ROYAL COLLEGE of PHYSICIANS of EDINBURGH

Response from the Royal College of Physicians of Edinburgh to the Scottish Parliament Health, Social Care & Sport's remote and rural healthcare inquiry

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

Fellows identified a range of issues that were specific to remote and rural communities and which they considered should be matters for the National Centre. These included: equity of access to CPD for all health care professionals, local training opportunities for post graduate health care professionals and having higher grades of trainee doctors spend time in remote and rural areas.

In addition, they raised strengthening local access to the training of new health care professionals at all levels and across all disciplines, removing or reducing the need to travel for training in community carer roles, band 3 and 4 advanced non-qualified roles, AHP, paramedic, pharmacy, nursing, advanced practice roles and post graduate medical careers; ensuring digitally enabled health care is fit for remote and rural communities; and ensuring rural community health care has access to community support teams, community nursing, local pharmacy and primary care teams alongside enhanced urgent care decision support and emergency care pathways.

More broadly- and this would be the case for the Remote and Rural Workforce Strategy also- Fellows consider there is an important task to be done in terms of promoting the advantages of working in a rural area. It is the College's view that detailed knowledge of the individual patient and the social context they live in can yield many benefits in the diagnosis and management of health problems and still represents an 'ideal' which should not be overlooked or undervalued. Smaller communities and the healthcare organisations that serve them can, in this light, be seen as extremely good places to educate and train an expanding healthcare workforce in good holistic practice, which is valued by patients.

Another important issue is that clinicians in remote and rural settings are often service-based, leaving little time for research and development. It is essential that we find ways to engage remote and rural doctors more in research on the issues that affect remote and rural populations.

Fellows indicated that further investment in and development of technology-enabled health care in hospitals and the community in remote and rural areas could help deliver secondary and tertiary care locally and potentially reduce the number of patients requiring travel to services in urban centres.

The College believes that rural patients and populations would benefit greatly from an 'enhanced prevention' approach with strategies of lifestyle intervention, adapted to cultural contexts, and pre-identification and intervention offered to high risk individuals. This would aim to reduce the number of emergency presentations which often have time-sensitive outcomes and get ahead of these devastating medical problems.

Fellows working in oncology expressed the view that the National Centre might be well placed to evaluate the quality of onward care of people with cancer in remote and rural locations, beyond the diagnosis and initial management. They indicated that it is possible to evaluate these challenges because of the information contained in cancer registries.

Some College Fellows also suggested that the National Centre could take a lead in terms of improving networking support for clinicians working in rural areas, for example through an annual conference bringing people together to share experiences and highlight best practice.

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

Again Fellows suggested a number of issues which were matters for the Scottish Government to address more generally. Overall funding levels for rural health care are obviously an important priority. There are many issues which impact on the attractiveness of remote and rural areas as locations in which to work. Fellows stated that often the cost of living remotely was greater than living in urban communities, when all costs are taken in to consideration such as the need for more travel, the expense of maintaining rural housing, cost of deliveries etc.

Some Fellows indicated that national pay scales do not always compete with the level of pay offered by other local jobs in other sectors or moving away to work in an urban environment. Fellows were keen to ensure that remote communities have good access to high-speed internet to facilitate digitally enabled healthcare and to ensure good transport links and connectivity to rural communities. Similarly, the lack of suitable and affordable accommodation is a vital issue and can affect the ability to attract and retain healthcare staff in remote and rural areas. Access to affordable childcare for clinicians and NHS staff is also important.

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

The Royal College of Physicians of Edinburgh looks forward to the forthcoming strategy which it considers is extremely important and overdue. The College considers that increasing the retention and recruitment of doctors and other healthcare staff within the NHS in remote and rural areas is of fundamental importance and should be at the heart of the strategy. Fellows are very aware that recruitment and retention of healthcare staff to remote and rural areas is an increasing challenge. In some rural areas there have been no applications to vacant consultant posts . The traditional approach of doctors applying for full time substantive post is no longer the way that rural boards can attract staff. There are more doctors considering hybrid work patterns – this puts pressure back on the full time substantive post holders and can affect the number of trainers per board. Furthermore, since remote and rural areas have a reliance on locums and hybrid workers in order to provide frontline services, the benefit in kind tax- tax that applies to certain benefits that employees receive from their employers- is having a detrimental impact on the willingness of doctors travelling to remote and rural areas to work. Health boards can be asked to increase the hourly pay rate to help compensate for staff who may lose out under the benefit in kind tax.

Fellows in remote and rural areas stated that a huge effort was required to develop a strategy to de-centralise training at all levels with far too much training currently taking place centrally, which neither adequately trains health care professionals to deal with all of the care needs of remote and rural patients, nor encourages them to settle in rural communities. Fellows emphasised that additional remote and rural jobs for doctors in training must have appropriate accommodation, travel expenses and support for these posts.

Being a Local Education Provider (LEP) is a key role for remote and rural boards because it brings:

• Trainees into the area to experience remote and rural practice making it more likely they will return in future to work.

• External scrutiny, which in turn improves quality of care provided.

Recruitment challenges can place additional strain on existing trainers and brings fragility to the LEP status of remote and rural health boards. We need to consider whether we can use additional team members in education and clinical supervision and if there is a place for more remote education supervision.

In addition, Fellows hope the strategy will contain specific proposals to boost recruitment and retention of senior doctors including within surgery, medicine, anaesthetics and general practice.

Some Fellows indicated that the strategy should help physicians and indeed all healthcare practitioners working in a rural setting to have parity of esteem with those in teaching centres and that this is an important cultural issue that needs to be addressed.

Many Fellows raised issues relating to how the generalist nature of clinical work in remote and rural areas can hinder doctors applying for vacant posts. There has been an increasing trend towards specialisation of the workforce in recent years and this has negatively impacted on the ability to recruit doctors to remote and rural areas where the training does not match the job they are required to undertake. Fellows would like to see the strategy build upon welcome initiatives such as the Rural Surgical Fellowship, Rural GP Fellowship and Credential in Rural and Remote Health (Unscheduled and Urgent Care). It was felt that training programmes might be reviewed to ensure generalist skills are included so trainees are able to work in rural areas.

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

Some Fellows raised the issue of staffing at visiting consultant level for service delivery, which in turn requires an uplift in consultant numbers across the country as a whole. They suggested that senior clinicians are best placed to deliver, train and upskill local workforce (eg GP with a special interest nurses, AHPs) and to enhance service delivery.

Fellows said they would welcome more engagement from health boards in advertising and promoting GPSI or career grade GP applications and enhanced engagement with local GPs in remote and rural areas to be trained in specialties where there is unmet need, to assist with service delivery in between the visiting consultant clinics.

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

Fellows noted that issues related to employment and immigration of overseas workers will require government attention, likely at both Scottish and UK levels. There is an over reliance on private agencies to support the workforce with international staff. There are more productive partnership models which national institutions can explore that can yield economic as well as educational benefits for international health care workers, as well as deliver better care and outcomes for patients.

Some Fellows highlighted tax or student loan incentives for staff taking jobs in rural areas in Australia - https://www.health.gov.au/our-work/workforce-incentive-program/doctor-stream#how-the-doctor-stream-works. It was considered useful to look at what other governments were doing successfully to attract staff to their

health systems and this included Brazil, Canada, the Philippines, Rwanda and South Africa. Given concerns regarding a brain drain affecting the rural workforce in developing countries, it was suggested that the government should consider partnerships and programmes which deliver mutual benefits in terms of addressing rural health challenges. Fellows indicated they would like to see a move away from international staff recruited from private agencies to more structured programmes of bilateral partnership. Fellows considered that the Medical Royal Colleges, such as the RCPE, had potentially valuable contributions to make here given their extensive international networks and existing schemes like the Medical Training Initiative

Issues concerning levels of pay and conditions that can compete with agency contracts, in order to attract and retain staff, are important but not only within the remit of the strategy. Fellows noted that at the moment it is very hard to encourage staff in hospitals to move on the substantive contracts and community staff are even harder to attract either using agency or substantive contracts.