TERMS OF REFERENCE

Population Health & Access Service Level Alliance

BACKGROUND

The foundation of the Canterbury Clinical Network 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 SLA 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 Development Groups;
6. Service Level Alliances (SLAs).

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 Population Health and Access SLA 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.

POPULATION HEALTH & ACCESS SERVICE LEVEL

1. BACKGROUND

1.1. The Population Health and Access Service Level Alliance was established in December 2017 to elevate the population health work in Canterbury to extend beyond the focus of PHO funded health promotion activities and improving access, to initiatives and approaches supporting improved health outcomes across the Canterbury health system and across partner agencies.

1.2. Previously a population health work group sat under the Flexible Funding SLA. This SLA had oversight for the health promotion spend across PHOs (Population Health in Primary Care Plan 2015 - 2018) and a proportion of 'Services to Improve Access' (SIA) and 'Care Plus' funds. The SLA's role was to develop and prioritise population health services that support people to take greater responsibility for their own health and making healthy choices, with a focus on improving access to primary health care for populations with higher health needs.

1.3. Through the new Population Health & Access SLA there is an opportunity to develop the Canterbury Health System's approach to promoting health and wellbeing, equity of access to health services and equity of health outcomes.

2. PURPOSE

The overall purpose of the Population Health & Access SLA is to ensure that the Canterbury Health System's approach is one that promotes health and wellbeing, ensures equity of access to health services and equity of health outcomes. This is undertaken by:

2.1. Monitoring:
  2.1.1. The Canterbury Health System's approach to promotion of health and wellbeing
  2.1.2. The equitability of access to services provided by the Canterbury Health System
  2.1.3. Canterbury's population health outcomes overall and for groups who experience inequitable health outcomes.
2.2. Providing oversight for Canterbury Health System's:
  2.2.1. Initiatives and plans aimed at improving equity of access to health services (for instance interpreter services and gender affirming health services)
  2.2.2. Population-based health programmes and plans (for instance Tobacco Control Plan and Alcohol Harm Minimisation Plan)
  2.2.3. PHO Health Promotion and Access plans
  2.2.4. Advocacy to ensure that health, wellbeing, sustainability and equity issues are explicitly addressed through local, regional and national policies or decision making.
2.3. Providing advice and make recommendations to the Alliance Leadership Team with respect to Canterbury Health System's approach to promotion of health and wellbeing, equity of access and equity of health outcomes

3. PRINCIPLES

The following principles were agreed with the PHASLA to guide our approach to priorities of the PHASLA.

Health inequality	'Health inequalities are unjust health differences that occur between social groups. Their fundamental causes lie in the socio-political power relations between population groups and social classes, and in the variations in the distribution of power, money and resources that result. These, in turn, result in differences in environmental and individual resources (e.g. the quality and availability of employment, housing, transport, access to services, and social and cultural resources). Health Scotland
Health equity	Equity of health outcomes is that different groups of people experience the same level of health status across the population.
Proportionate universalism	'Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need. Services are therefore universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need.' Health Scotland
Access	Access to health services is "the degree to which individual and groups are able to obtain needed primary health care services." Kringos, D.S., et al., *The breadth of primary care: a systematic literature review of its core dimensions.* BMC Health Serv Res, 2010. **10**: p. 65.
Flourish	Flourishing is about thriving, prospering, blossoming and growing and is about more than equitable outcomes. Canterbury Māori Health Framework
Wellbeing	Wellbeing is a state in which an individual/whānau can realise their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and are able to make a contribution to their community. Canterbury Māori Health Framework

Collective impact	Different organisations taking joint responsibility for efforts to improve outcomes in mutually identified areas. Canterbury Māori Health Framework

4. MANDATE

4.1. The Population Health & Access 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 population health services and approached including advocacy etc. that promote prevention wellness across the lifespan and across our health system.

5. SCOPE

5.1. In Scope:

- The alignment, planning and delivery of Population Health programmes; projects; services or opportunities;
- The coordination and reporting of agreed measurements of population health;
- Canterbury Health System and PHOs population health plans;
- Services to improve access and health promotion funding streams that come to PHOs;
- Determining and prioritising services to be established, continued and ceased relating to Population Health in Canterbury.

5.2. Out of Scope: The Population Health and Access SLA does not have the authority to:

- Directly advocate for policy and actions of other agencies to provide social and physical environments that support healthy choices and behaviours;
- Employ of staff;
- Contract for services.

6. MEMBERSHIP

6.1. 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;
6.2. The Population Health and Access SLA will review membership annually to ensure it remains appropriate;
6.3. Membership will include a member of the ALT;
6.4. 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;
6.5. It is the expectation that a member will be able to attend two-thirds of scheduled meetings annually, unless discussed and agreed with chair;
6.6. 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;
6.7. The Population Health & Access 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 through a process supported by the CCN programme office. The appointment will require endorsement from the ALT on recommendation from the SLA;
7.2. The role of chair will be appointed by ALT (i.e. an independent chair).

8. MEMBERS

The composition of the Inaugural Population Health and Access SLA is. Members may cover more than one perspective:

Consumers (x2)	Ingrid Robertson Melody Tuliau
St John Youth perspective	Jono Clayton
Health Sociology/Marketing	Dr Ann-Marie Kennedy
Social Services Provider	Anna Pope
Public Health Provider	Evon Currie
Community and/or Public Health	VACANT (Named alternate Dr Anna Stevenson)
Community and/or Public Health (Chair)	Dr Lynley Cook
Community Provider/NGO	Dave Jeffrey
CDHB Planning and Funding	Dr Carol Horgan
General Practice Urban X 2	Dr Alison Wooding Dr Kim Burgess
General Practice Rural	VACANT
Allied Health Community Provider (Pharmacy)	Gemma Claridge
PHO perspective	Laila Cooper
Māori Health Provider perspective	Alison Bourn
Māori Health perspective (Executive Member) ALT Sponsor	Wendy Dallas-Katoa
Pacific Health provider perspective (Executive Member)	VACANT
Lead Maternity Carer Perspective	Rose Barker
Culturally & Linguistically Diverse Populations	Ester Vallero
Facilitator	Koral Fitzgerald

9. ACCOUNTABILITY

9.1. The Population Health & Access SLA is accountable to the ALT who will establish direction; provide guidance; receive and approve recommendations.

10. WORK PLANS

10.1. The Population Health & Access 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 Population Health & Access SLA will actively link with other CCN work programmes where there is common activity.

11. FREQUENCY OF MEETINGS

11.1. Meetings will be held on a bi-monthly basis

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 Population Health & Access 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 Population Health & Access 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 a 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 Performance and Health Targets.

13. MINUTES AND AGENDAS

13.1. Agendas and minutes will be coordinated between the SLA chair and facilitator;
13.2. Agendas will be circulated no less than 5 days prior to the meeting, as will any material relevant to the agenda;
13.3. Minutes will be circulated to all group members within 5 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.

14. QUORUM

14.1. The quorum for meetings is half plus one Population Health & Access SLA member from the total number of members of the SLA.

15. CONFLICT OF INTERESTS

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

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 Population Health & Access SLA will design evaluation criteria to evaluate and monitor on-going effectiveness of SLA activities. Any evaluation will comply with the evaluations/outcomes 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.

ROLES

19. CHAIR

19.1. Lead the SLA to identify opportunities for service improvement and redesign;
19.2. Lead the development of the service vision 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 service innovation;
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 chair meetings to achieve outcomes in an 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;
22.2. Understand and utilise best practice and alliance principles;
22.3. Analyse services and participate in service design;
22.4. Analyse proposals using current evidence bases;
22.5. Work as part of the team and share decision making;
22.6. Actively participate in service design and the annual planning process;
22.7. Be well prepared for each meeting.

23. PROJECT MANAGER/FACILITATOR

23.1. Support chairs 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 REPRESENTATIVE

24.1. Provide knowledge of the Canterbury Health System;
24.2. Provide active links for the Funders approval processes;
24.3. Support the group to navigate the legislative and funding pathways relevant to the SLA;
24.4. 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 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 workstreams and service 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 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.
- Service Level Provision Agreements – agreements between the DHB and a service provider that are signed in conjunction with the SLA and specify expected outcomes, reporting and funding for the services to be provided.

ENDORSEMENT OF MINUTES

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

Date of agreement and finalisation by Population Health and Access SLA members: 8/06/2020

Date of endorsement from ALT: 14/07/2020

Date of endorsement from ALT for updates: February 2021, 27/4/21