**PE1698/Q**
Scottish Government submission of 7 June 2019

Following the meeting of the Public Petitions Committee session on the 9th of May, I was asked to provide further written information on three points:

- The underlying data and methodology used in the development of the Scottish Workload Formula (SWF);
- The role of the Technical Advisory Group on Resource Allocation in the development of the SWF and why it was not involved in the later stages of the SWF process, and;
- The distribution of the £23 million in additional funding made available to GP practices as part of the updated SWF.

Attached to this letter is an appendix setting out the Scottish Government's response to these questions.

I would like to record my thanks to all those contributing their time and expertise to this crucial debate on rural general practice. We have sought to engage constructively and comprehensively on this matter and we will continue to do so through the rural working group and other mechanisms. Indeed we have recently published case studies on best practice in rural areas (https://ihub.scot/improvement-programmes/primary-care/improving-together-interactive-iti/case-studies/). We all share the same goal of enhancing the services we provide to our patients and supporting the workforce.

It is important to emphasise once again that in developing the contract with the BMA, substantial consideration was given to the potential impact on rural general practice. As set out in the appendix, this included incentivising GPs to provide data that would help inform our negotiations on the new Contract. Unfortunately this received an insufficient response from rural practices.

Going forward, there is an important opportunity for rural, and indeed for all GPs, to help shape phase two of the contract. I very much hope this opportunity is taken.

The fifth meeting of Sir Lewis Ritchie's Remote and Rural General Practice Group took place on 4 June 2019. This was a highly successful event that engendered open and honest dialogue and began to get to the heart of some important issues. This is only the start and the intention is to run a series of the workshop style meetings throughout the year to continue to build upon the success of Tuesday. The Cabinet Secretary for Health and Sport joined the group and spoke to the members setting out her vision to think constructively on the wider design and delivery of health and social care services in remote and rural settings. She was clear that she saw rural healthcare providers as exemplars of innovation.

She emphasised that the new GP contract is significantly better than the previous one but requires the application of flexibility and innovation.

We have seen that GPs and other clinicians in many areas are not only facing complex challenges but through determination are overcoming them. Our rural healthcare providers deliver consistently high quality services for their patients precisely through local innovation and by working together across boundaries, changing and adapting as they see fit.

In thinking ahead to the next phase of primary care reform we want to build on and strengthen this unique rural approach, listening to communities of patients and providers and evolving Scotland’s rural primary care into a leading international example.

## Appendix

### 1) The underlying data and methodology used in the development of the Scottish Workload Formula (SWF)

This section explains the background to the contract negotiations, including how the previous allocation formula worked and the rationale for updating and improving the formula.

*Practice funding under the previous Scottish Allocation Formula (SAF)*

Prior to the 2018 GP contract, money was allocated to GP practices by way of the Scottish Allocation Formula. Under the SAF the single largest element of practice funding was the Global Sum which accounted for 64% of total practice payments. The SAF allocated, or divided up, the Global Sum to practices on the basis of their patient list size. The allocation was weighted for factors that increase GP workload as measured by consultation rates – including the age/sex profile of patients and deprivation. It was also weighted to compensate for the presumed additional cost of delivering general practice in rural areas.

The remaining elements of general practice funding were:

- Enhanced Services – additional payment for nationally specified services like vaccinations and the Extended Hours scheme;
- Premises – reimbursement of practice premises expenses based on an estimation of the rental value of the property;
- Seniority Payments – intended to be part of the pay of individual GPs to reflect experience
- Correction Factor payments – payments related to the 2004 agreed Minimum Practice Income Guarantee (MPIG).
- Quality Outcome Framework (QoF) payments which represented circa 20% of total general practice funding in 2014/15 – the final year of the operation of QoF in Scotland. The negotiated agreement in 2014/15 was for QoF payments to remain part of the total payments to general practices – renamed as Core Standard Payments. Practices received the average of their three years QoF payments up to the point of its abolition in 2014/15.

The SAF had two dimensions: a workload dimension and a unit cost dimension. Across these two dimensions, there were four elements that determined the share of the Global Sum an individual practice received:

- An age-sex adjustment;
- A deprivation adjustment;
- A market forces factor (MFF); and
- A rurality adjustment.

The size of the practice list, the age-sex composition of the practice population and the relative deprivation of patients' neighbourhoods were the key factors in determining the estimated workload of a practice. The rurality factor and MFF adjusted for variation in the costs of provision (i.e. expenses).

The different demographic and socio-economic characteristics of practice populations tended to influence the funding in different directions. The age-sex adjustment gave a larger weight to practices with an older population as older patients have higher consultation rates. Given higher life expectancy in less deprived areas, this adjustment moved funding to more

affluent areas. The deprivation adjustment worked in the opposite direction, whereas the rurality adjustment, on average, favours less deprived areas.

The overall result of the interaction of these different formula adjustments was a relatively flat per patient funding profile relative to population morbidity and mortality profiles and a mismatch between the funding profile and the consultation rate profile. This pattern is found in other countries, and referred to as the “Inverse Care Law” in academic literature on general practice funding.

There were many historical anomalies of practice funding related to the 2004 GP contract and to earlier national agreements. The MPIG – which guaranteed individual practices would have the same funding after the introduction of the 2004 contract as before – effectively solidified many historic funding streams at the practice level.

There were other historical funding anomalies, in addition to MPIG. Decisions in previous years, for instance, to maintain a floor of Enhanced Service income under which practices could not fall; and payment of “Paragraph 40” monies (again related to maintenance of income streams when related activity no longer existed) meant that while globally, the SAF broadly allocated the bulk of funding according to both need and presumed cost, locally there could be wide variation.

It was therefore possible, for example, to have two neighbouring practices, serving similar sized populations of similar demographics but with widely different total practice funding. This effectively meant that GPs providing similar care to similar populations over a similar time frame could be paid very different amounts. The perpetuation of these historically based funding differences, therefore, resulted in unfair and arbitrary differences in GP pay.

In light of the above the Scottish Government commissioned Deloitte to undertake a review of the SAF and to carry out statistical analysis to update and improve, where possible, the components of the formula.

*Summary of 2016 & 2017 Deloitte Reviews of Scottish Allocation Formula and Review of GP Earnings and Expenses in Scotland (the data underlying the SWF)*

The SAF had two broad dimensions: one capturing variation in the relative need/workload for primary care services across different populations; the second capturing variation in the unit cost of providing services across different geographies.

The Deloitte commission was therefore specified as two separate research projects: one analysing the relative need/workload aspect of the formula, the other analysing the unit cost aspect of the formula. The key findings are outlined below.

*Review of Scottish Allocation Formula (2016): Summary of Findings*

*The need/workload research.*

The two main determinants of relative need for health care services, or the relative workload facing primary care, are the age and gender profile of the practice population and the morbidity and socio-economic circumstances in the areas where the practice population live. The Deloitte analysis confirmed the continuing importance of these factors using updated data and improved statistical techniques. For example, they estimated that patients aged 75 years or older have up to three times higher need compared to patients aged 10 or younger;

and patients in the most deprived areas, with high levels of long-term sick and unemployed and limiting long-term illness, have up to 25% higher need for health care.

The main improvements recommended by the research were:

- the inclusion of patients who had not visited a GP (zero consultation patients) in the calculation of relative need;
- the estimation of age-sex and morbidity effects together, rather than calculating the age-sex effect independently; and,
- the updating of the data and use of new indicators for the morbidity and life circumstances adjustment.

*The unit cost research.*

The 2016 Deloitte research into the variation in the unit cost of providing primary care services across different geographies made some substantial criticisms of the SAF rurality adjustment. In particular that:

- it was applied to the income element of the allocation as well as to the true underlying costs of providing the service;
- it did not adequately take account of variation in practice list size in rural areas, where there can be large practices achieving economies of scale;
- there appeared to have been weaknesses in the method used to select and estimate the indicators of rurality.

Ultimately, however, lack of practice-level costs data stopped Deloitte from developing an alternative formula unit cost adjustment. The need to have more detailed data on practice-level costs was a major motivation for the commissioning of follow-up research from Deloitte in 2017.

*Review of GP Earnings and Expenses in Scotland (2017): Summary of Findings*

In 2017 Deloitte was commissioned to undertake a survey of practice earnings and expenses to provide a more informed understanding of the variation in GP income and in the costs of providing primary care services across different geographies.

The commission also instructed Deloitte to engage with sector experts to explore alternative options for remuneration and funding of primary care services.

To generate the data for the review Deloitte sent a request to 600 practices asking for information on levels of staffing and pay and for the practice accounts which provide details of the structure of practice costs. Of the 600 practices contacted, 109 provided the information requested. The key findings for costs and income are set out below.

*Key Findings - Costs*

Analysis of the sample data suggested that staff costs are the largest component (c.70%) of general practice costs (excluding GP partner salaries). The second largest component is premises costs (16%).

There is considerable variation in total costs between practices. Average costs per patient ranged from £49 (bottom decile) to £109 per year (top decile).

**Distribution of general practice costs**

| | Mean | P10 | P25 | P50 (median) | P75 | P90 |
|---|---|---|---|---|---|---|
| Cost (excluding dispensing) per patient | £76.5 | £48.9 | £55.7 | £66.8 | £82.2 | £109 |

Once patient case-mix (including deprivation) and location is controlled for, no difference in costs per patient located in areas with different levels of deprivation is identified. Smaller practices tend to exhibit higher costs (both total and staff costs) per patient than larger practices. Even after controlling for scale, remote practices had significantly higher costs per patient on average, however, there was found to be a very large range of costs per patient for remote practices.

*Key Findings – Income*

Average net income per WTE (whole time equivalent) partner GP is £99,000. However, there is considerable variability in net income, typically ranging between £63,000 (bottom decile) and £128,000 (top decile). In particular remote practices or practices with high numbers of partners tend to have lower net incomes.

There is some evidence that there are higher paid GPs working in urban areas compared with remote areas as the mean income is around 11% higher in urban areas, although median incomes are similar in both areas.

*Conclusions on the 2016 and 2017 reviews*

The Deloitte research developed an improved version of the workload dimension of the SAF formula. The implementation of that enhanced workload formula (as the SWF) would better recognise and fund the higher workloads in areas of high deprivation or morbidity.

The research also demonstrated that there is considerable unexplained variation in partner income between practices and that there are higher costs in remote practices, although these costs vary substantially between practices in remote areas for reasons that have not been identified.

*Background to the negotiations for the new GP contract 2018*

The 2018 contract was negotiated against a backdrop of general practice facing unprecedented challenges: increased workload; increased risk relating to staff and premises; and recruitment and retention. Doing nothing was not an option.

To meet these challenges it was recognised that the future of general practice could not be delivered through the GMS contract alone. There was an imperative to transform how primary care services are configured and delivered including significant investment in primary care workforce and infrastructure. It was critical that the contract was modernised to reflect and address the aforementioned challenges, alongside improving patient access to general practice and making becoming a GP a more attractive career option for medical students.

There was also a recognition that in transforming the role of the GP to be the 'expert medical generalist' in the community - focussing on complex care; undifferentiated illness; and outcomes, quality and leadership - we needed to make the best use of GP skills - managing uncertainty, holistic person-centred care and clinical leadership of an expanded team. To do this non-expert medical generalist workload needed to be redistributed to the wider primary care multi-disciplinary team, ensuring that patients have the benefit of the range of expert advice needed for high quality care.

The 2018 GMS contract offer was designed to meet these challenges, deliver a multi-disciplinary team to support the GP as expert medical generalist and deliver a strong and thriving general practice, sustaining high quality universal healthcare and realising Scotland's ambition to improve our population's health and reduce health inequalities.

*The new GP contract 2018 - Phase 1 – the methodology of the SWF*

Phase 1 involves the application of a new workload formula, the SWF, to an agreed pot of existing GMS funding streams. The workload formula recommended by the Deloitte 2016 review is the most up-to-date and appropriate formula. After negotiation, the BMA agreed that this workload formula should be used.

Previous GMS funding streams were also included in the new pot to be allocated by the SWF (the formula now covers over 85% of total GP funding):

- the previous Global Sum;
- Core Standard Payments; and
- Correction Factor (MPIG).

As with all changes to funding, any change could negatively affect practice funding if carried out with no additional investment. The necessary investment in this case amounted to £23m recurring, from 2018/19. This additional investment is to improve services for patients in areas where workload is highest.

The new formula (SWF) is a methodological improvement to the previous SAF. It is based on the best available evidence (the Deloitte reviews) and as such it more accurately reflects the workload of GPs. Compared to the workload-related weightings of the original SAF, the SWF gives greater weight to older patients and deprivation.

The analysis to develop the SWF used data from the Practice Team Information (PTI) Dataset. This data set holds data provided by a sample of almost 6% of Scottish Practices covering 363,000 patients. The Deloitte team analysed the data to ensure that it was representative, in particular, with respect to age, gender, deprivation and the urban rural mix. They concluded "overall, the population appears to be well represented by the sample."

Practice Team Information data was also used in a paper published in the British Journal of General Practice, in which the authors who are professors of primary care in Scotland (Gary McLean, Bruce Guthrie and Stewart Mercer) stated that the PTI data is "broadly representative of the Scottish population in terms of age, sex, deprivation and urban/rural mix".

The impact of deprivation on the workload of a practice is better reflected in the SWF than the previous SAF. Methodological improvements mean both deprivation in urban areas and isolated pockets of rural deprivation are now better addressed.

The additional £23 million investment means that using the SWF does not reduce the funding practices receive. Indeed the SWF reduces the number of practices that need an income guarantee as set out below.

*Comparison of the Income Guarantee in 2004 and 2018*

2004 – introduction of 2004 contract: 90% of practices on MPIG (cost £70m)
2017 – 51% of practices on MPIG (cost £18m)
2018 – new 2018 contract: 37% of practices on income and expenses guarantee (cost £23m)

Transition from old to new contract.

| | |
|---|---|
| Old contract: | 488 practices remained on the MPIG in 2017 |
| New contract: | 261 practices removed from MPIG |
| | 130 practices added to the income guarantee |
| | 227 practices remain on an income guarantee |

Resulting in 357 on the income guarantee in the new 2018 contract.

**2) The role of the Technical Advisory Group on Resource Allocation in the development of the SWF and why it was not involved in the later stages of the SWF process.**

TAGRA was established in August 2008 to review and maintain the NHS Scotland Resource Allocation Committee (NRAC) formula, which allocates funding to the territorial health boards for Hospital and Community Health Services. Its full remit is to:

- •Advise on the future maintenance and development of the NRAC formula for allocating resources to Health Boards for Hospital and Community Health Services and GP prescribing
- •Advise when the individual elements of the NRAC formula should be refined and improved as new methods and data become available
- •Consider issues raised in NRAC's Final Report and by stakeholders, as required by the Scottish Government, to prioritise and commission the investigation of these issues.
- •Ensure that the [NRAC] formula continues to allocate funds between Health Boards on a fair and equitable basis.

TAGRA's remit does not extend to the allocation of GP resources. Given its connection to GP pay in the context of independent contracting, the formula that supports allocation of GP resources is not a standard NHS resource allocation formula.

However TAGRA was asked to provide comments and technical input during the review of the SAF. The first presentation to TAGRA took place in August 2014 and TAGRA was provided with updates in all of its meetings in 2015 and 2016 until the conclusion of the review. This included presentations by the Deloitte team who undertook the analysis for the commissioned reports.

In relation to development of new formula, an Expert Technical Group with representation from the BMA and NHS experts from ISD (NSS Information Services Division) and PSD (NSS Practitioner Services Division) had lead responsibility for the development of the formula.

Ultimately the decision to apply the formula was a matter of negotiation between the Scottish Government and Scottish General Practitioners Committee. This was recognised by TAGRA in the minute of their meeting of 30 April 2015:

**"***a meeting had been held with John Matheson, as Chair of TAGRA, to further discuss the publication arrangements associated with the SAF Review.* ***This meeting noted a key difference between NRAC and SAF as being that the latter was directly related to a contractual negotiation process related to GP remuneration****. As such, the arrangements for the interaction of the SAF Review with TAGRA cannot jeopardise these negotiations*".

**3). The distribution of the £23 million in additional funding made available to GP practices as part of the updated SWF**

The application of the SWF to the (revised) Global Sum resulted in a reallocation of Global Sum funds between practices. Additional funding of around £23m was paid as income support to ensure that no practice had a reduction in funding. However, income support was not additional funding to those practices to which it was paid, but a continuation of the previous levels of support.

The actual increase in funding, i.e. the additional £23m funding, was received by the practices which had an increase in their allocation with the SWF. However, the substantive question is: what are the socio-economic circumstances of the recipients of the increased funding? The identity of the specific practices does not answer this question as practices typically provide care to patients from a range of socio-economic circumstances.

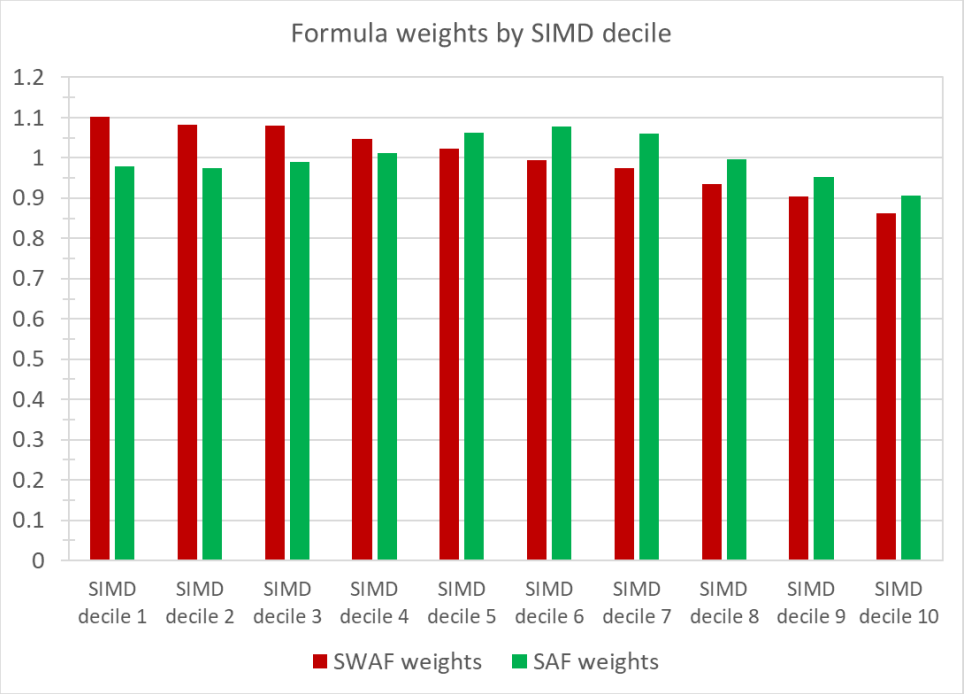
The deprivation-related diversity of practices is evident from ISD data which shows the SIMD decile where each practice's patients reside. The average proportion of a practice's patients who are in the SIMD decile (whichever decile that is) that has the largest share of that practice's patients is only 32%. So attributing entire practice lists to individual SIMD deciles can be misleading as, on average, two thirds of the average practice's patients will reside in 3 or more other SIMD deciles.

Furthermore, any practice may receive additional funding as a result of higher formula weight for its older or more deprived patients and lose funding because of a lower formula weight for its younger or less deprived patients; but the net effect for the practice will depend on the balance of those patients on its list.

To understand the socio-economic distribution of the additional funding it is necessary to have a patient-based analysis. This is consistent with operation of the formula itself, which is based on patient-level data: their age and sex, and the socio-economic characteristics of their place of residence. The formula estimates the funding required for each practice by adding up the funding required for each practice patient.

ISD have provided a patient's-residence-based analysis of the formula allocations to show how the formula allocates across the SIMD deciles. The figure below sets out that information. The figure shows the average weight for patients residing in each of the 10 SIMD deciles (where 1 is the most deprived; 10 the most affluent). The average weight for a patient in the most deprived decile (decile 1) under the SWF is 1.1 (i.e. 10% above the Scottish average), compared with 1.05 under the SAF. The average in the most affluent decile (decile 10) under the SWF is 0.86 (i.e. 14% below the Scottish average), compared with 0.94 under the SAF. It can be seen that the SAF gives a higher weight than the SWF in all 5 of the deciles in the most affluent half of the distribution.

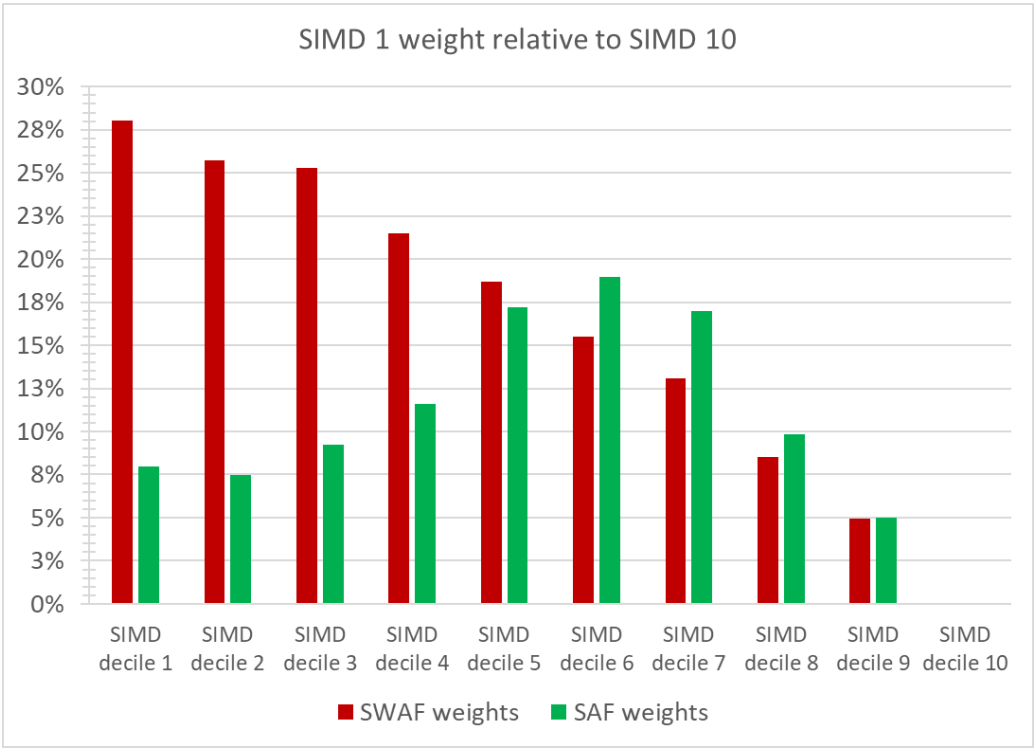
**Figure 1: Formula weights: distribution by SIMD deciles.**




Source: ISD calculations.

Figure 2 sets out the ratio of each decile's average weight to the most affluent decile i.e. the proportionate increase in the weight in each decile, relative to the most affluent decile. For example, with the SWF the average allocation per patient in the most deprived decile is 28% higher than the average allocation in the most affluent decile, but only 8% higher with the SAF.

**Figure 2: SIMD decile weight relative to the most affluent decile**




Source: ISD calculations.

These figures show clearly that the SWF is more pro-deprivation than the SAF. And the change in the formula has been in favour of deprived patients rather than affluent patients. It is important to note that this distribution data takes account of the full formula including all formula adjustments including, for example the age effect.

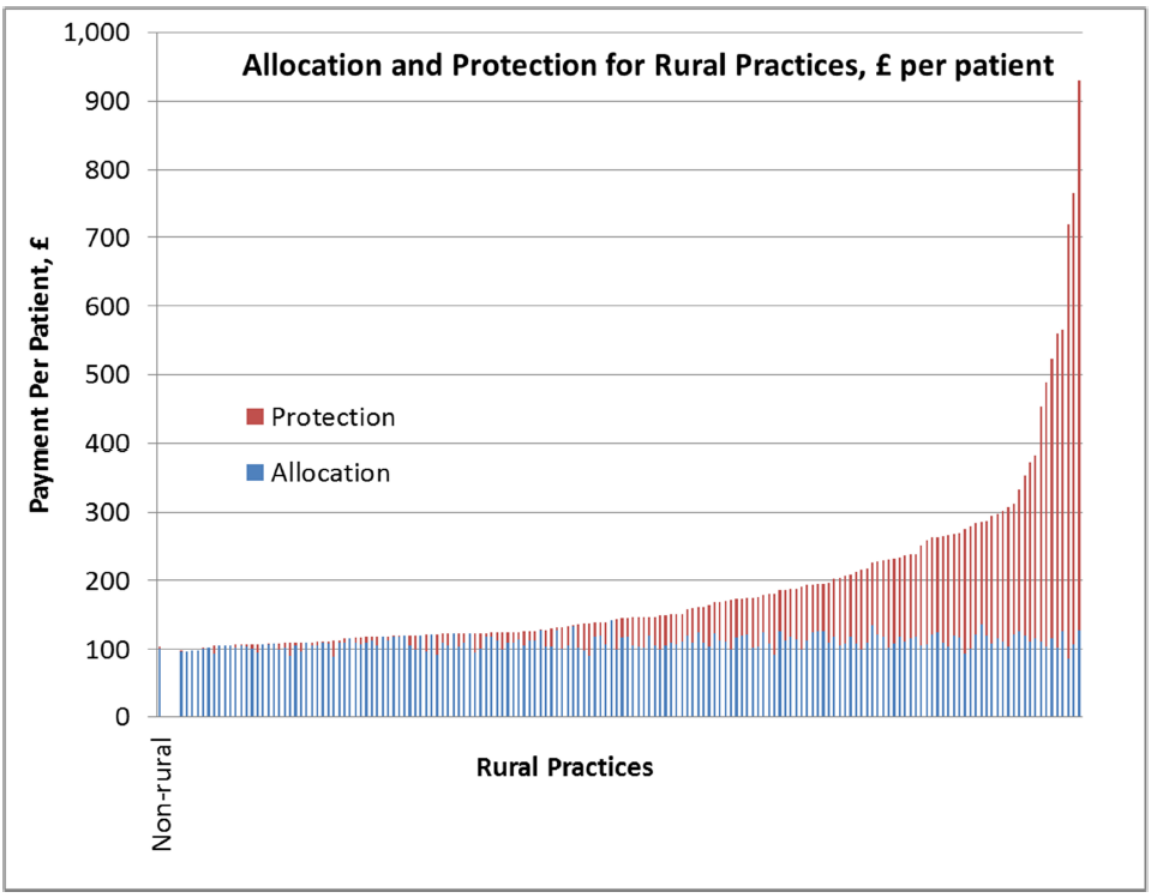
*Rural Proofing*

A number of steps were taken to rural proof the new GP contract.

Firstly the new funding formula is based on expected workload, and gives greater weight to older patients and deprivation – this includes older patients in rural areas and pockets of rural deprivation. We recognised that this meant that some practices in remote and rural locations would potentially receive less funding. We mitigated this risk by introducing a new income and expenses guarantee to ensure that no practice in Scotland would be worse off under the SWF.

This means that rural practices continue to receive a higher average payment per patient per practice. This payment is £104 in non-rural Scottish practices, compared with an average payment per patient per practice of £188 in very remote and rural practices. This increased average payment ensures that small remote and rural practices remain financially viable.

The following chart sets out the average payment per patient per practice for the practices which have more than 20% of their patient list living in remote or very remote small towns and remote or very remote rural areas. It separates the allocation the practices receive under the formula from the income protection. For comparison the chart also shows the average for the non-rural Scottish practices.



To further rural proof the 2018 GP Contract package, additional investment was announced to support recruitment and retention, in particular for GP practices in remote and rural settings. This includes:

a) Support for the 'GP for GP' Scheme. This is a scheme which provides a confidential service in NHS Highland to General Practitioners and their families at times of stress or illness, when they have difficulty going to their own GP. In the past it has supported Highland GPs with problems such as stress, depression, inability to cope, marital problems and bereavement. This scheme will be extended to remote and rural GPs across Scotland.

b) A Relocation Package. This incentivises GPs to relocate to rural practices by offering re-location costs, including where eligible, rent for 12 months, removal and storage costs, etc. up to a maximum amount of £5,000 per supported GP.

c) Substantially expanding the existing Golden Hello schemes from island practices to all practices in rural and remote areas.

d) The Scottish Government will continue to support the Scotland's new graduate entry medical course (ScotGEM). The course, which is run by the universities of Dundee and St Andrews with support from the University of the Highlands and Islands, has a particular focus on general practice and rural Working.

We also recognised that an issue of particular concern to some rural GPs was the Temporary Patient Adjustment due to their high levels of seasonal visitors. Practices are currently paid to treat Temporary Residents under the Temporary Patient Adjustment provisions of the Statement of Financial Entitlements. All GMS contractors currently receive a payment for unregistered patients as an element in their global sum allocation. The amount each contractor receives is based on the average amount that, historically, the contractor's practice claimed for treating such patients each year under the Red Book prior to 1 April 2003.

The Temporary Patient Adjustment leaves practices exposed to the risk of their number of Temporary Residents fluctuating while the resources to treat them remain constant. Under the new GMS contractual terms, practices will be required to report on numbers of Temporary Residents in 2018/19 to allow the Temporary Patient Adjustment to be reformed and uplifted on the basis that funding will follow activity as soon as practicable and by 2020/21, which should be of benefit to rural GPs.

*The new 2018 GP Contract - Phase 2*

Financial transparency is key to understanding the effect of geography on the cost of providing primary care services and the actual cost of running a GP practice, whether in a urban or rural setting. As part of the 2018 contract, we agreed with the BMA that all practices will provide income and expenses data, and work is ongoing to begin this data collection exercise.

This will significantly improve the understanding of the cost of delivering services across Scotland, including in rural communities. With this data we will be in a better position to refine the formula as necessary and address practice expenses in Phase 2. The dataset will allow the construction of a new unit cost adjustment, which would properly reflect variation in the costs of delivering services across different geographies. The data from the first Income

and Expenses collection is due by the end of 2019.  In addition, the workload element of the formula cannot be considered until more recent activity data is available, which is expected to be derived using SPIRE version 4 (due to be rolled out in 2020).