This Report was written by John Marwick of Sky Blue House Limited and Jo Esplin of Acqumen Quality Solutions under the Waimate Health Services Model of Care project sponsored by the South Canterbury District Health Board.

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Executive Summary

This paper proposes a new more integrated model of care for health services in Waimate. It describes the community, its health needs and current health service arrangements, explains why change is recommended and explores opportunities, barriers and processes associated with the recommended model of care and the establishment of an integrated family health centre. A strategic business case is provided in a separate paper.

The paper was developed as part of a project sponsored by South Canterbury District Health Board whose objectives were to:
- develop a model of care to meet the primary health care needs of the Waimate population
- develop a business case for a joint primary care location in Waimate to support this model of care
- discuss the proposed model of care and the business case with current healthcare providers and the local community.

The report is based upon 29 semi-structured interviews with 57 people from 27 key provider groups as well as a variety of reference sources. The proposals were subsequently discussed with the project sponsor and steering group and with members of the Waimate community at a public meeting.

The 2006 census showed South Canterbury District with a higher proportion (18 percent) of people 65 and over than the national average (12 percent) – and Waimate a slightly higher proportion (19 percent) than the rest of the South Canterbury District. The Waimate District population has higher levels of socio-economic deprivation than the rest of South Canterbury though not as high as the national average; but Waimate town is one of only two local areas with a deprivation score of 9 out of 10. The proportion of Maori in Waimate (5.2 percent) is lower than the District (5.7 percent) and the national average (14 percent).

There are two Waimate medical practices. Waimate Medical Centre has about 2,300 enrolled people with higher proportions of older and Maori people compared to Oak House Medical Centre’s 2,700. There were concerns about the length of time to get appointments for general practice care particularly at Waimate Medical Centre. This may in part reflect the high proportions of older people and an associated higher expected number of consultations for each doctor. It is calculated that, with current staffing, Oak House has workload per doctor that is 14 percent higher than the national average and Waimate Medical Centre 25 percent higher. Fees for adults at the Waimate Medical Centre are comparable to those in other small towns in the region and at Oak House are 25 percent higher. Fees were not identified as a barrier in the interviews.

The two practices employ four regular doctors (two full-time, two part-time) and various part-time locums making up approximately 3.5 full time equivalents in total. They also employ about seven practice nurses making 3.5 FTEs. Waimate has had a particular difficulty since about 2002 in recruiting doctors who wish to stay in the town for any length of time and many people identified a lack of consistent general practitioners as a major problem. Currently there are doctors who have been in town for some years and the community has shown it is keen to help retain them. However, the future population needs and the demands on practitioners under the current model of care mean that the sustainability of the current workforce cannot be considered secure.

Waimate has a range of other primary health services supplied locally: a pharmacy, two private physiotherapists and two days of community physiotherapy each week, three days of private dental service, a district nurse, a public health nurse, one and a half Plunket Nurse days per week and an ambulance station. There is a variety of visiting mental health and addiction services as well as a local counselling service. Longer term personal support services include home care for the elderly and people living with disabilities, meals-on-wheels, a day care service for the elderly and some mental health clients, and the Lister Home
which provides hospital and residential care for the elderly as well as two palliative care beds. Specialist secondary care is supplied at Timaru Hospital as are diagnostic services such as X-Ray and laboratory testing though blood samples are collected locally by nurses at both medical centres.

Generally the report found that the range of services available in Waimate (both publicly- and privately-funded) is appropriate but that there are issues with availability of general practice care, continuity of care, and that sustainability of workforce is not assured. At present little attention has been paid to assuring or improving the quality of services and a number of current premises are inadequate and / or will require significant capital investment in the near future. There is considerable scope to increase cooperation between health providers and practitioners – including between residential care and day care for the elderly.

The Government has plans for the establishment of multidisciplinary Integrated Family Health Centres and expects DHBs to start to lay foundations for such centres. When looking at how health services in Waimate might change opportunities to move towards such a development have been considered.

A continuum of options for change is presented:

<table>
<thead>
<tr>
<th>No change other than currently planned</th>
<th>Changes within current separate services &amp; businesses</th>
<th>Working across existing primary care services</th>
<th>Collocate core primary care services as separate businesses with some sharing</th>
<th>Collocation of more services with practices integrating into single business</th>
<th>Integration and collocation of wider services into one business</th>
</tr>
</thead>
</table>

These options are described and analysed against a set of criteria (see tables on pages 25 and 26). Some improvements can be achieved within current service configurations and existing premises but the most gains will come from closer working relationships and sharing between providers, with collocation providing the most opportunities to achieve this. Most improvements in workforce sustainability, patient access, efficiency and attention to quality are likely to be achieved by joint clinical governance and cooperation to establish a new multidisciplinary centre of excellence, innovation and training.

The following steps are proposed:

- Establish clinical governance and virtual teams across the town
- Build agreement about collocation of family health care with parallel discussions about coordinating and/or collocating care for the elderly
- Source and gain commitment from a capital investor(s) for new premises
- Design a professionally attractive centre of excellence and innovation
- Build a new centre
- Develop services in the new centre
- Explore greater integration later.

Chapter 4 looks at supporting and enabling these stepped changes to occur. Leadership will be needed – particularly a local champion or champions but also the local Primary Health Organisation (PHO), South Canterbury DHB, and the Waimate District Council can be important catalysts and supporters. The changes needed to establish a multi-disciplinary integrated family health centre in Waimate are significant and will need careful processes and management and an inclusive steering group to oversee the process. Detailed business and financial planning will be required as well as identifying one or more suitable capital investors, choosing a site and designing the facility.

In conclusion this report finds that a multidisciplinary integrated family health centre is possible in Waimate and would be the best way to attract and retain the range of staff needed to deliver quality services that will meet the community’s needs and sustainably improve accessibility and continuity. Support and opportunities exist for such a concept; considerable development work is needed to make it a reality.
1. Purpose, Background and Methodology

1.1. Purpose
This paper proposes a new more integrated model of care for health services in Waimate. It describes the community, its health needs and current health service arrangements, explains why change is recommended and explores opportunities, barriers and processes associated with change.

1.2. Background
Establishing and maintaining appropriate health services is a concern of communities, particularly rural communities, across New Zealand as in many other parts of the world. The challenges of attracting and retaining a suitable health workforce are particularly acute in smaller communities – as has been recognised by the Government in its recently announced voluntary bonding scheme for doctors, nurses and midwives who are prepared to work in hard to staff areas or specialties.\(^1\)

In Waimate there is a long history of community interest in ensuring local health services\(^2\). When the Waimate Hospital was closed in the 1980’s a day care service and a base for district nursing services were established in the old hospital premises, while a group including six local churches set up the Lister Home (residential care for the elderly including a geriatric hospital).

The Waimate Medical Centre was the only general medical practice in town until Dr Hammond Williamson left the Centre in 1992 and set up the Oak House Medical Centre. In 2003, two long-time practitioners left the Waimate Medical Centre and at that time residents petitioned the District Council to take over the business so that they would continue to have a choice of practice. The Council still owns the Medical Centre although the Council has now agreed to transfer the practice to Dr Sarah Creegan, the Centre’s current long-term general practitioner,\(^3\) from 25 May 2009. The Council in its 2006 – 2016 Long Term Council Community Plan noted that a project was under consideration to “construct and maintain a single-location Medical Centre Building.”

The South Canterbury District Health Board (South Canterbury DHB – responsible for health services across South Canterbury) and the Aoraki Primary Health Organisation (responsible for general practice and a number of other primary care services across the South Canterbury District) have recently been looking at the future of health services in Waimate and have been engaged with the District Council and with local providers. A number of providers had indicated that they were considering shifting from their current premises for various reasons and the DHB wishes to explore options for collocation of services and the model of care which would enable the best outcomes for the Waimate population.

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\(^1\) The South Canterbury area has not been included as a ‘hard-to-staff’ area in this project but general practice is recognised as a hard to staff branch of medicine: see [http://www.moh.govt.nz/bonding](http://www.moh.govt.nz/bonding)

\(^2\) For many years the Waimate Hospital was protected under an Act of Parliament: see *The Fifth Schedule: the story of Waimate’s open community hospital*; Shackleton, BE, 1984 Craig Printing Invercargill.

1.3. Methodology

In December 2008 the South Canterbury DHB, representatives from the Waimate District Council and other Waimate health service providers selected independent consultants, with a background in primary care, funding and health services planning, to undertake a review and make recommendations for future health service model of care options in the Waimate district. The project ran from January to May 2009.

A steering group was established and its Terms of Reference are attached as Appendix 1. The steering group approved the project plan (see Appendix 2). The objectives of the project were to:
- develop a model of care to meet the primary health care needs of the Waimate population
- develop a business case for a joint primary care location in Waimate to support this model of care
- discuss the proposed model of care and the business case with current healthcare providers and the local community.

The key health provider stakeholders were identified and 29 semi-structured interviews were held over a week in March 2009 (see Appendix 3) involving 57 people from 27 groups. The interview template is attached as Appendix 4. Interviews were recorded, summarized, analysed and used for drafting this report.

Options for the model of care were developed from the interviews and with reference to other material as described below. Draft options were tested with core stakeholders and the community of Waimate.
2. Current Situation

2.1. Demographics

As can be seen from Figure 1 Waimate, in common with the rest of the South Canterbury district, has a higher proportion of people aged over 45 and particularly of those over 65 than is the national average.

![Age groups of usually resident populations. Source: Census 2006](image)

The population is largely Pakeha: in the 2006 census only 5.2 percent of the Waimate resident population identified as Maori compared to 14 percent nationally and 5.7 percent across the South Canterbury District.

Waimate is one of the few areas of socio-economic deprivation in the South Canterbury District. According to the New Zealand Deprivation Index only 9 percent of South Canterbury people live in areas with a deprivation score of 9 or 10 compared to 21 percent nationally. However, as shown in Figure 2, 12.7 percent of people in the Waimate District live in areas scoring 9 or 10, and Waimate town is one of only two census areas units in the South Canterbury District where the average deprivation score is 9.

![Socio-economic Deprivation in Waimate District. Source: NZ Deprivation Index Based on 2006 Census](image)
These census data for age, ethnicity and socioeconomic deprivation data are even more evident in the makeup of those enrolled in Waimate’s two medical centres as shown in Figure 3 and Figure 4. Waimate practices have higher proportions of people aged 65 and over and fewer in the youth age group when compared to both the national PHO enrolment data and data for the local PHO (Aoraki PHO). Waimate is similar to the national average for socio-economic deprivation but more deprived than the rest of the PHO, whereas Maori make up a much smaller proportion of both the Waimate (especially Oak House) and PHO practices than nationally.

Figure 3 Age groups of enrolled populations. Source: PHO Enrolment Data January – March 2009

Figure 4 Socio-economic deprivation & ethnicity of enrolled populations. Source: PHO Enrolment Data January – March 2009
2.2. Grouping and criteria used for describing current services

In this section current health services are looked at in the following groupings:

- Generalist first-level services (e.g. general practice, pharmacy, emergency care)
- Targeted first-level services addressing a narrower group of people or problems (e.g. maternity, mental health, well-child, dentistry) or using particular therapies (e.g. physiotherapy, podiatry)
- Longer term personal support services (e.g. home and residential care for the elderly and disabled)
- Secondary care services (more specialised services that generally require referral – e.g. general surgery, cardiology or psychiatric services)
- Services in support of other health care (e.g. laboratory and X-ray).

In each grouping the following dimensions of services will be looked at where relevant:

- Accessibility (including aspects such as availability and cost)
- Quality (including technical quality, satisfaction, premises)
- Sustainability (including workforce, continuity of service and financial viability)
- Coordination and linkages (between services).

2.3. Generalist first level services

2.3.1. General Practice

Accessibility

There are currently two separate general practices in Waimate: Waimate Medical Centre and Oak House Medical Centre. According to January 2009 enrolment data Waimate Medical Centre had an enrolled population of some 2,300 people and Oak House about 2,700. Thus the total for both practices is around 5,000. The Waimate District had a usually resident population of 7,200 at the 2006 census. It is estimated that 95 percent of New Zealanders are enrolled in a PHO so it can be assumed these figures show that about a quarter of the Waimate District population is enrolled in practices outside Waimate town.

As shown in Figure 3, Oak House’s enrolled population is similar to the overall PHO enrolled population showing considerably higher than the national average proportions of people over 65 and lower proportions in the younger adult age groups. This trend is more marked in Waimate Medical Centre where 27 percent of the enrolled population is aged over 65 compared to 21 percent at Oak House, 18 percent in Aoraki PHO as a whole, and about 13 percent nationally.

Several interviews pointed to availability issues with general practice services. People sometimes have to wait two weeks or longer to get a routine medical appointment particularly at the Waimate Medical Centre and instances were mentioned of difficulty in being seen for urgent care both in the daytime and out of hours. The two practices share on-call arrangements but there were reports of times when no cover was available in Waimate.

The overall availability of doctors in Waimate is about 3.5 FTE GPs to 5,000 enrolled population (1.9 FTE at Oak House and 1.6 at Waimate Medical Centre): a ratio of one GP to 1,430 people which is similar to the national average. However, this ratio does not take account of the difference between the Waimate population and the national average. As shown above the Waimate population has a greater proportion of older patients. The national capitation funding for general practice services is based on data showing that in the 65+ age group 8.6 consultations can be expected each year compared to 3 in the 25-44 group and 5 at age 45-64. Using these expected consultation rates it can be calculated that nationally an average full-time general practitioner would expect about 5,800 patient consultations annually. By contrast with current
staffing levels a full-time doctor at Oak House is likely to have 6,600 consultations (14 percent above the national average) and at the Waimate Medical Centre 7,200 (25 percent above the national average). To have workloads comparable to the national average Waimate would need four FTE GPs.

Variation from national averages is of course to be expected and the Waimate situation is likely to be similar to other parts of the country, particularly other rural areas where it is difficult to attract and retain doctors. However, comparisons such as these help to explain some of the issues with availability and point to the need to consider different ways to deliver services and to attract staff – points which will be discussed later in this report.

Cost barriers are sometimes an important aspect of accessibility to general practice services. Costs were not mentioned as a common barrier in the provider interviews held for this project although they were identified in the 2006 Social Needs Analysis commissioned by the District Council. The fees for general practice consultations differ between the two practices in Waimate as shown in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Under 6</th>
<th>6-17</th>
<th>18-64</th>
<th>65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oak House</td>
<td>Free</td>
<td>$25</td>
<td>$35</td>
<td>$35</td>
</tr>
<tr>
<td>Waimate Medical Centre</td>
<td>Free</td>
<td>$25</td>
<td>$28.50</td>
<td>$27</td>
</tr>
</tbody>
</table>

As expected, fees vary between general practices across the region. The Waimate Medical Centre fees appear to be similar to other practices in the region with Oak House adult fees being at the upper end of fees. Adult fees have dropped significantly as a result of government funding increases since 2006.

Quality

Quality of general practice care can be measured in various ways and such measurements are becoming increasingly common in New Zealand and around the world. Ways to measure practice performance include the PHO Performance Management Programme, the Royal New Zealand College of General Practitioners’ Cornerstone Accreditation programme, and a number of tools such as patient satisfaction questionnaires. There are also increasingly requirements for individual practitioners to demonstrate their ongoing competence for example, vocationally registered general practitioners must take part in an ongoing programme called Maintenance of Professional Standards, and nurses have to show evidence of assessment of ongoing competence for registration with the Nursing Council.

The PHO Performance Management Programme is a national programme which all PHOs take part in. It uses various indicators of clinical performance. Data are collected quarterly, analysed both at the practice level and across the PHO, and there are financial incentives for achieving target levels of performance. As part of the Performance Management Programme the PHO is required to have clinical governance structures and

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4 Mackay, Sarah; *Waimate District Social Needs Analysis*; Waimate District Social Services Committee, 2006. This analysis occurred at about the time that fees for general practice were being reduced as a result of increased government funding.


6 The Cornerstone accreditation programme


8 Clinical governance has been defined as “a framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment
processes in place to help ensure safe high quality care. At present the performance management programme focuses on helping practices improve their performance and the PHO does not release data publicly although this may occur in future. The Aoraki PHO has a coordinator who works with local practices to help them understand the programme and identify where they can improve their performance. The coordinator regularly visits the Waimate practices for discussions with management and clinicians (doctors and nurses). A recent informal survey\(^9\) of general practitioner opinion about the national performance programme showed only limited and minority support for the programme in its current form and changes are likely to occur.

At this time neither of the Waimate practices has applied for the Royal New Zealand College of General practitioners’ Cornerstone practice accreditation programme. The programme is voluntary; so far about a quarter of all practices are accredited nationally including four out of South Canterbury’s 26 practices. Dr Creegan at the Waimate Medical Centre indicated that she hopes the practice will apply for accreditation in the next year or two. Accreditation is likely to be required in the future for practices that wish to be involved with training programmes.

Assuring the competence of medical practitioners is a responsibility of the Medical Council of New Zealand. There are currently four doctors with ongoing commitments in the two Waimate practices (two are full-time and two part-time) as well as a number of doctors on short term contracts. Two of the four doctors are registered with the Medical Council of New Zealand under the vocational scope of practice for general practitioners – meaning that they have passed certain training and assessment requirements and are demonstrating their ongoing competence in this area of practice. Of the other two doctors one is currently registered in the ‘general scope of practice’ (rather than as a vocationally registered general practitioner) and the fourth, as is normal with recent immigrants to New Zealand, is provisionally registered with the Council pending completing the requirements for admission to the general scope of practice.

The two practices employ about seven practice nurses who also work varying numbers of hours each week (approximately 3.5 FTEs). These nurses are all registered with the New Zealand Nursing Council in the Registered Nurse scope of practice, although one is currently studying towards the qualifications needed to become registered under the more advanced Nurse Practitioner scope of practice. Nurse Practitioners are, with suitable training, able to prescribe medications and order diagnostic tests.

This project has not involved any direct measures of patient satisfaction or community opinion. However, in the course of interviews and discussions many comments were made that one of the most important aspects of health care for the Waimate community was the need for better consistency and continuity of care over time. This was also identified as a significant need in Sarah McKay’s 2006 Social Needs Analysis for the District Council. The public meeting held in Waimate on 3 March 2009 is a clear demonstration of how important the community think it is to retain a general practitioner who has shown an interest in staying in the town; it was also a demonstration of the strong support that Dr Creegan has in the town.

Premises and equipment are another dimension of quality. Both medical practices lease premises that have been designed and built or adapted for general medical practice. The Waimate Medical Centre, a concrete block building, was built as a practice in the 1980’s and has had some internal adaptation since then. It is, however, generally considered to be not well suited to current medical practice and the building has

problems with heating, noise, and leakage. Oak House is a more adaptable building which has grown and changed somewhat over the years. It currently seems to be working adequately for the present model of practice.

**Sustainability**

A major challenge for many rural communities is retaining and recruiting sufficient general practitioners. This has been the case for Waimate in recent years and it is seen by those interviewed as a very important issue for the town. Currently, Dr Creegan has been at Waimate Medical Centre for two years and has recently agreed with the District Council that she will stay and take over the business. At Oak House the two part-time practitioners have been in Waimate for some years and Dr Fish, the fulltime doctor, has been in the practice for about a year. This represents a more stable medical workforce than had been the case over the previous five years. However, as described above, the demands on these doctors are quite high and people’s access to service is not ideal. Such considerations are likely to make it more difficult to sustain the current situation. Therefore it can be concluded that the sustainability of the town’s medical workforce is not secure.

Nursing workforce may be a little better placed. Many of the current practice nurses have been employed for some years – although Oak House’s most experienced nurse recently left the district and Waimate Medical Centre has just appointed a new experienced nurse. In step with developments elsewhere nurses are beginning to take on a bigger role in general practice service delivery in the town and this is likely to be to be crucial for the future sustainability of services.

Another aspect of sustainability is the financial position of the businesses. In recent years the government has significantly increased its contribution to general practice through the Primary Health Care Strategy. While this increased government contribution has to a certain extent been off-set by a drop in patient fees, overall the financial sustainability of general practice business has improved. However, one major change that has taken place with the strategy is that most government funding is now tied not to the number of times that doctors see patients but to the number of patients enrolled in the practice. This allows opportunities for new ways of planning and running the service and business; in particular it supports a wider use of nurses as well as doctors.

This project has not sought to have access to financial details of the Waimate practices. However, the Mayor has stated publicly that the Waimate Medical Centre has in each of the last two years paid back $20,000 of a Council loan and has still made a small profit. The owner of Oak House also indicated that the business is at this time financially sound.

**Coordination and linkages**

At times over the last 15 or so years there have been tensions between the general practices in Waimate and, as a result, coordination between health services in the town has sometimes been less than ideal. In more recent times there are signs of growing cooperation with doctors establishing a peer group to discuss clinical matters and with some social and educational gatherings involving a range of different local health professionals.

Interviews with other providers of services indicate that links with Waimate general practice vary and that there is certainly room for improvement. When asked about advantages of collocation of services to a single facility most providers stated that such a facility would make it easier to communicate effectively with the doctors and nurses in the general practices.
2.3.2. Pharmacy

Waimate Pharmacy is the only pharmacy in town. Two previous pharmacies were uneconomic as separate units and amalgamated within the last ten years. The current business is located on the main street.

The service provides the usual range of professional and retail community pharmacy services. In addition the chief pharmacist is accredited as a Medicines Use Review pharmacist and provides this service to clients under South Canterbury DHB funding.

At present there do not appear to be issues with access to pharmacy services in the town. The interviews did not raise any questions about aspects of service quality or satisfaction. The premises, like most of the shops on the main street, are quite old and have a considerable amount of space in addition to the retail space. Some of this space is used for storage and also the pharmacist has been able to make space available to the Arthritis New Zealand educator for client education sessions.

As with doctors there are difficulties with pharmacist workforce in rural communities. Paul Townend, the present chief pharmacist, has been in Waimate for quite a number of years and there is also second pharmacist working in the business. With an eye to ensuring that younger pharmacists understand small-town pharmacy and the opportunities it offers, the pharmacy is a training base for pharmacists during their intern period.

In terms of coordination the pharmacist seems to have well-established relationship with the two practices and their prescribers. Paul Townend has also been responsible for initiating some social meetings with a range of health practitioners across the town – dentists, physiotherapists, doctors and nurses.

2.3.3. Emergency services

St John Ambulance provides an emergency ambulance service in Waimate with two vehicles stationed in the town (one funded under the government contract and one funded by the local community). There is a paid ambulance officer in the day time during the week and volunteer officers the rest of the time. This level of service is higher than the standard level for a community of this size.

The two medical practices co-operate to provide after-hours urgent cover in the town. This generally works satisfactorily although it was reported that on a few occasions cover was not available. The Aoraki PHO has contractual responsibility for ensuring out of hours cover and has received some extra funding for the purpose. Waimate’s difficulties with ensuring doctor availability affects after hours cover. So far it seems Waimate has not used nurses to provide first contact advice as happens in a number of other rural communities.

2.4. Targeted first level services

2.4.1. Physiotherapy

There are two private physiotherapists based in the Waimate district both of whom mainly provide ACC-funded physiotherapy treatments for musculo-skeletal problems. Waimate physiotherapy operates from premises in the main street (very close to the Waimate Medical Centre) and Bridget Harrison is a physiotherapist in Waihao Downs.

In addition to these private physiotherapy services the DHB provides community physiotherapy services on two days a week in Waimate.
This level of local service seems to give reasonable access to physiotherapy for a community of this size. Two physiotherapy practices in Waimate compares to five in Timaru, three in Oamaru and none in Geraldine, Temuka or Twizel. There is also half a day’s chiropractic service each week which is currently provided out of the Oak House Medical Centre.

There did not seem to be any close linkages between these providers and other local health services – but, equally, there were few comments about the need for increased links.

2.4.2. Community nursing

The DHB provides District Nursing services based at the Hunter’s Hill Lodge site (part of the old hospital complex). During the week the service has one full-time registered nurse and four hours of enrolled nurse time each day, and at the weekend four hours each day of registered nursing. DHB management explained that this level of access compares favourably with the level of service in other similar-sized communities in the district.

The current Hunter’s Hill base is used both for the District Nursing service and also as a storage space for other DHB community services (physiotherapy and occupational therapy). It is an old building which needs significant maintenance and is not well-suited to its purpose.

As is usual for community nursing services throughout the country this service links back mainly to its hospital base and management. Referrals are received and allocated centrally in Timaru hospital. Some local GPs expressed frustration about this arrangement and thought that if they were able to make referrals directly to the local nurse (as was previously the arrangement) the service would be more responsive to local needs. There is communication with local practitioners when needed for particular clients but at present the community nursing does not appear to be involved in any ongoing way with other local Waimate primary care teams.

2.4.3. Public health nursing

There is a public health nurse responsible for the Waimate area and working with the schools. She provides a range of clinical and advisory services across the primary and secondary schools in the area. One public health nurse is what would be expected for a community of this size though, as noted in several interviews, there are many high need families in the area that mean high demands for public health nurse services. The nurse has links as needed to health, educational and social services in the area though it was noted that there are sometimes difficulties in arranging for educational needs assessments for children.

2.4.4. WAVE: health promotion services

The Wellbeing and Vitality in Education (WAVE) programme is an inter-sectoral health promotion programme in the Waimate District running since 2007 across three educational levels: Early Childhood, Primary and Secondary. Initiatives have been funded ($50,000 over the last two years) both through the Ministry of Health Healthy Eating Healthy Action programme and through South Canterbury DHB.

2.4.5. Well-child nursing

Well-child nursing services are provided by the Plunket Society from Plunket rooms in Waimate. Because of rising birth numbers in the last two years the level of service in Waimate has increased to 1.5 days of nursing time each week and half a day by a Karitane support worker. This level of service is in line with the national Plunket contract.
The Plunket rooms are also used for parenting education, movement and music classes, a playgroup and also by the DHBs’ visiting asthma nurse specialist.

There are reported to be good communications between Plunket nurses and other providers though inconsistent local doctors has made this harder in the past.

2.4.6. Maternity care

The South Canterbury District is different to all other parts of New Zealand in its provision of maternity care. Throughout the rest of the country only eight percent of births have a specialist obstetrician as the Lead Maternity Carer10 whereas over 85 percent of South Canterbury births have a specialist obstetrician as LMC. There are only two independent midwives in the South Canterbury district and they note that they have few requests to care for women in the Waimate area so it is likely that more than 95 percent of Waimate births have an obstetrician LMC. These births are managed by hospital-based continuity of care teams of midwives and obstetricians. Some ante-natal care is provided in women’s homes (or, early in pregnancy, in general practices) and some in Timaru hospital. Post-natal care after discharge from hospital is provided by midwives from the team who visit in people’s homes.

2.4.7. Oral Health care

The community dental service (provided by the Canterbury DHB) provides dental care to pre-school and primary school children for a number of weeks each year by therapists who visit the dental clinics in two Waimate primary schools. Adolescent care and more complex care for children is provided under contract with the private part-time dentist in the town. There are currently plans to replace the ageing clinics with a mobile dental service which will visit the town several times each year.

The private dental service is provided three days each week by two dentists from Oamaru. Premises are in the main street.

2.4.8. Mental health and addiction services

A range of mental health and addiction services are provided in Waimate for adults, children and adolescents. They use a variety of different premises in the town – sometimes in one or other medical centre, sometimes using a room available in the Heartlands Service Centre based in the old post office (operated in a number of rural and provincial centres by the Family and Community Services, a service of the Ministry of Social Development). Interviews showed that there is a lot of variability between services in their links with other primary health care services and in the extent to which they receive referrals.

Brief intervention treatments (usually up to four treatments) are provided for adults through a DHB-funded service provided by Southlink Health. This service takes referrals from GPs and currently uses a room at Oak House. A similar service for adolescents is provided by the Adventure Development Trust and uses a variety of premises (GP rooms are used in some other towns but were not available in Waimate). This Trust also provides adolescent drug and alcohol addiction programmes, mental health assessment and a programme for adolescents with behaviour and mental health issues.

DHB mental health and addiction services provide a number of services into the Waimate community. A six-weekly clinic for more severe mental health problems is based at the Waimate Medical Centre. The Smoke-Free service also runs smoking cessation groups in the Medical Centre.

Centrecare counselling is a longer term counselling service based in Waimate. It is partly funded by clients (like many other primary care health services) and receives some funding through, for example, the child and family service, the courts, and ACC. This service is provided from a converted house adjacent to the Lister Home.

2.4.9. Other targeted services

Other services that are supplied in Waimate include exercise and falls prevention services (South Canterbury DHB-funded), podiatry services (private visiting Lister Home), dietician services (at Lister Home), arthritis education (Arthritis New Zealand), Maori mental health services (provided through Arowhenua Whanau services) and a provider of cranio-sacral and Reiki therapy (Di Dennison, natural therapist).

2.5. Longer term personal support services

2.5.1. Home support services

Home support services are provided for the elderly, some younger people with disabilities, some requiring support because of injury, and, in a small number of cases, for young families with new babies.

An elderly person or a person living with a disability who may need support is first assessed by the Needs Assessment and Service Coordination (NASC) service which the DHB currently contracts to Southlink Health. Referrals to the NASC service come from individuals and their families, and from health and social care agencies. Southlink Health is an Independent Practitioner Association (IPA) to which both Waimate practices belong. It employs two part-time workers in Waimate. Southlink noted that greater continuity of GPs is an issue in Waimate.

If a Waimate person is assessed by the NASC service as eligible for subsidised support in their home they then have a choice of four providers: Access Health, Forward Care Home Health, Health Care New Zealand, and Presbyterian Support Services. All of these providers are based in Timaru but employ part-time carers in Waimate. They each have care-coordinators who visit clients in their homes, allocate an appropriate carer, and supervise care. Each organisation indicated that they sometimes contact health services for clients – particularly the district nursing service or occasionally through practice nurses at the medical centres. They identified lack of continuity of GP cover as an issue.

At one stage up to 2006 Forward Care Home Health sub-contracted Lister Home to provide home support services on Forward Care’s behalf. Lister Home reported that they grew to have some sixty clients and felt that it was an advantage to have a locally-based care provider. However, the sub-contract has since been withdrawn because Forward Care had concerns about being responsible for a workforce that they were not monitoring directly and difficulties in delivering the DHB contractual requirements through a sub-contracted provider.

2.5.2. Meals on Wheels

Lister Home provides a meals-on-wheels service from its kitchens. There are currently 54 clients and approximately 12,000 meals are delivered each year with deliveries every day except Christmas Day.
2.5.3. Day Care

Waimate Health Developments is an incorporated society which supplies day care services for elderly and some mental health clients. The service is provided from premises at Hunters Hill lodge – part of the old Waimate Hospital. The society owns the land and buildings and operates from those premises under a contract with the South Canterbury DHB. There are currently some 45 clients in total with 15 attending each of the four days each week that the centre is open. There are two supervisors (one a registered nurse) as well as two care assistants, a cook and an administrator.

The premises are old, costly to heat and require upgrading. However the interviewer heard from current board, staff and some of the clients that they believe their current site at Hunter’s Hill has a number of advantages in terms of space for walks and gardening and they like the aspect of the hills and open space that is a feature of the site. The board has a plan to fund some renovation of another building that they own on the site and to move the services to that building.

The day care services do not appear to be well linked in to other services in the town and, in particular, there is little coordination and some tension between that service and Lister Home’s residential care.

2.5.4. Residential care

Lister Home provides long-term residential care for the elderly including 40 rest home and 16 hospital beds (there is no dementia care unit) as well as short-stay respite care. There are also two palliative care beds for those with terminal illness.

The home is an incorporated society governed by a board of 12 with representation from local churches. The building was started when Waimate Hospital was closed and has developed over the years. Overall the building is a modern facility and there are plans for further development. The kitchens supply meals-on-wheels to around 60 clients.

There is currently a staff of about 70 including registered nurses, caregivers, cooking and cleaning staff and administrators. Residents are enrolled with one or other of the medical centres in town and general practitioners are contracted to provide medical services. There are visiting occupational therapy, physiotherapy, podiatry and ear-health practitioners.

2.6. Secondary care services

Most secondary care for the South Canterbury district is provided in Timaru Hospital. This includes in-patient, out-patient, and support services.

Some services for people with ongoing serious mental illness are provided in Waimate by way of a six-weekly rural psychiatric clinic. There are visiting mental health, child and adolescent psychiatric, and alcohol and drug services.

2.7. Supporting services

Laboratory services (both community and hospital-based services) for the district are provided by Medlab South from a laboratory at Timaru Hospital and their laboratory facilities in Christchurch with collection points in Timaru and Temuka. There is no separate collection point in Waimate but both medical centres have a contract with Medlab for their practice nurses to collect blood specimens which are then transferred to the laboratory by courier.
Radiology and other imaging services are provided at Timaru Hospital and at Timaru Radiology, a private radiology practice. As in most communities of its size there is no local radiology service in Waimate.

2.8. General observations about current services

Accessibility

The main concerns voiced about accessibility were the sometimes long wait for general practice appointments. This is at least in part a reflection of the number of doctors compared to the age structure of the population – particularly in the Waimate Medical Centre. If there were four FTE general practitioners for the community then the demands would be closer to the national average but there are at present only about 3.5 FTEs available.

Of course, even if it is possible to increase doctor-patient ratios by attracting another doctor, the economics of this need to be considered. More doctor hours for the same population would add costs (in medical salaries) which would not necessarily be balanced by increased income (since government funding is now independent of the number of times each patient is seen – only income from patient fees would increase). The business realities of such a change would need to be fully explored.

The time people wait to get an appointment is also affected by the way practices operate: the throughput of patients (the length of consultations and the time doctors and nurses spend on non-patient contact work), how frequently patients are recalled, what kind of health needs nurses manage, how practices manage or use phone and electronic consultations, and appointment schedules. Brief discussions with both practices suggest that at present little consideration has been given to different ways of organising these aspects of care delivery.

Accessibility was not a general issue for other health services. Te Runanga o Waihao representatives stated that, while the proportion of Maori in the Waimate community is low by national comparisons, there are a significant number of whanau who have high needs and who have problems accessing appropriate care. They stated that the only specific Maori services are irrelevant to local Maori since they are provided to certain clients by a provider from a different rohe and different runanga (Arowhenua Whanau Services). They suggest that there is a need for a local whanau ora worker to provide advocacy, links and ways to improve access to services. They noted that the DHB’s recently established Maori Advisory Committee has three Waihao representatives and this should be a helpful development.

Quality

As discussed above in respect of general practice services, continuously improving and demonstrating quality of service is increasingly receiving attention and this is a trend that is likely to continue as it has in other modern businesses. The current Government have indicated that they want DHBs to show how they are involving clinicians in helping to plan and develop health services and this should extend to all services not just those provided in hospitals.

The Primary Health Care Strategy states that PHOs will be expected to demonstrate the quality and safety of the services for which they are responsible. It also says that “high quality organisations and providers of primary health care will be those that have a culture of continuous improvement with individuals looking for learning opportunities and the organisation rewarding and supporting such behaviour.” Our observations so far fail to find formal signs of this in South Canterbury or in Waimate.

In terms of premises it is clear that they are currently a significant limitation at least for the Waimate Medical Centre, the Waimate Health Developments, and the DHB community nursing service. Moreover,
services that come into the town use a number of bases and sometimes, when they use one or other medical centre, this limits the referrals they receive because the service is seen as being particularly for that practice’s patients. The lack of a good central facility where both practices are collocated makes it unlikely that the DHB will move more services into the Waimate community.

**Sustainability: workforce considerations**

Another commonly voiced concern about health services in Waimate was the need to attract and retain general practitioners who are prepared to stay for some years in the community. The recent (March 2009) well-attended public meeting called to support the retention of Dr Creegan shows the importance of this issue in the community. While this particular matter has been settled, the challenge of attracting and recruiting staff, particularly doctors, will continue. The whole country faces significant challenges in ensuring sufficient general practitioners in the future especially given the increasing numbers of older people with the associated higher demands for health care. Rural communities are particularly difficult to staff.

The Government has recently announced a programme of voluntary bonding for doctors, nurses and midwives in hard-to-staff areas whereby new graduates will be paid a grant after three years if they work in hard-to-staff hospitals for two years and subsequently in a hard-to-staff area of practice. While South Canterbury is not designated as a place where it is hard to attract new medical graduates to the hospital, general practice is designated as a hard-to-staff area of practice. To make use of the incentives in this scheme as it currently stands Waimate and other similar South Canterbury communities would need to provide a vocational training programme for general practitioners who had completed their hospital training in a hard-to-staff hospital outside the district. The rules around the voluntary bonding scheme are set to be reviewed and it might be possible for the DHB to get recognition for an integrated training programme specifically for rural GPs involving hospital and rural practice training over five years.

The difficulty of attracting and retaining general practitioners also focuses attention on ways to deliver quality primary health care services with lower ratios of doctors to population. For example, practitioners such as nurses and pharmacists might deliver more and wider services, there could be greater use of non face-to-face methods like electronic and phone consultations, or more care might be given in groups where a number of patients can receive care and learn together (particularly for ongoing conditions). All of these methods and others are beginning to be developed and tested in New Zealand and around the world.

**Coordination and linkages**

In general terms there are few linkages between health services in Waimate. However, there has always been considerable community interest in health services in Waimate and this continues to the present – as shown by the support from the Council, South Canterbury DHB, Aoraki PHO and public interest in local debate in public meetings and the press.

Waimate has its share of local politics and history which can sometimes give rise to misconceptions, mistrust and stand in the way of otherwise good developments. The fairly recent history of the two medical practices in town probably explains why it was commonly stated that the two businesses needed to remain separate – even though in most other parts of the country a single general practice for 5000 patients would be thought of as quite an average-sized business and possibly more sustainable than a smaller practice.

Similarly, historical fears and concerns seem to colour considerations about care for the elderly – while it might make sense to have closer links between the services provided by Lister Home and other support care for the elderly in fact there seems to be a quite deep-seated tensions that may mean it would be difficult to examine possible gains in quality or efficiency at this point. There may be future opportunities to be explored at a more appropriate time.
3. Model of Care Options

3.1. What is a Model of Care
Our consideration of a model of care means what health services might be required for the people of Waimate and how they might be configured. This will include what providers and practitioners are needed to supply care now and in future; which services should each provider provide; how can the needed workforce be attracted and retained; where should services be based; what support is needed; and what further developments are possible.

3.2. Criteria to Guide Model of Care Development
The criteria listed in Table 2 below are based on the dimensions used for describing the current situation (see section 2.1 above) with the addition of acceptability and efficiency since any new proposals must find acceptability with key stakeholders and the community and, especially in the current economic climate, must be shown to be an efficient use of limited funds.

Table 2 Criteria to guide model of care development

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptability</td>
<td>The model will find acceptability among the key stakeholders and the community. The successful model will need to show how it builds on the strengths of current services and demonstrate how benefits justify any change.</td>
</tr>
<tr>
<td>Accessibility</td>
<td>The model will ensure timely, affordable and appropriate access to appropriate levels of care in the Waimate district particularly for those with the greatest health needs.</td>
</tr>
</tbody>
</table>
| Quality | The model will deliver good health outcomes by supporting high levels of technical quality and client satisfaction from services provided in suitable premises by well-trained practitioners of a range of disciplines working within their full scope of practice. 

The model should also be flexible enough to support continuous quality improvement and development over time as new ways of delivering care evolve. 

To achieve quality the models of care should have good clinical governance as well as organisational or business governance. |

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11 See the recent Government-commissioned report In Good Hands, Ministerial Task Group on Clinical Leadership, February 2009.
### Criteria | Description
---|---
**Sustainability: Workforce** | The model should aim to attract and retain the range of practitioners needed recognising that evidence shows that practitioners from rural backgrounds or who are exposed to rural practice in training are more likely to practice in rural areas. Recognising the difficulties of attracting health workers the model should ensure that scarce skills are used to best effect and fully use the capabilities of all workers in the town.

**Sustainability: Financial** | The model must be affordable and sustainable within current and/or newly identified funding streams.

**Coordination and linkages** | The model should improve linkages, coordination, collocation or integration between health services in Waimate to the extent that this will improve health care effectiveness.

**Efficiency** | The model will increase productive and allocative efficiency, by reducing unnecessary costs through improving service integration, workforce flexibility and by using facilities to their maximum or better capacity. It will encourage dynamic efficiency by being flexible enough to respond to changes in technology or service requirements in the future.

### 3.3. Identifying and Choosing among Options

#### 3.3.1. Government plans for integrated family health centres

In his letter of expectation to DHB chairs of 19 February 2009 the Minister of Health stated that:

*In 2010/11 we expect to build on the Primary Health Care Strategy by shifting some secondary services to more convenient primary care settings (at no cost to patients), and establishing multi-disciplinary Integrated Family Health Centres. Activities during the next year should lay appropriate foundations for the successful implementation of these initiatives in 2010/11."

However, it should be noted that Government statements about these new centres make it clear that there is no plan for Government to fund capital investment in such centres. In a speech on 6 March this year the Minister said, *“We don’t see the government as providing the capital for these centres; a responsibility that we see as resting with the private sector.”*

As well as being Government policy such centres appear to have considerable public support. A survey carried out by ShapeNZ on a representative sample of New Zealanders found that 60 percent supported the idea of *“Relocating some hospital services to Integrated Family Health Centres, which would provide a fuller range of services closer to patients. Centres would have doctors, nurses, specialists and allied health professionals, such as physiotherapists, podiatrists, and dieticians all in one location, in local communities.”*

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12 http://beehive.govt.nz/speech/speech+nz+private+surgical+hospitals+association

In examining health services in Waimate and discussing future models of care we have therefore looked for opportunities to move towards the development of a multi-disciplinary Integrated Family Health Centre.

In fact, the current project, along with a number of other similar developments in other parts of the country, pre-dates the latest proposals for integrated family health centres. The South Canterbury DHB has been in discussions with the Waimate community (through the District Council and its health forum) since mid-2008. The DHB has also progressed work on an integrated centre in Timaru.

3.3.2. A continuum of options for change

Table 3 below summarises a range of change options along a continuum from little or no change to a fully integrated centre with devolved services.
Table 4 looks at the options according to the criteria in section 3.2 above. The following section expands on the options.
<table>
<thead>
<tr>
<th>Description</th>
<th>Table 3 A Continuum of Options for Change In Waimate Primary Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change other than currently planned</td>
<td>Changes within current separate services &amp; businesses</td>
</tr>
<tr>
<td>Businesses and services are separate</td>
<td>Businesses and services are separate but make changes in the way care is delivered. GPs continue to compete on quality, access &amp; cost</td>
</tr>
<tr>
<td>Service Features</td>
<td>Services much as at present.</td>
</tr>
<tr>
<td>Workforce</td>
<td>No sharing of workforce or joint working. WMC may seek to develop teaching.</td>
</tr>
<tr>
<td>Workforce</td>
<td>Separating IT changes within practices</td>
</tr>
<tr>
<td>Administration and systems</td>
<td>Separate business systems continue</td>
</tr>
<tr>
<td>Governance</td>
<td>Individual organisation Governance</td>
</tr>
<tr>
<td>Advantages</td>
<td>Least threatening</td>
</tr>
<tr>
<td>Disadvantages / challenges</td>
<td>Does little to assure future workforce, develop quality, or maximise efficiency. Doesn't address facility upgrade issues</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>No change other than currently planned</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Businesses and services are separate</td>
<td>Businesses and services are separate but make changes in the way care is delivered. GPs continue to compete on quality, access &amp; cost</td>
</tr>
<tr>
<td>Acceptability</td>
<td>Least threatening but too many problems remain to ensure sustainability</td>
</tr>
<tr>
<td>Accessibility</td>
<td>Problems not addressed</td>
</tr>
<tr>
<td>Quality</td>
<td>Some changes will occur anyway</td>
</tr>
<tr>
<td>Sustainability: Workforce</td>
<td>Does little to assure workforce though may be some improved attractiveness at WMC</td>
</tr>
<tr>
<td>Sustainability: Financial</td>
<td>Uncertain – but current indications are positive</td>
</tr>
<tr>
<td>Coordination and linkages</td>
<td>No change</td>
</tr>
<tr>
<td>Efficiency</td>
<td>None indicated</td>
</tr>
</tbody>
</table>
3.3.3. Expanding on options and criteria

Deciding on or recommending an option is not a simple matter of scoring them against the criteria. A lot will depend upon the detail and how the options appear from the perspectives of different stakeholders, however some have better opportunities for the community of Waimate than others.

*Objectives for change*

In looking at options it is important to ask why change at all. The main objectives for change in Waimate which are mentioned by many stakeholders are to:

- ensure people have access to first level health services when needed
- attract and retain practitioners – particularly doctors and nurses – and so provide greater consistency and continuity of care
- ensure that the care available matches the needs of the population: particularly the high proportion of older people and the level of socio-economic deprivation
- assure adequate quality of service and of premises and equipment
- help make best use of all the services and funding available from various sources by avoiding duplication and increasing coordination.

*New ways of delivering first level services within existing structures and premises*

Providers can develop new ways of delivering primary care services without needing to join up across practices or organisations. Changes can involve:

- expanded roles and responsibilities: e.g. nurses providing first level care, pharmacists supporting chronic disease management, GPs offering minor surgery
- developing new ways of communicating using the internet and other communication tools
- making greater use of group consultations and expert patients concepts
- stronger links with other local services, e.g. community nursing and NGOs.

These sorts of changes can help address access issues, can improve the match between services and needs, and increase the focus on quality. They may increase the attractiveness to new practitioners and can increase efficiency.

However, their development would require significant leadership and effort within the organisations – particularly clinical leadership. There might be upfront costs for some aspects and the current premises may pose a barrier.

*Ways to attract and retain practitioners – lifestyle and professional aspects*

There are a number of ideas both in Waimate and across the country about attracting and retaining practitioners in rural areas – particularly nurses and doctors. Terms of employment and remuneration for practitioners are important in attracting new practitioners, but so too are less obvious issues such as ensuring a healthy work-life balance, support for practitioners’ families, and making transitions easy. These aspects can be addressed within individual practices – and they are already being addressed in Waimate practices.
Practitioners are also attracted by professional aspects of the work and the community. Giving students and young practitioners the chance to experience Waimate and building a supportive and challenging professional environment in the town will increase the likelihood that professionals will want to return and stay. These developments would be best to be looked at across the two practices and ideally with other providers in the town if they are going to be sustainable and multi-disciplinary. Teaching and training practitioners is already occurring but to go further it needs professional leadership, better premises and accredited practices and teachers. At present the space available for teaching is also quite limited and new premises and equipment would be very helpful to develop this.

These training and recruitment objectives are shared to a greater or lesser extent by many rural townships – and a number are trying to develop new models of care and in some cases new centres for collocation of services. One lesson to be learnt from the experience of others is that building a new facility before building strong support for how the facility will be used can be problematic – Levin is an example of such difficulties. The Golden Bay community is currently planning an integrated centre and has had to work carefully to ensure that the local medical centre continues to be a part of the development. Kaikoura, the West Coast, and Wairoa are other centres proposing centres of excellence and training while, after ten years’ planning, doctors in Alexandra have purchased a property for collocation.

**Quality and ensuring services match need – clinical governance across the town**

In the next few years the attention to quality of services and how well they match population needs will become increasingly important. There are likely either to be requirements that practices can demonstrate quality by way of accreditation or that opportunities and funding will only be available to practices that are accredited. Similarly, health professionals of all kinds will have increasing requirements to demonstrate ongoing competence.

It is hard to give attention to such matters when you are struggling to provide basic services and so far few practices across the Aoraki PHO have progressed far as yet on these issues. Aoraki PHO is part of the PHO Performance Management Programme and is required to have “clinical governance structures and processes ... such that clinicians are engaged and improvements in performance can be achieved.”

The PHO has established a Clinical Governance Committee with representation from a number of different provider and practitioner groups. According to the PHO’s strategic plan this committee “provides valuable guidance in clinical programme design and implementation, particularly with a view to ensure community/practice acceptance, accessibility, workforce and clinical safety and sustainability, maximizing health outcomes and closing gaps on inequalities.”

In future the PHO will be expected to increase further its efforts on quality and work more with practices to meet performance targets. In a town such as Waimate it would make sense for there to be coordinated approaches across the practices and the PHO could assist in increasing clinical contact between practices and other primary care providers across the town. The PHO has access to practice performance data which could be very valuable for quality improvement if agreement could be reached to share it between the practices.
One way to help clinical cooperation for continuous quality improvement across the town would be to start with a clinical project to tackle a particular health project — for example, to have a town-wide campaign to achieve high levels of influenza immunisation. Working between providers on such an issue can help to build up the confidence to move on to wider coordination and cooperation and to build the confidence for information sharing.

Sharing premises – Collocation of health services

Premises and equipment are an aspect of quality and efficiency. While some improvements in outcomes and in service delivery may be achievable by greater coordination between providers in separate buildings, services that share the same building have greater opportunities for service expansion, efficiencies, quality improvement, better access and developing a facility that will attract and retain practitioners so as to increase health service sustainability.

At present the Waimate Medical Centre, the South Canterbury DHB community nursing base and Waimate Health Developments day care centre are all in need of better space. To operate well as a new facility for an integrated family health centre, Oak House practice would also need to move into any new premises. If a new facility only housed one practice those other services that were collocated with the general practice might be seen as relevant only for people enrolled with the practice — and this would defeat the purpose of collocation. However, Oak House premises are currently adequate for that practice. While there are gains to be made for the practices and the town from collocation, careful planning and negotiation will be needed to get agreement from all the key stakeholders.

Other services in town would certainly benefit from and use shared meeting spaces which could also be used for group patient or community education. The South Canterbury DHB would have premises where they could deliver more services locally if they wished — or devolve services and funding to local primary care providers as envisaged in the Government’s plans for integrated family health centres. Given the size of the Waimate catchment there may be some secondary services that could be based, or visit (outreach model), in a shared health centre. It is unlikely that there would be sufficient volumes to include out-patient first specialist assessments (providing such assessments in a timely manner means that clinics have to be centralised to have large enough numbers). However, it may make sense to base some more routine out-patient care in Waimate and also perhaps ante-natal care, mental health services, and some specialist support for local primary practitioners.

A new centre would also allow some diagnostic services to be centralised. This could include a single collection point for laboratory specimens — particularly blood samples that at present take practice nurse time in the two medical centres. Some of those interviewed also hoped that a health centre would be able to house radiology services but it is unlikely that the volumes would justify the cost of running such a service.

A possible alternative to a new integrated centre could be just to bring together the two general medical practices. Oak House could be expanded to allow for this. The two practices could operate from the expanded premise but might still operate as separate individual businesses. Oak House and the Oak House site is not thought to be big enough to accommodate much other than the current doctors and nurses operating in the two medical centres. Such a centre could not include DHB community services, devolved secondary services, increased space for other visiting or devolved services, or telemedicine
opportunities as envisaged for the future. It is also unlikely to be able to allow for expanded teaching and training.

**Collocation of support services for the elderly**

It is at present unclear whether there are gains from collocating day care services for the elderly as part of a building that also houses a range of mainly primary health services. Day care services for the elderly more closely align with residential and respite care for the elderly. In many places around the country day care services, respite care and residential care are integrated services often provided from a single facility.

Day care, residential care and respite care all need space and facilities for activities, for daytime rest, for cooking, eating and personal cares. At present both the day care service and Lister Home provide these and there are likely to be efficiencies to be made by collocation. Any such efficiencies would depend upon the extent to which suitable space would be available within existing premises and to what extent new spaces and facilities would be required.

Collocation would not be straightforward because of current strongly held beliefs and feelings. Any such proposals would need to consider the benefits and costs associated with maintaining separate sites for provision of day care, respite and residential care. The DHB holds contracts with Waimate Health Developments and with Lister Home and is in a good position to require both these parties to work together to explore future options that will maximise service and efficiencies.

Primary health services have much less in common with day services for care of the elderly. There would be some gains from closer proximity between the two but proposals for a single facility joining health services and elderly support should be considered as a second level question.

**Coordination and / or integration**

While the gains from working more closely together and collocation of a range of services are reasonably clear, the costs and benefits of a variety of services joining together as merged businesses are more difficult to evaluate without further information.

There are likely to be economies of scale to be made by both collocating or merging the two general practices especially in a comparatively small town where a single practice would still only be a modest size compared to many group practices elsewhere. However, a merger would reduce competition in the town and would probably require an authorisation under the Commerce Act (a similar issue arose in Alexandra and the potential merger has been dropped as an option). It may be that the efficiency gains can be achieved in other ways such as by having two practices share the building and establish a separate company to supply services that could be shared (e.g. administration).
Integration of a wider range of services beyond just the two practices would be an even more challenging exercise. One possible development would be to devolve community nursing and allied health services and integrate them with first level services through general practice. This is a model that applies in a number of other countries such as the United Kingdom and in one or two places in New Zealand. Potentially, under an integrated model, all the publicly-funded services in Waimate could be viewed and managed as a single entity to achieve the best local results. Community nursing, midwifery, and allied health would work as an integrated team alongside doctors and nurses from the general practices to provide primary care services to the community. Shared records and equipment, single management, and flexible deployment of staff would be needed to allow the potential gains to be realised.

However, if integrating two private practices is a challenge then integrating public and private services in this way would be a greater one. Nevertheless there are potential gains and this sort of development merits further investigation.

3.4. An integrated health centre model: gains and opportunities

In considering the continuum of possible changes against the objectives for future health services in Waimate there is much to be gained from a more integrated model of care with collocation of services into a single health centre. Such change would:

- support new ways of working to let people get better access to care when needed
- better target services to the needs of the population
- support a centre of innovation, quality and training to attract and retain practitioners in Waimate
- provide opportunities for economies of scale and increased efficiency.

The current situation presents opportunities for the development of such an approach over the next two to three years:

- Several of the present facilities are out-dated and unsuitable and their occupants need to make building changes.
- There are a number of practitioners who have been in Waimate for a few years and who may be interested to be involved in leading innovative change.
- The community has shown that it is supportive and concerned about local health services – as have organisations including the DHB, the PHO, and various provider and professional groups.
- Finally, the Government is promoting the concept of multi-disciplinary integrated family health centres and expects DHBs to assist in their development. Waimate could become a model and example for such developments.

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14 Hokianga Health in the Far North and Ngati Porou Hauora Heelth, on the East Cape are examples. Canterbury DHB is currently exploring this type of development for Kaikoura where there is one general practice, inpatient beds in a small local hospital as well as DHB community services.
3.5. **The way forward**

The following steps represent a way to move towards an integrated family health centre.

3.5.1. Establish clinical governance and virtual teams across the town

With the support of the PHO establish a clinical governance structure across the town involving local practitioners including nurse and doctor leaders in both general practices. Focus on quality by sharing information and finding ways to continuously improve. Identify clinical projects to be worked on jointly by ‘virtual teams.’ Over time widen cooperation.

3.5.2. Build agreement about collocation

At the same time involve local providers, the DHB, PHO, and District Council in developing agreement on an integrated family health centre in a shared facility. Agree which services to include, what functions and staff to share (e.g. IT, receptionists), and the extent to which businesses would merge. At a minimum include both general practices, DHB community nursing services, space for visiting and devolved services and for teaching and training. Discuss the inclusion of pharmacy, physio, day-care and laboratory collection services with current providers. High level modelling of costs will be needed. Discussions should also be held at an early stage between Lister Home and Waimate Health Developments about benefits of closer working and collocation between these two services and also the possibility of being part of the primary care integrated centre.

3.5.3. Source and gain commitment from a capital investor(s)

Capital investment could be from one or more parties and could include configurations such as provider and investor mix and public and private mix. The reality of this would need to be tested. This may also be the stage to identify and tag suitable land with appropriate location, access and parking options.

3.5.4. Design a professionally attractive centre of excellence and innovation

With full involvement of future occupants, using experience of other similar centres and in discussion with educational institutes, design the integrated family health centre as a centre of innovation, excellence and training so as to increase the likelihood of recruiting new practitioners.

3.5.5. Build a new centre

Once sufficient agreements are reached and capital secured, build the centre.

3.5.6. Develop services in the new centre

Lead the development of the shifting, location and operation of services as agreed. Ongoing oversight and development will be needed to ensure all benefits are realised. This will require a new centre management team approach.

3.5.7. Explore greater integration later

Further integration may come later – the building should be flexible enough to allow for it and for future expansion if other services wish to be included later.
4. Supporting and enabling change

Waimate has tried more than once before to join up its health services and, although the conditions seem to be good at this time, change will need to be supported if it is going to be successful.

4.1.1. Leadership

The leadership that will be needed from various organisations and individuals is discussed here.

*District Health Board*

By sponsoring this project the South Canterbury DHB is supporting the community and helping deliver on the Minister’s expectation about multi-disciplinary integrated family health centres. The South Canterbury DHB will be an active player in the Waimate development by involving its community and support services in models of coordination as well supporting the devolution of appropriate secondary care.

*The District Council*

The Waimate District Council, like many other Territorial Local Authorities, has an interest in ensuring good local health services and it has gone further than most authorities by owning a local medical centre.

Although the Council has now agreed that it will divest itself of the Waimate Medical Centre\(^\text{15}\), it will continue to have a strong interest in health services so that it can achieve its agreed community outcome that “The health needs of the District are adequately provided for”\(^\text{16}\).

The 2008 annual report stated “Waimate District Council has a long-term interest in health. This vision may in time be supported by a purpose built medical facility bringing together all medical care offered in Waimate.” The 2006 Long Term Council Community Plan noted a project under consideration to “Construct and maintain a single-location Medical Centre Building” with a scheduled timescale of 2011.

The District Council will clearly be an important initiator, supporter, and enabler of developing a new model of care and bringing together local health services.


**Aoraki Primary Health Organisation**

The Aoraki PHO, the only PHO in the South Canterbury district, has a number of important roles. It has the direct contractual arrangements with general practices and therefore controls the main government funding to both Waimate practices as well as funds for health promotion, for services that will improve access to care for people living in deprived areas (including Waimate town), for Care Plus, and for the PHO performance management programme.

Under its contract the PHO must ensure that first level care – care provided by GPs and nurses – is sufficient to meet demand so it must be interested in recruiting and retaining practitioners.

The PHO also has a key role in ensuring quality and to achieve this it needs to support clinical governance across the organisation and at the local level.

The PHO board - which includes Waimate representation - has responsibilities for all of these functions and should be a key stakeholder and enabler for Waimate primary care developments. The Board has established a Clinical Governance Committee that should be well-positioned to support development of clinical governance in Waimate.

The PHO’s strategic plan\(^ {\text{17}} \) contains a number of objectives and actions which are very relevant to the Waimate situation in particular:

- Work with local communities
- Identify and remove health inequalities
- Offer access to comprehensive services
- Co-ordinate care across service areas to a one health system approach
- Develop the primary care workforce.

**Local champions**

Though various organisations have a central role, change is often most strongly promoted by individuals who have a vision that they believe in and which they can promote to others. Nurturing and supporting such individual leaders should be a part of the change management process. In the course of interviews for this project there seemed to be a number of individuals who might take up the challenge to become a local champion of health service change.

4.1.2. Change management processes and structures

A significant change such as this requires some structure and management. To ensure effective planning and oversight it would be prudent to establish a health services change group led by a strongly committed local leader. Representation on the group should include Aoraki PHO, South Canterbury DHB, the Council and the key health providers. Independent facilitation is sometimes useful in establishing such a group. Terms of reference for the

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\(^ {\text{17}} \) Aoraki PHO, Strategic Plan 2008 to 2013
group should ensure full involvement of all relevant parties, whether or not they sit on the group.

4.1.3. Finances

Organisations that are affected by any planned change need to know whether the change is likely to reduce or increase costs – and if an increase is likely they need to be able to see that it will be justified by benefits. Benefits of working more closely together have been outlined above but in order for individual providers to make commitments they will each need to undertake more detailed financial planning. This will, of course, be of greater importance if providers are considering moving into a shared building or merging businesses.

There are also costs involved with the change process itself. Various bodies including the DHB, the PHO, Southlink Health and the District Council may be able to give further support to the project financially and/or in kind (e.g. personnel to assist project management) – although financial support particularly from public funding may be more difficult given the current economic climate. A change of this sort in the model of care presents the PHO, DHB and practices with an opportunity to explore new ways of getting the greatest benefits from the current primary care funding and programmes.

4.1.4. New businesses and buildings

Business arrangements and structures

In considering closer working relationships between providers or collocation there will a range of possible new business arrangements and structures to consider. Some of the benefits of closer working can be gained without business changes; others will require agreements about sharing resources in order to gain economies of scale.

Even if businesses remain separate, legal advice will be needed to help shape new agreements especially for sharing a building. One possibility is that separate businesses may set up a jointly-owned entity to manage shared resources. If business mergers are considered this will need more extensive planning – including the Commerce Act restrictions mentioned on page 30.

Capital costs

If there is sufficient agreement in principle to proceed with collocation into a new building a source of capital funding will be needed. In the current economic climate it may be unlikely that public funds will be available for such a project and the Minister has already stated that he does not plan to fund capital investment in Integrated Family health Centres. On the other hand, the venture may be an attractive one for raising private funding.

If a health centre has commitment from publicly-funded health provider tenants it should offer an attractive investment opportunity. Moreover, Waimate low land prices and the current low bank interest rates should also help. The present government is likely to be supportive of such a private-public partnership approach.
Site

This project was not asked to consider sites for a possible new health centre, and it would be difficult to make any recommendations until more of the ground work had been undertaken to decide which services would be included.

However, it is worth noting that in the course of discussions two possible sites were mentioned in interviews. One of these is the vacant double section site at 16-18 Innes Street close to and owned by the Lister Home. The other site that has been mentioned is the old hospital site at Hunter’s Hill where there is a lot of space.

Picking a site for a facility is not straightforward and involves many different considerations such as size, location, accessibility, amenities, space for parking, cost and so on. These are matters that will need detailed consideration at a later stage.

Design

The design of a new centre will be critical. It will need to meet the needs of all potential tenants, clinicians, educators and the public, be flexible enough to accommodate increasing integration and possible growth in future, and yet be affordable. The design process should bring together the end users with experienced health centre planners and designers.
5. Conclusions

A multidisciplinary integrated family health centre is possible in Waimate. Such a centre, working from purpose-built premises, and exploring innovative, multi-disciplinary ways of delivering care would join a number of other communities that are establishing centres of excellence and teaching in rural primary care.

This is the best way for the town to attract and retain the practitioners that it will need in the future. It is the best way for providers to support each other in developing demonstrably high quality services that meet the health needs of the community and sustainably improve accessibility and continuity.

There is support for such a centre in Waimate and among key stakeholders. However, more preparatory work is needed to make the plan a reality. Parallel discussions are needed about the needs of the elderly and the benefits of cooperation and possible collocation of day care and residential services.

The initial aim should be to get firm agreement to a well-designed centre that would in the first instance house at least the two general practices and the DHB community services with these key tenants sharing some services between them. Other key local primary care providers such as pharmacy, physiotherapy and dentist should be welcome if they wish to join. The centre should include facilities for visiting primary and secondary care services, and for teaching and training.

Work should begin now on increasing clinical cooperation by establishing joint clinical governance across primary care services in the town and forming virtual teams to tackle shared clinical projects. A more joined-up approach to meeting local primary health needs will build the momentum and clinical leadership needed for new models of care delivery in an integrated family health centre.

At the same time a local leader is needed to head up a group that will follow through on the vision of a multidisciplinary integrated family health centre. The group would plan and oversee the establishment of the centre – including securing initial agreement from the key tenants. The process will take time, careful leadership and support from the District Council, Aoraki PHO and South Canterbury DHB.

Building a new centre will involve finding one or more capital investors, completing detailed business plans, choosing a suitable site and designing an affordable building. The building must not only provide a facility to meet multiple needs initially but must also be flexible enough to change and grow in response to future needs and consider physical access needs, including parking, for the public.

Establishing a multi-disciplinary integrated family health centre in Waimate will take commitment and will be a challenge but without it the town is likely to continue to struggle to build and retain the health services it needs in the future. There is good support for the concept and the time is right to seize the opportunity to build it now.

The accompanying preliminary business case explores the high level costs and benefits of the proposed model of care further. It recommends agreement to complete a more detailed concept design for a health centre.
Appendix 1  Steering Group Terms of Reference

Waimate Health Services Model of Care

STEERING GROUP

TERMS OF REFERENCE

<table>
<thead>
<tr>
<th>Document Control</th>
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<tbody>
<tr>
<td>Status</td>
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<tr>
<td>Date</td>
</tr>
<tr>
<td>Approved</td>
</tr>
<tr>
<td>Author</td>
</tr>
</tbody>
</table>
FUNCTION

The primary functions of the Steering Group are to:
- oversee and guide the project to successful completion
- ensure the project is strategically aligned with the District Council objectives for Waimate
- approve progress and support project managers
- communicate at times with key stakeholders and the community
- make recommendations to the project sponsor.

The Steering Group will operate as part of the project as laid down in the agreed Project Plan.

PRINCIPLES

All material requiring discussion and input will be distributed in reasonable timeframes to allow adequate consideration before discussion at meetings
- Agreed confidentiality will be adhered to
- Members will declare any actual or potential conflicts of interest at any stage of the project
- Action points rather than minutes will be recorded
- Members will accept responsibility for and undertake actions as delegated and agreed
- Meetings will commence and end on time
- Where clarification is sought that cannot be adequately addressed through the Steering Group, the matter will be escalated to Sponsor for comment or decision.

MEMBERSHIP

John Abraham
Tony Alden
Mavis Andrew
John Coles
Margaret Hill
Ian Moore
Jim Rayner

The chair will be elected from within the committee.

Where it is identified that additional skill or expertise is required within the Steering Group other members may be co-opted as required.

Where a member of the Steering Group cannot attend a particular meeting, they may nominate an existing Steering Group member to report back to them.

Note: Peter Bootsma and Karen Foster were co-opted onto the steering group at its second meeting.
MEETING VENUE AND FREQUENCY

Meetings will be held either face-to-face or by teleconference. Face-to-face meetings will be held in Waimate at a place stipulated in the notice of meeting unless otherwise agreed in advance. There will be at least three Steering Group meetings over the course of the project (that is before the end of April 2009). Dates of meetings will be set by the Chair of the Steering Group in consultation with members and the project managers.

AGENDA AND CIRCULATION OF MEETING PAPERS

The agenda will be:
Developed by the Project Manager with input from the Steering Group members via email
Circulated at least three days before each meeting
Any large documents (greater than half an hours reading) will be provided at least five days before the meeting or they will be deferred to the next meeting unless there is agreement that there is urgency.
All meeting materials will be provided in an electronic format only – it is the responsibility of individual members to print copies if they need printed format documents in meetings.
All documents circulated with the agenda should be treated as confidential, unless otherwise stated, so that items requiring discussion can be dealt with before being circulated to a wider group.

RECORDING

Key points and action points from meetings will be recorded and circulated no later than two working days after the meeting. Any points of contention or where consensus cannot be reached will be noted.

CONFIDENTIALITY

All information will be open unless otherwise stated.

CONFLICT OF INTEREST

All actual or potential conflicts of interest must be noted by the affected individual and recorded in meeting notes.
PROJECT PLAN

AND STAKEHOLDER ENGAGEMENT PLAN

Waimate Health Services Model of Care

<table>
<thead>
<tr>
<th>Prepared By:</th>
<th>John Marwick &amp; Jo Esplin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared For:</td>
<td>South Canterbury DHB</td>
</tr>
<tr>
<td>Date:</td>
<td>3 March 2009</td>
</tr>
<tr>
<td>Version:</td>
<td>2</td>
</tr>
<tr>
<td>Status:</td>
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</tr>
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</table>
Project Goal

The goal of this project is to develop a business case for a sustainable model of primary health care services for Waimate including proposals for collocation of services.

The expected project timeframe is from February to the end of April 2009. When authorised by the Sponsor this project plan will also constitute the Terms of Reference for the project.

Background

Currently there is a range of health services and providers in Waimate; some fully or partially funded by the district health board, some under national contracts from the Ministry of Health and ACC, and some funded through non-government organisations or privately. The services and providers that have been identified so far are listed in Appendix 3.

These services and providers are organised in various ways and based at a number of different locations and premises. The key health provider premises are two general practices (one privately-owned business and one owned by the Council), Lister Home (aged residential hospital and rest home care), Waimate Health Developments (day care services and physical activity as well as a base for DHB provider services), and the Waimate pharmacy. Currently the Council-owned general practice and Waimate Health Developments are considering relocation for sustainable site reasons and there is an opportunity to consider the best model of care for primary health care delivery in Waimate including a variety of options for forms of collocation.

The South Canterbury District health Board is funding this project in order to bring the providers together to explore options within the Waimate Community and to consider whether a community health centre with a current or new model of care is viable and what options there might be for collocation. Continued separation in four locations in town will place increasing fiscal pressure on already stretched human resources, fiscal resources, and health services and could potentially lead to the failure of key components of the community’s health services.

Objectives

The objectives of the project are to:
- develop a model of care to meet the primary health care needs of the Waimate population
- develop a business case for a joint primary care location in Waimate to support this model of care
- discuss the proposed model of care and the business case with current healthcare providers and the local community.

Project Definition

In Scope

The project will canvass and encompass all primary health care services, aged care services and NGO services provided for people living in or visiting the Waimate district (urban and rural areas). These include generalist first-level services provided through general medical practices, community nursing, home based support services, pharmacy and ambulance services. It also includes services for particular conditions including mental health and addiction, oral health, health of the elderly, hospice services, maternity care, and physical
therapy. Services specifically targeted at Maori are included. Complementary or alternative health service providers will be welcome to take part.

Primary care encompasses improving the health of individuals, families and the community; prevention, screening and early detection of disease; supporting self-care and care for family; assessing, diagnosing and treating episodes of ill-health; supporting and managing care for those with ongoing conditions; and supporting individuals and families in the community through all stages of life and death.

Consideration of models of care may include how services should be delivered (for example, face-to-face, electronic, or telephone communications with individuals or groups); who should deliver care (for example, registered health practitioners like doctors, nurses, midwives, pharmacists, physiotherapists; non-registered care assistants; volunteers, family members, and patients themselves); configuration and management of services; accessibility of care; and the location, organisation and funding of services.

Models of care will be consistent with and cognisant of the Primary Health Care Strategy, strategic plans of the South Canterbury DHB, the Waimate District Council and the Aoraki Primary Health Organisation, existing national and local contracts and health service arrangements.

The approach will include interviews and meetings with key stakeholders and an open public meeting to discuss the proposed model of care once it has been developed.

This project will include the development of a business case for a new model of care that will set the ground for more detailed business planning but it will not include detailed business or financial planning.

Out of Scope

The project will not specifically include specialist secondary services (although it will consider links to these services), broader public health services, or Ministry of Health funded disability support services that cover the people and population of the Waimate District. However, coordination and links with these services will be included as appropriate and relevant.

The project includes discussions with key stakeholders and an opportunity for public comment but it will not include a full survey of public opinion or a formal consultation process.

Approach

Project Management

The project will be managed by John Marwick, for Sky Blue House Limited, and Jo Esplin, for Acquemen.

John will be the principal contact for the project and will carry out the initial stakeholder interviews.

A project steering group will be established with Terms of Reference as in Appendix 1. Both Jo and John will be involved with meetings of the steering group, developing the draft model of care and resulting business case, discussing this with key stakeholders and the community; and developing all deliverable documents including the final business case.

Stakeholders

Community:
The resident population of the Waimate District
Wharekura-a-Tane, (Waitaha) and Te Runanga o Waihao Inc
The Mayor and members of the Waimate District Council

Health providers:
Primary health services providers (see Appendix 3)
The South Canterbury District Health Board as provider of both primary and secondary services to the local population
Community and Public Health, South Canterbury as providers of public health services
Aged care providers
Non Government Organisations
Any local private health care providers, e.g. home health care

Health service funders and organisations
South Canterbury District Health Board
The Ministry of Health (ambulance services, primary lead maternity care services, public health)
The Accident Corporation Commission
Aoraki Primary Health Organisation
Southlink Health

Owners of health services and health service premises
The Waimate District Council (owners of the Waimate Medical centre)
The owner of the Oak House medical centre
Owners of Lister House
Any other owners of health services or health service premises

Project governance and structure

The governance structure is as follows:

<table>
<thead>
<tr>
<th>Contract funding &amp;</th>
<th>Sponsor: South Canterbury DHB</th>
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<tbody>
<tr>
<td></td>
<td>Final sign-off</td>
</tr>
<tr>
<td>Steering group</td>
<td>Approve progress</td>
</tr>
<tr>
<td>Project managers: Sky Blue House &amp; Acqumen</td>
<td></td>
</tr>
</tbody>
</table>

The roles of each of the positions in the project structure are:

| Sponsor | Provide high level vision, project sign-off and mandate for the work to proceed. Ensure project is strategically aligned with the DHB’s objectives. |
Steering Group
(see Appendix for Terms of Reference)

Oversee and guide the project to successful completion; ensure project is strategically aligned with the District Council objectives for Waimate; approve progress and support project managers; may communicate with key stakeholders; make recommendation to project sponsor.

Project Managers

Guides and manages the day to day activity of the project; project planning, resource scheduling and reporting, leading specific work
Manages project risks, including the development of contingency plans and manages change
Communicates with sponsor and steering group on progress and issues

Project Assumptions

An open and transparent approach involving all key stakeholders will occur throughout the project
It is possible for the Steering Group to reach agreement on a preferred option
The preferred option may or may not require significant change and this will be determined as part of the development of options
Proposals for collocation of services or new models of care have not yet been agreed between any parties
Initial external communications will be undertaken by the Waimate District Council and the South Canterbury DHB and subsequently will be managed according to an agreed communication plan (see Communication activities below)
The project manager will keep the sponsor well informed through the steering group
The project team will have cooperation from key providers and access to all required information

Project Plan and Timeframes

Detailed plan

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Tasks</th>
<th>Completion date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Project Plan agreed</td>
<td>Finalise scope with sponsor and stakeholders Gather and undertake background reading Develop project and stakeholder engagement plan Develop key communication messages Establish Steering Group Agree project plan with steering group and DHB</td>
<td>20 February</td>
</tr>
<tr>
<td>2: Stakeholder Engagement</td>
<td>Contact all stakeholders and set up interviews and / or workshops to get their input Undertake interviews / workshops Record discussions Steering group meeting</td>
<td>14 March</td>
</tr>
<tr>
<td>3: Options Development and Validation</td>
<td>Coordinate and analyse all inputs, draw findings and develop options Undertake impact analysis and test with stakeholders and sponsor Work with facility people / organisations to establish ball park figures for any facility recommendations Validate options with stakeholders and draft report</td>
<td>31 March</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Tasks</td>
<td>Completion date</td>
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<tr>
<td>Tasks</td>
<td>Report / presentation to the key stakeholders</td>
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<tr>
<td>4: Draft Model of Care Report and Business Case</td>
<td>Draft model of care report</td>
<td></td>
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<tr>
<td></td>
<td>Test with sponsor and steering group</td>
<td></td>
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<tr>
<td></td>
<td>Revise paper and test with steering group again</td>
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<tr>
<td></td>
<td>Complete project – final steering group meeting (or teleconference – to be determined depending on the outcome of the project)</td>
<td>30 April</td>
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</tbody>
</table>

**Deliverables**

The project will produce:
- Project plan including stakeholder communication plan – mid-February
- Draft model of care and business case report – mid-April
- Final model of care and business case report – end-April

**Accountability**

The project managers will:
- Report to Margaret Hill (DHB) and John Coles (Mayor, Waimate Council)
- Meet with the steering group
- Work collaboratively with key stakeholders and facilitate discussions and option development
- Provide exception reports as required to flag and manage any emerging risks. The reports will be submitted to Margaret Hill and John Coles, (Mayor, Waimate Council)
- Provide ad hoc advice as required

**Reference documents and projects**

The following table outlines key reference documents and projects. The list is expected to be updated as the project progresses.

**Documents**

- The New Zealand Health Strategy
- The Primary Health Care Strategy
- Waimate District Social Needs Analysis September 2006
- Aoraki PHO Strategic Plan

**Projects**

- Timaru health centre project

**Risk register**

The following risk register will be maintained and updated each month throughout the project. Any new risks and other changes will be reported in the exception report.
Risks are assessed for likelihood and the impact on the project.
H = High M= Medium L= Low

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Status (new, existing closed)</th>
<th>Risk level (H, M, L)</th>
<th>Mitigation Strategy</th>
<th>Lead Responsibility (&amp; Support)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholders unavailable or unwilling to participate</td>
<td>New</td>
<td>L</td>
<td>Careful communication using Council, flexibility in scheduling</td>
<td>Council with project managers’ support</td>
</tr>
<tr>
<td>Failure to agree solution</td>
<td>New</td>
<td>M</td>
<td>Open communication, no pre-conceived solution, involve all parties, value existing contributions, provide options</td>
<td>Project managers</td>
</tr>
<tr>
<td>Lack of adequate information</td>
<td>New</td>
<td>M</td>
<td>Use multiple sources, base proposals on best available information</td>
<td>Project managers</td>
</tr>
<tr>
<td>Public opposition to proposals</td>
<td>New</td>
<td>L</td>
<td>Careful communication, opportunity for public input, provide options</td>
<td>Project managers and Council</td>
</tr>
</tbody>
</table>

**Stakeholder Engagement Plan**

Input from a range of stakeholders will be sought, welcomed and encouraged throughout the project.

**Stakeholder analysis**

An analysis of key stakeholders integral to the success of this project is noted below along with how they will be involved in this project. Appendix 3 contains a fuller list of health providers. The key stakeholders for contact will be those based in Waimate or offering a range of services to Waimate residents. The Waimate community are another key stakeholder group who will be offered the opportunity for input through a public meeting.
<table>
<thead>
<tr>
<th>Group / Organisation</th>
<th>Contact Person</th>
<th>Why We Need to Involve Them</th>
<th>How Will They Be Involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waimate District Council</td>
<td>John Coles, Mayor</td>
<td>Principal stakeholders in Waimate community and owners of Waimate Medical Centre</td>
<td>Steering group membership. Key Council members to have interview and opportunity to comment</td>
</tr>
<tr>
<td>South Canterbury DHB Planning and Funding</td>
<td>Margaret Hill, General Manager, Planning and Funding</td>
<td>Sponsor of project and funder of many services</td>
<td>As sponsor, plus interview and opportunity to comment</td>
</tr>
<tr>
<td>South Canterbury DHB Provider Arm</td>
<td>Christine Nolan, General Manager Clinical Services</td>
<td>Provider of a range of services for Waimate people</td>
<td>Interviews and opportunity to comment</td>
</tr>
<tr>
<td>Aoraki PHO</td>
<td>Karen Foster, Chief Executive Officer</td>
<td>Provider of a range of primary health care services directly and through contracts</td>
<td>Interviews and opportunity to comment</td>
</tr>
<tr>
<td>Oak House Medical Centre</td>
<td>Contact needed for centre staff</td>
<td>Provider of general practice services</td>
<td>Interviews and opportunity to comment</td>
</tr>
<tr>
<td>Waimate Medical Centre</td>
<td>Contacts needed for centre staff and owner</td>
<td>Provider of general practice services</td>
<td>Interviews and opportunity to comment</td>
</tr>
<tr>
<td>Lister House</td>
<td>Contact needed ?Ngila Houliston</td>
<td>Provider of aged residential care – hospital and rest home level care</td>
<td>Interviews and opportunity to comment</td>
</tr>
<tr>
<td>Waimate Health Developments</td>
<td>Contact needed</td>
<td>Provides day programme for elderly and disabled</td>
<td>Interviews and opportunity to comment</td>
</tr>
<tr>
<td>Southlink Health</td>
<td>Michelle Baldwin - Locality Manager</td>
<td>Rural GP development: support for local general practices Needs assessment service coordination – aged residential care and home based support services Brief intervention mental health service for adults</td>
<td>Interviews and opportunity to comment</td>
</tr>
<tr>
<td>Waimate Pharmacy</td>
<td>Paul Townend, pharmacist and owner</td>
<td>Provider of pharmacy services</td>
<td>Interviews and opportunity to comment</td>
</tr>
<tr>
<td>Arowhenua Whanau Services</td>
<td>Tim Russell</td>
<td>Provider of primary health services for Maori</td>
<td>Interviews and opportunity to comment</td>
</tr>
</tbody>
</table>
Communication activities

Communication serves several key goals: collaboration, information gathering, education and providing information to those groups impacted by any potential service configuration or changes in the future. The following table outlines activities that will occur through the project to achieve communication goals.

<table>
<thead>
<tr>
<th>Target Audience</th>
<th>Aim</th>
<th>Communication Tools</th>
<th>Who to action</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Sponsor</td>
<td>Ensure they are kept informed of progress and prepared to approve the final paper</td>
<td>Face-to-face meetings, emails, telephone, written reports</td>
<td>Project managers</td>
<td>As required</td>
</tr>
<tr>
<td>Steering Group</td>
<td>Ensure project meets its objectives and timeframes</td>
<td>Face-to-face and telephone meetings, emails, written reports</td>
<td>Mayor, Council CE and project managers</td>
<td>As required</td>
</tr>
<tr>
<td>Service providers</td>
<td>Expert advice from direct services and staff</td>
<td>Explanatory notice and invitation to participate Semi-structured Interviews, opportunity for electronic/written input Written reports Face-to-face meetings</td>
<td>Council with support of project managers Project managers</td>
<td>Initially During information gathering phase Once or twice</td>
</tr>
<tr>
<td>Waimate community</td>
<td>Opportunity for public comment to shape and comment on proposals</td>
<td>Public notice Public meeting</td>
<td>Council with support of project managers</td>
<td>Initially Once</td>
</tr>
</tbody>
</table>
Key messages

The project purpose, goals and timeframes
Open and collaborative process
Building on existing services
To ensure sustainable high quality service for the community

Authorisation

Signed: _______________________________________________________________
Margaret Hill, Manager,
Planning and Funding South Canterbury DHB
Project Sponsor

Date: ____________________

Signed: _______________________________________________________________
John Coles
Mayor, Waimate District Council

Date: ____________________
Appendix 3  List of Organisations Interviewed

Access HomeHealth Ltd
Adventure Development Trust
Aoraki PHO
Arthritis Foundation of New Zealand
Bridget Harrison Physiotherapist
Centrecare Counselling Service
Community and Public Health
Community Dental Service, Canterbury DHB
Di Dennison – natural therapies
Forward Care Home Health Ltd
HealthCare of New Zealand Ltd
Lister Home
Oak House Medical Centre, owner/manager & Dr S Fish
Plunket
Presbyterian Support
Project steering group
South Canterbury DHB, Manager Planning and Funding
South Canterbury DHB, Services Manager
South Canterbury Independent Midwives
Southlink Health
Sport South Canterbury
St John Ambulance
Te Runanga o Waihao
Waimate Health Developments
Waimate Medical Centre, chair, manager and Dr S Creegan
Waimate Pharmacy
Waimate Physiotherapy Clinic
**Appendix 4  Interview Notes for Provider Stakeholders**

*Waimate Health Services Model of Care*

**Name of organisation**

Date of Meeting
Present:

**Notes:** This interview is part of a project sponsored by the South Canterbury District Health Board working with the Waimate District Council to look at how primary health care services are provided for the people of Waimate. The information gathered in the interview will be used by the project managers to draft a report with proposals for possible service redesign. A draft of the report will be provided to the District Council and titles / roles there will be opportunity for comment before final proposals are agreed.

The interviewer will, with your agreement, make an audio recording of the interview.

The interview will be semi-structured – each of the main areas below will be covered. The sub-headings are designed as prompts to material that may be covered but are not meant to limit discussion.

*Please explain your involvement in Waimate health services*

Are you a service provider – if not, what does your organisation do?
What services do you supply?
How many people/services are supplied?
Is your organisation based in Waimate, if so whereabouts are your premises?
Does it give services to the people of Waimate?
How do you link with other health services in Waimate now?

*Tell me about staff involved in providing care in Waimate?*

<table>
<thead>
<tr>
<th>Type</th>
<th>People</th>
<th>FTE</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managerial</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Tell me about your premises/base

If you do not work from premises in Waimate where is your base – any issues with this? – would you work from Waimate premises if available?
Who owns your Waimate premises? If leased when does the lease end?
Any issues with your current Waimate premises? (prompt: size, disability access, refurbishment, parking, noise etc)

Tell me about the business

Who owns the business and how does this work?
Any issues with the business ownership?
Facilities / amenities

Tell me about the services and how they operate

Positive things
Things that could be improved
Opportunities – things you would like to develop
Challenges & issues

Your views about Waimate health services

What’s needed
Issues
Opportunities
Threats / challenges

Comments about possible collocation

Advantages
Disadvantages
Would you/your service like to be involved?
If yes, what would be needed

Anything else?