

Rural Practice Standing Group

Notes of meeting with the Tamar Faculty Board: Tuesday 31st August 2004

Present: Members of the Faculty Board Rural members attending specially to meet the Group Gordon Baird and Iain Mungall from the RPSG.

The provost of the Tamar Faculty warmly welcomed the representatives of the Standing Group to Plymouth and the meeting began with a presentation from Dr Baird. He said that this meeting was the first in a series of contacts with Faculties where there were considerable numbers of rural doctors. The intention of the Group was twofold: to raise the profile of rural practice in the College and to discuss common interests with other members practising in remote and rural areas and consider how the Group might be helpful to them.

Dr Baird looked first at the similarities in general practice throughout the UK, saying that the problems were the same, but that the solutions might be different in towns and in the rural areas. Solutions were dependent upon the resources available and that access to medical care was often the most important quality measure in rural practice. He said that while being a GP in a rural practice was rewarding and satisfying, there were often frustrations arising from lack of understanding among commissioning groups and urban colleagues of the constraints under which rural GPs operated.

He concluded by saying something about the work of the Standing Group, the groups with which it collaborated and the activities of its email group, to which he gave an invitation for those present to join.

Dr Baird's talk provoked a lively discussion, to which the main contributions are listed below

- Professor John Campbell of the Peninsula Medical School is appointing a researcher, Pauline McGlone to work on the rural agenda and offered to put her in contact with the group. He also wanted information on the current rural research agenda. Dr Baird suggested that the output from RARARI would be of interest.
- The educational needs of smaller practices were raised as a particular interest. It was suggested that rural doctors tended to look for courses in areas where they recognised their own needs. IT was seen as a partial solution to getting cover, but personal human contact was still very important. Tools such as video conferencing could be a support.
- It was suggested that rural people could feel like an ethnic minority in their own land and could be alienated from the urban mainstream (cf. the emergence of the Countryside Alliance), rural GPs could function as advocates and interpreters.
- Issues of inequality and social exclusion could be useful in making the conceptual link between country and city experiences.
- Rural medicine could be viewed as the epitome of "whole person" practice, but rural GPs also needed to be receptive to new research and technologies
- Rural practice was able to offer real continuity of care, which was being lost in group practices and co-ops

- There was a risk that this might sound like “us” and “them” – rural practice was not better, just different. The rural group was about valuing general practice and it had no wish to be divisive
- Commissioning enhanced and national services was particularly difficult in remote areas. Rural doctors could not just stop what they were doing and leave patients in the lurch. There was often a lack of knowledge within Trusts of the extent of existing rural services and accurate data collection could provide an information baseline on which to commission services.

Summarising, Dr Baird said that rural GPs were often dealing with vulnerable people in vulnerable communities. He thought that commissioning services and issues around community hospitals were key issues and referred people to the Solutions document on the RARARI website.

(www.community.rarari.org.uk)

ROYAL COLLEGE OF GENERAL PRACTITIONERS

CLINICAL NETWORK

RURAL PRACTICE STANDING GROUP

Minutes of the meeting of the Rural Practice Standing Group, held at the Derriford Hospital, Plymouth on 1st September 2004

Present: Dr Gordon Baird
Dr Iain Mungall
Dr Russell Walshaw
Dr James Moore

In attendance: Dr Pauline McGlone, researcher, Peninsula Medical School
Ms Fiona van Zwanenberg

1. Welcome and Apologies

Apologies for absence had been received from Drs David Johnston, Catti Moss, Walter Boyd, Malcolm Ward, John Wynn-Jones, Laura Marshall and Anna Wilson. Ms Jane Randall-Smith who was to deputise for John Wynn-Jones also sent apologies.

Dr Mungall opened the meeting and passed the chair to Dr Baird. Dr Baird took the opportunity to thank Iain for his leadership and support to the group and also mentioned Dr Derek Browne, who had retired from the group. He suggested a letter of thanks should be sent to him, from the group.

ACTION: Dr Baird

Dr Baird welcomed Pauline McGlone, who was attending as a guest, as a result of contact at the previous evening's meeting

2. Minutes of the previous meeting

The minutes of the meeting of 23rd April 2004 were approved and could be displayed on the web site

ACTION: Kathleen Dyer

3. Matters Arising

Dr Baird reported that, as requested, he had enquired about progress with the Rural Diploma planned by the Institute of Rural health. The response was that no immediate launch was likely due to more pressing priorities.

With reference to RARARI, Dr Baird said that a series of publications of its work was being produced, as part of the closure of the organisation.

ACTION: Eric McKenzie of RARARI to be asked to provide copies of these reports for distribution to the group and to Dr McGlone.

ACTION: Kathleen Dyer

4. Chair's report.

As outgoing chair, Dr Mungall provided an update on recent events. He said that the article on access to community hospitals had been rejected by the BMJ, but that he hoped it would be published in the BJGP. More positively, he reported that Professor David Haslam was convening a group from the Academy. He also said that their contribution to the Santiago meeting of WONCA had been published in the e-bulletin of the organisation.

The Information Sheet on rural practice was almost complete and would be submitted after final editing. There was still work to do on the planned occasional paper. Dr Baird agreed to assume the role of editor and co-ordinator, with Iain Mungall and James Moore providing support.

Finally, he mentioned that the new edition of *Country Matters* had been printed and distributed with rapidity and that a new edition would be ready in October. It would include a questionnaire from the Rural Health Forum and an article from Dr Baird on visits to faculties.

Dr Baird then spoke, mentioning the debt he felt to his predecessors, and saying that he felt there were two major issues facing the group – the perverse incentives arising from the new GMS contract and the challenge to reach out as a College to grass roots members practising in rural areas. He said that people in the College were beginning to express their concerns that the new contract was a risk to personal continuing care and that rural members in particular were already expressing this disquiet.

He reported on the meeting with the Tamar Faculty Board which had taken place the previous evening. It was judged successful and worth repeating, on the basis that it had brought people from the faculty to their first faculty meeting and had inspired at least two rural doctors to adopt a more positive view of the College.

There was some discussion about rolling out the programme of visits and there was concern about the demands on members' time and the expense involved in holding a series of group meetings around the country. It was decided that there was no need to involve the whole Standing Group in these visits and that only Dr Baird and one other member of the group should be involved in each visit, with the normal group meetings being held in London or as telephone conferences.

The planned schedule would be to meet the Aberdeen based NE Scotland Faculty in November and to have a telephone conference involving the whole group in the same month.

The next meeting would be held in January and there would also be a meeting with the East Anglia Faculty in the same month. Thereafter the group would meet in April, at the Blackpool venue for the Spring Meeting, with which the group would be involved.

ACTION: Kathleen Dyer to make these arrangements.

5. Financial report

Fiona van Zwanenberg presented a financial report, which demonstrated that the group would find it difficult to stay within budget, if other meetings this year were to be as expensive as the first one, in April. A discussion followed as to how to acquire additional

funding to support the programme of visits to faculties. This was unlikely to be available from College funds within the current financial year, although a request had been put to the Development Fund. Meantime, it was agreed to seek sponsorship specifically for meetings to promote communication with remote and rural GPs in the faculties. In addition to pharmaceutical company money it was agreed to look at companies interested in communication, such as BT, Ryan Air and Easyjet.

ACTION: Group members to send details of local contacts to Fiona, particularly Phoenix, who are already supporting Country matters. Fiona and Kathleen Dyer to take this forward.

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

Dr Mungall reported on a discussion he had had with a member of the organising group. Rural Practice was invited to do a session at the meeting, and, in keeping with the theme of the event, had been asked to include a patient perspective. It was agreed that the debate on pro-active versus reactive care, which had been cancelled in Bournemouth was still highly relevant and it was agreed that Iain would take forward the arrangements for this. A meeting of the Group would be arranged to coincide with the Spring AGM.

ACTION: Iain Mungall and Kathleen Dyer

7. Membership Structure

There was a lengthy discussion on this issue and several suggestions were advanced. It was agreed that final decisions should be postponed until a full meeting of the group could discuss them.

It was felt that there had been a lack of energy in the group recently, and that it should look for “new blood” and also consider phased retirement for the members. Clearly there was also a need for continuity, so no more than a third of the members ought to leave at any one time. The following suggestions should be discussed at a telephone conference involving everyone, in November

- Members were not “representatives” of any particular geographical area, but the group should strive to maintain coverage of the remote areas of Britain.
- New members should be nominated and approved by the whole group. Preferably, they should be identified by advertisement in *Country Matters* and/or the *Back Pages* of the *BJGP*.
- The length of tenure as Chairman should be three years, with the option to be re-elected for a further three.
- The group should continue to have representatives from DDA, GPC Rural Committee and other organisations, as agreed. These members would be identified by their organisations and would be subject to annual review.
- Membership of the group should normally be for three years, with a staggered rotation so that one third retired each year. There should be the option of renewing membership for a further three years.
- Members of the group should attend at least two meetings per year.
- Visitors to the group could be invited at the discretion of the Chair.

ACTION: Kathleen Dyer

8. Presentation from Dr Pauline McGlone

Dr McGlone explained that she had taken up her post at the Peninsula Medical School on that very day, so that she could only talk about activities that were still at the planning stage. She had a two-year appointment to raise the profile of rural health research in Cornwall, with two tasks: to set the research agenda for the Department and to ensure that this reflected the needs of the community. She asked what the group considered were the research priorities and said that she would like a member of the group to join the steering group for her post. She also requested information about other rural research networks.

Dr Moore agreed to join the Steering Group.

On issues, the group listed longitudinal care, patient transport, Out of Hours; access (including inability to say “no” when things went wrong on your doorstep), health and welfare issues for staff’ recruitment and retention’ appropriate training facilities for rural doctors, community hospitals, branch surgeries.

The group provided contacts with the Institute of Rural Health, the Rural Health Forum, the Highlands and Island health Institute, Jane Farmer at Aberdeen University and RaRaRi. They also mentioned the Solutions Group and its website.

Dr McGlone thanked them for their help and added that she hoped to get involved in evaluating new service models being developed in Cornwall and would maintain a contact with the Group. She said that it was already fairly clear that there needed to be research into what doctors, managers and patients felt about the changes.

9. Protected Learning Time for Rural Doctors

The group considered that rural doctors had different support needs in completing HPD. Because their practices were remote, they tended to need to travel to courses, incurring travel and residential costs, and could not easily make brief visits to neighbouring post-graduate centres. They also had additional needs, such as courses in accident medicine and advanced life support. (It was noted that BASICS training and equipment could be funded by a PCT, as part of an LES.)

ACTION: Dr Baird to write to Dr Hamish Meldrum, Chair of the GPC, calling attention to the additional needs of rural doctors, and copying this to John Maingay at the London Deanery.

10. Virtual Specialist Library for Rural Health

The Institute of Rural health is in the process of developing a virtual library on rural health and wellbeing, to provide rural practitioners with a resource of clinical and managerial information to support their practise. On 9th November, the Institute is holding an open meeting to consider this project.

ACTION: Interested members to contact Jane Parry on 01874 712576

It was agreed that Dr Baird would write offering continued support for this initiative and to identify a representative from the Group to serve on the Board, if required

ACTION: Dr Baird

11. RARARI

Although RARARI had now closed down, there had been a considerable amount of research generated, which was now becoming available in published form. It was important that this momentum was not lost and that the research was put to use

ACTION: Dr Baird to draft a letter to Dr Mac Armstrong, CMO Scotland, alerting him to the situation.

12. Impact of the New Contract

The group agreed that there were real problems in the areas of commissioning Out of Hours, minor injuries and pre-hospital care. If these areas are not commissioned by PCTs, it amounts effectively to the removal of a service, since they have been routinely provided by rural doctors.

It was noted, however, that a good deal of the anxiety felt about these issues may just be generalised worry about change and that the group needed hard evidence of what was happening, rather than just saying “this isn’t good enough.”

It was agreed that there was a role in monitoring progress, pointing out what was going well and where there were difficulties. The group’s policy should be to wait for the situation to settle, when they would be able to make focused comments; but that meantime there was a need to work with patient organisations, alerting them of situations where the service is being retrenched and explaining the role of GPs.

In this context of working with others, it was noted that the Group was still unsuccessful in getting nurse membership.

ACTION: Dr Baird to write to RCN asking for a representative from rural practice.

13. Reports from Members

Dr Walshaw said that there had been no GPC activity recently in relation to rural matters. He added that the GPC Rural Committee would meet again on 14th October and as usual would invite representation from the Rural Practice Group

Dr Moore said that the fate of cottage hospitals was the current problem in the South West. In the past, GPs had admitted their own patients to the local cottage hospital and had been responsible for their care during their stay in hospital. Now GPs were not responsible for admissions, the hospitals were seen as intermediate care facilities and the GPs were still expected to provide cover. While the previous system had relied on goodwill, many doctors were now pulling out of the service because of the demands of their own practices and there was a good deal of anger among rural colleagues about the situation.

Dr Mungall agreed that there was antipathy between local GPs and care trusts in his area too. The PCTs were under pressure because they were too small and were struggling to cover the range of enhanced services required. This was made worse because many of the managers were inexperienced and unaware of the services provided in the past by rural doctors. GPs, working together, could make an important impact on the situation, particularly if they kept patients informed and worked alongside them.

Dr Jane Randall-Smith had sent a written report.

14. Any other Business

Dr Baird mentioned a letter he had received from Dr C E Clark of the Mid Devon Medical Practice raising issues about rural professional isolation and dispensing. He had replied with a surprisingly positive letter about what had already been done.

ACTION: Dr Baird

He had also received a summary of the report to the House of Commons on Out of Hours and wished it to be circulated to the Group

ACTION: Kathleen Dyer.

15. Date of Next Meeting

The next meeting will be a teleconference in early November, preferably before the visit to the North East Scotland Faculty. Thereafter, the group will meet in January, date to be confirmed.

ACTION: Kathleen Dyer