TERMS OF REFERENCE
Hurunui Health Services
Development Group (HHSDG)

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).
5. Design/Development Groups.

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.

This Hurunui Health Services Development Group (HHSDG) will acknowledge and support the principles of the Treaty of Waitangi. We will strive for equitable health outcomes across our population/focus area through accessible, culturally appropriate services.

HURUNUI HEALTH SERVICES DEVELOPMENT GROUP (HHSDG)

1. BACKGROUND

In July 2015, a workshop was held in the Hurunui with representation of a wide range of community and health providers. The workshop explored areas of opportunity for service improvement with a focus on providing a sustainable health services, with the patient at the center of the model.
As an outcome of the workshop, two locally-led focus groups further explored improvement opportunities under the broad areas of workforce sustainability and integration of services. The recommendations from these groups informed the establishment and subsequent work of the Hurunui Health Services Development Group (HHSDG).
The HHSDG engaged with the community and a breadth of health providers delivering services in the district to develop a Model of Care. This included a number of recommendations for improving the communities' access to fit for purpose health services.
The Hurunui Model of Care was endorsed for implementation by the CCN ALT (April 2018) and the DHB Board (July 2018) with a shift in the HHSDG's focus to implementing the recommendations.

2. PURPOSE

2.1. To link with community-based providers and other groups such as the CCN Rural Health Workstream and other CCN alliance groups and undertake joint work as appropriate.
2.2. To provide oversight of health service improvement and sustainability initiatives for the Hurunui;
2.3. Be a vehicle for the Hurunui community to oversee the implementation of the Hurunui Model of Care by providing local leadership including monitoring, encouraging and holding to account transformational service improvement for health provision in the Hurunui;
2.4. To consider health issues within a broader scope of social services and other drivers of wellbeing;

2.5. To make specific recommendations, generally to those agencies with funding responsibility for a service, regarding the implementation of the Model of Care recommendations; and;
2.6. To act as a responsive central point of contact for ideas and information on the needs of people within the Hurunui, balancing the demands on the system for patient care and wellbeing, and the need for sustainable clinical services and business practices;

3. MANDATE AND SCOPE

In Scope

3.1. The HHSDG has the mandate to review current service activities for the Hurunui population with the intention of identifying areas and recommending where improvements can be made in the appropriate use of resources, improved patient outcomes, and/or service levels;
3.2. Members may be tasked to meet with relevant stakeholders and service providers to gain information and ideas for improvements with consultation designed to be simple and efficient, as well as effective.

Out of Scope

3.3. It is not within the scope of the HHSDG to contract with service providers or directly change existing contractual terms;
3.4. The HHSDG 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 HHSDG will review membership periodically to ensure it remains appropriate;
4.2. Further expertise will be brought in as and when required to provide support to the implementation;
4.3. 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;
4.4. It is the expectation that a member will be able to attend two-thirds of scheduled meetings annually, unless discussed and agreed with Hurunui Project Facilitator;
4.5. 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 Hurunui Project Facilitator and/or Chair will discuss with the member their future ability to participate in the HHSDG;
4.6. If a member is unable to attend a meeting an alternate can be used if organised and communicated to the Hurunui Project Facilitator ahead of the meeting; and
4.7. The HHSDG will be supplied with project management and analytical support through the Programme Office of the Canterbury Clinical Network and via the CDHB Planning & Funding team.

5. SELECTION OF MEMBERS

5.1. New or replacement members will be identified by the HHSDG for their required skills/expertise.
5.2. The chair will be appointed from within the HHSDG

6. MEMBERS

The composition of the HHSDG:

Perspective/Expertise/Locality	Name(s)
Aged Residential Care	Sue Coleman
Allied Health (TBC)	Vacant
ALT Sponsor / General Practitioner	Lorna Martin
Clinician (Amberley)	Vacant
Community Pharmacy	Violet Shan

Perspective/Expertise/Locality	Name(s)
Community Services Provider (Access)	Glenda Rich
Consumer	Tsarina Dellow
Consumer	Vacant
District Nurse (Cheviot)	Faye Daly
General Practitioner (Hanmer Springs)	Vacant
Hospital Nursing (Waikari)	Bernadette Earl
Local Government (& **Chair**)	Marie Black
Māori Perspective(Te Ngāi Tūāhuriri Rūnanga)	Deirdre Carroll
PHO (Waitaha Primary Health)	Bill Eschenbach
Practice Manager (Amuri)	Gary Mitchell
Practice Manager (Hanmer Springs)	Paul Walmsley
Practice Nurse (Waikari)	Sue Smith
St John	Cole Gillman
Youth Perspective	Vacant
Ex-officio	
CCN Programme Office	Linda Wensley
CCN Senior Project Facilitator (for HHSDG)	Koral Fitzgerald
CDHB Planning & Funding / Rural facilities	Win McDonald

7. ACCOUNTABILITY

7.1. The HHSDG is accountable to the CCN ALT via the Rural Health Workstream (RHWS) who will establish direction, provide guidance, receive and approve recommendations.

7.2. Model of Care Development - the HHSDG will agree on their Model of Care and submit it to the RHWS and ALT for their information and endorsement via the CCN Programme Office. CDHB Planning and Funding will be an active partner in the development of the Model of Care;

7.3. The HHSDG will actively link with other CCN work programmes where there is common activity;

7.4. Progress with implementing the Hurunui Model of Care recommendations will be reviewed by the HHSDG.

8. FREQUENCY OF MEETINGS

8.1. Meetings will be held regularly and every 2 months unless agreed otherwise by members; and

8.2. Meeting dates will be arranged in advance.

9. REPORTING

9.1. The HHSDG will regularly communicate with the community and key stakeholders on progress with implementing the Hurunui Model of Care;

9.2. The HHSDG will undertake reporting as required to the RHWS and ALT; with the membership endorsing the reports prior to presentation; and

9.3. Where there is a risk, exception or variance to the HHSDG's work plan, or an issue that requires escalation, a paper should be submitted to RHWS in a template provided by the CCN Programme Office.

10. MINUTES AND AGENDAS

10.1. Agendas and minutes will be coordinated by the Hurunui Project Facilitator;

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

10.3. Minutes will be circulated to all group members within 7 days of the meeting and minutes remain confidential whilst 'draft' and until agreed.

11. QUORUM

11.1. The quorum for meetings is half plus one HHSDG member from the total number of members on the HHSDG.

12. CONFLICT OF INTERESTS

12.1. Prior to the start of each meeting , conflict of interests will be stated and recorded on an Interests Register;
12.2. Where a conflict of interest exists, the member will advise the Chair and the Chair will manage this conflict of interest. The Interests Register will be a standing item on HHSDG agendas and be available to the Programme Office on request.

13. REVIEW

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

ROLES & RESPONSIBILITIES

14. FACILITATOR/CHAIR

14.1. Lead the team to identify and recommend a new MoC of the Hurunui district;
14.2. Develop the team to respond to a service need, engaging with key stakeholders and interested parties best suited for the purpose of developing an new MoC;
14.3. Develop project plans and implement within scope following direction from the group, CCN Programme Office and/or ALT as appropriate;
14.4. Drive the work plan by providing oversight and coordination, managing the resources and facilitating effective teamwork; be well prepared for meetings and work to guide discussion towards action and/or decision;
14.5. Meet with the other CCN leaders/facilitators to identify opportunities that link or overlap, share information and agree on approaches as appropriate.
14.6. Provide or arrange administrative support and proactively meet reporting and planning dates;
14.7. Keep key stakeholders well informed;
14.8. Identify, report on and manage risks associated with the HHSDG work activity.

15. HHSDG MEMBERS

15.1. Bring perspective and/or expertise to the HHSDG table;
15.2. Understand and utilise best practice and alliance principles;
15.3. Influence and recommend identified transformational service initiatives;
15.4. Develop close relationships with stakeholders and collaborative groups to ensure system-wide innovation and design principles;
15.5. Provide advice to the HHSDG group, wider clinical network (i.e. ALT) and Service Level Alliances (SLAs) as appropriate;
15.6. Support the principles of the Treaty of Waitangi;
15.7. Actively participate in the annual planning process via the RHWS;
15.8. Work as part of the team and share decision making and be well prepared for each meeting.

16. PLANNING & FUNDING REPRESENTATIVE/S

16.1. Provide knowledge of the Canterbury Health System;
16.2. Support the group to navigate the legislative and funding pathways relevant to the HHSDG;
16.3. Facilitate access to analytical support for the purpose of evaluation, reporting and monitoring.

TERMINOLOGY

- Canterbury Clinical Network (CCN) – an alliance of health care leaders, including rural and urban general practitioners and practice nurses, community nurses, pharmacists, physiotherapists, hospital specialists, Manawhenua ki Waitaha, CDHB planning and funding management, and PHO and IPA representatives.
- SLA Charter – outlines the purpose, principles, commitments and mandate of SLA leadership teams; provides a basis for individuals on the leadership teams to commit to the approach.
- Alliance Leadership Team (ALT) – the CCN alliance leadership team responsible for the governance of clinically-led service development.
- Alliance Support team – an operational group of alliance partners which supports the work streams and service SLA groups with prioritisation of design and delivery of health services. They support the ALT and assist with delivery of its goals.
- Service Level Alliance SLA – a group of clinical and non-clinical professionals drawn together to lead the transformational redesign, delivery of services or group of services in a specific area of the Canterbury health system.
- Workstream – a group of clinical and non-clinical professionals drawn together to lead the transformation of a sector or service. Not a contracting entity, they guide the decision making of the ALT through initiative design.
- Programme Office – includes the Alliance Support Team (AST), the Programme Director, Programme Manager, Communications Coordinator and CCN Administrator as well as a flexible resource pool of administration, project management and analysis for workstream and SLA groups.
- Service Level Provision Agreements – agreements between the DHB and a service provider that are signed in conjunction with the SLA and specify expected outcomes, reporting and funding for the services to be provided.

ENDORSEMENT

Date of agreement and finalisation by HHSDG members: 12 May 2021

Date of endorsement from ALT: 24 May 2021