TERMS OF REFERENCE

Community Services 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.

COMMUNITY SERVICES SERVICE LEVEL ALLIANCE (CSSLA)

1. BACKGROUND

1.1 The CSSLA was formed in November 2011 to enable the development of a new service model which allowed for an individual to receive community services that enable them to live safely within their homes and communities.' To date there has been development of a Community Services restorative home based model of care which incorporates Home Based Support (HBS) and District Nursing (DN).

During this time three CBS providers (Nurse Maude, Health Care of New Zealand and Access) were selected to continue to deliver services. The CBS service was intended to rollout in February 2011. However due to the impact of the earthquakes and transition of clients from the unsuccessful provider this process was delayed until August 2011.

2. PURPOSE

2.1. Monitoring and guiding of Community Services, as described in the Community Services specification. A critical component of this work will be to ensure the service is appropriately integrated with other primary, community services (including CREST) and emergent Integrated Family Health Service developments;

2.2. Provide strategic planning, design, prioritisation and oversee the ongoing development of the ongoing Community Services model across the Canterbury health system;

2.3. Reporting on the implementation's progress and key performance indicators to the ALT and Health of Older People Workstream on a quarterly basis;

2.4. Continuation of development of these services needs to fully account for service, workforce and financial sustainability while maximising service user outcomes;

2.5. Ongoing development of funding model, allocation and available resources from a range of sources;
2.6. Any recommendations for a change of funding allocation will need to go back to Planning and Funding for approval;
2.7. All recommendations for a change of funding approach will need to go back to ALT for approval.

3. SERVICE VISION

3.1. The service includes home and community support services (inclusive of community nursing services) for people who need support whether on a short or long term basis in their homes and community.
3.2. Services will align with the strategic objectives of:
- The New Zealand Health Strategy – 2000
- New Zealand Health Of Older People Strategy 2002
- The New Zealand Disability Strategy - 2001
- Primary Health Care Strategy - 2001
- He Korowai Oranga Maori Health Strategy -2002
- The Pacific Health and Disability Action Plan – 2002

3.3. The vision is a flexible service that:
- Is service user driven focusing on peoples decision making and goal attainment relating to being able to enable people to live at home and participate in community
- Is inclusive of family/whanau and other natural supports;
- Supports an integrated continuum of care by linking to both primary and secondary care.
- The aim is for a person to receive community services that enable them to live safely within their homes and communities and for them to take part in activities that supports and strengthen this objective

3.4. This objective will be achieved through:
- The promotion of recovery and return to independent living (self-care) through outcome focus, support services based on assessed need of the service user and family/whanau and other natural supports;
- Flexible, integrated and responsive services;
- Pro-active interventions to prevent or delay physical, psychological and social deterioration.
- Services are to incorporate and facilitated comfortable and dignified end of life based on informed choices and to consider participation of advanced care planning when needed.

4. SERVICE TARGETS

4.1. Key Performance Indicators will align with the frail elderly pathway initiative.

Previous Service Targets

The Key Performance Indicators will be further developed once information is available from the Frail Elderly Pathway, Health of Older People Workstream outcomes framework and the service development work from the Long Term Conditions Chronic Health Clients and the CDHB wide systems framework including rural

5. MANDATE

5.1. The SLA has the mandate to review current community service activities with the intention of identifying and recommend areas needing increased efficiencies and/or improved service levels;

5.2. Members have the authority to meet with relevant stakeholders and service providers to gain information and ideas for improvements;

5.3. The SLA will work together with service providers to develop an appropriate funding approach for service delivery.

6. SCOPE

6.1. In Scope – The scope of the service being overseen is described in the specifications for Community Services (previously District Nursing, Short and Long Term Home based Support) and CREST and Long Term Support Chronic Health Conditions (LTSCHC);

6.2. Out of Scope – Any contracts of service that falls outside the CCN objectives.

7. MEMBERSHIP

7.1. The membership of the SLA will include professionals and clinicians 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;
7.2. 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;
7.3. The SLA will review membership annually to ensure it remains appropriate;
7.4. Membership will include a member of the ALT;
7.5. 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;
7.6. It is the expectation that a member will be able to attend two-thirds of scheduled meetings annually, unless discussed and agreed with chair;
7.7. 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;
7.8. Each SLA will be supplied with project management and analytical support through the Programme Office.

8. SELECTION OF MEMBERS, CHAIRPERSON AND DEPUTY CHAIRPERSON

8.1. 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;
8.2. The chair and deputy chair will, in most cases, be nominated by members of the SLA. Where there is more than one nominee for either one or both positions, the election will be put to a vote. In some cases, the role of chair will be appointed by ALT (i.e. an independent chair).

9. MEMBERS

The composition of the Community Services SLA is:

Name(s)	Perspective/Expertise
Andrea Judd	GP in Kaikoura and on the Kaikoura SLA,
Carole Evans	Consumer
Steve Cate	Regional Manager, HCNZ
Glenda Rich	National Innovations Manager, Access
Sam Powell	General Manager, Clinical Services, Nurse Maude
Donna Hahn	Chair. Collaborative Care and Primary Care Liaison;
Ginny Brailsford	Pharmacist
Anne Roche/Val Fletcher	Physician, Community Geriatrician
Jane Evans	Clinical Nurse Coordinator –Transfer of Care Nurse, CDHB
vacant	Professional Leader, Occupational Therapy
Janice Lavelle	Service Manager - OPH&R
Deb Nind	Care Coordination Centre Manager
Irihapeti Bullmore	Manawhenua Ki Waitaha
Andrea Davidson	Service Development Manager, Planning and Funding
Jackie Cooper	Primary Care Nurse
Kate Gibb	ALT representative

10. ACCOUNTABILITY

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

11. WORK PLANS

11.1. The Community Services SLA 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 CDHB Annual Plan, legislative and other requirements;

11.2. The SLA will actively link with other CCN work programmes where there is common activity.

12. FREQUENCY OF MEETINGS

12.1. Meetings will be held bi monthly on the 1st Tuesday of the month with subgroup meetings being held when necessary resulting from the SLA meeting;

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

13. REPORTING

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

13.2. Reports will be provided by the SLA in a template provided by the CCN Programme Office;

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

13.4. Where there is a new innovation or service recommendation, a paper should be prepared in a template provided by the CCN Programme office;

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

14. MINUTES AND AGENDAS

14.1. Agendas and minutes will be coordinated between the SLA chair and facilitator;

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

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

14.4. 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.

15. QUORUM

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

16. CONFLICTS OF INTEREST

16.1. Prior to the start of any new programme of work, conflict of interest will be stated, recorded on an Interest Register;

16.2. Where a conflict of interests exists, the member will advise the chair and withdraw from all discussion and decision making;

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

17. REVIEW

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

18. EVALUATION

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

RESPONSIBLITIES

19. RESPONSIBILITY OF THE SLA

19.1. Apply the delegated funding available to lead the required service/service change;
19.2. Establish new work groups to guide service design;
19.3. 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 & RESPONSIBILITIES

20. CHAIR / CLINICAL LEAD

20.1. Lead the team to identify and recommend opportunities for service improvement and redesign;
20.2. Lead the team in the development of the service vision and annual work plan;
20.3. Develop the team to respond to a service need; engaging with key stakeholders and interested parties best suited for the purpose of service innovation;
20.4. Work with the project manager/facilitator and/or analyst to produce work plans and other reports as required;
20.5. Provide leadership when implementing the group's outputs;
20.6. Work with the facilitator to facilitate meetings to achieve outcomes in an economical and efficient manner;
20.7. Be well prepared for meetings and ready to guide discussion towards action and/or decision;
20.8. Provide strong clinical leadership across all SLA work activity;
20.9. Meet with the other CCN leaders to identify opportunities that link or overlap, share information and agree on approaches.

21. SLA MEMBERS

21.1. Bring perspective and/or expertise to the SLA table;
21.2. Understand and utilise best practice and alliance principles;
21.3. Analyse services and participate in service design;
21.4. Analyse proposals using current evidence bases;
21.5. Work as part of the team and share decision making;
21.6. Actively participate in service design and the annual planning process;
21.7. Be well prepared for each meeting.

22. PROJECT MANAGER/FACILITATOR

22.1. Support chairs and/or clinical leaders to develop work programmes that will transform services;
22.2. Provide or arrange administrative support;
22.3. Document and maintain work plans and reports to support the group's accountability to the ALT;
22.4. Develop project plans and implement within scope following direction from the group, CCN programme office and/or ALT as appropriate;
22.5. Work with the chair to drive the work plan by providing oversight and coordination, managing the resources and facilitating effective teamwork;
22.6. Keep key stakeholders well informed;
22.7. Proactively meet reporting and planning dates;
22.8. Activity work with other CCN groups to identify opportunities that link or overlap, share information and agree on approaches;
22.9. Identify report and manage risks associated with the SLA work activity.

23. PLANNING & FUNDING REPRESENTATIVE

23.1. Provide knowledge of the Canterbury Health System;

23.2. Support the group to navigate the legislative and funding pathways relevant to the SLA;
23.3. Facilitate access to analytical support for the purpose of evaluation, reporting and monitoring.

24. ALT MEMBER

24.1. Act as a communication interface between ALT and the SLA;

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

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

TERMINOLOGY

- 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.
- 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.
- Service level 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.
- Ops Leaders Group – the small operational arm of the ALT 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. Part of the Programme Office.
- Programme Office – includes the Ops Leaders Group, the Programme Leader, Programme Coordinator 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 District SLA and specify expected outcomes, reporting and funding for the services to be provided.

ENDORSEMENT

Date of agreement and finalisation by SLA members: 1 Dec 2015

Date of endorsement from ALT: 16 Feb 2018

Review date for TOR: Dec 2018