TERMS OF REFERENCE
Ashburton Service Level Alliance

BACKGROUND

The foundation of the SLA Charter is a commitment to act in good faith to reach consensus decisions on the basis of 'best for patient, best for system.' Each SLA member will sign the SLA Charter and agree to the principles contained within it.

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 (CCN)

- 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 SLA/WS 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.

ASHBURTON SERVICE LEVEL SLA

1. BACKGROUND

1.1. The Ashburton Service Level Alliance was established in 2015 to recommend how to best allocate Ashburton health services funding, to systematise service provision across the district, to ensure access and service equity to the population within the funding available.

2. PURPOSE

The Alliance will recommend the prioritisation and development of coordinated and integrated primary health (health and social services) and hospital services that will:

2.1. Recognise the needs and resources within services and communities;
2.2. Align service delivery and development with the strategic direction of the wider Canterbury Health System;
2.3. Recommend how services will be funded using collective decision making and available resources from a range of sources;
2.4. Work toward sustainable services both fiscally and clinically;
2.5. Recognise Ashburton's position as a part of the wider Health sector;

2.6. Assist the Canterbury DHB and the Ashburton District Community with strategic planning, design, prioritisation for Integrated Family Health Services;

2.7. Develop and maintain relationships with local council and other Government organisations and NGOs that impact on the health of the Ashburton population; for example Territorial Local Authority and their local health committee; Ministry of Social Development, Housing New Zealand.

2.8. The Ashburton SLA will also oversee the implementation, monitoring, evaluation and cessation of services and advise the CCN Alliance Leadership Team (ALT) of any risks to meeting service delivery requirements and the agreed wider health outcomes, including any unintended consequences.

3. EXPECTED OUTCOMES OF THE SLA

3.1. An implementable integrated model of care for Ashburton that will be flexible enough to meet the needs of the community now and into the future;

3.2. Agreed patient flow mechanisms and models of care across primary/secondary and tertiary services that support the right care is delivered in the right place at the right time and by the right person;

3.3. Services that meet the scope of the Canterbury DHB Annual Plan;

3.4. Supporting the establishment of integrated family health services that foster multidisciplinary community health care delivery;

3.5. One health system work force that is flexible to meet the health need of the Ashburton population now and into the future.

3.6. Support and establish improved communication across the health sector

4. MANDATE

4.1. The Ashburton SLA has the mandate to make recommendations to the funder/s on the design, development, provision and ongoing support and maintenance, of comprehensive health services and health related infrastructure across the Ashburton District.

5. SCOPE

5.1. In Scope: The Ashburton SLA can make recommendations to ALT, Canterbury DHB and Primary Health Organisations about:

- Determining and prioritising services to be established, continued and ceased relating to the health system providing for the Ashburton District population;
- Monitoring the allocation and use of the Ashburton health services funding to meet service and infrastructure commitments;
- Identifying and establishing processes for ceasing activity that is no longer a priority;
- Identifying and establishing processes for developing activity that is now required to meet a health need;
- Coordinating, monitoring and reporting on the implementation of health services prioritised by the Ashburton SLA.

5.2. The scope of the Ashburton SLA requires that consideration of the value of adopting local responses compared to consistent approaches across Canterbury will be required. This will require interaction with other Service Level Alliances within the system (e.g. Flexible Funding Pool SLA, Community Services SLA, Immunisation and Pharmacy SLAs). The Ashburton SLA will work with the ALT in developing a set of principles that will guide this consideration.

5.3. Out of Scope: The Ashburton SLA does not have the authority to

- Employ staff;
- Contract for services.

6. MEMBERSHIP

6.1. The membership of the SLA will include professionals who participate (e.g. referrers or providers) in the relevant services across urban and rural settings, those who work in key related services, and management from relevant health organisations and others who bring important perspective e.g. consumer, Maori, Pacific, migrant and/or rural voices;

6.2. 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 SLA to achieve success;

6.3. The SLA will review membership annually in February to ensure it remains appropriate;

6.4. Membership will include a member of the CCN ALT;

6.5. 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;

6.6. It is the expectation that a member will be able to attend two-thirds of scheduled meetings annually, unless discussed and agreed with the Chair;

6.7. 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;

6.8. Each SLA will be supplied with project management and analytical support through the Programme Office.

7. SELECTION OF MEMBERS, CHAIRPERSON AND DEPUTY CHAIRPERSON

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

7.2. The SLA will review the position of deputy chairperson annually at the February meeting and elect where appropriate;

7.3. An independent chairperson will be appointed by ALT. A deputy chair will be appointed from within the SLA, by the SLA.

8. MEMBERS

The composition of the Ashburton SLA is:

Members Name(s)	Perspective/Expertise
Gordon Guthrie	Independent Chairperson
Natahna Sim	Practice Nurse
Michelle Brett	Maori Leader/Maori Health Provider/St John
Toni Vainerere	Pacifica Community Leader
Jenny Gill	Allied Health (primary/secondary)/District Nurse/Aged Care Sector
Bernice Marra	Ashburton Health Services Manager Ashburton Hospital Operations
Carolyn Cameron (O'Brian)	Pharmacy (Primary/Secondary)
Chris Clark	Mental Health
Brenda Close	Director of Nursing, Ashburton Health Services
John Lyons	Ashburton Hospital Clinical Director
Gregory Robertson	Tertiary Clinical leader
Malcolm Wootton	General Practitioner (business owner)
Donna Coxshall	Consumer
Vacancy	**General Practitioner**
Kathy O'Neill	CDHB Planning and Funding
Carol Glover	Rural Health Manager, Pegasus Health
Sue Fowlie	ALT Member
Bill Eschenbach	Rural Canterbury Primary Health Organisation
Hiedee Harris	CCN ASLA Facilitator

9. ACCOUNTABILITY

9.1. The ASLA is accountable to the CCN ALT who will establish direction; provide guidance; receive and approve recommendations.

10. WORK PLANS

10.1. The ASLA 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 Targets, the Annual Plan, legislative and other requirements;

10.2. The ASLA will actively link with other CCN work programmes where there is common activity.

11. FREQUENCY OF MEETINGS

11.1. ASLA Meetings will be held eight weekly or as required;

11.2. Meeting dates will be arranged annually, taking into consideration ALT meetings; to ensure reporting is current and up to date.

12. REPORTING

12.1. The ASLA will report to the ALT on an agreed schedule via the CCN Programme Office;

12.2. Where there is a risk, exception or variance to the ASLA/WS work plan, or an issue that requires escalation, a paper should be prepared in a template provided by the CCN Programme Office;

12.3. Where there is a new innovation or service recommendation, a paper should be prepared in a template provided by the CCN Programme Office after due consideration and agreement in principle has been secured from the funder

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

13. MINUTES AND AGENDAS

13.1. Agendas and minutes will be coordinated between the ASLA chair and facilitator;
13.2. Agendas will be circulated no less than five working days prior to the meeting, as will any material relevant to the agenda;
13.3. Minutes will be circulated to all group members within seven working days of the meeting and minutes remain confidential whilst 'draft' and until agreed.
13.4. 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.

14. QUORUM

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

15. CONFLICTS OF INTEREST

15.1. Prior to the start of any new ASLA programme of work, member interests will be stated and recorded on an Interest Register;
15.2. Where a conflict of interest exists, the member will advise the chair and an open discussion will be made as to how the conflict will be managed
15.3. The Interests Register will be a standing item on ASLA agenda's and be available to the Programme Office on request.

16. REVIEW

16.1. These terms of reference will be reviewed annually at the last meeting of the year and may be altered intermittently to meet the needs of its members and the health system.

17. EVALUATION

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

RESPONSIBLITIES

18. RESPONSIBILITY OF THE ASLA

18.1. Apply the delegated funding available to lead the required service/service change;
18.2. Establish new work groups to guide service design;
18.3. Design evaluation criteria to evaluate and monitor on-going effectiveness of service delivery. Any evaluation will comply with the evaluations framework outlined by CCN and/or the ALT or funder.

ROLES

19. CHAIR

19.1. Lead the team to identify opportunities for service improvement and redesign;
19.2. Lead the development of the service vision and annual work plan;
19.3. Develop the team to respond to a service need; engaging with key stakeholders and interested parties best suited for the purpose of service innovation;

19.4. Work with the project manager/facilitator and/or analyst to produce work plans and other reports as required;
19.5. Provide leadership when implementing the group's outputs;
19.6. Work with the facilitator to facilitate meetings to achieve outcomes in an economical and efficient manner;
19.7. Be well prepared for meetings and ready to guide discussion towards action and/or decision;
19.8. Meet with the other CCN leaders to identify opportunities that link or overlap, share information and agree on approaches.

20. CLINICAL LEADERS

20.1. Provide strong clinical leadership across all ASLA work activity;
20.2. Serve as mentor and provide clinical guidance to ASLA members (where relevant).

21. ALT MEMBER

21.1. Act as a communication interface between ALT and the ASLA;
21.2. Participate in the development and writing of papers that are submitted to ALT;
21.3. Act as Sponsor of papers to ALT so papers are best represented at the ALT table.

22. ASLA MEMBERS

22.1. Bring perspective and/or expertise to the ASLA table;
22.2. Understand and utilise best practice and alliance principles;
22.3. Analyse services and participate in service design;
22.4. Analyse proposals using current evidence bases;
22.5. Work as part of the team and share decision making;
22.6. Actively participate in service design and the annual planning process;
22.7. Be well prepared for each meeting.

23. PROJECT MANAGER/FACILITATOR

23.1. Support chairs and/or clinical leaders to develop work programmes that will transform services;
23.2. Provide or arrange administrative support;
23.3. Document and maintain work plans and reports to support the group's accountability to the ALT;
23.4. Develop project plans and implement within scope following direction from the group, CCN programme office and/or ALT as appropriate;
23.5. Work with the chair to drive the work plan by providing oversight and coordination, managing the resources and facilitating effective teamwork;
23.6. Keep key stakeholders well informed;
23.7. Proactively meet reporting and planning dates;
23.8. Actively work with other CCN groups to identify opportunities that link or overlap, share information and agree on approaches;
23.9. Identify report and manage risks associated with the ASLA work activity.

24. PLANNING & FUNDING REPRESENTATIVE

24.1. Provide knowledge of the Canterbury Health System;
24.2. Support the group to navigate the legislative and funding pathways relevant to the SLA;
24.3. 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.

- ASLA 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 who supports the workstreams 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 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 ASLA members: 28 / 08 /2015

Date of endorsement from ALT: 14/9 /2015

Date of Review: 10 July 2019