PE1698/P
BMA Scotland submission of 7 May 2019

I wanted to write to you to provide information, both to you and the committee ahead of your consideration the petition on Medical Care in Rural Areas this week. I believe you are taking evidence on this from witnesses, including the Cabinet Secretary for Health on Thursday. Ahead of that session, I felt an update from the BMA might help your discussions. As a result, please find below our position on some of the issues raised.

In terms of the specific points made through the petition:

Calling on the Scottish Parliament to urge the Scottish Government to:

1. Ensure strong rural and remote GP representation on the remote and rural short life working group, recently established as part of the new GP contract for Scotland.

BMA: There has been good representation from rural GPs on the SLWG and, we hope that RGPAS will continue to attend and contribute to the process

2. Adjust the Workload Allocation Formula (WAF) urgently in light of the new contract proposals to guarantee that both primary and ancillary services are, at least, as good as they are now in ALL areas, so patients do not experience a rural and remote post code lottery in relation to the provision of health care.

BMA: The Income and Expenses Guarantee in Phase 1 of the new contract ensures that GP funding will be 'at least as good' as it was prior to new contract starting. The guarantee is without time limit. The intention of the work we are just commencing for phase 2 of the contract involves gathering income and expenses data on all practices. It is specifically intended to address any existing 'post-code lottery' funding issues by establishing a more level playing field for funding general practice across Scotland

3. Address remote practice and patient concerns raised in relation to the new GP contract.

BMA: Discussions are beginning on establishing pragmatic flexibilities to identify remote rural areas where the development of new services to deliver (for example vaccinations) in a different way is neither necessary nor desired by the community. These flexibilities will ensure that service provision in these areas will continue to be delivered from the remote practices.

For a more general briefing:

1: Introduction:

The BMA negotiated a new GMS contract with the Scottish Government that came into force in April last year and is now being implemented across Scotland.

The contract was subject to a vote of the profession and 71.5 per cent of those who took part supported its implementation. The contract aims to address the rapidly increasing workload demands that have threatened to overwhelm too many practices and negatively impact on retention and recruitment of GPs. Our view has always been that this was a contract that would restore hope to the profession, stabilise the situation after years of under-investment and increasing pressure caused by an ageing population. We believe it allows us to look to the future again with some optimism. For more details - and a full question and answer on various elements of the contract - please see the following on the BMA website.

But it is worth emphasising that solving the long standing and deep-seated issues GPs face was always likely to take time and would need further work to ensure appropriate solutions are found in all parts of Scotland.

And indeed, in rural areas, we have consistently set out that flexible solutions, sensitive to these challenges will need to be developed.

The following further specific points are also relevant:

2: Funding

There has been much discussion based on an erroneous suggestion that the new contract will have a negative impact on rural practices due to changes in the Scottish Allocation Formula (SAF).

For background, the new formula was developed as part of a 2016 review of the SAF and is a methodological improvement to the previous SAF. It is based on the best available evidence and as such it more accurately reflects the workload of GPs.

However, it is accompanied by a practice protection which means that the GP practices not exceeding their previous allocation will be protected from any potential funding losses. Absolutely no practice will lose money as a result of this protection. And this protection is in place long term - it is not temporary or likely to be removed as some have suggested. All practices continue to receive annual uplifts, and on top of that a further uplift when their practice lists are growing.

Of course, no funding formula is likely to be perfect, which is why we ultimately want to move away from such a system altogether as we head towards negotiating phase 2 of the contract. While this will need further negotiation and development, and again be only be introduced when approved by the profession, we hope to put forward proposals aimed at introducing guaranteed GP incomes and direct reimbursement of practice expenses in the long term. We believe this will particularly benefit rural practices, where we have found expenses to be higher.

3: Local Service Delivery

The current situation with implementation of the new contract is designed to be able to adapt to local circumstances and be influenced at a local level. To illustrate, the contract is not prescriptive about the way that new multidisciplinary team services are to be delivered locally and is specifically designed so that approval of plans from local GP representatives is required before delivery can progress. For example, in some small remote rural practices, it may be appropriate for GPs and health boards to agree that GPs can continue to deliver some services – such as vaccinations – that will be delivered in different ways in more urban settings. Essentially this sets the framework under which flexibilities can be explored in terms of local provision. It is simply not the case that this is a one-size fits all solution. While the principles around reducing inappropriate, excessive workloads, and reducing the financial risk of becoming a GP remain the same, the way these are applied in areas that are particularly remote and rural, will vary.

And there is of course a period of transition associated with all this work, which should mean no changes to services such as immunisations are arbitrarily and hurriedly made. The agreement is explicit that practices across Scotland may have to continue to provide services until 2021, which is the time set out for implementation of the first phase of the contract.

This should allow both time and the parameters to ensure the complex service changes needed to breathe new life into primary care across Scotland are implemented sensitively and effectively in remote and rural areas.

To aid this whole process, a Short Life Working Group on remote and rural issues is considering suggestions to ensure the contract works for these practices. This is an opportunity for those concerned to shape the way the contract works for rural areas, and we hope people will engage positively with it.

4: Benefits of the contract for rural areas

Of course, there are major benefits of the contract that will apply equally to rural practices, as they do to all parts of Scotland.

For example:

- A new minimum earnings expectation has been introduced from April this year. This will ensure that GPs in Scotland earn at least £84,630 (whole-time equivalent including employers' superannuation). GPs in rural areas can and should benefit from this if their income was below this level.
- All GP contractors who own their premises now have the option of taking out an interest free sustainability loan, up to the value of 20% of the existing-use value of the property. These loans will be funded by the Scottish Government's GP Premises Sustainability Fund. Legal details are being finalised on the first tranche of applications.
- The flexible introduction of an expanded Multi-Disciplinary Team to provide practices with new services to reduce workload.

5: Conclusion

There should be no illusions that persisting with the status quo that had led to the dire position of the profession was a viable option for anyone who wished to see a bright future for GPs and primary care in Scotland.

We needed a fresh approach, and the BMA is clear the contract delivers on that and takes the first steps to what we believe will be a sustainable future. Of course, this kind of change isn't easy or straightforward for any part of Scotland. And the BMA accepts that many issues are particularly acute for rural and remote areas - which have always faced very specific and deep-rooted challenges. It is crucial now that all parties work together to deliver on the commitments made, up the pace of change and transform general practice for the better - in remote and rural areas and across Scotland.

I would be very happy to help the committee with any queries on this, or follow up to the session later in the week,