**TERMS OF REFERENCE**

Integrated Respiratory Service Development Group

## BACKGROUND

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

- 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.

## INTEGRATED RESPIRATORY SERVICE DEVELOPMENT GROUP (IRSDG)

### 1. BACKGROUND

1.1. In 2008 a clinician-led working group agreed on the principles of an Integrated Respiratory Service for the people of Canterbury, facilitated by the Canterbury Initiative**.** The guiding principles were:
   - Services centered around the patient resulting in better patient outcomes;
   - Provision of more timely and more equitable referred patient services;
   - Provision of alternatives to hospital attendance;
   - Cooperation between service providers and health professionals across the sector;
   - Improvements in intervention, quality of care, respiratory disease awareness and patient education to assist in effective management of respiratory conditions.

1.2. The Integrated Respiratory Service was established to realise significant opportunities for developing the respective roles of primary and secondary services to support people with respiratory conditions. It was based on the expectation that early diagnosis of conditions such as COPD and sleep-related disorders and the management of these conditions in primary care settings could be improved through partnership and collaboration with primary and community providers. The model enabled secondary services to support primary care while freeing up capacity in secondary services for focusing on specialised interventions and complex cases.

## 2. PURPOSE

2.1. The purpose of the IRSDG is to:

2.1.1. Provide the governance and operational leadership for the Canterbury Integrated Respiratory Service;

2.1.2. Develop and monitor a seamless pathway for patients with respiratory disease;

2.1.3. Facilitate effective ongoing communication with all relevant parties;

2.1.4. Provide a clearing house for ideas and information on the needs of Canterbury's Integrated Respiratory Services, balancing the demands on the system for patient care and wellbeing and the need for sustainable clinical services and business practices;

2.1.5. Identify areas requiring redesign and propose transformational service improvement;

2.1.6. Link with respiratory service working groups and other CCN groups and undertake joint work as appropriate.

## 3. MANDATE AND SCOPE

3.1. In Scope:

3.1.1. The IRSDG has the mandate to review the current Integrated Respiratory Services with the intention of identifying and recommending areas needing increased efficiencies and/or improved service levels;

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

3.2. Out of Scope:

3.2.1. It is not within the scope of the IRSDG to contract with service providers or directly change existing contractual terms;

3.2.2. The IRSDG does not have the mandate to manage a programme of service delivery nor is it responsible for developing and delivering on the programme budget;

## 4. MEMBERSHIP

4.1. Membership of the IRSDG 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, management from relevant health organisations and may include others who bring important perspectives e.g. consumer, Maori, Pacific, migrant and/or rural voices;

4.2. 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 IRSDG to achieve success;

4.3. The IRSDG will review membership annually to ensure it remains appropriate;

4.4. 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;

4.5. 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 – those members who have not informed the minute-taker directly of their absence will be recorded as absent;

4.6. When a member is absent for more than two consecutive 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. SELECTION OF MEMBERS, CHAIRPERSON AND DEPUTY CHAIRPERSON

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

5.2. The chair and deputy chair will, in most cases, be nominated by members of the IRSDG. 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 may be appointed by ALT (i.e. an independent chair).

5.3. Consumer representatives will be appointed as defined by the Consumer Group nomination process;

5.4. Representation by Maori and Pacific communities will be in line with CCN policies.

## 6. MEMBERS

The composition of the IRSDG is:

| **Perspective/Expertise** | **Name(s)** |
|---|---|
| CanBreathe Nurse Manager | Carmel Gregan-Ford |
| CCN Alliance Leadership Team (ALT) | Lorna Martin |
| CDHB Charge Nurse Manager Ward 25 | Pip Crowther |
| CDHB Planning & Funding | |
| CDHB Services Manager Respiratory | Cathie Parkes |
| Chair | Richard Hamilton |
| Community Provider | Jill Baines (Primary care nurse) |
| Community Provider | Tracey Crofts (community nursing) |
| Community Respiratory Physician | Mike Epton; Michael Hlavac; Rachel Wiseman(CD Resp); |
| Consumer | Mac Renata |
| CRISS Nurse Manager | Maureen Trewin |
| GP perspective | Graham Whitaker |
| Integrated Services Team Lead | Heather Brunton |
| Allied Health perspective | David Chen |
| Māori Health Perspective | Mac Renata |
| Pacific Health Perspective | Losana Korovulavula |
| Pharmacy representative | |
| Refugee and migrant perspective | |
| Respiratory Section Head CDHB | Paul Kelly |
| Rural health perspective | Janetta Skiba |

## 7. ACCOUNTABILITY

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

## 8. WORK PLANS

8.1. The IRSDG 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;

8.2. The IRSDG will actively link with other CCN work programmes where there is common activity.

## 9. FREQUENCY OF MEETINGS

9.1. Meetings will be held every two months within normal working hours if at all possible;

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

## 10. REPORTING

10.1. The IRSDG will report to the ALT on an agreed schedule via the CCN Programme Office;
10.2. Where there is a risk, exception or variance to the IRSDG's work plan, or an issue that requires escalation, a paper should be submitted to ALT in a template provided by the CCN Programme Office;
10.3. Where there is a new innovation or service recommendation, a paper should be submitted to ALT in a template provided by the CCN Programme Office;
10.4. Where applicable, reporting will include progress against or contribution to Ministry of Health Performance and Health Targets.

## 11. MINUTES AND AGENDAS

11.1. Agendas and minutes will be coordinated between the IRSDG chair, the Integrated Community Services programme manager and administrator;
11.2. Agendas will be circulated no less than 5 working days prior to the meeting, as will any material relevant to the agenda;
11.3. Minutes will be circulated to all group members within 7 days of the meeting and minutes remain confidential whilst 'draft' and until agreed.
11.4. 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.

## 12. QUORUM

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

## 13. CONFLICT OF INTERESTS

13.1. Prior to the start of any new programme of work, conflict of interests will be stated and recorded on an Interests Register;
13.2. Where a conflict of interests exists, the member will advise the chair and withdraw from all discussion and decision making;
13.3. The Interests Register will be a standing item on IRSDG agendas and be available to the Programme Office on request.

## 14. REVIEW

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

## 15. EVALUATION

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

# ROLES & RESPONSIBILITIES

## 16. CHAIRPERSON/CLINICAL LEADER

16.1. Lead the team to identify and recommend opportunities for service improvement and redesign;
16.2. Develop the team to respond to a service need, engaging with key stakeholders and interested parties best suited for the purpose of service innovation;

16.3. Work with the ICS programme manager/facilitator and/or analyst to produce work plans and other reports as required;
16.4. Provide leadership when implementing the group's outputs;
16.5. Be well prepared for meetings and work with the ICS manager to guide discussion towards action and/or decision;
16.6. Meet with the other CCN leaders to identify opportunities that link or overlap, share information and agree on approaches.

## 17. IRSDG MEMBERS

17.1. Bring  perspective and/or expertise to the IRSDG table;
17.2. Understand and utilise best practice and alliance principles;
17.3. Influence and recommend identified transformational service initiatives;
17.4. Develop close relationships with stakeholders and collaborative groups to ensure system-wide innovation and design principles;
17.5. Provide advice to the IRSDG group, wider clinical network (i.e. ALT), workstreams and SLAs as appropriate;
17.6. Support the principles of the Treaty of Waitangi;
17.7. Actively participate in the annual planning process;
17.8. Work as part of the team and share decision making and be well prepared for each meeting.
17.9. Will nominate a delegate to attend in their place if unable to attend, where possible.

## 18. INTEGRATED COMMUNITY SERVICES PROGRAMME MANAGER

18.1. Provide or arrange administrative support;
18.2. Support chair and/or clinical leaders to develop work programmes that will transform services;
18.3. Document and maintain work plans and reports to support the group's accountability to the ALT;
18.4. Develop project plans and implement within scope following direction from the group, CCN Programme Office and/or ALT as appropriate;
18.5. Work with the chair to drive the work plan by providing oversight and coordination, managing the resources and facilitating effective teamwork;
18.6. Keep key stakeholders well informed;
18.7. Proactively meet reporting and planning dates;
18.8. Actively work with respiratory working groups and other CCN groups to identify opportunities that link or overlap, share information and agree on approaches;
18.9. Identify report and manage risks associated with the IRSDG work activity.

## 19. PLANNING & FUNDING REPRESENTATIVE

19.1. Provide knowledge of the Canterbury health system;
19.2. Support the group to navigate the legislative and funding pathways relevant to the IRSDG;
19.3. 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.
- Alliance Leadership Team (ALT) – the CCN alliance leadership team responsible for the governance of clinically-led service development.

- Alliance Support team (AST) – 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.
- Alliance Support Team (AST) – the small operational arm of the ALT who supports the workstreams and 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 Ops Leaders Group, the Programme Leader, Programme Coordinator as well as a flexible resource pool of administration, project management and analysis for workstream and alliance groups.
- Service level Alliance – 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 guide and influence the transformation of a sector or service. Not a contracting entity, they guide the decision making of the ALT through initiative design.
- Service Level Provision Agreements – agreements between the DHB and a service provider that are signed in conjunction with the District Alliance and specify expected outcomes, reporting and funding for the services to be provided.

## ENDORSEMENT

Date of latest endorsement from ALT: / / 2019

Review Date: 30 / 06 / 2020