ANNUAL REPORT

FOR THE YEAR 2012

RURAL HEALTH SOLUTIONS

Cover photo: Matapouri, Northland

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ABOUT US

Welcome to the New Zealand Rural General Practice Network's (the Network) Annual Report for the year 2011-2012.

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 18 staff (15.5 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.

Organisational structure

FROM THE CHIEF EXECUTIVE

Michelle Thompson

High level activities for 2013 will be providing input in to the Minister of Health's clinical integration work programme, implementing a revised Rural Ranking Score (RRS), growing the membership base, providing recruitment and immigration services, and providing management services to allied organisations such as the Rural Health Alliance Aotearoa New Zealand (RHĀNZ) and the New Zealand Rural Hospital Network (NZRHN).

Clinical integration

Much more emphasis will be placed on integrating primary care with other parts of the health service, the desired outcome being that patients are treated closer to home with fewer acute and unplanned hospital admissions. A more direct approach to shifting services – from secondary to community settings – will be adopted. For general practice, this is likely to involve enhanced access to diagnostics, direct referral to specific elective procedures, and access to specialist nurse and/or medical advice where acute demand is high e.g. gerontology, respiratory, diabetes, cardiovascular, paediatrics and allied health. A further round of services will be shifted subject to ministerial sign-off later in the year. Primary care has been given an unprecedented opportunity to participate upfront in this clinical integration planning. For the first time ever District Annual Plans (DAPs) will require sign-off by both DHBs and their local primary care networks. This consultation process is underway now so make sure you have your say.

Earlier in February we prepared a guide for members' discussions with their PHOs and DHBs. In addition to specific local issues we highlighted six that we think important for rural general practice in relation to clinical integration:

- **Urban/rural disparities** – the DAP needs to show a clear commitment to provide an equitable service across the whole of the DHB region.
- **Access to technology** – the DAP needs to outline how the DHB will ensure rural communities have equitable access to e-services and e-technologies.
- **Training and recruitment** – the DAP needs to show the DHB's plans for training and up-skilling members of the primary care team to ensure everyone is working at the top of their scope.
- **Expansion of the primary care team** – the DAP needs to show the measures being taken to ensure that services are integrated with the existing primary care team with which the patient identifies.
- **After-hours care** – the DAP needs to support provision of comprehensive and sustainable urgent and emergency care to rural communities.
- **Communications** – the DAP needs to detail how the difficultly of obtaining rural input into service development plans will be overcome.

Rural Ranking Score

Changes to the revised RRS have been approved in principle by the Minister. The new work score sheets will be distributed to DHBs, PHOs and practices at the end February. The new model will be finalised once the impact analysis has been completed by the Ministry and endorsed by the Minister. The proposed changes involve the introduction of an In/Out rule, tighter definitions around on-call, the removal of discretionary points and peripheral clinics, and inclusion of points for teaching activities. Transitional funding will be available to support impacted practices.

Growing membership

Membership of the Network stands at 1568 up from 1033 at the same time last year which roughly equates to 70% of rural general practices being represented. This is a really pleasing achievement and helps to strengthen our voice at the national level.

Providing recruitment and immigration services

NZLocums – the arm which manages the Government's rural recruitment contract – has exceeded its contractual targets for the year ended December 2012. The short term contact was exceeded by 10% and the long term contract was exceeded by 53%. Despite these fantastic results there remain serious workforce shortages across rural general practice. At the time of writing, we are aware of 56 permanent vacancies across 52 rural general practices; 14 of which are deemed critical. We are working with PHOs and DHBs to try and find solutions.

NZMedics – the arm which provides medical recruitment services to urban general practices and hospitals – fell slightly short of its revenue targets last year but reports good pipeline growth for the forthcoming year. Interest is especially strong from UK-based doctors impacted by austerity measures occurring in the NHS.

Our immigration service continues to grow with a further two staff members being granted their provisional license.

Providing management services to allied organisations

The Network is a founding member of the newly formed RHĀNZ – an incorporated society with charitable status which brings together health, social and political agencies to improve the health and well being of rural communities. The organisation currently has 15 members, including seven rural councils. The Network is providing management support services to RHĀNZ as well as the newly formed NZRHN. It is hoped that RHĀNZ will become a unified voice and resource for issues impacting the health of rural communities.

Strengthening governance

2013 is set to be a year of rapid change, requiring ongoing commitment to the principles of partnership and collaboration, the ability to think strategically, to be calm under pressure and excellent attention to detail. To this end, we will be proposing at this year's AGM, that the Board be given the ability to appoint a co-chair from within its ranks to assist with the predicted workload. We hope you support this resolution.

Word of thanks

To the Board and staff, my heartfelt gratitude to you all for your sustained efforts over the year – a better, smarter, nicer group of individuals would be hard to find. I am proud to be connected with such a special group of people who work tirelessly for the well being of their rural communities.

With very best wishes

Michelle Thompson

FROM THE CHAIR

Jo Scott-Jones

The 2012 – 2013 year has been dominated by the work involved in reviewing the Rural Ranking Score, but whilst this has been a major drain on the time of the Board and office staff, we have managed to not only report a return to a surplus budget, but also made significant progress in developing relationships across rural New Zealand and the health sector as a whole.

CE Michelle Thompson has once again been fundamental to our success. Her energy, skilled communication, personnel management and financial know-how have enabled the organisation to work its way through some of the busiest and most stressful projects we have undertaken in my time on the Network executive.

Core business

The recruitment of rural doctors and nurse practitioners, and support through locum services to rural practices in New Zealand remains critical to the continuation of health services in the most needy and hard to staff areas of our health system.

The office recruitment teams have once again more than achieved every target set by their contracts, and this has allowed many rural providers through the year to have a well earned break secure in the knowledge they have a locum who is able to cope with a rural community and its demands.

There remain several “hot spot” areas of high need that have been and will continue to be the focus of intense work to help address the needs of these communities.

Individual membership support this year has once again revolved around the burning platforms of after hours care and changes to the Rural Ranking Score (RRS) and the implications for rural support funding.

During the year the Network visited practices around the South Island providing the opportunity to identify unmet needs and provide a much needed support to rural practices and their workforce. This year has seen the membership grow by more than 50 percent as a result of “practice membership” subscriptions.

New service models

The Network has again been stretched in its response to the Minister of Health’s challenge to provide clinical leadership to the process of reviewing the RRS. 2011 saw a review of rural funding and assessment of the services rural practitioners provide, repeated modelling and revisions of a completely new scoring system, and this process continued through 2012.

Eventually the tension between trying to address the historical funding anomalies within a fixed funding pool proved to be difficult. The implications had we pursued wholesale change to the RRS were too great for us to sanction. As a result of all this work, we agreed with the MOH and DHB that a revamping of the current RRS was a more appropriate way forward.

At the time of writing, the new score has yet to be approved by the Minister of Health, but we are confident that it does help to ensure that rural funding goes to rural practices, and supports providers who are providing services within their communities in a better way than the previous score.

Building relationships

Network Board members continued to be involved in providing rural voices on committees in medical and nursing colleges and organisations; we have been part of the GP leaders’ forum, and provided support to the Ministry of Economic Development’s rural broadband advisory group.

The Rural Hospital Network is growing slowly, as is the membership of the Rural Health Alliance Aotearoa New Zealand (RHĀNZ). Modelled on the Australian Rural Health Alliance, this organisation brings together medical, nursing, pharmacy and allied health groups, with social and political organisations involved in rural communities to develop policy advice and advocate on behalf of communities with a strong unified cross-sector voice.

Internationally, the Network retains observer status on the WONCA rural health working party, and the work of the Network was able to be showcased in conference presentations at nursing and general practice conferences in London, Glasgow, Canada and the USA during the year. We can be proud of the fact that this organisation is leading the way in modelling a collaborative approach to primary health care issues across professions.

Our intention this year is to further enhance the strength of this approach by instituting a co-chair role involving a rural nurse and rural GP. The direct benefit of having a significant voice on the international stage can be seen in the range of locums and new providers we have coming to New Zealand through the locum service contracts.

Systems improvement

The Board undertook an appraisal of the Chairperson's role and function this year and in 2013 further review of Board member activities will occur along with a review of the strategic plan.

The changes implemented at last year's AGM to enable a constitutional change to be made with the approval of 75% of people attending the AGM allowed us to seriously review the current constitution with a view to making some changes. 2013 will see us further reviewing this work, and undertaking further consultation and discussion with members.

Jo Scott-Jones
Network Chairman

THE CORE EXECUTIVE

Jo Scott-Jones

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 2012's AGM. He is also a Board member of the Eastern Bay of Plenty Primary Health Alliance and by virtue of his position as Network chairperson is also a member of the GPLF. Jo is also a member of the Rural Broadband Initiative advisory committee.

Martin London

Treasurer 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 is also on the reference group for Health Workforce New Zealand's review of Training for General Practice. Martin holds a MB ChB (Bristol 1977), a Dip.Obst. (Otago) and is a Fellow of RNZCGP.

"The big issue this year was the ongoing review of the Rural Ranking Score (RRS). It was the Network that originally drove this issue but a unified revision with appropriate rewards and incentives for sustaining rural practices and access to services defied our best efforts. And those efforts, particularly on the part of Chairman Jo Scott-Jones, CEO Michelle Thompson and Linda Reynolds, were herculean. I do hope that our broader membership appreciates the time and thought they devoted in pursuit of a fair formula. Some useful modifications to the RRS have been achieved but we must expect more work in the years ahead.

These efforts exemplify how your organisation truly represents New Zealand rural practice. The Board is committed to working with the Ministry and DHBs, and when necessary challenging them, to find just solutions. Please support us with your membership and the information needed to campaign on your behalf. We'll need it. Our next big challenge is '24-hour care' on which hang many other aspects of sustainable and creative rural health services.

Very rewarding has been the recent rise in membership, largely thanks to the popularity of the practice membership levy and to the efforts marketing what we have to offer. Our South Island practice tour was a definite high point of the year.

As treasurer, I must congratulate the team on achieving a small surplus in challenging times and of receiving an unqualified opinion from our auditors – a great credit to their financial management."

Sharon Hansen

Deputy chairperson 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.

"The biggest issue of 2012 was undoubtedly the review of the Rural Ranking Score (RRS), and working on this issue has taken significant amounts of time and energy, particularly that of Network CEO Michelle Thompson and Linda Reynolds. With their knowledge of the sector and their patience in ongoing tweaking of the score, it would never have been possible to progress it to its current place. The leadership shown by Jo Scott-Jones and the support of the wider Board and the Network staff has also been invaluable.

Proposed changes to the RRS will impact on some practices. There will be winners and losers but it will give clear guidelines on who is and who isn't rural. A real low is the loss of our semi-rural colleagues, who may well have identified themselves as rural in nature and shared rural rosters and cared for rural peoples. Many will feel a commonality with rural communities more so than the urban communities that they are close to."

REGIONAL REPRESENTATIVES

Dr Ian Birch

Dr Ian Birch is the Board's Northern North Island representative and is based at Russell Medical Centre. Dr Birch attended the University of Bristol Medical School (1984-90), gained a Pharmacology BSc 2.1 (1987) and a MB ChB (1990). His post graduate education includes a Diploma in Child Health (Ireland 1994), a Diploma from the Royal College of Obstetricians and Gynaecologists (1995), he is a Member of the Royal College of General Practitioners (1996) and is a Fellow of the RNZCGPs (2000). Dr Birch has worked in the UK, Tanzania and in various parts of New Zealand. His interests out of work include playing the bugle, trumpet and saxophone and fishing and sailing, He describes himself as a lifelong football fan and enjoys reading and photography.

"2012 was my first year as a member of the Network Board. As I expected, this entailed a pretty steep learning curve. Some fairly major issues were tackled straight away including a look at restructuring the management set-up for the Network.

I felt more at home discussing the proposed Rural Ranking Scoring. Ultimately, a watering down of this tool was the only sensible possibility in my opinion.

My disappointment of the year was the introduction of free out-of-hours visits for under 6s – not quite so much at the decision but at the way it was implemented by the MoH, that is, with no consultation whatsoever. I hope we will not see a similar situation occur in future.

I was surprised by the high level at which the Network was involved in political discussions. This reflects on the maturity of the organisation and the respect that it has earned over the years and reflects favourably on the leadership of the Network."

Ross Lawrenson

Professor Ross Lawrenson is the Eastern North Island representative on the Board. Ross is Professor of Primary Care, University of Auckland and Head of the Waikato Clinical School. He first moved to New Zealand in 1981 working in Te Kuiti hospital and later becoming a general practitioner in Wairoa. In 1988 he moved back to the Waikato as Medical Superintendent in Community Health Services and District Hospitals. He returned to the UK in 1994 to take up an academic career at Charing Cross and Westminster Medical School. He then moved to the University of Surrey in 1998 becoming Dean of the Postgraduate Medical School. In 2005 he returned to the Waikato as Head of the Waikato Clinical School and Professor of Primary Care. He is particularly committed to the development of research and in supporting environments where students can get excellent clinical experience whether in hospitals or in rural and community placements. He is Chairperson of the New Zealand Committee of the Australasian Faculty of Public Health, a Fellow of the Royal College of General Practitioners (UK), a Fellow of the Faculty of Public Health (UK), Deputy Chair of the New Zealand Guidelines Group and Chair of the National Screening Advisory Committee.

"I have had a very active role in the field of rural health in 2012. The major initiative has been the development of the Rural Health Interprofessional Immersion Programme in Whakatane, which has involved the recruitment of academic staff and the development of a curriculum and the piloting of the programme. All seems to be on track for this to really take off in 2013.

I also chair the Midland Regional Rural Action Group which is part of the Midland Regional Clinical Service Planning Framework. I have been looking at ensuring a rural voice on all the clinical programmes and have encouraged the development of rural statistics for both maternity and cardiovascular health care services. I have continued with my rural health research and published a paper in 2012 on prostate cancer incidence and mortality in rural men and also presented a talk on management of palliative care for rural patients.

I was involved in the 2012 Network conference in Queenstown and supported the academic stream for that conference and am doing the same for 2013.

My major hopes for 2013 are that the primary care reforms that have been mooted by the Ministry of Health and National Health Board ends up supporting the development of rural general practice.

My other aim is to continue to emphasise the need for research into rural health issues."

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 FDRHMNZ (Fellow of the Division of Rural Hospital Medicine), and sits on the FDRHMNZ's governing committee and Board of studies.

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 and a strategic leadership diploma.

"Change is a certainty; it is the only way we will be able to cope with the ever-increasing health needs of an elderly population with an elderly health workforce. We have a choice as to whether we are involved in the planning of that change or whether we have it imposed upon us. At the Network we are firmly of the opinion that we need to be involved in the planning but I think that 2012 raises questions as to how we do this. The redevelopment of the Rural Ranking Score (RRS) has been a huge commitment in terms of time mainly from the staff at the Network, but also from the Board. The end result is a far more muted change than we had originally envisaged mainly due to our concerns of how any financial change would affect the stability of the practices concerned especially in times of such financial constraint.

My hope for 2013 is that we learn from the information that was gained during the process of developing the new RRS and that we apply this when we are involved in all change management. It is crucial that we remain engaged and that we develop the relationships which keep us involved at the highest level, as these processes of change will deeply affect not only the vast rural population, but all of us."

Kamiria Gosman

Southern North Island representative Kamiria Gosman: is of Nga Puhi, 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. She 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. She is currently an Independent reviewer for Quality Improvement and Accreditation.

"A comment often heard is 'what does the Network do for my membership...?' That's a good question.

The one certainty is "change". It is in the process of change that your membership has been invaluable to the officers of the Network and the management team to hear and know the issues that face rural professionals and their communities, such as sustainability.

The Rural Ranking Score has been one major piece of work undertaken by the Board on your behalf with the Ministry of Health and DHBs and is still a work in progress at the time of writing.

Thank you for the valuable information you have provided. It has enabled the Network to prepare, review, seek comments, and discuss at the Board table, review again in order to ensure that the best information is available to support you as members.

The paper 'The Rural Ranking Score – The Case for Change' acknowledges the 'complexity of the issues ...' and indicates the extent of the work undertaken by the Network on your behalf.

Your voice is important and your Membership ensures that voice is heard."

Rachel Hale

Rachel Hale: is a Nurse Practitioner in General Practice based at the Matamata Medical Centre. She attained a Masters in Nursing (Rural and Gerentology) 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 seven years and a Board representative for five and a half years. Her nursing career spans more than 30 years, all except five years in rural areas.

"2012 was a big year for me personally with a wedding to plan and attend in Canada. This allowed me to review another country's rural health system, as my son's new father-in-law is a rural GP in British Columbia (BC). His practice is vastly different from those in New Zealand (with medicare funding rather than via PHO, DHB and MoH), but the issue of no funding streams for nursing and nurse practitioners remains the same. He does not have a nurse in his practice because nurses cannot claim for services that they provide (and patients cannot claim from the insurer). So in BC, unless it is a large urban practice you do not see nurses providing care (even the simple dressing) without medical input. This is not very cost effective. In this rural practice the administration/ reception staff has level 1 or 2 paramedic training and the doctors do the rest. In New Zealand nurses can at least attract funding under the Rural ACC contract, fee for service payments and PHO/DHB funding pathways but there remain barriers to accessing GMS subsidies. Funding for rural nursing is a world wide issue with variances on the same theme.

For 2013 I look forward to the resolution of several issues that effect rural communities:

1. Authorised prescribing for NPs and the associated changes to the Medicines Act
2. The finalising of the Rural Ranking Score
3. The growth of RHAANZ as a strong voice for rural communities and their health."

Jane Laver

Dr Jane Laver is the North Island representative on the Board. Dr Laver is a GP partner in Dannevirke's Barraud Street Health Centre. Dr Laver began her medical training in 1980 at Guy's Hospital in south London and she qualified in 1985. She is also an ordained Minister in the Anglican Church.

"2012 has been another busy year juggling life as a rural GP with family, farm and the out-of-work commitments that keep me sane. I have managed to get some holiday-time, which is so essential for refreshment and reflection and emphasises the need for rural locum services.

The highlights of the year have been looking at the bigger picture of rural health in different forums and being able to take this back to a local level. I have taken on a leadership role with the Tararua Health Group and feel excited about our planning for the future. It reminds me about why I am doing this job in the first place and reinforces that it is where I belong.

Teaching also plays a major role. This involves Rural Medical Immersion Programme (RMIP) students, nurse practitioner interns, trainee interns, SHOs and registrars.

One of the frustrations has been making little progress on the after-hours Issues.

I am sure 2013 will bring some of the same as well as different challenges. It certainly feels that progress is being made on building relationships with those interested in rural health at many different levels."

Tania Kemp

Waimate Rural Nurse Specialist Tania Kemp is the Board's South Island representative. Tania holds a Diploma in Nursing (1993), a Degree in Nursing (2003), a Post Graduate Diploma in Advanced Nursing – specialising in 'rural' (2008) and is in the process of completing a Masters in Health Sciences-Endorsed. She is also PRIME trained and has taken part in after-hours/on-call role for the past eight years. During her career she has worked on the Chatham Islands, Pitt Island and the South Island West Coast, primarily in general practice with other roles including sexual health, family planning, and as a nurse educator and facilitator. Tania's interests outside work include spending time with her family, photography, walking and seeing every part of New Zealand.

"My highlights for 2012 included completing Masters (Nursing), which involved a small piece of research on 'the experiences of rural nurses providing first on-call' as part of my dissertation; but also joining the Board and being a part of the discussions on issues that impact on the providers and consumers at the coal face of rural practice. It was very satisfying to be a part of a Board that values the voice and views of all members of the general practice team as equal participants in providing the best care to our rural communities.

It has been an interesting year watching the development of a 'tool' to recognise the additional work rural health care providers do. I commend my Board colleagues for the time and effort that has gone into seeing that this is a fair and robust system.

I was nominated as a Network Board member to join the Major Trauma National Clinical Network earlier in the year – another learning curve and a very interesting group to be a part of. This ties in with my interest in PRIME and further developing the work of previous Board members in strengthening relationships with St John and ACC to support the work of PRIME practitioners in the field.

I look forward to 2013 and especially in seeing the work of some very dedicated people roll out in the form of the revised Rural Ranking Score. After three months away I am keen to become re-involved in the Board's work. Thank you to the Board and past Board members for your support of myself and others new to the role."

Sharron Bonnafoux

Hanmer Springs-based rural nurse specialist Sharron Bonnafoux is the Board's northern South Island representative. Her involvement with rural began in 1997 when she moved to Stewart Island as one of two District Nurses providing primary health care before being invited to join the team in Hanmer Springs in 2001. She holds post graduate diplomas in occupational health practice (1997), primary rural health care (2001), a Masters in primary health care (2006) and a post graduate certificate in health sciences looking at pharmacology and prescribing (2010).

Ray Anton

Ray Anton has been co-opted onto the Board as an honorary member. Ray holds a Bachelor of Science in Industrial Engineering and Operations Research from the University of California at Berkeley and a Masters Degree in Management from the University of Redlands.

He has been CEO of Clutha Health First for the past 10 years, chairman of the Board at John McGlashan College in Dunedin for the past eight years and is a Board member of the Otago Southland Employers Association.

His first six years in New Zealand were at the Otago DHB as the strategic planner and quality manager and previous to that he worked as a consultant for KPMG Peat Marwick and for a number of hospitals.

"As a new member to the Network Board representing the Rural Hospital Network, I have found the discussion and debate related to rural health services enlightening and very valuable to organisations delivering hospital services in rural areas. In the rural sector it is critical that all parties delivering health services work collaboratively. This is especially evident in our efforts to resolve the delivery of after-hours services. Our discussions with the Ministry of Health

have been informative in gleaning the direction of health service in the future. I am looking forward to participating with the Network Board in influencing the shape of rural health services in 2013. I am especially looking forward to attending the Network conference in Rotorua."

Riley Ridell

Riley, a year-four medical student based at the University of Otago's Wellington School of Medicine, grew up in Ngakuru, Manawahe, Rotoma and Rotorua. "We moved around as my Dad's hobby farm grew into more of a full time job. I chose a career in medicine after my grandfather told me I wasn't tough enough to be a farmer, and would have a more comfortable life as a urologist."

"As your student representative I am hoping to co-ordinate the rural high school visits across the country and make it easier to get these trips funded. In the long term I would like to see general practice become an attractive career option for ambitious students."

In 2013 Riley will be a Rural Medical Immersion Programme (RMIP) student in the Wairarapa, based in Masterton.

Rachel Goodwin

Rachel is also a year-four student based at the Auckland School of Medicine.Rachel comes from a small rural community of Raukawa in central Hawke's Bay. She attended Raukawa Primary School and then went to boarding school at Iona College. "Growing up in a rural environment I have seen first-hand how a strong community impacts life choices and healthcare. It is because of this that I wanted to be a part of the healthcare system, so that I could make a difference to these communities. I wanted to be a part of ensuring that rural communities have access to the best possible medical care and resources.

"Medical school encouraged my passion for rural health and I am strongly involved with the Auckland University rural health club, Grassroots. With Grassroots I have had the privilege of organising and participating in rural school visits, being a sports representative and vice president.

"I am excited about being one of the student representatives on the NZRGPN Board. Through this position I want to encourage exposure and promote rural medicine to the students in New Zealand studying healthcare careers and to ensure that they have positive learning experiences in rural medicine."

"We are the student representatives on the Network Board and are excited about what 2013 will have in store. Our main aim is to represent students studying to become healthcare professionals in New Zealand. Promoting rural health to the medical and other healthcare students in New Zealand is our next objective. We wish to ensure that they have positive learning experiences in rural practice. We want to increase the number of students who have rural experiences in their training and the number of students from a rural background. Finally we wish to raise the number of student members in both the rural health clubs of the New Zealand medical schools and also the Network."

STATE CONTRACTS COMMITTEE

David Clarke, Independent Chairperson, State Contract Committee

Reporting to the Network Board, the State Contracts Committee (SCC) has the 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 SCC in the last 12 months is in the following areas:

1. Ensuring the delegated authorities and process for vacancy allocation is embedded as standard practice for the Network. In addition, these processes were reviewed and confirmed as appropriate. One key addition was the creation of a hotspot threshold that when reached, urgent processes to rectify would be initiated.
2. The requirement for an NZLocums' marketing plan was analysed as there has been a view of potential oversupply of GP positions due to increased training in Australia. The Network's experience is that this is not the case and therefore it was decided that the SCC would not recommend a significant investment in marketing in Australia.
3. The Quality Plan was further developed and refined. It is now an extensive document and will be finalised in the next quarter.
4. The Committee received reports from the Network's accountants (BDO) with regards to the financial position and to confirm its solvency and adequate financial position.
5. The SCC recommended a 3% payroll administration fee after analysis.
6. Importantly the SCC reviewed the performance of the Network against the MoH contract. All targets have been met. Over the last 4 years there has been a decrease in the number of open hotspots and over a similar time period a significant increase in performance in locum support delivery – this is pleasing.
7. There has been some difficulty associated with the falling demand for short-term placements and the Network is taking steps to address this.
8. The SCC discussed workforce redesign and the potential role in specialist nurses filling some of the general practice tasks in particular for long term conditions. This is to form the basis for further research.

NZLOCUMS

Julie Wilson, General Manager Recruitment

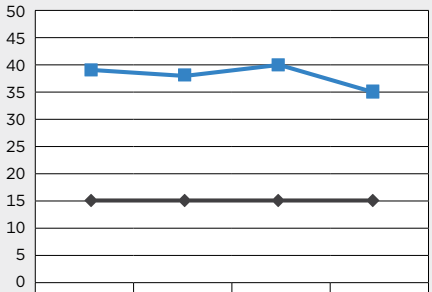
There are two components to the Ministry of Health's Recruitment Contract:

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. Our target delivery for 2012 was 60 placements, against which we made 92 placements (53% 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 2012 was to complete at least 85% of applications received, against which we delivered 95% (10% above target).

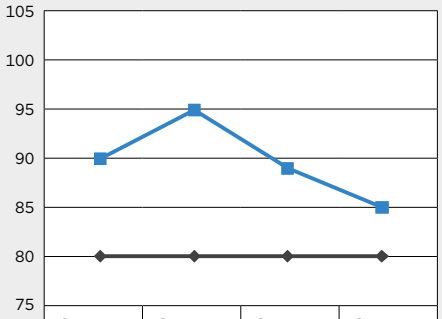
Performance against contractual targets for the 2012 calendar year:

Long term placements



	Quarter one	Quarter two	Quarter three	Quarter four
Completed	24	23	25	20
Long term target	15	15	15	15

Short term placements



	Quarter one	Quarter two	Quarter three	Quarter four
Percent completed	95	100	94	90
Target	85	85	85	85

Placements by DHB region

The top three DHB regions to receive locums sourced by NZLocums in 2012 were Southern, Waikato and Canterbury.

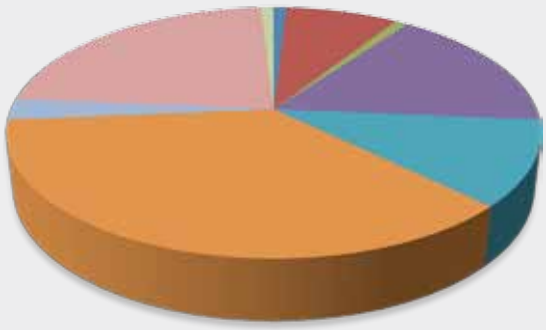
Where did our locums come from?

The top three countries from which NZLocums recruited locums in 2012 were: New Zealand, United States of America and England.

Rural general practice placements made by DHB region 2012

Auckland District Health Board	16
Bay Of Plenty District Health Board	11
Canterbury District Health Board	32
Counties Manukau District Health Board	12
Hawkes Bay District Health Board	19
Lakes District Health Board	5
MidCentral District Health Board	20
Nelson Marlborough District Health Board	2
Northland District Health Board	23
Southern District Health Board	63
South Canterbury District Health Board	3
Tairawhiti District Health Board	0
Taranaki District Health Board	20
Waikato District Health Board	62
Wairarapa District Health Board	11
Waitemata District Health Board	4
West Coast District Health Board	9
Whanganui District Health Board	3
	315

Countries from which locums were recruited in 2012

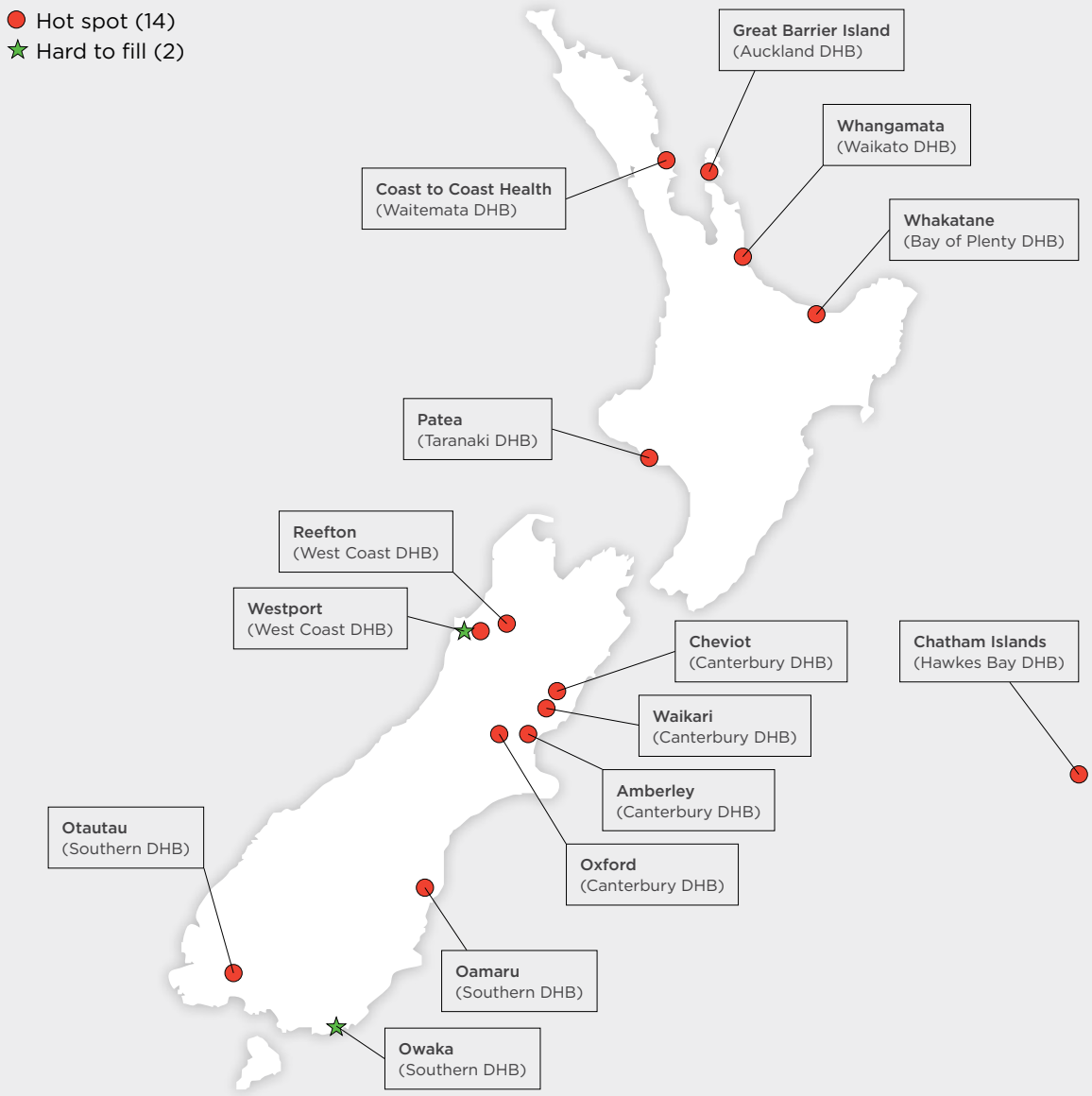


Belgium	1
Canada	9
Denmark	1
England	18
Netherlands	12
New Zealand	40
Scotland	3
United States of America	25
Wales	1

Strengthening relationships with PHOs and DHBs

A key focus of 2012 was to continue strengthening our 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. As a result of this ongoing strategy, there has been a drop in the “hard to fill” vacancies and hot spots.

Hard to fill and hotspot vacancies in rural general practice as at 31 December 2012



NZMEDICS

In 2012, NZMedics' strategic plan was to continue to target specialists in areas of high need throughout New Zealand. The focus remains on these three areas of specialty; Psychiatry, Emergency Medicine and Internal Medicine. NZMedics successfully exhibited at the ACP (American College of Physicians) Internal Medicine conference held in New Orleans in April and also the ACEP (American College of Emergency Physicians) Emergency Medicine conference held in Denver in October 2012. They will also attend the USPC (United Sates Psychiatric Congress conference) held in San Francisco in May 2013.

Leads from these conferences have already begun to show with placements due to follow within 12 months due to the length of time it takes to recruit overseas doctors and process them through the medical council and immigration processes.

Where did our medics come from?

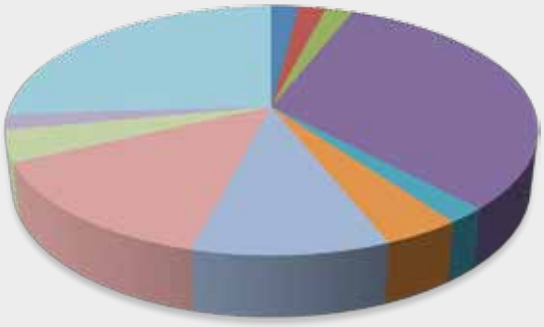
The top three countries from which NZMedics recruited in 2012 were: England; United States of America and New Zealand.

Immigration service

In 2012, two staff members gained their provisional license and are currently supporting Julie Wilson, General Manager – Recruitment in assisting all our International Medical Graduates (IMGs) with their immigration matters.

Our expectation is that both these new staff members will gain their full license in 2013 and the Network can then offer immigration services not only to our IMGs but to other health professionals recruited through other means. This will not only provide another income stream for the Network but will also add to the increasing number of services NZMedics and NZLocums can offer to both clients and candidates.

Countries from which medical professionals were recruited in 2012



Australia	1
Canada	1
Denmark	1
England	16
India	1
Ireland	2
Netherlands	5
New Zealand	7
Scotland	2
Singapore	1
United States of America	13
	50

FINANCIAL STATEMENTS

Summarised statement of financial performance*
for the year ended 30 June 2012

INCOME	2012	2011
Income Received	5,749,267	5,340,336
LESS: DIRECT COSTS	3,069,735	2,830,873
GROSS SURPLUS	2,679,532	2,509,463
LESS: EXPENDITURE		
Amortisation	78,504	75,475
Audit Fees	15,927	15,757
Legal Fees	9,386	37,082
Depreciation	27,809	40,747
Kiwisaver Employer Contribution	13,429	13,120
Rent	126,265	126,500
Salaries & Wages	1,244,937	1,317,831
Advertising	270,828	237,425
Conference & Trade Shows	73,250	23,898
Other Expenses	764,410	832,487
TOTAL EXPENDITURE	2,624,745	2,720,321
NET SURPLUS/(DEFICIT)	$54,787	($210,857)

Summarised statement of financial position*
as at 30 June 2012

EQUITY	2012	2011
Accumulated Funds	1,817,515	1,762,728
TOTAL EQUITY	1,817,515	1,762,728
Represented By		
CURRENT ASSETS	2,564,388	2,436,535
FIXED ASSETS	90,957	141,794
INTANGIBLE ASSETS	415,442	481,221
TOTAL ASSETS	3,070,787	3,059,550
CURRENT LIABILITIES	1,253,272	1,296,822
TOTAL LIABILITIES	1,253,272	1,296,822
NET ASSETS	$1,817,515	$1,762,728

Statement of movements in equity*
for the year ended 30 June 2012

	2012	2011
Balance at Beginning of Year	1,762,728	1,973,585
Net Surplus/ (Deficit)	54,787	(210,857)
Total Recognised Revenues and Expenses	54,787	(210,857)
BALANCE AT END YEAR	$1,817,515	$1,762,728

* The above financial information has been extracted and summarised from the 30 June 2012 audited accounts of the New Zealand Rural General Practice Network, for which an unmodified 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 14 December 2012. 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:

Dr Jo Scott-Jones
Chairperson

Dr Martin London
Treasurer

Dated 14 February 2013

AUDIT REPORT

PKF Martin Jarvie Chartered Accountants

PKF
Accountants &
Business Advisers

REPORT OF THE INDEPENDENT AUDITOR ON THE SUMMARY FINANCIAL STATEMENTS

To the Members of the New Zealand Rural General Practice Network Inc

The accompanying summary financial statements, which comprise the summarised statement of financial position as at 30 June 2012, the summarised statement of financial performance and statement of movements in equity for the year then ended and related notes, are derived from the audited financial statements of the New Zealand Rural General Practice Network Inc for the year ended 30 June 2012. We expressed an unmodified audit opinion on those financial statements in our report dated 14 December 2012. Those financial statements, and the summary financial statements, do not reflect the effects of events that occurred subsequent to the date of our report on those financial statements.

The summary financial statements do not contain all the disclosures required for full financial statements under generally accepted accounting practice in New Zealand. Reading the summary financial statements, therefore, is not a substitute for reading the audited financial statements of the New Zealand Rural General Practice Network Inc.

Executive Board's Responsibility for the Summary Financial Statements

The Executive Board is responsible for the preparation of a summary of the audited financial statements in accordance with FRS-39: Summary Financial Reports.

Auditor's Responsibility

Our responsibility is to express an opinion on the summary financial statements based on our procedures, which were conducted in accordance with International Standard on Auditing (New Zealand) (ISA (NZ)) 810, "Engagements to Report on Summary Financial Statements."

Other than in our capacity as auditor we have no relationship with, or interests in, the New Zealand Rural General Practice Network Inc.

Opinion

In our opinion, the summary financial statements derived from the audited financial statements of the New Zealand Rural General Practice Network Inc for the year ended 30 June 2012 are consistent, in all material respects, with those financial statements, in accordance with FRS-39.

PKF Martin Jarvie

14 February 2013
PKF Martin Jarvie
Wellington

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NETWORK MEMBERSHIP

Rob Olsen, Communications and Membership Manager

Major Membership activities this year include:

- Ongoing work on a review of the Rural Ranking Score in conjunction with the Ministry of Health and DHBs
- Offering "practice membership rate" for the 2012-13 financial year
- Organising the annual conference to be held in Rotorua in March, 2013
- Notification of change to constitution (clause 36)

Work on reviewing the Rural Ranking Score is ongoing. In late 2010 the Network circulated a survey to 210 practices seeking feedback to inform the redefinition of the RRS. This has been a complex piece of work and has been the number one priority for the Network during the past two years. A revamped version of it is set to be instituted in June 2013, pending MoH sign-off.

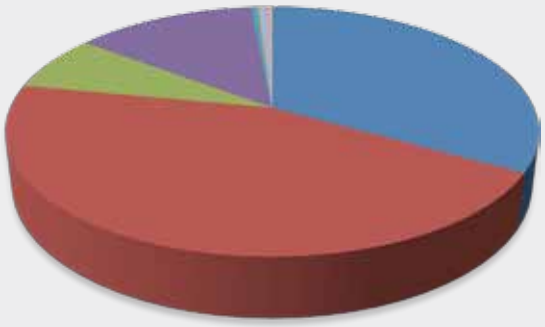
Conference

The Network's annual conference, the rural health sector's showcase event, will take place in March in Rotorua 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. This year's conference is entitled "Let's Get Connected", with a strong focus on IT/technology in health and the Rural Broadband Initiative (RBI).

Membership

Membership currently stands at 1568 (up from 1033 as at December 2012) – 520 Doctors (up from 434), 703 Nurses (up from 456), 114 Practice Managers (up from 98), 207 Administrators, 7 Friends (up from 2), 2 students (no change), 9 Others, 5 Affiliates, 1 Dual (RHN/Network). (See pie graph this page).

Network membership as at February 2013



Doctors	520
Nurses	703
Practice Managers	114
Administrators	207
Friends	7
Students	2
Others	9
Affiliates	5
Dual (RHN/Network)	1
	1568

Levy structure

The new practice rate has been offered to rural practices New Zealand-wide. It has been adopted in conjunction with the existing "Individual" rate. All rates have been marginally increased (from the 2011-12 financial year) to allow the Network to cover the costs of servicing membership.

The adoption of a financial year cycle instead of a calendar year cycle initially saw Members charged for six months Membership – from January 2012 to June 30, 2012, then invoiced for a full year from July 1, 2012 to June 30, 2013. This brings Membership into line with other financial cycles within the Network.

To date about 140 practices (from 198) have opted for the new practice rate.

Regional membership/advocacy visits

A round of Membership visits were undertaken following the Network's 2012 conference in Queenstown. Board Member Dr Martin London and Membership and Communications Manager Rob Olsen visited rural Canterbury practices as a follow-up to the earthquakes that have impacted the region since September 2010. Complimentary Membership was offered to Canterbury practices following the first quakes. Those practices are now paid-up practice members.

Practices on the West Coast of the South Island and Nelson/Marlborough areas were visited as part of that tour.

For 2013 visits are planned to the southern South Island and the eastern North Island.

Student membership

Two new student representatives were recently inducted to the Board. ARHA student representative Rachel Goodwin and Otago University school of medicine representative Riley Ridell take over from ARHA's Alisha Vara who completed two years in the role.

The Network has also provided funds to various student health clubs to assist with their activities.

Complimentary conference registrations have also been offered to each of the student groups – approximately 20 in total.

Work is ongoing on several issues and initiatives that ARHA and the Board are working on together. These include:

- Providing clarity around graduate career pathways in rural (via website or information pack given to new student Members)
- Providing a database of rural health professionals willing to assist students (work together to encourage more rural GPs to host students)
- Developing a database of rural GPs willing to host students
- Developing 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
- Following up on rural school visits by student rural health groups (SRHGs) designed to encourage younger students from rural areas to pursue careers in rural health
- Promoting NZRGPN membership to medical and nursing students and approach other groups such as student nursing associations
- SRHGs presenting a session at the Network's annual conference.

RURAL HEALTH SOLUTIONS

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