

## PE1698/I

Petitioner submission of 20 February 2019

### Firstly, in relation to the Scottish Government submission PE1698/G on the Scottish Workload Allocation Formula (SWAF).

As Scottish Rural Action (SRA) point out "Scotland does not formally rural-proof policy at present, although island-proofing is being introduced". I note that The Scottish Parliament passed the first ever Islands Bill in May which guarantees 'island proofing' of all policies from all levels of government. As the GP contract was introduced a mere month before, in April, it is astonishing that the architects of the contract were not aware that the Islands Bill was going through, and did not take the opportunity of considering an impact assessment. Even harder to understand, given the lost opportunity of 'island proofing' (which would have benefited rural and remote areas together with Deep End practices) is that the Technical Advisory Group on Resource Allocation (TAGRA), which provides advice on *all* resource decisions in the NHS, -was specifically prevented from providing an opinion on the impact of the SWAF. It would have been obvious, had their view been sought, that the SWAF would disadvantage those practices, both rural and deprived, that already had the greatest difficulty in recruiting doctors. The submission PE1698/D, from Prof Wilson highlights this lack of TAGRA oversight, as does the response from the petitioner PE1698/E but the Scottish Government has chosen to ignore answering this question *again*. It is important, now that the question has been asked a number of times in the public domain, that the Scottish Government are open and transparent about their rationale for not seeking advice on the SWAF from TAGRA.

There are a number of other key questions on the SWAF that remain unanswered in the SG submission PE1698/A and PE1698/G despite the issues being raised either in P1698, the submissions PE1698 B, C, D, F or my response in PE1698E. The issue is complex and perhaps it is more straightforward to ask some simple questions and request straightforward answers from the SG, which is done in the list below. The lack of consultation with TAGRA is crucial and is therefore repeated in order that it does not get ignored for the third time.

- Why was the Technical Advisory Group on Resource Allocation (TAGRA), which provides advice on ALL resource allocation decisions in the NHS, specifically prevented from providing an opinion on the impact of the SWAF when it was obvious that it would disadvantage rural practices that already had difficulty recruiting. SRA highlights that there are serious GP and other health worker recruitment and retention issues in rural areas and whilst measures have been taken to address this concerning and costly issue, it is common sense that GP contracts need to be attractive.

- Why is the SWAF analysis based on data from a small group of highly unrepresentative practices which stopped collecting data in 2013? These "PTI" practices stopped receiving funding at that stage because the SG considered the data to be useless. This is raised in PE1698/D and PE1698/E yet it remains unexplained *why* this data was used. SRA notes that the community response to the concerns expressed by rural GPs has been significant and should not be ignored yet this remains unanswered and ignored.
- Why did Deloitte not make the effort to obtain more up to date and representative data? The costs of obtaining a fresh data set would not be prohibitive. The contract was introduced with haste and concerns about the SWAF dismissed with the cause for the concerns not addressed. SRA considers ...." threats to health services need to be addressed transparently and urgently" yet the SG has yet to respond to this question.
- Why was the excess cost of supply of GP services in remote areas not taken into account in development of the SWAF? It is clear from the Deloitte pay and expenses report that rural GPs earn less and have to spend more on providing care than their urban colleagues. SRA notes that Health services in rural areas are also impacted on by the seasonal influx of migrant workers and tourists which can add significant pressure to health services at certain times of the year.
- Why is the SWAF based on a definition of workload which simply reflects the ability or willingness of practices to offer large numbers of appointments? Numbers of offered appointments are not at all directly related to medical need, they are actually a measure of practices' current ability to provide care. This measure leads to under-doctored practices inevitably losing out and inequality of provision. SRA considers that all citizens should have the same access to services, resources and opportunities regardless of where they live, and this includes medical care, yet the SWAF fuels inequalities.
- It is clear from the heatmap that almost all remote and rural practices lose out at least in part because their appointments are, on average more complex than urban practices. Remote practices provide a lot of care that would normally be provided in hospitals (specifically A and E work but other things too). Why was this not taken into account? SRA states that GPs are the frontline of medical services in rural communities and often include round-the-clock emergency care, due to the isolated nature of their location, yet this is being placed at risk by the SWAF.

- It is also clear from the heatmap that the most deprived urban practices lose out and the affluent ones' gain. For example, Milngavie practices gain but Possil and Gorbals lose. Why was the low life expectancy in the poorest areas not taken into account? SRA notes the "...recent decline in life-expectancy in rural communities on the west coast of Scotland highlighted in the New West Coast of Scotland: Health Needs Assessment Report". Why is the SWAF adding to this inequality?

It would be helpful if the SG could answer these *specific* questions surrounding the SWAF rather than, as mentioned in PE1698, deflecting enquiries, dismissing concerns and demonstrating a lack of understanding of the issues. Repeating how they commissioned Deloitte to 'review' the SWAF rather than commission a fresh formula and failing to explain why they did not interrogate the results and engage with TAGRA serves rural and remote patients poorly. PE1698/G mentions 'phase 2' but this hasn't happened yet (after nearly a year) and, as it has to be voted on, it may never happen. The SG refer to enhanced sustainability, but they have not addressed points of recruitment and retention in rural and remote areas raised in PE1698/E and have yet to explain why it is considered that rural and remote practices on 'income support' are equal to urban practices that have received increases. It is as if they have not read any of the documentation on the petition website, or, if they have, they do not feel they need to answer any of the questions raised by the authors. Their response remains woefully inadequate.

*Secondly, the transparency of the Remote and Rural General Practice Working Group.*

In PE1698/E it was noted that the membership and Terms of Reference of the SLWG were not in the public domain when the petition was raised. It is interesting that they have a two-tier system of *sharing or sensitive matters* (it is helpful that all of the material and the Petition Committees deliberations are transparent), but actually what has become clear is that the SLWG is entirely designed towards implementing a contract which is deeply damaging in rural areas. It is, unfortunately, unable to make recommendations which go against the contract's aims so further deliberation of its role and scope is counterproductive to the purpose of the petition.

*Thirdly, the appropriateness of the new GP contract for rural parts of Scotland.*

The Memorandum of Understanding restricts the provision of services to those managed by Health Boards, it does NOT allow allocation of funding to practices to provide services which further disadvantages patients. For example, with flu and other infectious disease immunisation, it is clear how it may work in Glasgow, but how would it work in a rural or remote area? A team may visit, for example, Barra, but what if the patients were not around at that time? They might visit time and time again, but they wouldn't have the chance of reaching the same level of coverage as a GP who can take

the opportunity to immunise the patient when they attend for any other reason.

In Caithness, for example, it is not possible for immunisation teams to be set up as originally thought and GPs are coming under pressure from the Board to continue to deliver immunisations *without being paid for it*. How are outbreaks of infectious diseases going to affect life expectancy in rural areas, as take up of immunisations will clearly have an effect? How are the SG are going to manage the consequences of their decision to ignore the adverse effects of the implementation of the contract?

Boards are simply not as good as GPs at delivering primary care services as the attached data from Caithness demonstrates. Board run practices are about twice as expensive as GP run practices and patients are extremely dissatisfied with the service they receive. Should this not be a concern from everyone's perspective?

It is also clear that the contract which promised pharmacotherapy to be delivered quickly and in every practice is encountering difficulties. Where was the due diligence in relation to this point (as well as the SWAF)?

- [https://www.pharmaceutical-journal.com/news-and-analysis/news/pharmacotherapy-so-service-may-have-to-be-altered-owing-to-workforce-shortages/20206172.fullarticle?firstPass=false#comments\\_form](https://www.pharmaceutical-journal.com/news-and-analysis/news/pharmacotherapy-so-service-may-have-to-be-altered-owing-to-workforce-shortages/20206172.fullarticle?firstPass=false#comments_form)

SRA note that "decisions by vote can easily be dominated by urban needs and where those decisions impact positively on urban areas, but negatively on rural areas, a different approach must be taken". Further guidance or policy around the contract are not going to have an effect, and reassurance, repetition or indifference is not helpful.

The petition PE1698 asked for the SWAF to be adjusted urgently to prevent a rural and remote post code lottery. This is still urgently required and the SG need to seek advice and commission a SWAF that is equitable and serves all citizens equally, or explain why they do not value patients in rural and remote areas and have prioritised the health of urban patients. The petition also asked for concerns from patients to be addressed, which has failed to happen. Nothing submitted by the SG in PE1698/A and PE1698/G is any different from when the petition to be raised and concerns have not been addressed. SRA confirm this view and suggests further investigation, this submission gives a very clear structure of the questions that need to be asked.

## Annex:

|                                       | Number of patients | Number of full-time equivalent permanent GPs | Number of FTE permanent GPs in 2004 | Number of full-time equivalent locums | Number of trainees since 2015 | Contractual status | Costs per patient per annum (payments made to practices exclusive of premises) | Percent of patients satisfied/very satisfied in patient experience survey 2018 | Percent responding "I knew the Healthcare professional well" |
|---------------------------------------|--------------------|--|-------------------------------------|---------------------------------------|-------------------------------|--------------------|--|--|--|
| Dunbeath                              | 534                | 1  | 1.5                                 |                                       | 0                             | GMS                | £714*  | 98   | 85   |
| Canisbay & Castletown                 | 2871               | 2  | 3                                   | 1                                     | 0                             | GMS                | £490*  | 96   | 69   |
| Princes St Surgery (Thurso & Halkirk) | 6,240              | 3  | 4                                   | 1                                     | 0                             | GMS                | £199†  | 79   | 47   |
| Pearson Practice                      | 2,187              | 1  | 1                                   |                                       | 0                             | GMS                | £133   | 93   | 74   |
| Lybster                               | 1,206              | 1  | 2                                   | 1                                     | 0                             | 2c                 | £749*  | 91   | 80   |
| Riverview                             | 7590               | 1  | 5                                   | 3                                     | 0                             | 2c                 | £268   | 76   | 32   |
| Riverbank                             | 5,510              | 2  | 4                                   | 2                                     | 0                             | 2c                 | £434   | 71   | 33   |
| <b>Totals</b>                         |                    | <b>11</b>                                    | <b>20.5</b>                         |                                       | <b>0</b>                      |                    |  | <b>Scotland 83%</b>  | <b>Scotland 50%</b>  |

### GENERAL PRACTICE IN CAITHNESS – A SUMMARY

\*Includes dispensing costs      † approx. 25% dispensing patients

Average cost per GMS patient: £273 (inc dispensing for approx. 45% of patients)

Average cost per 2c patient: £372 (inc. dispensing for 8% of patients)

Weighted satisfied score for GMS patients: 87%

Weighted satisfied score for 2c patients: 75%

Five of the 11 permanent GPs are almost certain to retire because of age within the next five years

Six of the 20.5 “permanent” GPs working in 2004 moved away to work elsewhere, 3 retired because of ill health and 3 because of age.