Draft – Subject to ratification at the next meeting

Minutes of a Formal Meeting of the Joint Committee of Clinical Commissioning Groups (JCCCGs) Held on Thursday, 3 September 2020 via Microsoft Teams Videoconference

Part I

Present		
Roy Fisher	Vice Chair (Chaired the meeting) Chair	Joint Committee of CCGs Blackpool CCG
Kevin Toole	Lay Member	Fylde and Wyre CCG
David Bonson	Chief Operating Officer	Blackpool CCG/Fylde and Wyre CCG
Graham Burgess	Lay Chair	Blackburn and Darwen CCG
Denis Gizzi	Chief Officer	Chorley and South Ribble CCG/ Greater Preston CCG
Dr Sumantra Mukerji	Clinical Chair	Greater Preston CCG
Debbie Corcoran	Lay Member	Greater Preston CCG
Geoff O'Donoghue	Lay Member	Chorley and South Ribble CCG
Dr Geoff Jolliffe	Clinical Chair	Morecambe Bay CCG
Hilary Fordham	Chief Operating Officer	Morecambe Bay CCG
Dr Richard Robinson	Chair	East Lancashire CCG
Julie Higgins	Chief Officer	East Lancashire CCG
Paul Kingan	Chief Finance Officer	West Lancashire CCG
Doug Soper	Lay Member	West Lancashire CCG
In Attendance		
Jane Cass	Locality Director	NHS England and Improvement
Elaine Collier on behalf of Gary Raphael	Head of Finance	Lancashire and South Cumbria ICS
Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
Sue Stevenson	Chief Operating Officer	Healthwatch Cumbria/Lancashire
Lawrence Conway	Chief Executive	South Lakeland District Council
Sarah Callaghan	Director of Education	Lancashire County Council
Dr Amanda Doyle (from Item 11)	Chief Officer	Lancashire and South Cumbria ICS
Dr Andy Curran	Medical Director	Lancashire and South Cumbria ICS
Andrew Bennett	Executive Lead Commissioning	Lancashire and South Cumbria ICS
Carl Ashworth (left during Item 7)	Director of Strategy and Policy	Lancashire and South Cumbria ICS
Peter Tinson (arrived during Item 7/left after Item 8)	Director of Collaborative Commissioning	Lancashire and South Cumbria ICS
Emily Kruger-Collier	Head of Programme Management Office	Lancashire and South Cumbria ICS
Rebecca Higgs	Business Support to Dr A Doyle	Lancashire and South Cumbria ICS
Louise Talbot	Secretary to the Governing Body	Blackpool CCG Minutes taken on behalf of the Lancashire and South Cumbria ICS

Routine Items of Business	
1.	**Welcome, Introductions and Apologies** **Welcome and Introductions -** The Committee Vice Chair, Roy Fisher (Chaired the meeting) welcomed members to the meeting of the Joint Committee of CCGs (JCCCGs) held virtually via Microsoft Teams videoconference. Andrew Bennett explained that there was a requirement for the meeting to be held with a formal status, therefore, it was a public meeting and the papers had been published on the website. There was an opportunity for members of the public to ask questions via the website however, Andrew advised that as mid-morning, no questions had been received. Should any questions be received, an individual response would be provided. **Apologies for Absence –** Apologies had been received from Gary Raphael, Dr Adam Janjua, Katherine Fairclough, Jerry Hawker, Louise Taylor, Dr Lindsey Dickinson, Neil Jack and Jackie Hanson. Members were advised that Dr Doyle was taking part in a national call and would join the meeting later.

2.	**Minutes of the Previous Meeting Held on 2 July 2020, Matters Arising and Actions** **Minutes -** Richard Robinson had been omitted from the previous minutes and Andrew Bennett had sent apologies which had been omitted. The Secretary would amend the minutes accordingly. **ACTION: LJT (√)** **RESOLVED: That subject to the amendment to be made, the minutes of the meeting held on 2 July 2020 be approved as a correct record.** **Matters Arising -** The matters arising log was reviewed and members noted the actions that had been completed. Other matters arising that had a completion date of 3 September 2020 continued to be in progress and would be reviewed at the next meeting. The Secretary would update the log accordingly. **ACTION: LJT (√)** Andrew Bennett reminded members that a standard item relating to the cell logs of decision-making was now included on both the ICS Board and the JCCCGs agendas in order that members were aware of the decisions taken by the cells. Elaine Collier referred to the item on the log relating to a report that was due to be submitted to the committee detailing allocations for the next financial year. Guidance on financial envelopes was still awaited however, once received, a report would be submitted to a future meeting of the committee. Elaine advised that there was likely to be a potential reset of allocations for 2021/22 with a pace of change, but guidance was still awaited. Doug Soper sought a progress update on the capital allocations discussed at the previous meeting. Elaine advised that allocations for capital for the current year have been set and that FIG had discussed setting up a group across Lancashire and South Cumbria to review how it could evidence/lobby for Lancashire having more of a fair share. Members were reminded that £215m capital allocations were made available during 2020/21 and some schemes were being progressed. Roy Fisher asked if accrual was allowed for capital schemes and Elaine advised that it is only for work in progress and with evidence to state that the work has been completed. Elaine further advised that that they would look to broker the capital in Lancashire and South Cumbria and a piece of work will be undertaken on month six however, if the funding isn't used, they would look to broker it across the North West for it to be returned in 2021/22.
3.	**Declarations of Interests** **RESOLVED: That all members of the Joint Committee of CCGs employed by a CCG declare a collective financial interest in respect of the item relating to commissioning reform. The Chair acknowledged that the committee discussion to be held would be to receive an update on current work and endorse the next stage.**
4.	**Key Messages** **Phase 3 Letter -** Andrew Bennett advised that the since the meeting held on 2 July 2020, the imminent publication of the phase 3 letter was expected. The letter was published on 31 July 2020 and the month of August was used as a planning month to address the requirements within the letter. Andrew further advised that the phase 3 letter, therefore, framed a number of areas to be discussed later in the meeting. **RESOLVED: That the Joint Committee of CCGs note the key message.**

Sustainability	

5.	**COVID-19 Updates**
	(a) Phase 3 Planning Update – Carl Ashworth presented a summary in respect of the phase 3 recovery and the planning and expectations from August 2020 through to March 2021. He highlighted the following:
	• ICS submitted portfolio of draft plans on 1 September 2020:
	  • System activity, performance and workforce plan template
	  • Cancer service plan
	  • Mental health service plan
	  • Winter plan – system flow assessment
	• In addition, an explanatory narrative was submitted to provide an explanation of the key elements of the delivery plans that drive the patient activity and performance figures; to set out how key services will be restored inclusively to help address health inequalities; and outline key challenges, risks and mitigating actions for a group of high priority service areas. Carl advised that a copy of the narrative had been shared with the ICS Board and a summary of the key aspects of the submitted activity and performance plans were included within the report.
	• In respect of the timescales of the development of phase 3 plans, Carl advised that at the time of the submission of the draft templates, further work was required to test and finalise the ICS approach to safely restoring services whilst planning to meet the demands of winter and a potential surge in demand arising from COVID-19 infections. He informed members, therefore, that on that basis the plans were considered to be 70% complete at the time of submission to the regional team on 1 September 2020 and subsequent presentation to the ICS Board the previous day.
	• The report detailed what has been taken account of within the plans so far and what remained to be completed.
	• Work would continue to be undertaken on further iterations of the plans, taking into account regional and national feedback up to the point where final drafts would be shared with ICS system leaders for sign off on 16 September 2020 prior to submission to the regional team on 21 September 2020.
	• Reference was made to the 'Table of what's in/what's not' and of particular note, taking into account 111First and the impact on A&E.
	• Carl explained that in parallel to the work on the phase 3 templates, UEC colleagues were also developing winter plans that would take account of various escalation scenarios.
	• Carl advised that for the 1 September 2020 submission, in line with national and regional guidance, the ICS team worked with providers to ensure that the base case was reflected in the activity templates. There was accompanying narrative that identified the broad measures that will have to be taken as a system in order to maintain the activity estimates made in the base case. Yet to be undertaken were detailed assessments of the measures to ensure continued patient safety, and maintenance of elective services under the scenarios described above. This would be included in the final submissions to the regional team.
	• Information was provided which modelled the impact of the acute bed numbers under the base case and the more likely second wave scenario.
	• As part of the portfolio of the phase 3 plans, the ICS was asked to complete bespoke mental health planning templates that seek to provide assurance that the planned spend both meets the Mental Health Investment Standard (MHIS) and Long Term Plan (LTP) investment expectations. Carl explained that initial analysis showed that planned investment met the MHIS expectation but did not meet the LTP expectations and consequently the mental health planning submission would fail. It had been agreed that the planning submission would be amended to reflect the delivery of all the LTP expectations which equated to additional investment of

£5.7m (recognising that the implementation of the NTW recommendations has resulted in an investment above LTP expectations in some areas, eg crisis pathway). The additional investment would be the priority for the system resource as we move into the financial regime for the second half of the year.

- In respect of out of hospital service plans, the challenges, risks and mitigating actions being planned to ensure that all expectations could be met had been included in the plan however, at present the impact upon project activity and performance had not been included in the plans.
- With regard to the financial implications, Carl explained that the ICS approach to finance at the current time is to assume no financial constraints for the measures providers can take for achievable options to meet NHS objectives (other than achieving best value for money). He further advised that this approach enables the system to understand the real financial impact of meeting the required targets. Achievable options (constrained by availability of staff) may still not be sufficient to meet all national requirements and understanding the cost of schemes will enable them to be prioritised. Members were informed that once the system has received its financial envelope, a re-assessment of our ability can be undertaken to meet our targets in the event that we are unable to proceed with lower priority schemes for financial reasons. The report provided examples of the costs of schemes that are not already included in block payments.
- A system workshop would be held the following week to bring together hospital and out of hospital perspectives to focus on closing the gap.

Carl drew members' attention to the summary of key points within the report:

- Recovery plans are at an early stage and need further refinement before submission of final plans in September.
- Restoration of elective work is constricted by available capacity such that, even for the base case scenario, 52 week waits will increase significantly by year end, although potential impact of use of IS has yet to befully reflected in plans.
- Impact of digital and other system efficiency improvements have not been fully reflected in plans as yet.
- Full impact of winter and other OOH schemes has yet to be reflected, although recovery expectations on OOH services are already significant and some of the winter schemes come at a cost yet to be secured.
- Base case model predicts shortfall of over 700 beds if all last year's activity returns – with a second wave of COVID, this would rise to over 1,000 beds, requiring significant step up in alternative approaches to demand management out of hospital.
- There is lack of clarity on the financial envelope – some £84m of schemes have been identified to cope with a further wave of COVID demand over the winter period.
- Impact of social distancing and IPC requirements plus redeployment of staff deemed high risk, willreduce staffing capacity by between 15%- 20%. Given this impact, and current level of vacancies and current/projected sickness absence, it is unlikely that we will have sufficient workforce of support the full restoration of service as per the Phase 3 Planning guidance.

Discussion ensued as follows:

Doug Soper made reference to the restoration of elective activity and sought clarification as to whether there were problems with one or two hospitals or whether there was a consistent inability to achieve the targets that the Department has set. Carl advised that this is a common challenge across all hospitals however, the scale varies between providers. He further explained that there is a reduction in theatre capacity in all Trusts and with the impact of infection control procedures, there isn't a confidence to start and put in place significant levels of activity.

Carl advised that further consideration is being given to using Burnley, Chorley and Kendal hospitals more extensively as selective sites and also the potential utilisation of the independent sector. He anticipated further clarification on this position over the coming weeks.

Debbie Corcoran asked if there was a parallel communications strategy planned or in development so that patients understand the impact and access. Neil Greaves advised that this was currently being worked on collectively with colleagues across the region and is discussed at weekly calls with communication and engagement colleagues.

Dr Geoff Jolliffe provided two views regarding the escalating 52 week waits. Firstly as a commissioner, it is important that there is a plan to reduce and manage this as it is not acceptable for the public, although understandable. Secondly, from a clinician point of view, it seemed impossible to him under present circumstances to increase activity sufficiently unless it can be undertaken via demand management.

Lawrence Conway sought clarification as to where the district councils fit into the system. He was advised that district councils are actively engaged in each of the ICPs. Individual districts councils are also linked to the PCNs locally.

Kevin Toole asked if the Nightingale hospitals were referenced/included in the plans and Carl advised that they were working on the basis that that capacity was still available and still an opportunity. There still needed to be an awareness of this along with the opportunities for mutual aid across providers before potentially moving patients outside of the area. His understanding was that capacity will still be there until the end of the winter period.

David Bonson informed members that as part of the submission, a separate but related return was required as each A&E Delivery Board was required to complete and submit a local assurance template which would then be incorporated into a bigger template. He commented that there was an opportunity for sign off at the SLE meeting on 16 September 2020 as part of the whole planning return at that meeting.

Richard Robinson sought clarification as to who SLE is and how they link back to the process and to the governing bodies. Carl explained that the SLE is made up of Chief Executives of all Trusts, Accountable Officers of CCGs and Chief Executives of upper tier local authorities along with the ICS Executives.

The Chair stressed the importance that once the plans have been signed off by the SLE that the JCCCGs should have sight of them on a confidential basis. Carl advised that this was the intention and had been included in the recommendation to the committee. A final report would be submitted to the next meeting. Andrew Bennett further advised that the conversations with regional colleagues will continue to take place so it would be part of the next committee meeting agenda. **ACTION: CA/AB**

Graham Burgess commented that whilst he was comfortable to accept the special circumstances and that the decision on this occasion was being made outside of the usual governance processes, he stressed the importance of acknowledging that this was an exception rather than the rule. He went on to say that whilst he accepted the timescales and urgency and the type of decisions to be made whether the SLE was the appropriate way to make decision on bigger issues. It should not become common practice particularly in respect of items later in the agenda. Members concurred with the comments made.

RESOLVED: That the Joint Committee of CCGs:

- **Note the key points raised and the draft status of the 1 September 2020 submission of the phase 3 plans.**
- **Support the proposal that the SLE meeting on 16 September 2020 is the point of system sign off of final plans.**
- **Receive a final report on the phase 3 plans at the October meeting of the JCCCGs.**

(b) Temporary Service Change – Emily Kruger-Collier gave a presentation on the assurance processes around temporary service changes across the system during the COVID-19 pandemic. She advised that at the beginning of the pandemic there was a need to respond and make critical and prompt decisions regarding temporary service changes as recognised by NHSE/I. Early decisions were made across NHS organisations in line with the guidance and legislation they are governed by.

Emily further explained that as the pandemic and the NHS level 4 status was sustained for a five month period, and now continues at level 3, the need and likelihood of additional, or existing temporary changes continuing, remains high. This has brought about the need for an assurance process to be established. Fortnightly submissions, and impact assessments are required by NHSE/I of the significant changes and is co-ordinated across organisations within Lancashire and South Cumbria. These are managed through the Hospital and Out of Hospital Cells as part of their command and control role to maintain oversight and assurance.

Members were advised that due to the complexity and rigorous processes that would normally be applied to such service changes, legal advice was sought.

Assurance processes to protect organisations, and those impacted, have been developed to align with the guidance and requirements for significant temporary service changes.

Emily highlighted the significant service changes currently in scope for the Lancashire and South Cumbria-wide assurance. She advised that some services had been removed from the list as they had been restored. Emily confirmed that this is in addition to any local assurance processes in place.

Emily explained the proposed decisions, review and assessment process in respect of managing requests and reviewing temporary service changes and took members through the process flow. She also highlighted the assurance process which was adjoined to the review and assessment.

In respect of ICP lead roles and responsibilities, SLE members have identified leads from their respective ICP areas to support the assurance processes. They are the lead contact and oversee and co-ordinate temporary service change processes for the ICP area. They act as the gatekeeper for existing and any future proposed temporary service changes. They also support the development of temporary service change requests, and associated impact assessments for services and organisations across their respective area. The lead also contributes to Lancashire and South Cumbria-wide developments and reviews regarding temporary service changes.

With regard to permanent service changes, Emily explained that this is not within scope of this work and that there is an expectation from NHSE/I that **all** temporary service changes are to be restored. For any permanent service changes, the NHSE/I assurance process must be followed, as set out in the 'Planning, assuring, delivering service change' guidance. Members were advised that there is already a process in

	place through the ICS decision-making framework which would apply to any permanent service changes and incorporates the requirements of NHSE/I. Emily drew members' attention to the next steps and advised that: • Quarterly impact assessments of significant temporary service changes were being undertaken for completion by 1 September 2020. • The development of a mini Standard Operating Procedure (SOP) with the identified ICP representatives to reflect the central and local assurance and monitoring processes. • The next update to the JCCCGs was scheduled for the November meeting as part of the assurance process**.** **ACTION: EK-C** Geoff O'Donoghue made reference to the closure of Chorley and South Ribble Hospital A&E Critical Care within the list presented and sought clarification on Emily's involvement in that particular process. Emily explained that in respect of individual service changes, discussions are held with CCGs, providers and NHSE/I colleagues and the information captured throughout the temporary service change. Jane Cass explained that there is a clear and robust process that the ICS follows and assured members that quarterly impact assessments are undertaken for the services listed. Dr Sumantra Mukerji made reference to the patient impact assessment form and outcomes and sought clarification as to what steps had been taken in terms of patient impact. Emily advised that public and patient impact is a significant part of the impact assessment, they are reviewed by the cells and any queries or further messages to be put in place are fed back to the providers as part of the assurance role, including patient impact. She further explained that it is the provider responsibility to undertake the patient impact assessment and put in place the necessary provisions or mitigations prior to the service change being initiated. **RESOLVED: That members of the committee note the report.**

6.	**Finance Report** Elaine Collier spoke to a circulated report which reported on the month 4 financial performance for the L&SC system in the context of the current finance regime and the response to COVID-19. She advised that the report had been written for the ICS Board and included updates on capital, ICS central functions and the scheme of delegation, which were not relevant but may be of interest to the JCCCGs. The Chair asked that in order to avoid confusion in the future, that any recommendations within a report for another meeting should be removed and only those pertinent to the relevant meeting should be included. This was noted. As at month 4 organisations continued to claim top up payments to ensure they could report a monthly breakeven position. The report included a summary which showed that CCGs had claimed £68.3m at the end of July to top up their allocations for cost pressures incurred, including £34.6m of COVID-19 related costs. Trusts claimed £90m over and above their block payments and planned top up levels, for cost pressures incurred and income shortfalls including £72.7m of COVID-19 related costs. Elaine explained that the new finance guidance and financial envelope for the second half of the year was awaited however, it was anticipated that it would be received during September. She advised members that notification of a new elective incentive process had been received which took effect from 1 September 2020. In order to help accelerate the return to near-normal levels of non-COVID-19 health services and to

	make full use of the capacity available between now and winter, notification has also been received stating that with effect from September, block payments will flex to reflect expected elective activity levels. It was deemed that the resources provided through the nationally determined finance arrangements were sufficient to fund performance levels of 80% elective procedures in September, rising to 90% in October; and 100% of last year's outpatient attendances from September to March. However, the financial impact of this on the L&SC system had still to be worked through and would need to be reflected in future plans and financial forecasts. Doug Soper made reference to the 25% reduction in the block payments given on activity which could incur a financial problem. Elaine advised that this was likely to be the case however, further information was needed to calculate the impact. Paul Kingan made reference to the delegations section of the report and whilst it was not a decision for the JCCCGs, he sought clarification about whether this would apply to decisions made about allocating the financial envelope that the ICS will receive for the second half of the year. Elaine explained that this section related to the ICS central functions budgets only. **RESOLVED: That the Joint Committee of CCGs note the report.**

7.	**SEND – Post Inspection Report (Lancashire)**
	Julie Higgins reminded members of the committee of the Lancashire SEND inspection revisit which took place on 9-12 March 2020. The OFSTED and CQC inspectors found sufficient progress had been made in seven of the 12 areas however, insufficient progress had been made in five of the 12 areas. The five areas have significant implications for health, and the DfE/NHSE/I are now to oversee an Accelerated Progress Plan that will deliver the required improvements over the next 12 months from 1 October 2020.
	
	Members were advised that although the revisit was conducted in March, the publication of the letter was delayed due to COVID-19, and was published on 5 August 2020.
	
	Hilary Fordham reminded members that Morecambe Bay CCG has a lead role for SEND across the ICS. She was reporting on the Lancashire county inspection report and it was noted that the other three upper tier authorities had previously been inspected. She stressed the importance of this being for the whole of the ICS and not just Lancashire and that there was a learning for everybody within the ICS.
	
	Hilary took members through the presentation and highlighted the following:
	
	• Sufficient progress had been made in the following seven areas:
	  • Strategic leadership and vision across the partnership
	  • Effective engagement with parents and carers
	  • Systems and processes of identification
	  • Quality of education, health and care plans
	  • Strategy to improve outcomes of children and young people with SEND
	  • Proportion of children and young people with EHC plans permanently excluded from school
	  • Inequalities in provision based on location
	
	Carl Ashworth left the meeting. Peter Tinson joined the meeting.
	
	• Insufficient progress made in the following five areas:
	  • Leaders understanding of the local area

- Weak joint commissioning arrangements that are not well developed or evaluated
- Absence of effective diagnostic pathways for autism spectrum disorders (ASD) across the local area
- Poor transition arrangements in 0-25 healthcare services
- Inaccessible Local Offer, and the quality of information published is poor

Hilary pointed out that the within the report, the inspectors did recognise that significant work had taken place however, there was more to do.

In respect of the CCG commissioning priorities, Hilary made reference to the ongoing strengthening of joint commissioning arrangements and in particular, highlighted to committee members the possible financial impact which may need to be revisited with a view to seeking support from all of the CCGs.

In respect of the ASD pathway, the plan will last for a year and there needs to be a commitment to this.

With regard to the transition arrangements in 0–25 healthcare services, whilst these services are commissioned, it appears to sit with paediatric services and there is often no corresponding service provision for adults. Hilary stressed the importance of ensure there is a process for supporting families through that process.

The other CCG commissioning priority related to health contributions to the Local Offer website.

Linking to the CCG commissioning priorities, Hilary drew members' attention to the health provider priorities.

Hilary took members through the next steps with DfE and NHSE/I in respect of the timelines and governance processes.

- Final report was published on the OFSTED website – 5 August 2020
- Communicated with all partners and media – 5 August 2020
- Submission of Accelerated Progress Plan to DfE and NHSE/I for outstanding action – 30 September 2020
- Establishment of a H&WB sub-committee for local scrutiny
- Monitoring by DfE and NHSE/I for the five areas where insufficient progress has been made – at six and 12 months
- For all other areas of ongoing improvement, a broader improvement plan to be developed, agreed and monitored by the SEND Partnership Board.

Hilary informed members that the JCCCGs was asked to nominate two Non-Executive members to join the sub-committee alongside the LCC Cabinet members for Health and Wellbeing and Children and Young People. It was suggested that they be drawn from the Fylde Coast and Central Lancashire which would give coverage at Governing Body level across the ICS (Pennine Lancashire and Morecambe Bay already being covered by the lead Accountable Officer and Lead Director respectively). Kevin Toole put his name forward on behalf of the Fylde Coast CCGs and the committee Chair, Roy Fisher, was comfortable with the proposal. In respect of Central Lancashire, this would be taken outside of the meeting and fed back to Andrew Bennett who would then inform Hilary accordingly. **ACTION: AB/HF (√)**

Committee members were advised that the SEND partnership will discuss the broader and wider plan at the next meeting to ensure the journey is followed through.

	Sarah Callaghan highlighted to members that we have as a local area 12 areas of action which is very unusual (typically only around five areas normally). She commented on the level of work that had been undertaken since November 2017 and since the inspection is phenomenal which is the word the inspectors used in their findings. Sarah further explained that although it was disappointing that not all 12 areas had made significant progress, the infrastructure was not in place originally and a tremendous amount of work has taken place to build on the relationships and put processes in place in order to work collaboratively. She finally commented that although there was a way to go, the feedback was that the ambition is there which was clearly evident and also evident from parents and carers. Julie Higgins reinforced both points made commenting that there is a really good leadership and delivery team around this and it has taken time to be built up. There were also extra pressures due to COVID-19 in family situations and it was important to focus on this as it does make a big difference in ensuring the services are right. **RESOLVED: That the Joint Committee of CCGs:** • **Note the positive improvements highlighted by OFSTED and the CQC.** • **Note the position regarding the continuing areas of significant concern where insufficient progress was made.** • **Support the priorities for delivery under the Accelerated Progress Plan for Lancashire, including recognition of the need to implement waiting list recovery plans for ASD across the whole ICS.** • **Note that two Non-Executive members would join the sub-committee of the Health and Wellbeing Board which will undertake the monitoring of the Accelerated Progress Plan. Kevin Toole would represent the Fylde Coast and the representative from Central Lancashire would be advised outside of the meeting.**
8.	**Mental Health Investment Position** Peter Tinson took members through the report relating to phase 3 mental health planning guidance for 2020/21 which was published alongside the *'Third phase of the NHS response to COVID-19'* correspondence received on 31 July 2020. Peter highlighted the key points from the guidance and informed members that there is a requirement to submit a number of bespoke mental health planning templates in accordance with the overarching phase 3 national planning timeline. He explained that the templates seek to provide assurance that the planned spend both meet the Mental Health Investment Standard (MHIS) and Long Term Plan (LTP) investment expectations. He commented that whilst Lancashire and South Cumbria CCGs investment meets the MHIS expectation, it does not meet the LTP expectations and consequently the mental health planning submission would fail. Peter drew members' attention to a table within the report which was a comparison of LTP expectations, planned investment and variance. Peter informed members that over the last few weeks, the national mental health and finance leads have been increasingly clear about the MHIS and LTP expectations and the consequences of them not being met, including regulatory interventions. He further explained that the LTP expectations, planned investments and variance should also be considered within the context of an historic underinvestment in mental health services when compared to recognised national benchmarks.

	Members were informed that the position was recently discussed by a number of Lancashire and South Cumbria ICS executives, CCG mental health lead commissioners and Lancashire and South Cumbria NHS Foundation Trust executives who agreed that the planning submission would be amended to reflect the delivery of all the LTP expectations and a paper prepared for the JCCCGs consideration. Peter explained that it effectively equated to additional investment of £5.7m and CCGs were being asked to support this investment. It was recognised that the implementation of the Urgent Mental Health Pathway recommendations has resulted in an investment above LTP expectations in some areas, eg crisis pathway. Peter informed members that a set of investment principles had been drawn up with CCG mental health lead commissioners and colleagues from Lancashire and South Cumbria NHS Foundation Trust. CCGs were asked to support the principles contained within the report. Paul Kingan made reference to the priorities from allocations for the second half of the year and sought clarification as to whether they would potentially reduce investment in other areas such as cancer services and whether it would be a pass over of money to providers or would CCGs have control as to how the money is to be spent. Peter acknowledged the first point made commenting that it would reduce the overall resource. He explained that the idea behind the principles is to ensure that the investment is effectively targeted across appropriate providers. Peter provided an example of where services could be mobilised very quickly. He further commented that it would be an 'open book' approach as to how the resource is used. Andrew Bennett commented that there is a very strong national leadership of this agenda and a clear expectation that the money does buy extra services for communities with rising demand. **RESOLVED: That the Joint Committee of CCGs:** • **Support the investment of an additional £5.7m to meet these expectations.** • **Support the principle that the investment is the top priority for the system resource as we enter into the financial regime for the second half of the year.** • **CCGs supported the investment principles which will be progressed by CCG lead mental health commissioners with Lancashire and South Cumbria NHS Foundation Trust and other provider colleagues and with CCG Chief Finance Officers' support.** *Peter Tinson left the meeting.*
9.	**JCCCGs' Work Programme Update** Andrew Bennett reminded members that the previous formal meeting of the committee which was held in March was prior to the COVID-19 pandemic. At that meeting, the committee agreed the work programme and had resubmitted it to CCG Governing Bodies. Due to the pandemic and the associated pause, the work within the programme had been severely affected. Andrew informed members that the intention was to go back out to leads to ask what their reasonable expectations are for the committee to consider for the remainder of the financial year. **ACTION: AB**

	RESOLVED: That the Joint Committee of CCGs receive the update and note the work to be undertaken to review and address the areas within the committee's work programme.
10.	**Report from the Commissioning Reform Group (CRG)** Andrew Bennett informed members that the purpose of the report was to provide the committee with an update of the business discussed by the Commissioning Reform Group (CRG) during its meetings in July and August 2020. Committee members were advised that the report asked them to note that a number of further actions would be taken with oversight from the CRG. Andrew made reference to the phase 3 letter/guidance and the expectations in respect of system reform. He also made reference to the letter issued by the Regional Director, Bill McCarthy, to system leaders with a request that an ICS implementation plan on system reform be drawn up for submission to the Regional Director by the start of October. Andrew explained that the plan would need to be agreed over the next month. He also emphasised the useful dialogue that had taken place with ICP Programme Directors who have offered to create a common narrative to support ICP development – this offer has been supported in principle by the CRG. Andrew identified a number of next steps that the CRG will need to take which included reviewing progress on the actions set out within the report. He advised members that it was imperative that a refreshed programme and timeline be developed by the CRG in which the key actions and decision points related to commissioning reform are identified. These would be incorporated within the wider system reform plan required by the ICS. Graham Burgess made reference to the workshop being arranged by the Commissioning Support Unit (CSU) to produce proposals for consolidated quality and performance reporting for consideration by the Joint Committee of CCGs. He expressed concern about the CSU convening the workshops as there would potentially be a conflict of interest if colleagues from the CSU are involved in providing advice and also taking views. It might be perceived that if the CSU is leading the process, it may result in them securing further work and Graham asked how it could be phased. Andrew advised that the workshop would be organised by the ICS and CSU colleagues would be invited to participate. Graham pointed out the nuance of driving the work programme but they could also benefit from the work programme. The Chair commented that the same issue had been raised at the CRG meeting and it was suggested that the workshop could take place as a recommendation from the CRG on behalf of the CCGs and manage the conflicts of interests. Committee members were comfortable with this approach. **RESOLVED: That the Joint Committee of CCGs:** • **Note the report from the Commissioning Reform Group** • **Note that a workshop would be arranged by the ICS, as recommended by the Commissioning Reform Group on behalf of the CCGs to produce proposals for consolidated quality and performance reporting for consideration by the Joint Committee of CCGs. Also noting the management of conflicts of interest in respect of the Commissioning Support Unit's involvement.** • **Note that the Commissioning Reform Group will prepare further implementation plans about other functions which can be consolidated.**

	• **Note the actions being taken by ICP Programme Directors to develop a narrative and timeline for the further development of Integrated Care Partnerships in the wider context of system reform.** ***Dr Amanda Doyle arrived at the meeting.***

For Information	
11.	**Minutes of the Commissioning Reform Group – 14 July 2020** **RESOLVED: That the Joint Committee of CCGs receive the minutes of the meeting.**
12.	**COVID-19 Cell Logs:** **(a) Hospital** **(b) Out of Hospital** **(c) Joint Cell Logs** Members were advised the cell logs were provided for information in order that committee members had sight of the decisions being made. Doug Soper commented that whilst he appreciated the sharing of the information, there was a statement on the logs that they were confidential and should not be shared. This would need to be taken into consideration particularly as the meeting papers, although a virtual Part I meeting, were available on the website. This was noted and would be actioned accordingly. **ACTION: AB/NG (√)** Clarification was sought in respect of decisions made and whether they were undertaken as a majority or a vote and whether there were conflicts of interest or, whether they were they still being worked up. Dr Amanda Doyle advised that the cells were set up to deliver mandated actions from NHSE/I who had asked that certain areas be delivered on the footprint of Lancashire and South Cumbria rather than a CCG decision on something new. She further advised that there are spending commitments and ultimately, the lead of the cell reports directly to Bill McCarthy. Decisions are, therefore, made on behalf of NHSE/I. **RESOLVED: That the Joint Committee of CCGs note the cell logs and receive the update.**

Any Other Business	
13.	**Any Other Business** There were no issues.

Date, Time and Venue of Next Meeting
The next Formal meeting would be held on Thursday, 5 November 2020 at 1.00pm-3.00pm via Microsoft Teams videoconference.