

## PE1698/E

Petitioner submission of 2 November 2018

Thank you for emailing me to inform me that the submissions requested in relation to my petition PE1698 have been received and inviting me to make a submission.

There are a number of issues from PE1698/B, PE1698/C, PE1698/D that I would like to link to the response from the Scottish Government in PE1698/A. I will address them as they arise according to the bullet points of their response.

- *Firstly, in relation to rural and remote GP representation on the Short Life Working Group (SLWG).*

The membership and Terms of Reference of the SLWG were not in the public domain when the petition was submitted so it is welcome news that there is rural GP representation on the SLWG. However it is shocking to hear that the Chair of the RGPAS is standing down from RGPAS in November and attributing this directly to "the lack of commitment to appropriate consideration of the impact of national policy on healthcare to rural communities" (PE1698/C). This does not sound reflective of the suggestion from the Scottish Government that there is a "....focus on collaboration and building trusting relationships....".

In the petition the concerns about rural and remote issues being kicked into the long grass of Phase Two were centered precisely around the risks of *delaying* rural proofing the contract. It was predictable that, over time, individuals who have knowledge and understanding of the complex issues involved will no longer be able to contribute, for any number of reasons, not only because they are a casualty of the "political machinations and game play" reported in PE1698C.

Also, of course, it is obvious that "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", something which was entirely avoidable, but is still redeemable. Unintended consequences, such as Arran deciding to "cease undergraduate placements on the basis that there is increasingly too much to do and consider", despite this having been identified as a priority, will have an impact on rural and remote healthcare in the future. This provides a litmus test of the degree of difficulty rural GPs are experiencing as a direct result of the new contract and "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" PE1698/C.

Issues about the new contract and the impact it will have on rural and remote

communities have been in the public domain since November 2017 ('Looking at the Right Map' referred to in PE1698C). A year has passed with no action being taken on identifying solutions but, in marked contrast, considerable effort has been expended by both the BMA and the Scottish Government in continuing their rhetoric (please read PE1698A) and ignoring the reality that the contract is not fit for rural purpose. They now need to accept "...that healthcare to many rural communities is being placed at risk" PE1698/C, and put equal energy into changing the 'direction of travel' for rural Scotland sooner rather than later.

It was also disappointing reading in PE1698/C that Scottish Government officials have warned members of the group not to comment publicly on the work of the SLWG. I am surprised that transparency and openness aren't standard as a way of engaging all interested members, reassuring patients and restoring trust. However, given the perturbing history cited in PE1698/D where, in the Technical Advisory Group on Resource Allocations in Scotland (TAGRA) meetings, "civil servants took the advice from the SGPC chair not to explore and address unmet need in primary care....." ([letter](#) dated 17th January 2018 written by Dr Helene Irvine) perhaps decision making behind closed doors with no accountability is accepted normal practice?

There continues to be great effort made in 'selling' the legitimacy of the contract by the Scottish Government as in the making of sweeping statements such as "the 2018 GP Contract.....voted for overwhelmingly in a poll", when, in reality, only 28% of practising GPs voted for the new contract, and in PE 1698/D the timeline regarding publishing of the impact of the new formula raises questions about enclosing a 'FAQs' document with the polling papers which left ".....little doubt that the potential for a substantial increase in remuneration would have contributed to the number of votes in favour of the contract". It will be astonishing to many people that, what appears to be an unethical and morally questionable decision to include material that may influence outcomes, was not questioned.

As the SLWG Terms of Reference are restricted to looking at the implementation of Phase One in rural areas, something that was not known when the petition was submitted, it just remains for the SLWG to follow their remit. There continues to be a need for questions to be answered around transparency of the SLWG and legitimacy of the original voting process together with how this, and the implications of the new contract for rural communities, are portrayed more honestly.

*Secondly, the issue of a need to adjust the (WAF) urgently.*

The Scottish Government continues to perpetuate the myth that "No practice has or will lose funding". It is certainly true that currently rural and remote practices are on 'income support' and have not lost funding, but this statement hides the fact that practices in

urban areas have enjoyed *increases*. PE1698/D states that "...it is clear that 'SWAF loser' practices are finding it increasingly difficult in a competitive employment market to attract GPs to work in them. Given that it is rural....practices that have historically found it most difficult to recruit, SWAF further disadvantages the practices that already have the greatest difficulties in recruiting and retaining doctors." PE1698/B also notes that "...the effects of the reduced funding in GP practices which seems likely to reduce Recruitment and retention of GPs and to make Communities less and less sustainable".

There is no security for rural GPs as issues "....have been 'parked' until Phase 2. However Phase 2 is not a guaranteed outcome; is subject to further negotiation; and will require acceptance by the Scottish General Practitioners' Committee (SGPC)" as outlined in PE1698/C. In simple terms I find it difficult to understand why it is acceptable that 80% of a workforce enjoy a pay rise, but the remaining 20% are told their pay will remain the same for a few years and then 'who knows' what will happen. Even if the income support were to be agreed for Phase 2 it is still grossly inequitable. It is a risk to the health care of patients living in rural and remote areas that this disparity is allowed to continue for any longer than it already has, and recognition that ".....more work is needed to provide reassurance that present stability on income and expenses will continue when Phase Two is agreed" is just not acceptable from the Scottish Government, who now need to demonstrate *what* work they have already taken on this issue and *when* it will be resolved.

The statement from the Scottish Government that "the SAF is based on the best available evidence" is vexatious, as opportunities for better evidence were *not* taken by Deloitte despite being advised how to obtain better information and how to make use of it. Perhaps this was done for expediency, but for whatever reason the Scottish Government are complicit, as described by Dr Helene Irvine (PE1698/D) who described how "the civil servants took advice from the SGPC chair not to explore and address unmet need in primary care and ways to measure it in the context of the SAF formula". That the Technical Advisory Group on Resource Allocations did not scrutinise and validate the SWAF thoroughly because of this advice is a betrayal of patients in rural and remote areas.

PE1698/D makes it clear that "The Deloitte team....used an outdated non representative sample based on data from Practice Team Information (PTI) practices. These were a very atypical set of 56 practices which covered 5.4% of the Scottish population. There was marked under representation of both deprived and remotely located practices. PTI stopped collecting data in 2013 because they were considered irrelevant to current practice."

As to the assertion that it "more accurately reflects the workload of GPs" PE1698/D outlines in detail why this is not the case and that the Deloitte report "uses a definition of

workload which poorly reflects need for care or indeed workload as we would understand it" because of their basic problem in using "the number of disease (Read) codes (and) by the number of consultations by patient" which did not include consultation time, detailed content or health inequalities.

I would think that if "The Scottish Government is committed to ensuring sustainable general practise services are available to patients in all communities in Scotland, including remote and rural communities" that they now listen to RGPAS and the expert advice of Professor Philip Wilson rather than continuing to use energy in obfuscating the issues.

The suggestion from Professor Wilson that "A small working group with statistical and health economic expertise, having access to a comprehensive recent primary care dataset as well as information on population health, earnings and expenses should be able to deliver sound recommendations for a fairer formula within a reasonable timescale" sounds like a sensible way forward. Given the murky history with the current SWAF perhaps this could be commissioned now in order to demonstrate a commitment to a more egalitarian system.

While this would be a way forward there remains a question of accountability in relation to the Chair of the SGCP (together with the decision maker in the BMA) and why civil servants took advice not to explore the issue of unmet need in primary care. Patients will be disturbed to discover that the scrutiny of the Technical Advisory Group on Resource Allocations in Scotland did not occur in the manner expected and will want reassurance that validation of a new SWAF is more robust.

- *Third and finally, address remote practice and patient concerns raised in relation to the new contract.*

The Scottish Government did 'commission the Health and Social Care Alliance to carry out a series of engagements' following overall agreement of the new contract. There was *one* rural event arranged in Portree. It was intensive patient lobbying that culminated in the inclusion of rural communities in the roll out of patient engagement and the opportunity for self facilitated meetings. Our experience is that little or no provision was made for rural and remote patients to find out about the new contract and the adverse impact it would have. We were required to do the work ourselves and try to disseminate information to others in a very short timescale, with no structures in place to do so. This 'Do It Yourself' approach to a major service redesign is a recurrent theme, as referred to in PE 1698/D, which notes that "...the onus being placed (increasingly) on rural GPs to identify how to resolve the current situation".

What this statement about 'engagement' also hides is that these meetings were designed to 'launch' the G.P contract, with the Primary Care Team stating at these

events that there had been patient consultation in relation to the Service Redesign. I think (as does the Chair of the RCGP P3 Committee) that 'Creating a Healthier Scotland' and 'Our Voice Citizens Panels' both fall short of compliance with CEL4 (2010) 'Informing, Engaging and Consulting with People in Developing Health and Community Care Services'. This was something that was not included in the petition, but I am sure will cause consternation if it is the case.

It would have been helpful for the Scottish Government submission to include examples of where the rural and remote Health Boards, Integration authorities and the Scottish Government have utilized the information in the 'Your GP and You' reports as opposed to ticking a box that they have 'engaged'. The submission PE1698/B demonstrates the inflexibility of a particular Board and HSCP, and the devastating impact on patients..... "The patients are leaving the practice to register elsewhere putting pressure on other practices, but the other practices are 5 miles and 10 miles away so that vulnerable groups have little alternative". If services are centralised the added costs for patients would place an unfair burden on people who already experience poor transport infrastructure (for example in my village a taxi to the nearest town is £45.00) and create a two tier service.

PE1698/B also mirrors many of the concerns rural and remote patients have repeatedly expressed regarding the delivery of services by a Health Board "The services put in place such as physio and Health and Well being Nurse are dependent on their being availability-holidays or illness mean the service is dropped and patients need to go back to seeing the GP." In rural and remote areas there is no economy of scale that makes the working model of the new contract where GPs are "supported by an expanded multidisciplinary clinical team working in practices and communities" viable.

It is positive that there is patient representation on the SLWG through the Chair of the RCGP P3 Committee. Given that the SLWG is focused on the implementation of Phase One only I am not sure what help it will be in resolving rural and remote issues given "...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" (PE1698/C).

I have met Sir Lewis Ritchie (Professor of General Practice, University of Aberdeen, Medical Advisor, Scottish Government and Chair of the Remote and Rural General Practice Working Group) and Fiona Duff (Senior Adviser, Scottish Government and member of the Remote and Rural General Practice Working Group), but as mentioned above it was clear that the scope of the SLWG is the implementation of Phase one, so other than repeating concerns (which have been extensively reported by myself and others through the Alliance 'Your GP and You' reports, a subsequent full report that I submitted to Fiona Duff together with emails and letters, as well as all the information

which has been supplied by RGPAS and RCGP) there is little else that I could bring to that meeting to effect the urgent attention that is required.

Rather than my views being 'highly valued' I feel they have been ignored, dismissed and disregarded. I understand that the Scottish Government Primary Care Team will be conducting a workshop at the Rural Parliament 2018 and I have concerns that they will, again, attempt to mis-sell the new GP contract to rural and remote patients as a positive move rather than a "...contract (that) has devalued and failed to support the scope of healthcare that is required and already delivered by rural GPs and their teams" (PE1698/C). I am pleased to hear that Sir Lewis is also planning to attend as he can, I trust, mitigate against this.

The current actions and previous omissions of the Scottish Government and BMA need to be challenged, unless the submissions provided in 1698 B/C/D by respected authors are not thought to be truly reflective of the current situation. The Scottish Government needs to commence work immediately on protecting the health care of patients in rural and remote areas. 1698/C notes that "the eco systems of rural healthcare are already fragile and dependent upon local rural GP leadership to alleviate ongoing issues of staffing, co-ordination, and community engagement". It would be a breach of trust if work to ameliorate this was not given highest priority.