

## System Level Measures and Financial Incentives - Guidance for DHBs 2016/17

**Note: confirmation of this guidance is pending negotiations with Primary Health Organisations. DHBs will be notified during May 2016 of any material changes to Annual Plan expectations.**

**Queries on this information can be sent to: [ipif@moh.govt.nz](mailto:ipif@moh.govt.nz).**

### **Background**

Implementation of the Integrated Performance and Incentive Framework (IPIF) continues in 2016/17, through the introduction and implementation of System Level Measures and financial incentives for primary care. In May 2015 the Minister wrote to DHBs outlining his desire to lift performance measurement from a transactional approach to one based on outcomes. Since then and since the implementation of the current IPIF performance measures, the New Zealand Health Strategy (the Strategy) has been updated.

The Strategy outlines a new high-level direction for New Zealand's health system over the next 10 years to ensure *All New Zealanders live well, stay well, get well*.<sup>1</sup>

The Strategy identifies five strategic themes for the changes that will take us toward the future envisioned.

One of these five is value and high performance. This theme aims to place a greater focus on health outcomes, equity and meaningful results. To do this the accountabilities of health organisations must be reoriented to reflect this focus. The performance and planning system must support the overall strategic direction and services at all levels of the system should provide high-quality care as a result of ongoing programmes of monitoring and improvement.

A Roadmap of actions sets out 27 areas for action over the next five years to implement the Strategy. Two of these actions are:

1. Develop and implement a **monitoring framework focused on health outcomes**, with involvement from the health and disability system, service users and the wider social sector. This work will build on the Integrated Performance and Incentive Framework and results-based accountability and aims to increase equity of health outcomes, quality and value; and
2. Work with the system to develop a **performance management** approach that makes use of streamlined reporting at all levels, to make the whole system publicly transparent.<sup>2</sup>

The Minister wrote to DHBs again in March 2016 (attached) announcing the System Level Measures and approach to financial incentives, decisions based in part on the contents of the refreshed Strategy. At that time he was clear about DHB expectations in terms of working jointly in alliances to improve performance, jointly developing Improvement Plans and the necessity to change local service models in order to meet the System Level Measures.

During the update of the Strategy, the Ministry of Health and the sector co-developed a suite of System Level Measures that provide a system wide view of performance. These System Level Measures engage the health sector more broadly (professions, settings and health conditions).

The performance of individual clinicians and/or provider organisations, through health activities and processes are measured by contributory measures. These individual groups must work as *one team* (another of the Strategy's five themes) to improve system level performance. The System Level

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<sup>1</sup> New Zealand Health Strategy Roadmap of actions 2016.

<sup>2</sup> Ibid.

Measures also resonate with the *care closer to home*, *people* powered and *smart system* themes of the Strategy. The contributions of these wider groups will be implemented over the next 18 months.

As 2014/15 and 2015/16 have been transitional years from the old PHO Performance Programme to IPIF, 2016/17 transitions PHOs and DHBs to a broader system view of performance while the Strategy implementation work programme is developed.

### **Measures for introduction in 2016/17**

The following six System Level Measures will be introduced in 2016/17:

- Total acute hospital bed days per capita
- Ambulatory sensitive hospitalisations (ASH) rates for 0 -4 year olds
- Patient experience of care
- Amenable mortality rates
- Youth access to and utilisation of youth appropriate health services – developmental
- Number of babies who live in a smoke-free household at six weeks post natal – developmental.

Youth access to and utilisation of youth appropriate health services and the number of babies in smoke-free households will be developed in 2016/17, including agreeing definitions and data sets with implementation planned from 1 July 2017.

System Level Measures have nationally consistent definitions and must be reported to the Ministry of Health. Contributory measures have nationally consistent definitions and data sets but are selected locally and do not need to be reported nationally. District alliances may agree to use a local indicator based on local data. This is considered a local continuous quality improvement activity and will not be used nationally for benchmarking performance. Local measures must be supported by contributory measures from the Measures Library.

A Measures Library (the Library) will be available at [www.hqmnz.org.nz](http://www.hqmnz.org.nz) by the end of May 2016. A Measures Guidance document will also be available by the end of May 2016.

The Library will include definitions for System Level and contributory measures, along with the location of different data sets.

The Library will include definitions for both the System Level Measures and contributory measures (such as numerator and denominator descriptions, data sources and calculation processes) and will reflect the iterative stage of each measure (e.g. 'In development', 'Validated', 'Active' or 'Abandoned'). Measures that have a status of either 'Active' or 'Validated' mean that they can be used immediately as their definitions have been agreed, peer review may have been undertaken and data is available to the sector for measurement purposes. Measures that have a status of 'In development' mean that they are currently being modelled and are not yet ready for use. Measures with a status of 'Abandoned' mean that they had begun to be developed, however for one reason or another, that development stopped. In these instances, the Library will provide reasoning as to why initial development has stopped and library users will be able to pick up, continue or join in discussions that may see the development of those measures (or derivatives of those measures) resume.

The Library will house all measures and will provide an interactive space for the sector to collaborate (i.e. Library users will be able to search for a measure, identify its status and origin).

The Guidance document explains the concept of System Level and contributory measures and how these can be selected and used, through data tools and processes, to drive quality improvement at a local level.

**PHO financial incentives for 2016/17**

A mixed approach to PHO financial incentives will be implemented in 2016/17. This includes two capacity and capability payments, acknowledging primary care’s concern about the lack of quality improvement infrastructure in their sector, and one ‘at risk’ performance payment. The \$23 million primary care performance funding will continue to be used to build the necessary primary care (PHOs and their contracted providers) capacity and capability to enable performance improvement. To successfully build this required capacity and capability it is important that this funding flow easily and freely to PHOs via current payment routes. Achievement of the System Level Measures is reliant on the contributions of a variety of providers. DHBs are expected to consider how the participation of other stakeholders (eg pharmacy, aged care services and midwives) are resourced to participate in developing and implementing Improvement Plans, and incentivised to improve performance.

The following table shows the payment process for the approach to financial incentives in 2016/17.

Size of Payment	Purpose	Paid When
25%	‘Up front’ capacity/capability payment to PHOs	20 July 2016
50%	Capacity/capability payment to PHOs on Ministry approval of Improvement Plan including Improvement Milestones for System Level Measures, a suite of contributory measures and evidence of stakeholder agreement with the Improvement Plan (as evidenced by PHO and DHB signatures).	20 November 2016  <b>OR</b> 20 December 2016 (for those whose Improvement Plans needed rework and/or external facilitation)
25%	‘At risk’ and paid to PHOs on achievement of incentivised measures (see below) based on Q4 performance.	20 September 2017

The following three System Level Measures and the two primary care National Health Targets will be incentivised through the PHO Services Agreement in 2016/17:

- Acute hospital bed days per capita,
- ASH rates for 0-4 year olds,
- Patient experience of care;
- National Health Target Better help for smokers to quit; and
- National Health Target of Increased immunisation for eight-month olds.

PHO incentive funding is equally weighted across all five incentivised measures. Fifty percent of the total PHO incentive funding will continue to financially support PHO contracted providers. DHBs and PHOs will need to agree their individual contributions (dollars or resource) to the implementation of the jointly agreed Improvement Plan. It is intended to financially incentivise youth access and number of babies in smoke-free household System Level Measures in 2017/18. PHOs that span multiple DHBs will be paid proportional to its enrolled population in individual DHBs based upon the performance of that district alliance.

**District alliance expectations – through the DHB Quarterly Reporting database**

DHBs, PHOs and district alliances will drive implementation. In their 2016/17 Annual Plans, DHBs must commit to provide a jointly developed and agreed Improvement Plan to meet jointly agreed Improvement Milestones for each System Level Measure. DHBs must submit the Improvement Plan, on behalf of their district alliance, to the Ministry by 20 October 2016 through the Quarterly Report database. The DHB must ensure that all stakeholders who have a significant contribution to make in developing and implementing the Improvement Plan (DHBs and PHOs as a minimum for 2016/17) work in partnership from the outset of the Improvement Plan(s) development.

The Ministry acknowledges that:

- The time frame for development of the Improvement Plan is tight
- The time frame for performance improvement is relatively short
- 75% of incentive funding will build quality improvement capacity and capability
- 2016/17 is an evolutionary year in a new way of working and lessons will be learnt during the year.

The Ministry will take the above four points into account when assessing submitted Improvement Plans, including Improvement Milestones and Quarter Four performance. In some cases the development of relationships and processes will be the most important factors to be considered. However Improvement Milestones must be quantified, though Ministry expectations for performance will be realistic. The Ministry expects variability in how Improvement Plans are presented, particularly in the first year. Alliances should remember that only the core requirements (refer below) will be used to assess Improvement Plans (unless there is a need for more information to justify the selected Improvement Milestones and suite of contributory measures submitted).

### **Improvement Plan Development**

The Improvement Plan is the only deliverable for Quarter One and when submitted to the Ministry will include:

- Improvement Milestones for the four System Level Measures (total acute hospital bed days, ASH for 0 – 4 year olds, amenable mortality rates and patient experience of care). The National Health Targets will continue in their current form, including the requirements to meet the national target and report quarterly. PHOs and DHBs are expected to meet the targets identified in each individual National Health Target
- a suite of contributory measures (number of these decided locally) for each of the four System Level Measures along with quantitative end-of-year goals for each contributory measure , and
- district alliance stakeholder agreement (DHB and PHO at a minimum) with the Improvement Plan, Improvement Milestones and the suite of contributory measures. All stakeholders (DHB and PHO at a minimum) must sign the submitted Improvement Plan.

Improvement Milestones and contributory measure end-of-year-goals must be a number that the alliance agrees that will either improve performance, maintain baseline or reduce variation.

### **Suggestions for developing Improvement Plans**

The quality and effectiveness of local alliances are critical to developing an appropriate quality improvement environment. Developing the necessary processes and programmes to improve quality (ie the Improvement Plan) are dependent on alliances embracing the culture and principles outlined in the Alliance Charter (Charter attached). The development and implementation of the Improvement Plan is an opportunity to align current work programmes under one banner (eg acute demand, Diabetes Care Improvement Package, ASH).

The following issues should be considered when developing the Improvement Plan:

- confirm the scope of the Alliance work programme for 2016/17 including, but not limited to development of the Improvement Plan and achievement of the System Level Measures
- whether Ministry of Health or third party assistance is likely to be required to jointly agree an Improvement Plan
- confirm appropriate ALT and SLAT membership to deliver on the agreed scope of work
- identify the project team and leads
- identify resourcing contributions from local parties (eg DHB and PHO), including who is responsible for writing the Improvement Plan on behalf of the participants
- construct a project plan
- identify how the Improvement Plan relates to current local quality/performance frameworks and metrics and agree how different performance data sets will be used to develop the Improvement Plan and reported to assess performance against the Improvement Plan
- use the Measures Library and its Guide –data, tools and improvement science processes
- PHOs and DHBs must provide their own performance data sets for contributory measures to inform the Improvement Plan development (eg PHO immunisation data, DHB acute readmission data)
- agree the specific activities each stakeholder group (DHB and PHO at a minimum) will take, including service model changes, that will help improve performance.

### **Local Improvement Plans**

The local Improvement Plan (which does not have to be submitted nationally but will be made available to the Ministry on request) is expected to include:

- specific activities, including those by the DHB (for example emergency department, outpatient clinic and medical ward service reconfiguration) and the PHO, to meet both the Improvement Milestones for the System Level Measures and the quantitative goals for the selected contributory measures. (Note: activity to improve performance against the National Health Targets will be included in those relevant sections of the Annual Plan)
- an investment logic that includes all the activities described above including DHB's and PHO's individual contributions (dollars or resource) to the development and implementation of the jointly agreed Improvement Plan; and
- a local reporting and accountability framework for all participants.

## Definitions – Improvement Milestones, contributory measures goals and Targets

Different terms have been used to ensure there is no confusion about the difference between National Health Targets and the performance expected for System Level Measures and contributory measures. The table below explains these different terms.

National Health Targets	Improvement Milestones	Contributory Measures Goals
<ul style="list-style-type: none"> <li>• Four DHB and two primary care targets</li> <li>• Reflects government priorities</li> <li>• Performance reported each quarter</li> <li>• Targets set nationally by the Ministry</li> <li>• Two primary care targets incentivised</li> <li>• Public reporting of performance against the targets</li> <li>• Paid on Quarter 4 performance</li> </ul>	<ul style="list-style-type: none"> <li>• Four System Level Measures</li> <li>• Reflects value and high performance theme of Health Strategy</li> <li>• Progress reported quarterly and performance reported in Q4</li> <li>• Milestones set by district alliances</li> <li>• Three System Level Measures incentivised</li> <li>• No public reporting of performance</li> <li>• Paid on Quarter 4 performance</li> </ul>	<ul style="list-style-type: none"> <li>• Measures contribute to achievement of the System Level Measure Milestones</li> <li>• Number of measures and goals defined by district alliances</li> <li>• Progress and performance reported locally at district alliance level</li> <li>• District alliances may choose to incentivise</li> <li>• No public reporting of performance</li> </ul>

### Improvement Plan assessment by the Ministry

The Ministry will assess and provide feedback on the Improvement Plan(s) by 30 November 2016 (at the latest), through an iterative process. Key dates are:

DATE	ACTIVITY REQUIRED	COMMENT
20/10/16	Improvement Plan(s) due to the Ministry	Through the Quarterly Report data base
ASAP	Ministry feedback on Improvement Plan with suggestions and/or required changes	Iterative – could be ongoing conversations with the Ministry up until 20/11/16
20/11/16	Reworked Improvement Plans must be submitted to the Ministry by this date	Improvement Plans can be resubmitted as many times as necessary between 20/10 and 20/11/16
30/11/16	Final assessments provided by the Ministry	There are likely to have been several conversations between the Alliance and the Ministry by this time

The district alliance must take all practical steps to amend and resubmit the Improvement Plan to reflect any material feedback by 20 November. The 50% capacity and capability payment will be paid to PHOs on approval of the Improvement Plan.

The Ministry may request teleconferences and/or face-to-face visits with district alliances to explore outstanding issues with completion of Improvement Plans. On these occasions the Ministry may provide guidance and/or facilitation to the district alliance(s) to progress completion of the Improvement Plan.

If after the Ministry's feedback all parties to the district alliance(s) use best endeavours but are unable to agree to an Improvement Plan by 20 November 2016, the Ministry will facilitate a resolution between the alliance members that results in an approved Improvement Plan for submission to the Ministry.

If the Improvement Plan was submitted on or before 20 October 2016, but the Ministry did not advise the district alliance that changes are required to gain approval of the Improvement Plan by 20 November 2016, the PHO will still be entitled to receive payment 2 in December 2016.

The Improvement Plan forms part of the DHB Annual Plan and as such will be made publicly available by the DHB, on its website, once it has been approved.

#### **Performance Assessment in Quarters Two, Three and Four**

Exception reporting is expected from district alliances, through the DHB Quarterly Reporting database. District alliance(s) that are not on track to meet their Improvement Milestones in Quarter Four are required to submit mitigation plans with their Quarter two and three Reports.

The Ministry may request teleconferences and/or face-to-face visits with district alliance(s) to discuss performance and/or mitigation plans in Quarters Two and Three. On these occasions the Ministry may provide guidance and/or facilitation to the district alliance(s) to improve performance.

If district alliance(s) do not achieve an Improvement Milestone in Quarter Four, the PHO will still be paid if the explanation submitted with the Quarter Four results satisfies the Ministry:

- that the district alliance had an Improvement Plan that was approved by the Ministry
- that the district alliance(s) took all reasonable steps that it could to ensure that the Milestone was achieved
- with the district alliance(s) reasons given as to why the Milestone was not achieved (through the Quarter Four reporting database); and
- that the Milestone was closer to being achieved in Quarter Four than it was on the first day of Quarter One.

#### **Quarterly Measure**

Reporting, with the exception of Quarters 1 and 4, is by exception. Acknowledgement of being on track to meet the System Level Measure Improvement Milestones only is required. If the district alliance(s) is not on track to meet the Improvement Milestones in Quarter 4, the DHB must submit a jointly agreed (by the DHB and the PHO) mitigation plan in Quarters 2 and 3. If the district alliance(s) has not achieved any Improvement Milestones in Quarter 4 they must submit an explanation for the non-performance.

- Quarter 1 – Improvement Plan delivered as outlined above
- Quarter 2 – On track to meet System Level Measure Improvement Milestones OR mitigation plan

- Quarter 3 – On track to meet System Level Measure Improvement Milestones OR mitigation plan
- Quarter 4 - performance against the System Level Measure Improvement Milestones along with explanation for non-performance if the Improvement Milestone has not been met.

### Minister's letter to DHB CEs



Office of Hon Dr Jonathan Coleman  
 Minister of Health  
 Minister for Sport and Recreation  
 Member of Parliament for Northcote

Chief Executive  
 DHB  
 Address

Dear XXX

### Value and high performance of the health system

When I last wrote to you (May 2015) about quality improvement and performance measurement for the health sector, I indicated an ambition to lift performance measurement from a transactional approach, to one based on outcomes. The refresh of the New Zealand Health Strategy that was then underway was an appropriate time to develop an aspirational outcomes-based approach that would guide the delivery of constantly improving health services.

One of the draft New Zealand Health Strategy's five themes is *value and high performance* which places an emphasis on measuring the performance of the whole system in order to determine the value the country receives from the system. As well as a system wide view of performance, we need the ability to measure outcomes for each of our system's component parts.

The Ministry of Health has been working closely with the sector to co-develop a suite of system level measures that provide this system-wide view of performance. Following my drive for strong clinical engagement and decision making, this work has been informed by strong clinical input. Achievement is reliant on the contributions of a variety of providers including district health boards (DHBs), primary care, pharmacy, aged care services and midwives. The need for different provider groups to work together reflects the *one team* and *closer to home* themes in the draft Strategy.

The system level measures and approach to financial incentives outlined below will be negotiated into the PHO Services Agreement.

### System level measures

The following system level measures are proposed for introduction in 2016/17:

- acute hospital bed days per capita
- ambulatory sensitive hospitalisation (ASH) rates for 0-4 year olds
- patient experience of care
- amenable mortality



- youth access to and utilisation of youth appropriate health services — a developmental measure
- number of babies who live in a smoke-free household at six weeks post-natal — a developmental measure.

### **Financial Incentives**

The first step in implementation of the proposed approach to financial incentives is through the PHO National Services Agreement in 2016/17.

The mixed approach to financial incentives, which sees 75 percent of PHO performance funding paid out for capability and capacity, acknowledges primary care's concern over the lack of quality improvement infrastructure in their sector. Placing some funding at risk is intended to drive quality improvement.

Acute hospital bed days, ASH rates and patient experience of care will be financially incentivised in 2016/17 along with the two primary care National Health Targets (Better help for smokers to quit and Increased immunisation).

### **Expectations of DHBs**

DHBs, PHOs and district alliances will drive implementation. In their 2016/17 Annual Plans DHBs must commit to provide an Improvement Plan (the Plan) to meet jointly agreed Improvement Milestones for each system level measure. With fifty percent of the PHO's incentive funding dependent on Ministry approval of this Plan, it is crucial that DHBs and PHOs work jointly to develop the Plan. DHBs must ensure that they work with the PHO(s) to develop a jointly agreed Plan. Local district plans must demonstrate the actions required by PHOs, emergency departments, outpatient clinics and medical wards to meet the system level measures. All stakeholders must sign the submitted Plan.

Ministry of Health officials will be in touch shortly with implementation details.

I encourage your DHB to take advantage of this opportunity to strengthen local relationships between primary and secondary clinicians and drive more patient- centred integrated health services.

Yours sincerely

A handwritten signature in blue ink, appearing to read 'Jonathan Coleman', with a long horizontal flourish extending to the right.

Hon Dr Jonathan Coleman  
Minister of Health

## **[Name] ALLIANCE**

### **LEADERSHIP TEAM CHARTER**

This Charter document outlines our commitments and the key principles and “rules of engagement” we will follow as members of the Alliance Leadership Team, and/or Service Alliance Leadership Teams, for the [Name] Alliance.

We are members of a group of key clinical leaders, key managers from provider organisations, and the [Name] District Health Board(s), who have been selected to successfully lead our Alliance to achieve its objectives. We have been selected not as representatives of specific organisations or communities of interest, but because collectively we provide the range of competencies required for our Alliance to achieve success.

While we serve at different levels within the Alliance framework, we share common objectives and commitments which are outlined in this Charter. The Charter should be read together with, and our actions and decisions must have regard to, the [Name] Alliance Agreement (“the Agreement”).

#### **Purposes**

Our purpose is to lead and guide our Alliance as it seeks to improve health outcomes for our populations, as outlined in the Agreement. We aim to provide increasingly integrated and co-ordinated health services through clinically-led service development and its implementation within a “best for patient, best for system” framework.

#### **Principles**

The foundation of our Agreement is a commitment to act in good faith to reach consensus decisions on the basis of “best for patient, best for system”. As a leadership team we will conduct ourselves and undertake our leadership role in a manner consistent with the Alliance principles, set out in the Agreement. These include:

- We will support clinical leadership, and in particular clinically-led service development;
- We will conduct ourselves with honesty and integrity, and develop a high degree of trust;
- We will promote an environment of high quality, performance and accountability, and low bureaucracy;
- We will strive to resolve disagreements co-operatively, and wherever possible achieve consensus decisions;
- We will adopt a patient-centred, whole-of-system approach and make decisions on a Best for System basis;
- We will seek to make the best use of finite resources in planning health services to achieve improved health outcomes for our populations;
- We will adopt and foster an open and transparent approach to sharing information; and

- We will actively monitor and report on our alliance achievements, including public reporting.

We acknowledge there are some areas where the DHB may exercise a reserved power as outlined in the Agreement. We understand the DHB will exercise its reserved powers in good faith and will consult with the Alliance Leadership Team before exercising a reserved power (subject to any need for urgency).

## **Commitments**

We will work closely and collaboratively with our team members, in an innovative and open manner, to produce outstanding results. To achieve this we make the following commitments:

- **Shared responsibility:** We will actively address all tasks and duties of our role as members of our leadership team, and will comply with the operational provisions and guidance for our team, as set out in the Agreement.
- **Shared decision-making:** We agree that our decisions will be made by consensus. We will use our best endeavours to facilitate unanimous decisions, and will not prevent a consensus being reached for trivial or frivolous reasons.
- **Shared accountability:** We agree that we will have a robust airing of views, but that once our team has reached a decision we will all abide by that decision and support it publicly. (This includes keeping confidential the views of particular individuals expressed during the discussion, but does not prevent us sharing the issues that were balanced in reaching that decision.)
- **Good faith:** We agree to openly discuss all matters that affect our ability to make firm decisions, including any conflicts of interest and any limits on our mandate (where we carry these from participant organisations), so that all members of our team are fully aware of any restrictions, caveats or further authority that may be required.
- **Confidentiality:** To encourage the open and transparent sharing of information we agree to keep confidential matters shared on a confidential basis, to enable improved decision-making.
- **Active engagement:** We agree our members' continuous involvement in and attendance at our team meetings is critical, and will make every effort to attend and participate fully.

If a member of our team does not act in accordance with our principles and commitments, our team will discuss the situation with the member involved. If no resolution can be found, that member may be removed in accordance with the process outlined in the Agreement.

## **Mandate and functions**

### ***Alliance Leadership Team***

For members of the Alliance Leadership Team, our role is set out in the Agreement. Broadly, our functions are to:

- Agree our Alliance Objectives and Key Results Areas within the scope of our Alliance Activities, including the systems and KPIs for assessing achievement of these;
- Agree the work, activity and services that need to be provided to meet our Alliance Objectives;
- Make recommendations on the method and form of contracting to give effect to agreed priorities and service delivery mechanisms, on a best practice basis;
- Monitor the outcomes of Alliance Activities, and use that information to inform our stakeholders (particularly our populations) and to guide further decisions on prioritisation and service change;
- Develop a process for how our alliance will annually review its scope and objectives, to keep refreshing our strategy and approach to meet our Alliance Objectives;

- Determine, run and review an agreed process for refreshing our membership; and
- Discuss with the DHB any potential exercise of a reserved power.

In respect of any Service Alliances, our role is to:

- Establish Service Alliances and other working groups as necessary to oversee the development and delivery of services that fall within scope of our Alliance, including determining the scope and objectives and approving the membership of such service alliances, and disestablishing groups as required;
- Provide system-level oversight and monitoring of the work done by Service Alliances, and ensuring connectedness and a whole of system approach to Alliance Activities;
- Adjudicate should any disputes arise within a Service Alliance that are unable to be resolved at that level.

### ***Service Alliance Leadership Team***

For members of the Service Alliance Leadership Team, the scope of our activities and decision-making is as determined on establishment of our Service Alliance, by the Alliance Leadership Team. Within that scope our role is broadly to review all aspects of the delivery of those health services to patients and develop new approaches to improve their effectiveness and quality. This includes deciding how such improvements would best be implemented, taking into account our fixed resources.

### **Release of liability**

As members of a leadership team for the [Name] Alliance, we are committed to direct and lead the Alliance in accordance with this Charter and the provisions in the Agreement. It is not our intention that our actions as members of our leadership team will give rise to an action in law from alliance participants or other members of our leadership team.

### **Commitment to serve**

On the basis of the above, I agree to serve as a member of a leadership team for the [Name] Alliance.