OFFICIAL REPORT
AITHISG OIFIGEIL

Public Petitions Committee

Thursday 9 May 2019

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Thursday 9 May 2019

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PUBLIC PETITIONS COMMITTEE
9th Meeting 2019, Session 5

CONVENER

*Johann Lamont (Glasgow) (Lab)

DEPUTY CONVENER

*Angus MacDonald (Falkirk East) (SNP)

COMMITTEE MEMBERS

*Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con)
*David Torrance (Kirkcaldy) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Richard Foggo (Scottish Government)
Jeane Freeman (Cabinet Secretary for Health and Sport)
Rhoda Grant (Highlands and Islands) (Lab)
Sir Lewis Ritchie (Remote and Rural Working Group)

CLERK TO THE COMMITTEE

Lynn Russell

LOCATION

The Robert Burns Room (CR1)

Scottish Parliament

Public Petitions Committee

Thursday 9 May 2019

[The Convener opened the meeting at 09:30]

Continued Petitions

The Convener (Johann Lamont): I welcome everyone to the ninth meeting in 2019 of the Public Petitions Committee.

Before we start, I welcome Lynn Russell, our new clerk, and I send Sarah Robertson every good wish for her new post in the Environment, Climate Change and Land Reform Committee and thank her for all that she did as clerk to the Public Petitions Committee.

We have one item on the agenda, which is consideration of three continued petitions.

Medical Care (Rural Areas) (PE1698)

The Convener: The first petition is PE1698, on medical care in rural areas, which was lodged by Karen Murphy, Jane Rentoul, David Wilkie, Louisa Rogers and Jennifer Jane Lee. I welcome Rhoda Grant MSP for this item.

Now that we have received submissions from the Scottish Government, Scottish Rural Action and the petitioner, a number of issues require further scrutiny, including the Rural GP Association of Scotland's resignation from the remote and rural working group, the calculation of the Scottish workload allocation formula, and the implications of the new general practitioner contract in rural parts of Scotland.

At our previous consideration of the petition on 4 April 2019, we agreed to invite the Cabinet Secretary for Health and Sport to provide evidence on the matters raised in the submissions that have been received to date, and I welcome Jeane Freeman today. The cabinet secretary is accompanied by Sir Lewis Ritchie, chair of the remote and rural working group, and by Richard Foggo, director of population health, from the Scottish Government. I thank you all for attending and I invite the cabinet secretary to provide a brief opening statement, after which we will move to questions.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you for the invitation to be here today.

I thank the petitioners for bringing this important issue to Parliament. The services that they and we are talking about are critical to the communities served.

The focus of the petition is on two main issues. The first is the new GP contract and its impact on rural general practice, and the second is Sir Lewis Ritchie's short-life working group. I will make brief remarks on those issues.

The new GP contract, which was negotiated with the British Medical Association, is Scotland's first stand-alone contract, and it has been in place for one year. In that time, some fundamental questions have been raised about whether the new contract values rural general practice and whether it ultimately threatens rural general practice.

It is important that I state very clearly, at the outset, that we value rural general practice, and that I do not believe that it is threatened by the new contract. Of course, rural general practice faces challenges, some of which, such as recruitment and retention, are shared with practices in more urban areas, and some of which are unique, not least the remote geography and what that implies for general practice. However, the new contract does not cause those challenges; it is expressly designed to address them.

The new contract does two things. First, it seeks to develop a new role for the GP as the clinical leader in the community that they serve, leading enhanced, more integrated teams to ensure that we continue to deliver the right care for patients at the right time. Secondly, it responds to the serious challenges that have been identified by the GP profession of increasing workload and risk, particularly the risk of owning property and employing staff. On those points, all GPs, whether urban or rural, can see real benefits to the new contract. The role of clinical leader in the community—the expert medical generalist—is a role that is already fulfilled by many rural GPs. In that sense, the contract is intended to enhance and not diminish rural general practice and to recognise the work that they do.

The issue is whether the measures that we are taking to reduce workload and financial risk, which includes a new workload formula and bigger teams employed by the health board, diminish that role. I am clear that the GP contract and the associated primary care improvement plans must allow flexibility to suit local circumstances, particularly in rural communities. I stress that no changes have been made to the GP contract in relation to services such as vaccinations.

If a rural GP practice wishes to continue to deliver vaccinations or other services that are set out in primary care improvement plans, it can do so. GP practices continue to be paid to deliver vaccinations, but we are also offering GPs the

opportunity to benefit from support from health boards if that improves outcomes for patients. Although flexibility is important, I believe that it is wrong to suggest that a team-based approach does not suit rural communities. For example, in the Western Isles, an integrated approach to vaccinations means that the uptake of flu vaccine among primary school pupils has increased from 67 to 74 per cent since its delivery was transferred from GPs to school nursing teams.

We have heard a number of concerns about the Scottish workload formula, which is a substantial component in determining the level of funding that a GP practice receives. First, it continues to be said that rural practices have lost funding as a result of the new contract. That is categorically not the case. We have invested £23 million to ensure that no practice loses funding. In addition, we have increased the overall value of the GP contract by £23.7 million, or 3.46 per cent, which rural practices also benefit from.

Secondly, it is said that, because we are having to protect the funding of rural general practice, we do not value it. However, my point would be that you protect what you value. I know that there is concern that protection might be removed at any point and that rural general practice has been more fragile because of that, but funding protection has been a feature of the GP contract since 2004. It was not an issue with the previous contract, and I do not believe that it should be an issue now. I cannot envisage a situation in which a Government of any political persuasion would remove that protection and thereby threaten rural general practice. The national health service depends on quality general practice.

Finally, it is claimed that, although the new formula better captures the variation in GP workload, it does not include the effect of geography on costs, and so does not reflect the reality of rural general practice. However, the funding steps that I have outlined mean that the change to the formula does not impact on the funding that practices receive. Transparency is the key to understanding the effect of geography on the cost of providing primary care services and the cost of running a GP practice, whether in an urban or a rural setting. Therefore, as part of the contract, we have agreed with the BMA that all practices will provide income and expenses data. That will significantly improve our understanding of the cost of delivering services across Scotland, including in our rural communities. Parliament has explicitly welcomed that development. Once we have that information, we will be in a better position to refine the formula as necessary. We will take that course of action into phase 2 of the GP contract.

We recognise that GPs in remote and rural communities work hard in exceptional circumstances, and I would like to assure the committee that the fundamental aim of the working group that Sir Lewis Ritchie chairs is to ensure that the voices of rural GPs are heard and to bring about agreed actions to strengthen the implementation of the contract in remote and rural areas. As the contract also impacts on patients and the wider primary care team, there is patient and multidisciplinary professional representation on the working group. It is fair to say that, since the inception of the group, Sir Lewis has worked tirelessly to build collaborative and trusting relationships, and I know that he will be happy to answer any questions that the committee might have. With his team, he has travelled extensively across Scotland, engaging with GPs, health board colleagues and rural communities and hearing their views. I am very grateful to him for joining us this morning to deal directly with any issues that members might want to raise.

Concern has been expressed that, because the representative of the Rural GP Association of Scotland has resigned, rural GPs are not represented on the group. We sincerely hope that RGPAS sends another representative, but I assure the committee that there are a number of rural GPs on the group and that the voice of rural GPs is being heard, while discussions continue in an effort to resolve the issue with RGPAS. I hope that it will return to the group.

We are taking a truly transformational approach with the new GP contract. Our aim is not only to preserve general practice as the cornerstone of our health service in Scotland but to ensure that it flourishes and strengthens. I believe that achieving that is possible by taking professionals and patients with us, building relationships and directly recognising that one size does not fit all. However, as with everything that is worth doing, there is always room for improvement, and we remain open to looking at how, in the short term and then in phase 2 of the GP contract and in the negotiations on that, some of the issues that people remain concerned about can be considered fully and steps can be taken to resolve them.

I am grateful to the petitioners for taking the time to ask questions, to challenge constructively and to allow me to explain the intentions behind the contract.

The Convener: Thank you. Before I move on to the substance of my question, could I ask what was done to island proof and rural proof the offer before the negotiations started?

Jeane Freeman: I ask Mr Foggo, who led the negotiations for us, to answer that.

Richard Foggo (Scottish Government): There were two phases to the proofing, which happened before the more recent statutory requirements for island proofing. In the early stages of policy development, we engaged, through a series of roadshows and engagements around Scotland, on the broad policy intentions—

The Convener: You know that there are people who are concerned about the level of consultation that was involved in those roadshows. I am more interested in what kind of process there was as opposed to conversations that you had. There is now a statutory responsibility for island proofing, but I think that people would accept rural proofing if that was done. What was done to test the offer before you took it anywhere to consult on it?

Richard Foggo: That was the second phase. Once the policy propositions were worked up, they went into the negotiating space. Evidence on the formula was gathered through various reviews and significant expert advice was taken to turn the policy propositions into the contractual propositions.

The Convener: Presumably, it will say in the paperwork, "These are the policy propositions. Here is the impact in an urban setting, a rural setting and an island setting." That will have been laid out before you went into negotiations.

Richard Foggo: The policy propositions are subject to an equality impact assessment, which includes an assessment of the impact on rural communities.

The Convener: Can you explain why the evidence that we have received is that this settlement means that urban areas do better out of the contract than rural areas and that, within urban areas, better-off areas do better than poor areas? How could that possibly happen if an equality impact assessment of the policy was done before you went into the negotiations?

Richard Foggo: It is worth setting out just how complex the GP contract is and just how many considerations have to be balanced. As the cabinet secretary has said and as the BMA has acknowledged, a lot of judgment calls are required in balancing a number of competing factors.

I should say two things; first, thematically, no specific issue was discussed more in the negotiations than the impact on rural communities. Secondly, from looking at all the different issues that we had to consider, we were absolutely clear that some of the fundamental propositions—in particular, protecting income—were critical to ensuring that there was no loss to rural communities.

The Convener: But you would accept that protecting income is not the same as enhancing income. Do you accept that the consequence of this contract is that the funds that are available go disproportionately to urban rather than rural areas and, within urban settings, go disproportionately to more prosperous areas rather than to poorer areas?

Richard Foggo: I would differentiate between two things. One is whether it was our explicit intention to frame the negotiations and the outputs in that way. The answer to that is absolutely not. There was no explicit judgment. The formula element in particular balances and rebalances based on objective evidence in relation to deprivation and age, which reflects an objective assessment of the impact of an ageing population and inequality in the Scottish population. That has a particular set of impacts in terms of urban and rural communities, but we came at it through the demographics, not through the nature of the communities that were impacted.

The Convener: Even I would not be so hard-hearted as to suggest that you would wilfully want to spend more money on better-off people than on poorer people. However, the evidence suggest that that has been the consequence of the contract. If an equality impact assessment or rural proofing had been done, that would have been evident, would it not? Are you saying that it was an acceptable trade-off that the consequence would be that deep-end surgeries in places such as Glasgow would do less well than better-off surgeries, and that rural areas would do less well than urban areas?

09:45

Richard Foggo: The starting principle was that income needed to be protected. If we applied the formula without that protection, your questions would be absolutely valid.

The Convener: Do you not accept the evidence that we have been given that the benefit goes disproportionately from the poorer to the better off and from rural to urban?

Richard Foggo: I do not accept it when expressed in that way.

The Convener: Forgive me. I want to ask about the letter from the Rural GP Association of Scotland to the rural short-life working group, which was submitted to us, announcing the resignation of the association from the working group. I am sure that you will agree that that is a serious matter. In connection with that, in general question time on 4 April 2019, the cabinet secretary stated:

"Sir Lewis has acknowledged the concerns raised by RGPAS members and has agreed to hold further discussions in due course towards their continuing

involvement in implementing the contract in our remote and rural communities."—[*Official Report*, 4 April 2019; c 6.]

Will you confirm that the working group cannot change the contract offer?

Jeane Freeman: The working group can raise issues with me directly when it feels that phase 1 of the contract requires modification and when it wants to have a direct input into the negotiations for phase 2 of the contract.

The Convener: So the working group can change it. We were advised that it could not.

Jeane Freeman: No. The working group can raise issues with me. Remember that the contract is a product of negotiation between the Scottish Government and the BMA, so any modification to phase 1 of the contract—any changes that might be necessary at this point—is again subject to negotiation between me and the BMA.

The group—I am sure that Sir Lewis Ritchie will want to comment on this—can raise and evidence directly with me any issues that are raised with it that it concludes should be looked at further by the Government and the BMA.

The Convener: Would you be willing to consider changing the terms of reference of the short-life working group?

Jeane Freeman: We have already had and continue to have that conversation with Sir Lewis.

The Convener: So you are willing to change the terms of reference if it—

Jeane Freeman: As you know, convener, I am always open to improvements.

The Convener: Excellent. In that case, if those who have resigned expressed a concern about that, would you be willing to look at their objections in order to bring them back on board? I hear what you are saying about there being other people who could provide representation, but there is clearly an issue if folk who are serious about representing rural GPs have resigned. If there was something that could help, would you be willing to look at it?

Jeane Freeman: Before I ask Sir Lewis to comment, I say that the other folk, as you put it, who are on the group are representative of the experience of being a rural GP. Therefore, their views are valid and important.

The Convener: With respect, your suggestion was that although people had resigned, it was okay, because there were other people there who came from a rural experience.

Jeane Freeman: No.

The Convener: I am asking whether you are willing to look at the terms of reference in order to bring back in those representatives, who obviously felt so seriously and strongly about the matter that they resigned.

Jeane Freeman: For clarity and for the record, I state that I did not say that it is okay that RGPAS has resigned because we have other rural voices. I said that it is important to understand that there are rural voices on the committee and that we are working to see whether RGPAS will return. I will now ask Sir Lewis to bring you up to date on the work that he has undertaken in that regard.

The Convener: What is the extent of rural GP representation on the group?

Sir Lewis Ritchie (Remote and Rural Working Group): There are about 10 general practitioners on the group. Initially, the group consisted only of general practitioners and officials, and one of my first requests was that we include a multidisciplinary component. We now have a nurse and an allied health professional on the group, as well as public representation. I was keen to ensure that that was built in at the start.

I was also keen to move forward quickly and get some advice on how the public should best engage in developing primary care through the implementation plan. In other words, I did not see the group as being comprised only of general practitioners, because the future of primary care is not confined to just one discipline; it is a multidisciplinary endeavour.

The resignation of David Hogg—in spite of my best efforts—was deeply regrettable. We are talking about a contract that will transform general practice in Scotland, which needs to be transformed because of the changing needs of society. The problem with transformation is that it is usually neither easy nor quick. However, there are aspects that can move ahead more quickly and pressingly than others.

On the convener's point about the terms of reference, as well as the membership, I have asked the Government—through the civil service—and the Scottish general practitioners committee of the BMA to look again at the terms of reference of my group. It has been defined in the media as a task force for primary care. However, in its current form, it certainly is not that. The terms of reference need to modified, and that needs to be done in conjunction with the community that we serve. I asked for that to be considered, and I understand that that has been accepted and that it will be considered.

Jeane Freeman: The group's terms of reference will be considered at its next meeting at the start of June, which I intend to attend.

The Convener: I accept that we need change and that change is complex. I cannot speak for the

rest of the committee, but do you share my concerns that those who are the most committed to delivering that change—the GPs and the teams around them who serve that community—are expressing grave concerns about the contract? That is why the short-life working group was established.

Sir Lewis Ritchie: As the cabinet secretary said, I and my colleagues have been travelling extensively throughout Scotland. If I am asked to lead an important endeavour, one of the first things that I do is listen to those who are delivering on the front line. We have been doing that and we will continue to do that, because listening to colleagues and observing the care that they deliver informs improvement. That listening is not necessarily through questionnaires and emails; I prefer to go out there.

I heard consistent concerns from people about feeling undervalued and about the new contract not helping uncertainty in relation to future planning. I have been giving that feedback to the Government and in discussions in the short-life working group. That is a diagnostic phase, if you like. To use a medical analogy, first, we ask what is wrong; that takes a little time to assimilate. However, we then need to get to the treatment phase. I hope that the meeting on 4 June—which will be a workshop and not a committee meeting—will bring other voices in, so that we can consider all the issues and determine a way forward.

I have had a number of meetings with Scottish Government civil servants and the SGPC of the BMA to map out the near future. I am assured that, following the workshop in June, the BMA and the Government will produce a joint statement to give clarity on the next steps. I have committed to writing a report on progress in relation to the implementation of the new GP contract by the autumn. I hope to lay out problems as well as examples of best practice, which are emerging even though it is early days. Examples of good practice need to be assimilated and spread, and lessons need to be learned and properly communicated where things have not worked. The word "communication" is all important in this matter. I will pause there, convener.

The Convener: It is always encouraging when a doctor accepts that there is something wrong and is willing to make a diagnosis. That sense that perhaps there is something wrong is a good starting point.

Brian Whittle (South Scotland) (Con): Following on from the convener's line of questioning, I have a point of clarification. Do you accept that there is a migration of GPs from rural to urban areas, especially to the better-off areas?

Jeane Freeman: I am not aware of any clear objective evidence to support that. I am not saying that it is not the case, but I have not seen objective evidence to support it. I accept that there are issues with the recruitment and retention of GPs in remote and rural practices, which is why we have taken a number of steps.

Brian Whittle: We have been gathering evidence that suggests that such a migration is taking place.

Jeane Freeman: If that is the case and you have evidence of that, I would welcome sight of it so that we can consider it, not only in our current implementation of phase 1 of the contract but as we enter into negotiations for phase 2. Sir Lewis would also be interested in that and, of course, the issue is one that plays to our wider workforce. If the evidence is there, I would be very happy to see it.

Brian Whittle: Most of us have mailbags that are full of stories of GP surgeries that are struggling in our areas. Many GPs are moving to an urban setting. We could easily gather quite a bit of evidence to show that that is the case.

Scottish Rural Action highlights that

"There are serious GP and other health worker recruitment and retention issues in rural areas and whilst measures have been taken to address this concerning and costly issue, it is common sense that GP contracts need to be attractive."

Why was the technical advisory group on resource allocation, which provides advice on all resource allocation decisions in the NHS, specifically prevented from providing an opinion on the impact of the Scottish workforce allocation formula when it was obvious that it would disadvantage rural practices that already had difficulty recruiting?

Jeane Freeman: I will ask Mr Foggo to give a more detailed answer to that, but I will say two things. The first is that my understanding is that TAGRA was not "specifically prevented", as you describe it. Secondly, TAGRA's role is to discuss resource allocation, while what we are talking about in the GP contract concerns pay. It is not easy or straightforward to combine the two in one area. However, TAGRA did have a role and I will ask Mr Foggo to describe that to you.

Richard Foggo: As the cabinet secretary set out, TAGRA has a role on resource allocation. A difficulty that we and the BMA have acknowledged is that there is a complexity around GP funding, which not only covers the amount of money that we believe is right to underpin GP services in those communities but provides GP pay. Therefore, the negotiations that we have with the BMA are, in effect, pay negotiations that also take up the question of resource allocation. As you would expect, the pay negotiations are

confidential, which has a particular impact on the transparency of those negotiations and—to go back to the points that the convener raised earlier—our ability to engage openly with the public and others in relation to what is happening in the negotiating room.

In that case, TAGRA was involved in the evidence gathering that allowed us to review the original Scottish allocation formula. At a number of meetings, TAGRA received updates on the development of that work and the outputs from it. TAGRA was involved in the gathering of evidence, but at the point at which a decision had to be made about the application of the formula, that was a matter for negotiation. The Scottish Government and the BMA have accepted that, in future, it would be better if resource allocation could be separated from considerations of GP pay, and that is an explicit aim of phase 2 of the contract.

If that were to happen, as is the case with board allocations, we would have a higher degree of transparency on the allocation formula for general practice, in which case TAGRA might have a clearer role. However, the combining of a pay negotiation, which is necessarily confidential, with consideration of how we allocate resources added a complexity that ultimately made it difficult for TAGRA to offer definitive advice.

10:00

Brian Whittle: I will ask you to keep me right here, convener, but is it not the committee's understanding that the assertion that TAGRA was involved goes against the evidence that we have? Perhaps we could get some follow-up information on that.

Richard Foggo: I will clarify that further. If the question is whether TAGRA was asked to advise on the final decision to apply the new formula to the GP contract, the answer is no.

The Convener: Was TAGRA given all the information that informed your decision on what you would offer? My understanding is that TAGRA was stood down from its involvement in the matter from 2016, so it would not have seen any of the detail after that.

Richard Foggo: The evidence of the review of the initial Scottish allocation formula was available to TAGRA. We then established an expert advisory group, which was separate from TAGRA, to offer us advice about the development of the new formula.

The Convener: TAGRA did not get the further information and was stood down from a process in which, in the past, it would normally have been involved.

Richard Foggo: TAGRA would not necessarily have been involved in that, and it was not explicitly stood down. We established an expert advisory group specifically to allow us to deal with the evidence in the context of the negotiations.

Brian Whittle: Why is the Scottish workload allocation formula analysis based on data from a small group of highly unrepresentative practices that stopped collecting data in 2013? Practice team information—or PTI—practices stopped receiving funding at that stage because the Scottish Government considered the data to be useless. That issue is raised in PE1698/D and PE1698/E. Why that data was used remains unexplained. Scottish Rural Action has noted that the community response to the concerns that have been expressed by rural GPs has been significant and should not be ignored, yet it remains unanswered and ignored.

Jeane Freeman: I do not believe that it has been ignored. My understanding is that the most up-to-date data that ISD Scotland had ended at 2013, and that it then stopped collecting the data because it had to take the time to build a new platform called the Scottish primary care information resource, or SPIRE. Now that it is moving into place, that resource, together with the objective data to do with costs, expenses and so on that we touched on earlier, will feed into phase 2 of the GP contract, which, on the basis of that more up-to-date data, will allow us to review the formula, along with the other matters that need to be discussed in that phase. I understand that the process will begin when the data on costs, expenses and so on becomes available to us from November of this year.

Perhaps Mr Foggo can take us through the rest of the supplementary information.

Richard Foggo: We went out to seek further data that would allow us to form a more refined judgment. Ultimately, we went out to 600 GP practices and asked them to provide us, on a voluntary basis, with data that would allow us to refine our assessment. We received only 109 responses, which did not provide us with a sufficiently robust basis for updating the PTI. I should say that that information is the most robust that we have to hand and that the data and assessment that were used were refined and methodologically improved. We also changed the census date and moved to a data-zone approach, so a number of methodological improvements were made to our assessment of that data.

Secondly, I should make it clear that the assessment of workload does not track real activity or real GP workload. In some submissions to the committee, it has been suggested that if, for example, areas are underdoctored or have coding issues, or consultations there have reduced, that

will have a direct impact on their GP funding. That is a misunderstanding of the methodology of the formula, which I will be happy to correct for the committee.

The formula does not track consultation rates or read codes; it looks at the populations that the practices serve and it adjusts for age, sex and other characteristics. It then forms a notional assessment of how many consultations would be generated from a population with those characteristics, which generates a factor that allows us to determine the allocation of resources. Factors such as fewer consultations taking place over a period of time, a GP being on leave or an error in the coding system are all accounted for.

The 2013 data was sufficient to allow us to form judgments. However, as the cabinet secretary said, our ambition is to create a much more up-to-date and transparent data set. Through the contractual negotiations, we have secured, for the first time, a contractual obligation on GP contractors to provide such data. Therefore, we will be able to get data not from 109 practices but from all 950 practices.

Brian Whittle: You disagree with the assertion that the Scottish Government considered the data to be useless.

Richard Foggo: Absolutely. I do not understand in what regard it was useless.

Brian Whittle: That has been the suggestion in the evidence that we have taken. We are raising the petitioners' concerns, and Scottish Rural Action has said that the concerns that GPs have expressed have been significant and remain unanswered. The only answer that I am getting back is, "That's not true."

Jeane Freeman: To be fair, I think that you are getting a bit more than, "That's not true." You are getting an explanation of how we worked on the basis of data that was from 2013. We recognise that the data was not as adequate as we would wish it to be, so we are undertaking a number of methodological and other changes and checks in an attempt to get to a point at which we can sensibly rely on it while we gather more objective and up-to-date data for phase 2.

In phase 1 of the contract, we had the choice to say, "The data that we have is from 2013—that'll no do no matter what we do with it." We thought about how we could go forward, given that we had a contract that had to be negotiated. Mr Foggo has described the efforts that were made to ensure that our use of the 2013 data was improved so that it was as robust as possible for the purposes of phase 1. However, phase 1 now includes an obligation on all 950 general practices to provide us with up-to-date data, which we will be able to use in phase 2.

Brian Whittle: Why did Deloitte not make the effort to obtain more up-to-date and representative data? The cost of obtaining a fresh data set would not be prohibitive. The contract was introduced with haste, and the concerns about the SWAF have been dismissed, instead of being addressed. Scottish Rural Action believes that

"threats to health services need to be addressed transparently and urgently",

but that the Scottish Government has yet to respond to those concerns.

Jeane Freeman: Scottish Rural Action's claim that the Government is not responding to concerns about the delivery of rural healthcare is unfair. I will not repeat all the various steps that we have taken, nor what we have said clearly this morning about there being more work to do to ensure that the contract adequately reflects the needs of all our communities across Scotland. To say that we are not doing anything is an untrue and unfair characterisation of our position.

Brian Whittle: Scottish Rural Action is not saying that you are not doing anything; it is saying that you are not responding and informing.

Richard Foggo: I do not accept the characterisation, given our attempts to secure additional data. I will remind you of what I said.

We went out to 600 practices to ask for that data, and we indicated that we would cover the cost of collecting it. Only 109 practices responded, which included an insufficient number of those in rural communities. I note that that would have been an opportunity for rural general practices to provide us with the data that underpins their assessment. Despite offering to pay for the collection of the data—I note the point is made that doing so would not have been prohibitively expensive; indeed, it would not have cost anything, because we were prepared to subsidise the cost—general practices were unable for many reasons, including their being hard pressed and their workload, to provide the data.

I correct one point. It is claimed that we made no attempt to update the data available to us. We made every attempt to do so, but unfortunately general practices did not feel able to provide us with the data on a voluntary basis, despite the offer of payment. Therefore, we have had to make it a contractual commitment in the GP contract to provide us with the data, which is in line with what the Parliament has previously said about transparency on GP funding.

Brian Whittle: It would be interesting to find out why the response rate was so low.

The Convener: Did you ask GP practices why they did not respond? Clearly, they are alive to the issues.

Richard Foggo: We returned to GP practices on numerous occasions to seek further volunteers. As I said, we offered a subsidy to 600 practices to ensure that they would not be financially penalised for providing the data.

Deloitte, the BMA and others made numerous attempts to get the data. The BMA, through its local contacts, encouraged—indeed, exhorted—local practices to provide the data. It understood how critical that data is for rural communities and, had rural general practices provided the data at that point, we might have been able to make a different assessment of where we stood.

The Convener: Sir Lewis Ritchie made the point that he prefers to talk to people rather than to email them. Did you have any direct conversations with rural GPs who did not engage in the process? The request seems very reasonable, so why on earth would they not comply? Have you asked them why they did not?

Sir Lewis Ritchie: I know for a fact that the ISD stopped collecting the data in 2013, because that coincided with the intended replacement of a national GP computer system with commercial alternatives. As Mr Foggo says, no alternative is in place. That is now being worked on. In fact, as I knew that the national system would be disbanded, I flagged up some years ago that we had to have a robust alternative in place. That is being worked up. I will stop there on that issue.

On formulas, the units that have been used do not express the richness of general practice in the round; in particular, they do not account for the diversity of practice in remote and rural areas. I would say to Government that any future development should be informed not just by formulas, but by what GPs do in remote and rural areas, because they do different things.

A GP in a remote and rural area can be a nurse, if the nurse is sick. They can be a paramedic, if the ambulance is out of area—a GP might attend a road traffic accident, for example. At times, the diversity is stark. For example, on a remote island, a GP may work all day to keep a sick patient at home and avoid an air evacuation. Such a situation happened very recently with one of my colleagues. No formula will account for that. Therefore, we need to be more sophisticated when looking at the diversity of what our rural colleagues do, how well they do it and how best that needs to be resourced and supported. I would like to shed a little light on that with my group.

Brian Whittle: I appreciate that point, Sir Lewis, but were those issues not taken into consideration at stage 1 of the production of the GP contract? We know those things to be the case.

Sir Lewis Ritchie: I cannot answer that. Mr Foggo may want to respond.

Richard Foggo: Those issues were absolutely considered. For the well-known reasons that Sir Lewis Ritchie stated, and a limit on any weighted capitation formula-based approach, in negotiations we actively considered removing altogether small, remote, rural general practices from the formula.

10:15

The reason that, with the BMA, we decided not to proceed with that was for precisely the reasons that have now come to pass—we feared that if small, remote, rural general practices were separated from the overall body of the GP profession, that would be portrayed as marginalising rural general practice. We made the decision to keep them in the formula precisely to ensure that they felt part of the overall GP provision in Scotland and to avoid marginalisation.

Rachael Hamilton (Ettrick, Roxburgh and Berwickshire) (Con): I am trying to grasp this. You acknowledged that perhaps the metrics were not taken into consideration or were not right for rural practices. Also, as Sir Lewis Ritchie said, the ISD had stopped gathering information in 2013. Additionally, there was no uptake of the information from GPs that maybe there should be a pause on that until the right information is there. I completely accept Sir Lewis Ritchie's points about the issues that the GP practices in my constituency have; for example, did the Scottish workload allocation formula also take into consideration other factors, such as providing health services to seasonal workers or tourists?

Jeane Freeman: Before I ask Mr Foggo to answer that specific point, I will say two things. I think that you, your colleagues and I agree that a number of issues in the phase 1 negotiation were not as ideal as we would have wished. The reasons for that are understood. For example, as we discussed in detail, although the data was from 2013, effort was made to ensure that, for the purposes of the negotiation, the data was robust. Of course, Deloitte was involved in that as well as in the other matters.

On the question about a pause, given that the contract is in two phases, in phase 2, which begins shortly, we can take account of issues that emerged from phase 1, so that we can consider again what more might be done with the formula and perhaps revisit the difficult question of whether to remove remote and rural practices from the formula. As Mr Foggo outlined, it is a judgment call over whether we take the risk that people, if we remove their practices, will perceive that they have been marginalised or whether we retain all practices in one Scottish GP family and then carry the risk that some of the issues that we discussed will emerge.

No formula is set in stone. Equally, no formula will ever be perfect. However, there is an opportunity to review how adequate the formula is. That is why the work of Sir Lewis Ritchie's group, the consideration of its terms of reference and how that, along with more up-to-date objective data, is fed into phase 2, are really important.

It is important for us to understand that this is not a final position in which no change or improvement is possible. At this point, there is consideration of whether we can take any steps before the conclusion of phase 2 to address some of those issues, not least the terms of reference of Sir Lewis Ritchie's group, but, in discussion with the BMA, any other pressing issues that we might move on. The contract is not entirely in our hands; it was negotiated with the BMA, which is the other major player in this.

Mr Foggo will respond to your specific point about seasonal workers, tourists and so.

Richard Foggo: We must understand that the application of the formula in its totality without income protection would have been inconceivable to us. A number of the hypotheticals that are run seemed to suggest that the application of the formula would not reflect the complexity of rural general practice and would result in an underfunding of rural general practice, so income protection is a critical component.

The existential threat that the BMA said was presented to general practice included workload. You asked why we did not pause. The answer to that is that we took a two-phase approach, part of which involved recognising that there were very many practices in Scotland, including some in rural areas, that were confronted by a serious workload challenge. It was the BMA's contention that, along with income protection to ensure that no practice lost out, we needed to invest to capture that additional workload. That is why we went forward with the workload formula, along with income protection.

The third part of Ms Hamilton's question was about seasonal workers. All practices, whether urban or rural, receive a fixed temporary patient adjustment for unregistered patients, and we have committed to look at the ebbs and flows on patient lists. Whether those relate to an increase in the number of registered patients or in the number of unregistered temporary patients, we have committed to look at that regime to make sure that it is up to date. Every practice in Scotland receives adjustments to accommodate for those ebbs and flows. We completely agree that, if we had better data, we would be able to form a better judgment on whether those indexes are as up to date as they need to be and whether the regime is as good as it could be, but GP practices are compensated to reflect those ebbs and flows.

Angus MacDonald (Falkirk East) (SNP): Good morning, cabinet secretary. A number of the issues to do with the Scottish workload allocation formula have been covered, but I was interested in what Sir Lewis Ritchie said about the situation on remote islands. In that context, I refer members to my entry in the register of interests.

Given the concerns that we have heard, will you still consider removing small remote general practices from the formula in the future, notwithstanding your view that those practices would be marginalised?

Jeane Freeman: I make it clear that I am not saying that it is my view that those practices would be marginalised; Mr Foggo did not say that, either. In the discussion, there was a debate about whether, in removing remote and rural practices from the main formula, there was a risk that those practices would perceive themselves to be marginalised. That issue was raised by the BMA. In the discussion that followed as part of the negotiation, the final decision was taken not to risk that.

However, that does not mean that we should not return to the issue. It is clear that there are improvements to be made—not least because of the improved data that we anticipated having in advance of phase 2, which, contractually, has been put into phase 1—on some of the issues that have been raised, partly through the committee's work, but primarily through Sir Lewis Ritchie's work. We need to consider what modification can be made to the formula to better reflect those concerns and the variation that exists between rural and urban practices in what GPs actually do. Whether that means that we will remove remote and rural practices from the formula or that we will find other ways to adequately address that diversity will form part of the discussion that goes into phase 2, which will involve the views that come via Sir Lewis Ritchie's group and from others.

That is why I said that no formula is set in stone. Clearly, what we have at the moment is not perfect. There are issues that need to be addressed and we need to consider how best to address them. Do we do that by removing remote and rural? That question will be returned to, and there may be alternatives to doing that. We have to have that discussion and see.

Sir Lewis Ritchie might want to add to that.

Sir Lewis Ritchie: One of the responsibilities of a chair, apart from trying to care for and support those round the table, is to get all the voices heard. I have spoken regularly with the chair of RGPAS, including last night, and I have seen her in her practice twice. I am deeply committed to getting all of those voices heard.

In your opening comments, convener, you mentioned my terms of reference, so we have already covered that. As a responsible chairman, I try to not just deal with what is on the tin lid of the remit but look laterally and think how we can do better than just addressing specific issues. In that regard, we have just received an international literature review of research on what might be best practice in other countries that also have remote and rural situations. The guiding principle there is that we can learn from others.

I am also asking the Government to sponsor a descriptor of what is distinct about general practice in remote and rural areas, so that we can actually see that richness and look at it in greater detail, and then move on that. Again on the international dimension, I am garnering the opinions of remote and rural practitioners who have experienced our developing models elsewhere. I would like all of that to be included. I would also like to include the support of Healthcare Improvement Scotland, the national agency, and potentially others including National Services Scotland, given its programme support capacity. All of that is on the table as we go forward to try to help our colleagues in remote and rural areas.

The Convener: That does rather beg the question why all that work was not done at the beginning, if we are committed to carrying out equality impact assessment and rural and island proofing.

David Torrance (Kirkcaldy) (SNP): Given the wide range of additional medical services that are offered by many GPs in rural communities and the isolated nature of their location, why was that additional workload not taken into account during the allocation formula analysis?

Jeane Freeman: We have largely answered that. Although there might be justification for the proposition that some of what is being discussed could have been better taken into account in the negotiations on phase 1, it is fair to say that it was taken into account. The important thing is that, as we implement phase 1 of the contract, we are willing to look for improvement, which is in large part why Sir Lewis's group was established, why he was asked to chair it and why we are considering strengthening and clarifying the group's remit.

I am happy to ask Mr Foggo to respond on how such issues were taken into account, but I should say that although our focus is rightly on remote and rural general practices, some issues of complexity of workload and demand on GPs also apply to practices in more urban settings, although in a different way. The convener mentioned the deep-end practices. Similar practices have a slightly different name here in the east, but they deal nonetheless with a complex cohort of patients with many different and demanding needs. The contract and the formula need to be able to take account of that, too.

Richard Foggo: I do not have much to add, other than to say that some of the complexity is captured through other means of remuneration. Not all of it is captured through the general medical services contract. Some rural general practices carry other contracts to provide other services, including community hospitals, for example. The general point has already been made that no formula can pick up on all the complexity.

10:30

We absolutely accept that the better the dataset, the more able we are to develop our concept of workloads. A question was asked about why we did not consider such things during negotiations. I absolutely assure the committee, having been in the negotiating room for two years, that all those matters were considered at considerable length and that, ultimately, judgments were made.

We are open to revisiting some of those judgments. Once we have the more up-to-date data on general medical services, we will be in a position to reflect on that workload. A judgment will then be made as to whether that should be captured through a formula or handled in a different way.

Complexity of general practice was the main consideration in relation to the formula—not just the complexity of rural general practice, which includes the logistical workload, the extra travel and all the other factors in relation to cost, but the nature of consultation and engagement in clinical practice. Other complexities in general practice were covered in the submissions, including unmet need, which is incredibly difficult for us to capture in any formula, given its potentially infinite nature.

David Torrance: I think that you have answered most of the next part of my question. However, in its submission, Scottish Rural Action mentions

"the recent decline in life-expectancy in rural communities"

that is highlighted

"in the New West of Scotland: Health Needs Assessment report."

How would you respond to the petitioners' concern that the Scottish workload allocation formula is adding to that inequality?

Jeane Freeman: I take such assertions very seriously indeed and would want to discuss with the petitioners in what way they think that the contract—as opposed to a range of other matters that we are attempting to address through the health portfolio—contributes to that. To say that

the workload formula is having an impact on the life expectancy of patients is a serious contention. I would want to consider it seriously and to understand the basis on which that assertion or that concern is being expressed.

It is not immediately clear to me why that link would be made. I do not know whether Sir Lewis Ritchie or Mr Foggo wants to add anything to that.

Richard Foggo: Again, we can provide the committee with considerable detail on the technical and methodological underpinnings of the formula, which includes the demographic characteristics of the population, including deprivation, age and so on, all of which are protected characteristics. That relates to the equality impact assessment.

Judgments are formed—we are quite clear that we placed a particular weighting on age and deprivation in assessment of the formula. We understood that the additional costs of provision of rural general practice were mainly in relation to expenses and the costs of running the businesses, and we reflected that we would have to consider those costs in phase 2.

I would be very happy to provide the committee with all the underpinnings, which set out in incredible detail all the component parts of the formula and how they capture the different demographics.

However, like the cabinet secretary, I have no evidence that there is such an impact. Given that we are only one year into the contract, it is difficult to see how, at this stage, we could in any credible way be seeing an impact on life expectancy. As the cabinet secretary said, that is a serious assertion: I imagine that it is quite early for there to be direct evidence of such an impact. We would be very interested in hearing that evidence.

The Convener: We have evidence that the settlement disproportionately benefits better-off areas in urban settings, as opposed to poor areas in urban settings, and that it disproportionately puts money into urban settings rather than into rural settings. We accept that evidence. We also have the body representing our rural GPs saying that there is a major problem here. That particular assertion is clearly very serious. Would it be possible to ensure that that conversation is held directly? That is for you to establish—we would not want to engage with that—but it is clear that the view is strongly held.

Before I bring in Rachael Hamilton, I have two quick questions. First, when will phase 2 start? Secondly, other than through the efforts of Sir Lewis Ritchie, how do you hope to engage with the RGPAS to encourage its involvement in phase 2?

Jeane Freeman: As I said, the data that will be gathered from practices that are part of phase 1 of the contract should be with us in November this year, and we expect phase 2 of the contract—I refer to the beginnings of the negotiation around that; there is a lot of preparatory work and discussion to be done between November and that point—to start from the spring of 2020.

The Convener: Will Sir Lewis's report inform what happens in November?

Jeane Freeman: Indeed, it will.

On your second question, Sir Lewis's report will absolutely inform all of that consideration. The primary way to engage the RGPAS in the work of Sir Lewis's group will be taken forward by Sir Lewis. I think that that is entirely proper. If, at any point, he thinks that there would be value in a further discussion between me and that body, I will always be open to that. I had—last summer, I think—a couple of discussions with the RGPAS and David Hogg. I am very happy to have discussions again, but I will take Sir Lewis's advice on the best way to deal with that.

Rachael Hamilton: The new GP contract, along with the memorandum of understanding, sees health boards taking on some responsibility for secondary care and non-core services, which will allow GPs to free up time for primary care. However, that is not necessarily happening in rural settings. Mr Foggo mentioned some good figures on the flu vaccination in the Highlands and Islands, but I did not quite pick up what he said about that, so perhaps he could repeat it.

I wonder whether vaccination transformation has been compromised because of roll-out of services and the geographical considerations that rural GPs have to take into account. I am speaking from experience, having spoken to GPs in my area who say that vaccination transformation is not being delivered as they would like it to be.

Jeane Freeman: I will make a couple of points first, and then Mr Foggo might want to add to that. Sir Lewis might want to make a couple of points, too.

The first thing to say is that alternative provision of immunisation programmes is an offer—it is not compulsory. GP practices in some remote and rural areas that have taken up that offer—the example that I gave was the Western Isles—feel that there has been improvement. However, I am equally conscious that other practices believe strongly that the offer does not meet the needs of their patients, so they want to continue to undertake the work themselves. They are entirely free and able to do so, because there is no compulsion. It is very important that that is clear. General practices in some of our island communities have made the point—I understand

it—that it makes more sense for them to continue to do what they have been doing than for a team to appear from the mainland to deliver it. That makes sense to me, too, if I am honest.

It is important to be clear that the programme is an offer. In some urban and town practices—not in our cities, but in towns—it is something that GPs welcome and want because they believe that it frees up time for them to do work that it is clinically appropriate that only they do, and to spend more time with patients. We should see the mixed picture, and act according to what makes most sense for the patients in a practice and what is the safest thing to do.

Rachael Hamilton: That is true, as long as it is being delivered and monitored. Are you monitoring that, and do you have a picture of how things are being transformed?

Jeane Freeman: We have the beginnings of a picture. Sir Lewis can say more about that.

Sir Lewis Ritchie: I have to declare an interest, in that I chair the Scottish health protection network oversight group. Nested under that, among many other things, is immunisation. I have agreed with my colleagues in that group that we need to be vigilant about immunisation uptake rates. Those are one of our crown jewels in Scotland and we need to take extremely seriously any change that threatens those rates.

It is clear from my perspective and that of my colleagues that, even when the vaccination transformation programme is in an advanced state, there will still have to be local delivery by GP teams in remote and rural areas. That needs to be clearly recognised. We need to support that. It is not something that will just be subsumed into some central team.

I am aware that in places such as Tayside, where the vaccination transformation programme has been in place for several years, the uptake rates have increased and GPs are keen to see the job done well—in that case, by people other than GP staff. However, I cannot see that happening in remote and rural areas, and we need to take account of that in terms of support.

Richard Foggo: As the cabinet secretary said, we have made no substantial changes to the contract in relation to vaccination and GPs continue to be paid for it. There was some prospect that, no earlier than 2021, or phase 2, we would look at how much of the transformation had happened, but there was always an acceptance, as stated in the contract offer, that there would need to be flexibility around remote and rural areas.

There is concern about vaccination transformation, which has been portrayed as a step that is being taken in order to reduce GP workload and that therefore creates the risks that you outlined. That is a narrow portrayal of what vaccination transformation is about. As Sir Lewis said, the programme has been under way many areas for a while. Vaccinations are becoming increasingly clinically complex, and that interacts with the workload burden on Scotland's GPs, so future proofing Scotland's vaccination programme from a public health perspective was a critical driver in our work.

Some people portray what is happening as involving a preparedness to sacrifice what Sir Lewis describes as Scotland's crown jewels for the sake of some modest efficiency. However, as the director of population health, which makes me responsible for policy on immunisation and vaccination, I can say that there was a public health imperative behind our looking at how vaccinations are delivered. There is, however, an absolute backstop that says that no vaccination programme will be transferred unless it is safe to do so.

Rhoda Grant (Highlands and Islands) (Lab): I have listened with interest to the evidence. It has given me a better understanding of why rural GPs have such a lack of trust. It is clear that the formula was devised for urban practices and ignored the health inequalities that remote and rural areas face, which the convener has pointed out. Those areas were clearly an afterthought, and the funding of GP practices in remote and rural areas was protected because it was acknowledged that it would be cut if they were run through the same contract. The fact that the issue is being looked at again is not because that was recognised early on; it is because of the outcry of patients and GPs in remote and rural areas.

I will pick up on some of the points that have been made in response to other members' questions, so I might dot about a bit.

One of the things that has been said about the formula and how you are gathering data is that you are considering the number of consultations. I have had experience of urban and rural GP services. I know that, if I go to my GP in Inverness, I will get a 10-minute appointment, and there will be a queue of people behind me. I also know that, when I was helping to look after my parents, the GP would make a 40-mile round trip on single-track roads to do a consultation.

If we ask a rural GP how many consultations they did today, they will reply that they did four or five. Immediately, they know that the formula will not work for them, because an urban GP would do 40 consultations, so it will look as though the rural GP is not doing anything. It is no wonder that they are not keen to provide that data to you; the basis on which you are asking for it is not the premise

on which they work. I do not think that you can answer that point now. You might need to look at the information that you are gathering and how you are gathering it.

10:45

Another thing about GPs' work in rural areas—Sir Lewis referred to this—is that a GP could spend a day working with a patient at home and keeping them out of hospital. The same is also true because they support rural hospitals as well as medical beds. I wonder how much cognisance has been taken of that. You mentioned that rural hospitals came under a different contract. Do medical beds and hospital at home also come under that different contract?

Jeane Freeman: Mr Foggo will deal with a couple of your points. Before he does, it is important for me to put on the record that income protection was not introduced because there was recognition that phase 1 of the contract and the formula was inadequate. As I said at the outset, protection has been there for rural practices since 2004. Generally speaking, a majority of GPs, including GPs in rural areas, were not content with that contract and wanted to see significant changes. The current phase 1 of the contract was not devised for urban GPs with no care given to equity. We have made it clear that that was neither our intention nor the intention of the BMA, which was the other partner in the negotiation. The BMA represents GPs in a range of settings.

Our acceptance that there are areas for improvement should not be mischaracterised as an acceptance that there was an uncaring approach with regard to phase 1 of the contract for remote and rural practices. It is simply a welcome recognition that, in phase 2, we are considering areas of further improvement for the implementation of the contract.

I will ask Mr Foggo to respond to Rhoda Grant's point about consultations, hospital beds and hospital at home.

Richard Foggo: I will build on responses to previous answers.

There are always choices to be made about the methodology that we use. As I mentioned before, we absolutely considered the complexity of the nature of the delivery of rural general practice. That gets back to a basic point. The value of rural general practice is not—and never can be—expressed through a formula. A formula is a device, of which there are many choices that we might make about how to divide our resources. That is not directly a way of expressing value. Those two debates make it difficult for us to compare and address apparent inconsistencies.

The methodological point about whether consultation rates are an appropriate way to assess workload is part of our consideration and we have acknowledged that it is not an adequate way to do it. On the broader point about whether or not, through the formula, rural general practice is valued, I am very regretful that the methodological choices around the formula have been connected so directly with the question whether or not we value rural general practice.

As the cabinet secretary said, income protection, which has been—and must be—a feature of weighted capitation approaches and formula-based approaches, is a standard feature of such contracts. Under the 2004 contract, it was not portrayed in the way that it is now being portrayed. The reflection for me, as to what change has happened, is to look back and to look forward to make sure that in future we look at how we present income protection and how it is understood. However, the connection between the methodology for the formula, which is very complex, and the question whether we value rural general practice, is nowhere near as direct as it is portrayed.

Rhoda Grant: If you are ignored, you feel undervalued, and the contract certainly ignored the work of rural GPs. If you put yourself in the shoes of rural GPs, you would understand why they feel undervalued.

I will move on to the protected salaries of rural GPs. I think that Mr Foggo said that this phase does not address such things as expenses and that those are the main costs for rural GPs. I find that difficult to understand, because property in rural areas is cheaper. Yes, they have to travel more miles, but the hours worked are the same, although sometimes they work greater hours, because they have to provide their own out-of-hours services. I cannot understand why expenses would be the main difference between the costs for rural and urban GPs.

Richard Foggo: If it is helpful—I want to be as helpful as possible—why do I not use the evidence that we have to provide you with as much clarity as I can on the various differentials in relation to the cost of providing rural general practice, incomes and so on? I hope that it will be helpful to provide you with data after the meeting. That would allow us to be clear about that point.

There is a lot of complexity in that, relating to all the different factors, and, based on our review work, we have some evidence on the cost base. As we have indicated, that is not adequate, but I can provide you with a summary, if that would be helpful.

Rhoda Grant: That would be useful.

We have been told this morning that there is no change in the vaccination programme and that GPs can carry on vaccinating. I assume that it is up to a health board whether that happens, because constituents are telling me that there is change. Patients, not of remote rural practices but of rural practices outside Inverness, have told me that they need to go to the Royal northern infirmary, which is a hospital for the elderly, to get their flu vaccine. Some of them are frail and have to get there by bus. There are maybe two or three buses a day, which means that they have to spend the whole day in Inverness. Many of them are not fit enough to do that, but that is what they are being told that they must do.

You are telling us that there is no change, but people are telling me that they cannot access the flu vaccine, because they are not fit enough to spend a day in Inverness; there is also the question of the affordability of travel.

Richard Foggo: The point that was made is that there is no compulsory change. There is change and, as Sir Lewis has indicated, that change is complex, and I think best—

Rhoda Grant: Who is initiating the change? I do not think that it is the GPs—I think that it may be the health board. If the health board thinks that that change will save it some money, perhaps it is not thinking about the patient experience.

Jeane Freeman: The contract offers the possibility of change, but the key element of any transformation of the immunisation programme in any particular area, or sub-area of a health board, is that it should be done safely and should hold to one of the important elements of our health service by being person centred. The board should be in discussion with GP practices about the best way to deliver immunisation programmes. If there are instances in which the result of that discussion is that patients are disadvantaged, we should know about that and we should take that up with the board, to find out why that is the case, because that does not seem to meet the criteria of being safe and person centred.

Sir Lewis Ritchie: An important principle is equitable care—that is, fair and accessible to all according to need. I would expect any service development—such developments are getting increasingly complex—to be, as Mr Foggo says, effective, equitable, accessible and affordable.

Any service development needs to make the best use of public monies. There is little point in constructing an elaborate mechanism if it will be highly costly and not make best use of public funds, so I would expect that consideration to be configured into any proposed change to immunisation. No one principle can be taken in isolation; they all need to be taken together.

The other point to make is that a judgment needs to be made in combination with those who deliver the service. Earlier, the committee heard me mention the communication issue, which will be vital as we go forward, given the fog of uncertainty that exists right now. Front-line teams are not necessarily sure about what is going on at board and at integration joint board levels, so we need to make every endeavour to chase away that fog. It will always remain in places, but we need to change the weather.

Rhoda Grant: You cited figures that showed the increase in the immunisation rate among schoolchildren in the Western Isles. Do you have similar figures for elderly people? Have you looked at immunisation rates across the board? You might not have the figures with you, but it would be interesting if the committee could have that information.

Richard Foggo: It is early days, so we do not have those figures, but I am very happy to keep you and the committee updated on the evidence that we have, if it will be of interest.

The vaccination transformation programme is very complex and is being done right down to the practice level. In other words, we are being absolutely clear at a fine-grain level about when the services can transfer. We are also doing the work thematically, by looking at different vaccination programmes. In some areas, the services for shingles are being transferred, and those for pertussis and flu are being transferred in others. Different things are going on, so there is a complex picture. Sometimes, from one area, we will have information relating to one programme but not to another, or we will have information relating to one demographic.

If Rhoda Grant is interested, I am happy to provide her with the information—in relation to the Western Isles, specifically, or more generally—when it is validated and can therefore be relied on.

Rhoda Grant: I am interested in the information more generally. However, you cited figures from the Western Isles, and I am slightly surprised that you gathered one set of figures—in a way, that was a no-brainer, because most children go to school, so that information can be captured easily—but that you do not have the structures in place to gather information on the elderly population. If I were you, I would look more at the programmes for the elderly population, given that you know that there will be difficulties with that group, rather than at those that you know will probably work better.

Jeane Freeman: I take your point. However, given that we target a number of groups through vaccination and immunisation, and given that the transformation programme is moving in different

ways across the country, I am interested in finding out whether the transformation programme has improved uptake among the target groups of people or whether it has had a negative impact. We cannot form a picture by looking at one set of figures for the whole of Scotland. For the different groups and the different immunisation programmes, we need to look at where there is change and at what difference that change is making.

Rhoda Grant: I imagine that elderly people are one of those target groups.

Jeane Freeman: Yes, indeed.

The Convener: I have a couple of final questions, which have been flagged up to me—forgive me if I get the technical language wrong. The technicalities of the matter are leading to people sending strong messages that they are unhappy because of the consequences of the choices that you have made. People have drawn those conclusions.

I was advised that there has been a shift, in rural practices, from an excess cost of supply approach to what I think is called a protected income and expenditure approach. The argument was made to me that the consequence of that change is that, although people are told that income will be protected, it is possible for the health board or partnership to withdraw the money at some point in the future, and that is creating insecurity in the system. Would the witnesses like to comment on that point?

The changes have been made because of the recognition that there is a shortage of GPs. In that context, there are issues about the attractiveness of working in particular areas and about the capacity for GPs to be supported in their work. Rural GPs who are deeply committed to their local areas are expressing anxiety about the sustainability of such general practices in the future.

11:00

Jeane Freeman: I will answer that question and will ask Mr Foggo to respond on the technical point of whether there was a shift from one approach to the other.

Notwithstanding the fact that the protected income element has been there since 2004—it is not new—I am aware that there is a concern that, because it is described and viewed as such, it is vulnerable to being removed. I attempted to address that—

The Convener: Am I right in thinking that more of the budget shifted over there? The issue is not that the model did not exist but that, in the course of this contract, there has been a shift in the income of the GP that makes more of their income vulnerable.

Jeane Freeman: I do not believe that to be the case, but Mr Foggo may be able to offer more detail. We attempted to maintain the financial recognition that our practices in remote and rural areas require to have income protection against any formula. We must bear in mind the fact that it is difficult for a formula completely to reflect the nature of such a practice compared with how GPs practise and work in more urban settings. I am keen, with Sir Lewis Ritchie's group, to look at how we can remove the concern and uncertainty about whether that level of income will continue or will be removed at some point in the future. That is part of the discussion that we are having.

I will let Mr Foggo respond on whether there has been a shift.

Richard Foggo: The committee's questions suggest that a technical, methodological change is being used to draw some quite profound conclusions. I will therefore make a couple of points that might help members' understanding of that, and I would be happy to brief them on the technical aspects of the matter.

Income protection is no more or less fragile than any other part of GP funding. Such funding is set on the basis of allocations from the Scottish ministers, which are approved by the Scottish Parliament.

The Convener: Will you explain the shift from excess cost of supply to protected income and why such a change was made? Then, perhaps, we will be able to work out whether it matters.

Richard Foggo: As I have said, that is the technical, methodological bit. In 2004, the Scottish workload allocation formula had two component parts: workload and unit cost. We gathered evidence on both, and we published reviews of that evidence. We had some evidence—it was also the imperative that emerged in negotiations with the BMA—that there was a crisis in relation to workload. We had enough evidence to move forward with the workload component of the formula, but we did not have sufficient data on unit costs. Therefore, we proceeded with a single-track formula to remove the unit cost component for this stage and replace it with income protection.

I believe that that is perhaps the shift that you are talking about, convener. However, I should say that it does not have a consequential impact in, for example, giving boards any more leeway to adjust funding as you have described. Funding is set nationally, and we do not commission GP services locally. Money flows through boards without their being able to adjust the GMS component of the contractual arrangement. Therefore, although a board might hold a contract with GP contractors, it

does not get to adjust the GMS component, which is set though national bargaining.

Convener, I suspect that your question conflates two or three elements. One is the methodological adjustment to the formula, the limits and prospects for improvement of which we have explained at length. Another is the making of a connection to GP funding. The overall value of the contract increased in the course of this version, so it is not just that income was protected; we added a further £23.7 million—

The Convener: Which went disproportionately to prosperous practices in urban areas.

Richard Foggo: No—the second uplift, which was the contract one, was separate from the income protection.

The Convener: Are you saying that all practices across Scotland got equal access to, and a proportionate amount of, that £23 million?

Richard Foggo: I am saying that, last year, two sums of £23 million—£46 million in total—were put into the total value of the contract. That was partly to cover income protection, but it was also to provide an uplift to all practices.

The Convener: Am I right in asserting that a disproportionate amount of that new money went to prosperous urban practices instead of deep-end practices in cities and rural practices?

Richard Foggo: The income protection—

The Convener: I am not asking about income protection; I am asking about the new money. Rural GPs are saying, "There's a problem here, and we're not being listened to about the issues that we are facing." One of the strongest and, we thought, compelling arguments that has been made is that, according to the evidence, a disproportionate amount of the new money has gone not to rural areas but to urban areas—moreover, not to poor urban areas but to more prosperous urban areas—precisely because of the formula or the choices that you made about what matters most.

If, for example, people living to a very old age is an important factor, the fact is that, proportionally speaking, those who live to such an age live in the better and more prosperous bits of our cities. Do you agree? Am I right, therefore, in thinking that a disproportionate amount of that new money went to prosperous urban practices, not to rural practices or poorer practices in our cities?

The cabinet secretary was quite right to highlight the issues that are faced in areas of significant deprivation in my own city, where people have comorbidity as well as other issues and challenges in their lives, but with those who manage to reach the age of 90—who, I acknowledge, will have other issues and deserve to be supported—doctors are dealing with a quite different situation.

I really appreciate the amount of time that the cabinet secretary has given us this morning, and we will need to reflect on what we have heard—as, I hope, the Government will, too. However, there is a very significant question at the heart of this issue. Is it the case that the contract as settled—on, it has to be said, a very small turnout of doctors—disproportionately benefits more prosperous urban areas instead of poorer urban or rural areas? If that is true, it shows that you have not done an equality impact assessment or any island or rural proofing.

Jeane Freeman: The equality impact assessment and the work that was done on the basis of the contract as negotiated did not demonstrate that that would be the consequence. The two areas that are focused on primarily in the workload element of the contract and formula are age and deprivation.

The Convener: My question is: can you give us evidence that a disproportionate amount of the new money went to poorer communities and rural areas? My contention is that you cannot. You might say, "We have factored those things in," and you might well have done so, but, as a consequence, the question that is being asked of you—and to which I have not yet had an answer—is: where did the new money go? How did it break down? How was it divided up? This is not about protection of income. I know that difficult arguments have been had in the past about changing the formula. Any Government of any colour will often put a floor in place to ensure that no one loses anything, but the fact is that people are losing out because they are not gaining from the extra money that has been made available.

Richard Foggo: We will, of course, provide you with that information, but the reason for my hesitation with regard to the word "disproportionate" is that the formula component and income protection form only one small part of the overall contract value. I want to make it very clear that the £23 million was not the only new money was put into the new contract last year—there was also the £45 million around the memorandum of understanding and the overall contract value. We would need to look at all of that in the round.

The Convener: I think that you should be able to tell us where the £23 million went. If there was an assessment of fairness and equality, it must be possible to say that the money was distributed in what might be regarded as an equal and fair way.

Richard Foggo: It went to the practices with the highest workload.

The Convener: That, in itself, raises a massive question. After all, as the cabinet secretary has said, workload does not necessarily equal a particular number. Ten-minute visits from, say, 40 people who really have no other issues in their lives but have something that they need to have looked at does not compare with what is happening in our deep-end surgeries or with some of the complexities that are faced in our rural areas. It just does not stack up.

Jeane Freeman: We will provide you with all that information, but workload is not solely about the number of people seen by a GP; it is also about the issues that a patient presents with, and that is how deprivation should be reflected in the workload element of the formula.

The Convener: Some of the campaigners in the deep-end surgeries sometimes talk about the perverse allocation of moneys, and to me it feels perverse that a poor community in Glasgow—or, I should say, a doctor trying to serve that community—should get less money out of this process than someone who might well be doing a very good, thorough and professional job but in a more prosperous area. I am conscious that I am taking up too much time on this, but we really need to get an answer to that question, and we are very much looking forward to what will come out of Sir Lewis Ritchie's group. I think that I speak for the committee when I say that we are encouraged by the comment that there will at least be a look at changing the terms of reference.

The other area in which I think there is a lack of clarity and on which I would like some more information is the role of TAGRA and why it was not involved in the later stages of the process. Everyone to whom I have spoken regards them as serious people who were doing a difficult job on resource allocation, and no one can understand why they did not continue to be engaged in the process or what would have been the consequences of that.

Brian Whittle: Going back to your earlier question, convener, I think that we need to look at the definition of workload in the contract. The cabinet secretary's definition of it seems reasonable, but I want to see whether that is reflected in the contract itself.

The Convener: We need to think about and reflect on the evidence that we have heard, and I have already said that I appreciate the amount of time that the cabinet secretary has spent with us. However, I am also interested in getting a response from the petitioners and, indeed, people who are involved more generally in GP practices about what has been said today. We, as a committee, will also want to come back to the matter.

I hear what Mr Foggo has said about the intention not being to make anyone feel marginalised or excluded from the process, but the reality is that people do feel that, and that issue must be addressed. If that has been caused by inadequate rural or island proofing or an inadequate equality impact assessment, the Scottish Government needs to go back and look at that.

Brian Whittle: The rural community undoubtedly believes that the GP contract treats rural practices unfairly. If we accept that as real—even if it is just a perception—and if we acknowledge that the issue of recruitment and retention is more acute in those practices, it is reasonable to conclude that urban practices are benefiting to the detriment of rural practices.

Moreover, given the evidence that we have heard today and evidence that we have received previously, it is clear that the consultation and data-gathering processes fell short of what was needed, and the GP contract has therefore been implemented without adequate data and consultation. More effort needed to be made in that respect. To be fair, I think that the Scottish Government has recognised that in its evidence this morning. It has acknowledged that changes must be made and that engagement with rural GPs and understanding of their specific concerns have been inadequate.

For me, though, the question is: what is happening in the meantime? Inequality will simply continue until the situation is changed. There is definitely a lot of work to be done here.

The Convener: In other work that we have done, we have heard from GPs about the pressures that they are under. Indeed, as part of our inquiry into support for young people with mental health issues, we have been trying to speak to doctors about the pressures on them when they have consultations with young people who might be facing challenges in their lives. There is a general issue about primary care, which, I think, the Health and Sport Committee is exploring. I do not want people to think that we do not respect or value our GPs—we understand the pressures that they are under—but we are looking forward to getting a response to some of the technical questions that we are asking. An update for the committee would be really useful, and, of course, we will want to get further submissions from those who will have heard today's evidence.

I am conscious that I have taken up a great deal of your time, cabinet secretary. Thank you very much. [*Interruption*.] I am sorry—I think that Rachael Hamilton has a comment to make. I will keep you just a bit longer, and then, I promise, I will let you go.

Jeane Freeman: General question time is coming up very soon, convener, and I am number 1 on the list.

Rachael Hamilton: I will be very brief. In the chamber, Miles Briggs asked that a cross-party delegation get together with the cabinet secretary following the next meeting with Sir Lewis Ritchie, which I believe is on 4 June. I simply remind the cabinet secretary that that would be very useful.

Jeane Freeman: I am aware of that.

Rachael Hamilton: Thank you very much.

The Convener: Thank you, cabinet secretary. I suspend the meeting briefly to allow you and your colleagues to leave the table.

11:14

Meeting suspended.

11:17

On resuming—

Pluserix Vaccine (PE1658)

The Convener: The next item on the agenda is consideration of another continued petition. We should have been dealing with PE1658, which relates to compensation for those who suffered a neurological disability after administration of the Pluserix vaccine between 1988 and 1992, but the fact is that we took longer than we thought we would over the previous item and we are now short of time. I propose, therefore, that we defer consideration of PE1658 and deal with PE1672 instead, to ensure that we give proper time and attention to both petitions. I would not want people to think that, because of the pressures of time, we were not able to explore all the issues fully. Do members agree?

Members *indicated agreement.*

Prescription (Scottish Law Commission Report) (PE1672)

The Convener: Our final petition this morning is PE1672, by Hugh Paterson, on the Scottish Law Commission report on prescription, which calls on the Scottish Government to take remedial action on the law relating to prescription and limitation. The Scottish Government has outlined what remedial action it is taking, including updating text to be placed on its website in relation to prescriptive periods and working with the Law Society of Scotland on any updated material that the society places on its own website. The petitioner considers that to be insufficient, suggesting that simply putting information on a website rather than providing it in hard copy "does not address" the issue.

Members might recall that, at an earlier consideration of the petition, back in May 2018, the committee discussed whether there might be merit in having some form of awareness-raising campaign. That view is reflected in the submission that has been received from Tony Rosser, who also suggests that a change in the Registers of Scotland's systems and procedures

"is both necessary and essential to protect owners."

Do members have any comments or suggestions for further action?

Angus MacDonald: In its response, the Scottish Government said that it would inform the committee once the updated material had been placed on the Scottish Government's website. However, that was five months ago. I know that the wheels of Government can grind exceedingly slowly, but I would have thought that it would have been able to get something up on its website within five months. That said, I note the petitioner's dissatisfaction with that action in general.

I have a lot of sympathy with the petitioner's stance, but I cannot help but think of the phrase "caveat emptor"—buyer beware. On the issue of the 20-year period that the petitioner is seeking to address, I suggest that, given that the Scottish Government does not intend to change the current situation and has no plans to amend the law of prescription, the committee should close the petition.

The Convener: The Scottish Government has made it clear that it is quite difficult to provide information in a way that captures everyone who might be caught up in the matter at some point in the future. However, in closing the petition, we could agree to write to the Scottish Government, pointing out that it has not yet delivered on the commitment that it made. That might satisfy the petitioner that that bit of the commitment is being met. Do members agree?

Members *indicated agreement.*

Rachael Hamilton: I do not think that we, on this committee, are alone in having such issues come up in our casework. Every MSP in this building will have come across them, and it is regrettable that there is not necessarily any solution that can be implemented practically and easily.

The Convener: The suggestion, then, is that we close the petition under rule 15.7 of the standing orders, on the basis that the Scottish Government has no plans to amend the law of prescription but has agreed to update the relevant guidance and that we will write to the Government, pointing out that it has made a commitment and that we expect it to fulfil that commitment. We also thank the petitioner for submitting the petition to Parliament

and remind him that he has the option of bringing the petition back at a later stage if he feels that there are matters that he wishes to pursue further with the committee. Does the committee agree?

Members *indicated agreement.*

The Convener: I thank everyone for attending.

Meeting closed at 11:22.

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