RURAL SERVICES REVIEW

SOUTHERN REGION

Final Report from the Rural Services Review Group

AUGUST 2024

WellSouth
Primary Health Network
Hauora Matua Ki Te Tonga

Foreword

If ever there was a timely focus needing to be placed on rural health services in Te Waipounamu, it is now.

The report before you reflects the daily reality for health professionals on the ground and offers both practical and affordable solutions for the future.

It amplifies the voices of many practitioners who have enthusiastically embraced the opportunity to share their challenges.

The myriad of geographical and service provision challenges accurately reflects the constraints of very large land area coupled with low population density. Adding these challenges to passionate, but too few, health professionals graphically portrays the scale of task before us.

The individuals committed to this mahi have been tireless, and exhaustive in pursuing the challenge. Delivering quality health services is a calling for this team, and they are to be congratulated for their commitment.

The provider driven principle-based approach has, I believe, delivered a report with prioritised and practical recommendations, which when acted upon will bring a significant change for the better across our rural populations.

Thanks must go to WellSouth for having the courage of their convictions to commission the report. The energetic and detailed approach both Jonathan Amos and Leonie Williamson have brought as project managers has been exemplary, many thanks.

I commend it to you.

Tracy Hicks
Chair, Southern Rural Services Review

Contents

Executive Summary	4
The Rural Services Review	6
Background	7
Approach	9
A unique environment	11
The Southern Region	12
Primary healthcare in the South	13
Provider consultation	17
Defining what 'good' looks like	24
Strategic priorities	25
Operational priorities	26
Clinical priorities	28
Recommendations for the future	30
1. Flexible – Adaptable ways of working, tailored to local needs	32
2. Local – A comprehensive range of services closer to home	35
3. Resilient – A high-performing, well supported, workforce	41
4. Effective – Working together to achieve positive outcomes	46
Top five priorities	50
Conclusion	53
Appendix A: Comparison of National and Rural Services Review priorities	54
Appendix B: Geographical Classification for Health for Te Waipounamu	55

Executive Summary

Rural specific issues identified by this review include inequities in service provision, funding, patient costs, and workforce; combined with poor access to services, transport inefficiencies, unsustainably high levels of clinical risk, and specific issues relating to the delivery of urgent and unplanned care, mental health, aged care, palliative care, and rural pharmacy provision in the Southern region.

The Southern Rural Services Review Group has consulted widely on these issues and undertaken a principles-based approach to identify what 'good' looks like for the key areas of rural health provision: equity; patient access; clinical risk; collaboration; workforce; 24/7 urgent and unplanned care; funding; mental health; aged care; palliative care; and rural pharmacy.

This process enabled the group to define their vision for sustainable rural health services that offer:

- Greater access to health services closer to home.
- Equitable access, costs, and funding for providers, staff, and patients both across the region and with urban providers.
- Adaptable ways of working that are tailored to local needs.
- A resilient and high performing workforce.
- Manageable and 'safe' clinical risk for providers AND patients.
- Positive patient outcomes from providers working together more effectively.

The detailed recommendations outlined in this report offer both strategic and tactical solutions to achieve this vision.

More specifically, the group has highlighted what they consider to be the top five most important changes required for rural health provision. These involve large-scale change which is not anticipated to occur in the short term but should be considered in the context of any national or regionally led initiatives.

Top five most important changes

1. **Sustainable development of the rural workforce to create a more attractive workplace for health professionals**
2. **Addressing 24/7 urgent and unplanned care**
3. **Delivery of equitable patient access for rural people**
4. **Efficient transport options for patients at an equitable cost**
5. **Achievement of manageable clinical risk for providers and patients**

To provide focus in the short-term, the group has also identified the top five actionable recommendations, that they believe would make a significant difference to the daily operations of rural providers and their patients:

- Provision of secondary specialist services in local areas to cater for local need, meet population demand, and to upskill local primary care teams so they may provide additional services locally.
- Primary care access to diagnostics and clinical access to results.
- Co-ordinated local training tailored for rural providers.
- A commitment to deliver a regional healthcare plan that provides a coordinated, multi-services approach to service planning.
- Process changes to enhance the transfer of patients between primary and secondary care.

Rural healthcare has gained increased attention following the publication of New Zealand's Rural Health Strategy 2023 and consequently this review is timely. Many of the recommendations made will support existing national and regional initiatives currently focusing on capitation funding, transport, unplanned and urgent care, PRIME, and rural services. Others will feed into PHO initiatives to improve services at a local level. The group endorse the recommendations made and urge the New Zealand health sector to consider them in these contexts as they shape the future of rural health services in the Southern Region.

The Rural Services Review

Commissioned in July 2022, the Rural Services Review is a 'provider-based' review of the issues and opportunities confronting healthcare services in the Southern Region.

Background

The Rural Services Review was commissioned by WellSouth as a response to ongoing issues relating to rural healthcare provision in the region.

The purpose of the review was to identify the key priorities of rural health and community providers and to develop actionable strategies to enhance services and outcomes in rural areas. To achieve this, the Review Group was tasked with producing a set of recommendations for change.

Included in scope are all services relating to the provision of rural primary care, the communities they support, and the interface between these services, rural hospitals, Hato Hone St John, and rural pharmacy.

Although the review is 'provider focused' it was vital that good representation was included from key groups across the region and that the review took place alongside both national initiatives and place-based planning activity currently drawing on the direct views of local communities in designing New Zealand's future health system.

A national context

Rural healthcare has been identified as a key priority in New Zealand's Health Framework. Te Pae Tata – the Interim NZ Health Plan, released in October 2022, identified keeping people well in their communities by improving access to healthcare for rural and remote communities as one of their 6 key priority areas. While in July 2023, the Ministry of Health published the 'Rural Health Strategy – 2023' which set out the following five key priorities to provide direction for improving rural health:

1: Considering rural communities as a priority group

2: Prevention, paving the path to a healthier future

3: Services are available closer to home for rural communities

4: Rural communities are supported to access services at a distance

5: A valued and flexible workforce

> 'Over 700,000 New Zealanders, nearly one in seven, live in rural parts of Aotearoa. This rural population has a greater percentage of children, older people and Māori compared to urban areas. Compared to urban populations, people living rurally, particularly Māori, Pacific, and those on lower incomes face inequitable access to care. Poorer access to health services relates to barriers around costs, socioeconomic deprivation, geography and distance, transport and telecommunications limitations, and the design of services. Access to hospital-level care is particularly affected by distance, travel times and associated costs.'
>
> Te Pae Tata, s.3.4: Rural Healthcare.

Te Tiriti o Waitangi

Te Pae Tata describes a clear vision for health equity, which has been adopted by the Rural Services Review Group in honor of their commitment to Te Tiriti o Waitangi, the Treaty of Waitangi. This approach considers:

'Our drive for health equity is the first foundation of our transformed health system and Te Pae Tata. We aspire to service delivery that gives all New Zealanders the opportunity to achieve good health and wellbeing outcomes, regardless of who they are or where they live. Equity is not only an issue of fairness; it is essential for building an inclusive society and economy where everyone can thrive. Although both equality and equity promote fairness, equality treats everyone the same regardless of need, while equity treats people differently acknowledging their different needs."

Review Services Review Group

An integral part of the Rural Services Review was the creation of an independent review group that offered a combination of experience, local knowledge, and expertise across the Rural Health Sector.

An application and appointment process saw 16 volunteer clinical and non-clinical members selected from local primary care providers, rural hospital specialists, community, and iwi representatives.

Independent Chair	Tracy Hicks
General Practitioners	Andrew McLeod Nic Norman Stephen Hoskin
General Practice Managers	Janette Dallas Susan Jones
Nurse Practitioners	Amanda McCracken Kate Stark
Iwi representatives nominated by mana whenua	Helen Wilson
Representatives nominated by the Pacific community	Silou Temoana
Community representatives nominated by Community Health Council	Jo McKay Kathryn Wright (stepped down January 2024)
Rural Hospital Specialists	Jennifer Keys (replaced by Emily Nelson January 2024) Rachel Lynskey
Community pharmacist	Liang Kooi Kok
Representative of Hato Hone St John	Pauline Buchanan (alternate David Baillie)
Māori health & social service provider CEO	Tracey Wright-Tawha

The project has been supported by a Project Manager appointed by WellSouth and overseen by the WellSouth leadership team and board.

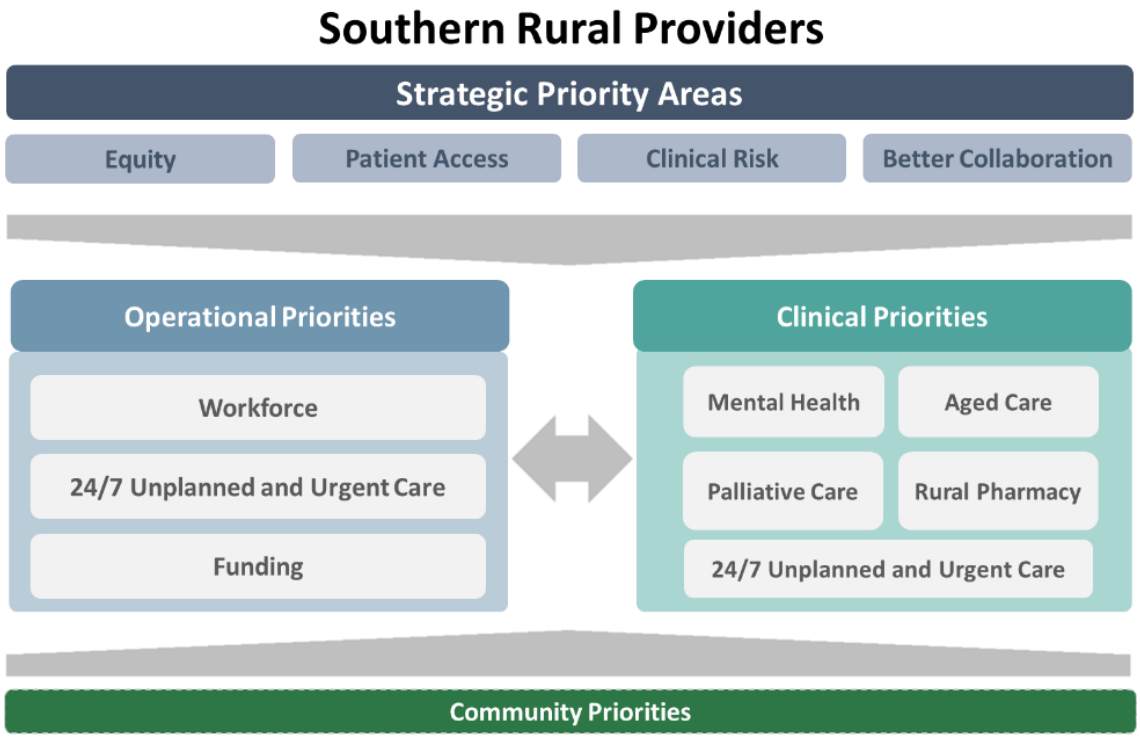
Approach

Consultation was undertaken with 60+ regional providers via an online survey and stakeholder workshop with participants asked to identify the main challenges and priorities for improvement in rural healthcare services in their area. Specific opportunities for collaborative approaches, innovative practices, and the management of clinical risk were also identified to support idea generation.

The output of this consultation was reviewed by the Rural Services Review Group and several regional specific priority areas were identified to guide the development of recommended actions using a principles-based approach. These priorities fall into one of the following four categories:

- Strategic priorities – Those overarching priorities that will drive the development of a sustainable rural healthcare system in the Southern region (Equity; Patient Access; Clinical Risk; Better Collaboration)
- Operational priorities – Key issues which impact day-to-day service delivery in the region (Workforce; 24/7 Unplanned and Urgent care; Funding).
- Clinical priorities – Specific clinical areas that are facing significant challenges and require immediate support (Mental Health; Aged Care; Palliative Care; Rural Pharmacy; 24/7 Unplanned and Urgent Care). *
- Community priorities – although this is a provider-based review, the group have identified the need to capture the voice of the community on an ongoing basis, both to inform service design and to measure the effectiveness of service delivery against community needs.

The review group recognised that many of the priority areas are intrinsically linked and subsequently inform recommendations made in other areas. This is particularly applicable to the four strategic priorities, which impact all aspects of healthcare delivery. This is depicted in the diagram below.



Rural Services Review Group, Southern, April 2024

*Note: other complementary reviews were identified during this period, specifically a review of Rural Maternity Services by Te Whatu Ora Southern. Given this, the Rural Services Review elected not to provide input in this area, enabling this important sector to be directly represented and have their own recommendations heard.

It was important to the group that the Rural Services Review linked closely with the new national direction for rural health service provision. The table located in Appendix A maps the Rural Services Review Group's priorities with those of Te Pae Tata - the Interim New Zealand Health Plan, and New Zealand's Rural Health Strategy 2023.

Recommendations development

Once the priority areas were identified, the group agreed a set of principles relating to 'what good looks like' for each. This not only enabled them to establish a future-forward vision for rural healthcare provision in the region, but also guided the development of the group's recommendations. During this process it became clear that several common themes arose when discussing the recommendations for each of the priority areas. These are:

1: Adaptable ways of working, tailored to local needs

2: Provision of a comprehensive range of services closer to home

3: Development of a high-performing, well supported workforce

4: Collaborative approaches enabling providers to work together to achieve positive patient outcomes.

The final recommendations naturally group into these four areas and have effectively created the basis of the group's vision for the future: building sustainable rural health services in the Southern Region.

As a final step the Review Group have identified their top five overall most important recommendations for change in rural healthcare, along with the top five actionable recommendations they'd like to see implemented in the short-term. This will provide clarity regarding the groups recommended areas of focus.

National, regional, and local contexts

Although the following recommendations have been developed in a local (Southern) context, it became apparent that many also applied in a national and regional framework. The group has identified the area of impact for each and promotes the sharing of these with relevant groups and forums as input to their planning processes.

A unique environment

The Southern Region is geographically vast, characterised by significant variances in terrain, climate, population, and economic prosperity; all of which present our primary care health network with significant challenges.

The Southern Region

The Southern Region incorporates a wide area, reaching south from the Waitaki River to Stewart Island and represents the largest geographic regions in New Zealand.

Geographically the region varies from mountainous terrain to river valleys and dry plateaus, forests, hills, and rugged coastlines. Southern also experiences some of the wettest, coldest, and hottest climates in the country; all of which contribute to some of the most treacherous and challenging road conditions.

Population

The regional population of 358,500 represents approximately 6.9% of New Zealand's total *(Stat's NZ, 2018)*. However, district populations vary significantly, with estimated population growth expected to remain relatively constant in Clutha, Gore, Waitaki, and Western Southland. Conversely, Wanaka and Queenstown are experiencing significant growth and are expected to expand by approximately 41% and 27% respectively by 2048 *(Sub-national population projections, Stat's NZ, 2018).*

	Estimated total population	Annual % change (year to 30 June 2023)
Central Otago	26,000	2.4%
Clutha	18,900	1.3%
Gore	13,050	0.54%
Queenstown	35,510	9.3%
Waitaki	24,300	1.3%
Wanaka	17,290	5.6%
Southland District (total)	32,700	1.2%

Infometrics, 2023

Seasonal fluctuations from tourism and itinerant workers in areas such as Wanaka, Te Anau, Queenstown, and Central Otago can result in significant population shifts of anywhere between 30,000 to 50,000 at a time, creating significant pressure on local utilities, accommodation, and particularly healthcare.

Local workforce

The migrant workforce accounts for approximately 12% of Otago's and 6% of Southlands regional workforce and is significantly higher than other regions. Most are employed in accommodation, food, agriculture, forestry, and fishing. Otago is also the third largest employer of essential skills workers, with most originating from the UK, Brazil, and India *(Regional Workforce Plan, MBIE, June 2022).*

Unemployment in Otago (2.5%) and Southland (3.23%) was also below the national average of 4% for quarter four, 2023 *(Infometrics, March 2023).* However, incomes vary widely across the region, with only Queenstown-Lakes above the median national household income of $127,423 *(Infometrics/Opespartners; January 2024)*. Likewise, this district is the only area in the Southern Region with median house prices above the national average.

	Median Household Income	Median House Price
Central Otago	$102,008	$792,814
Clutha	$98,954	$379,681
Gore	$74,410	$393,454
Queenstown-Lakes (incl. Wanaka)	$133,074	$1,677,669
Waitaki	$95,721	$465,778
Southland District	$108,600	$488,974
New Zealand	$127,423	$905,070

Infometrics, 2023; Opespartners, Jan 2024

Demographic variances

A core issue for the region is its aging population with populations in many districts above the national average. Currently, there is estimated to be approximately 30,000 people aged 65+ in Southern's rural areas, however this is expected to increase to 49,200 (64%) by 2048 *(Sub-national population projections, NZ Stat's, 2018).*

	Median Age
Central Otago	46.5
Clutha	42.6
Gore	43.6
Queenstown	36.4
Waitaki	45.6
Wanaka	36.4
Western Southland	39.1
New Zealand	37.4

NZ Census, 2018 estimates, NZ Statistics

The ethnic profile of the Southern Region also differs greatly from New Zealand's wider population, with a significantly higher proportion of NZ Europeans and lower numbers of Māori and Asian populations. Outside of the norm is Oamaru which has a proportionally higher number of Pacific Peoples than the region as a whole.

	NZ	Southern	Total Rural	Central Otago	Clutha	Gore	Oamaru	Queenstown	Wanaka	Western Southland
Asian	15%	7%	7%	5%	5%	5%	7%	10%	8%	7%
European	70%	78%	79%	84%	78%	81%	74%	77%	83%	79%
Māori	17%	10%	9%	9%	12%	12%	11%	5%	6%	11%
Other	2%	2%	2%	1%	1%	0%	1%	6%	3%	1%
Pacific Peoples	8%	3%	2%	1%	4%	1%	6%	1%	1%	1%

New Zealand Census, 2018, NZ Statistics

Primary healthcare in the Southern Region

There are currently 333,035 enrolled patients in the Southern Region; of these, 144,386 (43%) are classified as rural. Over the past four years, there has been an 5.7% increase in total enrolled patients and 7.4% in rural patients. (*WellSouth, April 2024*)

Total No. Enrolled Patients by District	
Gore	18,299
Clutha	13,946
Waitaki	25,302
Wanaka	18,094
Queenstown	31,707
Central Otago	24,065
Western Southland	12,973

WellSouth, April 2024

Overall, there are less Southern rural patients in the region categorised as being on the New Zealand deprivation index, except for Clutha, Gore, and Oamaru all of which have more patients in this category than the regional average.

Deprivation index (%M/P/Q5) by district	
Clutha	31%
Gore	24%
Western Southland	17%
Waitaki	27%
Central Otago	11%
Wanaka	7%
Queenstown	7%
All rural patients (Southern)	16%
All enrolled patients (Southern)	22%

WellSouth, April 2024

Rural Practices

Of the 78 practices in in the Southern network, 36 are considered rural. Practice workloads have increased overtime due to workforce issues combined with growing populations. As of April 2024, Southern's rural practices had an average patient ratio of 1654 patients per GP, significantly higher than the average for Southern's urban practices of 1572 per GP (*WellSouth, April 2024*), and the recommended average ratio of 1300-1400:1 by the Royal New Zealand College of General Practice. This pressure has resulted in nine rural practices from Tuatapere, Cromwell, Mataura, Gore, and Oamaru closing their books to new patients at the time of writing. Additionally, eight of Southern's rural practices are currently sole practitioner-led, and two are Nurse Practitioner led, creating additional risks for workforce and patient care in the region.

Capitation funding has not kept up to date with population growth in the South. Southern's rural funding contract has increased by approximately 7% over the past 4 years, while there have been an additional 35,755 patient enrollments. As a result, per patient costs equating to $30.80 in June 2020 are now $27.60. Using current numbers this is likely to deflate to $26.70 this year, of which practices will get even less *(WellSouth, February 2024)*.

Workforce

There has been an increase in Southern's rural general practice workforce over the past six months for all roles.

	Total No. Staff		Total FTE		Avg. Age	
	Oct 23	Apr 24	Oct 23	Apr 24	Oct 23	Apr 24
GP	127	140	79.1	87	50	51
Locums	27	30	n/a	n/a	58	57
Nurse	209	232	115	125	46	47
Admin Staff	175	185	110	123	51	52

WellSouth, April 2024

The average age of GPs across the region is consistent with national figures of 50.6 year (*Royal New Zealand College of General Practice, 2023*); however, seven practices have GPs with an average age of 55+ indicating future capacity risk to the network.

There were a reported 20 rural practices with known vacancies in 2023 with the majority relating to GP's and Registered Nurses. Meanwhile, 34% of GPs in the Southern Region have indicated they intend to retire in the next five years, and 44% have indicated they are at the high end of the burnout scale *(WellSouth, 2023)*.

Other services

Many rural hospitals across the region are owned by community trusts. These service large geographic areas and provide a range of secondary services including some outpatient clinics. Currently only Queenstown-Lakes, Gore, Oamaru, Invercargill, and Dunedin offer Emergency Department services. Inpatient beds are located at the following rural hospitals: Dunstan (24); Gore (16); Clutha (17); Queenstown-Lakes (12); Oamaru (30); and Maniototo (4) with some also catering for aged residential care. Distances from these facilities to base hospitals in Dunedin or Invercargill range from 1 hour (Oamaru, Gore, Clutha), 1.5 hours (Maniototo), to 2.5 hours (Queenstown-Lakes and Dunstan). A map of the Geographic Classification for Health for Te Waipounamu is in Appendix B and identifies the following rurality data for Southern's Rural Hospitals:

	% population by Geographic Classification for Health (GCH)		
Hospital	R1	R2	R3
Clutha Health First	62.7%	37.3%	-
Dunstan Hospital	-	91.1%	8.9%
Gore Hospital	21.9%	78.1%	-
Lakes District Hospital	100%	-	-
Maniototo Hospital	-	-	100%
Oamaru Hospital	95.6%	4.4%	-

Defining catchment boundaries and their populations for Aotearoa NZ's Rural Hospitals; Journal of Primary Healthcare, March 23

There are currently 32 rural pharmacies across the region with two pharmacy depots servicing patients in the relatively isolated regions of Lawrence and Tapanui. The Southern rural network currently has 25 aged care residential facilities. Significant risk has been identified in Queenstown and Wanaka where there are currently only three facilities, yet the 65+ population is estimated to increase by 51% over the next ten years (*2018 population projections, NZ Department of Statistics)*. Although, Central Otago and the Southland District offer several more facilities, they too are estimated to grow by approximately 33% in the same period (*2018 population projections, NZ Department of Statistics)*.

There is a shortage in local provision of mental health resources at a secondary level, however short-term intervention services provided by WellSouth are available at most of the Southern region's rural practices, with wait times ranging from 3.4 to 7 weeks (*WellSouth, March 2024*).

Hato Hone St John

There are currently 24/7 ambulance services in Oamaru, Balclutha, Alexandra, Wanaka, Queenstown, Te Anau, and Gore, with additional 12-hour coverage in Queenstown along with Cromwell, Otautau, and Winton. Volunteer resource is available at an additional 22 sites across the region as and when availability allows. 45% of all non-transport ambulance responses in Otago/Southland in the last 12 months have been to rural areas (*Hone Hato St John, March 2024*).

There are 20 PRIME practitioners (PRIME practice, Rural GP contractors, self-funders, and Locums) contracted across the region, many of whom also provide general practice afterhours coverage in conjunction with this service. In the last 12 months PRIME responses averaged 37 per month in rural areas. An additional 13 incidents per month were allocated but not attended. Overall, PRIME responds to an average of 55% of the incidents allocated in the region, significantly more than in other areas, and is the first arrived at the scene for an average of 25% of the incidents responded to. PRIME wait on average 35 minutes for a backup EAS ambulance in the Otago/Southland region (*Hone Hato St John, March 2024*).

Provider consultation

60+ providers from across the rural health sector were consulted with at the outset of the review to identify the challenges they, and their patients, are facing daily and to establish their priorities for change.

Wide-reaching involvement

60+ providers from across the region were consulted with at the outset of the review. This group were comprised of general practice, rural pharmacy, allied services, community and iwi groups, aged residential care, Hato Hone St John, and WellSouth.

What is working well?

Although this report sets out the Review Group's priorities and recommendations for change, the Southern Region continues to provide high quality health services day-after-day. The following provides a high-level overview of the areas that are performing well:

- There is believed to be strong community engagement with healthcare provision, particularly with voluntary services and community providers networking improving access for underserved groups.
- There are good networks and pockets of good collaboration, with the localities approach having seen positive results.
- Providers have good relationships with their patients and Manage My Health patient portals are providing some patients with an effective communication channel for accessing healthcare services.
- Although often small, healthcare teams have broad knowledge and often specialist skills to cater for patient need in their communities.
- Initiatives such as HealthCare Home and the use of multi-disciplinary teams is helping to share skills and expand services across the region.
- Patient pathways have improved with the limited services available. Health Pathways is working well to reduce the volume of tertiary visits, and access to services such as rural pharmacy depots and deliveries, and rural satellite general practice models aiding access.
- The increase in community and primary mental health care at mild to moderate levels is having a positive effect, as is the new community crisis support team in place in Central Otago.
- Despite clear access issues, the region's Ambulatory Sensitive Hospitalisations (ASH) admissions are low, however this is in large part due to the work done (for free) by providers.
- There are some outreach services working well with Immunisations, and the Te Waka Wahine Hauora (Women's Health bus) offers good local support, although it's not publicly funded.
- Extra funding for seasonal POAC and winter wellness checks have been positively received.

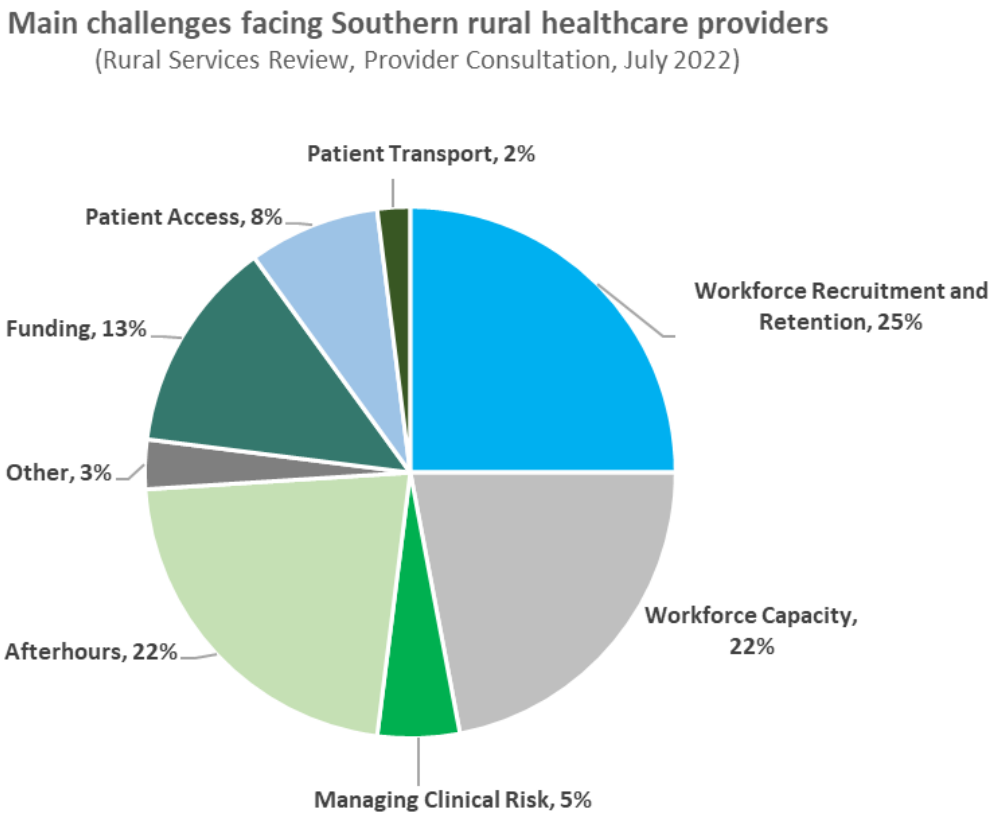
Consultation feedback

'The relationship between our healthcare team and patients is very special. This is our town; we share the space with each other and see each other all the time. It's like family!'

Rural Services Review, Community Consultation, 2022

Challenges

Providers were asked to identify the top three challenges they currently face as a rural health provider. Nearly half of the group identified workforce (capacity, recruitment, and retention) as the primary challenge encountered, followed closely by afterhours provision and funding.



Workforce:

Participants believe that the Southern region is disproportionately affected in terms of workforce retention and capacity. Currently, capacity doesn't meet population growth and struggles recruiting and retaining staff are leaving the existing workforce with significant workloads that are creating burnout and stress. Lower pay than urban or secondary professionals and a lack of recognition for the breadth of rural roles, combined with the pressure of working remotely with significant afterhours accountability are all creating issues for providers. Local providers are topping up salaries where they can, but overall primary care continues to experience significant loss of staff to secondary providers because of pay. Locums are difficult and expensive to obtain and overseas staff who have come into the area typically don't have the wide scope of skills rural practitioners possess and struggle with the workload and afterhours components of rural healthcare. Although one of the main attractions for staff coming to the South is the variety of outdoor pursuits on offer, accommodation is difficult to source, and affordability is a real issue. Training is a significant burden on practices with courses typically located in urban settings leaving providers to cover the cost of staff travel, accommodation, and replacement cover; while training content is not rural specific and doesn't consider the clinical diversity rural practitioners require, nor the multi-service input needed to deal with rural situations e.g., mass casualty incidents. More positively, participants reported that new roles such as health coaches, health improvement practitioners, and brief intervention services are taking some pressure off GPs.

Clinical Risk:

Participants highlighted an increasing concern with the amount of risk providers are encountering daily. Not only are these issues deterring potential new staff from working in the area, but fears are that if these concerns are not addressed both patient and staff safety will be significantly compromised. Providers are regularly working day and night increasing the risk to both themselves and their patients.

While many participants reported they were often working alone in large or isolated locations, leaving patients with insufficient cover when there are multiple incidents and increasing pressure on other emergency services to provide support in the field. A lack of secondary capacity is also adding pressure to primary providers and increasing patient complexity particularly for aged care and mental health. While distance and delays in accessing care is leading patients and providers to make decisions on whether it's safe or necessary to travel, which is often increasing patient acuity. Finally, insufficient local monitoring services afterhours is causing St John to transport low acuity patients, leaving no available local options for other, potentially higher acuity, patients.

Consultation feedback

'A number of services available in urban areas do not cover rural areas; and travel in many cases adds barriers to access.''

Rural Services Review, Community Consultation, 2022

Patient Access:

Significant population growth in the region and large seasonal populations, combined with workforce issues mean practices are struggling with high patient volumes. Several of Southern's general practices have now closed their books to new patients creating ongoing bottlenecks across the region. Large areas of the Southern region are underserved by secondary outpatient and specialist healthcare, particularly maternity, pediatric, chemotherapy and radiology, palliative care, community pharmacists, aged care, and mental health services. Stretched resources, distance, and variations in services have resulted in unclear patient pathways and poor co-ordination with patients often pushed around available services. Telehealth is not well utilised in the region, with patients frustrated by the triage process and citing providers poor understanding of local services and geography creating poor treatment solutions. Additionally, inadequate numbers of cultural providers mean the needs of our most underserved communities are not well met. Conversely, participants felt outreach services offer good opportunity in this area but are not currently sufficient in volume and reach to meet demand. Although there is a push to keep people out of hospitals there are few local community programs focusing on preventative medicine and providers find it difficult to engage rural communities when they have long distances to travel.

Consultation feedback

'Telehealth recently sent an Alexandra patient to Dunedin hospital, a 2.5-hour drive away, when they could have been seen a few kilometres down the road at Dunstan Hospital!''

Rural Services Review, Community Consultation, 2022

Transport:

Distance, roading and weather are significant issues in the Southern region. Transport options are poor, and the cost of travel is high. Often if ambulances are occupied and the helicopter can't fly, patients are required to drive themselves anywhere up to 2-3 hours to a base hospital in either Dunedin or Invercargill. Not only is Hone Hato St John stretched thin with low acuity cases and transfers distracting them from emergency provision, but driving hour caps mean transport to base hospitals can take many hours and require several ambulance-to-ambulance transfers, which depletes local staff numbers and increases patient risk. Additionally, there are insufficient transport options for patients and clients accessing routine and non-urgent appointments that are not in their immediate location creating further barriers to access for rural people.

Consultation feedback

'Central government has no idea what living outside a city is like when someone requires urgent medical intervention. Patients assume there is a government funded emergency system but there isn't! I spent 90 minutes alone with a haemorrhaging patient waiting for an ambulance that I already knew was in town.''

Rural Services Review, Community Consultation, 2022

24/7 Unplanned and Urgent Care:

Identified as one of the most pressing issues in the Southern region, urgent and unplanned care suffers from divergent interpretations of what it consists of, where, and who provides it. More immediate Emergency Department (ED) access is available for some rural districts (Gore, Oamaru, and Queenstown), but others are reliant on primary care, PRIME, and St John to support patient's afterhours with many staff working both their normal daily roster and afterhours. Fewer resources, and increasing demand combined with the complexity of urgent care in often large, isolated regions is causing greater risk and fatigue for clinicians, which is exacerbated by extreme winter conditions, poor roading, and large coverage areas. Current funding is insufficient to cover the actual cost of face-to-face or telehealth services and so high patient subsidisation is forcing many patients to drive long distances to access a 'free' afterhours service instead. Most of the regions rural hospitals are community owned trust hospitals, which receive less funding than centrally owned hospitals, and subsequently they are struggling to provide the necessary resources to support unplanned and urgent care. These variations in service across the region, mean that patients are unclear about where and when to access care and patient coordination is disjointed as providers look to address individual patient needs in this difficult environment.

> *'There is a big push for equity, however that seems to be solely based on ethnicity or high needs status, leaving rural patients severely disadvantaged. Access to hospital appointments is difficult and costly, and the cost for patients and families to travel to Dunedin is prohibitive.''*
>
> *Rural Services Review, Community Consultation, 2022*

Funding:

A review of the funding and capitation model is currently underway at a national level and subsequently is out of scope for the Rural Services Review. However, funding remains a critical factor in all Rural Service discussions due to the inconsistencies faced by rural providers and patients. Participants felt strongly that funding does not reflect actual costs to serve in rural areas and there is a disconnect between the fees patients pay, capitation and rising costs. Additionally, there is little transparency regarding how the funding is calculated and the process of disbursement. This is creating confusion and there is a generally held belief that funding is inconsistently applied across providers in the region. Furthermore, participants highlighted that funding does not enable providers to target the specific needs of those in their communities which is impacting patient outcomes.

Other:

Equity: Equity in a rural context is wide reaching impacting workforce, healthcare providers, and most importantly patients. Access to healthcare services for rural patients in terms of service availability (afterhours; diagnostic services like x-ray, blood testing, and ultrasound; cultural responses; allied and wrap around services), distance, and the cost of services is inequitable when compared to those living in urban areas. In 2016 a regional study found the average cost incurred by Central Otago residents associated with attending a base hospital in Dunedin was NZ$732 *(The cost of free; Journal of Primary Health Care, September 2016)*. While recent analysis showed approximately 11,140 blood tests were conducted by Wanaka Medical Centre in the year to 31 May 2024*:* creating significant pressure on clinic resources from the associated analysis and follow-up and signaling demand for a standalone blood service in the area *(Wanaka Medical Centre, June 2024)*. Inequities are also experienced by providers in relation to funding of services, pay parity, training costs and workforce planning when compared to secondary and urban providers.

Mental Health: Few secondary Mental Health resources combined with the barrier of distance is impacting primary care in the South. HIP's and Brief Intervention services have been well received, however there remains a gap in service for moderate to high acuity patients. Distance from inpatient beds, a lack of of crisis respite facilities, and little drug and alcohol support, mean these patients are relying on primary care. Unfortunately, stretched workloads mean primary care is struggling to provide the support required increasing the clinical risk for these patients.

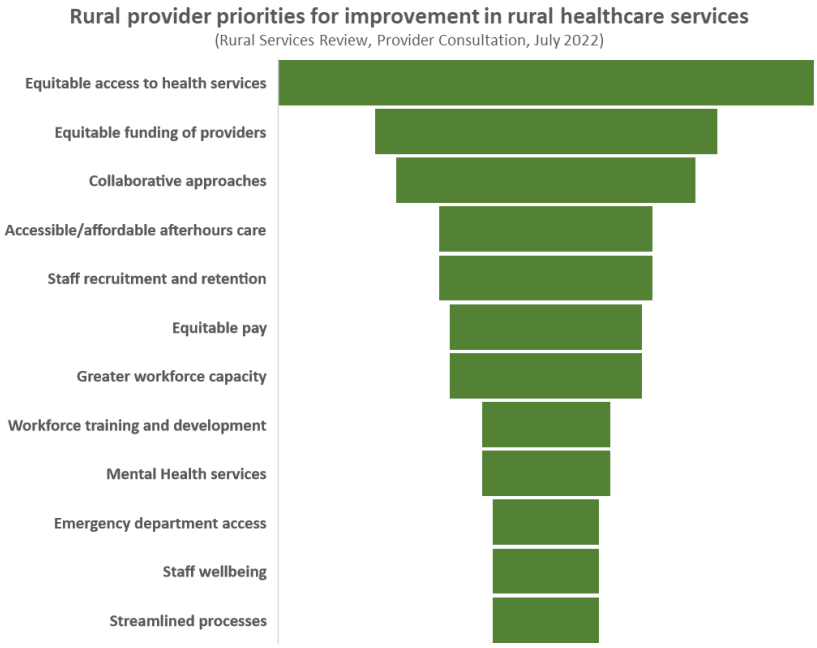
Aged Care: Participants believe that increasing populations, combined with few local dedicated services, will result in a significant healthcare gap for the elderly if not addressed. Providers shared concerns about delays in needs assessments, patchy home support, and a lack of rural respite care options. Poor co-ordination between agencies and inadequate management of the discharge process from hospital to home is creating issues for on call primary care providers as well as increasing patients' levels of acuity as they wait to be seen. Locally, there is little connection between councils, developers, and healthcare providers when building new facilities. Aged care providers cited recruitment as their main issue due to the lack of accommodation and high cost of living in some areas.

Palliative Care: Increasing demand in this space is putting additional pressure on general practice. Care of palliative patients takes more time and resources, and the distances rural providers travel to support their palliative patients at home creates additional costs. Funding in this area is not consistent with assisted dying, and the significant variation in patient needs and length of care means many of the associated costs are not covered. Finally, it was noted that there is no mental health and wellbeing support for the families supporting their loved ones at this critical time, nor the healthcare professionals who are tasked for caring for people within their own communities.

Rural Pharmacy: Rural Pharmaceutical services are also under threat with variation in service provision creating barriers to access for rural patients. This can include hours of availability and services relating to basic care and minor ailments. There continues to be some debate regarding the role of pharmacy in the provision of minor ailment services, however participants acknowledged it has worked well through COVID and they would like to see a further review of this model. Although there has been some success in the creation of close to home depots, providers are encountering issues with the collection of charges and with drug adherence. Equally, the return of prescription fees will contribute significantly to costs facing rural patients and will likely result in a reduction in patient outcomes. Finally, as with other providers, issues relating to pay and training options, is impacting workforce recruitment and retention leaving providers working overtime to support their communities.

Opportunities for improvement

When asked to identify their top priorities for improvement in rural healthcare services in the region, the group nominated equitable access to health services for rural people, especially to secondary services, as the most important priority. This was closely followed by equitable funding of providers when compared to urban providers. The third priority was the development of collaborative approaches such as multi-service solutions, knowledge sharing, joint consults, and the sharing of resources that would enhance service delivery across the region.



Opportunities to collaborate

Providers in the region pragmatically accept that resources are constrained and there is a need to find ways to work differently. Collaborative approaches that focus on better utilising each services core skills to support each other is seen as key to success in this area. However, for this to occur efforts must be taken to address issues relating to data, systems, processes, poor program delivery, and organisational misalignment such as connections between funders and the frontline and between providers and NGO's. Specific examples of where providers considered there are opportunities to collaborate include:

- Afterhours services including general practice, rural hospitals, ambulance.
- Crisis management
- Mental Health provision, including joint provider assessment of referrals.
- Onward patient transfers
- Sharing of services and resources between general practices when not universally available
- Co-ordination of secondary care referrals including appointments, transport, diagnostics
- Care plan coordination for patients with long-term or chronic conditions.
- Access to patient data e.g., discharge information
- Streamlining of pathways between primary and secondary care
- Better connections with NGO and allied providers
- St John and Fire for patient transport
- Centralised support for administration
- General practice and pharmacy services

Defining what ‘good’ looks like

Understanding and agreeing what ‘good’ looks like for each of the priority areas, enabled representatives to create a benchmark for change from which to generate their more detailed recommendations.

Identifying 'what good looks like' for each priority area

Adopting a 'what good looks like' approach to their recommendation's development enabled the Review Group to utilise the feedback gathered during the consultation, combined with their own expertise, to identify the key principles they considered would drive effective change in each priority area.

Strategic priorities

These are the overarching priorities that impact all areas of healthcare delivery and will effectively drive the development of a sustainable rural healthcare system in the Southern region.

Vision	Achieved by...
Equity: *Removal of barriers (i.e., costs, travel, service coverage) for rural patients, and particularly those who are underserved with no bias or assumption made, by providing access to primary and specialist healthcare closer to home that meets local needs AND keeps people out of hospital and well in the community.*	• Defining/re-designing services that align with Te Tiriti and Pae Ora to address equity to meet local demand and need. • Consumer engagement and lived experience driving all thinking. • Equitable and adequate funding to deliver local and specialist services closer to home. • Equitable funding for providers that considers rurality i.e. equitable funding across hospitals, free access to minimum services like x-ray and blood tests in local clinics. • Equitable pay, training, and support for our rural workforce in their own location
Patient Access: *Provision of healthcare services (primary services, community groups, specialist clinics, outreach etc.) that can be more easily and promptly accessed by patients closer to home complimented by a more effective local transport and telehealth system; that recognises the skill set of our rural workforce; and provides flexible funding so providers can offer the right service in the right context.*	• A long-term Southern healthcare plan to support delivery of services in context. • Access to healthcare for all i.e., no closed patient books, removal of costs • Sustainable and accessible (easier, quicker) afterhours services for all patients. • Adequate staffing, training, and remuneration that recognises their skill set and enables our rural workforce to deliver the services needed, closer to home. • Recognition of the actual costs of rural service provision, and flexible funding to ensure services meet the needs of the community they are serving. • Removal of additional costs for patients and support for seasonal populations. • Acknowledgment of population changes & provision of local services to meet demand. • Wider community consultation. • Greater education on what services are available to patients. • A transport system that meets patients' needs without delay or cost. • A telehealth system that compliments services already offered.
Clinical Risk: *A healthcare sector that is sustainable in the long-term, providing a 'safe' environment for rural patients, and the appropriate processes, resources, and*	• Modified ways of working that cater for differing local needs (with consolidated shared services in larger geographical areas) • Greater workforce planning that offers better work/life balance, remuneration, and wellbeing support • Provision of additional training that enables the workforce to effectively manage the greater risk encountered by distance and isolation.

support for our people to work effectively and responsibly.	• Clearer processes and protocols for acute and emergency situations, discharges, and referrals • Technology, tools, and support to protect isolated workers. • Agreement of 'safe' clinical capacity limits, tailored for each community and provider to minimise patient error, staff stress or burnout. • Access to speciality areas such as mental health, maternity, and palliative care to better support primary providers. • Single entry point to secondary care to streamline patient pathways. • Better support for ancillary services e.g., district nursing, home help, podiatry • Improved clinical transport through the adoption of innovative solutions. • Greater education on the rural emergency system for patients, and for telehealth providers on local systems/pathways so they may better support face-to-face care. • National access to patient data
Better Collaboration: *An open and supportive culture, where providers can effectively and sustainably deliver their core services whilst also working together to safely provide local solutions for the best possible patient care.*	• Development of holistic 'best fit' plans that include all rural providers and caters for both patient needs and Southern's unique geography. • Continued promotion of open and supportive relationships (formal and informal) between providers • Shared data and resources to improve planning and monitoring of outcomes. • Working together and sharing resources in local areas to reduce burnout and clinical risk i.e. buddy systems, co-operative rosters. • Opportunities to co-locate to provide support and better patient outcomes. • Standardised protocols and processes for patient care • Funding of collaboration initiatives for staff to share ideas and knowledge. • Education and support for patients navigating complex pathways.

Operational priorities

Operational priorities encompass the main challenges Southern providers are facing daily.

Vision	Achieved by...
Workforce: *A sustainable regional workforce with sufficient capacity to effectively manage patient workloads and provide optimal care (same day appointments and routine appointments within a week) for rural people; strengthened by recognition of our people for their specific skill set, provision of targeted regional training and wellbeing programs, and the creation of*	• Equitably remunerating all roles across primary and secondary care • Acknowledging the scope of rural roles by incentivising people to work in rural areas (pay, financial incentives, training, accommodation support) • Creation of a pool of GP/Nurse/Pharmacy locums who can cover leave and illness for multiple practices. • Delivery of a co-ordinated regional training program that focuses on practical (scenarios), team-based development, as well as strengthening relationships in local areas. • Reviewing the applicability of new roles to support the rural workforce. • Reducing the administrative load of practices • Creating flexibility in the system to better support wellbeing through informal collaboration, and targeting members of our workforce who need support (e.g., small practices and isolated workforces)

an attractive and rewarding place for people to work.	• Appropriate use of telehealth and other services to support people on the ground.
24/7 Unplanned and Urgent Care: *An effective and sustainable rural unplanned and urgent care model that prioritises face-to-face care and offers a functional service with equitable access that is comparable to urban provision (similar levels of service, at a similar cost, and in similar contexts); and that is adequately staffed with agreed levels of acceptable risk ensuring a safe environment for all.*	• Delivering a long-term regional plan for urgent and unplanned care, and delivery of all solutions within that context • Provision of 24/7 emergency access for all communities with face-to-face assessments a priority • Standardised protocols for care including access criteria and treatment pathways for each level of acuity, and agreement of the funding principles that support this. • Streamlined referral processes from primary to secondary. • Consideration of the role of allied health in supporting low acuity conditions • Manageable workloads and safety protocols for staff • Remuneration reflecting patient load and hours worked. • Greater collaboration between practices to service local areas • Fit for purpose facilities to support increased demand. • Education of telehealth providers on local services/geography etc
Funding: *Rural health funding that is delivered in an equitable context with an understanding of the real cost of service provision in rural areas to ensure financial support is fairly and consistently applied for all providers, reflects the needs of rural communities, and removes the cost barrier for rural people.*	• Setting of short, medium, and long-term goals for sustainable funding • Delivery of consistent and equitable approaches to funding and service provision across the region so where resources are constrained, they are equitably constrained. • Providing rural patients with the same access to services as in urban areas e.g., x-rays, bloods, by implementing a minimum set of services closer to home, with no or low financial barriers, and agreement of access criteria and treatment pathways for different levels of acuity • Enabling flexible funding so providers can meet the specific needs of their community. • Considering different ways of working to ensure general practices financial sustainability. • Remuneration and incentives reflect the scope and skill of rural roles, and proactively supports efforts to recruit and retain our workforce. • Assessing and applying the real costs of training and supporting a workforce. • Supporting flexible workforce initiatives so rural providers can better manage both staff wellbeing and their patient load e.g., leave, sickness, training.

Clinical priorities

The clinical priorities identified by the Rural Services Review Group are those targeted areas of healthcare that are facing significant challenges in the region and require immediate attention.

Vision	Achieved by...
Mental Health: *A rural mental health service that offers prompt, local patient assessments for all levels of acuity, along with enhanced referral pathways, better local services, access to specialist support, and prioritisation of high-risk underserved groups.*	• Additional funding for Mental Health and Addictions services to support GPs. • Longer primary care consults. • Appointment of specialists in under-resourced areas i.e. community psychologists • Appointment of GPsi mental health specialists to support local provision e.g., ADHD assessments. • Increased use of HIP's and BIS intervention services and consideration of other dedicated roles i.e. Nurses supporting ambulance on the frontline • Implementation of appropriate solutions for moderate to high needs patients • Good outpatient care and dedicated local facilities for respite care and for practitioners to assess patients. • Standard protocols for referrals • Relaxation of PHARMAC regulations for medications • Funding to cover GP overheads relating to provision of HIP's / BIS services. • Pursuing local solutions to collaborate and support needs assessments. • Better mental health training and awareness across the region.
Aged care: *Aged care solutions that provide dignified and respectful care for our aging population that keeps them healthy longer and enables them to be receive the best possible care close to their home and whanau.*	• Better recognition of population growth and appropriate resource planning • Authorising general practice to complete needs assessments to reduce wait time bottlenecks. • Increased local bed numbers, specifically respite care. • Provision of local specialist resource • Requirement for aged care facilities to have more qualified staff, to reduce the burden on ambulance and primary care. • Collaborative local efforts between service providers to plan for healthcare support when developing new facilities. • Improved collaboration and communication between service providers regarding patient pathways • Improved guidelines, protocols, and access to patient data • Funding of aged care support for GPs
Palliative care: *Patient centric palliative care solutions that offer more choice about where patients receive their care, and better local support for the families and healthcare providers who care for them.*	• A comprehensive package of local palliative services to meet individual patient needs and better co-ordination of appointments for those who must travel. • Equitable access to care for patients • Better communication between services e.g., hospice, GP, district nurses. • Improved access to hospice and respite care options. • Mental health support for patients, families, and healthcare workers in the Palliative space. • Greater recognition of the real cost of service provision for rural GPs and appropriate funding that is equitable with funding already provided for assisted dying.

Rural Pharmacy: *A sustainable rural pharmacy service that proactively supports primary care providers in achieving good health outcomes for rural people through access to medicines and advice closer to home.*	• Clarifying and agreeing the role of rural pharmacy in supporting general practice • Clinical pharmacists 'in practice' providing advice and supporting preventative initiatives. • Wider provision of local pharmacy options closer to home including mobile options. • Permanent removal of fees for prescriptions and non-funded medicines and funding of courier costs on prescriptions for rural delivery as an interim solution. • Legislative changes to expand the PSO supply list to provide better care options for rural professionals. • Workforce initiatives to support leave, sickness, training etc e.g., flexible locum pool.

These principles provide the basis for the vision and recommendations put forward by the group. During this process it became clear that many of these principles were applicable to all priority areas and as a result four key themes became evident. These are:

1: Adaptable ways of working, tailored to local needs

2: Provision of a comprehensive range of services closer to home

3: Development of a high-performing, well supported workforce

4: Collaborative approaches enabling providers to work together to achieve positive patient outcomes.

The final recommendations naturally group into these four areas and have effectively created the basis of the group's vision for the future: building sustainable rural health services in the Southern Region.

This vision and the supporting recommendations are outlined below.

Recommendations for the future

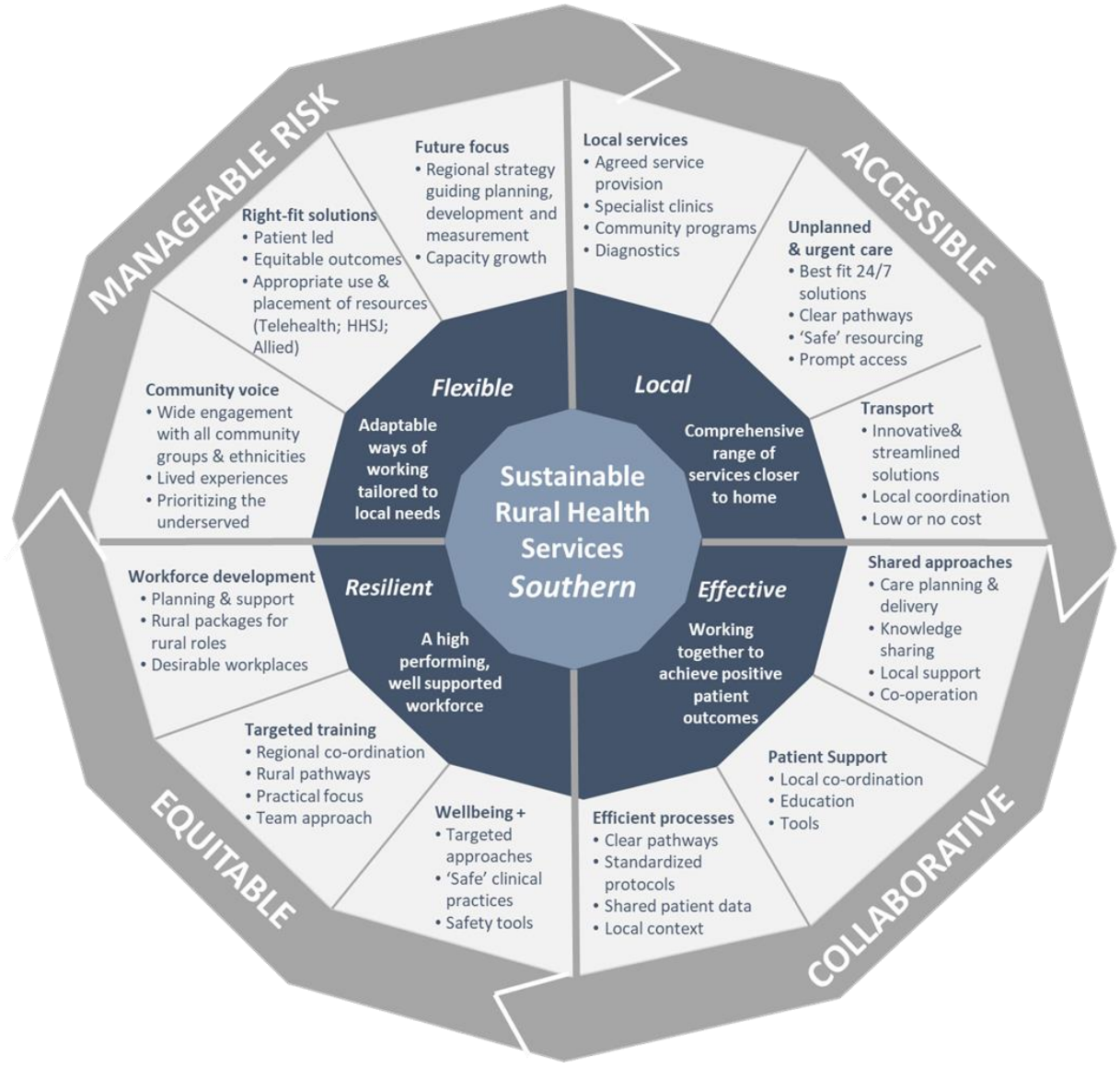
The review group passionately believe that the sustainability of rural healthcare services in the South will be achieved by working together more collaboratively, adopting adaptable and flexible ways of working, providing more services closer to home, and most importantly by developing and supporting a high-performing workforce. The following recommendations provide detailed strategic and tactical solutions for achieving this vision.

Rural Review Group's vision for the future

Using the output from the 'what does good look like' approach above, the Southern Rural Services Review Group have made many future-forward recommendations that they consider will achieve their vision of a sustainable rural health service in the region where:

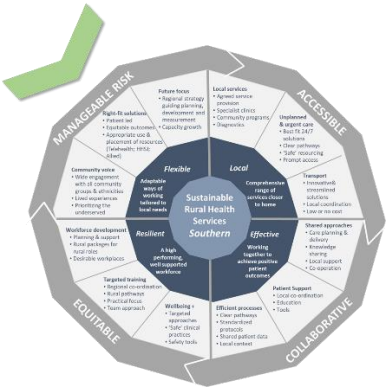
- Patients have greater access to health services closer to home.
- Providers, staff, and patients experience equitable access, costs, and funding when compared to urban settings.
- Adaptable ways of working, that are tailored to local needs, are implemented to create the best possible local solutions.
- Appropriate funding, support, and training are put in place to create a resilient and high performing workforce.
- Clinical risk is manageable and 'safe' for providers AND patients.
- Providers work together more effectively to achieve positive patient outcomes.

An overview of the Review group's vision can be seen in the supporting model.



The detailed recommendations provide strategic and tactical solutions for achieving the vision outlined above and have grouped naturally into the four strategic areas shown in the model above: flexible, tailored approaches; local services closer to home; a resilient and high performing workforce; and effective ways of working together. The following outlines the review groups detailed recommendations for each.

1: Flexible – Adaptable ways of working, tailored to local needs



Recommendations in this area are focused on building an equitable healthcare sector by creating a clear vision, that encompasses flexible and adaptable ways of working, removes barriers, and creates choice for patients.

Key deliverables include the development of a long-term regional plan for all rural health services to drive all short and medium-term activity, and to provide a basis for measuring performance. It is recommended that the regional plan is underpinned by a population-based index to ensure that the sector possesses the capacity it requires to meet patient demand and better manage workforce wellbeing.

The group strongly recommends the current national review of primary care funding appropriately addresses the inequities currently experienced by providers, patients, and the rural workforce that is outlined in this report.

Area	Recommendations	Priority areas	Rank#	Impact
1a.1 Local Strategy	Define a Southern Rural Health strategy that considers all regional patient and provider needs and looks forward 20-40 years from which to benchmark all short and medium-term planning and development activity.	E; PA; CR; W	1	Local
1a.2 Demand led services	Implement a population-based index for workforce acquisition to be reviewed and adjusted annually.	E; PA; W	1	National
1a.3 Primary care funding	Urgently review primary care funding, capitation, and rural fee for service models#, with a future-forward view to ensure healthcare delivery in our region is sustainable and produces equitable health outcomes. To consider: • All health provider view • Consistent funding between urban and rural providers to achieve equitable access, with agreement of what, if any, costs should exist for rural patients (balancing 'equitable' with 'sustainable') • Removing the individual burden of healthcare for rural patients as compared to urban i.e., low, or no, financial barriers to access. • Funding of services pushed out from secondary to primary care. • Flexible funding models that enable providers to target community need and the 'closer to home' concept of	E; PA; F	1	National

	serving people in local areas and keeping them out of hospital. • Refocuses funding on core general practice services rather than ring-fencing it for specific projects e.g., CLIC • The impact (cost, consult time, continuity of care) of changes in service provision with allied services treating minor acuity leaving GPs to deal with more complex and intensive cases. • Ongoing and holistic monitoring of funding models to ensure long-term sustainability. [#] *Including additional travel, training, afterhours, cost of emergency response on practices, equipment, restocking, and remunerating providers appropriately and equitably.*			

*Recommendations are ranked: 1=Critical; 2=Moderate; 3=Low.
#Priority areas: Equity (E); Patient Access (PA); Clinical Risk (CR); Collaboration (C); Workforce (W); Funding (F); Clinical Priorities (CP)

The group acknowledges the need for pragmatism in a constrained environment and believes strongly that developing 'right fit' solutions that meet the needs of each area will enable providers to deliver better patient outcomes. Integrated care hubs that combine general practice, community and cultural providers, or nurse-led practices with GP oversight, provide different options that cater for workforce shortages yet meet local demand. Telehealth must be used to compliment wider service provision; however, the group recognises that patient and provider training is required to ensure these services are used more effectively. Ambulance and PRIME services will continue to be vital to the region and require additional funding and support to best utilise their core skills. Finally, opportunities to work together either through the sharing of resources, co-location of providers, support of allied providers, and the equitable distribution of responsibilities in areas with scarce resources is seen as a means of sustaining rural teams whilst continuing to provide patients with continuity of care.

Area	Recommendations	Priority areas	Rank [#]	Impact
1b.1 Fit for purpose ways of working	Revise rural healthcare principles and models to ensure they value patients time, utilise the resources already in place, and create flexible, local solutions that mirror the quality of healthcare offered in urban centers; while significantly reducing the individual burden (cost, time, distance) of healthcare.	E; PA; F	1	National
	Introduce health models that target rural health challenges and provide appropriate training to upskill staff to meet demand in their specific locations	E; PA; W; CR	1	National
	Create opportunities to share resources: • Identify services that could be shared (e.g., afterhours, bloods, x-ray, wound care) • Co-located services to improve service provision, provide support, and reduce clinical risk e.g., combined ED/GP services such as phone support from base ED; GP/St John; paramedic support in rural EDs for Mental Health assists. Identify practices that could work together to share resources, services etc..	C; CR; W; PA	1	Local

	Promote Integrated Care Hubs that include general practice, Hauora Māori partners, Pacific health providers, and others that provide continuity of care but utilising different service models (where appropriate) to ensure long term sustainability e.g., more nursing capacity with GP oversight to cater for fewer GPs.	PA; W; CR	2	National
	Introduce a top-down focus on reducing wait times in primary care alongside ED and surgical 'wait time' targets.	E; PA	2	National
	Create collaborative and flexible approaches to healthcare for all primary, community, hospital, specialist services that cater for the specific geography and population needs of our region.	C; CR; PA; F; E	2	National; Regional ; Local
	Consider equitable distribution of responsibilities among professionals in low resourced areas to reduce fatigue (especially for afterhours services) i.e., use Telehealth and St John appropriately to triage patients, assess/treat minor ailments, access to patient information.	CR; W	2	Regional
1b.2 Telehealth	Review the role of telehealth so it compliments wider service provision ('right fit') without increasing clinical risk.	PA; CR;	2	Regional
	Develop and deliver a plan to improve and promote telehealth usage in a local context across the region i.e., identify resources required to set up practice and patient telehealth access and usage.	PA; C; W	3	Regional
	Subsidise telehealth fees so patients aren't disadvantaged when required to use this service	E; F; PA	2	National
1b.3 Rural Pharmacy	Reduce capacity issues in general practice by considering the role of pharmacies in the provision of vaccinations, minor ailment schemes, emergency contraceptives, and prescribing and assessing the financial and patient impact of removing these services from general practice and look at ways to collaborate.	PA; W; CR; CP	2	National

*Recommendations are ranked: 1=Critical; 2=Moderate; 3=Low.
#Priority areas: Equity (E); Patient Access (PA); Clinical Risk (CR); Collaboration (C); Workforce (W); Funding (F); Clinical Priorities (CP)

Although the review comprises a provider view of rural healthcare in the region, the group acknowledges the need to capture the voice of the community on an ongoing basis. Recent efforts under the Localities approach are seen as successful and accordingly it is vital that the community plays a key role in informing service design and measuring service delivery. Equally, greater effort is required to remove barriers for the underserved in the Southern region, with a particular focus on increasing the number of cultural providers and the delivery of integrated care options with wrap-around services for these groups.

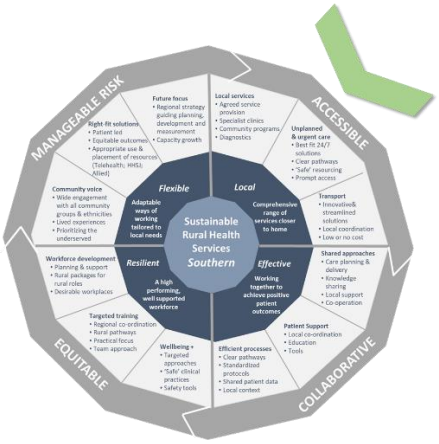
Area	Recommendations	Priority areas	Rank#	Impact
1c.1 Patient centric	Ensure the community voice and lived experiences are at the forefront of all service design, without duplicating existing mechanisms, by:	E; PA	1	National; Regional; Local

	• Incorporating direct feedback from rural communities when designing and implementing new services • Ensuring the right voices are heard, not just the most vocal. • Continuing the use of groups such as this when reviewing, developing, and delivering healthcare in our region • Ensuring recommendations made by this group are a key input to regional and national forums and initiatives			
1c.2 Prioritising key groups	• Provide a better focus on meeting our Te Tiriti obligations by removing barriers for the underserved in our communities and by prioritising delivery of integrated care options with wrap-around services for these groups. • Continue to promote all rural people as a disadvantaged group when considering access to healthcare. Ensure that assumptions regarding equity more clearly define rurality as a key component when developing health services. • Ensure services are designed and developed without traditional geo-demographic assumptions of eligibility and affordability as this often is not a true reflection of the patient base. • Create strong relationships with these groups and community providers so service design fits patient need	E; PA	1	National; Regional; Local

*Recommendations are ranked: 1=Critical; 2=Moderate; 3=Low.
#Priority areas: Equity (E); Patient Access (PA); Clinical Risk (CR); Collaboration (C); Workforce (W); Funding (F); Clinical Priorities (CP)

2: Local – A comprehensive range of services closer to home

It has been a long-held desire for rural providers and patients alike to have access to more healthcare services closer to home, reducing clinical risk and the pressures of distance, time, and cost of travel as well as enabling patients to be closer to their whanau. The group recognises that it is not possible for every community to have a full suite of services but agree that more core services must be located closer to our rural populations. Population demand in much of the Southern region has increased significantly driving demand for specialist clinics, outpatient care, and equitable access to diagnostics with urban populations. There is significant need for greater local mental health, and aged care services with many areas currently having little or no provision. Contracting local professionals to conduct services such as retinal screening will provide rural patients with greater and more prompt access, as well as ensuring the financial sustainability of local providers.



Area	Recommendations	Priority areas	Rank #	Impact
2a.1 Addres-sing	Assess and fill current gaps in local service delivery, when compared to urban centers, with urgent need e.g., mental health, chemo, maternity, pediatric, palliative care, clinical	PA; E; CR	1	Regional

service gaps	pharmacists. Consider consolidation of these services in larger geographic areas and provide transport options to improve patient access.			
	Ensure there is adequate equipment and a process for staff to access rapid back up in emergency situations.	PA; CR; E	1	Local
	Provide fee equitable (i.e., low, or no financial barriers) services as per urban centers: • Blood tests and x-ray (& others where identified) offered 'free' to patients in practice where a local option isn't available. • Emergency presentations such as chest/abdominal pain so patients aren't paying general practice fees as per urban ED's	E; PA; F	1	Local
2a.2 Preventa-tive care	Assess the gaps and initiate community programs targeting preventative health, especially for underserved groups e.g., long-term health conditions, smoking cessation, palliative care; and incentivise people to attend.	PA; E	2	Regional
	Reviewing current preventative programs, and if there are gaps deliver more, to keep elderly patients mentally and physically healthy including falls prevention, physio input to reduce orthopedic waiting lists, or 'third spaces' like community hubs that offer health benefits in a non-healthcare setting.	CR; PA; CP	2	Local
2a.3 Specialist clinics	Increase the number of specialist clinics in rural areas by: • Conducting patient demand led 'whole of cost'-benefit analysis i.e., identify areas where it is more cost effective to establish a specialist clinic in a specific area than have multiple patients travelling to the specialist. • Making rural clinics a mandatory component of specialists' employment contracts • Proactively driving the use of online (multi-service) video consults in practices facilitated by local nurses. • Utilising and funding allied health services in local areas more effectively e.g., pre/post-operative physiotherapy services; local optometry services providing retinal screens instead of specialists. • More regular access to local specialist care for elderly who struggle to travel. • Performing joint patient consults with GPs to upskill staff, better manage patient care plans, and to build relationships.	E; PA; CR; CP; F	1	Local
2a.4 Diag-nostics	Increase access to diagnostics in local regions, where either none exists OR only ACC access to private services is available, rather than forcing patients to drive hours for services such as MRI.	E; PA; F	1	Local
	Authorise all rural practices to directly arrange required patient investigations and point of care testing, to streamline health pathways and reduce time and cost to patient.	E; PA;	1	Local

2a.5 Palliative	Introduce community groups supported by health professionals to support palliative patients and their families.	PA; CP; C	2	Local
	Enable GPs to better support palliative patients in the community AND to provide patients with the ability to be closer to their whanau, by providing equitable access to palliative care funding for all patients, which is consistent with assisted dying, and reflects actual cost of service (weekend, overnight, home visits etc.).	PA; F; E;	2	National
	Consider funding palliative patients aged less than 65 when they require ARC or palliative services.	PA; F; E	2	National
2a.6 Mental Health	Improve secondary mental health services in regional areas i.e., there is currently one drug and alcohol counsellor in Otago/Southland and only monthly visits from a community psychiatrist to see adolescent patients.	PA; E; CP; CR	1	Local
	Provide more funding for Mental Health and Addictions services to support general practice in rural areas, including provision of funds to cover the cost of overheads and clinical time for HIPs and Health Coaches.	F; E; PA; CR; CP	1	Regional
	Create more Mental Health teams, Nurses, or Nurse Practitioners to manage the public sector workload 'safely and sustainably' in rural areas by: • Supporting afterhours care by taking pressure off general practices, ED's, St John and Police • Supporting other services such as ambulance in the community • Catering for underserved groups such as Māori and Pasifika	W; C; PA; E	1	Local
	Approve extended Mental Health consultations in primary health where needed	PA; F	2	National; Regional
	Provide dedicated mental health facilities for client meetings and ensure secondary care facilities are well staffed with sufficient beds to reduce the wait for inpatient stays.	PA; E; CR; CP	2	Local
	Establish local maternal, child and youth mental health services with prompt intervention and referral processes.	PA; CR; CP	1	Local
	Consider appropriate 'safe' solutions for patients with moderate to high mental health needs who don't fit within current threshold for BIS and have long wait times for secondary services.	PA; CR; CP	1	Local
2a.7 Respite care	Provide more respite care support and inpatient beds for aged care, palliative and mental health patients in rural areas.	PA; CR; CP	1	Local
2a.8 Aged Care	Develop community roles for aged care to co-ordinate patient pathways and reduce hospital admissions / acute presentations e.g., community nurse practitioners, community providers.	PA; CR; CP	1	Local

	Identify and assess opportunities to create additional aged care facilities in areas with low provision or increasing population growth, including more placements for dementia patients close to home.	PA; E; CR; CP	1	National; Regional
	Provide primary care with funding to support aged care patients in the community i.e., currently unfunded for organising patient admission to facilities.	PA; F	2	National; Regional
2a.9 Rural Pharmacy	Renewal of funding for urgent prescription charges in rural areas is critical. In the interim, funding of courier charges will assist rural patients with access to medicines.	PA; F; E; CP	1	National; Regional
	Review rural pharmacy services to ensure rural people have good access to medicines when and where they need them rather than having to travel to main centers e.g., use of depots; longer opening hours; rural deliveries.	PA; CR; CP	2	Regional
	Review the role of rural clinical pharmacists in medicine review and management i.e., needs assessment and service co-ordination especially in areas with significant aged populations.	PA; CR; CP	2	Regional
	Provide a system to source non-PSO medications e.g., thrombolysis; adenosine etc.	PA; CR; CP	2	National

*Recommendations are ranked: 1=Critical; 2=Moderate; 3=Low.
#Priority areas: Equity (E); Patient Access (PA); Clinical Risk (CR); Collaboration (C); Workforce (W); Funding (F); Clinical Priorities (CP)

Of major concern is the risk confronting the region with unsustainable 24/7 urgent and unplanned care services, resulting from insufficient funding, and a cost for service model which creates significant financial barriers for patients. Variations in geography, roading, weather, population, and distance to secondary care mean that it's necessary to consider the 'best fit' solutions for each area to meet their specific needs. Feedback from the group is that the long-term financial sustainability of providers must be balanced against patient need when designing solutions to ensure their ongoing viability. However, there is consensus that access to urgent care must be more accessible from a time, distance, and cost perspective than it currently is, and both patient and workforce safety is paramount.

Area	Recommendations	Priority areas	Rank#	Impact
2b.1 Localised 'patient centric' review	Access to unplanned and urgent care in the Southern region is in crisis, with a lack of resources, inconsistent delivery, growing populations, and geographic challenges. It is recommended that an independent 'patient centric' review is undertaken to determine the 'best fit' solutions for each area, with adequate funding and resourcing allocated to create a safe and sustainable service. Key considerations: • Approaches must address population growth, seasonal demand, community need, and distance to care. • Solutions must address the opportunity cost (workload and staff costs) for rural providers delivering daytime and	E; PA; F; C	1	Local

	afterhours emergency care via a 24/7 roster as well as continuing to provide normal practice services. • The role of current providers delivering urgent care is acknowledged when identifying opportunities to enhance services. • Service provider responsibilities are clarified, and opportunities for services to collaborate identified. • Equity gaps in funding are addressed for all providers (general practice and rural hospitals) • Clear patient pathways are developed to better manage patient flows. • Fit for purpose of current infrastructure is reviewed and interim options identified, while long term solutions developed.			
	Agree principles/criteria for equitable patient access (fees, travel, wait-times, distance) for different levels of acuity and different access points to determine what qualifies for emergency care, while ensuring best use and long-term financial sustainability of local resources i.e., 'similar levels of service, at similar cost, in similar context'. As a minimum standard, status 1 and 2 level patients should have free access to 'after-hours' emergency care within their local area, and consideration should be given to level 3 patients where it isn't safe to wait till 'normal hours'.	PA; E; W	1	Regional
	Provide more urgent mental health services and pathways into secondary care to remove pressure on general practices, EDs, St John, Police.	PA; CP; CR	1	National; Regional
	Urgent attention should be given to Central Otago and Te Anau[#] where people don't have direct 24/7 access to an ED; and areas such as Mataura where patients no longer have GP support and consequently are placing significant pressure on Gore ED. *[#]Complete cost-benefit analysis of the provision of afterhours care in general practice vs. other options i.e., to determine the feasibility of different options.*	E; PA; CR	1	Local
	Consider other health models for 'safe' resourcing afterhours to remove current additional risk placed on St John i.e., other agencies offering coverage in small areas; more effective use of telehealth in triage and streamlining access to care; collaborative approaches between services and workforce to provide respite for staff.	PA; CR; C	2	Regional
	Increased urgent care monitoring of patients at home/practice in areas with local ED's rather than transporting them.	PA; E; CR;	2	Local
2b.2 Funding local general	Address current inconsistent provision of afterhours funding by agreeing a common approach to funding of afterhours across the region i.e., 'when resources are constrained, they should be equally constrained'.	E; F	1	Local

practice service provision	Provide a scheme to remove rural patient's afterhours costs e.g., a definitive, long-term funding lines for POAC to enable better planning and resourcing of patient care such as POAC funding for emergency visits in locations where no ED exists.	PA; F; E;	1	Local
	Prioritise funding for seasonal and transient populations from other parts of the country who require care but are not eligible for healthcare in our region to ensure general practice and rural hospitals are not financially disadvantaged e.g., seasonal worker POAC funding.	E; PA; F	1	National
	Include funding for acute Mental Health crises as part of emergency care without financial incentives to use Mental Health and Addictions.	PA; F;	1	National
	Consider funding pathways for urgent and unplanned care that encompass cultural factors	E; PA; F	1	National
2b.3 St John	Increase government support for St John to provide affordable ambulance and emergency care as appropriate i.e., 'in an ideal world we'd have a fully subsidised ambulance service'.	PA; E; F	1	National
	Assess service utilisation across region, accounting for long transport times, to determine if the region is under resourced and review placement of services as appropriate.	PA; E; F	1	Regional

*Recommendations are ranked: 1=Critical; 2=Moderate; 3=Low.
#Priority areas: Equity (E); Patient Access (PA); Clinical Risk (CR); Collaboration (C); Workforce (W); Funding (F); Clinical Priorities (CP)

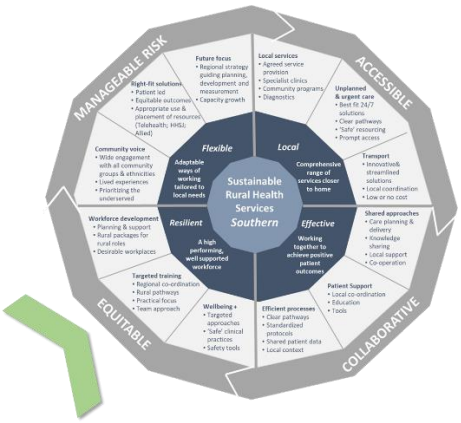
Underpinning the delivery of local services is an ineffective transport model which is impacting patient care through delays to definitive care and insufficient linkages to outpatient care. This situation is increasing practice workloads and costs with providers forced to deliver prolonged care while awaiting transport, as well as increasing the risk of emotional harm from deteriorating patient acuity due to delays in travel. The review group have identified transport as one of their top five priorities and believe that innovative solutions, greater options, and a reduction in the cost of travel for patients will significantly help to remove the individual burden of travel for rural people who need to access healthcare at a distance.

Area	Recommendations	Priority areas	Rank#	Impact
2c.1 New transport models	Develop innovative models for transport in rural areas e.g., volunteer drivers (without clinical backgrounds) for first responder vehicles used in conjunction with general practice or PRIME clinical support; Fire department support; multi-patient transfers, health shuttles etc..	PA; E; CR	1	Regional
2c.2 Patient transfers	Increase funding for onward transfer of patients to secondary/tertiary locations	PA; F;	1	National
	Create seamless transfers to tertiary care, which removes the need for primary care to monitor patients (often afterhours) for long periods while awaiting transfer e.g., improved logistics management, resourcing of additional	PA; E; CR; F; W	2	Regional

	scheduled patient transfer services via dedicated ambulances in rural areas.			
2c.3 Disability transport	Assess Disability transportation across the region and consider all options including shuttles and community funded services (such as that undertaken in Hokonui). Identify champions to drive relationships in this area.	PA; C;	2	Local
2c.4 Removing cost barriers	Fund transport costs for patients who must travel out of areas for tertiary appointments or afterhours care to remove disadvantage, reduce barriers to care, and improve patient access.	E; PA; F; CR	1	National
2c.5 Coordination	Provide appointment and travel coordination services in local areas for those who do need to travel to main centers such as palliative and aged care patients.	E; PA;	1	Local

*Recommendations are ranked: 1=Critical; 2=Moderate; 3=Low.
#Priority areas: Equity (E); Patient Access (PA); Clinical Risk (CR); Collaboration (C); Workforce (W); Funding (F); Clinical Priorities (CP)

3: Resilient – A high-performing, well supported workforce



Feedback from the review illustrated the good will and passion of the Southern region's rural workforce, all of whom are committed to working together to deliver the best possible outcomes. The following recommendations look at ways of improving rural workforce capacity, and creating a highly skilled, well supported workforce that is resilient and able to perform to the highest standard. The group believes these improvements will, in turn, create a desirable place to work.

Better workforce planning, and the implementation of more flexible employment mechanisms to enable rural practitioners to manage work life balance, along with targeted rural packages and incentives will assist in the recruitment of new staff into the area.

Of note, recent research identified that approximately 30% of all graduating medical students who originally came from the Southern Region intended to return to work there long-term (*Medical School Outcomes Database Project, MSOD Scientific Committee, 2023*), indicating there are opportunities to target this potential workforce.

The addition of new roles will support our workforce and assist rural people in navigating healthcare pathways, while extending Nurse and GP roles to deliver services on the ground such as needs assessments, outreach services, and prescribing will provide more autonomy enabling our healthcare professionals to work more effectively. The group also believes that extending community provider contracts will not only give providers more certainty but will enable stronger local relationships to be fostered and greater continuity of care.

Area	Recommendations	Priority areas	Rank#	Impact
3a.1 Workforce planning	Better workforce planning and funding to ensure staffing levels in primary care and rural hospitals adequately meet demand and can provide the care the community needs.	W; CR	1	National
	Introduce employment mechanisms that create workforce flexibility so staff can better manage workloads	CR; W;	2	National
3a.2 Recruitment and retention	Pay parity for ALL staff in rural hospitals and the primary sector with urban colleagues. Including consideration of payment for weekend hours, afterhours, and statutory holidays; as well as pay parity between GP's and locums (incl. telehealth locums) to reduce competition	E; W; F	1	National
	Introduce a package of allowances and incentives specifically for the rural workforce that accurately reflects the scope of roles, patient load and hours worked, to help attract and retain staff including, support and funding for relocation of overseas staff or new staff transitioning into rural roles.	W; F	1	National
	Identify opportunities to provide accommodation support to help attract and retain staff.	W; F	1	Local
	Focus on equitable funding, provision of incentives (not bonding), sustainable workloads, and local autonomy (ability to treat locally, and access tests etc.), and positive in-practice training experiences, to create desirable workplaces that will entice for all medical, nursing, and allied health students and staff to come to rural areas.	W; F	2	Local
	Increase volumes of students in health programs and collaborate with tertiary institutions to promote locality	W;	2	Local
3a.3 Identify & assess new roles	Understand potential new roles and how they may be integrated within NZ to address capacity issues and regulate appropriately e.g., Physician Associates	W; CR;	2	National
3a.4 Nurse prescribing and enhanced care	Clarify the role of Nurse Practitioners in general practice so they are utilised safely and appropriately	CR; W	1	National
	Change legislation allowing NPs to prescribe s.29 medications and allow practices to hold more funded medications.	PA; CR; CP	1	National
	Increase Nurse Practitioners / Nurses numbers by incentivising, training, upskilling and supporting existing staff	PA; W	2	National
	Authorise practice nurses for outreach services like immunisations in remote locations for GP continuity of care	PA; CR	2	National
	Allocate dedicated district nurse resource to rural palliative patients	W; E; PA	2	Local

3a.5 Community providers	Offer community providers who currently contract for 6-12 months to Te Whatu Ora, long-term contracts to create more certainty for providers and continuity of care for patients	E; PA; CR	2	Local
3a.6 Flexible workforce cover	Provide a pool of shared locum resources across multiple practices and pharmacies to manage workloads, support training release, and staff wellbeing for all professions.	W; CR; PA	1	Local
	Fund transport/accommodation fees for locums sourced via NZ locums as urban practices don't pay these costs.	F; W; E	2	National
	Encourage the use of medical, allied, and nursing students for paid holiday work to support staff leave as well as enabling students to experience the job and build relationships with rural providers for longer-term employment.	W;	2	Local
3a.7 Aged care	Require aged care facilities to have more qualified healthcare staff on duty to reduce the burden on ambulance and general practice; and work with local councils to ensure rest home medical care for new facilities has been adequately addressed by all local stakeholders (e.g., afterhours) prior to being built.	W; PA; CR; CP	2	Local
	Reduce current needs assessment wait times by funding GPs/NPs to perform these assessments in the community and create better pathways to access rest homes and inpatient bed OR consider attaching staff to local hospitals to complete pre-discharge needs assessment.	PA; E; CR; CP	1	Local
	Develop community roles to co-ordinate aged care patient pathways and reduce hospital admissions / acute presentations e.g., community nurse practitioners, community providers, health navigators.	PA; CR; CP	2	Local
3a.8 Mental Health	Extend authorisations to assess and refer patients in Rural areas where there are few visiting psychiatrists and pediatricians to reduce bottlenecks and smooth patient pathways i.e. • St John to assess and refer. • GPsi Doctors to diagnose and initiate medication for certain conditions e.g., ADHD. • Resource Drug and Alcohol services and implement appropriate criteria to reduce wait times. • HIP's permanently funded in general practice	PA; E; W; CR; CP	1	Local

*Recommendations are ranked: 1=Critical; 2=Moderate; 3=Low.
#Priority areas: Equity (E); Patient Access (PA); Clinical Risk (CR); Collaboration (C); Workforce (W); Funding (F); Clinical Priorities (CP)

Delivery of a locally based, coordinated training program specifically for rural providers that focuses on areas of need and promotes multi-services solutions will not only significantly reduce cost, but will also ensure that our workforce is highly skilled, clinical risk is managed, and front-line teams work together more effectively to deliver high quality outcomes for rural people.

Area	Recommendations	Priority areas	Rank #	Impact
3b.1 Training and support	Prioritise rural workforce training so people can access training the same way the urban workforce can, while also reducing the financial and capacity burden training places on rural providers.	E; W; F	1	Local
	Design and deliver a coordinated training program for the region, which includes mobile training units that provide practical local 'simulation or scenario' based exercises for rural teams practicing at top of scope e.g., stitching; casts; minor op's; obstetrics and pediatrics'; emergencies; mass incidents; APLS/ATLS; diabetic management; first-aid etc.	W; CR; PA	1	Local
	Consider use of specialists to provide 'on-the-job' training to upskill rural teams so they can reduce the number of referrals to secondary services for minor services. Performing joint patient consults will also upskill staff, help to better manage patient care plans and build better relationships.	W; CR; PA; C	1	Local
	Consider multi-service training opportunities in local areas for the teams working together on the ground particularly mass casualty incidents e.g., general practice, ambulance, rural hospital to build capability and enhance relationships.	W; C; CR	1	Local
	Create a rural training pathway for Nurses e.g., Clinical Nurse Specialists; Nurse Practitioners that values them and enables them to work at top of scope.	W;	1	National
	Sharing of training resources between rural hospitals and local GPs for scenario training where possible.	W; CR; C	2	Local
	Systems training for practices on the software used to communicate with hospitals.	W;	2	Local
	Provide mental health education for all health professionals in relation to mental health presentations and increasing understanding what support is available.	W; CR; CP	2	Local
	Specific training for nurses within aged care facilities, hospices (e.g., how to use a syringe driver), and training for GPs regarding aged care needs assessments etc.	W; CR; CP	2	Local
	Regional peer review / CME sessions to share knowledge, ideas and provide support	W; C	3	Local

*Recommendations are ranked: 1=Critical; 2=Moderate; 3=Low.
#Priority areas: Equity (E); Patient Access (PA); Clinical Risk (CR); Collaboration (C); Workforce (W); Funding (F); Clinical Priorities (CP)

Workforce wellbeing was a key theme for the review group. A greater investment in wellbeing support and better resourcing to cover sick leave, leave, and training is key to the retention of our people. Safe clinical capacity limits and the implementation of tools to support staff working in isolated situations will not only ensure individual safety but will help to make rural roles more attractive to potential employees.

Area	Recommendations	Priority areas	Rank #	Impact
3c.1 Wellbeing	Define and agree appropriate 'safe' clinical capacity limits that are tailored to the needs of each community and organisation (e.g., manageable shifts, reasonable rosters, driving etc..) to reduce burnout, stress, and patient error.	W; CR	1	National; Regional
	Invest in workforce wellbeing and support for people in rural areas through better resourcing for sick leave, manageable hours, safe driving practices, and development of work/life approaches e.g., a relief fund to allow sole practitioner pharmacists to take leave.	W; F; CR	1	Local
	Identify people currently suffering from burnout and provide a program of support so we don't lose them	W; CR	1	Local
	Provide workers in aged care, mental health, and palliative areas with support to help with the emotional toll of caring for people in their own communities.	W;	2	Local
3c.2 Safety	Implementation of apps like 'get home safe' to track practitioners who are working alone in isolated areas	W; CR	1	Local

*Recommendations are ranked: 1=Critical; 2=Moderate; 3=Low.
#Priority areas: Equity (E); Patient Access (PA); Clinical Risk (CR); Collaboration (C); Workforce (W); Funding (F); Clinical Priorities (CP)

4: Effective – Working together to achieve positive patient outcomes

Creating a provider network based on collaboration and shared approaches is one of the group's primary goals. In a resource constrained environment, the ability to work flexibly and to share approaches will enable rural providers to better support each other and their patients. Engaging and communicating with patients on how to use the service options available to them appropriately will also reduce some of the pressure currently facing providers. While, building more efficient and streamlined processes will reduce bottlenecks and confusion in the system and will enable providers to focus more on delivering their core services.

Planning for and creating a culture of collaboration will benefit providers by helping them to share knowledge as well as providing an active support network. Members of the network have shared examples of where informal collaboration is working well with providers providing buddy support coverage for their smaller colleagues when they struggle with sickness, as well as offering back up in volatile situations where providers are working in isolation. They are keen to ensure the benefits of these practices are promoted and celebrated across the region. Conversely, more formal approaches to coordinated care planning for aged care or mental health patients will help to ensure their patient support and pathways run more smoothly.

Area	Recommendations	Priority areas	Rank#	Impact
4a.1 Planning	Review national/regional program delivery to ensure they cater for the patients with the most need and improve co-ordination and timing, so providers have more time to plan and resource.	C; W;	2	
	Develop collaborative approaches for practices who are closely located and share local knowledge to use locum services, telehealth, and afterhours rosters to address clinical risk and workforce burnout and reduce travel / accommodation costs.	C; W; PA; CR;	2	National; Regional
	Create a clinical leadership program to further develop and implement the changes required in rural areas.	C;	3	National
4a.2 Closer collaboration between providers	Recognise the clinical skill set each health sub-sector provides when developing new solutions and encourage them to work together better to achieve efficient patient outcomes.	W; C; CR	2	Regional
	Consider opportunities for collaboration between providers in service design/delivery e.g.,	C; CR; CP; W	2	Regional

	• Combined Mental health, primary care and rural hospitals crisis assessments to support staff in a controlled setting. • General practice and other healthcare professionals e.g., district nurse for diabetic / wound management; pharmacists for medicine review/management/compliance packaging. • Co-ordinated care planning including all aged / palliative care service providers e.g., aged residential care, hospice, dist. nurses, general practice, hospital			
4a.3 Creating a culture of collaboration	Deliver programs that build a co-operative and collaborative culture between all services i.e., no more 'this is gastro not general surgery'.	C; PA; W;	2	Regional
	Share and encourage examples of service providers using their clinical strengths informally to support each other e.g., afterhours support between St John and general practice in local areas.	C; CR	2	Local
	Establish a rural service group to develops tools and collaborative approaches to overcome rural challenges.	C; W	2	Local
	Identify mechanisms that build upon informal collaboration already occurring locally between primary care providers (especially smaller practices) who are struggling to cover sick leave etc.., e.g., buddy system relationships, or the appropriate use of virtual health. Consider rewarding practitioners who offer this support, so they are not financially disadvantaged.	C; W; F;	2	Local
4a.4 Engagement	Introduce local community support networks to discuss local issues and ideas, and build knowledge and relationships, especially for new Healthcare professionals, sole practitioners, pharmacists etc.	C; W	2	Local
	Recognise current 'best practice' in our region (e.g., ED Consultant's support of general practice) and promote better communication between providers in other areas, particularly where silos exist e.g., GP/aged residential care/Rural Hospital	C; W;	2	Local

*Recommendations are ranked: 1=Critical; 2=Moderate; 3=Low.
#Priority areas: Equity (E); Patient Access (PA); Clinical Risk (CR); Collaboration (C); Workforce (W); Funding (F); Clinical Priorities (CP)

Better educating rural people on how to use the healthcare system and to understand what services are available to them will significantly reduce bottlenecks. Portal and Telehealth usage is not understood to be high in the Southern region, with education of both patients and providers required if these are to support face-to-face services effectively. Conversely, a greater focus on preventative programs along with support for navigation services or local coordination of appointments will improve patient pathways and reduce some of the burden currently placed on providers.

Area	Recommendations	Priority areas	Rank#	Impact
4b.1 Education	Wider and more frequent delivery of Mental Health campaigns and activities in rural areas.	CP; PA; E	1	Local
	Wider implementation of suicide prevention programs	CP; PA; E	1	Local
	Develop and deliver a communications plan educating rural people on the service options available in their areas e.g., Telehealth, emergency care, afterhours care, websites for specific conditions (asthma, croup) etc.., with the goal of reducing public use of ambulance as key point of access to urgent or afterhours care so they may focus on their core purpose.	PA; CR;	2	Local
	Promote patient access to wraparound support using health navigator service.	PA	3	Regional
	Targeted education for elderly patients on how to use telehealth or patient portals, and on the availability of healthcare options.	PA; CP;	3	Regional
4b.2 Assistance	Employ Health navigators or community support roles to assist people in navigating the health system (not health professionals)	PA; F; W	3	Regional review
4b.3 Appointment management	Resource local co-ordination of specialist appointments and travel, to allow for same day visits and group travel	PA; F; C; E	1	Local action

*Recommendations are ranked: 1=Critical; 2=Moderate; 3=Low.
#Priority areas: Equity (E); Patient Access (PA); Clinical Risk (CR); Collaboration (C); Workforce (W); Funding (F); Clinical Priorities (CP)

Streamlined processes and more defined protocols for acute care, afterhours, triaging, referral, and discharge processes will benefit both providers and patients alike. Identification of single points of access into secondary care will smooth patient pathways and reduce provider workloads; while universal access to patient data is considered a high priority and should be progressed with urgency. Education of telehealth providers on local geography (distance, terrain, roading) and services will improve local usage with patients referred via the correct pathways and this in turn will help to reduce some of the capacity issues experienced across the network.

Area	Recommendations	Priority areas	Rank#	Impact
4c.1 Patient pathways	Develop systemic pathways for triaging or assessing patients including face-to face and telehealth, and improve the referral process to allied or community services e.g., physio, community pharmacist, district nurses	C; PA; CR	2	Regional
	Provide standardised protocols and systems for rural patients to create consistent, clear pathways e.g., afterhours care; assessment and management of acute care in rural; rural mental health; palliative care; elderly healthcare for on call	C; PA; CR	2	Regional

	doctors supporting ARC on dealing with newly discharged patients who aren't registered with their practice; OR management of prescriptions between hospital & ARC			
	Create a single point of access from general practice into hospital to ensure patients get to the right area promptly (one phone call per admission; one referral for secondary care).	CR; PA;	2	Local
	Ensure rural general practice is provided with prompt access to senior hospital clinical expertise	PA; C; CR	2	Local
4c.2 Process improvement	Streamlining of patient discharge process via the development of 'live' access to clinical notes and medication charts for hospital, general practice, rest home, and Pharmacy access to ensure patients receive timely care e.g., Medimap system used in Hospice is a good example of technology that works well.	CR; PA; C	1	National
	Clinical notes are reformatted to ensure key messages are adequately conveyed in discharge letters e.g., findings, clear action points at the top of the notes	CR; W; C	2	Regional
	Create a repository of practice developed guidelines and protocols for clinical areas such as standing orders, MPSO and non-MPSO medication stock limits etc. for all practices to access and use (balancing time and space of stocking too much vs. unable to treat due to too little).	C; CR; W	2	Regional
	Reduce GP administrative load by identifying and promoting opportunities to improve inbox management.	W; PA;	3	Regional
4c.3 Telehealth	Refine telehealth triage processes to improve patient experience. The current triage escalation process is repetitive and slow, leading patients to refuse to use telehealth	CR; PA	1	National
	Targeted education of telehealth providers on local services and geography to improve triage and patient referral / transport processes so patients are referred to the closest and most appropriate provider.	CR; PA; W	1	Local
	Streamlining referral and transfer of patient notes back to GP from afterhours telehealth consults.	CR; PA; W	1	National; Local
4c.4 Data and Insights	Delivery shared patient information platform across NZ for access by all healthcare professionals to streamline patient pathways and reduce clinical risk	CR; PA	1	National
	Develop and implement a shared data insights platform to monitor health outcomes and support regional planning	C; F; PA; CR	2	National
	Automate data collection on key health programs to reduce time impact on practice staff.	W; PA	3	National; Regional

*Recommendations are ranked: 1=Critical; 2=Moderate; 3=Low.
#Priority areas: Equity (E); Patient Access (PA); Clinical Risk (CR); Collaboration (C); Workforce (W); Funding (F); Clinical Priorities (CP)

Top five priorities

The review group has provided a wide-reaching and comprehensive set of recommendations for change. The top five represents the group's view of the most important changes required to improve rural healthcare in the region. It is their hope that the key stakeholders will focus on these areas as a priority.

Top five priorities

The final step in the review process for the Rural Services Review Group was to identify and agree their top priorities for rural healthcare in the Southern Region. During their discussions, the group recognised that there were several recommendations that were extremely important to them but required large scale change and therefore were unlikely to be resolved in the short-term. Given this, they agreed to complete two lists. The first outlines the overall most important changes they wish to see addressed for rural health services. The second is a list of actionable recommendations that the group believe would make a significant positive impact to the daily lives of health providers and patients that they recommend are implemented in the short-to-medium term.

Top 5 overall most important changes to rural healthcare identified by the Rural Services Review Group	
1	Sustainability and development of rural workforce that will create a more attractive workplace for health professionals, specifically: • Pay parity for staff across primary, secondary, urban/rural. • Resolution of issues such as resourcing of afterhours services so that rural professionals are no longer consistently overloaded; support by secondary care; greater local autonomy regarding diagnosis and patient care to recognise and grow rural skills as well as providing more effective and efficient patient care i.e., scenario based and multi-disciplinary training that reflect the skills rural workforces requires to be effective. • Opportunities to develop 'rural expertise' through research and specific rural development pathways. • Act on the recommendations outlined in by the Rural Services Review
2	Addressing 24/7 urgent and unplanned care, specifically: • Equity of patient access to urgent and unplanned care closer to home in rural areas at all times • Provision of 'afterhours' care in rural areas
3	Delivery of equitable patient access for rural people including: • Provision of more services locally • Definition and agreement of patient access for different levels of acuity, with low or no financial barriers • Consideration of the need to ensure the financial stability of rural service providers within an equitable context.
4	Efficient transport options for clients/patients for routine appointments and non-urgent care when the service cannot be offered in the patient's immediate location and that this is provided on a scheduled basis, at an equitable cost to the patient. This may include the use of non-clinical transport solutions such as appropriately funded health shuttles or alternative transport options. This will remove the resourcing impact on St John who are currently supporting low acuity patient care in rural areas and will enable them to focus on their core service provision – emergency care.
5	Achievement of manageable clinical risk in rural areas by: • Enabling shared access to patient data • Informal and formal collaborative processes that enable healthcare providers to support each other i.e. when sick or need leave etc. • Establishing reasonable clinical workloads to improve staff wellbeing and reduce patient risk. • Single point of entry for referrals from primary to secondary care • Clear and efficient patient pathways for different levels of acuity afterhours • Tools, processes, and support to ensure staff and patient safety

Top 5 actionable recommendations for change in the short-medium-term	
1	Provision of secondary specialist services (e.g., chemo, orthopaedics, minor operations, mental health), to cater for local need AND to train and upskill local primary care teams to perform a wider range of non-primary services (e.g., minor skin op's, pipelle biopsies, joint injections etc) at an equitable cost for patients.
2	Primary care access to diagnostics i.e. MRI, x-ray, blood tests, retinal screening, alongside provision of clinical access to results. Retinal screening to be done by local optometrists.
3	Delivery of co-ordinated local training in rural areas with appropriate practical training for the teams who deliver the services on the ground i.e. mass casualty incidents; minor operations; suturing; casts; paediatric care; with reduced training costs for practices, to reduce demand in hospitals, delays to service, and poor outcomes.
4	Commitment to a regional healthcare plan that appropriately assesses the clinical needs of Southern's population and provides a co-ordinated multi-service approach to support ongoing service planning.
5	Process changes to enhance the transfer of patients between primary and secondary care, specifically referral and discharge processes to ensure that: • GPs are no longer required to complete tasks that should occur in secondary care (e.g., tests that they are not authorised to request). • Discharge information is timely and clear in relation to patient action plans and provider accountability for tasks. • Primary care has an opportunity to give feedback about discharge letters to secondary providers via a feedback mechanism to the consultant and writer.

Conclusion

The Rural Services Review Group has undertaken a significant process to identify the priorities and recommendations of healthcare providers in the Southern Region. Although many of the recommendations are not new to New Zealand's health landscape, they represent the issues and priorities that remain top of mind for the healthcare representatives who are at the coal face daily.

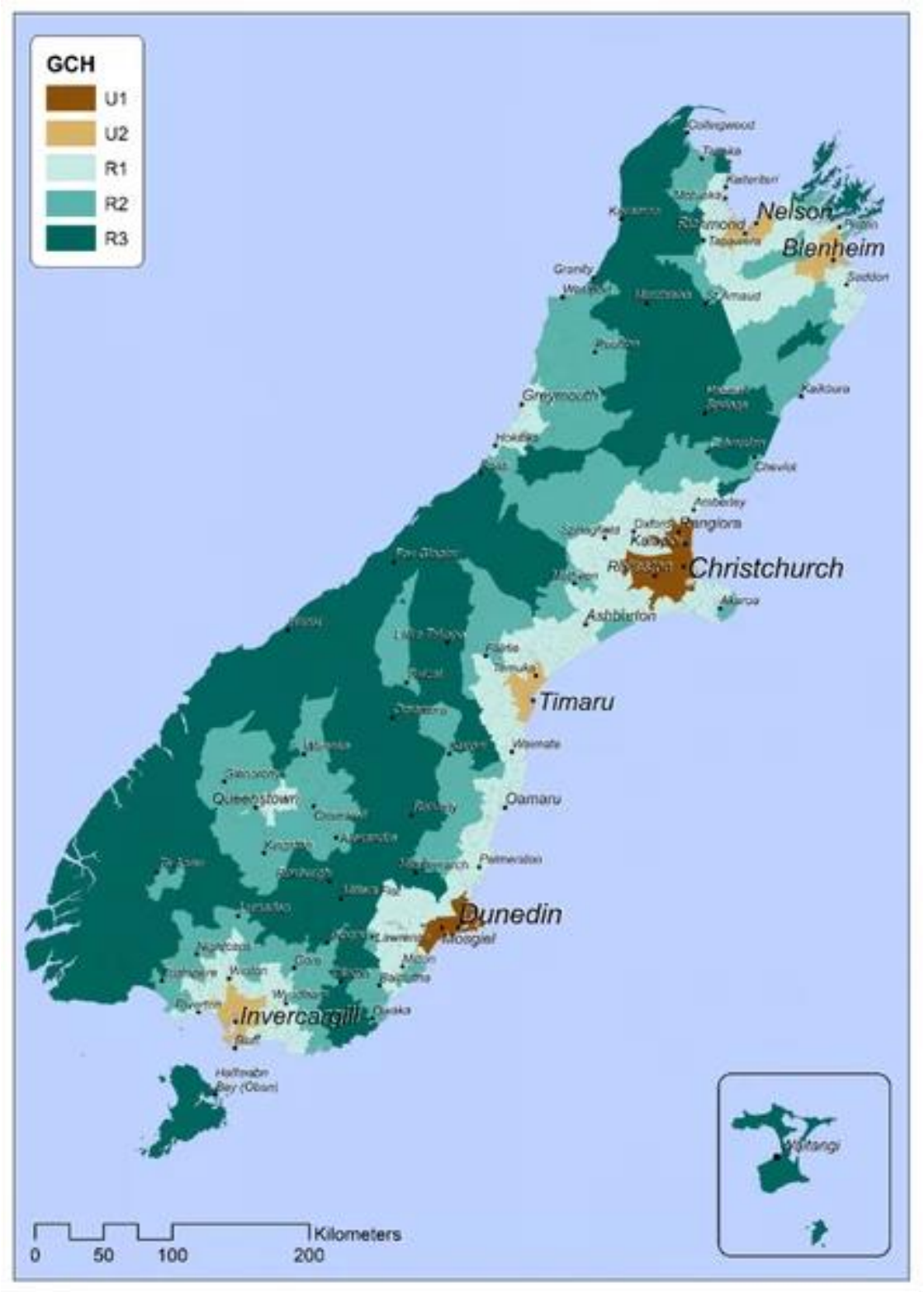
Significant inequities remain in rural health which inhibit achievement of the New Zealand's desired health outcomes in underserved areas.

As a result, the group strongly recommends that funders, planners, advisers, and community advocates, both nationally and locally, continue to push for change in healthcare provision for our rural communities.

Appendix A: Comparison of National and Rural Services Review priorities

National Priorities	Southern Rural Review Group priorities										
	Strategic priorities				Operational Priorities			Clinical Priorities			
	Equity	Patient Access	Clinical Risk	Better Collaboration	Workforce	24/7 Unplanned & Urgent care	Funding	Mental Health	Aged Care	Palliative Care	Rural Pharmacy
Te Pae Tata Priorities											
Placing whanau at the heart of the system to improve equity and outcomes	✓	✓				✓		✓	✓	✓	✓
Embed Te Tiriti o Waitangi across the health sector	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Develop an inclusive health workforce	✓	✓	✓	✓	✓			✓	✓	✓	✓
Keep people well in their communities	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Develop greater use of digital services to provide more care in homes & communities		✓	✓	✓		✓		✓	✓	✓	✓
NZ Rural Health Strategy 2023 Priorities											
Considering rural communities as a priority group	✓	✓				✓	✓	✓	✓	✓	✓
Prevention: paving the path to a healthier future	✓	✓	✓				✓	✓	✓	✓	✓
Services are available closer to home for rural communities	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rural communities are supported to access services at a distance	✓	✓	✓	✓		✓	✓				
A valued and flexible workforce	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Appendix B: Geographical Classification for Health, Te Waipounamu



Drafted by Leonie Williamson, Project Manager – Rural Services Review, WellSouth Primary Health Network
On behalf of the Rural Services Review Group.
August 2024

For more information or for any queries, please contact the practicenetworkteam@wellsouth.org.nz.