



Royal College of
General Practitioners

Being Rural: exploring sustainable solutions for remote and rural healthcare

RCGP Scotland Policy Paper written by the Rural Strategy Group Scotland

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Executive summary

Remote and rural healthcare in Scotland has reached a crisis with problems with recruitment & retention for GP practices from Stranraer in Wigtownshire to Whalsay in the Shetland Islands. The causes of the crisis are complex and multi-factorial and have the potential to adversely impact on safe and effective patient care. When brought together, as is the case, these issues (listed below) constitute a particularly challenging environment in which to recruit and retain both GPs and other healthcare professionals to remote and rural environments.

- Connectivity (mobile phone/broadband)
- Transport
- Fragility of support services
- Workload (including the 24 hour commitment)
- Professional development
- Education & Training
- Professional and social isolation, including
- Adverse effects on family life

To effectively support remote and rural practice, RCGP Scotland is committed to working constructively with Scottish Government, health boards, NHS Education for Scotland (NES), and other stakeholders to:

- Help eradicate current inequalities in access to good primary healthcare provision in rural areas.
- Increase recruitment and retention for rural practitioners through actions at school, undergraduate, GP training and continuing postgraduate development levels.
- Promote rural general practice in Scotland as the exciting and rewarding career that it is.
- Achieve better mobile and broadband coverage throughout remote and rural areas of Scotland to better manage patient care.

Introduction

Remote and rural healthcare in Scotland is experiencing a deepening crisis and is in urgent need of review and reshaping. RCGP Scotland sees general practice services in remote and rural areas to be founded upon the same generalist and community-based principals as general practice everywhere; the approach epitomises the 'essence of general practice'.¹

The growing recognition of the need for generalism in healthcare is a welcome development. This means that in rural areas, the GP often has to undertake a much wider role in acute illness and trauma than his/her urban colleagues, often with limited backup and support. Experience shows that innovations in rural areas can be rolled out to the benefit of the wider NHS and translates well to non-rural settings.

In the past, the focus has tended to be on the Highlands and Islands, however, we recognise now that this is an issue across both Highland and Lowland Scotland, affecting all rural Health Board areas.

Background

GP recruitment and retention is increasingly difficult throughout the country, but has reached crisis point in remote and rural areas.

There are currently a wide variety of groups looking at different aspects of the problems, including Scottish Government, NHS Education for Scotland, NHS Highland, RCGP Rural Forum, the Centre for Rural Health² and the Dewar Group which recently held a conference in Fort William³ to mark the centenary of the 1912 Dewar Report.⁴

During July 2013, an RCGP delegation led by UK President, Dr Mike Pringle visited practices in the Western Isles to seek further insight into the particular problems experienced in these practices (Appendix 1).

Historical context

Providing health care in rural areas of Scotland has always been a challenge. The clan system had a well developed medical system⁵ in the Highlands informed by European Universities, but this disintegrated in the aftermath of the Jacobite rebellions. In the 1850s, attention was drawn to the inadequacy of medical care, but it was not until the Dewar Report of 1912⁴ that sufficient political will existed to tackle this problem. The resulting Highlands and Islands Medical Service was the first state-funded comprehensive health system and was the sole model for the NHS white paper 30 years later.⁶ Soon after the formation of the NHS continuing problems were noted, particularly in the Birsay Report of 1967.⁷

More recently, Professor Sir David Carter's 'Acute Services Review' (1998)⁸ raised the problems of healthcare in remote communities. This led to a recommendation that both a 'task force'⁹ to consider the needs of remote communities and a resource centre should be set up. Partly as a consequence of this, the Scottish Executive Health Department invested £8 million in the Remote and Rural Area Resource Initiative (RARARI), a 3-year project (2000–2003) which gave workers in remote and rural areas the opportunity to explore aspects of healthcare delivery. This project achieved much, including supporting BASICS Education, that currently provides an

important resource to continue to support emergency pre-hospital care across Scotland. However, since 2003, it has proved more difficult to fund specific remote and rural initiatives.

Recent events

Recruitment and retention of GPs is difficult across Scotland and the UK. In rural areas of Scotland, increasing numbers of practices are now being run at considerable cost by locums or directly by Health Boards under “2c contracts”. These arrangements come at a higher cost and may have an adverse effect on continuity of care. High profile recruitment campaigns such as in West Lochaber have been unable to recruit doctors¹⁰ and NHS Greater Glasgow & Clyde has been unable to recruit to the Isle of Cumbrae despite 3 attempts.¹¹

Pharmaceutical services, resilience of general practice and dispensing

GPs and patients are currently very concerned about loss of GP dispensing services in remote and rural areas. For example, on the Isle of Cumbrae the loss of dispensing led to the resignation of the incumbent GPs who felt that the practice was no longer viable. Following this, the Health Board has continued, for over a year, to provide locum cover whilst seeking a variety of options for more permanent staffing. A comprehensive view of this issue is contained in the paper prepared by Dr Kate Dawson in response to the pharmacy application in Benbecula . In May 2014, Drymen has experienced a loss of GP services for the same reasons, and Aberfoyle is currently under threat. This is a critical issue that has been recognised by Scottish Government who are planning changes in legislation to ensure the needs of patients are not prioritised above the commercial interests of pharmacy service providers¹².

In line with the implementation of new government policy on Prescription for Excellence¹³, Scottish Government has introduced new regulations on the control of entry for new pharmacies in rural areas. This will require health boards to designate some areas as remote and rural and empower them to refuse an application if it would adversely affect the provision of other medical services in that area.

These regulations came into place on 28th June 2014.

<http://news.scotland.gov.uk/News/News-scrutiny-for-pharmacy-applications-cfa.aspx>)

Improving Infrastructure, Patient Care & Professional Development for GPs

1. Connectivity - Mobile Phone and Broadband Coverage

Lack of investment has resulted in poor mobile phone signal and poor broadband internet connections. The decision to allow mobile reception providers to cover a percentage of population rather than land area has been detrimental to rural populations. The rollout of 4G ultra-fast mobile networks has begun and yet many rural areas of Scotland have no mobile signal at all. For example, the Applecross, in Wester Ross community now has a fast broadband link from Broadford on Skye, but no mobile reception. This is causing a digital version of the 'inverse care law' that needs to be recognised at a national level.¹⁴ Rural areas - which have the most to gain from telehealth - have the poorest connections. Rural practices which often operate from a number of branch surgeries, are often limited in services provided by having inadequate or unreliable connectivity.

The Scottish Government has recognised the importance of fast internet links to remote and rural areas. BT is at an early stage of a rollout of fast broadband with the target of 97% coverage by 2017. It is hoped this will provide opportunities for technology to improve healthcare in remote areas and will also be important for community resilience.^{15 & 16}

2. Geography/Transport

In the Dewar Report⁴ (1912) the Highlands and Islands were described as follows:

"The country is rugged, roadless, and mountainous, and where not composed of islands is very largely peninsular on the seaboard, and inland is broken up by lakes and rivers. The weather conditions, too, and particularly in the winter-time, add enormously to the difficulties of travel."⁴

Much has changed, but the basic description of the area remains valid. Many roads, even some main roads, remain single track. Public transport options are scarce and where they exist, are often interrupted by the weather.

The care of seriously injured or ill patients becomes both challenging and prolonged for the rural GP who relies on a generalist approach to make difficult decisions in a resource-poor environment. The Emergency Medical Retrieval Service (EMRS)¹⁷ has developed into an essential link to bring consultant-led critical care to rural communities, and optimise the retrieval journey to larger centres of expertise. However, there are specific implications in the care of the psychiatrically unwell with transfer off the islands requiring air transport and trained CPN escorts resulting in delay in transfer for definitive treatment and considerable strain on GP services.¹⁸

Patient transport generally is difficult in many rural communities with perceptions that the ambulance service is relatively underfunded in rural areas leading to delays in transport.

3. Fragility of Support Services

There is an interdependence between services especially given the shared, extended roles and if one service fails it has a marked knock on effect on the others: such as loss of palliative care trained nurses and loss of radiography services.

For example, “The recently introduced National On-Call Agreement has had the effect that on-call periods for radiographers attract a much smaller retainer fee than previous contracts allowed. No rural-proofing has been considered for this national change, and this has introduced a significant pay cut to all radiographers accepting a new contract; particularly those who are moving to or wishing to accept a permanent contract in rural areas.

There are further difficulties in implementing compensatory rest periods and other conditions of employment, with the effect that expectations remain for these components to be waived by rural staff. The effects of this on provision of radiography services are starting to be seen in areas that have required to recruit new radiography staff, however the full ramifications are yet to become apparent. Indeed, as well as radiography staff, this also has had an impact on emergency and retrieval services, community nursing and other support services which are vital to rural healthcare.”¹⁹

4. Managerial Priorities/Professional Representation

Managerial Priorities

We recognise that many managers of health services for remote and rural areas work extremely hard to provide resilient and high quality health care. However, there are perceptions in some areas that geographical distance from managerial support and decision making at Health Board level causes difficulties. The reality is that remote and rural issues do take up an inordinate amount of management time. Service models are hard to change and recruitment and retention is time consuming and costly.

In the Western Isles, great progress has been made in Lewis around the Western Isles Hospital in the range and sustainability of services available, including that for OOH, but this has been perceived by some of the more remote GP practices to be at the detriment of primary care services in other locations.

Clinics in the Uist & Barra Hospital are staffed by consultants who come from Stornoway, but as patient transport is centrally funded by Scottish Government and staff transport is funded by the Health Board then there is inevitably Health Board pressure to centralise clinics.

Professional Representation

An example of issues around professional support & representation is seen in areas like Campbeltown & Lochgilphead. These areas are remote & isolated, the hospitals are staffed by GPs and provide a highly effective ‘blue light’ emergency receiving response. The model of care is one which is entirely compatible with the direction of travel of Scottish Government’s 2020 vision, bridging the primary/ secondary care

divide. However, supporting the model may need different forms of professional representation to those that currently exist.

5. Workload

The nature of rural practice is different from urban areas. Whilst the numbers of patient contacts tends to be less in rural practice, other factors contribute to different pressures on rural GPs.

These include:

- 24 hour commitment - many remote and rural areas have been unable to opt out of the out of hours (OOH) provision or where, as in Lewis and Harris, some have opted out, the burden of provision has fallen on the remaining GPs. An informal poll at the 2013 Remote Practitioners' Association of Scotland (RPAS) meeting suggested that 60% of RPAS members were involved in covering OOH. In these areas, some innovative solutions have been developed (see Appendix 1) with close working with nurse and ambulance extended role practitioners, but these models need further thought and investment to work across different geographical areas. The fact remains that many GPs continue to carry full responsibility for 24 hour care, and despite moves to shift workload to other professionals, GPs remain ultimately responsible for much of the clinical care in rural areas.
- Increased pressure during the OOH period – rising patient expectations, particularly from patients who have moved from central locations to rural locations, combined with rising prevalence of multiple morbidities, is creating a more complex and frequent workload on OOH and community hospital services.
- Scope of work - in many of the remote practices the GP also provides a variety of other services, e.g. GP led specialist clinics in areas like dermatology and paediatrics, immediate (BASICS) care, medical support to search and rescue services. Some of this work is not contractually recognised despite requiring specific training.
- Professional isolation exacerbated by poor access to broadband, difficulty in hiring/funding locums, and the inevitable impact of geographical distance on increased travel times. This can result in stressed doctors. Recent tragedies including suicide²⁰ are testament to the great pressures faced by rural GPs.
- Shift of care from secondary to primary care – a national drive²¹ as described in the Routemap to the 2020 Vision. The aim is to look after more patients at home rather than hospital, including swifter discharge from hospital, and has resulted in an inequitable pressure on rural areas where there are already challenges in providing multidisciplinary input. Specific examples include home dialysis, management of post-operative infection and community-based chemotherapy. It also includes the presentation of temporary residents where access to notes and previous investigations is limited. Increased prevalence

of comorbidity makes clinical judgements for acute presentations far more challenging, and again this is even more of an issue when treating tourists and other visitors.

- The General Medical Services (GMS) contract – negotiations between the Scottish General Practice Committee (SGPC) and the Scottish Government are ongoing at present with a stated aim of encouraging longer term stability and a greater focus on quality outcomes. This may well allow the opportunity for greater flexibility to support service development, better control of workload and a more stable income base for GP practices thus aiding recruitment. However, these negotiations are at an early stage and there is a need to ensure that new contractual developments will support rural models of health provision. RCGP Scotland supports a greater focus on quality and community based care. Contract negotiations in the rest of the UK are following a different focus and are less certain as to impact on workload, especially in rural areas.

6. Education and Training

The WHO Global Policy Recommendations²² – ‘Increasing access to health workers in remote and rural areas through improved retention’ - makes five clear, evidence-based recommendations in regard to education. We have added a sixth on premises and the estate for rural general practice:

- *Get the ‘right’ students*

Cochrane Review²³ states that recruiting from a rural background increases the chance of graduates returning to practise in rural communities. The Highland Schools Medical Mentor Scheme²⁴ is run by the RCGP North of Scotland Faculty. It aims to redress the perceived imbalance rural students’ face to get into medical school. It is a successful scheme, but limited by the burden that is placed on the volunteer GP mentors. Raigmore Hospital also has a successful ‘Doctors at Work Scheme’²⁵ run annually to enable students to get structured work experience. Unfortunately, there is little or no community work experience involved.

- *Train students closer to rural communities and bring students to rural communities*

Undergraduate rural placements

It is important for students to have positive experiences of rural health early in their career, but only a limited number of Universities encourage and actively facilitate their students being attached to remote or even rural practice. Aberdeen and Dundee Universities are good examples of best practice given the effort they make to facilitate and encourage rural student placements.

Electives and special study modules (SSMs/SSCs) are important gateways for students to access rural practice, and there are many examples of where this has been effective in stimulating interest in rural practice as a career. However, these

programmes need to be funded adequately, with the increased costs to students recognised. Dundee and Aberdeen have achieved an effective means of covering these costs, and the means of doing so should be made available to other Scottish universities – in medical schools as well as placements for other members of the healthcare team. Consideration should also be given by Health Boards to provide 'Dewar Bursaries' to assist undergraduates financially to gain rural work experience, ideally open to students from across the country.

Other countries, notably Australia and Canada, have situated major teaching and research units in rural areas, not in cities, a policy which has had success in increasing recruitment.²⁶ Academic rural research both into educational requirements and into clinical and health policy is important and needs to be encouraged and better resourced in Scotland.

- *Foundation Year exposure to rural practice*

There are limited examples of where this has been possible. There are many opportunities for stimulating and challenging FY2 attachments in rural areas. This is a significant opportunity for people to experience life in rural practice and also an excellent opportunity to learn generalist medical skills.

- *GP specialty training schemes*

The recently established 'Rural Track GP Training' by the Scottish Deanery is growing in popularity. There is an opportunity to increase input to the scheme and extend to other parts of rural Scotland. However, there are currently limited opportunities for trainees to join other rural-focussed GP training schemes. Many rural placements are bundled with other, less rural placements because of geographical boundaries and the constraints of training posts currently available. Current trainees could be offered opportunities to select specific rural placements, which will offer a range of practice including community hospital and pre-hospital work, as part of the core RCGP Training Curriculum. Development of this could be modelled on the current 'rural track' training programme²⁷, which is currently limited to practices within the North of Scotland Region.

Current training regulations are perceived as problematic for small practices with low list sizes to achieve adequate throughput of patients for GP training. Imaginative solutions could be sought for this, including rural GP trainees spending some time in urban practices, possibly on an exchange basis.

It is also important to stimulate interest in rural practice for GP trainees on non-rural track schemes. This would be facilitated by taster weeks or visits to rural practice, or allowing GP placements to be undertaken in areas remote from the hospital component. Thus, hospital jobs in inner city areas could be combined with GP placements in remote and rural areas.

- *Match curricula with rural health needs*

On a broader front, there could be considerable benefit in revising undergraduate and postgraduate curricula to include rural health topics so as to enhance the

competencies of health professionals working in rural areas, and thereby increase their job satisfaction and retention.

GP training is currently shorter than all other UK medical or surgical specialities, and less than half the duration of some of the specialities, but while the length of training has stayed the same, general practice continues to evolve.

General practice in all geographical settings is facing the dual challenge of an ageing population with complex, multiple co-morbidities. The structural changes that the NHS is undergoing will demand much more of your average GP in terms of clinical, managerial and leadership skills. More and more patients will be treated outside of hospital, in their homes and communities.

RCGP recommended in 2012 enhanced and extended training for general practice. Central to this is a minimum training time in all general practice programmes of four years with at least 24 months spent in primary care. This is not to question current training or the skills of existing trainees and recently qualified GPs: it's about ensuring that GP training keeps up with the demands of an increasingly challenging and complex environment, including that of remote and rural practice.

<http://www.rcgp.org.uk/policy/rcgp-policy-areas/enhanced-and-extended-speciality-training-in-general-practice.aspx>.

David Greenaway's 'The Shape of Training Review'²⁸ stressed the importance of generalist skills in the NHS of the future. These are exactly the skills that are required to function competently in remote and rural areas. In addition the current GP Specialty Curriculum includes the competency of 'community orientation' – a prerequisite for rural practice. These skills will also be needed for the forthcoming 'Integration of Health and Social Care in Scotland'²⁸ a key Scottish Government policy.

- *Facilitate professional development*

To design continuing education and professional development programmes that meet the needs of rural health workers and that are accessible from where they live and work, so as to support their retention. In order to do this effectively, all rural health workers must have good connectivity to broadband and mobile phone services.

NHS Education Scotland (NES) has developed post-CCT Rural Fellowships²⁹ providing high quality work experience and training for GPs who have completed specialty training. Places are limited to 12 per year and the posts are jointly funded by NES and the territorial health boards. These posts are well funded and are an attractive opportunity to develop remote and rural skills. They have a good track record of recruitment into remote and rural GP posts, and the scheme could usefully be expanded.

BASICS Scotland³⁰ provides a wide range of extended skills training, suited to the needs of a rural clinician with support from NES.³¹

Rural practice also benefits from experienced GPs moving to remote and rural areas mid-career. Progress is being made to facilitate this with specific training opportunities to prepare doctors for the different challenges involved. The RCGP Rural Forum has developed a proposal for an educational package along these lines. (see Appendix 3).

Various options exist to support “at distance educational engagement” such as the NES RRHEAL Education Platform.³² Such platforms host content and links to material that is specifically relevant for remote, rural and island healthcare teams. This is another good reason to ensure that rural areas have adequate broadband connectivity.

- *Ensure surgery premises are adequate for GP training and undergraduate teaching*

In some rural areas, surgery premises are also not fit for purpose for training or teaching. Lack of consulting room capacity is a barrier to a practice moving toward training practice status. Investment in estate for rural general practice should be seen as a priority by rural health boards.

7. Family Life

Housing

One of the big attractions to working in remote and rural Scotland is the chance to live in areas of outstanding national beauty. Unfortunately, the reality can mean a housing shortage because of the demand for holiday homes and lack of available land to build on.

Employment for Spouses/Partners

Doctors spouses/partners may well be in the same profession or employed in support services. As highlighted by the Dewar report, lack of opportunities for spouse employment acts as a disincentive for doctor recruitment.

Education

Access to good schools is challenging due to lack of availability of good schools and travel distance between home and school.

Mobile Phone/Broadband Coverage

Connectivity in some rural areas can be very poor and this has implications for families to stay in touch with relatives. Lack of good internet provision causes great frustration and can interfere with the families’ ability to engage with services as well as childrens’ educational access to the benefits of social media that their urban counterparts take for granted.

8. Social Isolation

Isolation may not be just professional, but also social. Whilst the outdoors lifestyle is a winning factor, the remoteness of island and rural communities is also off-putting. Other parts of Scotland have similar lifestyle opportunities yet do not suffer from the same distance issues.

9. Remote and Rural Profile and Branding

One unfortunate result of the crisis in recruitment has been the development of negative perceptions of the remote and rural careers. RCGP Scotland believes that remote and rural practice offers exciting and rewarding opportunities to provide high quality, community based care. There is a need for these opportunities to be built on and how this is portrayed will be important. Examples such as the Youtube videos for the salaried GP vacancy on Arran³³ or experiences of GP rural-track trainees need to continue³⁴. There is also a need to work with rural communities to change perceptions to more positive ones.

The Deep End project and associated meetings have been successful in capturing the experiences of inner-city GPs. The RCGP Scotland “Time to Care Remote and Rural Deprivation Project”³⁵ recognises that deprivation is not only an urban issue.

The website RuralGP.com which is supported by the Remote Practitioners Association for Scotland (RPAS) has been a successful mechanism for raising the profile of remote and rural practice, creating a clear identity for remote and rural practice and providing a forum for debate on rural issues.

It is encouraging that a major outcome of the European Union Recruit and Retain Project³⁶ has been the proposal for specific funding for a “Why Rural?” brand and media campaign to support recruitment to rural areas across Europe. This will be closely aligned to NES Strategy for Attracting and Retaining Trainees in Scotland (StART).³¹

In addition the Remote and Rural Healthcare Educational Alliance (RRHEAL)³⁷ is currently hosting the website of the developing Scottish School of Rural Health and Wellbeing. This currently has an advisory board of Universities and NHS organisations⁴⁷. It aims to provide high quality remote and rural education, training and research programmes that support the current and future remote and rural health and social care workforce to improve the health and wellbeing of people living in remote and rural communities in Scotland.

Improving the Patient Experience

The main priorities of this paper are laid out in order to address the over-arching principle of improving patient care. All of the issues highlighted, if not addressed reasonably and without unnecessary delay, have the potential to adversely impact on the quality of patient care.

For GPs the world over, their first priority is to their patients. It is an indication of the level of commitment and care that general practice in remote and rural areas, despite the challenges and pressures that they face daily, continue to provide high standards of care within this challenging environment. However, it is evident that lack of connectivity in scattered communities, transport issues, GP training opportunities, the fragility of support services, increasing workload, social isolation and family life are all affected by the lack of proper infrastructure which is taken for granted in urban areas.

The present and the future of providing quality patient care is currently not sustainable for remote and rural communities. RCGP Scotland is committed to being a key partner in developing sustainable solutions. We welcome engagement with Scottish Government, NES, Health Boards and partners in a constructive dialogue to help resolve the issues currently adversely affecting remote and rural communities.

Recommendations and Actions Matrix

Policy area	Recommendations and Actions	Notes/Comments
1. Connectivity - Mobile Phone and Broadband Coverage	To ensure rural areas have effective digital links for health care delivery, learning, commerce and leisure	Scottish Government is investing in rural broadband. RCGP Scotland met with Scottish Government representatives in May 2014 to discuss the challenges. Throughout 2014/15, RCGP Scotland will continue to meet with Scottish Government and their agencies to develop strategies to resolve this issue throughout remote and rural areas.
2. Transport	To ensure transport infrastructure is adequate to support patient and lab services	The Rural Parliament ³⁸ will be an important opportunity to ensure the healthcare impacts of transport are acknowledged. RCGP Scotland will seek an opportunity to ensure this is recognized and to lobby for continued investment in rural transport infrastructure.
3. Isolation & Fragility of Support Services	Rural proofing of health care workers contracts	RCGP Scotland will raise the rural proofing of NHS health workers' contracts with Scottish Government.
4. Workload & Contractual Issues	a. A new GMS contract needs to ensure resilience and the continued financial viability of practices that are providing essential care to remote and rural areas	RCGP Scotland will seek further meetings with SGPC to discuss how remote and rural factors are recognised in the GMS contract negotiations.

	<p>b. Recognition of the role of dispensing GPs in remote and rural areas</p>	<p>Scottish Government consulted and reported on this issue in June 2014. The report stressed that pharmacy applications will be more transparent to local communities and will give patients a stronger voice; that Health Boards will be required to apply new tests when considering pharmacy applications in clearly designated and clearly identified remote and rural areas and importantly, that Boards will be given powers to refuse a pharmacy application if it was deemed that it “would adversely affect the security and sustainable provision of existing NHS primary medical and pharmaceutical services in the area.”</p> <p>http://news.scotland.gov.uk/News/News-scrutiny-for-pharmacy-applications-cfa.aspx)</p> <p>The Rural Strategy Group continue to monitor the implementation of the new regulations and report to members on progress, where appropriate.</p>
<p>5. Education, Training & Professional Development</p>	<p>Get the ‘right’ students – facilitating recruitment of medical students from rural areas</p>	<p>RCGP Scotland will use existing academic links to ensure selection procedures do not discriminate against applications from rural areas where opportunities to meet entrance requirements may be limited. A paper on this issue will be brought to the Scottish Academic Forum in September.</p> <p>RCGP Scotland supports mentoring and work experience schemes, particularly those that include rural generalist work exposure.</p>
	<p>Train students closer to rural communities and bring students to rural communities</p>	<p>RCGP Scotland will use existing academic links, including the Scottish Academic Forum to promote the use of rural student attachments in all medical schools in Scotland.</p> <p>RCGP Scotland will consider how a ‘Dewar Bursary’ scheme could be encouraged, funded and administered to encourage student attachments to rural GP practices.</p>

	<p>Foundation Year exposure to rural practice</p> <p>GP specialty training schemes</p>	<p>RCGP Scotland will use existing deanery links to promote rural 'foundation year' attachments across Scotland.</p> <p>RCGP Scotland supports the continuation and extension of the current GP Rural Track training. This may require exploration of how perceived barriers to small remote practices being actively involved in specialty training could be overcome.</p> <p>RCGP Scotland encourages taster week or visits to rural practice for GP specialty trainees on non-rural track schemes.</p>
	<p>Match curricula with rural health needs</p>	<p>RCGP Scotland will use existing RCGP, academic and deanery links to encourage a focus on rural generalist skills in undergraduate and postgraduate curricula to help ensure future doctors have sufficient skills to work in rural areas.</p>
	<p>Facilitate professional development</p>	<p>RCGP Scotland supports and encourages the further development and growth of the NHS Education Scotland (NES) Rural Fellowships.</p> <p>RCGP Scotland supports the RCGP Rural Forum proposal for training opportunities for established doctors who are seeking to move to rural areas.</p>

	General Practice Premises	RCGP Scotland will work with SGPC (Scottish General Practice Committee) to ensure surgery premises are adequate for GP consulting, training and undergraduate teaching
6. Remote & Rural Profile and Branding	To ensure career opportunities in rural healthcare are seen as exciting, rewarding and to be aspired to	The “Recruit and Retain” project is initiating a “Why Rural?” media campaign to provide a consistent positive brand. This needs to be built on and include an historical perspective to ensure health care workers are aware of the opportunities and achievements. RCGP Scotland will support this project, making use of its media and communications tools.

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20 <http://www.scotsman.com/news/scotland/top-stories/small-isles-gp-found-dead-1-2277841>

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22 World Health Organisation published the Global Policy recommendations – 'Increasing access to health workers in remote & rural areas through improved retention' <http://www.who.int/hrh/retention/guidelines/en/>

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