Shaping the Future Together

Report of the Remote and Rural General Practice Working Group

January 2020

Scottish Government
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Chair's Foreword

The Remote and Rural Group (the Group) was formed by Scottish Government and BMA in June 2018, to support the implementation of the new GP Contract for remote, rural and island populations. This recognises that there is no 'one-size-fits-all' approach to implementation. Delivering high quality general practice and primary care is a shared endeavour throughout Scotland. Colleagues who work in remote and rural areas encounter additional challenges, requiring distinct roles and contributions.

The Scottish Government and BMA agree that there is much potential value for rural communities in the policies introduced under the new Contract. In the Joint Statement, they also recognise that to support rural areas to release this potential they require tailored solutions, at national, regional and local levels.

The Group's membership was drawn from a diverse field of expertise across rural primary care. It includes GPs, other clinicians, administrative and support staff from Health Boards and Health and Social Care Partnerships (HSCPs) working in a range of rural environments. The current Group membership, including public representation, is provided in Annex A. In line with its refreshed terms of reference (Annex B) the multidisciplinary membership of the Group will be augmented to reflect its wider remit.

We have sought to enhance our understanding of how implementation is progressing with an extensive programme of engagement. We have visited many remote, rural and island communities across Scotland to listen to the experiences of colleagues at first-hand (see Figure 1).

We witnessed and were encouraged by the distinguished work of GPs, multidisciplinary clinical teams and support staff. We saw and heard the difficulties they face, at times very stark. We also observed how they were innovating and overcoming these difficulties, working with their local communities and other care providers. Many colleagues described this as a vital aspect of remote and rural general practice. We were privileged to observe this at first-hand.

As part of our work, we also commissioned research to examine evidence of descriptors and models of remote and rural general practice and primary care, both nationally and internationally. We have engaged with and welcome the work of Health Care Improvement Scotland, the Scottish School of Primary Care and Rossall Research & Consultancy.

The new GP Contract encourages and seeks to support GPs to work more collaboratively and progressively in their efforts to support and enhance general practice, and to ensure it is fit for the future. Scotland's rural GPs and multidisciplinary team members, in concert with HSCPs, Health Boards and communities are striving to achieve this. While transformation of primary care services is essential - it will be neither easy nor quick. This is reflected in variable progress to date in implementing Phase 1 of the GP Contract throughout Scotland. A quickening of pace is now required.

We believe that there is more the Scottish Government and BMA can do to support GPs, Health Boards and HSCPs to implement the Contract in remote, rural and island areas. The recommendations and key messages set out in this report are intended to help realise that.

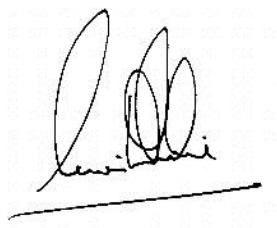
The positive progress to date is welcome but there are many more miles to travel.

The Scottish Government and BMA have both agreed that the Group should no longer be considered 'short-life'. Instead it will remain in place at least over the course of the three-year period of implementation set in motion in April 2018, with a refreshed remit to increase opportunities for the Group to offer advice. Most importantly, this applies not only to the transitional period for implementing Phase 1 of the Contract, but also to inform what comes next, as the Scottish Government and BMA undertake further joint negotiations to shape the future.

Getting right the future of general practice and primary care, the lynchpin of NHS Scotland, is of paramount importance, both for those who receive and deliver services. This needs to be done well, done with resolve and done together. We hope that this Report will help to underpin that aspiration for remote, rural and island communities throughout Scotland.

Acknowledgements

In closing, I am indebted to Group members for their ongoing commitment and support, and to all clinical, support and administrative colleagues that we have visited or spoken to during our engagement programme. The contribution and support of the public and the Royal College of General Practitioners Scotland (RCGP) Patient Partnership in Practice (P^3) Group, is much appreciated. Finally, I am particularly appreciative of my support team, for their steadfast professionalism.



Lewis D Ritchie
Chair, Remote and Rural Working Group

Key Messages

- The original remit of the Remote and Rural Group (the Group) was to support implementation of the Contract in remote and rural areas. This was the basis for our initial extensive programme of engagement visits speaking to, hearing and learning from colleagues. This learning has helped to inform this report.

- The Group was formed at a time of considerable change in the national primary care landscape. Delivering primary care transformation was recognised as needing shared vision, novel relationships, effective collaboration, good communications, trust and flexibility. This should be driven by local priorities, within the context of nationally agreed principles, delivered by strong clinical and managerial leadership.

- Over time, the work of the Group has sought to assist implementation of the Contract, but also to inform future policy and contractual developments. We have sought to act as a sounding board via workshops and to directly gather views from those planning, providing and redesigning services locally in remote, rural and island communities.

- For these reasons, the Group, with the agreement of Scottish Government and the BMA, will continue to work as a forum with direct engagement of GPs, clinicians, service planners and public representatives.

- As part of its revised terms of reference (included as Annex B), the Group will, as appropriate, provide advice to the Scottish Government and BMA on remote and rural aspects of the current and future iterations of the GMS Contract, including Phase 2.

Summary of Recommendations

Our recommendations are grouped under two headings that represent common themes emerging from discussions. *Refining Rural Enablers* sets out recommendations to support the ongoing process of implementing Phase1 of the GP Contract, by tailoring the response to implementation challenges to fit a remote and rural context. *Preparing for the Future* carries across some of those ideas but also builds on the Group's refreshed role as an ongoing forum for dialogue with rural GPs and other stakeholders in order to support any future contractual developments, including Phase 2.

Preparing for the Future

The Scottish Government and the British Medical Association should:

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

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

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

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

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

Refining Rural Enablers

The Scottish Government in concert with all stakeholders should:

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

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

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

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

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

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

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

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

Group Members, speakers and attendees at the September 2019 Workshop

PART ONE

Context: Challenges and Opportunities

The New GP Contract

The 2018 General Medical Services Contract was launched on 1 April 2018. It is the first GP Contract to be negotiated entirely within Scotland and was agreed jointly by the Scottish Government and the Scottish General Practitioners' Committee (SGPC) of the British Medical Association (BMA), with Health Boards and Health and Social Care Partnerships supporting its implementation. This agreement is made up of a number of components: the existing GMS (17J) Regulations and PMS (17C) Agreement were refreshed and updated; a new formula, the Scottish Workload Formula (SWF), for determining national funding for each General Practice was introduced, and the Scottish Government began a three year period of transforming primary care which aims to improve access for patients, address health inequalities and improve population health including mental health, provide financial stability for GPs, and reduce GP workload through the expansion of the primary care multidisciplinary team.

For the Scottish Government, the new Contract is intended to support and enhance General Practice by improving the GP role, and reducing existing financial instability, risks, and inappropriate workload.

For GPs, the new Contract seeks to provide greater support in their daily clinical practice and to enhance the potential to attract and retain new recruits and existing experienced GPs. It recognises the expert medical generalist role of the GP, exercising leadership and support of colleagues working in MDTs and through GP Clusters.

To realise this, the Scottish Government and BMA agreed to six priority services to be commissioned by Health and Social Care Partnerships (HSCPs) and delivered by territorial Health Boards, to be implemented across a transformation period running from 1 April 2018 to 31 March 2021:

- **Vaccination Transformation Programme** – services to be Board run by 2021
- **Pharmacotherapy** - a pharmacotherapy service for the patients of every practice by 2021
- **Community Treatment and Care Services** – a service in every area, by 2021, starting with phlebotomy
- **Urgent Care** – a sustainable advanced practitioner service for urgent unscheduled care as part of a practice or cluster-based team by 2021
- **Additional Professional Roles** - the addition of members of MDT such as physiotherapists and mental health workers.
- **Community Links Workers** – non-clinical staff, totalling initially 250 nationally, providing support to patients who need it, starting in deprived areas.

This transformation programme is supported by increased investment to HSCPs to deliver this change, guided by a Memorandum of Understanding, agreed by the Scottish Government, BMA, Health Boards and HSCPs. The Memorandum of Understanding (MoU) sets out the seven key principles, in line with the guiding principles published in the national review of Out of Hours (OOH) services published in 2015: *Pulling Together - Transforming Urgent Care Services for the People of Scotland*, that should guide primary care redesign, namely that future services should be:

- safe for patients and staff
- outcome focussed
- affordable
- person-centred
- effective
- equitable
- sustainable

The BMA and Scottish Government agreed that a transitional period of three years would allow for these services to be safely and sustainably transferred in line with the MoU principles. The Scottish Government asked all 31 Health and Social Partnerships to work locally with Boards and their GP-Subcommittees to develop Primary Care Improvement Plans (PCIPs).

The Remote and Rural General Practice Group

The Scottish Government and BMA agreed to establish a Remote and Rural General Practice Working Group, to provide advice and give recommendations to the Scottish Government and the BMA on ways to ensure that the views of rural clinicians and communities are better recognised in primary care policy development. The Group was formed in June 2018, initially on a short life basis (The membership of the Group is listed in Annex A).

The original remit of the Group was to carry out the following activities:

- To engage with and seek the views of stakeholders involved in developing and implementing Primary Care Improvement Plans in rural areas, to gather learning of best practice, and emerging opportunities and challenges.

- Provide advice and support to HSCPs on the implementation of policies to deliver the 2018 GMS Contract and Memorandum of Understanding in remote and rural areas.

- Consider and provide advice and recommendations to the Scottish Government on any issues which are thought to affect / have been stated to affect the implementation of primary care redesign and Phase 1 in rural areas, in line with the development of HSCP's Primary Care Improvement Plans and NHS Boards.

- Provide advice to the Scottish Government and Scottish General Practitioners Committee of the BMA on ways to ensure that remote and rural practices can fully benefit from the changes in the new 2018 GMS Contract.

The agreed output for the Group was to provide advice to the Scottish Government. Advice from the Group was also to inform negotiations taken forward by the Scottish Government and the BMA. The Group was also to provide a report to the Scottish Government to include a description of the Group's activities, including stakeholder engagement, evidence gathering, and lessons learned, and a summary of its recommendations. Details of how the Group has provided advice under its terms of reference are set out in this report.

Rural Fund

The Scottish Government requested that the Group inform the investment of additional funding intended to provide support for remote and rural general practice and primary care. This funding should be deployed to fund projects that support implementation in remote and rural areas, including recruitment and retention initiatives. We have referred to elements of this fund throughout this report. A full breakdown of the allocated funds in 2018/19 and 2019/20 is included as Annex C to this report. The Rural Fund presently stands at an annual allocation of £2 million.

Rural Group Engagement

Group membership comprises a range of representatives including GPs and colleagues from remote and rural locations, representatives of Health Boards, HSCPs with rural populations, the Rural GP Association for Scotland (RGPAS), and the Patient Representative P^3 Group of RCGP. A list of the Group's members and observers is included as Annex A to this report.

As at December 2019, the Group has met on six occasions. We have sought to carry out an inclusive programme of engagement to hear directly from colleagues living and working in Scotland's rural communities about how best to deliver on our remit. This programme includes interviews carried out with Group members and others, and a programme of visits to remote and rural communities across Scotland to meet and listen to GPs, Health Boards, HSCP teams and public representatives. We have also been working closely with the Scottish Government Primary Care team as they monitor the implementation of Primary Care Improvement Plans.

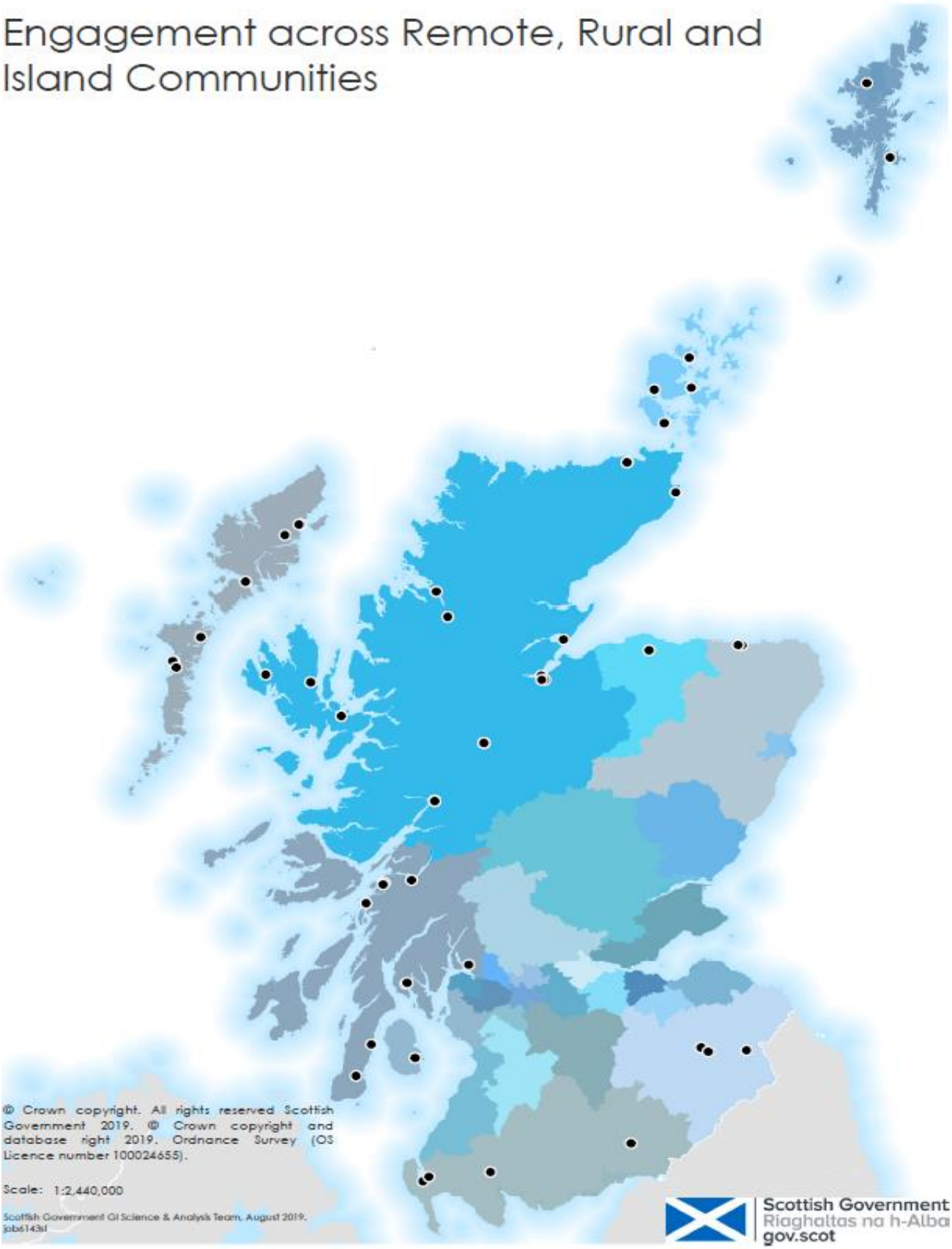


Figure 1 – Group Engagement Map – Each Point indicates an area where visits were made with primary care clinicians, other care providers and service planner

Defining Remote and Rural General Practice

The Group agreed that we would not seek to develop a new definition of 'Remote and Rural' for General Practice in Scotland and by extension create arbitrary lines that exclude the experience of some GPs and general practices from consideration under the Group's remit. Instead, we have sought to understand how existing definitions are applied now, and how well those definitions are supporting rural communities. This operating principle reflects what is set out in the MoU, which emphasises that implementing the Contract is about delivering services that fit the needs of communities, as well as available workforce capacity and resources.

A range of definitions and criteria are available for different purposes. At national level definitions of rurality are used to inform the National Resource Allocation Committee (NRAC) Formula. **Figure 2** shows the Scottish Urban / Rural Classification (SURC) 8-fold categories used to delineate 'rural Scotland' as covering the green and blue areas on the map. Together, this covers 70% of the land mass of Scotland[1]. 17% of Scottish General Practices are located in Rural Areas[2], serving 9% of Scottish patients. There are marked differences between rural communities in Scotland, but in general they have an older population. They have a smaller proportion of people living in the most deprived areas as defined by the Scottish Index of Multiple Deprivation but still have significant smaller pockets of deprivation.

[1] https://www.gov.scot/publications/scottish-government-urban-rural-classification-2016/

[2] Based on GP practice location: https://www.isdscotland.org/Health-Topics/General-Practice/Publications/data-tables2017.asp?id=2065#2065

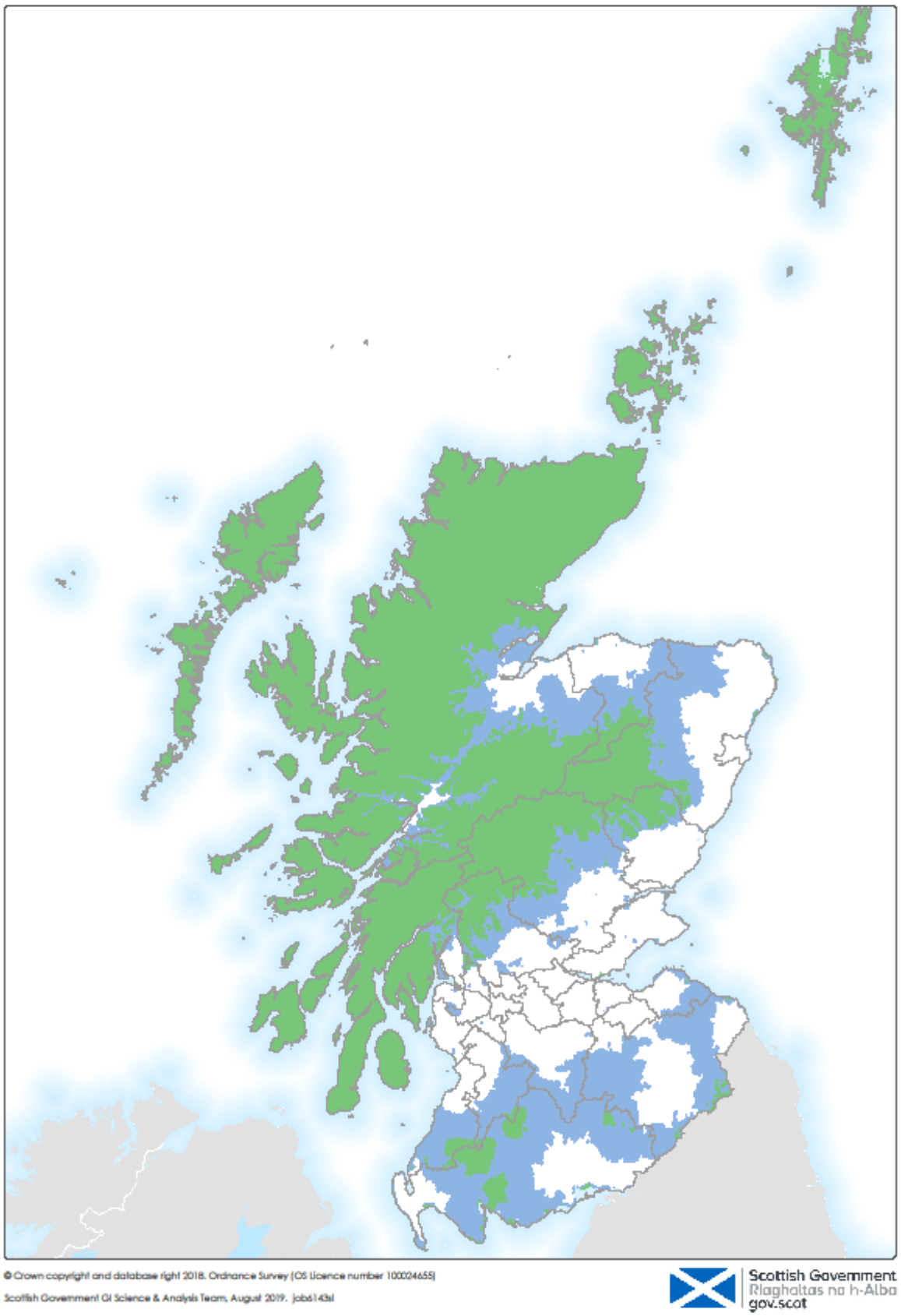


Figure 2 - Map of Rural Scotland using Scottish Urban / Rural Classification 8-fold categories. The Blue areas are 'Remote' and the Green areas 'Very Remote' using the 8-fold categories.

Practices in remote (blue) areas of the map are a 30 to 60 minute drive from a settlement of at least 10,000 people. Practices in remote small towns may often be as large as those in urban areas, but those in more rural areas are usually smaller.

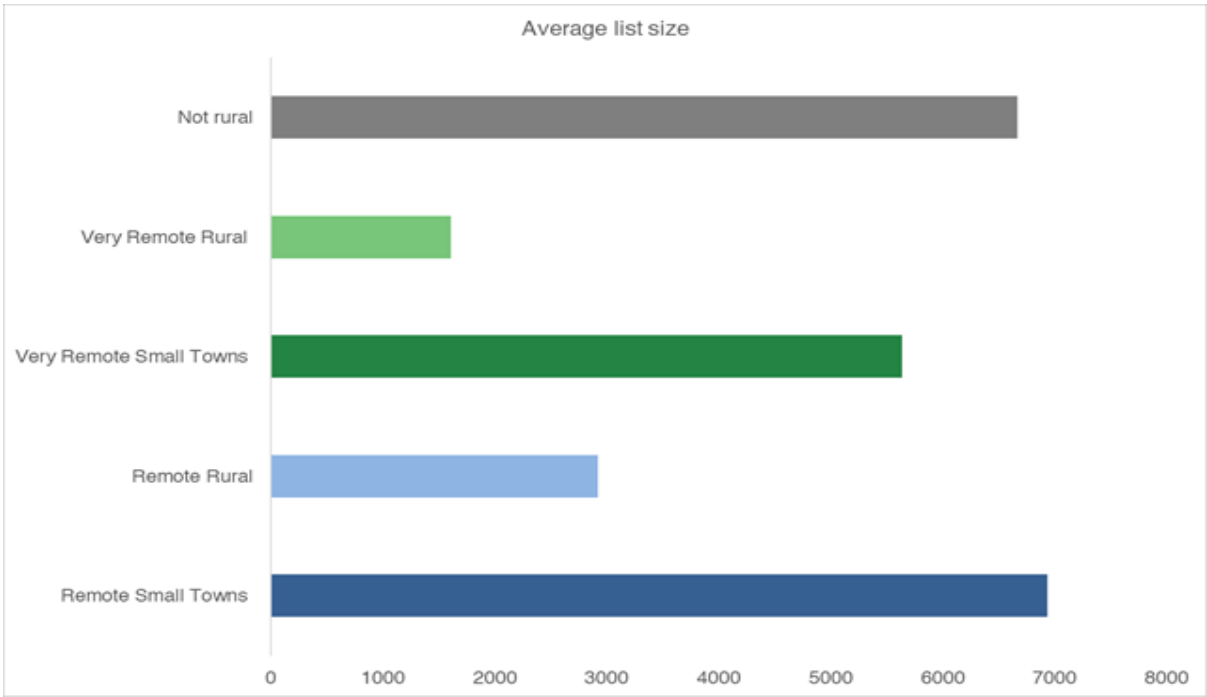


Figure 3 – Average List Size

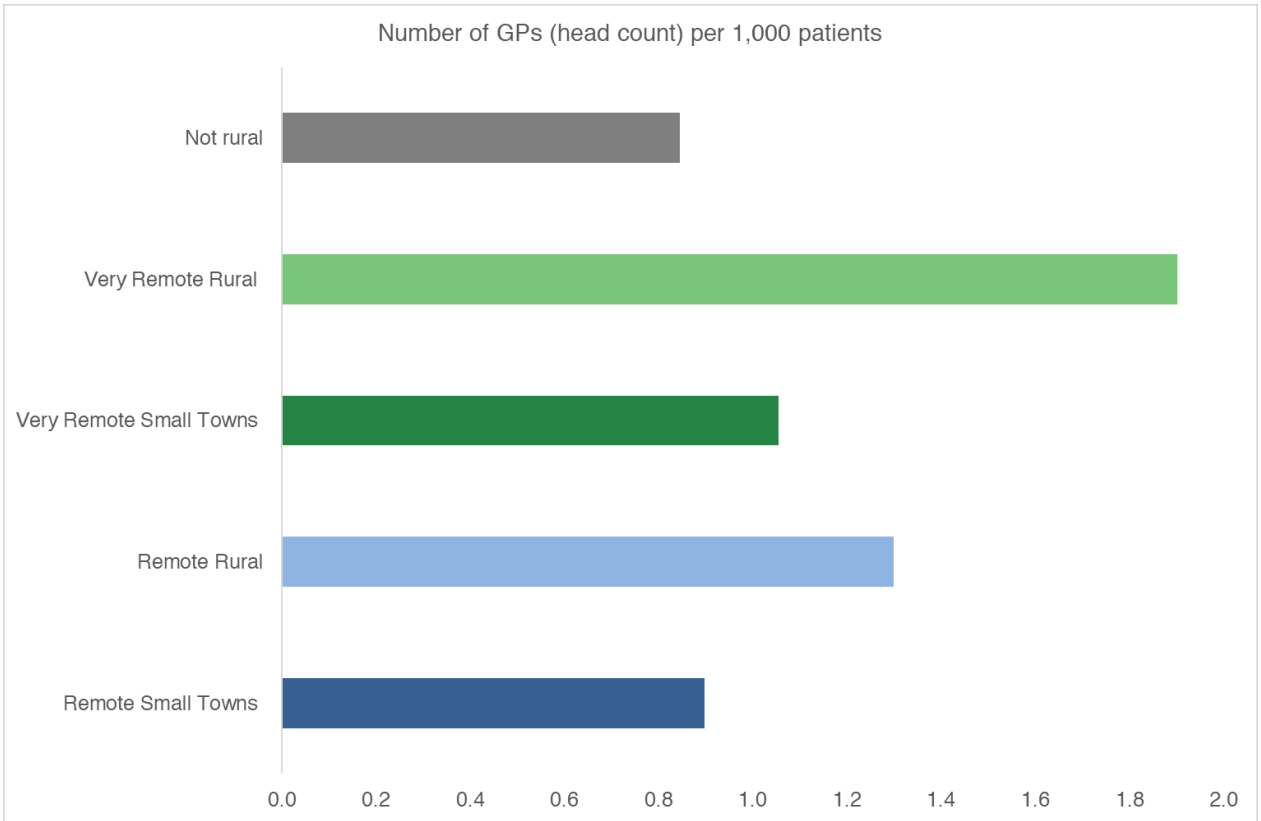


Figure 4 – Number of GPs (head count) per 1000 patients

As described in Figure 3 and Figure 4, practices in very remote (green) areas of the map are more than a 60 minute drive from a settlement of at least 10,000 people. They tend to have smaller list sizes and also have the highest number of GPs per 1,000 patients. They are much more likely to be dispensing practices. A greater proportion of these practices are managed by local health boards.

Although existing data helps us to describe broad characteristics of remote and rural GP practices, they cannot tell us about the experience of GPs and other clinicians delivering health care in those areas. They do not inform us about the effectiveness of the clinical teams working in and around rural practices, or their resilience to short and long-term workforce challenges. Through our engagement programme, and by considering the progress of Primary Care Improvement Plans, it also appears that there are GPs working in practices across Scotland outwith Figure 2 green or blue areas, who face similar challenges.

The Group engaged the Scottish School of Primary Care to provide a Briefing Paper examining the specific nature of descriptors and challenges of remote and rural general practice to allow us to better understand its distinct contributions and challenges. Professor John Gillies presented a draft version of this work (*Rural General Practice in Scotland: Descriptors and Challenges*) at the September 2019 meeting of the Group.

The SSPC report is based on extracts from GPs and NES rural fellows' experience of rural general practice in Scotland. The evidence gathered indicated that defining aspects of rural general practice involve a greater need to provide emergency care of patients, addressing the health needs of geographically dispersed patient populations, 24 hour on-call responsibility and the importance of continuity of care. The SSPC Briefing Paper has since been published to support our work.

It has informed our programme of engagement, as well as the advice we have provided to the Scottish Government and BMA throughout our meetings. We have encouraged them to support HSCPs to work with their local partners and the public to determine population needs in Primary Care Improvement Plans.

Over the course of our engagement programme, we consistently heard that the delivery of healthcare to rural communities posed unique challenges and demanded tailored solutions. The lower density of population and the distances needed to travel within rural areas to receive and deliver care, and the distance of travel to secondary care facilities, require rural practitioners to acquire and maintain a broad range of skills and knowledge.

We have repeatedly heard that one size does not fit all, when considering future models of healthcare provision. Individual rural general practices have evolved to meet the specific needs of their communities, their geography and the impact on care delivery of adverse weather and transport issues. They normally provide a wider range of services to their patients, including intermediate care, that in an urban environment would be delivered by other clinical colleagues. They tend to live within

the communities they serve and will often take on additional roles outside their immediate professional remit to address unmet need. The smallest of these teams in very rural or island areas are composed of a GP, nurse and receptionist. Small teams can be fragile whether a practice is urban or rural, and they depend on individuals and are vulnerable to illness or resignation. Attracting new GPs and clinicians to fill vacant posts can be particularly challenging in rural communities.

The distinctiveness of the rural GP role needs to be better understood within the profession, by associated clinical and administrative professionals and by Boards and HSCPs working to deliver healthcare services in rural areas. Over the course of our work we have listened to rural GPs describe their day-to-day role and how each can differ significantly from their peers in urban areas. We have also listened to their views about how the new Contract impacts on that role.

This remote and rural GP role is eloquently described by Dr Kirsty Brightwell GP, Western Isles, in her personal reflection: 'Remote and Rural General Practice and the New GP Contract: a Crisis of Identity'. Dr Brightwell shared her reflection with the Group, which is reproduced in full in this report, with her kind permission, as Annex D.

The Remote and Rural GP Role

We heard from a range of individuals and groups that the expert medical generalist role described by the new GP Contract is already in place for GPs working in rural practices. This is largely due to smaller team limitations and access to clinical services dispersed across wider geographies. The strengths of these broad generalist teams are informed by research we commissioned from HIS, SSPC and Rossall Research & Consultancy and based on:

- An intimate knowledge of patients, their circumstances and needs in small and close knit remote and rural communities
- Working together closely with all team members
- Networking with geographically distant colleagues providing expert advice and support, when needed.
- Supporting each other in times of difficulty or crisis. This function is important in providing resilience to geographically isolated teams that work within the same communities that they and their families live in.
- Understanding factors which are unique to each setting, such as how service delivery can be affected by travel times, geography, weather and the limitations of available infrastructure.

This approach to care is not exclusive to rural practice. The Govan SHIP, a project involving four Deep End Practices in Glasgow, was built around a number of these principles and has produced evidence indicating the success of its approach. It represents a structure of care delivery and philosophy, rather than an urban/rural

divide. It is important that the new Contract is flexible enough to incorporate these core values and philosophies.

The extended role of rural practice is predicated by the need to provide urgent care and the desire to reduce patient travel, especially in the elderly. It can perhaps be broadly categorised as follows:

- Emergency Care - The provision of lifesaving care to critically ill and injured patients in the community. In some very remote locations this care may need to be delivered continuously for several hours whilst waiting for patient evacuation to distant acute hospital services.
- Urgent Care - Care for conditions that are not life-threatening but require a response before the next routine care service is available, including: minor injuries, fractures, wounds requiring closure, acute illness and mental health crisis. Rural practitioners often deal with greater uncertainty and manage increased risk in the absence of more locally accessible diagnostic facilities, Accident and Emergency/Emergency Departments and acute (secondary) hospital care services.
- Intermediate Care - Provision of a wider range of care within the community (including community hospital care, where available), managing acute illness in the home and delivering ongoing complex out of hospital care (ideally with remote consultant support). Effective palliative and end of life care is of paramount importance. In remote and rural areas, delivery of palliative and end of life care is often constrained by distance (more lengthy home visit travel requirements) and may be compounded by adverse weather conditions.
- Additional Roles - The rural team may often take on additional or extended roles due to the absence of other professionals such as social workers, community psychiatric nurses, physiotherapists, occupational therapists, or carers.

Many GPs we spoke to, emphasised that remote and rural general practice offers enhanced opportunities for continuity of care and more intimate knowledge of patients, their families and life circumstances.

We heard significant concerns that the 2018 GP Contract did not fully appreciate the nature of the rural GP role and the differences to delivering general practice in rural communities. These concerns were amplified by members of the public through a petition to the Scottish Parliament's Petitions Committee. The Committee considered the petition and have referred the matter on to the Health and Sport Committee for further discussion. There were concerns expressed that the requirements of the new Contract would be difficult, inefficient and expensive to implement, with the risk of providing inferior patient outcomes by disrupting continuity of care and fragmenting the service.

In late 2017, the Rural GP Association of Scotland (RGPAS) published *Looking at the Right Map),* a detailed response to the proposed new GP Contract. In that document RGPAS set out their agreement with the positive, aspirational aims of the Contract and broadly welcomed the multidisciplinary team approach. However, they also set out their concerns about the lack of detail to achieve those proposals, as well as how additional investment would address lack of training opportunities, recruitment and funding to realise transferred services. A key concern was their criticisms of the Scottish Workload Formula (SWF), which was used to determine revised payments to general practitioners in Scotland. The implications and limitations of the SWF were discussed in detail at the Petitions Committee of the Scottish Parliament on 9 May 2019.

Across our interviews and visits, there was clear recognition that the diversity and richness of general practice needs to be better recognised and rewarded. This is amplified in the briefing paper commissioned from the Scottish School of Primary Care and the report from Rossall Research & Consultancy.

An Income-Expenses Guarantee was introduced alongside the SWF formula to ensure no practice actually lost funding. However, it created the impression among some rural GPs that the distinctiveness of their role had not been appropriately recognised, and so was undervalued. RGPAS concluded from their analysis of the SWF that: "*The new formula simply fails to reflect the workload and services provided by rural GPs and their teams*." They felt undervalued because their impression of the SWF is that it failed to recognise the complexity and breadth of remote and rural general practice.

The Group also heard concerns that the Income and Expenses Guarantee was not seen as permanent, and that it could be changed or removed at some point in the future resulting in planning blight and a significant disruption to rural general practice stability. The Scottish Government and BMA have made clear that the Guarantee will remain in place until a new funding model is in place that either maintains or improves the current funding offer.

The joint Scottish Government-BMA negotiation team is working towards this as part of their plans for Phase 2 of the Contract. This will involve using income and expenses data gathered nationally to develop funding models that better reflects the true costs of delivering general practice services across Scotland. This is set out in the *2018 General Medical Service Contract in Scotland* document:

"The guarantee to protect GP practice income and expenses in Phase 1 will continue until there is a proposal acceptable to the profession for the introduction of Phase 2. Future funding uplifts will apply to all GP practices' share of the total, derived by the new formula during Phase 1, including the new income guarantee. Population increases will apply to the formula sum only." (p21)

This assurance has been reiterated in communications by both the Scottish Government and BMA. However, while engaging with rural GPs, the Group has continued to hear of uncertainty around the nature and duration of that commitment.

The first recommendation of this report fully acknowledges these ongoing concerns and addresses them foursquare.

We note that RGPAS also recognised (in their report) that Deep End Practices working in urban areas of high deprivation expressed similar concerns about facing distinct challenges. While Deep End practices are outwith the scope of this report, we recognise that there is a shared issue here. Rural practices and those in the areas of highest deprivation face not only national challenges, but also ones that are distinct to the realities of delivering general practice in a unique setting.

Retention and Recruitment

Difficulties with recruitment and retention remain a significant challenge across Scotland and the whole of the UK - but can be worse in remote and rural communities. In some areas there is an over-reliance on expensive locums, placing an increased administrative burden on incumbent GPs. Locum availability, along with cost and the logistics of travel and accommodation, especially during tourist seasons, result in additional pressures. The extended role of rural practice, particularly the provision of pre-hospital emergency care, can be a significant barrier to both recruitment and obtaining locums. Accessible, affordable and relevant education, appropriate to the broader scope of care provided by rural practitioners, can be difficult to find and this can also be affected by the availability and cost of locum cover.

Throughout our engagement work, we heard a shared view of the importance of developing a clear vision of training, recruitment and retention of GPs and indeed of the wider MDT. This requires clear routes for training and continued professional development in the extended skills and knowledge required for rural practice throughout the "recruitment pipeline", and strategies to support GPs and the MDT in their posts are essential. We commend and support the recent report, *Undergraduate Medical Education in Scotland*, led by Professor John Gillies, promoting greater use of general practice for undergraduate medical education, and in this context within remote and rural settings. We have extended this to include the training of other multidisciplinary team members, reflected in our tenth recommendation.

Service Redesign Challenges

Across the Primary Care Improvement Plans – and regardless of urban or rural composition - digital connectivity and suitable premises are regarded as key enablers to support service redesign:

- In rural areas, the availability of reliable digital connectivity enables high quality day to day delivery of care. Video conferencing allows rural GPs and other clinicians to develop mutually supportive networks with colleagues, and speak to patients, without incurring travel time to do so. It also supports innovative ways of

delivering MDT input to rural practices, such as the work being done through NHS Near Me in NHS Highland. In our visits and engagement across rural communities we heard of how delivery challenges are intensified by poorly resourced IT provision and access to IT support.

- We frequently heard concerns that available premises cannot easily support an expanded MDT or make best use of opportunities to improve recruitment by offering spaces to train and mentor prospective GPs and other multidisciplinary clinicians. We saw examples of excellent facilities able to support these aspirations, but we also heard first hand of the barriers to realising them where GP premises are not able to achieve this. These concerns are reflected in our sixth, seventh and tenth recommendations.

Vaccination Transformation Programme (VTP) and Community Treatment and Care Services (CTAC)

Of the six key priorities set out in the Memorandum of Understanding, the greatest concerns raised across our engagement were around the Vaccination Transformation Programme, Community Treatment and Care (CTAC) Services, and Urgent Care Services.

Rural practices take pride in their high vaccination rates and see the delivery of readily accessible vaccinations as an opportunity for the team to hear, observe and gain a sense of family and continuity. They fear that this may be jeopardised by a visiting service, as is the chance of opportune vaccination during other interactions. Widespread concerns were expressed that moving to a non-practice employed/based team, could diminish accessibility and sustainability of service, ultimately adversely impacting on vaccination rates. The phrase: “If it’s not broken, why fix it?” was heard most often, with regard to this service, which is of paramount importance for primary prevention from infectious diseases. Despite this concern, we have seen some notable success in this area. NHS Western Isles has developed a successful model that uses Health Board employed teams (described in more detail later in this report). However, this is a pressing matter - we understand that a review of the governance and delivery of the Vaccination Transformation Programme is presently underway within Scottish Government.

In smaller populations the demand for individual elements of service is smaller and less predictable, creating challenges around service planning, sustainable resourcing, and resilience of the clinical team. The provision of CTAC services within rural practices helps support the employment of generalist nurses within the team. This nursing resource, well supported, can be utilised flexibly to deliver many aspects of care as required. An important element of general practice is the ability to respond to clinical need within an appropriate timeframe. This requires a team of sufficient capacity and capability. In rural practice, experienced staff with a broad skill set are required to meet the wide diversity of demand.

We often heard concerns raised that removing CTAC and urgent care services from practices could risk reducing the rationale for employing a suitably broad generalist team. As reflected in the RGPAS report: *Looking at the Right Map*, it is important to understand where rural economies of scale favour these service provision models.

Views were expressed that providing these services through HSCP/Board employed staff may reduce the ability of practices to respond to variable demand, would be more expensive than the existing model and would lead to services being less resilient where staff travelling further distances to work would be more vulnerable to travel disruption. There seemed to be an initial perception that the required model was of a centralised team, travelling out to rural areas, or requiring patients travelling to designated treatment rooms. We have seen from Primary Care Improvement Plans submitted by HSCPs that the 'no one-size-fits-all' approach encouraged by the Scottish Government and BMA has been largely embraced, although it is still early days. We are encouraged by the variety of flexible, innovative models deployed across the six service redesign work streams. As reflected in the recommendations of this report, the Group believes it is vital that those innovative models are supported and appropriately evaluated. Where successfully evaluated (see our twelfth recommendation), these should be promoted as examples for rural areas but potentially across the whole of Scottish general practice and primary care.

However there remains a widely held concern that these models are more vulnerable to impact from logistical issues, such as poor weather, absence within the team or from visiting colleagues. When this happens, the workload could revert to local practices that may lack team capacity and resources to deal with unscheduled increased demand on their time and resources. In addition, as we aim to reduce our impact on the environment and carbon footprint, serious consideration needs to be given to prevent increasing distances travelled by patients and staff.

Additional pharmacotherapy, physiotherapy, psychiatric nursing and community link worker services

The provision of additional professional roles; pharmacotherapy, physiotherapy, mental health workers and community link workers were in general welcomed by rural practices. Concerns were expressed regarding the ability to recruit them to rural areas and how services could be configured to maximally utilise the small allocation of time to individual practices.

Some GPs have expressed a strong desire to directly employ members of the MDT, which does not align with the GP Contract aim to improve stability in general practice by reducing the risks to partnerships related to staff employment. The motivation for wanting to employ staff is about seeking flexibility and the ability to coordinate staff working within the team to deliver care to the practice community. There is a fear that employment by the local HSCP or Health Board will result in staff being deployed over wider areas, threatening loss of close working relationships and continuity of care. This is an issue of trust and collaborative working. We have heard that in areas where GPs have well developed working relationships with HSCPs and

Boards there are fewer problems in teams composed of individuals with different employers. Where relationships are historically less developed there is a sense of greater risk attached to service redesign. As we move forward, nurturing professional relationships and trust will be key, as will meaningful, co-production and engagement with local communities. This is reflected in the eighth and ninth recommendations in this report, and also the fourth recommendation to support dispensing practices.

Key Messages

- There is no single definition of a rural GP. It is a continuum of experience, influenced by many factors such as the needs of communities, the demands of geographies and infrastructure, and the surrounding network of clinical support. These factors are ever-evolving and yet determine the realities of the day-to-day job. To support implementation, national policy makers and regional and service planners should seek to listen, understand and respond to the experiences of the clinicians in these roles.

- The expert medical generalist role set out in the new GP Contract describes an approach that has been in place in rural communities since the Highlands and Islands Medical Service was established following the 1912 Dewar Report. This model contributed to the development of the UK National Health Service.

- In our early engagement there was a strong sense that the new Contract did not do enough to support GPs faced with the specific challenges characteristic of rural primary care. There was a clear sense that the exceptional opportunities for learning, innovation and progressive working in remote and rural areas had been overlooked.

- We believe that this perception is gradually changing over time as Primary Care Improvement Plans bring GPs together with HSCPs, Boards, as well as with patients and communities. This is happening alongside other developments such as the maturation of GP Clusters that also support co-produced, intelligence driven service planning. The intense collaboration and momentum required to deliver PCIPs must continue unabated. This needs to carry on after the three-year transition period ends (end March 2021) and requires not only pragmatism but boldness and innovation. This holds true not just for remote and rural areas but for all of Scotland.

Meeting of Remote and Rural General Practice Workshop – September 2019

PART TWO

Primary Care Improvement Plans: Innovation and Implementation

Primary Care Improvement Plans

The Memorandum of Understanding (MoU) establishes a national governance framework in which Health and Social Care Partnerships must, based on their statutory role (set out in the Public Bodies (Joint Working) (Scotland) Act 2014), and working collaboratively with Health Boards as contractors of GP Practices, commission primary care services and service redesign to support the role of the GP as an expert medical generalist. This MoU was agreed by the Scottish Government, BMA, Health Boards and HSCPs in November 2017 and finalised and published in April 2018 alongside the 2018 GP Contract Offer.

Chief Officers' views on implementation Part 1 – Implementation Enablers
In May 2019 the Rural Group agreed to canvass Chief Officers for their views in relation to the implementation of the new Contract. This work was led by Pam Dudek, CO for Moray HSCP. In the feedback received, Chief Officers raised risks with Contract implementation that link to:

- Funding
- Workforce including recruitment challenges
- Premises in terms of space to accommodate the new and expanding teams alongside wider infrastructure requirements that would support the changing working environment.
- The TUPE aspect was raised as a concern, as this has not been found to be straight forward, and so some national support around this may be helpful to consider.

These areas of risk are being considered and monitored through the recent refresh of the PCIPs and local mechanisms of monitoring via the GP Cluster Groups, GP Subcommittees and Local Medical Committees alongside formal sign off by the IJBs. These risks are not unique to the GMS Contract and form the bedrock of the case for change in Scotland as set out in the Christie Commission 2011, noting the workforce and funding pressures versus demand from the demographic profile of Scotland over the following 20-30 years period.

There was an overwhelming belief that the process of implementation was underway and that this was very much coherent with the wider redesign being pursued through integration. Generally. the local experience was positive in terms of ambition albeit considering the inherent risks already noted. The process of development of PCIPs appears to have been viewed as positive and a good lever for dialogue and change locally.

The MoU sets out the Scottish Government's commitment to increase funding in direct support of general practice annually each year up to £250 million by 2021-22, distributed to HSCPs via the Scottish Resource Allocation formula (often referred to as the NRAC formula as it was developed by the NHS Scotland Resource Allocation Committee) for the specific purpose of delivering PCIPs.

The National GMS Oversight Group is the main oversight Group established by the MoU. It is chaired by the Director for Community Health and Social Care and meets quarterly with representatives from the SGPC, HSCPs and NHS Boards, as the MOU signatories, to oversee implementation of Primary Care Improvement Plans.

The MoU commits HSCPs and Health Boards to produce PCIPs that demonstrate how the funding will enable the redistribution of work from GPs to others and to optimise the role and functionality of the wider MDT. HSCPs are expected to refresh and reconfirm continuing local agreement for PCIPs in April each year, with revised plans – setting out progress achieved in the previous period and providing updates on expected progress for the year ahead - shared with the Scottish Government. HSCPs must agree their PCIPs in collaboration with local GPs through Health Boards and their GP subcommittees of the Area Medical Committee. Primary Care Improvement Plans should state clearly whether they have been signed off by the MoU partners.

The Group's remit is to support implementation of the new Contract in remote, rural and island communities. We have been working closely with the Scottish Government Primary Care Team to understand how PCIPs for rural areas are developing compared to the national picture. Our first group of recommendations are intended to support rural PCIPs to increase the pace of change, safely and sustainably, and in better recognition of the rural GP role.

Across Scotland, we have seen and heard many examples of areas taking an innovative approach to implementing these services. We sought to record these experiences and one of our early successes was to work with iHub Scotland to create a platform for promoting these as Case Studies of creative, effective ways to deliver the MoU services. GPs are working with their local teams, Boards and HSCPs to scale up creative solutions that may have been in place for some time or become the early adopters of new ideas. We have seen first-hand the ethos of rural exceptionalism in action. Our recommendation to develop a National Centre for Remote and Rural Health and Social Care (Recommendation 5) is based in part, on realising the benefits of gathering and sharing these ideas.

Analysis of the PCIPs indicates there has been a clear acceleration of both the pace and the scale of the development of primary care multidisciplinary teams of health and care professionals across all areas of Scotland since 2018, and a step change in the nature of clinical leadership in the GP profession in co-designing reform. This is testament to strong partnership working across service commissioners and providers.

Pharmacotherapy appears to be the most progressed across all plans, and where positive impact is being felt by GPs. Positive progress is also underway around planning and implementing mental health support and recruiting community links workers. Particular challenges have been evident with the Vaccination Transformation Programme, Community Care and Treatment Services and Urgent Care Services.

Across all plans there are several commonly cited barriers impeding implementation, and where solutions have been developed to overcome them there has been quicker and more effective progress:

- **Workforce** - The supply of skilled qualified staff remains the biggest single obstacle to implementation. Some areas are working to address this through models that optimise skills mix and test a range of digital solutions. While an increase in the workforce is clearly needed, there is also considerable potential to be unlocked by maximising the skills of the existing workforce. We address this in the second and ninth recommendations.

- **Digital and physical infrastructure** - There is an urgent need for reliable, interoperable and remote access IT and appropriate hardware to support rapidly expanding services and teams who may need to work remotely. IT systems across primary and social care need to support multidisciplinary working. The Scottish Government is establishing a primary care digital programme board to improve governance.

  It is necessary to develop the NHS estate, including GP practices, to support the shift in the balance of care into the community and facilitate the expansion of Multi-Disciplinary Teams The existing model of GP premises ownership posed a risk to the sustainability of general practice. As part of the new Contract, a GP Premises Sustainability Fund was established to address this through loans to practices which own their premises and a process for practices to transfer their leases to Boards. In addition, further consideration is needed about what support is being offered to upgrade premises where they are owned by Health Boards. Digital and physical infrastructure issues are addressed in the sixth and seventh recommendations.

- **Change management capacity** - change does not happen by itself. It is an incremental process and requires a supportive infrastructure which needs to include commitment, money, time, strong leadership and a clear pathway to change, together with evidence of impact. Planning for change needs the time and involvement of staff who are already delivering services and are stretched due to workload pressures. This requires major shifts in values, relationships and care systems.

  Health and Social Care Partnerships and the GMS National Oversight Group have asked the Scottish Government to consider whether further change management support could be provided to assist with implementation, and the

Rural Group is contributing its views to that developing work. We address this in the eighth recommendation.

Progress in Remote, Rural and Island Communities

Broadly these same barriers and enablers are evident across remote and rural areas of Scotland, although many areas note challenges relating to their geographical situation – including problems relating to recruitment and dis-economies of scale when setting up MDTs. Colleagues in NHS Highland and North Highland Health and Social Care Partnership noted particular risks around equity for all practices, and that geographical challenges mean that a single model is not achievable in all MoU areas.

Pharmacotherapy, Additional Professional Roles, Community Link Workers

The MoU sets out the services to be transferred to Health Boards. There are professional roles naturally associated with those services, such as musculoskeletal provision by physiotherapists in first-point-of-contact roles. Across our engagement, we found support for recognising the importance of considering a wide range of roles with the aim of providing expertise that enhances the already extended skill set of the Rural Primary Care Team. The concept of "Generalists Delivering Specialist Services" might be a useful way of considering the roles and further potential of Rural Primary Care Teams.

External advice and support should be readily available to the teams, with clear pathways to access support. The external MDT team may include:

- Hospital Consultants
- Specialist Nurses
- Access to experienced nurses and AHPs in geographically distant teams
- Pharmacists
- Physiotherapists
- Community Mental Health Teams
- Community Link Workers
- Occupational Therapy
- Health Visitors

The level of involvement of the external MDT could vary, depending on the size and location of the Rural Primary Care Team.

The challenge is to plan these services around existing and expected workforce capacity and doing so in a sensible way that recognises where factors such as long travel times across rural areas will risk impacting on the availability and quality of the service for patients. For example, a small island team, or a team working across a large dispersed area, might get little in terms of *visiting* specialist MDT services, but may utilise their specialist input to clinical care and specialist advice through remote access working, telephone conversations or video consultations.

Rural case study: GP Near Me

We have seen effective examples of this approach for Pharmacotherapy services in rural areas. Video consulting is being used by the primary care team in NHS Highland to improve access to care.

Under the Highland Near Me model, a GP practice has its own virtual waiting area. Patients enter the virtual waiting room via a "start video call" button on the practice's website. They are then held in the virtual waiting room until a clinician connects their call. Multiple clinicians can consult simultaneously, mirroring a physical waiting room in the practice.

The virtual consulting model was first tested by the NHS Highland rural pharmacy team. In a Health Foundation funded project, they demonstrated that not only was it possible to provide medication reviews for patients remotely but that patients actively preferred it, because they could attend the consultation from home/work rather than travel to the practice.

That learning led to further testing with GPs and practice nurses, plus members of the wider primary care team including community mental health workers, physiotherapy and a health visitor. There are currently 10 practices in NHS Highland involved, and it is expected to be extended further.

Access to care is improved in two ways: patients can attend appointments remotely by video, and clinicians can work remotely from a GP practice. For patients, this is useful for people who are at work, find it difficult to travel due to physical or mental health, have caring responsibilities or transport barriers. For clinicians, remote consulting can improve availability of visiting clinicians, improve sustainability of practices, and improve work-life balance for clinicians by cutting travel or enabling home-working.

However, the challenge with Near Me is remote access to clinical information. The video consulting is the easy part, ensuring the clinician has full read-write access to all appropriate information can be more difficult.

Dr Neil Houston, one of the GPs involved in testing Near Me in primary care, said: *"Being able to see a patient in their own environment gave me a much deeper understanding of their situation than during a telephone call or in the GP Practice. This was particularly striking when video consulting with a new parent who was struggling to cope: I saw her distress more clearly and built a closer rapport with her because I could see her in her own home."*

Remote consulting is not a panacea. There will always be a need to see some patients in person. But it is a positive solution for improving access to care. The Group recognises the benefits of supporting these innovative approaches. The Group approved an investment of £200,000 from the 2019/20 Primary Care Rural Fund to support the deployment of Attend Anywhere to remote and rural practices. Innovative digital solutions that enable opportunities for remote care, training and collaborative working should be embraced at all levels of implementation. We also address this in Recommendation 6.

This is one of many possible ways to use creative MDT roles to effectively support remote and rural general practice.

> "In Dumfries and Galloway, we have been able to embed Primary Care Mental Health Nurse (PCMHN) sessions within each GP practice within a relatively short space of time. This was not without teething problems, however, feedback now that the nurses are in post is extremely positive."
>
> – Justina Ritchie, Lead Nurse CMHN, NHS Dumfries and Galloway

Rural case study: Pharmacotherapy in NHS Dumfries and Galloway

Another creative approach to using MDT roles is being used in NHS Dumfries & Galloway. The HSCP area covers a large geographic area, with three main towns and a large community dispersed across 23 settlements with populations of 4500 or less. The area is supported by a central hospital and a Community and some Cottage Hospitals. Workforce challenges and long travel times for centrally based MDTs created a sustainability risk for the new service, and there was an additional concern that recruiting to new Pharmacotherapy roles would risk destabilising existing services in secondary and community care.

To address these challenges, the Board developed an innovative recruitment plan based on creating bespoke posts that included student technician roles and options for split-working between acute and community pharmacies. The HSCP built resilience into this model working collaboratively with local partners from its inception. They agreed a memorandum of understanding with key stakeholders, worked with the existing locality GPs, GP clusters, practice managers and pharmacists to develop an overarching action plan. A consistent approach was created across localities by agreeing a shared induction pack for new recruits. They also considered the wider recruitment picture by targeting areas in the North of England and Ireland that were not actively recruiting in the same roles, developed strong relationships with Schools, Colleges, Universities, and Pharmacy Schools to connect to the upcoming pharmacy workforce, and sought advice and best practice from other Health Boards.

This work has led to 80% of the initial 25WTE newly identified vacancies successfully recruited to without destabilising community hospital pharmacy services. The Student Technician model won a Scottish Pharmacy Award for Innovation and a highly commended award at the 2018 national SP3AA conference.

> "From an AHP perspective, progress across remote and rural areas is mixed. All Boards, with the exception of NHS Dumfries and Galloway, have introduced or are in the process of introducing the first contact physiotherapy practitioner model within the practice. This has proven challenging in many remote and rural areas due to difficulties in recruitment and/or access to suitable accommodation."
>
> – Joan Pollard, Associate Director of Allied Health Professions

Rural Case Study: First Contact Physiotherapy (FCP) in Rural practices in North West Scotland

FCPs are operational across 20 practices in North and West Highland, covering Skye, Lochalsh, Wester Ross and Caithness with Lochaber & Sutherland expected to follow in due course.

Implementation of the FCP service into rural general practice has presented several challenges, including the unique geography and character of the region. Serving widely dispersed small communities, clinicians travel considerable distances on single track roads. In addition, applying the agreed 1:13000 model in NHS Highland meant smaller allocation of resource to smaller practices.

Previous access to MSK Physiotherapy included a mixed model, mainly determined by the availability of services. Referred by GPs, some patients travelled long distances to physiotherapy services based in local hospitals. Some attended a visiting physiotherapist in the GP practice. Patient waits were consistently high across all areas.

Collaborative working with GPs, physiotherapists and practice managers developed the FCP approach at each local level. All were keen to have a FCP on site, as part of the team, and it quickly became evident that in rural practice there is a well-established and resourceful community spirit. Everyone works together to reach pragmatic solutions to issues relating to geography and remoteness from larger centres of population. Creating flexible delivery enabled mutually agreeable solutions, with a commitment to revisit and review, e.g. practices with small allocations agreed a fortnightly visit might work best, practices with 2 sites settled on alternate weekly visits to each site. These options reduce clinician travel thereby maximising appointments and see patient travel reduce whilst delivering on the primary aim to reduce the MSK workload for the GPs.

FCP implementation is project managed by Lead AHP, E-health, GPs, practice managers and physiotherapy leads, thus providing robust governance and support, promoting from the outset a culture of collaboration. The commitment and sense of joint-purpose has been clearly evident moving from planning to implementation and has been a major factor in finding solutions to challenges as the service is developed.

While the overall pace of implementation for Pharmacotherapy, Additional Professional Roles and Community Link Workers services in rural areas is mixed, these examples show there is enthusiasm to try new, creative approaches that are sustainable, equitable and demonstrate the benefits of flexible roles that encompass both service delivery and educational functions.

Urgent and Unscheduled Care, and Home Visits

A good example of how national challenges are exacerbated by rural realities is seen in the provision of Urgent and Unscheduled Care and home visits. Recruitment and

retention difficulties in a rural practice with a widely dispersed population means much time is lost to travel when providing home visits to patients.

Rural Case Study – Home Visit Service in Wigtownshire

In Wigtownshire, an audit carried out in 2018 showed that their most rural practices lost 19 hours per week to travel for visiting patients. To free up GP time, NHS Dumfries and Galloway working with SAS recruited three paramedics to work across two rural practices using a rotational model that ensured no skills atrophy for acute and trauma care for the paramedics. The paramedics delivered home visits allocated by the GP, who offered advice by telephone if needed. After 6 weeks there was a 45% reduction in GP time spent visiting patients. While this freed up GP time in the practice, they continued to see urgent presentations to the practice when they arose.

This practical service reflects the reality we have seen and heard across our engagement about the role rural GPs serve in their communities as a provider of urgent and emergency services due to sometimes long travel times involved for other first responders such as SAS. This role is often 24/7 and in smaller remote communities it can also include the management of severe trauma and life-threatening illness. Configuration of these services requires input from GPs, SAS staff, experienced generalist nurses and other appropriate members of the Rural Primary Care Teams and will differ depending in part on remoteness and availability of Community Hospitals, Rural General Hospitals, SAS and OOH services.

The Rural Group recognises the benefits of freeing up GP time and reducing home visits through using paramedics and other resources, however we also recognise that the emergency role is intrinsic to the work of a very rural GP. Currently, there is no standard national or regional specification or payment model for rural GPs and practices for providing a pre-hospital emergency response, except for those in North Highland, Western Isles and Dumfries & Galloway. GPs in other rural areas do it as a voluntary part of their rural GP role and receive no additional funding for it. We think this needs to be better understood, recognised and reflected at regional and national levels.

We have agreed to the use of the Rural Fund to begin addressing this. The Pre-Hospital Emergency Care Fund was set up to reimburse remote and rural GP Practices for having GPs and practice employed practitioners (with BASICS training) on call for their expertise in an event of emergency. This will help develop a comprehensive co-ordinated network of trained and equipped BASICS Responders across remote and rural Scotland. This scheme will begin as a pilot on 1 January 2020 and go live across Scotland from 1 April 2020.

The Rural Group has also agreed to establish a sub-group to consider what more can be done to help rural GPs delivering pre-hospital emergency care. The sub-group will, for example, consider what standard drugs and equipment should be available in all BASICs Responder practices and what pastoral and mental health

support is available for practitioners who may need support following attendance at a traumatic incident. We will update the Rural Group website as this work progresses.

"While I believe we would all welcome and support the need for shifting the model to a more integrated approach based on an extended workforce model, it is also important to recognise that historically rural areas, especially, but not exclusively, in smaller practices provide a more holistic model that larger urban practices. This has therefore made the approach around Community Care and Treatment Services and Vaccination programmes more challenging and in some situations less supported than is perhaps the case in urban settings.

In the future, while ensuring we maintain the focus on the key principles in the Contract, I believe it is important that we also properly explore the flexibility required to make sure the Contract is fit for purpose in the rural context - this should be a key area of future focus."

- Ralph Roberts, Chief Executive, NHS Borders and SRMC Chair

Community Treatment and Care Services, and the Vaccination Transformation Programme

The Community Treatment and Care (CTAC) work stream, encompassing services such as phlebotomy and wound care management, and the Vaccination Transformation Programme (VTP) have been a clear focal point for the challenges of implementation across rural communities. Throughout our engagement programme rural GPs shared concerns about the ability of visiting MDTs to deliver an effective and cost-efficient service. There is significant pride in the vaccination rates achieved by practices and a concern that the same rates would not be achieved with a new model. It was felt that the current system was performing as good or better than a Board delivered service could provide. There was also concern about the impact on patients if new service models created the need to travel to treatment room centres.

CTAC and vaccination services are at the forefront of an ongoing dialogue involving rural GPs, Boards and HSCPs, the BMA and the Scottish Government focused on what flexibility is available within the context of service redesign to recognise these issues.

Our engagement work, alongside our work to develop and promote Case Studies or service redesign, has provided a number of examples of creative solutions used to implement safe, sustainable CTAC and vaccination services.

Case Study: CTAC and Vaccination Service in NHS Western Isles

NHS Western Isles (NHSWI) has 9 GP practices across 6 island groups. Staffing resources compounded with the geography of the islands created a challenge to developing a VTP team that maintained patient safety and quality of service. NHSWI

decided to take an innovative approach that recognised that the models of travelling VTP teams used in other areas was simply too impractical for their geography and would risk creating a service that could not meet the MoU principles. They developed a model that uses the existing highly skilled local team in an overlapping CTAC and vaccination service. To achieve this they applied a number of creative solutions such as using PCIP funds and Transfer of Undertakings (TUPE) rules to support already skilled staff to move into the Community Nursing Team, and identifying where staff had transferable skills, or additional educational and training needs.

This approach allowed NHSWI to integrate Pertussis and Teen vaccinations into the maternity and school nursing teams respectively. In its first year, vaccination rates increased from 67% in 2017/18 to 74% in 2018/19. This change also allowed for systemisation and standardisation of practice throughout NHSWI.

Flexibility

The successful model used in NHSWI is an example of the effective application of the expectation set out in the GP Contract Memorandum of Understanding that a flexible approach, determined locally, would be necessary for successful implementation:

"The extent and pace of change to deliver the changes to ways of working over the three years (2018-21) will be determined largely by workforce availability, training, competency and capability, the availability of resources through the Primary Care Funding:" (p.8).

This is also described in the Scottish Government's National Health and Social Care Workforce Plan for Primary Care in Scotland (Part 3), published in 2018:

"The extent and pace of change over the next three years will be determined locally but will be affected by a number of factors including workforce availability, degree of skills enhancement and the needs of individual practices or practice clusters. In a small number of cases it may be locally determined that GPs and their staff continue to provide some of these services, for example in some very small remote and rural practices. Patient safety will also be a determining factor in local implementation in that the changes will only be made when it is safe to do so. These changes will require investment in the skills of the workforce so that these match the service needs." (p.34)

However, the Group recognises that it is one thing to prescribe flexibility and another to define its limits. We found that there is considerable variance in understanding the intent of the MoU and the emphasis it places on supporting flexible, intelligence driven models of care.

Over the course of our early work we have contributed advice, based on the expertise of our members and our learning from listening to the rural GP experience, to the Scottish Government and BMA to help set out further clarity on flexible implementation models:

- Primary Care Improvement Plan Guidance (March 2019) – this document, reproduced as Annex E, was agreed jointly by the BMA and Scottish Government, was informed by feedback from the GMS Oversight Group and advice offered by the Rural Group. The document reiterated the messages in the MoU around the importance of local collaboration and local insight into specific circumstances and that *"in rare circumstances it may be appropriate for GP practices, such as small remote and rural practices, to agree to continue delivering…services through locally agreed contract options".* It set the expectation that these agreements would be reached through local appraisal of the population needs and options available for service delivery.

  It also reminded HSCPs of the importance of preserving continuity of care, reflecting key concerns raised throughout our engagement – and highlighted specifically by RGPAS in their *Looking at the Right Map* report – that moving to models of Board delivered services increased the risk of disrupting existing models that preserved continuity of care. The Scottish Government requested that PCIPs note in their plans how local implementation partners were maximising continuity of care in establishing new services and expanding the MDT. It set an expectation that *"where appropriate, reconfigured general medical services should continue to be delivered in or near GP practices".*

- Joint statement (September 2019) – This document was agreed by Andrew Buist, Chair of the SGPC, and Jeanne Freeman MSP, Cabinet Secretary for Health and Sport. It was developed following their attendance at a meeting of the Group in June 2019, where a number of concerns were raised about the Options Appraisal process:

  "We have listened to the views expressed at the Rural General Practice Working Group on 4 June 2019 and in particular the view that further guidance is required around implementing the flexibilities contained in the Contract. We will therefore develop options appraisal guidance on how these principles can be operationalised. The expertise of the Rural Working Group will assist in developing this guidance."

  The statement also recognised the emerging role of the Group itself in offering advice to both parties on implementation, reflecting the Group's positive contribution in helping to elevate the concerns raised throughout our engagement up to that point:

  "*It is vital that our response to these recommendations is developed collaboratively with the Working Group, and remote and rural GPs and their teams more widely*."

  The document set out the intention for a refreshed role for the Group, in which it would no longer be considered 'short-life'. This build on the positive contributions made by the Group to highlight both the challenges of rural general practice and the opportunities for innovative solutions that we were encountering through our engagement work. It set us on a path of agreeing new terms of reference to enable the Group to be better at enhancing rural

general practice as international exemplars of service delivery. This role is now reflected in our new terms of reference, published on our Group website.

- Options Appraisal Guidance (December 2019) - This document provides further clarity to the September guidance about the circumstances where GPs would continue to deliver services. It sets out a detailed process including principles that should be applied to all cases considered, the scope and governance of the appraisal, and arrangements for reporting and review.

Chief Officers' views on implementation Part 2 - Flexibility

In terms of further guidance generally or specifically in relation to flexibilities, there was a mixed response, with many COs stating that they were very clear and had worked with SG, and locally with their GP Subcommittee and Local Medical Committee to consider and agree any points where clarity would be helpful, however for a small number of respondents there was a feeling that further assistance/guidance may be helpful. Concern was raised that any further flexibility should be proportionate, as some areas had progressed well, and any significant change in direction would potentially undermine the work to date.

By far the biggest areas of concern relating to the MoU were the Vaccination Transformation Programme and the Community Treatment and Care Service, and how this might translate in a remote and rural setting.

For the VTP it appears that concerns regarding lack of clarity/flexibility were mainly in this area and there was a need for stronger support and further opportunities for shared learning. All areas are working through their VTP programmes of work with the aim of identifying the level of issue to be addressed or seeking to ensure the flexibilities available are applied to secure sensible solutions.

For the Community Treatment Rooms most remote and rural areas - but not all - were still trying to work out how this would be discharged successfully with some areas using the link with the Health Improvement Scotland Team for Primary Care to work through this, taking a shared learning approach.

General Practice Funding, Contract Implementation and Options Appraisal

The new GP Contract sets out the goal of transferring services from GP delivery towards board supported provision, while keeping practice resources stable. This is intended to reduce workload, allowing GPs and their teams to focus on more complex care, keeping more care in the community and improving overall patient outcomes.

The MoU recognises that these changes might not be possible in very remote and rural areas where there is no viable alternative provision under the principles of the MoU. In these circumstances the BMA and SG have established an expectation that

GPs and their practice staff may continue to deliver some of the MoU services. The Rural Group has contributed to the developing understanding of this flexibility through its input into PCIP advice, the joint statement, and Options Appraisal Guidance.

A common concern expressed was that medium and long term funding arrangements should be agreed and resolved for those practices that would necessarily have to continue to provide services in the best interest of their local communities. While this mainly applies particularly to vaccinations this may also affect community treatment and care services and urgent care services.

Few of the commitments in the MoU were accompanied by changes to GMS or PMS regulations. The Scottish Government has made clear that services will only transfer and be removed from future iterations of the regulations, when it is appropriate under the principles of the MoU to do so.

The MoU sets out the main purpose of the Primary Care Improvement Fund as to pay for recruitment of more board-employed multidisciplinary team members to support practices to transfer MoU services. However, the issue of funding was notable across our engagement, and has been raised in particular by RGPAS. Some GPs from a range of practices in remote locations, as well as in towns located in urban areas, have indicated that where they are continuing to deliver MoU services they would be able to offer a better service if supported to do so from Primary Care Improvement Funds.

The shared position of the Scottish Government and BMA is that all GP practices that can do so under the principles of the MoU should transfer MoU services, by April 2021. They also recognise that there will be a small number of practices for which support under the MoU principles is not likely to be available in the short or medium term. The intention has been to use the 3-year transition period of implementation to identify those practices so that better support can be made available to them in any future iteration of the national funding model. Options appraisals will play a vital role in that process, as will data on practice income and expenses currently being gathered across Scotland's GP practices.

The BMA and Scottish Government have committed to re-evaluating this position as we move towards the end of the MoU transition period (April 2021) and will work with the Rural Group and Oversight Group to respond to concerns arising in the interim.

To this end, initiatives have been introduced via the Rural Fund that will help to shape proposals for future funding models alongside the Options Appraisal and data gathering work. In particular, new funding has been made available for change management support in rural areas, improved financial support for dispensing practices, investment to target improved use of IT in remote and rural areas, and the Pre-Hospital Emergency Care fund that is helping to introduce a standardised approach to recognising and remunerating GPs for responding to emergency situations in their communities. These are discussed in more detail in Part 3 of this report.

Chief Officers' views on implementation Part 3 - Suggested Way Forward

In general, no appetite was expressed for moving away from the current MoU requirements but there is perhaps a need to ensure that understanding of flexibilities is clear in all partnerships.

Local Primary Care Leads should ensure good involvement and communication with those practices in remote and rural settings, to ensure appropriate support is in place to allow the best solutions to emerge for those local populations, applying flexibilities as appropriate.

Risk assessments should support the PCIPs and confidence ratings to ensure good surveillance in implementation. A shared position on the risk appetite may be worthy of consideration.

Engaging with Patients and Communities

"It is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. However, the level of patient engagement varies across HSCPs, with poor engagement leading to concerns around continuity of care.

Each HSCP should ensure that patient engagement is a key part of their Primary Care Improvement Plans. Scottish Government should assess these plans and showcase the ones that have communicated well with patients and the public."
– Colin Angus, Chair, Patient Representative, RCGP P^3 group

The MoU sets out clearly that:

'*HSCPs have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their Strategic Plans and take decisions on the size and shape of local health and social care services on a collective basis based on dialogue with the local communities and service users. In relation to the development of the Primary Care Improvement Plan that would include (but not be limited to):*

Patients, their families and carers, Local communities, SAS and NHS 24, Primary care professionals (through, for example, GP Subcommittees of the Area Medical Committee and Local Medical Committees), Primary care providers, Primary Care staff who are not healthcare professionals, Third Sector bodies carrying out activities related to the provision of primary care.

In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care based on an understanding of patient's needs, life

circumstances and experiences it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. HSCPs should ensure that patient engagement is a key part of their Primary Care Improvement Plans.'

From January 2018, some rural patients raised concerns about the implementation of the Contract in rural areas, with particular concerns around the long-term sustainability of rural General Practices. The Rural and Remote Patients Group was launched in February 2018 with the setting up of a Twitter and Facebook campaign to raise their concerns about the implementation of the Contract.

Members of this group initially raised their concerns through the third sector group Health and Social Care Alliance Scotland (the Alliance). The Scottish Government commissioned the Alliance to deliver workshops across Scotland in February and March 2018 to engage with patients around the delivery of the Contract. These were held across a mix of urban/rural communities and including Portree, Skye. The Alliance also developed a facilitator's toolkit for local communities and groups to use to discuss the impact of the Contract to their local areas. A number of areas, particularly in Argyll & Bute, utilised this tool and fed into the Alliance report: *Your GP and You* that provides a summary of the outcomes of this work.

The Remote and Rural Patients Group submitted the Rural Patients Petition to the Public Petitions Committee in May 2018, outlining their concerns about the new GMS Contract. This, along with other submitted evidence, was considered by the petition committee on a number of occasions, including a session attended by the Cabinet Secretary for Health and Sport in May 2019. Dr David Hogg (former Chair of RGPAS) and Mrs Karen Murphy (Rural and Remote Patient Group) were invited to give evidence to the Health and Sport Committee in October 2019. The Petitions Committee agreed to refer the petition to the Health and Sports Committee as part of their work considering the future of Primary Care.

In recognition of the concerns of rural patients, the Rural Group agreed at its first meeting in June 2018 that it was important that there was rural patient representation on the group. The chair of the RCGP P^3 group, Colin Angus was approached and kindly agreed to join the group in August 2018. In this role Colin Angus undertook engagement with Karen Murphy from the Rural and Remote Patients' Group.

In September 2018 we met with Karen Murphy, lead for the Rural and Remote Patients group, in Oban, to discuss the concerns of the group. This meeting covered a range of topics including the role and remit of the working group, patient representation on the working group, SWF and the impact of the Contract on the long-term sustainability of rural practices. They agreed that ongoing communication with GPs and communities was important and the development of a Rural Group website would be helpful.

The Rural Group website was launched in October 2018. The terms of reference, minutes of the meeting and the regular rural bulletins are published on the Group website. To date the Group has published six Bulletins, which share the work of the group, details of engagement visits and other areas of interest.

In November 2018, the team attended the Scottish Rural Parliament in Stranraer, alongside the Scottish Rural Medicine Collaborative. The team, including Colin Angus, ran an interactive workshop with members on the impact of the Contract on rural communities. There was a lively discussion with the main theme from the public being how could they get involved in helping to design and support local services. There was also concerns raised about the sustainability of services, with a particular focus of challenges in Dumfries and Galloway, where the Rural Parliament met.

At the December 2018 meeting of the Group, Colin Angus presented a paper on patient engagement, and in particular, highlighted the requirements of HSCPs to engage with the public on any changes to primary care services.

In addition, Colin Angus led on promoting a Case Study of good practice in community engagement in the Clydesdale locality, South Lanarkshire HSCP. The Locality recognised that there was a gap in the existing arrangements for public engagement in the area and collaborated with NHS Lanarkshire on a range of engagement activities including presenting at local community and voluntary groups, engaging with pupils and staff at Biggar High School, and ensuring that strategic groups within South Lanarkshire HSCP included community representatives. This example of good practice has been recorded as a case study and added to the iHub Scotland website as a resource for others to learn from and apply to their own engagement work.

Further engagement with the public and communities about the implementation of the Contract is ongoing and being considered by each HSCP as part of their Primary Care Improvement Plans.

Visits with colleagues throughout remote and rural Scotland

PART THREE

Looking Ahead: Recommendations for Rural General Practice

Preparing for the Future

The following recommendations are intended to support the Scottish Government and BMA to sustain and enhance primary care delivery across remote, rural and island communities for the future.

Recommendation 1

The Scottish Government and British Medical Association must continue to state their unequivocal commitment to maintaining the Income & Expenses Guarantee under current contractual and funding arrangements.

Rationale: The Group welcomes all efforts to reassure rural GPs that the income and expenses guarantee will be in place as long as it is needed. The Scottish Government and BMA should consider different and better ways to communicate and reinforce this message across the profession. This work should include clarity around uplifts as well as set out how this assurance will be safeguarded by both parties.

Local collaboration through the PCIP process will help improve relationships over time. The Group will also continue to promote examples of co-produced solutions through our work on Case Studies. The Scottish Government and BMA should continue to explore opportunities to reiterate this message at national, regional and local levels.

Recommendation 2

New terms and conditions arrangements, developed as part of Phase 2 or any further iteration of the GP Contract, should clearly recognise the diversity of remote and rural general practice.

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

Rationale: The Scottish Workload Formula (SWF) introduced in the new GP Contract favoured practices with high intensity workloads. As a result, a large number of rural practices have their income assured by the Income & Expenses Guarantee rather

than by the formula. Across our engagement, this was widely regarded by remote and rural General Practitioners as a missed opportunity to show value for their role and recognise its distinctiveness.

This issue is not new. Historically, most of these practices would have received income stability through the Minimum Practice Income Guarantee (MPIG), used since the 2004 GP Contract. In the years prior to the 2004 Contract, many practices were supported through the Inducement Practitioners Scheme and had been Inducement Practices pre-2004.

The Inducement Practitioners Scheme made payments to GPs practising in areas where Scottish Ministers, after consultation with the Scottish Medical Practices Committee (SMPC), accepted that it was essential to maintain a medical practice even though the area was sparsely populated or was for some other reason unattractive to practitioners. In advising Scottish Ministers as to a practice's "essentiality", the SMPC considered its notional patient list size, the location of the practice, the number and location of surrounding practices, the likely level of income etc. Where Scottish Ministers accepted that a practice was essential, the GP was entitled to receive inducement payments.

The effect of the inducement payment was to underwrite the practice by the provision of a guaranteed minimum income. To calculate the level of inducement payment, allowable practice expenses were deducted from the GPs gross income (from all professional sources) to arrive at net income. The amount by which the net income fell short of the guaranteed income (the inducement yardstick) was the inducement payment.

The GMS Contract in 2004 radically changed the method of payment for rural GPs and brought them in line with other practices. The "Red Book" and the concept of an intended average net income (and hence the yardstick for Inducement Practitioners) was abolished. This signalled the end of the Inducement Practitioners Scheme.

Payments under the new Contract were based on the needs of the population i.e. the Global Sum and Minimum Practice Income Guarantee (MPIG), the Quality of Outcomes Framework (QOF) and the wide range of directed, national and local Enhanced Services, some of which were specific to rural areas. GP income, therefore, was largely determined by the efficiency with which the practice provided these services. Ex Inducement practices tended to have a large MPIG due to small list sizes.

In addition, practices were eligible for an increasing range of Health Board administered payments including reimbursement for the costs of covering maternity, paternity, adoption, and sickness leave. Some historical payments relating to annual leave, study leave and other forms of leave continued for ex inducement practices in some areas.

Through consideration of these historic examples, and the present dissatisfaction with the current formula, it is very likely that no national formula can ever be developed that will equitably respond to the needs and circumstances of very small remote and rural practices.

Future funding arrangements should be cognisant of areas of complexity across rural, urban and deep-end practices i.e. multiple sites, dispensing practices, levels of deprivation and other factors. It should also be cognisant of the specific impacts of national pressures, such as issues related to pensions, and their specific impacts on rural primary care – 'rural proofing'. Future models of provision and resource allocation should also take account of international experience, drawing on the reviews commissioned by the Group from HIS, SSPC and Rossall Research & Consultancy.

Recommendation 3

A set of criteria for the use of the Rural Fund should be developed, recognising and supporting the distinct role of rural GPs and multidisciplinary teams.

Rationale: The Group has provided advice about how the Rural Fund should be used for a number of projects in 2018/19 and 2019/20. These projects seek to address themes emerging from across our engagement as well as from analysis of enablers in the Primary Care Improvement Plans. These projects are intended to help create positive momentum around regional and national initiatives that will over time shape and inform policies that will determine the future of General Practice in remote, rural and island communities.

We suggest that the Group should be invited by the Scottish Government to develop a set of criteria based on formalising this approach. If agreed, the Group will develop criteria that considers the cost, scale and timeframe for delivery for its current and future projects. It will also consider whether to support medium-longer term projects that go beyond the 3 year implementation period (to April 2021 and beyond). This should include comprehensive impact analysis of supported projects and join this work up with other intelligence driven projects and stakeholders. The Group will also consider possible criteria for extending the projects it supports, including further support for multidisciplinary team roles.

Recommendation 4

A package of support for dispensing practices, should continue to be developed through the Dispensing Working Group that will protect and enhance the sustainability of Scotland's dispensing practices.

Rationale: Dispensing GP practices are located in remote, rural and island communities and are invaluable to the communities they support. They are located in communities who do not have access to Community Pharmacy services largely on account of lack of commercial viability. Practices can be required to dispense by their health boards following a decision by the Area Pharmaceutical committee (APC). This is not discretionary and is subject to judicial review.

A GP dispensing practice not only prescribes patients medicines but has to stock and dispense those medicines to patients in a safe and timely manner. This has both financial, commercial, training and patient safety implications to the practice, GP and practice staff.

The Dispensing Group, was formed to consider a number of issues relating to dispensing practices including the impact of implementing the new GMS Contract, including the role of pharmacists and pharmacy technicians delivering a pharmacotherapy service. The Group has worked to identify opportunities to develop and support dispensing practices to continue providing a high quality, safe and sustainable service. This includes areas such as IT provision, staff training and patient safety initiatives.

Currently there are no agreed national guidelines around how a Dispensing GP Practice should operate. The group has commissioned NHS Highland to develop draft national guidelines, based on work previously done in Highland to support 2C practices, and building on the work of the Dispensing Doctors Association to support Scottish dispensing practices. Early discussions have also begun on developing a bespoke Scottish training package for dispensing practice managers and administrative staff.

The Group has encouraged the Scottish Government to support GP dispensing practices from the Rural Fund (£500,000 in 2018/19 and £301,080 in 2019/20). Funding has been used to support Dispensing Staff Training and to help implement the Falsified Medicines Directive in all GP dispensing sites.

The Scottish Government should continue to support the Rural Group to continue this work, and to extend its scope to how future funding models will better support dispensing practices to provide informed guidance to the Scottish Government and BMA negotiating teams.

Refining Rural Enablers

These recommendations are focused on enablers that will support primary care redesign and GP Contract implementation across remote, rural and island communities.

Recommendation 5

A National Centre for Remote and Rural Health and Social Care should be established to foster and promote innovation and excellence in Scotland and internationally.

Rationale: The time is right to support not only general practice, primary care and clinical practice in Community Hospitals and Rural General Hospitals, but also the wider project of health and social care integration by creating a National Centre for Remote and Rural Health and Social Care. The Centre should serve as a platform for inter-professional sharing that should promote and foster rural innovation both nationally and internationally.

The Centre should be developed to deliver against a number of priorities:

- **To be a multiplier for rural innovation** - It should provide strategy and leadership for stakeholders working to improve remote and rural health and social care for patients and service providers. It should cover a broad range of fields including care quality, quality improvement and assurance, health and social care integration, recruitment and retention, training and education of clinicians, and e-health, digital technologies and telehealth care. Its role should support linking individuals and groups to develop and deliver collaborative projects and distil lessons to allow application of the learning to other areas of Scotland – rural and urban - and to deliver models at scale.

- **To spread and contribute to Scotland's Rural Healthcare story using data to show that our rural clinicians and service providers are exemplars** - It should coordinate with groups such as the Primary Care Evidence Collaborative, the Remote and Rural Healthcare Alliance (RRHEAL) and the Scottish Rural Health Partnership (SRHP), to utilise the growing evidence base of innovation in remote and rural settings, explore projects to address unwarranted clinical variation in rural areas, and provide intelligence driven evaluations and recommendations to the Scottish Government and other stakeholders.

- **To lead on promoting Scotland's Rural Healthcare on a national and global stage -** It should transform this work into a platform for engagement with regional, national and international stakeholder networks to promote Scotland's success in delivering high quality healthcare. In collaboration with Universities, other academic and research groups such as the Scottish School of Primary Care, the nascent Faculty of Remote and Rural Healthcare of the

Royal College of Surgeons of Edinburgh and others. It should help build networks that gather and disseminate the learning from other countries with successful rural healthcare delivery models.

The Centre will support delivery of a stronger response to the concerns of stakeholders in rural primary care and rural communities. The Centre should be developed in line with the Scottish Government's National Performance Framework vision for Health and use evidence intelligently to continuously improve and challenge existing healthcare models and have a focus on resolving needs in order to achieve positive health, care and wellbeing outcomes.

This approach is supported by studies commissioned by the Rural Group to compare current models of MDT working in rural primary care provision in a range of developed countries. Health Improvement Scotland carried out a rapid review that indicated there is much value in further study of international solutions to delivering primary care services in remote, rural and island communities. The Group also commissioned research from Rossall Research & Consultancy, led by Dr David Heaney: to identify and compare current models of multi-disciplinary team working in rural primary care provision in a range of countries. The research comprised 20 interviews of healthcare experts across 8 countries. Dr Heaney's work concluded that the culture and context of rural communities has motivated innovation in health service delivery across the world. The report is available on the Rural Group website.

Recommendation 6

Efforts should be renewed to make maximum use of information technology and digital connectivity in the provision of remote and rural primary care.

Rationale: The Group recognises the need for IT developments to support multidisciplinary working, through better-connected systems, remote consultation and virtual services. Alongside national initiatives to enable uptake of technology and improve digital connectivity, there is a need for a wider cultural shift across Boards, HSCPs and Practices to embrace technology enabled health and social care. During our engagement programme, we encountered examples of effective local collaboration to implement digital solutions, such as NHS Near Me that have been helpful to support effective implementation of MoU work streams.

To better address challenges at practice level, HSCPs should work closely with GP Sub Committees to support the deployment of new systems. In addition, engagement beyond primary care is needed to better understand how technology and connectivity can address the needs specific to local populations.

The Group welcomes the Scottish Government's national investment of £3,085,000 to Health Boards to improve IT infrastructure within GP Practices. This is intended to

improve the basic infrastructure, such as hardware and software, used by GP practice and multi-disciplinary team staff and to enable the development of the services set out in the MoU and the subsequent Primary Care Improvement Plans developed by HSCPs and Local Medical Committees. The Scottish Government has also set out plans to establish a primary care digital programme board to improve governance and the Rural Group should have opportunities to feed views into that developing work.

The Group recommends that the Scottish Government consider what further work can be done to support these national measures in rural areas. Through the Rural Fund, the Group has supported initiatives targeted at smaller, remote, rural and island Health Boards. In 2019/20 an additional £200,000 has been allocated to NHS Borders, Dumfries and Galloway, Highland, Orkney, Shetland and Western Isles.

A further £200,000 from the Primary Care Rural Fund is being allocated to Health Boards to assist with the deployment of Attend Anywhere (NHS Near Me) to remote and rural general practices. *Attend Anywhere (NHS Near Me)* is increasingly being seen as a viable tool to support GP practices and the wider multi-disciplinary team and the development of primary care services in rural areas. NHS Ayrshire and Arran, Borders, Dumfries and Galloway, Grampian, Highland, Orkney, Shetland, Tayside and Western Isles have each received £22,000 for the deployment of Attend Anywhere (NHS Near Me) in 2019/20 to support the roll out to rural practices.

Digital Connectivity as well as Health and Wellbeing are strategic priorities in the recently published (October 2019), Scotland's Islands: Proposed National Plan.

Recommendation 7

More effective collaboration with Health Boards and HSCPs is necessary to improve pressing physical infrastructure issues across remote, rural and island general practice, to better support multidisciplinary working, training and education.

Rationale: The development of multidisciplinary teams is one of the important objectives of the GP Contract. The Group has also heard a number of rural GPs highlight the importance of space to host training and education for clinical undergraduates and postgraduates, particularly GP training. (see the ninth and tenth recommendations below) This is widely regarded as an important factor in contributing to rural recruitment as prospective GPs and MDT members are more likely to take up posts in areas where they have trained.

The Group agreed on the importance of creating additional physical space for growing teams, and training needs. Health Boards and HSCPs should consider physical space during future infrastructure and workforce planning and should commit to essential improvements and upgrades. The Group welcomes the Scottish

Government continuing to develop the GP Premises Sustainability Fund to support physical infrastructure.

Recommendation 8

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

Rationale: We frequently heard from GPs, and representatives of Health Boards and HSCPs in smaller rural areas that due to their smaller size they have issues with project management and quality improvement capacity and expertise to develop and deliver PCIPs.

The Primary Care Improvement Fund is allocated to Health Boards using the Scottish Resource Allocation Formula. The Formula calculates target shares (percentages) for each NHS Board based on a weighted capitation approach that starts with the number of people resident in each NHS Board area. The formula then makes adjustments for the age/sex profile of the NHS Board population, their additional needs based on morbidity and life circumstances (including deprivation) and the excess costs of providing services in different geographical areas.

Across our engagement, we have heard that very remote areas have a diseconomy of scale that means funding change management support is more costly and difficult to implement. Resources for change management also extend to effective engagement with the GP bodies. The development of strong, robust working relationships and trust is essential for the effective co-production of service delivery models. In rural areas, bringing local stakeholders together can inevitably involve long travel times, and be dependent on geographic and weather factors, or rely on often sub-optimal technological solutions that can incur an additional cost and time. The amounts allocated through this formula present challenges for Boards and HSCPs with very remote communities.

It is clear through our engagement and through the evidence of the Primary Care Improvement Plans that clinicians and managers need to understand each other's priorities and pressures, and have time to develop strong, mutually trusting relationships. Strong clinical leadership will be required alongside robust management support.

In some cases, project management support is funded out of the Primary Care Improvement Fund (PCIF) to implement the Contract although this has not been the case uniformly, especially for smaller Boards for the reasons given above. The Scottish Government should prioritise developing measures to support change management in remote, rural and island general practice.

The Rural Group has used the Rural Fund to take forward initial work that can inform this process. In 2019/20 we established a fund of £117,252 to assist the three island Health Board/HSCPs with administrative/project management support. NHS Orkney, Shetland and Western Isles are each allocated £39,804 each.

Recommendation 9

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

Rationale: Across our interviews and visits there was a common view that remote and rural general practice and primary care needs to provide a wider range of services, requiring clinicians to maintain a broader repertoire of knowledge and skills. The breadth of services delivered varies across the spectrum from a small, remote practice to large urban practices. It is a continuum and the required skill sets of practitioners in two equally rural practices of similar sizes may differ. For example, one practice may support a Community Hospital and practitioners would therefore require additional skills to deliver these services. This creates specific recruitment and retention challenges that need tailored solutions to ensure the sustainability of rural general practice.

The Group welcomes the work of the Scottish Rural Medicine Collaborative (SRMC) in bringing together rural health boards and other key stakeholders including BMA, RCGP and NES to co-produce creative solutions to rural recruitment and retention challenges.

One example of this innovative approach is the Scottish Rural Medicine Collaborative project '*Rediscover the Joy of General Practice'* which was successful in recruiting 33 GPs to its first Rural GP Support Team in 2019. When asked about what attracted them, applicants cited the project's clear aims and vision, the emphasis on values, supportive teamwork, flexible working structures and collaboration across four Health Boards to address rural recruitment. The provision of training and a unified system for pre hospital emergency care provision allowed experienced urban GPs to consider working in rural and remote areas. SRMC will continue to work collaboratively with other organisations and stakeholders to continue to expand this work.

The Group recognises the SRMC's achievements and recommends that the Scottish Government support the SRMC to expand its work into efforts to improve MDT recruitment and retention. For example, nurses within small Rural Primary Care Teams undertake functions that span Practice Nursing, Community Nursing and Emergency Care Nursing. Elements from all these separate nursing career options in urban areas are required by rural nurses and needs to be recognised, delineated and supported.

The Group has supported the SRMC and other initiatives to help rural recruitment and retention with the 2019/20 Rural Fund. We have supported the allocation of:

- £342,218 to NHS Highland to support the Scottish Rural Medicine Collaborative.
- £69,450 to NHS Shetland to support the Rediscover the Joy of General Practice Project.
- £200,000 to continue support for Rural Relocation expenses reimbursements for GPs taking up posts in rural areas, and £400,000 to fund Golden Hello recruitment incentives for rural GP posts.

Recommendation 10

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

Rationale: Training of GPs and the MDT is an essential component of recruitment and retention. Practices that already struggle to recruit often lack capacity to take on trainees. Mechanisms need to be established to support GP and MDT training in rural practice.

The Group recognises the vital importance of bringing students into rural areas and notes the evidence base that increasing training in rural areas has a strong positive impact on trainees choosing to work in rural areas in their future careers.

The Scottish Government's policy is to support a significantly greater component of undergraduate medical education within the community, in general practice and primary care. As mentioned before, the *Increasing Undergraduate Education in Primary Care* Group Report, led by Professor John Gillies, published in October 2019, made a number of recommendations to achieve this. Other disciplines are following suit, for example more clinical attachments for pharmacy students are being piloted. This also has relevance to digital connectivity (Recommendation 6) and premises/physical infrastructure (Recommendation 7), and the role of SRMC (Recommendation 9) discussed above

Further work is needed to identify funding required to support the expansion of training practices in rural areas. It should also be aligned with wider work to improve capacity, personnel and space to enable this. This work should include MDT students, and should look at discovering successful training initiatives and exploring ways to upscale and transfer those to other clinical roles.

A better understanding of the different elements of care and the skill sets required to deliver them would allow Rural Primary Care Teams to describe the work they undertake and through this the training they require. Significant work in this area is

already underway. The Remote and Rural Education Alliance (RRHEAL) has developed training programmes to support rural practice and this work could be further developed to offer greater clarity and accessibility to training programmes and an improved understanding of what other training programmes are required to allow comprehensive educational support to Rural Primary Care Teams. NHS Education for Scotland (NES) undertook some in depth work looking at the skills and competencies required of GPs providing services within community hospitals. This work was used to establish the Acute Care Rural Fellowship. The RCGP developed additional curricula requirements for rural GP training which forms the basis for the Rural Track GPST programme.

Recognition of the broader skill set required of rural practitioners along with resources to allow easy access to training would improve connectivity of rural practitioners, retention and resilience as well as helping rural practitioners to feel valued. This could also include provision of funding to allow rural practitioners to attend educational events and for the provision of videoconference training programmes with the facilities for both synchronous (live) participation and asynchronous (watching recorded educational sessions at times convenient to practitioners). See also Recommendation 6 regarding digital connectivity.

Recommendation 11

The method of funding allocations to territorial Boards with significant remote and rural areas, including Island Boards, should be reviewed, in light of changing demographics and evolving models of care provision.

Rationale: Throughout our engagement programme and in discussions of the Group, we heard queries expressed as to whether the current method of funding allocations to remote, rural and Island Boards remained reliable, taking fair account of remote and rural characteristics. These include: demographic changes, evolving models of care provision, digital innovation, sparsity, deprivation, excess supply costs, travel costs and the logistical impact of having the sea separating communities.

Recommendation 12

Proportionate mechanisms should be in place to assess and evaluate new models of care provision in remote and rural areas and to assimilate and disseminate best practice.

Rationale: In the past some areas of governmental policy have been implemented locally, without adequate evaluation of impacts and outcomes, both foreseen and unforeseen. Such assessment must be proportionate and would be helpful in determining what works, does not work and what should be considered best practice. We would envisage that the proposed National Centre for Remote and Rural Health and Social Care (Recommendation 5) would have a key role in this.

Annex A - Group Membership

Sir Lewis Ritchie, Mackenzie Professor of General Practice, University of Aberdeen, and Medical Advisor, Scottish Government (Chair)

Colin Angus, Chair, Patient Representatives, P3 group, RCGP

Dr Jonathan Ball, GP, NHS Highland

Dr Hugh Brown, GP, NHS Ayrshire & Arran

Dr Andrew Buist, Chair, SGPC; GP, NHS Tayside

Dr Andrew Cowie, Deputy Chair, SGPC; GP, NHS Tayside

Dr Paul Davidson, NHS Highland Associate Medical Director (GP, NHS Highland)

Pamela Dudek, Chief Officer, Moray Health and Social Care Partnership

Fiona Duff, Senior Advisor, Scottish Government

Dr Charles Dunnett, GP, NHS Dumfries & Galloway

Aidan Grisewood, Deputy Director and Head of Primary Care, Scottish Government

Dr David Hogg, Deputy Chair, RGPAS. Resigned 12/03/2019 (Dr Alida MacGregor, Chair RGPAS, invited representative, attended workshops 04/06/19, 26/09/19, 16/01/20)

Joanne Jenkins, Senior Nurse, NHS Lanarkshire

Dr Denise McFarlane, GP, NHS Grampian

Dr Brian Michie, GP, NHS Western Isles

Dr Patricia Moultrie, Deputy Chair, SGPC

Joan Pollard, Associate AHP Director, Dumfries and Galloway

Ralph Roberts, Chief Executive, NHS Borders and Chair, Scottish Rural Medicine Collaborative

Joyce Robinson, Argyll and Bute, Primary Care Lead

Dr Kirsty Robinson, GP, NHS Borders

Dr Charlie Siderfin, GP, NHS Orkney; Medical Advisor, Scottish Government

Dr Emma Watson, Senior Medical Advisor, Health Workforce, Scottish Government

Dr Tony Wilkinson, GP, NHS Orkney

Dr Chris Williams, RCGP Scotland Representative

Annex B – Revised Working Group Terms of Reference 2019/20

Remit

To provide advice and give recommendations to the Scottish Government and Scottish General Practitioners Committee (SGPC) of the British Medical Association (BMA) on ways to ensure that the views of remote and rural general practices, including island practices, are recognised and taken account of in rural primary care policy development. The Group may cover any issue relevant to rural primary care (including social care) but in particular, the Group will focus on:

- Monitoring, providing advice and making recommendations to Scottish Government and HSCPs on the implementation of the 2018 GMS Contract and Memorandum of Understanding in remote, rural and island areas;
- When appropriate, providing advice to Scottish Government and SGPC on remote and rural aspects of the current and future iterations of the GMS Contract (including phase two);
- Monitoring, making recommendations and evaluating the use of the Rural Fund;
- Providing advice to the Scottish Rural Medicine Collaborative and any other identified bodies with an interest in rural healthcare on shaping their work programmes;
- Providing advice to National NHS Boards and Bodies on shaping their assistance to primary care providers in rural and remote settings.

Membership

- The Membership of the Group will include Scottish Government, British Medical Association, Health Boards, HSCPs, Rural Clinicians, Scottish Health Council and Patient Representation. The clinical membership should include representatives from both General Practitioners and the multi-disciplinary team.

Governance

- The Group will be chaired by Sir Lewis Ritchie and the secretariat will be provided by Scottish Government. Sir Lewis will sign off on all deliverables produced by the Group, ensuring that these are developed collaboratively.
- The Group will report to the Cabinet Secretary of Health and Sport via the GMS Oversight Group
- Where appropriate, the Group may establish sub-groups regarding specific issues. The Dispensing Short-Life Working Group is an example of a sub-group and will hereon be considered a sub-group of the Working Group.

Meetings

- The Group will meet up to four times a year and may correspond more frequently through email discussion.
- The Group will usually be organised as roundtable and workshop-style discussions.

Deliverables

- A minute will be published within two weeks of each Group meeting.
- The Group will make recommendations every year on how the Rural Fund should be used.
- The Group will make a short statement provided every year on the Primary Care Improvement Plan process.
- The Group will provide an annual report to the Cabinet Secretary for Health and Sport to include a description of the group's activities, including stakeholder engagement, evidence gathering, and lessons learned, and a summary of its recommendations. The Scottish Government and BMA will respond to this report.

Annex C - Rural Fund Allocation 2019/20

Dispensing Fund

1. The Scottish Government invested £301,080 for territorial Health Boards to support GP dispensing practices.

2. As part of the 2018 GP Contract Offer, the Scottish Government committed to establish a short life working group to consider the current dispensing arrangements for practices in Scotland and look for mutually beneficial improvements. Consequently, £300,000 is being allocated in 2019/20 to support dispensing GP Practices. This money has been allocated solely to the Health Boards which have dispensing GP Practices, in relation to how many dispensing practices each Health Board has.

3. This funding is to be used to support Dispensing Staff Training and implement the Falsified Medicines Directive.

4. Additional training is available through the Buttercups Dispensing Course to assist practice staff working in dispensing practices. Funding will be made available for dispensing staff to register for the Buttercups training course in 2019-20. This funding will be backdated to 1 April 2019 for those practices whose staff have already undertaken or applied to undertake the training in 2019/20.

5. The European Parliament and the Council of the European Union adopted the Falsified Medicines Directive in 2011. In 2019, the full requirements will be implemented. The directive is designed to protect patients and the supply chain from counterfeit medicines. Meeting the requirements of this directive will require practices to obtain Dispensing IT software. This allocation includes funding of £2,000 for each practice to help meet the requirements of the directive.

6. The allocation for NHS Highland, includes an additional £1080 for development of National Guidance for Dispensing Doctors.

PHEC Reimbursement Fund

7. The Pre-Hospital Emergency Care (PHEC) Fund of £100,000 was set up to reimburse remote and rural GP Practices for having GPs and practice employed practitioners (with BASICS training) on call for their expertise in an event of emergency near them. This fund will begin on 1 January 2020 and will cover claims made until 31 March 2020.

8. This is intended to clearly recognise the distinct additional pre-hospital emergency response skills required by rural GPs and clinicians, and to encourage remote and rural GPs and practitioners to provide high quality pre-hospital emergency care to a recognised standard. This will help develop a comprehensive co-ordinated network of trained and equipped BASICS Responders across remote and rural Scotland.

9. Currently, there is no standard national payment to rural GPs and practices for providing a pre-hospital emergency response, except for those in North Highland and the Western Isles. GPs in other rural areas do it as a voluntary part of their rural GP role and receive no additional funding for it. Therefore, we propose to reimburse remote and rural GP Practices for having GPs and practice employed practitioners (with BASICS training) on call for their expertise in an event of emergency near them.

Change Management

10. The GP Contract is a substantial reform programme that requires some services to be delivered differently. In some cases, these will be moved out of general practice into community settings and the primary care workforce will adopt expanded and enhanced roles. A fund of £117,252 was set up to assist the three island Health Board/HSCPs with administrative/project management support required to implement the GP Contract and MoU.

11. Health and Social Care Partnerships (HSCPs) as commissioners of primary care services should have resources to put in place to implement the contract.

12. In some cases, project management support is funded out of the Primary Care Improvement Fund (PCIF) to implement the Contract although this has not been the case uniformly, especially for smaller boards.

13. Therefore, a fund of £117,252 is set up to directly support the three island Health Board/HSCPs with administrative/project management or quality improvement support required to implement the GP Contract. NHS Orkney, Shetland and Western Isles are each allocated £39,804.

IT Support Package

14. In 2019/20, investment of £3,085 million is being made available for Health Boards to improve IT infrastructure within GP Practices. The main purpose of this investment is to improve the basic infrastructure, such as hardware and software, used by GP practice and multi-disciplinary team staff and to enable the development of the services set out in the MoU and the subsequent Primary Care Improvement Plans developed by HSCPs and Local Medical Committees.

15. To address the issue of smaller, rural Health Boards being unable to make the same improvements as larger Boards, we are allocating an additional £200,000 from the Rural Fund. NHS Borders, Dumfries and Galloway, Highland, Orkney, Shetland and Western Isles will receive funding on this basis.

16. A further £200,000 from the Primary Care Rural Fund is being allocated to Health Boards to support the deployment of Attend Anywhere (NHS near me) to remote and rural practices. ‘Attend Anywhere’ is increasingly being seen as viable tool to support GP practices and the wider multi-disciplinary team and the development of primary care services in rural areas.

17. This funding is to assist with the deployment of Attend Anywhere to remote and rural general practices.

18. NHS Ayrshire and Arran, Borders, Dumfries and Galloway, Grampian, Highland, Orkney, Shetland, Tayside and Western Isles will each receive £22,000 for the deployment of Attend Anywhere.

19. The Scottish Government invested an additional £400,000 to support wider IT improvements and the deployment of Attend Anywhere (NHS near me) to remote, rural and island GP practices. This funding has been allocated as part of the *Primary Care Digital Improvement* letter of 12 September 2019 issued to eHealth leads.

20. The Scottish Government is allocating £342,218 to NHS Highland to support the Scottish Rural Medicine Collaborative. This funding has been allocated as part of the *Primary Care Fund: GP Recruitment and Retention 2019/20*.

Rediscover the Joy

21. The Scottish Government allocated £69,450 to NHS Shetland to support the Rediscover the Joy in General Practice Project.

22. The Scottish Rural Medicine Collaborative (SRMC) project 'Rediscover the Joy of General Practice' was successful in recruiting 33 GPs to its first Rural GP Support Team in 2019. When asked about what attracted them, applicants cited the project's clear aims and vision, the emphasis on values, supportive teamwork, flexible working structures and collaboration across 4 Health Boards to address rural recruitment. The provision of training and a unified system for pre hospital emergency care provision allowed experienced urban GPs to consider working in rural and remote areas. SRMC will continue to work collaboratively with other organisations and stakeholders to achieve this.

Recruitment and Retention Support

23. The Scottish Government allocated £200,000 to support Rural Relocation expenses, and £400,000 to fund Golden Hellos as set out in the Statement of Financial Entitlement. These initiatives will help address workforce challenges across remote, rural and island general practice. This funding was allocated as part of the Primary Medical Services (Revenue) Allocations for 2019-20.

Breakdown of Overall Rural Fund Expenditure* – 2019-20

NHS Board	Dispensing Fund	PHEC Reimbursement Fund	Change Management Fund	Rediscover the Joy	Scottish Rural Medical Collaborative	Relocation Package and Golden Hello	Rural IT top up	Attend Anywhere	Total
Ayrshire & Arran	£9,890	£5,505				£34,000		£22,222	**£71,617**
Borders	£9,890	£1,835				£11,000	£30,000	£22,222	**£74,945**
Dumfries & Galloway	£39,560	£5,505				£34,000	£30,000	£22,222	**£131,287**
Fife	£3,297								**£3,297**
Forth Valley	£3,297					£8,000			**£11,297**
Grampian	£26,374	£8,257				£61,000		£22,222	**£117,853**
Greater Glasgow & Clyde	£3,297								**£3,297**
Highland	£136,245	£56,881			£342,218	£300,000	£50,000	£22,222	**£907,566**
Lanarkshire	£3,297					£4,000			**£7,297**
Lothian						£15,000			**£15,000**
Orkney	£9,890	£3,670	£39,084			£27,000	£30,000	£22,222	**£131,866**
Shetland	£26,374	£8,257	£39,084	£69,450		£38,000	£30,000	£22,222	**£233,387**
Tayside	£3,297	£3,670				£34,000		£22,222	**£63,188**
Western Isles	£26,374	£6,422	£39,084			£34,000	£30,000	£22,222	**£158,102**
Total	**£301,080**	**£100,000**	**£117,252**	**£69,450**	**£342,218**	**£600,000**	**£200,000**	**£199,998**	**£1,929,998**

***Figures in table are rounded to nearest pound**
£10,000 is spent on Dr David Heaney Review
A grant of £40,000 is awarded to BASICS Scotland
£20,002 is set aside for expenses of the Remote and Rural Working Group
Including above expenditure, Primary Care Rural Fund totals to £2 million.

Annex D – Remote and Rural General Practice and the New Contract: a Crisis of Identity

By Dr Kirsty Brightwell, GP, Western Isles

The 2018 GP Contract in Scotland was inevitable – the old one had come to an end in 2016. The content was perhaps predictable: reduction of risk for GPs as employers, property owners and clinicians with money promised to even out earnings and provide a team around the practices to share the load and free up the GP to meet the requirements of General Practice now and in the future.

Much promise was made in terms of support to a professional workforce under threat. A team to support the work, a focus on quality, a minimum income guarantee and a desire to work collaboratively to create solutions together to the presentations forged by complex, system-based problems of distress, poverty and austerity.

What wasn't expected by those meeting in closed rooms, shut off from the world over the 4 years of negotiations was the remote and rural backlash. These concerns, initially expressed through the language of finance, contained a sense of loss which is little to do with money and everything to do with identity. The new contract set out a vision of a very different future for General Practice. The idea that others would provide services traditionally met by the practices, challenges what it is to be a remote and rural GP.

General Practitioners have had years in glorious isolation especially in remote and rural Scotland. We have been the architects, the foot soldiers and the warriors. For small health boards with little resource it has made economic sense to contract GPs to provide services. As working employers, we have some control over our workforce (we often make up the largest part of it) and enough flexibility in terms of skills to accommodate niche services such as sexual health, minor surgery and out of hours. Indeed, when the Vaccination Transformation Programme was announced there was generally very little concern in the remote boards as it was anticipated that the practices could be relied upon to pick up the slack.

Some practices have become reliant on this additional funding to maintain the staffing required to keep small practices in remote locations open 8 am – 6 pm Monday to Friday. A symbiotic relationship developed with GPs as innovators, crafting local solutions for their populations and Health Boards assured of the quality of service through reporting structures and the lack of complaints. When it worked, the local population was well-served, less dependent on secondary care and did not have to travel for services.

We have never defined it but being a remote and rural GP felt like the pinnacle of General Practice. As our secondary care colleagues became more specialised gravitating towards, larger tertiary care facilities with aspirations of professorship, the GP in search of betterment could become an expert generalist in a remote setting.

A rural GP is the original Expert Medical Generalist. We are at the top of our game in terms of clinical knowledge and skills. We don't have the luxury of sending our patients to an A&E 10 minutes down the road and our patients want to stay at home

or in their communities for as long as possible. We are specialists in individuals and communities. We know our patients, staff and therefore the local community sometimes over several generations. With these relationships comes trust and a desire to do the right thing. We are personally invested in the future of our communities. We are driven by the need to do the right thing for our patients.

In recent years the difficulties facing practices in Scotland in terms of a reduced workforce and increasing demands have started to percolate through to remote and rural areas. Where this has de-stabilised practices, it has been disastrous. Health Boards are left with the near impossible task of providing 24/7 primary medical services to people no matter where they live without consistent, senior clinicians leading the team. The result is escalating costs and dissatisfaction.

The new contract comes at this time of huge challenge. We should be careful not to conflate the challenges with the contract. The dwindling supply of GPs, increasing rates of consultation and ever more complex combinations of problems are not the fault of the new contract. The end of QOF with the fundamental shift in how we deliver services to those with long term conditions brings much opportunity. Remote and rural GPs are well placed to show others how it is done. It may feel like our identity is threatened but I suggest the opposite is true. Our identity, what it means to be a rural GP is what the rest of Scotland needs to develop. The new contract has much to recommend it, but remote and rural GPs have been doing it for years. In this crisis of GP identity remote and rural has much to be proud of. We offer to the rest of the country a template for the future of General Practice.

Annex E – Primary Care Improvement Plan Guidance March 2019

Issued by the National GMS Oversight Group

1. The National GMS Oversight Group comprises senior representatives of the four signatories to the Memorandum of Understanding HSCPs and NHS Health Boards. The Oversight Group most recently met on 23rd January 2019, where it agreed the future reporting cycle of Primary Care Improvement Plans.

2. The first iteration of local Primary Care Improvement Plans were required to be shared with Scottish Government by end July 2018. These plans covered the period April 2018 to end March 2019. As we approach a new financial year, we expect all HSCPs to be creating the second iteration of these plans to cover the period April 2019 to end March 2020.

3. As stated in the 18th February 2019 letter from Richard Foggo, Head of Primary Care, Scottish Government, the second iteration of PCIPs should be drafted in collaboration with the GP Sub Committee and agreed with the relevant Integration Joint Board as soon as practicably possible after 1st April 2019. In addition, an agreed Local Implementation Tracker, covering the period July 2018 to March 2019 inclusive, is required to be completed collaboratively by local partners and shared with Scottish Government by 30th April 2019. All updated Primary Care Improvement Plans and Local Implementation Trackers should be developed and agreed by the relevant GP Sub Committee.

Memorandum of Understanding

4. The Memorandum of Understanding (MOU) effectively provided agreed guidance from the four parties of the Oversight Group to local partners for use in developing the first iteration of PCIPs. The core tenets of the MOU remain agreed and in place – in particular, that the development of primary care redesign in the context of delivery of the new GMS Contract should accord with seven key principles to ensure that services are:

- Safe
- Person-Centred
- Equitable
- Outcome focussed
- Effective
- Sustainable
- Affordable

Local Workforce Planning

9. The new Local Implementation Tracker will capture intelligence on a regular basis on local workforce recruitment activity and projections as the multidisciplinary team expands.

10. Effective workforce planning to enable primary care reform requires actions at national, regional and local levels. The forthcoming National Integrated Health and

Social Care Workforce Plan will include proposed national actions building on the insight and intelligence provided by the first PCIPs.

11. The analysis of the first iteration of PCIPs found that the expression of local workforce planning approaches was generally weak across the plans and description of specific local actions and levers to increase workforce supply (including consideration of workforce skill mix) were generally absent from plans.

12. Plans to address workforce supply should be complemented by plans to address issues of workforce capability that go beyond those of professional competence. It is expected that these will consider the skills necessary to deliver successful user-led service redesign in a collaborative, multidisciplinary environment.

13. The second iteration of PCIPs are required to have clear sections on local actions related to workforce planning and supply and how potential gaps will be addressed.

Patient Engagement

14. Both the MOU and the Primary Care Improvement Fund allocation letter of 23 May 2018 stress the need for effective engagement of patients and service users as plans are developed. The MOU states:

“In order to ensure that the provision of any new or reconfigured service has a patient-centred approach to care based on an understanding of the patient’s needs, life circumstances and experiences, it is important that patients, carers and communities are engaged as key stakeholders in the planning and delivery of new services. HSCPs should ensure that patient engagement is a key part of their Primary Care Improvement Plans”.

15. Analysis of the first iteration of PCIPs considered by the Oversight Group indicated that while there was evidence of strong engagement between HSCPs, Health Board professional leads, and the GP profession (in both co-producing and agreeing the plans) engagement with the wider public and patient engagement activities were less consistently evident across the first iteration of plans.

16. The second iteration of PCIPs should set out how local partners are ensuring that patient engagement is a key part of their plan.

Infrastructure

17. Both physical and digital infrastructure are key enablers of service redesign.

18. In relation to physical infrastructure specifically, all Health Boards are required under CEL 35 (2010)2 to have Property and Asset Management Strategies. As well as covering NHS owned property, they are required to include other assets used for the delivery of NHS services such as property held by independent contractors and leased premises.

19. In relation to Primary Medical Services in particular, all Health Boards are required to

- “have in place a plan for the development of premises to support the provision of Primary Medical Services. This plan must be approved in consultation with the local Area Medical Committee. This plan should be updated annually and be consistent with the Health Board’s wider Property Strategy.”
- A Policy for Property and Asset Management in NHS Scotland CEL 35(2010): https://www.sehd.scot.nhs.uk/mels/CEL2010_35.pdf
- Primary Medical Services – (Premises Development Grants, Improvement Grants And Premises Costs) Directions 2004, Direction 8 available at www.sehd.scot.nhs.uk/gpweb/7/index7_dir.html

20. It is necessary for service plans to be developed in order for Health Boards to then plan the development of premises to support those services. Accordingly, HSCPs and Health Boards must work closely together in these planning processes.

21. In relation to digital infrastructure, the costs of supplying hardware and providing software licenses to additional staff to support primary care service re-design are core workforce costs that must be identified in PCIPs.

22. The second iteration of PCIPs should set-out what local processes are in place to identify both the physical and digital infrastructure needed to support Primary Care service re-design. They should also set out what resources are required locally for both physical and digital infrastructure.

23. The second iteration of PCIPs must demonstrate that Health Board’s plans for the development of premises to support the provision of Primary Medical Services have taken account of the need to support Primary Care service re-design.

Funding

24. The analysis of the first iteration of PCIPs identified that 18 of the 31 Integration Authorities (IAs) plans included indicative funding profiles for more than one service priority for the initial three year period covered by the MOU. The analysis of in-year returns showed further refinement of expenditure profiles. The new Local Implementation Tracker will routinely capture PCIF spend and profiled expenditure against each of the six areas of service redesign. It is our expectation that all IAs will now be in a position to complete this element of the tracker in full.

Evaluation and understanding impact

25. The Primary Care Improvement Fund allocation letter of 23 May 2018 asked local partners to include in their PCIPs consideration of how changes will be evaluated locally.

26. The second iteration of PCIPs should include a description of how changes are being monitored and evaluated locally.

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