

A coordinated approach to GP recruitment and retention

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Fiona Strang is currently the CEO of the BDGP and has been now for nearly 12 years having commenced work as a program manager in 1998. During these 12 years she has overseen the growth of the Division from the corner of an office with two staff with a budget of around \$350,000 to an organisation of 31 employees with three major offices spread over 200 km and an annual budget of \$4 million. Prior to beginning work within the Division movement she worked as a speech pathologist and quality manager following graduation from the University of Queensland, where her primary degree was in speech pathology. Subsequent postgraduate qualifications have been obtained in practice management. She is currently a Director of the Gunnedah Rural Health GP Super Clinic, which is establishing a community-owned not-for-profit multidisciplinary health centre in Gunnedah, which has been badged as Super Clinic Number 36 by the Federal Government. This facility is expected to open in late 2011. Her role in the Division has been to oversee patient orientated clinical service projects, however her role as CEO in recent times has been to develop significant partnerships with NGOs, state and national health-related organisations and notably the local state-funded area health service. These relationships have assisted in recruitment and retention of health professionals across an isolated rural area and the development of collaborative projects that assist in the maintenance of health professionals and the provision of services to our rural areas. Despite the intense workload and travel across rural areas, Fiona is married to Peter and is also the proud mother of James who recently graduated in engineering and Annabelle who is completing her degree in communications (social enquiry) and international studies.

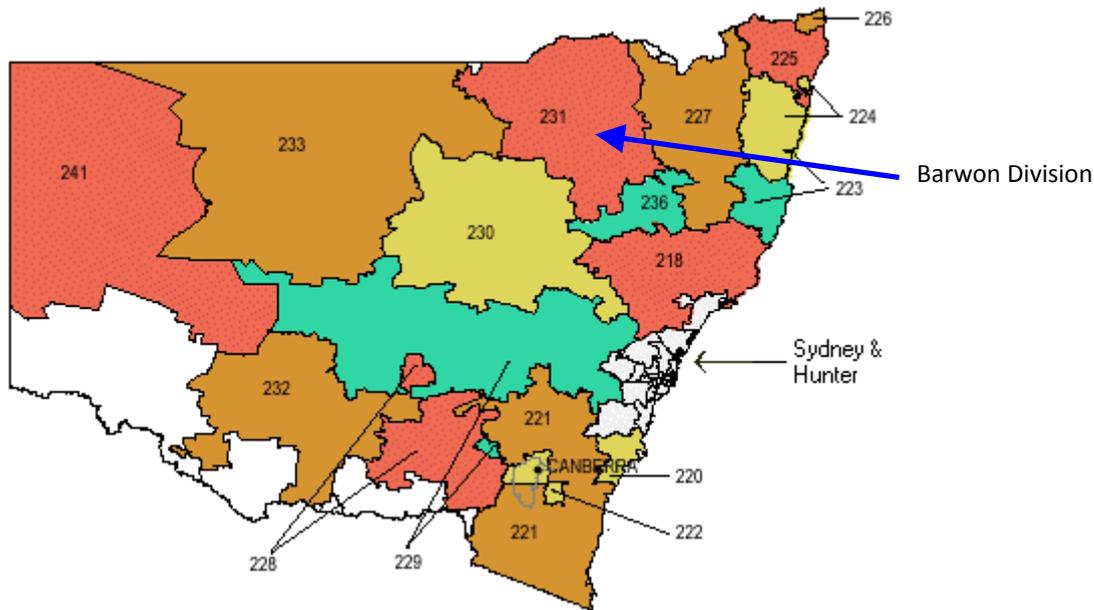
Scott McLachlan is responsible for directing and managing the eight clusters across Hunter New England, which include 33 hospitals and MPSs, 62 community health services, area-wide drug and alcohol service, oral health, aged care and rehabilitation and involved in developing some of the area clinical networks. Scott's role involves managing and leading the improvement of primary care services, service redesign ensuring integration across networks to achieve quality health care delivery. Scott works closely with the Director of Clinical Operations and the Director of Operations, Acute Networks as well as the directors accountable for other clinical networks to promote integration of services which meet the health needs of the community. He works with key stakeholders, including Divisions of General Practice, DADHC, DOCS and other partners to enable integrated primary care approaches and develop working partnerships in order to benefit the community. Scott is a graduate of the ACHSE Management Development Program and has a Bachelor of Human Movement and Management Major—Marketing, Financial and Human Resource Management from *Southern Cross University*, Lismore. Scott is based in Tamworth.

Estrella Lowe PhD is the Manager for Rural Medical Services Initiatives with the NSW Rural Doctors Network. A project manager with experience in State and Federal government departments as well as the non-government sector, Estrella's current position includes working with rural communities as they formulate local responses to medical workforce shortages. Estrella also works in the area of succession planning for individual rural GPs, and her past experience has been in education, journalism, Indigenous health and community-based nutrition programs in developing nations.

Introduction

A landmark succession planning collaboration initiated by the Barwon Division of General Practice in the north west of NSW is improving GP recruitment and retention outcomes in the area and providing a model for collaboration that is being implemented in other divisional areas in the state.

The initiative grew out of the Division's frustration with a situation common across rural NSW where three organisations (the Division, Hunter New England Area Health Service [HNEAHS, since January 1 2011 known as Hunter New England Local Health Network, HNELHN] and NSW Rural Doctors Network [RDN]), as well as individual GPs and recruitment agencies, worked in relative isolation to recruit doctors to the area. The collaboration has been particularly groundbreaking because it is predicated on Local Health Network recognition that work to recruit and retain GPs impacts directly on the capacity to provide hospital services in rural areas.



Map of NSW Divisions of General Practice

The region encompasses 43,000 square kilometres and includes eleven medical towns with combined populations of 54,000. Of these towns, seven are either solo or duo towns while another four are multi practitioner proceduralist towns offering obstetrics, surgery and anaesthetics. All except the northernmost town have an acute, state-run facility (hospital or Multipurpose Service [MPS]), serviced by Visiting Medical Officers (VMOs) who are GPs and all have challenges with recruiting and retaining health and medical staff.



Map of the Barwon Division

The procedural towns are Moree, Narrabri, Manilla and Gunnedah. Solo towns are Mungindi, Boggabri and Wee Waa. Duo towns are Bingara, Barraba, Collarenebri, and Warialda.

These demographics present specific recruitment and retention difficulties including:

Solo and duo towns

- May be severely affected when a GP decides to move on from the town, because in the absence of a prompt replacement, the medical workforce in the town is either obliterated or halved.
- Those with an acute facility require the town GP to be on call 24/7 or at best, 1 in 2. This is a punishing and anti-social schedule which militates against recruiting a replacement GP.
- In the absence of a town GP, the Local Health Network (LHN) must implement emergency measures to cover the hospital or Multi Purpose Service (MPS). Locum cover is not among the options available to the LHN in these small towns.

Proceduralist towns

- Because of Australia-wide shortages, these towns often face severe problems replacing exiting proceduralists, particularly since the replacement needs to possess at least similar procedural skills as the exiting GP.
- This is complicated by the need to keep a viable mix of proceduralists in the town to provide first and second on call, and reduce their routine non-procedural on-call requirements.
- In the absence of a viable mix of proceduralists, certain proceduralists can find themselves the only one of their kind in the town, with associated 24/7 on call loads.
- Shortages of GP proceduralists pose particular service provision problems for hospitals that are serviced by VMO proceduralists rather than the staff specialists common in larger referral hospitals.

In addition to these problems, other issues impinge on recruitment and retention in all towns regardless of size and service range: These include:

- A shortage of teaching infrastructure despite supervisory capacity, especially important given the increased numbers of medical students (and in due course, registrars) requiring training placements
- In many rural locations, outdated infrastructure, both in private rooms and in hospitals, is neither conducive to team based health care nor attractive to potential recruits.
- The recent advent of government funding streams for improving GP surgery and teaching facilities has provided opportunities to strengthen infrastructure in some towns. These streams include National Rural and Remote Health Infrastructure Program, funding available to the medical universities, and in some cases, Superclinic funding.
- Long distances from urban centres where numbers of GP extended families and/or schooling children are located, necessitating regular weekend leave from the GP's town.

Clearly the most effective and efficient local response to such complex challenges would result from pooling resources, expertise and areas of influence of relevant stakeholders. It was in recognition of this that the Barwon Division of General Practice proposed a collaboration of the Local Health Network, the Division, the workforce agency (RDN) and later the Rural Training Provider, in this case, first as New England Area Training Services (NEATS) and then merging to become GP Synergy.

Challenges in establishing the collaborative

While it was clear that the medical towns would benefit from three key stakeholders (later a fourth key stakeholder joined) combining resources, several barriers needed to be addressed.

Confidentiality

Because all three organisations collect different but equally confidential data on towns' GPs and medical services, the issue of sharing that data to give a complete picture of the medical workforce status presented a

major challenge. Specifically, Barwon Division collects a wealth of confidential information through staff interactions with surgeries and GPs; RDN annually surveys rural GPs about their hours, intentions to remain in the town, special interests, as well as demographics, with the answers to all but a core of demographic items being guaranteed confidential (RDN is only permitted to release de-identified data); HNELHN keeps sensitive data on VMO hours, credentialing and emergency rosters. The three organisations could only progress as a group if they agreed that the sole purpose of sharing data was to combine recruitment and retention forces, and that any data shared in the collaboration must remain confidential. To this point, the agreement has not needed to be formalised because all three (subsequently four) collaborators have strict confidentiality standards for staff.

When the fourth organisation—the Rural Training Provider, GP Synergy—joined the collaborative, that organisation brought confidential information about the placement and progress of GP registrars in the area.

As the organisations worked together greater trust developed, leading to an increasing willingness to share a range of additional information, compounding the benefits of the collaboration.

Divergent motivation for recruiting and retaining rural GPs

While all three organisations have the interests of rural communities at heart, the differing nature of their core business gave each a slightly different take on recruiting and retaining GPs. Within their area, Barwon Division supports General Practitioners and their staff to deliver the best possible primary health care to the Barwon region. RDN, on the other hand, has state-wide responsibility for recruiting and retaining rural GPs in more than 200 towns; at the same time, HNELHN is responsible for maintaining state funded hospital services in its area which is larger than Barwon Division's area and smaller than RDN's, and therefore HNELHN's interest is more in hospital services than general practice. When GP Synergy later joined the group, that organisation brought an interest in quality training placements for registrars.

Therefore the three organisations needed to find their common ground, as well as understand and harness their differences to work on a shared vision of maintaining viable medical services in their towns. In the proceduralist towns it was necessary to understand the balance between proceduralists, particularly the necessity for anaesthetics for surgery and obstetrics.

Public versus private, state versus federal nexus

Both Barwon Division and RDN are non government organisations supporting rural GPs who in the main are business people providing private medical services from their rooms and largely remunerated through a combination of Medicare (federal) rebates and patient contributions (private). By contrast, HNELHN is a state-government instrumentality providing rural hospital services utilising credentialed rural GPs who are remunerated from state funding for public patients in hospital (and may also earn some income from private patients in the hospital) but earn the majority of their income working in private practice.

Establishing the collaborative

The collaboration began with high level talks between the three organisations instigated by the CEO of the Barwon Division. The regional training provider (RTP) was invited to the meeting at a later time. The favourable outcomes of these talks ensured the selected delegates from each of the organisations had their organisation's mandate to collaborate.

Organisation representatives on the collaborative are:

- from Barwon Division: CEO and Chair
- from HNELHN: Director of Primary Care and Community Networks, Senior Consultant Rural Recruitment, the three Cluster Managers who between them cover Barwon towns, Medical Director for the Barwon towns
- from GP Synergy—Regional manager
- from RDN—Manager Rural Medical Services Initiatives.

Representatives nominated to participate in the collaborative were selected because they were able to:

- harness relevant information and resources from their respective organisations for the collaborative's consideration
- report back to their organisation on issues and activities arising from the collaboration
- speak for their organisation at collaborative meetings
- for the benefit of the collaborative effort, implement strategies on behalf of their organisation or negotiate to have them implemented

Bi-monthly meetings of up to 2 hours duration were held beginning with a face to face meeting and proceeding to a combination of face to face and teleconference. On occasion a special half-day face to face meeting was called to deal with long term planning issues.

Data collection and integration

(Fictional sample for "My Division" is at appendix 1)

To support this project, in 2007 the Division combined information from its database with responses to a capacity survey from all its GPs and practices, with limited data from the RDN database. In addition the Division CEO and Chair visited each practice over a period of three days to gather information not routinely kept by any of the three organisations. This initial gathering of data resulted in a synthesis of information including:

- numbers of consulting rooms and their use patterns
- capacity to train registrars and resources (current and needed) to do so
- capacity to train medical students and resources (current and needed) to do so
- accommodation available for students and registrars
- IT and telecommunications equipment
- use of practice nurses
- developments assisting the practice
- situations discouraging the practice
- plus a range of data on the GP workforce
- demographic data by town that included future developments impacting on the population of the town, such as proposed mines.

To that RDN added information from its state-wide database which is informed by annual GP and practice manager surveys. In this way RDN filled some gaps in demographics, hours, qualifications, interests, and intentions to move,

From its area of expertise HNELHN contributed data on individual doctors' VMO status.

As trust has developed between the groups, members of the collaborative have increasingly taken the opportunity in regular meetings to share sensitive information that has come to their attention. This has allowed the collaborative to mature into an extremely well informed group capable of making knowledgeable decisions in the best interests of key stakeholders and consumers alike.

The development

Through discussions at regular meetings of the three groups (later joined by the Rural Training Provider, GP Synergy), it became clear that this collaborative had three roles to fulfil:

- combining resources to manage service provision difficulties at the town level as they arose
- improving service arrangements across the towns to increase the chances of retaining existing GPs
- planning strategies to deal with predicted workforce changes over the next five years both in GP practices and in rural hospitals.

The outcomes to date

Combining resources to manage service provision difficulties

In the past three years a range of GP shortages have arisen, mostly because a replacement cannot be found before a GP moves to a new location. Because all four organisations combine their differing local information sources, generally intentions to leave are now known in advance of any doctor's departure. As the departures have loomed and then occurred, the collaborative has discussed the resulting service provision problems both for surgery consultations and for the local hospital, and agreed on the part each would play in a strategy to alleviate the problems. Depending on circumstances, this has led to combined recruitment advertising, Local Health Network practical support for strategies implemented by the Division and vice versa, and the Local Health Network providing occasional emergency locum coverage for a hospital until normal services can be restored.

This outcome has only been possible because for the first time, through the collaborative, the four organisations have been able to quickly pull together their respective resources to address a crisis, and then through open communication, ensure a coordinated approach is maintained. For example, in one of the larger procedural towns, a six-consulting room practice run from a capital city was about to close because of a variety of unfortunate circumstances, including the inability to recruit. Down to three procedural and one generalist GPs from 7 proceduralists and three registrars, the town's procedural capacity was on the brink of collapse, and was in danger of losing significant purpose-built infrastructure along with a diminished practice that nonetheless had great potential. In response, the collaborative came together in an emergency teleconference, potential solutions were tabled and a resulting strategy utilising the resources of all players was selected. Tasks were allocated appropriately across three of the organisations, and the collaborative was kept up to date on developments by email. The outcome secured was that a GP remaining in the town took over the practice and the building. The infrastructure remains functional in the town, the practice remains open with two additional GPs already recruited and more in the pipeline, and the procedural capacity of the town has been strengthened.

This level of cooperation would not have been possible five years ago because of historical distrust between the organisations and the lack of communication between them, leading to the inability of any single organisation to see and deal with the complete picture, as well as act in the interests of all players. Instead, several solutions appropriate to individual organisations and developed in isolation would have been likely, often leading to organisations working either at cross purposes or in duplication.

Improved service arrangements

The organisations in the collaborative have agreed that retention plays an important part in maintaining services in an environment of GP shortages. An array of strategies has been developed to ease the demands of 24/7 or one-in-two on call requirements on GPs in the Division's smaller towns. For example, the Division has negotiated with on-call GPs in the larger towns to also cover by telephone a smaller town whose GP is occasionally away for the weekend. In addition, the Division manages a Second-On-Call roster where rostered GPs and health services are notified whenever a small town is to be without a GP after hours or on weekends. While not a replacement locum service, the program allows small town GPs the opportunity to attend evening Continuing Professional Development events in another town, to take sick leave, and leave town for a weekend to attend to family matters or to training needs. In collaboration with the Division, HNELHN has value

added to the strategy by providing a locum on occasion, or implementing alternative emergency service arrangements in an affected hospital.

HNELHN has also given priority to a number of Barwon Division towns as it rolls out a program developed in the town of Walcha. This program increases the ability of rural hospital nurses to triage and then manage a selected range of presentations common in Emergency Departments, all without GP involvement. In this way, on-call GPs only attend the Emergency Department for cases they alone can manage. In Walcha the general practitioners have been very satisfied with the outcome. While the total number of patients presenting at the Emergency Department did not reduce significantly, the proportion for which the doctor's presence is required has decreased, leading to a significant improvement in quality of life for the GPs.

Another improved service arrangement has come about through discussions with GP Synergy about the key service provision roles rural registrars fulfil, particularly in the smaller towns (where one registrar can almost double the town's medical capacity) and particularly carefully selected, more experienced trainees. Armed with this knowledge, in 2010, GP Synergy was successful in attracting good quality, appropriate registrars to three of the smaller towns, thereby increasing the workforce in those towns by up to one third.

Improvements through planning strategies for the longer term

To develop the proactive side of this collaborative, RDN was asked to facilitate two half-day workshops for collaborative members focused on mapping the five-year expectations of service provision change in each of the towns both in terms of surgery consultations and hospital development. From these workshops common themes across towns emerged, as well as themes particular to individual towns. HNELHN discovered that many of its looming problems with an ageing nursing and allied health workforce were mirrored in the medical fraternity's concern about an ageing medical workforce and what that meant for maintaining services in the future.

While still considering how best to plan for widespread, impending shortages, the collaborative took on a number of longer-term strategies. For example, in a solo-doctor town desperate for two more GPs and in danger of losing its one remaining GP through excessive workload, HNELHN trained a well-matched overseas-trained applicant who twice had been unable to clearly demonstrate his professional knowledge to the Medical Board to improve his exam-sitting skills in an Australian setting. In the meantime, GP Synergy was able to locate and place a registrar in the town, thereby diminishing the load on the solo GP.

The locum costs and service gaps for rural hospitals in HNELHN have been growing significantly over previous years, placing significant financial pressure on the LHN. Through the efforts of the collaborative, a number of workforce gaps that would have placed further stress on this system have been filled and alternative support systems have been designed, providing benefit to all of the towns within the Division.

The spread of the model

The collaborative was of such benefit to HNELHN in the Barwon Division towns that it requested the system be implemented in its other rural towns. Hence, two additional collaboratives were established and are following the model initiated in Barwon Division, each with similar early outcomes.

Partly through the interest that HNELHN generated by presenting the collaborative outcomes to a meeting of the State's rural Local Health Networks in 2010, RDN has been invited to workforce talks with other Local Health Networks that cover a good deal of rural NSW. The networks covering these rural regions regularly experienced occasions when significant numbers of their rural hospitals had no on-call coverage over a weekend.