TERMS OF REFERENCE

Laboratory 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.

LABORATORY SERVICE LEVEL SLA

1. BACKGROUND

The Laboratory SLA commenced early in 2011 to review and redesign the delivery of community lab services in Canterbury. A transitional alliance oversaw the change to lab services being provided by the DHB laboratory and a single private community provider. In late 2012, the present Laboratory SLA was convened to embed and guide the new, integrated laboratory service in Canterbury.

2. PURPOSE

2.1. To work within the Canterbury Health Systems as a fully integrated laboratory service for the residents of Canterbury in all hospital and community settings. The Service Level Alliance will establish the policies and prioritise resources to deliver the planned outcomes and monitor the performance of the delivery of the vision by the laboratory services and health system;

2.2. We will have two laboratory providers with a common interface and shared quality, audit, education systems and processes;

2.3. Provide strategic planning, design, and prioritisation of Laboratory services across the Canterbury health system;

2.4. Ensure value for money in Laboratory services in Canterbury.

3. FUNCTION

The Laboratory alliance's functions are to:

3.1. Provide clinical leadership in the future development of the Canterbury and West Coast Laboratory Services;

3.2. Provide governance and strategic direction for the operational leadership group and work streams;

3.3. Development of clear service expectations and policy direction for the Laboratory Service providers;

3.4. Provide clear service planning with regard to current and future service opportunities and prioritise annual work programmes;

3.5. Balance the demands on the system for patient care and wellbeing with the need for sustainable clinical services and business practices;

3.6. Recommend how services will be funded using collective decision making and available resources from a range of sources;

3.7. Monitor and oversee Key Performance areas identified for the Laboratory Services and feed into District Annual Plan around deliverables, targets, etc.;

3.8. Develop efficient and aligned IT systems that will support the delivery of Laboratory Services and appropriate sharing of clinical information;

3.9. Ensure efficient investment in the infrastructure that supports the delivery of Laboratory Services.

3.10. Identify and support the development of education programmes that improve the overall utilisation and effectiveness of Laboratory Services for our population;

3.11. Communicate proactively with all stakeholders;

3.12. Link with other service level alliance groups and work streams;

3.13. Recognise the impact of changes within Canterbury on clinical laboratory service provision within the South Island;

3.14. Promote effective communication and collaboration among all key stakeholders.

4. THE SERVICE

4.1. SERVICE VISION

The service vision detailed in this section was developed as a part of the work to inform the design of Canterbury's clinical laboratory services.

Implementation of this vision will be achieved through a careful alliance process and some detail may be amended following consideration of patient choice, patient privacy and ethical aspects.

This SLA will develop and define service models to provide integrated laboratory services for Canterbury. These models will ensure that people get the right service at the right time. This model will provide efficient and aligned systems that enable appropriate sharing of clinical information. This integrated laboratory service should have the following attributes:

4.1.1. The patient is central to the health care system and the laboratory system. As such laboratory tests are not perceived as a commodity and the professionals who deliver the service are seen as an integral part of the patient care team and as part of a high performing health system;

4.1.2. Canterbury has a clinical laboratory service that provides services to the full range of health services within Canterbury as well as receiving work referred from outside of Canterbury. It continues to support and grow specialist technology, specialised testing, reference and research capacity encouraging the recruitment and retention of a highly skilled and motivated workforce;

4.1.3. Laboratory services will support equity of health outcomes by reducing barriers to access for patients and will be designed to improve the quality of the patient's experience. The

laboratory system is adaptable to the changing health care environment and deliver better care, sooner and more conveniently for patients and referrers;

4.1.4. The appropriate choice of tests is ethical, focussing on clinical outcomes the optimal use of finite resources, and health system impact. The result of the chosen test should be able to be acted on. Complementary ongoing education supports clinical decision making. Tests previously ordered by any other healthcare provider are visible at the time of subsequent clinical interactions to reduce unnecessary duplication;

4.1.5. Ordering is done electronically with accompanying relevant clinical information and patient and referrer contact information to remove data entry errors and allow for easier communication. Both clinician and laboratory provider are able to see when a test is ordered and when it is actioned by the patient with patient friendly recalls in place. Urgent requests based on clinical need are appropriate and limited so they can be actioned immediately;

4.1.6. Sample collection locations are readily accessible to patients of all ages, backgrounds, geographical locations and socio economic status, and to contracted laboratory test requestors including GP's, midwives and specialists. They support the needs of the patient in their operating hours, experience and communications. Sample collection is undertaken by registered phlebotomists or suitably qualified competent health professionals where available and in an environment which supports quality samples. Rural locations are supported to collect, store, maintain and transport samples to ensure sample quality;

4.1.7. The transport system for samples is intelligently designed to ensure the viability of samples while addressing the capacity needs of the laboratory providers, with systems that allow the tracking of samples and results by referrers and patients;

4.1.8. Samples are analysed in a setting to the highest quality and accredited standards by a stable staff of world class medical laboratory scientists and technicians, pathologists and support staff with capacity to respond to unplanned changes in demand and crisis management. The system has contingency capacity in service and data management in the event of an emergency. The easy interaction of referrer and provider IT system reduces manual entry and improves sample flow and removes after-hours communication issues;

4.1.9. The philosophy of laboratory service is to support increased quality, efficiency and the reduction of costs and errors within their own service. They inform the health system through timely feedback on emerging issues and opportunities to improve clinical outcomes;

4.1.10. Results and interpretation are timely, accurate and available when and where the patient encounter with their health professional occurs. Clinicians are provided with results and interpretation. This is available to appropriate members of the patient's shared care team. Readily accessible post analysis for all members of the patient's clinical team is available. Feedback on ordering patterns is available and shared positively with the clinician and supported by education. Information is timely and provided in a multi-disciplinary clinical governance framework;

4.1.11. Patients have all results, both normal and abnormal shared with them on a timely basis. Patients are able to access interpretation of their results through a patient shared electronic record;

4.1.12. Patients, clinicians, and laboratory providers work together to optimise patient outcomes and ensure appropriate utilisation of the resource across the whole health system:

4.2. SERVICE TARGETS/KEY RESULT AREAS

Key Result Areas will be defined by the service level alliance based on achieving a best for patient best for system service. Service targets will be monitored within the Canterbury Laboratory Service and Canterbury Health System which identify:

- Effectiveness;
- Consumer and referrer satisfaction;
- Quality systems and continuous improvement;
- Efficiency and reduction of waste and duplication.

4.3. SERVICE BUDGET

4.3.1. Canterbury DHB is allocated funding based on our population mix (e.g. age, deprivation rurality) from Vote Health to provide health services for its entire population. Funding will be allocated to Hospital lab services and community lab services through approval of an operational budget for the CDHB lab and a bulk funded contract for services for the community provider.

4.3.2. The SLA operational costs will be determined in the work plan and approved by the CCN ALT;

4.3.3. Any savings or underspend from the amount allocated for the Lab SLA will be retained and subject to prioritisation by the Canterbury Clinical Network.

5. MEMBERSHIP

5.1. The membership of the Laboratory SLA will include professionals who participate (e.g. referrers or providers) in Laboratory 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;

5.2. 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, with the exception of the representatives from CHL and CSCL where substitues are able to be nominated by the members - to ensure key stakeholders are represented and the meetings are effective;

5.3. The SLA will review membership annually to ensure it remains appropriate;

5.4. Membership will include a member of the ALT;

5.5. 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;

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

5.7. 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;

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

6. SELECTION OF MEMBERS, CHAIRPERSON AND DEPUTY CHAIRPERSON

6.1. 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;

6.2. 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).

7. MEMBERS

The composition of the Laboratory SLA is:

Name(s)	**Perspective/Expertise**
Dr Andrew Rawstron	*Rural GP*
Dr Anja Werno	*Chief of Pathology CHL*
Chris Kippax	*Nurse Practitioner*
Dr. Chris Leathart	*Urban GP*
Garth Munro	*ALT member - Chair*
Dr. Guy Mulligan	*Community Pathologist*
Vacant	*Urban GP*
Ken Beechey	*Medical Laboratory Scientist*
Mary Webster	*Medical Laboratory Scientist, Canterbury Health Labs* *Member, Rapaki Māori Women's Welfare League*
Megan Hopper	*SLA Facilitator*
Mr. Peter Davidson	*Public and private medical specialist – deputy chair*
Dr. Peter Gootjes	*CEO Southern Community Labs or substitute*
Prof. Richard Geary	*Public medical and private medical specialist*
Ralph La Salle	*Planning and Funding representative*
Rose Barker	*Midwife*
Kirsten Beynon	*GM, Canterbury Health Labs or substitute*
Ellen McCrae	*Consumer*

8. ACCOUNTABILITY

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

9. WORK PLANS

9.1. The 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 District Annual Plan, the "Better Sooner More Convenient" Implementation Plan, legislative and other requirements;

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

10. FREQUENCY OF MEETINGS

10.1. Meetings will be held on a four-weekly schedule or otherwise as agreed to accommodate surgical rosters.

10.2. Meeting dates will be arranged annually to accommodate clinical schedules.

11. REPORTING

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

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

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

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

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 3 days prior to the meeting, as will any material relevant to the agenda;
12.3. Minutes will be circulated to all group members within 7 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.

14. CONFLICTS OF INTEREST

14.1. Prior to the start of any new SLA or programme of work, conflicts of interest will be stated, recorded on an Interest 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 SLA 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.

RESPONSIBLITIES

16. RESPONSIBILITY OF THE SLA

16.1. Apply the delegated funding available to lead the required service/service change;
16.2. Establish new work groups to guide service design;
16.3. 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

17. CHAIR

17.1. Lead the team to identify opportunities for service improvement and redesign;
17.2. Lead the development of the service vision and annual work plan;
17.3. Develop the team to respond to a service need; engaging with key stakeholders and interested parties best suited for the purpose of service innovation;
17.4. Work with the project manager/facilitator and/or analyst to produce work plans and other reports as required;
17.5. Provide leadership when implementing the group's outputs;
17.6. Work with the facilitator to facilitate meetings to achieve outcomes in an economical and efficient manner;
17.7. Be well prepared for meetings and ready to guide discussion towards action and/or decision;
17.8. Meet with the other CCN leaders to identify opportunities that link or overlap, share information and agree on approaches.

18. CLINICAL LEADERS

18.1. Provide strong clinical leadership across all SLA work activity;
18.2. Serve as mentor and provide clinical guidance to workstream/SLA members (where relevant).

19. ALT MEMBER

19.1. Act as a communication interface between ALT and the SLA;
19.2. Participate in the development and writing of papers that are submitted to ALT;
19.3. Act as Sponsor of papers to ALT so papers are best represented at the ALT table.

20. SLA MEMBERS

20.1. Bring perspective and/or expertise to the SLA table;
20.2. Understand and utilise best practice and alliance principles;
20.3. Analyse services and participate in service design;
20.4. Analyse proposals using current evidence bases;
20.5. Work as part of the team and share decision making;
20.6. Actively participate in service design and the annual planning process;
20.7. Be well prepared for each meeting.

21. FACILITATOR/OPERATIONAL MANAGERS GROUP

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

22. PLANNING & FUNDING REPRESENTATIVE

22.1. Provide knowledge of the Canterbury Health System;
22.2. Support the group to navigate the legislative and funding pathways relevant to the SLA;
22.3. Facilitate access to analytical support for the purpose of evaluation, reporting and monitoring.

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.
- BSMC – Better, Sooner, More Convenient Health Care, Ministry of Health's 2010-2013 initiative.

- 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: 15/ 09 / 2017

Date of endorsement from ALT: 16 October 17

Date of next Review: June 2018