



Looking at the right map?

Identifying a positive direction of travel for the future of
Scottish rural general practice



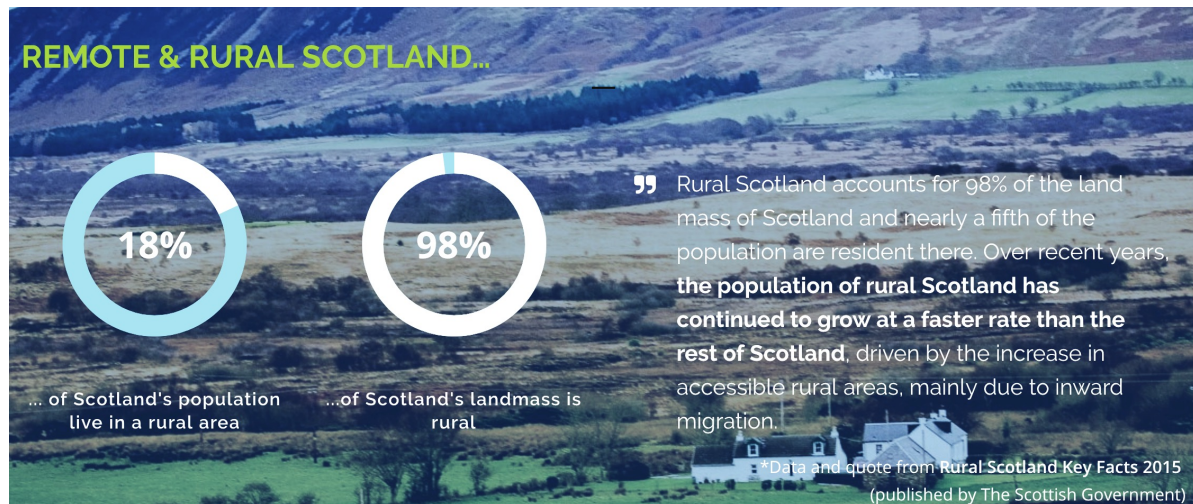
A response to the 2018 new GP contract proposal

25th November 2017

Dr David Hogg, Chair | Dr Alida MacGregor, Vice-Chair
on behalf of the RGPAS committee

EXECUTIVE SUMMARY

- We recognise the efforts and commitments demonstrated in the process so far from BMA Scotland and the Scottish Government.
- We recognise the importance of defining a positive and promising direction of travel for the future of primary care in Scotland.
- RGPAS is committed to being a collaborative partner in ensuring that proposed changes are relevant and effective in addressing the acute challenges that currently exist in Scottish rural practice.



The new contract proposal

- Our members generally report a willingness to engage with the aspirations of the proposed contract, and agree that themes of workload, recruitment risk and sustainability resonate with their concerns.
- However our members report frustrations with the highly aspirational content of the proposals, without adequately defined commitment and detail on how these are to be achieved.
- The multidisciplinary team approach is broadly welcomed, however it is difficult to understand how this additional resource will materialise when experience of services such as pharmacy and physiotherapy indicates significant lack of training opportunities, recruitment and funding in present services.

Specific areas of opportunity

The flexibilities required to provide effective services to rural communities respond well to the autonomous and innovative approach of the independent contractor model. However whilst we understand the need for more controlled workload and reduced risk, we are concerned that there is a **loss of autonomy** in the new contract proposals, such that **sustainability** of practices will become more challenging, and practices will be **destabilised**. The proposal mentions opportunity for dialogue to configure flexibility in local GP services, but there are not enough **safeguards for dialogue** to adequately enable this mechanism. Recent experience is that **capacity for dialogue** is suboptimal in HSCPs and primary care directorates such that innovation will be stifled and access to care will reduce.

Rural practice is ripe for finding cost and access **economies of generalism**. Rural practice is, arguably, where the scope of practice allows the greatest opportunity for providing **Realistic Medicine**. There are times when wider MDT involvement is contradictory to effective and holistic medical care, and our members feel that this contract does not offer enough for rural practices to resource and control the services which they wish to offer to their communities. We sincerely wish to work constructively and collaboratively to better represent rural practice in the contract proposals, and hope that the following expansion on the above concerns assists in us achieving this goal.

INTRODUCTION

The Rural GP Association of Scotland (RGPAS) welcomes the opportunity to provide a constructive response – driven by our members’ feedback – on the proposed new GP contract. We have sought to engage with the Scottish General Practice Committee (SGPC) over the last year and indeed we believed that we were making progress on this front.

However, our members have reported significant concerns about the information provided on the proposed new GP contract. We believe that certain key features in the proposal intended to address the challenges faced by the profession, will instead destabilise rural practices in delivering the patient-centred Realistic Medicine that they strive to provide to their communities. This report attempts to collate and summarise these concerns with the aim of providing suggestions to SGPC of opportunities in which a more realistic direction of travel can be found for the future of rural general practice in Scotland.

We intend for this to be a helpful, contextual, and realistic means forward and the RGPAS committee – all practicing rural GPs – are committed to playing a co-operative part in the rural-proofing of the GP contract proposals.

An opportunity for Scottish rural general practice

We recognise the need for a new vision for the future of general practice in Scotland. We are cognizant of the evidence and views presented which indicate a clear need to redefine how primary care services are provided across Scotland’s communities. We highlight the fact that Scottish rural general practice has been a fervent landscape for innovation, patient-centred and progressive primary care delivery. Since the Dewar report of 1912, rural practitioners have presented solutions to the challenges of community-based medicine, and been mindful of the opportunities offered by realistic generalist and multidisciplinary team service provision.

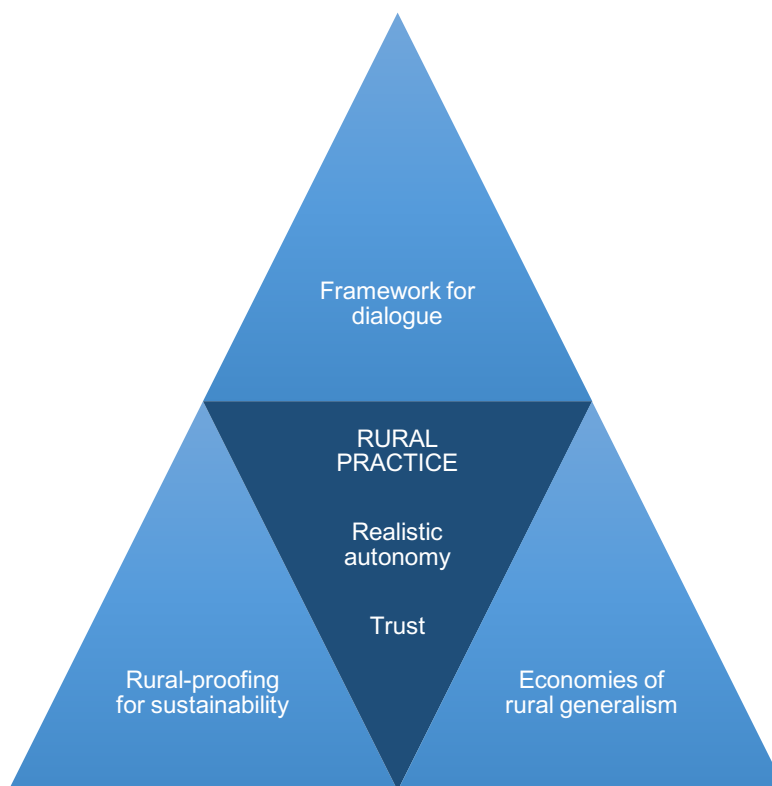
The GP contract proposal is clearly the summation of considerable efforts to work with the Scottish Government to define a positive future for Scotland, and we pay tribute to those involved in those efforts over the last year. Their determination to propose helpful and meaningful changes to Scottish primary care is not questioned nor doubted. The aspirations of the document are broadly in keeping with what we were hoping to see from this proposal: workload definition, greater roles for our multidisciplinary colleagues, reduced professional risk and alignment with similarly aspirational documents such as Improving Together (on cluster working) and Realistic Medicine.

However, RGPAS members report a range of consistent concerns about the proposed direction of travel, particularly the destabilising impact that is anticipated from a non rural-proofed set of proposals. Furthermore, it is felt that the aspirations lack the detail required to derive assurance that implementation will be suitably realistic and pragmatic for rural communities.

- Our members report an anticipated overall **loss of autonomy** in their role and control of the practice teams that they have evolved and invested in. We are keen to identify opportunities to retain the autonomy that centralisation of resource threatens. A key enabler of autonomy (and subsequent innovation) is **trust**, and our observations in this document are aimed at enabling a greater level of trust to be found in the dialogues necessary to achieve the aspirations of a new GP contract.
- Our members report a fear that this loss of autonomy will quickly destabilise existing practice structures and teams. Such structures are especially fragile in rural practice. Destabilisation goes against the core aspirations of the proposed contract, hence our compulsion to report these concerns at this stage of the process, and identify provision of **rural-proofing for sustainability**.
- We recognise the attempts to build in flexibility to the implementation of the proposed contract for rural communities. However much of the opportunity for this flexibility seems dependent on setting up dialogue with Health & Social Care Partnerships (HSCPs) at the individual practice level. We are concerned about the lack of a **framework for dialogue** along with necessary

safeguards to ensure that any such dialogue is time-efficient, has accountability, and is feasible. Experience to date indicates significant difficulties in achieving meaningful dialogue with HSCPs and health board entities. Much of this is due to limited capacity of health board teams, lack of accountability and diversion of resources towards currently collapsing or collapsed practices. It is essential that capacity and enablement exists within mechanisms intended to maintain the flexibilities required in rural practice, especially to avoid further practice collapses as a result of ineffective dialogue.

- The proposed direction of travel aims to maximize the benefits of economies of scale and wider delegation of workload to the multidisciplinary team (MDT). We wish to propose an alternative approach, where relevant **economies of rural generalism** exist. It is evident that for areas with challenges of peripherality and lower population density, the economies of generalism make for far more cost-effective, comprehensive and realistic patient care. Our members are very concerned that devaluing this core aspect of rural general practice – especially in areas where MDT rollout is more challenging to implement – will have a significant impact on maintaining access to realistic and high quality medicine.



This document will take each of the chapters of the proposed contract, and present the challenges and opportunities for each of these domains.

The original GP contract proposal (Scottish GP Committee/Scottish Government) can be obtained from this link: <http://www.gov.scot/Publications/2017/11/1343>

EXPERT MEDICAL GENERALISM

Sustainability There are several mentions of the ‘expert generalist’ role of the GP, and the plans to focus GP input on the management of complexity in the context of multidisciplinary teams. However, our members struggle to see acknowledgement of the wider scope of medical generalism that exists in rural practice, and how this role will be protected (and indeed expanded). Much of the clinical presentation in rural practice is similar to core general practice, but the expanded spectrum of care requires a significantly expanded CPD framework, skillset, and recognition of its importance in rural healthcare delivery.

Rural GPs are in an ideal position to extend their current expert medical generalist roles, and our members report that they are keen to accept increased workload of this nature, providing that it is resourced and can be flexibly implemented in their local community.

Framework It is being proposed that individual practices will be required to negotiate with the HSCP to find resource and sustainability for services outwith the core contract. However, there is a commonality amongst extended services in rural practice, that we would like to see recognised in a **rural package** to streamline those dialogues, in order to ensure that negotiation is cost-effective and to ensure that locally-provided services remain sustainable where that makes sense.

Rural Generalism The scale of expert medical generalism – with consequent economies of time and finance – needs to be better represented and supported in the proposed contract. Many of our members simultaneously deliver student teaching, registrar training, community hospital cover (including A&E and inpatients), forensic services, leadership in HSCPs and clusters, business planning as well as core general practice in resource-limited settings. We believe that more could have been done to recognise the time required for competency maintenance, peer networking and enabling resource for additional services. The challenges of distance often call upon our members to provide investigations and care that would ordinarily be provided in secondary care, often to avoid further expense to health boards and to provide a more realistic approach to medical care. This approach makes sense and provides tremendous economies of generalism, but this is not reflected in any part of the contract proposal.

PAY AND EXPENSES

Sustainability We welcome the efforts to make general practice less risky and to control onerous workload pressures. However, we are concerned that much of the extended services that are inherent in rural practices, are not adequately reflected in the proposals. The removal of the rurality weighting from the allocation formula is not, in itself, a concern as we agree that this had variable accuracy in representing extra rural workload. However the proposed Workload Allocation Formula falls short in recognizing the inevitable and inherent aspects of rural practice, including areas that remain unresourced in the current contract. Furthermore, the Scottish Index of Multiple Deprivation (SIMD) is widely regarded as being less effective in measuring deprivation in rural areas, than more urban ones. We are concerned that there will therefore be a proportional drop in funding to rural practices when this is introduced to the GP Workload Formula. Evidence and details of this can be provided.

Other inherent aspects of rural GP workload – including minor surgery, pre-clinic investigations and immediate medical care (BASICS) is also missed out of the current proposals. Whilst we recognise the role that the rural Short Life Working Group may play in improving definition of rural services that will be resourced, our members are concerned that this consideration is not inherent to Phase One proposals, and that proposals from this will be subject to Phase Two implementation being agreed.

Framework We acknowledge the commitment to protect practice income in Phase 1. We do however want to see more explicit commitment that sustainability payments to rural practices will be maintained and protected, including when new ownership of a practice occurs. Experience is that health boards will redefine these sustainability arrangements (locum backfill, associate salary cover, retainer fees for additional services and ongoing inducement payments etc.) with limited or no notice when new arrangements are being drawn up. This has engendered further lack of trust in the contractual

relationships necessary to safeguard autonomy and innovation of practices in rural settings. We also wish to highlight here the damaging effects of IR35 legislation and pension arrangements that are making it more difficult to attract locums, although we recognise that this is outwith the direct control of SGPC.

Rural Generalism Rural GP teams are extremely well placed to deliver significant economies of generalism at great cost-effectiveness to the Scottish Government. We are concerned that the absence of recognition for the extended work in rural practice, and assumed redirection of resourcing through centrally-managed teams, will affect patient care and end existing significant cost-efficiencies that rural practices currently deliver. The time, access and cost efficiencies of GPs providing a range of high quality healthcare to smaller communities is a feature of rural practice that is naturally evident to current rural GPs. We fear that the economies of generalism may not be adequately enabled and resourced in the new contract proposals, particularly for communities of 1000 patients or less.

MANAGEABLE WORKLOAD

Sustainability We recognise the need to address issues relating to type and scale of workload for the future of GP services in Scotland. However, again, we feel that the aspiration to move workload out to wider teams will destabilise rural practices. In practices that are more isolated due to peripherality, geography or island status, there is a low level of confidence that centrally-located MDTs and other teams will be able to provide the services intended. The resulting situation will put onus (often unresourced) back on those GP teams to provide the service. Examples include vaccinations, first-contact physiotherapy, hub-located pharmacy input and treatment & care services. SGPC appear to have taken the view that this would be a very small number of practices. We disagree, and a significant proportion of our members are concerned that it has been underestimated how many practices will be required/compelled to offer these services. Furthermore, it is not clear whether protected income streams, which for non-affected practices will see continued funding for work that is no longer contractually required, will be cited as existing resource such that pressures will be placed on practices to opt back in to providing these services in the absence of additional resource. In this instance we would propose that additional funding streams are implemented in order to avoid disparity between the benefits of this measure between rural and urban practices.

Framework Rural workload is different, subject to unusual pressures (even including poor weather, or interruptions from immediate medical care or poor connectivity). We agree with the aspiration to see a culture change in the approachability of health boards/HSCPs to address this, but again, given previous experience, are not convinced that such co-operation or capacity exists at present to do so. More safeguards are required. Furthermore our members wish to have an explicit role in the specification of job descriptions of our MDT colleagues, and we would like to see a mechanism detailed to allow this important contextual influence to be enabled.

Rural Generalism Due to unusual pressures on workload in rural practice, there is much to gain (and money to save) through realizing economies of rural generalism. If capacity exists, and opportunities are defined to maximize the benefits of rural generalism, this more stratified approach to clinical care has the potential to offer considerable cost benefits to the NHS budget.

IMPROVING INFRASTRUCTURE - PREMISES

Sustainability The premises benefits of the proposed contract are welcomed, and the significant investment is recognised. It is evident that some of our members – both those who own and lease premises – stand to benefit considerably from reduced risk. In addition, the effect on reducing the risk of owning premises (and the intended knock-on effect on recruitment) is seen as an important step forward for the future of primary care.

Framework Safeguards to guide minimum expectations of premises provision and the dialogue to effect this would be welcomed. As above, trust in existing mechanisms to work collaboratively and achieve implementation is lacking due to existing experience, which has seen considerable delays (of

years) to basic estates repairs including health and safety concerns. The Memorandum of Understanding is not adequate to reassure our members that HSCPs have the capacity, motivation and obligation to engage effectively. We would like to see a greater contractual obligation for HSCPs and health boards to provide premises that are fit for purpose and which are conducive to the work required in delivering the aspirations of the proposed contract.

Rural Generalism The economies of generalism allow realistic medicine to be provided within one encounter, often within one room. The larger the MDT, the more premises are required to accommodate the different specialties involved and it is not clear if the capital investment required to create this space has been adequately planned for in the proposals. Physiotherapists, pharmacists, community nursing, mental health support, treatment services and chronic disease management services will require rooms and space, along with co-ordination to ensure optimal use of facilities. However, for practices who are used to delivering services under a more generalist approach, the expansion required in premises could be potentially significant.

It should also be recognised that at present, additional space is often used for teaching of students and training of registrars. If consulting rooms/space become limited, a fear is that students – in particular – may be displaced out of facilities that allow lone consulting experience. That said, the opportunities for expanding and modifying premises – if backed up with the safeguards of a dialogue framework – has the potential to provide the much-needed upgrading required across rural Scotland.

IMPROVING INFRASTRUCTURE – IT

Sustainability General practice in Scotland is awaiting a much-needed IT platform upgrade from existing EMIS/Vision software. Current medical records are held on IT solutions which are over ten years old. The benefits in dashboard-style oversight of patients' data will enable new ways in which clinical data can be presented and interpreted. Specific opportunities include better use of IT in safe DMARD monitoring and longitudinal trend-analysis in chronic disease management. Remote access for GPs (and their teams) can have considerable benefits for retention in enabling easier time management. However Scotland's slow roll-out of digital connectivity is creating inequalities in rural Scotland, and thwarting the development of eHealth in collaboration and technology-enhanced care.

Framework The measures for sharing the role of data controller with health boards is welcome.

Rural Generalism Data-sharing proposals will facilitate access to the patient record by the MDT, and this is welcomed. Ongoing connectivity challenges in rural Scotland continue to present frustrating limitations on the development of the expert generalist role, including communication and collaboration with team colleagues, including remote assistance. Up to date, accessible and connected IT is required to allow rural GPs to engage in effective dialogue with HSCPs to implement the proposed contract aspirations. We hope that the connectivity of rural Scotland (both cellular '4G' and broadband) will be addressed as a matter of urgency by Digital Scotland. Our members continue to cite woefully inadequate connectivity as a major barrier to providing realistic medicine in rural communities.

REDUCING RISK

Sustainability We recognise the need to respond to the apparent apprehension expressed by newer GPs about taking on risk when becoming a GP partner. Our experience is that there remains an appetite for innovative accountability, collaborative leadership and entrepreneurialism amongst many GP trainees and First5s. Indeed, we wonder if this is a key attraction for recruitment to rural practice, in terms of being able to maximize the responsiveness of the independent contractor model to deliver services to a defined community. It is possible to maintain autonomy of services whilst ensuring that extra investment goes directly towards service provision within the independent contractor model, and we wonder if the benefits of this approach have not been fully exploited in the proposed contract.

Framework The efforts to reduce the risks in general practice are supported in general. However we need to safeguard and support the dialogue interfaces that will be necessary to allow those

negotiations that will be necessary to develop local services. Opportunities for effective dialogue will be the rate-limiter to the flexibility required by rural practices, and therefore these contact points require appropriate time and terms of engagement to be available from the outset.

Rural Generalism Rural GPs are already experts at managing clinical and non-clinical risks and uncertainty. The independent contractor model of service delivery is a cost- and time-efficient model, and we are pleased to see this acknowledged in the proposals. There are further opportunities to enable talented and ambitious GPs to contribute effectively with leadership and innovation in order to improve access to realistic medicine for Scotland's rural communities. The proposed GP contract must not limit these opportunities, particularly where cost effectiveness can be realised and clinical care optimised.

BETTER CARE FOR PATIENTS

Sustainability The nature of rural generalist medical care means that rural GPs are frequently invited to a wider range of contacts who wish to involve rural practitioners in service improvement e.g. retrieval/prehospital/third sector/education/recruitment services and projects. The centralization of MDT/resource management will require the community perspective and expert view that rural GPs can – and currently are – using to help shape practice-delivered services for patients. However raising expectations of this valuable input without appropriate time and resource will result in disengagement and loss of this expertise to the detriment of patient access.

Framework We are concerned that patient-centred service decisions are likely to be driven more by ongoing crisis management responsibilities of HSCPs, with a detrimental effect on effective practice-level service planning. For example, a practice that has invested heavily in developing practice-located services, and tailoring those to community needs, is likely to face destabilisation if the management of these services is taken over by more centralised decision-makers, particularly where resource is redeployed to 'firefight' in struggling practices. Smaller practices need adequate safeguards to ensure that resources are not relocated due to priorities outwith that practice's interests.

Rural Generalism With greater peripherality, rurality and remoteness, comes increased difficulty in providing peripatetic services. Recruitment difficulties (especially where the aim is to achieve relocation of MDT professionals to rural areas) are at least similar for MDT colleagues if not more problematic, and experience of the Northern Peripheries Project demonstrates this. Furthermore, existing ecosystems of primary care are fragile, and the impact of apparently small decisions (particularly when made at cluster or HSCP scale) and the net effect of applying higher oversight runs the risk of losing existing financial and time economies of generalism.

Fragmentation of clinical care services, especially when there are undue pressures to devolve workload to a wider team without appropriate consultation, threatens to lose the holistic, continuity of care that is so relevant to the aims of Realising Realistic Medicine.

It is very encouraging to note the recognition around the primary/secondary care interface. Current mechanisms are inadequate in enabling effective shared decision making between primary and secondary care colleagues. The process for integrating email communication with consultants and other specialist colleagues into the patient record remains clunky. Despite this, rural GPs generally report enjoying good relationships with secondary care experts, and are well placed to instigate pre-clinic tests and investigations to achieve maximal efficacy from the patient's encounter with patient care. This must be enabled and enhanced with adequate resource to ensure time, space and equipment to provide this in rural communities. Rural GPs are keen to expand opportunities to reduce inequalities of access to secondary care, and this also includes increasing access to videoconferenced secondary care contacts.

BETTER HEALTH IN COMMUNITIES

Sustainability The potential role of clusters in improving collaboration and shared clinical governance between rural practices is welcome. Our recent membership survey highlighted a broad spectrum of success to date with cluster formation, however we see this as a positive step including for smaller and single-handed GP practices. The opportunities for clusters to enable 'communities of practice' is important for peer review and reducing professional isolation especially in more remote practices.

Framework The aspirations of increasing protected time to enable cluster and other collaboration is welcome. The proposals fall short of offering more specific resource for this, and the initial proposal of one session per month per practice will need considerable increase if effective cluster and QI work is to be enabled.

Rural Generalism The economies of generalism are likely to be boosted by improved accessibility to 'quality improvement at scale' – being able to collaborate with other practices who have similar challenges and sharing the increased workload from the wider spectrum of care offered by rural practices. We welcome the aspirations articulated in 'Improving Together' and particularly hope to see efforts to include isolated and remote practitioners continue.

SUMMARY

RGPAS recognises and appreciates the significant efforts and determinations that have gone into the proposed contract document. We appreciate the need to address the challenges on general practice in Scotland as a whole.

We identify the proposed opportunities for Phase One engagement as being important steps in the transformational changes required. However, our members feel that greater clarification and specification is required to understand and address the aspirations outlined in the contract proposal. If it is agreed that Phase One will proceed, we will welcome the opportunities afforded – including the Short Life Working Group on Rural Practice – to engage with SGPC and Scottish Government. However, we are concerned that without more clarity and definition now, including addressing some of the issues raised above, that the present proposals are not far-reaching enough to address the current pressures on Scottish rural general practice in a way that our members feel confident enough to vote yes.

Nearly a fifth of Scotland's population lives in rural areas. Only two percent of Scotland's land mass is urban. The future of rural healthcare provision is therefore vitally important to the country as a whole and the majority of this healthcare is currently provided by GP-led practice teams. Our members already demonstrate dedication and commitment towards achieving better healthcare for their patients. We offer this report with the aim of extending that ambition for Scotland's rural communities in the proposed changes to the new GP contract.

Dr David Hogg, Chair
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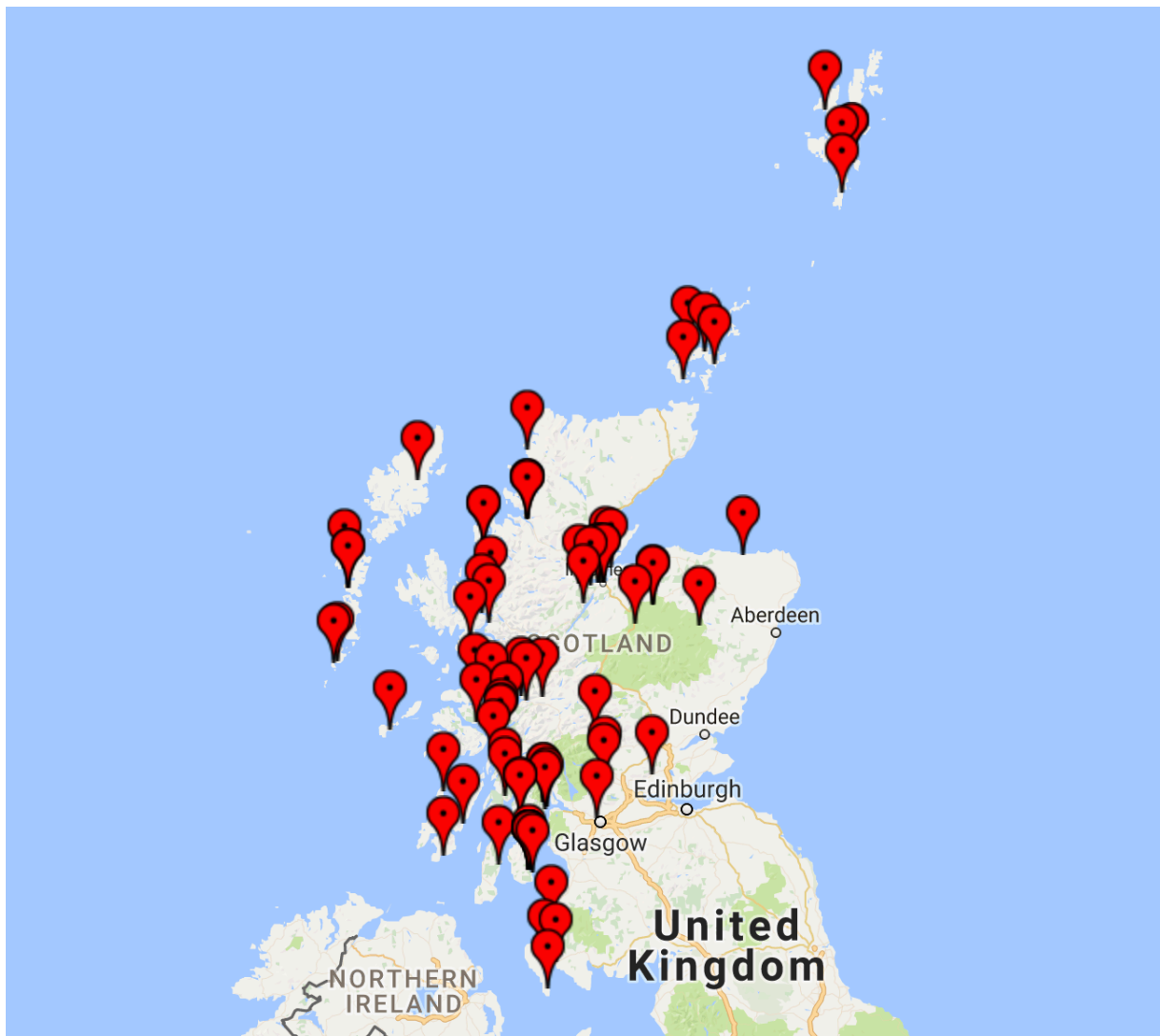
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ABOUT RGPAS

- £20/year membership fee, sign up online at www.ruralgp.scot/join
- Previously known as the Remote Practitioners Association of Scotland, and the Inducement Practitioners' Association.
- Currently over 90 rural GPs across Scotland
- Annual conference held in November, in Inverness each year
- Strong activity in undergraduate engagement, member support and representing the attractions, opportunities and challenges of rural practice
- Email chatline is main method of communication, along with scheduled videoconference opportunities, SurveyMonkey and direct email to committee members.
- More details at www.ruralgp.scot or follow us on twitter/facebook/instagram @RuralGPScot
- Email hello@ruralgp.scot with any queries or suggestions

Map of current members as of November 2017:



Members of RGPAS have a common aim which is to uphold and develop high quality rural medical services in their respective areas. Many of our members work in single-handed or small isolated Practices, and therefore the Association provides an invaluable link to others who are in the same sort of situation, with similar challenges and opportunities to innovate.

RGPAS is keen to extend its membership to any GP who feels they would benefit from joining. In addition, we are just about to make membership available for students and trainees who wish to express an interest and find out about opportunities in Scottish rural practice.