

## **PE1698/C**

Rural GP Association of Scotland submission of 14 October 2018

### Chair of the Rural GP Association of Scotland

Thank you for the opportunity to respond to the above Petition being brought to the Scottish Parliament Public Petitions Committee. I reply personally, but with the perspective from my role as Chair of the Rural GP Association of Scotland.

GPs in rural Scotland pride themselves in offering generalist, pragmatic and realistic medical care. Rural general practice goes hand-in-hand with working with limited resources; an extended scope of practice; personalised and accountable medical services; maximising use of the multidisciplinary services that exist; and tailoring services to the needs of communities as far as we are able. RGPAS has identified the phrase 'economies of rural generalism' to summarise the wide range of patient-centred and cost-effective approaches that are provided by rural GP teams in order to achieve high-quality generalist medical care as geographically near to patients as possible. These efforts currently help to reduce some inequalities of access to healthcare that exist as a result of infrastructure, hidden rural poverty and connectivity. The scope of rural general practice is such that it is not unusual to find GPs who provide psychological interventions (which is sorely lacking in many areas) side-by-side with emergency and pre-hospital responses, these being far outwith the scope that is recognised by any previous or current GP contract. Additional services – for example pre-hospital-clinic blood tests - are often provided by GP teams, who, whilst not being contractually resourced to do this, do so in order to sustain realistic access to interventions. And yet an opportunity to see this unfunded work become recognised in the context of a new contract, as well as the Realistic Medicine agenda, has been missed. These extended services are an example of the unrecognised elements of rural generalism, and the new contract has devalued and failed to support the scope of healthcare that is required and already delivered by rural GPs and their teams.

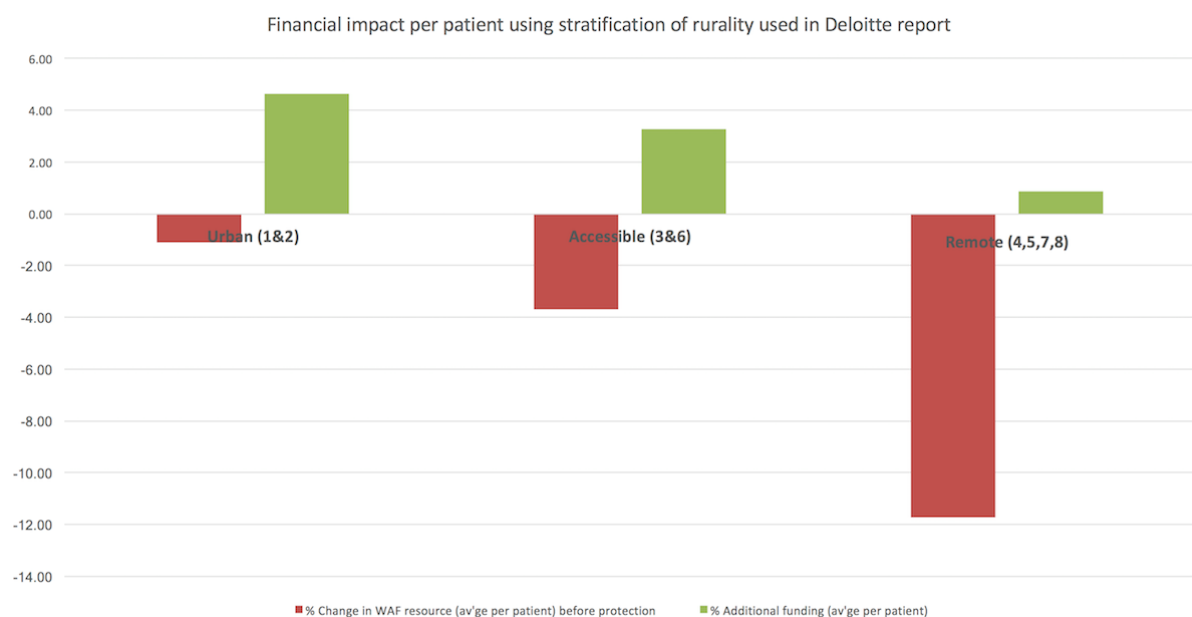
The new contract has promised a range of support for general practice across Scotland. However, a lack of rural-proofing has caused worrying inadequacies of the intended provision of services including vaccinations, physiotherapy, and pharmacist input. Many of these promised services are simply impossible to provide in rural areas, or will be disruptive and problematic to provide on the scale and approach being proposed. It is of particular concern that measures to find alternative means of service provision where the model of large-practice MDT provision isn't relevant have been left to 'local dialogue' - without any framework for that dialogue being defined.

The underpinning resource for the new contract comes from the new Scottish Workload Allocation Formula (SWAF). It has now been demonstrated that, partly due to the interpretation of the commissioned Deloitte report, the SWAF has failed to take into account the extra costs of supply of services in rural areas. There are analysts with far greater credibility and ability than me who have already offered their critical assessment of this, and have highlighted the anticipated negative effect of the SWAF on the resource allocation to rural healthcare. Concerns

have been raised too that the effects of this will simply exacerbate inequalities of healthcare, difficulties with recruitment and retention, and unhelpful uncertainty for primary care teams and managers. This comes at a time when the ecosystems of rural healthcare are already fragile and dependent upon local rural GP leadership to alleviate ongoing issues of staffing, co-ordination, and community engagement.

Prof Phil Wilson, Director of the Centre for Rural Health has conducted a more comprehensive analysis of the SWAF and its problems and this has been provided as a separate written submission to the Committee (PE1698/C) which the RGPAS Committee endorses.

Here is a graph from the financial impact data which illustrates our concern around the workload allocation formula and its skewing against rural practice (before the protected income guarantee is accounted for):



Supporters of the new contract, including its architects, will claim and have already claimed that income is 'protected', such that practice teams will not see any decrease in their actual funding. However, there are several reasons why this is of limited reassurance:

1. It appears that reflecting true workload from the scope of rural practice offered has been consigned to the 'too difficult' pile, and for a country where over 20% of the population live in a rural area, this seems short-sighted.
2. Our understanding is that the usual scrutinization process of the proposed SWAF by TAGRA – normally a respected and important step for defining Scottish resource allocation - was not followed.
3. General practice is already under-resourced, and the gains to be had from investment in primary care (and subsequent savings in secondary care) have not been provided to rural areas.

4. The precedent set by accepting a formula that has not been rural-proofed is already causing concern in connection with other allocation formulae, including for NRAC and other public service resource allocation in Scotland.
5. The income protection to practices is not guaranteed in the longer term, and this is likely to affect recruitment and retention of current GP posts in rural Scotland.

The rural Short Life Working Group has now been established, and I have been appointed as a contributing member. I have every trust that its chair, Sir Lewis Ritchie, will do what he can to enable the group to meet its Terms of Reference. However, it should be noted that the ToR is restrictive in looking at the implementation of Phase 1 of the new contract in rural areas, and that potential refinements as part of Phase 2 will only be considered at the invitation of the Scottish GP Committee. Furthermore, we have been warned by Scottish Government officials not to comment publicly on the work of the SLWG and so I am restricted in what I can report of my observations of its progress to date.

It has been openly stated that attempts to address the health needs of Scottish rural communities have been 'parked' until Phase 2 of the new GP contract. However, Phase 2 is not a guaranteed outcome; is subject to further negotiation; and will require acceptance by the Scottish General Practitioners' Committee (SGPC). We need to see immediate action.

The petition mirrors many of our own concerns regarding the impact of a non-rural-proofed GP contract on the delivery of healthcare across rural Scotland. We spent much time and consideration compiling a response to the contract proposals in our document 'Looking at the Right Map?' back in November 2017, and yet we still have had no response from the SGPC nor departments such as Primary Care at the Scottish Government regarding the concerns raised. I would encourage Petition Committee members to consider reading this report, which is available on [RuralGP.com](http://RuralGP.com).

I will be stepping down as RGPAS Chair at our AGM in November this year. Shaping implementation of the new contract in rural Scotland needs someone with less despondency and greater ability to understand the political machinations and game play than I can offer. I am a relatively young rural GP (still with more years' service to give than I have given so far), and I take great satisfaction and privilege in the clinical work that I do. However, I have become disheartened and disaffected by the lack of commitment to appropriate consideration of the impact of national policy on healthcare to rural communities. I sincerely hope that more able confreres will find the energy and agility required to engage with the decision-makers and hierarchy of Scottish health policy. I have no qualifications and limited credibility in that area, and my experience of negotiating through this hierarchy has been negative, with the onus being placed (increasingly) on rural GPs to identify how to resolve the current situation. So much time, effort, and optimism could have been saved if appropriate scrutinization and rural-proofing had been applied from the outset of contract development. Indeed, we were invited to input informally at the negotiation stage - but our comments and feedback have not been taken into account.

The last year has exposed a number of challenges to the process of understanding how we now have a contract that doesn't seem fit for purpose in rural communities, and yet it is a contract to which the principles are being steadfastly adhered - despite growing evidence that the 'direction of travel' just isn't the right one for rural Scotland. There needs to be a commitment from Scottish Government to rural-proof its policies from the outset, and adequate co-production and patient representation (which has been missing from the new contract development) will be vital to this. There needs to be acceptance that healthcare to many rural communities is being placed at risk, as well as an acknowledgement that there are longer-term ramifications as highlighted above. The role and benefit of small or single-handed practices in some communities needs to be recognised, and supported with greater clarity and reassurance. To address these concerns regarding the implementation of the new contract in rural areas, there must be ready acceptance of the issues raised, and a commitment to ensuring that health inequalities will not be worsened further by a lack of understanding of the ecosystems that are currently working well in the provision of rural healthcare.

There also seems to be considerable reliance on busy rural GPs to sort out the fallout from this contract. The delivery of rural healthcare in Scotland already depends on large amounts of goodwill and unrecorded commitment from GPs and our colleagues, but this reliance on additional goodwill to surmount the challenges created by a contract that devalues and destabilises rural practice in Scotland is unrealistic. Rural GPs already have to advocate for their patients and communities on a regular basis, but the additional requirement to represent our concerns about a national contract implemented without appropriate rural-proofing is proving to be an unfortunate and unhelpful addition to current workload levels. Already a number of skilled and committed rural GPs have decided to leave practice as a result of the uncertainties and frustrations created by the present situation. At the other end of the recruitment pipeline, the toll of increased workload from the new contract (both in terms of figuring out and negotiating local implementation, as well as national representation) has impacted on the provision of undergraduate education, at a time when this has been identified as a priority due to the increased need for undergraduate placements in Scotland. On Arran, we have recently decided to cease our undergraduate placements on the basis that there is increasingly too much to do and consider in order to sustain and preserve current patient services.

It is clear, therefore, that we need to see more centralised commitment to the scrutinization and rural-proofing of policy implementation before we can aspire to having a contract that will work for all of Scotland's population.

I would be happy to discuss any of the contents of this letter, and am happy to be contacted by email should that be helpful.

### All RGPAS committee members

All RGPAS committee members can give multiple similar examples of the issues Dr Hogg raises. David has worked extremely hard to find solutions to the problems faced by rural health services and the adverse effects of the new contract. Dr Hogg is an outstanding chair of RGPAS. The discouragement that has led him to step down as chair is particularly significant. We can ill afford to lose such talent. That this has happened is further evidence of the seriousness of the problem.

We, the RGPAS committee, wholeheartedly support and endorse Dr Hogg's evidence and analysis. It is also an accurate reflection of the views we have heard from our membership.