Ontario
Palliative Care
Network

Terms of Reference

Clinical Advisory Council

Version 2

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Version 1	May 12, 2016
Version 2	Draft for approval by Executive Oversight

REVISED DRAFT September 2018

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Ontario
Cancer Care Ontario
Action Cancer Ontario

Ontario
Palliative Care
Network

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1. Background/Context

1.1. Ontario Palliative Care Network Mandate

Established in March 2016, the Ontario Palliative Care Network (OPCN) is an organized partnership of community stakeholders, health service providers and health systems planners working towards a common goal of creating a coordinated, standardized approach to high-quality, sustainable and person-centred hospice palliative care for all Ontarians, regardless of age or disease type.

The OPCN has the same vision as that highlighted in the *Advancing High Quality, High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action* (the Declaration):

> *Adults and children with progressive life-limiting illness, their families and their caregivers will receive the holistic, proactive, timely and continuous care and support they need, through the entire spectrum of care both preceding and following death, to:*
> - *help them live as they choose, and*
> - *optimize their quality of life, comfort, dignity and security.*

Led by the 14 Local Health Integration Networks (LHINs) and CCO, and in partnership with Health Quality Ontario (HQO) and the Quality Hospice Palliative Care Coalition of Ontario (the Coalition), the OPCN has a mandate to:

- Act as a principal advisor to government for quality, coordinated hospice palliative care in Ontario
- Be accountable for quality improvement initiatives, data and performance measurement and system level co-ordination of hospice palliative care in Ontario
- Support regional implementation of high-quality, high-value hospice palliative care

The work of the Clinical Advisory Council (CAC) will be guided by OPCN's Action Plan and other strategic priorities and initiatives approved by Executive Oversight.

1.2. OPCN Strategic Directions and Priorities

To achieve OPCN's goals and to fulfill its mandate, the OPCN establishes clear strategic directions and priorities to guide its work in advancing hospice palliative care in Ontario and against which we can measure progress. This includes:

- Identifying provincial priorities and initiatives that advance hospice palliative care across the province and support local implementation of quality coordinated hospice palliative care
- Identifying ways to assess the effectiveness of the system over time
- Engaging provincial and regional partners in the ongoing design and delivery of hospice palliative care in Ontario
- Leveraging the existing resources of CCO, LHINs, HQO and the Coalition.

OPCN's strategic direction and priorities are defined in its Action Plan and other strategic priorities and initiatives approved by Executive Oversight.

1.3. Structure of the Ontario Palliative Care Network

The OPCN provincial governance structure is comprised of the following governance bodies supported by a Secretariat.

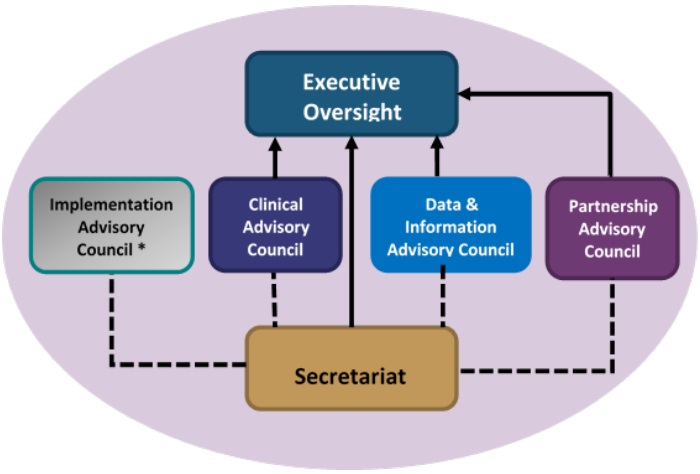
1. Executive Oversight
   - Provides executive leadership to the work of OPCN and ensures accountability from the LHINs, the Coalition, CCO and HQO

2. Partnership Advisory Council (PAC)
   - Gathers insights and recommendations from the networks/organizations represented by its membership
   - Provides advice to the Executive Oversight to help ensure plans for quality, coordinated palliative care are informed by a diversity of partner perspectives

3. Clinical Advisory Council (CAC)
   - Provides clinical input into proposed improvements in palliative care
   - Provides advice to OPCN Executive Oversight on clinical implications of policy

4. Data and Information Advisory Council (DIAC)
   - Provides ongoing strategic advice for performance measurement and management for the OPCN
   - Provides guidance on data and measurement for effective planning and delivery of care across regions, sectors and populations to advance priorities of the OPCN

5. Secretariat
   - Leads the execution of the OPCN mandate
   - Provides subject matter expertise and research and analytical skills to support the work of the OPCN and its governance bodies
   - Supports the operational and tactical activities of the OPCN



*** Implementation Advisory Council** has been dissolved effective August 1, 2018**.** Governance mechanism to advise Executive Oversight on OPCN's mandate to support regional implementation is under review.

NOTE: OPCN is considering whether to establish a new advisory committee for advice on operational management of implementation related to OPCN deliverables. These Terms of Reference will be updated when plans for that committee are confirmed.

2. Purpose, Principles, and Accountability of the Clinical Advisory Council

The Clinical Advisory Council, and any of its sub-groups, is accountable to the OPCN Executive Oversight.

The purpose of the CAC is to provide advice and recommendations to the Executive Oversight and other Advisory Councils for clinical improvements in hospice palliative care in Ontario, as well as advice on the clinical implications of policy, access to care, quality improvement strategies and service structure for the palliative care system in Ontario.

In fulfilling this role, the CAC will:

- Fulfill its responsibilities related to the OPCN's strategic directions and priorities.
- Strive for interprofessional collaboration.
- Keep the experiences, perspectives, and needs of individuals with a life-limiting illness and their family/caregivers at the centre of its purpose.
- Work in partnership with the other Advisory Councils of the OPCN to ensure alignment of provincial direction and recommendations.
- Promote a person-centred approach, and ensure the work of the CAC is undertaken in accordance with the guiding principles of transparency, equity, evidence-base, performance-orientation, active engagement and value for money.
- Collaborate with the Regional Multidisciplinary Clinical Co-Leads Table to gather advice, insights and recommendations from clinical partners to inform activities of the OPCN.
- Propose provincial direction for hospice palliative care education and mentorship to guide local and regional improvements and to support an integrated approach to hospice palliative care.
- Identify clinical best practices, evidence, and guidelines to support the advancement of high quality and patient-centred multidisciplinary hospice palliative care in the province.
- Support the identification of clinical priorities, and the development of quality standards to drive practice change.
- Contribute to the building of sustainable multidisciplinary capacity in regional clinical services and leadership.

3. Membership, Roles and Responsibilities of Individual Members

3.1. Co-Chair Model and Role

The CAC will be Co-Chaired by the OPCN Provincial Clinical Co-Leads.

The Co-Chairs will be responsible for creating an engaging environment where members have meaningful opportunities to contribute to agendas and discussions. The Co-Chairs will lead the meeting in a way that ensures advancement of the agenda within the timelines allocated for specific agenda items.

As ex officio members of the Executive Oversight, the Co-Chairs will be responsible for sharing the CAC's perspectives and advice with the Executive Oversight.

3.2. Membership

The Clinical Advisory Council will be comprised of no more than 16 members including the two Co-Chairs.

The Clinical Advisory Council member selection criteria will be competency based, representing a balance of skills, expertise, and experience needed for CAC to fulfill its mandate and responsibilities. (See Appendix A for further description)

Membership should include individuals with the following skills and expertise:

- In-depth, up-to-date knowledge both at the micro/clinical level and/or the macro/systems level
- Cultivates bold, innovative, systems thinking
- Clinical and/or program leadership
- System expertise
- Academic leadership
- Experience as a healthcare provider
- Experience with and/or appreciation of inter-professional perspectives
- Clinical health informatics and/or decision support
- Quality and/or performance improvement
- Change management
- Individuals whose expertise and knowledge reflect the experiences and perspectives of the constitutionally recognized populations of First Nations, Inuit, Metis and urban Indigenous (FNIMuI), Francophone, and other priority populations

A Co-Chair of each of DIAC and PAC, or their delegate, will be an *ex officio* member of CAC.

3.3. Duration of Service

The Clinical Advisory Council Members are appointed for a two year term. At the end of each two-year cycle, the Co-Chairs will review the membership and make a recommendation to the Executive Oversight regarding membership for the next two-year term. Existing CAC members may be asked to continue for the next two-year term with no limit to the number of terms they may serve.

If a member resigns their CAC membership before the end of their two-year term, the Co-Chairs will determine whether to replace the member taking into consideration the remaining make-up of the Council and the competencies, expertise and experience needed for the Council's work and Action Plan deliverables for the remainder of the two-year cycle. The new member's term will be only until the full membership review at the end of the current membership cycle.

3.4. Linkages & Partnerships

Linkages with the 14 Regional Palliative Care Networks will be enabled through collaboration with the Regional Multidisciplinary Clinical Co-Leads Table.

Members will bring to the CAC broader perspectives from organizations/sectors/networks that they are aligned to and they will share information about OPCN and CAC activities that has been approved for distribution back to their sectors/organizations/networks.

3.5. Individual Accountabilities of Clinical Advisory Council Members

Clinical Advisory Council members will demonstrate a solid commitment to the OPCN's vision and mandate, and, in alignment and partnership with their Regional Multidisciplinary Clinical Co-Leads and Regional Network Directors colleagues as well as in accordance with the Declaration and the strategic direction of the OPCN, will act as champions for hospice palliative care in their respective LHIN area.

Clinical Advisory Council members are not representing a specific constituency but are invited to participate as system-level contributors, bringing expertise and a true desire to advance the system as a whole (not just one sector, service, professional interest or geographic area).

Clinical Advisory Council members will:

- Regularly attend Clinical Advisory Council meetings.
- Prepare to participate in meetings by reading materials made available before the meeting.
- Participate fully in discussions.
- Actively listen and contribute to open exchange of information and ideas.
- Generate future agenda topics.
- Become familiar with other OPCN Advisory Councils Terms of Reference to understand how the other Councils' work complements that of the Clinical Advisory Council.
- Demonstrate systems critical thinking by:
    - questioning and challenging the status quo in clinical practice and delivery of palliative care services;
    - identifying clinical opportunities and challenges; and
    - providing strategic advice and insight related to clinical improvements.
- Contribute as a member of an expert panel, other working group, or sub-committee(s) of CAC or other OPCN Advisory Councils as necessary.
- Declare any actual or perceived conflicts of interest in advance of participating in discussion on the matter in which the conflict arises. Declaration of actual or perceived conflict of interests does not preclude individuals from participating in discussions but they should not vote upon a matter where there is a declared actual or perceived conflict.
- Act as an OPCN champion with their respective organizations/affiliations.

3.6. Attendance Requirements

Regular attendance at meetings is required to ensure continuity and enable decision-making. Inconsistent attendance by a member without cause will be identified and may result in the member being contacted by the Co-Chairs to discuss their continuation on the Council. Delegates will not be permitted.

The preference is for members to attend meetings in person, as long as travel is not a barrier; however teleconferencing and/or videoconferencing will be available to ensure maximum participation.

3.7. Confidentiality

As part of a member's role on this Council, they may have access to information which the OPCN desires to keep confidential. Every member will respect the confidentiality of matters brought before the committee or any of its subcommittees or task forces. Meeting materials, including slides, which are confidential, will be clearly identified at each meeting or in written (including email) correspondence.

When such material is no longer confidential and may be circulated externally, the members will be notified by the Co-Chairs.

4. Logistics and Processes

4.1. Decision Making

The Clinical Advisory Council will strive for effective and efficient decision making, accomplished using consensus decision making procedures. Consensus is defined as general agreement of the Clinical Advisory Council or a shared set of assumptions and agreement to move forward in a particular manner held by all or most of the members of the Clinical Advisory Council. If consensus cannot be achieved, the following will apply:

a) a decision on the issue will be deferred until further information is provided if it is deemed that clarification is required for a future decision to be made; or
b) as a last resort a decision will be made by a formal vote based on Roberts Rules. To conduct a vote, at least two-thirds of the current Council membership (including the Co-Chairs) must be present at the meeting. When a vote is taken, the motion will pass by a simple majority (50% plus 1) of the current Council membership (including the Co-Chairs).

4.2. Annual Workplan

The CAC will develop an annual workplan based on its deliverables in the OPCN Action Plan and other initiatives to fulfill its mandate. The workplan will be developed in the last quarter (January – March) of each year and presented to the Executive Oversight for approval. The approved workplan will guide the scheduling of CAC meetings for the coming year.

4.3. Establishing Sub-Groups

To gather focused knowledge, skills and expertise for a specific task or deliverable of the Clinical Advisory Council, working groups, expert panels, etc. may be struck from time to time. Prior to establishing any such group, the Co-Chairs will ensure that the work is aligned with the CAC's mandate and deliverables in the OPCN Action Plan and confirm with the Director of the OPCN Secretariat the availability of Secretariat resources to support the work.

Membership of a sub-group will be guided by the specific competencies, expertise and knowledge needed to undertake the work of the sub-group as well as OPCN's commitment to engagement of Francophone and FNIMuI representation. CAC may seek input from the Partnership Advisory Council about potential sub-group members. Opportunities will be sought to engage patients, families and caregivers to contribute to this work in a meaningful way.

4.4. Frequency of Meetings

The Clinical Advisory Council will meet a minimum of four times a year with additional meetings scheduled as required based on the annual work plan deliverables and at the call of the Co-Chairs. The regular meeting schedule will be determined annually based on the CAC's annual workplan and ongoing advisory role to the OPCN Executive Oversight.

4.5. Meeting Agenda and Minutes

Efforts will be made to ensure that Meeting Agendas and related materials are prepared and distributed one week in advance of Clinical Advisory Council meetings. Agendas are to be approved in advance by the Co-Chairs.

Minutes of meetings will reflect any decisions made by the membership including details of any motions and, if that formal approach is used, any vote. Meeting minutes will be sent with the agenda for the next meeting.

To support members in communicating with their respective networks and organizations after a meeting, meeting highlights will be prepared and distributed to CAC members by email within five business days of the meeting. This will include clarification of any documents from the CAC meeting that are not to be shared outside the Council meeting.

4.6. Secretariat Support

OPCN Secretariat staff will provide operational and logistical support to the Clinical Advisory Council and its sub-groups, and as such, will attend all its meetings.

5. Stakeholder Guide

In an effort to ensure that appropriate and consistent OPCN messages are delivered when responding to media inquiries and other external requests about OPCN or CAC's work, Clinical Advisory Council members are requested to refer media inquiries to OPCN Secretariat Director also informing CAC Co-Chairs.

6. Review

These Terms of Reference will be reviewed at a minimum at the end of each two-year cycle of the Council with input from the Co-Chairs and members of the CAC. Any recommended revisions to the Terms of Reference will require approval of the OPCN Executive Oversight.

7. Appendices

7.1. Appendix A: Council Competencies

The Clinical Advisory Council Members' Competencies may include, but are not limited to:

Clinical and Program Leadership

- Strong knowledge and understanding of hospice palliative care best practices and guiding principles
- Effective communicator with the ability to present / listen to various viewpoints and deal with conflicting opinions
- Able to bring an objective, regional perspective to the discussions
- Strong knowledge and understanding of hospice palliative care needs across the Province
- Ability to work with multiple cross sector providers to develop a common plan and build consensus
- Negotiation experience

- Experience in collaborative approaches

System Expertise

- Knowledge of and experience in community development and engagement
- Effective working relationships with and understanding of the broader health system and other related stakeholders including those in primary care, community support services, spiritual care, pharmacy etc.
- Knowledge of and experience in regional planning
- Ability to be a system thinker
- Knowledge and understanding of current health care policy and legislation

Scholarship/Academic Leadership

- Strong knowledge and understanding of hospice palliative care research, evidence based best practices and guiding principles
- Strong experience in knowledge translation and transfer to practice

Clinical health informatics and decision support

- Knowledge of and experience in data interpretation/analysis

Quality and Performance Improvement

- Knowledge of and experience in quality improvement and program evaluation
- Knowledge of and experience in research, best practices, education and knowledge transfer

Change Management

- Knowledge of and experience in change management

Caregiver Expertise

- Knowledge and expertise in clinical hospice palliative care service delivery
- Knowledge of and experience in a caregiving role

Health Equity and Cultural Competence

- Experience in delivering hospice palliative care in various settings; (community and home-based, facility-based, residential-based, rural and remote regions)
- Knowledge of and experience in working with First Nations, Inuit, Metis, urban Indigenous (FNIMuI), Francophone, pediatrics, and vulnerable/marginalized populations
- Ability to recognize cultural differences and to adapt healthcare services to meet culturally unique needs at all levels of care
- Understanding and appreciation for the unique challenges faced by different populations that have difficulty accessing healthcare services due to barriers such as homelessness, poverty, linguistic barriers, and social exclusion