

**APPENDIX 4 – THE GRAFTON REPORT STAGE 2
(2004)**



**Buller Health Services Project
(Draft) Model of Care Options**

October 2004

Contents:

- 1.0 Introduction
 - 2.0 Service Configuration Options
 - 2.1 Reefton
 - 2.2 Westport
 - 2.3 Karamea
 - 2.4 Ngakawau
 - 2.5 Supporting Commentary
 - 3.0 Governance Options
 - 3.1 Facility Ownership
 - 3.2 Strengths and Weaknesses of Governance Options
 - 3.3 Buller Medical Service
 - 4.0 Models of Care
 - 4.1 Health Trends in New Zealand
 - 4.2 Key Identified Issues with Buller Health Service Delivery
 - 4.3 Evaluation Criteria
 - 4.4 Integration
- Appendix:
- 1. Financial Analysis
 - 2. Area Briefs and Sketch Designs
 - 3. Previous Health Services Options for Buller and Reefton

1.0 INTRODUCTION

The purpose of the Buller Health Services Project is to develop a plan for a new health service delivery environment in the Buller district. The goal, as outlined in the project's Terms of Reference is to:

"Identify a preferred way forward that will configure health services so that they are clinically and financially sustainable and meet the health needs of the Buller community".

Sections 2 and 3 of this report contain options for both new service delivery configurations and governance arrangements. Alongside these options is an analysis of the strengths and weaknesses of each. Supporting commentary is also provided regarding certain features in the new options.

Section 4 of this report provides information relating to the context in which the options were developed. It gives a brief overview of both the key health trends in New Zealand and restates the key identified issues with Buller Health Service delivery. It also contains the criteria against which a final model of care should be evaluated.

Appendix 1 contains a financial analysis of the options outlined in Sections 4 and 5. Appendix 2 contains preliminary area briefs and sketch designs for both Westport and Reefton under a new 8-bed service delivery environment. It is noted that the core capital costs contained in the financial analysis were based on these area briefs and designs, with appropriate variations made according to inpatient bed numbers. Appendix 3 provides a brief overview of the recommendations of previous health reviews done in Buller in the last few years.

The options contained in this document will be the subject of discussion with all the key stakeholders in the coming month. The feedback received will be considered and final options will be released around mid-November. At that stage all stakeholders will be asked to identify their preferred service configuration and governance options.

Once this process has been completed a final report on the Buller Health Services Project, written by Grafton Consulting Group, will be submitted to the Buller District Council (and West Coast District Health Board as the joint funder of the project). The identified views of stakeholders will be taken into account when the final report is considered.

Ultimately, the preferred options will form the basis of a new model of care for the Buller District.

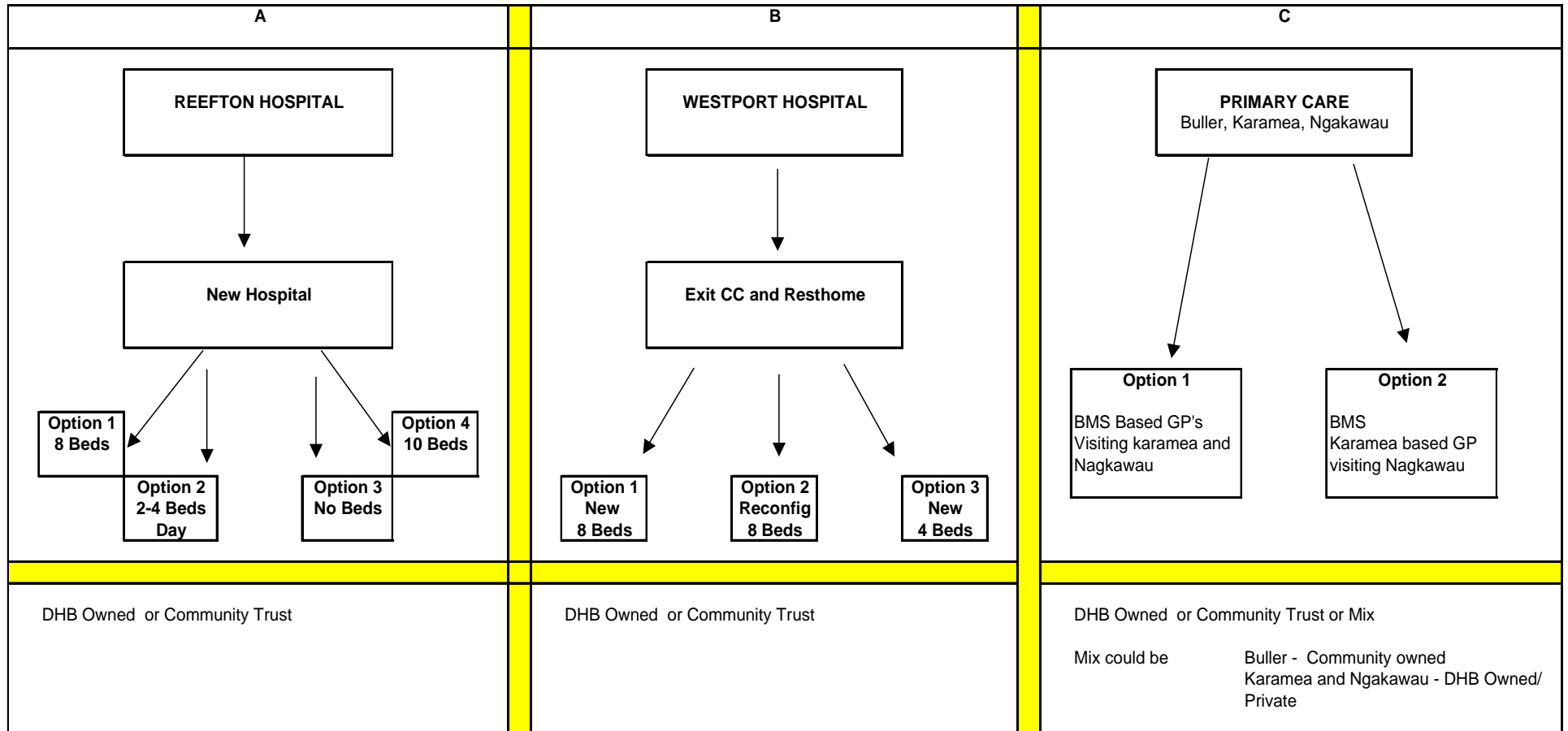
2.0 SERVICE CONFIGURATION OPTIONS

This section outlines the service configuration options for the four areas of the Buller District – Reefton, Westport, Karamea and Ngakawau. While the status quo option has been outlined in each of these areas, this should not be automatically taken to mean that the status quo is considered a viable option.

To assist in the consideration of these options, an analysis is provided of the strengths and weaknesses of each. Supporting commentary is also provided at the end of this section in relation to some of the specific features of the various options.

An overview of the new options is provided overleaf. The detailed description of each option in a particular area follows on subsequent pages.

Overview of Options



2.1 Reefton

	Status Quo	10 Beds	8 Beds	2-4 Bed Day Hospital	No Beds
GP Services	<ul style="list-style-type: none"> Independent, 2 person GP practice 	<ul style="list-style-type: none"> Independent, 2 person GP practice 	<ul style="list-style-type: none"> Independent, 2 person GP practice 	<ul style="list-style-type: none"> Independent, 2 person GP practice 	<ul style="list-style-type: none"> Independent, 2 person GP practice
Inpatient Services	<ul style="list-style-type: none"> 5 GP beds 5 continuing care beds 20 rest home beds Medical cover provided by GP 	<ul style="list-style-type: none"> 2 GP beds 8 aged care beds (mix of rest home and continuing care) Medical cover provided by GP 	<ul style="list-style-type: none"> 4 GP beds – incl. palliative and respite care 4 continuing care beds No rest home beds Medical cover provided by GP 	<ul style="list-style-type: none"> 2-4 Day Stay Beds – for assessment/ treatment but no overnight stay No continuing care beds No rest home beds Medical cover provided by GP 	<ul style="list-style-type: none"> No inpatient beds
Community Nursing Services	<ul style="list-style-type: none"> Rural Nurse Specialist (1.0 FTE) District Nursing (1.4 FTE) Public Health – incl. Well Child (1.4 FTE) 	<ul style="list-style-type: none"> Rural Nurse Specialist (1.0 FTE) Generalist Primary Care Nurses - as per Neighbourhood Nursing Project (2.8 FTE) 	<ul style="list-style-type: none"> Rural Nurse Specialist (1.0 FTE) Generalist Primary Care Nurses - as per Neighbourhood Nursing Project (2.8 FTE) 	<ul style="list-style-type: none"> Rural Nurse Specialist (1.0 FTE) Generalist Primary Care Nurses - as per Neighbourhood Nursing Project (3.5 FTE) 	<ul style="list-style-type: none"> Rural Nurse Specialist (1.0 FTE) Generalist Primary Care Nurses – as per Neighbourhood Nursing Project (4.0 FTE)
Emergency Services	<ul style="list-style-type: none"> PRIME – on call roster shared between GPs and PRIME trained nurses St John – volunteer service Trauma stabilisation 	<ul style="list-style-type: none"> PRIME – on call roster shared between GP and PRIME trained nurses St John – current configuration Trauma stabilisation 	<ul style="list-style-type: none"> PRIME – on call roster shared between GP and PRIME trained nurses St John – current configuration Trauma stabilisation 	<ul style="list-style-type: none"> PRIME – on call roster shared between GP and PRIME trained nurses St John – current configuration Trauma stabilisation 	<ul style="list-style-type: none"> PRIME – on call roster shared between GP and PRIME trained nurses St John – current configuration Trauma stabilisation
Outpatient Clinics	<ul style="list-style-type: none"> Diabetes, Dietician, Podiatry, Paediatrics, General Medicine 	<ul style="list-style-type: none"> Retain current range 	<ul style="list-style-type: none"> Retain current range 	<ul style="list-style-type: none"> Retain current range 	<ul style="list-style-type: none"> Retain current range
Allied Health	<ul style="list-style-type: none"> Radiology - very limited plain film x-ray, 20 hours per week 	<ul style="list-style-type: none"> No radiology service Visiting OT and Physio 	<ul style="list-style-type: none"> No radiology service Visiting OT and Physio 	<ul style="list-style-type: none"> No radiology service Visiting OT and Physio 	<ul style="list-style-type: none"> No radiology service Visiting OT and Physio

West Coast DHB Buller Health Business Case

August 2008

Mental Health	<ul style="list-style-type: none"> • Visiting OT and Physio • Visiting CMH team 	<ul style="list-style-type: none"> • Visiting CMH team 	<ul style="list-style-type: none"> • Visiting CMH team 	<ul style="list-style-type: none"> • Visiting CMH team 	<ul style="list-style-type: none"> • Visiting CMH team
	Status Quo	10 Beds	8 Beds	2-4 Bed Day Hospital	No Beds
Other Services	<ul style="list-style-type: none"> • Domestic Assistance/Personal Care • Meals on Wheels 	<ul style="list-style-type: none"> • Domestic Assistance/Personal Care – 1.0 FTE increase • Field Worker/Needs Assessor (0.5 FTE) • Meals on Wheels 	<ul style="list-style-type: none"> • Domestic Assistance/Personal Care – 1.0 FTE increase • Field Worker/Needs Assessor (0.5 FTE) • Meals on Wheels 	<ul style="list-style-type: none"> • Domestic Assistance/Personal Care – 1.5 FTE increase • Field Worker/Needs Assessor (0.5 FTE) • Meals on Wheels 	<ul style="list-style-type: none"> • Domestic Assistance/Personal Care – 2.0 FTE increase • Field Worker/Needs Assessor (0.5 FTE) • Meals on Wheels
Facility	<ul style="list-style-type: none"> • Reefton Hospital • Internal Kitchen 	<ul style="list-style-type: none"> • Closure of Reefton Hospital • Greenfields development of new integrated facility • No kitchen – meals outsourced 	<ul style="list-style-type: none"> • Closure of Reefton Hospital • Greenfields development of new integrated facility • No kitchen – meals outsourced 	<ul style="list-style-type: none"> • Closure of Reefton Hospital • Greenfields development of new integrated facility • No kitchen – meals outsourced 	<ul style="list-style-type: none"> • Closure of Reefton Hospital • Greenfields development of new integrated facility • No kitchen – meals outsourced

2.1.1 Strengths and Weaknesses of Reefton Service Configurations

Reefton	Strengths	Weaknesses
Status Quo	<ul style="list-style-type: none"> • No immediate loss of local service delivery • Retention of 'hospital' seen as a victory by the community 	<ul style="list-style-type: none"> • Does not address long term clinical viability e.g. declining/ageing nursing workforce and health professionals working outside of scope of practice • Does not address financial viability – no improvement in deficit position, which is likely to worsen • Perceived as no action after successive reviews – further reviews likely due to core issues remaining unresolved. • Facility does not meet new quality standards - no opportunity to address due to deficit. Facility will continue to deteriorate • Does not address equity issues – Reefton over-serviced compared to other rural areas
10 Beds	<ul style="list-style-type: none"> • Retains core aged care inpatient services – provides security and a community focus • New facility provides efficient (best practice) working and clinical conditions • New facility signals an investment in the future of local health service delivery • Reduction in service delivery means less demand on restricted nursing pool • Greater level of integration through new facility design and operational practice • Increased domestic assistance/personal care helps people stay in own homes for longer • Reduction in GP beds will encourage more efficient usage of beds for short-stay assessment and monitoring rather than for 'social' admissions. • Better alignment (on an equity basis) with service delivery in other small rural communities • Delivers financial savings of \$129k 	<ul style="list-style-type: none"> • Negative community reaction to reduction in inpatient beds and discontinuation of radiology service • Does not completely address issues around health professionals working outside of scope of practice • Loss of some local healthcare jobs • Community may not perceive the value of a new facility • Focus is still more on inpatient services rather than on community / primary care

West Coast DHB Buller Health Business Case

August 2008

	per annum	
<i>8 Beds</i>	<ul style="list-style-type: none"> • Core inpatient services retained – provides security and a community focus • New facility provides efficient (best practice) working and clinical conditions • New facility signals an investment in the future of local health service delivery • Reduction in service delivery means less demand on restricted nursing pool • Better alignment (on an equity basis) with service delivery in other small rural communities • Greater level of integration through new facility design and operational practice • Increased domestic assistance/personal care helps people stay in own homes for longer • Delivers financial savings of \$62k per annum 	<ul style="list-style-type: none"> • Negative community reaction to loss of rest home beds, radiology and small reduction in continuing care and GP beds • Does not completely address issues around health professionals working outside of scope of practice • Loss of some local healthcare jobs due to closure of rest home and streamlining of other inpatient services • Travel will be required for people to visit any relatives transferred to other rest home providers out of the immediate area • Community may not perceive the value of a new facility • Focus is still more on inpatient services rather than on community / primary care
<i>2-4 Bed Day Hospital</i>	<ul style="list-style-type: none"> • Provides for limited local assessment and treatment on a day stay basis – with patients going home or transferred to Grey Hospital as required • Reduces the demand on a restricted nursing pool – no night-duty cover required • Focus shifts to primary care and health and wellness promotion rather than inpatient services • Frees up financial resources to invest more in community services and other priority areas • New facility signals an investment in the future of local health service delivery • Higher level of alignment (on an equity basis) with service delivery in other small rural communities • Greatly reduces clinical risk issues regarding the delivery of inpatient services • Provides a financial saving of \$335k per annum. 	<ul style="list-style-type: none"> • Community resistance to elimination of 24 hour inpatient, continuing care, rest home services, plus discontinuation of radiology • Will create more demand for inpatient beds at Grey Hospital • More patients and families will be required to travel for treatment and to visit • Loss of many local healthcare jobs. • Will result in increased ambulance transfers – volunteer service already under pressure
<i>No Beds</i>	<ul style="list-style-type: none"> • Focus is on primary care and health and wellness promotion rather than inpatient services 	<ul style="list-style-type: none"> • Community resistance to elimination of inpatient services – could lead to 'hands around the

	<ul style="list-style-type: none"> • Frees up financial resources to invest more in community services and other priority areas • Better alignment (on an equity basis) with service delivery in other small rural communities • Eliminates clinical risk issues regarding the delivery of inpatient services • Provides the greatest financial saving of \$606k per annum. 	<p>hospital' situation</p> <ul style="list-style-type: none"> • No local inpatient beds lessens care options for elderly/people with chronic conditions that may only require a short stay for stabilisation to get them back in their homes • Will create more demand for inpatient beds at Grey Hospital • More patients and families will be required to travel for treatment and to visit • Loss of many local healthcare jobs. • Risk of losing GP who considers inpatient beds an integral part of his service delivery • Retaining suitably qualified and experienced RNs on an on-call basis to cover emergency would be more difficult as would the ability of these staff to maintain their scope of practice. • Will result in increased ambulance transfers – volunteer service already under pressure
--	---	---

2.2 Westport

	Status Quo	8 Beds + Maternity (New)	8 Beds + Maternity (Reconfig)	4 Beds + Maternity (New)
GP Services	BMS practice	BMS practice	BMS practice	BMS practice
Inpatient Services	8 medical inpatient beds 1 palliative care bed Medical cover provided by MOSS/GPs	8 medical inpatient beds – incl. palliative Medical cover provided by MOSS/GPs	8 medical inpatient beds – incl. palliative Medical cover provided by MOSS/GPs	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 • Nutritional Services 	<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

	• Obstetrics			
	Status Quo	8 Beds + Maternity (New)	8 Beds + Maternity (Reconfig)	4 Beds + Maternity (New)
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 • Greenfields 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 • Greenfields development of an integrated facility incorporating primary and secondary care • Collocation of BMS, dentist, private physio and St John • No kitchen – meals outsourced

2.2.1 Strengths and Weaknesses of Westport Service Configurations

Westport	Strengths	Weaknesses
Status Quo	<ul style="list-style-type: none"> • Retention of hospital unchanged provides a sense of historical continuity • No disruption to staff or continuing care/rest-home residents 	<ul style="list-style-type: none"> • Does not address financial viability – no improvement in deficit position, which is likely to worsen • Perceived as no action after successive reviews – further reviews likely due to core issues remaining unresolved. • Facility does not meet new quality standards - no opportunity to address due to deficit. Facility will continue to deteriorate • Limited opportunity to change service culture and operational practices • Continued DHB service provision of aged care not in line with MoH preference and NZ trend
8 Beds + Maternity (New)	<ul style="list-style-type: none"> • New facility will drive efficiencies and changes in service delivery culture • New facility signals an investment in the future of local health service delivery • New facility will provide up-to-date clinical environment that is attractive to staff and meets all building regulations and quality standards • Will maximise the use of staffing resources due to better building layout and placement of clinical services (important when there is a tight staffing pool esp. RNs) • Integration of GP practice alongside emergency will streamline daytime and after-hours service delivery. Could result in sharing of administration resources between practice and hospital • Collocation of other primary care providers will enhance clinical integration between primary and secondary care and foster closer relationships and communication between providers • Collocation could result in financial 	<ul style="list-style-type: none"> • New jobs will be available in aged care private sector but wage rates may be slightly lower • Community may perceive a reduction in service quality with private provider aged care service provision • Potential risk that no private provider found for aged care services, in which case DHB would continue to be provider of last resort • Community may not perceive the value of a new facility given low level of financial improvement

West Coast DHB Buller Health Business Case

August 2008

	<p>efficiencies between providers i.e. single ordering from same suppliers to obtain bulk discounts</p> <ul style="list-style-type: none"> • Private provider for aged care in line with rest of NZ and preference of MoH • Provides a financial saving of \$153k per annum 	
<p><i>8 Beds + Maternity (Reconfigure)</i></p>	<ul style="list-style-type: none"> • Not seen as 'wasting' an existing resource • Sometimes can be a cheaper capital option • Provides a financial saving of \$5k per annum 	<ul style="list-style-type: none"> • May not be able to achieve desired level of integration between primary and secondary care due to pre-existing design limitations • Less operational efficiencies due to pre-existing design limitations • May not achieve collocation of other primary care providers – less likely to collocate to 'old' facility • Decanting may be an issue – disruption to staff and patients
<p><i>4 Beds + Maternity (New)</i></p>	<ul style="list-style-type: none"> • Reduces the demand on a restricted nursing pool • Reduces the demand on GPs in terms of hospital coverage • Focus shifts to primary care and health and wellness promotion rather than inpatient services • Frees up some financial resources to invest more in community services and other priority areas • New facility signals an investment in the future of local health service delivery • Reduces some clinical risk issues regarding the delivery of inpatient services • Provides the greatest financial saving of \$171k per annum. 	<ul style="list-style-type: none"> • Community resistance to reduction in inpatient beds • Will create more demand for inpatient beds at Grey Hospital • More patients and families will be required to travel for treatment and to visit • Loss of some local healthcare jobs. • Will result in increased ambulance transfers

2.3 Karamea

	Status Quo*	Visiting GP ex BMS	Resident GP Covering Ngakawau
GP Services	<ul style="list-style-type: none"> Resident GP Guaranteed Minimum Income Practice 	<ul style="list-style-type: none"> Visiting GP ex BMS <ul style="list-style-type: none"> - 8 hours of GP clinics per week - 4 hours of phone consults per week 	<ul style="list-style-type: none"> Resident GP who covers Ngakawau and is clinically integrated with BMS (0.9 FTE) <ul style="list-style-type: none"> - 16 hours Karamea (incl. on-call) per week - 8 hours Ngakawau per week - 8 hours BMS per fortnight
Nursing Services	<ul style="list-style-type: none"> Rural Nurse Specialists (1.0 FTE) 	<ul style="list-style-type: none"> Rural Nurse Specialists (1.0 FTE) Nurse Practitioner (1.0 FTE) 	<ul style="list-style-type: none"> Rural Nurse Specialists (1.4 FTE)
Emergency Services	<ul style="list-style-type: none"> PRIME – on call roster shared between GP and RNS St John – volunteer service 	<ul style="list-style-type: none"> PRIME – on call roster shared between NP and RNS St John – current configuration 	<ul style="list-style-type: none"> PRIME – on call roster shared between 2 part-time RNS St John – current configuration
Administration	<ul style="list-style-type: none"> Part time Administration Assistant 	<ul style="list-style-type: none"> Part time Administration Assistant 	<ul style="list-style-type: none"> Part time Administration Assistant
Other Services	<ul style="list-style-type: none"> Domestic Assistance/Personal Care 	<ul style="list-style-type: none"> Domestic Assistance/Personal Care – current levels 	<ul style="list-style-type: none"> Domestic Assistance/Personal Care – current levels
Facility	<ul style="list-style-type: none"> Coast Health Care Practice Rooms 	<ul style="list-style-type: none"> Retain existing facility 	<ul style="list-style-type: none"> Retain existing facility
IT Infrastructure	<ul style="list-style-type: none"> Stand-alone 	<ul style="list-style-type: none"> Link Karamea Practice to BMS for shared medical records Video-conferencing – link with BMS for peer review and some clinical consults 	<ul style="list-style-type: none"> Link Karamea Practice to BMS for shared medical records Video-conferencing – link with BMS for peer review and some clinical consults

* In reality the status quo for the past year has been no GP with 2.0 FTE Rural Nurse Specialists

2.3.1 Strengths and Weaknesses of Karamea Service Configurations

Karamea	Strengths	Weaknesses
Status Quo	<ul style="list-style-type: none"> • Retaining a dedicated resident GP has community support • Gives the community a feeling of security • Continuity of care 	<ul style="list-style-type: none"> • Challenge to retain GP due to professional and social isolation • Clinical risk issues due to GP practicing in isolation • Risk of GP boredom or dissatisfaction due to low volume practice • If a GP is not retained, community uncertainty continues
<i>GP ex BMS</i>	<ul style="list-style-type: none"> • Visiting GP is not working in isolation as is part of the BMS team – clinical support and peer review not an issue • Provides a clinical model for other remote rural areas as use of nurse practitioners becomes a core component of primary care • Community can focus on supporting local health professionals rather than spending considerable energy either attracting and retaining a GP • Effectively this has been the status quo position (with the exception that the Nurse Practitioner will have a higher level of training) – no discernible change in community health status as a result • Rural Nurse Specialists and Nurse Practitioners work as a team and provide each other peer support 	<ul style="list-style-type: none"> • GP has to travel – weather conditions may disrupt service delivery on occasion • Risk that BMS may not have sufficient staff to service Karamea • May not always have the same GP visiting. If so, no continuity of care for patients • Community may perceive that 8 hours of GP clinics is inadequate and that a nurse practitioner is a 'lesser' service
<i>Resident GP Covering Ngakawau</i>	<ul style="list-style-type: none"> • Gives community a sense of security by having a resident GP (although would be out of the community during the week) • GP would not be practicing solely in isolation by having one clinical day per fortnight as part of BMS team who can provide some peer review and clinical support • Utilising one GP for Karamea and Ngakawau eliminates any potential 'boredom' issues associated with a part-time practice in an isolated area 	<ul style="list-style-type: none"> • GP would still be largely practicing in isolation • GP would have regular nights away from home and frequent travel • Risk if GP is unable to be retained

2.4 Ngakawau

It is noted that the following options for Ngakawau are dependent on the preferred option for Karamea. If there is to be no resident Karamea GP, then the default option is the Status Quo.

	Status Quo	GP ex Karamea
GP Services	<ul style="list-style-type: none"> • Visiting GP Clinics ex BMS 	<ul style="list-style-type: none"> • Visiting GP clinics – 12 hours per week ex Karamea
Nursing Services	<ul style="list-style-type: none"> • Rural Nurse Specialist 	<ul style="list-style-type: none"> • Rural Nurse Specialist (up to 1.0 FTE)
Emergency Services	<ul style="list-style-type: none"> • PRIME • St John – volunteer service 	<ul style="list-style-type: none"> • PRIME – as per current on-call system • St John – current configuration
Other Services	<ul style="list-style-type: none"> • Domestic Assistance/Personal Care 	<ul style="list-style-type: none"> • Domestic Assistance/Personal Care – current levels
Facility	<ul style="list-style-type: none"> • Coast Health Care Practice Rooms 	<ul style="list-style-type: none"> • Retain existing facility
IT Infrastructure	<ul style="list-style-type: none"> • Currently none • In future could like to BMS computer system for shared medical records 	<ul style="list-style-type: none"> • Link to BMS computer system for shared medical records

2.4.1 Strengths and Weaknesses of Ngakawau Service Configurations

Ngakawau	Strengths	Weaknesses
Status Quo	<ul style="list-style-type: none">• Continuity of service delivery	<ul style="list-style-type: none">• Risk that when BMS staff levels are low peripheral clinics cannot be maintained• Lack of GP continuity if using rostered BMS GPs to service Ngakawau
GP ex Karamea	<ul style="list-style-type: none">• Dedicated GP will provide continuity of care	<ul style="list-style-type: none">• Risk if no Karamea GP is retained. Service delivery may default back to BMS

2.5 Supporting Commentary

The following supporting comments are made in relation to the new service configuration options:

- The Reefton Neighbourhood Nursing model is supported and it is suggested that this innovation be considered for Westport. Under the model nurses practice in a comprehensive and integrated way and are no longer practicing exclusively in one area of responsibility. The creation of a more generalist nursing role is considered to best meet the needs of both the Reefton and Westport communities as they will focus on community health issues.
- The model of advanced nurses, such as rural nurse specialists and nurse practitioners, operating satellite clinics in outlying areas in partnership with a visiting GP, is becoming more common. Often seen by a community as 'stand ins' for the GP, these nurses diagnose and manage people's conditions to a certain level. However, it is still the doctor's role to confirm diagnoses and prescribe a treatment regime, therefore these nurses have clear consultative channels with GPs and other medical clinicians at the base hospital when medical input is required, and they operate under standing orders. The use of appropriately trained nurses for first response emergency calls is well established, especially in remote rural area.
- The move to transfer aged care services in Westport to the private sector is in line with the practice in the rest of New Zealand. Only 2% of continuing care services are now provided by DHB owned providers (i.e. Coast Health Care). It is expected that all DHB owned providers will eventually exit this service as it is no longer considered core business. The private sector operates under the same service specifications as public hospitals. In the case of no alternative provider being found, the DHB would continue to be the provider of last resort.
- The major reduction or disestablishment of rest home beds in Reefton is made on the basis of their very low level of utilisation. These utilisation levels are expected to decline further as people are increasingly supported to remain in their own homes. In addition, stakeholder feedback and service delivery patterns suggests that people are delaying entry into aged care facilities due to Government means testing and that by the time residential aged care is inevitable they need a higher level of care i.e. hospital level continuing care.

The new options for Reefton involve increased community nursing and/or domestic assistance/personal care, as well as the addition of a field worker/needs assessor. This is to facilitate an increased focus on keeping people in their own homes for longer.

- There has been a six-bed increase in continuing care recommended for Westport. This is because the current service is operating at capacity and the aging population is increasing. This will also cater for any flow on effect of any service delivery changes in Reefton.
- The expected increase in population in Reefton due to new mining operations will increase demand for primary care services, rather than inpatient hospital

services. It will also mean that adequate emergency services need to be in place. Oceana Gold (Blackwater and Globe projects) have a commitment from an organisational perspective to provide a safe working environment and have indicated that it is willing to discuss joint initiatives for any necessary enhancements to emergency/trauma and associated services.

- The new options do not provide for a radiology service in Reefton. The current part-time (20 hours) radiology technologist can only x-ray the abdominal area, arms, legs and chest, but not back, head and neck areas and it is unlikely that a more qualified radiographer could be attracted to Reefton to provide a complete service on a limited part-time basis. Further, digital radiology is the way of the future but the cost of installing this in Reefton (given current volumes) cannot be justified, nor can building extra space in a new facility for an old machine with limited lifespan.
- It is recommended that a teleradiology system be installed in Westport. Teleradiology is a means of electronically transmitting radiographic patient images and consultative text from one location to another. Teleradiology is progressively being phased in over most of New Zealand and it is appropriate that this be installed as part of any new capital investment.
- The West Coast DHB's PrISM project (Primary Integration Systems Management) aims to link all primary care practices (both DHB and privately owned) on the West Coast to a central server. In principle, this will eventually enable GPs and rural nurses in a particular locality to access patient records no matter where they are seen (i.e. in Karamea, Ngakawau or Westport), providing the proper confidentiality and privacy protocols are in place regarding the sharing of information.

On the proviso that these protocols are established, it is recommended that there be a shared patient records system established for the Northern Buller area. This recognises the fact that patients in this area may not be exclusively accessing primary health care services in their home area e.g. they may be travelling from Karamea and Ngakawau down to Westport for services. Further, it recognises the fact that clinicians working in remote areas, such as Karamea, are often conferring with their colleagues in Westport by phone over patient care. It would therefore be beneficial for each to have the full patient records in front of them.

Having shared records means that appropriately authorised clinicians would be able to see a patient's essential medical details, especially significant medical conditions, allergic reactions, long-term medications, previous treatment plans etc., so that an individual receives coordinated and integrated primary care.

It is noted that the sharing of medical records will require the installation of an IT system in Ngakawau, which is currently without any computerised practice management system. It is understood that the installation of such a system is planned by West Coast DHB.

- It is recommended that greater use be made of video-conferencing for patient care and professional development purposes to reduce the effects of practitioner isolation. As broadband capacity is increased in Karamea, the

installation of video conferencing equipment in the practice (that links, in the first instance, into BMS) should be a priority. Reefton also requires video-conferencing capacity and this should be established when the town has adequate broadband capacity.

- It is noted that remote access technology, such as pocket personal computers linking clinicians, such as community nurses, into a patient database, is a tool to be considered in the future when wireless network coverage improves on the Coast. Such technology has, in a pilot project in Northland, show itself to improve the effectiveness of service delivery when you have health professionals working out in the field.
- It is recommended that a part-charge be instigated for triage level 4 and 5 patients who present in at either Reefton or Buller hospital's accident and medical (emergency) area. This is in response to concerns expressed by stakeholders about inappropriate usage of this service and for the other reasons outlined below.

Both Buller and Reefton deliver accident and medical care. This care is mainly for non-scheduled GP services for minor injuries and illnesses, and provides resuscitation and limited stabilisation prior to referral to a higher level of care. As well as providing an A&M service, Buller and Reefton Hospital's provide a local trauma service, with basic stabilisation prior to transfer.

Patients are triaged upon presentation to the hospital. Triage is the process of assessing a person's condition based on their clinical descriptions to see how serious the illness or injury is. Those who are assessed as being the sickest or most at risk get treatment first. Triage level 1 is the most urgent, with the patient requiring immediate attention. Triage levels 4 and 5 are the least urgent and the patient is deemed to require GP level care. It is noted that the vast majority of presentations at Buller and Reefton Hospital's are triage level 4 and 5.

Currently, people at triage levels 4 and 5 who present to the A&M (emergency) area of the hospital for treatment do not incur a part-charge. However, if someone goes to see a GP, and receives the same level of care, they do incur a part charge. As both are the equivalent service, instigating a part-charge in the A&M would create more equity. In addition, it will assist in strengthening the financial viability of the GP practice (particularly in Westport) and encourage more appropriate service usage.

It is recommended that the part-charge be applied across the whole 24- hour period. This is to discourage people deferring the use of the GP service when they need it in favour of free care after-hours. Deferring care is not a good practice as some conditions can deteriorate quickly and then people are sicker or may be at greater risk.

It is noted that other places in New Zealand, such as Hawera and Porirua, have part-charges for their level 4 and 5 triage patients.

- The options for Reefton entail the development of a new health facility, either with or without inpatient beds. As well as the previously stated issues in Section 2 regarding facilities, it is noted that a change in service configuration

will mean that a significant portion of the old facility will no longer be utilised from an operational perspective. Given the extent of reconfiguration that will be required in this case, it is considered that a purpose built facility is the best way forward in order to harness the most operational efficiencies.

- The facility options for Westport include either a reconfiguration and a new build. This will be required as the shift of continuing care beds into the private sector will fundamentally alter the functional viability of the existing facility and the new service configuration entails a high level of integration of the GPs with the A&M/Emergency and Outpatients area. The collocation of other primary care providers in Westport is also recommended and therefore these providers would need to be accommodated. At this stage it is assumed, based on previous experience, that the capital costs would be similar.
- It is noted that both Westport and Reefton are, according to the *Roadside to Bedside* document, health centres. Health centres vary in size and scope, with most offering primary and community health services, with some having inpatient beds (usually GP managed beds for low level, sub-acute care, continuing care beds, and primary maternity beds). Under any new service configuration, they will continue to be health centres. Secondary care services will continue to be delivered at Grey Base Hospital.

3.0 GOVERNANCE OPTIONS

The following governance matrix provides a range of different governance options for each of the new service delivery configurations outlined in Section 4.

The ticks indicate that the governance option is considered to be feasible whereas the crosses indicate that such an option is either considered unrealistic or unworkable.

It is noted that the eventual preferred option may contain a mix of governance arrangements. For example, a Community Trust might take over service delivery in Westport, but Reefton could still be owned and managed by West Coast DHB. Alternatively, the preferred option may be for one type of governance arrangement for the entire Buller district.

Governance Matrix

	DHB	Community Trust	DHB/Private	Private	Trust/Private
Karamea					
<i>Visiting GP ex BMS</i>	✓	✓	✗	✗	✗
<i>Resident GP Covering Ngakawau</i>	✓	✓	✓	✗	✓
Reefton (excl. GP Practice)					
<i>10 Beds</i>	✓	✓	✗	✗	✗
<i>8 Beds</i>	✓	✓	✗	✗	✗
<i>2-4 Bed Day Hospital</i>	✓	✓	✗	✗	✗
<i>No Beds</i>	✓	✓	✗	✗	✗
Westport (excl. BMS)					
<i>8 Beds + Maternity (New)</i>	✓	✓	✗	✗	✗
<i>8 Beds + Maternity (Reconfig)</i>	✓	✓	✗	✗	✗
<i>4 Beds + Maternity (New)</i>	✓	✓	✗	✗	✗
Westport					
<i>BMS</i>	✓	✓	✗	✓	✓

Each of the governance options are explained below:

Governance Option	Explanation
DHB	Coast Health Care, the DHB owned service provider, would continue to be responsible for the delivery of the particular health service as per its current service contracts. Staff would continue to be employed by Coast Health Care.
<i>Community Trust</i>	A Community Trust would hold the budget and be the provider for the service delivery area as per service contracts negotiated with the DHB/ACC/MoH or any other funding agency. Staff would be employed by the Community Trust or provide contracted services to the Trust via another agency.
<i>DHB/Private</i>	Health service delivery would be the joint responsibility of both Coast Health Care and private provider/s. For example, Karamea could have a mix of Coast Health Care staff (i.e. rural nurse specialists) and a self-employed GP.
<i>Private</i>	The service is privately owned and managed. Staff are either employed directly by the owner/s or provide contracted services to the owner via another agency. It is noted that the Reefton GP practice is currently privately owned, as are most GP practices in NZ. A private owner could be a GP or group of GPs, a franchise group such as 'The Doctors' or an IPA such as Southlink Health etc.
<i>Trust/Private</i>	The service is owned and managed by a Community Trust and private owners, via a joint management company

At this stage no detail has been provided as to the structure of any Community Trust. There is a range of different options/models available in terms of the number and type of trustees that could represent the community, the election method, length of term and operational structure etc. These will be explored should a Community Trust for some or all of the above service areas be a preferred option.

3.1 Facility Ownership

The above governance options relate to what agency/organisation has the responsibility for, and control over, the delivery of health services. However, while an organisation, such as a Community Trust or DHB, may have responsibility for service delivery, this may not necessarily extend to owning the facility that these services are delivered from.

Many health providers only lease their facility (and sometimes their equipment). Given this, there is another avenue for community involvement in health service delivery – that of facility ownership.

The various Greenfields service delivery options outlined in Section 4 will require a significant capital investment. Should this be the preferred option, the community, via

a Trust or the District Council, may be in a better position to finance this investment than the DHB (due to its declining funding pathway and current deficit position) and may obtain lower-cost financing that that available through the Crown.

The option of community ownership of new health facilities therefore needs to be taken into account as part of the broader consideration of governance options.

Note:

Rental income, regardless of who is the service provider, provides the revenue to the facility owner to cover the cost of capital.

3.2 Strengths and Weaknesses of Governance Options

	Strengths	Weaknesses
DHB	<ul style="list-style-type: none"> • Continuity of service delivery and employment arrangements • DHB/Coast Health Care familiar, providing a perception of security 	<ul style="list-style-type: none"> • Some community and staff dissatisfaction with DHB service delivery continues. DHB continues to be a target of negative media coverage, affecting retention and recruitment of health professionals and community perceptions • DHB, if under continued financial pressure, could potentially reduce service delivery over time – community has little control. • Management at a distance – issues with timeliness of decisions and responsiveness continue • CAPEX decisions part of a larger region-wide process – Buller may be low priority • DHB may remain in non-core business i.e. owning and managing primary care practices
Community Trust	<ul style="list-style-type: none"> • Provides local ownership and control – increased certainty over local health service delivery • Local governance and management means more responsive and timely decision making processes • Less local issues decided at a distance • Ability to develop innovative local solutions to local issues, particularly around the retention and recruitment of health professionals • Trust will invest any surpluses it generates back 	<ul style="list-style-type: none"> • Community would take both the clinical and financial risk for service delivery e.g. if service running at a deficit it will be the responsibility of the Trust (and not the DHB) to implement measures to address this. • Requires sustained long-term community commitment – concern has been expressed as to community capacity and expertise to operate a Trust. • Loss to Coast Health Care of corporate overhead contribution • Viability of Base Hospital may be at risk if referral patterns

	into local health service delivery priority areas, as determined by the community	change (though this is not a given) <ul style="list-style-type: none"> • Trust may be seen as to Westport focused – though Karamea and Reefton could opt out • Perception that a Community Trust cannot deliver services to the same standard as DHB
DHB/Private	<ul style="list-style-type: none"> • Risk sharing 	
Private	<ul style="list-style-type: none"> • Private owners more commercially focused and will drive financial efficiencies • Private owners tend to respond to issues quicker as they tend to affect the bottom line 	<ul style="list-style-type: none"> • Can be perceived as too financially driven at the expense of other considerations
Trust/Private	<ul style="list-style-type: none"> • Risk sharing 	

The financial analysis contained in Appendix 1 provides a brief overview of the potential financial impacts of governance structures.

It is noted that the various Buller communities may ultimately decide they do not want to establish a community trust that takes ownership of a particular area of health service delivery. Should that be the case they may wish to establish a trust whose role would be to formally represent the community on health related matters while having no direct responsibility for local health service delivery. In effect, this has been the role played by the Buller District Council, but a community trust would widen the representation. Such a trust would probably establish formal links with West Coast DHB, West Coast PHO and other relevant health organisations.

3.3 Buller Medical Service

One of the key drivers in establishing the Buller Health Services Project was the issues relating to Buller Medical Service. As a result there has been considerable discussion over whether a community trust could provide better governance and management of the practice. Obviously, a key consideration in determining whether to take over the practice relates to its financial viability.

A current financial analysis has shown the practice as having approximately a \$135k deficit (including \$85k of corporate overhead). However, based on some stakeholder feedback, it is possible that BMS may not be receiving adequate revenue to match the costs of covering the hospital and delivering services to Ngakawau. In addition, there has been anecdotal evidence supplied that financial controls within the practice may not be as tight as they could be.

Medical Assurance, an organisation with considerable experience in the financial structures of GP practices, has stated that each GP in a rural area such as the West Coast (excl. the GP covering the hospital) should be able to generate approximately \$250k per annum (fee-for-service or capitation model). The vast majority of GP practices have an expense ratio of just below 50% of this annual turnover, excluding GP salaries. Therefore, using this as a basis, a BMS practice with 5 FTE GPs could be expected to deliver a modest \$25k return per annum after paying GP salaries.

It is further noted that while there would still be a level of organisational overhead in the practice under a community trust structure, this is likely to be considerably less than the current allocation of West Coast DHB corporate overhead.

In effect, it is considered that with a combination of community governance, tight financial management and a review of BMS's hospital and Ngakawau service contracts, the practice could be made financially viable. However, to lessen the financial risk to a trust in the first 3 years of operation (whilst bedding in changes and new structures) it is recommended that there be a turnaround clause in any change of ownership agreement with West Coast DHB. In such a clause, a specified sum would be covered by the DHB each year should the practice continue to initially operate in deficit and this sum would progressively decline from year 1 to year 3.

Should a community trust take over, it is recommended that the organisational structure of the practice be reviewed. As part of this a new Business Manager role could be created that is focused on delivering the strategic objectives of the practice.

4.0 MODELS OF CARE

Sections 2 and 3 of this report detail a number of different service configuration and governance options for the Buller district. These options can be combined in various ways, with each combination representing a distinct model of care.

In evaluating these options it is important to outline the context within which they were developed. While much in the way of contextual information has previously been supplied in the Situational Analysis and other reports circulated to stakeholders, there is some key information that is worth mentioning or restating. This information relates to the broad health trends in New Zealand and the key identified issues regarding health service delivery in Buller.

Following this contextual information, certain criteria have been provided against which any final model of care, incorporating preferred service configuration and governance options, needs to be evaluated.

4.1 Health Trends in New Zealand

The following trends in health service delivery in New Zealand are referenced in relation to the consideration of the models of care:

- a) **The concentration of high cost and high technology services in base hospitals.** This intensification is a response to increasing specialisation in healthcare, increasingly sophisticated diagnostics and equipment, and specialist staff shortages. Maintaining high levels of clinical quality and clinical safety is critical;
- b) **The decline of traditional rural hospitals.** The concentration of secondary services at the base hospital has resulted in a reduction in the scope and capacity of smaller local hospitals. The secondary care inpatient beds that have remained locally have been increasingly used for less acute cases (step down beds), aged care services and primary maternity services. Outpatient clinics are delivered by visiting, rather than resident, specialists;
- c) **Changing care patterns.** There is an increased emphasis on prevention and primary care. The aim is to keep people well and out of hospital. Hospital stays, when required, have decreased in length and the focus is on getting people back in their homes as soon as possible. There has been increased resources for community-based services, particularly around support for independent living;
- d) **Increased collaboration between providers.** There is a sustained effort by health providers to work more collaboratively so that patients receive integrated care. In particular, primary and secondary providers are increasingly working more closely together;
- e) **Ongoing financial constraints set against rising demand for services.** This forces funders and providers to continually look for the most efficient and effective ways of providing care to their communities;
- f) **Scarcity of health professionals.** Obtaining staff for many different health professions is becoming more difficult. In particular there is a nationwide shortage of GPs, RNs and midwives. These shortages are generally more acute in rural areas;

- g) **Increasing risk management.** The focus on risk management has increased in response to cases of medical misadventure and litigation. There is constant pressure on both health professionals and administrators to ensure defined standards. The Health Practitioners Competence Assurance Act is an example of legislation recently created to manage clinical risk;
- h) **Greater community involvement in health.** There is an increasing trend towards involvement of local communities in the planning, funding and delivery of local services within their community. For example, DHB and PHO Board's contain community representatives and many communities own and manage their health services via community trusts.

4.2 Key Identified Issues with Buller Health Service Delivery

Against the broader health trends outlined above, there are a number of long-standing issues affecting the future sustainability of local health service delivery in the Buller district. These issues have been identified and/or verified in consultation with key stakeholders and include:

- a) **Shortage of GPs** – Although a national problem, there have been some specific local factors identified as impacting on GP retention and recruitment, particularly in Westport. These include negativity in the media, unsustainable workloads (esp. around after-hours and hospital cover), frustration at perceived failures in DHB practice management (BMS), social and professional isolation, restrictive or unsupportive community environment, and difficulties taking leave/accessing continuing medical education. Shortages have resulted in long GP waiting lists, little continuity of care (due to extensive use of locums/short-term staff) and periodic closures of hospital.
- b) **Shortage of other health professionals** – Supply of RNs is an issue at both Reefton and Buller Hospitals. Reefton also has shortages of Ends and caregivers and the current staff pool is very stretched in terms of covering time off. There have been periodic shortages of other health professionals also, such as physiotherapists. Outpatient clinics rely on specialist staff availability, but there are gaps in specialist cover at the base hospital. The current health workforce in Buller is aging, with no younger cohort identified to replace it.
- c) **Clinical skill levels/scopes of practice/quality service** – high level of skill required of GPs, nursing staff at Buller and Reefton Hospitals, as well as rural nurse specialists in Karamea, Ngakawau and Reefton. This is due to the isolation and the range of conditions needing treatment. Some GPs have felt insufficiently trained to provide hospital cover, particularly for emergencies, and Reefton Hospital staff said that they are all working outside of their scope of practice. Ensuring a high quality service with appropriately trained staff working within defined scopes of practice becoming harder. Service volumes may not be enough to ensure clinical safety.
- d) **Outdated facilities** – Both Reefton and Buller Hospital facilities are outdated and not reflective of current clinical best practice. They are poorly designed and do not meet new quality standards. The facilities have been maintained at a bare minimum in recent years and much of the equipment is old. The current infrastructure likely to be costing more than is necessary.

- e) **Access to health services** – Buller's large area and geographic isolation presents challenges in terms of people being able to access health services, especially since there is no public transport. There is a heavy reliance on the ambulance service, and air transport for emergencies. Cost is also an issue in terms of accessing services as a large number of Buller residents are on some form of government benefit.
- f) **Financial deficit** – Service delivery in the Buller District (excluding Karamea, Ngakawau, and community services) are running at a \$1.7 million deficit. Low clinical volumes (i.e. numbers of patients) mean that there are very limited or no economies of scale. This deficit needs to be addressed due to West Coast DHB's declining funding pathway under population based funding. It has been acknowledged that the current Government's funding model does not fit the West Coast.
- g) **Service equity** – West Coast DHB's Funding Division has highlighted the need for an equitable level of service delivery, when compared with different areas of the West Coast and other similar sized areas in the rest of New Zealand. Previous reviews have identified that there are some levels of over-servicing.
- h) **Community uncertainty/lack of control** – Community has often felt dis-empowered and at the mercy of decisions made outside of the district regarding health service delivery. Long-standing uncertainty over the future of health services has created anxiety and a desire for control.

4.3 Evaluation Criteria

As noted in Section 1, the future health service delivery environment in Buller must be clinically and financially sustainable. However, as well as these two criteria there are a number of others against which a final model of care, encompassing the preferred service configuration and governance options, should be evaluated. All of the main evaluation criteria are therefore outlined below.

The final model of care should be:

- a) **CLINICALLY SUSTAINABLE** – This means that there must be confidence that suitably trained and experienced staff can be recruited and retained, and that services meet appropriate quality standards. This covers both primary and secondary sectors.
- b) **FINANCIALLY AFFORDABLE** – Total spend must be equitable in terms of the DHB's overall responsibilities and financial sustainability has to be considered within realistic DHB funding streams. The cost of capital redevelopment must also be considered.
- c) **PATIENT FOCUSED** – ensuring that the needs of patients/clients are provided for in a caring environment that respects cultural differences and through a process that is easy to understand.
- d) **ACHIEVABLE** – Many models fail because they are unrealistic in scale, requiring enormous amounts of resources and reconfiguration that cannot be achieved due to pre-existing constraints.
- e) **FLEXIBLE** – ensuring future changes in health needs and service delivery methods can be accommodated.
- f) **INTEGRATED** – providing an environment that supports coordinated, 'seamless', multidisciplinary service provision to clients and maximum capacity for sharing of resources.
- g) **ACCESSIBLE** – ensuring that services are accessible by the local population.
- h) **ENABLING OF COMMUNITY PARTICIPATION** – so the community has a say in local health service delivery.
- i) **CONSISTENT WITH PRIORITY HEALTH CONCERNS** – as outlined in key strategic directions and priorities such as the New Zealand Health Strategy, the New Zealand Disability Strategy, Primary Health Care Strategy, Roadside to Bedside Framework etc.

4.4 Integration

There are a number of references to integration in this document. It is noted that this has been a key consideration in the development of the various options because it is a well-established means of improving the efficiency and effectiveness of health service delivery. Integration has become a key feature in many of the recent models of rural health service delivery, both in New Zealand and overseas. It can involve:

- *Clinical integration* – the coordination of patient care between a number of different providers and across different care settings
- *Functional integration* – the coordination or shared management of administrative and support activities
- *Financial integration* – the pooling of financial resources and sharing of financial risks and benefits
- *Physical integration* – the collocation of a range of different providers under one roof

In New Zealand, integrated health services at a local community level are often equated with the creation of what has been termed 'one stop shops'. Generally, this has involved a physical integration of the primary and secondary care providers in a particular area into a single facility, resulting in greater levels of clinical integration at a local level. Full financial and functional integration has frequently occurred via the establishment of a community trust.

While the benefits vary according to the precise configuration, there are some core advantages that a one stop shop can provide for rural communities. These include:

- Sharing of resources – avoids costly duplication and helps to consolidate the facilities and equipment needed to recruit and retain health professionals
- Improved access – this is achieved in the simplest way due to services being spatially and/or logistically integrated. This makes for 'easier health shopping'
- De-stigmatisation of certain health services (e.g. sexual health, mental health) – by them being included alongside other functions of a general health centre
- Increased teamwork and communication – the streamlining of care between general practice, specialist health professionals (i.e. consultants doing outpatient clinics), community services and other providers, such as the pharmacist, helps breakdown communication barriers and allows for more teamwork
- The development of multi-skilled generalist roles, particularly in nursing - 'one stop shops' have often rendered traditional nursing roles and titles redundant and resulted in a shift to new forms of practice better reflective of the health needs of the community and service delivery demands.

West Coast DHB Buller Health Business Case

August 2008

Appendix 1

SUMMARY	Status Quo	Option 1 8 Beds (new)	Option 2 8 Beds (reconfigured)	Option 3 4 Beds (new)
GP Services	BMS Practice	BMS Practice	BMS Practice	BMS Practice
Inpatients	8 Med Inpat beds 1 Palliative care Cover by Moss/GP's	8 Med Inpat beds Inc Pal Cover by Moss/GP's	8 Med Inpat beds Inc Pal Cover by Moss/GP's	4 Med Inpat beds incl. pal Cover by Moss/GP's
Aged Care	17 CC Beds 27 Rest Home Beds	23 CC Beds - private 27 Rest Home - private	23 CC Beds - private 27 Rest Home - private	23 CC Beds - private 27 Rest Home - private
Maternity	4 Maternity Beds LMC Midwives (2.0) Core Midwives (1.2)	2 Maternity Beds LMC Midwives (1.6) Core Midwives (1.0)	2 Maternity Beds LMC Midwives (1.6) Core Midwives (1.0)	2 Maternity Beds LMC Midwives (1.6) Core Midwives (1.0)
Community Nursing	DN PH Diabetes Educator	As per current levels creation of generalist nursing roles	As per current levels creation of generalist nursing roles	As per current levels creation of generalist nursing roles
Emergency Services	Level II AM St John Volunteer Trauma Stabilisation	Level II AM (with charges) St John Volunteer Trauma Stabilisation	Level II AM (with charges) St John Volunteer Trauma Stabilisation	Level II AM (with charges) St John Volunteer Trauma Stabilisation
Outpatient Clinics	12 specialties	12 specialties	12 specialties	12 specialties
Allied Health	Radiology OT/Physio/SW/NASS	Digital at current levels	Digital at current levels	Digital at current levels
Mental Health	Community MH A and D CAFS	at current levels	at current levels	at current levels
Other Services	DA/PC M on W Surgical Bus	at current levels	at current levels	at current levels
Volumes				
Inpatients				
GP Beds	1,849	56%	1,849	63%
CC beds	6,297	101%	0	0
Resthome Beds	8,761	89%	0	0
Maternity - Births	19		19	19
Maternity - Post natal Stays	36		36	36
Ambulatory				
Emergency	1,419		1,419	1,419
Outpatients	3,421		3,421	3,421
Financials \$,000				
Revenue Opportunities				
Triage 4/5 charging			30	30
Staffing Costs	2,171		958	997
Outsourced Staffing Costs	200		195	129
Clinical Supply Costs	164		75	70
Infrastructure Costs	625		273	249
Total Direct Costs	3,160		1,501	1,589
Overheads				
Buller Site - Depreciation	166		325	300
Buller Site - Maintenance	192		61	56
Laundry	28		5	4
Labs/Rad/Pharm	134		81	78
Corporate Overhead	281		240	240
Total Costs	800		713	678
Net Costs	3,960		2,244	2,392
New Facility Cost			6,500	6,000
Facility Life			20	20
Other Costs resulting				
Volumes				
Aged Care Patients - in private	0	8,761	8,761	8,761
Continuing Care - in private	0	6,297	6,297	6,297
Inpatients - Grey Hospital	0	0	0	535
Costs				
Resthome @ \$85 per night		745	745	745
CC @ \$130 per night - private		819	819	819
Inpatients @ \$100 per nigh (marg)		0	-	54
Increased transportation costs				20
Total Additional Costs	-	1,563	1,563	1,637
Total Cost	3,960	3,807	3,955	3,789
Potential Saving		153	5	171

Appendix 2

Appendix 3

PREVIOUS HEALTH SERVICES OPTIONS FOR BULLER AND REEFTON

Due to the long-standing nature of some of the trends and issues outlined in Section 2 above, health service delivery in the Buller District has been reviewed several times in recent years. The following is a brief summary of these previous reviews, excluding any work done previously for the Buller District Council by Grafton Consulting Group.

Again, this information is to provide a wider context to the new service configuration and governance options outlined in Sections 4 and 5.

The first review, undertaken by Morton & Gollop, was completed in 1998. For clinical safety and financial reasons, Morton and Gollop recommended large-scale reductions in local service delivery in Buller and Reefton. Specifically, they recommended the removal of virtually all inpatient capacity at the Reefton and Buller Hospital sites.

Following Morton and Gollop, the Dunt Report, completed in 1999, was generally supportive of the status quo range of services in each community. However, Dunt acknowledged the possibility of exiting the rest home beds in Reefton and supported private provider service provision, if it was more efficient, for the remaining aged care services in the region.

The most recent review was completed in 2000. The review was initiated by Coast Health Care, the Health Funding Authority and the Crown Company Monitoring and Advisory Unit and was undertaken by Deloitte Touche Tohmatsu. The report, titled *Health Services Options for Buller and Reefton*, recommended the following after an analysis of a number of different service delivery options (overleaf):

With regard to this last review, it was acknowledged at the time of its release that the options had been developed prior to the 1999 election and would therefore need to be reworked to ensure that they were consistent with the strategic direction of the new Government.

As it transpired, the resulting changes to the health sector structure, including the creation of District Health Boards, meant that no action was taken at the time to progress the preferred options outlined overleaf.

Health Service Options for Buller and Reefton (Deloitte's, 2000)

Buller	Reefton
<p>Philosophy: Improved integration of primary and secondary services and a strengthened focus on primary/community health services</p> <p>Services:</p> <ul style="list-style-type: none"> • Outpatient services • Maternity beds and services • Flexi beds for short-stay admissions and stabilisation • Community-based services • GP services • Emergency (PRIME) services • No rest home or continuing care beds in core hospital configuration - but a JV with another provider that incorporates rest home beds, continuing care beds, day centre and assisted living units/villas – located on hospital grounds. <p>Governance: Establish a 'community agency' to manage and operate the facility and services</p> <p>Facility: Greenfields/purpose built</p>	<p>Philosophy: Improved integration of primary and secondary services and a strengthened focus on primary/community health services</p> <p>Services:</p> <ul style="list-style-type: none"> • Outpatient services • Small number (2-4) of flexible beds for short stay admissions and stabilisation • GP services • Community-based services • Emergency (PRIME) services <p>Governance: Establish a community health care agency with strong GP input.</p> <p>Facility: Greenfields/purpose built</p>

