The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

RURAL STRATEGY AND ACTION PLAN

Approved by the College Board August 2014

The Action Plan sets out to address the vision of the Rural General Practitioners' Chapter and Division of Rural Hospital Medicine over the next 10 years.

RNZCGP
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Vision for rural medical practice in 2024

> *"Improved health outcomes for rural communities through the work of high quality, well trained medical generalists working within multidisciplinary teams."*

Background

In November 2013 board members of the Rural General Practitioners' Chapter (the Chapter) and the Division of Rural Hospital Medicine attended a workshop to develop the RNZCGP's Rural Strategy.

The following definition was adopted to encompass the rural general practitioner and rural hospital doctor in New Zealand:

> *"A rural general practitioner is a high quality and well-trained medical generalist working within a multidisciplinary team who strives to improve the health outcomes of rural communities."*

The definition aligns with the strategic vision.

The Rural Strategy sets out to address the following key areas:
1. Definition of rural general practice in New Zealand
2. Models of care
3. Ensuring quality and safety
4. Recruitment and retention
5. Education
6. Research and evaluation

Rural General Practice

Rural general practice is often defined by the distance between the rural practice environment and the resources of the nearest urban centre (such as the base hospital, hospice, community mental health service, advanced ambulance services or home support agencies). However, distance is not just geographic; it is also cultural, economic and perceptual.

Rural New Zealand has characteristics and challenges that influence what health services are needed and how they are delivered. These include large distances and geographical features that affect the ease of access to health services. The extra travel costs that rural people incur make access to primary health care services particularly difficult for the people of rural communities. Service delivery in rural areas must focus on providing comprehensive primary health care for rural communities.[1]

In New Zealand, few rural communities will be more than two or three hours from a secondary hospital, but mountainous geography and extreme weather events can quickly isolate an area. Similarly, distance and geography may make it difficult for rural people especially those on low incomes or with chronic health problems to access their local health services, and travel to centralised secondary or tertiary services. Many older patients will choose to stay close to home and family, cared for by their local health professionals.

[1] National Health Committee, *Rural Health: Challenges of Distance, Opportunities for Innovation*, February 2010, accessed at http://nhc.health.govt.nz/archived-publications/nhc-publications-pre-2011/rural-health-challenges-distance-opportunities.

Rural doctors must be true generalists. Rural general practitioners must be able to work independently in an extended general practice role, providing “birth to death” care for their patients. They work in environments which their more urban counterparts do not, such as at road accidents, and provide safe and effective pre-hospital care and transfer for patients who require admission to base hospital. Many rural general practitioners are also vocationally registered as “rural hospital doctors”. Rural hospital doctors work independently, providing generalist secondary level care across the entire spectrum of clinical presentations; managing inpatients in their local rural hospital.

Rural practitioners play a vital role in rural communities, bringing with it the satisfaction of knowing they are really making a difference to the lives of individuals and the community. But they also face the challenges of availability and visibility, along with issues of social and professional isolation.

Rural Strategy Action Plan

Objective 1:
Promote a greater understanding of rural practice and rural health practitioners and their value to the New Zealand health sector

Rational
The overall goal of the RNZCGP is to improve the health of all New Zealanders through high-quality general practice care. Evidence of the benefits of a health system with a strong primary care base is abundant and consistent, extending to the major causes of death and disorders as well as to reducing disparities in health across major population subgroups.[2] The value of generalist care, particularly in rural communities, is often not appreciated by other healthcare professionals and members of the public. Misperceptions can have detrimental consequences for workforce recruitment, morale and retention. Therefore, it is vital to increase stakeholders' understanding of the value of quality rural generalist care. Rural practice needs to be promoted particularly to funders, managers and non-rural providers.

Defining rural general practice in New Zealand is difficult.[3] Rural health is subjective. Rural general practice involves people regarding the local practice as their medical home, being at a distance from other health services, and the ease of access to appropriate healthcare. Membership of the Chapter is open to any member of the RNZCGP who identifies themselves as being rural. Practices and practitioners who define themselves as being rural should be allowed to do so.

Goals
- To ascertain a greater understanding of who we are as rural practitioners by:
  - reviewing data already collected;
  - undertaking further research on rural practitioners.
- To promote a greater understanding of the value of rural general practice to our stakeholders and the health sector in general.
- To encourage a positive perception of rural general practice by the health sector and members of the public.
- To highlight rural general practice as a career choice to undergraduate medical students and postgraduate doctors.

Stakeholders who can help achieve these goals
- New Zealand Rural General Practice Network
- Universities and medical schools
- Medical colleges
- Regulatory authorities
- Government
- Patient groups
- Media
- Rural Health Alliance Aotearoa New Zealand (RHANZ)

Action points
- Analyse the demographics of rural practitioners.

[2] Barbara Starfield and others, "Contribution of Primary Care to Health Systems and Health", *The Milback Quarterly,* Vol. 83, No. 3, 2005, pp. 457 – 502.
[3] Recent developments in the way rural practices are funded will see the Rural Ranking Score being replaced by a flexible funding model within local alliancing arrangements. Funding will be allocated to individual DHBs. However, the definition of a rural practice (30km or 30 minutes from a base hospital) under the Rural Ranking Score will remain.

- Review data already collected on rural practice and rural practitioners.
- Undertake further research on:
  - the number of RNZCGP members who consider themselves to be in rural practice;
  - factors considered important in classifying oneself as rural;
  - distance from the nearest base hospital;
  - possibly the number of rural GPs not affiliated with the Chapter (eg, by analysing data from the Rural General Practice Network).
- Promote the value of rural generalist care, for example by case studies and articles in *GP Pulse*.

Objective 2:
Further develop rural integrated services with a focus on improving access for rural populations, improving health equity, and maintaining quality and safe care.

Rational
In 2009, New Zealand saw the introduction of a new policy direction for health – "Better, Sooner, More Convenient Health Care in the Community". It recognises that further improvement in the quality of health and disability services will come from a system that is predominantly based around better community and primary care. It sets out to create an environment where health professionals in the community are actively encouraged to work with one another, and with hospital-based clinicians to deliver co-ordinated and co-operative health care. High-functioning community-based, integrated healthcare services are particularly needed to meet the needs of New Zealand's ageing population, and people with multiple and long-term conditions. A greater use of technology and innovation and less division between primary, secondary and social care teams and organisations are implicit.

Small, isolated populations and higher levels of deprivation, which are closely associated with poor health status, are a feature of some rural regions, including in more affluent rural communities. In rural New Zealand, a larger proportion of Māori are in high deprivation areas than are Māori in urban areas. There is a direct correlation between rural areas with high levels of deprivation and the proportion of Māori in the community.[4]

Health systems based on strong and better integrated primary care can deliver better patient outcomes and experiences more efficiently. As part of the Ministry of Health's initiatives to strengthen primary care performance, a potential Integrated Performance and Incentive Framework (IPIF) has been designed to respond to the need for better integration of primary and secondary care services. This is an exciting opportunity for us to be generalists in our own right at a high level of achievement. Further, the College acknowledges that strategic standards should not be compromised because they seem difficult to meet. For example, it would not be fair to compromise a rural area because it is difficult to staff.

In the rural setting, models of care should best fit the needs of the rural patient's journey and deliver tangible outcomes. They need to be flexible according to context (such as the demographics of the locality). Models of care will depend on the mix of the multidisciplinary team (eg, GP, nurse, allied health professional and regional hospital) and its skill base which is typically broader than in the urban setting. Rural general practice typically involves community and patient-centred primary healthcare delivered by a multidisciplinary team. The rural GP deals with emergencies and continues to provide care until the patient reaches secondary care. The rural generalist usually offers a 24-hour model of care, which may involve rural nurses contacting the GP by telephone.

[4] National Health Committee, *Rural Health: Challenges of Distance, Opportunities for Innovation*, February 2010, accessed at http://nhc.health.govt.nz/archived-publications/nhc-publications-pre-2011/rural-health-challenges-distance-opportunities.

Goals

- To support and encourage more integrated services in rural communities particularly for patients with long-term conditions and complex health needs.
- To support and encourage appropriate and accessible healthcare in rural communities to reduce health inequities between population groups while reflecting the principles of the Treaty of Waitangi.
- To support and encourage the use of remote consulting, telehealth and virtual-consultation technologies to improve accessibility and increase service capacity.
- To enable practices and individual rural practitioners to deliver high quality and safe care, and fulfill training and education requirements by:
  - ensuring that an appropriate rural perspective is sought and included in developing the Foundation Standard and advanced level standards;
  - encouraging rural practices to participate in RNZCGP Cornerstone accreditation.

Stakeholders who can help achieve these goals

- Medical colleges
- Nursing Council of New Zealand
- Government
- Local authorities
- Patient organisations

Action points

- To promote the value of the integration of primary care with other community services, such as Whānau Ora, as a means of addressing inequities for at-risk families.
- To undertake further research on deprivation in rural practice and the equity of healthcare between the rural and urban patient.
- Ensuring that an appropriate rural perspective is sought and included in developing the Foundation Standard and advanced level standards.
- Encouraging rural practices to participate in RNZCGP Cornerstone accreditation.

Objective 3:
Increase the capacity and sustainability of the rural practice health workforce to meet population and service needs

Rational

New Zealand's environment includes an ageing population and resultant increase in patients with long-term conditions and complex health needs, a shift of health services from hospitals to communities, and the development of community-based integrated care services. This requires a greater number of highly skilled, generalist-trained healthcare professionals.

New Zealand's rural setting has had a long-standing shortage of health practitioners, and recruitment is unlikely to improve if we continue with the status quo. Undergraduate education is both failing to recruit students from rural areas and is strongly biased towards settling students into urban areas. Currently, about 10 per cent of GPEP graduates enter rural practice with 90 per cent remaining in the urban setting. Ideally, 25 per cent should enter rural practice.[5] There is a waiting list for training in rural hospital medicine, and entry into immersion programmes is competitive.

New Zealand needs to ideally recruit and retain a predominantly New Zealand-trained health workforce. In light of multidisciplinary teams, this includes nurses and other allied health professionals. Being a student in a rural area, undertaking pre-vocational education and GP registrar training in rural areas all play an important role in recruitment. International evidence

[5] Fourteen percent of the New Zealand population is rural, but more GPs per rural capita is needed.

has shown a beneficial effect on all doctors who spend time in rural practice even if only on their future dealings with the rural sector. Important factors for retention include fair remuneration, work-life balance, adequate numbers of staff and collegiality. If rural practitioners are happy, this will help to attract others. Therefore, we should contribute toward factors influencing doctors to work in rural practice.

A GP should also be able to enter rural general practice and know that when they relocate, they will be replaced and it is safe for them to leave. This includes not being entrapped for fear of abandoning both the community and assets.

Goals

- To increase the number of doctors choosing a career in rural general practice by:
  - Promoting strong academic leadership for rural health in our health science academic institutions.
  - Promoting students of rural origin (including secondary school students and mature students) to enter medical school.
  - Maximising exposure to, and promoting careers in, rural general practice to medical students and postgraduate trainees. For example, by creating a rural attachment for all GP registrars, and developing programmes similar to Australia's John Flynn Placement Program[6] for medical students.
  - Ensuring all medical students and doctors have the opportunity to gain a positive experience of working and training in rural general practice settings. Ensure practices can well accommodate students, make them feel valued and that they can make a difference. The rural practice experience should be exciting, fun and collegiate.
  - Encouraging medical schools to track medical students with a declared interest and providing longitudinal mentoring of rurally inclined medical students by rural health professionals.
  - Pushing, publicising and better funding the Post-graduate Generalist Placement (PGGP) education programme[7] for PGY2 and PGY3 registrars.
- To ensure a sufficient supply of generalist training opportunities and placements by:
  - Expanding the capacity and resource of rural practice based education and GP teachers and educators.
  - Promoting the development of rural practice training programmes for other health professionals such as nurses and nurse practitioners.
- To maximise the contribution of already qualified health practitioners by:
  - Adjusting the imbalance and maldistribution of health workforce between urban-rural New Zealand.
  - Providing adequate support to doctors and practices to tackle workload and the on-call burden including having sufficient staff and good utilisation of staff.
  - Supporting work-life balance, the ability to have time off and protecting against burnout including supporting practices to operate family-friendly and flexible working policies.
  - Obtaining scholarships for further study and/or travel to encourage fellows who opt to stay in rural locations long-term.
  - Promoting collegiality – Skype peer groups, local education eg, urban consultant specialists talking to peer groups and implementing CME into the practice.

Stakeholders who can help achieve these goals

- RNZCGP's Recruitment and Retention Working Group

[6] The John Flynn Placement Program is part of the Australian Government's strategy to attract more doctors to rural and remote areas. It is funded by the Department of Health and administered by the Australian College of Rural and Remote Medicine (ACRRM). Medical students are placed with a rural doctor during holiday periods for eight weeks over a four year period.

[7] Trainees in their second or third postgraduate year can apply to be placed for three months in a rural general practice approved by the RNZCGP.

- Medical Council of New Zealand
- Medical schools
- Rural practices and practitioners
- Rural Health Alliance Aotearoa New Zealand
- Rural community groups

Action points
To ensure rural health forms part of the discussion of the RNZCGP's Recruitment and Retention Working Group and includes the following points:

- Maximising exposure to, and promoting careers in, rural general practice to medical students and postgraduate trainees.
- Ensuring all medical students and doctors have the opportunity to gain a positive experience of working and training in rural general practice settings. For example, by pushing, publicising and better funding the Post-graduate Generalist Placement (PGGP) education programme for PGY2 and PGY3 registrars.
- Adequate support for doctors and practices to tackle workload and the on-call burden.
- Good work-life balance, the ability to have time off and protection against burnout.
- Scholarships for further study and/or travel to encourage fellows who opt to stay in rural locations long-term.
- Collegiality eg, Skype peer groups, local education (such as urban specialists talking to peer groups) and implementing CME into the practice.

Objective 4:
Enhance the skills and flexibility of the rural medical workforce to provide complex care

Rational
Rural practitioners need enhanced and extended training to attain the appropriate skills and expertise to meet the health needs and expectations of rural patients and the wider rural community. Following general practice training, the rural GP typically acquires extra skills, many of which are included in the rural hospital medicine training programme. The rural GP should have a basic skill mix and more elements for further rural practice. These elements might include Primary Response in Medical Emergencies (PRIME), Early Management of Severe Trauma (EMST), Advanced Cardiac Life Support (ACLS) training, and rural specialist skills. Further, the safe rural practitioner should be required to comply with extra standards arising from rural practice.

Questions have been raised about whether RNZCGP's current training model adequately prepares doctors for the breadth of rural practice. The GPEP1 academic programme comprises very little rural specific education. The rural component of further GPEP training depends on the location of the practice and how the practice is organised. Acute care, trauma and emergency care are particularly lacking.

The work of the rural GP and the doctor practising in rural hospital medicine frequently overlap.[8] It is also accepted that in the rural setting, practitioners' roles are less clearly defined. Therefore, it would seem sensible for there to be little difference in the training pathways for rural hospital medicine and rural general practice.

The rural sector has traditionally been a leader in postgraduate education and training for general practice. This needs to be maintained and built on. Medical students often describe

[8] At the start of 2014, almost half (23 out of 50) of those who are undertaking or who have completed the Rural Hospital Medicine Fellowship training programme have also undertaken vocational training in general practice.

rural GPs as excellent role models – they have a good rapport, practise good medicine and involve students in patient management.[9]

Goals

- To investigate aligning the two training programmes of rural hospital medicine and general practice.
  - Consider applying lessons learned from other training programmes, such as remote vocational training in Australia (eg, the post-graduate diploma in rural and remote medicine) and the orthopaedic model in urgent care physician training programme.
  - Liaise with the Nursing Council of New Zealand about the sharing of educational resources for rural nurse practitioners.
- To ensure trainees receive appropriate exposure to rural general practice by:
  - supporting a wider range of rural training practices to accommodate trainees;
  - accrediting practices for rural training if the model of care and range of patients are typical of the rural experience;
  - including more rural specific education in the GPEP1 academic programme;
  - facilitating adequate training in acute care, trauma and emergency care and on-call work during GPEP;
  - expanding virtual education to allow trainees to work in rural areas while completing GPEP1 and beyond.
- To enable individual rural practitioners to fulfill training and education requirements and deliver quality and safe care and. For example by:
  - adding "The Practitioner" to IPIF with progression through quality levels;
  - developing guidelines on incentives for being a GP practising at an excellence or advanced level. Incentives might involve status and remuneration (eg, rights of direct hospital admission, hospital waiting lists and diagnostic services).

Stakeholders who can help achieve these goals

- Medical Council of New Zealand
- Nursing Council of New Zealand
- Australian College of Rural and Remote Medicine and other Australian academic institutions

Action points

- To establish a working group between the Rural General Practitioners' Chapter and Division of Rural Hospital Medicine to plan ways of aligning future training. The working group will:
  - consider training models which combine training for rural hospital medicine and rural general practice;
  - look at models for a post-fellowship pathway to rural practice (eg, a post-graduate diploma in rural practice) to allow GPs to gain the appropriate skill set (with optional elements).

  Training could potentially result in either:
  (1) dual fellowships of rural hospital medicine and general practice; or
  (2) Fellowship of the RNZCGP and a post-graduate diploma.
- To investigate ways for trainees to gain exposure to rural general practice such as:
  - supporting a wider range of rural training practices to accommodate trainees;
  - accrediting practices for rural training if the model of care and range of patients are typical of the rural experience;
  - including more rural specific education in the GPEP1 academic programme;

[9] Johanna E Parker, Ben Hudson and Tim J Wilkinson, "Influences on final year medical students' attitudes to general practice as a career", *Journal of Primary Health Care*, Vol. 6, No. 1, March 2014, p. 56, 62, accessed at: http://www.rnzcgp.org.nz/assets/documents/Publications/JPHC/February-2014/JPHCOSPParkerMarch2014.pdf.

- facilitating adequate training in acute care, trauma and emergency care and on-call work during GPEP;
- expanding virtual education to allow trainees to work in rural areas while completing GPEP1 and beyond.

- To include the following action points in the RNZCGP strategy:
  (a) To investigate the possibility of adding "The Practitioner" to the Integrated Performance and Incentive Framework (IPIF) with progression through quality levels.
  (b) To investigate extended/advanced competencies for the rural health practitioner.

Objective 5:
Increase academic activity to improve effectiveness, research (evaluation) and quality

Rational
Rural practice should be driven by good data. Educational activity and research are vital to evidence-based service improvement, establishing a positive learning environment, and data management. The benefits of more academic and quality-improvement activity include a more integrated, multi-disciplinary workforce, an evidence-based approach to practice, improved health outcomes and greater patient safety. Current data might help to formulate research questions for rural practice in New Zealand. However, much of the good work arising from past surveys and research is now becoming out of date.

Goals
- To undertake high-quality and meaningful research on rural general practice by:
  - increasing the level of research opportunities;
  - promoting the position of the research GP registrar.
- To formulate policy to promote rural health research that is academically rigorous and credible amongst our peers.
- To consider what we want to find out about rural health care through research such as on:
  - Who we are (workforce).
  - Clinical operational information.
  - Current pros and cons of rural practice.
  - Is it really a catastrophe?
  - Are there any areas that are particularly bad?
  - Gaps in rural practice.
  - Ability for doctors (eg, young mothers) to work part-time.
- To undertake further research on areas identified.

Stakeholders who can help achieve these goals
- Within RNZCGP:
  - Research Education Charitable Trust (RECT)
  - Rural Chapter
  - MOPS (Does it have a rural emphasis?)
  - Education (teachers, registrars, PGGP)
  - Career plans produced in GPEP1 (Do the plans include rural practice?)
- Health Research Council
- Medical Council of New Zealand (data on rural doctors)
- DHBs/PHOs (numbers of patients, rural ranking scale)
- Ministry of Health – Health Workforce New Zealand, Health Quality and Safety Commission (Atlas of Healthcare Variation)
- Networks and Alliances – New Zealand Rural General Practitioners Network, NZ Locums (data on numbers of locums and practices needing locums)
- BPAC (Best Practice Advocacy Centre)
- Academic facilities/universities
- Health and Disability Commissioner's Office

- Ron Janes (rural doctor survey (last 2007))

Action Points

- Investigate whether the RNZCGP's Research Education Charitable Trust (RECT) could make funding rural research a priority or call for expressions of interest.
- Promote the research GP registrar position.
- Investigate accessing research funding for registrars (eg, from the Health Research Council).
- To undertake further research on rural health care, which might include:
  - having a minimum data set of rural practices (or accredited GP training practices) with data collated annually;
  - collecting data on deprivation in rural practice;
  - looking at equity of healthcare between the rural/urban patient.

Rural Strategy Action Plan

Objective 1:
Promote a greater understanding of rural practice and rural health practitioners and their value to the New Zealand health sector

Goals

- To ascertain a greater understanding of who we are as rural practitioners by:
  - reviewing data already collected;
  - undertaking further research on rural practitioners.
- To promote a greater understanding of the value of rural medical practice to our stakeholders and the health sector in general.
- To encourage a positive perception of rural medical practice by the health sector and members of the public.
- To highlight rural practice as a career choice to undergraduate medical students and postgraduate doctors.

	Action	**Responsibility**	**Other stakeholders**	**Timeline**
1	Analyse the demographics of rural practitioners.	Quality, Research & Policy Group	Rural Health Alliance Aotearoa New Zealand (RHĀNZ) New Zealand Rural General Practice Network Universities and medical schools Medical colleges Regulatory authorities Government Patient groups Media	1 year
2	Promote the value of rural generalist care, for example by case studies and articles in *GP Pulse*.	Membership Services Group		2 years
3	Undertake research on such issues as: - number of RNZCGP members who consider themselves to be in rural practice; - factors considered important in classifying oneself as rural; - distance from the nearest base hospital; - number of rural GPs not affiliated with the Chapter (eg, by analysing data from the Rural General Practice Network).	Quality, Research & Policy Group		2 years
4	Review data already collected on rural practice and rural practitioners	Quality, Research & Policy Group Learning & Practice Development Group		2 years

Objective 2:
Further develop rural integrated services with a focus on improving access for rural populations, improving health equity, and maintaining quality and safe care.

Goals

- To support and encourage more integrated services in rural communities particularly for patients with long-term conditions and complex health needs.
- To support and encourage appropriate and accessible healthcare in rural communities to reduce health inequities between population groups while reflecting the principles of the Treaty of Waitangi.
- To support and encourage the use of remote consulting, telehealth and virtual-consultation technologies to improve accessibility and increase service capacity.
- To enable practices and individual rural practitioners to deliver high quality and safe care, and fulfill training and education requirements by:
  - ensuring that an appropriate rural perspective is sought and included in developing the Foundation Standard and advanced level standards;
  - encouraging rural general practices to participate in RNZCGP Cornerstone accreditation.

	Action	**Responsibility**	**Other stakeholders**	**Timeline**
1	Encouraging rural general practices to participate in RNZCGP Cornerstone accreditation.	Membership Services Group Learning & Practice Development Group		1 year
2	Ensuring that an appropriate rural perspective is sought and included in developing the Foundation Standard and advanced level standards.	Quality, Research & Policy Group		1 year
3	To promote the value of the integration of primary care with other community services, such as Whānau Ora, as a means of addressing inequities for at-risk families.	Membership Services Group Rural General Practitioners' Chapter RNZCGP Division of Rural Hospital Medicine		2 years
4	To foster research on deprivation in rural areas and the equity of healthcare between the rural and urban patient.	Rural General Practitioners' Chapter RNZCGP Division of Rural Hospital Medicine		3 years

		Quality, Research & Policy Group		

Objective 3:
Increase the capacity and sustainability of the rural practice health workforce to meet population and service needs

Goals

- To increase the number of doctors choosing a career in rural practice by:
  - Promoting strong academic leadership for rural health in our health science academic institutions.
  - Promoting students of rural origin (including secondary school students and mature students) to enter medical school.
  - Maximising exposure to, and promoting careers in, rural practice to medical students and postgraduate trainees. For example, by creating a rural attachment for all GP registrars, and developing programmes similar to Australia's John Flynn Placement Program[10] for medical students.
  - Ensuring all medical students and doctors have the opportunity to gain a positive experience of working and training in rural settings. Ensure practices can well accommodate students, make them feel valued and that they can make a difference. The rural practice experience should be exciting, fun and collegiate.
  - Encouraging medical schools to track medical students with a declared interest and providing longitudinal mentoring of rurally inclined medical students by rural health professionals.
  - Pushing, publicising and better funding the Post-graduate Generalist Placement (PGGP) education programme[11] for PGY2 and PGY3 registrars.
- To ensure a sufficient supply of generalist training opportunities and placements by:
  - Expanding the capacity and resource of rural practice based education, and teachers and educators.
  - Promoting the development of rural practice training programmes for other health professionals such as nurses and nurse practitioners.
- To maximise the contribution of already qualified health practitioners by:
  - Adjusting the imbalance and maldistribution of health workforce between urban-rural New Zealand.
  - Providing adequate support to doctors and practices to tackle workload and the on-call burden including having sufficient staff and good utilisation of staff.
  - Supporting work-life balance, the ability to have time off and protecting against burnout including supporting practices to operate family-friendly and flexible working policies.
  - Obtaining scholarships for further study and/or travel to encourage fellows who opt to stay in rural locations long-term.
  - Promoting collegiality – Skype peer groups, local education eg, urban consultant specialists talking to peer groups and implementing CME into the practice.

	Action	**Responsibility**	**Other stakeholders**	**Timeline**
1	Promote collegiality eg, Skype peer groups, local	Quality, Research & Policy Group		1 year

[10] The John Flynn Placement Program is part of the Australian Government's strategy to attract more doctors to rural and remote areas. It is funded by the Department of Health and administered by the Australian College of Rural and Remote Medicine (ACRRM). Medical students are placed with a rural doctor during holiday periods for eight weeks over a four year period.
[11] Trainees in their second or third postgraduate year can apply to be placed for three months in a rural general practice approved by the RNZCGP.

	education (such as urban specialists talking to peer groups) and implementing CME into the practice.	Membership Services Group		
2	Maximising exposure to, and promoting careers in, rural general practice to medical students and postgraduate trainees.	Learning & Practice Development Group Membership Services Group Rural General Practitioners' Chapter RNZCGP Division of Rural Hospital Medicine	Medical Council of New Zealand Medical schools Rural practices and practitioners Rural Health Alliance Aotearoa New Zealand Rural community groups	2 years
3	Ensuring all medical students and doctors have the opportunity to gain a positive experience of working and training in rural settings, for example, by obtaining greater funding for the Post-graduate Generalist Placement (PGGP) education programme for PGY2 and PGY3 registrars.	Learning & Practice Development Group		2 years
4	Ensure adequate support for doctors and practices to tackle workload and the on-call burden.	Membership Services Group Rural General Practitioners' Chapter RNZCGP Division of Rural Hospital Medicine		2 years
5	Promote good work-life balance, the ability to have time off and protection against burnout.	Membership Services Group Rural General Practitioners' Chapter RNZCGP Division of Rural Hospital Medicine		3 years

6	Obtain scholarships for further study and/or travel to encourage fellows who opt to stay in rural locations long-term.	Membership Services Group		3 years

Objective 4:
Enhance the skills and flexibility of the rural medical workforce to provide complex care

Goals

- To investigate aligning the two training programmes of rural hospital medicine and general practice.
  - Build on the strengths of the existing two training programmes.
  - Investigate practices and lessons learned of other training programmes, such as remote vocational training in Australia (eg, the post-graduate diploma in rural and remote medicine) and the orthopaedic model in urgent care physician training programme.
  - Liaise with the Nursing Council of New Zealand about the sharing of educational resources for rural nurse practitioners.
- To ensure trainees receive appropriate exposure to rural general practice by:
  - supporting a wider range of rural training practices to accommodate trainees;
  - accrediting practices for rural training if the model of care and range of patients are typical of the rural experience;
  - including more rural specific education in the GPEP1 academic programme;
  - facilitating adequate training in acute care, trauma and emergency care and on-call work during GPEP;
  - expanding virtual education to allow trainees to work in rural areas while completing GPEP1 and beyond.
- To enable individual rural practitioners to fulfill training and education requirements and deliver quality and safe care and. For example by:
  - adding “The Practitioner” to IPIF with progression through quality levels;
  - developing guidelines on incentives for being a GP practising at an excellence or advanced level. Incentives might involve status and remuneration (eg, rights of direct hospital admission, hospital waiting lists and diagnostic services).

	Action	**Responsibility**	**Other stakeholders**	**Timeline**
1	To establish a working group between the Rural General Practitioners’ Chapter and Division of Rural Hospital Medicine to plan ways of aligning future training. The working group will: - consider training models which combine training for rural hospital medicine and rural general practice; - look at models for a post-fellowship pathway to rural	Rural General Practitioners’ Chapter RNZCGP Division of Rural Hospital Medicine Learning & Practice Development Group	Medical Council of New Zealand Nursing Council of New Zealand Australian College of Rural and Remote Medicine and other Australian academic institutions	2 years

	practice (eg, a post-graduate diploma in rural practice) to allow GPs to gain the appropriate skill set (with optional elements).	Quality, Research & Policy Group		
2	To investigate ways for trainees to gain exposure to rural general practice such as: - supporting a wider range of rural training practices to accommodate trainees; - accrediting practices for rural training if the model of care and range of patients are typical of the rural experience; - including more rural specific education in the GPEP1 academic programme; - facilitating adequate training in acute care, trauma and emergency care and on-call work during GPEP; - expanding virtual education to allow trainees to work in rural areas while completing GPEP1 and beyond.	Learning & Practice Development Group Quality, Research & Policy Group Rural General Practitioners' Chapter RNZCGP Division of Rural Hospital Medicine		2 years
3	To include the following action points in the RNZCGP strategy: (a) To investigate the possibility of adding "The Practitioner" to the Integrated Performance and Incentive Framework (IPIF) with progression through quality levels. (b) To investigate extended/advanced competencies for the rural health practitioner.	Quality, Research & Policy Group		3 years

Objective 5:
Increase academic activity to improve effectiveness, research (evaluation) and quality

Goals

- To undertake high-quality and meaningful research on rural practice by:
  - increasing the level of research opportunities;
  - promoting the position of the research GP registrar.
- To formulate policy to promote rural health research that is academically rigorous and credible amongst our peers.
- To consider what we want to find out about rural health care through research such as on:

- Who we are (workforce).
- Clinical operational information.
- Current pros and cons of rural practice.
- Is it really a catastrophe?
- Are there any areas that are particularly bad?
- Gaps in rural practice.
- Ability for doctors (eg, young mothers) to work part-time.

- To undertake further research on areas identified.

	Action	**Responsibility**	**Other stakeholders**	**Timeline**
1	Investigate whether the RNZCGP's Research Education Charitable Trust (RECT) could make funding rural research a priority or call for expressions of interest.	Quality, Research & Policy Group	RNZCGP teachers, medical educators, registrars and PGGP Health Research Council Medical Council of New Zealand (data on rural doctors) DHBs/PHOs (numbers of patients, rural ranking scale) Health Workforce New Zealand Health Quality and Safety Commission (eg, Atlas of Healthcare Variation) New Zealand Rural General Practitioners Network NZ Locums (eg, data on nos. locums and practices needing locums) BPAC (Best Practice Advocacy Centre) Academic facilities/universities	2 years
2	To undertake further research on rural health care, which might include: - establishing a minimum data set of rural practices (or accredited GP training practices) with data collated annually; - collecting data on deprivation in rural areas; - looking at equity of healthcare between the rural/urban patient; - considering whether GPEP1 career plans should include rural practice; - reviewing availability of MOPS activities to rural practitioners and/or availability of MOPS activities with a rural theme.	Quality, Research & Policy Group Learning & Practice Development Group		2 years
3	Investigate accessing research funding for registrars (eg, from the Health Research Council).	Learning & Practice Development Group		3 years
4	Promote the research GP registrar position.	Learning & Practice Development Group Quality, Research & Policy Group		3 years

			Health and Disability Commissioner's Office Ron Janes (rural doctor survey (last 2007))	

Monitoring and Evaluation Framework

Purpose of the monitoring and evaluation framework

The monitoring and evaluation framework will allow for an understanding and monitoring of the progress made in the implementation of the Action Plan of the Rural Strategy. The framework will help to ensure the RNZCGP is following the direction set. It also provides a mechanism to evaluate long-term changes produced by the Rural Strategy on the identified priority issues.

Responsibilities and frequency on monitoring and evaluation

The Coordinator will regularly liaise with the responsible Group Managers and/or others on actions and record progress against the corresponding action points. As the RNZCGP is experiencing moderate changes (both internally and externally), progress on the Action Plan will be monitored on at least a three to four-monthly basis.

Group Managers will provide the Chief Executive with regular up-dates (at least four-monthly) on the status toward achieving the actions and goals assigned to them. The reporting mechanism will be facilitated by the Coordinator and status reports. The updated status reports will be placed on the SMT meeting agenda at regular intervals.

The Chief Executive or Group Manager (Quality, Research, Policy) will provide regular reports (four to six-monthly) to the Board of the Rural General Practitioners' Chapter or Chair of the Board of the Chapter and the Division of Rural Hospital Medicine on the status of implementation of the Action Plan including progress toward the action points and overall strategic goals. The Rural Chapter and Division of Rural Hospital Medicine will review progress against the Action Plan four to six-monthly.

The Chief Executive will regularly report (bi-annually) to the RNZCGP Board about the status of implementation including progress toward the action points and overall strategic goals.

Monitoring and evaluating the status of implementation of the Action Plan

Although the Action Plan sets out to address the vision over the next 10 years, the initial status reports focus on the first three years of implementation. At the end of this period, the overall progress on the Action Plan will be reviewed.

During regular review, it is important to:

- ensure that activities are kept within the parameters of the agreed objectives and goals of the Rural Strategy;
- ensure the activities are consistent with RNZCGP's vision and values;
- monitor internal and external changes (see below) which might require changes to the strategy or affect the ability to achieve the objectives and goals.

During review, determine whether the goals and objectives are being achieved. If yes, then acknowledge, reward and communicate the progress. If no, it would be helpful to consider the following questions:

- Will the action points be achieved according to the timelines set? If not, why not?
- Should the deadlines for completion be changed? (Evaluate efforts before making changes.)
- Are there adequate resources (eg, money, equipment, facilities, training) to achieve the action points?
- Are the goals and objectives still realistic?
- Should priorities be changed to put more focus on achieving the goals?
- Should the goals be changed? (Evaluate efforts before making changes.)
- What can be learned from monitoring and evaluation to improve future efforts?

Reporting results of monitoring and evaluation
Progress against each action point will be monitored using the status reports (below). This will enable an evaluation and review of the overall progress towards meeting the objectives and goals of the Rural Strategy. Where relevant, record the following information in the status reports:

- answers to the above questions;
- trends on the progress (or lack of) toward goals and objectives;
- recommendations about the status;
- any actions needed by management.

Deviating from the plan
The Action Plan is a guideline; not a strict roadmap that must be followed. Factors which may necessitate a deviation from the Action Plan include changes in the external environment, changes in members' needs (resulting in different organisational goals) and changes in the availability of resources to continue with the original plan. The most important aspect of any deviation is understanding what is going on and why.

Potential changes which might prevent achievement of the objectives and goals or require deviation from the Action Plan include:

- changes to the medical school curriculum;
- changes to requirements for entry to medical school;
- implementation of the Medical Council of New Zealand's prevocational training requirements including mandatory community placements for prevocational trainees;
- availability of general practice placements during the early postgraduate years (to help to confirm general practice as the first career choice);
- implementation of changes to the GPEP Year 1 training programme;
- long-term funding for GPEP training from HWNZ;
- funding for the Post-graduate Generalist Placement (PGGP) education programme;
- available funding through the RNZCGP's Research Education Charitable Trust (RECT);
- action taken following work by the RNZCGP's Recruitment and Retention Working Group (under Membership Services Group);
- the retention of general practitioners on the Essential Skills in Demand List (Long Term Skill Shortage List) maintained by the Ministry of Business, Innovation and Employment (making it easier for employers to bring in skilled migrants to fill specific vacancies);
- implementation of the RNZCGP's Foundation Standard and the Ministry of Health's Integrated Performance and Incentive Framework (IPIF), evolution of *Aiming for Excellence*, and subsequent progress including of the accreditation and monitoring processes;
- development of rural service level alliancing by the sector;
- level of rural funding available;
- rural community practices having experienced nurses.

Rural Strategy Years 1-3: Report on progress

Objectives
Objective 1: Promote a greater understanding of rural practice and rural health practitioners and their value to the New Zealand health sector
Objective 2: Further develop rural integrated services with a focus on improving access for rural populations, improving health equity, and maintaining quality and safe care
Objective 3: Increase the capacity and sustainability of the rural practice health workforce to meet population and service needs
Objective 4: Enhance the skills and flexibility of the rural medical workforce to provide complex care
Objective 5: Increase academic activity to improve effectiveness, research (evaluation) and quality

Year 1

	Action	**Responsibility**	**Timeline**	**Record activity**	**Comments** Eg, ability to meet timelines, adequacy of resources, whether still realistic, changes to priorities, goals and deadlines, and learnings Also consider: trends of progress, recommendations, further actions.
Objective 1: Action 1	Analyse the demographics of rural practitioners	Quality, Research & Policy Group	Year 1		

Objective 1: Action 3	Undertake research on such issues as: - number of RNZCGP members who consider themselves to be in rural practice; - factors considered important in classifying oneself as rural; - distance from the nearest base hospital; - number of rural GPs not affiliated with the Chapter (eg, by analysing data from the Rural General Practice Network).	Quality, Research & Policy Group	Year 1		
Objective 1: Action 4	Review data already collected on rural practice and rural practitioners	Quality, Research & Policy Group	Year 1		

Objective 5: Action 2	To undertake further research on rural health care, which might include: - establishing a minimum data set of rural practices (or accredited GP training practices) with data collated annually.	Quality, Research & Policy Group Learning & Practice Development Group	Year 1		
Objective 2: Action 1	Encouraging rural general practices to participate in RNZCGP Cornerstone accreditation.	Membership Services Group Learning & Practice Development Group	Year 1		

Objective 2: Action 2	Ensuring that an appropriate rural perspective is sought and included in developing the Foundation Standard and advanced level standards.	Quality, Research & Policy Group	Year 1		
Objective 3: Action 1	Promote collegiality eg, Skype peer groups, local education (such as urban specialists talking to peer groups) and implementing CME into the practice.	Learning & Practice Development Group Membership Services Group	Year 1		

Year 2

	Action	**Responsibility**	**Timeline**	**Activity**	**Comments** Eg, ability to meet timelines, adequacy of resources, whether still realistic, changes to priorities, goals and deadlines, and learnings Also consider: trends of progress, recommendations, further actions.

Objective 1: Action 2	Promote the value of rural generalist care, for example by case studies and articles in *GP Pulse*	Membership Services Group	Year 2		
Objective 2: Action 3	To promote the value of the integration of primary care with other community services, such as Whānau Ora, as a means of addressing inequities for at-risk families.	Membership Services Group Rural General Practitioners' Chapter RNZCGP Division of Rural Hospital Medicine	Year 2		

Objective 3: Action 2	Maximising exposure to, and promoting careers in, rural general practice to medical students and postgraduate trainees.	Learning & Practice Development Group Membership Services Group Rural General Practitioners' Chapter RNZCGP Division of Rural Hospital Medicine	Year 2		
Objective 3: Action 3	Ensuring all medical students and doctors have the opportunity to gain a positive experience of working and training in rural settings, for example by obtaining greater funding for the Post-graduate Generalist Placement (PGGP) education programme for PGY2 and PGY3 registrars.	Learning & Practice Development Group	Year 2		

Objective 3: Action 4	Promote adequate support for doctors and practices to tackle workload and the on-call burden.	QRP Group Membership Services Group Rural General Practitioners' Chapter RNZCGP Division of Rural Hospital Medicine	Year 2		
Objective 4: Action 1	To establish a working group between the Rural General Practitioners' Chapter and Division of Rural Hospital Medicine to plan ways of aligning future training. The working group will: - consider training models which combine training for rural hospital medicine and rural general practice; - look at models for a post-fellowship pathway to rural practice (eg, a post-graduate	Rural General Practitioners' Chapter RNZCGP Division of Rural Hospital Medicine Learning & Practice Development Group Quality, Research & Policy Group	Year 2		

	diploma in rural practice) to allow GPs to gain the appropriate skill set (with optional elements).				
Objective 4: Action 2	To investigate ways for trainees to gain exposure to rural general practice such as: - supporting a wider range of rural training practices to accommodate trainees; - accrediting practices for rural training if the model of care and range of patients are typical of the rural experience; - including more rural specific education in the GPEP1 academic programme; - facilitating adequate training in acute care,	Learning & Practice Development Group Quality, Research & Policy Group Rural General Practitioners' Chapter RNZCGP Division of Rural Hospital Medicine	Year 2		

	trauma and emergency care and on-call work during GPEP; - expanding virtual education to allow trainees to work in rural areas while completing GPEP1 and beyond.				
Objective 5: Action 1	Investigate whether the RNZCGP's Research Education Charitable Trust (RECT) could make funding rural research a priority or call for expressions of interest.	Quality, Research & Policy Group	Year 2		

Objective 5: Action 2	To undertake further research on rural health care, which might include: - establishing a minimum data set of rural practices (or accredited GP training practices) with data collated annually; - collecting data on deprivation in rural areas; - looking at equity of healthcare between the rural/urban patient; - considering whether GPEP1 career plans should include rural practice; - reviewing availability of MOPS activities to rural practitioners and/or availability of MOPS activities with a rural theme.	Quality, Research & Policy Group Learning & Practice Development Group	Year 2		

Year 3

	Action	Responsibility	Timeline	Activity	Comments Eg, ability to meet timelines, adequacy of resources, whether still realistic, changes to priorities, goals and deadlines, and learnings Also consider: trends of progress, recommendations, further actions.
Objective 2: Action 4	To foster research on deprivation in rural areas and the equity of healthcare between the rural and urban patient.	Quality, Research & Policy Group Rural General Practitioners' Chapter RNZCGP Division of Rural Hospital Medicine	Year 3		
Objective 3: Action 5	Promote good work-life balance, the ability to have time off and protection against burnout.	Membership Services Group Quality, Research & Policy Group Rural General Practitioners' Chapter RNZCGP Division of Rural Hospital Medicine	Year 3		

Objective 3: Action 6	Obtain scholarships for further study and/or travel to encourage fellows who opt to stay in rural locations long-term.	Membership Services Group	Year 3		
Objective 4: Action 3	To include the following action points in the RNZCGP strategy: (a) To investigate the possibility of adding “The Practitioner” to the Integrated Performance and Incentive Framework (IPIF) with progression through quality levels. (b) To investigate extended/advanced competencies for the rural health practitioner.	Quality, Research & Policy Group	Year 3		

Objective 5: Action 3	Investigate accessing research funding for registrars (eg, from the Health Research Council).	Quality, Research & Policy Group	Year 3		
Objective 5: Action 4	Promote the research GP registrar position.	Learning & Practice Development Group Quality, Research & Policy Group	Year 3		