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 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.

FALLS & FRACTURES SERVICE LEVEL ALLIANCE

1. BACKGROUND

1.1. The Falls & Fractures Service Level Alliance (F&FSLA) was established in October 2017 as a time-limited (3 year) group to enhance and improve the falls and fragility fracture prevention work in Canterbury. ACC recognised the pioneering work and outcomes achieved by the Canterbury health system over the last five years through taking a comprehensive 'Whole of System Approach to Falls Prevention' and the development of an innovative evidence-based community falls and fracture prevention strategy.

1.2. Four outcome measures agreed as a nationwide framework contributing to Agnes staying well and independent at home are:

- Fewer fall injuries;
- Fewer serious harm falls and fractures;
- Improved recovery (both hospital and home);
- Integrated falls and fracture care across the system.

1.3. A Falls and Fragility Fractures Prevention Redesign Workshop was held in March 2017, with a set of outcome actions and approaches to promote connection and enhancement of existing services across the Canterbury health system and intersectorally , including:

- Strengthening and increased cohesion of Canterbury Health System's approach to addressing risk and protective factor's both at an individual and whānau's health, as well as well as at a community and population level;
- Exploration and introduction of innovative, evidence informed initiatives, approaches and models of service delivery; and
- Working closely with our intersectoral partners to share data for improvement and to capture the mutual benefits of aligned approaches that are reflected in tangible outcomes for Agnes and her whānau.

2. PURPOSE

The purpose / outcomes of the Falls & Fractures SLA are:

2.1. Lead the following agreed outcomes measures from the ACC & Canterbury / West Coast Health system alliance Business Case:
   2.1.1. Fewer fall injuries
   2.1.2. Fewer serious harm falls and fractures
   2.1.3. Improved recovery (both hospital and home)
   2.1.4. Integrated falls and fracture care across the system
   2.1.5. Staying well and independent at home

2.2. The Canterbury Falls and Fracture Prevention Re-Design planning workshop highlighted areas for improvement, including (but not limited to):

- Improved equitable access to culturally-appropriate services
- Increasing access to community falls prevention classes;
- Increase the reach to the 'at risk' population that are not yet injured or unwell (pre-fall group);
- Increase integration with Fracture Liaison Service;
- Increase Vitamin D use in Aged Residential Care;
- Improved targeting of in-home programmes to the most at-risk people;
- Using InterRAI data to identify early risk indicators for falls;
- Focus on falls in dementia care (a source of approximately 25% of annual hip fractures);
- Increase referral for falls and osteoporosis treatment on discharge from hospital after fragility fractures;
- Developing more systematic approaches to population level interventions; and
- Identifying the integration matrix that coordinates the delivery of services for people at risk of falls.

3. PRINCIPLES

Principles that underpin the work of the Falls & Fractures SLA are to align with the CCN Charter, existing CCN workstreams and SLAs (in particular, HOPWS , Population Health, CSSLA, Urgent Care SLA, Rural Health WS, Pharmacy SLA & ReAlign) for continued promotion and visibility of services.

3.1. The Canterbury health systems support the outcome framework with the overarching vision that evidence-based approaches to this at- risk population will contribute to Agnes staying well and independent at home and receive services closer to home.

3.2. Refer to accepted Best Practice evidence and Falls guidance, including (but not limited to) Health Quality and Safety Commission 'Reducing Harm from Falls' programme, Bone Care 2020, International Osteoporosis Foundation (IOF) Capture the Fracture Best Practice Framework, Australia and New Zealand Hip Fracture Registry, ACC Cross Agency NZ guidance for falls and osteoporosis management;

3.3. Following the principles of collective impact (*see **Appendix 1***):
   3.3.1. Engage in continuous quality improvement and redesign, including ongoing revision of regional pathways to keep them current (including leveraging off other health systems and national learnings);
   3.3.2. Provide linkages, collaboration and integration across the system, including (but not limited to) with ACC, St John, primary care, Green Prescription, Medicines Management Service, CREST, social isolation services, OPHSS specialist services, allied health and Aged Concern;
   3.3.3. Work towards single point of navigation for preventing falls and fragility fractures – 'no door is the wrong door' ;
   3.3.4. Work as a cross sector partnership, with integration across providers, and links with other programmes – utilise existing providers' capability (e.g. HBS follow up exercise support), refer to other appropriate services (e.g. Senior Chef if lack of food in patient's home), rest home subsidies for healthy living programmes, targeted exercise for identified patients in ARC.
   3.3.5. Advocating for 'Prehab rather than rehab' - prevention, earlier intervention and education;

3.3 Advocate for a stronger focus on self-assessment and self-management, including public health campaigns in schools, churches, culturally and linguistically diverse (CALD) environments and other social settings;

3.4 Measure and monitor falls and fragility fracture prevention outcomes across the Canterbury health system.

4. SERVICE TARGETS

Key Performance Indicators will align with the work plan, System Level Measures (SLM) and National Falls and Fragility Fractures Outcomes Framework (set outcomes and metrics).

Relevant local contributory measures will be developed as required by the F&FSLA to ensure outcomes for Agnes are achieved.

Outcome	**Minimum Outcome metrics**
Fewer falls injuries	• *ACC claim by fall injury* • *ACC claim by fall and fracture* • *Age stratified to match intervention 65+ for community class reach* (*see **Appendix 2***)
Fewer serious harm falls and fractures *(**SLM**)*	• *Acute hospital admissions for fractured neck of femur* • *Acute hospital admissions for a fracture as a result of a fall* • *Acute presentation to ED for falls related injuries* *(All age-stratified 75 yrs+).*
Improved recovery at home and in hospital *(**SLM**)*	• *Hospital:* o *Access to both hospital and community rehabilitation services* o *Length of stay for 75yr+ as a result of a fractured neck of femur* o *Mortality post - fractured neck of femur* • *Home :* o *Reduced readmission rate post- fractured neck of femur*
Integrated falls and fracture care across the system	• *Number of referrals to the Falls Champion service from secondary care, primary care or the community* • *Measure of how many community residing fractured neck of femur patients are referred to the in home Community Falls Programme* • *Care pathway activity: combined Falls, Fracture Liaison Service & Osteoporosis management pathway utilisation across the sector.*

5. MANDATE

5.1. The SLA will focus upon developing sustainable models of service delivery that ensure outcomes are achieved for Agnes.

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

6. SCOPE

6.1. **In Scope:**

6.1.1. The Falls & Fractures SLA can make recommendations to ALT, Canterbury DHB and Primary Health Organisations about:

- The alignment, planning and delivery of Falls & Fractures programmes; projects; services or opportunities;
- The coordination and reporting of agreed measurements of Falls & Fragility Fractures prevention;
- The Canterbury Community Falls Prevention Service;
- Education / Population Health messages through an intersectoral national approach;
- Determining and prioritising services to be established, continued and ceased relating to Falls & Fragility Fracture prevention in Canterbury.

6.2. **Out of Scope**

6.2.1. Any contracts for services.

7. MEMBERSHIP

7.1. The membership of the Falls & Fractures 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 including 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 perspectives required for the SLA to achieve success;
7.3. The Falls & Fractures SLA will review membership annually to ensure it remains appropriate from year to year to reflect the progress of outcomes across the three-year targets.
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 the 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. The Falls & Fractures SLA will be supplied with project management and analytical support through the CCN Programme Office and CDHB.

8. SELECTION OF MEMBERS, CHAIRPERSON AND DEPUTY CHAIRPERSON

8.1. New or replacement members will be identified by the Falls & Fractures 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 Falls & Fractures SLA is:

PERESPECTIVE / EXPERTISE	REPRESENTATIVE
Independent Chair	Ian Town
Primary Care	Rose Laing
Community Provider/s	Shaye Millar – Nurse Maude
Sports Canterbury – Lead Contract	Rebecca Logan
Geriatrician/s	John Geddes – Orthogeriatrician
ACC Cross Agency Partner	Jennifer Harris
ARC	Claire Tovey - Oceania Healthcare
Consumer/s	Valda Reveley Gillian Mendonca
Fracture Liaison Nurse Specialist	Lynda Te Momo
Falls Champion	Heather Bushaway
St John - Falls Prevention SME, Canterbury	Hanka Sikma
Access / equity / population perspective	Kathy Simmons – Manawhenua ki Waitaha
Clinical Lead / Allied Health	Ken Stewart
CDHB P&F	Mardi Postill - Team Leader, Older Persons' Health Rentia Hurter – Service Development Manager
CCN Facilitator	Jules Wilke

10. ACCOUNTABILITY

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

11. WORK PLANS

11.1. The Falls & Fractures SLA will agree on their annual work plan alongside the HOPWS 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 Falls & Fractures SLA will actively link with other CCN work programmes where there is common activity.

12. FREQUENCY OF MEETINGS

12.1. Meetings will be held 4-5 times per year for 2 hours duration, in normal business hours.

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 Falls & Fractures SLA will report to the HOPWS and ALT on an agreed schedule via the CCN Programme Office;
13.2. Where there is a risk, exception or variance to the Falls & Fractures SLA work plan, or an issue that requires escalation, a paper should be submitted to HOPWS and ALT in a template provided by the CCN Programme Office;
13.3. Where there is a new innovation or service recommendation, a paper should be submitted to HOPWS and ALT in a template provided by the CCN Programme Office;
13.4. Where applicable, reporting will include progress against or contribution to Ministry of Health Performance and Health Targets (System Level Measures and Equity Outcome Actions).

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 7days prior to the meeting, as will any material relevant to the agenda;
14.3. Minutes will be circulated to all group members within 7 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 Falls & Fractures SLA member from the total number of members of the SLA.

16. CONFLICT OF INTERESTS

16.1. Prior to the start of a programme of work, conflict of interests will be stated and recorded on an Interests Register.
16.2. Where a conflict of interests exists, the member will advise the chair and the chair will be responsible for managing the declared conflict which may include requesting the member withdraw from the room or the discussion.
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 Falls & Fractures SLA will design evaluation criteria to reflect the National Falls & Fracture Outcome Framework and evaluate and monitor on-going effectiveness and quality of SLA activities. Any evaluation will comply with the evaluations framework outlined by CCN and/or the ALT or CDHB as the funder.

RESPONSIBILITIES

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

20. CHAIR

20.1. Lead the team to identify opportunities for service improvement and redesign;
20.2. Lead 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. Meet with the other CCN leaders to identify opportunities that link or overlap, share information and agree on approaches.

21. ALT MEMBER

21.1. Act as a communication interface between ALT and the SLA;
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. CLINICAL LEADER

22.1. Provide strong clinical leadership across all SLA work activity;
22.2. Serve as mentor and provide clinical expertise/guidance to Workstream/SLA members and as part of a national leadership role to share local learnings with other NZ health systems and ACC/MOH/HQSC

23. SLA MEMBERS

23.1. Bring perspective and/or expertise to the SLA table;
23.2. Understand and utilise best practice and alliance principles;
23.3. Analyse services and participate in service design;
23.4. Analyse proposals using current evidence bases;
23.5. Work as part of the team and share decision making;
23.6. Actively participate in service design and the annual planning process;
23.7. Be well prepared for each meeting.

24. PROJECT MANAGER/FACILITATOR

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

25. PLANNING & FUNDING PERSPECTIVE

25.1. Provide knowledge of the Canterbury Health System;
25.2. Support the group to navigate the legislative and funding pathways relevant to the SLA;
25.3. Provide 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.
- 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.
- Alliance Support Team (AST) – the small operational arm of the ALT who supports the workstreams and service SLAs 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 AST, the Programme Director, Programme Manager; Communications Advisor and Administrator/Project 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 OF TERMS OF REFERENCE

Date of agreement and finalisation by Falls & Fractures SLA members: **14 May 2018**

Date of endorsement from ALT: **20 May 2018**

APPENDIX 1: Collective Impact Principles of Practice

1. Design & implement the initiative with a priority on equity
2. Include community in the collaborative
3. Recruit & co create with cross sector partners
4. Use data to continuously learn, adapt and improve
5. Cultivate leaders with unique system leadership skills
6. Focus on programme and system strategies
7. Build a culture that fosters relationships, trust and respect across participants
8. Customise for local context

Collective Impact Principles of Practice.p

APPENDIX 2: ACC falls claims table

Representing the projected increase of claims and the demographic projections from StatsNZ as the baseline for subsequent year reduction baselines. These are annual level aims, pending adjustments in forward projection and population statistics.

	Measure source	2016 Baseline	Expected Numbers End of year 1 (2017)	Expected Numbers End of year 2 (2018)	Expected Numbers End of year 3 (2019)
Fewer falls	ACC claims data	18052(CDHB) 1073 (WCDHB)	**19139 (CDHB)** **1172 (WCDHB)**	**20004 (CDHB)** **1298 (WCDHB**	**20765 (CDHB)** **1425 (WCDHB)**