

BMA GP Scotland contract FAQs

BMA Scotland

2018



Will GP partners continue to have independent contractor status?

Yes. GPs made clear their desire for the maintenance of independent contractor (IC) status in the BMA UK Survey (15,560 responses) of 2015 with 82% supporting its continuation.

The Scottish Government, and Scottish General Practitioners Committee (SGPC) agreed that the 2018 Scottish GP Contract should remain an independent contractor contract.

The new contract has to meet the HMRC rules for independent contractor status and SGPC and Scottish Government have agreed to ensure that this is the case. The main benefit of IC status for GPs is the independence from line management and the GPs' ability to control and adapt their working day and environment, including their teams, to meet the needs of their patients under the contract. The tax benefits of IC status have reduced over the years, but they are still important to practices.

How does the 2018 Scottish GP contract address the challenges facing remote and rural practices?

The contract package is intended to offer benefits to general practice as a whole and also to encourage more young doctors to choose general practice as a career. However, we recognise that GPs work differently across the country and there are specific challenges facing doctors working in different areas.

General Practice operates differently in remote and rural areas and some of the 2018 Scottish GP contract don't easily fit remote & rural practices. The Earnings and Expenses Review confirmed that rural practices have higher expenses and the contract addresses this in phase one with income and expenses protection. In phase two (subject to the second Poll) we intend to meet these higher expenses directly. We also intend to have secure income to the GPs in remote and rural in phase two.

A Remote & Rural Working Group has been established to look at ways the contract can be effectively implemented in remote and rural areas. The RRWG allows SGPC and Scottish Government to bring in expertise to inform the negotiating process when appropriate, which has worked well for both premises and data sharing.

How do these proposals relate to the money announced by the Scottish Government for investment in general practice?

In 2016 the Scottish Government announced increased investment in primary care and general practice which would build to £500 million recurrent by 2021. It was agreed that half of this amount, £250 million, would be negotiated with SGPC to directly support general practice.

In 2017/18 £71.6 million was invested through the Primary Care Fund to directly support general practice. This figure increased to £108.73 million in 2018/19. Further investment will see this increase over the three financial years from 1 April 2018 to £250 million in 2021-22. It will pay for the costs of formula transition, new staffing, premises arrangements etc.

Funding

Why was the Scottish Allocation Formula (SAF) replaced with the Scottish Workload Formula?

The new Scottish Workload formula was developed as part of a 2016 review of the SAF and is a methodological improvement to the previous SAF. It is based on the best available evidence and as such it more accurately reflects the workload of GPs.

The main improvements recommended by the research were:

- the inclusion of patients who had not visited a GP (zero consultation patients) in the calculation of relative need
- the estimation of age-sex and morbidity effects together, rather than calculating the age-sex effect independently
- the updating of the data and use of new indicators for the morbidity and life circumstances adjustment.

Compared to the workload-related weightings of the original SAF, the new formula gives greater weight to older patients and deprivation.

The new Scottish Workload formula was introduced alongside a £23 million investment funding practices that receive a greater allocation under the new formula; and a practice protection which means that the GP practices not exceeding their previous allocation will be protected from any potential funding losses. This change results in a reduction in the number of practices dependent on payment protection.

We have been monitoring the impact of the funding formula during implementation.

Why does the contract framework talk about whole time equivalent (WTE) GPs working a 40 hour week?

We know that GPs work in a huge variety of ways across Scotland, working different numbers of sessions and different numbers of hours per session. There is no standard measure of how many hours a full time GP works in a week.

The Earnings and Expenses Review, which was jointly commissioned by SGPC and Scottish Government, analysed information from 109 practices. In order to compare information between practices it used a 40 hour week as a WTE GP. This is also useful as we can make comparisons with colleagues working in other specialties in this way too.

The data in that report shows that, based on a 40 hour week, an estimated 20% of GP partners are paid less than £70k per annum (excluding private work and excluding any employer superannuation). This is why the minimum earnings expectation outlined in the contract framework is based on a 40 hour week.

For GP partners working less than a 40 hour week this minimum earnings expectation would still apply and would be calculated on a pro-rata basis.

This does not mean we think that full time GPs only work 40 hours a week (we know that many work in excess of 50 hours per week), or that we expect all GPs to move to working a 40 hour week – it's a tool to allow us to compare GPs across the country.

Services/practice team

How will my practice staff be affected?

We know that there are some concerns over how the proposals might impact staff.

Our core principle is that practice staff and their terms and conditions of service must be respected. No part of the 2018 Scottish GP contract, in either phase one or phase two, would forcibly change the way that practices employ their current staff. Practices will continue to employ their practice managers, receptionists, practice nurses and health care assistants. For practices who have employed a wider range of staff there will be no changes in phase one.

It is possible in future that some practice staff may wish to join the teams of practice-attached staff provided by the integration authorities/NHS boards under Transfer of Undertakings (Protection of Employment) Regulations 1981 (TUPE) rules. Again, this will not be forced on staff under the contract and will be a practice decision. Guidance will be developed to support this process as the contract develops towards phase two.

My practice nurse provides many of the services that would be provided by new attached staff. What does this mean for my practice?

The 2018 Scottish GP contract provides additional primary care staff that would work alongside and support GPs and practice staff. The expectation is that the new attached staff will reduce GP and existing GP staff workload and improve patient care. As the workload of existing staff is reduced, we expect that practices will focus their existing staff on activities that can more directly support GPs as Expert Medical Generalists. We accept that this transition will take time, but we see revised roles for existing practice staff as a key way to support GPs and reduce their workload.

My practice has already employed a pharmacist (or other additional staff). How will I benefit under the new contract?

Practice staffing is variable, and the 2018 Scottish GP Contract is sensitive to these differences. Practices can be reassured that they will have the funding to support any additional staff they have employed, as current funding is stabilised and protected indefinitely. This will extend into phase 2 where staff expenses will be directly reimbursed.

Practices will have the option of accepting additional practice attached staff and refocussing the work of their existing staff to best address the needs of the practice. Practices through their cluster can influence the plans supporting the delivery of new attached staff. Where a practice has already employed a member of staff, they could indicate a preference to receive additional staff covering another area of work as a priority.

How will the multidisciplinary team work?

The GP will operate as a senior clinical decision-maker leading the team to improve outcomes for patients. Non practice-employed staff will be line managed by the integration authorities to directly act as a member of the practice multidisciplinary team. Cross cover arrangements for holiday, maternity sickness etc will be covered by the integration authority to ensure service continuity for the practice.

As senior clinical decision-maker the GP will largely direct the day-to-day working of the staff within the team. However, it is expected that many of the staff will work in an autonomous way, meeting patients' needs, on most occasions, without recourse to the GP.

We want these team members to be embedded as part of the practice team. Already you will have experience of staff that you direct clinically but don't employ.

It will be the health board's responsibility to ensure the service is maintained.

New role/new relationships

Will training be provided to help GPs perform the new GP role?

GPs are already expert medical generalists; these proposals simply build on this. However, we anticipate that both current trainees and existing GPs are likely to require additional training opportunities to perform this new role. We anticipate that as the primary care multidisciplinary team (MDT) are recruited the six priority areas within service redesign will be transferred over to the MDT such as vaccinations.

We have an express intention to achieve regular protected time in the working week to enable all GPs to undertake training, quality work and leadership. This may take some time to achieve as it requires a significant increase in the total GP workforce to make it possible.

We have made commitments with one session per month for every practice as a first step in this direction.

Data collection

Why does the contract framework state that GPs will provide workforce, income and expenses data as part of the proposed arrangements?

The lack of data on income, expenses and workforce makes it very difficult to safely plan for changes to funding to general practice, to ensure that general practice is sustainable. Collecting data on income, expenses and workforce in general practice is a contractual commitment and will begin in Autumn 2019. Gathering this data will allow for greater sustainability of practices and for a more appropriate match of resources to workload.

The collection of practice data on workforce, income and expenses to inform negotiations on the second phase of the GP contract. Understanding the effect of geography, list size, the makeup of the practice population, etc. on the cost of providing primary care services and the actual cost of running a GP practice, whether in an urban or rural setting, is essential to negotiating a contract that meets the needs of GPs and their patients across Scotland.