NHS
North East London
Integrated Care Board

North East London Primary Care Collaborative

TERMS OF REFERENCE

Introduction	1. The NHS North East London Integrated Care Board ('**ICB**') and the providers of all primary care services including pharmacy, dentistry and optometry who are all partners of the North East London Integrated Care System ('**ICS**'), have come together to form the North East London Primary Care Collaborative Sub-Committee (the '**sub-committee**'). 2. The sub-committee has been established to enable Primary Care leaders to work collaboratively, with a shared purpose, and at scale across north east London. The sub-committee will aim to reduce inequalities in health outcomes, improve patient access and experience; improve resilience of primary care services (e.g. by mutual aid); and ensure that services deliver value for money whilst maintaining and improving quality, productivity and reducing unwarranted clinical variation.
Status	3. The sub-committee is established by the Population Health and Integration Committee ('the PH&I Committee') as a sub-committee. 4. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the sub-committee and may only be changed with the approval of the PH&I Committee. Additionally, the membership of the sub-committee must be approved by the Chair of the PH&I Committee. 5. The sub-committee and all of its members are bound by the ICB's Constitution, standing orders, standing financial instructions, policies and procedures of the ICB.
Authority	6. The sub-committee is authorised by the ICB 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 sub-committee, with agreement from the ICB, will follow the processes for commissioning any professional advice. The sub-committee may establish groups to assist the committee to undertake its functions but it cannot delegate decisions to such groups.
Purpose	7. The sub-committee will also be known as the Primary Care Collaborative and will: (a) Agree the clinical consensus for primary care services strategy and transformation programmes at scale across all practices including pharmacy dentistry optometry in North East London. This includes agreeing and setting direction in the context of national and local strategic planning requirements and maintaining the oversight of implementation and delivery.

(b) The collaborative will work to reduce inequities in care provision and inequalities and unwarranted variation in outcomes for patients and residents.

(c) The collaborative will provide coherent and structured clinical leadership for primary care services across the Integrated Care system through the representation of place based clinical leaders and with clinical colleagues and partners within other provider collaboratives

(d) Agree a common approach and standards where needed across primary care services

(e) Act as a forum for learning and sharing best practice based on robust data

(f) Provide a forum for other provider collaborative groups to engage with primary care services across the ICS

(g) Support work occurring across and within the place-based partnerships to improve population health and healthcare

(h) Ensure primary care services are delivering productivity and are focused on continuous quality improvement.

8. Matters delegated to the sub-committee are set out in an operational scheme of delegation, which has been developed by the ICB. The sub-committee, through its members is authorised by the Board to take decisions in relation to those matters.

9. As the list of Delegated Functions develops, they shall be exercised with particular regard to the sub-committee's priorities and objectives, as described in the North East London Primary Care Services Plan, which the sub-committee shall develop and which will be approved by the PH&I Committee on behalf of the ICB.

10. In addition, the sub-committee will support the ICB, 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; and the 5-Year Strategy

(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.

11. In supporting the ICB to discharge its statutory functions and deliver the strategic priorities of the ICS, the sub-committee will, in turn, be supporting the ICS with the achievement of its ICS wide priorities -

- Employment and workforce
- Long term conditions

- Children and young people
- Mental Health

Chairing Arrangements

12. The Primary Care Collaborative shall be co-chaired by the ICB Board Primary Care Partner Members on account of their specific knowledge, and skills and experience. The Chair will agree the agenda and ensure that its work and discussions meet the objectives set out in these terms of reference.

13. The Deputy Chair role will be covered by the North East London Associate Medical Director lead or nominated deputy. The term of office for the Deputy Chair will align to their tenure of appointment or following a significant change in the scope and function of the sub-committee following an annual review, whichever is sooner.

Membership and quoracy

14. The sub-committee 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 sub-committee.

15. The members are as follows:

    (a) Primary Care Partner Members (Co-Chairs)

    (b) Chief Strategy and Transformation Officer

    (c) Associate Medical Director or designated Deputy

    (d) Managing Director for Primary Care

    (e) Representation from the relevant provider groups:
    - 2 General Practice clinicians
    - 2 Pharmacy clinicians
    - 2 Dentistry clinicians
    - 2 Optometry clinicians
    - 1 Primary Care management representative

    (f) Healthwatch and or patient group representation to be agreed

    (g) Chief Finance and Performance Officer or nominated Representative

    (h) Chief Nursing Officer or nominated Representative

16. Members from the participating provider groups organisations shall have appropriate delegated responsibility in order to make decisions for their organisation on matters connected with the sub-committee'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.

17. When determining the membership of the sub-committee, active consideration will be made to diversity and equality, geographical and service spread

18. With the permission of the Chair members as 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 Chair's decision regarding authorisation of nominated deputies is final.
Participants	19. Only members of the sub-committee have the right to attend meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the sub-committee. 20. The following individuals who are not members of the sub-committee will also be expected to attend (a) Representation from place based clinical leadership and primary care as agreed by the local partnership (b) Officers or Subject Matter Experts (SME), as required to undertake the business of the sub-committee e.g Training hub representative (c) A DASS from North East London ICS 21. The sub-committee 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 sub-committee.
Collaborative working	22. The sub-committee will work with other provider collaboratives, joint committees, committees, or sub-committees which have been established by the ICB. This may include, where appropriate, aligning meetings or establishing joint working groups. 23. In particular, the sub-committee will, through the Managing Director of Primary Care and other Primary Care ICB officers as appropriate, work with: (a) NHS England; (b) The Primary Care Contracts sub-committee ('PCCS'), (c) The Place ICB sub-committee and any groups that have been established at place for the purposes of primary care. (d) the Local Medical Committee(s) ('LMC') (e) Local Pharmaceutical Committee(s) ('LPC') (f) Local Optical Committee(s) ('LOC') (g) Local Dental Committee(s) ('LDC') (h) Primary Care Networks ('PCNs') (i) Primary Care Federations 24. The sub-committee 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 sub-committee. Such groups must operate under terms of reference approved by the sub-committee, and have due regard to the applicable statutory duties which apply to the ICB.

Resource and financial management	25. The sub-committee will operate in accordance with the ICB's governance framework, as set out in its Constitution and Handbook standing financial instructions and associated policies and procedures. and wider ICB policies and procedures, except as otherwise provided below:
Meetings, Quoracy and Decisions	*Scheduling meetings* 26. The sub-committee will meet on a bi-monthly basis. Additional meetings may be convened on an exceptional basis at the discretion of the Chair. 27. The PH&I Committee, Board, Chair or Chief Executive may ask the sub-committee to convene further meetings to discuss particular issues and for advice. *Quoracy* 28. The quoracy for the sub-committee will be five members and must include two ICB Officers. 29. If any member of the sub-committee 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. 30. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. *Voting* 31. Decisions will be taken in accordance with the standing orders. The sub-committee will ordinarily reach conclusions by consensus. When this is not possible, the Chair may call a 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 sub-committee will hold the casting vote. The result of the vote will be recorded in the minutes. *Papers and notice* 32. A minimum of five 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 33. 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* 34. It is for the Chair to decide whether or not the sub-committee 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* 35. Where confidential information is presented to the sub-committee all those who are present will ensure that they treat that information appropriately in light of any confidentiality requirements and information governance principles. *Minutes* 36. 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 sub-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 shall be signed by the Chair. *Governance support* 37. Governance support to the sub-committee will be provided by the ICB's governance team. *Conflicts of interest* 38. 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	39. Where there is any uncertainty about whether a matter relating to a Delegated Function is within the remit of the sub-committee in its capacity as a decision-making body, including uncertainty about whether the matter relates to: (a) a matter for determination by a board or other governance structure; 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	40. Where any decision before the sub-committee is novel, contentious or repercussive across services which fall outside its remit, then the sub-committee shall give due consideration to whether the decision should be referred to the PH&I Committee of the ICB.

41. With regard to determining whether a decision falling within paragraph 40 shall be referred to the PH&I Committee for consideration then the following applies:

    (a) The Chair of the sub-committee, at their discretion, may determine that such a referral should be made.

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

42. Where a matter is referred to the PH&I Committee under paragraph 50, the PH&I 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 to a subcommittee for determination.

43. In addition to the sub-committee's ability to refer a matter to the PH&I Committee as set out in paragraph 40, the PH&I Committee, or its Chair and Deputy Chair (acting together), may determine that any decision falling with paragraph 40 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 40 to the Board of the ICB.

44. Notwithstanding paragraph 40 where a matter relates to a function which has been delegated to the ICB by NHS England and is 'novel, contentious or repercussive,' the sub-committee shall ensure that the matter is referred for decision and approval in accordance with the Delegation Agreement. (The current version of the Delegation Agreement requires such matters to be referred to ICB's Chief Executive Officer, Chief Finance Officer or Chair and also requires approval by specified NHS England officers).

Behaviours and Conduct

45. 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.

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

Accountability and Reporting

47. The sub-committee is accountable to the PH&I Committee and will report to the Committee at each of its meetings on progress it discharges, its responsibilities and priorities.

	48. The sub-committee will submit copies of its exception reports and when agreed, minutes and a report to the PH&I Committee following each of its meetings. 49. The sub-committee 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. 50. Where the sub-committee considers an issue, or its learning from or experience of a matter, to be of importance or value to the NEL 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 sub-committees as appropriate. 51. In the event that the PH&I Committee or its Chair, or the Chair or Chief Executive of one or more of the member groups requests information from the sub-committee, then the sub-committee will ensure that it responds promptly to such a request. *Reporting into the sub-committee* 52. Any structures established by the sub-committee, including the four primary care sector collaborative groups, will be directly accountable and report into the sub-committee. 53. As indicated above a Director of Primary Care will provide director support to each of the four primary care sector collaborative groups and will attend meetings of the sub-committee to ensure ICS management support to primary care in the Place Based Partnerships reflects agreements reached in the collaboratives.
Review	54. The sub-committee will review its effectiveness at least annually. 55. 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 for approval.

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