Annex B

Extract from *Rural Fund Discussion Paper*

Rural Fund Spend 2018/19

The following table sets out how funding to support rural general practice has been spent in 2018/19.

Name	Fund
Scottish Rural Medicine Collaborative – 2nd phase	£230,000
Relocation package (excludes salary costs)	£200,000
Golden Hello	£400,000
Support to Dispensing Practices	£500,000
Funding to National Services Scotland to support SWAN IT in rural practices	£150,000
Rediscover the Joy of General Practice	£180,000
Reflect and Rejuvenate	£20,000

Scottish Rural Medicine Collaborative (SRMC)
Continuing this project from 2016 – 2018, SRMC seeks to develop a unified recruitment and retention strategy, create a community of Scottish Rural GPs and the wider multi-disciplinary team, organisations and health boards to provide mutual support through education and professional networking.

Relocation package
The GP relocation package, to support GPs who wish to relocate to rural areas, has increased from £2,000 to £5,000 and widened eligibility from island practices to all 160 remote and rural practices.

Golden Hello Scheme
A Golden Hello payment is payable to a GP, who takes up a post in either a practice in a location attracting payments for remoteness and rurality or the post is in a practice with a patient list attracting payments for deprivation

Support for Dispensing Practices
Through the work of the Dispensing Short-Life Working Group, funding is to be used to cover training costs for dispensing staff. Funding will also be provided to dispensing practices to rollout Quality Improvement activities around interventions for patients on Non-steroidal Anti Inflammatory Drugs (NSAIDs) with support from Healthcare Improvement Scotland (HIS). Finally funding will be provided to support the costs associated with implementing the Falsified Medicines Regulations which come into effect in February 2019.

Funding to National Services Scotland to support SWAN IT in rural practices
Funding is to be provided to National Services Scotland (NSS) to improve secure internet connections for rural GP practices.

Rediscover the Joy of General Practice
A collaboration of four rural Health Boards, Shetland, Orkney, Western Isles and Highland, to develop a scheme to attract experienced GPs to work in rural practices on a flexible basis for a maximum number of weeks a year. GPs employed on the scheme would be provided with BASICs training and mentorship.

Reflect and rejuvenate – a project to support GP Retention
A collaboration of rural health boards to encourage urban and rural GPs to take part in 1-3 week exchanges. This fund would support the travel and accommodation expenses of GPs taking part in exchanges. Administration would be provided by the NHS Shetland HR team, set up to support Rediscover the joy of general practice (above)

Extract from *Finding Rural Solutions Paper – (Draft) - 18/02/19*

- **Potential Outputs**

Outlining Potential Different Models for Service Delivery
It appears that some believe that a "centralised model of service delivery" is the preferred model. Providing different case studies, perhaps even with a hypothetical case study, might help some think more creatively about how care could be delivered in rural communities. RGPAS have called for a discussion framework for GPs with HSCPs to facilitate the development of more appropriate models. The MOU already provides a framework and perhaps the provision of alternative models might help facilitate more creative discussions.

International Study of Rural Primary Care Models
Commission an international study to look at different models of rural primary care to inform further development of appropriate models.

Describing Rural Practice
Describing the additional roles and functions undertaken by rural Primary Care might have a number of benefits including:

1. A broader understanding and recognition of the additional roles Rural Primary Care teams undertake and help rural practitioners to feel more valued.
2. The development of a framework to delineate the skills and knowledge required and allowing the development of educational programmes. This would support:
    - Recruitment by allowing potential applicants to use the framework to delineate their educational needs and access appropriate training.
    - Retention through the provision of remote access training programmes, focussed on the educational needs of rural practitioners.

Comparative Study of the Overall Health Care Costs of Rural and Urban Populations
This would provide evidence as to whether rural practice provides more cost effective care. If this was found to be the case then further research into the factors that allow this could help develop effective models of care in both rural and urban environments.

Developing Trust and Collaborative Working between Rural Practitioners and HSCPs
The SG team has become aware of a lack of engagement and trust between rural GPs and HSCPs/GP Sub / LMC. Whilst some GPs are very engaged, others are not and feel ill informed and disempowered. There are no doubt many reasons for this, but geographical separation seems to contribute to the problem.

The Clusters have been charged with ensuring quality within General Practice. If the MDT is to become more central in the delivery of Primary Care, then MDT representation and input will be important. Do the Clusters have a role in ensuring equitable distribution of resource?

For the Rural Primary Care Team suggested in this paper to work, despite members having different employers, there needs to be a shared acceptance of responsibility between the different employers (GMS practices, HSCPs, SAS). One of the strengths of small teams being employed by GMS practices is that when a member of staff is absent the entire team works together to make up for the shortfall. In rural practices this is particularly important when to provision of locum staff can be particularly problematic. How can the same degree of cohesion be developed and maintained in teams where members have different employers?

- **Potential Rural Fund Projects**

Developing Different Models for Service Delivery in Rural Areas
There appears to be a widespread belief that a "centralised model of service delivery" is the preferred model. Providing different case studies, perhaps even with hypothetical case studies, might help more creative thinking around how care could be delivered in rural communities.
RGPAS have called for a discussion framework for GPs with HSCPs/HBs to facilitate the development of more appropriate models. The MOU already provides a framework but the provision of alternative models might help facilitate more creative discussions.

1. Creating case studies of current models
2. Creating "dummy" case studies outlining different potential models.
3. Providing guidance to HSCPs/HBs around the development of different models.

Gain a better understanding of which practices/Clusters/ HSCPs/HBs have particular issues around this and provide support to allow better engagement which might include:

1. Additional support to small rural HBs/HSCPs to:
    a. Employ shared project managers.
    b. Forge closer links with other HB project teams to learn from their experience.
2. Organise a rural event to look at learning from other HBs/HSCP and alternative models of delivery. Attendees might include

a. Primary Care Managers / PCIP Implementation Teams

b. GP Sub Chairs

c. Innovative rural practices with alternative models of care

d. Rural Group Members

Recruitment and Retention

Recruitment and retention of GPs and the MDT is essential for the successful implementation of the Contract. implementation of Phase 1 will not succeed without significant recruitment. Practices with recruitment issues do not have the capacity to engage with PCIP co-production and feel disenfranchised from the process.

Initial indications are that the "Rediscover the Joy of General Practice" project is going to succeed in recruiting in excess of 20 GPs to work within the Islands and Highland. It has generated a lot of interest. Once recruitment of the first tranche is complete it will be important to take stock of lessons learnt from the initial campaign and then move swiftly to recruiting a Scotland-wide Rural GP Support Team. It is likely that this will attract more GPs to work within a team, using the resources of all the rural HBs to publicise and aid recruitment. Discussions with applicants indicate that it is the joined up, collaborative approach of the project and the sense of hope that it brings that has attracted them to apply.

NHS Scotland needs to continue developing and publicising our collaborative and values based approach to working. Strong relationships, team working and fostering a mutually supportive environment should become a central part of our working and recruitment campaign. Therefore, supporting the development of both formal and informal supportive networks across rural practice should be valued as an output from the rural group.

We have heard and seen collaborative working between practices and suggestions of how bigger practices could support smaller practices through exchanges, supporting practitioners to maintain skills, such as coil insertion, and involving peripheral practices in their practice education programmes through VC. This could be supported through a fund focussed on meeting additional expenses incurred through collaborative working and providing any infrastructure requirements. Collaborative working should be encouraged to grow organically rather than being contracted, allowing freedom of development. This work would be an extension of the "Reflect and Rejuvenate" fund, established to support travel and accommodation expenses for practice exchanges.

Early indications are that "Rediscover the Joy" will succeed in recruiting to the Rural GP Support Team. Once the first tranche of recruitment to the Island and Highland HBs is complete (early April) a rapid review of this initial test of change will be undertaken and then we will move to a second recruitment campaign for a national Rural GP Support Team, bringing in the other rural HBs. Careful consideration should be given as to how the team should be used to optimise benefit. Utilising the team to provide capacity and headspace for rural GPs to engage in planning and having time to work alongside HSCP/HB colleagues could be particularly beneficial.

Given the central importance of recruitment and retention to the sustainability of Scottish General Practice, when considering solutions for rural practice we need to clearly delineate the relationship and function between the Rural Group and SRMC. The third important group that needs to be included in this work are the Primary Care Leads. It will be important to develop a clear overarching strategy around rural Phase 1 delivery, recruitment and

retention. For a lasting solution is to be found for rural practice a clear national vision for the delivery of rural primary care needs to be developed and jointly held by GPs, Primary Care teams, HSCPs, HBs, BMA and SG.

Describing Rural Practice

Describing the additional roles and functions undertaken by rural Primary Care might have a number of benefits including:

3. A broader understanding and recognition of the additional roles Rural Primary Care teams undertake and to help inform data collection for Phase 2.

4. The development of a framework to delineate the skills and knowledge required and to support the development of educational programmes. This would support:

    - Recruitment by allowing potential applicants to use the framework to delineate their educational needs and access appropriate training.

    - Retention through the provision of remote access training programmes, focussed on the educational needs of rural practitioners.

Infrastructure

We have consistently heard about the inadequacy of broadband connections to rural practice. This not only hampers the day to day delivery of care, but is holding back innovative ways of delivering MDT input to rural practices. Poor connectivity limits confidence in IT solutions to improve delivery through applications such as Attend Anywhere.

Poor quality VC significantly hampers the ability of rural GPs to effectively contribute to management meetings or to develop mutually supportive networks with distant colleagues.

We saw evidence of poorly resourced IT provision with old hardware and poor IT support to rural areas. Poor connectivity and software prevent the effective use of IT on home visits with data needing to be entered on return to the surgery. This is cumbersome and time consuming and also limits, or even precludes, the wider MDT contributing to the patient record.

Many rural GP premises are HB owned. We have seen examples of fantastic facilities which lend themselves well to the development of MDT working, but we have also seen inadequate premises that do not provide an efficient working environment and stand as a significant barrier to MDT working. Inadequate premises also have an impact on recruitment and retention. Capital funding for HB premises development is required to allow transformation of primary care in some areas.

Comparative Study of the Overall Health Care Costs of Rural and Urban Populations

A comparative study of the overall cost of primary and secondary care per head of population for rural and urban populations could provide important insight into the true costs of healthcare. It might lead to further areas for research to understand what factors underlie any differences which could then inform healthcare policy.

We also heard from some that they fear that the direction of travel is to move to salaried models of GP provision.

Developing Trust and Collaborative Working between Rural Practitioners and HSCPs
We have witnessed a lack of engagement and trust between some rural GPs and HSCPs/GP Sub / LMC. Whilst some GPs are very engaged, others are not and feel ill-informed and disempowered. There are no doubt many reasons for this, but geographical separation seems to contribute to the problem.

A number of GPs have suggested that the Clusters could have a role in ensuring equitable distribution of resources between practices and in ensuring that the MDT resource is coordinated from a local clinical perspective, rather than from a managerial HSCP/HB perspective. This could help build confidence and trust.

International Study of Rural Primary Care Models
Commission an international study to look at different models of rural primary care to inform further development of appropriate rural models of healthcare provision.

Extract from BRIEFING FOR CABINET SECRETARY FOR HEALTH AND SPORT - *for Public Petitions Committee – 09.05.19*

Annex D

Q&A

Rural Group

How is the Rural Working Group addressing the issues raised by RGPAS around the practical implementation of the contract?

- The Rural Working Group is gathering case studies that demonstrate effective implementation of the new contract in the face of rural challenges.

- The Group has sought to better understand recruitment and retention issues, and is collating a range of successful measures at local, regional and national levels. The intention of the Group is to capture that work in a year 1 report to be published later this year.

How will the Scottish Government ensure there is better engagement and feedback between the Rural Group and rural GPs?

- The Chair of the Rural Group and his team have carried out a wide programme of engagement with rural GPs.

- We value the views and contributions of rural GPs, and the Rural Working Group will continue to engage with rural GPs across Scotland as it continues this important work

Implementation

RGPAS anticipate that services will need to be curtailed as a result of the current contract making for unsustainable conditions. How will the Scottish Government prevent this*?*

- The Memorandum of Understanding, published alongside the 2018 GP contract clearly states that GPs are involved in service planning locally through their GP sub-

committees and they should be involved in all aspects of developing local Primary Care Improvement Plans. We are already seeing that collaborative relationships and trust are being built locally which did not exist before the new contract, and we must count that as a success.

- To reiterate this, on 14 March 2019, we issued guidance to Integration Authorities around our expectations for their revised Primary Care Improvement Plans due over the next month, including encouraging them to explore flexibility to deliver redesign in rural areas

The recent RGPAS survey raises concerns about the effectiveness of service redesign under the new contract, specifically in the Vaccination Transformation Programme. How is the Scottish Government protecting services in rural communities?

- The Scottish Government recognises that in many communities, particularly those in remote and rural communities, it may be safer for GPs to continue providing certain services to avoid fragmentation of care. We expect Integration Authorities to work with local GPs to determine the safest and most effective way to deliver services and evidence, where appropriate, if it is determined that services should continue to be provided by a GP.

What examples are there that demonstrate effective implementation of the new contract in the face of rural challenges?

- A number of Health and Social Care Partnerships are developing innovative solutions to address rural challenges. For e.g. Pharmacy Anywhere model in NHS Highland successfully addressed its recruitment difficulties, and enabled pharmacists to work from any location.

- NHS Dumfries and Galloway identified pharmacy resource gaps within each Locality, and successfully recruited pharmacists and pharmacy technicians to these gaps.

- Similarly, 71% of patients seen have accessed the Advanced Physiotherapy Practitioner directly via reception, successfully reducing demand on GP appointments in Drumnadrochit Medical Practice.

How will the Scottish Government ensure there is a joined-up approach to rural healthcare going forward?

- We are currently in discussions with the Scottish Rural Health Partnership, which is part of the University of Highlands and Islands, about the potential of establishing a **Centre of Excellence for rural healthcare**. This centre would look at gathering knowledge and sharing information across rural areas in Scotland in a co-ordinated manner rather than a piecemeal approach. It would also consider the whole rural healthcare system rather than focus specifically on one aspect of care. I am happy to keep the Committee updated as these discussions progress.

<u>Remote Practice And Patient Concerns</u>

Did the Scottish Government conduct an adequate impact assessment around island and rural proofing the contract?

- An Equality Impact Assessment (EQIA) supporting the new GP Contract and accompanying service redesign was published alongside the Contract regulations in April 2018. This EQIA refers to a number of patient and community engagement events that took place to seek feedback on potential positive and negative impacts of these policies. The EQIA also drew from existing national data sets, such as the Health and Social Care Experience Survey, to evidence supporting conclusions that show the direction of travel set out in these policies was in line with wishes of patients, carers and communities.

How did the Scottish Government ensure people in rural populations were kept informed of proposed changes from the GMS 2018 Contract?

- The Scottish Government commissioned the Health and Social Care Alliance to carry out a series of engagements with patients and patient representative groups across Scotland, including a wide range of rural communities.

- This culminated in the publication of the "Your GP and You" report. This report provided valuable feedback to Health Boards, Integration Authorities, the Scottish Government and general practice on how the new GP contract might be implemented to best address the needs of patients across Scotland.

How does the Scottish Government address remote practice and patient concerns raised in relation to the new GP contract?

- Integration Authorities have a statutory duty to engage with local patient and community groups when designing local services.

- On 14 March 2019, we published guidance for the second iteration of Primary Care Improvement Plans, restating that patient engagement must be a key part of these revised versions. These revised Plans will be shared with us in the coming weeks, and once received, we will work with Integration Authorities to ensure they are meeting this requirement.

- I want to reassure the petitioners and the committee that we will ensure Integration Authorities are engaging with the remote and rural population, and are addressing their concerns in relation to the new GP contract. Because only with that genuine involvement of GPs, health professionals and patient groups will we improve care for everyone, everywhere in Scotland.

Q) How will patients know when it is best to see the GP or another member of the primary care multidisciplinary team?

- GPs and their practice staff already provide advice and referrals to other services including community optometry and physiotherapy. However, no one who needs to see a GP or is unable to choose an alternative will be forced to go elsewhere. We will continue to ensure that will be trained to refer patients to the right person at the right time and the right place.

- In 2018/19 we have invested £2.5 million to provide additional training to develop the skills of the whole practice team, and this includes £500,000 to ensure receptionists and practice managers can access training to refer patients to the most appropriate source of help or advice.

Q) What steps did the Scottish Government take around Island and Rural proofing the contract?

- The Scottish Government undertook an Equality Impact Assessment (EQIA) to ensure the needs of people are taken into account during the development and implementation of the 2018 GMS Contract.

- An EQIA supporting the new GP Contract and accompanying service redesign was published alongside the Contract regulations in April 2018. The Islands (Scotland) Act came into force in May 2018, a month after we had negotiated the contract.

- However, as part of this EQIA, we have considered the potential impact of the 2018 GMS Contract in rural areas. As a result of this assessment, in 2018/19 we invested £7.5 million in in GP recruitment and retention, including support for rural GPs.

GP Numbers

How will the new contract help GP recruitment and retention?

- We are committed to increasing the number of GPs in Scotland by at least 800 over the next decade.

- Our £7.5 million Recruitment and Retention Fund is supporting rural general practice through a variety of means.

- The GP contract package provides specific support to rural GPs including an additional £850,000 for relocation and recruitment costs in 2018/19.

- We have increased GP relocation packages from £2,000 to £5,000, as well as expanded the eligibility for £10,000 Golden Hello incentive payments from island practices to all 160 remote and rural practices.

Update on Sir Lewis' Review of out-of-hours services on Skye?

- NHS Highland is building a new hospital 'Hub' - a health and social care resource centre in Broadford to replace the existing Dr MacKinnon Memorial Hospital. This is part of a wider redesign of services across the area, including developing Portree Community Hospital as a 'Spoke'. The new modern facility and staffing arrangements at Broadford would allow out-of-hours medical cover to be co-located with all in-patients beds on the island 24/7, provide safer out-of-hours nursing cover, co-location with local health centre and set-up a main base for all staff groups.

- The Full Business Case, totalling an additional £1.5 million of revenue funding, is due to be submitted to the Capital Investment Group (around May) and if approval is given, construction will start later in the year.

Extract from *Rural Core Brief*

Rural-Proofing The Contract

Lines to take:

- No GP practice in Scotland has lost funding due to the new contract and health board funding will be unaffected. The GP Practice income guarantee is a long-term feature of GP contracts and will be in place as long as it is needed.

- There will be no cut to any Health Board's funding due to the new contract.

- The GP contract package provides specific support to rural GPs including an additional £850,000 for relocation and recruitment costs in 2018/19.

- We have increased GP relocation packages from £2,000 to £5,000, as well as expanded the eligibility for £10,000 Golden Hello incentive payments from island practices to all 160 remote and rural practices.

- The contract allows GPs, local communities and other healthcare service providers to take a more active role in how their Primary Care is delivered, and is accompanied by considerable investment to help implement plans safely and effectively. For these reasons we consider the contract to be rural proofed.

- We are taking a number of steps to improve and stabilise pay for all GPs:

    - From April 2019 we have introduced a minimum earnings expectation of £86,430 (whole time equivalent) for all GP partners.
    - In 2018/19 all practices received a 3% pay uplift. This uplift, and future uplifts, are additional to the income and expenses guarantee. This means that practices receiving the guarantee had a pay rise in 2018/19, (as did all other practices).
    - The next phase of the GP contract will see negotiations with the BMA over the introduction of a new GP income range comparable to that of consultants and direct reimbursement of agreed expenses.

Dispensing Working Group

The group meets on a three-monthly basis in either Edinburgh or Glasgow. Minutes of the meetings are in the Documents section at the bottom of this page.

Petition PE01698: Medical Care in Rural Areas

Lines to take:

- GPs from rural areas are core to the Working Group's composition, the group also includes representatives from a number of NHS Boards and Integration Authorities in remote and rural areas.

- No practice has or will lose funding as a result of the new GP contract. The new Scottish Workload Formula gives greater weight to older patients and deprivation compared to the workload-related weightings of the original Scottish Workload Formula (SWF).

- As local service planners, HSCPs are statutorily responsible to ensure they are engaging with local patient and community groups. On 14 March, we published guidance for the second iteration of PCIPs, reiterating that patient engagement must be a key part of their planning process going forward.

Background:

A petition has been lodged with the Scottish Parliament calling on the Scottish Parliament to urge the Scottish Government to:

- Ensure strong rural and remote GP representation on the remote and rural short life working group, recently established as part of the new GP contract for Scotland.
- Adjust the Workload Allocation Formula (WAF) urgently in light of the new contract proposals to guarantee that both primary and ancillary services are, at least, as good as they are now in ALL areas so patients do not experience a rural and remote post code lottery in relation to the provision of health care.
- Address remote practice and patient concerns raised in relation to the new GP contract.

On 21 December 2018, we published a response to the Petition PE1698 assuring the committee that the views of patients, their families and carers are highly valued by the Scottish Government and will continue to be sought as implementation plans progress. We are happy to provide any further information the committee requests.

As of 01 April 2019, the petition has 122 signatures. Written submissions have been lodged to the Public Petitions Committee, and the Committee have written to the Scottish Government asking for further information on two occasions, the last response issued on 21 December 2018. The petition continues to receive written evidence.

Extract from *First Minister Questions 23 April 2019*

GPs

- Scottish Greens call for funding to halt fall in GP numbers – Party Debate 24 April
- GPs concerned that new GP contract will result in a drop in immunisation rates in rural areas - The Scotsman, 15 April and BBC News

Top Lines

- Our new GP contract is aimed at tackling GP workload and investing in the wider primary care team, and we are seeing encouraging progress across the whole country.
- We are continuing to increase our investment in primary care, as we shift the balance of care towards the community.
- In the year to come, we plan to exceed the £110 million we invested in the contract and wider primary care reform in 2018-19.
- By the end of the Parliamentary period our additional investment in direct support of general practice will be £250 million.

GREEN PARTY DEBATE ON ADDRESSING SCOTLAND'S GP RECRUITMENT CHALLENGES.

- Alison Johnstone has lodged a motion for a debate in Parliament on Wednesday 24 April calling for an urgent review of GP recruitment, investment, resources and funding.
- The *Herald* reported that the Scottish Government amendment which said GP support and reimbursement would be 'considered in partnership' with doctors and medical leaders was defeated by 60 votes to 61.

- We know there are challenges in some areas with GP recruitment and retention. That's why we have:
  - Published the first Primary Care workforce plan which set out a comprehensive strategy to tackle some of the GP recruitment and retention challenges.
  - Will soon be publishing the integrated workforce plan that will support workforce planning with a focus on understanding the future workforce requirements.
  - Developed our unique Scottish GP contract, which tackles workload, reduces risk to GPs, and stabilises GP income.
  - Committed to recruiting 800 more GPs (already up by 75 GPs this year), by a range of targeted interventions at every stage in the GP career from education through to retirement.
  - Invested to build the multi-disciplinary team in primary care, to tackle workload and address the root causes of GPs leaving.
- We are committed to investing £250 million more by the end of this parliament in direct support of general practice, as part of our commitment to increase community investment by £500 million by 2021-22 and shift the balance of care.
- We will continue to review and improve GP recruitment and retention initiatives in collaboration with the Scottish General Practitioners Committee of the BMA.

Extract from *First Minister Questions 29 April 2019*

GPs

ISSUE:

- **GPs concerned that new GP contract will result in a drop in immunisation rates in rural areas - The Scotsman, 15 April and BBC News**
- **Dozens of GPs close down in North-East and Highlands & Islands – Conservative research reported in Press & Journal, 29 April 2019**
- **Parliamentary debate 24 April on GP recruitment and investment – SG amendment defeated**

Top Lines

- The new GP contract tackles GP workload by a managed transition of tasks such as vaccinations to other members of the primary care team.
- No service will be transferred unless it is safe and sustainable to do so.

- Record number of GPs in Scotland
- By the end of the Parliamentary period our additional investment in direct support of general practice will be £250 million.
- The new GP contract tackles GP workload by a managed transition of tasks such as vaccinations to other members of the primary care team.
- No service will be transferred unless it is safe and sustainable to do so.

RURAL VACCINATIONS – Dr Philip Wilson, a GP and professor of rural health care, opposed to the contract, claimed there's potential risk to patients from vaccinations changes

- The Rural Working Group, chaired by Sir Lewis Ritchie, is considering the issues raised by GPs in rural areas to ensure the new contract is delivered safely and meets the needs of our rural communities.

PRACTICE CLOSURES – P&J reports on Conservative party press release that 25 practices have closed in north Scotland since 2008 - 14 in Highlands and Islands and 11 in Grampian

- We have a **record number of GPs** working in Scotland. The number (headcount) of GPs in Scotland in 2018 was 4,994, a rise of 75 GPs from 4,919 in the previous year (after remaining around 4,900 for the previous 9 years).
- The number of trainee GPs in 2018 was at its highest for over a decade.
- Trend over a number of years has been towards **fewer, larger practices**.
    - The number of practices in Scotland decreased by 8% since 2008, reflecting a trend towards fewer, larger practices.
    - The number of patients registered with GP practices continues to rise slowly year on year.
- This does not mean a reduction in service. Patient safety is always the priority when a change to practice provision is proposed.

GREEN PARTY DEBATE ON ADDRESSING SCOTLAND'S GP RECRUITMENT CHALLENGES.

- **Alison Johnstone motion Wednesday 24 April calling for an urgent review of GP recruitment, investment, resources and funding was passed. SG amendment defeated.**

- We know there are challenges in some areas with GP recruitment and retention. That's why we:
    - Published the first Primary Care workforce plan which set out a comprehensive strategy to tackle some of the GP recruitment and retention challenges.
    - Will soon be publishing the integrated workforce plan that will support workforce planning with a focus on understanding the future workforce requirements.
    - Developed our unique Scottish GP contract, which tackles workload, reduces risk to GPs, and stabilises GP income.

- Committed to recruiting 800 more GPs (already up by 75 GPs this year), by a range of targeted interventions at every stage in the GP career from education through to retirement.
- Invested to build the multi-disciplinary team in primary care, to tackle workload and address the root causes of GPs leaving.

- We are committed to investing £250 million more by the end of this parliament in direct support of general practice, as part of our commitment to increase community investment by £500 million by 2021-22 and shift the balance of care.
- We will continue to review and improve GP recruitment and retention initiatives in collaboration with the Scottish General Practitioners Committee of the BMA.

Extract from SCOTTISH GREEN PARTY DEBATE – ADDRESSING SCOTLAND'S GP RECRUITMENT AND RETENTION CHALLENGE

WEDNESDAY 24 APRIL - BACKGROUND BRIEFING

Annex B

11. Specific outcomes from Sir Lewis Ritchie's group on rural GP;

The Rural Group is working on delivering the following outcomes:

- **Case studies to support implementing the new GP Contract in rural Communities.**

We recognise that our rural communities face unique challenges that require creative solutions to overcome. That is why in its first year, the Rural Group is focused on promoting and sharing learning from rural communities where primary care redesign is successfully being implemented by embracing collaborative working or innovative solutions.

The Group is refining this learning into a number of case studies that will be shared with service providers and published online in due course. These case studies will highlight locally driven innovative solutions to deliver primary care redesign in rural areas.

- **Supporting the Rural Fund and informing its use in 2019/20**

The Rural Group is providing expert advice to inform what projects the fund supports. This is directing investment into GP recruitment, retention and sustainability in rural communities.

The Primary Care Division within Scottish Government has profiled £2 million Rural Fund to be spent in 2019/20 and beyond. Some of the funds set out below (SRMC, relocation package, Golden Hello and support to dispensing practices) will be recurring funding, and the Rural Group is considering how best to use the remaining unallocated resource. Funding provided in 2018/19 has been allocated as set out below:

Remote and Rural Fund - 2018/19	Funding
Scottish Rural Medicine Collaborative supporting a range of recruitment and retention projects	£200,000
GP for GP Scheme (SRMC) supporting rural retention	£30,000
Relocation support for GPs moving to rural posts.	£200,000
Golden Hello recruitment incentives	£400,000

Support for Dispensing Practices (to align with Community Pharmacy initiatives)	£501,000
Highland and Island recruitment – Reflect and rejuvenate	£20,000
Highland and Island recruitment – Rediscover the joy in General Practice	£182,206
SWAN (IT/digital improvement role out to rural boards – via NSS)	£150,000
Total	**£1,683,206**

- **Informing the work of the Scottish Government, joint SG and BMA negotiations, and of the GP Contract Oversight Group which includes the BMA, Boards and IAs.**

As set out in the Terms of Reference for the Rural Group, its expert advice informs the views of joint discussions and negotiations taken forward by the Scottish Government and Scottish General Practitioner's Committee of the BMA.

The group's advice contributed to the development of guidance recently shared with Integration Authorities in March 2019. This guidance reiterated and further developed the Scottish Government's and BMA's shared recognition that there will be some areas of Scotland, particularly rural, where for reasons of patient safety it is sensible for GPs to continue to deliver some services. The guidance empowers GPs, Health Boards and Integration Authorities to work together to decide where it is appropriate to do this, by agreeing options appraisals.

Extract from *Briefing for* BRIEFING FOR CABINET SECRETARY FOR HEALTH AND SPORT - *Health and Sport Committee*

ANNEX A

SUMMARY PAGE

Purpose of meeting: The Remote and Rural General Practice Working Group has invited you to attend a workshop the group is holding to reflect on the first year of progress in implementing the new contract, to discuss ways of implementing a flexible model of service redesign in rural areas, and consider a work programme for 2019/20.

The Cabinet Secretary has been invited to provide a five minute opening speech before answering questions from the members of the Group. A speaking note is set out in **Annex B**.

Top lines on key issues are provided in **Annex C**. Supplementary questions are set out in **Annex D**.

Agenda and papers for the meeting are attached separately.

ANNEX B

SPEAKING NOTE

- Good afternoon – I am delighted to be here today at the 5th meeting of the rural working group. It's great to see so many of you here today.

- I'd like to begin by saying thanks to Sir Lewis and its members of the Remote and Rural Group who have worked tirelessly to make a success of this group.

- Unfortunately I can't be with you the whole afternoon, but I look forward to hearing outputs from many productive discussions.

GP contract

- The new GP contract is an innovative and truly ground breaking achievement that will reduce risk to GPs, and help to reduce and refocus the high workload that we recognise is in itself threatening the sustainability of General Practice.

- **My simple message to you today is that we value rural general practice.**

- We recognise rural general practice faces challenges, some of which are shared across Scotland, like recruitment and retention, and some that are unique to the geography and infrastructure of rural communities. .

- We also recognise that those challenges present across the nation are also frequently exacerbated in remote and rural communities, and that we need to ensure our solutions to national issues also fit the distinctive role of the rural GP.
- I, along with the BMA, believe that the new contract addresses those challenges.

- The new GP contract does two things: first, it seeks to develop a new role for the GP as the clinical leaders in the community, leading enhanced more integrated teams, to ensure that we continue to deliver the **right care for patients at the right time**.

- Secondly, it responds to the serious challenges identified by the GP profession: increasing workload and risk, in particular the risk of owning property and employing staff.

- On both points, I believe all GPs – whether urban or rural - can see real benefits from the new contract.
- Indeed I believe that the role of clinical leader in the community – the "expert medical generalist" – is a role already fulfilled by many rural GPs.

- In that sense, the contract is intended to **enhance** rural general practice and support rural healthcare professionals.

Rural Flexibility

- I am absolutely clear that the GP contract and the associated Primary Care Improvement Plans have to allow for flexibility to suit local circumstance, in particular in rural communities.

- I want to stress: there have been **no changes** to the GP contract in relation to services such as vaccinations.

- If a rural GP practice wishes to continue to deliver vaccinations or the other services set out in Primary Care Improvement Plans then it can do so.

- Indeed, GP practices continue to be paid to deliver this service.

- Through the contract, we are offering the opportunity to GPs to benefit from support from Health Boards if that improves outcomes for patients and ensures the sustainability of their practices.

Rural Working Group

- We recognise that no contract and no formula within it can address the full complexity and challenge of a rural general practice that is fit for the current and future demands of an ageing population.

- This group was set up precisely to look at solutions that lay beyond the contract as no formula no matter how sophisticated is able to capture the **complexity of rural general practice**.

- Since its inception, the Group has carried out a wide programme of engagement with rural GPs across Scotland in order to gather Case Studies to share good practice and innovative solutions to implement the new contract in rural communities – and **this must continue**.

- I am also acutely aware of the criticisms and perceived shortcomings of the contract. The contract was developed to strengthen, not weaken, general practice across Scotland, to make being a GP an attractive life-long career for our current and future medics and to offer the best quality care possible to all patients irrespective of where they live.

- Not all the solutions can be found immediately. To deliver our most ambitious plans we must wait for new data currently being gathered that will determine the next stage of the contract .

- That will significantly improve our understanding of the cost of delivering services and the cost of running a GP practice, whether in an urban or a rural setting.
- I was also recently asked by the petitions committee if the terms of reference for this group will be reviewed and; I'd like to invite each and every one of you to consider how this group can find common ground, build on the achievements of its first year, and use today as an opportunity to look ahead to the future.

- The task of the Scottish Government and BMA is to ensure the new contract fits the realities of rural general practice, and to answer that question we need your insight, and expertise.

- The Scottish Government and my colleagues in the BMA are here today to listen, learn and seek a better understanding of just how to make sure that happens.
- And so today, under the banner of these aspirations, I'd like all of us to work together in the true spirit of collaboration to find meaningful solutions that will seek to address the issues raised.

Conclusion

- Let me be absolutely clear as Cabinet Secretary for Health, I am committed to ensuring that General Practice, whether in rural or urban or deprived or affluent settings is protected, persevered and strengthened. I assure you I am listening, I need you to as well and I need you all to work with us to help make rural general practice stronger that it ever has been.