NHS
North East London
Integrated Care Board

North East London Community Health Collaborative

TERMS OF REFERENCE

Introduction

1. The NHS North East London Integrated Care Board ('**ICB**') and the following NHS providers of community services, who are all partners of the North East London Integrated Care System ('**ICS**'), have come together to form the North East London Community Health Collaborative (the '**Community Health Collaborative**'). The NHS Trust and Foundation Trust providers of community services are:
   (a) Barts Health NHS Trust ('**Barts**')
   (b) Barking, Havering and Redbridge University Hospitals NHS Trust ('**BHRUT**')
   (c) East London NHS Foundation Trust ('**ELFT**')
   (d) Homerton Healthcare NHS Foundation Trust ('Homerton')
   (e) North East London NHS Foundation Trust ('**NELFT**')
2. For the purpose of these terms of reference, the providers shall be known as the **'NHS Partner Organisations.'**
3. The Community Health Collaborative has been established with a view to enabling the NHS Partner Organisations to work collaboratively, with a shared purpose, and at scale across multiple places in North East London, to reduce inequalities in health outcomes, access and experience; improve resilience (e.g. by mutual aid); and ensure that specialisation and consolidation can occur where this will provide better outcomes and value.

Status

4. The Community Health Collaborative is established by the Population Health and Integration Committee ("the PH&I Committee") as a Sub-committee of the PH&I Committee.
5. These Terms of Reference set out the membership, remit, responsibilities and reporting arrangements of the Community Health Collaborative and may only be changed with the approval of the PH&I Committee. Additionally, the membership of the Community Health must be approved by the Chair of the PH&I Committee.
6. The Community Health Collaborative and all of its members are bound by the ICB's Constitution, Standing Orders, Standing Financial Instructions, policies and procedures of the ICB.

Authority

7. The Community Health Collaborative is authorised by the ICB Board to take all necessary actions to fulfil the remit described within these terms of reference, including obtaining professional (including legal) advice, commissioning reports and creating groups. The Community Health Collaborative will follow the processes described by the Board for commissioning any professional advice. The Community Health Collaborative may establish groups to assist the committee to undertake its functions but it cannot delegate decisions to such groups.

Purpose

8. The Community Health Collaborative has been established in order to:

   (a) Provide the NHS Partner Organisations with the ability to collaboratively direct and oversee the delivery of high-quality patient care relating to in-scope community health related services in North East London;

   (b) Support the development of further collaboration between the NHS Partner Organisations;

   (c) Enable collaboration with an emphasis on minimising health inequalities, striving to: embed joint accountability, improve equity of access to appropriate and timely health services;

   (d) Ensure and encourage the engagement of all the partner organisations of the ICS, with a view to shaping the future of community services across North East London;

   (e) Enable the joint exercise of the Delegated Functions in a simple and efficient way.

9. **Annex 1** lists the Delegated Functions, which have been delegated to the Community Health Collaborative by the Board of the ICB. Matters delegated to the Community Health Collaborative are also set out in an operational scheme of delegation, which has been developed by the ICB. The Community Health Collaborative, through its members set out at paragraph 20 below is authorised by the Board to take decisions in relation to those matters.

10. The NHS Partner Organisations acknowledge that as the collaborative continues to develop, the focus of the Community Health Collaborative will be on determining the vision and arrangements for future collaboration. Consequently, it is expected that the arrangements described in these terms of reference will evolve, including to bring further functions within scope overtime.

11. As the list of Delegated Functions develops, they shall be exercised with particular regard to the Community Health Collaborative's principles and strategic aims, as described in the **North East London Community Services Plan**, which the Community Health Collaborative shall develop and which will be approved by the PH&I Committee on behalf of the ICB, and by the other NHS Partner Organisations in accordance with their own governance requirements. A summary of the Community Health Collaborative's principles and strategic aims shall be contained at **Annex 2**, which also contains details about the collaborative's initial work plan noting this will be developed further.

12. In addition, the Community Health Collaborative will support the ICB, and where relevant the other NHS Partner Organisations, to achieve the aims and the ambitions of:

    (a) the Joint Forward Plan;

    (b) the Joint Capital Resource Use Plan;

    (c) the Integrated Care Strategy prepared by the NEL Integrated Care Partnership;

    (d) where applicable, the joint local health and wellbeing strategies and associated needs assessments prepared by the eight health and wellbeing boards; and

    (e) where applicable, the plans prepared by the seven place-based partnerships, within the ICS's area.

13. The Community Health Collaborative will prioritise its work against the strategic priorities of the ICS and the ICS operating principles[1] set out here.

14. In supporting the ICB to discharge its statutory functions and deliver the strategic priorities of the ICS, the Community Health Collaborative will, in turn, be supporting the ICS with the achievement of the 'four core purposes' of Integrated Care Systems, namely to:

    (a) Improve outcomes in population health and healthcare;

    (b) Tackle inequalities in outcomes, experience and access;

    (c) Enhance productivity and value for money;

    (d) Help the NHS support broader social and economic development.

15. The Community Health Collaborative is also a key component of the ICS, enabling it to meet the 'triple aim' of better health for everyone, better care for all and efficient use of NHS resources.

Chairing Arrangements

16. The Community Health Collaborative will be chaired by Chief Executive NELFT appointed on account of their specific knowledge, and skills and experience making them suitable to chair the Community Health Collaborative and who will agree the Community Health Collaborative's agenda and ensure that its work and discussions meet the objectives set out in these terms of reference.

17. The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these terms of reference.

18. Community Health Collaborative members may appoint a Vice Chair from its members. If a Chair has a conflict of interest then the Vice Chair or, if necessary, another member of the Community Health Collaborative will be responsible for deciding the appropriate course of action.

19. The term of office for the Chair and Deputy Chair will align to their tenure of appointment or following a significant change in the scope and function of the Community Health Collaborative following an annual review, whichever is sooner.

Membership

20. The Community Health Collaborative members will be appointed by the Board in accordance with the ICB Constitution and the Chair of the ICB will approve the membership of the Community Health Collaborative.

21. The Community Health Collaborative shall have 12 members drawn from the NHS Partner Organisations, as follows:

ICB:

(a) Chief Strategy and Transformation Officer or nominated representative

(b) Chief Participation and Place Officer or nominated representative

Barts:

(c) 2 representatives (one executive and one clinician)

BHRUT:

(d) 2 representatives (one executive and one clinician)

Homerton:

(e) 2 representatives (one executive and one clinician)

ELFT:

(f) 2 representatives (one executive and one clinician)

NELFT:

(g) Chief Executive

(h) and one other representative

22. It is expected that members from the NHS Partnership Organisations shall have appropriate delegated responsibility from their respective trust or foundation trust in order to make decisions for their organisation on matters connected with the Community Health Collaborative's remit or, at least, will have sufficient responsibility and be ready to move programmes of work forwards by holding discussions in their own organisation and escalating matters of importance.

23. When determining the membership of the Community Health Collaborative, active consideration will be made to diversity and equality.

24. With the permission of the Chair of the Community Health Collaborative, the members of the Community Health Collaborative set out above, may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf. The decision of the Chair regarding authorisation of nominated deputies is final.

Participants

25. Only members of the Community Health Collaborative have the right to attend Community Health Collaborative meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Community Health Collaborative. The following individuals who are not members of the Community Health Collaborative will also be expected to attend meetings:

    (a) Service user/Carer representatives (Minimum 2)

    (b) Nominated Local Authority representative

    (c) Nominated Place representative

    (d) Wider Community Health Provider Network representative TBD

26. The Community Health Collaborative may invite others to attend meetings, where this would assist it in its role and in the discharge of its duties. This shall include other colleagues from the partner organisations within the ICS, professional advisors or others as appropriate, at the discretion of the Chair of the Community Health Collaborative.

Collaborative working

27. In exercising its responsibilities, the Community Health Collaborative may work with other provider collaboratives, joint committees, committees, or sub-committees which have been established by the NHS Partner Organisations or wider partners of the ICS. This may include, where appropriate, aligning meetings or establishing joint working groups.

28. In particular, the Community Health Collaborative will, as appropriate, work with:

    (a) The place-based governance structures within the area of the ICS.

    (b) The North East London MHLDA Collaborative, the North East London Acute Provider Collaborative, the North East London VCSE Collaborative and the North East London Primary Care Collaborative.

29. The Community Health Collaborative does not have the authority to delegate any functions delegated to it by the ICB Board. However, the Community Health Collaborative may establish transformation boards, working groups or task and finish groups, which do not have any decision-making powers but may inform the work of the Community Health Collaborative. Such groups must operate under terms of reference approved by the Community Health Collaborative, and have due regard to the applicable statutory duties which apply to the ICB.

Resource and financial management

30. The NHS Partner Organisations have made arrangements to support the Community Health Collaborative in its exercise of the Delegated Functions.

31. Further information about resource allocation and financial management is contained in the ICB's standing financial instructions and associated policies and procedures.

Meetings, Quoracy and Decisions

32. The Committee will operate in accordance with the ICB's governance framework, as set out in its Constitution and Handbook and wider ICB policies and procedures, except as otherwise provided below:

Scheduling meetings

33. The Community Health Collaborative will meet on a bi-monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Chair.

34. The PH&I Committee, Board, Chair or Chief Executive may ask the Community Health Collaborative to convene further meetings to discuss particular issues on which they want the Community Health Collaborative's advice.

Quoracy

35. The quoracy for the Community Health Collaborative will be at least one member from each NHS Partner Organisation, including the Chair or Deputy Chair.

36. If any member of the Community Health Collaborative has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

37. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Voting

38. Decisions will be taken in accordance with the Standing Orders. The Community Health Collaborative will ordinarily reach conclusions by consensus. When this is not possible, the Chair may call a vote. Only members of the Community Health Collaborative may vote. Each member is allowed one vote and a simple majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Community Health Collaborative will hold the casting vote. The result of the vote will be recorded in the minutes.

Papers and notice

39. A minimum of seven clear working days' notice is required of the date and time of a meeting. Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed. Supporting papers must be distributed at least five clear working days ahead of the meeting.

40. On occasion it may be necessary to arrange urgent meetings at shorter notice. In these circumstances the Chair will give as much notice as

possible to members. Urgent papers shall be permitted in exceptional circumstances at the discretion of the Chair.

Virtual attendance

41. It is for the Chair to decide whether or not the Community Health Collaborative will meet virtually by means of telephone, video or other electronic means. Where a meeting is not held virtually, the Chair may nevertheless agree that individual members may attend virtually. Participation in a meeting in this manner shall be deemed to constitute presence in person at such meeting. How a person has attended a meeting shall be specified in the meeting minutes.

Confidential information

42. Where confidential information is presented to the Community Health Collaborative, all those who are present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles.

Meeting minutes

43. The minutes of a meeting will be formally taken in the form of key points of debate, actions and decisions and a draft copy circulated to the members of the Committee together with the action log as soon after the meeting as practicable. The minutes will be submitted for agreement at the next meeting where they will be signed by the Chair.

Governance support

44. Governance support to the Community Health Collaborative will be provided by the ICB's governance team.

Conflicts of interest

45. Conflicts of interest will be managed in accordance with the policies and procedures of the ICB and those contained in the Handbook and shall be consistent with the statutory duties contained in the National Health Service Act 2006 and any statutory guidance issued by NHS England.

Disputes

46. Where there is any uncertainty about whether a matter relating to a Delegated Function is within the remit of the Community Health Collaborative in its capacity as a decision-making body within the ICB's governance structure, including uncertainty about whether the matter relates to:

    (a) a matter for determination by a board or other governance structure of an NHS Partner Organisations; or

    (b) determination by a placed-based committee of the ICB or another provider collaborative, or wider-ICS governance structure,

    then the matter will be referred to the ICB Director who is responsible for governance within the ICB for consideration about where the

matter should be determined, taking professional advice as appropriate.

Referral to the PH&I Committee

47. Where any decision before the Community Health Collaborative is novel or contentious or repercussive across services which fall outside its remit, then the Community Health Collaborative shall give due consideration to whether the decision should be referred to the Population Health & Integration Committee of the ICB.

48. With regard to determining whether a decision falling within paragraph 47 shall be referred to the PH&I Committee for consideration then the following applies:

    (a) The Chair of the Community Health Collaborative, at his or her discretion, may determine that such a referral should be made.

    (b) Three or more members of the Community Health Collaborative, acting together, may request that a matter for determination should be considered by the PH&I Committee.

49. Where a matter is referred to the PH&I Committee under paragraph 47, the Committee (at an appropriate meeting) shall consider and determine whether to accept the referral and make a decision on the matter. Alternatively, the PH&I Committee may decide to refer the matter to the Board of the ICB or another of its committees or subcommittees for determination.

50. In addition to the Community Health Collaborative's ability to refer a matter to the PH&I Committee as set out in paragraph 48, the PH&I Committee, or its Chair and Deputy Chair (acting together), may determine that any decision falling with paragraph 47 should be referred to the PH&I Committee for determination. The Board of the ICB, or its Chair and the Chief Executive (acting together), may also require a referral of any decision falling with paragraph 47 to the Board of the ICB.

Behaviours and Conduct

51. Members will be expected to behave and conduct business in accordance with:

    (a) The ICB's policies and procedures including its Constitution, Standing Orders and Standards of Business Conduct Policy which includes the Code of Conduct which sets out the expected behaviours that all members of the Board and its committees will uphold whilst undertaking ICB business.

    (b) The NHS Constitution;

    (c) The Nolan Principles;

52. Members must demonstrably consider equality diversity and inclusion implications of the decisions they make.

Accountability and Reporting	53. The Community Health Collaborative is accountable to the PH&I Committee and will report to the Committee on how it discharges its responsibilities. 54. The Community Health Collaborative will submit copies of its minutes and a report to the PH&I Committee following each of its meetings. A copy of the summary report will also be provided to the Finance, Performance and Investment Committee. 55. .The Community Health Collaborative will provide the PH&I Committee with an Annual Report. The report will summarise its conclusions from the work it has done during the year. 56. Where the Community Health Collaborative considers that an issue, or its learning from or experience of a matter, to be of importance or value to the North East London health and care system as a whole, or part of it, it may bring that matter to the attention of the Director who is responsible for governance within the ICB for onward referral to the PH&I Committee, the Board of the ICB, the Chair or Chief Executive of the ICB, the Integrated Care Partnership or to one or more of ICB's committees or subcommittees as appropriate. 57. In the event that the PH&I Committee or its Chair, or the Chair or Chief Executive of one or more of the NHS Partner Organisations requests information from the Community Health Collaborative, then the Community Health Collaborative will ensure that it responds promptly to such a request.
Review	58. The Community Health Collaborative will review its effectiveness at least annually. 59. These terms of reference will be reviewed at least annually and more frequently if required. Any proposed amendments to the terms of reference will be submitted to the PH&I Committee or approval.

Date of approval:	29 May 2024
Date of review:	May 2025
Version:	2.0

Annex 1 – Delegated Functions

Planning[2]	
The Community Health Collaborative will undertake the following specific activities in the domain of Planning:	
1	Making recommendations to the PH&I Committee in relation to, and contributing to, the Joint Forward Plan and Joint Capital Resource Use Plan and other system plans, in so far as it relates to the provision of, and the need for, Community Services in the ICB's area and the exercise of the ICB's functions.
2	Developing and approving the North East London Community Services Plan and overseeing implementation and delivery of the initial workplan, in so far as that requires the exercise of ICB functions.
3	Responsibility on behalf of the ICB for engagement with partner organisations within the ICS (including primary care) on matters relating to the provision of, and the need for, Community Services with a view to ensuring that such needs are considered within wider system planning.
[ ]	
The Community Health Collaborative will undertake the following specific activities in the domain of [ ]:	
1	
2	
3	
[ ]	
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1	
2	
3	

[2] Other sections can be added over time, e.g. finance, quality, leadership, emergency planning, transformation, engagement.

Annex 2- Principles, strategic aims and work plan 2022/2023

The following priorities and objectives are summarised from the North East London Community Services Plan for 2022/2023:

Principles

1	*The primary relationship of Community Health Service (CHS) providers is with "Place":* • *In the NEL context this means place level* • *This reflects the model of service delivery, which is in a patient's own home or very close to it and which requires close collaboration with primary care , social care and children's' services*
2	Collaboration across all CHS providers at an ICS level should be focused on: • areas where there are clear population health needs that are best supported at an ICS or multi-borough level, including multi-borough work with local authority partners where agreed with partners • achieving common standards (agreed with partners) to reduce unwarranted variations and address inequalities in health outcomes, access to services and experience • improving resilience by, for example, providing mutual aid / fragile services

Strategic Aims

1	Provide longer term strategic planning championing the benefits and speciality of community services
2	Recognising the key role of community services in place-based service integration providing a strategic rather than operational role
3	Provide coordination, oversight and assurance on the delivery of the existing workplan of Ageing Well / Virtual Wards / / Covid Pathways / CHS trajectories
4	To co-produce models of care, outcomes and operating framework for the delivery of community services with patients and carers and through sharing best practice
5	Opportunities for addressing workforce challenges and to improve recruitment and retention including the development of new roles / resilience

6	Reduce unwarranted variation in current provision of community health services, particularly those services which have the greatest impact on health inequalities
7	The Collaborative will support the shift in care models to support prevention
8	To Collaborative will support development of BCYP services at place where the collaborative can add value at a system level
9	The Collaborative will have clinical and care leadership that represents the diversity of the workforce providing support in patients' homes
10	The Collaborative will support enabling innovation through technology and digital solutions in community health services eg remote monitoring for long term conditions

Work Plan

1	**Operating Plan deliverables** • Delivering a reduction in CHS waiting times to pre-covid pandemic levels or better • Delivery of the Ageing Well Programme working with partner organisations • Delivery of the Virtual Wards aspiration • Oversight of the three Covid pathways (Pulse Oximetry, Long Covid, Covid Virtual Wards)
2	**Service quality and resilience** • Making best use of community bed capacity and improving resilience to winter / Covid pressures • Work with Workforce Leads from the ICS to address common recruitment and retention issues through innovative employment and training approaches • Increase resilience in fragile services e.g. dietetics • CYP services
3	**Strategy and development** • Develop a vision and strategy for CHS within the ICS and agree a CHS Outcomes Framework • Engage in end-to-end pathway planning through clinical networks and other provider collaboratives