

ROYAL COLLEGE OF GENERAL PRACTITIONERS

CLINICAL NETWORK

RURAL PRACTICE STANDING GROUP

Minutes of the meeting of the Rural Standing Group held at Galgorm Manor Hotel, Ballymena, Northern Ireland on 11th November, 2003

Present: Dr Iain Mungall
Dr Derek Browne
Dr Catti Moss
Dr David Johnston
Dr Laura Marshall
Dr James Moore
Dr Russel Walshaw
Dr Gordon Baird
Dr Walter Boyd

In attendance: Fiona van Zwanenberg
Val Fiddis
Gilliam Jackson

1. Apologies

There were apologies from Drs Jim Cox, John Wynn-Jones and Malcolm Ward. The Chairman announced that Jim Cox now wished to retire from the group. Members paid tribute to his work for rural medicine and it was suggested that Professor Dame Lesley Southgate be asked to write a letter of appreciation from the College. It was agreed that Dame Lesley should be asked in a personal capacity, although she was about to retire as President

ACTION: Fiona van Zwanenberg.

Dr David Johnston announced that since becoming Secretary to the Northern Ireland Council, he would find it difficult to attend all the rural meetings. He introduced Dr Walter Boyd, a GP from County Tyrone, who would act as an alternate and attend meetings when he could not.

2. Presentation from the Northern Ireland Council

Val Fiddis, Regional Manager Northern Ireland and Gillian Jackson, Quality and Information Manager, gave a presentation on the work of the Northern Ireland College, specifically how they have run an outreach programme to raise the profile of the College among doctors in Northern Ireland, particularly in the more remote areas.

Val said that the College was now officially recognised as the voice of general practice in Northern Ireland, with journalists and administration seeking their views on matters of the day. Council has adopted a localised version of the Strategic Plan endorsed by UK Council and has also approved a Manifesto document for the future. Evidence of the growing influence of the College is provided by the take-up of Quality Awards – applications to the QPA programme have doubled and both the Northern and Western

Health Boards have adopted the College Practice Accreditation programme, with funding provided for participating practices. The Boards have also funded a toolkit for use by candidates.

The single most effective action taken to promote the College and College membership was the development of a sub-regional structure. With a £10,000 loan from College funds, the Council has opened a North-Western office near Londonderry. The funding has gone to provide protected time for one local doctor and to pay for secretarial expenses. The lead doctor has established a virtual group involving all members in the area and has done a series of practice visits and presentations. The results have been extremely positive in terms of re-vitalising the membership and raising the profile of the College.

Val concluded by explaining that the work was on-going and that the College in Northern Ireland was seeking to build recognition and joint-working with the health Boards, as well as obtaining financial support from them for projects.

The group was impressed by the work in Northern Ireland and discussed whether the model of using a College “champion” in a rural area where there was little College activity might not be replicated in other areas.

ACTION: Dr Baird will talk further to Val Fiddis about possible similar work in Scotland.

3. Minutes of the Previous Meeting

The minutes of the meeting of 16th June were approved.

4. Matters Arising

Dr Mungall gave some feedback on progress with developing the paper for the Academy which had been discussed in the context of the reported meeting at the Academy of Medical Royal Colleges. He said that the idea was to develop a working party from various Colleges, which would produce guidelines. Laura Marshall reported that she had been at a similar meeting in Scotland which was establishing a working party on rural hospitals in Scotland. It was noted that a forthcoming report on surgical services was being produced by a group led by John Temple and that it was understood that the College would be asked to comment on this.

5. Report from the Chairman

Dr Mungall said that most of his energies recently had been devoted to the paper on access, which had been considered at the Council Executive Committee. There was a good deal of favourable comment and he had been asked to expand it in the light of these comments and bring it back to CEC in January.

He had led a session at the Santiago WONCA conference, which had been generally a very successful event.

In his home area, Dr Mungall said that Northumberland had at last taken on a rural health agenda and that the chair of the PCT was sitting on the rural health forum advisory board. The PCT had adopted the model developed in Worcester for rural health transport.

Turning to the topic of the future of the group; Dr Mungall said that he felt that it was time to re-focus, and to undertake some more academic work. Although the group was recognised as a Standing Group of College, it still needed to justify its existence, and this could be done through demonstrating outcomes of its activities. He said that it was time to be thinking of a successor as Chair and asked members for their preliminary thoughts, with a view to a decision in April. The group also needed to recruit someone to take Jim Cox's place.

6. Financial report

Fiona van Zwanenberg presented a brief financial report. The group was operating within its budget, but at the cost of having only three meetings in the financial year 2003-2004. Because of the difficulty in getting locum cover in remote areas, the group had suffered disproportionately from the increase in locum fees.

The group discussed briefly the issue of identifying a source of project funding, to support any activities outwith regular meeting costs. Suggestions made included the Countryside Agency and the Scottish Executive – it was noted that RaRaRi was closing down and there might be Scottish funding available as a result.

It was agreed that work on Out of Hours cover might be very worthwhile – the group was agreed that, if the new contractual arrangements for Out of Hours went wrong, it would set rural practice back 50 years. There is no anonymity for rural doctors – whether or not they are on call, sick patients will still turn up at the door or call them in the night, if there is no choice available. The group felt that although PCOs have a mandate to provide 24 hour cover, many have not yet got to grips with this. They are required to engage with local doctors and existing services, and rural doctors should be lobbying their LMCs to ensure that this happens.

An additional out of hours issue affecting rural doctors was their place within large schemes. Most large schemes covered both town and country areas and where urban doctors were involved they were increasingly opting out – not providing the cover themselves and paying for someone else to do it. Doctors in urban areas did not have the same pressing need to engage with a local scheme and would not provide cover if this extended to a large rural and urban area.

7. Aims and Objectives

Following on the discussion of identifying external funds and looking for a new impetus, the group also went on to confirm its aims and objectives, and to consider ideas for action research and for a publication. Dr Boyd was submitting an abstract to the Spring Meeting on some work he had been doing on access of farmers to health promotion in the Clogher Valley, in collaboration with the local Department of Health and Social Care. It was suggested that the Institute of Rural health might be interested in publishing this work,

The group discussed writing a new occasional paper on rural medicine and brainstormed ideas for various sections

- Re-visiting “What is quality rural practice” and considering what constituted quality in relation to key issues
- Out-of-Hours
- Pro-active v. reactive care, valuing reactive care

- Access
- Distance decay – the further away you live, the less likely you are to have a face-to-face consultation with a GP
- Compromise and excellence – developing the theme that compromise is not necessarily the poorer solution, for example a patient on the Isle of Lewis, who chose a major mastectomy and care thereafter on the island, rather than a lengthy period of travel away to the mainland for less radical treatment
- Telephone consultation – the point was made that distance may not be the only factor at work, independence and capacity for self-care are factors of rural living and personality may have had a role in the patient choosing to live in a remote area in the first place
- Linked aspect of rural health knowledge and expectations of care
- Health outcomes in rural areas
- Equitable funding – with reference to the Scottish Arbutnot report and the work of the rural health forum
- Generalism and the interface with hospital care
- Community hospitals
- Remote learning/ multi-disciplinary learning
- Management issues – multi-skilling, multi-tasking e.g. nurses are told they can no longer fill patients' medicine boxes with a day's pills in compartments, with the result that it is left to relatives or home helps to take charge of this.
- Demographic changes in the countryside
- Transport infrastructure and economy
- Defining standards for rural practice – Laura referred to a rural health competencies mapping exercise which would be carried out in Scotland in the next six months
- Recruitment and retention – particularly the implications for rural single-handed doctors, who appear likely in future to become the only single-handed practitioners still working. How are they to be supported?

ACTION: Dr Mungall will circulate a draft contents list for this publication, for comment and development. He will ask members to suggest sections which they would like to develop, or will nominate people items of work.

Once the draft chapters are agreed, the Group will forward this to Professor Ruth Chambers in her role as Chair of the College's Publishing Management Group, for consideration for publication by the College.

8. The new GMS Contract and Rural issues

Dr Walshaw began a discussion on the opportunities and threats contained in the new contract for GPs in rural practices. Crucial areas were Out of Hours and Choice. With regard to provision of a 24 hour service, where there were no centres within suitable distance, some of the work will need to come into general practice, accompanied by specific funding. This gives rural GPs an opportunity to negotiate and to get resources locally. There will also be an opportunity for GPs with Special Interests to get resources in their local areas. There were a lot of opportunities, provided rural doctors were ready to say "No" unless there was adequate local funding.

He also mentioned that there were options for new premises and that doctors considering the idea should communicate with their PCOs right away. They should get their applications into the system, even if they did not yet have detailed, costed plans.

It was agreed that Patient Choice was much harder to deliver in the rural areas. While single-handed practice was rapidly becoming phased out in the cities, large conglomerate practices were not feasible in remote rural areas. If a locally enhanced service is deemed necessary, the PCT will have to be fully responsible and will need to find the money to resource the service.

The European Working Time Directive will also impact on the service provided by District Nurses working in remote areas, or supporting ambulatory care centres. More staff will be needed.

Dr Walshaw was pessimistic about the future of dispensing in general practice, believing that it was on the way out as part of harmonising with EU regulations. The future he thought lay with visiting pharmacists, who could provide a service at set hours.

Discussion of the challenges facing GPs in the rural areas led on to consideration of recruitment and retention. It was noted that 20% of graduating doctors never register. There were currently not enough doctors to staff general practice, even without the anticipated decline in small practices. Eventually, it was agreed, it may be up to market forces – if doctors in the Highlands and Islands simply pack up and leave, PCTs will have to fly in locums. Dr Marshall recounted that her island had recently lost a part-time doctor, who was being replaced by a locum paid at £450 a day.

It was agreed that it was difficult to say “No,” because of responsibility to patients who lived locally and to whom the doctor was the link with health care, but Dr Walshaw said that rural GPs must take up firm positions and negotiate through the problems which will occur.

9. Friday 23rd – Sunday 25th April 2004, Spring Meeting, Bournemouth

After discussion with the organising committee, it had been agreed that the Rural Practice Group should have a strand running right through the programme, rather than a separate session. Gordon and Iain were considering submitting an abstract, and it was agreed that members of the group would raise points relating to a rural perspective, as appropriate, throughout the meeting.

The group would have its meeting on the Friday morning, prior to the opening of the Symposium on Friday afternoon. Members would meet for a meal on the previous Thursday evening.

ACTION: Dr Browne agreed to arrange the dinner and to book a room for the meeting at the conference venue – the Royal Bath Hotel – for the Friday morning at 10 a.m.

10. Santiago Conference

Dr Wynn-Jones was not present to report on this, but everyone had seen his written report. Dr Mungall said that his main impression had been of how far ahead the Australians and Canadians were in supporting rural medicine – with rural universities, inducements to employment in remote areas etc.

11. Rural Diploma

The project has been a bit delayed, as the Santiago conference occupied so much of Dr Wynn-Jones' energy in the past year. Some modules were still outstanding, and there is no clear information about deadlines or payment.

The group expressed some concern about whether the Diploma was ultimately commercially viable. The content was excellent, but there was a feeling that writing it was in some ways "the easy bit." Although surveyed doctors had expressed enthusiasm for the project, this did not necessarily mean that they would actually sign up. Even if Deaneries supported the diploma and paid the fees, making the time available would be a major barrier. There was a feeling that this might prove to be a first class project whose time had not yet come.

12. Local Reports

Dr Marshall reported that she had taken part in a joint meeting in St Andrews with colleagues from Norway discussing aspects of rural practice.

Dr Moss raised the issue of the effect on her local Out of Hours Co-operative of a growing centralisation. The Co-op catchment area covered both town and country and rural practices were being increasingly marginalised.

Dr Moore agreed with this analysis and said that, in Cornwall, Out of Hours services were still in a state of flux

13. Any Other Business

Dr Mungall reported that there had been little progress in building formal links with nurses. Although the group could continue to support rural nurses in arguing that rural nursing has an individual identity, the RCN has so far resisted the idea of developing a rural nursing forum

ACTION: Dr Mungall to write to Lyn Young asking about progress.

Dr Mungall also mentioned that another edition of *Country Matters* was due and that he was putting this together.

14. Date of next Meeting

The next meeting would be at 10am on Friday April 23rd at the Royal bath Hotel, Bournemouth.