Canterbury
District Health Board
Te Poari Hauora ō Waitaha

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RE Official Information Act request CDHB 9811

I refer to your Official Information Act request dated 7 March 2018 seeking the following information from Canterbury DHB, pertaining to the nature and funding levels of the Rural Service Level Alliance Teams (SLATS).

- **I would like to know the names of the members of SLAT or SLATs in your DHB and see a copy of the minutes of their last meeting.**

Canterbury's district health alliance, the Canterbury Clinical Network (CCN), has a Rural Health Workstream (RHWS) which oversees various initiatives to assure the sustainable provision of health services for rural communities. The RHWS supports a Technical Rural Subsidy Group (TRSG) which advises on the development and operation of an allocation formula for rural general practice subsidies. The TRSG took-over responsibility for this work in 2017 from the former Rural Funding Service Level Alliance.

Please refer to **Appendix 1** (below) for the membership of both the RHWS and TRSG and the minutes of the last meetings. (Minutes of the Canterbury Clinical Network's Rural Health Workstream meeting 12 February 2018 and Minutes of the Canterbury Clinical Network's Technical Rural Subsidy Group meeting 1 September 2017).

- **In addition, I would like to know the amount of rural funding your SLAT is given to allocate per year, from which rural funding streams and how many rural practices fall under its remit.**

In the 2017/18 funding year the Canterbury pool for rural general practice subsidies is $1,664,237 excl GST. Fourteen practices receive funding from this pool, via a single rural funding stream – Rural Premium Services.

- **What initiatives does the rural funding pay for?**

Rural general practice subsidies, alongside other DHB funding streams and supports, enable practices to provide their communities with access to First Contact, Urgent Care and related services to a similar level to that available to urban communities. This funding recognises the additional costs faced by rural general practices in recruiting and retaining staff, and in meeting their community's need for timely access to urgent care after-hours, amongst other things.

It is important to note that the Canterbury DHB supports rural community access to primary care in a variety of ways beyond rural general practice subsidies. Key examples are:

- via the CCN, facilitating collaborative development of health services with local providers and community representatives – currently in the Hurunui and Oxford areas;
- the nurse-led telephone triage of calls by patients to the practice seeking urgent care after-hours – this provides timely self-care advice to patients and reduces the burden on local doctors and nurses rostered on-call; and
- funding to general practices for packages of additional acute care for patients in the community who would otherwise be referred to hospital.

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB website.

Yours sincerely

Carolyn Gullery
General Manager
Planning, Funding & Decision Support

Appendix 1

Membership of the Canterbury Clinical Network's Rural Health Workstream

Name(s)	Perspective/Expertise
Prof Ian Town	ALT appointed Independent Chair
Dr Lorna Martin	Doctor with rural GP experience ALT Member with current rural experience
Jo Telarico	Nurse currently working in rural general practice
Dr Andrea Judd	Doctor with rural GP experience Experienced in developing and delivering services to remote rural residents
Vacant	Clinician from an acute or rehab hospital service familiar with rural issues
Jo Telarico	Rural Nursing (Nurse Practitioner)
Justine Schroder	Rural midwife
Vacant	An allied health professional with current experience of service delivery to rural areas including remote rural
Julie Barless	Community member with connections with Territorial Local Authority Health Committees
Michael James TEMPORARY	CDHB Funding & Planning staff member familiar with rural issues
Jane Cartwright	CCN Contractor supporting Akaroa IFHS Project
Shona Urquhart-Bevan	Rural Health Project Manager and ASLA Facilitator
Bill Eschenbach	Rural manager with in-depth understanding of rural health issues, obstacles and solutions. Provide national advocacy channel to Rural Health groups (RHAANZ, NRHAG) Deputy Chair
Carol Glover	Rural manager with in-depth understanding of rural health issues, obstacles and solutions.
Win McDonald	Rural secondary care operational manager
Joana Kahu	Linkages to Manawhenua Ki Waitaha, with rural health sector experience
Koral Fitzgerald	CCN Project Facilitator

Membership of the Canterbury Clinical Network's Technical Rural Subsidy Group

Name(s)	Perspective/Expertise
Prof Ian Town	ALT-appointed Independent Chair
Kim Sinclair-Morris	CCN Director
Koral Fitzgerald	CCN Facilitator
Bill Eschenbach	PHO - Rural Canterbury
Allan Masters	PHO – Pegasus Health
Michael James	CDHB Planning & Funding

Rural Health Workstream (RHWS)
Minutes/Action Register

Venue: Pegasus Health, 401 Madras Street, Christchurch	
Date: Monday 12th February 2018	**Time:** 4:30-6:15pm
RHWS Members Present: Julie Barlass, Natalie Blake (from 5pm), Jane Cartwright (until 5:30pm), Bill Eschenbach, Michael James, Win McDonald, Lorna Martin, Justine Schroeder, Jo Talarico, Ian Town (Independent Chair), Shona Urquhart-Bevan (from 5:15pm)	
Other Attendees: Koral Fitzgerald (Facilitator), Angela Blunt (via VC)	
Apologies: Andrea Judd , Carol Glover, Jaana Kahu	
Guest Speaker/s: Dr John Garrett (via VC, 4:45-5:00pm)	

Action Register			
Item	**Action**	**Responsibility**	**Date due**
WIP	Ethics framework to be shared with RHWS, for rural input.	**Andrea**	Following CSSLA work group progress
WIP	Advocate for CSSLA to reinvigorate the CREST8 case mix model for home based support to support rural, and for CCN to lead a short design group to progress with RHWS	**Andrea / Koral**	Update next meeting
1	Share learnings from Kaikoura to support Akaroa progress.	**Win / Andrea**	When required
2	Arrange for John Garret to attend / present on model utilised (with success) on the West Coast.	**Koral**	January 2018
3	First draft 2018/19 work plan for email review by mid-December for comment/suggestions by RHWS.	**Ian / Koral**	15th December 2017
4	Comment/suggestions and prioritisation on reviewed 2018/19 work plan.	**All RHWS members**	15th January 2018

	Item	Discussion/Action
	Welcome	Meeting opened at 4:41pm. Ian welcomed attendees.
	Apologies	Sustained as noted above.
1	**Interest Register**	No changes received. RHWS RoI Feb 2018.pdf
2	**Approval of the Previous Minutes**	Minutes reviewed. *Motion*: That the minutes circulated of 27th November 2017 are adopted as a true and correct record. *Moved*: Ian *CARRIED* RHWS Minutes and Actions 27.11.17 FINA
3	**Discussion**	**RuFUS & use of telehealth** *Dr John Garrett (paediatrician & former National Telehealth Forum Chair)* John is a RuFUS (Rurally-Focused Urban Specialist) in paediatrics for Canterbury & West Coast DHBs. Previous Chair of the National Telehealth Forum until 2017. Over the past 8 years, have been successfully utilising telehealth for specialist care delivery, including the past two years to Chatham Islands. Developing a South Island strategy to go to the South Island Alliance to encourage standardisation and a systematic change management programme / training across specialist workforce. Needs to be coordinated with devices and networks, to be cost efficient and have economy of scale to run good education and increase adoption of the tool. Opportunities: videoconferencing (VC) has the greatest advantage to the patients – they invest the most to receive healthcare including significant travel time. There is an increased number of clinicians who are using telehealth as a tool to reduce that investment for patients (mostly those who cover Canterbury & WC DHBs), including Kaikoura (mobile VC unit). VC units also in

	Item	Discussion/Action
		Nelson. Example: Mapped out all patients north of Cheviot that would usually attend a clinic in Christchurch. In a year, 2000 patients made 8000 visits to Christchurch, some who have very short appointments. Opportunity: increase specific request for remote consultation in relevant referral letters - note frailty, limited access to transport – 'is there a possibility to conduct a consultation by telemedicine with me as the primary care provider?' Win noted there have been local success with referral arrangements whereby the coordinator requests if the consultations can be done via telehealth (including urology, orthopaedics and cardiac follow up appointments). Cost of work may be a few hours versus few days for remote rural patients. • Use for Study Days; • Alignment of investigations and follow up referrals on the same day (e.g. ultrasound and obstetrician consult for maternity services); • New Akaroa rebuild will have a VC technology; • Hanmer Springs have done a number of sessions for orthopaedics and paediatrics; • Most remote practices have equipment to use telemedicine (may require upgrade) as interconnectivity issues with various providers; • PHO / DHB staff attendances via VC at rural meetings saves travel time; • Significant cost savings to the system in addition to patients. Using telehealth for planned patients suggested as a focus; acute patients more difficult, e.g. GP hosts the telehealth for a specialist with their patient in-room. RHWS can advocate for our health system to find a Telehealth Champion in each specialist department (prompt Chief Medical Officer / Divisional Heads) to train others as a departmental mission to improve the patient experience. Primary care-led initiative with attendance at clinic being the exception, not the rule. In Kaikoura for oncology consults through VC; a Practice Nurse sits in (no funding attached for that time) – to discuss with P&F. Strengthens links between primary and tertiary care. Considered through medical insurance? Bill continuing to push at the national forums; rollout of RS2 (second wave broadband) through rural areas. **ACTION 1:** Send a letter to key DHB CMO to advocate for progression of this. Access SIAPO document discussed; link to leadership group in CDHB to identify how to provide a positive effect to all three foci: patient, specialist and tertiary unit users.
4	**Previous Action update**	Provided summary in agenda pack taken as read.
5	**Work Plan**	**2017/18 Work Plan – Q3** Provided dashboard taken as read. Action 3.1: spoke to Canterbury Community Pharmacy Group (CCPG) colleagues on this shared piece of work. A number of processes in planning; not yet translated to action. Reflected on the significant volume of actions linked here. Access of Medication Management Services (MMS) to rural communities underway. • Natalie noted an opportunity to send a pharmacist up to Hanmer Springs once per month to work directly with patients in the area. • Win noted a medication check is done prior to discharge / transfer of care in hospital where there is no pharmacy near their home, including having medication on hand (medication reconciliation). **ACTION 2:** Natalie to speak with Koral and CCPG to explore this model further. Action 1.3 & 1.4: delayed progress. **2018/19 Work Plan** Today, the first level of review by the CDHB Accountability Lead, Pacific & Maori Caucuses has been received. Feedback provided; most minor modifications. *Note*: Technical Rural Funding Group (previously Rural Funding SLA) has their own work plan; updates will be provided through RHWS: add to monitoring section of RHWS Work Plan (complete).

	Item	Discussion/Action
		2018_19 RHWS Workplan v2 - Feb 201 • Review focus of Action 2.1 to review ways to strengthen workforce for GPs, Nurse Practitioners, allied health, midwifery, etc. Will also be pushed at National fora. • Leads added: Lorna to 2.2; Andrea to 1.2 • Noted added hospitals for Action 3.1 (note: Accountability Team suggests taking out list as business case will include variables). **RHWS Project Work for 2018** Koral's report taken as read. Linkages with Canterbury Initiative / HealthPathways in progress to avoid duplication of work in the system. Consider timeframe modifications: noted approx. 3 month window for HealthPathway changes.
6	**SLA & Regional Reports**	Provided reports taken as read; additional updates included below: Akaroa • Website link to be completed: http://www.akaroahealthhub.org.nz Rural Sustainability Project / ASLA • Activity in Methven & Rakaia influenced by Ashburton SLA work. • Hurunui community consultation extended to 28th February. • After-hours provision continues to be a topic of focus. Kaikoura Angela spoke to report; attached. Update to RHWS - Kaikoura Feb 2018
7	**PHO Reports**	**RCPHO Report** Bill's report taken as read. **Pegasus Health Report** Carol report taken as read.
8	**Risk Register**	No new risks identified, nor change in rating.
9	**Correspondence**	Noted. Urgent Care SLA and RHWS meeting last October – representatives from RHWS unsure of next steps, no further meeting planned. Koral to check in with Ruth to explore.
10	**Key Messages**	• Dr John Garrett (paediatrician & former National Telehealth Forum Chair) videoconferenced into the meeting to discuss his role of RuFUS (Rurally-Focused Urban Specialist) in paediatrics for Canterbury & West Coast DHBs, highlighting telemedicine as a crucial tool for best for system / best for rural patient outcomes. • Reviewing of the proposed 2018/19 work Plan for RHWS discussed. • There is significant progress of the model of care for Akaroa: the centre will be known as Akaroa Health – Te Hauora o Rākaihautū. • Model of care developments and community feedback continues in the Hurunui and community engagement will begin in Oxford and Surrounding Areas shortly.
	Next agenda items	Advise Koral of potential speakers / topics for discussion by **mid-March 2018.** • Rural maternity services and opportunities discussion.
	Next meeting date	**16th April 2018** All standing Reports and action updates are due to Koral via email by Friday **6th April** 2018.
	Meeting Closure	6:15pm

Glossary	(HHSDG) Hurunui Health Service Development Group
(ACP) Advanced Care Plan	(MSD) Ministry of Social Development
(ALT) Alliance Leadership Team	(NGO) Non-government Organisation
(ARC) Aged Residential Care	(OT) Occupational Therapist
(BIS) Business Information Systems	(OTC) Over The Counter (medicines)

(C&PH) Community & Public Health (CCCC) Canterbury Community Care Coordination (CCN) Canterbury Clinical Network (CCMS) Connected Care Management Solution (CDHBs) Canterbury District Health Board (CI) Canterbury Initiative (CME) Continued Medical Education (CNS) Clinical Nurse Specialist (CPAC) Clinical Prioritisation Advisory Committee (CP) Community Pharmacy (CREST) Community Rehabilitation Enablement & Support Team (eMeds) Electronic Medicines Management (EoL) End of life (FFP) Flexible Funding Pool (GPTs) General Practice Teams (HCS) Health Connect South (LMC) Lead Maternity Carer (MH) Mental Health (MoC) Model of Care (MoH) Ministry of Health	(PaperLite) moving from a paper to an electronic platform for medical records (PCW) Partnership Community Workers *(Pegasus Health PHO terminology)* (PHOs) Primary Health Organisation (PICS) Patient Information Care System (P&F) Planning and Funding (PMS) Patient Management System (PN) Practice Nurse (QFARC) Quality, Finance, Audit and Risk Committee (RFP) Request for Proposal (RSAG) Rural Sustainability Advisory Group (RuFUS) Rurally-Focused Urban Specialist (SLA) Service Level Alliance (SLT) Speech Language Therapist (SMO) Senior Medical Officer (ToR) Terms of Reference (TRAG) Technical Rural Advisory Group (WS) Workstream

Technical Rural Subsidy Group (TRSG) Meeting NOTES

Venue: Pegasus House, 401 Madras Street, Christchurch	
Date: Friday 1 September 2017	**Time:** 12:30 – 1:45 pm
Present: Koral Fitzgerald (CCN), Michael James (P&F), Allan Masters (Pegasus Health), Kim Sinclair-Morris (CCN Director), Ian Town (Independent Chair)	
TeleConf: Bill Eschenbach (RCPHO)	

Item	Discussion/Action

	Meeting opened 12:35pm.
	Koral provided a summary of responses, current as of this morning. Ian spoke with most of the 'declined' sites to ensure we understood the principle-based reasons. Four sites are undecided currently.
	• For both the Practice and population share percentages, both sit under 50% acceptance.
	• Influence of practices closer to Christchurch and/or expected to lose funds in the proposed v5 declined.
	• All declines were requested reasoning; responses included:
	  • Cheviot situation
	  • Rurality
	  • Practice sustainability concerns
	  • Loss of population weighting factor
	  • 'Fundamentally flawed'
	  • DHB relationship distrust, concern about changes
	  • We need more money, generally

Summary	No coherent objection to the principles raised, but the anticipated outcomes determined signing status. A number agreed on the principles but would not sign due to weighting of scoring for providers. <u>ALT Update (18th September):</u> • Provide summary of responses / statistics, explaining process steps and outcome, classifying near urban versus remote rural. • 'Disappointing but not disastrous' • Recommendation will be to continue v3 for a set period as planned, to allow continued flow of funds. Oxford and Akaroa will be the two Sole Rural practices that the DHB will be most concerned about (disadvantaged by staying on v3). Already engaged in Model of Care (MoC) / support at both sites. Agreed a funding 'sweetener' is unlikely to get a required volume of practices over the line as the principles were generally accepted. Opportunity now to focus on dealing with MoC development throughout the rural sites to review longer-term funding. Back-up plan suggested a Plan B (modified v3), applying the 40km proxy to change the "can't / won't" share issue, including a summary noting we are aware that these principles were meant to compensate remote / unable to share practices. A new conversation would be required if we were to suggest a modified v3; decided not to proceed.
Next steps	• Communication to Practices: individualised with feedback received. • Mike to instruct PHO contracts renewal. • TRSG to pause, reconvene post-MoC completion and/or considerable change in the landscape. *Thanks provided to the group for their dedication and resilience.* **ACTIONS** • Koral to create response summary document for TRSG. • Koral to explore opportunity to link into national (or South Island) SLATs / working groups to ascertain their roadblocks and share our learnings; consider advocating for PSAAP to review the 75% agreement requirement. Draft letter from 2yrs ago to MoH could be refreshed. • Next steps in flowchart to begin once final responses received – handover to CDHB / PHOs.
Closed	1:15pm