Health, Social Care and Sport Committee

Remote and Rural Healthcare Inquiry

6 February - Online Engagement

Rural GPs and Multi-Disciplinary Teams (MDTs)

Collated Notes

<u>Points raised by MDTs</u>

- Recruitment and retention of staff
  - MDT participants highlighted that, in their experience, when staff are in post they usually stay. However, big issue with regards to recruitment. Often recruitment relies on whether the appropriate candidate already lives in the local area. Very difficult to attract people outwith the local area to move.
  - Skills also need to be very wide-ranging.
  - The participants highlighted that there has been a particular shift in recruitment over the last 3 years. Now need to advertise multiple times for posts throughout the year to find suitable candidates.
  - There is also an issue in recruiting in tourist areas, such as Aviemore, as wages offered are not competitive enough to entice individuals to move to the area for work.
  - Lots of recruitment currently from England, but this is a symptom of NHS Highland being short on staff – as the latter is where they would usually pull from.
  - They also highlighted that many foreign applicants apply, but often they are not properly qualified for the post.
  - In terms of midwifery specifically, it was noted that Community Midwives used to be paid more than hospital midwives. Now with work life balance, hospital midwives can do 3 12 hour shifts instead of being full time in the community, which is a more attractive option for many.

- Training
  - Participants were asked how easy it is to access training.
  - Participants highlighted that it is difficult to support learning giving understaffing in communities. Hard to release staff to do further training, and there is no money inventive from a midwifery perspective, so many see it as an unwise career move.

- Career progression
  - It was noted that there are often a lot of part-time staff on MDTs, making it difficult to get everyone through training.
  - There is also a lack of development posts in rural areas – the example was given that there is only 1 specialist midwife in the whole of NHS Highland. It was noted that even these specialist posts are still banded at a 6, the same as other midwife posts, so the incentive to progress is not there either.

- Digital services

- Participants highlighted that there has been an increased used of digital infrastructure during and post-COVID. Examples were given in the use of NearMe in multiple practices, as well as digital records such as BADGERNET.
- However, issues with connectivity are still widespread in remote and rural areas – meaning some staff need to connect to WiFi in the patient's home in order to properly update records or manage systems which require internet.
- Teams is also commonly used for training, meetings, and clinical dialogue with consultants or specialists regarding treatment for patients rather than full referrals.

- Access to spaces in GP practices
  - MDT participants highlighted that there is an issue with GP practices becoming fuller and fuller. This leads to issues for MDTs booking into GP practices to offer their services.
  - They highlighted that face-to-face meetings in GP practices are difficult to arrange now. Often times patients can only be seen between 9-1 in some cases, due to scheduling conflicts.
  - They also highlighted there is no space to open up Hubs if necessary.
  - An increase in nurses, medical students, increased demand for mental health services and differing rules regarding booking spaces across different GPs was seen as a challenge.
  - One participant highlighted that the current GP contract, particularly with regards to contract rules and developments, are not working for NHS Highland.

- Immunisations
  - As part of the discussion around spaces, participants highlighted significant challenges when it comes to immunisations.
  - It used to be the case that immunisations could be kept in a fridge in GP practices, now often not the case, with many midwives needing o bring immunisations in cooler bags as fridges aren't maintained in some rural GP practices.
  - They also highlighted that vaccinations, particularly flu jabs, have proven more of a challenge to administer in rural areas. One participant stated they do not do any vaccines in GP practices.

<u>Points raised by Rural GPs</u>

- Recruitment and retention
  - One participant highlighted that their practice hasn't experienced many issues with recruitment and retention, mainly because they've been in a position to recruit former trainees who are now GPs. However, recruitment on the MDT side is more challenging – particularly for admin roles, with the cost-of-living crisis creating issues and constraints on how much admin staff can be paid.
  - Other areas of the Highland region are more impacted than others – for example, limited issue in Inverness when compared to Caithness/Sutherland etc.
  - Participants also reported an increase in independent contractor practices being handed back to health boards – which is an increase trend in North Highlands, where a third of practices are now board run.

- It was noted that Scot Gov has a goal for 800 GPs, while participants stated that 1000 are actually needed.
- Participants also spoke of the experience of smaller, one or two practitioner practices reporting high turnover of staff. A key reason being they are not being treated well.
- Also, difficulty in training staff within practices. Rural GPs and nurses are jacks of all trades but find it difficult to properly train when future funding is unclear.
- Participants also noted that smaller practices have limited succession planning, so there is no natural route for younger GPs to progress. One participant noted positives when it comes to an increase in rural placement of students but expressed concern about retaining staff because of the GP contract.
- Currently a lack of incentive across all areas for prospective rural GPs to work in remote and rural areas. This often goes beyond just pay – access to schooling, employment for spouses are all key factors.
- Also cost of fuel – many GPs need 4x4s to access rural areas resulting in bigger outgoings for petrol.
- GPs reported morale as being low and feeling devalued currently.

- GP Contract
  - Participants stated that the GP contract had "noble foundations" but have subsequently encountered problems. Many were of the view that the contract is impossible to deliver.
  - Many stated they are ending up in a limbo situation where they can't recruit locally, so end up shouldering work that should have been taken by the health board. This issue is particularly acute in the Highland region – notably when it comes to vaccine uptake because of the difficulty from older people accessing services digitally.
  - Participants also noted the GP contract is not geared towards supporting the independent contractor model.
  - One participant noted that the 2004 contract worked well for encouraging partnerships.
  - One participant expressed concern that there is no appropriate framework for rural practices to be dealt with in a structured way by HSCPs.
  - They indicated that their involvement with the contract has been much more than they had anticipated. The welcomed the fact that their local HSCP has understood that the contract wouldn't work as written so have sought to work with local practices to increase flexibility.
  - One participant suggested there is a lot of danger in what's been put in the contract. They argued that its implementation has had a detrimental effect on health outcomes and has resulted in a wider divide between remote and urban healthcare provision. They cited vaccine programmes, including for measles, as an example, where it cost more, levels of uptake were poorer, resulting in worse outcomes. They suggested this could have been predicted from the outset.
  - They added that they had voiced concerns at the outset but had not been listened to. A national model has been followed which doesn't work in remote areas. Its implementation contradicts net zero goals and ambitions for sustainable healthcare.
  - One participant argued that there was something about the relationship between rural practices and the Scottish Government that was fractured at the time of the introduction of the new GP contract. This had to do with rural weighting having been removed from the formula for allocating funding. They described the contract as a "central belt practice style contract". They suggested they could immediately see the

challenges it would bring with implementation in rural areas. They suggested there has been a determination to implement the new contract despite rural GPs calling for more flexibility and continuing to say it isn't working.
- Participants reported having been repeatedly told they couldn't divert from the contract and described this as an "ongoing battle". They acknowledged that the original aim of the contract was to develop extended teams and to provide greater stability but concluded that it has failed in this aim, concluding that it also does not represent good value for money for the taxpayer.
- Potentially good for central belt, but issue for rural GPs.

- Data issues
  - Participants were asked if there is data available on the difference in retention rates between independent practices and those practices run by the health board.
  - One participant indicated this was something they had looked into but had been unable to find any decent evidence. Participants also noted that NHS Highland publish a 6 monthly list of new starts and departures. While there is not much difference in the number of new starts now compared to five to ten years previously, they pointed out that there are now many more departures.
  - One suggested such data would be worth looking at and that producing such data shouldn't be too difficult to do. Anecdotally, they indicated they were aware of there being much better retention in independent practices compared to health board run practices in their local area and this was likely to be replicated in other areas as well.
  - Participants were asked whether those leaving the healthcare sector are given an exit interview and whether it would be possible therefore to know where those individuals are going.
  - Participants responded that there has never been any take-up of exit interviews within the sector.
  - One added that they were aware of such an exercise having been undertaken by Glasgow Local Medical Committee. However, they added that when the idea had been raised in their local area, there was no interest in doing it. As far as they were aware, they said this is not happening for any medical staff.
  - Participants were asked if there were any available statistics on rates of turnover of staff in remote and rural practices.
  - One participant responded that they had never seen any such data coming out of NHS HR.
  - Participants were asked if there was any evidence of practitioners leaving Scotland to practice in Australia or New Zealand.
  - Participants responded that there is anecdotal evidence but no statistical evidence they were aware of.
  - One participant suggested the closest one could get to quantitative data on rates of staff turnover would be to look at the shift from 17J to 2C practices, the number of practices that have collapsed annually, and been handed back to the health board. They suggested looking at these trends would give an idea of what's happening in terms of staff turnover rates.

- In this context, participants suggested that the rate of change from partnership to salaried status is probably a measurable metric that could help to give a picture of what's happening in the sector.
- One participant noted that, although they are being told that more graduates are coming out of training now, the level of interest in individual vacancies is less than it was ten years ago. This suggests many of these graduates are going elsewhere although they also conceded that this may also be due to the fact that many are choosing not to work full time.
- They suggested that, in this context, it is important to look at full time equivalent posts rather than headcount numbers.
- One participant highlighted that Public Health Scotland provides quarterly data in this area but raised concerns that some of the data appeared to be inaccurate. They agreed that it would be really useful to have reliable data in this area as a standard metric.