PE1698/G
Scottish Government submission of 21 December 2018

Thank you for your letter of 26 November 2018 regarding questions from the Committee arising from their further consideration of Petition PE1698. I am replying as Head of the Primary Care Division in the Scottish Government. The information provided here corresponds to the specific requests for further information set out in the bullet list in your letter.

How the Scottish Workload Formula was calculated.

The 2004 Scottish Allocation Formula (2004 SAF) provided payments to GP practices through the Global Sum on the basis of their patient list size. The allocation was weighted for factors that affect GP workload, such as age/sex profile of patients and deprivation. It was also weighted to compensate for presumed additional costs such as delivering general practice in rural areas. The remaining elements of general practice funding were comprised of payments for:

- Quality and Outcomes Framework (payments related to achievement of quality indicators)
- Enhanced services (nationally specified services like vaccinations and extended opening hours)
- Premises (reimbursement of practice premises expenses based on an estimation of rental value of the practice property)
- Seniority Payments (payments to reflect individual GP experience)
- Correction Factor payments related to the 2004 Minimum Practice Income Guarantee (MPIG)

The 2004 SAF remained broadly unchanged following its introduction, however, it was criticised by GPs as being complicated, lacking in transparency and being unresponsive to the changing needs of the population. In 2016, as part of the negotiations for what would become the new GP contract, the Scottish Government commissioned Deloitte to review the 2004 SAF and to carry out statistical analysis to update and improve, where possible, the components of the formula.

The 2016 Deloitte Review of the Scottish Allocation Formula and the 2017 Deloitte Review of GP Earnings and Expenses in Scotland demonstrated unexplained variation in both GP earnings and GP expenses with no obvious connection between this variation and the differing needs of the populations GP practices serve.

The research allowed the development of a revised version of the 2004 SAF formula which better recognises and funds the higher workloads in areas of high deprivation or morbidity. This formed the basis of the 2018 Scottish Workload Formula which uses more up to date data on demographics and an improved methodological approach, which, for example, better reflects small pockets of deprivation in rural areas in comparison to the 2004 formula. The Scottish Workload Formula, as part of the wider contract changes, delivers:

- An improvement in **transparency** of what public investment in general practice funds

- an improvement in the **equity** of resource allocation – with more funding for practices with higher workload
- **enhanced sustainability** of general practice both in the short term (practice income guarantee and minimum earnings expectation) and in the long term (phase 2 guaranteed pay scale; direct reimbursement of expenses; reduced risk; a model more attractive to future cohorts of GPs)
- **improved quality** of service provision – funding to enable the GP time a practice population needs; enabling, for example, longer consultation times when clinically required.

To ensure that no practice lost any funding as a result of the application of the new formula, a new Income and Expenses Guarantee was introduced. Income guarantees are an existing feature of GMS contracts, for example, the previous contract included the Minimum Practice Income Guarantee (MPIG).

The transparency of the Remote and Rural General Practice Working Group

The Remote and Rural General Practice Working Group ("the Group") is chaired by Sir Lewis Ritchie with a membership of General Practitioners from a broad variety of rural communities across Scotland. The Group also has representation from the British Medical Association, the Royal College of General Practitioners (RCGP) and the Rural GP Association for Scotland (RGPAS). In addition, there are also representatives from NHS Boards, Integration Authorities, the public and the membership has been expanded to include nursing and allied health professional representatives.

At its first meeting on 12th June 2018, the Group "*acknowledged the importance that its work be open and transparent, and recognised the need to balance this against discussing confidential or sensitive matters. The secretariat will ensure papers are marked as either for sharing or sensitive. Papers for sharing may be circulated among the organisations the group members represent, and sensitive papers should not. The group agreed that communications to the wider public would be managed by the whole group using a communications strategy*".[1]

To support this, a Remote and Rural Working Group webpage has been created where the Terms of Reference and minutes of the meetings are shared publicly. The webpage also includes a Rural Bulletin, which highlights the engagement work of Scottish Government officials between meetings.

The group has agreed to engage with and seek the views of stakeholders involved in both providing and using primary care in rural areas. This work will promote and share the lessons from communities where primary care redesign is successfully being implemented. To achieve this, Sir Lewis Ritchie has commenced a wide ranging programme of engagement with GPs, and other clinicians and healthcare service planners and deliverers, working in remote and rural areas. The group is also developing a number of case studies demonstrating best practice already being carried out in rural areas which will be shared with service providers in due course.

The appropriateness of the new GP contract for rural parts of Scotland.

[1] Minutes of Meeting of 12 June 2018

The 2018 General Medical Services Contract recognised that rural and remote GPs share much of the same generalist workload as their colleagues in urban areas. In many rural areas, being the GP means being the expert medical generalist providing the broadest range of skills because of their remoteness, because they usually have smaller primary care teams and because the locality services that may be available in areas with larger populations may not be available.

Both the new GP contract and the accompanying Memorandum of Understanding allow flexibility in how primary care services are delivered. In allowing this flexibility we recognise that for a number of reasons (including, but not limited to, differing levels across the country of deprivation, rurality, age of population) a “one size fits all” uniform approach to delivery is not desirable.

In rural areas this allows delivery of the contract to be adapted to meet local needs. The most appropriate treatments, interventions, support and services will continue to be accessible, provided in the most appropriate place by the right person at the right time to everyone. The Memorandum of Understanding includes seven core principles for service redesign: safe; person-centred; equitable; outcome-focused; effective; sustainable; and affordable.

I hope this information is helpful and assures the committee that the views of patients, their families and carers are highly valued by the Scottish Government and will continue to be sought as implementation plans progress.

I would be happy to provide further information to the committee on any of the topics mentioned here.