel is problematic – historically travel to Stornoway was easier by boat than by road. It is easier for residents based on Uist to travel to Glasgow for procedures and treatment rather than Stornoway. Links have improved over the past few years although some limitations still remain.

In terms of recruitment and retention, 5 or 6 school students from Lewis go into medicine each year but not all choose to train as GPs and it is rare for them to choose to practice locally. There is currently only one GP practising on the island, Dr Margaret Ferguson, who is originally from the area. There are limitations to practising in such remote communities – many who are attracted to work here due to wishing to take advantage of the proximity to outdoor pursuits soon find themselves limited by mobile phone network problems which, for example, make it impossible to leave the house or be out of network range when on call (for single handed GPs this is severely limiting and isolating).

GPs on the island used to be responsible for post mortems and undertook approximately 40-50 of these per year. Bodies are now shipped to Inverness for this which causes delays to

funeral arrangements etc. A discussion took place on the loss of specialist services within general practice including GP obstetrics and the subsequent loss of skills and confidence amongst the professionals.

Visit to Western Isles Hospital

The group visited Western Isles Hospital where Dr Brian Michie gave a tour of the out of hours and acute care unit and introduced us to key individuals involved in extended primary care activities and acute OOH services, including:

- Agnes Munro, Emergency Department Senior Charge Nurse
- Jacek Rychter, Consultant Anaesthetist
- Fiona McLean, Radiology Manager

In 2004 on call arrangements were affected by the new contract and by the development of NHS24. At this time around half the doctors on the island opted out of out of hours services, some provided support through the transition and approximately 10 – 12 GPs continued to provide out of hours services. On Lewis a system has been developed where, in addition to standard out of hours GP services GPs also manage out of hours acute services including paediatrics, psychiatry A&E triage and other services. GPs on the island are therefore required to have a wide and varied range of skills in order to deliver out of hours services effectively. There are no 'fly in' locums for OOH here. It was noted that this system is stable because of the people who are involved in developing, delivering and managing this service; this is not a one size fits all approach and the people involved need to be able to work with risk and manage a wide portfolio of skills. Joint leadership from the lead GP, Brian Michie and Sister Munro has been crucially important here

It was fascinating to see first hand this innovative system which has been set up in order to provide effective multidisciplinary out of hours patient care. Many nurses have been trained up to specialist practitioner level in order to be able to deliver the complexities of care required under the system. The group received an overview of the integrated care pathways for acute coronary syndrome and stroke, devised by a local GP, Dr Dave Rigby. We also saw the system used by the hospital for stroke thrombolysis which utilises telehealth systems to allow communication with specialists on the mainland. It was noted that despite the challenges of rurality the hospital has one of the best response times for stroke in Scotland due to the success of the system implemented.

Search and Rescue Helicopter Base

Dr Brian Michie arranged for a visit to the search and rescue helicopter base at Stornoway Airport. Search and rescue services were taken over by Bristow at the beginning of July and the personnel at the base very kindly took the time to show us round and explain about the complexities of their role and to outline in detail the procedures which are followed when conducting rescues. Dr Michie regularly assists the search and rescue team and helped to give an understanding of the complexities of delivering medical care in such a challenging and pressured environment. We also got to look at one of the new Sikorsky S-92 Search and Rescue helicopters (costing £55 million)

Reception with Lewis and Harris based GPs

On Wednesday Evening Dr Bob Dickie has arranged for an informal reception with local GPs at the Western Isles hospital. The following individuals attended:

- Dr John Smith
- Dr Andrew Naylor
- Dr Clare Carolan
- Dr Peter Greenstock
- Professor Dick Collacott
- Dr Bob Dickie
- Dr Brian Michie
- Dr Neil Davis
- Kate Dixon (AiT on Rural Training Track)
- Christopher Mulholland (AiT on Rural Training Track)

During the reception there was an informal round table discussion about the current challenges and opportunities for GPs in the area and the following points were raised:

- It was felt that it was important for GPs working in remote and rural areas to be involved in teaching and training wherever possible as this facilities greater interaction with other professionals, enriches a GP's experience and prevents professional isolation.

- Medical student placements can originate from anywhere within the UK or Europe but are often arranged in conjunction with Aberdeen University where there are strong links with the medical school. Medical students feel that undertaking a rural placement enriches their training experience and value the opportunity for close working with patients made available in such areas.

- Dr Andrew Naylor's practice is taking part in filming for a BBC Alba documentary on general practice which links to the centenary of the publication of the Dewar Report.

- There needs to be a good rapport with secondary care colleagues in order to overcome the difficulties of remoteness, e.g. being equipped for emergencies such as accidents and suicides.

- As a rural GP there are a lot of commitments vying for your time, it's difficult to get the opportunity to do training/ CPD activities and this is exacerbated by the ongoing recruitment and retention issues.

- In the UK there has been an overall increase in medical student numbers but they are mainly opting for secondary care or part time work. GP full time equivalents have not necessarily increased.

- There a range of issues which have contributed to the recruitment and retention problem including:
  1) Social issues and lifestyle – isolation not just for GPs but also their families/ spouses.
  2) The extended role of GPs in these areas and additional skills and ability to manage risk which are needed.

- The development of the nurse practitioners role is welcome but care must be taken to establish where the boundaries are with general practice. What is the College's

position on this? Does the College have a role in fostering an understanding of interdisciplinary team working? Multi-disciplinary learning environments tend to provide a richer training experience, such as BASICs.

- General practice is good at being flexible and adaptable. We need to think about professional roles and boundaries. The joint RCGP/NES Developing Leadership programme being developed by RCGP Scotland is multi-disciplinary and the NES practice based small group learning and other high level courses produced are open to wider primary care colleagues.

- Recruitment and retention issues are pointed at the moment across Scotland. The Rural Fellowships were developed in response to a similar crisis in the 1990s. RCGP Scotland is working with the Scottish Government on this issue and attention needs to be given to the issue. RCGP Scotland has also developed a Rural Strategy Group in order to facilitate close working with relevant stakeholders in relation to potential solutions and to pull together the various workstreams, including Dr Jim Douglas' work with the Dewar Group.

- The RARARI scheme was also discussed and it was noted that this has been an initial funder of the BASICS programme. The scheme also raised issues such as off island transport for psychotic patients. Interest was noted in relation to the suggested development of a rural post-graduate school.

- The strong link with Aberdeen University is a good hook in terms of getting undergraduates to train in rural areas. Exposure at undergraduate level gives the inspiration to carry on practising in a rural setting. Could Glasgow and Edinburgh Universities also link in this way? It was agreed that encouraging undergraduates to consider rural GP as a career choice would greatly improve the current recruitment situation as by the postgraduate stage most trainees have already made informal decisions about where they wish to base their career.

- The GP trainees agreed that the NES specific remote and rural training track was really very helpful. It was suggested that BASICs training could be mandatory for remote and rural training as this would demonstrate the specialist skills needed to work in such areas.

- There was discussion about whether a city based trainees could undertake a 6 month placement in remote and rural as it was felt that people may be keen to see what working in the environment would entail but feel restricted to central belt locations. It was agreed that inner city GP is very different to rural GP and that it would be beneficial to allow people to see both sides and decide on their options in an informed way, especially if this was built in at undergraduate level.

- It was agreed that it is important to ensure that undergraduates have a clear idea of what GPs do, not just visiting a practice and discussing what GP entails.
    - GP experience needs to come earlier in UG training and be more positively formed.
    - General practice covers all the main skills developed during training so is a great thing to demonstrate to trainees.
    - There is a culture of dismissing GP by other medical professionals – this does much to treat GP as an unfavourable career choice.
    - There is still a strong element of luck involved in getting specific GP placements, more should be done to make the process easy for

people who know they want to work in an area with recruitment issues.
- GP themselves should be enthusiastic role models and care must be taken to show this side in training sessions.

- Currently word of mouth is the only way for undergraduates to feed back to peers about positive training experiences and placements – small group feedback including a reflective process would help to raise the profile of successful remote placements and encourage others to think of this as an option.

- Getting involved in the community is important for a remote and rural GP – would a more explicit community orientation aspect to the curriculum be worthwhile?

11 July 2013

Visit to Lochmaddy Medical Practice

Departing from Stornoway at 9am, we drove down to the ferry terminal at Leverburgh via the Isle of Harris which gave us a brief opportunity to enjoy some of the wonderful scenery the Western Isles have to offer. We then took the ferry to Berneray and drove over the causeway to North Uist where we arrived at Lochmaddy Medical Practice to meet with the following individuals:

- Dr Gerry Wheeler, Practice Partner
- Helen MacLean, Practice Manager
- Dr Barbara Pilkington
- Dr Amanda Woods

Dr Wheeler who moved to Lochmaddy after having trained in Dundee and practising in Glasgow, Australia and New Zealand gave us a tour of the practice which has one partner and two salaried GPs. A previous attempt to recruit a second partner for the practice has been unsuccessful.

Lochmaddy Medical Practice is a dispensing practice and a detailed discussion took place on current pressures linked to the reliance of the practice on its dispensing service in order to fund the two salaried GP posts – without this funding the practice would be single handed. Currently there is no protection for small dispensing practices in Scotland despite this service having a positive effect on practice funding and on patient care. Patients would also be required to travel up to 20 miles in order to pick up a prescription if the current pharmacy application to the health board were to be successful.

It was noted that when a pharmacy opens in Scotland it can specify a catchment area and can subsequently expand this catchment area at a later stage. Public opposition to the introduction of a pharmacy and the impact this could have on the economic viability of a GP practice do not seem to have any bearing on the success of pharmacy applications. The practice is currently running a campaign in conjunction with other GPs in Benbecula in order to draw attention to the potential impact of this on island GP services.

In Lochmaddy out of hours care is provided under contractual arrangements with the community hospital in Benbecula. One of the wards at the hospital has long stay beds for approved elderly patients requiring continuing hospital care. Dr Wheeler was responsible for introducing a first response thrombolytic service within the community.

The practice, from Health Board owned premises was a wonderful facility with a multiuse clinic which until recently held weekly physiotherapy, dietician and podiatry clinics for patients. Recently the health board has stopped providing these weekly services but did not inform the practice directly of these changes. Patients will now need to travel to Benbecula in order to access these services. There is a health visitor based in Benbecula who visits the practice once a week.

The practice has an excellent and engaged practice patient group (PPG) which was set up by Dr Wheeler when he first started working in the practice. The PPG group have been instrumental in supporting the ongoing campaign to protect the practice's dispensing role.

The practice also has a dedicated room for GP trainees to use. One of Dr Wheeler's interests is GP training and when he became a partner at the practice he was keen to take on trainees. After Dr Wheeler had taken the time to train as a trainer the practice was informed by the Deanery that they had been turned down as a training practice as they could not provide 90 patient contacts per week. The practice does take on medical students for training, usually from Aberdeen University or University College London.

Training and recruitment processes have been centralised under the Modernising Medical Careers programme and this has caused some restrictions and inflexibility in terms of rural general practice. A one size fits all approach does not reflect the unique challenges for rural general practice, particularly in very remote areas. Could some flexibility be introduced in recognition of this?

It was noted that the introduction of revalidation will have an impact on locum availability as this will reduce the number of retired GPs who may undertake some locum sessions throughout the year, providing holiday cover for example in remote practices. Such individuals may opt not to go through the revalidation process and will therefore stop all clinical work.

What would solve out of hours cover here?

- Getting support right for community mental health – there is no community psychiatric nurse for psychiatric problems or issues with psychotic patients out of hours.
- Radiology services could be improved and would help in instances such as road traffic accidents. Out of hours even relatively small issues such as dislocated shoulders can prove challenging without radiology support.
- The hourly pay for out of hours is much lower than that provided to GPs in other areas such as Stornoway. This makes it very difficult to get locums to take shifts here. Should pay be judged purely on caseload – there is less pay here but equal service need.
- GPs are being used as a provider of last resort here. The Western Isles hospital model relies heavily on specially trained nurses and extended role ambulance paramedics but nurses here are not trained to fill this gap. This also poses a recruitment problem.
- The out of hours solution developed on Arran was helpful. The catalyst for this was that the GPs had a unified voice and this led to a system with both better pay and support. Replicating this model may not be feasible but what lessons can be learned from this successful outcome?

Visit to Uist and Barra Hospital

On the 12 July the group visited Uist and Barra Community hospital and were given a tour of the facilities by GP (dermatology) Dr Kate Dawson, GP (surgeon) Dr Andrew Senior, Dr Frances Tierney (GP and anaesthetics) and Macmillan Nurse Lorna Senior. Facilities at the hospital include:

- Small A&E treatment room
- Out of Hours GP clinic and acute service rooms
- Rooms for allied health professional services
- Radiology room with full PACs facilities.
- Endoscopy room and small recovery ward
- Operating theatre and anaesthesia room
- Labour/maternity room
- 29 beds including care of the elderly services
- Palliative care unit including relatives' room

During the tour the following points were noted:

- Approximately 150-200 endoscopy services were provided at the hospital each year – this is just on the boundary of required figures.
- Despite having the appropriate facilities, x-rays cannot be performed out of hours due to lack of availability of a radiographer. Air ambulance service is often used for road traffic accidents and other emergencies.
- Tourism does not create an major increased demand for A&E services.
- There is no duty pharmacist in the hospital so out of hours dispensing is very limited.
- The hospital is moving to an electronic records system with integrated record keeping.
- Operating theatre is seldom used due to the fact that an consultant anaesthetist must be present in person during procedures but this is not feasible.
- Obstetrics service is midwife led – there are about 30 deliveries per year and GPs are on hand for technical assistance if needed. Only low risk pregnancies are eligible for labour on the ward. First time labours are not allowed at the hospital and women must travel to the mainland before they reach term if complications or risk may be likely during delivery.
- There is no nursing home on the island so the hospital provides this facility. Continuous care is expensive so it is difficult to get a bed.
- Ward occupancy rate is normally around 70%.
- Psychiatry is a big problem here out of hours – the hospital is a designated area of safety but 2 community psychiatric nurses need to be with a sectioned person in order to allow air ambulance transportation.
- Dr Dawson informed the group that she was keen to develop a patient safety forum to move forward issues identified through significant event analysis and to take on changes. This would build links with the Risk Manager.
- Patient travel cost is covered by the Scottish Government but clinician and staff travel is covered by the health board.

It was noted that changes in Stornoway to the out of hours services have been radical and successful but have only happened in the past 5 years and so are relatively recent. It was felt that given these changes it now feels as though Benbecula is getting left behind. It was felt that out of hours services here would soon become a big problem with no discernible solution – and agreed that local GPs are well placed to develop a solution to these issues. If

Healthcare Improvement Scotland started looking at community hospitals would this be of help?

We also received an update on the current GP services in Benbecula provided at Griminish Surgery at which Dr Dawson, Dr Tieney and Dr Senior are partners alongside Dr Mark Johnson. Most of the practice's patients are based in Benbecula but there are 200 in North Uist and some as remotely as Eriskay. Patients stay on the list despite the distance as they appreciate the continuity of care that comes from knowing their GP. The practice is a dispensing practice and currently dispenses to around 2500 patients. GP sessions are structured as ten minute patient appointments with 5 minute gaps.

In Benbecula there are ongoing recruitment issues. The outdoors lifestyle is a winning factor but the remoteness of the island is a very off-putting factor for some as there are other environments that have the same lifestyle opportunities but which do not suffer from the same distance issues. New starters are less likely to want to take on out of hours care and the out of hours services relies on having GPs with their own specialisms. On the island GPs with specialist training are all due to retire in the next ten years.

Dr Frances Tierney is passionate about training and the practice takes medical students as well as school leavers. It was felt that it was important to encourage people to consider remote and rural medicine at undergraduate level as people have epiphanies as undergraduates about where and how they want to work.

There are current issues with the practice premises which restrict teaching and training. There are only two consulting rooms for four partners. When the hospital was originally built it was intended for the GP Practice to be based on site but due to funding issues this did not go forward. It is hoped that eventually funding will be found to allow the practice to be co-located with the hospital but this is not seen to be a current priority.

The group also received an update on the ongoing issues relating to the dispensing status of the practice, which as in Lochmaddy, is at risk due to applications for pharmacy services. It was asked whether the health board are aware of the special circumstances of dispensing practices on the island and suggested that a formal letter outlining this be made to the health board around this and other structural concerns affecting services here.

It was agreed for Dr Dawson to share information about the ongoing dispensing issues with Dr Hal Maxwell as these may be able to act as a template for practices dealing with the same issues.

Discussions relating to dispensing issues included:

- Professor Pringle informed the group that his practice had started its own pharmacy and would be able to put Dr Dawson in contact with a colleague to advise regarding the practicalities of this.
- Does a pharmacist have to be on site or can a pharmacy technician dispense?
- Running costs for a pharmacy can be high as there would need to be high stock levels due to the remote location.
- Should pharmacy start thinking about utilising modern technology such as video links in order to provide services? Could a pharmacist in person be a retrograde step in this context?
- The outcome of the Wilson Report about pharmaceutical care in the community should be out soon. Dr Gillies agreed to chase this up and update appropriately.

- A simple change to the law on dispensing doctors to recognise that dispensing practices do provide suitable pharmaceutical services would greatly improve the situation.
- Dr Dawson agreed to contact Dr Brian Keighley, BMA Chair with any further problems.

It was suggested that the local GPs should consider writing with specific concerns and arrange a meeting with the Medical Director and Chief Executive of the Health Board setting an agenda with the aim of suggesting solutions to current issues. The community hospital is a fantastic resource and should be utilised to its full potential and not seen simply as part of the district nursing team services.

The recent changes to CHP structures and the introduction of Health and Social Care Partnerships were discussed. There is no CHP covering the island and it was assumed that there would be one Health and Social Care partnership created to cover the whole of the Western Isles. It was noted that the current healthcare situation and structures worked very differently across the 8 regions here and that this must be recognised. It was felt that this had the potential to be a big change in how healthcare was structured here and that there was an opportunity to change things for the better by building on dynamic GP leadership and networks. Activities are in place to start to take this forward – monthly health and social care meetings are held with colleagues and Dr Dawson regularly engages with colleagues when in Stornoway in order to build links and raise the profile of issues here. Dr Dawson is also working to build links with local GPs in order to get a clear understanding of local workforce pressures and future trends.

Reception with GPs from the Southern Isles

In the evening the group attended an informal dinner at Langass Lodge accompanied by the following group of GPs from the Southern Isles from whom we received a very warm welcome:

- Dr Stephen Bird
- Dr Kate Dawson
- Dr Louise Hodgson
- Dr Mark Johnson
- Dr Danny McGhee.
- Dr Barbara Pilkington
- Dr Andrew Senior
- Dr Francis Tierney
- Dr Gerry Wheeler
- Dr Karen Wilson
- Dr Amanda Woods

For several GPs this was the first opportunity for them to meet with other colleagues and the opportunity to mix and network with colleagues and College representatives was greatly valued with several GPs commenting that they appreciated the visit and its timing. The meal also allowed RCGP representatives to get further feedback from local GPs in relation to ongoing issues such as recruitment and retention.

Monday 15 July

Visit to Carloway Surgery, Isle of Lewis

Professor Pringle and Dr Gillies, accompanied by Nickie Pringle visited this surgery en route back to Stornoway airport. The practice has five surgery premises over a large area covering about 5000 patients, with two GP partners and four salaried GPs. We also viewed Dr Margaret Ferguson's impressive portraits painted over many years and more information about the paintings can be found at http://margaretfergusonart.com/

Actions Agreed

- LR to update University colleagues on the suggestion for facilitation of a feedback process for medical students to share information about successful placements with each other.
- KD to email updates on EMREC transition to MP for info.
- JG to chase up Wilson Report and update KD as appropriate
- JG to feed back training issues to NES
- HM to keep in contact with KD regarding dispensing issues

Next Steps

- JR to complete feedback report and share with RCGP representatives for approval.
- HM to develop a paper analysing findings from the visit with suggested next steps for discussion at Scottish Council in September
- Regular communication to be established with Western Isles GPs to keep the dialogue going.
- HM and JG to update Dr Malcolm Ward, Chair of the Rural Forum on the outcome of the visit and agreed next steps

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