TERMS OF REFERENCE

Primary Care Capability Service Level Alliance

BACKGROUND

The foundation of the Alliance 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 Alliance 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. Alliance Support Team (AST);
3. Programme Office;
4. Workstreams
5. Service Level Alliances (SLAs);
6. Service Development Groups and
7. Other work groups or project groups.

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.

The Primary Care Capability SLA will acknowledge and support the principles of the Treaty of Waitangi and the provisions of Te Tiriti o Waitangi. We will strive for equitable health outcomes across our population/focus area through accessible, culturally appropriate services.

PRIMARY CARE CAPABILITY SERVICE LEVEL ALLIANCE

1. BACKGROUND

1.1. The Primary Care Capability Service Level Alliance was established in March 2018 to give increased focus to the integration of the patients' experience by bringing together a number of integration elements and enablers across the Canterbury health system.

1.2. Enablers such as Collaborative Care and the Integrated Family Health Service (IFHS) were previously governed by a joint CCN governance group, whereas other elements such as the Enhanced Capitation and its associated work groups are all elements that previously sat under the Flexible Funding Pool SLA.

1.3. In addition to this, the Pharmacy SLA has been focusing on the integration of Pharmacy with general practice to effect a more integrated and accessible experience for service users.

1.4. This new SLA provides the opportunity for strengthening the orientation and delivery of primary care services around the needs of people and their whanau, to ultimately drive towards improved and equitable health system outcomes.

2. HEALTH SYSTEM OUTCOMES

Alignment to the Canterbury Health System Outcomes framework is central to achieving a vision of integration alignment across the Canterbury health system and the new Primary Care Capability SLA is expected to contribute of the following outcomes:

1. Increased planned care and decreased acute care
2. Decreased Institutionalisation rates

3. Decreased wait times
4. Delayed/avoided burden of disease and long term conditions
5. No wasted resource

Furthermore primary care sustainability is an expected outcome.

3. PURPOSE

The Primary Care Capability SLA will provide leadership to activities that enable access to coordinated and integrated primary care; and deliver a better patient experience and equitable health outcomes. The SLA will have an initial focus on providing strategic system leadership to strengthening the capability and capacity of general practice, and 'future' models general practice (as opposed to the traditional models).

It is proposed the purpose of the Primary Care Capability SLA includes:

1. Supporting equitable access to primary care services.
2. Supporting the capacity and capability in Primary Care by influencing the ongoing development of primary care (and initial general practice) models of care towards sustainable provision of services orientated around the needs of the person and their whanau.
3. Providing strategic leadership to Canterbury health system enablers that facilitate patient's access to timely and well integrated primary care including: the Integrated Family Health Service (including the Health Care Home framework); Collaborative Care; Enhanced Capitation; and Low Cost Access funding.
4. Providing strategic leadership to and/or monitoring Primary Care Patient Experience information, including what is available through the national survey implemented by the Health and Quality Safety Commission.
5. With the Pharmacy SLA monitoring the integration elements of the Pharmacy SLA.
6. Determining metrics indicative of the impact / outcomes of various primary care enablers e.g. Planned: Unplanned Improvement Tool.
7. Responding to the government's strategic direction and health initiatives as they relate to primary care including the Minister of Health's Primary Care Review (expected June 2019) and ensure regional links with the South Island Alliance activity, such as workforce development, as it relates to primary care.
8. Identifying and making recommendations on the integration of care across our health system to maximise the value gained from the available resources.
9. Strengthening consumer engagement in their care and monitor the patient experience as a measure of integration.
10. Evaluating any 'one off' integration projects led by the PCC SLA in the context of how they relate to and form part of the system view of integration.

4. MANDATE

4.1. The Primary Care Capability SLA has the mandate to make recommendations to ALT and the funder/s on the design, development, provision and ongoing support and maintenance, of comprehensive health services that promotes integration across our health system.

5. SCOPE

5.1. In Scope: It is expected that the Primary Care Capability SLA can make recommendations to the Alliance Leadership Team on:
   1. Opportunities for enhanced primary/community/secondary care integration and equitable access to primary care services ;
   2. Our system enablers e.g. Collaborative Care, IFHS including the Health Care Home framework Enhanced Capitation, and their implementation in the Canterbury context and the integration elements of the Pharmacy SLA.

3. Measurements of integration e.g. System Level Measures, Planned: Unplanned Care Improvement approach.
4. Sustainability of primary care including Very Low Cost Access (VLCA) general practices.
5. Make recommendations on services to be established, continued and ceased relating to integration of the Canterbury health system.
6. The monitoring, reporting and evaluation of enablers of primary care.
7. Equitable health outcomes and culturally appropriate services across our population.

Out of Scope: It is not anticipated that the Primary Care Capability SLA will have the authority to:

8. Employ staff;
9. Contract for services.

6. MEMBERSHIP

6.1. The membership of the Primary Care Capability SLA will include innovators who participate 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 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 Primary Care Capability SLA will review membership annually to ensure it remains appropriate;

6.4. Membership will include a member of the 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 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. The Primary Care Capability 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 Primary Care Capability SLA for their required skills/expertise. A nomination process will be used. The appointment will require endorsement from the ALT on recommendation from the Primary Care Capability SLA;

7.2. The role of Chair will be appointed by ALT (i.e. an independent Chair).

8. MEMBERS

The composition of the Primary Care Capability SLA is as follows:

Name(s)	Perspective/Expertise
Sarah Vane	Consumer Perspective X 1 (ideally parent; high user)
Vacant	Community provider (i.e. Trust or NGO run service provider)
Ken Stewart	Allied Health
Erin Wilmshurst	CDHB Planning Funding (GM or Team Leader)
Gail McLauchlan	Population Health
Georgia McLean	Pharmacy (Chair or Clinical Lead Pharmacy SLA/ALT)
Jackie Cooper, Clinton Newbury	Primary Care X 2 (GP and nurse - rural and urban)
Angus Chambers, Lisa Brennan, Lorna Martin	PHOs x3 (Clinical Leads/CEOs or their senior delegate)
Fiona Blair	Rural Health Integration

Covered through the Pharmacy Perspective	Pharmacy integration
Les Toop	System Level Measures
Angus Chambers	ALT member/Sponsor
Lovey Ratima-Rapson	Maori Perspective
Malu Tulia	Pacific Perspective
Nick Grant	St John Youth perspective
In attendance: CCN Programme Office: Linda Wensley Facilitators: Hiedee Harris IFHS and Collaborative Care Programme Leads/Clinical Leads as required	

Note: a number of members bring a range of perspectives

9. ACCOUNTABILITY

9.1. The Primary Care Capability SLA is accountable to the ALT who will establish direction, provide guidance, receive and approve recommendations.

10. WORK PLANS

10.1. The Primary Care Capability 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;

10.2. The Primary Care Capability SLA will actively link with other CCN work programmes where there is common activity.

11. FREQUENCY OF MEETINGS

11.1. Meetings will be held bi monthly, or as agreed by the SLA.

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 Primary Care Capability SLA 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 SLA work plan, or an issue that requires escalation, a paper should be submitted to ALT in a template provided by the CCN Programme Office;

12.3. Where there is an innovation or service recommendation, a paper should be submitted to ALT in a template provided by the CCN Programme Office;

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

13. MINUTES AND AGENDAS

13.1. Agendas and minutes will be coordinated between the Primary Care Capability SLA Chair and program manager/facilitator;

13.2. Agendas will be circulated no less than seven (7) 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 (7) 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.

15. CONFLICT OF INTERESTS

15.1. An Interests Register will be a standing item on Primary Care Capability SLA agenda's and be available to the Programme Office on request.
15.2. Prior to the start of any new programme of work, conflict of interests will be stated and recorded on an Interests Register.
15.3. 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. REVIEW

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

17. EVALUATION

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

RESPONSIBILITIES

18. RESPONSIBILITY OF THE SLA

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 visions 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 innovation and integration;
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. ALT MEMBER

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

21. CLINICAL LEADERS

21.1. Provide strong clinical leadership across all SLA work activity;
21.2. Serve as mentor and provide clinical guidance to SLA members (where relevant).

22. SLA MEMBERS

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

23. PROJECT MANAGER/FACILITATOR

23.1. Support the chair 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. Activity 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 SLA work activity.

24. PLANNING & FUNDING PERSPECTIVE

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

- 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 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.
- Alliance Support Team AST– the small operational arm of the ALT who supports the work streams 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 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.

ENDORSEMENT OF MINUTES

Agreement and endorsement of these TOR should be dated and recorded in the minutes.

Date of agreement and finalisation by Primary Care Capability SLA members: June 2019 (by email).

Date of endorsement from ALT: 17 June 2019