Auckland Waitemata Rural Alliance

Summary Report

Rural General Practices' Services Stocktake

June 2016

Auckland Waitemata Rural Alliance

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Appendices:

All data contained in the Appendices is uncleansed and presented as it was received from the participating rural practices.

Appendix One: First Stage Blank Template Document
Appendix Two: Summary of the First Stage
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Appendix Four: Summary of the Second Stage

Auckland Waitemata Rural Alliance

1. Executive Summary

The Auckland Waitemata Rural Alliance conducted its inaugural meeting on 13 May 2015 with the second meeting held on 3 September 2015. At the second meeting, the Terms of Reference were finalised, the Chair and Deputy elected, and goals and priority areas of focus were agreed.

The first area of focus for the work plan centred on increasing services in, or near, to communities and to overcome many aspect difficulties associated with care provision and the tyranny of distance found in rural areas. All New Zealanders, no matter where they live, require to be provided with equitable and appropriate services, with a view to eliminating, as much as is possible, any inequalities.

In order to increase service/treatment provision, the Rural Alliance needed to understand what services/treatments were currently being provided by rural general practices domiciled in the Auckland and Waitemata Districts. Conducting a stocktake of services was proposed.

Undertaking this stocktake of services delivered by rural general practices has been invaluable by:

- Highlighting the volume of services delivered by rural general practice
- Emphasising the services/activities made more difficult due to rurality
- Identifying knowledge gaps around utilisation of available external services/funding streams
- Providing evidence of patient and practice need
- Ensuring the Auckland Waitemata Rural Alliance Work Plan is well informed and supported with critical rural practice data.

The two stage approach undertaken brought the sheer volume of services/treatments provided to the attention of each practice completing the template. The resulting summarised list was then used to provide a comprehensive list for the second stage where practices were asked to identify their top ten, high clinical need activities/treatments from the complete list.

By grouping the quantity of practices which had identified an activity as a priority for them, the second stage quickly highlighted those activities identified by the majority of practices. Addressing any shortfall in the provision of these activities will form the initial focus of the Rural Alliance's Work Plan.

The process followed is described in this Summary Report. The findings of this report alongside the associated work plan, will be living documents which will be revisited, referred to and modified over time.

2. Background

On 12 September 2013, the Rural Advisory Group (RAG) recommended to Ministers that the national Rural Ranking Score (RRS) mechanism, which has been used to distribute funding support to rural general practice, should be replaced by local rural service level alliancing arrangements. The alliancing arrangements were to be transitioned from 1 July 2014.

Alliancing provides a more 'fit for purpose' arrangement that promotes and facilitates integration, regional service planning, alliance funding and planning, all of which supports service development and integrates this with funding and financial risk management in a shared risk framework. Alliances create a high trust, low bureaucracy environment with high quality and accountability.

The key goal of an Alliance is to promote clinical leadership in the health system, producing aligned clinical and financial accountability and supporting patient centred clinically led decision making in health services.

3. Auckland Waitemata Rural Alliance

Prior to establishing the Rural Alliance, Auckland and Waitemata District Health Boards (DHBs) undertook an engagement process with rural primary care providers with a view to creating an Auckland Waitemata Rural Alliance. The aim of this consultation with PHOs and general practices was to gain genuine buy-in to give the Rural Alliance a strong foundation to work from. It was essential to the DHBs to ensure clinical representation, leadership and commitment to the Rural Alliance from front line staff working and living in rural areas.

The Rural Alliance conducted its inaugural meeting on 13 May 2015 with the second meeting held on 3 September 2015. At the second meeting, the Terms of Reference were finalised, the Chair and Deputy elected, and goals and priority areas of focus were agreed.

The Rural Alliance has been setup to provide advice and direct improvement in care and services across rural areas in Auckland DHB and Waitemata DHB. The Rural Alliance has a particular focus on patient centred care, service delivery, integration and sustainability issues. It will advise the Auckland Waitemata District Alliance on issues that impact on rural primary healthcare, rural community services and provide a rural lens on all health services.

The Rural Alliance has representation from rural general practices covering the areas of Wellsford, Warkworth, West Rodney, Waiheke Island and Great Barrier Island, servicing a combined enrolled population of 58,530* patients.

**The above figure is only a proxy for the rural resident population as it doesn't include people who aren't enrolled with a general practice, or who may live in a rural area, say Wellsford, but are enrolled in a general practice in say Albany, because that is where they work.*

4. Geographical Coverage

Auckland DHB is based in Auckland City and covers Auckland Central and the Hauraki Gulf Islands with a population of 482,015 people.

Rural areas are Waiheke Island and Great Barrier Island.

Waitemata DHB is based in Takapuna, and covers North Shore City, Waitakere City and the Rodney district with a population of 582,765 people.

Rural areas are North Rodney (Wellsford, Warkworth), West Rodney (Huapai, Kaipara, Kumeu, Waimauku, Helensville).

5. Rural Alliance Membership

The Rural Alliance includes membership from:

- The Wellsford primary care team (Coast to Coast Healthcare)
- The Warkworth primary care team (Kawau Bay Health, Kowhai Surgery)
- The West Rodney primary care team (Country Medical Centre, Huapai Medical, Kaipara Medical, Kumeu Village Medical, Silver Fern Medical Centre, Waimauku Medical)
- The Waiheke Island Primary Care team (Piritahi Health Centre, Oneroa Accident and Medical and Waiheke Health Trust)
- The Great Barrier Primary Care team (Aotea Health)
- One representative each from Auckland PHO, ProCare Networks Limited and Waitemata PHO
- DHB clinical and funder representation

On 3 September 2016, Dr John Elliott from Kumeu Village Medical was elected as Chair. Dr Kate Baddock, Kawau Bay Health, was elected as Deputy Chair.

Secretariat support is provided by Lis Cowling, Auckland and Waitemata DHBs.

Auckland Waitemata Rural Alliance

6. The Auckland Waitemata Rural Alliance Work Plan

The Auckland Waitemata Rural Alliance will work to ensure that all people, no matter where they live, have a reasonable ability to live, work, and to contribute to, and be part of, New Zealand society by ensuring rural people have equitable outcomes to those living in urban areas.

To achieve this, the Rural Alliance has agreed to focus on certain priority areas in their work plan which will reduce a patient's need to travel by increasing access to diagnostics and interventions in the rural areas. The work plan will be a living document that is built on over time.

The work plan will determine activities to assist primary care services in rural areas to be comprehensive, sustainable, and provide continuity of care by the right person, at the right time, in the right place. A further focus of the Rural Alliance will be overseeing and providing direction in an advisory capacity for the review of health services on Waiheke Island.

The following goals and priority areas were agreed by the Rural Alliance Members on 3 September 2016:

Agreed Goals

The agreed goals of the work plan will be:

- Avoid hospitalisations
- Keep people in the community
- Clinical commitment
- High needs, Maori, Pacific and Q5 populations targeted

Agreed Priority Areas

The following outlines the agreed priority areas:

Year 1

- Providing oversight on the review of health services on Waiheke Island
- Increasing the reach and access to diagnostic services in rural communities
- Increasing access to treatments – e.g. Aclasta, Iron infusions, Venesection, Chemotherapy – sharing practice guidelines and increasing competency
- Increasing access to therapeutics – dispensing practices; structure and rules
- Accessing services via Telehealth – e.g. outpatients appointments

Year 2

- Development of Multi-Disciplinary Teams; Mental Health, Shared Care, Specialists in the Community

Year 3

- Step Up, Step Down Beds in clinics and rest homes

Understanding Current Rural Services

Before work can commence on advocating and supporting additional diagnostic, therapeutic and treatment access, it is necessary to understand the degree of variation in services currently being delivered. It is of note that rural general practices do not offer a consistent

range of services to their patient populations and that there is limited awareness of this of this by rural general practices.

To ensure that the Rural Alliance Work Plan is able to successfully achieve its goals, it was identified as important to gather baseline information and have a clearer understanding of the current environment.

It was proposed that a stocktake of services delivered by Auckland Waitemata DHB Rural General Practices was undertaken to establish this baseline. The stocktake and gap analysis will then inform the subsequent development of the Rural Alliance Work Plan.

7. Rural General Practices' Services Stocktake

It was proposed that the stocktake be broken down into the following Steps:

Step 1 – General Practice

Undertake a stocktake of all services currently being delivered by Auckland and Waitemata DHB's rural general practices. This will provide a better understanding of the degree of variation and reasons for this.

Step 2 – District

Identification of the key deliverables in the District Annual Plans and links with rural projects already underway across the Auckland and Waitemata DHBs, such as the West Rodney project, that are rurally focused. This will assist with ensuring the work plan is in alignment.

Step 3 – National

Investigate the range of Rural Services delivered nationally to provide context for the local stocktake. It is expected that this process will provide greater understanding of potential opportunities for additional support as we examine what is being provided within our Districts.

Step 4 – Contractual

Outline the DHB and MoH Agreements pertaining to services delivered in Rural Communities.

Step One – General Practice

a. The First Stage:

The first template (Appendix 1) was emailed out to all rural general practices in December 2015. The front page provided background information on the Rural Alliance and the purpose behind the request to complete the template. It asked for a list of all services and treatments provided by each general practice team.

Columns requested information on each to be further broken down as follows:

- Name of Service/Treatment
- Brief Description: (if needed)
- Administered by: (GP or PN or other – please specify)
- Funded by: (PHO, MoH, DHB, Other – please list) or Not Funded:
- Number of Patients Accessing Monthly on Average
- Supported by: (e.g. Other Practice, Secondary/Specialist)
- Notes/Comments: (if needed)

It was pre-populated with a number of example services, shaded in green. The template was a word document.

AUCKLAND WAITEMATA RURAL ALLIANCE - RURAL GENERAL PRACTICE, SERVICES STOCKTAKE

Practice Name:		Address:	
Practice Contact:		Email Address:	

Name of Service/Treatment	Brief Description: (if needed)	Administered by: (GP or PN or other – please specify)	Funded by: (PHO, MoH, DHB, other – please list, or not funded)	Number of Pts accessing: monthly average	Supported by: (e.g. Other Practice/ Secondary/ Specialist)	Notes/Comments: (if needed)
Examples only :						
Aclasta	*Infusion*	*GP*	*Not funded (Pt charged)*	*2*		
Venesection	*Bleeding for Haemachromatosis*	*PN*	*PHO*	*1*	*Haematologist*	*By own Venesection Kit*
Cellulitis	*Administering IV Antibiotics*	*PN*	*POAC*	*3*		*Cellulitis Kits from POAC*
Street Light Expansion	*Project to increase the number of street lights to encourage walking, promoting physical activity.*	*Practice Team*	*Local Council*	*Multiple*	*Local Council*	

December 2015 Page **2** of **5**

Rural General Practices were supported to provide this information by the member on the Rural Alliance, selected to represent their geographical area.

Ten of the eleven rural general practices completed and returned their template. This equated to a return rate of 91%. All data collected was collated by the Rural Alliance's Secretariat.

b. The Second Stage:

The second stage (Appendix 2) included a worksheet which contained the high level list of general practice activities collected from the practices that completed and returned the previous first stage of the Rural Service Stocktake Spreadsheet. On this new template, general practices were asked to identify their ten top, high clinical activities including any services/treatments that their practice would like to provide but aren't currently, and the resources and support they would need to better enable the practice to provide said services/treatments. This template was provided as an excel document.

It contained three columns as follows:

- **RED**: "Top Ten High Clinical Priority" – to list the general practice's Top Ten High Clinical Priority activities - ranked from 1 (highest priority) to 10. Additional services/activities could be added to the bottom of the list.

- **BLUE**: "Of the Top Ten, which would you like to provide but are not currently?" – Activities that the practice is either not currently providing or that it could provide better should they have access to additional services/support.

- **GREEN**: "What is the reason for not delivering ..." – identifying the barriers (funding, workforce skill etc.).

AUCKLAND WAITEMATA RURAL A
RURAL GENERAL PRACTICE, SERV

This template:

The following worksheet named "Summary" con
completed and returned the previous Rural Serv
high clinical activities including any services/t
and support you would need to enable you to p

Please complete the three left columns as follo

RED: "Top Ten High Clinical Priority" - which o
identify these in this column ranked from 1 (hi
of this list.

BLUE: "Of the Top Ten, which would you like to
you are either not currently providing or that y
select from the three drop comments - "Not pr

GREEN: "What is the reason for not delivering

Please feel free to add comments in the final

The final stocktake document will be present
develop a work plan that successfully meets

Please complete by 18 April 2016 and re
Lis.cowling@waitematadhb.govt.nz

Background Information:

The Auckland Waitemata Rural Alliance has
in Auckland DHB and Waitemata DHB.
The Rural Alliance has a particular focus on

Instructions | Summary | Do not use

Top Ten: High Clinical Priority Ranked 1 to 10 (1 = highest priority)	Of the Top Ten, which would like to provide but are not currently or could provide better should you have access to additional services/support?	What are the reasons for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other? List as many as applicable.	Name of Service/Treatment	Brief Description	Comments
			Aclasta	Infusion	
			Allergy Desensitisation	Monthly 1 hr visit	
			AOD Services		
			BP Checks	Opportune/booked and serial BPs	
			Care of chronic conditions	CVD, Diabetes, Insulin initiation	
			Care of chronic conditions	Extra follow with GP instead of specialist care due to transport costs and difficulties. Greater support required from GP because due to no rest home facilities available.	
			Catheterisation	Acute Urinary Catheterisation	
			Cellulitis/Pyelonephritis	Administering IV Antibiotics	
			Child Protection Services	Intervention, co-ordination and referral in cases of abuse with CYPS	
			Clinics - Adolescent/Youth	Patients under Age 22	
			Clinics - Nurse	Diabetes, GASP, CVD, Smears, Mental Health, Weight Management	
			Clinics - Nurse, Maori Health Issues	On-going project by Clinic nurses	
			Community Mental Health	Acute assessment. Monitoring, risk assessment and depot service	
			Contraception - Family Planning	Depo prevera contraceptive injection / Emergency contraceptive/family planning education & pregnancy testing	
			Contraception - IUD / Copper / Mirena	Assessment, Insertion, Review, Removal	
			Contraception - Jadelle Insertion / Removal	Assessment / Minor Surgery for insertion & Removal	
			Contraception and STI - Sexual Health	Contraception, ECP, STI Screening	
			District Nursing	Home based care	
			Drug dependant patient (otherwise CADS clients)	Patient management of difficult, disruptive pts with drug dependency	
			Drug Testing	Pre employment/Winz	
			Drug Testing	Drug testing for Workplace medical	
			Ear - Tympanogram	Assessment of ear function	
			Ear Suction/Syringing	removal of wax	
			Early identification and management of Cognitive Impaired patients	Completion of physical assessment and various forms (MOCA) to aid in diagnosis	
			ECG	Booked or urgent procedures to determine cardiac function	
			Emergency - ACC - Accidents	Assessment/ triage/consultation/ treatment	
			Emergency - Ambulance presentations	Assessment/ triage/consultation/ treatment	
			Emergency Dental		
			Emergency Equipment & Supplies	Defib, ECG, Allergy Mgmt, Cardiac Concerns, Penthrox pain relief	
			Emergency Management and Planning	Lead agency, with Police, Fire and DOC to form Community Civil Defence team	
			Extended hours – Rural on call phone consult/consults	To provide longer hours of operation to local community	
			Family Therapist		

Nine of the eleven rural general practices completed and returned their template. This equated to a return rate of 82%.

General Practice Stocktake Findings

Format:

The first template was provided as a word document. Most practices were able to complete and return this in the same format, however for a couple, it became problematic. Faxing the document back to the secretariat meant that data was unable to be cut and pasted for easy analysis.

To counter this, the second template was provided as an excel document. All practices were able to email the original excel template back.

First Stage:

The first stage created an opportunity for general practice staff to reflect on the vast number of treatments and services provided from their general practice. Practice staff completing the template were required to further document who delivered each service/treatment, how it was funded, how many patients accessed it on an average monthly basis and who supported the activity, whether it was a secondary specialist or within their own practice. Many practices submitted comprehensive lists and added detailed comments.

When summarised, the first stage provided valuable information on the variances in service provision, funding streams accessed, and internal or external support for treatment provision. The first stage has provided valuable, detailed information that will assist with finalising activities for the Rural Alliance Work Plan. It will be used to provide the evidence of need for the activities/treatments which will be focussed upon initially. Over time, and as the work plan matures, the first stage of the stocktake will provide a valuable resource to referred back too.

All treatments/activities submitted were summarised and used to populate the second stage of the services stocktake. Only the first two columns outlining the name of the service/treatment and description of the service/treatment, were used for the second stage.

Second Stage:

The information from each returned excel template was pasted in a master spreadsheet and identified by practice of source.

This enabled activities to be grouped by the quantity of practices which had identified an activity as a priority for them. Those activities that had been identified by the most practices were listed first, then the second most listed next, and so on. The second phase was completed and returned by 9 out of 11 general practices (82%).

Rating 1 to 10	Top Ten: High Clinical Priority	Of the Top Ten, which would like to provide but are not currently or could provide better should you have access to additional services/support?	What are the reasons for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other? List as many as applicable.	Name of Service/Treatment	Brief Description
	High Priority	Training is needed	GP training, and funding for equipment	Imaging - Basic Ultrasound	Diagnostic Tool
3		currently only access through primary options for DVT – Funding issue	pay GP a fee commensurate with the skill, equipment etc required for the procedure. Our nearest family planning is in Takapuna and there is a long waiting list. However , patient only has to pay $20 there. Realistic fee for GP would be $150. Jadelle most commonly used by young girls who are unable to pay.	Imaging - Basic Ultrasound	Diagnostic Tool
			training for more GP's year course	Imaging - Basic Ultrasound	Diagnostic Tool
	High Priority	We have 3 days a week access (working hours only) for X Rays	Funding and equipment	Imaging - Chest X-rays	
4		limited access through primary options in acute setting. Funding issue	Chest Xrays – limited availability in acute setting through primary options, but does seem to work quite well for acutes. Would be nice to be able to access for non acutes in the community.	Imaging - Chest X-rays	
	High Priority	We have 3 days a week access (working hours only) for X Rays	Funding and equipment	Imaging - Radiology	Limbs
8		Happy with current provision		Radiology Services (limbs)	
7		Happy with current provision		Palliative care	
2				Palliative Care	Management of palliative patient care, consults, phone consults ar paperwork
6		Could be provided better	Very time consuming work. No hospice beds avaible on the island.	Palliative Care	Management of palliative patient care, consults, phone consults ar paperwork
10			Lack of funding to support some patients needs	Palliative Care	Management of palliative patient care, consults, phone consults ar paperwork
8		Very limited and inconsistent funding. Stream.	Palliative care and palliative care home visits. Pitiful inconsistent funding for this. Almost always runs out. Have to scrabble around trying to find alternative means of funding or transfer cost onto patient or work for nothing! In rural setting , we are heavily involved in terminal care compared with in the urban setting and usually patients or hospice have access to us 24/7. Hospice is funded for their nurses and	Palliative Care - Home Visits *	Terminal Care in pts home

Stocktake Discussion

The master sheet was then used to guide discussion at the Auckland Waitemata Rural Alliance meeting held on 21 April 2016. Although it had been unable to be circulated prior to the meeting, due to the late addition of a large practice's data, by grouping activities the patterns were immediately visible and able to be easily discussed.

The results were also discussed in the context of the updated New Zealand Health Strategy to identify services/activities which could have direct influence. These included activities such as such as X-rays for children aligning to the Ambulatory Sensitive Hospitalisations (ASH), under 4's.

Discussion also concentrated on identifying those services which are either rural specific or made more difficult by the rural environment, alongside where there are inconsistencies and gaps in service provision by practice/geographical area.

Of note, the information collected also pointed towards the need for clearer communication of services currently available for rural practices to access, such as the Primary Options for Acute Care service (POAC) service. For instance, some practices identified that they would like to be able to re-hydrate patients under POAC; a service which is currently funded and available for Acute Adult Dehydration.

Identified Top Clinical Activities:

The services which have been identified as top clinical priority by the most practices are listed below in order of identified priority:

1. Imaging – Ultrasound and X-rays
2. Palliative Care
3. POC Testing:
    - International Normalised Ratio (INR)
    - C-reactive protein (CRP)
    - Troponin
    - D-Dimer
    - Full Blood Count
4. Wound Management
5. Minor Surgery

As a result, the Rural Alliance members agreed that the first activities to be addressed in the work plan would be aligned with these identified priority activities.

Step Two – District Context

Key deliverables from the District Annual Plans and links with rurally focussed projects already underway across the Auckland and Waitemata DHBs, such as the West Rodney project, will assist with ensuring the work plan is in alignment.

Auckland DHB – Annual Plan

Primary Care

- *Review Auckland and Waitemata District Alliance to identify improvement opportunities by 31 December 2015 (this will include alignment of all current Service Level Alliances – Rural, After-Hours, Pregnancy and First Year of Life, Youth and Rheumatic Fever.*
- *Rural funding will be allocated as per the historical/current arrangements in 2015-16.*
- *The Rural Alliance Work Programme will consider rural funding allocations:*
    - *Review completed by December 2015*
    - *Implemented updated rural funding allocation plan by March 2016*

The Terms of Reference adopted for the Rural Alliance were based on those currently in use for the District Alliance. As such, they were aligned from conception.

The historical funding/current rural funding arrangements will continue in 2016-17 year. The Rural Alliance Work Plan will be updated in accordance with the areas of focus determined by the services stocktake and subsequent Rural Alliance discussions. Funding or expansion of existing services (such as POAC) to implement activities will be requested through the appropriate channels of both Auckland and Waitemata DHBs.

Waitemata DHB – Annual Plan 2015-16

a) Prime Minister's Youth Mental Health Project

- *Identify strategies to increase access to youth-appropriate health services in rural areas by March 2016*
- *Opportunity for delivering Child and Adolescent Mental Health Services (CAMHS) and Altered High services are fully explored and changes implemented to maximise access (particularly in rural and under-served areas) by June 2016*
- *CAMHS will review service provision – develop a configuration plan to allocate resources to meet population demand, projected growth, need in rural areas and underserved populations by December 2015*

The proposed expansion into Rodney district will be through a 4 stage process:

Stage 1: Dedicated CAMHS and Infant MH services (6 FTE) delivering services to the Rodney district (Red Beach based) from July 2016
Stage 2: Expansion to 11FTE based in Red Beach and Warkworth from January 2017
Stage 3: Pending further expansion based in Hibiscus Coast and Warkworth from January 2018.
Stage 4: Pending additional in Hibiscus Coast, Warkworth and Helensville by 2025.

The Rural Alliance will ensure it is kept informed of the expansion and activities through the secretariat relationship with the Mental Health Team.

b) Suicide Prevention and Postvention Planning

- *The plan and actions will be guided by the Advisory Group and the Inter-Agency Working Group, and will prioritise at-risk populations including, e.g. Youth/Rural/Maori.*

The secretariat is a member of the Suicide Prevention and Postvention Advisory Group. This ensures that appropriate information flows between the Advisory Group and the Rural Alliance.

In February 2016, the secretariat and the Suicide Prevention Programme Manager worked together to plan and coordinate the delivery of rural SafeTALK workshops – one of the Ministry of Health's responses to the impact of mental wellbeing on rural communities by ongoing climate and economic pressures. The workshops were based on 'SafeTALK', which is an American programme adapted by Lifeline. The rural SafeTALK workshop was tailored for the NZ rural environment by Dr Annette Beautrais and was delivered across rural New Zealand through the Rural Health Alliance Aotearoa (RHĀNZ). These workshops are designed to upskill health and social service professionals in suicide risk assessment and prevention strategies.

Workshop locations
The Rural Alliance nominated Great Barrier Island, West Auckland, Warkworth and Wellsford for consideration as locations to hold the Rural SafeTALK workshops. Waiheke Island was not selected for the initial round of workshops due to similar workshops having been run on the Island previously and RHAANZ wishing to prioritise un-serviced areas. In order to ensure the best possible coverage, a day-time Warkworth workshop was added to the evening sessions planned for Kumeu and Wellsford. Great Barrier's workshop was also planned to be a day time event.

Workshop Summaries
In general, the 4 workshops attracted a total of 71 attendees with a good mix of primary care staff, allied services and support personnel.

Future Collaborations
The secretariat represents the Rural Alliance on the National RHAANZ Clinical Champions Forum. This position will enable stronger links to be formed with rural specific support agencies and alongside strengthening relationships with the Rural Alliance and Suicide Prevention and Postvention Advisory Group. On 17 June 2016, RHAANZ announced two new Rural Mental Health initiatives they will soon have underway. The first is the development of a Framework to Improve Mental Health and Addictions Outcomes for Rural New Zealanders and the other, the continuation of the work addressing the impact of mental wellbeing on rural communities by ongoing climate and economic pressures. This work will continue to be supported by the secretariat on behalf of the Rural Alliance.

c) West Rodney Locality Work

Review of West Rodney Health Services

The Planning, Funding and Outcomes Team are working with ProCare Limited to explore options that build primary care capacity, capability and sustainability in the West Rodney area. This will also act as a foundation for service integration through the scoping of new models of care and the strengthening of relationships between primary and secondary care.

This involves identifying what each practice needs to do to be able to respond to the various service integration activities, to align with the Waitemata DHB Annual Plan (2016-17) deliverables. This will primarily focus on how best to ensure that the practices are ready to interface with the wide range of service integration areas, from a capability and capacity point of view.

Next steps include mapping the Procare Business Plan information against the Rural Alliance stocktake information, to help:

- Highlight the key drivers for each practice (individual and collectively)
- Highlight the similarities and differences for each practice
- Inform different options (e.g. may identify Safety in Practice (SiP) as a potential framework).

Step Three – National Context

On 16 March 2016, Dalton Kelly (CE) and Linda Reynolds (Deputy CE) from the New Zealand Rural General Practice Network (NZRGPN) visited Dr John Elliott, Chair of the Rural Alliance.

During this meeting and in previous conversations, it was confirmed that nationally, there is currently no visibility of activities/services delivered by rural general practices.

During this meeting the Auckland Waitemata Rural Alliance shared:

- Proposal document – rationale and methodology around undertaking a Rural Services Stocktake preceding the development of the Auckland Waitemata Rural Alliance Work Plan,
- Stage One Template - Rural General Practices, Services Stocktake – all activities/services, and
- Stage Two Template - Rural General Practices, Services Stocktake – Top Ten, High Clinical Need.

It is understood that the NZRGPN will use these documents to form a national rural general practice, services stocktake.

The recent refresh of the New Zealand Health Strategy has been timely for the Rural Alliance. There is already alignment with many of the guiding principles for the roadmap of actions 2016 and more than can be built upon, over time:

1. *Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi*
2. *The best health and wellbeing possible for all New Zealanders throughout their lives*
3. *An improvement in health status of those currently disadvantaged*
4. *Collaborative health promotion, rehabilitation and disease and injury prevention by all sectors*
5. *Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay*
6. *A high-performing system in which people have confidence*
7. *Active partnership with people and communities at all levels*
8. *Thinking beyond narrow definitions of health and collaborating with others to achieve wellbeing*

Additionally, the Rural Alliance will maintain close alignment with the District Alliance, tasked with determining the new Service Level Measures which will replace the Integrated Performance and Incentive Framework (IPIF) from 2016-2017, to ensure their work plan is complementary.

Step Four – Contractual Context

Current contracting arrangements will be considered only in the context of the projects outlined in Section 8: Services Stocktake – Recommendations. It is anticipated that existing contracts will remain in place during the projects initiation phase to ensure that patients in rural settings are not adversely affected.

8. Services Stocktake – Recommendations

In September 2015, the Rural Alliance agreed that the goals of the work plan would be:

- Avoid hospitalisations
- Keep people in the community
- Clinical commitment
- High needs, Maori, Pacific and Q5 populations targeted

With the agreed priority areas to be:

- Increasing the reach and access to diagnostic services in rural communities
- Increasing access to treatments – e.g. Aclasta, Iron infusions, Venesection, Chemotherapy – sharing practice guidelines and increasing competency
- Increasing access to therapeutics – dispensing practices; structure and rules
- Accessing services via Telehealth – e.g. outpatients appointments

Carrying out the general practices' services stocktake has assisted the Rural Alliance to determine the baseline information, create a clearer understanding of the current rural environment and identify which activities from the agreed priority areas to focus on first. The top clinical priorities, alongside understanding the national context and the various project work underway in both Waitemata and Auckland DHBs, has enabled the Rural Alliance members to be in agreement around its four inaugural projects. Although the projects have been numbered one to four, this is not necessarily the order in which they will be developed or implemented.

All work proposed will be mindful of maintaining regional consistency, especially when considering Great Barrier Island.

Project One: Imaging - Ultrasounds and X-rays

A) To increase funded access to both ultrasounds and x-rays for rural general practitioners to maximise positive patient outcomes by providing early diagnosis and treatment, closer to their patient's home. For rural patients, local provision will eliminate the need to travel.

Securing faster turnaround times (ten days to two weeks from the current six weeks) will help with on-going management of patients in the community and reduce the need to refer to hospital clinics. It will allow GPs to diagnose conditions in a timely manner and put in place the appropriate and localised, patient care plan. Time spent having to recheck the status and position of these patients on hospital waiting lists is avoided, alongside the need to constantly review and update their associated care plans. This will assist to maximise a GP's time and resources in an already overburdened, rural primary care sector.

The project will look into service provision and funding models to increase the provision of locally based ultrasounds and x-rays, along with the eligibility criteria.

B) To consider the provision of ultrasound machines for Clinician Performed Ultrasounds (CPU) within rural general practices.

CPU is considered to be a useful 'extension of the stethoscope' by providing 'yes' or 'no' answers to clinical questions. For example, 'is it gallstones, a foreign body, aneurism'? The function is limited but valuable as a diagnostic and triage tool. It is important to note these CPUs are not considered a substitute for a sonographer performed /radiologist reported ultrasound but rather as complementary too. For example, a CPU scan may avoid the need for a sonographer performed scan or determine a full scan is still required but can be deferred.

C) To advocate on behalf of Aotea Health to remove the license barrier to rural general practice which prevents them from performing chest x-rays on Great Barrier Island.

Project Two: Point of Care (POC) Testing

To explore the options of providing Point of Care (POC) testing in rural general practices to aid in diagnostics and finalisation of care plans. The following tests have been identified as the most clinically valuable and could all prevent hospitalisations:

- International Normalised Ratio (INR)
- C-reactive protein (CRP)
- Troponin
- D-Dimer
- Full Blood Count

The project will investigate the initial purchase cost of POC Testing Machines, the ongoing costs of consumables, maintenance schedules, and any training requirements. These costs will be considered alongside the cost of avoidable hospitalisations, practice costs and travel costs, etc. These will be viewed alongside an estimation of the social cost/implication to patients and their families in comparison to providing comprehensive diagnostic services 'Closer to Home'.

Project Three: 'Rural' Primary Options for Acute Care (POAC)

The stocktake highlighted the opportunity to develop an expanded range of services and interventions for rural general practices through a POAC type model. The stocktake also highlighted that not all rural practices were aware of the extent of services currently available through the POAC service.

The project will explore the extension of POAC, or establishment of a rural specific division of POAC, which would provide an extended range of services and interventions for rural general practices. The project will also look at how to create better lines of communication for currently available POAC services and for any new service additions.

The project will investigate:

- Adding palliative care, imaging, wound care, minor surgery, etc., as identified by stocktake (understanding that this could also include the provision of specialised dressings). Need to establish access criteria with potential to look at those who have difficulty travelling, or options such as sharing care with District Nursing for wound care services. Also, potential to add infusions such as Ferinject, being mindful of practice's access to supplies.

- Investigate the funding restrictions for rehydration and cellulitis cases which require complex interventions over and above standard presentations.

It may also be appropriate for activities to be added such as:

- Jadelle insertion/removal
- ECGs
- Extended care for patients requiring nebulisers or infusions
- Homecare help
- Extended Palliative Care Services – to provide mileage/time resource where hospice style support is limited and patients are supported at home
- Extended care if a patient refuses to go to hospital

The project will also determine if:

- Rural POAC Governance and service variances should be provided and overseen by the Rural Alliance
- The rules, including targeting and prioritisation, should be made by the Rural Alliance on behalf of rural general practices
- Decisions on what to fund should be made locally
- Access details such as using Senior GPs to ensure that POAC is used appropriately by Locums, etc., or if packages for episodes of care should be made available.

It was also discussed that this service could sit outside of the POAC model, contracting instead with PHOs or individual practices and that this may increase general practice innovation. This will also be investigated as part of this project.

Project Four: Rural Broadband

One of the biggest problems for rural communities is Rural Connectivity. The Government has invested heavily in the provision of broadband for rural schools but rural health has not been as fortunate.

The lack of affordable rural broadband for rural general practice will negatively affect both the Government's and Minister of Health's number one funding priority of delivering better health services, as the inequity gap for rural populations widens. Telemedicine has been held in front of rural medicine for a long time but without rural broadband, it simply won't work.

At a national level, RHAANZ is pushing hard to bring this problem to light. Project Four will see the Rural Alliance working alongside RHAANZ and all other invested organisations to urgently secure Broadband for Rural General Practices.

Project Evaluation

The Rural Alliance will be responsible for developing the measures to be evaluated for each project. A DHB Public Health Physician will be approached to ensure that the measures are patient outcome focussed and meaningful for rural general practice. These may include:

- ✓ Reduction in ASH Rates
- ✓ Social impact on the community (via patient questionnaires)

The Rural Alliance also understands that all projects/activities need to be in place long enough to show real outcomes - minimum three to five years.

Auckland Waitemata Rural Alliance

9. Conclusion

Whenever a work plan requires an increase in an activity, the current level of activity is required in order to accurately measure any improvement or rates of success. Undertaking the Rural General Practices' Services Stocktake has ensured that the Auckland Waitemata Rural Alliance now has this baseline measure. Alongside this, understanding the DHBs, local and national priorities will ensure all activities are aligned, integrated and moving in the same direction.

The Auckland Waitemata Rural Alliance would like to thank the rural general practices who participated in the Stocktake of Rural General Practices' Services (in alphabetical order):

Aotea Health
Coast to Coast Healthcare
Huapai Family Medical Practice
Kawau Bay Health
Kowhai Surgery
Kumeu Village Medical Centre
Oneroa Accident and Medical
Ostend Medical Centre
Piritahi Hau Ora Trust
Waimauku Doctors

Appendix One – First Stage Blank Template Document

AUCKLAND WAITEMATA RURAL ALLIANCE - RURAL GENERAL PRACTICE, SERVICES STOCKTAKE

Background Information:

The Auckland Waitemata Rural Alliance has been set up to provide advice and direct improvement in care and services across rural areas in Auckland DHB and Waitemata DHB. The Rural Alliance has a particular focus on patient centred care, service delivery, integration and sustainability issues. It will advise the Auckland Waitemata District Alliance on issues that impact on rural primary healthcare, rural community services and provide a rural lens on all health services. The Rural Alliance has representation from rural general practices covering the areas of Wellsford, Warkworth, West Rodney, Waiheke Island and Great Barrier Island, servicing a combined enrolled population of 58,530 patients.

The Rural Alliance will work to ensure that all people, no matter where they live, have a reasonable ability to live, work, and to contribute to, and be part of, New Zealand society by ensuring rural people have equitable outcomes to those living in urban areas.

To achieve this, the Rural Alliance has agreed to focus on certain priority areas in their work plan to reduce a patient's need to travel by increasing access to diagnostics and interventions in the rural areas. A further focus of the Rural Alliance will be overseeing and providing direction in an advisory capacity for the review of health services on Waiheke Island. In order to work towards developing a final Rural Alliance Work Plan, a stocktake of rural services delivered by general practices is required to provide a baseline.

This template:

Please complete the following table with all the services and treatments that are provided by your general practice team. There are four examples, shaded in green to get you started. All data collected will be collated by the Rural Alliance's Secretariat and the results redistributed back to you as a first draft. This will allow for corrections and additions. During this second stage, your practice will be asked to identify any services/treatments that you would like to provide but aren't currently, and the resources and support you would need to enable you to provide said services/treatments.

The final stocktake document will be presented to the Rural Alliance alongside a gap analysis. This will allow the Rural Alliance to develop a work plan that successfully meets the needs of rural general practice and the rural population served.

Please complete by 29 January 2016 and return, via email, to the Rural Alliance Secretariat: Lis.Cowling@waitematadhb.govt.nz Thank you.

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AUCKLAND WAITEMATA RURAL ALLIANCE - RURAL GENERAL PRACTICE, SERVICES STOCKTAKE

Practice Name:		**Address:**	
Practice Contact:		**Email Address:**	

Name of Service/Treatment	**Brief Description:** (if needed)	**Administered by:** (GP or PN or other – please specify)	**Funded by:** (PHO, MoH, DHB, other – please list, or not funded)	**Number of Pts accessing:** monthly average	**Supported by:** (e.g. Other Practice/ Secondary/ Specialist)	**Notes/Comments:** (if needed)
Examples only :						
Aclasta	*Infusion*	*GP*	*Not funded (Pt charged)*	*2*		
Venesection	*Bleeding for Haemachromatosis*	*PN*	*PHO*	*1*	*Haematologist*	*By own Venesection Kit*
Cellulitis	*Administering IV Antibiotics*	*PN*	*POAC*	*3*		*Cellulitis Kits from POAC*
Street Light Expansion	*Project to increase the number of street lights to encourage walking, promoting physical activity.*	*Practice Team*	*Local Council*	*Multiple*	*Local Council*	

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Appendix Two – Summary of the First Stage

Name of Service/Treatment	Brief Description: (if needed)	Administered by: (GP or PN or other)	Funded by: (PHO, MoH, DHB, other) or Not Funded	Number of Pts accessing: monthly average	Supported by: (e.g. Other Practice/ Secondary/ Specialist)	Number of Practices
ABPM 24 hour	24 hour blood pressure monitoring	PN	Not funded	5		1
ACC - Accidents	Assessment/ triage/consultation/ treatment	GP/PN x 4	ACC x 2, ACC/Patient x 2	between 80 and 1056 (total 1677)	ACC/Secondary services if required x 2	4
ACC - Community dressings	No approved providers completing these request via ACC	PN	ACC	12		1
Aclasta	Infusion	GP/PN x 2, GP x 2, PN x 2	Not funded (Pt charged) x 5, Blank	between 1 and 5 (total 16)	Specialists protocols	6
Administration - GP and PN	Paperwork/referrals/results/patient phone contacts/report reading and actions/parking forms/travel letters/death certs	GP/PN	Not funded	around 1600		1
Adolescent Clinics	High School Sexual health	GP x 1, PN/GP x 1	PHO x 2	Variable, 24		2
After Hours Drug Dispensing	No pharmacy open after hours and weekends	GP	MPSO /not funded Pt fee $5.00	106		1
Allergy Desensitisation	Monthly 1 hr visit	PN	ACC	2	DHB Allergy Team	1
Ambulance presentations	Assessment/ triage/consultation/ treatment	GP/PN x 3	Patient/ACC/POAC x 2, PRIME - Not funded x 1	Variable, 20, not noted	Other agencies as required	3
Antenatal / Postnatal	Antenatal/Postnatal Care	GP/PN x 3, GP/LMC x 1	Partly PHO x 2, DHB x 1, MoH x1	between 10 and 82 (total 154)	GP/PN	4
AOD Services		GP x 1	NDSA x 1, Patient/PHO Mental Health x 1	between 20 and 38 (total 58)	MDT x 1	2
Audiometry	Full range screening for OCC Health / ACC referrals	PN specialist	Private/Company	34		1
B12 / Iron	Injection	PN x 2	MPSO/Patient x 2	between 45 and 92 (total 137)	GP x 2	2
Basic Travel Vacc/Advice		GP	Not funded (Pt charged)	Between 15 and 20	Travel Clinic	1
Basic Ultrasound	Diagnostic Tool	GP x 2	Not funded (Pt charged) x 1, Not funded x 1	Trial, 24	GP x 1	2
Blood collection	Bloods where no service available and swabbing on behalf of Labtests who no longer undertake	GP/PN	MoH	600	Labtests	1
Blood test	Acute / Urgent / Remove barrier when access to Lab test limited	PN x 2, GP/PN x 1, Phlebotomist/PN x 1	Patient/Practice x 2, Lab/Practice x 1, SIA/Patient x 1	between 20 and 1630 (total 2088)	GP x 2, Practice x 1	4
Bowel Screening and referral	Consultation and referral	GP x 3, PN/GP x 1	PHO x 1, PHO/DHB x 2, Not funded x 1	between 4 and 5 (total 13)	Secondary x 1	4
BP Checks	Opportune/booked and serial BPs/On script repeats/as required	PN x 3, PN/GP x 1	Clinic/Patient x 1, Not funded (Pt charged) x 1, Free x 1, Blank x 1	between 56 and 120 (total 236)		4
Care of chronic conditions	CVD, Diabetes, Insulin initiation	GP/PN x 1, PN x 1	Mostly PHO funded x 2	22		2

Name of Service/Treatment	Brief Description: (if needed)	Administered by: (GP or PN or other)	Funded by: (PHO, MoH, DHB, other) or Not Funded	Number of Pts accessing: monthly average	Supported by: (e.g. Other Practice/ Secondary/ Specialist)	Number of Practices
Care of chronic conditions	Lots of patients require extra follow with GP instead of specialist care because of transport costs and difficulties. We have lots of patients that require greater support from GP because we have no rest-home on the island. These patients have the max home support x 1, CVD/Diabetes/Insulin Initiation x 2	GP/DN x 1, GP/PN x 1, PN/KWK x 1	PHO/DHB/Patient x 2, CarePlus/DIAP x 1	between 12 and 223 (total 283)	Tele-communications with relevant specialist (Gerontologist) x 1	3
Casting	Immobilise Limb	PN x 2	ACC x 2	between 6 and 18 (total 24)	GP/X-ray/Nurse x 1, GP/PN x 2	2
Catheterisation	Acute Urinary catherisation	GP/PN x 2	POAC or patient, Not funded (Pt charged)	between 4 and 10 (total 14)	Secondary, GP	2
Catheterisation	Acute Urinary catherisation	GP x 2	Not funded (Pt charged) x 1, Patient/Practice x 1	between 1 and 2 (total 3)	POAC (varies) x 1	2
Cellulitis	Administering IV Antibiotics	PN x 6, PN/GP x 3	POAC/Patient x 2, POAC x 6, Patient/POAC/ACC	between 1 and 42 (total 108)	GP, GP/PN x 2, Blank x 5	9
Cervical Smear	Disease Screening	PN/GP x 4, GP x 1, PN x 1	PHO/Patient x 4, Not funded (Pt charged)/SIA/PHO x 2	between 16 and 80 (total 146)	PN/GP, PN	6
Chest X-rays/Ultra Sound		GP	Some Non funded (Pt charged)	4	POAC will fund on request	1
Child Protection Services	Intervention, co-ordination and referral in cases of abuse with CYPS	RNS	DHB Contract	infrequently	CYPS/Police	1
Chronic Wound Management i.e lower leg ulcers	Assessment, Review Planning, Dressing, Diagnosis & Ongoing Treatment	PN/GP x 4	Patient x 4	Between 3 and 54 (total 69)	PN/GP, PN, Blank	4
Clinic - Maori Health Issues	On-going project by Clinic nurses	PN/GP	PHO assistance with funding	Multiple	Local iwi	1
Clinics	Diabetes, GASP, CVD, Smears, Mental Health, Nurse Led Clinics	PN/GP x 1, PN x 2	PHO x 2, PHO/Patient x 1	between 40 and 44 (total 164)		3
Community Mental Health	Acute assessment. Monitoring, risk assessment and depot service	PN x 2, GP x 1	DHB Contract x 1, Patient/PHO x 1	Varies in numbers and time taken (one pt. can be all day)	DHB Psych Services x 1	2
Contraception IUD / Copper / Mirena	Assessment, Insertion, Review, Removal	PN/GP x 2, GP x 3	Patient x 3, Not funded/SIA/WINZ 1, Funded/Non funded x 1	between 2 and 54 (total 120)	PN/GP x 2, Blank x 2	5
Dermoscopy	Removal skin lesion	GP x 5, Blank	Not funded (Pt charged) x 5, Blank	between 4 and 24 (total 43)	GP x 2, blank x 2	6
Dialysis	mobile units within the clinic for more access	GP/PN				1
District Nursing	Home based care	PN	DHB Contract	varies	DHB Specialists	1
Dressing/Wound care management	Post surgery/injury	PN/GP x 2, PN x 1	ACC/Patient x 3	between 10 and 17 (total 27)	Some coming from secondary/private care, 10 patients 20-30 visits	3
Drug dependant patient (otherwise CADS clients)	Patient management of difficult, disruptive pts with drug dependency, or discharged from CADS to GP care	GP x 3	GMS x 1, Not funded (Pt charged) x 1, DHB/Patient x 1	between 5 and 20 (total 41)	Secondary x 1	3
Drug testing	Pre-employment/WINZ/workplace medical	PN x 4, GP x 1	Not funded (Pt charged) x 5	between 1 and 12 (total 20)	ESR Drug Testing Co. x 1, PN x 2	5
Ear Suction	Non-invasive removal of wax, high risk pts	PN/GP, GP, PN Specialist	Patient x 2, Patient/SIA	between 7 and 98 (total 123)	GP/PN, Ear Suction Machine, Blank	3
Ear Syringing	Wax removal	PN x 4, PN/GP x 2	Not funded (Pt charged) x 6	between 8 and 40 (total 106)	GP x 2, GP/PN x 2, Blank	6

Name of Service/Treatment	Brief Description: (if needed)	Administered by: (GP or PN or other)	Funded by: (PHO, MoH, DHB, other) or Not Funded	Number of Pts accessing: monthly average	Supported by: (e.g. Other Practice/ Secondary/ Specialist)	Number of Practices
Early identification and management of Cognitive Impaired patients	Completion of physical assessment and various forms (MOCA) to aid in diagnosis	GP/PN	Patient	6	Secondary	1
ECG	Booked or urgent procedures to determine cardiac function	PN x 6, GP/PN x 3	POAC or when not funded (Pt charged) x 2, High Needs funded by PHO x 1, Not funded (Pt charged) x 5, Not funded/SIA/WINZ x 1	between 3 and 63 (total 113)	GP /Secondary Specialist, Secondary/Ambulance, GP/PN x 2, Cardiologist x 2, Blank x 2	9
Emergency (Equipment & Supplies)	Defib, ECG, Allergy Mgmt, Cardiac Concerns, Penthrox pain relief etc.	GP x 1, GP/PN x 2	Non-funded (Pt charged) x 2, Patient/Practice x 1	Around 4 (total 8)	St Johns to hospital – varies x 1	3
Emergency Dental	Dentist visits irregularly. Also includes support of the visiting DHB School Dental Therapy services (referring children and encouraging parents to attend)	GP x 2, GP/PN x 1	DHB Contract x 1, Not funded (Pt charged) x 1, Patient/SIA x 1	between 3 and 25 (total 33)	Dentist x 1	3
Emergency Management and Planning	Lead agency, with Police, Fire and DOC to form GBI Community Civil Defence team x 1, Cornerstone ongoing reviews and updates	PN x 1, all staff x 1	DHB Contract x 1, Practice/PHO x 1		DHB and St John	2
Extended hours – Rural on call phone consult/consults	To provide longer hours of operation to local community	GP x 3, GP/PN x 1	Not funded (Pt charged) x 3, DHB	Between 36 and 300 (total 436)	Practice x 1	4
Family Planning	Depo prevera contraceptive injection / Emergency contraceptive/family planning education & pregnancy testing	PN	Not funded (Pt charged)	25	GP	1
Family Therapist			MSD	19	MDT	1
Fractures	Assessment & management of Fractures including applying various castings	GP/PN x 2, GP x 2, PN x 2	ACC x 4	between 1 and 30 (total 36)	Hibiscus Radiology & other agencies x 1	4
General Practice consults		GP		1697		1
Green Prescription Referrals	Health promotion & physical activity programme	GP x 1, PN/GP x 2, PN/KWC/GP x 1	Harbour Sport x 1, Practice x 1, CarePlus/KWC x 1, Not Funded x 1	between 10 and 20 (total 30), Multiple	Albany Harbour Sport	4
Haemodialysis and CAPD	Nurse's Cottage set up for one patient who mainly manages this himself – RNS only required when problems arise	RNS	DHB Contract	2	Renal Physicians	1
Helicopter evacuations	Altogether 3 hrs average time wise	GP/Rural Nurse Specialists (RNS) x 1, GP/PN x 1	ACC/DHB contract x 1, PRIME Not Funded x 1	approx. 74 annually	Auckland Rescue Helicopter Trust/St John x 1	2
Home Care/Home Visits	Assessment and referral to Home Services, Allied Health, Geriatricians etc. x 2, Patients unable to attend clinic x 1	PN x 1, GP/PN x 2	DHB Contract x 1, Patient/Practice x 1, PHO/Not funded x 1	between 4 and 6 (total 10 but variable)	DHB Allied Health/Support Group Trust x 1	3
Home visits – patients not able to get to clinic	Not including palliative care	GP x 3, GP/PN x 1	Not funded (Pt charged) x 3, Practice/Patient x 1	between 2 and 5 (total 9)		4
Immunisation - Company Flu Vaccines		PN x 3	Not funded (Pt charged) x 3	35 to 50 per month for coys in season		3
Immunisation - non funded	Eg Menactra, Pneum 23, Neisavac C, Varilrix	GP/PN x 3, GP x 1, PN x 2	MoH x 1, Not funded (Pt charged) x 5	between 2 and 20 (total 34)	GP x 1	6
Immunisation - NZ Schedule & Funded Vaccines	Administration of Vaccine	PN x 4, GP/PN x 2	MoH x 4, DHB/Practice x 1, Funded/Not Funded x 1	between 44 and 865 (total 1103)	GP x 2, Practice x 1	6

Name of Service/Treatment	Brief Description: (if needed)	Administered by: (GP or PN or other)	Funded by: (PHO, MoH, DHB, other) or Not Funded	Number of Pts accessing: monthly average	Supported by: (e.g. Other Practice/ Secondary/ Specialist)	Number of Practices
Immunisation - Travel Vaccines	Administration of Travel Immunisations	PN x 2, GP/PN x 1	Not funded (Pt charged) x 2, MoH x 1	between 3 and 16 (total 29)	GP x 2, GP/PN x 1	3
Immunisations	National imms schedule, travel, gardasil, Zostavec etc	PN	MoH for national schedule	36		1
Incision & Drainage	Procedure for drainage of infected abscess	GP assisted by PN x 2, GP x 2	POAC, Not funded (Pt charged) x 3	between 4 and 8 (total 16)		4
Injections	Administration for various reasons. No secondary service available locally	GP/PN x 2	Not funded (pt fully charged), Various funding arrangements	between 47 and 50 (total 97)		2
INR Test	Instant Diagnostic Blood Test	Phlebotomist/PN x 1, PN x 2, Pharmacy x 1	Patient x 1, DHB x 1, SIA/Patient x 1, Lab Tests Contract x 1	between 6 and 57 (total 83)	GP x 1, Labtests/DHB x 1	4
Inter-Agency Meetings	Police, Special Ed, School Principals, CYPS and Practice	PN	DHB Contract	Quarterly		1
Intra articular injection	Administration of steroid injection	GP x 4	ACC or Not funded (Pt charged) x 4	between 3 and 20 (total 27)	Secondary/specialist	4
Iron	Infusion	PN x 2, GP/PN x 1	Not funded (Pt charged) x 3	between 1 and 3 (total 5)	GP x 2, Haematologist	3
IUD Insertion/Removal	Insertion, Management & Removal	GP/PN x 3, GP x 2	Patient/POAC x 2, Not funded (Pt charged) x 2, Blank	between 1 and 4 (total 13)	PN/GP x 2, Blank x 3	5
Jadelle Insertion / Removal	Assessment / Minor Surgery for insertion & Removal	GP x 4, GP/PN x 1	Not funded (Pt charged) x 3, PHO/Patient, WINZ/SIA/Patient	between 1 and 4 (total 10)	PN/GP x 2, Blank x 3	5
Laboratory Services	Venepuncture etc.	PN	Labtests	150	Labtests	1
Liquid Nitrogen	Application of Liquid Nitrogen	PN x 2, PN/GP x 5	Not funded (Pt charged) x 7	between 12 and 201 (total 468)	GP/PN, GP at another practice	7
Longer management of acute patients after assessment	Observation of patients after initial treatment to determine if transfer to hospital is required	GP/PN x 3	POAC/Not funded x 1, Patient/Practice x 2	between 2 and 30 (total 45)		3
Managing standard orthopaedic care	Backslabs to most limb plaster and fibreglass cast. Interim management of more complex cases with MMH	GP/PN x 2, GP x 1	ACC x 3	between 3 and 50 (total 63)	DHB/MMH/Radiology x 1	3
Maternity care	Includes Home Births, First Visits	Midwives/GP Obstetricians x 2, LMC x 1, GP x 1	MOH Rural Maternity x 1, MoH x 2, Not Funded/Not Charged x 1	Between 1 and 12 (total 23)	DHB Women's Health x 1	4
Medical - Work Place	Health Assessment for Fitness to work	GP/PN x 2	Patient/Employee	between 5 and 7 (total 12)	GP/PN x 2	2
Medicals - Drivers Licence		GP x 2	Not funded (Pt charged)	between 6 and 14 (total 20)	GP/PN	2
Medicals - Immigration	Accredited Provider for Immigration Medicals	GP/PN	Not funded (Pt charged)	4		1
Medicals - Insurance		GP x 3	Usually funded by Insurer x 1, INS/Company/Patient x 2	between 6 and 20 (total 43)		3
Medicals - Other: Insurance Medicals, Pre employment Medicals, Drivers Medicals, Dive Medicals, Sea Farers	Range of other medicals completed by Medical team supported by PN	GP/PN x 2, GP x 1	Usually funded by Insurer/Patient x 1, INS/Company/Patient x 2, Not funded (Pt charged) x 1	between 30 and 800 (total 890)	Practice x 1	3

Name of Service/Treatment	Brief Description: (if needed)	Administered by: (GP or PN or other)	Funded by: (PHO, MoH, DHB, other) or Not Funded	Number of Pts accessing: monthly average	Supported by: (e.g. Other Practice/ Secondary/ Specialist)	Number of Practices
Mental Health	Completion of Kessler assessment and referral. Often to private counsellors as lack of funding and available services Our team pick up social service role for patients arranging transport to hospital or links to other support services. We also undertake weekly obs for patients with eating disorders that would otherwise be done in secondary environment.	GP x 3, GP/PN x 1	PHO/Patient x 2, PHO/Patient/Practice x 1	between 9 and 50 (total 94)	PHO/Secondary x 1	4
Minor Surgery	Wedge resection/lesion removal/Punch biopsy	GP x 2, GP/PN x 1, GP assisted by PN x 1	DHB Contract/Patient x 1, PHO/Patient x 1, Not funded (Pt charged) x 2	between 4 and 85) (total 114)		4
Minor Surgery / Punch Biopsy	Removal of skin lesion	GP x 5, GP/PN x 1	Not funded (Pt charged) x 6	between 1 and 16 (total 68)	PN, GP, many on-referred, Dermatologists, Blank	6
Minor Surgery Boil	Minor Surgery	GP x 5	Not funded (Pt charged) x 5	between 3 and 12 (total 25)	GP/PN x 2	5
Minor Surgery Infected Sebaceous Cyst	Minor surgery	GP x 5	Not funded (Pt charged) x 5	between 2 and 6 (total 13)	GP/PN x 2	5
Nasal Cautery		GP x 3	Not funded (Pt charged) x 3	between 1 and 2 (total 5)		3
Nebulising	Management of acute COPD/Asthma	GP/PN x 3, GP x 1, PN x 1	POAC/Patient x 1, Non-funded (Pt charged) x 2, Patient x 1, ACC x 1	between 10 and 30 (total 60)	Secondary x 1, DHB Fracture Clinic x 1	5
Oxygen concentrator	For patients awaiting O approved therapy COPD	GP	Not funded	0- 2 varies		1
Palliative Care	Management of palliative patients, additional care, home visits, consults, phone consults and resulting paperwork	GP/PN x 4, GP/DN x 1, GP x 3	DHB Contract x 1, PHO x 3, Practice/Patient x 1, PHO Palliative Care/SIA/or not funded x 3	between 2 and 20 (total 41 but variable)	Hospice/Secondary Palliative Team x 4, MDT x 2, Practice x 1	8
Phlebotomy - Home	No services North of Warkworth /All rest homes	PN	Patient charged/Free not funded	25		1
Phone Triage	Dedicated nurse triage to maximise capacity against demand	PN x 2, PN/HML x 1	Not funded x 1, Free x 1	between 54 and 1000 (total 1054)		3
Plunket Nursing	Regular Under 5's well child clinics, B4 School Checks (B4S)	PN x 2	DHB Contract Plunket (B4S), PHO/DHB x 1	average 10 (total 20)	DHB Paeds, OT, Physio	2
Point of Care Blood Tests	INR /TROP T / FBC/ CBC .	GP/PN	Practice	50		1
Post Op Dressings	Non ACC	PN x 2, GP/PN x 1	Not funded (Pt charged) x 3	between 10 and 40 (total 50)	Specialist/RSC	3
PRIME (plus 24/7 practice on-call)	Own on-call system x 2	GP/PN x 2	DHB/St John/ACC x 1, ACC x 1, Blank x 1	80 plus	St John x 1	2
Psychosocial Services	Liaison with social service agencies, Counselling	GP/PN x 2	DHB Contract x 1, Patient/Practice/PHO x 1	varies, 20	Counsellor/Community Worker x 1	2
Public Health Nursing	Public Health Screening, Infectious diseases, School-based Services, Special Ed.	PN	DHB Contract	varies	ARPHS	1
Pyelonephritis	Administering IVAB	PN x 3, GP	POAC x 3, Not funded (Pt charged)	between 1 and 4 (total 12)	GP/ Specialist x 2, Blank x 2	4

Name of Service/Treatment	Brief Description: (if needed)	Administered by: (GP or PN or other)	Funded by: (PHO, MoH, DHB, other) or Not Funded	Number of Pts accessing: monthly average	Supported by: (e.g. Other Practice/ Secondary/ Specialist)	Number of Practices
Radiology	Limbs	GP x 1, Radiographer/GP&PN x 1	ACC/Patients x 1, ACC/Radiology Contract/SIA/Patient x 1	between 4 and 241 (total 245)	DHB Radiologist x 1	2
Re hydration of severely dehydrated patients	Administration of rehydration fluids	PN x 2, PN/GP 2	POAC x 4	between 2 and 6 (total 10)	GP x 2, Blank	4
Rest Home /Rural Hospital Medical cover	GP's provide cover to 4 local facilities	GP	Facility	280		1
Script requests	Includes controlled drug requests too	GP/PN x 3	Not funded (Pt charged) x 2, Not funded/SIA/DHB x 1	between 212 and 715 (total 1227)		3
Sexual Health	Contraception, ECP, STI Screening	GP/PN x 2	Patient /Funding <25 PHO x 2	between 48 and 94 (total 142)	PN/GP x 2	2
Sexual health and Contraception	IUCDs etc.	GP/PN	Patient/DHB Contract (under 25s free)	varies	Family Planning	1
Short Stay overnight care	If unable to evacuate (weather) or care for pts in their own home	PN	DHB contract	infrequently	DHB Specialists	1
Smoking cessation	Management and opportunistic smoking cessation support and advice	PN x 1, GP/PN x 3, GP/PN/HCA x 1	PHO x 2, PHO/Pt charged x 1, Not funded (Pt charged) x 1, Not funded/KWC x 1	between 5 and 300 (total 576)	PHO assistance x 1	5
Social Work Services		GP/PN	MSD	28	MDT	1
Spirometry	For special authorities/asthma and COPD, Checking Pt for COPD	PN x 6, GP/PN x 1, GP x 1	Not funded (Pt charged) x 5, PHO x 1, PHO/Patient x 1, Not funded/SIA/Company x 1	between 2 and 35 (total 73)	DHB Respiratory x 1, GP x 1, GP/PN x 2	8
Steroid Injections	Tendonitis, joint issues, etc	GP	Not funded (Pt charged)	3	POAC varies	1
Tamariki Ora / Well Child	WCC and B4 School checks as per program and contract	PN x 2, PN/GP x 1	DHB/Plunket x 1, Practice x 1, PHO x 1	between 9 and 64 (total 83)	PN x 1	3
Troponin / INR	Instant Diagnostic Blood Test	Phlebotomist/PN x 1, PN x 1	Patient x 1, Not funded/SIA x 1	between 12 and 50 (total 62)	GP x 1	2
Tympanogram	Assessment of ear function	PN x 2, GP x 1	Not funded (Pt charged) x 2, Not funded (provided free) x 1	between 10 and 30 (total 40)	GP x 1	3
UTI Treatment	Assessment / Diagnostic Test / Oral AB / Follow Up	GP/PN x 4	Not funded (Pt charged) x 4	between 22 and 50 (total 94)	GP/PN x 2	4
Vasectomy	Southern Cross Affiliated Provider	GP x 2	Southern Cross x 1, Patient/SIA x 1	between 1 and 2 (total 3)		2
Venesection	Bleeding for Haemachromatosis	PN x 6, GP/PN	DHB contract x 2, Not funded (Pt charged) x 5	Between 1 and 10 (total 34)	Haematologist x 3, GP x 2, PN, Blank	7
Vitamin C/Magnesium infusion		PN, Blank	Not funded (Pt charged), Blank	Between 2 and 8 (total 10)		2
Walk-in acute patients	Assessment/triage/consultation/ treatment of medical problem/illness	GP/PN x 2	Patient/POAC/except ACC x 2	200	Other agencies as required	2
Warfarin Management	Pt-Lab-Dr(results)-Nurse (ring Pt)	GP/PN x 2, PN x 1	Practice x 2, Free with Patient Consult x 1	between 50 and 150 (total 300)	Lab x 1	3
Wedge Resection	Mostly ingrown toenails	GP x 3	Non funded (pt charged) x 3	between 1 and 2 (total 3)		3

Name of Service/Treatment	Brief Description: (if needed)	Administered by: (GP or PN or other)	Funded by: (PHO, MoH, DHB, other) or Not Funded	Number of Pts accessing: monthly average	Supported by: (e.g. Other Practice/ Secondary/ Specialist)	Number of Practices
Womans Health	Smears/Insertion of pessary rings/Breast examination	GP x 3, GP/PN x 1	U22 (PHO) or Not funded (Pt charged) x 2, Not Funded (Pt charged) x 1, Not Funded (Pt charged)/SIA/PHO x 1	between 50 and 120 (total 170)		4
Wound Closure Accident	Minor Surgery to close wound	GP/PN x 3, GP x 2	ACC/Patient x 4	between 14 and 36 (total 65)	PN/GP x 2	4
Wound Management	Regular Wound review and Dressing. Change until wound healed	PN x 2	Not funded (Pt charged) x 2	between 82 and 124 (total 224)	Nurse/review with GP x 2	2
Woundcare Management & Suture removal	Follow-up from minor surgery/ACC/ and medical.	GP/PN	ACC/POAC/if not funded, patient pays	500	Secondary/Specialist	1
Youth Health	Patients under age 22	GP x 1, GP/PN x 1, GP/PN/SWX HLTH x 1	PHO if eligible x 3 (Patient pays otherwise)	Average 10 per practice (total 30)		3

Appendix Three – Second Stage Blank Template Document

AUCKLAND WAITEMATA RURAL ALLIANCE - RURAL GENERAL PRACTICE, SERVICES STOCKTAKE

This template:

The following worksheet named "Summary" contains the high level list of general practice activities collected from the practices who completed and returned the previous Rural Service Stocktake Spreadsheet. This new Template will help to identify any services/treatments that your practice would like to provide but aren’t currently, and the resources and support you would need to enable you to provide said services/treatments.

Please complete the three left columns as follows:

RED: "Top Ten High Clinical Priority" - which on the list are your general practice's Top Ten High Clinical Priority activities - please identify these in this column ranked from 1 to 10 (highest priority). If need be, please add any additional services/activities to the bottom of this list.

BLUE: "Of the Top Ten, which would you like to provide but are not currently?" - please identify in this column

GREEN: "What is the reason for not delivering ..." - in this column please identify the barriers (funding, workforce skill etc).

Please feel free to add comments in the final box on the right. Thank you for taking the time to complete this Template.

The final stocktake document will be presented to the Rural Alliance alongside this gap analysis. This will allow the Rural Alliance to develop a work plan that successfully meets the needs of rural general practice and the rural population served.

Please complete by 8 April 2016 and return, via email to the Rural Alliance Secretariat, Lis Cowling:
Lis.cowling@waitematadhb.govt.nz

Background Information:

The Auckland Waitemata Rural Alliance has been set up to provide advice and direct improvement in care and services across rural areas in Auckland DHB and Waitemata DHB.
The Rural Alliance has a particular focus on patient centred care, service delivery, integration and sustainability issues. It will advise the Auckland Waitemata District Alliance on issues that impact on rural primary healthcare, rural community services and provide a rural lens on all health services. The Rural Alliance has representation from rural general practices covering the areas of Wellsford, Warkworth, West Rodney, Waiheke Island and Great Barrier Island, servicing a combined enrolled population of 58,530 patients.

The Rural Alliance will work to ensure that all people, no matter where they live, have a reasonable ability to live, work, and to contribute to, and be part of, New Zealand society by ensuring rural people have equitable outcomes to those living in urban areas.

To achieve this, the Rural Alliance has agreed to focus on certain priority areas in their work plan to reduce a patient’s need to travel by increasing access to diagnostics and interventions in the rural areas. A further focus of the Rural Alliance will be overseeing and providing direction in an advisory capacity for the review of health services on Waiheke Island. In order to work towards developing a final Rural Alliance Work Plan, a stocktake of rural services delivered by general practices is required to provide a baseline.

Top Ten: High Clinical Priority Ranked 1 to 10 (10 = highest priority)	Of the Top Ten, which would like to provide but are not currently?	What is the reason for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other?	Name of Service/Treatment	Brief Description
			Aclasta	Infusion
			Allergy Desensitisation	Monthly 1 hr visit
			AOD Services	
			BP Checks	Opportune/booked and serial BPs
			Care of chronic conditions	CVD, Diabetes, Insulin initiation
			Care of chronic conditions	Extra follow with GP instead of specialist care due to transport costs and difficulties. Greater support required from GP because due to no rest home facilities available.
			Catheterisation	Acute Urinary Catheterisation
			Cellulitis/Pyelonephritis	Administering IV Antibiotics
			Child Protection Services	Intervention, co-ordination and referral in cases of abuse with CYPS
			Clinics - Adolescent/Youth	Patients under Age 22
			Clinics - Nurse	Diabetes, GASP, CVD, Smears, Mental Health, Weight Management
			Clinics - Nurse, Maori Health Issues	On-going project by Clinic nurses
			Community Mental Health	Acute assessment. Monitoring, risk assessment and depot service
			Contraception - Family Planning	Depo prevera contraceptive injection / Emergency contraceptive/family planning education & pregnancy testing
			Contraception - IUD / Copper / Mirena	Assessment, Insertion, Review, Removal
			Contraception - Jadelle Insertion / Removal	Assessment / Minor Surgery for insertion & Removal
			Contraception and STI - Sexual Health	Contraception, ECP, STI Screening
			District Nursing	Home based care
			Drug dependant patient (otherwise CADS clients)	Patient management of difficult, disruptive pts with drug dependency
			Drug Testing	Pre-employment/Winz
			Drug Testing	Drug testing for Workplace medical
			Ear - Tympanogram	Assessment of ear function
			Ear Suction/Syringing	removal of wax
			Early identification and management of Cognitive Impaired patients	Completion of physical assessment and various forms (MOCA) to aid in diagnosis
			ECG	Booked or urgent procedures to determine cardiac function
			Emergency - ACC - Accidents	Assessment/ triage/consultation/ treatment
			Emergency - Ambulance presentations	Assessment/ triage/consultation/ treatment
			Emergency Dental	
			Emergency Equipment & Supplies	Defib, ECG, Allergy Mgmt, Cardiac Concerns, Penthrox pain relief etc.
			Emergency Management and Planning	Lead agency, with Police, Fire and DOC to form Community Civil Defence team
			Extended hours – Rural on call phone consult/consults	To provide longer hours of operation to local community
			Family Therapist	
			Fractures	Assessment & management of Fractures including applying various castings

Auckland Waitemata Rural Alliance

Top Ten: High Clinical Priority Ranked 1 to 10 (10 = highest priority)	Of the Top Ten, which would like to provide but are not currently?	What is the reason for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other?	Name of Service/Treatment	Brief Description
			GP Administration	Paperwork/referrals/results/patient phone contacts/report reading and actions/parking forms/travel letters/death certs
			Haemodialysis	Dialysis
			Helicopter evacuations	Altogether 3 hrs average time wise
			Home Care	Assessment and referral to Home Services, Allied Health, Geriatricians etc.
			Home Visits	Patients unable to attend clinic
			Home visits – patients not able to get to clinic	Not including palliative care
			Imaging - Basic Ultrasound	Diagnostic Tool
			Imaging - Chest X-rays	
			Imaging - Radiology	Limbs
			Immunisations - Company Flu Vaccines	Imms
			Immunisations - non funded	Non schedule immunisations - Zostavac, Menactra, Pneum 23, Neisavac C, Varilrix
			Immunisations - NZ Schedule & Funded Vaccines	Administration of Vaccine
			Immunisations - Travel Vaccines	Travel immunisations
			Infusion - Iron	Infusion for anaemia
			Infusion - Vitamin C/Magnesium	Infusion
			Injection - B12 / Iron	Injection
			Injections	B12/Iron/Desense/Hormone
			Injections - Intra articular	Administration of steroid injection
			Injections - Steroid	Tendonitis, joint issues, etc
			Inter-Agency Meetings	Police, Special Ed, School Principals, CYPS and Practice
			Laboratory Services	Venepuncture etc.
			Longer management of acute patients after assessment	Observation of patients after initial treatment to determine if transfer to hospital is required
			Managing standard orthopaedic care	Backslabs to most limb plaster and fibreglass cast. Interim management of more complex cases with MMH
			Maternity Care - Antenatal / Postnatal	Antenatal, postnatal care
			Maternity Care – first visits	Includes Home Births
			Medicals - Immigration	Accredited Provider for Immigration Medicals
			Medicals - Other: Insurance Medicals, Pre employment Medicals, Return to Work, Drivers Medicals, Dive Medicals, Sea Farers	Range of other medicals completed by Medical team supported by PN
			Mental Health referral and management	Completion of Kessler assessment and referral. Often to private counsellors as lack of funding and available services Our team pick up social service role for patients arranging transport to hospital or links to other support services. We also undertake weekly obs for patients with eating disorders that would otherwise be done in secondary environment.
			Minor Surgery	Biopsy, Lesion removals, wedge resections, Cysts

Top Ten: High Clinical Priority Ranked 1 to 10 (10 = highest priority)	Of the Top Ten, which would like to provide but are not currently?	What is the reason for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other?	Name of Service/Treatment	Brief Description
			Minor Surgery	Wound closure
			Minor Surgery - Incision & Drainage	Procedure for drainage of infected abscess
			Nasal Cautery	
			Nebulising	Management of acute COPD/Asthma
			Palliative Care	Management of palliative patients, additional care, consults, phone consults and resulting paperwork
			Palliative Care - Home Visits	Terminal Care in pts home
			Phone Triage	Dedicated nurse triage to maximise capacity against demand
			Plunket Nursing	Regular Under 5's well child clinics, B4 School Checks (B4S)
			PN Administration	Screening/recalls/HUHC/Emails & repeat scripts
			POC - Blood test	Acute/Urgent/Remove barrier when access to Lab Test Limited
			POC - INR Test	Instant Diagnostic Blood Test
			POC - Lab test	Phlebotomy clinics
			POC - Troponin	Instant Diagnostic Blood Test
			PRIME (plus 24/7 practice on-call)	(Own on-call system on GBI)
			Psychosocial Services	Liaison with social service agencies, Counselling
			Public Health Nursing	Public Health Screening, Infectious diseases, School-based Services, Special Ed.
			Re hydration of severely dehydrated patients	Administration of rehydration fluids
			Referrals - Green Prescription	Health promotion & physical activity programme
			Rest Home /rural hospital Medical cover	GP's provide cover to local facilities
			Screening - Bowel Screening and referral	Consultation and referral
			Screening - Womans Health	Cervical Smears
			Script requests	Includes controlled drug requests too
			Short Stay overnight care	If unable to evacuate (weather) or care for pts in their own home
			Skin - Dermoscopy	Removal skin lesion
			Skin - Lesions, Aldara and Liquid Nitrogen	Application/education of Aldara - Application of liquid nitrogen
			Smoking cessation	Management and opportunistic smoking cessation support and advice
			Social Work Services	
			Spirometry	For special authorities/asthma and COPD
			Tamariki Ora / Well Child	WCC and B4 School checks as per program and contract
			UTI Treatment	Assessment / Diagnostic Test / Oral AB / Follow Up
			Vasectomy	Southern Cross Affiliated Provider/Other
			Venesection	Bleeding for Haemachromatosis
			Walk-in acute patients	Assessment/ triage/consultation/ treatment of medical problem/illness
			Warfarin Management	Pt-Lab-Dr(results)-Nurse (ring Pt)
			Womans Health	Insertion of pessary rings/Breast examination

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Top Ten: High Clinical Priority Ranked 1 to 10 (10 = highest priority)	Of the Top Ten, which would like to provide but are not currently?	What is the reason for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other?	Name of Service/Treatment	Brief Description
			Wound - Chronic Wound Management i.e. lower leg ulcers	Assessment, Review Planning, Dressing, Diagnosis & Ongoing Treatment
			Wound - Dressing/Wound care management	Post surgery, Non-ACC
			Wound - Dressing/Wound care management	Post surgery, ACC

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Appendix Four – Summary of the Second Stage

Rating 1 to 10	Top Ten: High Clinical Priority	Of the Top Ten, which would like to provide but are not currently or could provide better should you have access to additional services/support?	What are the reasons for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other? List as many as applicable.	Name of Service/Treatment	Brief Description
	High Priority	Training is needed	GP training, and funding for equipment	Imaging - Basic Ultrasound	Diagnostic Tool
3		currently only access through primary options for DVT – Funding issue	pay GP a fee commensurate with the skill, equipment etc required for the procedure. Our nearest family planning is in Takapuna and there is a long waiting list. However , patient only has to pay $20 there. Realistic fee for GP would be $150. Jadelle most commonly used by young girls who are unable to pay.	Imaging - Basic Ultrasound	Diagnostic Tool
			training for more GP's year course	Imaging - Basic Ultrasound	Diagnostic Tool
	High Priority	We have 3 days a week access (working hours only) for X Rays	Funding and equipment	Imaging - Chest X-rays	
4		limited access through primary options in acute setting. Funding issue	Chest X-rays – limited availability in acute setting through primary options, but does seem to work quite well for acutes. Would be nice to be able to access for non acutes in the community.	Imaging - Chest X-rays	
	High Priority	We have 3 days a week access (working hours only) for X Rays	Funding and equipment	Imaging - Radiology	Limbs
8		Happy with current provision		Radiology Services (limbs)	
7		Happy with current provision		Palliative care	
2				Palliative Care	Management of palliative patients, additional care, consults, phone consults and resulting paperwork
6		Could be provided better	Very time consuming work. No hospice beds available on the island.	Palliative Care	Management of palliative patients, additional care, consults, phone consults and resulting paperwork
10			Lack of funding to support some patients needs	Palliative Care	Management of palliative patients, additional care, consults, phone consults and resulting paperwork
8		Very limited and inconsistent funding. Stream.	Palliative care and palliative care home visits. Pitiful inconsistent funding for this. Almost always runs out. Have to scrabble around trying to find alternative means of funding or transfer cost onto patient or work for nothing! In rural setting , we are heavily involved in terminal care compared with in the urban setting and usually patients or hospice have access to us 24/7. Hospice is funded for their nurses and have a great network through fundraising to fund their ancillary services, but there is NO FUNDING for GP!	Palliative Care - Home Visits *	Terminal Care in pts home

Auckland Waitemata Rural Alliance

Rating 1 to 10	Top Ten: High Clinical Priority	Of the Top Ten, which would like to provide but are not currently or could provide better should you have access to additional services/support?	What are the reasons for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other? List as many as applicable.	Name of Service/Treatment	Brief Description
6		Very limited and inconsistent funding. Stream.	Palliative care and palliative care home visits. Pitiful inconsistent funding for this. Almost always runs out. Have to scrabble around trying to find alternative means of funding or transfer cost onto patient or work for nothing! In rural setting , we are heavily involved in terminal care compared with in the urban setting and usually patients or hospice have access to us 24/7. Hospice is funded for their nurses and have a great network through fundraising to fund their ancillary services, but there is NO FUNDING for GP!	Palliative Care *	Management of palliative patients, additional care, consults, phone consults and resulting paperwork
8		Not provided at all	equipment is very expensive and cost will need to be passed onto the patient	POC - Blood test	Acute/Urgent/Remove barrier when access to Lab Test Limited
			funding support	POC - Blood test	Acute/Urgent/Remove barrier when access to Lab Test Limited
11		Could be provided better	consumable costs are passed onto patients	POC - INR Test	Instant Diagnostic Blood Test
			funding ongoing	POC - INR Test	Instant Diagnostic Blood Test
			funding	POC - Lab test	Phlebotomy clinics
			funding	POC - Troponin	Instant Diagnostic Blood Test
			cost of dressings prohibitive within primary care	Wound - Chronic Wound Management i.e. lower leg ulcers	Assessment, Review Planning, Dressing, Diagnosis & Ongoing Treatment
3				Wound - Dressing/Wound care management	Post surgery, Non-ACC
3				Wound - Dressing/Wound care management	Post surgery, ACC
			cost to patients funding	Wound - Dressing/Wound care management	Post surgery, Non-ACC
			ACC community contract required	Wound - Dressing/Wound care management	Post surgery, ACC
9		Could be provided better	equipment is very expensive and cost will need to be passed onto the patient	Minor Surgery	Biopsy, Lesion removals, wedge resections, Cysts
11		Happy with current provision	same as any emergency services	Minor Surgery	Wound closure
8			funding can be a barrier to some patients	Minor Surgery	Biopsy, Lesion removals, wedge resections, Cysts
11		Happy with current provision		Minor Surgery - Incision & Drainage	Procedure for drainage of infected abscess
7			funding doesn't cover complex cases	Minor Surgery - Incision & Drainage	Procedure for drainage of infected abscess
	High Priority	Could provide much better with additional nursing staff	Could provide much better with additional nursing staff	Clinics - Nurse	Diabetes, GASP, CVD, Smears, Mental Health, Weight Management
3				Clinics - Nurse	Diabetes, GASP, CVD, Smears, Mental Health, Weight Management
11		Could be provided better	nurse time limited for following up with targets	Clinics - Nurse	Diabetes, GASP, CVD, Smears, Mental Health, Weight Management

Rating 1 to 10	Top Ten: High Clinical Priority	Of the Top Ten, which would like to provide but are not currently or could provide better should you have access to additional services/support?	What are the reasons for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other? List as many as applicable.	Name of Service/Treatment	Brief Description
	High Priority	Could provide much better with additional nursing staff	Could provide much better with additional nursing staff	Clinics - Nurse, Maori Health Issues	On-going project by Clinic nurses
	High Priority	Could provide much better with additional nursing staff	Nursing staffing levels	Care of chronic conditions	CVD, Diabetes, Insulin initiation
	High Priority	Could provide much better with additional nursing staff	Could provide much better with additional nursing staff	Care of chronic conditions	Extra follow with GP instead of specialist care due to transport costs and difficulties. Greater support required from GP because due to no rest home facilities available.
1				Care of chronic conditions	CVD, Diabetes, Insulin initiation
11		Happy with current provision	nurse time limited for following up with targets	Care of chronic conditions	CVD, Diabetes, Insulin initiation
	High Priority	We could do this better if well resourced	We have a paucity of funding for after hours (it operates at a loss) and we require designated facilities for Waiheke	Emergency - Ambulance presentations	Assessment/ triage/consultation/ treatment
1				Emergency - Ambulance presentations	Assessment/ triage/consultation/ treatment
2		Could be provided better	limited by funding especially after hours. We are funded as a GP but have to provide A& E without provision for this. Often GP's/nurses are fully booked and then need to provide this on top of patient load	Emergency - Ambulance presentations	Assessment/ triage/consultation/ treatment
5			POAC procedure not followed by St John causing issues of presentations without prior knowledge and therefore resources cannot be effectively allocated.	Emergency - Ambulance presentations	Assessment/ triage/consultation/ treatment
			The admin load for GPs is prohibitive to a work/life balance. Is putting people off becoming medical practitioners, is a huge strain on GP time after a full days clinic.	GP Admin work	
	High Priority	Admin support needed	We are under resourced for this	GP Administration	Paperwork/referrals/results/patient phone contacts/report reading and actions/parking forms/travel letters/death certs
2				GP Administration	Paperwork/referrals/results/patient phone contacts/report reading and actions/parking forms/travel letters/death certs
11		Could be provided better	This has to be done but GP's nurse limited with time to complete the appropriate paper work	GP Administration	Paperwork/referrals/results/patient phone contacts/report reading and actions/parking forms/travel letters/death certs
	High priority	There is no provider on Waiheke	Since the Immigration Department designated GPs to immigration medicals, Waiheke has been left with no GPs to do immigration medicals	Medicals - Immigration	Accredited Provider for Immigration Medicals
			limited number accepted to provide	Medicals - Immigration	Accredited Provider for Immigration Medicals
4				Medicals - Other: Insurance Medicals, Pre employment Medicals, Return to Work, Drivers Medicals, Dive Medicals, Sea Farers	Range of other medicals completed by Medical team supported by PN

Auckland Waitemata Rural Alliance

Rating 1 to 10	Top Ten: High Clinical Priority	Of the Top Ten, which would like to provide but are not currently or could provide better should you have access to additional services/support?	What are the reasons for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other? List as many as applicable.	Name of Service/Treatment	Brief Description
			Aviation medicals require certification	Medicals - Other: Insurance Medicals, Pre employment Medicals, Return to Work, Drivers Medicals, Dive Medicals, Sea Farers	Range of other medicals completed by Medical team supported by PN
	High Priority	We could do this better if well resourced	We have a paucity of funding for after hours and emergency care(we operate at a loss) and we require designated facilities for Waiheke	Re hydration of severely dehydrated patients	Administration of rehydration fluids
1				Re hydration of severely dehydrated patients	Administration of rehydration fluids
11		Happy with current provision	essential service as A&E	Re hydration of severely dehydrated patients	Administration of rehydration fluids
4			funding is not adequate to cover the complex cases	Re hydration of severely dehydrated patients	Administration of rehydration fluids
			see our note re diet/nutrition assessment, funding to look at patients diets and pre/post conception vitamin levels/bloods etc	Maternity Care - Antenatal / Postnatal	Antenatal, postnatal care
			additional funding to provide excellent first visits for pregnant pts, need longer than usual appointment to do it well	Maternity Care – first visits	Includes Home Births
			LMC domain	Maternity Care – first visits	Includes Home Births
5		Happy with current provision		Maternity Services	
	High Priority	We could do this better if well resourced	We have a paucity of funding for after hours and emergency care(we operate at a loss) and we require designated facilities for Waiheke	Walk-in acute patients	Assessment/ triage/consultation/ treatment of medical problem/illness
3				Walk-in acute patients	Assessment/ triage/consultation/ treatment of medical problem/illness
10		Could be provided better	limited by funding especially after hours. We are funded as a GP but have to provide A& E without provision for this. Often GP's/nurses are fully booked and then need to provide this on top of patient load	Walk-in acute patients	Assessment/ triage/consultation/ treatment of medical problem/illness
1			restricted by available capacity & resources	Walk-in acute patients	Assessment/ triage/consultation/ treatment of medical problem/illness
1				Cellulitis/Pyelonephritis	Administering IV Antibiotics
2			often funding does not adequately cover complex cases	Cellulitis/Pyelonephritis	Administering IV Antibiotics
7			Cellulitis/pyelonephritis – IV treatment. Usually covered by primary options or ACC (although Primary options becoming increasingly difficult to deal with and are screwing down our fees)	Cellulitis/Pyelonephritis*	Administering IV Antibiotics
			GP nurse training	Contraception - IUD / Copper / Mirena	Assessment, Insertion, Review, Removal

Rating 1 to 10	Top Ten: High Clinical Priority	Of the Top Ten, which would like to provide but are not currently or could provide better should you have access to additional services/support?	What are the reasons for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other? List as many as applicable.	Name of Service/Treatment	Brief Description
2			contraception – Jadelle Insertion/removal. Our PHO does not provide any funding for Jadelle insertion. The most we can claim is $30 for U22 visit (again funding severely capped and inconsistent) I am aware other PHO's pay GP a fee commensurate with the skill, equipment etc required for the procedure. Our nearest family planning is in Takapuna and there is a long waiting list. However , patient only has to pay $20 there. Realistic fee for GP would be $150. Jadelle most commonly used by young girls who are unable to pay.	Contraception - Jadelle Insertion / Removal	Assessment / Minor Surgery for insertion & Removal
			GP training .	Contraception - Jadelle Insertion / Removal	Assessment / Minor Surgery for insertion & Removal
	High Priority	Could provide much better with additional nursing staff	Could provide much better with additional nursing staff	District Nursing	Home based care
11		Could be provided better	work with DN	District Nursing	Home based care
			not funded . WDHB service	District Nursing	Home based care
			not likely to charge patient the full amount of what it costs to carry out ECG, expertise needed to monitor results, maintain equipment	ECG	Booked or urgent procedures to determine cardiac function
11		Happy with current provision	essential service in both emergency and follow up care	ECG	Booked or urgent procedures to determine cardiac function
3			some patients cannot pay the charge	ECG	Booked or urgent procedures to determine cardiac function
	High Priority	We could do this better if well resourced	We have a paucity of funding for after hours (it operates at a loss) and we require designated facilities for Waiheke	Emergency - ACC - Accidents	Assessment/ triage/consultation/ treatment
1		Could be provided better	limited by funding especially after hours. We are funded as a GP but have to provide A& E without provision for this. Often GP's/nurses are fully booked and then need to provide this on top of patient load	Emergency - ACC - Accidents	Assessment/ triage/consultation/ treatment
6			limited by lack of capacity and resources available	Emergency - ACC - Accidents	Assessment/ triage/consultation/ treatment
	High Priority	We could do this better if well resourced	We have a paucity of funding for after hours and emergency care(we operate at a loss) and we require designated facilities for Waiheke	Emergency Management and Planning	Lead agency, with Police, Fire and DOC to form Community Civil Defence team
11		Happy with current provision	GM on Civil Defence Group	Emergency Management and Planning	Lead agency, with Police, Fire and DOC to form Community Civil Defence team
10				Emergency Management and Planning	
2				Immunisations - NZ Schedule & Funded Vaccines	Administration of Vaccine
11		Happy with current provision	essential but very time consuming for follow up, and limited reward	Immunisations - NZ Schedule & Funded Vaccines	Administration of Vaccine
9			limited by public perception i.e. delaying childhood imms	Immunisations - NZ Schedule & Funded Vaccines	Administration of Vaccine

Rating 1 to 10	Top Ten: High Clinical Priority	Of the Top Ten, which would like to provide but are not currently or could provide better should you have access to additional services/support?	What are the reasons for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other? List as many as applicable.	Name of Service/Treatment	Brief Description
3		Happy with current provision		Laboratory Services	Venepuncture etc.
			Labtests no community service funding issue above with	Laboratory Services	Venepuncture etc.
9		Could be provided better		Laboratory Services (Our only on the table issues are Point of Care testing (INRs) and Telemedicine. These came from the Community Hui as being what the islanders wanted)	Point of care INRs = set up costs/expense
	High priority	Need better liaison and support from CYFS	Our multidisciplinary team does a great job but serious cases fall short due to lack of support form CYFS	Child Protection Services	Intervention, co-ordination and referral in cases of abuse with CYPS
11		Happy with current provision		Child Protection Services	Intervention, co-ordination and referral in cases of abuse with CYPS
				Clinics - Adolescent/Youth	Patients under Age 22
1			limited funding only	Clinics - Adolescent/Youth *	Patients under Age 22
3				Early identification and management of Cognitive Impaired patients	Completion of physical assessment and various forms (MOCA) to aid in diagnosis
			some funding around this would be ideal, can be led by nurses but is timely and costly	Early impaired cognitive function	
	High Priority	We could do this better if well resourced	We have a paucity of funding for after hours and emergency care(we operate at a loss) and we require designated facilities for Waiheke	Emergency Equipment & Supplies	Defib, ECG, Allergy Mgmt, Cardiac Concerns, Penthrox pain relief etc.
11		Could be provided better	limited by funding especially after hours. We are funded as a GP but have to provide A& E without provision for this. Often GP's/nurses are fully booked and then need to provide this on top of patient load	Emergency Equipment & Supplies	Defib, ECG, Allergy Mgmt, Cardiac Concerns, Penthrox pain relief etc.
	High Priority	We could do this better if well resourced	We have a paucity of funding for after hours and emergency care(we operate at a loss) and we require designated facilities for Waiheke	Extended hours – Rural on call phone consult/consults	To provide longer hours of operation to local community
11		Could be provided better	Very low funding for an essential service Recruitment of GP's difficult because of on call package	Extended hours – Rural on call phone consult/consults	To provide longer hours of operation to local community
	High Priority	We could do this better if well resourced	We have a paucity of funding for after hours and emergency care(we operate at a loss) and we require designated facilities for Waiheke	Helicopter evacuations	Altogether 3 hrs average time wise
11		Could be provided better	limited by funding especially after hours. We are funded as a GP but have to provide A& E without provision for this. Often GP's/nurses are fully booked and then need to provide this on top of patient load	Helicopter evacuations	Altogether 3 hrs average time wise
			? Aged or unwell	Home Care	Assessment and referral to Home Services, Allied Health, Geriatricians etc.

Rating 1 to 10	Top Ten: High Clinical Priority	Of the Top Ten, which would like to provide but are not currently or could provide better should you have access to additional services/support?	What are the reasons for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other? List as many as applicable.	Name of Service/Treatment	Brief Description
			relevant for Rural practices more so in our areas,, cost in time/travel not all HV pts are palliative so no other funding stream to feed into GP never really gets fully reimbursed for their time on these	Home Visits	Patients unable to attend clinic
	High Priority	Not providing	We require support from ADHB and access to the infusions	Infusion - Iron	Infusion for anaemia
			process ? Protocols .	Infusion - Iron	Infusion for anaemia
			Ultrasound access and training	Injections - Intra articular	Administration of steroid injection
			More GP training under ultrasound	Injections - Steroid	Tendonitis, joint issues, etc
	High Priority	We could do this better if well resourced	We have a paucity of funding for after hours and emergency care(we operate at a loss) and we require designated facilities for Waiheke	Longer management of acute patients after assessment	Observation of patients after initial treatment to determine if transfer to hospital is required
			Practice capacity rooms	Longer management of acute patients after assessment	Observation of patients after initial treatment to determine if transfer to hospital is required
4		Could be provided better	Can use POP but better products are cost prohibitive	Managing standard orthopaedic care	Backslabs to most limb plaster and fibreglass cast. Interim management of more complex cases with MMH
5			Managing standard orthopaedic care – funded through ACC usually	Managing standard orthopaedic care*	Backslabs to most limb plaster and fibreglass cast. Interim management of more complex cases with MMH
			funding for nurse follow up phone calls for mental health patients, esp upon new diagnosis. Also acute mental health consults can involve family, CAT teams a time burden on always busy GP days	Mental Health referral and management	Completion of Kessler assessment and referral. Often to private counsellors as lack of funding and available services Our team pick up social service role for patients arranging transport to hospital or links to other support services. We also undertake weekly obs for patients with eating disorders that would otherwise be done in secondary environment.
5		Could be provided better	See brief description	Mental Health referral and management	Completion of Kessler assessment and referral. Often to private counsellors as lack of funding and available services Our team pick up social service role for patients arranging transport to hospital or links to other support services. We also undertake weekly obs for patients with eating disorders that would otherwise be done in secondary environment.
3				Nebulising	Management of acute COPD/Asthma
11		Happy with current provision	same as any emergency services	Nebulising	Management of acute COPD/Asthma
	High Priority	could provide better	currently understaffed with nurses and administration	PN Administration	Screening/recalls/HUHC/Emails & repeat scripts
2				PN Administration	Screening/recalls/HUHC/Emails & repeat scripts
3		Happy with current provision		PRIME	

Auckland Waitemata Rural Alliance

Rating 1 to 10	Top Ten: High Clinical Priority	Of the Top Ten, which would like to provide but are not currently or could provide better should you have access to additional services/support?	What are the reasons for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other? List as many as applicable.	Name of Service/Treatment	Brief Description
11		Could be provided better	Limited GP's to complete with very little reward. Practice loses money when on call	PRIME (plus 24/7 practice on-call)	(Own on-call system on GBI)
	High Priority	Could provide much better with additional nursing staff	Could provide much better with additional nursing staff	Public Health Nursing	Public Health Screening, Infectious diseases, School-based Services, Special Ed.
			WDHB and NDHB provide .Scope of nurses limited	Public Health Nursing	Public Health Screening, Infectious diseases, School-based Services, Special Ed.
	High Priority	could provide better with equipment and training	Dermatoscopes and training for GPs	Skin - Dermoscopy	Removal skin lesion
			education equipment	Skin - Dermoscopy	Removal skin lesion
			inter-agency meetings when required coroner, WINZ/CYFS not allowed for in normal work time, certainly not on charged to pts ether	Social Work Services	
			funding outside GP	Social Work Services	
			access to contract to provide	Tamariki Ora / Well Child	WCC and B4 School checks as per program and contract
6		Happy with current provision		Tamariki Ora/Well Child	
			again another job that takes GP/Nurse time and contact with patients, updating notes, not funded but has to be fitted into everyday	Warfarin Management	Pt-Lab-Dr(results)-Nurse (ring Pt)
2				Warfarin Management	Pt-Lab-Dr(results)-Nurse (ring Pt)
9			provide this service for patients but patient has to pay for administration which creates financial barrier for some.	Aclasta*	Infusion
	High Priority	We already provide this through a multidisciplinary team including AOD, social work, Whanau therapist		AOD Services	
3				BP Checks	Opportune/booked and serial BPs
			cost of holding catheters, time for insertion usually out of hours another time burden not fully compensated by what we can charge pts/claim from POAC	Catheterisation	Acute Urinary Catheterisation
4		Happy with current provision		Community Mental Health	
			Funding to support visits	Drug dependant patient (otherwise CADS clients)	Patient management of difficult, disruptive pts with drug dependency
			under 13's /education nurses	Ear Suction/Syringing	removal of wax
			no x-ray just A/bs	Emergency Dental	
			funding outside PMHO	Family Therapist	
1		Happy with current provision		General Practitioner Services	
3				Immunisations - non funded	Non schedule immunisations - Zostavac, Menactra, Pneum 23, Neisavac C, Varilrix
3				Immunisations - Travel Vaccines	Travel immunisations
			Vit C issues with ????????	Infusion - Vitamin C/Magnesium	Infusion
3				Injection - B12 / Iron	Injection

Rating 1 to 10	Top Ten: High Clinical Priority	Of the Top Ten, which would like to provide but are not currently or could provide better should you have access to additional services/support?	What are the reasons for not delivering: Funding, Workforce Skill (GP or PN), Equipment, Practice Capacity, Secondary Support, Other? List as many as applicable.	Name of Service/Treatment	Brief Description
			time taken by GP/Nurses around discharge summary- updating pts medication records, contacting the patients, then follow up discharges if original had errors - not funded at all another item that needs to be fitted into already full days,	Medication reconciliation post discharge/clinic letters	
			nasal Packs ....low presentations	Nasal Cautery	
3				Psychosocial Services	Liaison with social service agencies, Counselling
			nil within Wellsford area .	Referrals - Green Prescription	Health promotion & physical activity programme
7		Not provided at all	no rest home on the island	Rest Home /rural hospital Medical cover	GP's provide cover to local facilities
2		Happy with current provision		Rural Nursing Services	
			no family planning clinics	Screening - Womans Health	Cervical Smears
1				Script requests	Includes controlled drug requests too
	High Priority	We could do this better if well resourced	We have a paucity of funding for after hours and emergency care(we operate at a loss) and we require designated facilities for Waiheke	Short Stay overnight care	If unable to evacuate (weather) or care for pts in their own home
5				Skin - Lesions, Aldara and Liquid Nitrogen	Application/education of Aldara - Application of liquid nitrogen
10			Smoking cessation – all recognise this as a health priority and yet there is no direct funding stream for this in general practice!	Smoking cessation*	Management and opportunistic smoking cessation support and advice
11		Not provided at all		Telemedicine	Internet speed/ set up costs
3				UTI Treatment	Assessment / Diagnostic Test / Oral AB / Follow Up
			core function of GP central to all health issues, if time is taken for diets to be looked at can make some amazing changes	Value and Importance of diet assessments in general practice	
			GP training .	Vasectomy	Southern Cross Affiliated Provider/Other
11			Can sometimes use care plus funding but often younger people don't qualify or, if comorbidities, funding has been used for other visits.	Venesection*	Bleeding for Haemachromatosis