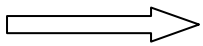


Appendix 3 Roles - Manager of Buller Health

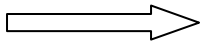
Position Description

Manager of Buller Health

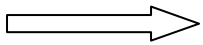


Strategic Planning the “Buller Health” Plan
Skills, vision, passion, communicator, listener
Possible issue – takes time to learn about Health

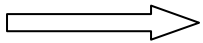
Quality



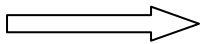
Developing and enhancing relationships



Represent Buller Health
For External & Internal Stakeholders



People Manager rather the Process Manager



Managing Diversity (of range of services)

Implementation

Consultation - Feedback loop

Write “Buller Health Plan”

Create Manager of Buller Health role

Establish Clinical Advisor Roles and Clinical Advisor “Team”

Links with the DHB

Consumer Reference Group

Communication Strategy for Implementation

Change Agent for Initial
Appointment

Appendix 4 Overview of the Grafton Report

The Grafton Group was contracted by Buller District Council, to review options for primary care in Westport and Reefton. The West Coast DHB offered financial support for the Grafton process and the scope of the project was extended to cover all health services in the Buller.

The process involved consultations with staff from both primary and secondary services, District Council and DHB management, and the community by way of a community steering group. All of these four sectors were consulted over the geographical area of the Buller District Council, Karamea, Westport / Northern Buller and Reefton sites and communities.

Periodically the process produced reports for consideration and analysis framing the development of the final report. These reports included a Situational Analysis, Recruitment and Retention and, Community health ownership models.

The final report proposed a matrix of four options for Reefton, Westport and Karamea, encompassing primary and secondary care. This final draft was then released as the Models of Care document for consultation and framing the final report and recommendations.

Reaction to the models of care draft was mixed with different communities reacting in different ways. In Reefton a community meeting resulted in an action group, which chose to deal directly with the DHB over previously unresolved issues and those contained in the report. While in Westport a mix of sessions lead by steering group members and a community meeting provided community feedback. The Karamea community chose the status quo as during the period of the project they had recruited a GP and wished to consolidate his presence.

The final report generally recommended that all services be retained but aligned better for improved integration, take advantage of changes in physical proximity, and implied improved communication and co-ordination. While some of the options indicated exit of services on the part of the DHB, this was primarily in ownership rather than that of service delivery. Some services were recommended to be enhanced.

The Final Report was tabled at the Buller District Council meeting on the 8th of December 2004. Reaction at that meeting was not overly supportive of the report itself, however the report was passed to the West Coast DHB Board for their consideration, which has occurred in the first quarter of 2005. A consultation round being aligned with the DHB strategic plan consultations occurred in the 2nd quarter of 2005.

The matrix over leaf shows the four options for each site and the service mix proposed for each option.

	Status Quo	8 Beds + Maternity (New)	8 Beds + Maternity (Reconfig)	4 Beds + Maternity (New)
GP Services	<ul style="list-style-type: none"> BMS practice 	<ul style="list-style-type: none"> BMS practice 	<ul style="list-style-type: none"> BMS practice 	<ul style="list-style-type: none"> BMS practice
Inpatient Services	<ul style="list-style-type: none"> 8 medical inpatient beds 1 palliative care bed Medical cover provided by MOSS/GPs 	<ul style="list-style-type: none"> 8 medical inpatient beds – incl. palliative Medical cover provided by MOSS/GPs 	<ul style="list-style-type: none"> 8 medical inpatient beds – incl. palliative Medical cover provided by MOSS/GPs 	<ul style="list-style-type: none"> 4 medical inpatient beds – incl. palliative Medical Cover provided by Moss/GPs
Aged Care	<ul style="list-style-type: none"> 17 continuing care beds in Buller Hospital 27 rest home beds in Kynnersley Rest Home 	<ul style="list-style-type: none"> 23 continuing care beds – private provider 27 rest home beds – private provider 	<ul style="list-style-type: none"> 23 continuing care beds – private provider 27 rest home beds – private provider 	<ul style="list-style-type: none"> 23 continuing care beds – private provider 27 rest home beds – private provider
Maternity Services	<ul style="list-style-type: none"> 4 maternity beds LMC midwives (2.0 FTE) Core midwives (1.2 FTE) 	<ul style="list-style-type: none"> 2 Maternity beds LMC midwives (1.6 FTE) Core midwives (1.0 FTE) 	<ul style="list-style-type: none"> 2 Maternity beds LMC midwives (1.6 FTE) Core midwives (1.0 FTE) 	<ul style="list-style-type: none"> 2 Maternity beds LMC midwives (1.6 FTE) Core midwives (1.0 FTE)
Community Nursing Services	<ul style="list-style-type: none"> District Nursing Public Health Diabetes Educator 	<ul style="list-style-type: none"> As per current levels Creation of generalist nursing roles as per Neighbourhood Nursing 	<ul style="list-style-type: none"> As per current levels Creation of generalist nursing roles as per Neighbourhood Nursing 	<ul style="list-style-type: none"> As per current levels Creation of generalist nursing roles as per Neighbourhood Nursing
Emergency Services	<ul style="list-style-type: none"> St John – mix of paid/volunteer staff Trauma stabilisation Level II A&M 	<ul style="list-style-type: none"> St John – current configuration Trauma stabilisation Level II A&M – instigate patient charges for triage levels 4 and 5 	<ul style="list-style-type: none"> St John – current configuration Trauma stabilisation Level II A&M – instigate patient changes for triage levels 4 and 5 	<ul style="list-style-type: none"> St John – current configuration Trauma stabilisation Level II A&M – instigate patient changes for triage levels 4 and 5
Outpatient Clinics	<ul style="list-style-type: none"> Orthopaedic Anaesthetics Audiology Diabetes General Medicine General Surgery Gynaecology 	<ul style="list-style-type: none"> Retain current range Investigate expansion of private clinics 	<ul style="list-style-type: none"> Retain current range Investigate expansion of private clinics 	<ul style="list-style-type: none"> Retain current range Investigate expansion of private clinics

	<ul style="list-style-type: none"> Nutritional Services Obstetrics 			
Outpatient Clinics (cont.)	<ul style="list-style-type: none"> Ophthalmology Paediatric Medical Podiatry 			
Allied Health	<ul style="list-style-type: none"> Radiology - Plain Film OT Physio Social Work Field Worker/Needs Assessment 	<ul style="list-style-type: none"> Teleradiology (digital) Other Allied Health services at current levels 	<ul style="list-style-type: none"> Teleradiology (digital) Other Allied Health services at current levels 	<ul style="list-style-type: none"> Teleradiology (digital) Other Allied Health services at current levels
Mental Health	<ul style="list-style-type: none"> Community Mental Health Alcohol & Drug Child, Adolescent and Family Service 	<ul style="list-style-type: none"> Same as current 	<ul style="list-style-type: none"> Same as current 	<ul style="list-style-type: none"> Same as current
Other Services	<ul style="list-style-type: none"> Domestic Assistance/Personal Care Meals on Wheels Surgical Bus 	<ul style="list-style-type: none"> Domestic Assistance/Personal Care – current levels Meals on Wheels Surgical Bus 	<ul style="list-style-type: none"> Domestic Assistance/Personal Care – current levels Meals on Wheels Surgical Bus 	<ul style="list-style-type: none"> Domestic Assistance/Personal Care – current levels Meals on Wheels Surgical Bus
Facility	<ul style="list-style-type: none"> Buller Hospital Internal Kitchen 	<ul style="list-style-type: none"> Closure of Buller Hospital Greenfield's development of an Integrated facility incorporating primary and secondary care Collocation of BMS, dentist, private physio, pharmacy and St John No kitchen – meals outsourced 	<ul style="list-style-type: none"> Reconfiguration of current hospital buildings, integrating primary (GPs) and secondary care Possible collocation of dentist, private physio, pharmacy and St John Meals may be outsourced 	<ul style="list-style-type: none"> Closure of Buller Hospital Greenfield's development of an integrated facility incorporating primary and secondary care Collocation of BMS, dentist, private physio and St John No kitchen – meals outsourced

**APPENDIX 3 – THE GRAFTON REPORT STAGE 1
(2003)**



Buller Health Services

Future Options: An Initial Report

Prepared by

Grafton Consulting Group

For

Buller District Council

October 2003

Contents

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Attachments

- A. Buller Expenditure – Actual Figures for 2002-03**



1.0 EXECUTIVE SUMMARY

Buller District Council has been actively involved in various activities in the health sector in recent years in order to ensure that services considered vital to the wellbeing of the community continue to be available. As a result of its engagement in health, the Council has identified a number of key issues regarding service delivery in Buller. These are:

- Recruitment and retention of GPs and other health professionals
- The clinical and financial sustainability of Buller Hospital
- Access to health services and adequate service provision in the satellite areas of Ngakawau and Karamea
- Local community control over health services and certainty for the future

To address these issues, Buller District Council has looked several times at the possibility of setting up a Community Trust for the purposes of taking over some health service delivery from West Coast District Health Board (WCDHB).

In July 2003 Buller District Council appointed Grafton Consulting Group to prepare a report for Council. This report is the result of Grafton's investigations and contains financial information regarding current service delivery in Buller, options for the future configuration of services, an outline of how a community trust might operate and initial recommendations as to the best way forward.

The initial financial analysis contained in this report, based on estimated revenue and actual expenditure figures, indicates that both Buller Hospital and Buller Medical services are running at significant deficits.

After an assessment of the various service delivery options, Grafton believes that the key service elements required in Buller to address the current issues and to best meet the long-term health needs of the community are:

- The creation of a Buller Community Trust
- A new service configuration for Buller Hospital as outlined in Section 6.5
- Private provider service provision for continuing care and Kynnersley Rest Home
- A new integrated health facility, incorporating both primary and secondary care services, owned by a Buller Community Trust and leased to the service provider/s
- Hospital health service delivery provided by a Buller Community Trust
- Privatisation of Buller Medical Service, with a Buller Community Trust owning the practice buildings
- Incentives for GPs, such as furnished accommodation and cars, provided by a Buller Community Trust
- A Karamea practice with a self-employed GP operating independently using WCDHB owned facilities
- A Ngakawau practice that is serviced by either the Karamea or Buller Medical Service GPs using WCDHB owned facilities.



It is recommended that the key service delivery elements outlined above be adopted by Buller District Council as the basis for further investigation and analysis, through the development of a detailed business case.

Grafton considers that the risk of not proceeding with this project include:

- Continued community uncertainty and anxiety over health service delivery
- Further deterioration of services - service cuts at Buller Hospital are a possibility by WCDHB
- Further loss of qualified medical professionals, including GPs and nursing staff
- Loss of economic development opportunities – people and businesses reluctant to move to areas with few, inadequate or insecure health services.

2.0 INTRODUCTION

Buller District Council has been actively involved in various activities in the health sector in recent years in order to ensure that services considered vital to the wellbeing of the community continue to be available. To achieve this goal, the Council has looked several times at the possibility of setting up a Community Trust for the purpose of taking over some health service delivery from WCDHB.

As background, two reports - the *Health Service Options for Buller and Reefton* undertaken by Deloitte in 2000 (commissioned by Coast Health Care, the Health Funding Authority and the Crown Company Monitoring and Advisory Unit), and a *Health Care Needs Assessment Study* undertaken by Professor David Dunt in 2001 - recommended changes to health service delivery in Buller.

Subsequent to this, in February 2002, Grafton Consulting Group provided a report to Buller District Council that outlined various options for the delivery of health services in the Buller District. Grafton's report took into account the identified issues and recommendations made in the previous two reports outlined above.

At this time Grafton recommended that a 'partnership' with Coast Health Care be explored in which the Buller community took over ownership of the Hospital while Coast Health Care continued delivering the services. As an alternative, Grafton said that the Council could explore the option of forming a Community Trust to take over ownership and management of health services.

Following this report, a meeting was held between Buller District Council and WCDHB. At this meeting WCDHB made a presentation to Buller District Council outlining how it believed the new PHO environment would be the answer to the problems facing Buller. Following this, at a meeting between Grafton and Buller District Council it was agreed that the Council would work with WCDHB before making any decisions regarding the establishment of a Community Trust and any increased Council participation in health issues.

The establishment of a West Coast PHO has been the focus of Buller District Council efforts regarding health services until earlier this year. However, it has since been recognised by Buller District Council that the new PHO environment has not resolved the fundamental issues regarding health service delivery in the Buller district. These issues are:

- Recruitment and retention of GPs and other health professionals
- The clinical and financial sustainability of Buller Hospital
- Access to health services and adequate service provision in the satellite areas of Ngakawau and Karamea
- Local community control over health services and certainty for the future

During a meeting between Buller District Council and South Link Health it was suggested that the Council should look to support local health services through



ownership and Buller Medical Services via a Trust, rather than activities through the PHO model.

Given this advice, and the fact that the fundamental issues outlined above remained unaddressed, Buller District Council decided to progress the Community Trust option, first outlined by Grafton Consulting Group in February 2002, and formally engage WCDHB in discussions regarding a Trust taking over some health services in Buller, particularly the GP services provided by Buller Medical Service.

In July 2003 Buller District Council appointed Grafton Consulting Group to prepare a report for Council regarding a proposal for progressing the above option. It provided a confidential briefing paper outlining the Council's current involvement in health and its requirements for the report.

At the same time, WCDHB agreed to engage in the process and it advised Buller District Council it would provide assistance regarding the consideration of the above option. At the request of WCDHB a confidentiality agreement was signed by both Grafton Consulting Group and Buller District Council that agreed to utilise the information provided only for the intended purpose.

Following its appointment, meetings were initially held between Grafton Consulting Group and key stakeholders, including the CEO of WCDHB, John Luhrs. Whilst acknowledging that the Council's primary focus was the future of Buller Medical Services, Grafton identified that since GP services were intertwined with the hospital, satellite areas and aged care service provision, the focus of an initial scoping report should be wider than the original Council brief.

Grafton Consulting Group met with Simon Murray of Buller District Council on 16th September 2003 to further clarify its expectations of the content of this report. It was agreed that the report should contain the following:

- Financial information regarding current service delivery in Buller and an identification of any funding issues
- A range of options for the future configuration of services (including how Karamea and Ngakawau could fit in) that address the wider service delivery issues
- A outline of how a Community Trust might operate
- Initial recommendations to the Council as to the best way forward
- An outline of how to proceed going forward

It was also agreed that service delivery at Reefton was not to be part of the focus at this stage.

The following section outlines the process undertaken in preparing this report.

3.0 PROCESS

In preparing this report Grafton Consulting Group has met with the following stakeholders:

West Coast DHB	<ul style="list-style-type: none"> • John Luhrs (CEO) • John Goulding (General Manager Finance) • Robin Williams (General Manager Primary Care/ Director of Nursing) • Wayne Champion (Finance Manager) • Ebel Kremer (General Manager Operations) • Kevin Hague (General Manager Planning and Funding)
Buller Medical Service	<ul style="list-style-type: none"> • Colin Rea • Graham Jelley • Steve O'Donnell
Dr Ken Mills	
Buller District Council	<ul style="list-style-type: none"> • Simon Murray • Susan Gill
O'Connor Rest Home	<ul style="list-style-type: none"> • Jude Moss (Manager)
Karamea Practice	<ul style="list-style-type: none"> • Jenny Roumieu (Rural Nurse Specialist) • Heather Maw (Rural Nurse Specialist/Clinical Nurse Leader)
Karamea Medical Association Trust	<ul style="list-style-type: none"> • Rosalie Sampson • Other Trust Members

Grafton Consulting Group has also visited the following facilities:

- Buller Hospital (with a tour provided by Lynne Southon)
- Buller Medical Service
- Ngakawau Medical Centre
- Karamea Medical Centre

The information, options and recommendations contained in the following sections of this report is based on background reports and papers supplied to Grafton Consulting Group, financial and volume information supplied by WCDHB, stakeholder comments and the assessment of facilities visited. It also draws on our previous experience in health service reconfigurations, particularly in smaller rural areas.

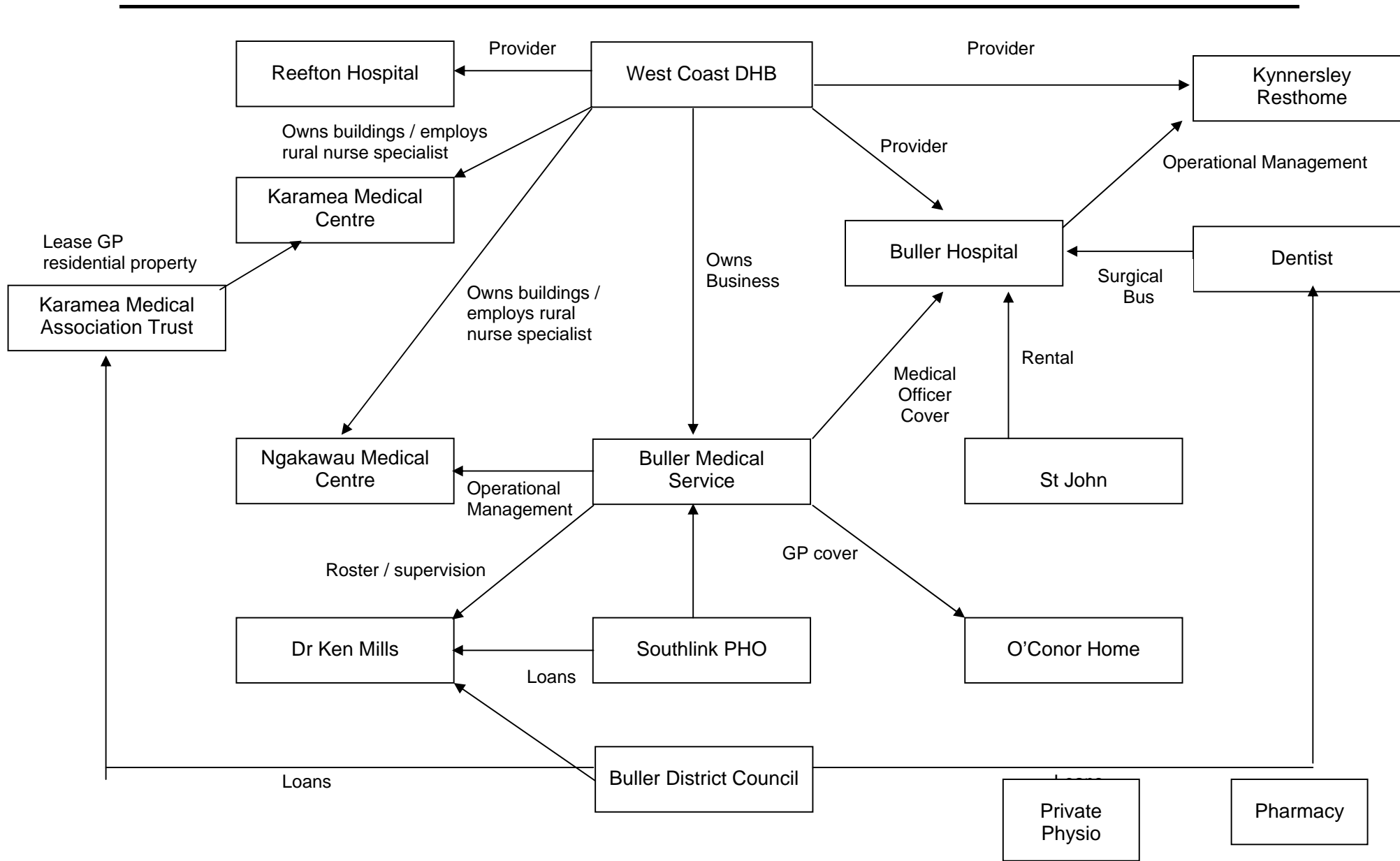
The above process has been facilitated by Buller District Council.

4.0 CURRENT SERVICE DELIVERY RELATIONSHIPS

The diagram overleaf is an outline of the current service delivery relationships in the Buller District.

CURRENT HEALTH SERVICE RELATIONSHIPS – BULLER

AUGUST 2008



5.0 FINANCIAL INFORMATION

WCDHB has supplied Grafton Consulting Group with expenditure information from 2002-03 from the following service areas:

- Buller Hospital
- Buller Maternity
- Kynnersley Rest Home
- Buller Medical Service
- Karamea Nurse
- Reefton Hospital (incl. Rest Home)
- Ngakawau

This expenditure information is contained in Attachment A.

WCDHB have also supplied information about the current service volumes for Buller. However, it has not released any revenue information to Grafton Consulting Group or Buller District Council regarding the services delivered in the Buller District. Therefore it has been difficult to gain an accurate picture of the current financial situation regarding the various Buller health services.

With regard to financial information, the position of WCDHB is that Buller District Council must not assume that all of the current funding channelled into Buller health services will continue at the same level. Like many other District Health Boards in New Zealand, WCDHB has a financial deficit that it must address (approximately \$2.5million) and as a consequence it will be looking at all of its operations closely, including Buller, in terms of what savings might be made.

Given this, WCDHB considers that the focus of any discussions regarding the future of health services should be on what services for Buller are appropriate and sustainable (both clinically and financially) and what is the best way to configure them.

It is likely that some alternative structure for health service delivery, such as a Community Trust, may be the eventual outcome of the process initiated by Buller District Council. If this occurs WCDHB will be in the position whereby it is negotiating a funding package with this Community Trust. Whilst WCDHB has indicated that it is keen to exit services in favour of Community Trust service delivery, it believes that releasing current revenue information may prejudice its position in any future negotiations regarding those services.

Since Buller District Council wishes to have some indication of the current financial state of health service delivery in its district, Grafton Consulting Group has provided the following information based on its **estimates** of likely revenue for individual services using the volume data provided by WCDHB. These estimates are based on our experience in the financial analysis of other health services in different parts of the country, particularly rural areas.

It is to be reiterated that the following information is based on estimates only and should not be quoted in any other context.

5.1 Buller Medical Service



The estimated revenue had been calculated by multiplying the number of GP patient contacts of 21,739 for the previous year by the full non-subsidised GP charge of \$38. This methodology was recommended by Medical Assurance, a financial services company for GPs, as a way of working out a broad estimate of likely revenue for a GP practice. It will be approximate only as revenue streams vary depending on the precise demographic profile within which the GP practice operates.

Using this methodology the estimated revenue for Buller Medical Service is \$826k.

As a way of cross checking the validity of this method, Medical Assurance also advised that the average revenue currently generated per GP in New Zealand is between \$230 and \$250 per annum. Utilising these figures, the revenue for the 3.5 FTE GPs in Buller Medical Service (excluding the GP who works at Buller Hospital) would be between \$805K and \$875k. The estimated revenue above is within this range.

Using this estimated revenue and the WCDHB actual expenditure figures for Buller Medical Service and Ngakawau (which is serviced by Buller Medical Service and whose patient contacts are included in the figure cited above), the following is the likely financial situation for Buller Medical Service:

Buller Medical Service	2002/03
Revenue (<i>estimated</i>)	826,000
Direct Expenditure (incl. Ngakawau) (<i>actual</i>)	995,454
Contribution to Overheads (<i>estimated</i>)	(169,454)
Corporate Overhead (incl. Ngakawau) (<i>actual</i>)	98,302
Surplus/(Deficit) (<i>estimated</i>)	(267,756)

It is likely that additional revenue and subsidies are channelled through Buller Medical Service but the nature and the extent of these are unknown.

It is noted that Buller Medical Service will have a bulk-funded contract for delivering services to Ngakawau. Ngakawau is a 'special area' in that patients do not pay GP or Practice Nurse Charges. Special areas were set up in the 1940s to ensure health services were delivered to isolated communities. District Health Boards are required to continue special areas unless they gain Ministerial approval for a change in status.

5.2 Buller Hospital

The estimated revenue for Buller Hospital utilises the volume data (either contracted or actual) supplied by WCDHB and combines this with the likely bed day rates for continuing care and medical inpatients and benchmarked information gained from similar health facilities elsewhere in New Zealand.

The estimated revenue excludes any revenue for community nursing and mental health as these services are excluded in the expenditure data supplied by WCDHB.

Buller Hospital	Contacted or Actual Volumes	Estimated Rate	Estimated Revenue
Medical Inpatients	2467 bed days	\$280	690,760
Continuing Care	6205 bed days	\$130	806,650
Emergency	1400 patient contacts	\$50	70,000
Radiology	3624 films	\$60	217,440
Meals on Wheels	14202 meals	\$3.60	51,127
Physio/OT	Est.		60,000
Outpatients	Est.		70,000
Maternity	30 Labour and Birth 40 Post Natal Stays 5 Ante Natal Classes	\$1363 \$2004 \$1225	128,775
Rental St John Mental Health	Est.		70,000
TOTAL			\$2,164,752

Buller Hospital	2002/03
Revenue (<i>estimated</i>)	2,164,752
Direct Expenditure (<i>actual</i>)	2,412,101
Contribution to Overheads (<i>estimated</i>)	(247,349)
Corporate Overhead (<i>actual</i>)	707,308
Surplus/(Deficit) (<i>estimated</i>)	(954,657)

It is likely that additional revenue and subsidies are channelled through Buller Hospital but the nature and the extent of these are unknown. Rural Hospitals have historically received subsidies or premiums from previous health authorities, due to the difficulty of making services viable in remote areas. These have frequently been continued under District Health Boards.

5.3 Implications

Regardless of any subsidies that may inflate the estimated revenues, in real terms it is very likely that both Buller Medical Service and Buller Hospital are incurring significant deficits under their current operating structure.

Other communities, when faced with their local health services incurring deficits that threaten their future, often focus on the extent of Corporate Overhead charges assigned to smaller health facilities. This figure is challenged because it is usually a major component of the deficit figure. With regard to this several comments are made:

- a) Large and/or complex organisations with multiple foci usually have high levels of corporate overhead. District Health Boards in particular have to maintain large structures due to their governance, risk management, human resource and reporting requirements etc. These costs must be apportioned to different service areas.
- b) Allocation methodologies in applying corporate overhead charges across services and facilities do vary between District Health Boards. Without seeing

those methodologies it is difficult to assess whether the WCDHB allocation of corporate overhead to Buller services is fair and reasonable.

- c) Smaller organisations, such as Community Health Trusts, often have significantly lower levels of overheads. This is due to their smaller, and often more streamlined, organisational structure and because they can better focus on making many small savings that increase the overall efficiency of the business.

The likely financial situation regarding Buller health services means that a change in structure is imperative if Buller is not to experience incremental cuts in services, as a result of WCDHB financial pressures, that alter their clinical viability long-term. The following sections outline some options for change.

6.0 IDENTIFIED SERVICE DELIVERY OPTIONS

The various health services delivered within the Buller District (excluding Reefton) have been analysed and the options going forward assessed. This section outlines these options.

6.1 Aged Care

The only long-term option considered viable for aged care services is private provider service provision.

Over the years there has been a major shift away from hospital-based aged care services. Rest home care has been well established in the private sector for a long time and, more recently, the trend has also been towards private provider service provision of continuing care. Only 2.6% of people currently receiving continuing care services in New Zealand are in a DHB operated facility. The Ministry of Health's competitive pricing model for aged care services has meant that the private sector has become the most efficient provider of services.

There are currently three aged care facilities in Buller. These are:

- | | |
|--|---------|
| • O'Connor Rest Home – Stage 2 | 33 Beds |
| • Kynnersley Rest Home – Stage 2 | 27 Beds |
| • Dunsford Ward, Buller Hospital – Continuing Care | 17 Beds |

Coast Health Care, the provider arm of WCDHB, is the service provider for Kynnersley Rest Home and Dunsford Ward. Whilst it is WCDHB's responsibility to ensure service coverage for these services, Coast Health Care does not have to be the provider.

Should WCDHB exit these services it will tender for a new service provider/s. With regard to this, Grafton Consulting Group has been informed that the Board of O'Connor Rest Home is looking at extending their facility to take over residents from Kynnersley Rest Home.

It is noted that it is possible no alternative providers will be found. In this case, Coast Health Care may have to be the provider of last resort. However, many private aged care organisations are looking at expanding their network of facilities throughout New Zealand and this represents a commercial opportunity.

A potential gap in aged care services for Buller is a secure dementia facility. Currently, people who require a secure facility are placed in Seaview psychogeriatric facility in Hokitika, a considerable distance away from their families. Whilst there may not be sufficient numbers to sustain a dementia unit in Buller, a combined continuing care/dementia unit may be viable under a private provider. This requires further investigation.

6.2 Karamea GP Services

The Karamea GP practice is currently a guaranteed minimum income practice in that \$52k of the GPs income is guaranteed due to the small population of approximately 700 registered patients. On top of this guaranteed minimum income figure there is a rural subsidy paid to the GP of \$26k and additional income can be generated by part-charges. It is estimated that the GP's income would be in excess of \$100k per annum.

The Karamea Medical Association Trust is a local organisation that owns furnished accommodation that is leased to the GP for \$145 per week. The Trust loan to purchase the GP home was provided by Buller District Council and the outstanding loan amount is approximately \$13k. In addition to owning the GP's home the Trust's role is also to facilitate the recruitment of GPs.

With regard to this latter point, a new GP is due to start working in Karamea shortly. The Karamea Medical Association Trust has been working closely with WCDHB to acquire this GP. The previous GP resigned due to ill-health.

WCDHB own the GP practice buildings and these are provided free of charge to the GP. WCDHB also employ two part-time Rural Nurse Specialists (who are also the practice nurses) for the area. These nurses have a very wide scope of practice and are extremely competent and resourceful. They are both PRIME (Primary Response in Medical Emergencies) trained and have been recently covering all medical emergencies in the area in the absence of a GP.

The challenge for Karamea is retaining a GP given the social and professional isolation that living and working in Karamea entails. However, it must be said that the new GP will be well supported by the Rural Nurse Specialists and the Karamea Medical Association Trust.

The Karamea Medical Association Trust has strongly stated that they want their GP to be resident in the area.

Given the above, three options are considered to viable for the future of Karamea GP services. These are:

1. Status Quo

Under this option the current situation is maintained.

Whilst the Karamea Medical Association Trust is keen for the guaranteed minimum income practice to continue, and it does provide a sufficient income for the GP, there is a 'boredom' risk. The GP only services around 700 patients and this equates to approximately 2.5 – 3 days work per week. This may be great for a GP who is keen to semi-retire and/or to exploit the wonderful recreational opportunities the area has to offer in their time off (recognising on-call responsibilities), but may equally foster boredom and dissatisfaction in others who may realise they like the challenge that a busier practice offers.

2. Karamea GP takes over Ngakawau Clinics

Under this option the Karamea GP would take over the service contract for Ngakawau from Buller Medical Service.

Ngakawau has approximately 950 registered patients and, combined with Karamea's 700 registered patients, a viable GP practice could be created. Such a practice would mean that the GP might not require all, or indeed any, of the guaranteed minimum income that they currently receive. This is a potential saving for WCDHB.

It is noted that a 1600 patient practice is financially viable according to Medical Assurance. Indeed, they state that rural practices like this often generate more income than their urban counterparts.

The self-employed GP would be resident in Karamea but split their time between Karamea and Ngakawau, with perhaps ½ day per fortnight in Westport also. They would have to structure their clinic times in a manner that suited the needs of themselves and both of the communities they serve.

Under this option it is recommended that WCDHB continue to employ the Rural Nurse Specialists in both areas and provide the practice facilities to the GPs at nominal or no charge.

It is also recommended that either the Karamea Medical Association Trust or WCDHB purchase a vehicle for the GP (given the travel involved) and lease it on a self-funding basis. Having the correct support infrastructure in place, such as a house, car and practice rooms, is essential in recruiting and retaining GPs in rural areas.

One of the advantages of this option is that Ngakawau residents will have continuity of care by having one GP dedicated to their area. The Buller Medical Service GPs vary depending upon availability. Another advantage is that it provides a GP with a potentially lucrative and challenging practice, with greater opportunity for closer professional linkages with colleagues in Westport.

Travel time may be an issue for a GP with this option. It is also noted that adverse weather conditions occasionally cut off Karamea for short periods and this may impact on the delivery of clinics in either locality. However, this is infrequent and could be managed.

3. Resident Karamea GP employed by Buller Community Trust

Under this option the Karamea GP would be employed by a Buller Community Trust. They would either be employed part or full-time, depending if they were covering Ngakawau or not.

This option is only viable if done in conjunction with a Buller Community Trust taking over Buller Medical Service. All GPs would be employed via an operating company, owned by the Trust, and all GP revenue and expenditure would be managed via this company.

While this option could work there are no obvious advantages over and above the other two options. It is also unlikely to generate support from the Karamea Medical Association Trust as they are wary of any Buller Community Trust being responsible for their health services.

6.3 Ngakawau GP Services

Given that Ngakawau is straddled between Westport and Karamea it makes sense for it to be either serviced by the Karamea-based GP or the Westport-based GPs.

Ngakawau is not a viable practice on its own, nor can a Karamea-type guaranteed minimum income situation be justified as it can be serviced reasonably easily by a GP on either side.

Therefore the options for Ngakawau are for it to continue to be serviced by Buller Medical Service, or by the Karamea GP (refer to Section 6.2 above).

WCDHB should continue to employ the part-time Rural Nurse Specialist, who has recently started work in Ngakawau, and provide the GP practice facility.

6.4 Buller Medical Service

Buller Medical Service is owned and managed by WCDHB. It currently has 4625 registered patients (excluding Ngakawau) shared between 4 GPs (3.5 FTEs). There is approximately 1 practice nurse employed per GP (3.8 FTEs).

Another GP (0.9 FTE) is also employed through Buller Medical Service to provide medical cover for Buller Hospital's medical inpatients, emergency and continuing care residents. They also assist with any overflow patients from the other GPs. This position has recently been vacant and as a consequence there has been a period whereby no medical inpatients have been admitted to Buller Hospital.

Buller Medical Service currently covers Ngakawau patients with clinics held each morning depending upon GP availability. The Ngakawau practice nurse is also employed through Buller Medical Service.

The Buller Medical Service GPs provide medical cover for O'Connor and Kynnersley Rest Home and this takes up approximately 3 hours of GP time per week.

The on-call roster is 1 in 5 weekdays and weekends (town cover includes Dr Ken Mills, but he does not cover the Hospital). Buller Medical Service has weekend clinics

on Saturday and Sunday from 10am-11am and 5pm-6pm. Every 5th weekend there are no clinics at Buller Medical Service as they are delivered from Ken Mill's practice rooms.

With regard to Buller Medical Service accounts, all creditors are paid directly by WCDHB after being certified correct. Although no accounts for Buller Medical Service were provided, except the expenditure information referenced in Section 5), a comment was made by the Practice Manager that Buller Medical Service usually runs at a loss.

WCDHB has recently approved \$75k capex for Buller Medical Service for renovations to their practice rooms and a new server for their computer system.

The GPs at Buller Medical Service have expressed frustration over their current working conditions, especially what they perceive as WCDHB bureaucracy that they consider impacts their ability to run the business efficiently. Whilst not necessarily opposed to the idea of a Community Trust taking over Buller Medical Service they did not want to swap one unresponsive employer (i.e. WCDHB) with another and they wanted to be actively engaged in any process and decisions regarding the future.

As part of the process for preparing this report, Grafton Consulting Group talked to Dr Ken Mills, the only GP practicing independently in Westport. He made the following comments regarding Buller Medical Service:

- Buller Medical Service was government subsidised (via WCDHB) and could not have survived on the income it has produced until now. It does not charge for things that self-employed GPs are required to in order to make a viable practice.
- WCDHB has never come clean on Buller Medical Service financials, with expenses being fudged and revenue streams disguised.
- The GPs working for Buller Medical Service have no ownership of what goes on in the practice, especially with regard to managing inefficiencies.
- Buller Medical Service does not have a stable workforce. Patients are being neglected because of a lack of continuity of care, because the GPs are not responsible for the practice as a whole (due to their employee status), and clinical follow-ups are sometimes deficient.

Grafton Consulting Group considers that there is a certain amount of validity regarding the financial aspects of Dr Mill's comments but is not in a position to ascertain the validity of the clinical aspects of his comments.

Given the above, three options can be considered for the future of Buller Medical Services. These are:

1. Status Quo

Under this option the current situation is maintained, with WCDHB continuing to own and operate Buller Medical Services.

While the current situation is workable from the perspective of ensuring the delivery of primary care services to Westport and surrounding areas it is doubtful that WCDHB wishes to continue owning and operating Buller Medical Services as it is not part of its core business (and a likely contributor to its deficit). Further, the GPs are unhappy with the working conditions under the current structure, as outlined above, and this is impacting on the retention of GPs (with one recently resigning).

2. Buller Medical Services Privatised

Under this option Buller Medical Service would be owned and operated by either 2 GP shareholders or it would become a collectively owned practice by all GPs who are self-employed. Negotiations would be required with WCDHB over the purchase of the practice.

Under this option it is recommended that the practice does not provide medical cover for the hospital, except on the after-hours roster. The rationale for this is covered in Section 6.5.

Depending upon the Karamea option, this practice may or may not cover Ngakawau. If it did not cover Ngakawau the number of GPs would need to be reduced from 3.5 FTE to 3 FTEs to give a financially viable doctor: patient ratio of 1:1540 (4625 registered patients ÷ 3 FTEs). If the practice does cover Ngakawau 3.5 FTE GPs could be sustained.

A major disincentive for GPs wanting to practice in rural areas is any requirement to purchase practice facilities (and homes) and be tied into a long-term 'bricks and mortar' investment that may be very difficult to sell at some future date. Many GPs want to come to a rural area and practice for a certain period of time without making a permanent commitment to living there long-term.

This does not necessarily mean that GPs coming to a rural area are only interested in a short-term period of service. However, it does reflect the fact that GPs, like other people, want to have a certain capacity for mobility given the range of lifestyle and career choices that are available in society today.

Given this, it is recommended that under this option a Buller Community Trust own a Buller Medical Service practice facility and leases this facility to the GPs on a self-funding principle. Building a new GP facility, preferably integrated into a new hospital facility, is recommended given the less than optimal state of the current Buller Hospital/Buller Medical Service building.

It is also recommended that a Buller Community Trust purchase good quality furnished GP housing and vehicles and lease these to GPs, also on a self-funding principle. It is considered that there are always going to be incentives required to recruit GPs to Westport and provision of practice facilities, accommodation and a car will go some way to addressing this requirement.

Under this option Dr Ken Mills may consider amalgamating his practice with Buller Medical Service as the structure would enable him to continue to be self-employed but in an environment that may reduce his overheads due to the potential savings achievable within a collective practice.

The main advantage of this option is that the GPs will have a financial stake in ensuring an efficient and well-managed practice. In the long-term this will be beneficial to the people of Buller. Although Buller Medical Service is estimated to be making a loss a present the main contributing factors to this are its current operational structure, the allocation of WCDHB corporate overheads, and few incentives for staff to manage the practice in the most efficient manner possible.

It is acknowledged that there are always risks involved in running a business versus the security of receiving a guaranteed employee pay check. However, there will be sufficient external support and incentives in place for GPs, via a Buller Community Trust, to lessen these risks.

Under this option there is also the potential for the GPs to increase their income. Using \$826k as the estimated revenue (refer Section 5.1) for 3.5 FTE GPs and a 50% expense ratio (which Medical Assurance advises is the average ratio), this equates to a net income of \$118k per GP. Utilising the actual expenditure figure on Medical Staff (GP salaries) supplied by WCDHB, the likely incomes at present average \$93k per GP.

3. Buller Community Trust Owns and Operates Buller Medical Service

Under this option a Buller Community Trust takes over ownership and management of Buller Medical Service from WCDHB.

Buller Community Trust would own the Buller Medical Service practice facility, and as with option 2 it is recommended that this be a new facility. The Trust would form an operating company and appoint directors to this company. The operating company would hold all service contracts and employ a Practice Manager, the GPs, nursing and administration staff.

Again, as with option 2, Buller Medical Service may or may not cover Ngakawau depending upon the Karamea option.

The new structure also may or may not involve Dr Ken Mills, but it is very likely he would expect Buller District Council or a Buller Community Trust to purchase his practice (probably the 'goodwill' and equipment, with the practice property being sold) if he was going to become an employee of Buller Medical Service.

It is again recommended that a Buller District Trust purchases furnished accommodation and cars, to be leased to GPs on a self-funding principle, as a recruitment and retention incentive.

The advantage of this option over the status quo is that the practice will likely be more financially viable as its overheads will be reduced (with no WCDHB corporate overhead allocation) and its operation managed more efficiently than is possible at a distance by WCDHB. It also provides the community with more local control over their health services.

A potential disadvantage is that the GPs may find working under a Buller Community Trust little different from working for WCDHB, and thus the level

of work dissatisfaction may continue. If this turns out to be the case then the level of GP turnover will likely continue. It is noted that the current Buller Medical Service GPs seem to be seeking autonomy and freedom to make business decisions, yet they are always likely to experience some constraints with being an employee, even if they are managed more directly by a local organisation.

6.5 Buller Hospital

Buller Hospital is a satellite rural hospital feeding into the base hospital in Greymouth that is 100 kms to the South. The hospital services a catchment area of 9 thousand people. The following is an overview of current services:

Medical Inpatients

- Foote Ward - 8 beds (licensed for 6 patients)
- % Occupancy (Sept 02 – Aug 03) = 80.7%
- Actual Volumes (July 02-June 03) =1993 bed days
- Average Length of Stay = 2.27 days
- Medical cover provided by GP employed through Buller Medical Service

Maternity

- Kawatiri Ward – 4 postnatal beds and 1 birthing suite
- Labour and Birth (July 02 – June 03) = 26
- Postnatal Stays (July 02 – June 03) = 38
- Days utilised (Sept 02-Aug 03) = 141.5 days

Continuing Care

- Dunsford Ward – 18 beds (licensed for 17)
- % Occupancy (July 02 – June 03) = 89.8%
- Actual Volumes (Sept 02 – August 03) = 5,573
- Average Length of Stay = 397.19 days
- Medical cover provided by GP employed through Buller Medical Service

Palliative Care

- Dunsford Ward – 1 bed
- % Occupancy (Sept 02 – Aug 03) = 24.9%
- Actual volumes (Sept 02 – Aug 03) = 91 bed days
- Average Length of Stay = 6.46 bed days
- Medical Cover provided by GP employed through Buller Medical Service

Emergency

- Actual number of patient contacts = 1482
- Medical Cover provided by RNs in Foote Ward and GP employed through Buller Medical Service

Outpatients (Visiting Specialist)

(clinics and attendances over last financial year)

- ACC Orthopaedics 3 clinics / 79 attendances
- Pre-Anaesthetics 52 clinics / 106 attendances



- Diabetes 8 clinics / 103 attendances
- ENT 1 clinic / 4 attendances
- General Medicine 23 clinics / 268 attendances
- General Surgery 46 clinics / 609 attendances
- Gynaecology 4 clinics / 43 attendances
- Ophthalmology 8 clinics / 283 attendances
- Orthopaedics 31 clinics / 688 attendances
- Paediatric Medical 15 clinics / 172 attendances
- Psychiatric 378 attendances
- Urology 1 clinic / 5 attendances

Meals on Wheels

- Total number of meals for last 12 months = 14, 202
- Average number of clients = 66

Radiology

- Number of x-rays (Sept 02 – Aug 03) = 3624
- 628 inpatient and 2996 GP and self referred

An initial analysis has been carried out of the services delivered from Buller Hospital in order to establish what might be a more efficient service configuration for the future. This analysis examined the current utilisation volumes, as outlined above, the types of services required in Westport given the distance of the various Buller communities from the base hospital, and whether the viability of certain services could be maintained in terms of having adequate staffing levels (including specialist staff at the Base Hospital) for clinical safety.

The following table (overleaf) compares the existing service configuration with a new service configuration that would be appropriate and sustainable for the needs of the Buller community.

For the suggested new service configuration it is recommended that a new, smaller health facility be built. It is noted that Buller Hospital is an old facility that is not optimally configured from either a modern service delivery or staffing perspective and its operational viability would be further diminished if there were no continuing care ward or kitchen, as suggested in the new configuration. If a new facility was built it might be better for it to be on a new site so as to maximise the rationalisation of the current Buller Hospital land. This would need to be investigated.

It is to be emphasised that the suggested new configuration is the result of a preliminary analysis only and would require greater refinement should this project proceed to the next stage. Further analysis would also be required in order to ascertain its financial viability, in terms of any operational budget and capital cost, should a new facility be part of the equation.

Service	Existing Configuration	New Configuration
<i>Medical Inpatients</i>	8 beds Maximum stay 72 hours Medical Cover provided by Buller Medical Service GP	6 beds (1 x isolation room/swing bed for maternity) Maximum stay 48 hrs Medical Cover to be provided

		by a MOSS employed by the Hospital during regular hours. After-hours cover provided by rostered GPs.
<i>Maternity</i>	4 beds	2 beds
<i>Continuing Care</i>	17 beds	None Private Provider Service Provision
<i>Palliative Care</i>	1 bed	1 bed
<i>Emergency</i>	Level II A&M	Level II A&M
<i>Outpatients</i>	ACC Orthopaedics Pre-Anaesthetics Diabetics ENT General Medicine General Surgery Gynaecology Ophthalmology Orthopaedics Paediatric Medical Psychiatric Urology	Discontinue ENT and Urology clinics but continue others
<i>X-ray</i>	Plain Film Service	Plain Film Service
<i>Physiotherapy</i>	In-house Physiotherapist	Public Private Partnership – utilising private physio in town for public work in hospital
<i>OT</i>	In-house OT	In-house OT
<i>District/Community Nursing</i>	Provided	Provided at current levels
<i>Mental Health</i>	A&D CAFs CMH	A&D CAFs CMH
<i>Public Health</i>	Provided	Provided at current levels
<i>Hydrotherapy</i>	Pool Facility	No Pool Facility
<i>Surgical Bus</i>	Visits Every 5 Weeks	Review Clinical Efficiency
<i>Kitchen</i>	Provides meals to Hospital and Kynnersley Patients	No Kitchen – Meals Outsourced

It is noted that the medical cover for the Hospital is currently provided by GPs at Buller Medical Service, who are contracted to provide 24-hour cover by WCDHB. One GP at Buller Medical Service is largely dedicated to the Hospital during normal working hours, while the others provide after-hours cover in the evenings and weekends. In discussions with the Westport GPs however, there was dissatisfaction expressed as to the current arrangements for hospital cover. Some GPs do not like covering the hospital (with some locums refusing to do so), and sometimes feel ill-equipped to do so. This is cited as a reason for GPs leaving the district. It has also been reported that on occasions a GP has arrived in Westport only to find they will be covering the hospital and, contrary to their expectations, not providing GP services. This has led to high levels of discontent.

Given the above, a MOSS (Medical Officer Special Scale) should be employed through the hospital, rather than Buller Medical Service, for regular daytime medical

cover. It is believed that this will more clearly delineate the requirements and expectations of this role to potential employees and ensure the Hospital has someone with the appropriate level of professional expertise to cope with the demands a small rural hospital. However, there is no way around the GPs providing some after-hours cover for the hospital as it would be uneconomic to employ 24-hour/7day a week MOSS cover.

Having outlined a suggested new service configuration, the following options can be considered for the future of Buller Hospital. These are:

1. Status Quo

Under this option the current situation is maintained with WCDHB continuing to operate Buller Hospital.

While clearly a 'do nothing' approach should always be considered it is unlikely to be a long-term option. The likely financial situation of Buller Hospital means that some changes are inevitable. In this, WCDHB has signalled that it is keen for a service reconfiguration to put the Hospital on a more sustainable footing, be it under its management or that of a Community Trust.

There is also clearly a perception in the community that if the Status Quo is maintained a slow 'death by a thousand cuts' may be the Hospital's fate.

2. New Service Configuration

- *Existing Facility*
- *WCDHB Ownership and Service Provision*

3. New Service Configuration

- *New Facility*
- *WCDHB Ownership and Service Provision*

Under these two options the new suggested service configuration is implemented, as outlined above, using either the existing facility, or a new facility. The facility will be owned by WCDHB and its provider arm, Coast Health Care, will deliver the services.

As previously stated, Buller Hospital is an old facility that is not optimally configured from either a modern service delivery or staffing perspective. The new service configuration would further diminish its operational viability given that the kitchens would be closed and there would be no continuing care ward. However, it may be possible to reconfigure the existing Hospital structure to make a new service configuration workable from an operational perspective.

It is noted that the costs of reconfiguration versus building a new facility are often similar. While reconfiguration may be a cheaper option, the advantage of a new facility is that it provides an up-to-date clinical environment and maximises staffing and resources. The constraints of existing structures in the reconfiguration of old buildings often result in less efficiencies being achievable.

With regard to service provision, the advantage of Coast Health Care is that it provides a level of comfort to the community around risk and clinical safety because of the fact that it is part of WCDHB and a larger organisation that can call on other resources. While this level of comfort is largely based around perception, there is concern that if a Community Trust takes over service provision there will not be adequate management skills within the community (and thus on the Trust board) for the Hospital to operate effectively and safely.

The disadvantage of continued WCDHB ownership and operation of health service delivery in Buller is that the community has little direct control over the future of their health services. It will also be harder to put the hospital on a financially sustainable footing due to the level of WCDHB corporate overhead that will still need to be maintained.

4. New Service Configuration

- *New Facility owned by a Buller Community Trust*
- *WCDHB Service Provision*

Under this option the new suggested service configuration is implemented utilising a new facility owned by a Community Trust. WCDHB's provider arm, Coast Health Care, will continue to deliver the health services.

The advantages of a new health facility have been briefly outlined above. However, obtaining the capital for a new facility, if that was proved to be the most financially viable and efficient option, may be problematic for WCDHB. The Ministry of Health has limited funding available within its capital funding envelope and has recently implemented a prioritisation process for capital projects that all DHBs must go through. Not all projects will receive funding through this process.

Therefore the advantage of this option is that the community could raise the required capital via its own sources. It could then build the facility and subsequently lease it to WCDHB. If there was any revenue generated to the Community Trust through this lease long-term once loans are paid off, then this could be channelled into new services, equipment or incentives for medical personnel.

The advantage of Coast Health Care continuing to be the provider has been outlined above.

5. New Service Configuration

- *New Facility owned by a Buller Community Trust*
- *Buller Community Trust Service Provision*

Under this option a Buller Community Trust would build and own a new health facility and, via an operating company, hold service contracts to deliver local health services.

This model has successfully operated in other parts of the country, such as Gore and Balcultha. In these areas a Community Trust, on behalf of their local communities, raised capital to build new health facilities and took over

service delivery. Since the commencement of these new operations, loans for the buildings have been paid back on time and there has been an increase in local services through efficient management of the service contracts.

The main advantage under this option is that the community can take full control of their health services, with the potential for more services to be delivered within the available funding due to a more streamlined structure, with lower overheads, and the aforementioned efficient management.

The experience of other communities where a Trust is operating is that there needs to be the 'right' people, with a balance of expertise, as board members and directors and that this needs to be sustained long-term. There is a perception by some stakeholders that this may not be achieved in Buller.

The main disadvantage of this option is that the community takes all of the clinical and financial risks associated with local health service delivery.

Section 7 outlines some service delivery scenarios based on combinations of the various options outlined in this section.

7.0 POSSIBLE FUTURE SERVICE STRUCTURES – 7 SCENARIOS

This section takes the various options outlined in Section 6 and combines them into 7 different future service structure scenarios. With each of the scenarios (excluding Scenario A – Status Quo) a diagram has been included to illustrate the service structure and key organisational relationships and linkages.

7.1 Scenario A

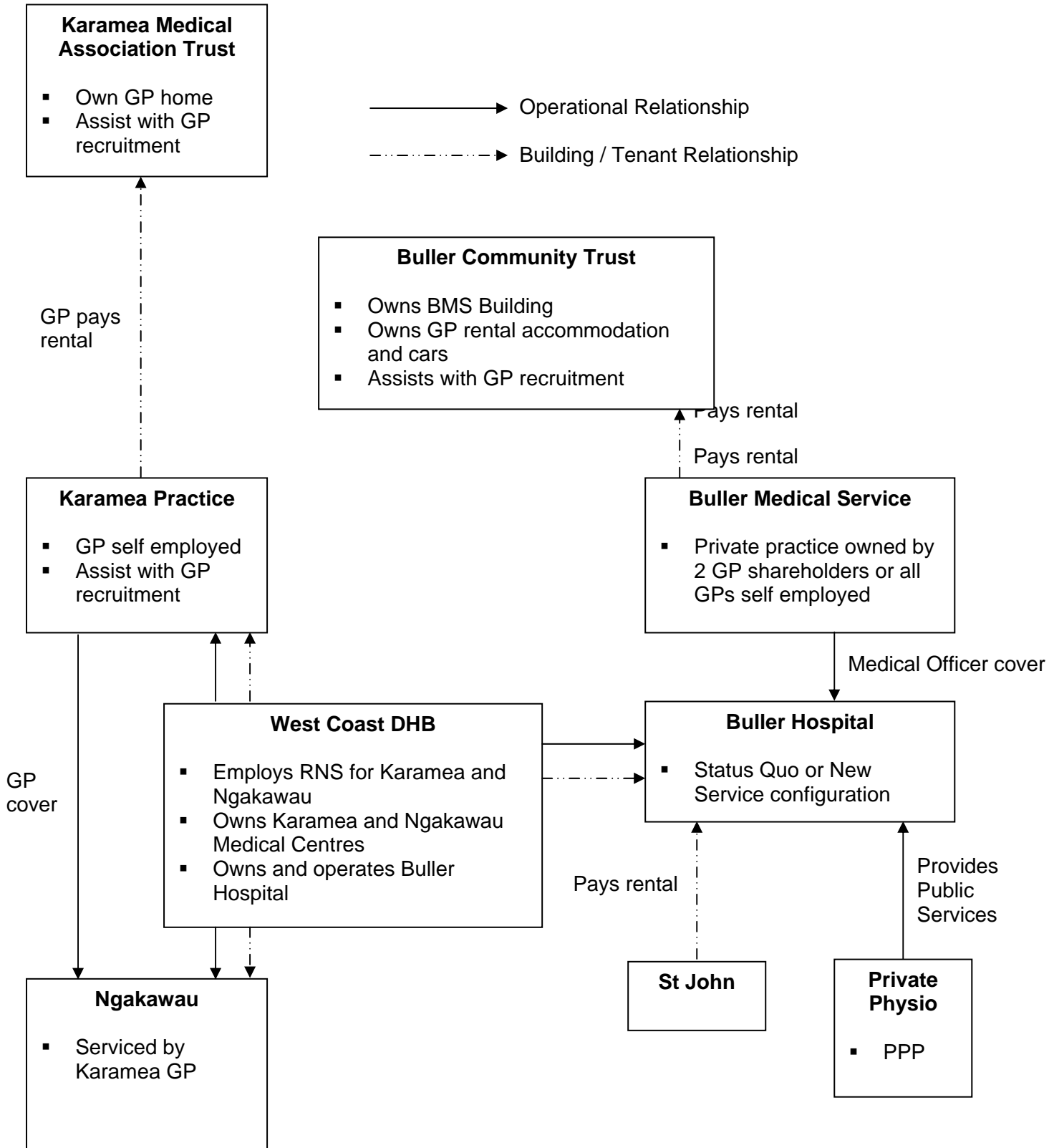
Buller Hospital	<ul style="list-style-type: none"> • Status Quo
<i>Karamea</i>	<ul style="list-style-type: none"> • Status Quo
<i>Ngakawau</i>	<ul style="list-style-type: none"> • Status Quo
<i>Buller Medical Service</i>	<ul style="list-style-type: none"> • Status Quo

7.2 Scenario B

Buller Hospital	<ul style="list-style-type: none"> • Status Quo OR New Service Configuration – WCDHB owned and operated (old or new facility)
<i>Karamea</i>	<ul style="list-style-type: none"> • Self-employed resident Karamea GP • GP takes over Ngakawau Clinic • Rural Nurse Specialists employed by WCDHB • Medical Centre buildings owned by WCDHB
<i>Ngakawau</i>	<ul style="list-style-type: none"> • Serviced by Karamea GP • Rural Nurse Specialist Employed by WCDHB • Medical Centre buildings owned by WCDHB
<i>Buller Medical Service</i>	<ul style="list-style-type: none"> • Business Privatised – At least 2 GP shareholders or all GPs self-employed • New Facility – owned by Buller Community Trust and leased to BMS

	<ul style="list-style-type: none"> • Will cease covering Ngakawau • Will cease Medical Officer cover for Hospital except after hours⁺ <p>⁺ Only if new service configuration for Hospital</p>
<i>Aged Care (Continuing Care/Kynnersley)</i>	<ul style="list-style-type: none"> • WCDHB Exits Service* • Private Provider Service Provision* <p>*Only if new service configuration for Hospital</p>
<i>Buller Community Trust</i>	<ul style="list-style-type: none"> • Owns Buller Medical Services building • Owns rental properties for lease to GPs • Owns cars for GPs to lease • Assists with GP recruitment
<i>Karamea Medical Association Trust</i>	<ul style="list-style-type: none"> • Owns Karamea GP rental accommodation • Assists with Karamea GP recruitment

Scenario B – Structure / Relationship Diagram



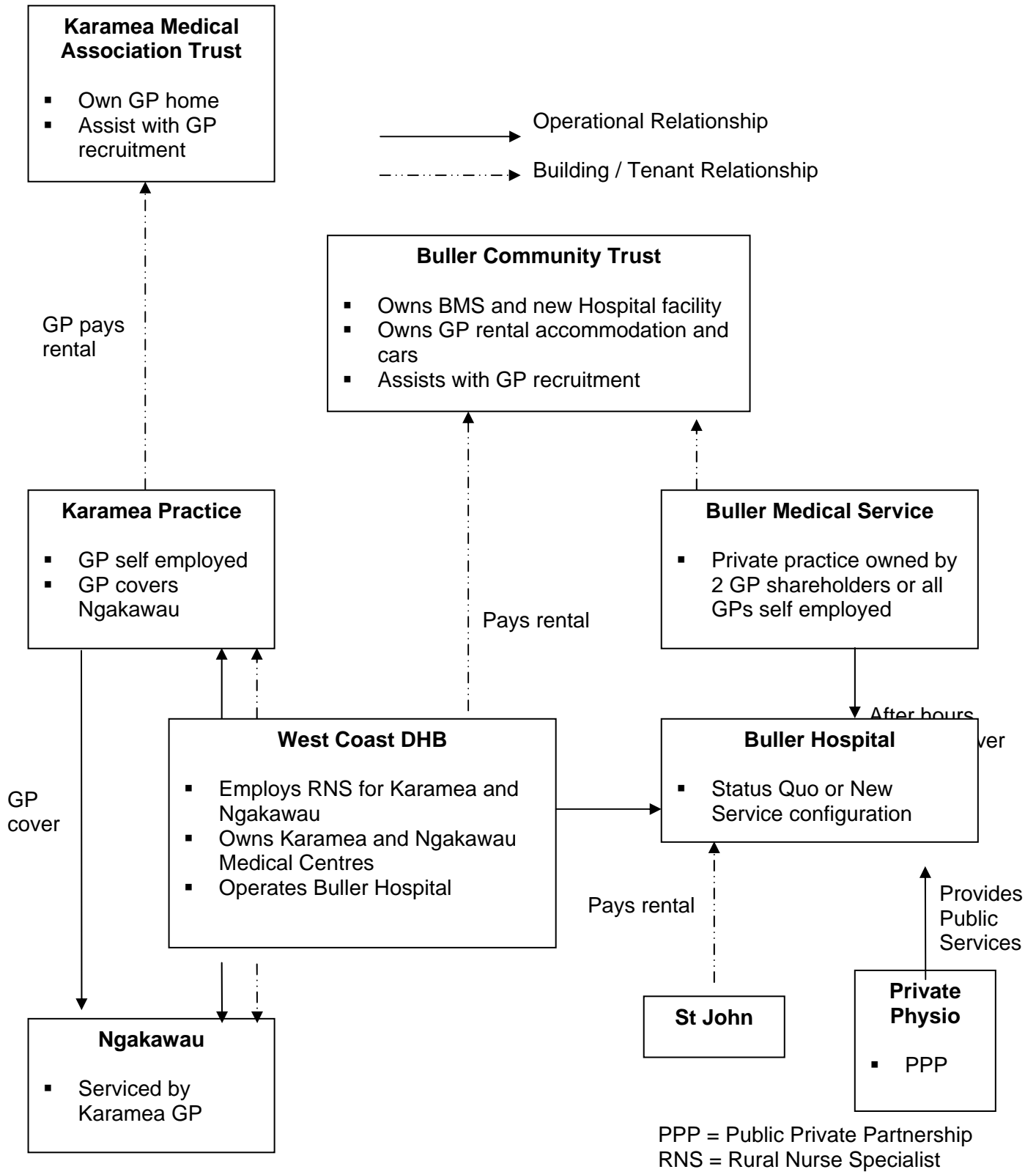
* only if Status Quo for Hospital

PPP = Public Private Partnership
 RNS = Rural Nurse Specialist

7.3 Scenario C

Buller Hospital	<ul style="list-style-type: none"> • New Service Configuration • WCDHB Service Provision • Medical Officer employed through Hospital not through Buller Medical Service • New Facility – Buller Community Trust Owns building and leases to WCDHB
<i>Karamea</i>	<ul style="list-style-type: none"> • Self-employed resident Karamea GP • GP takes over Ngakawau Clinic • Rural Nurse Specialists employed by WCDHB • Medical Centre buildings owned by WCDHB
<i>Nagakawau</i>	<ul style="list-style-type: none"> • Serviced by Karamea GP • Rural Nurse Specialist employed by DHB • Medical Centre buildings owned by WCDHB
<i>Buller Medical Service</i>	<ul style="list-style-type: none"> • Business Privatised – At least 2 shareholders or all GPs self-employed • New Facility – owned by Buller Community Trust and leased to BMS • Will cease covering Ngakawau • Will cease Medical Officer cover for Hospital except after hours
<i>Aged Care (Continuing Care/Kynnersley)</i>	<ul style="list-style-type: none"> • WCDHB Exits Service • Private Provider Service Provision
<i>Buller Community Trust</i>	<ul style="list-style-type: none"> • Owns Buller Medical Services building and leases to BMS • Owns new Hospital Buildings and leases to WCDHB • Owns rental properties for lease to GPs on a self-funding principle • Owns cars for GPs to lease on a self-funding principle • Assists with GP recruitment
<i>Karamea Medical Association Trust</i>	<ul style="list-style-type: none"> • Owns Karamea GP rental accommodation • Assists with Karamea GP recruitment

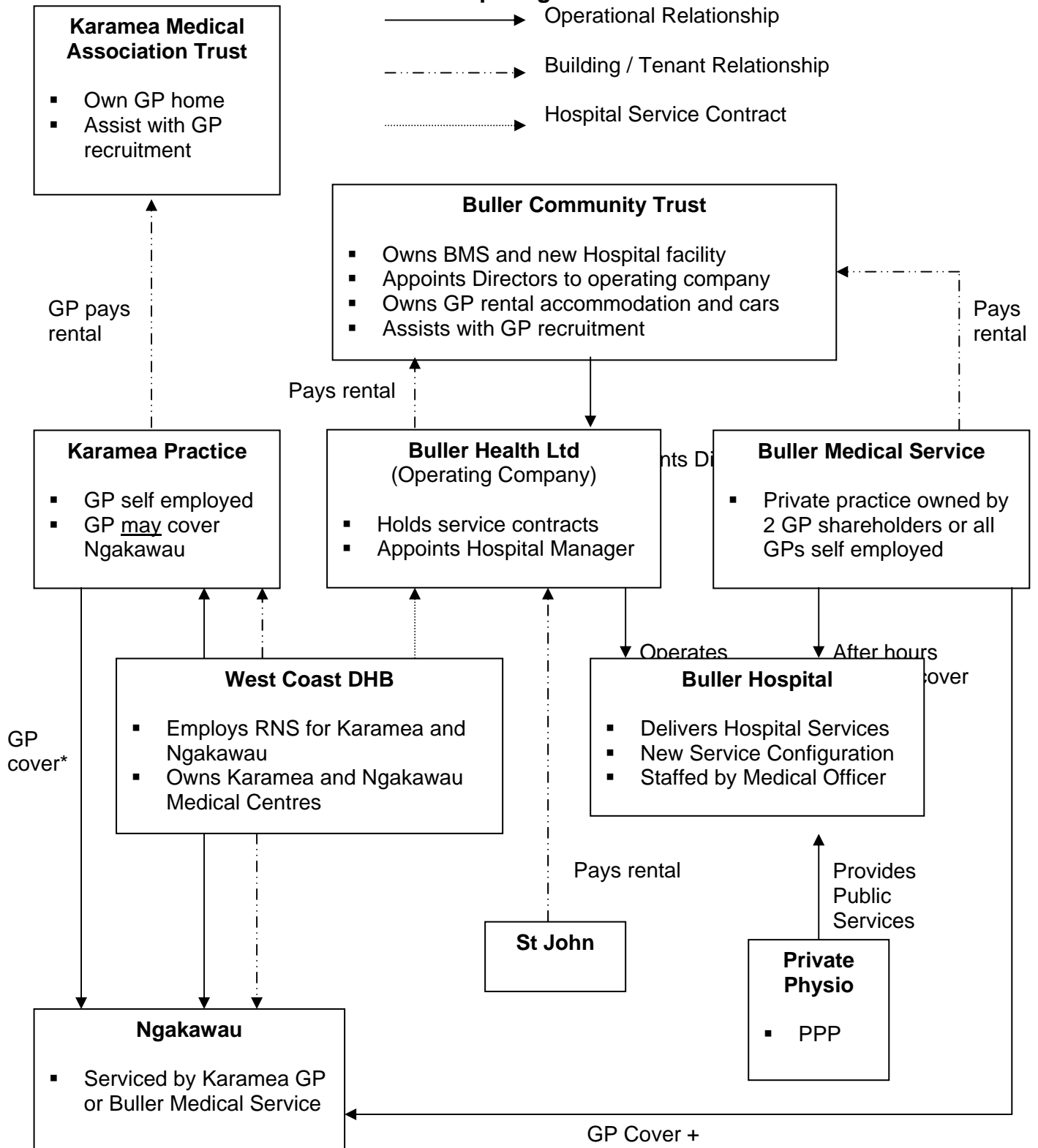
Scenario C – Structure / Relationship Diagram



7.4 Scenario D

Buller Hospital	<ul style="list-style-type: none"> • New Service Configuration • Buller Community Trust Operation of Hospital Service Provision • Medical Officer employed through Hospital not through Buller Medical Service • New Facility – Buller Community Trust Owns Building
<i>Karamea</i>	<ul style="list-style-type: none"> • Status Quo OR Self-Employed Resident Karamea GP takes over Ngakawau Clinic • Rural Nurse Specialists employed by WCDHB • Medical Centre buildings owned by WCDHB
<i>Nagakawau</i>	<ul style="list-style-type: none"> • Serviced by Karamea GP OR serviced by Buller Medical Service • Rural Nurse Specialist employed by WCDHB • Medical Centre buildings owned by WCDHB
<i>Buller Medical Service</i>	<ul style="list-style-type: none"> • Business Privatised – at least 2 GP shareholders or all GPs self-employed • New Facility – owned by Buller Community Trust and leased to BMS • Either will or will not operate Ngakawau Clinics (depending on Karamea option) • Will cease Medical Officer cover for Hospital except after hours
<i>Aged Care (Continuing Care/Kynnersley)</i>	<ul style="list-style-type: none"> • WCDHB Exits Service • Private Provider Service Provision
<i>Buller Community Trust</i>	<ul style="list-style-type: none"> • Owns new Hospital facility • Owns Buller Medical Services building • Operates Buller Hospital Service Provision – via operating company • Owns rental properties for lease to GPs on a self-funding principle • Owns cars for GPs to lease on a self-funding principle • Assists with GP recruitment
<i>Karamea Medical Association Trust</i>	<ul style="list-style-type: none"> • Owns Karamea GP rental accommodation • Assists with Karamea GP recruitment

Scenario D – Structure / Relationship Diagram



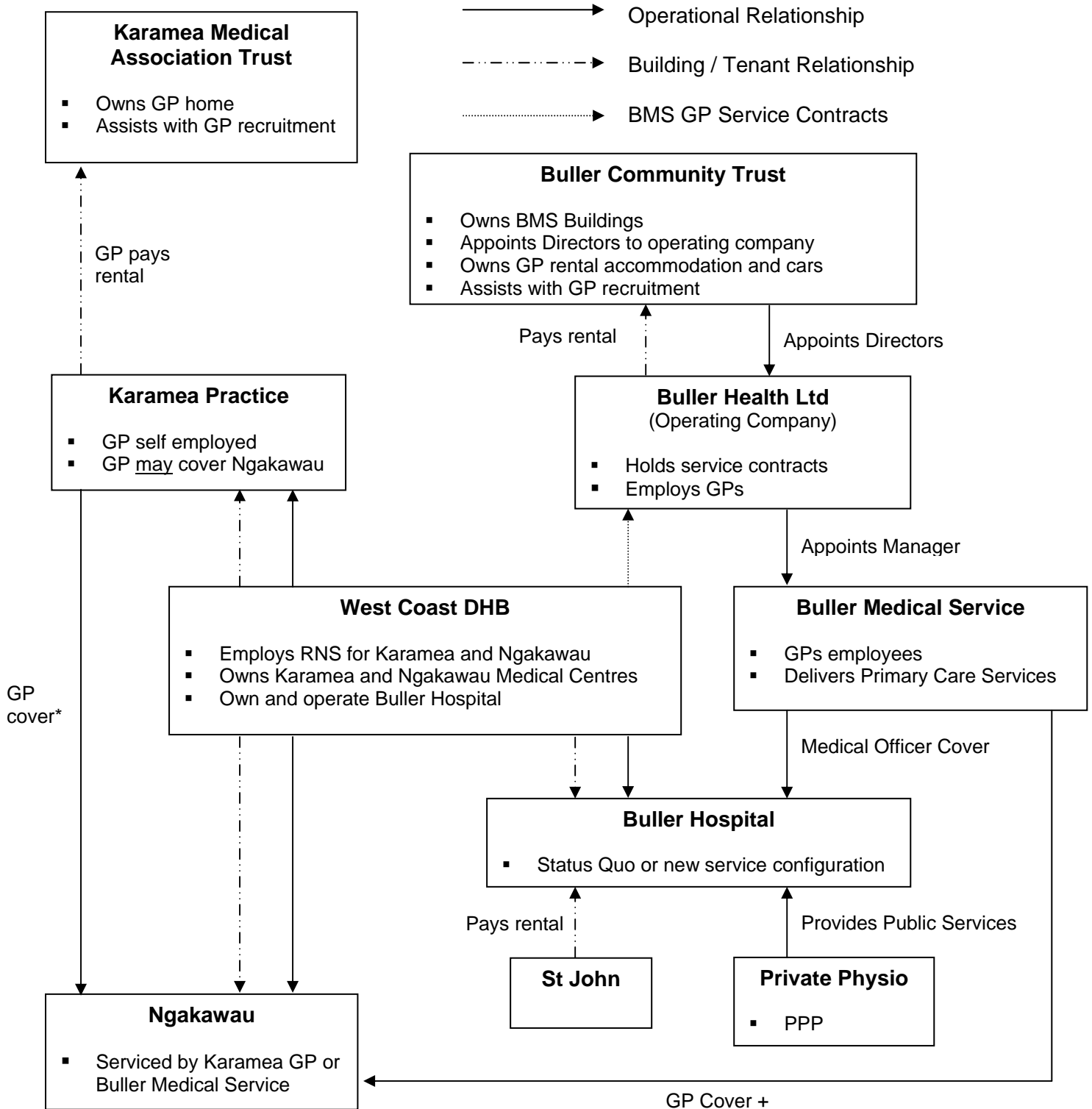
* If GP takes over Ngakawau
 + If Buller Medical Service covers Ngakawau

PPP = Public Private Partnership
 RNS = Rural Nurse Specialist

7.5 Scenario E

Buller Hospital	<ul style="list-style-type: none"> • Status Quo OR New Service Configuration - WCDHB owned and operated (old or new facility)
<i>Karamea</i>	<ul style="list-style-type: none"> • Status Quo OR Self-Employed Resident Karamea GP takes over Ngakawau Clinic • Rural Nurse Specialists employed by WCDHB • Medical Centre buildings owned by WCDHB
<i>Nagakawau</i>	<ul style="list-style-type: none"> • Serviced by Karamea GP OR serviced by Buller Medical Service • Rural Nurse Specialist employed by WCDHB • Medical Centre buildings owned by WCDHB
<i>Buller Medical Service</i>	<ul style="list-style-type: none"> • Business Owned by Buller Community Trust with GP employees • New Facility – owned by Buller Community Trust • Either will or will not operate Ngakawau Clinics (depending on Karamea option) • Will cease Medical Officer cover for Hospital except after-hours⁺ <p>+ Only if new service configuration for Hospital</p>
<i>Aged Care (Continuing Care/Kynnersley)</i>	<ul style="list-style-type: none"> • WCDHB Exits Service • Private Provider Service Provision
<i>Buller Community Trust</i>	<ul style="list-style-type: none"> • Owns and operates Buller Medical Services • Owns rental properties for lease to GPs on a self-funding principle • Owns cars for GPs to lease on a self-funding principle • Assists with GP recruitment
<i>Karamea Medical Association Trust</i>	<ul style="list-style-type: none"> • Owns Karamea GP rental accommodation • Assists with Karamea GP recruitment

Scenario E – Structure / Relationship Diagram



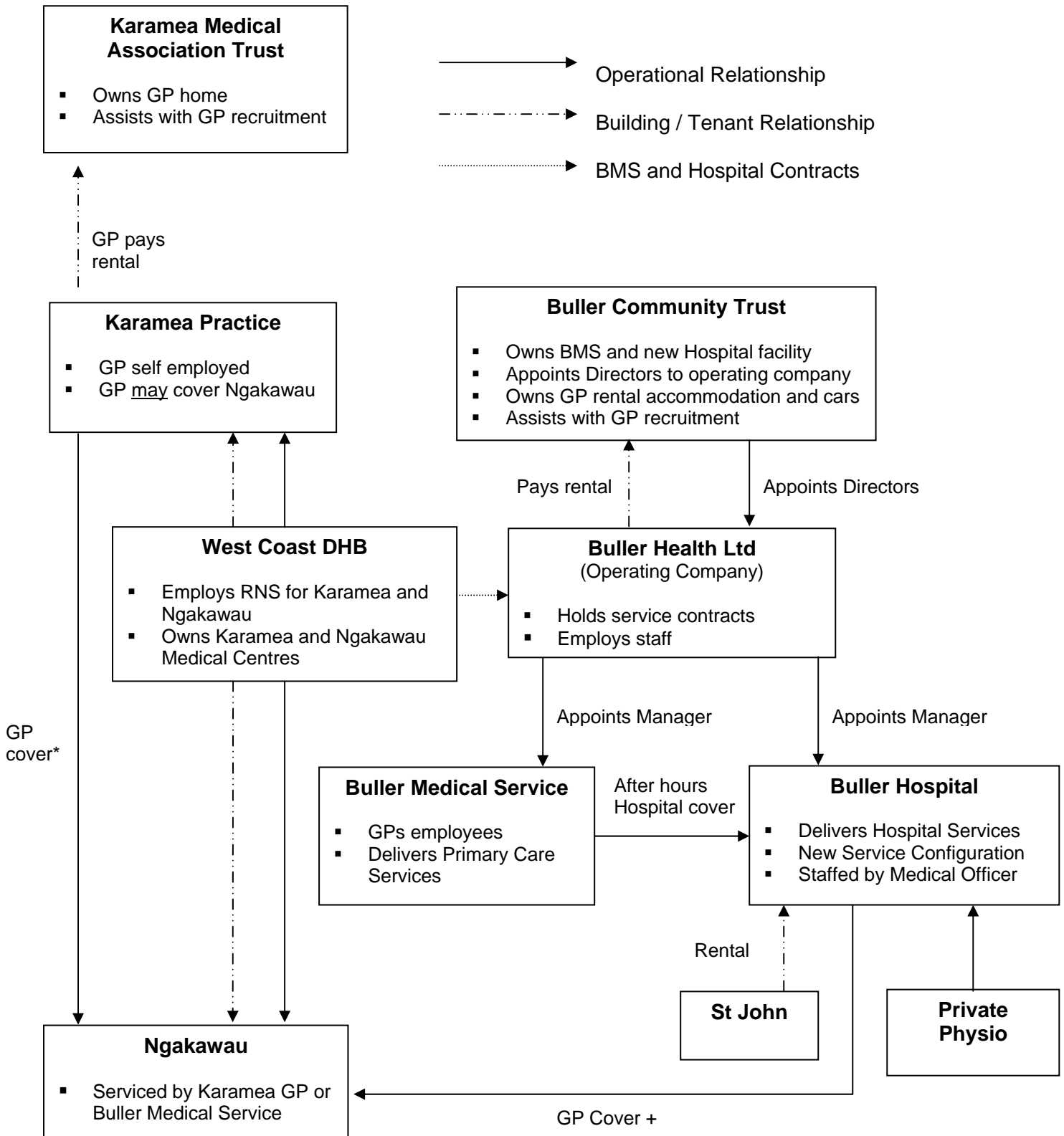
* If GP takes over Ngakawau
 + If Buller Medical Service covers Ngakawau

PPP = Public Private Partnership
 RNS = Rural Nurse Specialist

7.6 Scenario F

Buller Hospital	<ul style="list-style-type: none"> • New Service Configuration • Buller Community Trust Operation of Hospital Service Provision • Medical Officer employed through Hospital not through Buller Medical Service • New Facility – Buller Community Trust Owns Building
<i>Karamea</i>	<ul style="list-style-type: none"> • Status Quo OR Self-Employed Resident Karamea GP takes over Ngakawau Clinic • Rural Nurse Specialists employed by WCDHB • Medical Centre buildings owned by WCDHB
<i>Nagakawau</i>	<ul style="list-style-type: none"> • Serviced by Karamea GP OR serviced by Buller Medical Service • Rural Nurse Specialist employed by WCDHB • Medical Centre buildings owned by WCDHB
<i>Buller Medical Service</i>	<ul style="list-style-type: none"> • Business owned by Buller Community Trust with GP employees • New Facility – owned by Buller Community Trust • Either will or will not operate Ngakawau Clinics (depending on Karamea option) • Will cease Medical Officer cover for Hospital except after-hours
<i>Aged Care (Continuing Care/Kynnersley)</i>	<ul style="list-style-type: none"> • WCDHB Exits Service • Private Provider Service Provision
<i>Buller Community Trust</i>	<ul style="list-style-type: none"> • Owns and operates new Hospital facility • Owns and operates Buller Medical Services • Owns rental properties for lease to GPs on a self-funding principle • Owns cars for GPs to lease on a self-funding principle • Assists with GP recruitment
<i>Karamea Medical Association Trust</i>	<ul style="list-style-type: none"> • Owns Karamea GP rental accommodation • Assists with Karamea GP recruitment

Scenario F – Structure / Relationship Diagram



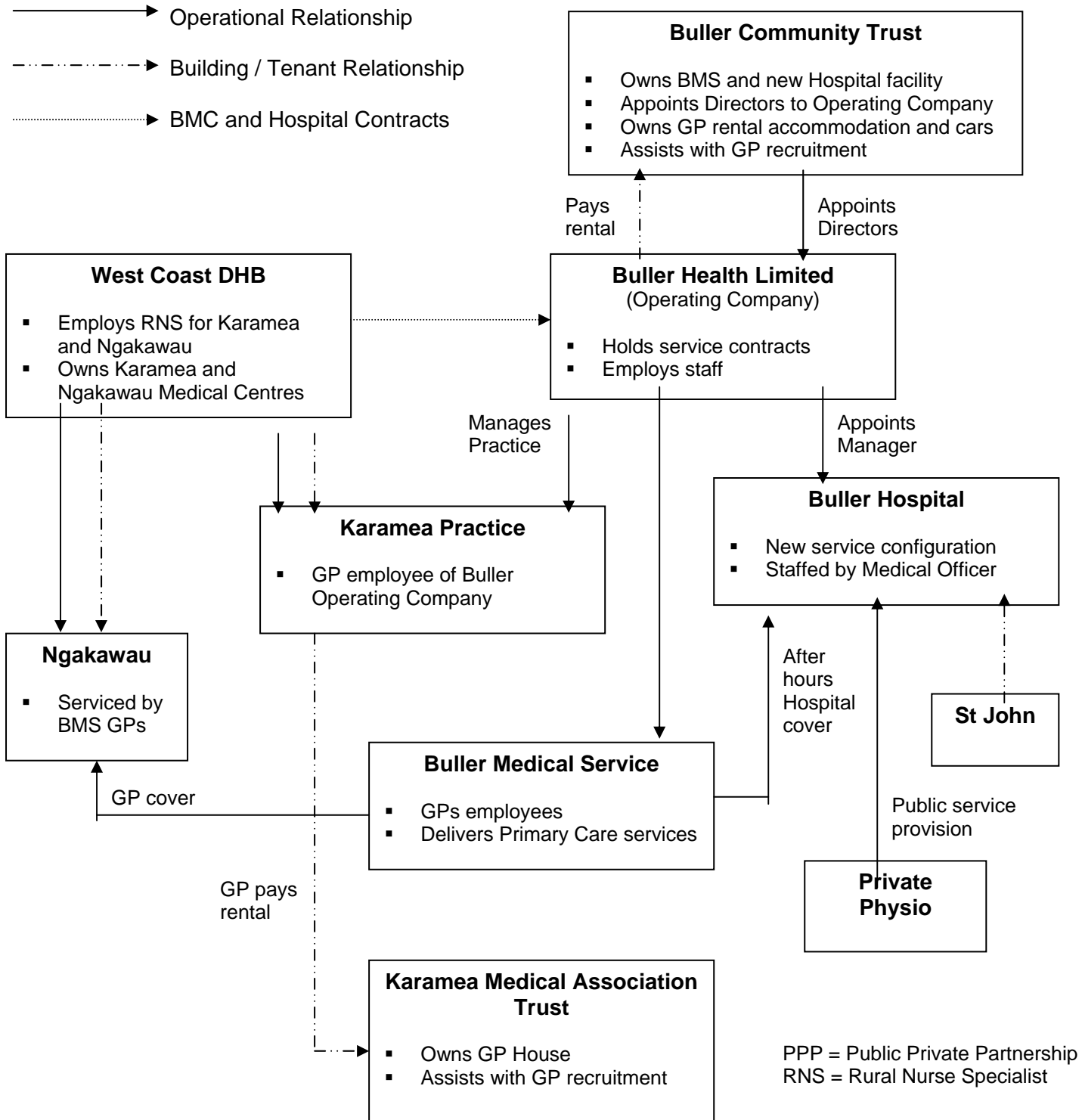
* If GP takes over Ngakawau
 + If Buller Medical Service covers Ngakawau

PPP = Public Private Partnership
 RNS = Rural Nurse Specialist

7.7 Scenario G

Buller Hospital	<ul style="list-style-type: none"> • New Service Configuration • Buller Community Trust Operation of Hospital Service Provision • Medical Officer employed through Hospital not through Buller Medical Service • New Facility – Buller Community Trust Owns Building
<i>Karamea</i>	<ul style="list-style-type: none"> • GP Practice Operated by Buller Community Trust who employs GP • Could Cover Ngakawau • Rural Nurse Specialists employed by WCDHB • Medical Centre buildings owned by WCDHB
<i>Nagakawau</i>	<ul style="list-style-type: none"> • Serviced by Karamea GP OR serviced by GPs at Buller Medical Service • Rural Nurse Specialist employed by WCDHB • Medical Centre buildings owned by WCDHB
<i>Buller Medical Service</i>	<ul style="list-style-type: none"> • Business owned by Buller Community Trust with GP employees • New Facility – owned by Buller Community Trust • Either will or will not operate Ngakawau Clinics (depending on Karamea option) • Will cease Medical Officer cover for Hospital except after-hours
<i>Aged Care (Continuing Care/Kynnersley)</i>	<ul style="list-style-type: none"> • WCDHB Exits Service • Private Provider Service Provision
<i>Buller Community Trust</i>	<ul style="list-style-type: none"> • Owns and operates new Hospital facility • Owns and operates Buller Medical Services • Operates Karamea GP Practice • Owns rental properties for lease to GPs on a self-funding principle • Owns cars for GPs to lease on a self-funding principle • Assists with GP recruitment
<i>Karamea Medical Association Trust</i>	<ul style="list-style-type: none"> • Owns Karamea GP rental accommodation • Assists with Karamea GP recruitment

Scenario G – Structure / Relationship Diagram



8.0 COMMUNITY TRUSTS - OPERATION AND STRUCTURE EXAMPLES

The following information is provided to Buller District Council in order for it to have some concrete examples of how Community Trusts have been structured and operated in other parts of New Zealand, in particular Gore and Balclutha. The trust's established in these areas have previously been viewed by Buller District Council as possible models for it to adopt, should the formation of a Trust be the preferred way forward.

8.1 Balclutha

The Community Trust was set up in 1997 in response to the planned closure of Balclutha Hospital. The community wanted to retain local services so it set up a Trust to secure community ownership of required new health infrastructure and the operation of health services.

Structure

Clutha Health Incorporated was formed to finance and own a new health facility on behalf of the community in Balclutha. It is an Incorporated Society with charitable tax-exempt status and has a Board membership of ten. This membership is comprised of the following:

- Five elected members - elected at the same time as the local body council elections.
- Three appointed members (one of whom has to be a GP) - appointed by people who work in the facility
- One Clutha District Council representative
- One Ministry of Health representative

The Board of Clutha Health Incorporated is charged with appointing a board of six suitably qualified and experienced directors to run Clutha Community Health Company Limited, of which it is the sole shareholder. This Company also has charitable status and holds the contracts to provide health services to the people of Clutha funded by the District Health Board, the Ministry of Health and ACC. It also sub-contracts some health services. The Company is the employer of all staff members and its Directors appoint the manager of the health facility.

The Clutha Community Health Company Limited leases the health facility from Clutha Health Incorporated. However, the Company owns plant and equipment. Under this structure there is a separation of the Company as the provider of health services and the Society as Landlord. This helps protect the Board of Clutha Health Incorporated (in terms of liability) as all they do is own the building and act as the interface between the public and the provider of services. In turn, the Company has limited liability but has no asset base if sued.

Operation

An Incorporated Society has to have members and for Clutha Health Incorporated all people residing in its selected operating area are deemed to be members. The

operating area for Clutha Health Incorporated is the Clutha District Council boundaries.

As previously stated, five members of Clutha Health Incorporated are elected. This is done at the same time as the local body elections, on a three-year cycle, and is organised through the local returning officer at a cost to the society. Appointees hold office until the expiration of the term of office of the elected members and may from time to time be reappointed.

The mix of Board members ensures that there is not the capacity for the organisation to be captured by special interest groups. As an extra protection, changes to the constitution of Clutha Health Incorporated must go to the Clutha District Council for ratification. At present Clutha Health Incorporated is looking at changing its constitution to replace the Ministry of Health appointee with an Iwi appointee.

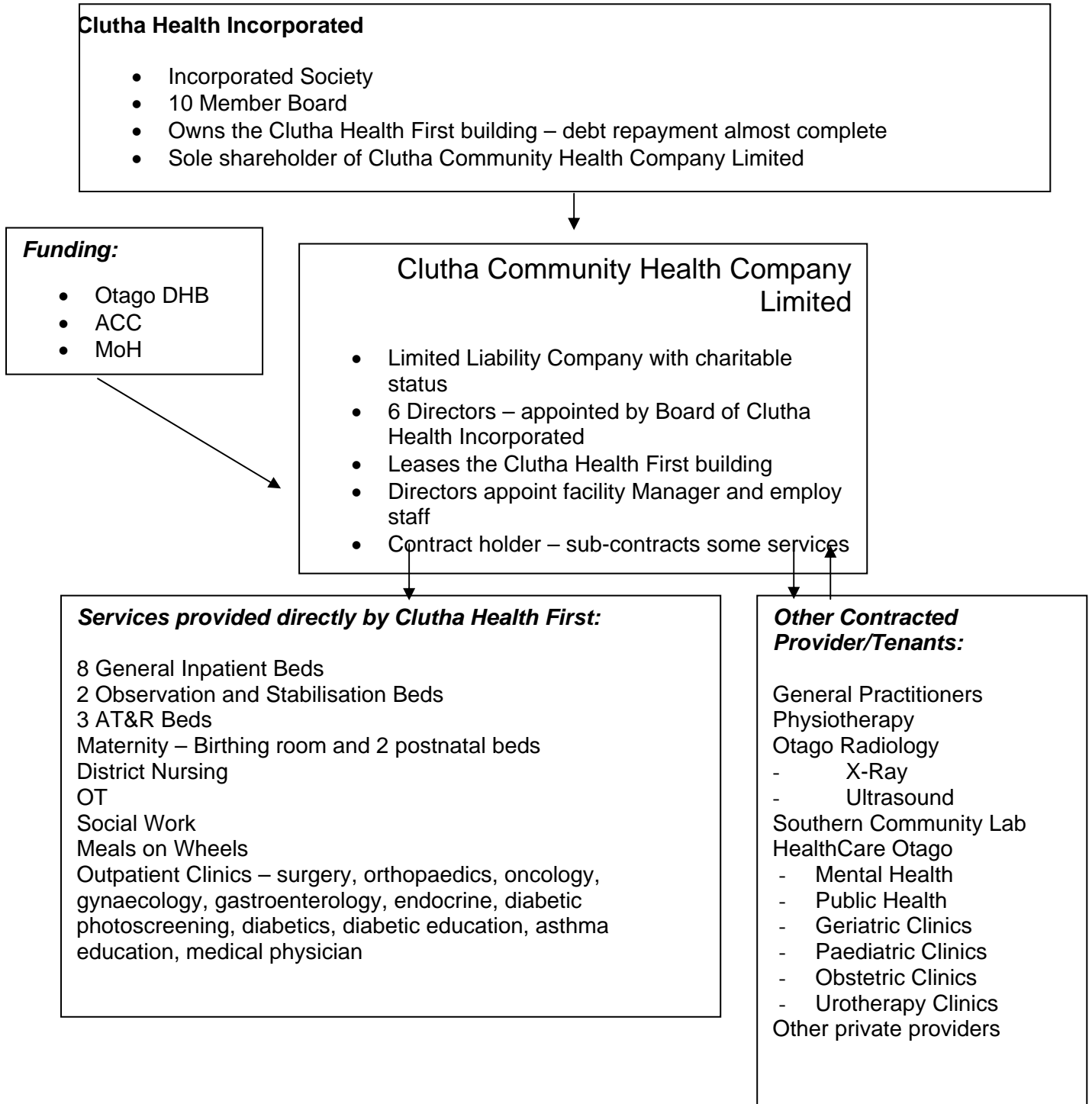
Clutha Health Incorporated has an Annual General Meeting and has community meetings on health issues as required. The Board receives quarterly reports (approximately) from the Directors of Clutha Community Health Company Limited that details the performance of the Company.

Those involved in the Trust state that a critical factor in its success is having board members and company directors with sufficient expertise and experience. With regard to the current Directors of Clutha Community Health Company Limited, there are two accountants, a doctor, two community people with commercial and governance experience, and an ex-health manager. Directors operate at the level of making and reviewing policy and overseeing the Company's performance and are not involved in day-to-day management.

The Directors of Clutha Community Health Company Limited were paid a total of \$17,000 last year for their services. Board Members of Clutha Health Incorporated receive no payment but are reimbursed for direct out of pocket expenses for attending meetings.

The lease rental paid by Clutha Community Health Company Limited to Clutha Health Incorporated is utilised for repaying the loan taken out for the construction of the new facility. It is also used to offset the Society's per annum running costs.

Structure of Balclutha Community Trust and Health Service Delivery



8.2 Gore

The Community Trust was set up in 1998 in response to the planned closure of Gore Hospital and the withdrawal of health services. As in Balclutha, the community

wanted to retain local services so they set up a Trust to secure community ownership of new health infrastructure and the operation of health services.

Structure

The Trust is structured in the same way as Balclutha in that it has two tiers – an incorporated society (Gore and Districts Health Incorporated) and an operating company (Gore Health Limited), both of whom have charitable tax-exempt status. The Incorporated Society financed the building of the new Gore Hospital, after the old facility closed.

There can be between 8 and 15 Board Members of Gore and Districts Health Incorporated. Six are elected members from its operating area (Gore District Council, the West Otago and Clinton Wards of the Clutha District Council, Te Tipua and Toes Toes Ward of Southland District Council), and others are appointees from Gore District Council (1), Iwi (1), Local General Practitioner (1) and Local Health Professionals (2). The Board has the power to co-opt members if specific needs are unmet.

The Board of Gore and Districts Health Incorporated appoint a minimum of three or a maximum of seven suitably qualified and experienced directors to run Gore Health Limited, of which it is the sole shareholder. This Company holds a five-year service contract with Southland District Health Board to provide health services to the residents of its operating district. It also receives revenue from the Ministry of Health and ACC and sub-contracts some health services. The Company is the employer of all staff members and its Directors appoint the manager of the health facility.

Gore Health Limited leases the health facility from Gore and Districts Health Incorporated. As with Balclutha, under this structure there is a separation of the Company as provider of health services and the Society as Landlord.

Operation

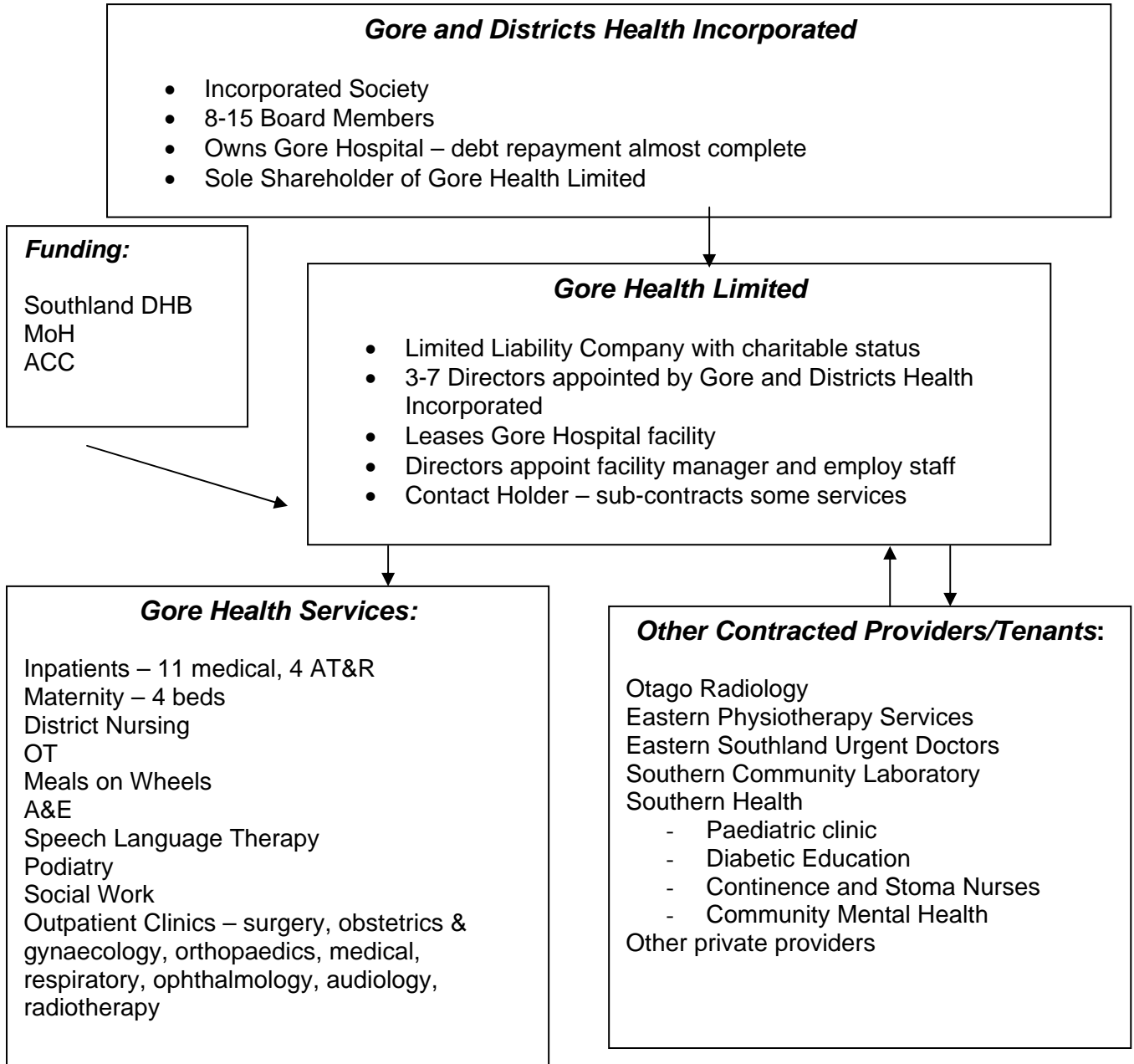
All people residing in Gore and Districts Health Incorporated operating area who are eligible to vote in local body elections are deemed to be members. Board Members are elected at the same time as the local body elections, on a three-year cycle, and the election is organised through the local returning officer at a cost to the society.

Gore and Districts Health Incorporated has an Annual General Meeting and has community meetings on health issues as required. The Board meets quarterly and receives reports from the Directors of Gore Health Limited that details the performance of the Company. The role of the Board is to provide policy advice and direction and is not involved in the management of the operating company.

The Directors of Gore Health Limited meet once a month. Current directors include an accountant, a lawyer and a pharmacist and the former Chairperson of Gore and Districts Health Incorporated. The Directors receive a \$5000 honorarium per year. Board Members of Gore and Districts Health Incorporated receive no payment but are reimbursed for direct out of pocket expenses for attending meetings.

The lease rental paid by Gore Health Limited to Gore and Districts Health Incorporated is utilised for repaying the loan taken out for the construction of the new facility. It is also used to offset the Society's per annum running costs.

Structure of Balclutha Community Trust and Health Service Delivery



8.3 Comment

In taking over health service delivery in Balclutha and Gore, both Community Trusts had to engage with the health funder, then the Health Funding Authority, over the service contracts and associated revenue.

As outlined in Section 5, WCDHB is anticipating that the establishment of a Buller Community Trust, which will take over some or all of local service delivery, is a likely outcome of this process. Therefore it has not disclosed revenue information so as to not prejudice its negotiating position.

It is noted that a similar situation was experienced by both the Gore and Balclutha communities, in dealing with their local health authorities, prior to the formation of their Trusts.

9.0 INITIAL RECOMMENDATIONS

Grafton Consulting Group believes that the following key service elements are required in Buller in order to address the current issues and to best meet the long-term health needs of the community. As outlined in Section 2, a wider focus, looking at all service delivery areas, has been adopted because of the inter-relationship of many of the key issues.

The key elements are:

- The creation of a Buller Community Trust
- A new service configuration for Buller Hospital as outlined in Section 6.5
- Private provider service provision for continuing care and Kynnersley Rest Home
- A new integrated health facility, incorporating both primary and secondary care services, owned by a Buller Community Trust and leased to the service provider/s
- Hospital health service delivery provided by a Buller Community Trust
- Privatisation of Buller Medical Service, with a Buller Community Trust owning the practice buildings
- Incentives for GPs, such as furnished accommodation and cars, provided by a Buller Community Trust
- A Karamea practice with a self-employed GP operating independently using WCDHB owned facilities
- A Ngakawau practice that is serviced by either the Karamea or Buller Medical Service GPs using WCDHB owned facilities.

The key elements are best encapsulated in Scenario D (Section 7.4).

It is therefore recommended that the key service delivery elements outlined above be adopted by Buller District Council as the basis for further investigation and analysis, through the development of a detailed Business Case.

It is further recommended that this Business Case process be undertaken in two phases.

Phase One will entail the following:

- Stakeholder and community consultation to get 'buy in'
- More in-depth analysis and refinement of options and structures
- Financial modelling of the options
- Development of facility options, including concept design and area brief
- Identification of a final preferred option

Phase Two will entail:

- Analysis of what revenue will be required to deliver services under any new organisational structure, such as a Community Trust
- Development of operational budgets
- Negotiation with WCDHB over future service contracts
- Establishment of a new organisational entity
- Facilitation of GPs into a new structure

It may be appropriate that Phase One of the Business Case process be jointly funded by WCDHB given its interest in a new and sustainable service configuration being developed for Buller and its interest in exiting what it considers non-core services.

Grafton Consulting Group estimates the likely cost of developing a full business case at \$XXX. Should Buller District Council decide to progress this project, Grafton will provide a more detailed outline of the business case process and a cost breakdown for its services.

The risks of not proceeding with this project include:

- Continued community uncertainty and anxiety over health service delivery
- Further deterioration of services - service cuts at Buller Hospital are a possibility by WCDHB
- Further loss of qualified medical professionals, including GPs and nursing staff
- Loss of economic development opportunities – people and businesses reluctant to move to areas with few, inadequate or insecure health services.

