**Terms of Reference – Leadership Team**

**Vision**

To provide compassionate, coordinated, and comprehensive end-of-life care to individuals living in (name of First Nation) community.

**Terms**

Purpose:

The Leadership Team will help facilitate the coordination of services as follows:

1. Provide a forum for information sharing and promote collaboration amongst Team members.
2. Through information sharing, identify issues and/or deficiencies requiring attention and discussion. The Team will troubleshoot together and come up with solutions that work for everyone.
3. Maintain communication with appropriate networks of care and community partners.
4. Support and share educational opportunities for all involved (professionals’ education).
5. Promote the Team as a resource to be accessed by the public/promote awareness of the Team at the local level (public education).
6. Evaluate the program/process on a continuous basis in order to make adjustments and improve upon the delivery of end-of-life care in the community.
7. Arrange for/participate in case conferencing on an as needed basis.
8. Develop communication tools and processes to facilitate the sharing of information between service providers.
9. Ensure that all providers are “kept in the loop” regarding the client’s (and family’s) needs, concerns, and overall care. Maintain regular and open communication with all other team members.
10. Arrange for debriefing following a death. Use the debriefings to discuss “lessons learned” that might be shared with other Team members.

Membership:

Members will include, but are not limited to, representatives from community groups, service providers and professionals within institutional settings as well as external to the community. These representatives will have a sincere commitment to individuals, and their families, who are living with advanced stage illness and nearing end-of-life. In addition, members should also include anyone who is directly involved in the care of clients who are close to end-of-life. This could include the client’s case manager, physician, in-home nurses, homemaker, palliative volunteers, spiritual advisor/clergy, counsellor and mental health service provider.

At a minimum, specific areas of representation should include:

Physicians Mental Health Services

Hospital Home Care Providers

Home and Community Care Spiritual and/or Traditional Knowledge Carriers

Community Counselling Palliative Care Volunteers

The Chair will be the Community Lead and who will be responsible for: calling meetings, setting the agenda and facilitating the meeting itself. The Community Facilitator will serve as the Recorder.

Meetings:

* Meetings will be held a minimum of once per month.
* Additional meetings may be called throughout the month according to need.
* Meetings will be scheduled for the X day of each month from X (time).
* Unless otherwise noted, the meetings will take place at [Insert Community Name]
* Agendas will be set with input from Team members. The agenda and last meeting’s Minutes will be e-mailed/faxed to members at least 24 hours prior to the meeting.