**Terms of Reference – East of England NHSE**

 **Professional Nurse Advocate Critical Care Shared Decision Making Council**

1. **Background and context**

When applied between professionals the process of shared decision-making offers a non-hierarchical approach to collective leadership. This can drive forwards quality and service improvements, supporting innovation and delivering better outcomes for individuals, populations and staff.

Whether involving decisions that affect the day to day work of teams or those concerning communities, organisations or the profession; by coming together in this way and underpinned by the relevant evidence-base this provides us with a strong collective professional voice.

National Shared Decision-Making Councils bring together nurses and midwives who have a strong clinical focus at the point of care from a variety of clinical and practice backgrounds across the system.

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By utilising shared decision-making and collective leadership principles the Council will bring insight to the consideration of a range of issues and opportunities and help support, advise and inform NHSE/I national policy leads around development and implementation of policy. ​

1. **Duties and responsibilities**​

At a Regional level, a Shared Professional Decision-Making Council’s role is to support discussions and influence policy through to the National team bringing the application of it’s point of care expertise and experience.

In practice this means: ​

* providing relevant evidence-based advice (where available) and support, on areas such as: ​
	+ ways of working and delivery PNA models; ​
	+ identifying any opportunities in respect of system change and improving patient care and the experience of nursing;
* sharing and discussing relevant learning;
* sharing and discussing matters related to their expertise, background and practice; ​
* be available to support regional leads as a point of reference to give views, identify risks and opportunities; while making suggestions on solutions to issues and challenges;

Council members participate as individuals. Whilst they will often reflect and present their experiences in their current organisation, they do not take part formal representatives of their employing organisation.

Views and feedback from council members are welcomed.

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1. **Membership**​
* Membership of the council will be representative from a variety of Critical Care providers throughout the East of England. The PNA experience within the variety of Critical Care units will capture an appropriate range of views and experience.
* Councils will strive to ensure diverse perspectives among the membership and will reach out as required to include representation across the protected characteristics.
* The emphasis of membership is on PNA whose role is focused at the point of care. Overall composition of the council remains representative of the overall workforce.
* The council will have a nominated **Chair and deputy**.

Councils may also wish to consider:

* The ideal number of members. 20 members would suit most councils but may need to be varied up or down to ensure effective meetings/discussions. ​
* To allow the group to ‘gel' it may be suitable to set membership of the council at one year, but the optimum arrangements may vary by council and councils may wish to avoid or, equally, encourage wholesale membership changes from time to time.

**3.   Regional support for the Council** ​

* Each Shared Decision-Making Council is supported by a clinical lead within NHSE/I, Regional PNA Advisor.
* The NHSE/I clinical lead will work in partnership with their council to identify and agree areas and topics for discussion and will support their council to make connections, as required, across NHSE/I relating to the professional, clinical and operational matters raised.

Councils may also consider:

* Defining to secretariat arrangements including how the NHSE/I team support the council logistically in terms of arranging meetings, circulating papers etc.
* Any specific support for the chair and deputy chair such as pre-meets, regular catch-ups etc.

**4.   Frequency**​

Councils may consider:

* The frequency of meetings. Whilst most councils have settled into a monthly frequency, councils may prefer more tailored arrangements for example building in longer sessions at a set interval.

**5. Relationships and policy alignment**

* Although members do not formally represent their trusts it may be necessary for members to secure the approval of their trust when, for example, experiences or processes based in the members organisation is to be presented to a wider audience.
* The NHSE/I clinical lead for the council feeds the advice and recommendations of council into their overall policy responsibility and reports such feedback and advice, as required, into NHSE/I National PNA steering group

Councils may also wish to:

* Reflect other arrangements for feeding in the input of councils and other relationship/dependencies for example with national programmes and advisory groups.
1. **Standing agenda**
* Agendas will be agreed between the Regional lead and the chair based on discussions at the group.

Councils may also wish to:

* Consider whether there should be any standing items for their council.
1. **Review**

The Council will review the terms of reference, and the relevance and value of its work at least annually. ​