Canterbury Clinical Network
Transforming Health Care. Whanau Ora ki Waitaha.

TERMS OF REFERENCE
Rural Health Workstream

BACKGROUND

The Canterbury Clinical Network (CCN) was established to provide clinical leadership and demonstrate alliance principles across a multi-disciplinary team. The CCN leads the development of services across the sector where innovation and transformational change is required. The CCN consists of:

1. Alliance Leadership Team (ALT);
2. Programme Office;
3. Workstreams or Focus Areas;
4. Service Level Alliances (SLAs).

GUIDING PRINCIPLES OF CANTERBURY CLINICAL NETWORK

- Taking a 'whole of system' approach to make health and social services integrated and sustainable;
- Focussing on people, their families and communities, keeping them at the centre of everything we do;
- Enabling clinically-led service development; whilst
- Living within our means.
- The Rural Health Workstream will acknowledge and support the principles of the Treaty of Waitangi.

RURAL HEALTH WORKSTREAM (RHWS)

1. BACKGROUND

1.1. Since its establishment in January 2012 the Rural Health Workstream has progressed a range of initiatives designed to support the objectives of improved access to health services, and improved outcomes, for rural communities.

1.2. The Workstream is working to achieve equity of outcome across Canterbury by reviewing and planning the organisation and structure of rural health care services in context of the wider Canterbury health system. This includes defining rural in the Canterbury context, promoting clinically and fiscally sustainable health services in rural areas, encouraging and recommending innovative solutions that support rural health services, and providing recommendations with a rural focus to other CCN Workstreams and Service Level Alliances. This includes workforce considerations and fiscal review to ensure best system value from the structure our health services, working collectively as a system.

1.3 The Rural Health Workstream is focused on supporting the Rural Sustainability Project in developing fit for purpose visions of sustainable health services for rural areas. The Canterbury Health System's approach to this is using the Model of Care framework as the methodology to address the needs and service planning & delivery in rural communities. There are Service Level Alliances (SLAs) or Service Development Groups (SDGs) in place to implement agreed Models of Care for the communities of Hurunui, Kaikōura, Oxford and Surrounding Areas, Ashburton and Akaroa.

1.4 The Workstream is also supporting the Technical Rural Subsidy Group (formally the Rural Funding Service Level Alliance) to establish a model for the allocation of rural subsidies across Canterbury.

2 PURPOSE

The Rural Health Workstream exists to make recommendations towards meeting the health needs and improving the health outcomes of the rural Canterbury population.

It will do this by:

- Reviewing current services and planning the future organisation and structure of rural[1] health care services in context of the wider Canterbury health system so that equity of outcome across Canterbury is achieved;
- Promoting clinically and fiscally sustainable health services in rural areas;
- Encouraging and recommending innovative solutions that support rural health services;
- Understanding and monitoring population trends across rural communities;
- Identify emerging issues for rural health service delivery;
- Provide a national advocacy channel to and from rural health groups, including (but not limited to) the Rural Health Association Aotearoa New Zealand (RHAANZ) and the National Rural Health Advisory Group (NRHAG), in addition to regional developments and opportunities, including the South Island Workforce Development Hub.
- Providing cross-links with, and supporting recommendations of a rural focus to the various SLAs and Workstreams across the Canterbury health system.

3 MANDATE AND SCOPE

3.1 In Scope :

The Rural Health Workstream is steering and informing rural community engagement and service development processes.

The Rural Health Workstream has the mandate to review current service activities with the intention of identifying areas needing increased efficiencies and/or improved service levels.

Members have the authority to meet with relevant stakeholders, especially consumers, and service providers to gain information and ideas for improvements.

3.2 Out of Scope:

It is not within the scope of the Workstream to contract with service providers or directly change existing contractual terms;

The Workstream does not have the mandate to manage a programme of service delivery nor is it responsible for developing and delivering on the programme budget.

4 MEMBERSHIP

4.1 The membership of the Workstream will include consumers with rural experience, Manawhenua ki Waitaha representation, professionals who participate (e.g. referrers or providers) in the relevant services across rural settings, those who work in key related services, management from relevant health organisations and community groups;

4.2 Members are selected not as representatives of specific organisations or communities of interest, but because collectively they provide the range of competencies required for the alliance to achieve success;

4.3 As the Rural Health Workstream focuses on specific approaches, it may be to form Working Groups and/or co-opt members as required;

4.4 The Workstream will review membership annually to ensure it remains appropriate, with a view of a 3 year maximum term;

4.5 Membership will ideally include a member of the CCN Alliance Leadership Team (ALT);

[1] Rural practices are those serving a community that:
- is in an area defined by Statistics NZ as rural, minor urban, or secondary urban area; and
- has a population of 15,000 people or less; and
- with a clinic at least 30 km or at least 30 min travel time as calculated by AA Maps from Christchurch Hospital.

4.6 It is the expectation that a member will be able to attend two-thirds of scheduled meetings annually, unless discussed and agreed with Chair. They should discuss participation with their originating organisation, especially if activity takes place during work hours;

4.7 A member may nominate an alternate person if they are unable to attend a meeting. The member is responsible for providing all necessary information to the alternate;

4.8 Remuneration for meeting attendance will be as defined in the CCN Remuneration Policy. Attendance lists should be collected and forwarded to the Programme Office for payment;

4.9 When a member is absent for more than two consecutive group meetings without prior apology, or if the member is not able to contribute to the good of the group, the Chair will consider their membership status for revocation, following discussion with the member or reasonable attempts to contact the member;

4.10The Workstream will be eligible for project management and analytical support through the Programme Office.

5 SELECTION OF MEMBERS, CHAIRPERSON AND DEPUTY CHAIRPERSON

5.1 New or replacement members will be identified by the Workstream for their required skills/expertise. The appointment will require endorsement from the ALT on recommendation from the Workstream;

5.2 The Deputy Chair will, in most cases, be nominated by members of the Workstream. Where there is more than one nominee for either one or both positions, the election will be put to a vote.

5.3 The role of Chair may be appointed by ALT (i.e. an independent Chair).

6 MEMBERS

The composition of the Rural Health Workstream will be determined by the need for the following perspective and expertise. This includes project-specific resources to be sourced as and when required in a time-limited capacity through ex-officio linkages across our health system.

Name(s)	**Perspective/Expertise**
Bill Eschenbach	Rural manager with in-depth understanding of rural health issues, obstacles and solutions (Waitaha Primary Health). Provide national advocacy channel to Rural Health groups (RHAANZ, NRHAG) Deputy Chair
Brenda Close	Rural secondary care clinical manager (nursing). Experienced in developing and delivering services to rural residents.
Cole Gillman	St John Experience in providing Emergency Services and linkage to PRIME services.
Craig Watson	Rural manager with in-depth understanding of rural health issues, obstacles and solutions (Pegasus Health).
Andrea Judd	Doctor with rural GP experience Experienced in developing and delivering services to remote rural residents
Lorna Martin	Doctor with rural GP experience ALT Member with current rural experience
Jo Talarico	Nurse Practitioner with experience in rural settings
John Luhrs	ALT appointed Independent Chair
Julie Barlass	Community member with connections with Territorial Local Authority Health Committees
Michael James	CDHB Funding & Planning staff member familiar with rural issues
Violet Shan	An allied health professional with current experience of service delivery to rural areas including remote rural (Community pharmacy)

VACANT	Youth perspective
VACANT	Rural midwifery experience
VACANT	Pasifika and/or CALD perspective
Win McDonald	Rural secondary care transition
Jaana Kahu	Manawhenua Ki Waitaha representative, with rural health sector experience
Kate Rawlings	South Island Workforce Development Hub (Programme Director), experience in strengthening workforce opportunities.
Ex Officio	
Emma Crew	Rural provider - Akaroa
Linda Wensley	CCN Programme Manager
Jane Cartwright	CCN Independent Advisor
Julia Mead	CCN Project Facilitator
As required	Project-specific, time-limited expertise as required

7 ACCOUNTABILITY

7.1 The Workstream is accountable to the ALT who will establish direction; provide guidance; receive and approve recommendations.

8 WORK PLANS

8.1 The Workstream will agree on their annual work plan and submit it to the ALT for approval via the CCN Programme Office. The work plan will be influenced by the CCN Strategic Plan, Ministry of Health annual plan, the District Annual Plan, legislative and other requirements;

8.2 The Workstream will actively link with other CCN work programmes where there is common activity, in particular:

8.2.1 Ashburton Service Level Alliance (ASLA)

8.2.2 Health of Older People Workstream (HOPWS)

8.2.3 Community Services Service Level Alliance (CSSLA)

8.2.4 Mental Health Workstream (MHWS)

In addition, proactive connection across all CCN activity will be made on a regular basis, to provide and advocate for rural consideration on specific programmes of work. A feedback loop will be required back to RHWS from any connected alliance on progress, roadblocks and opportunities.

9 BUDGET

9.1 The Programme Office will support the development of an operational budget for the Rural Health Workstream, which will be authorised by the ALT.

10 FREQUENCY OF MEETINGS

10.1 Meeting dates will be arranged annually, taking into consideration ALT meetings; to ensure reporting is current and up to date, and so that members are able to fully participate.

10.2 Meetings are usually held 8 weekly per annum, with the option of virtual connection.

11 REPORTING

11.1 The Workstream will report to the ALT on an agreed schedule via the CCN Programme Office;

11.2 Where there is a risk, exception or variance to the Workstream's work plan, or an issue that requires escalation, a paper should be submitted to ALT in a template provided by the CCN Programme Office;

11.3 Where there is a new innovation or service recommendation, a paper should be submitted to ALT in a template provided by the CCN Programme Office.

11.4 Where applicable, reporting will include progress against or contribution to Ministry of Health Performance and Health Targets.

12 MINUTES AND AGENDAS

12.1 Agendas and minutes will be coordinated between the SLA Chair and Facilitator;

12.2 Agendas will be circulated no less than 5 working days prior to the meeting, as will any material relevant to the agenda;

12.3 Minutes will be circulated to all group members within 5 working days of the meeting and minutes remain confidential whilst 'draft' and until agreed.

12.4 Copies of the approved minutes will be provided to the CCN Programme Office for inclusion on the CCN website. Any confidential or sensitive material should be excluded.

13 QUORUM

13.1 The quorum for meetings is half plus one Workstream member from the total number of members of the Workstream.

14 CONFLICT OF INTERESTS

14.1 Prior to the start of any new Workstream or programme of work, conflict of interests will be stated and recorded on an Interests Register.

14.2 Where a conflict of interests exists, the member will advise the Chair and withdraw from all discussion and decision making;

14.3 The Interests Register will be a standing item on Workstream agenda's and be available to the Programme Office on request.

15 REVIEW

15.1 These terms of reference will be reviewed annually and may be altered intermittently to meet the needs of its members and the health system.

16 EVALUATION

16.1 Prior to the commencement of any new programme of work, the Workstream will design evaluation criteria to evaluate and monitor on-going effectiveness of Workstream activities. Any evaluation will comply with the evaluations framework outlined by CCN and/or the ALT or CDHB as the funder.

ROLES & RESPONSIBILITIES

17 CHAIRPERSON

17.1 Lead the team to identify and recommend opportunities for service improvement and redesign;

17.2 Develop the team to respond to a service need, engaging with key stakeholders and interested parties best suited for the purpose of service innovation;

17.3 Work with the project manager/facilitator and/or analyst to produce work plans and other reports as required;

17.4 Provide leadership when implementing the group's outputs;

17.5 Be well prepared for meetings and work with the project facilitator to guide discussion towards action and/or decision;

17.6 Meet with the other CCN leaders to identify opportunities that link or overlap, share information and agree on approaches.

18 ALT MEMBER

18.1 Act as a communication interface between ALT and the Workstream;

18.2 Participate in the development and writing of papers that are submitted to ALT;

18.3 Act as Sponsor of papers to ALT so papers are best represented at the ALT table.

19 WORKSTREAM MEMBERS

19.1 Proactively bring perspective and/or expertise to the Workstream table;
19.2 Understand and utilise best practice and alliance principles;
19.3 Influence and recommend identified transformational service initiatives;
19.4 Develop close relationships with stakeholders and collaborative groups to ensure system-wide innovation and design principles;
19.5 Provide advice to the Workstream group and the wider Network (i.e. ALT) as appropriate;
19.6 Support the principles of Te Tiriti o Waitangi ;
19.7 Actively participate in the annual planning process;
19.8 Work as part of the team, share decision making and be well prepared for each meeting.

20 PROJECT MANAGER/FACILITATOR

20.1 Provide or arrange administrative support;
20.2 Support Chair and/or clinical leaders to develop work programmes that will transform services;
20.3 Document and maintain work plans and reports to support the group's accountability to the ALT;
20.4 Develop project plans and implement with in scope following direction from the group, CCN programme office and/or ALT as appropriate;
20.5 Work with the Chair to drive the work plan by providing oversight and coordination, managing the resources and facilitating effective teamwork;
20.6 Keep key stakeholders well informed;
20.7 Proactively meet reporting and planning dates;
20.8 Activity work with other CCN groups to identify opportunities that link or overlap, share information and agree on approaches;
20.9 Identify report and manage risks associated with the Workstream work activity.

21 PLANNING & FUNDING REPRESENTATIVE

21.1 Provide knowledge of the Canterbury Health System;
21.2 Support the group to navigate the legislative and funding pathways relevant to the Workstream;
21.3 Facilitate access to analytical support for the purpose of evaluation, reporting and monitoring.

TERMINOLOGY

- Definition of Rural - There are a range of definitions for rural. For the purposes of these Terms of Reference the widely recognised definitions as used by Government agencies apply: Rural with high urban influence; Rural area with moderate urban influence; Rural area with low urban influence; or Highly rural/remote area.

  Within the current eligibility for rural subsidy, rural practices are those serving a community that:

  - Is in an area defined by Statistics NZ as rural, minor urban, or secondary urban area; and
  - Has a population of 15,000 people or less; and
  - With a clinic at least 30 km or at least 30 min travel time as calculated by AA Maps from Christchurch Hospital.
- Alliance Leadership Team (ALT) – A group of predominantly clinical leaders from across the Canterbury Health System, led by an independent Chair, responsible for the governance of clinically-led alliance service development.
- Alliance Support Team (AST) – A group who provides the support function to ALT, providing advice and guidance on the prioritisation and funding of health services that have been recommended by the service level alliances (SLAs) and workstreams (WS).
- Programme Office – A small team of employees who provide the day-to-day operational support to ALT, AST, the SLAs and the workstreams. Personnel include: a Programme Director, a Programme Manager, a Communications Team, a

Technology Lead, a Project Administrator/coordinator plus a flexible resource pool of administration, project management and analytical support for SLAs and workstreams.

- Service Level Alliances (SLA) – Alliances of clinical and non-clinical professionals drawn together to lead the transformational redesign, and delivery of services (or group of services) in specific areas of the Canterbury health system.
- Workstreams (WS) – Groups of clinical and non-clinical professionals and providers that guide and influence the transformation of a sector or service. Not a contracting entity, they guide the decision making of the ALT through recommendations on service design and delivery.
- District Alliance Agreement Signatories – Providers of health services in Canterbury who have agreed to work together in an alliance framework.
- Service Level Provision Agreements – agreements between the DHB and a service provider that are signed in conjunction with the District Alliance and specify expected outcomes, reporting and funding for the services to be provided.

ENDORSEMENT

Date of agreement and finalisation by Workstream members: **November 2021**

Date of endorsement from ALT: **xxx**

Date of Next Review: **July 2022**