Bruichnain House
Delmore
Inverness
IV3 8RG
31/12/2017

Ms Shona Robison
Cabinet Secretary for Health, The Scottish Government

Dr Alan McDevitt,
Chair, Scottish General Practitioners Committee

Dr Andrew Buist,
Deputy Chair, Scottish General Practitioners Committee

The Electoral Reform Society

Dear Ms Robison, Dr McDevitt, Dr Buist and ERS Officials,

Re: call for annulment of Scottish GP Ballot

In early December 2017, GPs throughout Scotland received ballot papers for a poll concerning the proposed new contract agreed between negotiators from the BMA Scottish General Practitioners Committee and Scottish Government. Enclosed with the voting papers was a document entitled 'Frequently Asked Questions' incorporating a section entitled 'Mythbusters'. This document, written in the first person plural, appears to be designed to elicit agreement with the terms of the new contract and it contains none of the arguments against the terms of the contract which were raised around the time of the BMA Roadshows in November or subsequently. I have never before received a ballot paper from the Electoral Reform Society along with a document encouraging me to vote in only one way, in the same envelope.

Part of the new contract involves increased funding for some practices in Scotland. The foundation for this funding allocation is a revision of the Scottish Allocation Formula (SAF), now called the Scottish Workload Allocation Formula (SWAF). The FAQ document enclosed with my ballot paper states the following: "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 now more accurately reflects the workload of GPs." This statement is misleading and inaccurate.

The SWAF adopted in the contract followed a review by economists from Deloitte (http://www.gov.scot/Resource/0052/00527541.pdf). The effect of the review would be to allocate the lion's share of the additional GMS funding to practices in the Central Belt of Scotland – please see the map of practices (in green) gaining additional funding at this link: https://www.google.com/fusiontables/DataSource?docid=13SLV8fjU8S5LvhiMcmbUWpK8imuntSf2f1f1r_g7. There is not only an unfair allocation of funding to urban Central Belt practices, but the additional funding fails to reach may of the poorest "Deep End" practices in Scotland too. Although the FAQ document states that no practice will lose out financially should the new contract be implemented, it is clear that it will become increasingly difficult in a competitive employment market to attract GPs to work in the areas that have not received extra funding. The SWAF therefore further disadvantages the practices that already have greatest problems recruiting and retaining doctors.

The Deloitte work appears to be fatally flawed. Along with Dr Andrea Williamson, an academic GP colleague in Glasgow, I was approached by their team in January 2016 because they wanted to gain access to a GP record dataset we were working with. We were not able to give them what they were looking for – ie up-to-date, comprehensive, patient-level data – because the 150 participating practices had not given permission for anyone except the research team to access their records. The Deloitte team did not make any further efforts to obtain an informative representative source of patient-level workload data (see below) and instead used an outdated non-representative sample. It is interesting that page 1 of the report states "Deloitte accepts no responsibility for its use …, including its use by the Scottish Government for decision making or reporting to third parties". They go on to say "Deloitte has neither sought to corroborate this information nor to review its overall reasonableness" which is a curious thing to say in a report funded by Scottish taxpayers.

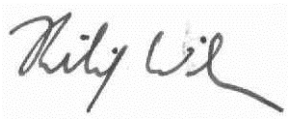
Overall the Deloitte statistical/econometric methods are reasonable but their assumptions are not. The basic problem is that "practice workload" is measured by the number of Read codes and by the number of consultations by patient, and it is this definition of "practice workload" that Scottish Government and the BMA have used to make their resource allocation recommendations. They were not able to access any information about, for example, consultation time or content (eg minor surgery, immediate/urgent care) and this is presumably why they wanted our data. They also say in the executive summary "Health inequalities related to … geographical shortage of GPs are, by and large, beyond the control of existing practices and therefore could not be significantly addressed through the workload model. Addressing these sources of health inequalities requires a separate analysis and potentially allocation mechanism." Under-doctored areas where GP recruitment is difficult will inevitably record fewer Read codes per patient and consultation numbers and so will be interpreted falsely in their model as being 'low workload' areas. In such cases 'workload', as defined in the allocation formula, will be roughly <u>inversely</u> proportional to need. There is no attempt in the model to address unmet need and thus health inequalities are likely to be maintained or increased.

The workload models used by Deloitte are based on data from Practice Team Information (PTI) practices. These were 56 very atypical practices which covered 5.4% of the Scottish population. There was marked under-representation of both deprived and remotely located practices. PTI stopped collecting data in 2013. The Deloitte team decided not to incorporate remoteness into their models because it was too difficult from a statistical point of view (ie "too big a risk of bias in the estimates"). They were obliged to use a simple binary variable in their model: 'urban' or 'rural' because they had not made the effort to obtain their own representative dataset including the full range of remote and rural practice and, unsurprisingly, they found that rurality did not significantly correlate with their definition of workload. The Deloitte report thus represents a facile piece of modelling, based on a historical dataset from an unrepresentative group of practices and uses a definition of workload which poorly reflects need for care or indeed workload as we would understand it. It also fails to account for the additional per-capita costs of running small practices in remote areas providing comprehensive emergency and intermediate care as well as general medical services.

GPs were not made aware of the overall impact of the SWAF on the pattern of funding for rural and Deep End practices in the FAQ document, and most GPs did not become aware of the 'big picture' impact of SWAF until mid-December. GPs were presented with a biased set of arguments in the FAQ document and so many will have voted 'yes' before they became aware of the negative and divisive aspects of the new contract on the profession as a whole in Scotland. Eighty nine percent of the members of the Rural GP Association of Scotland have already rejected the new contract and 93% consider that SGPC has failed to represent the interests of rural practices. Deep End practices have

also rejected the terms of the contract. I therefore request that the poll be annulled with immediate effect because of lack of due process and fair procedures, and re-run in the context of a balanced presentation of the cases for and against the contract.

Yours sincerely,



Philip Wilson DPhil FRCPCH FRCGP
Professor of primary care and rural health
Director, Centre for Rural Health
University of Aberdeen

Cc Rural GP Association of Scotland Committee
Dr Anne Mullin, Chair, Scottish Deep End GPs.
Dr Iain Kennedy, Secretary, and Dr Jonathan Ball, Chair, Highland LMC
Richard Foggo, Dr Gregor Smith, Scottish Government