NHS
South East London

Integrated Care Board

Clinical and Care Professional Committee (CCPC)

Terms of Reference

1 July 2022

1. Introduction

1.1 The NHS South East London Integrated Care Board (ICB) Clinical and Care Professional Committee (CCPC) [the "committee"] is established as a committee of the ICB Board. The committee has no executive powers other than those specifically delegated in these terms of reference. These terms of reference can only be amended by the ICB Board.

1.2 These terms of reference set out the role, responsibilities, membership, and reporting arrangements of the committee under its terms of delegation from the ICB Board.

1.3 All members of staff and members of the ICB are directed to co-operate with any requests made by the CCPC.

2. Purpose

2.1. It is recognised that ensuring clinical and care professional leadership is integral to the way we work as a system and will require a distributed approach across the health and care partnership.

2.2. The role of the committee should be understood as leadership group and as a body responsible for convening a broader network of clinical and care leaders to support existing leadership in the system.

2.3. The ICS partnership has committed to clinical and care professional leadership and alignment with the five ICS clinical and care professional leadership design principles included within national ICS implementation guidance[1]:

1. Ensure that the full range of clinical and professional leaders from diverse backgrounds are integrated into system decision-making at all levels, supporting this with a flow of communications and opportunities for dialogue.

2. Nurture a culture that systematically embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.

[1] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0664-ics-clinical-and-care-professional-leadership.pdf

3. Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate protected time, support and infrastructure to carry out this work.

4. Create a support offer for clinical and care professional leaders at all levels of the system, one which enables them to learn and develop alongside non-clinical leaders (e.g. managers and other non-clinical professionals in local government and the VCSE sector), and provides training and development opportunities that recognise the different kind of leadership skills required when working effectively across organisational and professional boundaries and at the different levels of the system (particularly at place).

5. Adopt a transparent approach to identifying and recruiting leaders which promotes equity of opportunity and creates a professionally and demographically diverse talent pipeline that reflects the community served and ensures that appointments are based on ability and skillset to perform the intended function

2.4. This committee is designed to operate in a way that interlinks to other key decision-making parts of the ICB and broader system's governance arrangements. The CCPC is additive and complementary - where a single conversation with representatives across the SEL system is helpful.

2.5. The committee is primarily in focused upon ensuring coherence as opposed to direct decision making, enabling change through escalation and influence, ensuring a multi-professional perspective, establishing a more systematic improvement and transformation method linked to population health, and sharing learning and best practice through ICB and regional channels.

2.6. The CCPC reflects national expectations as set out in the ICS design framework, best practice from systems elsewhere, the input of system leaders from across SEL who contributed to the engagement process undertaken over 2021-22, and lessons learned from the previous OHSEL Clinical Programme Board and SEL Clinical and Care Leadership Group.

2.7. The CCPC will, together with other relevant ICB committees and groups, undertake the following functions on behalf of the ICB:

2.8. **Population health management** – lead coordination of the ICB's approach to implementing a population health management approach across the full scope of the ICB's activities.

2.9. **System-wide clinical and care strategy** – to review and provide clinical advice and guidance in relation to the development of operational and strategic plans

2.10. **Care pathway transformation and innovation** – routine review of new or proposed clinical pathways to understand and advise on clinical impacts, workforce implications, key messages and implementation requirements.

2.11. **Patient and public engagement** – to shape the development of the ICB's patient and public engagement strategic approach and take assurance on the organisation's engagement activities and processes.

2.12. **Continuous improvement and innovation** – to drive forward the improvement and innovation agenda across the partnership, ensuring learnings and good practice are disseminated and embedded and that innovation in other areas are harnessed and enacted in south east London.

2.13. **Clinical and care professional development** – together with ICB workforce leaders to lead an on-going development and support offer for clinicians and care professional leaders within the ICS and ensure leaders maximise their impact their respective areas of interest and across the partnership more broadly.

2.14. **Establishing a broad-based and multi-disciplinary ICB clinical senate** – with the aim of significantly enhancing the breath of clinical input and expertise in the development of clinical strategy and proposals for clinical transformation.

2.15. **General clinical advice and input into other ICB functions** – to receive requests from other key ICB functions where clinical advice and input is required. This will include the below functions as a minimum:

- Workforce resilience linked to the ICB Workforce programme.
- Quality assurance and safety linked with IBC Quality & Performance Committee, System Quality Group and CNO and CMO membership.
- Professional leadership support and development linked to the ICB Workforce programme and workforce lead role membership.
- ICB care pathway and enabler work programmes.
- Leadership in research and evidence.
- Care standards as requested by ICB, ICS or regional programmes.

2.16. See Appendix One for a view on how the CCPC will deliver its functions under matrix arrangements with other parts of the ICB governance.

3. Duties

3.1. The committee is an integral part of the wider ICB governance arrangements and will maximise its impact by working in close alignment with other parts of the organisation's governance: key committees, ICB clinical transformation programmes and enabler programmes. The CCPC will operate with the following distinct responsibilities:

3.2. To oversee two designated areas on behalf of the ICB: population health management and engagement assurance.

3.3. To provide clinical and care professional input into ICB / ICS programmes and other key functions. This will involve detailed consideration of information on clinical strategy, service and pathway changes and will involve the committee considering impacts and making recommendations to inform the proposed change. The committee may also consider information on risks or issues which have been identified with a potential clinical impact and advise on these accordingly.

3.4. To direct cross-system clinical work where there is not a programme established to own that activity.

3.5. To offer a review and constructive challenge of clinical proposals or cases for change developed within the ICB or broader ICS partnership.

3.6. Interact with region and other partners outside of the ICS in order to input from a clinical perspective to regional programmes and to understand and adopt learning and innovation from other places.

3.7. To convene a broad-based, multi-disciplinary clinical senate with broader representation from system clinical and care clinical leadership to engage a broader cohort of clinical leaders on matters related to clinical strategy, transformation and programmes of change.

4. Accountabilities, authority, and delegation

4.1. The authority delegated to the committee is set out in the ICB's Scheme of Reservation and Delegation.

4.2. The committee will act to agree and report against all duties within its scope as recorded in section 3 (above). It will report on its activities to the ICB Board.

4.3. The committee is responsible for overseeing activities related to population health management and engagement assurance.

4.4. The committee will receive reports from each of its sub-committees as well as minutes of meetings and relevant supplementary reports.

4.5. The committee will be provided with a regular opportunity to hear from representatives of its sub-committees. It will be able to act on recommendations or proposals that arise at its sub-committees in line with the ICB Scheme of Reservation and Delegation.

4.6. The committee will together with the ICB Planning and Finance Committee operate dual reporting lines from ICB care pathway programme boards and key enabler programme boards and workstreams where appropriate. The CCPC will receive updates on progress from clinical leaders in these programmes and offer its support and clinical input as requested.

4.7. The committee may establish a working group or task and finish group to lead work under a defined term of reference/ engagement. The committee must agree by majority on the establishment of any of the groups and formally agree their terms of reference.

5. Membership and attendance

5.1. The committee members shall be appointed by the Board in accordance with the ICB Constitution. When determining the membership of the committee, active consideration will be made to equality, diversity and inclusion.

5.2. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

5.3. The membership seeks to incorporate a broad clinical representation from across the health and care system in south east London; including representation from acute trusts, community providers, mental health providers, general practice, nursing, the ICB executive leadership team, and social care.

5.4. ICS partners with both a medical director and chief nurse / chief nursing officer, will be able to nominate one of these postholders to act as the representative of that organisation on the CCPC. It is also permissible for the representative member to change between postholders on a meeting-by-meeting basis.

5.5. The committee will be constituted of the following postholders:

- ICB Medical Director (Co-Chair)
- ICB Chief Nurse (Co-Chair)
- 1 x SEL Director of Public Health or Consultant in Public Health
- Medical Director or Chief Nurse Officer, Guy's & St. Thomas' NHSFT
- Medical Director or Chief Nurse Officer, King's College Hospital NHSFT
- Medical Director or Chief Nurse Officer, Lewisham and Greenwich NHS Trust
- Medical Director or Chief Nurse Officer, Oxleas NHSFT
- Medical Director or Chief Nurse Officer, South London and Maudsley NHSFT
- Clinical Director, Bromley Healthcare
- 1 x Clinical Lead ICB Primary Care Group
- 1 x local authority executive representative
- ICB Executive Director of Planning
- ICB Chief Pharmacist
- Allied Health Professional Representative
- 6 x Borough clinical leads representing each LCP

5.6. Committee members will be responsible for ensuring relevant issues or activities within their own organisation are discussed where they are relevant to the work of the committee. Intelligence should be shared with the committee from other discussions held within organisations, partnerships or at a regional level.

5.7. It is expected that members can make decisions on behalf of their organisations (up to the limits delegated to them) and do so within any set timeframe, securing sign off and cascade from own organisations where applicable.

5.8. Should a committee member be unavailable they are responsible for ensuring a suitable deputy is able to identified to attend the meeting on their behalf.

5.9. In addition to the standing membership, other individuals from across the Integrated Care System may be invited to attend as required. It is anticipated that representation from ICS clinical networks / collaboratives and transformation programmes will be requested by the committee on a regular basis.

5.10. The committee is permitted with agreement of the chair and a majority of members to formally co-opt additional members and/or other subject matter specialists to broaden the range of input should this be deemed necessary.

6. Chair of meeting

6.1. The committee shall satisfy itself that the ICB's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

6.2. The meeting will be co-chaired by the ICB Medical Director and ICB Chief Nurse Officer. These post-holders will chair the meeting in sequence.

6.3. At any meeting of the committee, the chair designated chair for that meeting if present shall preside. If the chair is absent, the co-chair shall preside. If the designated co-chair is temporarily absent on the grounds of conflict of interest, the other co-chair shall preside.

7. Quorum and conflict of interest

7.1. The quorum of the committee is at least 50% of members of which the following must be present:

a. The ICB Medical Director or ICB Chief Nurse
b. 3 x ICS partner medical directors
c. 3 x LCP clinical leads

7.2. The committee will operate with reference to NHS England guidance and national policy requirements and will abide by the ICS's standards of business conduct. Compliance will be overseen by the chair of the committee.

7.3. The committee agrees to enact its responsibilities as set out in these terms of reference in accordance with the Seven Principles of Public Life set out by the Committee on Standards in Public Life (the Nolan Principles).

7.4. Committee members will be required to declare any interests they may have in accordance with the ICB's Conflict of Interest Policy (included within the Standards of Business Conduct Policy). Members will follow the process and procedures outlined in the policy in instances where conflicts or perceived conflicts arise.

8. Decision-making

8.1. Where a decision is required, it is expected that this will be reached by consensus. Where a vote is required to decide a matter, each member may cast a single vote. In the event of equal votes, the chair will have a casting vote.

9. Procedure of decisions made outside of formal meetings

9.1. The committee chair will arrange for the notice of the business to be determined and any supporting paper to be sent to members by email. The email will ask for a response to be sent to the committee chair by a stated date. A decision made in this way will only be valid if the same minimum quorum described in the above paragraph, expressed by email or signed written communication, by the stated date for response, states that they are in favour.

9.2. The ICB's governance team will retain all correspondence pertaining to such a decision for audit purposes and report decisions so made to the next meeting. A clear summary of the issue and decision agreed will then be recorded in the minutes of this meeting.

10. Frequency

10.1. The committee will meet once every month and a minimum of six times over the course of a year.

10.2. All members will be expected to attend all meetings or to provide their apologies in advance should they be unable to attend.

10.3. Members are responsible for identifying a suitable deputy should they be unable to attend a committee meeting which needs to be agreed with the chair and notified in advance.

10.4. Nominated deputies will count towards the meeting quorum if attendance has been agreed by the committee chair.

10.5. Members and staff from ICS partner organisations are expected to contribute to reasonable requests for information and input to the work undertaken by the committee.

11. Reporting

11.1. Papers will be made available five working days in advance to allow members to discuss issues with colleagues ahead of the meeting. Members are responsible for seeking appropriate feedback.

11.2. The committee will report on its activities to the ICB Board via minutes. In addition, an accompanying report will summarise key points of discussion, items recommended for decisions, the key activities undertaken or coordinated by the committee; any actions agreed to be implemented.

11.3. The minutes of meetings shall be formally recorded and reported to the ICB Board for the purposes of assurance and made publicly available as part of ICB meeting papers.

12. Committee support

12.1. The committee will be supported by members of the ICB's governance team.

12.2. The meeting secretariat will ensure that draft minutes are shared with the Chair for approval within three working days of the meeting. Draft minutes with the Chair's approval will be circulated to members together with a summary of activities and actions within five working days of the meeting.

13. Monitoring adherence to the Terms of Reference

13.1. The co-chairs of the committee will be responsible for ensuring the committee abides by the terms of reference.

14. Review of Arrangements

14.1. The committee shall undertake a self-assessment of its effectiveness on at least an annual basis. This may be facilitated by independent advisors if the committee considers this appropriate or necessary.

14.2. These terms of reference shall be reviewed by the committee chair and ICB chair on an annual basis, with changes proposed for approval to the ICB Board.

Appendix 1: Mapping CCPC functions to the broader IBC governace

CCPL Function	A) Direct Reporting line	B) Indirect support to programmes/ICS governance/collaboratives	C) Directed by ICB	D) Regional link
Population health	Reporting from PHM sub group	Involvement through identified lead role		Regional interface with the most appropriate system clinical governance forum e.g. quality and safety, IPC, CCPB
Care pathway transformation/ innovation	Through routine review and input as required	Involvement through identified programme/enabler/collaborative lead roles	If requested	
System-wide clinical and care strategy	*Would lead the development of any stand alone clinical strategy / would provide system clinical and professional input into overall strategy/ planning*			
Workforce resilience		Involvement through workforce programme lead roles		
Quality Assurance and Safety		Involvement through CNO/CMO and system quality leadership and governance	If requested	
Patient and public engagement (PPE)	Reporting from PPE subgroup	Involvement through identified lead role		
Continuous improvement and innovation	Reporting from SEL System Leadership Collaborative	Involvement through identified lead role		
Professional leadership support and development		Involvement through workforce programme lead roles		
Leadership in research & evidence		Involvement through KHP clinical leadership roles	If requested	
Care standards		For consideration where requested by ICB/ICS/regional programmes	If requested	