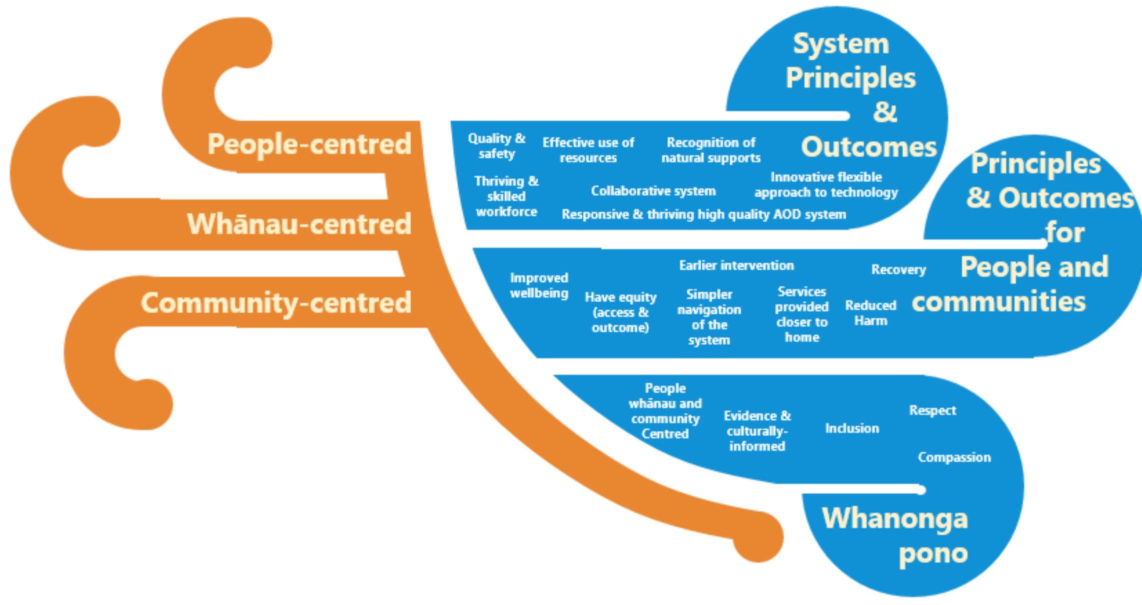
Capital and Coast, Hutt Valley and Wairarapa Alcohol and Other Drug Model of Care

He aha te mea nui o te ao

He tangata he tangata he tangata



3DHB AOD Collaborative

Terms of Reference

Annual review next due: April 2023

Version Control

Version	Date	Description
V2.0	08/03/2022	Draft presented to the AOD Collaborative Hui for endorsement
V2.01	05/04/2022	Draft finalised following governance confirmation from the 3DHB MH&A Commissioning Forum

Endorsement

Name	Governance Role	Signed	Date
Carole Koha, CEO, Te Waka Whaiora	AOD Collaborative Co-chair		08/04/2022
Sam McBride, Addictions Clinical Lead, MHAIDS	AOD Collaborative Co-chair		06/04/2022

Distribution List

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AOD Collaborative	All stakeholders

Confidentiality

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1. Background and context

3DHB Alcohol and Other Drug Model of Care

The 3DHB Alcohol and Other Drug Model of Care[1] (the Model) was developed over two years in response to an alcohol and other drug (AOD) system of care that was seen as failing individuals, whānau, and communities. The Model was finalised and endorsed by the 3DHB Boards' in 2021[2].

The Model recognises the following principles:

- People, whānau and communities with substantially improved wellbeing through equity of access and outcomes, for those with the greatest need.
- Sector partners working inclusively and respectfully to create a person, whānau and community-centred system of a care using integrated and collaborative approaches.
- A system of care that is visible, easy to navigate, accessible earlier, and closer to home.
- Effective use of resources, with an innovative approach to technology-use.
- High quality, safe services based equally on evidence and culturally informed best practice.
- A thriving and skilled workforce

The Model was developed to support the redevelopment of the AOD sector, enabling greater service integration and enhancing its ability to address inequities for Māori, and its priority populations: Pacific people and people with disabilities.

The Model's has five direction setting and overlapping goals:

1. Driving equity of access and outcomes
2. Privileging the voice and contribution of those with lived experience
3. Growing a whole of population approach
4. Building a recovery-focused system of care
5. Working collaboratively.

The Model identifies five Priority Pathways – these are Māori, Pacific, Youth, Rural/Remote and Severe. Each pathway links to the other Priority Pathways.

A key enabler for implementation of the Model is the 3DHB Alcohol and Other Drug Collaborative. The role of the Collaborative is to ensure that the Model is implemented effectively and promotes a strategic, integrated and effective AOD system of care across the 3DHB region.

The 3DHB Alcohol and Other Drug Collaborative Network (the Collaborative) was established in August 2021, following the dis-establishment of the steering group that led the development of the Model.

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[1] 3DHB Alcohol and Other Drug Model of Care, April 2021

[2] 3DHB Alcohol and Other Drug (AOD)Model of Care and Priority Investment, DSAC, April 2021

At the request of the Collaborative, the Model's objectives were condensed under the most appropriate goal and the responsibilities of the Collaborative or Strategy Performance and Planning given clearer definition. This work was endorsed by the 3DHB Collaborative Hui in December 2021 and the final draft circulated to the Collaborative in January 2022. The result is a working document which enables the Collaborative to operationalise the Model's deliverables into an iterative implementation plan[3].

3DHB AOD Collaborative scope

The Model describes a clear mandate for the Collaborative to drive change across the 3DHB AOD continuum of care with a focus on improving equitable access and outcomes for people and whānau adversely impacted by substance related harm. This will be achieved by identifying opportunities to collaborate for collective impact and develop effective service pathways for individuals and whānau to achieve equitable recovery orientated outcomes. Priority will be given to the voice of Māori and Pacific in addressing these challenges.

The Collaborative will develop a sector led and integrated service development response that effectively meets the needs of people with AOD issues.

The Collaborative will achieve this by establishing a provider led platform for the AOD sector to work together on the following challenges and opportunities:

- identifying service fragmentation and workforce gaps and increasing service integration
- increasing viability, coordination and equity of access to Priority Pathways for priority populations
- supporting the development of the necessary relationships and pathways that will improve coordination of care delivery, including outreach
- providing scope and support to address issues relating to inequity
- monitor and review activity and outcomes of the system of care
- building locality-based service design and delivery with enhanced AOD service coverage

Exclusions

The Collaborative functions and work programmes will not include:

- Supports and services solely targeted to gambling-related harm or other behavioural addictions
- Contractual or funding negotiations related to individual providers

Uphold Te Tiriti o Waitangi

The Collective will uphold the principles of Te Tiriti o Waitangi by doing the following:

- inviting Mana Whenua representatives to attend the meeting in keeping with partnership principles
- when considering the leadership structure of the group, positions will be offered to Māori providers in participation
- ensure that health outcomes for Māori are equal to those of non-Māori

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[3] 3DHB AOD Model of Care, Streamlined goals and objectives, January 2022

- provide for Māori self-determination and mana motuhake[4] in the development, design, delivery and monitoring of health services
- provide for and properly resource kaupapa Māori health services, offering kaupapa Māori services and supports first to those who identify as Māori to ensure choice
- ensure that all health services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care
- work in partnership with Māori, including Māori with lived experience of addiction, and Māori AOD providers, in decision-making, development, design, delivery and monitoring of AOD services

Pro-equity service commissioning

The Collaborative is committed to implementing the 2DHB Pro-Equity, People-based Commissioning Policy (the Policy). The Policy recognises that people have differences in health that are not only avoidable but unfair and unjust, therefore equity means different people with different levels of advantage require different approaches and resources to get equitable health outcomes.

This Policy describes the equity standards that health commissioners must meet when commissioning new health services and supports and/or recommissioning existing services and supports. The Policy identifies four overlapping and non-sequential phases in the commissioning cycle: Understanding the People We Serve, Designing with our Partners and Communities, Implementing, and Reviewing.

Collective impact methodology

Collective impact methodology provides a structure for how the Collaborative can work to mature trusting and effective relationships and collective success for equitable improvement for the 3DHB AOD continuum of car. Working towards collective impact means that Collaborative participants come with no individual agendas, they commit to no duplication and bring their strengths to solve issues that cannot be solved individually.

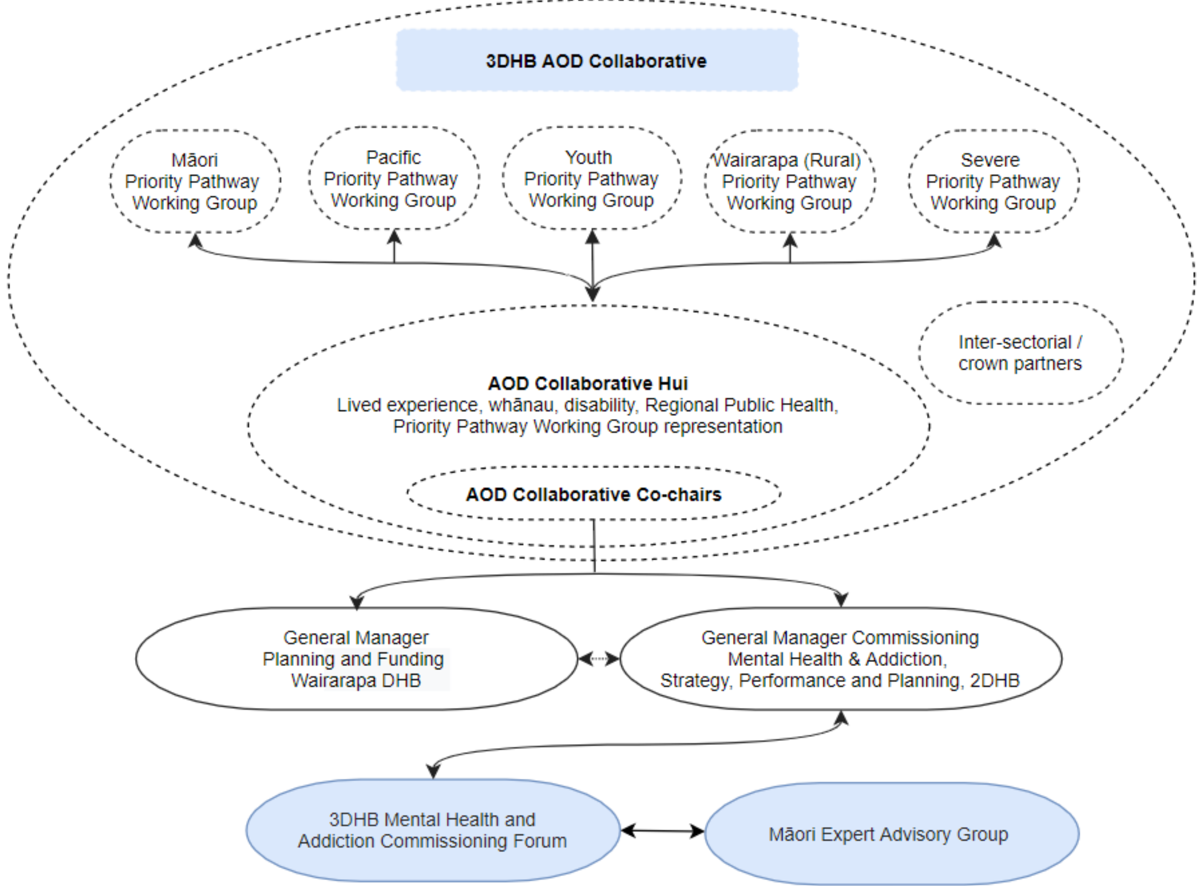
There are five widely recognised conditions to ensure success of initiatives that are working to achieve collective impact[5].

1. Common agenda –collective understanding of the problems and a shared vision for change
2. Share measurement – collecting data and measuring results; focus on system performance management and shared accountability
3. Mutually reinforcing activities – coordination through a joint implementation plan
4. Continuous communication – consistent and open communication with a focus on building trust
5. Backbone support – resources and skills to convene and coordinate the Collaborative

[4] independence, sovereignty, authority - mana through self-determination and control
[5] https://ssir.org/articles/entry/collective_impact

2. 3DHB AOD Collaborative Network and Governance

The Collaborative has broad membership from across the sector as represented in the below diagram and is explained in the following section.



Responsibilities

The Collaborative is an advisory group comprised of stakeholders that represent the full AOD continuum of care. The full continuum includes health promotion through primary care to severe need. It also includes relationship with inter-sectorial partners.

All Collaborative members are responsible for contributing to collective impact, participating based on trust and applying the principles of collective impact, responsibility and accountability which means each member will support the group and be responsible for success.

Membership

The Collaborative membership includes representatives on the five Priority Pathway Working Groups (PPWG), the AOD Collaborative Hui and the Co-chairs and the Wairapapa, Hutt Valley and Capital and Coast addiction services portfolio managers. Other members such as interagency representatives will be seconded as the Model's implementation plan iteratively evolves.

Priority Pathway Working Groups

The PPWGs focus on collective impact for Model's implementation. PPWG work plans and deliverables are aligned to the iterative implementation plan.

PPWG members consist of representatives across the 3DHB who deliver addiction services in a specific priority pathway area and/or who have AOD lived experience.

Each PPWG has an appointed convenor (the PPWG Convenor), who chairs PPWG meetings, represents the PPWG at AOD Collaborative Hui meetings and liaises closely with the AOD project manager to plan working group agendas and sign-off PPWG minutes for circulation to the wider AOD Collaborative membership.

Membership from the PPWG, also participating in the AOD Collaborative Hui will be confirmed with the AOD Collaborative Co-chairs and senior business owner.

AOD Collaborative Hui

So that the Hui is a functional size, and mindful of resource efficiency, members will be conduits with aligned providers and organisations. Linked or representative membership will be recorded (see appendix 1).

AOD Collaborative Hui (the Hui) members are senior representatives from a broad range of cross sector AOD providers, agencies, services and organisations, including AOD lived experience and disability. These senior representatives have endorsement from the sector or organisation that they represent to and participate in collective decision making.

These representatives are capable of operating within service design and development responsibility and providing oversight. They are strategic and tactical. They have knowledge of current frontline service delivery considerations.

The Hui will promote whole of sector links to other and broader groups and agencies where it is not necessary to be 'in the room' but where linkages and participation on specific issues are sought.

The Hui members are responsible for:

- collective decision making to implement the Model
- developing and implementing a strategic program plan to achieve the Model's goals and objectives[6]
- acting as a key professional forum which communicates appropriate information back to stakeholders within or relevant to members own District Health Boards, NGOs, PHOs and communities
- identifying and assessing specific clinical and organisational risks and providing sufficient support to providers and key stakeholders to mitigate risk as required
- supporting the five PPWGs to further develop, refine, finalise and deliver their pathways and associated work-plans
- ensuring Te Tiriti is honoured and embedding a pro-equity commissioning approach
- coordinating activity to ensure the development of integrated service provision is part of an overall system of care
- sharing knowledge and expertise to inform implementation of the Model of Care
- developing solutions to effectively implement the Model of Care and respond to population need
- providing solutions that address access and visibility of the AOD sector
- identifying system gaps and service need and prioritise service development requirements
- promoting effective clinical and social strategies to improve outcomes

[6] 3DHB AOD Model of Care – Streamlined goals and objectives - January 2022

- promoting collaborative relationships across the health and social sector
- drafting proposals for new investment or substantive change/ resource reallocation to improve the AOD continuum of care

3DHB AOD Collaborative Co-chairs

The Collaborative has two chairs (the Co-chairs). The Co-chair role is to maintain the strategic and focus of The Collaborative and act as key point of contact with the project manager to oversee development and delivery of the Model's iterative implementation plan.

In addition to chairing the AOD Collaborative Hui, the Co-chairs may also represent the Collaborative within forums such as the Partner Provider & Stakeholder Collaborative Network forum[7] or the 3DHB Mental Health & Addictions Commissioning Forum.

2DHB General Manager Commissioning, Mental Health & Addictions

All proposals for decision and recommendations made by the Collaborative to the DHB will be considered by General Manger, Mental Health and Addictions, Strategy Planning and Performance, 2DHB (senior business owner).

A response will be provided to the Collaborative outlining the decision, rational and proposed actions at the AOD Collaborative Hui meetings. The close relationship between The Collaborative and Strategy, Planning and Performance (SPP) should make this an efficient process.

3DHB AOD Collaborative Governance

The 3DHB Mental Health and Addictions Commissioning Board[8] will provide governance to the 3DHB AOD Collaborative. High level programme plans endorsed by the AOD Collaborative Hui will be presented to the 3DHB Mental Health and Addictions Commissioning Board for endorsement.

The Commissioning Board will provide direction and oversight of the Collaborative integration with the sub-region's locality development and relationship with other forums and work programmes that the Commissioning Board governs.

Backbone support – Project management, data management, secretariat support

Project management resource is critical to assist the Collaborative plan and manage the Model's implementation. These roles support the Collaborative through ongoing facilitation, technology and communications support, data collection and reporting, and handling the myriad logistical and administrative details needed for the Collaborative to function effectively and smoothly. Currently resourced from the 2DHB Strategy Planning and Performance Mental Health and Addiction team, the project management is a dedicated role separate from the participating stakeholder organisations.

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[7] The Partnership Provider and Stakeholder Forum is a network of organisations that deliver mental health and addictions services in the 2DHB region. This Forum meets to share information, inform locality network development, promote pro equity services and provide information to the 3DHB MH&A Commissioning Forum with the overarching goal of supporting connected development of mental health services in a locality based setting.

[8] 3DHB MH&A Commissioning Forum provides advice and recommendations to the 2DHB Executive Leadership Team to significantly influence the redesign of the MHA system of care, including determining the priorities and the pace and scale of change.

3. Collaborative Rules

These rules apply to meetings for both the PPWGs and the AOD Collaborative Hui.

For convenience where the Co-chairs are mentioned, this is the PPWG Convenor for PPWG meetings. The term secretariat is generic for the project manager or project support person who is responsible for secretariat support to the specific forum meeting.

Apologies

If a member of the Collaborative is unable to attend a meeting, they need to inform the secretariat and one or both of the Co-chairs as soon as possible, prior to the meeting.

Members representing lived experience can nominate a substitute to attend a meeting if unable to attend. The Co-chairs must be informed, via the secretariat, of the substitution at least 2 working days prior to the scheduled nominated meeting. Other Members are not able to nominate substitutes to attend meetings.

If both Co-chairs cannot attend the Hui, the chair role with be deputised to a PPWG Convenor.

If a PPWG Convenor cannot attend a PPWG meeting, the Convenor will appoint a meeting chair from the PPWG.

Quorum

Meetings will be deemed quorum if there is an agreed representation at the meeting. No less than eight (8) people will form a quorum for the AOD Collaborative Hui. Meetings will be postponed and, or rescheduled if there is not a quorum.

Due to varying PPWG member numbers, the PPWGs will agree a quorum when the working group is established.

Decision making

The Collaborative members will make recommendations, decide things together and make proposals based on best understanding of the needs of tāngata whaiora and whānau. The members will work with principles of collective responsibility and accountability. Each member will support the group and be responsible for success. Members are expected to work in partnership to achieve agreement.

The Co-chai's will be supported by collaborative members with authority to lead discussions to reach agreement, and propose compromises if views are different. The Co-chairs will also recommend processes to follow if agreement about a way forward is not reached on any issue.

Minutes will record dissenting views. Decisions requiring resolution of differences, allocation of resource and support for investment will be referred, as required, to the 3DHB Mental Health and Addiction Commissioning Forum.

The Mental Health and Addiction Commissioning Forum will review and advise on decisions if the AOD collaborative finds they are outside the remit or unable to be decided or advised in The Collaborative.

Agenda

The agenda, with attached meeting papers will be distributed at least three working days prior to the next scheduled meeting.

It is expected that all pre-meeting documents circulated will be reviewed prior to the meetings.

Minutes and meeting papers

Meeting papers and reports will be shared electronically via email to the 3DHB AOD Collaborative. They are a 'public' record unless explicitly labelled as a 'confidential'.

The minutes of each meeting will be recorded and distributed by secretariat.

The minutes, including attachments, shall be provided to all Collaborative members no later than five working days following each meeting.

PPWG minutes will be shared electronically with the AOD Collaborative Hui agenda pack for noting at the next scheduled meeting.

AOD Collaborative Hui minutes are circulated to both the Hui and PPWG membership to ensure good communication across the Collaborative.

Meeting dates/times/venue

Meetings will be held approximately on a six weekly basis at a location convenient to all parties. Video conferencing (e.g. Zoom) will be available and may at times be the preferential meeting venue

An extraordinary meeting may be called by the Co-chairs and held, providing a Quorum is met.

Due to expediency, papers may, from time to time, need to be circulated for action prior to a scheduled meeting, i.e. out of cycle; this is done at the sole discretion of the Co-chairs or PPWG Convenor.

Conflict of interest

Collaborative members must inform a Co-chair and/or secretariat prior to, or at the beginning of a meeting if an actual or potential conflict interest exits. Declaration of and withdrawal of members due to a potential or actual conflict of interest must be duly recorded in the meeting minutes.

Reporting and accountability

The minutes from Hui and PPWG meetings will form a record of the matters discussed and recommendations made.

The Collaborative may be required to provide information and submit proposals for AOD service development.

The Collaborative is accountable to the 3 DHB Mental Health & Addictions Commissioning Forum.

The Collaborative will be responsible for preparing quarterly summary reports for the governance group. The report will detail:

- recommendations for any system changes that will support transformation of AOD services across the region
- work programme and deliverables progress
- narrative detailing any issues related to the network function, provider interface/relationships, scope and work programme

4. Appendix 1 - AOD Collaborative Hui Membership and Sector/Organisation Representation

Members	Priority Pathway Working Group	Organisation	Role	Sector or Organisation Representative
Alapua Poas	Pacific & Youth	Taeaomanino Trust	Team leader	
Andrea Boston		Regional Public Health, Hutt Valley DHB	Senior Public Health Advisor	Public Health
Carole Koha	Māori	Te Waka Whaiora	CEO	
Chris Nolan		SPP-MHA	GM MH&A SPP	
Clarissa Ventress		MHAIDS	MHAIDS Child & Adolescent Ops Manager	
Debbie Jordan		SPP-MHA	AOD MOC Project Manager	
Derek Challenor	Severe	The Salvation Army Bridge	Director	
Evelien Post	Youth	PACT	Services Manager	
Fiona Mills		CARENZ	Clinical Manager	
Jeanette Harris	Māori	Māori Health		
Jenna Jeffcoat	Rural	Pathways	Service and Relationship Manager	
Jenny Ngarimu	Māori	Ora Toa Mauriora Mental Health & Addictions Services	Manager	Te Rūnanga o Toa Rangatira
Jeremy Tumoana	Maori & Youth	Te Paepae Arahi Trust	General Manager	
John Mellors		MHAIDS - Hutt Valley	Alcohol & Other Drug Clinician	
Kellie Huxford	Rural	Pathways	Clinical Nurse specialist	
Lauren Swan		MHAIDS	Associate Operations Manager - CMHT	
Lena Leatherby	Māori	Ngā Tekau Alcohol and Other Drugs Service	AOD Clinician	
Lynda Ryan	Māori	Takiri Mai Te Ata - Whanau Ora Collective	Manager	
Nanai Muaau	Pacific	Toloa Mental Health Service, Pacific Health Service, Hutt Valley	Executive Director	
Nathan Brown		SPP-CCDHB	Senior Health Insights Analyst	
Pene Saunders-Francis	Rural	LEAG	Lived Experience	
Peter Barnett		LEAG		

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Members	Priority Pathway Working Group	Organisation	Role	Sector or Organisation Representative
Peter Mellars	Māori	Ora Toa	Service Manager	
Rachel Kenny	Rural	Pathways	Team Coach	
Richard McGrath	Rural	Pathways	Senior Medical Officer	
Ronald Karaitiana	Maori & Rural	Te Hauora Runanga o Wairarapa	CEO & WRDHB Board Member	
Rongo Patel	Severe	MHAIDS - Addictions	Team Leader	
Sam McBride	Severe	MHAIDS - Addictions	Addictions Clinical Lead	
Simon Phillips	Māori	Maraeroa Marae Health Clinic	CEO	
Sipaia Kupa		SPP-Pacific	Senior Systems Development Manager	
Vacancy	Youth	MHAIDS - Te Roopu Kaitiaki - Specialist Youth Addiction Service		
Taone O'Regan	Severe	Aro Mai - Housing First Collaboration Wellington, DCM	Operations Manager	
Theresa Nimarota	Pacific & Youth	Taeaomanino Trust	CEO	
Trish Chivers		MHAIDS ELT	Allied Health	
Vacancy		Planning & Funding - WrDHB	System Development Manager	
Vacancy	Disability			
vacancy	Youth & Rural	MHAIDS CAMHS (Wairarapa)		