

ROYAL COLLEGE OF GENERAL PRACTITIONERS
CLINICAL NETWORK

RURAL PRACTICE STANDING GROUP

Minutes of the meeting of the Rural Practice Standing Group, held in Imperial College, Meeting Room 8, Seminar and Learning Centre, Level 5 of the Sherfield Building on Wednesday, 19 January 2005 at 11.00 a.m.

Present: Dr Gordon Baird - **Chairman**
Dr Iain Mungall
Dr James Moore
Dr Catti Moss
Dr Malcolm Ward
Dr John Wynn-Jones

In attendance: Kathleen Dyer

1. Welcome and Apologies

Apologies for absence had been received from Drs David Johnston, Russell Walshaw, Walter Boyd, Laura Marshall and Anna Wilson and Ms Jane Randall-Smith.

2. Minutes of the previous meeting

The minutes of the meeting of 17 November 2004 were approved and could be displayed on the web site.

ACTION: Kathleen Dyer

3. Matters Arising

There was further discussion relating to the agreed membership structure outlined in Minute 7: Membership Structure in the minutes of the RPSG's meeting of 1 September 2004. Dr Baird asked members of the RPSG to look at the September minutes on the Group's webpage if they want to review the membership process. Dr Baird asked members of the Group to contact him if they wanted to discuss any further amendments; currently the process of electing members and the terms for ongoing members would stand as outlined in minute 7. He clarified that the Structure is in place to establish an ongoing review of the Group's membership but it should not deter existing members from continuing their membership on the Group.

The Group agreed that the membership structure of the RPSG should continue to maintain a UK balance.

Dr Baird will be advertising for new members before the next meeting and the members of the Group will be kept informed of the process.

Action: Dr Baird to look at the protocol for advertising and recruitment process for new members and proceed with the process of advertising for new members and he will be consulting all members of the Group throughout the selection process.

4. Report from the Chairman

Networking

Dr Baird felt it was important that the RPSG link closely with other groups/sections within the College and also strengthen its networking with other local groups and projects. Meeting with RCGP Faculties can be seen as part of this process. Dr Baird reported that he will be meeting with Nat Wright, the Chairman of the Health Inequalities Standing Group (HISG), which is housed within the Clinical Network, to discuss rural issues that might be relevant to both Groups. He asked members whether they had any rural issues they would like him to discuss with Nat Wright. He reported that the HISG has organised a conference with the RCGP Yorkshire Faculty entitled 'Health inequalities and the new GMS contract: Assessing the impact – Informing the review' on Friday, 18th March 2005 and Dr Baird will be speaking during the afternoon workshop session on rural deprivation.

The RPSG agreed that the following issues might be relevant:

- Patient advocacy
- Rural deprivation
- Access to care
- OOH (rural doctors' lost role/responsibility – lack of high standards of care with current system)
- Education and Research (need for observational research)

Action: Kathleen to request an electronic version of the Health Inequalities programme/application and circulate to all RPSG members.

5. Financial report

There were no significant changes to expenditure since the previous meeting. Dr Baird was pleased to report that the Group had managed to raise £2,500 from Phoenix to cover its meetings with the Faculties.

6. Review of meetings with faculties

There has been reasonable success achieved with the RPSG's meetings with the RCGP Faculties. So far Drs Baird and Moore had met with the Tamar and NES Faculties and Drs Baird and Moss were about to meet with the East Anglia Faculty after this meeting. The main themes that were emerging for the Group to consider in its role are: What aspects of rural healthcare provide good patient care? What do patients want? The RPSG should play informer to the Commissioning Bodies i.e. NHS 24/Direct? Should the Group have a view re: commissioning? Should the RPSG focus a good percentage of its energy into education and research and publications? The RPSG should not be the 'Gate Keeper' on commissioning – it should be for patient choice/advocacy?

Action: Dr Gordon Baird to write a paper outlining the RPSG's achievements following the meetings with Faculty Boards.

Dr Baird had expressed an opinion via email prior to this meeting that there should be national funding for England, Ireland and Wales similar to that of the funds that were allocated to the RARARI project for Scotland which fired a debate on whether new organisations similar to RARARI should be created. Dr Wynne-Jones felt that if funds were to become available for rural areas in England, Ireland and Wales there were plenty of existing organisations and groups that would be able to develop their expertise further to enhance standards of rural health care without the need to create another organisation. Dr Baird clarified that he had not meant that another organisation such as RARARI should be imposed merely that there is a need for funding on a national level of which RARARI is one example.

Action: Items for next meeting's Agenda:

- How do we deliver good standards for rural patients?
- The Rural Health Forum has been working for the last 7 years to bring different organisations together.
- The group should continue to support and look at developments and funding for rural health bodies and organisations across England, Ireland and Wales.
- How do we produce an effective business plan that would achieve 'ring-fenced' funding for Rural Health?

7. Spring Meeting in Blackpool, April 8-10th 2005

Dr Mungall reported that the organiser who was responsible for organising participating groups' slots is ill. The RPSG's slot has been cancelled. However, members of the RPSG who are planning on attending the spring meeting could hold a private meeting and dinner.

8. Country Matters

Dr Mungall reported that the next issue of Country Matters would be produced in the next six to eight weeks. The RPSG agreed the following topics:

- OOH and the impact of the new GMS contract
- Introducing the new Chair, Gordon Baird
- Paper on cancer care that is being published in the next week or two
- The European and remote journal/Medline
- Excerpts of the RPSG minutes
- Patient transport schemes

- Education Paper
- Dr Wynn-Jones will contribute pieces on the virtual library and the rural proofing tool kit.

9. Reports from Members

Dr Iain Mungall

Dr Mungall reported that the changes under the new GMS contract have not improved services instead services have deteriorated one example being that there are no healthcare services operating in regions by midnight. The overall view taken up by professionals is that OOH services in his area are becoming largely autocratic and centralised. The two major problems in his area are OOH services and closures of branch surgeries.

Dr Malcolm Ward

Dispensing

Dr Ward reported that analysis of PPA PACT data undertaken by the DDA has shown that the cost of dispensing by doctors compares favourably with the cost of medicines to the NHS when prescribed and dispensed in community pharmacy, which he believes has helped to secure a future for dispensing by doctors. However he expressed concern about the ramifications of the Pharmacy Contract starting in April 2005 on dispensing costs. Dr Ward also alluded to some last minute potential problems re the proposals to change the rural dispensing regulations however he was hopeful that these could be resolved. He advised that further information on these issues could be found on the DDA website.

Dispenser training

Dr Ward advised the Group about the importance of the DH consultation document "Regulation of Health Care Staff in England and Wales". He said it seemed likely that the Government would require dispensers in dispensing practice to be regulated by 2007 – 2008 and that in anticipation of this the DDA had commissioned Buttercups Training Services Ltd to produce a NVQ level 2 course for dispensers with a view to producing a NVQ level 3 course later. He referred the group to the DDA website for further details.

Dr John Wynn-Jones

There was not enough time at this meeting to discuss the major issues which Dr Wynn-Jones brought to the meeting. The RPSG members agreed that these issues should be placed high up on the next Agenda. Kathleen is to ensure that the following items are listed with those under the last action point in minute 6 above:

- Seeking ongoing funding for existing medical education and research organisations that support a high standard of rural healthcare for patients in England, Ireland and Wales.
- Look at the current funding situation which is partly covered by a mixture of organisations such as the Countryside Agency, public health agencies and the DH.
- The IRH has been funded this year to develop and implement the concept of a grouping of rural PCTs and this will be promoted at the UKPHA conference in April and formally launched in June.
- OOH; branch surgery closures; border issues;

Dr Wynn-Jones reported that the Diploma is stagnant at the moment; there is currently no funding available for implementation.

The IRH has been running since 1997 and it has played a role in developing work such as the Euripa listserver; Website and Journal. It has built up a substantial national and international network for rural health issues.

10. OOH Services/NHS Direct/24

The RPSG discussed the deterioration of OOH Services further and decided that it should write to NHS Direct/24 to determine what mechanism is in place to collect data on patient feedback from the system re: how the system is working across the board. Dr Baird is to draft a letter to NHS 24. The RPSG also agreed that separate letters should go to NHS 24 (Scotland); NHS Direct (England) and the equivalents in Ireland and Wales and invite someone from NHS Direct to one of its meetings.

Actions: - Dr Baird to draft a letter to go to NHS 24/Direct.

- Invite an Official from NHS Direct to a RPSG meeting
- Depending on results from the RPSG's investigations it should keep the suggestion on board to write to defra to fund and investigate the standard of service to consumers (patients).

11. Date of next meeting

The RPSG decided that it would meet in May 2005: one of the following dates would be confirmed for May: 4th, 6th, 11th, 16th, 17th or 18th.

(Sub-note: the next meeting date 11 May 2005 at 2.00 p.m. was confirmed by email discussion following this meeting)

Actions from meeting with Dr Nat Wright re: the conference to be held in Yorkshire on Friday, 18th March 2005 entitled 'Health inequalities and new GMS contract: Assessing the impact – Informing the review'

1. Dr Wynn-Jones offered to invite a rural researcher to give a presentation at the conference on 18th March.
2. Form a joint RPSG and HISG sub-group/team to write an evidenced based editorial for the BJGP following the conference.

Notes of a Rural Practice Group meeting in Cambridge with the East Anglia Faculty Board on Wednesday 19th January 2005.

Dr Gordon Baird and Dr Catti Moss attended this third meeting in a series of encounters between the rural group and members of faculties with a significant rural membership. The Rural Group representatives had been invited to attend the Faculty Board meeting to make a presentation and lead a discussion. Thereafter, Dr Baird and Dr Moss adjourned to a separate room, where they met informally with rural members of the Faculty, who had been invited to attend that evening.

Dr Mike Knapton, Faculty Chairman, welcomed the visitors and introduced Ms Claire Morris, the Director of Primary Care of the Cambridge PCT who was also attending as a guest of the Faculty Board.

Dr Baird gave a brief presentation on the work of the Rural Practice Group and the reasons behind the current series of visits to Faculties. He talked about the history of the rural group and its priorities, and his belief that there were no fundamental differences between rural and urban practice, but that the problems presented differently and might need different solutions. Doctors practising in remote situations needed to be multi-skilled and flexible. He believed that the impact of the new contract and re-organisation of patient care threatened the continuity of the central doctor-patient relationship, which was particularly important in remote, stable communities. He deplored the spread of “tick-box” approaches to personal care and while conceding that guidelines had their place, felt that rural practice still exemplified a different tradition, in which it was not true that “if it’s not measurable, it’s not important.”

Dr Knapton thanked Dr Baird for his “refreshing and humanising” views, which provoked a lively discussion. The main issues raised were

- Community hospitals and the problems involved in resourcing these: low bed occupancy, cover, the need for a needs assessment that didn’t solely look at cost, but also included the consequences for patients and their families; cross-boundary funding issues; the role of the GP as advocate – “if we can demonstrate the need, we should deliver it.”
- Quality issues in small facilities: a balance between competence and quality – a hospital needed to be large enough to do enough of a procedure to ensure competence, but the highest quality care might be so far away as to be less valued than merely competent care.
- PCTs operate in a complex, managed environment. Their work based on “counting things” which does not necessarily reach to the heart of what personal care involves. An aspect of the advocacy role is to help PCTs understand the consequences to patients of *not* having the things that the PCT- may not value.
- Training for rural practice: recent experience in Orkney had demonstrated that Island GPs have to deliver service of a kind in which they have not been trained; there were

opportunities – RaRaRi had funded rural fellowships for young doctors; could learn from Australia which offered rural training as a separate discipline.

- East Anglian experience: rural practice increasingly becoming a job with set hours, as in the cities: farmers becoming increasingly IT competent, though there are still isolated villages without public transport. Lots of migration and second-homes alongside very poor. There was also a very large population of Portuguese migrant labour working on the land, in the fens, and living in poor conditions and in poverty.

- Revalidation: difficult for rural doctors; need support for time out of the practice.

Dr Moss and Dr Baird were thanked for their contribution and Gordon repeated his aim of improving the contact between the College and rural and remote members, whom he invited to join the rural email network.

The separate discussion with rural members which followed on to the Board meeting developed some of the topics listed above and introduced new ones. Gordon opened the discussion by saying that he and Catti were there to listen – what were the issues affecting them and what did they want the rural group to do?

One member posed the question of what was “Rural?” He said that his PCT area embraced two small towns of similar size – one was on the Inter-City rail line and included a large number of commuter homes, while the other did not have a train station and had almost no incomers living there. Only one had any rural “feel” about it, despite superficial similarities. Gordon provided some references on rurality and clinical periferality, which was a related concept. The group went on to discuss hidden pockets of rural deprivation, and the inner city equivalents.

The group discussed changes and how it might be possible to use changing to create improvement. It was noted that most real improvement in primary care has been GP led and managers needed to be reminded that if you can demonstrate that change means better care, doctors will adopt it willingly. It was felt that doctors in remote practices had actively sought out that situation, they will tend to sit out periods of change and uncertainty and act as a buffer for such change between the administration and their patients. This tended to be a characteristic of small practices, wherever they were situated.

From the PCT perspective, Claire Morris said that lots of current targets were based on experience in towns and rural doctors could make their experience known and help PCTs to shield practices from the more irrelevant issues. This led to a discussion of what was getting better and what was worse. Ambulance services were a case in point, of perverse incentives. In an attempt to meet response time targets, services were giving up on the boundary areas and keeping ambulances at the centre, instead of locating them towards the edges, so that the majority of calls could be within approved response times and, in practice, they were never going to be achieved at the edges, so why bother having ambulances parked up on the perimeter of the area?

Terminal care was no longer possible because of Out of Hours arrangements and increasingly people went into Community hospitals for such care.

There was a general feeling that rural doctors were struggling under an inappropriate burden of urban solutions, and the College group should take on the responsibility of pointing this out. Many of the issues related to poverty and public transport, not so much to clinical issues. But on balance, being a rural GP was a good life with an opportunity to provide people with the chance to see a doctor of their choice, within a reasonable time. There was a need to develop tactics to support this vision – proper reflection could reduce the unexpected effects of change.

Fiona van Zwanenberg
February 2005.