








Network*News*

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'Rural Health Solutions'

Queenstown to host conference 2012 *see page 11*

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Doctor, minister, teacher, Mum ...

Dr Jane Laver is a woman of many talents. As well as being a GP partner in a busy Dannevirke practice she is also an ordained Minister in the Anglican Church, a French teacher and a mother of four children aged 18, 17, 15 and 12.

Dr Laver recently joined the Network Board as its North Island representative and while she acknowledges there is a lot to learn, she says she is looking forward to the challenges offered.

She and her husband Guy live in the small southern Hawke's Bay town of Weber, not far from Dannevirke where she is a partner in the Barraud Street Health Centre. The Lavers run 1500 deer on two properties – 360 and 280 acres each. Originally from South Wales, Dr Laver admits she had no farming experience prior to meeting her husband, who is a farmer.

Dr Laver trained at Guy's Hospital in south London very near to London Bridge. She recalls her first flat as being "an absolute dive of a place". They were council flats near the Tower Bridge that no-one wanted to live in, so they put students in them because they looked after the properties and did things to improve them. She remembers it as an interesting place to live. There were two suspicious fires that brought everyone out on to the street. One was caused when a lighted object was pushed through the flat door of a transgender man. "It was a great way to meet your neighbours," she says.

Dr Laver began her medical training in 1980 and qualified in 1985, then worked in ED, paediatrics and obstetrics for four years in London and Devon. She had already decided that general practice was where her future lay. As fate would have it, a job advertised in the British Medical Journal brought her to New Zealand and Hastings in 1991 where she again worked in paediatrics. "I was single at the time".

"And then I met my husband through a work friend." Children followed and three years off work. "Then I thought if I don't go back to work now I won't have the confidence to go back at all."

Her GP at the time – Murray Bycroft – offered her a job. "I jumped at the chance," she says.

In 1995 there were four practices in Dannevirke. Now there is one main health centre with one other practice.

One of the best things about being a rural GP is living in the community you work in, she says. In fact one of her children once asked her if she was famous because "everyone knows you". She is often approached out of hours by people who are patients. "One woman showed me her breast in the supermarket." She draws the line at patients turning up at her house telling people she does not have equipment at home. "You have to be quite firm."

Dr Laver doesn't attend a lot of roadside accidents although she does get called out to crashes on occasion. The ambulance staff "know where I am" so she does get the call from time to time if someone is having a baby, for example. Overall the community is very supportive. They rally around the practice and it's been fantastic for the children to grow up in a rural community. "All of our children went to local primary schools."

The downside of living rurally is the amount of travel involved getting children to and from various events, for example.

Though proclaiming not to be fluent at French and "a little bit better than O Level", Dr Laver teaches French to local year six, seven and eight students. "I offered because I knew they had to learn another language as part of the curriculum."

Her interest in the language is strong. She has a sister living in France with French-speaking children – and Dr Laver and her husband host French students through the family connection and a student exchange through a college in France, which has been running for three or four years.

However, her interest in the language is set to take off next year when her youngest goes to high school and she has a bit more time on her hands.

Her other claim to fame is as a Minister in the Anglican Church. It's a role she



NEWBEE – Dr Jane Laver is the new North Island representative on the Network's Board.

describes as a "local shared ministry". About five people share the role which covers church services, sermons, weddings, funerals and baptisms. Weber had its own Minister but that situation became uneconomic and the idea for a shared ministry was hatched and "my name was put into the hat and I accepted the challenge".

Brought up as a Baptist – Dr Laver's grandfather was a lay preacher in that church – she had not been active in it but rediscovered her faith after the birth of her first child.

The local ministry is mainly involved in community and everyday work. Family hardship and child health and poverty are a real concern for Dr Laver. "A lot of general practice is ministry-related work. It's a good fit," she says.

"It's not recognised that children are suffering and that there's child poverty in New Zealand. We have a terrible record in rural New Zealand," says Dr Laver citing the high rate of rheumatic fever in Maori children in Northland as an example.

"I see people struggling to put good food in front of their children."

Notes from the Chair

The importance of speaking to each other

By Network Chairman
Dr Jo Scott-Jones

In a world that is becoming increasingly dependent on technology to communicate – and rightly so under many circumstances - we should not forget the power of face-to-face conversation, around the table to negotiate and air our differences, issues and problems.

For a group of people whose work involves expert levels of communication, health professionals seem oddly disabled when it comes to discussing change in the way services are to be delivered or funded.

As a good Catholic boy should, let me first say "mea culpa, mea culpa," having realised the power of email and the written word to confuse, to distort and to make opinions seem concrete.

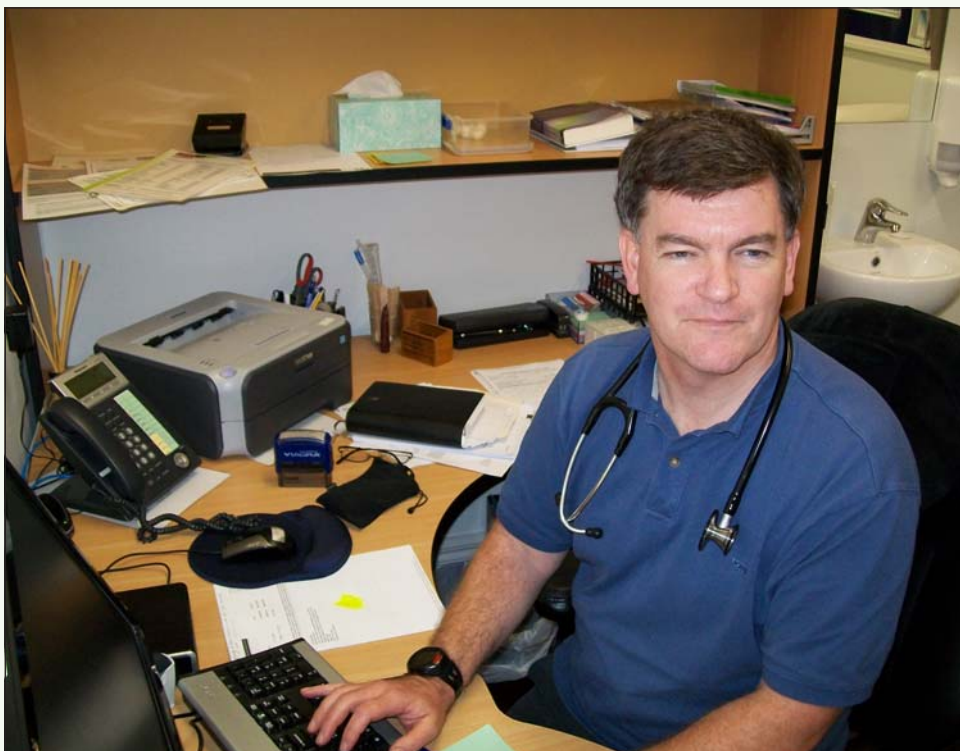
In the past I have fallen into the trap of using the convenience of the electronic age to respond to questions and make statements when a conversation would have been much more fruitful and less open to misinterpretation.

As I watch the Network team dampening the various "bushfires" that are flaring around the country, the absence of real conversation seems a common theme.

Many Maori value communication "kanohi ki te kanohi" or "face to face" and once again society as a whole would benefit from learning from the culture of indigenous people. We need to speak to each other.

There is good evidence that communities which have high levels of "community cohesion" are more sustainable and healthier.

It is a running joke that levels of communication between health providers in small communities can be compared to the Middle Eastern conflict, with the dispute over the 1968 borders paralleled by the competitive nature of small practices compounded by fiercely independent providers whose memories are long and whose capacity to forgive is short.



DOCTOR IN THE HOUSE: Jo Scott-Jones at his Opotiki practice.

We first need to begin by helping ourselves; it is important to develop communities of interest in your own region. Getting together with your local colleagues across disciplines on a regular basis is the foundation for good engagement with funders and planners when in future they come looking for your opinions on proposed change.

It is clear that change is in the wind. No-one can have listened to the budget without hearing the strain in the ropes as health once again got the lion's share of new spending. DHBs work as independent bodies from the MoH, trying to serve their population's health needs within their allowed budgets, and unfortunately the further away you are from the base hospital the more costly your service becomes to the bean counters.

We may argue that the services we provide in rural communities are essential to the people who live and work in the economic powerhouse of our commodity driven, export dependent country, but we have

to be able to justify how we are using the public money on which we depend.

We need to show clearly what benefit our communities get from the money government and DHBs invest in our services.

The Network is developing a "Rural Proofing Tool" that aims to give guidance to policy makers and planners to help them consider the impact of regional change on rural communities and to help them better communicate with rural people.

Providers can help by developing strong links with community through patient participation groups, linking in with the local councils (we have paved the way for you through the rural and provincial mayors forum), and your kaumatua and iwi connections.

But most of all, you can help by burying whatever hatchets you have and talking to your colleagues.

See also profile – page 6

Kirsty's time and efforts as chairperson recognised

Members of the Network Board and invited guests paid tribute to immediate past chairwoman Kirsty Murrell-McMillan at a dinner in her honour in Wellington recently.

Kirsty resigned as Network chair earlier this year to focus on her career, attaining Nurse Practitioner status, and her family.

Kirsty was the first nurse to lead a general practice-based organisation in New Zealand and the world. She succeeded Wellsford-based Dr Tim Malloy in 2008 and served three years as chair. Opotiki-based doctor Jo Scott-Jones took over the reins in March this year.

Kirsty was presented with artwork by Whangarei fabric artist Shirley Julian at the Wellington dinner. The piece depicts the Network logo, a map of New Zealand, the Registered Nurse's Star, Lake Manapouri, mountains, forests, Roxburgh and stylised images of Dunedin and Invercargill where Kirsty taught nursing. The piece was also inspired by Kirsty being the first nurse to lead a general practice-based organisation in New Zealand.

Kirsty joined the Board in 2004 in an ex-officio role then as a regional representative before taking over as chair. She says her appointment was seen as a "natural progression" in line with the merger between the Rural General Practice Network and the Rural Nurses National Network. "It seemed to be a natural progression in that that general practice was made up of doctors, nurses and practice managers and that allowed for the governance and leadership of the organisation to have a nurse at the helm."

She believes the Network needs to encourage doctors and nurses to get involved with the Network to ensure succession not only on the Board but also at chair level.

"It's irrelevant who you are. Less needs to be made about a person's occupation and more about whether they have the leadership qualities and skills to do the chair's job."

Kirsty remains "very passionate" about rural general practice and the role of rural nurses

in the general practice team. She wants to remain part of the Network family and to work alongside of, and offer support to, nurses and practitioners at a grass roots level as well as in a "wise heads" capacity alongside people such as Tim Malloy and Graeme Fenton, a far North GP and long-time Board member.

Kirsty says she could not have acted as chair without the "wise heads" back up. "What became very clear to me as chair was I could not have done it without that support.

"There were many people waiting for a nurse to fall over and say we couldn't do it or that we didn't have the ability to do it. I think that my tenure proved that we really could do it. But you have to realise that you don't know everything and there are plenty of people out there who will help and support you in that role."

The biggest challenges she faced included understanding rural funding, how general practices work, the needs of the people who work in the sector, and how the locums' recruitment contract worked.

Top of the list of achievements were "working with an incredible board", retaining and securing funding, (including after-hours funding), reviewing and installing a new PRIME curriculum, holding the organisation together in uncertain economic times and getting around general practices, meeting people and seeing first-hand what the issues are. Being admitted as a member organisation to WONCA was another highlight. "There were many things we achieved as a team," says Kirsty.

Being part of the General Practice Leaders' Forum and being able to articulate within that forum that rural general practice worked as a team, was another hallmark of Kirsty's time as chair.

Having more time to focus on her career and family has been "absolutely



THANK YOU: Kirsty (top right and bottom) and the artwork presented to her at the Wellington dinner in her honour. Also pictured (top) are Kirsty's husband Chris (left) and Board member Kim Gosman.

fantastic", says Kirsty. "One of the things I feel strongly about is that being involved in an organisation or sector politically and nationally involves a huge amount of personal commitment and it's not for the faint-hearted. It's extremely demanding and we do have to rotate that leadership."

Kirsty paid tribute to Dr Jo Scott-Jones in his role as chair since taking over in March this year.

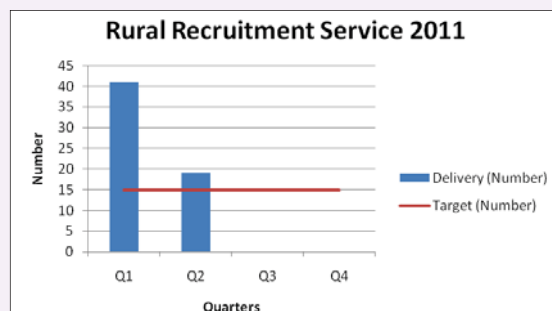
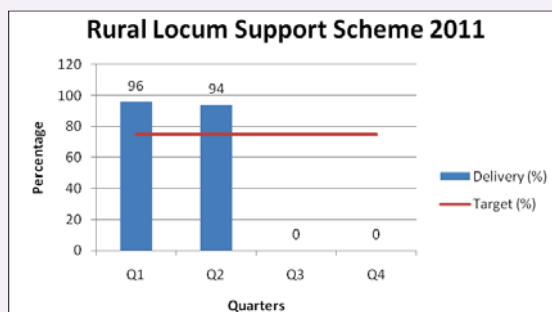
NZLocums' second quarter targets on track

There are two components to the Ministry of Health's Recruitment Contract managed by the Network: Rural Recruitment Service (long term) and Rural Locum Support Scheme (short term).

The following figures and bar graphs show NZLocums' performance against recruitment contract targets for the second quarter of 2011.

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 the second quarter of 2011 was 15 placements, against which we made 19 placements (26% above target), year to date 60%.

Rural Locum Support Scheme – 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 the second quarter of 2011 was to complete at least 75% of applications received, against which we delivered 94% (19% above target), year to date 95%.



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Q and A with Network Chairman Dr Jo Scott-Jones

NN: Where are you from originally and when did you come to New Zealand?

JSJ: **Liverpool in England, and arrived here via Sheffield, Bristol, Newcastle in Australia, then Kawerau and Opotiki in 1992.**

NN: Where did you meet your wife and what does she do (professionally and family)?

JSJ: **We met at University in Sheffield although she is also from Liverpool and we probably met first at a 6th form mass about three years earlier, she is a deputy principal and English teacher at Trident high school in Whakatane.**

NN: How many children do you have and how old are they?

JSJ: **We have five children aged 11, 15, 19, 21 and 22.**

NN: When did you decide you wanted to study medicine/become a doctor?

JSJ: **I never wanted to do anything else, my Dad was a nurse and I think it was the chocolates he brought back from the ward that first got me thinking this was a rewarding job.**

NN: What are your qualifications/achievements?

JSJ: **I have a diploma in geriatric medicine, sports medicine, obstetrics, membership of the UK college of GPs, fellowship of the RNZCGP, who awarded me a distinguished services medal a couple of years ago, and completed my Masters of Medical Sciences in 2010. I am currently studying for a certificate in clinical education.**

NN: What brought you to rural practice and Opotiki?

JSJ: **We came to New Zealand with a plan for a six month trip and found ourselves in a wonderful part of the**

world, met some great people and found satisfying work.

NN: What's the most challenging and rewarding aspects of working in rural health?

JSJ: **Rural communities are often areas of high need, where people are desperately grateful for what you can offer, where the broadest range of skills can be utilised, and the sense of community is warm and enveloping, all of these benefits can be very challenging as well.**

NN: What motivated you to get involved in the political/organisational/governance side of rural health (i.e. the Network Board)?

JSJ: **I have always been the sort of person who fills embarrassing silences in meetings, and cannot stop myself asking questions, it was only a matter of time before someone was going to ask me to put some time behind my mouth. I am also aware that there are people who will get involved in governance, and others whose energy will go elsewhere, I think if you have an interest in how things work and improving systems, you have a responsibility to follow that interest.**

NN: Did you imagine you'd be at the helm of the Network?

JSJ: **No.**

NN: What's the most challenging aspect of it so far?

JSJ: **Time management and answering questions from reporters, I can see it will be incredibly easy to say something really stupid in answer to a leading question.**

NN: Looking back, what have been the best and worst (separately) experiences in health?

JSJ: **I really enjoy teaching and recently an ex-student approached me and said how much he had enjoyed his time in the surgery 10 years ago, which was lovely, but perhaps the most exciting time was delivering unexpected twins, the second one a breech presentation, I was so chuffed I came home and mimed the experience to my wife using a couple of the kids' stuffed toys and a pillow, I think she was heavily pregnant herself at the time.**

The worst time has to be attending a car accident where there were multiple casualties, and although we managed the scene well, we were unable to save a nine year old girl who had a chest injury.

NN: What advice would you give to young medical/nursing students looking to rural as a health career?

JSJ: **Our students are always reflecting on the range of work they get to do in rural practice, and I think that rural communities offer young professionals a fantastic training base, sometimes you have to ask to receive and I would encourage students to actively look for opportunities to do training in rural settings.**

NN: What do you do in your spare time?

JSJ: **Spare time? I'm sorry? Am I missing something?**

I enjoy taking part in the local theatre group, listening to music and reading.... and the kids....and supporting my wife.

NN: What New Zealander do you admire the most?

JSJ: **I have a good friend who personifies many rural New Zealanders. In a quiet unassuming way he is absolutely dedicated to his family, and his community, he is a person whose word is his bond, and whose friendship once earned is honest and solid.**



Is enough being done to attract graduates to rural areas?

By Alisha Vara,
Network Board student representative.

The short answer to that question, in my opinion, is NO.

It's a little bit sad that the government has to 'bribe' us to come to rural places to work – supposedly the students who grew up rural who are more likely to go back to rural places to work – therefore Auckland introduced their ROMPE (Rural Origin Medical Preferential Entry Scheme) and Otago introduced admission through the New Zealand Rural Origins sub category. However, a part of me can't help thinking that if we had more exposure to the rural health workforce during our time at medical school – then the option to go rural would be more significant for a whole lot of students.

During my six years at medical school, I will spend two weeks on a rural GP placement in my fourth year, and three or six weeks on a rural GP placement in my sixth year. Some people are lucky enough to go to Whangarei for a year if they're from Auckland, or go to rural immersion programmes for the Otago students for an extra taste of rural. Still, the number of students in their fifth year going to Whangarei is only 24. Roughly speaking, the overall number of clinical weeks for fourth, fifth and sixth year students is around 110. With only eight weeks of rural exposure, that's only 7 per cent of my time at medical school. That's terrible, no wonder students don't want to go to rural placements – they've hardly experienced it. Ultimately, the big city with its flash hospitals and power dressing suits is more enticing.

One of the issues the medical faculty claims to have is that generally there are not enough places for medical students to go to. On our selective in fifth year (four weeks of a placement wherever in the world we want to go), if we choose to stay

in New Zealand there is one rule: no GP placements, because apparently, there's not enough GPs to go around. Last time I checked Auckland was overrun with GPs. Is the problem that not enough senior GPs are putting their hands up to teach? Or is it truly a lack of teachers. One of the most important things from this year that I have learnt is, your teacher is everything. Your consultant/registrar/house officer on your team IS everything. If your team doesn't want to teach you (and many don't), then you are left to fend for yourself in the big bad world of medicine.

When I become a doctor- I can honestly say, I hope I become a good teacher first. Good rural teachers equals happy students on rural placements, which in turn equals students who want to come back and be rural doctors. Elementary isn't it?

On a separate but closely associated note, most medical students I know complain a lot about money or rather the lack of it. That's why Otago students have it better in some respects – flatting is so cheap for them compared to Auckland or the other bigger centres – try paying weekly living costs \$210 for rent plus expenses plus food on a \$161.20 weekly budget from the government. It's ok though, we're all going to be doctors someday right, earning a lot of money?

One of the best things about my rural placement was that accommodation was dirt cheap compared to my overpriced flat in Newmarket, Auckland. And another thing, if I choose to go to a rural workplace when I graduate, and stay there for three to five years the government will give me an extra \$10,000 a year to live. Add in cheaper living costs compared to the big city, spectacular rural scenery, and a relaxed lifestyle in the country, then surely we have a winner!

Midwifery system hailed as world leader

New Zealand midwives provide the best care in the world for mothers and newborn babies.

That's how international delegates attending a major international conference on midwifery and maternity care have described New Zealand's midwifery led maternity model of care.

They acknowledged that New Zealand is leading the world in setting the standards for midwifery practice and professionalism, citing midwifery education, regulation and training, and strong collaboration with other health professionals.

The State of the World's Midwifery report, published by 29 leading world health agencies was launched at the conference. The report highlighted "midwifery services as the focus of global efforts to realise the best possible care during pregnancy and childbirth for every woman and her newborn".

Extra funding for better nursing care for patients

Health Minister Tony Ryall has approved an extra \$800,000 over two years to help nurses better match the needs of their patients with the staff and resources available.

Mr Ryall says six District Health Boards are already running a programme to better match staff and resources to patients (the Care Capacity Demand Management (CCDM) programme).

"These DHBs are provided 12 months, onsite support from a nurse-led group called the Safe Staffing Healthy Workplaces Unit which works with clinicians and other staff to remodel staffing and resources to achieve the best fit."

The CCDM programme fits in with and adds value to other DHB innovations – like the Productive Ward – which are aimed at ensuring that care is well organised and well run.

There are plans for three more DHBs to take up the CCDM programme in this financial year and the extra Government funding will enable a further six to participate over the next two years.

Fabulous Fielddays – spreading the word

The Network took its place amongst the agricultural machinery, animals and town and country folk at the recent Hamilton Fielddays in conjunction with the Mobile Surgical Services team and Programme Incubator Hawke's Bay.

The surgical bus, high tech equipment, its dedicated team, Incubator, Network staff – which included several Board members – along with representatives from the Pat Farry Rural Education Trust, occupied a large corner site in the centre of the sprawling Fielddays site at Mystery Creek.

Several thousand people took the opportunity to see the inside of the surgical bus and talk to staff, then exited into a large marquee where more high tech equipment was on display and staff ready to answer any questions members of the public asked.

The Network was there primarily to promote itself, its role in locum recruitment

and retention and general advocacy to the public. Board Members Dr David Wilson, Dr Fiona Bolden, Matamata Nurse Practitioner Rachel Hale and Raglan nurse Claire Davies volunteered their time to staff the Network stand and surgical bus.

Dr Wilson, from Whitianga, was the "Johnny on the spot" when St John officers referred a man with an eye injury to the surgical bus. As luck would have it there was an optometry student and slit lamp on site as part of the surgical bus entourage.

In a 10-minute operation Dr Wilson extracted a small metal fragment out of the patient's cornea. "I used the lamp to see what was in the eye and focus on it while I dug it out with a sterile needle. I had to numb the eye with a local anaesthetic from the surgical bus."

Dr Wilson was also busy out of the operating theatre offering spot mole checks

to passersby, which proved popular.

Dr Bolden said the experience was "inspiring".

"I really enjoyed it. They were a friendly crew; the technology was fantastic and gave me new insights into what could be possible in the future with adequate funding."

Rachel described the experience as interactive, revealing and fun. "I interacted with a lot of people and was amazed at the amount of rural men who don't have regular health checks. Some were seeing their doctor once in 10 years unless it was for an injury. Many people had never heard of the surgical bus service or the Network. Others were amazed at the technology now available such as BP cuffs and electronic self-monitoring that enable people to track their health at home.

Mobile Surgical Services was awarded the "Best Site Premier Feature Area".



Network deputy chair Rachel Hale (right) talks to visitors to the surgical bus marquee.



Crowds at the Fielddays' site. The surgical bus is located centre left of the photo.



Board member Dr David Wilson removes a metal fragment from a man's eye with the aid of a slit lamp.



Pat Farry Rural Health Education Trust promotions manager Sarah Swale (right) explains the concept to a member of the public.

Programme Incubator has a future vision for rural health

Hawke's Bay-based Programme Incubator is blazing trails promoting medical and health sector careers to secondary school students across rural New Zealand with a helping-hand from DHBs.

The award-winning initiative aims to link classroom learning with the workplace to develop a regionally competent and appropriate workforce able to apply best health practices and address community health issues New Zealand-wide.

The Hawke's Bay-developed and controlled initiative was launched in 2007 and currently covers five rural DHBs around New Zealand - Hawke's Bay (18 regional and one national school), Tairāwhiti (six regional schools in the North Island's East Coast), Northland (four regional schools), Taranaki, (seven regional schools), West Coast (South Island, two regional schools) and Southland (four regional schools), with the managed rollout seeing all DHBs expanding participating school numbers.

The programme provides professional staff, infrastructure, training and resources to schools on-site to provide experiences from the health sector, to students.

Approximately 800 students are involved nationwide, about 400 of them in Hawke's Bay. The programme is fully funded by the DHBs although *Programme Incubator* Manager Wynn Schollum says he is pursuing community based funding in a partnership approach for each region.

In Hawke's Bay between 120 and 150 DHB staff – about two or three each session – give up their time to work with the students. Those involved cover mental health, social work, medical, nursing physiotherapists and occupational therapy professionals – providing a health sector-wide awareness of opportunities.

"It's about having the right staff in the right place. There needs to be equity in health professionals across our sector, for example Maori are greatly underrepresented across all professions," says Mr Schollum.

The main aim is to get kids who are achieving through school, to identify health



FOSTERING THE FUTURE: Wynn Schollum is pictured with one of the interactive "toys" designed to give young people a hands-on opportunity to health careers.

as a career and to future-proof the sector's workforce through local staffing - improving in both recruitment and retention. Promoting personal health amongst students and whānau is a huge secondary outcome, says Mr Schollum.

The programme has identified a gap between directed learning in low-decile schools and self-directed learning in high-decile schools, which impacts on the workforce down the line. There are developments now, within the programme and associated tertiary providers, looking at supporting this transition.

A running database is kept on students involved in the programme in order to track their progress.

Some students are offered paid internships during term breaks to further promote the career path.

"They are getting to touch and feel health,

which is what the programme is based on. It exposes the yuk factor and engages with students' emotional intelligence in this 'feel for health'."

The programme carries several key messages for students:

A medical qualification offers overseas travel but "we want you to come back", money, personal health and well-being and exposure to the "team" workforce.

It has won four national innovation awards across the three sectors of IT, Health and Public Service.

Programme Incubator recently featured at Fieldays at Mystery Creek as part of the Mobile Surgical Services road show. Hands-on displays attracted youngsters to try their hands at tasks such as keyhole surgery – tying knots and unwrapping Minties using the procedure.

Rural Broadband Initiative connecting heartland NZ

Last month, Telecom and Vodafone began rolling out faster broadband deep into rural New Zealand, offering the kinds of services currently enjoyed in urban areas.



By Paul Leslie, Telecom's head of community relations

To be completed over six years, the RBI will bring major improvements to internet access in rural New Zealand. The project is based on using five technologies – copper, fibre, fixed wireless, digital microwave radio and mobile – to deliver broadband deep into New Zealand's rural heartland.

Telecom's role in the RBI is to deliver the Government's objective of connecting 93 per cent of rural schools to ultra-fast broadband, by building and delivering the fibre-based fixed infrastructure and services. To achieve this, Telecom will connect around 750 schools, as well as six hospitals, to enable broadband speeds of 100Mbps.

And, as well as hooking up rural schools and hospitals, Telecom's network arm, Chorus, will be laying around 3,100km of new fibre, to deliver fast broadband deeper into rural New Zealand. This builds on the 27,000km of fibre Telecom already has in the ground - that's enough to cover the trip from Bluff to Cape Reinga 12 times over.

This means half of all rural lines will be able to access speeds of over 10Mbps and over a third will be able to access speeds of over 20Mbps – the kind of broadband that's currently available in urban areas, capable of sending and receiving large files (such as music and photos) quickly, accessing and downloading content-rich websites and streaming video.

This new fibre will also enable about 40,000 lines into rural homes, halls, sheds and offices to get broadband for the first time.

Within the first year, about 500 rural schools – covering over 80 per cent of rural pupils - will benefit from this ultra-fast broadband service, enabling them to access online resources, stream video over the internet, take part in online learning sessions and all kinds of other high-speed internet-based activity. During the same period, five hospitals (Waikari, Murchison, Gisborne, Tuatapare Maternity, and Dunstan) will also be connected to fibre.

And because all infrastructure built under the RBI is open access, other internet service providers can use it to deliver their own broadband straight to customers. More than 50 service providers like TelstraClear, Callplus, Slingshot, Orcon, Actrix, and Farmside already offer these products in urban areas, and will now be able to do so in rural communities – that means more choice and better value for customers.

Telecom is committed to keeping rural communities and key stakeholders such as the Network fully up to speed with the project. Visit our website to learn more about how the RBI will benefit your community and your practice.

www.telecom.co.nz/rural-broadband

The Network is working with Telecom and other parties involved in the Rural Broadband Initiative (RBI) to distribute information and get feedback about broadband, how it works and how it can benefit rural general practice and rural communities generally. Your feedback and questions are welcome. During September the Network will also survey rural practices about their broadband status, capability and expectations. The survey will be electronic and sent via email. Keep an eye out for it.

Network chairman Dr Jo Scott-Jones has been named as a member of the National Advisory Committee that will provide ongoing advice and guidance to the MED, Telecom and Vodafone on issues affecting the RBI rollout. Its focus is at the national level to: provide feedback on the RBI plans, taking into account the views, expectations and concerns of rural end users; facilitate collaboration between the RBI partners and key rural stakeholders during the rollout of the RBI; and to identify opportunities for raising awareness of the RBI amongst rural end users and stimulating demand for rural broadband services. Dr Scott-Jones encourages Members to: find out what the RBI is doing in their locality, in particular where the fibre will go; think about how they will fund their connection and what additional IT upgrades they might need (i.e. webcams, security systems); contact their local councils to ensure positive relationships exists towards the RBI partners (otherwise uptake of the service in your area may be slower) and to think about the functionality this initiative will bring to their practice in terms of telemedicine (support for practice activities) and e-health (support for patient care).



Queenstown to host Network conference, March 2012



The Changing Face of Rural Health

The New Zealand Rural General Practice Network's annual conference returns to the South Island next year. Queenstown will host rural health's showcase event from March 8-11 at the Millennium-Copthorne hotels.

The conference's theme is "The Changing Face of Rural Health", designed to encompass innovations, developments, research, technology and trends in the sector. This will include general topics such as the Rural Ranking Score, Rural Broadband Initiative, the Integrated Family Health Centre, the team approach to rural health, along with a host of medical and clinical sessions and workshops.

Conference committee co-conveners are rural hospital doctor James Reid and Kaikoura practice nurse Deb Bailey. Other committee members are Raglan GP and Network Board member Dr Fiona Bolden, Amberley practice manager Mike Northmore, new Network Board Member Professor Ross Lawrenson, Dr Pragati

Gautama, medical student Alisha Vara, Network communications manager Rob Olsen and Wendy Boyce from Conference Innovators.

Early Bird registrations will be open from November 2011 to February 2012 and don't forget that Network Members get a significant discount on the registration fee. If you are not a Member visit www.rgpn.org.nz and click on the "Join the Network" tab.

The conference will also host the gala launch of the Pat Farry Rural Education Trust

fundraiser – a wine and art auction to be held on the Saturday night (March 10).

A five kilometre and 10 kilometre fun run is also planned. Registration will be by koha with proceeds going to the Pat Farry Trust.

Details of the programme and other conference events and highlights, the auction and the fun run will be advised at a later date via the Network and official conference websites and the Network's fortnightly newsletter – e-zine.



TOP SPOT: The Millennium Hotel is the main conference venue. Pictured top is the Galaxy Ballroom and the garden setting (above).

Practice Membership rate coming soon

The 2012 calendar year heralds the introduction of a discount rate for practices joining the Network.

The "Practice Rate" was approved by the Network's Board earlier this year and offers a tiered pricing structure based on the number of staff per practice.

The new rate collectively gives all staff in a practice Membership under the existing categories – Full Membership with voting rights (Rural GP/MOSS and Rural Nurse/Nurse Specialist/Nurse Practitioner) and Associate Membership with no voting rights (Rural Hospital Nurses/Midwives/Rural Practice or Hospital Managers/Other Health Professionals).

Should a practice not wish to join under the new rate, it is still possible to join as an individual.

Network Membership manager Rob Olsen says the new practice rate offers a significant cost saving for practices as a whole in contrast to individuals joining the Network. Membership benefits include advocacy at local, regional and national levels, annual conference registration discounts, the opportunity to contribute to a range of submissions relevant to rural health and access to sector information and updates through the Network's e-newsletter and quarterly magazine.

A new student Membership rate - \$40 for the duration of the student's medical or nursing training – is also now available.

The range of Membership rates will be offered to practices in November 2011, in line with renewal notices for the 2012 calendar year.

For more information contact Network communications and membership manager Rob Olsen on 04 495 5887, 021 82 2468 or email: rob@rgpn.org.nz

Online self-diagnosis on the rise

An epidemic of cyberchondria has doctors warning patients to steer clear of self-diagnosis on the internet, a new phenomenon that they say is causing a lot of unnecessary emotional distress.

Queenstown doctor Val Miller said she has even been forced to arrange MRI and CT scans for patients in some cases, knowing they did not require them. The patients had so convinced themselves of their illness after researching symptoms on the internet.

"They then think they shouldn't have to pay (for the scan) but their insurance company won't pay if it's not medically indicated," Dr Miller said.

Patients were increasingly arriving at her surgery, having "Googled" their symptoms, convinced they had some serious disease like cancer when in fact it was something minor.

(Courtesy Southland Times)

Strong demand for disaster response workshops

About 300 nurses turned up across the country – about half in Christchurch – to a series of nursing workshops on meeting emotional needs after disasters.

Frances Hughes, one of two nurse specialists running the workshops, said the demand highlighted the need for ongoing education to meet communities' psychosocial needs following disasters like the Christchurch quakes.

The four workshops were offered by the College of Mental Health Nurses and led by Hughes, commissioned by WHO to provide guidance to nurses following the 2005 Boxing Day tsunami, and Australian colleague Margaret Grigg, who coordinated the Victorian government's psychosocial response to the 'Black Saturday' bushfires.

Hughes said the workshops described what were normal emotional and behavioural responses following an emergency and provided nurses with some basic skills and tools to help people in their community to recover and rebuild.

(Courtesy Nursing Review)

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