

RURAL PROOFING THE NEW GMS CONTRACT

Institute of Rural Health

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1.0 INTRODUCTION

This report examines the new GMS contract from the rural perspective. Primary care is an essential part of health service delivery and in rural and remote parts of the UK it is the mainstay of health care provision (Cox, 1995). Certainly in the past (and to a large extent at present), there has been a tendency to take a 'one size fits all' approach to the development of policy and an assumption that services and policies developed on the basis of evidence from urban areas will be readily applied in rural areas. There is increasing recognition that this is not the case and organisations such as the Institute of Rural Health are helping to build the evidence base on rural health issues to inform the development of rurally sensitive policy and practice.

The new GMS contract has considerable implications for GPs, practice staff, patients and primary care organisations and these will have been considered to varying degrees during the development and negotiation of the contract. However, an assessment of the contract from the rural perspective has not been formally undertaken. At the time of writing it is still early days in the implementation of the new contract and there will need to be long term evaluation as to the impacts of the changes on patients, practitioners and organisations. Nevertheless it is important to examine the contract with a view to its potential impacts (both positive and negative) on rural communities so that long-term evaluation can focus on important issues for rural areas and that GPs, practices and patients can consider ways of maximising benefits or minimising disadvantages as appropriate.

This piece of work has been funded by the General Practitioners' Defence Fund and been carried out by the Institute of Rural Health (IRH). The IRH is working for the sustainable health and well-being of people and communities in rural areas through three key areas of activity: research, education, and policy analysis.

1.1 What is Rural Proofing?

In 2000 the Government presented the rural white paper entitled "Our countryside: the future – A fair deal for rural England". The white paper set out a vision for rural England and developed ten themes as a platform to enhance and sustain rural areas. These ten themes were developed to:

1. Support vital village services
2. Modernise rural services
3. Provide affordable homes
4. Deliver local transport solutions
5. Rejuvenate market towns and a thriving local economy
6. Set a new direction for farming
7. Preserve what makes rural England special
8. Ensure everyone can enjoy an accessible countryside
9. Give local power to country towns and villages
10. Think rural

(Department for the Environment, Transport and the Regions, 2000)

Included in the future objectives for rural policy were the desires to: facilitate sustainable economies; secure equitable access to services for people living in rural areas; to conserve rural landscapes and habitats; increase opportunities for all people to enjoy the countryside; and develop better links between the government and rural communities by developing closer working arrangements between government departments, local authorities and other non-governmental agencies. These objectives were developed following responses from rural people and communities to a consultation document (DETR, 1999).

Rural proofing was developed by the Countryside Agency in England following the publication of the Rural White Paper, which set out the Government's commitment to ensure its policies take account of the specific needs of rural areas. The Countryside Agency, which was set up as a consequence of the white paper, has developed a checklist, which comprises a list of questions for agencies to address when deciding on policy to ensure that the needs of the population in rural areas are considered. Rural Proofing is currently a statutory requirement at government departmental level. The statutory process means that there is a methodology to measure the impact of policy in rural areas.

Rural Proofing states that policy makers should systematically

- Think about whether there will be any significant differentials in rural areas
- If there are any such impacts assess what these might be
- Consider what adjustments or compensations might be made to fit rural circumstances

(Countryside Agency, 2004)

Rural Proofing should be applied to all policies and should be built into programme and policy design prior to implementation. There is also a requirement for all government departments to produce an annual report about their approach to rural proofing and an annual assessment of the rural proofing process is published by the Countryside Agency. As well as the requirement for all Whitehall departments to rural proof their policies, there is now an obligation for the process to be adopted in the Government Offices for the Regions. These regional offices are expected to work with other local agencies to encourage policy implementation that is equitable in rural communities. Rural Affairs Forums, which bring together key stakeholders in each region can use rural proofing to influence regional and local policy development. It is important to engage senior officials in the rural proofing process in order that the initiative is cascaded down through the system and so there can be a champion of rural affairs within each department. It is also important that the process is seen as an aid to policy development to ensure appropriate implementation in rural areas.

Rural Proofing for Health is an initiative of the Institute of Rural Health which commenced following the publication of 'Think Rural Health' (2002). Funding was obtained from the Department of Health and latterly from Defra

(Department for the Environment, Food and Rural Affairs) to develop a Rural Proofing for Health toolkit to enable Primary Care Organisations (PCOs) to implement policies that are rurally sensitive and to help achieve equitable access to health services for all people living in rural and remote communities. The initial stages of the project involved developing the evidence base and a questionnaire was sent to 60 rural Primary Care Trusts (PCTs) in England to establish the challenges that they face in delivering services to rural populations. An analysis was carried out and the results published as a briefing paper (2003). There has also been more in depth work carried out in collaboration with three PCTs to further develop the evidence base. The final stage of the project is currently underway to develop the different sections of the toolkit and to trial and validate it with the participating PCTs. The toolkit sections will consist of questions to be answered about the likely impact of policies on people living in rural and remote areas. There will also be solutions to policy implementation and examples of good practice. The aim of rural proofing for health is to ensure that local health policy and methods of delivery are rurally sensitive.

1.2 Aim of the report

The aim of this work has been to answer the following question:

What are the implications of the nGMS contract for rural GPs, rural primary care services and rural patients in the UK?

It must be emphasised that this report only takes the rural proofing process so far. An integral part of rural proofing is to adjust the policy in light of findings, and with respect to this piece of work that is therefore the responsibility of others. This report presents the results of a formal rural proofing process and makes recommendations about how to tackle the rural implications.

2.0 METHODS

Rural proofing, as developed by the Countryside Agency, is a robust and systematic assessment of policy. The methods for this study are based on the rural proofing approach and further detail about the Countryside Agency Rural Proofing – policy makers checklist can be found at www.countryside.gov.uk. For this project, the methodology can be split into four stages.

Stage 1 - Core team to read and rural proof the nGMS contract

Three members of staff from IRH form the core team to undertake the rural proofing:

- Dr Jenny Deaville, Research Manager
- Kate Mitchinson, Policy Manager
- Helen Swindlehurst, Rural Proofing Officer

Over a series of 5 working meetings, the team read the full GMS contract in detail and applied the Countryside Agency's rural proofing checklist systematically to each chapter.

Stage 2 Gathering expert opinion

To assess the impact of the nGMS contract across the UK the core team felt it important to obtain feedback from those actively involved in implementing the new GMS contract. A questionnaire (see Appendix) was sent out to the following groups:

- Rural group of the Royal College of General Practitioners
- A sample of 30 rural Primary Care Organisations (PCOs) across England (22), Wales (3), Scotland (4) and Northern Ireland (1).

Eight responses were received in relation to the survey of Primary care Organisations, 2 from Wales, 1 from Scotland and 5 from England.

The results were collated and the comments have been used to illustrate key points arising in the rural proofing process. Comments are provided in italics in the key findings section.

Stage 3 Validation of findings with rural GPs

The results of the rural proofing process and the feedback from the survey of experts have been written up in a final report. This report will be presented to a meeting of the Rural Practice Sub-committee of the General Practitioners Committee (BMA). Members of this sub-committee represent the spectrum of rural general practice and therefore will be able to assess the main findings of the report against their own experiences of implementing the contract.

Stage 4 Preparation of final report and dissemination

The findings of the meeting with the Rural Practice Sub-Committee are summarised and included in this final report. The findings of the report will have relevance to all rural primary care practitioners and organisations in the UK in addition to policy makers at national level. It is intended that the report be disseminated widely.

3.0 KEY FINDINGS

It is clear from the rural proofing process that the new GMS contract has the potential of having both positive and negative impacts on rural GPs, practices, patients and PCOs. The main points are outlined below along with the key emerging recommendations.

3.1 The availability of services

Historically, rural and remote practices have offered a wide range of services to meet the needs of their communities (Deaville, 2001). This is because they have often been the only local provider of health care. Many of the services traditionally provided by rural practice (such as minor surgery) are within the 'additional' and 'enhanced' service categories and so under the new GMS contract there is an opportunity to recognise and reward practices for offering these services.

Some of the respondents to the questionnaire acknowledged this positive aspect:

The new GMS contract has allowed GPs in rural areas to be remunerated for work previously undertaken through good will, eg minor injuries, first responder.

Rural GPs will at last be rewarded for the complete holistic type of service they have traditionally provided outwith GMS services through the enhanced services budget, hopefully compensating for lower incomes due to lower list sizes.

In addition to the potential to recognise existing services, the new contract also allows for the development of new services to meet the needs of local people:

Increased availability of enhanced services, ie the chance to provide services more locally.

The new GMS contract has taken some services nearer to rural patients through the introduction of enhanced services eg anticoagulation and near patient testing. There is no evidence that rural patients have been disadvantaged.

The introduction of enhanced services will encourage the provision of non GMS services for rural patients close to home....

However, despite these potential positive impacts, in practice there appear to be some real concerns about the finance available for enhanced services and the knock on effect that this will have on rural communities. PCOs have a fixed budget for enhanced services and so, whilst in the past rural practice would perform, for example, the number of minor operations required by their patients, there is now the potential for PCOs to cap these services where there are funding constraints. This has a disproportionate impact on rural patients as they have a lack of choice of other providers. This issue was mentioned by a large number of respondents:

Unfortunately it looks as if there are insufficient funds to pay for enhanced services adequately and this may actually result in withdrawal of services previously provided on a goodwill basis.

As certain enhanced services seem not to be funded..... patients face having to travel considerable distances to secondary care facilities for services which used to be offered by their GPs.

Some GPs are not being paid for the minor injuries they do and a few GPs have withdrawn the service (or at least threaten to).

Several of the respondents felt this placed them in a very difficult position:

Quality services already being delivered are not covered by enough resources under enhanced services (moral dilemma – continue without payment or stop).

Rural GPs in general have already been providing quality outcomes above the levels in the new contract and also provided many of what are now badged 'enhanced services'. There is not enough money to pay for what rural GPs provide now. This leaves them with a moral dilemma.

One respondent has made the decision to continue providing the same level of service for their patients without funding:

Negative impact is the loss of funded minor injuries service for our practice (at present we will continue to provide this service unfunded.... as we feel it is part of our remit as rural GPs.

The following respondent summed up this dichotomy between the potential benefits of the new contract and the reality of its implementation, which has real disadvantages for rural patients:

If the Health Boards do allow more services to be carried out locally rural patients may have less to travel for certain procedures. However our health board has already advised that our patients should go to the Minor Injuries Unit at the hospital and are not releasing the funding to allow us to provide this service. This is a decrease in our service provision and I have grave concerns that this will be used as a reason for further centralisation of services.

In addition, there is a potential risk for the reduction of additional services to rural patients. GPs are now able to opt out of additional services, and whilst the PCO has a duty to ensure that these services are available elsewhere this may mean that patients now have to travel greater distances than was previously the case. Whilst it is unlikely that rural GPs will opt out of providing key additional services to their patients, it is theoretically possible and would have a detrimental impact on rural patients who have limited choice of health care provider. It would have a particularly negative impact on women and children and older people experiencing social exclusion as 'additional services' focus on services for these sections of the community. This issue was not raised as a concern in the survey with rural GPs and PCOs, but was identified as a theoretical concern during the rural proofing phase.

Recommendations

For rural PCOs there is the opportunity to commission locally relevant enhanced services. PCOs should take the opportunity to develop appropriate services at a local level in rural communities fostering development, innovation and good practice, eg providing new IT infrastructures, telemedicine, development of community hospitals to provide intermediate care.

Maximum distances should be considered for access to particular services, (for example minor injuries, minor surgery, child health surveillance etc) and standards set which are linked to funding.

3.2 Out of hours

The new Out of Hours (OOH) arrangements have meant a significant change to the service received by patients. Whilst in many urban areas deputising services and co-operatives have been in operation for a while, many rural patients have continued to receive the OOH services provided by their own practice. This means that with the new contract the change will be felt more keenly by rural patients who for the first time will no longer see their own GP or a GP from their practice but will have to travel to a primary care centre to seek care. This centralisation of services is likely to mean that most rural patients will have to travel further to access OOH. This may lead to patients not accessing care when necessary and result in poorer health outcomes. Studies have shown that distance decay (decreasing utilisation with increasing distance from the service) occurs for both primary and secondary care (Higgs, 1999) and it would be worthwhile undertaking research to assess whether distance decay occurs in relation to accessing OOH.

Most of the respondents to the questionnaire raised the issue of OOH cover as being the most significant change to affect rural practice and rural patients. Many of the concerns were about the resourcing of the new OOH arrangements and whether it will provide an adequate service.

OOH cover – is extremely difficult to deliver an equivalent service. Especially Sat AM where a lot of patients work away all week and previously used Sat AM as an open access slot.

The rural patients are potentially seriously disadvantaged by the lack of easy and immediate access to quality primary care.

One respondent recognised this challenge but also felt that there could be positive outcomes as a result.

Out of hours services will be particularly challenging in rural areas – ensuring adequate coverage within available resources. However this situation should lead to more productive alliances with ambulance and other out of hours providers and a more integrated service ultimately.

There were also concerns that rural patients would be less likely to receive a home visit under the new system.

Considerable worries over the safety of OOH services.... It seems rural patients are less frequently visited...

Although the out of hours centres say they will treat all patients equally, and they are able to visit, realism suggests it is very unlikely that they are going to visit patients who may take 3-4 hour round trips when there is only one doctor covering a primary out of hours centre. Whereas a similar condition close to the centre may well be visited, the remote and rural patient is much more likely to be 'scooped and run' by an ambulance service which will be pretty stretched, as there is little or no extra resource going into the ambulance service at this point in time.

The last quote also raises the concern aired by other respondents that the ambulance service is being required more by the new OOH arrangements and that this means there is less capacity to react to emergency calls.

The board....abdicates all responsibility for blue light life threatening emergencies to an Ambulance service that already cannot meet its statutory obligations.

A final area of concern is that whilst local rural GPs are familiar with their terrain, the new OOH providers may not be aware of the geography of an area or local weather conditions.

Increased reliance on OOH providers that may not understand rurality and the difficulty of many patients.

It is not clear whether NHS24 is capable of making appropriate decisions for patients in the light of the complexity of local geography, weather and service provision.

Many of the respondents recognised that it is still relatively early in the implementation of the new OOH arrangements and that it will take time to fully assess the impacts for rural patients and rural GPs. It is important that these are monitored and evaluated in future.

Recommendations

The impact of the new OOH arrangements should be monitored and evaluated. This should include mapping new service configurations and examining all aspects of access to the service, for example measuring demand on ambulance services, use of patient transport vehicles and levels of home visits for comparable health issues.

PCOs should examine the unit cost of delivering OOH in rural areas where the geography and road networks lead to higher costs.

If PCOs work in partnership with local ambulance trusts there is an opportunity to maximise use of patient transport vehicles for transportation of staff and equipment out to patients or to transport patients into primary care centres.

There should be greater clarity over what constitutes a remote or isolated area in order that those areas affected can have a protected service.

Research is required into the knowledge and attitudes of GPs to geography and access issues and into the impact of the new OOH services on uptake (eg distance decay). Travel time rather than distance should be used as the measure for access.

3.3 The investment in and use of Information Management and Technology

Under chapter 4 of the new GMS contract plans for developing IM&T systems are outlined under a national IM&T programme. PCOs will be responsible for funding the purchase, maintenance, upgrading and running costs of integrated IT systems in addition to telecommunications. New investment in IM&T has the potential to benefit rural practice through greater access to information and other resources and better communications systems. This could have positive knock on benefits for education and training, reducing professional isolation, research, and reducing travel for meetings. Rural practice however could also be comparatively disadvantaged due to the slower introduction of broadband in many rural and especially remote areas and this should be recognised by PCOs in planning their investment in IM&T.

Improved technology and investment in IM&T could also facilitate the development of a single patient record, which could reduce unnecessary visits and would have a more significant impact in rural areas. Research and development into this should be encouraged.

Only a few of the respondents to the survey raised the investment in IM&T as an issue for rural practice and these were to raise concerns about the level of funding available.

The new contract requires a good computer network and we have had a number of very concerning problems with our software packages. We have explored changing to other systems but there is no new money to allow this change to take place.

Recommendations

PCOs should monitor the effect of access to broadband in rural practices and take into account that not all practices will have access to broadband at the present time.

Research and development into the single patient record should be conducted.

3.4 Resourcing rural primary care

The new contract sees a large investment and expenditure on primary care from 2003 to 2006, which should benefit all patients. It can be argued that this may be felt even more strongly in rural areas where there is the potential for the funding to be used to provide a wider range of services at a local level.

Under the previous funding mechanisms it has been argued that rural practices were disadvantaged financially as additional payments were made for deprivation based on the Jarman Index which was inherently biased towards urban areas (Deaville, 2001). Under the new funding formula (Carr-Hill), additional needs are measured directly through morbidity and mortality data and therefore this should be an improvement in the recognition of health needs in rural areas. However it should be recognised that morbidity data is largely a reflection of the utilisation of services and that this may still disadvantage rural areas where there is evidence of a culture of self reliance (Boulanger, 1999) and patients seek help at a later stage in disease development (for example cancer, Campbell et al, 2000). Consequently there is potentially a higher level of unmet need in rural communities, which will not be recognised in the distribution of funding.

It is positive to note that rurality is also explicitly recognised in the new formula, replacing the existing scheme which was based on mileage payments. The new formula is based on GP expenses as an indication of unavoidable costs related to delivering services, in addition to population density and dispersion. It is beyond the scope of this study to undertake an in depth analysis of this new method of assessing the extra costs associated with rurality and further research is recommended. As the new contract beds in, it will become evident to rural practices whether they feel that they are adequately funded to counteract the extra costs associated with rurality and it is worth returning to this issue in the medium and long term. However, at the

outset there appears to be negative feeling among rural GPs in relation to the funding of rural practice.

More money is needed to service a sparse population. If there is no more cash for rural areas then services will be inferior to urban equivalents.

No account taken of rural deprivation and the extra cost of providing care over several thousand square miles.

Not clear yet whether replacement of rural mileage payments by global sum will financially disadvantage rural practices and therefore patients.

The financial impact of diseconomies of scale was also considered in the new funding mechanisms due to the recognition that small practices would incur disproportionately high expenses. A strong diseconomies of scale effect was identified for low list sizes, and that this would have a negative impact on the distribution of the global sum across all practices, therefore no allowance for diseconomies of scale has been allowed due to the fear that it would encourage practices to disaggregate or avoid amalgamation. It is difficult to assess whether this has particularly disadvantaged rural areas. Whilst many rural practices do have low list sizes there are also many single handed and small practices in urban areas where property prices and rentals are arguably higher. However it is clear that some rural GPs do feel let down by the lack of allowance for diseconomies of scale.

Robbed by the failure of Carr-Hill, especially the removal of diseconomies of scale element.

Recommendations

Consider evidence for unmet health need in rural areas and feed into the review of the Carr-Hill formula in 2005/6, paying particular attention to the effectiveness of morbidity data as a direct measure of health need given that it is largely based on utilisation of services.

Research needs to be undertaken into the effect of the Carr-Hill formula on rural resource allocation and rural practice.

It is uncertain whether the new contract will ensure the viability of rural practice (standing alone from income generated from dispensing). Therefore it is recommended that the situation is monitored in the longer term particularly as the new de-regulation of pharmacies impacts on dispensing practices.

3.5 Professional issues for rural GPs

The recruitment challenges that have faced general practice in the UK in recent years have been particularly acute in rural areas. Rural general practice is sometimes seen as a backwater, and rural practice has been less able to take advantage of deputising services or co-operatives to cover the out-of-hours commitment. The new contract brings in a number of changes that will potentially make rural general practice more attractive and may have a positive impact on recruitment. For example, all but the remotest GPs are now able to opt out of OOH so reducing the workload;

Rural GPs would have been a dying breed but for OOH co-ops and now under GMS the right to contract out of OOH services. It is difficult enough to attract professionals to [a rural area] due to poor facilities, poor roads, poor railway connections, lack of housing, lack of jobs for family members...

Ability to opt out of providing 24hr cover for their patients is a real boon

Wonderful to be clear of on-call

However whilst many rural GPs see the removal of OOH responsibility as a benefit and a solution to recruitment and retention difficulties, some rural GPs see the changes as a decline of what they see as the traditional rural doctor.

I think there is a feeling of shock amongst rural GPs that their traditional hard working way of life has suddenly been totally devalued and the traditions which are based on intimate knowledge of patients and communities are undervalued for tick-boxing of numbers and a centralisation of services to primary care centres.

It is interesting to note this dichotomy in views; some feel that the new contract will save rural practice whilst others feel that it is devaluing the traditional vocation of a rural GP.

The new contract lays out a clearer career structure, improved access to CPD, research and information resources through investment in IT and protected learning time for GPs and practice staff. There is therefore considerable potential for improvement in the working environment for rural GPs with a consequent knock on impact on recruitment. It is also positive to note the recognition given in the new contract that practices in rural and remote areas may not have the same options as other areas and therefore will require additional support which will need to be provided by PCOs. However many of these changes will be down to the local PCO and there may consequently be different experiences across the UK. It will be important to monitor and evaluate the support given by PCOs across the UK to their rural practices. At this early stage there appear to be positive experiences from rural GPs in relation to the support from their PCO:

Seem to have a PCT which is looking imaginatively at reconfiguring services from secondary to primary care with the possibility of proper resources.

Relationships with GPs have been close, supportive and generally mutually beneficial.

Recommendations

Monitor the support provided by PCOs to rural practices across the UK.

PCOs and practices should seize the opportunities within the new contract to ensure that rural practice is sustainable and offers an attractive career option for those entering general practice.

The implementation of new IM&T structures across the whole of the UK offers the potential to develop innovative solutions to overcome professional isolation.

3.6 The impact on rural patients

3.6.1 Improved local provision of services for patients

For rural patients the new GMS contract has the potential to have a significant positive impact. Significant investment in primary care may see the provision of a wider range of services delivered at a local level. The new contract also supports the development of initiatives such as the 'expert patient programme' and facilitating partnership working between patients and practitioners to improve self-management of long term conditions. The result of this should be that management of chronic conditions is available more locally and so will reduce the need for patients to travel long distances to secondary care facilities.

If the Health Boards do allow more services to be carried out locally rural patients may have less to travel for certain procedures.

Increased availability of 'enhanced services' ie the chance to provide services more locally.

The thrust of the new contract encourages chronic disease management to be as close to the patient as possible and this obviously has advantages for rural patients.

The new quality payments should also ensure that a high quality of service is available to all.

Quality aspects may help to ensure that rural patients enjoy equity of access to high quality chronic disease management provided target setting is reasonable....

Under the new contract patients are free to register with any practice in the area, however there will obviously be less choice for patients in rural areas where services are dispersed. Practices also have the facility to seek to close their lists where there are concerns over workloads and GPs must negotiate this with their PCO. Again however rural practices may be less able to use this option due to a lack of alternative provider. Rural PCOs will therefore be more likely to have to find additional funding to keep a practice list open if this should arise.

Recommendations

When practices are undertaking patient satisfaction surveys it will be important to consider the rural dimension, for example issues around access and transport. This information should be aggregated at a PCO level and can help in service configuration, planning and delivery.

Opportunities should be taken to pilot innovative services in rural communities in partnership with secondary care and other key stakeholders.

3.6.2 Increased travel for patients

Whilst there is considerable potential for the increased range of local appropriate services for rural patients, there is also the potential of increased travel. This is particularly the case for OOH services and enhanced services such as minor injuries as discussed in previous sections.

Changes in the OOH service means that patients will no longer be seen at the X centre at weekends and up to midnight in an evening but will have to travel to the Y centre in Z which is around twice the distance.

Change in OOH may make access more difficult

It is also possible that practices may opt out of additional services, such as child health surveillance. The response of PCOs may be to commission additional or enhanced services directly from alternative providers at a centralised location. This will consequently reduce accessibility for rural people, and particularly disadvantage the elderly or parents at home with young children and without access to private transport.

A further change that has been prompted by the new contract is the closure of many branch surgeries which fail to meet the criteria to be a second main/split site. Whilst it is important to recognise the issues around the quality of

premises that some of these premises operate from, many branch surgeries operating for under 20 hours a week offer/ed a useful and meaningful amenity for their community. It is positive to note however that the contract specifically excludes outreach and branch surgeries operating in non-typical premises for outlying consultation facilities, such as village halls, from meeting these criteria. Further research is required into the impact of these changes to branch surgeries on the accessibility to primary care in rural communities.

Recommendations

The distance that patients will have to travel must be considered in any service reconfiguration. Other aspects of accessibility must also be taken into consideration, for example access to public transport, private car ownership, community transport schemes.

PCOs and practices should take every opportunity to develop joint service provision to support outlying consultation services in isolated communities. For example when adapting/constructing village halls or other community buildings.

More in depth research is required into the scale of branch surgery closures and the impact that this has on rural patients.

3.7 The impact on rural primary care teams

There is flexibility within the new contract to use other health professionals if a GP vacancy arises. This provides more flexibility and time to recruit a GP but it also means that practices have the flexibility to employ other health professionals instead of additional GPs according to practice needs. Practices can therefore configure their own services to meet local need. This is a positive step forward as in some rural areas it might be easier to recruit other types of health professional. Several of the respondents to the survey saw the potential now available to developing new types of teams:

Opportunity for development of integrated nursing teams to deliver chronic disease management.

Achieving the targets of the new contract will stimulate further the development of the primary care team. Much will depend on good management skills and the development of IT systems. Much of the clinical work will be done by practice nurses and nurse practitioners. There will be incentives to develop services in house that might previously have been carried out in secondary care that may require recruitment of staff new to primary care such as physiotherapists, podiatrists etc.

As a small semi-rural practice with a relatively low income we had struggled to attract a new partner. As there was no PMS in Wales this option to solve our problem was denied us. The new contract has allowed us to receive the income for the missing partners and employ salaried doctors.

However there is also some concern over the amount of resources available and the time it will take to re-shape primary care teams.

Because of [the lack of financial resources] it is unlikely that there will be new real development opportunities for some years. There are already integrated nursing teams but more may be expected to be implemented.

4.0 CONCLUSIONS AND RECOMMENDATIONS

Overall the new GMS contract has significant potential to improve healthcare for rural patients and to improve working conditions for rural GPs. There are certain clear issues however where rural GPs are less able to take advantage of opportunities available under the new contract, for example some remote GPs will not be able to opt out of OOH services or of providing additional or enhanced services. Investment in IM&T should help tackle isolation for rural GPs but broadband is slow in coming to rural and remote areas and so rural GPs are at a relative disadvantage. The new contract offers the opportunity to recognise the wide range of services that rural GPs have long been providing, however there are real concerns over funding restraints which may actually mean services are withdrawn from rural communities which will have a significant negative impact on rural patients in terms of accessing services.

So whilst the new GMS contract appears to provide many positive opportunities at face level, it does highlight the importance of rural proofing a policy such as this at a developmental stage, because in practical terms it is less easy to implement certain aspects in a rural area. The contract does explicitly refer to the difficulties imposed by rurality and remoteness in terms of delivering services and tasks PCOs with the responsibility of supporting rural practice. The details of this support are sketchy at present and are the responsibility of individual PCOs and therefore it will be important to monitor the response of PCOs across the UK and look for examples of innovative and good practice which could be transferred elsewhere.

Overall Recommendations

PCOs need to rural proof their action plans with regard to delivering strategic change and implementing the new contract. This has particular relevance to commissioning of alternative additional and enhanced services as centralisation of services may have an adverse impact on geographical access for patients living in rural and remote areas.

BMA/GPC/RCGP and others should support research with regard to the cost of delivering services in rural areas. Attention should be given to emerging evidence on rural issues by UK wide expert groups.

The UK wide expert groups will also need to consider rural evidence and developments emerging from other sources, eg cross governmental rural definitions; classification of PCOs containing rural practices.

Further research should be conducted into the support given by PCOs across the UK to rural practices. A database of innovative and good practice in implementing the new GMS contract in rural areas should be developed and shared in order to promote the transfer of evidence.

5.0 PROCEEDINGS FROM THE WORKSHOP WITH THE RURAL PRACTICE SUB-COMMITTEE OF THE GPC

5.1 Attendees at the workshop

The findings of this report were presented to a meeting of the Rural Practice Sub-committee of the GPC on 2nd March 2005 at BMA House. Present at the meeting were:

Rural Practice Sub-committee members:

Dr Russell Walshaw (Chairman of the Subcommittee, GPC member, Secretary of East Yorkshire and North Lincolnshire LMC)
Dr Peter Holden (GPC negotiator for rural affairs)
Dr David Bailey (Deputy Chairman, GPC Wales)
Dr John Givans (GPC member and Secretary of North Yorkshire LMC)
Dr Brian Patterson (GPC member and Chairman of BMA Northern Ireland)
Dr Neil Thomas (GPC member)
Dr Malcolm Ward (Chairman, Dispensing Doctors' Association)
Dr Gordon Baird (Chairman, Royal College of GPs Rural Practice Group)

Institute of Rural Health:

Dr Jennifer Deaville, IRH
Helen Swindlehurst, IRH

5.2 Findings from the workshop

Considerable discussion was generated by a presentation of the main findings of the project. The following is a summary of the key points raised in the workshop under each of the report headings.

5.2.1 The availability of services

- The workshop queried whether there was evidence on differential commissioning of enhanced services, ie commissioning of services from urban rather than rural practices. It was suggested that research should be conducted into the commissioning of enhanced services.
- The group felt strongly that travel times rather than distance should be the measure used when examining access.

5.2.2 Out of hours

- There was some disagreement about the impact of the loss of Saturday morning surgery. Some felt that Saturday morning surgery had always just been used as an emergency appointment facility and as such that need would still be met by Out of Hours. Other members

felt that Saturday morning surgery was seen as a useful service to patients who commuted out of the area during the week for work purposes and as such the changes to the service provision have disadvantaged rural patients.

- The group felt that in reality it was likely that a patient would be less likely to receive an Out of Hours visit if they lived at the opposite side of the Co-operative due to the pressure on resources. It was felt that there should be more cross-boundary cover between co-operatives to ease this situation.
- It was felt that ambulance response times should be disaggregated so that urban and rural response times are evident. In rural areas it appears that ambulance response times are being met but this is only because of the influence of response times in urban areas.
- The group felt that it is likely that distance decay occurs with Out of Hours services. Research into this would be valuable.
- It was emphasised that the Department of Health should examine the recommendations made under the Out of Hours section in particular.

5.2.3 The investment in and use of Information Management and Technology

- The level of IM&T funding was queried. For example it was commented that IM&T is not funded at a level that would provide video conferencing across the primary care organisation, and is sometimes not enough to provide adequate basic computer equipment. Many primary care organisations are a long way from having telemedicine linkages and the lack of a level playing field between areas was mentioned.
- There was some debate about the value of telemedicine links, and there was a concern that rural people may feel marginalised if video linking becomes the norm.
- The argument for investment in IM&T needs to be made in parallel with the need to tackle the locum shortage, ie face to face meetings are more difficult for rural practitioners because of the difficulties in obtaining locum cover.
- It was argued that in areas where broadband over land is unlikely there should be a commitment to provide broadband by satellite.

5.2.4 Resourcing rural primary care

- The group felt strongly that diseconomies of scale should be brought back into the global sum formula. It was commented that the Inland

Revenue are able to break down data to postcode level with regard to revenue. Whilst the data will be at least 2.5 years old it still provides a source of detailed information which could be relevant for analysis.

- The group were interested to note the impact that FMD may have had on resource allocation because the utilisation rates used were for 2001/2002. This must be emphasised to the team undertaking the review of the formula.
- It was commented that dispensing has made many rural practices financially attractive and this should be separated as an issue within the new contract. There should be emphasis on the argument for a separate rural practice supplement.

5.2.5 Professional issues for rural GPs

Practice premises that have been purpose built or converted to be fit for purpose are rarely capable of conversion back to domestic use. There is therefore an issue in terms of finding 3rd party developers to invest in rural areas because there is often no other use for such premises at a later date.

- The group agreed that there was little information or clarity about the type of support available to rural practices from primary care organisations. There was a call for this to be quantified.
- There was interest in the idea of twinning urban and rural practices, however more information on how these would work is required.

5.2.6 The impact on rural patients

- An emphasis on providing better transport infrastructure was made.

5.2.7 The impact on rural primary care teams

- The group were happy with the comments and recommendations made under this section.

5.2.8 General comments

- It was emphasised that rural proofing should be about the outcome rather than the process – the current Defra rural services standard is limited in its scope to address some aspects of access to care. For example the current access to care standard is access to a health professional/GP within a 24/48hr timescale and does not cover geographical access.

- Comment was made that more detailed research into how palliative care and chronic disease management programmes are configured in rural areas to achieve the best outcomes for patients was required.
- The group felt strongly that an independent body funded by Government should be able to commission and undertake research and inform planning on a UK wide basis.

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GLOSSARY

BMA	British Medical Association
CPD	Continuing Professional Development
Defra	Dept for Environment, Food and Rural Affairs
DETR	Department for Environment, Transport & the Regions
FMD	Foot and Mouth Disease
GMS	General Medical Services
GP	General Practitioner
GPC	General Practice Committee
IM & T	Information Management & Technology
IRH	Institute of Rural Health
LIFT	Local Improvement Finance Trust
OOH	Out of Hours
PCO	Primary Care Organisation
PCT	Primary Care Trust
PFI	Private Finance Initiative
PMS	Personal Medical Services
RCGP	Royal College of General Practitioners
UK	United Kingdom

Appendix - Survey questions to RCGP and PCOs



Impacts of the new GMS contract on rural areas

Please take a few minutes to give your views on the impact of the new GMS contract on rural areas. The information you provide will be collated and analysed to contribute to a report, commissioned by the GPC looking at the implications of the new contract for rural practice and rural communities. The data will be anonymised and you will not be identified in the report.

1. What do you feel are the impacts of the GMS contract on the following:
 - Rural patients
 - Rural GPs
 - Rural primary care teams
 - Rural primary care organisations
2. Does the degree of rurality (for example sparse, remote, urban-rural fringe) affect the impact of the contract? If so, please expand.
3. As the new GMS contract is implemented, are you able to comment on any negative or positive impacts locally, regionally or nationally?

THANK YOU FOR YOUR CONTRIBUTION

Please send this form either by e-mail to jennyd@irh.ac.uk; or by mail to: Dr Jenny Deaville, Research Manager, Institute of Rural Health, Gregynog Hall, Newtown, Powys, SY16 3PW.