



Ms Shona Robison
Cabinet Secretary for Health
The Scottish Government

12th December 2017

Dear Ms Robison,

Realistic Rural Medicine and the Proposed New GP Contract

Many thanks for taking the time to schedule a call with me tomorrow. I appreciate that you have a busy schedule. I will be very pleased to discuss the proposed GP contract, and the concerns that our members have about its impact on rural practice.

We recognise the attempts to address a number of key areas of concern in the sustainability of Scottish primary care services, and we appreciate the efforts – including from yourself - that have shaped the proposed changes so far. However, we are concerned that an important opportunity has been missed to adequately address the main drivers of this new contract, specifically those of addressing workload and improving recruitment and retention of GPs.

It has been openly stated that attempts to address the health needs of Scottish rural communities have been ‘parked’ until further work is enabled in Phase One, should the new contract go ahead. This is particularly worrying as you will be aware that nearly 20% of Scotland’s population live in a remote or rural area, with considerable spikes in activity due to tourist activity and some seasonal industries. We believe that we need action for rural primary care services now. Delaying implementation of outcomes from the Rural Short Life Working Group until Phase Two will be too late to enable the considerable innovation that rural practice can contribute to developing Scottish primary care services in line with Realistic Medicine.

Indeed, when Realistic Medicine was published, its sentiments resonated strongly with our members. It has been observed – including by individuals in the Scottish Government – that rural general practice epitomises the rich benefits of practising Realistic Medicine. The economies of generalist care – both in terms of finances and reducing unnecessary investigation/treatment – are clear to see by those of us who frequently have to balance the provision of emergency, palliative and community hospital medicine in the context of geographical challenge.

It is widely regarded that Scottish rural practice has led the future of primary care services on a national basis. That has happened ever since the Dewar Report of 1912, which I’m sure that you are familiar with, along with the fact that subsequent approaches developed for Scottish highlands and islands laid the blueprint for the UK National Health Service. We believe that Scottish rural practice still holds that potential for innovative change today.

It was therefore with some considerable concern that we read the proposal for the new GP contract.

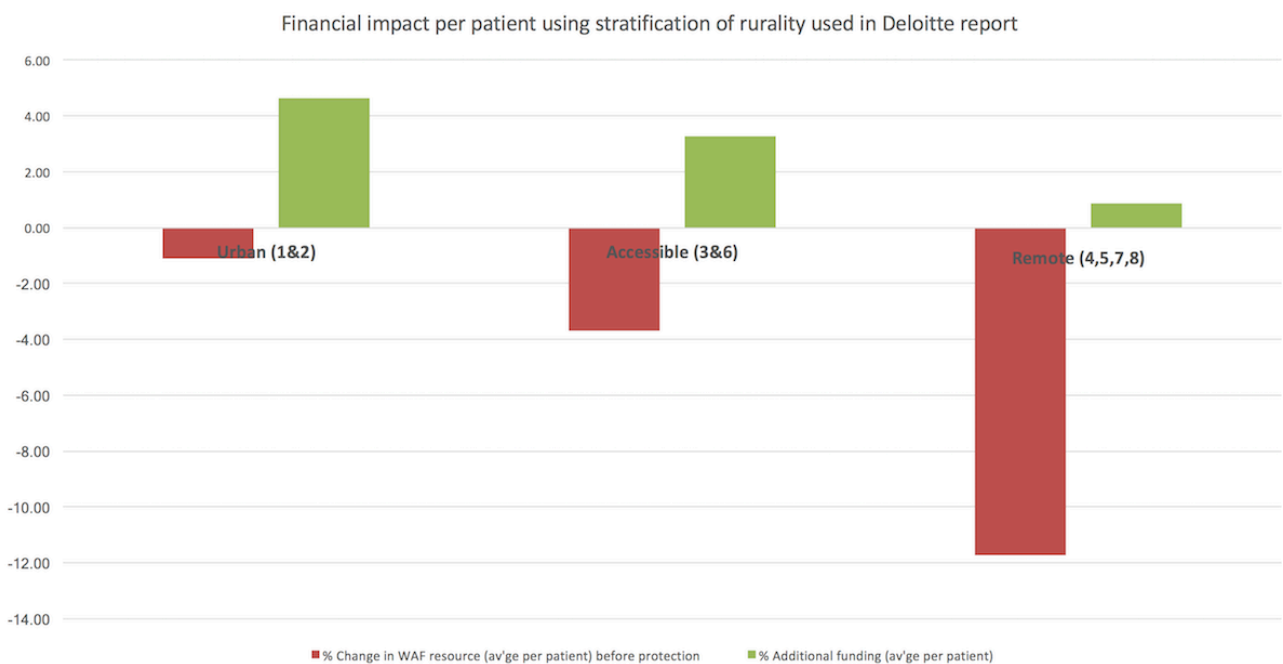
Chair **Dr David Hogg** (Isle of Arran)
Vice Chair **Dr Alida MacGregor** (Tighnabruaich)
Secretary **Dr Susan Bowie** (Shetland)
Vice Secretary **Dr Kate Dawson** (Benbecula)
Treasurer **Dr Malcolm Elder** (Carradale, Kintyre)

Dr Jim Finlayson (Inverness) Undergraduates Lead
Prof Phil Wilson (Inverness) Research Lead
Dr Richard Weekes (Ullapool) Additional Member
Dr Angus MacTaggart (Islay) Additional Member
Dr Douglas Deans (Inverness) Co-opted Member

Our RGPAS email discussion group has facilitated helpful discussion over the last few weeks regarding the proposed GP contract. Anxieties have been aired, reassurances offered, collaboration kindled and innovation stimulated. We are genuinely committed to participating in the positive development of a future-proofed primary care service for Scotland. However this cannot be at the expense of rural communities, with the fragmentation and confusion of care that we foresee with the proposed contract. For example, flexibility for local service design seems to be reliant on multiple dialogues without any supportive framework, and this is one of the primary concerns outlined in our full contract response *Looking at the Right Map?*, published recently via RuralGP.com.

The proposed workload allocation formula seems heavily weighted against rural communities. We are aware of the negative press over the last fortnight which has included this issue. We hope to move on from that, as soon as we can, but we still await the clarifications requested regarding the protection of some income streams which play a particularly important part of sustaining rural practices.

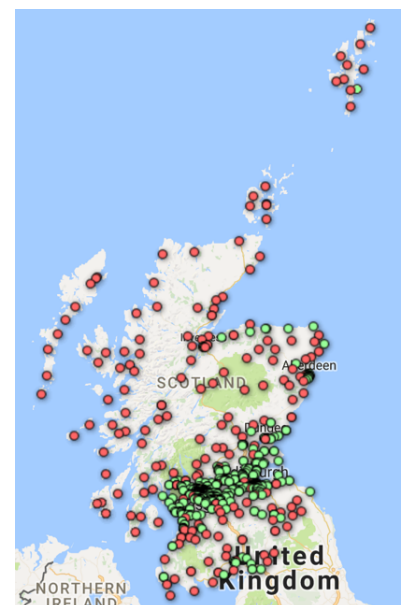
Here's a graph from the financial impact data which illustrates our concern around the workload allocation formula and its skewing against rural practice:



On the right is a map that shows which practices require income protection (red) and which will see additional funding (green). As a result, our members are feeling a real sense of being undervalued by the proposals, and the attached graphics are just one reason for that. Our members have been advised of drops of up to 85% between 2017 income and that which they could expect from the proposed workload allocation formula. Despite this drop being protected, our members feel despondent that the new contract has ignored the needs of rural healthcare from the outset, and we wonder why so little attempt has been made to address these needs now.

Whilst there is a visual urban/rural divide evident on first reading, we are now aware that our urban colleagues who serve particularly deprived populations are similarly disappointed with the manner in which the proposed workload allocation formula will redistribute resource.

We understand that our colleagues who work in 'Deep End' practices – those who serve some of Scotland's most deprived communities and where workload and inequalities are greatest – are surprised that the workload allocation formula is not delivering much-needed resource to them either.



I have discussed our concerns with Dr Anne Mullin, Chair of the Deep End GP Project, and it is evident that we share similar concerns about the workload formula.

Dr Mullin has given me permission to share observations communicated amongst the Deep End GP group:

“ The analysis of the data of all Deep End practices is complete [...]. As you can see the funding allocation has not produced the consistent increase in funding to Deep End practices that would allow unmet need and the inverse care law to be addressed. In reality this means that funding streams for patients in the most deprived third of Scotland are not at parity with the rest of the population. This situation will continue to impact on A&E departments, hospital use and premature mortality and morbidity, as documented in many Deep End reports. That is an unfortunate consequence of the inaccuracy of the weighting formula.

Furthermore, we are somewhat perplexed that the proposed allocation formula does not seem to have been scrutinised for its impact on both rural and deprived practices in Scotland. We are particularly confused as our experience has been that Scottish Government mechanisms usually place a high degree of scrutiny on the deployment of resource allocation methods. We would be interested in understanding what governance processes were employed prior to its approval for the proposed contract.

I am delighted that RGPAS and Deep End share the same commitment to informing discussion - which we would like to see take place urgently - to revise the workload allocation formula such that it can properly support the aspirations of the Scottish Government to stabilise, sustain and secure the future of realistic primary care.

Despite the above concerns, we remain committed to positively influencing the future of Scottish general practice and we hope that the Scottish Government will recognise the useful contribution that RGPAS and our Deep End colleagues are able to bring to this process.

I look forward to our telephone call, and hope that the above information is helpful to provide some background to our concerns.

With kind regards,



Dr David Hogg
Chair - chair@ruralgp.scot

Cc RGPAS Members