Appendix 2 Healthcare in Remote and Rural Areas

Aberdeenshire Health and Social Care consultation response:

What are the most important issues we should look at when we do our inquiry about healthcare in remote and rural areas of Scotland?

The definitions of 'Remote and Rural' or 'Urban Environment' are limiting Aberdeenshire as to how to progress with services. Aberdeenshire Health and Social Care Partnership (AHSCP) need to look at the variations across localities - for instance:

- Pockets of rurality.
- Explore how to adapt services to meet a large geographical area with variations in demographics.
- Aberdeenshire are not rural enough to be called strictly rural but has extreme pockets of rurality and a very large geographical area to cover.
- Consider recruitment and retention and blended roles.
- Consider hub and spoke models to reach population areas and make best use of resources.

The recent CMO report is looking to support realistic medicine and streamlining services to create efficiencies. This is something AHSCP are hugely in support of, however when challenged with distance, travel, and transport – ways in which to support this way of working to its maximum needs to be explored.

Some of our practices have expressed their views below. The themes are all driven by close connections to their patient populations with a long-established willingness to work broadly and pragmatically across professional licence. Rurality demands this flexibility, but we have a contract that neither recognises nor funds this, instead arranging care based on fragmentation of service that can only be met with the transport, infrastructure, and workforce options of urban areas. We need to ensure that ideas are deliverable with the workforce we have.

Inverbervie

The current GP contract based on the MOU 2 is failing in rural areas because of the low population density in rural areas and the large geographical areas practices cover. The concepts described in MOU2 where services are provided by HSCPs to reduce GP workload have failed to deliver because the small practice populations only attract a small part-time resource at best with the tight financial constraints and once travelling is factored-in, there is nothing like the resource required to provide a service to these populations. Fundamentally, it costs more to provide patient facing services in rural areas.

The MOU itself promises services which seem impossible for Scotland to deliver, and this is more pronounced in rural areas. There are not enough pharmacists, ANPs or GPs and training numbers are insufficient. Retention is poor in the case of GPs in training and pharmacists and ANPs are in short supply and will work

only where the terms and conditions are most favourable and are demanding unaffordable salaries. Remote and rural communities are suffering more with this.

Given the financial and workforce constraints, the creation of hubs to provide services is sensible but transport is a real issue and provision of transport would help make these services viable and acceptable to the public.

For General Practice to be sustainable, recruitment and retention needs to be addressed and a more content workforce would go a long way to improving this. The current MOU has not improved working conditions for remote and rural GPs and a more flexible approach with recognition of the true challenges involved in delivering services to remote and rural communities is required.

Portlethen

Fundamentally we feel that rural/semi-rural practices are so much more diverse in size, geography, demographic and service delivery than city practices. Therefore, the contract does not work when it is delivered as a one size fits all. Each practice has very different needs. We feel service delivery would be much better if practices were given their own budgets that would be ring fenced for staffing and we would be accountable to SG to advise what we had spent the money on.

Transport is key to service delivery success in these practices. This can reduce demand on DN staff and practice HV's. Portlethen community bus is a good example of this. Could rural/semirural practices get a transport allowance?

CTAC staff are given higher wages for less skilled roles. This makes it very difficult to recruit and threatens the stability of the work force. CTAC apparently do not have a training budget, no equipment and poor sickness cover. This increases demand on GP practices to support a service that was supposed to take the pressure of GP's.

We feel an acute care hub would be detrimental to continuity and further destabilise our practice.

Huntly

From our point of view in Huntly where we are well off compared with some rural practices, our thoughts are to emphasize the difference of needs between a rural and city practice. Aberdeenshire patients who often have no mode of private transport (and neither do friends and family) struggle to make their way to city hospitals even when they are well enough. The difficulty is heightened especially in wintertime. Public transport for those accessing non-urgent health care is still poor but regarding ambulance provision which has gone through very difficult times, we cannot emphasise enough how very dangerous this can be for an unwell patient waiting for hours at times to be taken to secondary care.

We believe that if community hospitals were adequately supported this would help greatly to address the imbalance of provision of care which inevitably happens, especially when there are no beds for those approaching end of life and

whose quality of care can be vastly improved by admission. As a community who have traditionally relied on Jubilee hospital for acute admissions as well as rehabilitation, we are always keen to try to improve our service but feel that the Aberdeenshire wide budget is often not balanced correctly to support staff looking after local people locally.

On discussing with secondary care consultants there are many potential areas where community hospitals could help if adequately provisioned. We already offer day case services, for example blood transfusions, certain infusions, venesection etc. In Huntly we are fortunate to have X-Ray, physiotherapy and OT on site and satellite clinics from Elgin and Aberdeen are of great benefit. With support and vision there is room to expand this, but changes like this inevitably need governmental change.

Regarding the Primary Care Improvement Plan we feel that the Scottish rural population has been let down by the lack of understanding of the practical difficulties in applying this to certain areas. Urgent care doesn't 'work' due to the vast travelling distances involved. Pharmacotherapy and CTAC are vastly under-provisioned from lack of recruitment in many rural areas, also with no cover for absences. It has been hardest on patients and health professionals whose practices have folded with the lack of staffing and increase of pressure of work over the last couple of years. Much of Scotland's attraction is its unique and beautiful rurality. This calls for a different, unique support from our government.

Turriff

Healthcare in rural locations cannot be considered in isolation, need to consider poor public transport links, additional time that it takes to do home visits due to distance to be covered and rural deprivation meaning that the cost of a taxi or even the cost of fuel to cover travelling to a hub rather than a local centre means accessing healthcare is prohibitively expensive for some.

When centralised resources are split on a per 1000 patient basis small practices lose out and the resource is worse than useless. For example, if a practice is getting a WTE pharmacist/15000 patients and they have 1000 patients they are entitled to around 2 and a half hours of pharmacist time per week - barely enough time to make it worth coming to the practice or to do anything useful - this is a major problem with how the PCIP funding is being split.

The difficulty of recruitment and retention to rural area's is increasing. More needs to be done to ensure that these roles are attractive and sustainable in both health and social care - this is especially true for home carers who must travel further between their visits and don't get adequately remunerated for their time or their mileage. Also applies to medical and dental clinicians, community nurses, allied health professionals - pretty much everyone involved in community health in more rural areas.

Mobile phone and broadband coverage are still an issue in a lot of rural locations meaning that technological solutions such as video consulting are less useful.

Community Pharmacies in rural areas are rapidly closing as they are less financially viable; this is a massive loss to communities and widens health inequalities.

Overall feeling in new GP contract not fit for purpose in more rural areas. We need much higher number of GPs per population, and MDT doesn't work well for smaller more rural areas. We need to keep and boost the senior doctor heavy model who can do everything and not segment off primary care to different professionals. Centralising not helpful for healthcare. Hubs might be cost efficient but not good for patient care.

Rhynie

Rhynie Medical Practice at AB54 4WA is a Branch Surgery of the Inverurie Medical Group, a large GMS practice in Inverurie itself with Branch Surgeries in Kintore and Rhynie. The Rhynie practice is 21 miles from the main practice and has a practice list of around 1100 patients. Daily, there is one GP present with an Administrative Staff/ Dispensers of 5 including our Dispensary Manager. Rhynie is approximately 9 miles from other local practices- Huntly to the north and Alford to the south. Key issues for us relate to national and local factors:

- GP recruitment and retention. Although a wider issue affecting all practices, the constant concern about retaining staff and recruiting new GP's is all pervasive and practices can easily reach a tipping point where it becomes impossible for them to maintain the service agreed in their contract. Small practices are especially vulnerable in this regard. Although we, with other rural practices have good links with Aberdeen University Dept of General Practice and regularly have senior students with us, it is unlikely that they would choose this setting even if they decided on a career in GP.

- Recruitment and retention of nursing staff in the practice. This is a pertinent issue with us having lost a highly experienced Practice nurse who delivered the majority of our Chronic Disease Management as well as providing normal nursing and phlebotomy input. With the failure to recruit so far to replace her, much of the routine work is passed on to the Duty GP's, eroding time for more general clinical work.

- Ensuring links between the practice and District Nursing / health Visiting colleges. In years past, we were fortunate in having our DN's and HV's working part-time from a base in our premises, facilitating support and discussion. Staffing difficulties have led to centralisation of these teams in neighboring Huntly and Alford and our communication is now by phone and, despite our colleagues' willingness to help, they too have limited resources.

- Links with Substance abuse teams, Macmillan nurses and Podiatry who came to the practice have been lost during Covid and our links to these services are now by phone and patients must travel to see these PAMs services.

- Access to Laboratory Services/ transport. We have a courier service to take Laboratory samples to the main labs in Aberdeen Royal infirmary on 2 out of 5 days which limits how quickly we can expedite results for urgent investigations.

- Public Transport Links to surgery and local Cottage Hospital / X Ray / Physiotherapy. Reductions in bus services have restricted access to the surgery for patients who do not have their own transport and at times, this may increase the need for home visiting when patients who need face to face to face assessment are unable to travel. Our local X Ray resource is in Huntly and patients at times have issues about travelling for investigations there.

- Access to Emergency SAS support. Our nearest ambulance station is in Huntly and, although our Ambulance colleagues work hard to get to us quickly, their service is often constrained and so we sometimes must support patients at home or in the surgery until help arrives - with a single-handed GP and no practice nurse, everything else then must wait.

- Remoteness for Secondary and Tertiary Care. Although our patients are used to having to travel, this is a burden for those needing to travel frequently for cancer-related treatments.

- Vulnerability to Extreme weather. Everyone is affected by these events, but it sometimes means that medical and other staff are unable to reach the surgery or normal light/ power/ water are lost making it impossible to maintain a service.

Alford

Patients of Remote and Rural practices are suffering an inequality of care due to a lack of understanding by government that practices are unable to provide services in the same way as urban practices. The main issues/considerations are:

- Rurality - lack of transport, lack of local services, unable to recruit.
- Increasing house builds with no thought to impact on practices and no funding to help improve access/services.
- Lack of transport to hospital - bus services are being cut.
- Poor recruitment and retention of all staff (not just GPs).
- Lack of Pharmacists.
- Emergency Response Times (have to wait for hours, even if one hour response requested).
- Lack of Accessibility to Services Locally.

- Close Hubs and offer services from practices once again with the funding, and staff, allocated to Hubs (patients currently have a 40+ mile round trip for vaccinations and/or bloods).
- Lack of strongly worded guidance for patients directing them to the correct service.
- Allow Pharmacies to offer more.
- Single shared record.

What is your postcode? This helps us find out where issues are happening in different areas of Scotland.

AB43 6SX
DD10 0RU
AB12 4QL
AB54 8EX
AB53 4DQ
AB54 4WA
AB33 8FL