Minutes of Rural Forum Steering Group AGM & Strategic Planning Meeting

Minutes of the Rural Forum Steering Group held on Saturday 20 January 2018
Meeting Commenced at 10:30

PRESENT:
Dr Robert Lambourn  
Dr Christopher Clark  
Dr Hal Maxwell  
Dr Miriam Dolan  
Dr Melanie Plant  
Dr Christopher Williams (telephone conference)  
Mrs Jane Randall-Smith  
Dr Frances Gerrard  
Miss Rosannah Jackson  
Dr Sanjeev Maskara  
Dr Melanie Plant  
Mr Michael Critchell  
Ms Matilda Sims  
Professor Helen Stokes-Lampard  
Mr Mark Thomas  
Dr Malcolm Ward  
Dr John Wynn-Jones  
Dr Alistair Fraser (partial teleconferenced)  

Rural Forum Chair  
English Representative on RFSG  
Scottish Representative on RFSG  
Northern Ireland Representative  
Welsh Representative on RFSG  
Scottish Representative on RFSG  
EURIPA Representative on RFSG  
Director of Community Based Learning, Cardiff University  
Medical Student, Aberdeen University  
First5 Representative on RFSG  
Welsh Representative on RFSG  
Medical Student, Aberdeen University  
Membership Experience Manager, RCGP  
National Faculty Manager, Operations, RCGP  
Northern Ireland Representative (retiring) RFSG  
RCGP Chair  
Scottish Representative & Former Chair (retiring)  
WONCA Representative on RFSG  
Vice President of Health for Royal Dutch Shell  

IN ATTENDANCE:
Paula Lythgoe  
Rural Forum Administrator

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<td>1.</td>
<td>CHAIR’S ANNOUNCEMENTS</td>
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Rob started the meeting off by thanking everyone for attending and asking the group to introduce themselves and what they would like to get out of the meeting. Rob listed the group’s objectives. |
| 2.   | APOLOGIES FOR ABSENCE |  
Apologies were received from Miss Casey-Ann Seaniger & Mr Ed Wilson |
| 3.   | DECLARATIONS OF INTEREST |  
The Chair asked those present to be aware of their personal interests and to declare them if relevant to items discussed. |
| 4.   | INFORMATION GOVERNANCE & DATA SECURITY RISK MANAGEMENT |  
The Chair reminded members present to be diligent regarding data security and information governance. |
5. MINUTES OF MEETING TUESDAY TUESDAY 29 AUGUST 2017

The minutes of the previous meeting held on Tuesday 29 August 2017, were agreed to be a true and accurate record.

6. MATTERS ARISING/ACTION LIST

There were no matters arising from previous minutes.

7. PROFESSOR HELEN STOKES-LAMPARD, RCGP CHAIR

Helen joined the group between 11:00-12:00. Helen briefed the group on her background and informed the group she was attending as an observer and to get a better understanding of the challenges the Rural Forum face.

8. RCSEd PROPOSED REMOTE/RURAL FACULTY – ALISTAIR FRASER

Dr Alistair Fraser, Vice President of Health for Royal Dutch Shell, based in The Hague, Netherlands joined the group via telephone conference at 11:15. Alistair briefed the group on his background. He runs a team of 450 who cover anything with health; animal testing, provision of medical care and delivery of care in the North Sea. Currently any medic working for Shell receive one month’s training, but there is no standard of global training and this can be very random. Alistair would like the Royal College to help set the standards required. They require trauma, public health, occupational health, stress management, holistic care. He ideally wants quality of care in remote locations. He is hoping to set up a Remote and Rural Health Faculty in Edinburgh, to cover not just the UK and Europe, but also many other countries. He is drafting a business case which is due to be submitted to the Royal College of Surgeons in February. Alistair informed the group that he would like to work collaboratively with the RCGP Rural Forum. If the group are interested they can contact Michael Lavelle-Jones, President, Royal College of Surgeons, Edinburgh. Email address: presidentpa@rcsed.ac.uk

9. CHAIR REPORT – WHERE WE HAVE COME FROM, WHERE WE ARE NOW

Rob’s reported that the Rural Forum are in a strong position with the College and that they believe in One College.

John Wynn-Jones was a founder member of the Rural Forum (1993) along with Jim Cox and Iain Mungall. In 1998 Jim and Iain along with other contributors produced a book; Rural Healthcare.

In 2008 the Rural Forum Standing Group assembled a business case to College to become a Rural Faculty albeit non-geographical. The case went to UK Council. The Rural Forum Standing Group were not granted Faculty status, but a two-year pilot was conceded. Paula joined the now Rural Forum Steering Group (RFSG) in March 2010 as Administrator.

Over the years the RFSG have applied for a seat on UK council, but have been unsuccessful. Rob attended a meeting last year with Simon Ashmore and Nigel Mathers to explain why the Rural Forum are different and why they need a seat on Council. Nigel responded that: ‘I would explore the possibility of the Rural Forum having observer status on Council, but as mentioned in our discussion, there are other College special-interest groups also seeking member or observer status on Council’.

Rob described his practice in Wooler, Northumberland which reflects many of the rural practices in the UK. They are two hours plus from the nearest District General Hospital so have many more challenges. Like Rob’s practice many are small with few colleagues to discuss and are isolated and often have poor broadband facilities.

The financial history of the Rural Forum is that originally, they were given an annual budget of £6835 which covered telephone conferencing, face to face meetings and subsistence. This figure did not include the administrator’s salary. Although Rob was informed at the meeting with Simon Ashmore that the figure had increased to £9000 P.A. this now included the administrator’s salary, which the group had not been made aware of, so this was naturally disappointing.
The high points over the past year:

- Attended the All Party Parliamentary Group – Felt listened to and had discussion with Stephen Dorrell
- Invited to NHS National Insurance Research Meeting – Felt valued
- Extended training posts in Cumbria and Northumbria

Mark Thomas informed the group that the College have an internal consultation on local structures since a large number of members are not engaged with the Faculties. Mark suggested that the RFSG respond to the internal consultation. The group discussed why they felt the Rural Forum should have a seat on UK Council. It was agreed that the Rural Forum submit their case on the local structures and reiterate why they should have a seat on UK Council.

10. **ED WILSON – HEAD OF DEVOLVED COUNCILS**

Apologies were received from Ed Wilson.

11. **NORTHERN IRELAND REPORT – DR MIRIAM DOLAN**

The new Northern Ireland representative on the RFSG, Miriam Dolan reported that in Northern Ireland there is still the ongoing problem of recruitment and retention and the fact that Northern Ireland have the oldest cohort of GPs in the UK is adding to the problem. Smaller rural practices are failing to attract GPs. The Bengoa Report produced last year has changed the way care can be delivered. Previously care was too secondary care focussed, but the report has addressed this.

There are Federations up and running in Fermanagh with Clinical Pharmacists in practices. This is proving very positive from a workload perspective. Other practices in Fermanagh are still struggling with 3-4 closing.

More medical student placements at Queen’s University is a positive outcome which will hopefully result in more GP placements.

As always general practice has lots of challenges ahead. Miriam feels her new role is to engage with the Rural Forum and local structures. Miriam has a seat on Northern Ireland Council. She suggested that Sharing Good Practice should be a future agenda item on the Rural Forum agenda. What works in Rural Practice?

Mark informed the group that the College have a plan in place to have a portal both for urban and rural GPs, which they can access.

12. **SCOTLAND REPORT – DR HAL MAXWELL & CHRIS WILLIAMS**

Hal Maxwell reported the main issue of note in Scotland has been the new GMS/PMS contract which has been the main focus of activity for the SGPC.

There was a special Scottish LMC conference on 1 December to debate the contract provisions so far. The contract has been broken into two phases:

Phase 1 essentially starting the process with the introduction of a new workload allocation formula (WAF), a guaranteed minimum income per GP with an adjustment factor for those practices for whom the WAF fails to deliver an uplift and an investment pot to primary care to start the process of development of the expanded workforce to support practices. Phase 1 also introduced a phased loan system to allow practices to buy out of premises ownership & eventually pass the responsibility to Health Boards.

Phase 2 is to look at specific issues including dispensing and rural workload & funding and a move towards a full reimbursement of all practice expenses. Both SGPC & the Scottish Government are adamant that this is not a move to a salaried service but there is some scepticism amongst practices.
Phase 1 went out to ballot in December and the results of this supported the acceptance of the contract, although the ‘turnout’ for the poll was lower than would have been hoped. As phase 1 was accepted then negotiations around phase 2 will proceed. A short life working group (SLWG) is to be convened to look at rural issues, with representation from the Remote GP Association of Scotland (RGPAS) and the Dispensing Doctors Association.

The WAF has produced a very stark division in funding with the central belt seeing an uplift but rural & ‘deep end’ practices seeing no uplift and a dependence upon an adjustment factor payment to retain existing funding levels. There has been a great deal of disquiet (putting it mildly) amongst both rural GPs, as represented by RGPAS - http://ruralgp.com/ and the ‘deep end’ practices the latter who have stated that:

**The binary choice of voting for the status quo or voting YES to Phase 1 of the proposed contract is now unacceptable given the inherent bias within the SWAF. The DE Steering Group has argued that the SWAF should be reworked, it has proved to be divisive and in some practice the finance allocations defy logic. We would support a formula that functions as an economic tool to address inequity of funding across general practice – rural, urban, affluent and deprived.**

Given the failings of the WAF then there is probably a need to try and highlight just what defines workload in both rural & deep end practices and there may be scope for further academic review around this issue.

Chris Williams informed the group that a poll conducted on the new Scottish GP Contract has caused real division and unhappiness, particularly in rural areas. The Rural Short Life Working Group have been identified by the contract. Results are as evidence-based as possible with the College remaining impartial with the Scottish Contract.

12a. **HMRC IR35 RULE CHANGE**

Malcolm Ward started the debate off regarding the HMRC IR35 rule changes. He described to the group that he feels it is an anti-avoidance tax legislation. The changes in which sessional GPs are paid by an intermediary leaving the sessional GPs responsible for being taxed at source. A number of maverick health boards have applied this inappropriately and the debate is ongoing. Essentially the Health Boards are treating sessional GPs as salaried employed and not self-employed. 13% of income is being deducted in National Insurance contributions causing confusion. Payment is being made through payroll as though the sessional GPs are salaried, but without the benefits of being an employee. The net amount of salary is greatly reduced. Lots of locums are affected. Tools provided by HMRC are not particularly helpful. Malcolm enquired if anyone know if the BMA are taking this forward. Unfortunately, this is not the case.

13. **WALES REPORT – DR MELANIE PLANT**

The Welsh Government is strongly committed to the NHS and has legislation in place which makes it very difficult to use any private company to provide NHS services. However, Wales only trains a small number of doctors and is struggling to recruit to all rural hospitals and GP practices in general but the lack of GPs has been seen over the last 5 years in rural areas. This has led to practice closures in Betsi Cadwaller. Powys, Ceredigion and Hwyl Dda and even in Cardiff. There is now toxic stress in the working life of GPs and cases of GPs losing their homes and pensions when the practice closes. Wales are looking at practice property but no decisions have yet been made.

The various areas have responded with various solutions with Powys working along the concept of piloted services which can be ‘picked’ by practices depending on need e.g. pharmacy input supporting clinical work, front line physio services, mental health workers front line, ANP and Paramedics as well as Physician’s Assistants in the Primary Care Team. What is clear is that these other clinicians need mentoring and experience in primary care before they are useful members of the team. Training in primary care and courses aimed at preparing clinicians for primary care are non-existent and practices cannot afford the time and expense of training new staff. It is also now clear that the GP role in managing, supporting and being responsible for the patients seen by those other clinicians requires a mutual respect and trust for this to work hence a ‘new’ paramedic arriving in a team to undertake visits on behalf of the GP cannot be an instant fix.
There is also recognition that e.g. the physio service- a physio sees a front-line GP patient in 40 minutes. A GP takes 5 minutes to assess and send the same patient with advice to physio. What the patient experiences is of course different and the physio reduces the referrals in to the physio department saving money for the LHB. Hence a practice needing support from a physio should partially fund the post but the LHB should also fund the post. This is not yet widely accepted.

The sustainability framework brought in to support practices struggling financially as MPIG was removed is a problem. The way this funding is allocated and decided is not transparent and the applicants are not invited to meetings. There is an emphasis on the funding being a one off to initiate a change that makes the practice sustainable. The new GP contract disadvantaged rural practices and included no funding for branch surgeries hence that view of sustainable funding will never be achieved. Practices in rural Wales cover large areas with patients scattered throughout the area. Our practice covers 600 square miles with 2 fully functional branch surgeries. Visits can take 1 hour driving. There remains little recognition that rural practices provide all services from that provided by pharmacies to emergency care with all the rest in between for the same funding provided to single site practices providing only GMS and LES services. Added to this burden is the now routine 3-4 hours wait for 999 and urgent ambulances which increases the stress and strain within the teams.

Recruitment remains at crisis level. Cardiff has declared that it is prioritising students from rural backgrounds but this is not being seen in North Powys. The issue remains that rural children have lower expectations of achievement within the school and have little preparation for the hoop jumping interviews which other schools fully prep for. Rural children travel 6 hours a day to attend ‘high level’ courses and talks e.g. ‘seren’ network. There needs to be an awareness of how far the rural child travels and what could reduce that travelling as well as a recognition and allowance of the communities and the attitudes they come from or we will never get children from rural areas getting into medical schools. The RCGP has run one course now for 6th form students in north Powys but this needs to be replicated in all areas and more than one event. Careers masters in the schools need to be contacted and supported.

OOH provision is a massive threat. 111 is being pushed as a solution by the Welsh Government but it is not an effective triage service and the algorithms do not work for elderly frail, palliative or children with cases of inappropriate admissions overuse of ambulances and A and E services, as well as most patients still needing a proper triage. Shropdoc a gold standard GP led service which covers Powys and is integrated into daytime services is now in difficulty financially for many reasons. Powys LHB held an options appraisal meeting regarding OOH to which 2 GPs were invited - one had no OOH experience and emailed as he was unable to go to the meeting but no one else was invited, the other GP was emailed the day before the meeting to say it was cancelled. It is unclear who was at the meeting or what was discussed but the decision was made that Powys would run its own OOH services from September with a July to September transition. This service would rely on Powys GPs. This would effectively end GP services in Powys as there are not enough GPs to run an OOH service and an in hours service and the current strain on practices and GPs who live in their practice areas means there is no capacity to take this on nor the wish to. It has been intimated by the LHB that GPs will be ‘made’ to participate. This would lead to many ‘throwing in the towel’. It is being discussed at the LMC in Chester today. It is though a major crisis for the area.

14. **ENGLAND REPORT – DR CHRIS CLARK**

Chris Clark reported Recruitment and Retention is the overarching challenge across the South West, you will not be surprised to learn.

2016 Figures suggest that 91% of training posts across the region are filled. Neither the best nor worst figures for England. Within this figure there are local areas of low uptake, all of which are areas of rurality – central Somerset, North Devon and Cornwall. These areas have recently been able to offer £20k “golden hello” payments to potential trainees with some anecdotal evidence of impact – too early to say for sure.

Retention is a challenge not confined to rural areas. I know of posts unfilled for up to 2 years in St Ives for example. Arguably one of the most desirable destinations in Cornwall. Reason for failure to retain was remoteness.

Retention overall will challenge our area going forwards: A recent large study from our
department reveals that 20% of GPs intend to quit direct patient care within 2 years and 40% within 5 years. Desire to quit rises rapidly beyond age 52 – younger than previously found.¹

Couple this with the difficulty in recruiting trainees and the challenge is clear.

University of Exeter is bidding for additional medical student places on the background of delivering graduates interested in primary care. Tamar Faculty is working actively to develop resources and contacts to facilitate work experience in primary care, including rural. Work experience applicants currently find difficulty in gaining exposure due to concerns over indemnity, confidentiality and time availability.


15. **AGM**

Agenda item carried forward.

16. **INTERNATIONAL REPORT – WONCA**

John Wynn-Jones report attached.

17. **EURIPA – NEXT RURAL HEALTH FORUM**

Jane informed the group that the next EURIPA Annual Health Forum is due to take place in Israel on 14-16 November 2018. The theme will focus on caring for the elderly and rural.

Jane also mentioned the French General Practice Conference which is due to take place on 5-7 April 2018 in Paris.

18. **LINKS WITH OUTSIDE ORGANISATIONS**

The Rural Forum already have meaningful links with outside organisations including WONCA, EURIPA, BASICS Scotland, UCLAN to name a few. Rob to email group list of contacts to which they can add to list in an email discussion.

19. **DR FRANCES GERRARD, DIRECTOR OF COMMUNITY CLINICAL LEARNING**

Frances informed the group of her role. I have overall responsibility with a team of other academic GPs for clinical placements in the community (with a heavy emphasis on general practice). Cardiff University School of Medicine is the only medical school available in Wales to applicants with A levels, although we work collaboratively with the Graduate Medical School at the University of Swansea.

There is a dearth of Welsh domiciled applicants applying to medicine – only 572 last year (about 580 this year) and only about half apply to Cardiff at all, although we are engaged in an active outreach policy and Widening Access initiatives. to increase Welsh applicants applying to medicine. The majority of undergraduates at the medical school currently originate from England, although approximately 30% come from Wales in recent years.

As an all Wales medical school one of the challenges with placements is poor north to south connections by public transport.

Wales has two official languages, Welsh and English, and Cardiff School of Medicine is pro-active in supporting students with Welsh language and learners in its curriculum, as it recognises the importance of Welsh speakers being able to be supported in their health needs in their chosen language.

The undergraduate curriculum for medicine changed in 2012 to incorporate case-based learning, and medical students have their first clinical exposure in primary care from Year 1. There are optional (student selected component) placements in general practice through the first four years of the course. Although all students spend two months in general practice in their final year, earlier placements are currently shorter and two initiatives have been developed to increase teaching through General Practice - one is replacing an eight week hospital based block in Year 3 with GP for an increasing proportion of students, and
the second is a new longitudinal integrated clerkship being piloted for 13 Year 3 students from the autumn 2018 in Bangor and Aberystwyth where students have most of their learning for a year based in primary care. This is based on established in Australia, Canada and the USA and being piloted by Dundee University. Cardiff University School of medicine is supportive of the need to recruit and retain doctors to all parts of Wales and promote General Practice as an important career option

**UNDERGRADUATE TRAINING – ROSANNAH JACKSON & MICHAEL CRITCHELL**

Rosannah and Mike informed the group about their positive experience at Aberdeen University as medical students and what is on offer to them if they decide to choose General Practice as their specialty.

During their fourth year (they are currently second year medical students) which is split into 9 five week blocks, ALL medical students will spend one or two blocks based in Inverness and if they decide to do a GP placement while there, they will experience remote and rural GP.

The Remote and Rural Programme is unique to Aberdeen University. The students are given the opportunity to spend the whole of their fourth year based in Inverness. The rotations are attached to Community Hospitals and GP Practices in the Highlands and Islands with regular sessions in Inverness. You will receive tutorials on:

- The challenges of Remote and Rural Medicine
- Remote and Rural Career Paths
- Winter Mountain Skills
- Pre-Hospital Emergency Care

During their fifth year they would experience eight week placements with the opportunity to do a placement at a peripheral site.

- Hospital placements: Inverness, Elgin, Wick, Fort William, Western Isles and Shetland
- General Practice Placements: Grampian, Highland, Western Isles, Orkney, Argyll and Dumfries and Galloway

While in Inverness

- Placements in Medicine, Surgery, Psychiatry and GP
- Tutorials, bedside teaching and theatre sessions
- Opportunity to experience medicine in R and R areas
- Learn about issues specific to living and practising in rural areas
- Develop different skills in pre-hospital care

In their year one they were given the opportunity to attend Aviemore Expedition in April 2017. This expedition was funded by a donation from a ‘patient partner’ The 2-day expedition in the Cairngorms was to experience R and R GP, Community Hospitals and the R and R lifestyle. This included:

- ‘Speed dating’ activity with rural GPs
- Presentation from rural GPs
- History taking
- First aid training
- Outdoor activities

Presentation attached

**MEMBERSHIP EXPERIENCE – JAMES ROBERTS**

James reported on the Membership Survey to the group. It was split into segmentation and profiling of the members. He informed the group that the relationship with College and its members has positives and negatives. It recognises that Rural GPs, OOHs and Locums have distinct, different needs. The College are launching a new database in May this year which should prove more interactive.

Chris Bull, Student Engagement Manager at the College is hosting 7 regional conferences between March-May and he would be more than willing to promote rural general practice at these.
The College are trying to attract GPs to re-join the College and have found that there are large GP practices where none of the GPs have never been members whereas practices with 4 or fewer GPs are more inclined to re-join.

There is a new Mentoring Scheme being piloted in four Faculties for First5 members, which will have accredited mentors, properly supporting volunteers as a College voluntary organisation.

James spoke about the RCGP Local Support Research Findings report which asked members what could be done locally and how the College could provide this. James will circulate this report to the RFSG. (report attached)

22. **MEMBERSHIP UPDATE**

Paula circulated documentation with data from August 2017 and January 2018 to reflect RFSG membership.

23. **RURAL FORUM CONFERENCE FEBRUARY 2019**

Jane Randall-Smith had explored holding the Conference next year at Shropshire Education Centre, but this was not viable. Jane will make enquiries with Chester University at their new centre in Shrewsbury. Jane will feedback on this. To be discussed at next telephone conference.

24. **RCGP ANNUAL CONFERENCE 2018**

To be discussed at next telephone conference

25. **WHERE WE WANT TO BE AND HOW WE GET THERE - ASPIRATIONS**

Rob asked the group to list their aspirations. These include:

- Rural Faculty
- Voting seat on Council
- Strengthen links with Deaneries
- Training of Advanced Practitioners
- Workforce fit for purpose
- Local structures
- Rural report for Council (Helen’s suggestion)
- Stronger influence over other work happening within the College
- Rural proof activities within the College
- Rural Forum rep on Membership Experience Board. Equity, age, gender; has a youth focus to it
- Communicating with Rural Forum Membership
- Videoconferencing

26. **ANY OTHER BUSINESS**

No other business to report

27. **DATE OF NEXT TELEPHONE CONFERENCE/FACE TO FACE MEETING**

To be discussed