Promoting the networking, support and advocacy of the Rural General Practice Workforce
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Welcome to the New Zealand Rural General Practice Network’s (the Network) Annual Report for the year 2010-2011.

The Network is the only nationwide membership-based organisation in New Zealand to represent the specific interests of rural health. It is a Wellington-based national organisation with 16 staff (15.3 FTE) that derives its income from multiple revenue streams, as follows:

- Provision of contracted professional national and international rural general practitioner recruitment and locum support services to the Ministry of Health. These services are provided by our team of Relationship Managers and Recruitment Administrators under the brand of NZLocums.

- Provision of fee-for-service professional recruitment services for locum placements, urban and rural (where criteria do not meet the Ministry’s guidelines under the contracts). These services are clearly delineated from our Ministry contracted services and are provided by our team of Relationship Managers and Recruitment Administrators also under the brand of NZLocums.

- Permanent placement of medical professionals, sourced nationally and internationally to fill vacancies in primary, secondary and tertiary care. These services are provided by our separate team of Relationship Managers and Recruitment Advisors under the brand of NZMedics.

- Membership services, immigration services and the annual conference are provided by a core group of Network staff under the brand of NZRGPN.
It has been a very busy year in many other respects too and the Network has been very fortunate to have retained the services of CE Michelle Thompson. Michelle, her team, the Board and Conway Powell successfully won the tender for the provision of the rural locum service from the Ministry of Health – a very high priority for the Network. I congratulate everyone for their work and success in winning the tender for recruitment of rural doctors and nurse practitioners to support rural practices in New Zealand.

Board strategy this year has focused on ensuring a rural health workforce to best serve rural communities by securing revenue streams, retention of staff, sustainability of the organisation and advocacy for members.

The Board has supported the recruitment team by visiting a number of areas where there are recruitment and retention difficulties, and meeting with general practices, PHOs and DHBs. Key results from these visits are:

We need strong working relationships in order that DHBs consult and plan well to support retention of rural practitioners; DHBs need their awareness raised to be cognisant of the unique health needs of rural communities; services need to be funded so that patients are able to be cared for closer to home; rural communities have a responsibility to understand and to support the needs of new practitioners and their families coming to their areas; and finally what stood out to me most clearly was the need for change to traditional team structures and a need in some areas to work smarter with their rural practitioner resources to reduce the high turnover in some of the more hard to fill areas.

Retention of staff and the creation of a healthy workplace have involved:

Providing opportunities for the Board and Network staff to meet more regularly; undertake a Board performance survey; ensure senior management and Board members contribute to policy determination and strategic direction; and that Board members are supported with job descriptions, induction and portfolios of responsibility. We believe that the work started on revising the structure of the Board now needs to be revisited. The Network is also constrained by resources to fund regular face-to-face meetings. To this end the Board Chair in conjunction with the CE has been exploring issues such as Board size, the desired balance between skills and regional representation and budget and succession planning.

Dr Martin London has chaired the membership committee and developed a membership strategy alongside membership manager Rob Olsen. This includes the development of a revised membership fees structure that is practice inclusive. A strong membership drive has been the responsibility of the whole Board however, in current economic times a rise in nurse membership cost last year saw a number of nurses not renew their subscriptions. Unless we can show value to nurses to be members and display genuine engagement of rural nurses to be involved on the Board, to be involved in addressing the predicted rural nurse shortages, to continue to support the growth of rural nurses students, integration of rural nursing in under-graduate curriculum, support for practices to provide teaching and learning for both under-graduate and post-graduate nurses within rural practices and integration of all students in a rural community, we will fail as an organisation supporting rural work force.
In the advocacy role this year, there has been considerable call by practices for help with disputes within practices, between practices, around service provision such as rural radiology licensing, Rural Ranking Score revisions and disputes with DHBs/PHOs. However, the bulk of the Board’s energies have gone into the development and modelling of a new Rural Ranking Score (RRS). Rural funding has been devolved from central government to DHBs as part of their base line funding in line with the Better Sooner More Convenient policy environment. Over the years different DHBs and latterly PHOs have developed their own interpretation on the RRS sheet. There has not been national consistency in application of the RRS or availability of funding to rural general practices. Over the past two years we have worked hard to model a RRS based on rural service provision including criteria such as distance to base hospital, types of emergency services, provision of extended after-hours clinics, 24/7 palliative care, support to rest homes, remoteness, and seasonal population fluctuations. The emphasis on this model has been on the allocation of points for the provision of arrangements for after-hours care but recognising the complexity of services that rural practices provide. The CE and Board will present this material to the AGM for consideration, guidance and endorsement.

Doctors from Canterbury this year demanded that it be made compulsory for general practice registrars to serve time in rural practices. This plea has largely fallen on deaf ears by the country’s colleges but internationally it has been recognised as being a very effective way of ensuring rural general practices have doctors. The late Dr Pat Farry worked hard to develop the country’s first rural emersion training for 5th year medical students and the Pat Farry Rural Education Trust continues to focus on supporting rural training of all health professionals. Tim and Nancy Malloy have campaigned to have a multi-discipline emersion site for all health students in Wellsford. These remain isolated programmes and there is a need to grow and sustain a rural workforce. Other essential needs include increasing the incentives for rural registrar training equal to other hospital based disciplines by DHBs, assisting practices to be rural training sites for all health professions, supporting rural specific practice-based post-graduate training for rural nurses and having practice support that will enable change towards provision of more integrative care.

After careful consideration, I have decided to resign as Chair of the Network. I have very much enjoyed my three years leading the Board but now feel the time is right for me to focus on completing my nurse practitioner training and for the Board to have the opportunity to appoint a new Chairperson who can be supported by Michelle well in advance of next year’s AGM. The Board will be appointing an interim Chair at the March Board meeting just prior to conference.

I wish to take this opportunity to thank members for their engagement with me in the role of Network Chair, for the privilege and opportunity to be able to visit, understand and share with me many of your rural areas, your issues and practices. Rural practitioners are the most well-skilled, grounded practitioners with which I have worked. I challenge you all to maintain the Network as an organisation that respects and continues the partnerships of nurses and doctors, as Dr Tim Malloy my dear colleague began, and to continue to promote the concept of the rural team.

Yours sincerely

Kirsty Murrell-McMillan
Chairperson
However, in the indomitable spirit of our Cantabrian colleagues “life must go on” and it for this reason we have decided to continue with our annual conference this month (17-20 March) and I feel it is appropriate to write about the Network’s achievements over the last year, which while important to us and of which we are duly proud, do seem inconsequential in the wider context of life at present.

Operational highlights for the 2010-2011 year were:

• Exceeding the contractual targets of the Ministry of Health’s recruitment contract ending December 2010;

• Securing the Ministry of Health’s new recruitment contract for a further three years – 1 January 2011 to 31 December 2013;

• Strengthening relationships with rural practices, PHOs and DHBs to better understand the specific recruitment issues pertaining to their regions and then working together to resolve;

• Progressing the Rural Ranking Score Review in conjunction with the board, members, Ministry of Health and DHBs;

• Working with the board to determine the strategic direction for the next three years. The essence of the desired direction is a move away from the more singular role of advocacy for rural general practice towards the wider role of becoming a rural health solution provider and leader for the overall rural health sector.

Presentations on progress with the Rural Ranking Score Review and the proposed Strategic Direction will be made to members as part of the Annual Meeting to be held on Saturday 19th March – we hope to see you there.

I have very much enjoyed my return to the helm at the Network. Over the past 15 months, our achievements have been many and would not have been possible without the dedication, loyalty and hard work of the whole team – governance and management alike. I offer my heartfelt thanks and gratitude to you all.

Recent events in Christchurch have made the theme of our conference Family Matters even more pertinent and some would argue that in times like this, families are All that Matters. Kia Kaha Christchurch

Michelle Thompson
Chief Executive
michelle@rgpn.org.nz

As I sit down to write this column we are two weeks on from the devastating earthquake in Christchurch and a national state of emergency prevails – a first in our lifetimes. The tragedy and suffering this earthquake has caused – and will continue to cause – is beyond comprehension and is likely to have far reaching implications for our nation’s psyche, balance sheet and health services, both rural and urban, for years to come. That it has occurred within such a short space of time of the September earthquake, the Pike River Mining tragedy, severe flooding in Northland, severe droughts in parts of the North Island and storms in Southland, seems particularly cruel. We remain in close contact with Members, the Ministry of Health and other national general practice organisations to assist wherever possible with the immediate and on-going rural general practice workforce needs created by these unpredictable and vicious forces of nature.
The Core Executive

Kirsty Murrell-McMillan

Chairperson Kirsty Murrell-McMillan: works as a Nurse Practitioner candidate at Mataura Medical Centre in Southland and for the University of Otago as a Professional Practice Fellow in the Dunedin School of Medicine, to develop Invercargill as a centre for learning in General Practice. She holds RPN, R Comp. N., BN, MN with merit (Rural and Remote), P.G. Cert Prof Studies, qualifications. She has a broad nursing background spanning 30-plus years. Her career began as a psychiatric nurse and after completing her comprehensive nursing training in Southland she moved to work in a number of areas including surgical nursing, research, quality management and hospital management care of older adults. She has taught nursing in the post graduate and undergraduate programme at the Southern Institute of Technology, rural nursing/primary health care in year three of the bachelor of nursing programme at Otago Polytechnic over the past 10 years.

Kirsty was appointed to serve on the Transition Board for the merging of the Otago-Southland PHO, and is now a Trustee Board member of Southern PHO (serving 280,000 enrolled patients in Otago and Southland). Kirsty took over as the Network chairperson in March 2008 from Dr Tim Malloy, having recently served three years on the Executive Board representing the South Island, and is, by virtue of being chairperson of the Network, a member of the General Practice Leaders Forum (GPLF).

Jo Scott-Jones

Deputy chairperson Dr Joseph Scott-Jones: has been GP principal in Opotiki since 1992. He holds MB ChB (Sheffield UK 1986), MRCGP (UK), FRNZCGP, DGM, Dip Obs, Dip Sports Medicine, MMsc (Auckland) qualifications. He was previously a regional representative on the Board and was re-elected at last year’s AGM. He is also chairperson of the Eastern Bay of Plenty PHO and by virtue of his position as Network deputy chairperson is also a member of the GPLF.

“2010 was a very eventful year, seeing my return to the NZRGPN board after an absence of several years and into the deputy chair position, which has been a reasonably steep learning curve. The Network is focused on caring for its membership and it has been fantastic seeing how this has progressed over the years, the conference opportunity to get together with like-minded colleagues, and the positive up-beat feeling of the people who were there was a particular highlight of last year, I am fully expecting more of the same in March 2011.

2010 has seen confirmation of the continuation of the NZ locums contract, which has had knock on effects both in the morale and the capacity of the staff to perform their work, including the ongoing practical support of regions which have staffing difficulties. The affects of this work on the health of communities cannot be overestimated, the Network has a lot to be proud of.

I am excited by the work we have done with the Rural Ranking Score and am hopeful we will have a robust tool that will enable increased levels of funding to continue to flow to areas where rural providers are working hard to enhance rural health outcomes. I am also keen to see the further development and implementation of a rural proofing tool that will ensure rural issues are always considered carefully when new policies or services are developed.”
David Wilson

Secretary Dr David Wilson: has been based in Whitianga for 19 years as a principal in Mercury Bay Medical Centre. He was initially co-opted onto the Board and has been Secretary for seven years. He served on the New Zealand Palliative Care Council for 18 months. David holds an MBBS (London, 1978); attained membership of the (British) Royal College of General Practitioners in 1987 then membership/fellowship of the Royal New Zealand College General Practitioners in 1998. He is also chairperson of the Nominations Committee, a sub-committee of the Network Board.

“During 2010 it has been a privilege to support Network chairperson Kirsty Murrell-McMillan and the Network staff in their hard work for rural New Zealand healthcare. While a lot of Kirsty’s work has been behind the scenes and specific to various communities with problems, members should be aware of her huge contribution and energy and that of the great team we have in Wellington.

“Rural”, in the form of the Network, has always punched significantly above its weight in the health machinations of New Zealand and it has been a privilege to be part of that.

My aspirations for 2011 actually look like they may have some traction, compared with similar thoughts a year ago. The Rural Ranking Score debate is being given impetus by the Minister of Health and I hope we will be able to deliver a fair and manageable way of financially recognising the burden of after-hours care. Providing after-hours care is never cost effective, but for the majority of our members it is part of the responsibilities of the job, and has to be done. The Network will continue to ensure that DHBs are aware of the necessity of funding it adequately.

I look forward to more communication and cooperation between the various organisations involved in providing and supporting rural health.”

Rachel Hale

Treasurer Rachel Hale: is a Nurse Practitioner in General Practice based at the Matamata Medical Centre. She attained a Masters in Nursing (Rural and Gerontology) and a BBS from Massey University. She is also a member of the Board’s sub-committee – the State Contracts Committee – established to oversee the governance of the Ministry’s recruitment contracts. Rachel has been a Network Member for five years and a Board representative for three years. Her nursing career spans more than 30 years, all except five years in rural areas.

“Last year (2010) has had its extremes for me both professionally and personally. The high was gaining credentialing as a Nurse Practitioner with the scope of Older Person from NZNC. This elation was tempered with the knowledge that the hard work was just beginning, because just being at the leading edge of advanced nursing practice in New Zealand means there is no framework to follow so you have to create your own. So the goal for 2011 is to continue to develop a specialised service for my rural community that can be used by other communities.

The NZRGPN has had a diverse and involved programme this year including the development of the business case that won the Ministry of Health locum contact, the development of a strategic plan for the future and the work on the Rural Ranking Score. The supportive board and the great team at head office make me proud to be an executive member.”
Graeme Fenton
Northern North Island representative Dr Graeme Fenton: joined the Network Board in 2009. After graduating MB ChB from Otago School of Medicine in 1965, Graeme established Moerewa Medical Services in Northland in 1967 and has looked after generations of families. Graeme was made a Distinguished Fellow of the Royal New Zealand College of General Practitioners in September 2009. He served on the Northern RHA Board in 1997 and was Director of the Institute of Rural Health from 2000-2001. He established the Northern Rural General Practice Consortium and is Chair of the Te Tai Tokerau PHO Board. Recently he has been involved in improvements to the after-hours service in the Bay of Islands and is working with local GPs and the Ngatihine Health Services to develop an Integrated Primary Health Centre in Kawakawa.

“2010 demonstrates the highs and lows of life. The two earthquakes in Christchurch with the enormous destruction and loss of life will affect New Zealanders (and especially Cantabrians) for years to come; the Network’s success securing the MoH locum contract, the ongoing battle to preserve the right of rural health professionals (and people) to decide their own destinies, the Northland floods, the increasing success of NZLocums to support general practice with a continual stream of locums and a Minister of Health who appears to value rural general practices are other points worthy of mention. There will be ongoing challenges but I would like to applaud and thank, for the past year, all my fellow Board members ably led by Kirsty Murrell-McMillan, and pay tribute to CEO Michelle Thompson and her hard working and very able team.”

Stephen Graham
Southern South Island representative Dr Stephen Graham: is a former deputy chair and treasurer of the Network and until recently was a GP based at Te Anau. Stephen is now working as a locum after recently returning to New Zealand from Nepal where he travelled with his family. Stephen holds a MB ChB 1990 (Otago), and is a Fellow (2003) RNZCGP.

“Stephen left Te Anau in mid-2010 for Dunedin where he has worked as a locum in Dunedin and surrounding areas, as well as three-month long locum stints in rural Australia.”

James Reid
Rural Hospital Doctor representative Dr James Reid: is a full time senior medical officer at Lakes District Hospital in Queenstown and has worked there for eight years. He was previously a general practitioner in Wellington. He has an MB ChB from Otago 1988, DpObst 1990 and FDRHNMNZ (Fellow of the Division of Rural Hospital Medicine), and sits on the FDRHNMNZ’s governing committee and board of studies.

George Tripe
North Island representative Dr George Tripe: has been in general practice since starting in Porirua East in 1974. Ten years ago he gave up his own practice in the Porirua Basin and has since been working as a locum in both New Zealand and Australia in predominantly rural places. For the last five years he has had a part-time appointment as Medical Advisor to the New Zealand Institute of Rural Health. He joined the Network Board in March this year. George holds a MB ChB, 1971 (Otago) and is a Member (1980) and Fellow (1998) of the Royal NZ College of General Practitioners.
Fiona Bolden

Western Middle North Island representative Dr Fiona Bolden: is from Devon in the United Kingdom and completed an MB ChB at Bristol University in 1990. In 1991/92 she came to New Zealand and worked in Napier. After returning to the UK and completing her GP training she took up a partnership in Devon where she worked for five years. In 2001 she returned to New Zealand working as a locum in Te Awamutu and then in Kawhia. In 2002 Fiona joined a practice in Raglan, which she bought in 2004. She holds MRCGP, FRNZCGP, Dip Ac (diploma in acupuncture) qualifications, did two years psychiatry in the UK and completed one year of a diploma in psychiatry. She is currently completing the second year of a strategic leadership diploma. Fiona is a member of the rural advisory group for Pinnacle and the GP advisory group.

“It is just over a year since I joined the NZRGPN Board and that year has been an interesting one as I find my feet on the Board and begin to understand the processes; the full extent of the issues faced by all of us as rural healthcare workers and how we may be able to influence these. I have enjoyed getting to know the Board members especially in our face to face meetings, of which we have had two this last year, to discuss strategic planning for the Network. We need to be very clear about our direction for the future, which is as always, firmly attached to the rural workforce; its retention, recruitment and development. One of our key areas of work over the last year has been helping to develop a revised Rural Ranking Score, which we hope will help send the rural funding out to those practitioners providing services for rural people in a more equitable way.

Locally, instead of working under the Waikato PHO, my practice is now under the Midlands Health Network. This network has the first integrated family health centre pilots up and running; we watch their development with interest.

For the future I hope that we will find some new ways of providing rural healthcare through integration between rural healthcare workers to help meet the increasing needs of an aging population coupled with the predicted decrease in the GP workforce. I hope that this will result in improved access to excellent healthcare for those living rurally provided by a happy team of health practitioners.”

Kamiria Gosman

Southern North Island representative Kamiria Gosman: is of Nga Pui, Ngati Kahungunu ki Wairoa and Ngati Tautahi descent and has lived in the central North Island plateau for 32 years, currently residing in Turangi. Kamiria is a retired nurse and midwife and was Chief Executive Officer of Tuwharetoa Health Services Limited for 15 years. Kamiria has extensive experience and expertise in a range of health services, nursing, midwifery, child and family health, and education. Kamiria held a position as Director of Rural Health for the North Island – Nursing for three years with the Institute of Rural Health, now the NZ Institute of Rural Health. Kamiria is currently an Independent Reviewer for Quality Improvement & Accreditation.

“During 2010, it was a great pleasure to work alongside the Network’s senior management team and to learn about their roles, visit practices, key District Health Board and Primary Health Organisation managers and link with other health providers during the course of the visits. Taranaki, Whanganui, Taupo, the Central North Island plateau, Taihape, Marton, Bulls, Foxton, Palmerston North, Shannon, Waipukurau, Dannevirke, Masterton, Carterton, Greytown, Martinborough and Featherston were amongst the rural sites visited.

The successes were in the Board and Management team working together to raise the profile of the Network, listening to the views of general practitioners, practice managers, staff, planners, funders, general managers and Māori, and the sharing of information. A key outcome was the importance of relationships and the challenge of maintaining them.

I look forward to continuing to build these relationships throughout 2011 and beyond.”
South Island representative Dr Martin London: has been a rural GP since 1983 and a salaried practitioner for the South Westland Practice since 2005. He is a Clinical Senior Lecturer at the University of Otago for the Rural Medical Immersion Programme, convener and founding member of the New Zealand Rural General Practice Network (1992) and intermittent board member since that time. Martin is on the Rural Premium Review Panel and Chair of the Network’s Membership Committee. He pioneered the original rural GP locum service via the Centre for Rural Health (Christchurch) in 1996. Martin holds a MB ChB (Bristol 1977), a Dip.Obst. (Otago) and is a Fellow of RNZCGP.

“We could all be forgiven for abandoning hope that the Rural Ranking Score review would ever deliver the goods of a more rational and fair distribution of funds. It’s been ongoing for over four years. However, with recent progress, the maturing of relationships and the trust that goes with it and the fact that it’s an election year, I genuinely believe that we’ll see resolution very soon. Staff and their teams have done a huge amount of work to this end and the rural practices will owe them thanks when it’s finally signed off.

The other big development I hope to see this year is an expansion of the Network membership, particularly through the introduction of ‘Practice Membership’ rate and the greater involvement of rural students. These will broaden our representation and, more importantly, lay foundations for new leaders to emerge.

It’s a privilege to have an active part in the Network. Spending time with the team and being involved in meaningful change for rural health is its own reward.”

Northern South Island representative Sharon Hansen: is a Nurse Practitioner based in Temuka. Sharon has both Bachelor’s and Master’s degrees in Nursing, has diplomas in psycho paediatrics and general obstetrics and in 2007 she attained Nurse Practitioner status. Sharon joined the Board in 2007 as Southern South Island region representative.

Darran Lowes, outgoing student representative: Darran is chair of the Aotearoa Rural Health Apprentices (ARHA) and is a fourth year medical student from Tauranga studying at the University of Auckland.

“Sitting on the NZRGPN board as the Student Representative for the past year has been a fantastic opportunity to learn more about the great work that the Network does and to work with the various rural student health groups around the country. The biggest highlight would be helping to organise part of the Network Conference and working with some very creative and talented students with a passion for rural health. I will soon be handing my role on the board over to Alisha Vara, an Auckland medical student who comes in with some great ideas after a year on the Grassroots Rural Health Club executive.”
State Contracts Committee

David Clarke, independent chairperson, State Contracts Committee

Reporting to the Network Board, the State Contracts Committee (SCC) has responsibility for monitoring the Network’s performance and delivery under the Ministry of Health-funded Rural Locum Support and Rural Recruitment Service contracts.

The key focus of the committee during the last financial year has been to consider the following issues:

**Protocols and Delegations**

Previously defined and agreed protocols and delegations are regularly monitored by the SCC to ensure compliance.

These protocols set out how the NZLocums team fairly prioritises and handles issues such as: Hotspot cover, Board members’ applications for locum cover and discretionary assistance.

NZLocums also has a prioritisation model and reporting framework, which have been developed and implemented within the NZLocums’ procedures.

**Review of recommendations made in the LECG audit report (August 2007)**

The review of the LECG audit report was completed in 2010 and in order to ensure compliance with two recommendations made by the LECG, the following points were noted:

Governance arrangements – The State Contracts Committee now has a rural Nurse Practitioner on the committee. (Rachel Hale having recently qualified).

Developing a vision for integral rural services – the Network is involved in a review of rural funding in a BSMC environment.

**Risk Management**

The committee is pleased to report that, following the tender process in September 2010, the Network successfully retained the MoH contract.

There will be ongoing work in developing and updating quality and risk management plans.

**Members of the State Contracts Committee are:**

- David Clark, chairman
- Dr Bernard Conlon, General Practitioner
- Rachel Hale, Nurse Practitioner
- Dr Michael Miller, General Practitioner.

Out of the initial 12 hard to fill vacancies identified for the Network to concentrate on in 2010, visits have been made to 11 of the practices and meetings held with the DHB/PHO and practice teams to explore the challenges to recruitment and retention in the region. The visits have been conducted by a small team from the Network, generally comprising of Board members and senior managers from the Network staff team meeting with either Planning and Funding Managers or Primary Healthcare Portfolio Managers at DHB level with representatives from PHO and practice, dependent upon location.

Five of the vacancies identified as being “hard to fill” have now been filled.

This work will be continuing with ongoing engagement with key stakeholders taking place during 2011.

**Service delivery to Hot Spot practices**

Following concern expressed by the committee in 2009 and in line with the Executive Board’s strategic plan, the NZLocums’ team undertook a series of meetings around the country to engage more closely with the DHBs/PHOs and practice team in areas where there were long held permanent vacancies. These “hard to fill” vacancies were those identified as having had an unfilled vacancy for a permanent GP for longer than three years.
There are two components to the Ministry of Health’s Recruitment Contract:

- **Rural Recruitment Service** – the purpose of this service is to assist eligible rural providers (currently those with a rural ranking score of 35 or more) with recruitment of long term or permanent General Practitioners and Nurse Practitioners (with prescribing capabilities). Our target delivery for 2010 was 60 placements, against which we made 161 placements (268% above target).

- **Rural Locums Support Service** – the purpose of this service is to ensure that eligible providers (currently those with a rural ranking score of 35 or more, but excluding those in Northland) can access up to two weeks’ locum relief per 1.0FTE, per annum. Our target for 2010 was to complete at least 85% of applications received, against which we delivered 86% (1% above target).

**Performance against Contractual Targets for the 2010 Calendar Year:**

### Short Term Placements

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<th>Target</th>
<th>Percent Completed</th>
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<tr>
<td>Quarter 2</td>
<td>85</td>
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<td>85</td>
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### Long Term Placements

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</tr>
<tr>
<td>Quarter 2</td>
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<tr>
<td>Quarter 3</td>
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<td>15</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>30</td>
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Placements by DHB region

The top three DHB regions to receive locums sourced by NZLocums in 2010 were Southern; MidCentral and Waikato.

Rural General Practice Placements made by DHB Region 2010

Where did our Locums come from?

The top three countries from which NZLocums recruited locums in 2010 were: United States of America; Canada and England.

Countries from which Locums were Recruited from in 2010
Strengthening Relationships with PHOs and DHBs

A key focus of 2010 was to strengthen relationships with PHOs and DHBs to better understand the long term recruitment issues pertaining to their region, then to work together to solve the “hard to fill vacancies” and “hot spots”. This year members of the management team, working alongside various board members, attended meetings with DHBs, PHOs and practices around the country. A further series of visits is planned for 2011.

Hard to fill hotspot vacancies in Rural General Practices as at 31 December 2010

1. Vacancies which have been on our books for more than three years.
2. Are unplanned and unresolved recruitment problems. They are not yet under control but are being worked on consistently in conjunction with the DHB and PHO.
Quality Assurance

We strive to place clinically sound and culturally competent locums into clinically sound and culturally competent practices and we ask specific feedback from locums and practices at the end of each placement as part of our quality improvement processes. We also conduct an annual satisfaction survey, the latest of which was conducted in May 2010, to which 50 currently placed locums and 79 rural general practices responded to structured questionnaires.

Feedback from the Locums:

Responses indicated a very high level of satisfaction by locums in the service provided by NZLocums staff:

<table>
<thead>
<tr>
<th>Question No</th>
<th>Question wording</th>
<th>% of locum respondents ranking NZLocums performance as Excellent or Very Good</th>
<th>% of locum respondents ranking NZLocums performance as Good</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>How easy was it to find/access the NZLocums recruitment service?</td>
<td>80%</td>
<td>18%</td>
</tr>
<tr>
<td>2</td>
<td>How knowledgeable /helpful were NZLocums staff during the recruitment process?</td>
<td>86%</td>
<td>10%</td>
</tr>
<tr>
<td>3</td>
<td>How would you rate the NZLocums orientation programme on arrival?</td>
<td>75%</td>
<td>20%</td>
</tr>
<tr>
<td>4</td>
<td>How well did the actual locum placement(s) meet your overall expectations?</td>
<td>75%</td>
<td>23%</td>
</tr>
<tr>
<td>5</td>
<td>How well were you supported by the NZLocums team throughout the process?</td>
<td>85%</td>
<td>10%</td>
</tr>
</tbody>
</table>

We also received some useful suggestions for quality improvements which we have implemented, or are in the process of addressing.

- Improve quality of information provided in the practice profiles – to make it easier for the locum to decide upfront whether to accept work
- Introduce minimum standards for accommodation across the country as there is currently too much variability. Comfortable queen size bed and internet access were deemed particularly important
- Enhance the orientation programme.

Feedback from general practices

Responses from rural general practices also indicate a high level of satisfaction as well as a very high level of knowledge about the rural recruitment services provided by NZLocums. 96% of respondents had used NZLocums for finding a locum or a new GP; 93% said the GP/Locum completed the placement; asked how well did the Locum/GP recruited by NZLocums meet the practice’s needs, 81% of respondents answered excellent or very good and 18% good; 81% rated the overall services provided by NZLocums as excellent or very good.

We also received some useful suggestions for quality improvements which we have implemented, or are in the process of addressing. However, some suggestions such as manufacturing more locums – especially those willing to do on call and are PRIME trained as well as striking a sessional rate that reflects market rates for the locum but which is also affordable to practices, remain a continual challenge.
Recruitment of Nurse Practitioners

The Network has a strong ethos with regard to the role of nurse practitioner (NP). The Network Board currently has two NPs and 1 NP candidate. The two NPs are both assessors for the Nursing Council of New Zealand and one sits on the States Contracts Committee.

For many years, we have actively promoted the value of NPs to rural general practice through NZLocums and have actively sought and encouraged applications from rural practices for NP placements for the rural recruitment service. Facilitating the recruitment and retention of NPs in rural general practice is consistent with the direction of the Government’s Better Sooner More Convenient health policy i.e. patients get better access to services which are closer to home – especially important for patients with high social needs (as opposed to those with high medical needs) – which equates to better health outcomes.

Since 2004, the Rural Recruitment Service has specified the recruitment of general practitioners and nurse practitioners. While we have exceeded the delivery targets for this contract every year these placements have all been for general practitioners rather than nurse practitioners.

Despite our concerted efforts to promote and encourage placement of NPs into rural general practice over many years, there have been, up until now, literally no requests for NP placements coming through from rural general practice.

We have asked ourselves why this might be? The reasons for this are complex:

• Youthful nature of the profession – the concept of NP and how it fits within the rural general practice team has not been well understood by the various professional groups. Therefore, it has been difficult to make placements for which there is no demand.

• NCNZ registration processes – current registration processes are lengthy and cumbersome. It takes a long time for a nurse to progress to becoming a NP – after nine years New Zealand has only approximately 81 NPs, 27 of whom have a scope of practice in primary care (with very few in rural health) and we understand that the youngest NP has just been registered at 32 years of age. Overseas trained NPs cannot work in NZ until they have NZ registration and they must follow the same process as for NZ-trained practitioners, which can take up to two years. Overseas trained NPs find the cultural competency component particularly challenging and tend to under-estimate its importance. However, we support holding the bar high with regards to cultural competency; even more so for rural communities which tend to be characterised by high Māori and high needs populations.

Thus, the low numbers of NZ trained NPs and the cumbersome registration process for overseas trained NPs has meant that the number of NPs the Network could have legally placed into rural general practice – even if there was a demand – has been very small.

We want to see NPs placed into rural general practices through the rural recruitment process.

Accordingly, during recent years the Network has undertaken research to better understand the readiness of rural general practice to include NPs in their workforce. Our most recent survey, undertaken in August 2010, indicates there is an increased acceptance of the NP role, in particular recognition of the value NPs can bring to the rural general practice team – both in terms of revenue and improved health outcomes for patients.

For this survey, 50 practices across a wide geographical range were selected to participate in the survey and all 50 practices submitted a response. Out of the 50 practices surveyed:

• 8 (16%) already engage the services of a NP
• 34 (68%) were interested to explore the possibility of engaging a NP
• 8 (16%) were not interested in engaging a NP.
On the basis of our research and experience, together with findings from the DHBNZ-led NP Pilots, we believe a multi-pronged approach is needed if the placement of long term and permanent NPs is to be successful in future, in rural general practice.

The Network has a philosophical preference to grow the NP workforce in New Zealand. There are many New Zealand nurses keen to step up to a higher clinical level and who are capable of doing so, given the right support and this most importantly would help keep our nurses in New Zealand. However, should an international NP wish to come to NZ and be prepared to put themselves through the registration process and meet the cultural competency requirements – and there was no domestic candidate available – then NZLocums would willingly process an application.
NZMedics

NZMedics had another busy year making placements in urban rural practice and in specialties such as: Orthopedics; Emergency Medicine; Anaesthetics; Paediatrics; Geriatrics/Gerontology and Radiology. During 2010 NZMedics also introduced two new services aimed at assisting organisations which experience large intakes of medical staff at various points in the year, with Human Resource activities such as processing Medical Council of New Zealand applications and immigration applications.

Where did our Medics come from?

The top three countries from which NZMedics recruited in 2010 were: United States of America; England and New Zealand.

Countries from which Medical Professionals were Recruited from in 2010

- England
- Germany
- New Zealand
- Philippines
- United States of America
- Holland

Immigration Service

In 2010 Julie Wilson, General Manager Recruitment, gained her Provisional Immigration Licence and is able to provide immigration advice – under supervision – to all our International Medical Graduates should they require it. This is proving to be a valued complementary service and Julie is on track to apply for her full license in 2011 at which time other recruitment staff will commence their provisional immigration status.
Summarised Statement of Financial Performance*
For the year ended 30 June 2010

<table>
<thead>
<tr>
<th>INCOME</th>
<th>Notes</th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income Received</td>
<td></td>
<td>6,917,952</td>
<td>5,296,881</td>
</tr>
<tr>
<td>LESS: DIRECT COSTS</td>
<td></td>
<td>4,033,337</td>
<td>2,778,441</td>
</tr>
<tr>
<td>GROSS SURPLUS</td>
<td></td>
<td>2,884,615</td>
<td>2,518,440</td>
</tr>
<tr>
<td>LESS: EXPENDITURE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amortisation</td>
<td>4</td>
<td>66,491</td>
<td>-</td>
</tr>
<tr>
<td>Audit Fees</td>
<td></td>
<td>11,748</td>
<td>14,016</td>
</tr>
<tr>
<td>Legal Fees</td>
<td></td>
<td>58,181</td>
<td>99,093</td>
</tr>
<tr>
<td>Depreciation</td>
<td>3</td>
<td>50,984</td>
<td>47,271</td>
</tr>
<tr>
<td>Kiwisaver Employer Contribution</td>
<td></td>
<td>13,861</td>
<td>-</td>
</tr>
<tr>
<td>Loss on Sale</td>
<td></td>
<td>-</td>
<td>2,429</td>
</tr>
<tr>
<td>Rent</td>
<td></td>
<td>88,397</td>
<td>51,596</td>
</tr>
<tr>
<td>Salaries &amp; Wages</td>
<td></td>
<td>1,272,810</td>
<td>1,069,546</td>
</tr>
<tr>
<td>Advertising</td>
<td></td>
<td>193,154</td>
<td>212,965</td>
</tr>
<tr>
<td>Conference &amp; Trade Shows</td>
<td></td>
<td>48,461</td>
<td>82,903</td>
</tr>
<tr>
<td>Other Expenses</td>
<td></td>
<td>811,868</td>
<td>686,941</td>
</tr>
<tr>
<td>TOTAL EXPENDITURE</td>
<td></td>
<td>2,615,955</td>
<td>2,266,760</td>
</tr>
<tr>
<td>NET SURPLUS</td>
<td></td>
<td>$268,660</td>
<td>$251,680</td>
</tr>
</tbody>
</table>
## Summarised Statement of Financial Position*

For the year ended 30 June 2010

<table>
<thead>
<tr>
<th>EQUITY</th>
<th>Notes</th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accumulated Funds</td>
<td></td>
<td>1,973,585</td>
<td>1,704,925</td>
</tr>
<tr>
<td><strong>TOTAL EQUITY</strong></td>
<td></td>
<td><strong>$1,973,585</strong></td>
<td><strong>$1,704,925</strong></td>
</tr>
</tbody>
</table>

Represented By

| CURRENT ASSETS          | 8     | 2,548,617  | 1,658,634  |
| FIXED ASSETS            | 3     | 166,898    | 142,746    |
| INTANGIBLE ASSETS       | 4     | 556,696    | 262,281    |
| **TOTAL ASSETS**        |       | **3,272,211** | **2,063,661** |
| CURRENT LIABILITIES     | 2     | 1,298,626  | 358,736    |
| **TOTAL LIABILITIES**   |       | 1,298,626  | 358,736    |
| **NET ASSETS**          |       | **$1,973,585** | **$1,704,925** |

## Statement of Movements in Equity

For the year ended 30 June 2010

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at Beginning of Year</td>
<td></td>
<td>1,704,925</td>
</tr>
<tr>
<td>Net Surplus/ (Deficit)</td>
<td></td>
<td>268,660</td>
</tr>
<tr>
<td>Total Recognised Revenues and Expenses</td>
<td>268,660</td>
<td>251,680</td>
</tr>
<tr>
<td><strong>BALANCE AT END YEAR</strong></td>
<td></td>
<td><strong>$1,973,585</strong></td>
</tr>
</tbody>
</table>

* The above financial information has been extracted and summarised from the 30 June 2010 audited accounts of the New Zealand Rural General Practice Network, for which an unqualified opinion was issued. The Auditors, PKF Martin Jarvie have reviewed the summary financial report prepared in accordance with FRS-39 and for consistency with the full financial report. The summary financial report does not provide a complete understanding as provided by the full financial report of the financial performance and financial position of the entity adopted on 18 February 2011. The data represents the performance of the New Zealand Rural General Practice Network activities. A full set of accounts is available to Members of the Society upon request to the Chief Executive.

Authorised:

Kirsty Murrell-McMillan  
Chairperson

Rachel Hale  
Treasurer

Dated 9 March 2011
Audit Report

To the readers of the New Zealand Rural General Practice Network (the Network) Summary Financial Report

We have audited the summary financial report of the Network for the year ended 30 June 2010 as set out on pages 19 to 20.

Responsibilities of the Executive Board

The Executive Board is responsible for the preparation of a summary financial report in accordance with generally accepted accounting practice in New Zealand. It is our responsibility to express to you an independent opinion on the summary financial report presented by the Executive Board.

Basis of Opinion

Our audit was conducted in accordance with New Zealand Auditing Standards and involved carrying out procedures to ensure the summary financial report is consistent with the full financial report on which the summary financial report is based. We also evaluated the overall adequacy of the presentation of information in the summary financial report against the requirements of Financial Reporting Standard 39: Summary Financial Reports (FRS-39).

Other than in our capacity as auditor we have no relationship with, or interest in the Network.

Unqualified Opinion

In our opinion, the information reported in the summary financial report complies with FRS-39: Summary Financial Reports and is consistent with the full financial report from which it is derived and upon which we expressed an unqualified audit opinion in our report to the Readers dated 18 February 2011.

We completed our work for the purposes of this report on 9 March 2011.

PKF MARTIN JARVIE
Wellington
**Network Membership**

**Communications and Membership Manager, Rob Olsen**

**Major Membership activities this year include:**

- Working on a review of the Rural Ranking Score in conjunction with the Ministry of Health and DHBs
- Providing additional support (moral and workforce) following recent tragedies including the Pike River Mine disaster and the two earthquakes in Canterbury
- Successfully tendering for the Ministry of Health contract for the supply of Rural Recruitment and Locum Support Services
- Organising the annual conference to be held in Wellington in March, 2011.

Late last year the Network circulated a survey to 210 practices seeking feedback to inform the redefinition of the RRS. This is a complex piece of work and will be the number one priority for the Network in the coming months. In September 2010 the Ministry of Health called for expressions of interest in the contract for the supply of Rural Recruitment and Locum Support Services. This was the first time the contract had been put out for public tender and resulted in the Network retaining the service to supply locum doctors and nurse practitioners to rural general practices in New Zealand.

The Network has provided significant resource and moral support in response to major disasters last year, including provision of GP locum support to Greymouth following the Pike River Mine disaster in November 2010 and has worked alongside GPNZ supporting practices in the Canterbury region following the two earthquakes, one in September 2010 and the other in February 2011.

The Network’s annual conference, the rural health sector’s showcase event, will take place in March in Wellington this year. The conference is an opportunity for Members and others to join together for CME accredited workshops and plenary and concurrent sessions, hear keynote speakers and network and socialise with peers.

**Membership**

Membership currently stands at 531 – 315 Doctors, 185 Nurses, 15 Managers, 8 Friends, 4 Others, 2 Midwives, 2 students. (see pie graph this page).

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**Network Membership as at November 2010**

![Pie chart showing membership breakdown]

**Levy structure for 2012**

In order to provide more flexibility to current members and to attract new members to the Network, the Board has approved a two option membership levy structure for the 2012 calendar year (see chart below). However, please note that the new practice rate does not replace the existing individual rate structure, nor is there any change to voting rights under the Constitution – this is still on an individual basis.

It is hoped that the new levy structure will build Membership and generate adequate revenue to enable the organisation to better deliver upon the strategic direction determined by the board.

According to our database there are 1548 rural general practitioners (and others): (717 Nurses, 563 GPs, 268 Others/Managers, etc). The introduction of a practice rate could potentially result in another 700 Members signing up for the 2012 year and beyond.

<table>
<thead>
<tr>
<th>Practice size</th>
<th>Cost</th>
<th>Comparable to existing individual rate (average size)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 5 staff</td>
<td>$279</td>
<td>$335</td>
</tr>
<tr>
<td>5 – 10 staff</td>
<td>$579</td>
<td>$615</td>
</tr>
<tr>
<td>10 – 20 staff</td>
<td>$1079</td>
<td>$1515</td>
</tr>
<tr>
<td>20 or more staff</td>
<td>$1479</td>
<td>$1675</td>
</tr>
</tbody>
</table>
Regional Membership/advocacy visits

Visits to practices in the lower North Island and Northland have taken place (December 2010 and February 2011) to promote Membership and raise Conference awareness. Several more visits around the six regions are planned during the year.

Following the September 4 Christchurch earthquake visits were also undertaken to rural Canterbury practices as part of the Network’s efforts, in conjunction with GPNZ, to support rural practices in the region.

Student Membership

Outgoing Aotearoa Rural Health Apprentices representative and the Board’s student representative, Darran Lowes, has highlighted several issues and initiatives that the two groups could work on together. These include:

• NZRGPN to provide clarity around graduate career pathways in rural (via website or information pack given to new student Members)

• Provide a database of rural health professionals willing to assist students (work together to encourage more rural GPs to host students)

• Develop a database of rural GPs willing to host students

• Develop students as future leaders in rural health – NZRGPN could facilitate leadership development seminars where rural health professionals could pass on their skills. The annual NZRGPN conference could be the forum for this type of seminar

• Involve NZRGPN in follow up on rural school visits by student rural health groups (SRHG) designed to encourage younger students from rural areas to pursue careers in rural health

• SRHG promote NZRGPN membership to medical students in Auckland and Otago and approach other groups such as student nursing associations

• SRHG present a session at the NZRGPN annual conference.

The Board is currently looking at ways to incorporate these activities into the Strategic Plan for 2011-2013.
German-born GP and keen photographer Astrid Bodendieck, is working in Balclutha as a locum GP through NZLocums.