Rural Services APPG

Meeting
All-Party Parliamentary Group on Rural Services

16th January 2014, 12.30pm – 1.30 pm
Dining Room C

PRESENT
Graham Stuart MP (Chair)
Roger Williams MP
Janice Banks ACRE
Councillor David Jeffels – Scarborough Borough Council
Jon Carroll (from Graham Stuart's Office)
Nick Falci (from Graham Stuart's Office)
Edward Winfield (from Therese Coffey MP's Office)
Matthew Sutton (from Nigel Adams MP's Office)
Pippa Page (from Sir Nick Harvey MP's Office)
Graham Biggs (RSN)
Brian Wilson (RSN)

Speakers
From the BMA: Dr Peter Holden GP Executive Lead for Rural Matters accompanied by Susan Bahl of the BMA's Public Affairs Division.
From NHS England: Ben Dyson, Director of Commissioning Policy & Primary Care
From the Department of Health: Rachel Markey, DH Primary Care Lead

1. Notes of previous meeting

The minutes of the previous meeting (17th December 2013) were agreed.

The Chairman would invite a Department for Transport Minister to address the Group.

2. Presentations

The Chairman outlined the context of the Groups' wider concern about NHS funding allocations, which worked to the disadvantage of rural areas.

Presentations were invited from the three speakers to help the Group understand rural implications from the planned phasing out of the Minimum Practice Income Guarantee (MPIG).

Dr Peter Holden himself a practicing GP and a BMA negotiator for the 2004 GP contract explained that, when the Government introduced its 2004 formula for weighting the capitation payments made to GP practices, no factor for diseconomies of scale was included because of concerns about single handed practices. This left some GP surgeries facing bankruptcy, so MPIG was created by raiding the practice premises budget to correct the shortfall.

He commented that in the "old system" deprivation statistics got into the Global Sum calculation but did not reflect rural deprivation.

He added that the sums involved were small in terms of wider NHS budgets, the MPIG having been reduced already to £116m per year (from £250m) or less than 2% of average NHS spend on GP services.

Its phasing out could be a particular issue where it causes surgery closures in areas with no other practice nearby or where public transport is limited.

It is taking place alongside other pressures for some rural practices, such as loss of dispensing rights and difficulties attracting GP partners/employees to more isolated locations.

Dr Holden noted that Scotland is retaining MPIG and Wales has found another solution for affected practices by capping MPIG reductions at 15%.

(A copy of Dr Holden's presentation is attached to these notes).

Ben Dyson (NHS England) said the MPIG issue was by no means just a rural one and the practices that would lose most from its phasing out are very varied (some large, some small). NHS England supports the removal of MPIG. It "corrupts" a funding formula, the rest of which is based upon known factors that predict GP workload i.e. age, sex, nursing homes, morbidity and mortality, and rurality. He said that MPIG also presents a major barrier to engaging GP practices in collaborative work to improve quality, due to the income inequality it created.

MPIG was making good GP practice losses when the 2004 formula was introduced. However, there were many reasons why GP practices may have had the pre-2004 incomes that they had. MPIG is therefore seen as a historic anomaly. GP practices now with relatively low NHS incomes, yet who don't receive MPIG, see it as inequitable.

The savings from the removal of MPIG would be returned to GP practices nationally through the funding formula.

Most GP practices benefitting from MPIG receive only modest sums from it. However, there are 98 "outliers" that receive more than £3 per patient (it has been confirmed since the meeting they account for 7.1% of overall expenditure on MPIG). The 98 are both urban and

rural – slightly more are urban. NHS England fully accepts it may be a tough issue for the outliers.

Four things they are doing are:

- Monitoring the impact of MPIG phasing out on GP practices;
- Working with CCGs to explore the case for commissioning specific services from those impacted;
- Exploring different business models that could help affected GP practices e.g. federation, sharing back offices; and
- Undertaking a wider programme of work with the BMA General Practitioners Committee to look again at the funding formula.

The phasing out of MPIG over seven years would enable the impact to be reviewed over time and would enable 'unique practices' to be identified.

Ben Dyson confirmed that the Government had primarily set up the funding formula review to improve access to primary care services in deprived areas. However, NHS England, working with the BMA, wished to look at the formula in the round and to focus on what factors determine GP workload and if it fairly reflects equitable distribution based on the characteristics of practices. He said that NHS England sees a compelling case for directing more of the NHS's resources into Primary Care (general practice services, district nursing services etc.). CCG's were being encouraged to put £5 per head extra into Primary Care in 2014/15.

Rachel Markey (Department of Health) confirmed that concerns about the equity of resource distribution led to the decision to reduce reliance on MPIG in 2007 and then phase it out over 7 years from April 2014. DoH has asked NHS England to work with affected GP practices over the phase out period.

She said that Ministers are keen to see the outcome of the formula review, including whether it identifies particular rural issues.

Graham Biggs (RSN) read out emails from two GP practices affected by the withdrawal of MPIG to illustrate the potential impacts.

The following points were discussed:

- Whilst MPIG withdrawal affects both rural and urban GP practices, the impact for patients can be expected to be greater in rural areas;
- There will be winners as well as losers amongst rural GP practices, since most do not receive MPIG and that money will be recycled into the allocation pot;
- The 98 outlier practices have all been informed of the change. However, NHS England advised it cannot release the practice names without their agreement. This was seen as potentially frustrating efforts to monitor and assist them. The BMA may be able to help

seek their agreement. It was noted that the names of practices elsewhere in the UK have been released;

- Given the outliers are such a mixed group and a few cases are quite extreme, the only solution may be a flexibly applied one. It was agreed that the situation needed careful monitoring, leaving open the possibility of financial help in difficult cases – the phase out over 7 years facilitated this approach;
- A further issue was the need for higher levels of investment in GP practice premises, especially if the expectation is that a wider range of health services should be available there;
- The age profile of the GP workforce is a major concern, with large numbers due to retire. Government has asked Health Education England to increase the number of GP trainees, though the length of training was noted. There may also be scope to use the existing NHS workforce more efficiently. NHS England is interested in (non-financial) incentives to make GP posts in rural areas more attractive. Dr Holden stated that in his view nothing would induce GP's coming up for retirement to stay.

The Chairman thanked the three presenters.

The Group agreed that this issue would be reviewed in the future once the impacts of the first year's reduction could be ascertained

3. Rural Health Network

Graham Biggs (Rural Services Network) referred to a note prepared for the group about the Rural Health Network's progress. There had been a very successful conference in autumn 2013 and one organisation attending has volunteered to host for the 2014 conference. Thought needs to be given how to take forward the policy issues that were raised.

NHS England noted that the CCG funding allocations for 2014/15 had been announced. The Group would be interested to meet with those responsible for the allocations at NHS England (Sam Higginson) and on ACRA (name to be advised) – Jon Carroll and Edward Winfield to liaise on this.

A meeting was taking place soon to explore the scope for a Rural Crime and Safety Network.

4. Local government provisional settlement 2014/15

Graham Biggs (Rural Services Network) said the Efficiency Support for Services in Sparse Areas grant, which had been a one off in 2013/14, has been extended for two more years at a level of £9.5 million and is now integral to the funding formula. Whilst this is welcome it falls far short of the adjustment called for by the Rural Fair Shares Group (£25 million per year, cumulatively until 2020).

DCLG Minister, Brandon Lewis, has said his Department and Defra plan to commission a joint study on rural service provision costs. They will share the draft brief for this with RSN. Although the evidence gathered should be useful, it was noted the study could delay Government from taking further corrective action. The study would need to deal with the

difficulty in achieving like-with-like cost comparisons in urban and rural areas, given that service levels were typically lower in rural areas.

It was noted that rural authorities had fared badly in this year's funding settlement in Wales, because of a focus on (urban) deprivation.

5. Any other business

The recent rural debate in the House of Commons was felt to have been high quality, though it was a pity more MPs were not able to attend.

6. Next meeting

11th March 2014 (to be confirmed). It is hope this will be with the chair of the EFRA Select Committee.