

EQUALITIES IMPACT ASSESSMENT

<p>Title of Policy</p>	<p>The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018 (GMS)</p> <p>and</p> <p>The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018 (PMS)</p>
<p>Summary of aims and desired outcomes of Policy</p>	<p>General Practice is critical to sustaining high quality universal healthcare and to realising Scotland’s ambition to improve our population’s health and reduce health inequalities.</p> <p>The terms of the 2018 GP contracts will reflect both above named regulations when they come into force. The two separate regulations (as reflected in respective model contacts) have a common policy intent. Consequently, for the purposes of this document, unless expressly stated, the policy intent and impact of the regulations will be addressed as one.</p> <p>The policy reflected in both sets of regulations and the 2018 contractual terms has the aim of helping to improve patient access to GP Services, better contributing to improving population health, including mental health, and helping to mitigate health inequalities. Some of these improvements will result from future changes to wider primary care services instigated by the regulations taking effect.</p>

	<p>The policy aim of the 2018 GP contract is to also enhance the GP role to make the profession a more attractive career choice for new and existing GPs. The policy seeks to reduce the risks of becoming a GP Partner, increase the stability of General Practice funding, provide increased transparency on workforce and activity data, improve practice sustainability and improve practice infrastructure.</p>
<p>Directors: Division: Team</p>	<p>Directorate for Population Health, Primary Care Division, GP Contract Team.</p>

1. Introduction

- The Impact Assessment model
- Background

2. Research and Stakeholder Engagement

3. Results

- Impacts on General Practitioners
- Impact on Patients
- Impact on Multidisciplinary Team

4. Conclusion and Next Steps

1. Introduction

IMPACT ASSESSMENT MODEL

The public sector equality duty requires the Scottish Government to assess the impact of applying a proposed new or revised policy or practice. It is a legislative requirement under the Equality Act 2010. More importantly, however, most policies impact on people. People are not all the same and policies should reflect that different people have different needs. The Equality Act 2010 covers protected characteristics that are relevant to the public sector equality duty including: age, disability, gender reassignment, sex, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2018 and The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2018 (hereafter referred to as “the regulations”) will, when they come into force on 1 April 2018, introduce terms into the respective model contracts which for the purposes of this document are referred to as the Scottish GP Contract (2018 contract). The contractual terms introduced into the 2018 contract have been developed to re-invigorate general practice and re-energise its core values.

Both sets of the regulations underpin the wider policy outlined in *The 2018 General Medical Services Contract in Scotland*¹ policy statement published on 13 November 2017. Not all features of the 2018 contract require regulatory provision but the regulations are a critical part of the reform of Primary Care Services in Scotland to improve patient care. The regulations will be accompanied by several sets of directions to Health Boards and guidance for GP Contractors. This assessment will therefore encompass the impact of the regulations themselves and the wider policy changes associated with the 2018 contract.

This Equality Impact Assessment (EQIA) has considered the potential impact of the 2018 contract on each of the protected characteristics. The new 2018 contract is being introduced by the regulations, which subject to Parliamentary procedure, will come into force on 1 April 2018.

Given the 2018 contract’s relevance to health care in Scotland, we have also determined that it is necessary and proper to include a Health Inequalities Impact Assessment (HIIA) as part of this review.

The HIIA considers the social determinants of health, impacts on human rights, and the potential impacts of a policy on population groups who are vulnerable to unfair differences in health outcomes and health inequality.

These population groups include people who are:

¹ <http://www.gov.scot/Resource/0052/00527530.pdf>

- Carers
- People affected by homelessness
- People involved in the Criminal Justice System
- People affected by addictions and substance misuse
- NHS Primary Care staff
- People on low incomes
- People with low levels of literacy
- People living in deprived areas
- People living in remote, rural and isolated areas
- People affected by discrimination / stigma
- Looked after and accommodated children and young people
- Refugees & Asylum Seekers

This list is non-exhaustive, and where relevant will include regard to Human Rights and Child Welfare.

Further work on the impact of the new 2018 contractual terms on equalities will continue after it is implemented. In particular, local Primary Care implementation and improvement plans drafted with the collaboration of GPs, Local Medical Committees, Health Boards and Integration Authorities will have due regard to equality impact assessment where appropriate.

The new 2018 contractual terms will affect GP contractors, practice staff, the wider primary care multidisciplinary team and patients. For this reason, this report will separately examine impacts on GP contractors, the multidisciplinary team, and patients.

Background to the Policy

A strong and thriving general practice is critical to sustaining high quality universal healthcare and realising Scotland's ambition to improve our population's health and reduce health inequalities.

The regulations are required in order to accelerate the refocusing of the GP Role and to support the implementation of the new 2018 contract agreed between the Scottish Government and the Scottish General Practitioners' Committee (SGPC) of the British Medical Association.

Introducing these regulations and wider contractual measures that sit outwith regulations will help meet the Scottish Government's vision for the future of primary care services: a vision of general practice and primary care at the heart of the healthcare system, where people who need care will be more informed and empowered, with access to the right professional at the right time, remaining at or near home whenever possible. Our vision is for an expansion of multi-disciplinary teams, made up of a variety of healthcare professionals, to work together to support people in the community, allowing GPs to spend more time with patients in specific need of their expertise.

This policy aims to support our national outcomes, including:

- We live longer, healthier lives;
- Our children have the best start in life and are ready to succeed,
- Our people are able to maintain their independence as they get older,
- Our public services are high quality, continually improving, efficient and responsive.

Negotiations between the Scottish Government and SGPC concluded in November 2017 and the full contract offer was published on 13 November 2017.² To inform SGPC's decision on whether to implement the proposed new 2018 contract in Scotland, a poll of the profession was held between 7 December 2017 and 4 January 2018. The poll was open to all GPs working in Scotland, including trainees and locums.

On 18 January the SGPC announced that the contract offer had been accepted. Its decision was informed by a poll of their members which showed 71.5% supported the offer.

Key features of the regulations and new 2018 contractual terms are designed to support a refocusing of the GP role as the expert medical generalist. This role builds on the core strengths and values of general practice – expertise in holistic, person-centred care – and involves a focus on undifferentiated presentation, complex care and whole system quality improvement and leadership. This will enable GPs to do the job they trained to do and enable patients to have better care.

A refocusing of the GP role will require future measures brought about by wider changes to primary care services. Some tasks currently carried out by GPs will, in future, be carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care. Integration Authorities, SGPC, NHS Boards and the Scottish Government have agreed priorities for transformative service redesign in primary care in Scotland over a three year planned transition period.

These priorities include vaccination services, pharmacotherapy services, community treatment and care services, urgent care services and additional professional services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services. GPs will retain a professional role in these services in their capacity as expert medical generalists.

² <http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-Contract>

Engagement with patients, and other professionals delivering primary care, is key part of the development and delivery of this service redesign. A Memorandum of Understanding³ between Integration Authorities, SGPC, NHS Boards and the Scottish Government, sets out agreed principles of service redesign (including patient safety and person-centred care), ringfenced resources to enable the change to happen, new national and local oversight arrangements and agreed priorities. The proposal to transfer services over the next three years will be set out in Health and Social Care Partnership Primary Care Improvement Plans.

Once the service redesign has taken place these services will not revert to being a practice responsibility without the agreement of GPs.

The regulations and 2018 contractual terms relating to general medical services contracts ("GMS contracts) will also reform and improve general practice funding to provide stability to practices. Starting from April 2018 a new funding formula will be introduced for GMS contracts, in the Statement of Financial Entitlements (the directions concerning payments to general medical services contractors). Practices operating under PMS arrangements may agree with their Health Boards to be paid on different terms, but funding made available to Health Boards will be based upon the new formula.

The funding formula aims to better reflect practice workload, supported by an additional investment of £23 million. Alongside this a new practice income guarantee will operate to ensure practice income stability. From April 2019 a new minimum earnings expectation to ensure no GP partners earns less than £80,430 (including pension contributions) NHS income for a whole-time equivalent (WTE) post will be introduced.

The regulations and 2018 contractual terms will introduce significant new arrangements for GP premises, GP information technology and information sharing. The effect of these arrangements will be a substantial reduction in risk for GP partners in Scotland, and a substantial increase in practice sustainability. The sustainability of general practice is critical for better care for patients.

Practice core hours will be maintained at 8am-6.30pm (or as previously agreed through local negotiation). Online services for patients will be improved and online appointment booking and repeat prescription ordering will be made available where the practice has the functionality to implement online services safely.

GP cluster quality improvement was introduced by the 2016/17 Statement of Financial Entitlements for GMS contracts in Scotland. The regulations and new 2018 contractual terms will include new provision on cluster quality improvement, further

³ <http://www.gov.scot/Topics/Health/Services/Primary-Care/GP-Contract/Memorandum-of-Understanding>

embedding the cluster quality improvement role. GP cluster core functions include an intrinsic function to improve care for their practice populations through peer led review and an extrinsic function to meaningfully influence the local system on how services work and on service quality. There will be a refreshed role for the GP Sub Committee in enabling this extrinsic function by facilitating the provision of combined professional advice to the commissioning and planning processes of Integration Authorities and NHS Boards.

GP clusters will have a clear role in quality planning, quality improvement and quality assurance. Directions will be introduced to support this new role. GP clusters will be supported to improve their local population's health through the increased transparency of practice data. This will be facilitated by both Public Health and Local Intelligence Support Team (LIST) analysts who will help to provide information on demographics, population health and to interpret population health improvement data, advising on future activity and wider research to help drive improvements. Under the regulations and 2018 contractual terms, practices will be required, on request, to supply practice data and related information for planning purposes including workforce planning and management of health and social care services.

Research and Stakeholder Engagement

The following section describes the research and engagement carried out to inform the development of contract and this impact assessment.

RESEARCH

Financial Research

Since 2004 the Scottish Allocation Formula (SAF) has been the weighted capitation formula used to allocate part of the general medical services budget to general practices across Scotland. The budget allocated by the SAF is known as the Global Sum and covers the largest part of the payment to general practices. The SAF aims to compensate practices for their workload and differences in unit costs.

The Scottish Government commissioned Deloitte to review the SAF and recommend improvements to the formula. This informed the new workload formula described in the contract offer:

1. Scottish Allocation Formula – GMS Workload model⁴
This shows the details of how the new formula was derived. The new Scottish Workload Formula is based on individual patient data – their age, sex and deprivation status – to estimate individual patient weights that are proportional to the workload they are expected to create.
2. Scottish Allocation Formula – GMS Unit cost formula review⁵
This provides a discussion of costs adjustments in the SAF and possible improvements. The new Scottish Workload Formula consequently does not include cost adjustments.
3. Review of GP Earnings and Expenses⁶
This review reports the findings of a survey of practice earnings and expenses. It provides a more informed understanding of the variation in GP income and practice expenses across different geographies, which helped determine the level of the income floor in the proposed contract.

The change in the formula means that practices' shares of the total available funding change. Under the regulations and 2018 contractual terms, every GMS practice will receive an income and expenses guarantee in order to ensure stability of funding.

⁴ <http://www.gov.scot/Resource/0052/00527541.pdf>

⁵ <http://www.gov.scot/Resource/0052/00527542.pdf>

⁶ <http://www.gov.scot/Resource/0052/00527540.pdf>

This will also apply to practices operating under PMS arrangements unless practices agree with their Health Boards to be paid on different terms.

Workforce Research

The Scottish Primary Care Workforce Survey is compiled by Information Services Division (ISD), part of NHS National Services Scotland. ISD is a recognised producer of Official Statistics in Scotland and works to the Code of Practice for Official Statistics which is maintained by the UK Statistics Authority.

The survey captures aggregate workforce information from Scottish general practices and each of the Health Board-run GP Out of Hours services. It provides the most comprehensive information available on the staffing cohort of general practice, both in hours and out of hours, but does not provide the cost. The costs of running a practice are a matter for the GP partners, including what they pay their employees. The 2015 survey was published in June 2016.⁷

The results of the survey helped to inform negotiations on the new GP contract offer. The 2015 results for Scottish general practices are based on survey data received from 561 Scottish general practices, 58% of Scotland's practices, which between them provide primary care services to approximately 60% of Scotland's registered patient population. The results include information on:-

1. Estimated Whole Time Equivalent (WTE) numbers of GPs in post in Scottish general practices, along with information on patterns of sessional commitment by age and gender (a GP's week is typically defined in terms of sessions rather than hours, with a working day generally being comprised of two or sometimes three sessions).
2. Estimated headcount and WTE numbers of nurse practitioners and other registered nurses employed by Scottish general practices, along with information on the age profile of these staff.
3. Use of locum GP time and extra nurse time by Scottish general practices.
4. Known vacancies for these professional groups in general practices at a fixed census date.

The estimated Whole Time Equivalent (WTE) number of GPs in post in Scottish general practices declined by 2% between 2013 and 2015 (from 3,735 to 3,645).

⁷ <https://www.isdscotland.org/Health-Topics/General-Practice/Publications/2016-06-14/2016-06-14-PrimaryCareWorkforceSurveyScotland2015-Report.pdf>

Routinely available GP headcount information⁸ indicates a recent levelling off in the numbers of GPs working in general practices after a number of years of general increase.

Responding practices had used GP locums and/or sessional GPs in the year ending 31 August 2015. An estimated 350 WTE was input to all general practices over this one year period. This is higher than the 290 WTE estimated from the 2013 survey.

In addition, 70% of responding practices reported that one or more of their own GP(s) had worked extra sessions over the year, over and above their regular sessional commitments. These extra sessions (for example to cover for colleagues on annual leave or sick leave) collectively amounted to an estimated 55 WTE of GP time over the year.

The regulations and 2018 contractual terms includes mandatory requirements for GPs to provide practice data (which may include workforce data), on request, and subject to directions to Health Boards issued by Scottish Ministers and consulted upon with SGPC. This is intended to facilitate workforce planning in the future.

Social Research

Patient Health and Care Experience Survey

The Scottish Health & Care Experience Survey (successor to the GP and Local NHS Services Patient Experience Survey) asks about people's experiences of:

- accessing and using their GP practice and Out of Hours services;
- aspects of care and support provided by local authorities and other organisations; and
- caring responsibilities and related support.

The survey has been run every two years since 2009. The survey and sampling approach have been developed by the Scottish Government in consultation with a range of stakeholders including Health Boards, Integration Authorities, NHS National Services Scotland and patients.

The latest survey was completed in 2015/16. The survey was sent to a random sample of over 100,000 patients who were registered with a GP in Scotland in October 2015 for completion between November 2015 and January 2016. 111,611 surveys were returned by people who used primary care services across every area of Scotland. Their views formed a substantial evidence base which informed the

⁸ www.isdscotland.org/Health-Topics/General-Practice

government's policy decisions on the new contract model, including new provisions to improve patient access and the expansion of the multidisciplinary team.

Some of the core findings from the Scottish Health and Social Care Experience 2015/16 Survey include:

- a) The majority (87%) of patients and care users report a positive experience of their GP care.
- b) Whilst most patients reported positive experiences of accessing GP services, however access continues to be an area of relative concern for respondents.
- c) Positive ratings for overall arrangements to see a doctor fell to 71%. This is down 10 percentage points from the 2009-10 survey.

Creating a Healthier Scotland National Conversation

In August 2015 the Scottish Government began a National Conversation on what a Healthier Scotland would look like. People from all corners of the country and from a wide variety of backgrounds took part. They talked about lifestyles, diet, mental health, ageing, exercise and lots of other aspects of health and wellbeing - good and bad - that affect them and their families. They talked about caring for relatives and supporting people to live independent lives. They discussed their views and experiences of health and social care, and what they would like to see happen in the future.

Over 9,000 people took part in the Conversation at 240 events over a six month period. In addition, many people provided their views and comments directly by postcard, email or through our social media channels. Twitter, Facebook and blog activity reached over 360,000 people and registered thousands of visits, 'likes' and re-tweets.

Whilst some people could see their GPs on the day they asked, many were unhappy with the length of time it took to get an appointment, particularly if they wanted to see a specific doctor. Long waiting lists to see specialists was another issue, with many comments about delays in accessing mental health support. While there was usually recognition of increasing demand for services and the impact that has on waiting lists, people also reported a lack of communication about how long they would need to wait and what other support was available in the meantime.

Patients said they wanted more flexible services, with appointments that fit in with their lives, including work and caring commitments. Extended opening hours, including evening and weekends, would prevent them having to take time off work for their own appointments or for the people they look after. Other suggestions

included booking appointments or ordering repeat prescriptions online, emailing staff, drop-in sessions allowing them to see a health professional other than their doctors, using computers or smart phones for online services such as Skype consultations. These were highlighted as ways to take the pressure off primary care, reduce physical access issues and support self-management.

The findings from the Conversation have been used to inform a number of published reviews and policy documents such as the National Clinical Strategy, the Government's response to the Out of Hours Review and the Public Health Review.

In 2015 the Scottish Government, in partnership with a number of representative organisations including the Scottish Health Council, the Health and Social Care Alliance Scotland, Health Improvement Scotland and COSLA formed the group Our Voice to carry out a national survey taking views of the health services in Scotland.

The Our Voice Citizens' Panel was established to be nationally representative and has been developed at a size that will allow statistically robust analysis of the views of the Panel members at a Scotland-wide level. As of 2018 there are 1,216 Panel members from across all 32 local authority areas. Panel members were randomly selected from the general population and invited to join the Panel. Some targeted recruitment also took place in order to ensure that a representative Panel was recruited.

Some of the core findings from the Our Voice Citizens' Panel surveys included:

- a) 60% of Panel members agreed that they would take an appointment with another healthcare professional if they were offered this when phoning their GP practice for an appointment with a doctor. Panel members indicated that some services such as pharmacist and physiotherapy services were not currently available at their practice. The expansion of these services is a core element of the new contractual package.
- b) 78% of panel members said they would consider going directly to other healthcare professionals if they had been happy with the treatment they received.
- c) 63% of panel members said they would feel comfortable with sharing some basic information with their GP Practice receptionist about why they need an appointment. The future of primary care services will require GP practice receptionists to perform an important role in assisting patients and carers to access the most appropriate source of help, advice or information.
- d) 83% of panel members believed that professionals should – with the appropriate safeguards – be able to share your medical information with other

health and social care professionals who are involved in your care, in order to support your on-going healthcare. This supports the expansion of the multidisciplinary team.

STAKEHOLDER ENGAGEMENT

Contract Negotiations

The regulations and 2018 contractual terms are the result of significant constructive engagement, over an extended period, between the SGPC and the Scottish Government, as the parties authorised to negotiate the Scottish GP Contract. All the commitments made and the ambitions for future change set out in the contract offer and policy statement document of 13 November 2017 are shared and agreed.

The policy positions around which the SGPC have negotiated the 2018 contract are informed by regular and wide-spread engagement with their membership at all levels. The SGPC is a committee within the BMA recognised as the body which negotiates the GP contract in Scotland with the Scottish Government.

The SGPC is made up of 40 GP representatives from all parts of Scotland (elected by Local Medical Committees). The SGPC is kept up to date as negotiations progress and it gives the negotiating team a mandate to pursue specific negotiating aims. The committee's actions are also guided by the policy created at the annual Scottish Local Medical Committee (SLMC) conference.

As the representative Union, the BMA led consultation with the profession on the new contract. This included holding roadshows in all 14 Health Board areas from January to June of 2015. Further roadshows were held in 11 Health Board areas between 3 February and 16 March 2016 to update on progress and gather more feedback. This consultation helped to inform the Primary Care Vision and the Expert Medical Generalist Role. Updates on the development of the contract negotiations were published in *General Practice: Contract and Context. Principles of the Scottish Approach*⁹ on 3 November 2016. This was updated by a further publication on 11 May 2017.¹⁰

The policy statement which underpins the new contract was published jointly by the Scottish Government and SGPC on 13 November 2017. This publication was followed by a series of stakeholder engagement events held across Scotland in every Health Board area to discuss the proposals with clinicians, Health Boards and Integration Authority officials. SGPC held a poll of the profession between 7

⁹ <http://www.gov.scot/Publications/2016/11/7258/downloads#res-1>

¹⁰ <http://www.gov.scot/Publications/2017/05/2382>

December 2017 and 4 January 2018 to seek their views on the new contract offer. On 18 January 2018 SGPC announced that the profession had accepted the offer.

Engagement with the profession, the public, NHS Boards and Integration Authorities will continue throughout the implementation of the new 2018 GP contract. Integration Authorities have a statutory duty via the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 to consult a wide range of local stakeholders and professional groups on their Strategic Plans and take decisions on the size and shape of local Health and Social Care services on a collective basis based on dialogue with the local communities and service users.

Working and Advisory Groups

The Scottish Government created a number of working groups to develop policy and provide advice on the plans for the 2018 GP contract. Membership of the groups included representation from relevant stakeholders across the Health Service.

- GMS Contract Reference Group: To provide expert advice and support for the development of the GMS contract.

Membership: Senior representatives from Primary Care, Integration, and Finance departments from Health Boards and Health and Social Care Partnerships, and the Scottish Government.

- GP Premises Short Life Working Group (subsequently the GP Premises Implementation Group): To implement the findings of the GP Premises Group in order to improve GP Practice stability in contractor premises and update the Premises Directions.

Membership: Representatives from Primary Care and Health Finance teams in the Scottish Government, Health Boards, SGPC, Primary Care Leads, the Scottish Property Advisory Group and the Strategic Facilities Group.

- Practice Sustainability Working Group: To implement recommendations to improve GP practice sustainability in their workload.

Membership: Representatives from Primary Care in the Scottish Government, RCGP, SGPC, clinical and administrative Primary Care Leads.

- Information Sharing Short Life Working Group: To develop improved guidance for Boards and GP Practices on use of Patient data and the GP Patient Record.

Membership: Scottish Government Primary Care and e-Health teams, SGPC, representation from IT and Data Management teams in Health Boards, National Services Scotland. The terms of reference of this group was established with the support of the Information Commissioner's Office Scotland.

- GP Cluster Advisory Group: To implement the findings of the December 2016 report *Improving Together* to advance the quality of care through GP clusters.

Membership: Office of the Deputy Chief Medical Officer for the Scottish Government, Primary Care and Health and Social Care Integration teams, HIS, NES, NSS, SGPC, RCGP, PC leads, Chief Nursing Officer

- National Primary Care Leads Group: To provide operational and clinical advice from Boards on issues relating to Primary Care.

Membership: Health Boards and key partner agencies such as PSD and NHS 24.

- Family Health Services Executive Group: To provide advice and recommendations on financial issues in Primary Care to the Scottish Government, Health Board Directors of Finance and other relevant parties regarding all Family Health Services.

Membership: Health Board Directors of Finance or senior board individuals with financial responsibility for Primary Care, SG Health and Social Care Directorate.

Results - Impacts on GP Contractors, Salaried and Trainee GPs.

Background

The majority of GPs working to provide primary medical services in Scotland are independent contractors either self-employed or operating partnerships running their own GP practices.

As of 1 October 2017, there are 956 GP practices¹¹ in Scotland and 78% use the independent contractor national GMS contract. GPs operating under the independent contractor Primary Medical Services (Section 17C) or Health Board-run 2C arrangements provide services based on local agreements with the Health Board.

As of 1 October 2017:

- 779 practices operated under a GMS Contract;
- 121 practices operated under a 17C agreement; and
- 55 practices operated under the 2C arrangement¹².

The Primary Care Workforce Survey Scotland 2015 estimated that 83% of GPs were Independent Contractors¹³. It estimated that there were around 660 salaried GPs (15%) and 105 GP retainers (2%).

The survey also found that salaried GPs are more likely to work fewer sessions per week than GP Partners – with a third working up to 4 sessions per week, compared with 7% of partners.

There is still an important, continuing role for salaried GPs. The regulations and 2018 contractual terms will continue to specify that salaried GP Contracts should be on terms no less favourable than the BMA Model Contract.

The survey found that more than a third of GPs working in general practice were over 50 years old, and that 56% of GPs are female.

¹¹ <http://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/Practices-and-Their-Populations/>

¹² Health Boards operate other 2C practices to provide various services however only 55 have patient lists, as at 1 October 2017.

¹³ http://www.isdscotland.org/Health-Topics/General-Practice/Workforce-and-Practice-Populations/Workforce/national_primary_care_workforce_survey.asp, p.7.

Summary of results – Impact on GPs

Population Category	Impact (Positive, Negative, None)
Age	Positive
Sex	None
Race	None
Disability	None
Religion or belief	None
Sexual orientation	None
Gender reassignment	None
Pregnancy and maternity	Positive
Marriage and civil partnership.	None
Carers	Positive
People affected by homelessness	N/A
People involved in the Criminal Justice System	N/A
People affected by addictions and substance misuse	N/A
People with low incomes	N/A
People with low literacy.	N/A
People living in deprived areas.	Positive
People living in remote, rural and isolated Areas	Positive
People affected by discrimination / stigma	None
Looked after and accommodated children and young people	N/A
Refugees & Asylum Seekers	None

Impacts

The new contractual terms are designed to treat all GPs equally, and therefore appear to have no detrimental effect on the basis of the protected characteristics.

Age

There will be a positive impact on GPs through the **age** protected characteristic.

The new contractual terms should make working in General Practice more appealing to GPs of all ages. We recognise that GPs work under significant workloads. This has been made clear through negotiations with the SGPC, as informed by regular surveys of the profession, and with discussions with clinical stakeholders. GP contractors carry the responsibility for providing staff, maintaining their practices' physical and digital infrastructure in addition to providing patients with services - all of which increases workload for GPs. We recognise that these responsibilities are increasingly perceived as unwanted liabilities and risks by potential GP partners and for many have become a barrier to recruitment, retention and retirement.

Many of the future changes which will be instigated by the implementation of the new contractual terms are designed to reduce this workload. The GP Premises National Code of Practice, and premises sustainability loans support GPs to manage and maintain premises, as well as reducing GPs' concerns about the 'last person standing' scenario which stakeholders tell us is encouraging many GPs to opt for early retirement, and discouraging trainees from taking on GP contractor responsibilities.

In addition, the regulations and new contractual terms will implement proposals on information sharing that have been developed with the support of the Information Commissioner's Office in Scotland. The regulations will introduce contractual requirements that GPs are joint data controllers along with their contracting Health Boards in relation to their patient records. This will reduce the potential risks of GP contractors to being liable for data breaches.

In addition to these changes that will support GPs of all ages, the Scottish Government is making available a package of support for GPs in the first five years of their career. This will include funding to allow for Professional Time Activities, and mentoring support from experienced GPs.

To help retain experienced GPs the Scottish Government is also working with NHS Education for Scotland to create a new 'Staying in Practice Scheme', which will fund 100 coaching places each year for the next 3 years, and will fund tailored support for the GP appraisals process from 2018.

We therefore expect these changes to have a positive impact on younger GPs and older GPs because the new 2018 contractual terms are now more attractive to trainees, who are typically younger, and to encourage those in the later stages of their career, who are typically older, to remain working in the profession for longer.

Pregnancy, Maternity and Carers

There will be a positive impact on GPs who fall within the ***pregnancy and maternity*** protected characteristics as well as GPs who have responsibilities as ***carers***.

The new 'Staying in Practice' scheme will improve the existing GP Retainer Scheme which allows GPs who cannot commit to a more substantive GP post to continue working in General Practice. This can be particularly beneficial for GPs with childcare and carer responsibilities.

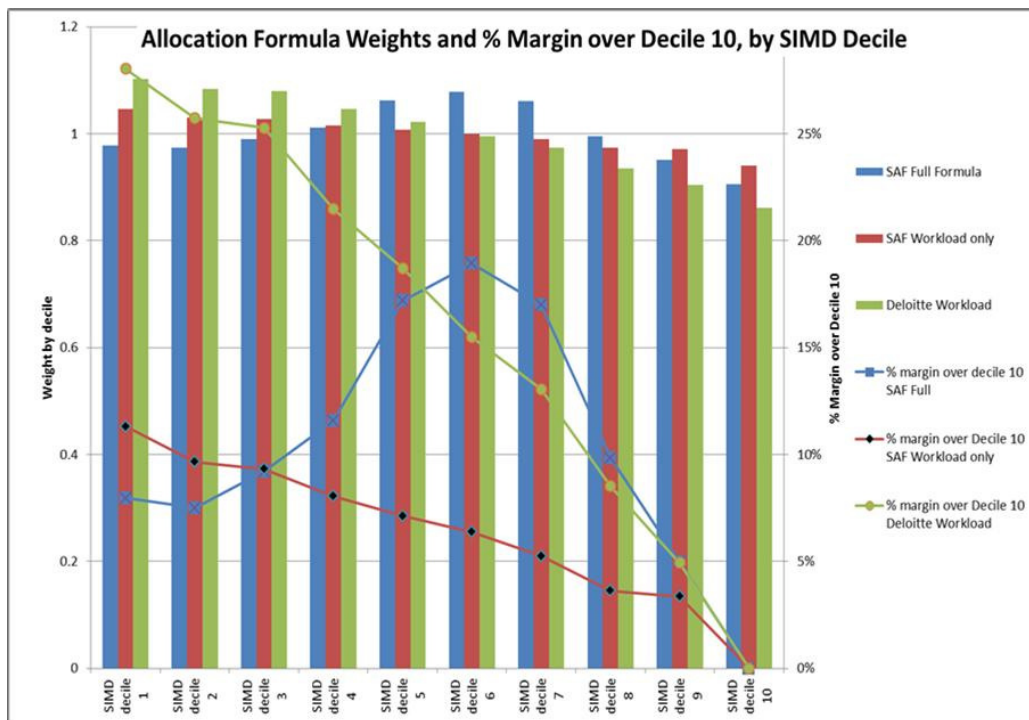
GPs working in Deprived Areas

There will be a positive impact on GPs whose patients live in areas of ***deprivation***.

The new GMS contract package includes an improved workload formula under the Statement of Financial Entitlements directions which has a positive impact for most GP practices located in deprived areas, and for practices with large elderly populations. The majority of Deep End practices will receive increased funding from this investment.

The new formula was developed following a 2016 review of the Scottish Allocation Formula (SAF) and is a methodological improvement to the previous SAF. It is based on the best available evidence and as such it more accurately reflects the workload of GPs. We have committed to monitor the impact of the funding formula during the implementation of the new GMS contract to ensure that no practice is destabilised.

The graph below illustrates the shares of funding which the formulae would allocate by deprivation deciles, based on the location of the patients. The proposed new formula has a significantly higher weighting for deprived (and older) patients compared to the workload component of the SAF formula (and the full SAF formula, including rurality and market forces factor adjustments). The new formula is based on smaller geographical areas than in the past and can therefore identify smaller pockets of deprivation. The practice-level impacts will be less pronounced than those shown below due to the heterogeneous nature of the patient mix within practices.



The expansion of the multidisciplinary team will allow patients across Scotland, including in deprived areas, to access the most appropriate member of the practice team at the right time. We are investing to recruit 250 Community Links Workers by 2021, who will focus on supporting patients, focused in areas of deprivation.

Furthermore GP clusters will be supported to improve their local population's health through the increased transparency of practice data. This will be facilitated by both Public Health and Local Intelligence Support Team (LIST) analysts who will help to provide information on population health and to interpret population health improvement data, advising on future activity and wider research to help drive improvements.

The intended effect of these changes is to promote Scottish general practice in economically deprived areas as a positive career choice, and to support practices in those areas to enlarge their multidisciplinary team so that a wider range of health and care professionals are available to their patients.

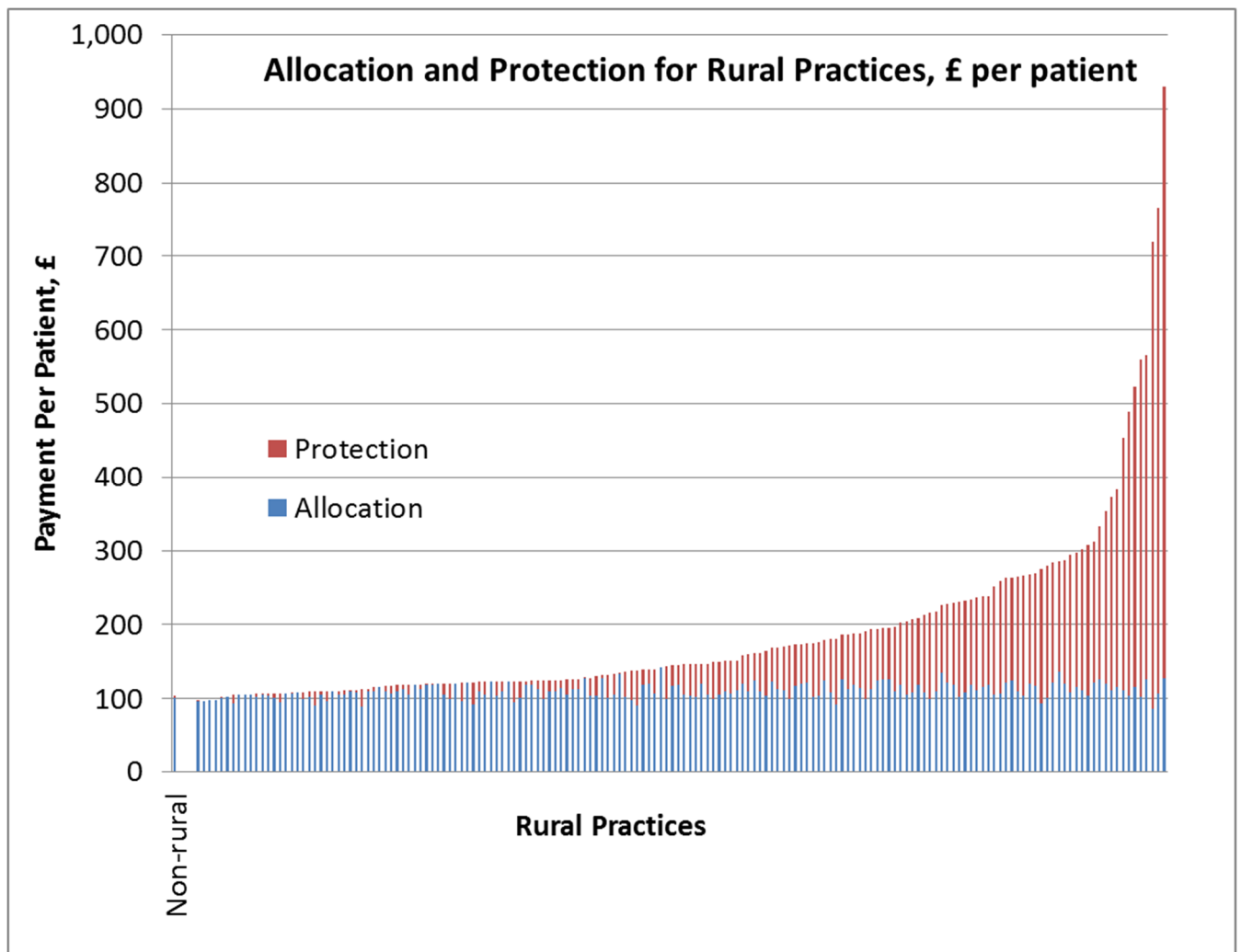
GPs working in Rural Areas

There will be a positive impact on GPs working in practices in rural areas.

£110 million will be invested in 2018/19 to support the introduction of the new contract and transformational service redesign within Primary Care including the expansion of the multidisciplinary team. This will be of benefit to practices in all parts of Scotland including rural practices.

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

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



The average payment per patient per practice is £104 in non-rural Scottish practices, compared with an average payment per patient per practice of £188 in very remote and rural practices. This ensures that small remote and rural practices are financially viable.

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

The Temporary Patient Adjustment leaves practices exposed to the risk of their number of Temporary Residents fluctuating while the resources to treat them remains constant. Under the new GMS contractual terms, practices will be required to report on numbers of Temporary Residents in 2018/19 to allow the Temporary

Patient Adjustment to be reformed and uplifted on the basis that funding will follow activity as soon as practicable and by 2020/21, which should be of benefit to rural GPs.

As part of the 2018 GP Contract package, additional investment has been announced to support recruitment and retention, in particular for GP practices in remote and rural settings. This will include:

- a) Support for the 'GP for GP' Scheme. This is a scheme which provides a confidential service in NHS Highland to General Practitioners and their families at times of stress or illness, when they have difficulty going to their own GP. In the past it has supported Highland GPs with problems such as stress, depression, inability to cope, marital problems and bereavement. This scheme will be extended to remote and rural GPs across Scotland.
- b) A Relocation Package. This will incentivise GPs to relocate to rural practices by offering re-location costs, including where eligible, rent for 12 months, removal and storage costs, etc. up to a maximum amount of £5,000 per supported GP.
- c) Substantially expanding the existing Golden Hello schemes from 44 to 160 practices in rural and remote areas.
- d) The Scottish Government will continue to support the Scotland's new graduate entry medical course (ScotGEM). The course, which is run by the universities of Dundee and St Andrews with support from the University of the Highlands and Islands, has a particular focus on general practice and rural working

The intended effect of all these changes is to promote rural Scottish general practice as a positive career choice, support medical students to actively choose general practice and encourage the alumni to stay in/return to rural General Practice in Scotland.

Impact on the Primary Care Multidisciplinary Team

Background

Under the new contractual terms we expect GPs to be less involved in more routine tasks, with these tasks being delivered by other health professions in the wider primary care multi-disciplinary team.

This transformational service redesign will be supported by a Memorandum of Understanding (MOU) between the Scottish Government, SGPC, Integration Authorities and Health Boards. This MOU represents a statement of intent from all of the parties to deliver the wider support and change to primary care services required to underpin the contract.

In line with the MOU, Integration Authorities and Health Boards will place additional primary care staff in GP practices and the community, who will work alongside GPs and practice staff to reduce GP workload. The focus areas for service redesign starting in 2018 are:

- a) Vaccinations Services;
- b) Pharmacotherapy Services;
- c) Community Treatment and Care Services;
- d) Urgent Care Services; and
- e) Additional professional and non clinical services including acute musculoskeletal physiotherapy services, community mental health services and community link worker services.

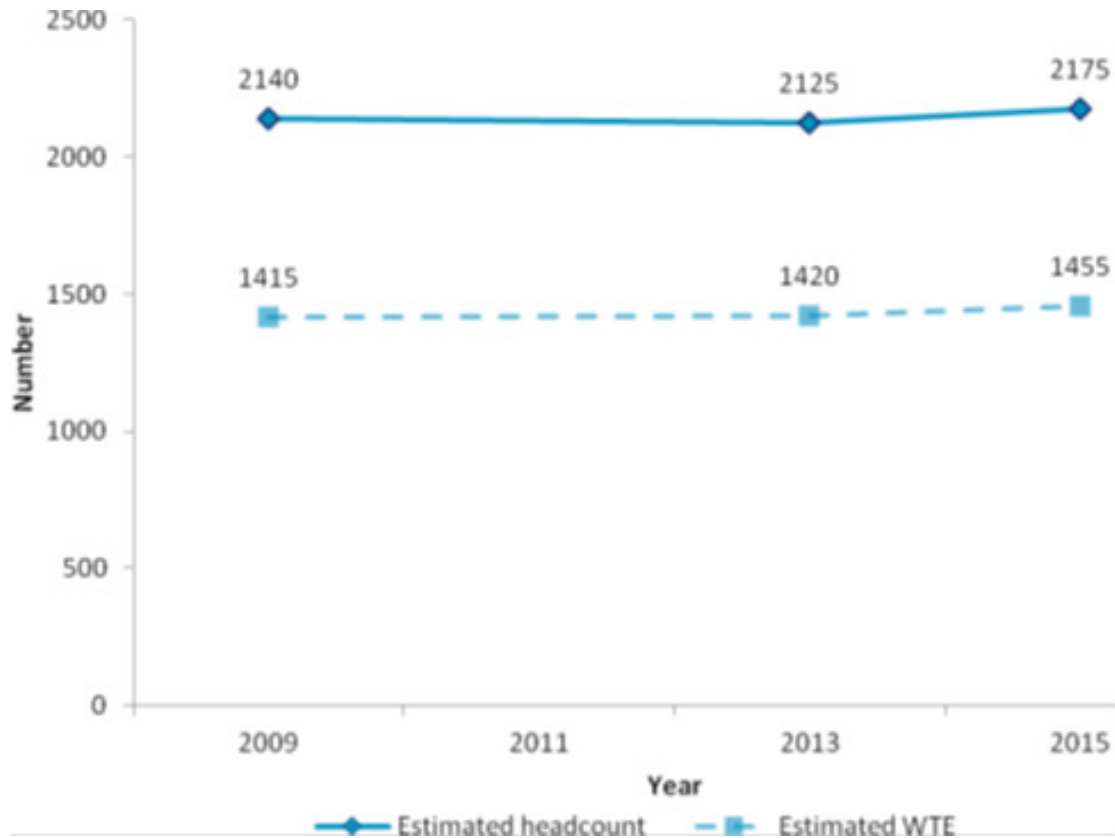
The MOU will be clear that service redesign will be agreed locally, in consultation with patients and the general practice workforce.

The new regulations and 2018 contractual terms will also introduce a framework for data collection. As part of this it will be mandatory for practices, upon request, to provide practice data – which may include GP and practice staff vacancies for planning purposes. This will facilitate future workforce planning.

To achieve this, the training needs of GPs and members of the wider primary care multi-disciplinary team, will need to be considered, developed and delivered. The third part of National Health and Social Care Workforce Plan: Part 3 Primary Care will set out plans for the development and training of GPs and this wider primary care multi-disciplinary team and is due to be published early 2018.

The estimated number (headcount) of registered nurses employed by general practices in Scotland at 31 August 2015 was 2,175. This is a slight increase from

2,125 registered nurses in 2013. A quarter of these (555) were Nurse Practitioners or Advanced Nurse Practitioners, 1,620 of these were General Practice / Treatment Room Nurses.



Estimated registered nurse headcount and Whole Time Equivalent, Scotland; 2009 – 2015¹⁴

An estimated WTE 1,820 registered nurses and healthcare support workers were employed by Scottish general practices in 2015, an increase of 2% (from 1,420 to 1,455) and 23% (from 300 to 365) respectively. The figures from this survey do not represent the entire registered nurse workforce working in Scottish general practices. They exclude nurses who are employed by Health Boards but who work in independent contractor practices.

¹⁴ <https://www.isdscotland.org/Health-Topics/General-Practice/Publications/2016-06-14/2016-06-14-PrimaryCareWorkforceSurveyScotland2015-Report.pdf>, p.24.

Summary of Results – Impact on Primary Care Multidisciplinary Team

Population Category	Impact (Positive, Negative, None)
Age	None
Sex	None
Race	None
Disability	None
Religion or belief	None
Sexual orientation	None
Gender reassignment	None
Pregnancy and maternity	Positive
Marriage and civil partnership.	None
People who are carers	Positive
People affected by homelessness	None
People involved in the Criminal Justice System	None
People affected by addictions and substance misuse	None
NHS Primary Care Staff	None
People on low incomes	None
People with low literacy	None
People living in deprived areas	None
People living in remote, rural and isolated areas	None
People affected by discrimination / stigma	None
Looked after and accommodated children and young people	None
Refugees & Asylum Seekers	None

Impacts

The new contractual terms are designed to treat all members of the multidisciplinary team equally, and therefore appear to have no detrimental effect on the basis of the protected characteristics.

In order to refocus the GP role to spend more time with the patients who need their care the most, the new 2018 contract will require some tasks currently carried out by GPs to be carried out by members of a wider primary care multi-disciplinary team – where it is safe, appropriate, and improves patient care.

Integration Authorities, the SGPC, NHS Boards and the Scottish Government have agreed priorities for transformative service redesign in primary care in Scotland over a three year planned transition period. These priorities include vaccination services, pharmacotherapy services, community treatment and care services, urgent care services and additional professional services including acute musculoskeletal physiotherapy services, community mental health services and community link

worker services. GPs will retain a professional role in these services in their capacity as expert medical generalists.

This transformative service redesign will mean that there will be significant expansion of the primary care team. Consequently there will be increased employment opportunities in all areas of Scotland across these professions.

Future changes to wider primary care services instigated by the Regulations taking effect include opportunities for existing staff, both clinical and non-clinical to further develop their skills. This will include a refreshed role for general practice nurses as expert nursing generalists. They will provide acute and chronic disease management, enabling people to live safely and confidently at home and in their communities, supporting them to manage their own conditions wherever possible. There will also be opportunities for practice receptionists to develop their skills, in order to support patients with information on the range of primary care multidisciplinary team services available, or to increase their role in the management of practice documentation and work optimisation.

We expect that the refocusing of the multi-disciplinary team towards Board employed staff providing services previously delivered by GPs should allow for better resilience including cover for maternity leave and unplanned absences to care for young children and other dependents. This should mean a positive impact. This wider resilience and connection to workforce planning could well have wider positive impacts.

Impact on Patients

Background

The objectives of the new 2018 contractual terms include enhancing the experience of primary care for patients, improving patient access to services and reducing health inequalities.

The refocused role of the GP introduced by the new 2018 contractual terms is intended to allow GPs more time to treat patients most in need of their skills, and to have a more significant role in influencing how local Primary Care service provision is designed.

The expansion of the multidisciplinary team will allow patients to access the right healthcare professional at the right time, and free up GPs to have longer consultations with patients where needed.

The average (or mean) size of a Scottish GP practice in terms of numbers of registered patients was 5,900 in 2016,¹⁵ however there was considerable variation, ranging from under 200 patients for practices in remote locations or practices which addressed specific health needs of patients (e.g. those with challenging behaviours or homelessness), to practices of over 20,000 patients in densely populated urban areas.

The Scottish Health and Social Care Experience survey is carried out every two years, the 2015-16 survey was published in June 2016.¹⁶

We have used these results, as well as other stakeholder information, to inform the development of the contract in the context of impact on patients.

Over 100,000 individuals registered with a GP practice in Scotland responded to the 2015/16 Health and Care Experience Survey. The survey asked respondents to feedback their experiences of their GP practices and out of hours care. The survey also asked about experiences of social care services and asked specific questions of those with caring responsibilities.

The 2015/16 Survey indicates, as in the previous survey, that patients were generally positive about the actual care and treatment they received at GP practices, with practice nurses getting particularly positive results. Medication was another area

¹⁵ <https://www.isdscotland.org/Health-Topics/General-Practice/Publications/2016-12-13/2016-12-13-GPWorkforce2016-Report.pdf>

¹⁶ <http://www.gov.scot/Resource/0050/00500340.pdf>

where responses were notably positive. The four most positively answered questions relating to GP care were all in relation to medicines

On the whole, the majority (87%) of patients and care users report a positive experience of their GP care. However, an overarching finding across a number of aspects of the survey was that patients across Scotland were slightly less positive about their experiences than in the previous survey in 2012/13. There continued to be considerable variation in scores between individual GP practices, suggesting that patients' experiences may be very different depending on which GP practice they attend.

Summary of Results

Population Category	Impact (Positive, Negative, None)
Age	Positive
Sex	Positive
Race	Positive
Disability	Positive
Religion or belief	Positive
Sexual orientation	Positive
Gender reassignment	Positive
Pregnancy and maternity	Positive
Marriage and civil partnership.	Positive
Carers	Positive
Homelessness	Positive
Involvement in Criminal Justice System	Positive
Addictions and substance misuse	Positive
Staff	Positive
Low Income	Positive
Low Literacy	Positive
Living in Deprived Areas	Positive
Living in Remote, Rural and Isolated Areas	Positive
Discrimination / Stigma	Positive
Looked after and accommodated children and young people	Positive
Refugees & Asylum Seekers	Positive

Impacts

The Regulations and new contract package will have a positive effect on the basis of the protected characteristics for patients, as they are intended to apply equally to all those affected by its provisions. All patients should benefit from the improvements that the new contract will bring to GP services.

The new funding formula better aligns funding with workload, which will have a positive impact for GPs working in practices located in deprived areas, and for practices with large elderly populations

The 2018 contractual terms, as described in the contract framework document published in November 2017, outlines a refocused role of the GP intended to allow GPs more time to treat patients most in need of their skills. Such patients are described as those with undifferentiated presentations, and with complex care needs. Undifferentiated presentations require the skills of a doctor trained in risk management and holistic care with broad medical knowledge to make initial assessments on the most appropriate care. Patient with complex care needs can include the elderly, who have general frailty conditions associated with age, and children or adults with multiple conditions including mental health problems or significant disabilities.

All patients are anticipated to see positive impacts through the proposed service redesign that will be instigated as part of the wider changes to Primary Care Services which will be instigated along with the 2018 contractual terms. These changes include:

- Expanding the multidisciplinary team so that patients can access the right healthcare professional at the right time. This will include community link workers, which can be particularly useful in deprived communities, and vaccinations services for all patients including vaccinations and immunisations delivery for babies and young children.
- Improved access through online services, including practice websites, online appointment booking and online repeat prescription ordering as soon as the functionality is available. These changes will benefit patients across society, and could be particularly beneficial for patients in rural areas who previously had to travel long distances to order repeat prescriptions. All practices will also continue to offer their existing practice leaflets and telephone services, so that people who are not able to use the internet are not disadvantaged.
- Methodological improvements to the GMS funding formula will allocate funding according to expected workload. It provides a relatively higher weighting than the previous formula both to older patients and to patients living in deprived areas. Funding for patients in all other areas will be kept stable by the minimum practice income guarantee. This will be supported by additional investment of £23 million.
- The regulations have changed rules on telephone services so that practices will not be able to operate any premium rate phone numbers with an 09 prefix.

Within the conditions of the regulations, this will benefit all patients phoning to make appointments, especially those on a low income.

- Through cluster working GPs will become more involved in influencing the wider system to improve local population health. They will have a clear role in quality planning, improvement and assurance, informed by more comprehensively collected data. This will allow GPs to directly influence outcomes for their local communities, which could include focusing on particular multi-morbidities, homelessness, disabilities or refugee and asylum seeker health.

These changes will contribute towards improving population health, reducing health inequalities and improving patient access to general practice services.

Conclusion

Based on the currently available evidence, the Scottish Government has concluded that no changes to the provisions of the regulations are necessary as a result of this EQIA, as the regulations are intended to apply equally to all those affected by its provisions and appear to have no detrimental effect on the basis of the protected characteristics. The regulations and other future measures which will be instigated once the contract is implemented are intended to make a meaningful difference to improve patient care, and improve the GP and practice team roles.

There are gaps in the evidence base on certain protected characteristics such as the age and gender of the different primary care workforce groups. The new regulations will help to address this issue for future workforce planning by requiring practices to provide workforce data.

There are also gaps in the evidence base around protected characteristics such as religion, sexual orientation and gender. We will continue to apply a systematic approach to identifying and addressing gaps in our evidence at a national level, in a manner which compliments and supports local planning. This will include engagement with equalities organisations representing those population groups.

Next Steps

The new regulations are due to come into force on 1 April 2018.

A National Oversight Group with representatives from the Scottish Government, the SGPC, Integration Authorities and NHS Boards will be formed to oversee implementation by NHS Boards of the GMS and PMS contract in Scotland and the Integration Authority Primary Care Improvement Plans, including clear milestones for the redistribution of GP workload and the development of effective multidisciplinary team working.

Further engagement with patients, equalities groups and the primary care workforce is crucial to the successful implementation of the contract and transformational service redesign.

A series of public engagement events are being held across Scotland during February and March 2018, and in line with Integration Authorities' statutory duty to consult a wide range of stakeholders on service redesign this will be followed by local engagement to assist Integration Authorities and Health Boards to flexibly redesign services specific to their local needs.