

Sharing and Adopting the Learning Gregynog Conference 20th September 2011

Introduction

The conference was held to highlight the innovative practice and achievements of rural health and wellbeing projects and initiatives that have taken place as a result of funding in Wales by the Rural Health Innovation Fund. The Rural Health Innovation Fund is one aspect of implementation of the Rural Health Plan for Wales, which states: "Rural health cannot be considered in isolation from social, economic, transport, housing and social care matters, reinforcing the need for rural proofing and integrated planning and service delivery."

The aim was to learn from and exchange the good practice demonstrated by the wide range of different approaches being taken to deliver health and wellbeing services in rural areas, through projects which focussed variously on workforce development, health promotion, access to services, voluntary support services and telemedicine.

The day also aimed to explore ways to build on this learning, as a first step towards ensuring that successful initiatives are transferable, mainstreamed and sustainable.

Lord Elystan Morgan gave the opening address

Lord Elystan Morgan chaired the steering group for the Rural Health Plan. He highlighted the major themes that had emerged in rural health provision and placed them in the wider rural context.

Extensive analysis of published literature from all over the world did not unearth any startling revelations but confirmed three major issues:

- Access – access to both emergency and routine health care services in rural areas presents a major barrier to equitable health care.
- Integration – there is a failure to integrate health care provision both within and between services. This leads to wasteful duplication and poor information exchange.
- Community cohesion – community engagement and an informed sense of ownership should be supported and maintained by the mainstream services, with significant involvement of the voluntary sector.

Rural health care provision is further affected by the ageing demographic in rural areas, lower incomes and lower standards of living, and poor transport infrastructure.

The health and care needs of different rural communities vary enormously but these themes can be regarded as constants and there needs to be a whole-system rather than sporadic response - a cultural change that challenges adherence to entrenched systems and professional defences. This requires the creation of new roles that cross boundaries, and of mechanisms that enable localities to provide all the services they can safely discharge. It also highlights the vital importance of education and training.

Health policies should be rural-proofed, should acknowledge the greater cost of rural health provision, and think in terms of 'community' rather than 'modules'. The local team has the knowledge of the needs of their local community. Developments that arise spontaneously from the energy of the community will be sustainable and will reinforce community cohesion.

Adequate and equitable health care is a basic human right. It is a matter of justice.

Making a Difference – Delivering Better Rural Health

Helen Howson, Head of Primary and Community Health Strategy, Medical Directorate, Welsh Government

Working up from the grassroots enables an understanding of what are the key issues for people and what they think are the solutions. The challenges to rural health provision are to:

- get the right services to the right person in the right place in the right time,
- engage local people, organisations and professionals to work in partnership,
- provide a broad, effective and affordable range of health and social care services which focus on supporting health and wellbeing and promoting independence.

Access – of people to services or services to people – will require new and different solutions e.g. telemedicine.

Integration – of service models and systems, of workforce and services – is critical in a time of restricted resources, to avoid duplication and make best use of skills.

Community cohesion and engagement again makes best use of resources, in this case the potential within rural communities to take responsibility for and ownership of health care.

The Rural Health Implementation Group (RHIG) took account of the work already underway (e.g. community transport schemes, integrated care centres etc) and updated the Implementation Plan in the light of this learning and experience to identify short, medium and long-term deliverables.

The Rural Health Innovation Fund (RHIF) projects were designed to further this learning by:

- Stimulating and supporting innovative and sustainable solutions, supporting the key themes outlined in the Rural Health Plan.
- Developing and testing models of integrated, sustainable working across health and social care addressing integrated systems, service delivery, planning and workforce development.
- Strengthening local ownership, engagement and local networks supporting health and well being in rural communities.
- Enabling joint workforce training and developments supporting plans for new skills, roles and responsibilities.
- Identifying and sharing examples of good practice to inform service delivery.

Thus local projects tested new approaches to service delivery while the two development sites tests new models of rural health planning. The 15 Rural Health Innovation Projects (RHIPs) covered a range of issues, including mental health, outreach services, telehealth, and carers support. These were then evaluated for their impact. The test is whether they made a difference, achieving better outcomes for people living in rural areas - whether in fact local people feel the difference.

Rural Health website/Gwefan Iechyd Gwledig

<http://wales.gov.uk/topics/health/nhswales/healthstrategy/ruralhealth/?lang=en>

Rural Health mailbox/Blwch post Iechyd Gwledig

ruralhealth@wales.gsi.gov.uk

Developing the “Rural Practitioner” role

Dr Lyndon Miles, Chair of RHIG Task & Finish Group

A sub-group of 25 representatives including the LHBs, the Welsh Government, the BMA, local authorities, IRH and WCVA considered the identity, role and necessary skills of the Rural Practitioner.

A rural health practitioner fulfils a range of roles, with the required skills driven by patient needs. The challenge is to develop the workforce to supply this model of care, given the constraints in rural areas. Each rural area has different circumstances and needs. However in comparison with urban areas there are generally lower numbers of staff, covering greater areas, and with some services lost to centralisation. Specialisation/centralisation improves quality and cost-effectiveness but both distances services and lowers the status of the services available locally, reducing patient independence and ownership.

Service provision therefore needs a sensitivity to local circumstances and a recognition that the ‘balance points’, between local and centralised provision, are complex, varying with each area and each service. A mature health system will map out these balance points, which may be complex viewed from the centre but should become clearer from the locality perspective and should be driven by the locality model.

Planning the model of care involves primary and secondary care health professionals but also social care and the third sector, and needs to address out of hours and unscheduled care, the integration of services and cross border issues. To take one example, Community Hospital services could include a complex and extensive range of services, again making use of third sector input and incorporating community services such as carers’ centres, family planning and re-ablement.

This re-modelling will need workforce re-design. There are policies already in place in Wales but locally creative and innovative solutions are needed for rural areas. Integrating teams and extending the skills of team members (through programmes such as Design for Competence, D4C) can prevent duplication of visits and release resources of e.g. doctors. Training in IT can increase both competence and confidence.

Education and CPD (continuing professional development) programmes improve recruitment and retention of rural medical staff, and co-operation with the universities is needed to re-balance medical education to reflect rural healthcare. This includes defining and developing rural competencies – the specific skill sets for rural practice and the Diploma in Rural Medicine, increased rural placements for undergraduates, flexible support and mentoring and speciality training posts in rural areas, and a reasonable proportion of Fellowships in rural areas.

Rural Health Telemedicine

Dr Alan Axford, Chair RHIG Telemedicine Group, and Delyth Lewis, Telemedicine Manager

Dr Axford gave the background to the development of Telemedicine, particularly in Ceredigion, while Delyth Lewis, seconded as Telemedicine Service Manager and available to provide support and training, gave several examples of telemedicine in use.

Telemedicine(TM) (see below for definitions*) is not new in Wales, having been in routine use in Ceredigion since 2000, with a specific application to cancer care through the South (West) Wales Cancer Network set up in 2005. One imperative of the Rural Health Implementation Group is to ensure that the use of telemedicine is maximised across rural Wales, as a further impetus to providing care by a multi-disciplinary team rather than individual professionals.

This involves not just exploring the potential and encouraging further development of services but encouraging people to actually use them. There is a lot of equipment 'still in the box', partly because of lack of awareness of what is available but also to do with lack of confidence and the necessary skills to make use of it. Videoconference training can therefore both make use of and facilitate progress in the application of this technology.

The objective of the Group was to identify and map current successful telemedicine services and share good practice; to support health boards in their development and implementation of telemedicine services; and to conduct a specific feasibility study, in four pilot rural GP practices, on the use of web cameras.

To date in Wales videoconferencing has been used for "virtual" multidisciplinary team meetings, management and clinical meetings, education and training sessions, transmission of data and for clinical contacts between professionals, between professional and patient and between medical and non medical staff. In addition electronic "store and forward" is used for diagnosis/triage of dermatology images.

The benefits impact on both patients and health professionals. For patients it improves local access to healthcare, offers a quicker diagnosis and treatment plan, reduces waiting times, and journeys, for expert consultations, and in general furthers equality of healthcare service to patients in rural areas. In increasing access to specialist opinion it is in effect enabling retention of local provision. For staff it makes more efficient use of their time (consulting not commuting), offers remote supervision of generalist staff, reduces travelling time (and attendant CO2 emissions) and expenses of attending meetings, increases opportunity for staff participation in education meetings, bringing together more people with a broader range of experience, and increase educational sessions and sharing good practice. In particular it addresses the prescription for multi-disciplinary care, enabling participation in virtual meetings of the whole range of relevant staff.

As instances of TM in use:

Neurology clinics held every three months were too infrequent to meet local demand and necessitated a 150 mile/four-hour return journey for the consultant. The new service model enables the patient to attend the local clinic to videoconference, accompanied by a nurse, with the consultant in Swansea. There is now a similar model for pre and post laryngectomy speech therapy.

In Paediatric Cardiac services, telemedicine enables the immediate transmission of echocardiography images (live and recorded), making a critical difference to diagnosis and treatment times.

In palliative care it can offer access to frequent ad hoc advice, reducing staff travel time and leaving them more time to spend with patients.

Further developments involve image transmission for dermatology and ophthalmology, and minor injuries advice and diagnosis from A&E departments to staff in community hospitals. Patient satisfaction with these new models has been surprisingly high.

The obstacles encountered to these developments are partly technical (for example a lack of sufficient primary care bandwidth) but are more to do with lack of awareness, under-utilisation, reluctance to use the technology and lack of on site support. Providing training and user guides, and nominating 'super user' enthusiasts at local sites will change attitudes and increase confidence. In addition each Health Board should have a nominated member with responsibility for telemedicine.

There has been much progress to date, particularly in Hywel Dda and Betsi Cadwaladr University Health Boards, and there is potential for the establishment of a national Telemedicine Forum of clinical champions and health board members, and collaboration with organisations to develop national telemedicine systems. Success is dependent on successful engagement with Health Boards, service users and the support organisations, e.g. NHS Wales Informatics Service, Welsh Health Video Network and NLIAH.

Telemedicine is supported by the Welsh Government and welcomed by rural patients. It works, is cost-effective, reliable and secure. Its use is increasing worldwide and it has enormous potential in Wales. It is an additional resource, not a replacement. It's not frightening and help is available if needed.

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* Telemedicine - The practice of medicine using technology to provide clinical services at a geographically separate site. Service can be delivered in "real time" using interactive videoconferencing, or through "store and forward" which relies on the transmission of images and data for review immediately or at later time.

* Telecare - The use of technology to provide monitoring of real time emergencies and lifestyle changes over time in order to manage the risk associated with frailty and independent living

* Telehealth - The use of technology to provide remote monitoring of people living with a chronic condition and to support self-management and delivery of care.

Highlights on Rural Health Innovation in Wales

Stephanie Best, Rural Health Scholar, and Dr Fiona Williams, Research Manager IRH

Their presentation looked at the process of innovation and what had been learned from the range of Rural Health Innovation Projects (RHIPs); and commented on the two Development Sites, operating at the strategic level, with the aim of increasing understanding of the practicalities of implementing improvements in rural service delivery.

A 'good idea' can come from anywhere but is not enough unless it is put into action, and shared. The process can take years but programmes such as the 1000 Lives Plus are committed to accelerating the process of putting good ideas into action. The RHIPs were intended to:

- Stimulate and support innovative and sustainable solutions
- Develop and test new models of integrated, sustainable working
- Strengthen local ownership, engagement and rural networks
- Support joint workforce training and developments
- Identify and share examples of good practice to inform service delivery

There was a diverse range of projects including local and national initiatives, with strong voluntary sector involvement. Service redesign and extending practitioners roles were required for some projects to allow a variety of different routes to services for clients, such as video and computer access. Amongst the challenges for the projects were tight timescales and development of new referral pathways.

Each project has had its own aims and objectives and the outcomes are not always easily measurable. But the benefits of good networking and of integrated working are a constant and now there is the need to share the evaluation conclusions.

In terms of the development sites, Hywel Dda focused on a particular area, Crymych, in terms of the three themes:

Access to services via co-ordinated delivery systems and re-drawing service maps;
Integration of planning and delivery teams, joint care packages and integrated workforce plans; and
Community Cohesion, identifying gaps and establishing community networks.
Powys, in contrast, took a county-wide approach looking at four discrete areas of work – the role of the Rural Health practitioner, telehealth and telecare services, the governing framework, and citizen and stakeholder engagement.

It is apparent that perceptions of access issues vary widely but that rural isolation is a reality and that there is great scope for telehealth and telecare. Integration of the workforce will have an impact on planning and needs an understanding of how levels of care interface and what the 'glue' is to bring organisations together. Community cohesion will be enhanced by increasing information exchange and developing relationships between the statutory and third sectors. There is a lack of understanding in the statutory sector of the breadth and complexity of the voluntary sector. Both sectors need to address confidentiality issues and concerns. Community needs differ, and they change over time. The LHBs need a flexible approach to work with this dynamic.

Project activities are still continuing and the impacts are currently difficult to define but there is now the basis for an evaluation framework for ongoing monitoring, review and evaluation, and useful learning has been achieved to date. The Rural Health Plan has provided a 'lens' for observation and initiated a culture shift in service provision. Wales is on the international stage for rural health and social care provision and commissioners and providers from further afield are looking at Wales to see what is developing.

Developing new ways of working in rural communities:

The workshops discussed the learning from the projects and how this can be taken forward.

Telemedicine and ICT

Discussion

Given the successful working of telemedicine (TM), the group looked at the barriers that are preventing its wider use i.e. a lack of awareness of its character and benefits, and technophobia/ignorance on the part of the potential user. Previous bad experience in the early days of the technology needs to be overcome. Training is therefore critical and Wales is uniquely placed to make this available. The breakthrough in Ceredigion was the appointment of a dedicated and informed manager and the availability of training that can achieve competence and confidence within a day.

However an additional barrier is the lack of commitment and engagement from existing IT departments within the health service. IT departments have their own agenda, funding for IT within the HBs is decreasing and it is difficult to plan IT budgets because they are discretionary and hence residual. There was a suggestion that the IT budget could be combined with the transport budget as an incentive to re-balance the services.

There is currently more local interest than at HB level. Telemedicine needs to be made an integral part of HB strategy, and to feature in medical training, with the E-health competency framework a part of both undergraduate and post-graduate training. The role of telemedicine was omitted from service reconfiguration plans. There was the suggestion that there should be a Ministerial Directive requiring each HB to report each year on how much was spent on the development of telemedicine. An increased emphasis on telemedicine would link with the imperative to keep more elderly patients out of hospital.

LAs and social care are currently on different networks to the health service. Achieving compatibility is feasible but needs funding and the will to make it work. There are also issues between primary and secondary care. Powys has particular problems because it deals with so many different providers and it is difficult to get them all on board and the biggest problem is achieving compatibility of Welsh and English IT systems. But telemedicine itself could be used to facilitate integrated working across organisations and professional groups.

There is also a lack of awareness on the part of the patient (patient request for the telemedicine option would help stimulate demand). Patients assume they will have to travel and for chronic conditions this can mean considerable fatigue and cost (for MS sufferers a trip to the specialist may mean a day of rest and preparation and two days after for recovery) and may mean that GPs put off referring.

Co-operation with the CHCs and third sector organisations could raise awareness and have an important role in supporting and creating demand. Making Community Hospitals a focus, involving third sector staff in 'chaperoning' sessions, including chaplains and care home staff in training, will all help to demystify the technology, raise public knowledge of its potential and stimulate demand. 'MyHealth Online' could advertise the option. There is also a CPD benefit from a telemedicine consultation in that the primary care health professional is learning from the consultant.

In Canada multidisciplinary teams meet (via video-conferencing) to put together the patient treatment plan and this can include the patient and their family and could also include third sector input. The British Antarctic Expedition is controlled medically from Aberdeen, even including surgical procedures.

Shropshire is already using video-conferencing for cancer reviews and is planning its use in the prison health service (following the work done by the Airedale NHS Foundation Trust). In psychiatry there are benefits from both the patient and clinician perspective. It is also particularly applicable to the treatment of COPD, diabetes and chronic heart failure. BCUHB is looking to develop volunteer training for 'supervised' monitoring and maintenance of medical equipment e.g. hearing aids. There is potential for the use of mobile phones and apps for diagnosis and treatment.

Recommendations:

- TM must be part of medical training and offered also to existing staff and third sector staff.
- There should be an all-Wales TM strategy
- Public awareness of the existence and potential of the TM option should be stimulated.

Community Engagement

Discussion

This workshop explored the learning, opportunities, and challenges arising from the projects and specifically how to achieve genuine and effective community engagement in developing initiatives. The challenges included identifying those in need, forging working relationships with GPs, and with all service providers, and dealing with the constraints of time and funding. Useful learning arose from specific projects/areas/issues and from the overall focus on community involvement – where and why does it work well or badly?

When planning services, it is sometime challenging to identify real need in rural communities. Need may not be apparent from demographic evidence. An example was given of the difficulty of identifying trends and health needs in older males.

In Ceredigion Age Cymru has run a pilot project on 'Reaching the hard to reach'. It helps if there are already good connections with other groups, in this case between Ceredigion Association of Voluntary Organisations, Age Cymru and community transport. In Pembrokeshire the Community Pharmacists Project developed the role of the pharmacist as a member of a community palliative care multidisciplinary team.

There is still work to be done in working with GPs, particularly with regard to the sharing of information. Building relationships and confidence about referrals and information exchange requires much preparation and discussion to overcome reservations. In some cases GPs had no awareness of the local projects but once aware were keen to be involved.

Barriers to sharing information exist across all organisations and services. Few people had heard of WASPI (Wales Accord on the Sharing of Personal Information). Further complications arise in work across borders or in different LHBs with their different systems. Health and social care co-operation on training and workforce development can give a powerful message to workers on the ground (and the service user) In particular the statutory sectors need to value and engage with the third sector. There can be a cultural barrier to working with 'unqualified' personnel and a lack of knowledge about their potential contribution. Investing time in volunteer training and in engagement with community groups brings extra benefit to local initiatives.

It is impossible to engage without resources. Sustaining funding is a constant challenge and a stress on any initiative. There was frustration also at the limited time available for the projects and concern that short projects raise expectations. Partnerships are time-intensive, whether developing constructive relationships between service providers or creating effective community engagement. Partnerships that are not sustained represent a real loss of shared expertise and innovation. And collating information and assessing outcomes may need an extended period after the end of a project. The RHIF runs the risk of never understanding the real gains from the projects because of these short timescales and it was suggested that they are followed up again in six months time.

There is already a lot of activity taking place on the ground. The need is to work closely with what is there and what is required, and to continue to redesign in the light of operation. We can learn from regional innovations. Hereford PCT has worked on information provision, developing an electronic directory of services relevant to health improvement that anyone can access. Ceredigion LA has put effort into developing third sector networks, extending support for carers and increasing access to advocacy services. Worcestershire, with an estimated 1400 deprived households, looked at the best way to communicate with people and developed teams of local residents, housing officers, health practitioners, and pharmacists. Sharing resources and working in small teams they canvassed door to door to encourage people to access services.

Specific work was done on suicide prevention, identifying problems exacerbated in rural settings (stigma, fear, confidentiality issues) and aiming to build the response capability of both GPs and communities, publicising to overcome stigma, developing training and building resilience.

Whatever changes are made they will work best when the community is engaged in them, feels ownership of them and is committed to their success. So the need is to look at the nature of communities and ask why some are healthy and vibrant and with a strong sense of community; what the effects are of significant in-migration upon community cohesion; and why a sense of community

is so important to people. In Suffolk service users say a sense of strong community, where people know each other and feel connected, is more important than service configuration.

Engagement itself needs to be better understood, drawing out the different reasons for engagement, when to do and how to do it. (The 1000 Lives+ Engagement workstream might be useful here). Effective engagement is an important tool to increase ownership, and community ownership is particularly important to maximise access to and the effectiveness of rural health services.

If we are trying to do something different we may need different techniques and the community needs to be kept informed and to be 'sold' the idea. If changes are made without the goodwill of population then community involvement is lost. For example Friends of community hospitals and care homes can be made to feel disenfranchised when buildings they have financially supported are sold on or demolished or developments of services are at the expense of much loved and supported institutions.

So making sure the community is on board is not just an extra gesture but essential to change and development with a community focus.

Next steps

- sharing learning, and establishing systems for effective transfer of information
- maintaining partnerships once a project has ended
- clear analysis of project outcomes and necessary modifications in order to decide which to take forward and replicate.

Service Improvements and New Planning Models for better Rural Health

Discussion

The discussion focussed on the need for integration – of health with social care, of the statutory services with the third sector; and clarification and rebalancing – between primary and secondary care, between local and centralised services. Key to all of these is information exchange.

Being clear about what the third sector can offer, and valuing this contribution, will enable effective integration into both service provision and planning. The third sector conducts its own fundraising and can bring added value to service provision but may also need additional resources, of money and training, to take on all the roles expected of it.

Since the third sector works with both health and social care it can be part of the integration of the two. Whereas health and social care organisations are co-operating at the level of actual service provision there needs to be more co-operation at strategic level. This co-operation should include mental health care provision. And the mix of services available needs to be made clearer to the service user. These changes will only happen if people are committed to co-operation.

There is also a divide between a focus on primary or secondary care, between generalists and specialists. The health and wellbeing focus, with its strong emphasis on health promotion and the prevention agenda, starts from the position of keeping people out of hospital rather than what happens when they leave hospital. There needs to be a balance of resources between centralisation and decentralisation, shifting resources back into local communities and into primary and community teams. But this focus on local provision has been de-emphasised by the establishment of larger health boards.

Telemedicine may have the potential to help overcome these divisions, enabling better co-operation between primary and secondary care and the delivery of specialist services in localities.

If services are to be more community-based we need to be clear about the character and diversity of the communities we are dealing with. Communities will have their own resources – the existence of Good Neighbour schemes for example, and developments should aim at including and valuing these formal and informal set-ups (statutory services find it difficult to talk to neighbours for example, though their input may be crucial to the wellbeing and independence of their neighbour).

It helps if communities know their own profile, and can co-operate in developments that will increase community capacity and resilience. Information from communities should feed into planning developments and intelligence should be channelled back to the communities. It may be difficult to identify need within a local culture of self-sufficiency, particularly in an ageing population – for example, when one partner in a hitherto self-sufficient couple is widowed, independence may become isolation.

In small localities the allocation of services by numbers of population will not work and the challenge needs to be set to acute sectors – how will you provide services to communities? How can we enable communities to work with statutory partnerships and make these partnerships sustainable?

Of major importance to achieving all this is effective information exchange. Compatibility of information systems is essential; common eligibility criteria, single patient records, and joint planning prevent duplication. A willingness to share, between the different statutory services, between the service provider and the patient, and with third sector partners, maximises expertise as well as preventing confusion.

There is also scope for exchange of good practice in looking at how other areas handle information and planning, for example the customer journey mapping exercise underway in Worcestershire, and a greater willingness to make use of new technology to improve exchange.

Recommendations for Next Steps for the Rural Health Implementation Group

- Realistic timescales - it is difficult to properly test new ways of work in 12 months and small pots of funding do not promise sustainability
- Integration of services and the workforce - joint working and joint planning across organisational boundaries
- Valuing and incorporating third sector input
- Recognition of the health needs of rural populations, and in particular examining the data to identify local need and pockets of deprivation
- Focussing on the health promotion, preventive agenda, for example promoting a healthy ageing population of Wales rather than dealing with illness
- Sharing information, between providers and with the service user

Workforce Development

Discussion

Workforce development requires a clear strategic lead, a clarification of current roles and how they need to change (specifically towards far more integration, including co-operation with the third sector, and a change in focus to community-based medicine), attention to rural recruitment and retention, and above all an investment in staff training and development.

There needs to be a strategic lead from the Welsh Government, to be interpreted as appropriate in the ethos of the local organisation. This needs to take into account clinical governance and professional competencies but also the interface between professional roles.

This should happen at all levels, with a recognition of the value of all grades - we lose care-workers to stacking shelves, and fail to capitalise on the existing skills and expertise that could be shared between, for example, health and social care staff. There are existing co-operative networks, for example pharmacists already have informal networks with carers for delivering medication. This needs to be formalised without scaring people off or raising their defences.

While professional boundaries are less of an issue at lower grades, with staff on the ground being more prepared to share their learning, the barriers increase further up the scale. There are fears of delegation to non-registered staff, and a lack of confidence about extending one's competencies, understandably in new staff who may resist stepping outside their initial training. To change the culture people need to see the new roles working. Building in an expectation of changing and expanding roles, with the operational systems in place to facilitate this, will enable a more flexible and proactive delivery of health care.

Understanding the potential contribution of the third sector, being prepared to share information, and involving service users and carers, will facilitate integrated working and reduce duplication. Third sector umbrella organisations, such as WCVA can have a role to play at the strategic level. Involvement of service users is part of the change towards patient-centred, community-focussed medicine. In Wales this will include a recognition of Welsh language issues but in all rural areas it requires a recognition of the character and needs of rural communities.

This should begin with the training of students (in both medicine and social care), to raise awareness of health inequalities and the necessary difference in delivery of services in rural areas, but also to enthuse students with the possibilities of rural practice, encouraging rural placements for students and promoting rural medical practice and careers.

This rural emphasis should continue beyond the undergraduate level to foundation, consultant and GP training and CPD. Increased clinical learning placements in rural practice and innovative and accessible CPD will help to retain staff and rebalance the status of the generalist and specialist health professional. Consultant appointment committees could function differently in rural community hospitals. For GPs it was suggested that one Welsh VTS (Vocational Training Scheme) scheme be re-badged as rural and that there should be a reasonable proportion of F2 grade doctors in rural GP practices. Inter-professional learning, between health professionals and between health and social care, could also take place both at undergraduate level and post-graduation.

Workforce development requires above all an investment in staff development, training and appraisal i.e. an upfront investment in time and resources before capacity is developed and released. It is essential to invest to grow but there are resources available in sharing learning and existing expertise. Much training is university based. It is necessary to invent what is needed, and for universities to recognise and accredit work-based learning.

Flexible and accessible competency-based training and accreditation, releasing non-registered staff time for training and development, and allowing professional and non-registered staff to undertake some training together will help to retain, and make best use of, a skilled workforce.

Recommendations

- rural proofing of health workforce development policies
- a competency-based team approach to workforce development
- rural medicine and rural health given the attention and focus that reflects the needs of rural Wales.

Plenary session

The session began with attention being drawn to ‘the elephant in the room’ in this case mental health, often ignored in general discussion. Other comments focussed on the need to transfer attention and funding back to primary care and the inevitable slow progress of this, and a suggestion that the rural health discussion is still dominated by the medical model, rather than communities being allowed to, and resourced to, take responsibility for their own health.

Restricted resources require innovative solutions and in particular working with the third sector but it was queried whether the third sector is changing and innovating to the same degree.

GP income used to reflect the number of elderly patients, on the understanding that everyone over 70 was seen once a year. The increase in the elderly population of Powys is unsustainable in terms of services required. To tackle an ageing demographic, chronic diseases, and complex combinations of diseases, it is necessary to treat early rather than reactively. Screening provision and screening uptake is lower in rural areas.

In conclusion, we need to review and act upon what we have learned from the development sites and the innovation projects, and enthusiasts and champions are needed to move the initiatives forward.

Wales should congratulate itself on its recognition of and emphasis on rural health care, but the Rural Health Plan was not designed to gather dust on a shelf and should continue to be implemented

The presentations from this conference, from Helen Howson, Dr Lyndon Miles, Dr Alan Axford & Delyth Lewis, and Stephanie Best & Dr Fiona Williams, are available on the IRH website www.irh.ac.uk

Conference report compiled by Helen Porter for the Institute of Rural Health.