Healthier Lancashire & South Cumbria

Formal Joint Committee of CCGs
Thursday 03 September 2020 13:00-14:30 - MS Teams Teleconference
Agenda

Item	Description	Owner	Action	Format
Routine Items of Business				
1.	Welcome, Introductions and Apologies	Chair	Note	Verbal
2.	Minutes of Previous Meeting and Actions	Chair	Approve	Attached
3.	Declarations of Interest	Chair	Note	Verbal
4.	Key Messages	Dr Amanda Doyle	Note	Verbal
Sustainability				
5.	Covid-19 Updates (a) Phase 3 planning update (b) Temporary Service Change	 Carl Ashworth Emily Kruger	 Discuss Note	 Presentation Presentation
6.	Finance Report	Elaine Collier	Discuss	Attached
7.	SEND – post inspection report (Lancashire)	Julie Higgins/ Hilary Fordham	Discuss	Attached
8.	Mental Health Investment position	Peter Tinson	Approve	Attached
9.	JCCCGs Work Programme Update	Andrew Bennett	Note	Verbal
10.	Report from the Commissioning Reform Group	Andrew Bennett	Approve	Attached
For Information				
11.	Minutes from the Commissioning Reform Group • 14 July 2020	Andrew Bennett	Note	Attached
12.	COVID-19 Cell Logs a. Hospital b. Out of hospital c. Joint cell logs	Dr Amanda Doyle	Note	Attached
Any Other Business				
13.	Any Other Business	Chair		

Date and Time of the Next Joint Committee:
Thursday 01 October 2020, 13:00-15:00, MS Teams

Minutes of the Joint Committee of Clinical Commissioning Groups (JCCCGs)
Thursday 02 July 2020, 13:00-15:00
Microsoft Teams Teleconference

Present		
Roy Fisher	Vice Chair Chair	JCCCG Blackpool CCG
Graham Burgess	Lay Chair	Blackburn and Darwen CCG
Lindsey Dickinson	Clinical Chair	Chorley and South Ribble CCG
Geoff Jolliffe	Clinical Chair	Morecambe Bay CCG
Denis Gizzi	Chief Officer	Central Lancashire CCG
Debbie Corcoran	Lay Member	Central Lancashire CCG
Jerry Hawker	Chief Officer	Morecambe Bay CCG
Paul Kingan	Chief Finance Officer	West Lancashire CCG
Sumantra Mukerji	Clinical Chair	Greater Preston CCG
Geoff O'Donoghue	Lay Member	Greater Preston CCG
Doug Soper	Lay Member	West Lancashire CCG
Adam Janjua	GP and Chair	Fylde and Wyre CCG
Julie Higgins	Chief Officer	East Lancashire CCG
Neil Jack	Chief Executive	Blackpool Council
David Bonson	Chief Operating Officer	Fylde Coast CCGs
In Attendance		
Jane Cass	Locality Director	NHS England and Improvement
Jackie Hanson	Director of Nursing	NHS England and Improvement
Amanda Doyle	Chief Officer	Lancashire & South Cumbria ICS
Neil Greaves	Head of Communications and Engagement	Lancashire and South Cumbria ICS
Sue Stevenson	Chief Operating Officer	Healthwatch Cumbria
Gary Raphael	Executive Lead for Finance and Investment	Lancashire and South Cumbria ICS
Andy Curran	Medical Director	Lancashire and South Cumbria ICS
Carl Ashworth	Director of Strategy and Policy	Lancashire and South Cumbria ICS
Rebecca Higgs	Business Support to Dr A Doyle	Lancashire and South Cumbria ICS
Rachel Pickford	Corporate Business Manager	Lancashire and South Cumbria ICS

Standing Items	
1.	**Welcome, Introductions and Apologies** Chair Roy Fisher welcomed members to the Joint Committee of CCGs (JCCCGs) held virtually via Microsoft Teams. Apologies were received from Andrew Bibby, Louise Taylor, Gary Hall, Lawrence Conway and Katherine Fairclough.
2.	**Minutes of the Previous Meeting Held on 4 June 2020 and Matters Arising** The minutes of the previous meeting held on 4 June 2020 were reviewed. Geoff Jolliffe was not present at the previous meeting however in the apologies section he pointed out his name had been spelt with a double 'e'. Richard Robinson is also documented as being a 'Lay Member'. Adam Janjua requested that 'Acting' is removed from his title of Acting Chair. These amendments will be made to the draft minutes which were otherwise agreed as a true and accurate record. The matters arising log was reviewed. With regards to the work programme going through each CCG Governing Body, this has now been completed and the programme has been approved subject to current arrangements. Some queries have been received from Julie Higgins which is being worked through with Andrew Bennett. The second action pertaining to the circulation of shared integrated partnership material has been completed. The third action about reconvening a meeting between AOs and ICP Programme Directors to connect work with the wider commissioning Agenda is taking place this afternoon. This action is also now closed.

3.	**Declaration of Interests** All members of the Committee declared a financial interest in the agenda. It was acknowledged by the Chair that no formal decisions are requested or planned for the meeting. The LSC system will continue to work differently in a pandemic environment for some time to come. Members recognised that the JCCCGs will therefore discuss the implications in the way the system operates. No other interests were declared.
4.	**Key Messages** • **Update on Phase 3 planning guidance** • **Regional Framework for Phase 3** Dr Amanda Doyle advised members that phase 3 planning guidance is still awaited and that a formal letter is expected to be received in approximately 1 week. Gary Raphael advised members that for phase 2, bids in response to Infection Prevention and Control (IPC) will be submitted this Friday for things that do not increase capacity. There is also a submission due next Wednesday for all the things that do increase capacity. Phase 2 is due to finish at the end of August 2020. Members will be briefed in relation to capital bids later in the agenda. Dr Amanda Doyle advised that the phases are determined by levels of the COVID-19 pandemic and that different parts of the country will be in different phases at different times.
Sustainability	
5.	**COVID-19 Updates** • **Summary Briefing from the Two Cells** Dr Amanda Doyle provided an introduction to the summary from the two cells. The PowerPoint slides were assumed read and Dr Amanda Doyle advised members that the update comprised multiple items including detailed information regarding the planning submission to the region from the system, follow on work required about capacity planning and pathway work required as a result, updates on testing and actions taken around nosocomial infections. There would also be a focus on health inequalities and constitutional target performance. Gary Raphael reminded members that planning and follow on work was in progress at the time of the last Joint Committee of CCGs and he described the outcome from all the work undertaken up until 16 June 2020. Gary drew members' attention to a table in the slide deck on capital requirements totalling £175.5m and provided a summary of work undertaken in the acute Trusts, mental health and primary care to assess the bids required to be able to respond to the consequences of COVID-19. £49m will be required to comply with IPC and there will be a need to plan for more capacity. Seating in the Emergency Departments will need to be considered to accommodate patients. Potential revenue consequences of all capital schemes will need to be understood. £22m will be required for Seacole Units, £14.2m will be needed in extra staffing cost in critical care and the outcome of planning means specific asks around capital are required with advice to region on costs in revenue terms. Detailed forms are being completed for the region to outline the detail behind the £175.5m. Gary reiterated information about the submission on Friday around IPC compliance and around next Wednesday's submission whereby each scheme will need to be described. All information will provide a basis for determining the best way to respond to COVID-19. Paul Kingan queried how realistic the figures are. Gary advised that this is not the usual process of knowing what may be available. NHS England and Improvement are gathering the necessary intelligence for the Treasury to take a view on what will be required this year and needs to be in place by January 2021 or preferably earlier. The ICS is not being encouraged to submit anything that needs to be implemented before

	this time. Dr Amanda Doyle advised cells are being asked to develop plans for some of this work. Discussions are being held with the region around what needs to be delivered ensuring costs are realistic. Currently plans are not affordable within the allocations the ICS is expected to receive. Geoff Jolliffe suggested this may be an opportunity to develop whole system capacity and recommended engaging GPs. Dr Amanda Doyle advised that significant capacity will need to be planned for winter as a second wave of COVID-19 is expected with some Business As Usual (BAU) running in parallel and factoring in IPC requirements. Digital advances need to be retained as this will 'slicken' ways of working and will assist in tackling waiting lists. Dr Amanda Doyle provided some reassurance in that the system capacity plan cuts across a whole range of cells for input including GPs and hospital clinicians from ever part of the patch. Graham Burgess discussed timescales for response and queried which programmes need to be delivered quickly. Gary Raphael confirmed there is currently no timescale for the response however prioritisation would be covered in the finance section of the agenda. David Bonson pointed out the focus on beds and that community providers have been focusing on Home first and how community provision can be maximised across the system. The ask from NHS England and Improvement was to focus on beds at this point in time for the plan and primary and community care also have a large part to play. Carl Ashworth reiterated the main points picked up through the conversation with Geoff Jolliffe around system planning and reinforcing the way in which demand can be diverted away from bed based care is crucial in advance of winter. Work is being undertaken with ICPs to look at high volume, low risk pathways so that demand can be managed appropriately outside of hospital. Implementation is anticipated by September 2020 including demand in relation to respiratory and associated pathways. Dr Amanda Doyle relayed to members the current position on testing. Doug Soper queried the figures for cases in terms of pillar 2 not being recorded and asked if figures are obtainable. Dr Amanda Doyle advised figures are not currently accessible however provided assurances that the Local Resilience Forum (LRF) are working hard on this. Advice is being provided to the general public to stay at home and do not test if symptoms have occurred over 2 months. Figures are currently providing an indication of trend rather than actual numbers. Geoff Jolliffe referred to page 32, waiting lists by speciality in April 200 and pointed out that the figure has worsened since then which will result in issues for patients and how the ICS engages with them. Dr Amanda Doyle advised members that the capacity to deliver some of the interventions is significantly reduced meaning that only urgent cases can be carried out. Endoscopy procedures for example are aerosol generating procedures and require full Personal Protective Equipment (PPE). There are also issues with patients not wanting to attend hospital due to the risk of catching COVID-19. Some work is being carried out to improve messaging and manage expectations and symptoms whilst patients are waiting. Sue Smith advised colleagues that scenario setting is being undertaken in Cumbria which may help to alleviate some concerns. David Bonson referred to slide 33 and queried why Lancashire has higher prevalence than other parts of the North West and nationally. Gary Raphael explained there is a large focus on 52 week waits nationally as well as diagnostics which is not out of line with Cheshire and Merseyside and Greater Manchester. The waiting list is increasing

	and a new Elective Care Group has been established to look at this and comprises representation from the out of hospital cell.
6.	**Finance Report** Gary Raphael advised members about the finance reports that were written for the ICS Board with a view to this coming to the Joint Committee of CCGs. On the second report, item 6b, the JCCCG is not being asked to approve the recommendations, rather to note the recommendations. Item 6a reports the significant capital asks and informing region about revenue consequences. It is not anticipated that the ICS will receive everything asked for and a prioritisation process is being initiated. Colleagues were apprised about the process being undertaken and were provided with some background on what is happening in relation to capital. Once all bids had been submitted by relevant organisations including primary care providers and mental health services, these were summarised and ICPs were asked to undertake a level of prioritisation. Trusts have already prioritised their bids and a system financial view has been considered by Directors of Finance and the Finance and Investment Group (FIG) who have made recommendations to the ICS Investment Committee. Following this third level technical review, recommendations will then be made to the ICS Board to emphasise everything submitted as a system in terms of what is needed. If the ICS only gets a proportionate share, it has been agreed that the ICS will recommend prioritising rather than the region doing this. The infrastructure is not as well developed as other parts of the North West therefore the ICS intends to lobby the region for a disproportionate share of regional capital resources. Colleagues are working on data to support these claims. A request has also been made for the rapid notification of capital availability for preparedness purposes. To summarise, the prioritisation process will continue through the ICS Investment Committee and will involve co-opting clinical colleagues from primary and secondary care to ensure this is correct. In terms of revenue, the system is seeking to get to grips with this with CCGs and Trusts. This report highlights the revenue consequences of capital schemes. A wider piece of work is being led by Elaine Collier as the shape of finances is changing. The amount of spending on Trusts has been nationally set with consequences for the remainder of budgets. The format of the report shows the impact of all changes that need to be tackled in year and next year and emphasis will be on how the system recovers finances next year; this is something that must be started from now. From August 2020 a round of meetings will be held to gather the picture from both Trusts and CCGs in terms of their financial position. Roy Fisher discussed £43m being claimed by Trusts over and above block payments. Gary advised that this is mainly due to revenue costs and this figure is extrapolated to the end of the year until ICSs are provided with a block sum. Escalating costs are also considered when setting control totals and it is necessary to look at trends in spending patterns. Jerry Hawker discussed the risks of revenue expenditure and highlighted the importance of collectively managing risk in a way the finances are working, for example considering the impact as a result of QOF payments not being taken into account when setting budget levels. A further revenue report will be brought to the next JCCCG meeting. Paul Kingan raised concerns around lines of responsibility and accountability and

	recommended further clarification around the governance and decision making framework in light of the new cell structure to better prepare for COVID-19 response. A decision tree will be released in the next couple of weeks alongside the governance. Gary pointed out the changing landscape and reiterated from previous discussions that CCGs' expenditure is committed and a better understanding of this would be beneficial to inform the way in which the ICS operates for the remainder of the year. The papers were noted.
7.	**Resources for Quality Improvement and Nursing Leadership** Jackie Hanson shared some PowerPoint slides to brief the JCCCG on work started across Lancashire and South Cumbria reviewing CCG nursing and quality resources and options for further collaborative working in the future. Building on strong collaborative working in relation to safeguarding and Continuing Healthcare (CHC) has become clearer over the last few months and in view of COVID-19, there are vacancies and gaps in nursing and quality teams in CCGs. Time needs to be taken to strengthen collaborative working and thought needs to be given to how all CCGs move forwards in relation to quality assurance and how this is reported into the hospital and out of hospital cell structures. The slides outline the next steps including resource mapping across all CCGs including Commissioning Support Unit (CSU) resources to identify key areas where there are gaps and issues and to get an understanding for the short and long term. This will involve consolidating and streamlining functions of CCGs going forwards and a range of options will be brought back to the JCCCG for further consideration. Jerry Hawker advised members about a conversation recently held around workload on nursing and quality teams due to their involvement in IPC, testing and other areas during COVID-19. Jerry provided a couple of observations including separating what needs to be carried out in the short term in relation to COVID-19 as opposed to what might be sensible ways of working differently. Secondly Jerry reminded colleagues that there are number of Chief Nurse roles that currently fall outside of the remit of the Executive Team which will need managing carefully. Dr Amanda Doyle described the importance of understanding nursing and quality from a capacity leadership perspective, recognising that providers are busy introducing changes to the way in which they work to deal with the maximum number of patients safely. Consideration is being given to pooled waiting lists for elective patients and cancer patients to ensure diagnostics can be carried out more quickly. The system is moving from a place based approach to working jointly across the system which highlights the importance of collaborative working. Roy Fisher raised a concern on behalf of CCG Chairs in terms of patients in deprived areas and those moving to hospitals outside of the area and issues around transport. Dr Amanda Doyle acknowledged this and advised members that the ICS will need to ensure plans take into account these issues, also recognising that the impact of COVID-19 is expected to worsen health inequalities. The ICS is not currently in a position to provide guarantees around this; however this subject is under discussion. Gary Raphael also recommended ensuring that equitable access to Trusts for procedures and treatment is considered going forwards. Doug Soper acknowledged this principle and also highlighted the complexity of putting this in place. He described this would be essential for life threatening cases, however pointed out the risks of doing this for elective activity in terms of patients who do not attend. Doug recommended starting something on a smaller scale. Dr Amanda Doyle advised that the hospital cell is leading on this piece of work and it has been suggested that 2 specialities are tested

	to be begin with. The paper received today was noted.
8.	**Extension of NHS 111 Contract** David Bonson discussed 999, 111 and PTS decisions forming part of the JCCCG work plan as the service move towards becoming more integrated. The current 111 contract was due to end in September 2020. The intention was to align 111 and 999 services for efficiencies and for effectiveness for which a service specification was due to be agreed in May/June 2020. This has been delayed due to COVID-19. During this time a clinical system to support 111 services has needed replacing and the lease of Middlebrook has also needed renewing. A business case was developed to support North West Ambulance Service (NWAS) and security to deal with the COVID-19 response. Action has since been taken to agree an extension to the contract at the end of September 2020 and a number of leads in key areas are working with NHS England and Improvement. If during the extension the service specification is agreed, it will be possible to move to a new specification providing a 3 year extension with additional costs to NWAS to provide 111 services plus some additional resources to achieve standards. There will be a non-recurrent commitment and an annual non-recurrent commitment. Any costs up to that value can be considered in a transparent way. This paper was brought to the JCCCG to apprise members of the action being taken. Jerry Hawker flagged up a wider financial concern about inconsistency in the way the NHS is now operating. A process and commitment for additional investment was undertaken for 2020-21followed by a period of 'lockdown' due to COVID-19. Jerry reminded members about a number of other areas across the community, primary and secondary care that have already been committed to which are currently frozen. Jerry urged a transparent process will be required to make a fair assessment about non-COVID-19 related costs for 2020-21. Dr Amanda Doyle advised members that Bill McCarthy has outlined resource commitment for COVID-19 and non COVID-19 related costs will be subject to the cells. Ambulance services were clarified specifically with NHS England and Improvement due to related issues that fall out of the remit of the cells. A specialist cell has been set up for ambulance and 111 services with regional oversight who will oversee any issues and commitment to resources. Gary advised members that the format for future reporting on a system basis will ensure any issues are highlighted. Prioritisation will enable the ICS to map and influence where governance needs to be applied at various levels and a forecast will need to detail what will happen by 1 April 2021-22. Roy Fisher advised a number of CCGs had planned to invest monies this year and these have now been removed. Jerry reiterated the importance of a process by which the ICS works through the risks of not investing and prioritising one investment over another. Dr Amanda Doyle advised that not all of the investment described will be stopped, for example mental health and learning disabilities will receive additional investment not solely directed to CCGs but being dealt with at system level. There is also national and regional focus around how population health management and health inequalities are addressed for example. Doug Soper reinforced Gary's point about clarifying governance and systems and requested copies of minutes from the cells so the JCCCG is sighted on these. Members were in agreement with this point. A report will brought back to future JCCCG meetings. Dr Amanda Doyle advised that the JCCCG has oversight of commissioning decisions that are being made throughout the governance arrangements. Those decisions are technically made by NHS England and Improvement through the cells. Doug Soper

	requested a written process that can be circulated for distribution to CCGs. Gary advised members that Elaine Collier is working with all organisations to determine commonalities for system accountability. The ICS is currently exploring how COVID-19 has changed the way things are done. In terms of a Level 4 incident, Jane Cass reiterated NHS England and Improvement take control of the finances; ensuring systems are integral to the leadership of the cells led by Dr Amanda Doyle and Kevin McGee. Doug Soper outlined the implications of not documenting decisions should these be subject to audit and recommended clear processes and lines of reporting as a protection mechanism. Dr Amanda Doyle advised members that an informal discussion is being held with KPMG next week to get their perspective and a report will be brought back to the next meeting. Doug explained it would also be useful to gather auditor recommendations around best practice. Jerry Hawker supported the need for a process as a public accountable body whether as a system or through individual organisations. The CCGs have always balanced investment versus available resources and there still remain concerns around the transparency of legacy costs. Jerry recommended a report to the JCCCG on allocations for next year so members are apprised of what is expected.
9.	**Next Steps for System Development** Dr Amanda Doyle presented a paper on the next steps for system development in Andrew Bennett's absence. This update was provided following a meeting with ICP and CCG Chairs. Members were also reminded about the letters sent by Bill McCarthy about system governance and decision making and how Dr Amanda Doyle intended to approach this locally as per her letter sent to CCGs last week. The letter received in response to this from CCG Chairs indicates a general sense of unhappiness and lack of clarity around the way things are working. Members received an appended list of managers and clinicians who are involved in the cells and sub-cells. Further to Andrew's discussion with ICP and CCG Chairs a proposal has been made to reinstate the Commissioning Reform Group (CRG). This group was overseeing the process and move towards a CCG merger and was postponed on the advice from NHS England and Improvement to delay this non-essential work due to COVID-19. Following discussions the Centre would be amenable to the ICS reinstating some of this work if possible and whilst being mindful of adding to workloads in the current climate, it has been agreed to re-start the CRG to work through some of the concerns and issues. Roy Fisher emphasised the need for participation and supported the reinstating of CRG. Jane Cass reiterated that nationally from the Centre discussions have been reinitiated for those systems who feel they are able to pursue and progress towards commissioning reform and CCG mergers. With regards to the role and development of a local infrastructure, the development and strengthening of ICPs can be considered as part of commissioning reform and Jane recommended focusing on the development of ICPs to support discussions. Graham Burgess supported the reintroduction of CRG however highlighted the risk of talking about 1 CCG under the current climate as this may distract from other issues at present. Clear governance, transparency and communication around a new structure

	were recommended. Denis Gizzi reiterated points made about reforming the way in which the system works and that CRG would support how this is managed. Denis recommended taking learning from the last 2-3 months forward as part of discussions. Geoff Jolliffe commended the efforts, integrity and ambition taking place at cell level and described concerns being more around connectivity. Geoff described a variety of ways to communicate with GPs and also the sense of disconnect which was not happening prior to COVID-19. There are concerns being raised in primary care about capacity planning which will require some planning support on different ways of working. Geoff also advised the JCCCG that Lay Members are feeling very disconnected and have the capacity to help reintroduce some check and balance. Jerry Hawker raised a risk around losing the narrative between command and control and ambition as an ICS. A set of commitment towards integrated care, placed based care and neighbourhoods is a particular area of concern. Jerry recommended improving the narrative for the short term and the long term. Feedback is being received from staff who are feeling undermined and insure about their future because of language used around CCGs. Jerry emphasised the importance of people and their job roles being more important than an organisation itself. Jerry supported Denis' comment on system working and roles in order to protect people. Dr Amanda Doyle reminded colleagues that the ICS must improve and reduce health inequalities and clinical care within the resources available. Dr Amanda Doyle recommended being realistic about what can be managed within certain timescales recognising that a connection must be made with members as appropriate. Dr Amanda Doyle recognised that the future will look very different and advised a narrative to inform staff and how they can be skilled up. Doug Soper queried representation on CRG from West Lancashire. Roy Fisher advised a Terms of Reference (ToR) is available for the group and Dr Amanda Doyle agreed the importance of having representation from every economy if those representatives agree to do it. Jane Cass referred back to a sense of purpose for staff and drew members' attention to investing time in outlining next steps so staff can find their place at an ICP or ICS level.
Any Other Business	
10.	**Any Other Business** The Commissioning Reform Group (CRG) is taking place on 14 July 2020. This group is not a decision making body therefore it will report into the Joint Committee of CCGs. A discussion will be held outside of the meeting to decide who will Chair the first meeting as Roy Fisher is not available. The next Joint Committee of CCGs will take place on 3 September 2020.
Date and time of next meeting: Thursday 03 September, 13:00-15:00, MS Teams Meeting Dates of Future Meetings: 01 October 2020	

Healthier Lancashire & South Cumbria

Joint Committee of CCGs - Matters Arising Log

Item Code	Title	Responsible Lead	Status	Due Date	Progress Update
JCCCG200702-06	A revenue report to be brought to the next JCCCG meeting	Gary Raphael	Completed	03.09.2020	A finance report is on the JCCCG Agenda on 03.09.2020.
JCCCG200702-07	An options appraisal for quality improvement and nursing leadership resourcing across Lancashire and South Cumbria to be brought to a future JCCCG meeting for further consideration	Jackie Hanson	In progress	01.10.2020	In progress.
JCCCG200702-08	Cell reports to be brought to future JCCCG meetings	Andrew Bennett	Completed	03.09.2020	This is now a standing item on the JCCCG Agenda starting 03.09.2020.
JCCCG200702-08	Protection mechanisms to be put in place for audit purposes when reporting decisions through the cells and for auditor recommendations to be sought in terms of best practice.	Dr Amanda Doyle	In progress	03.09.2020	In progress.
JCCCG200702-08	A report detailing allocations for the next financial year to be shared with the JCCCG for investment purposes.	Gary Raphael	In progress	03.09.2020	In progress.

Joint Committee of Clinical Commissioning Groups (JCCCGs)

Title of Paper	ICS Finance Report		
Date of Meeting	3 September 2020	Agenda Item	6

Lead Author	Elaine Collier, ICS Head of Finance	
Contributors	Paul Havey, ICS Finance	
Purpose of the Report For noting the M4 financial position updates.	Please tick as appropriate	
	For Information	✓
	For Discussion	
	For Decision	
Executive Summary	This paper reports on the month 4 financial performance for the L&SC system in the context of the current finance regime and the response to Covid. This paper was written for the ICS Board and therefore includes updates on capital, ICS central functions and the scheme of delegation, which are not relevant but may be of interest to JCCCG.	
Recommendations	For noting	
Next Steps		
Is this a level 1 or Level 2 decision?	Level 1	Level 2

Equality Impact & Risk Assessment Completed	~~Yes~~	~~No~~	Not Applicable
Patient and Public Engagement Completed	~~Yes~~	~~No~~	Not Applicable
Financial Implications	~~Yes~~	~~No~~	Not Applicable

Risk Identified	Yes	No
If Yes : Risk		
Report Authorised by:		

ICS Finance Report

Introduction

1. This paper reports on the month 4 financial performance for L&SC partners and ICS central functions in the context of the current finance regime and Covid response. It also reports on the revised scheme of delegation for the ICS and seeks approval for the limit reserved for the Board.

Current finance regime

2. As described in previous reports, the response to Covid has changed the way that finances are being managed in 2020/21, with all organisations incurring significant costs that could not have been planned for before the start of the year. Organisational financial performance is therefore not being managed against the plans that were set at the start of the year. Instead, the national team have calculated in-year allocations for CCGs and monthly block payments plus a planned top up for trusts based on run-rate data from 2019/20, with an ability to claim additional top ups for Covid related costs.

3. This regime initially covered the period April to July which explains why the following tables currently only report positions to July. It has now been confirmed that this regime will continue for August and September, although some new arrangements will apply from 1 September 2020.

New finance regime and elective incentives

4. We still await the new finance guidance and financial envelope for the second half of the year but expect to receive this during September. However, we have received notification of a new elective incentive process which will start to take effect from 1 September 2020. To help accelerate the return to near-normal levels of non-Covid health services and to make full use of the capacity available between now and winter, we have been notified that with effect from September, block payments will flex to reflect expected elective activity levels. It is deemed that the resources provided through the nationally determined finance arrangements are 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.

5. Where activity is delivered in line with expectations, system level funding will be paid in full. For activity in excess of expected levels, incentive payments will be paid but similarly, deductions will be made from the funding envelope where activity is below expectations. This is new guidance and the impact of this will need to be reflected in future plans and financial forecasts.

6. For July, organisations continued to claim top up payments to ensure they could report a monthly breakeven position. The summary table below shows that CCGs claimed £68.3m at the end of July to top up their allocations for cost pressures incurred, including £34.6m of Covid 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 related costs.

Table 1a – L&SC summary financial position as at the end of month 4, July 2020:

L&SC - M04	Year-to-date			YTD
	Plan	Actual	Under/(over) spend	of which COVID
	£m	£m	£m	£m
CCG financial position	0.0	(68.3)	(68.3)	34.6
CCG Retrospective Top Up	0.0	68.3	68.3	
Commissioner Total	**0.0**	**0.0**	**0.0**	**34.6**
Trust Income excl Top Up	882.2	851.2	(31.0)	
Pay	(644.9)	(692.0)	(47.1)	35.6
Non Pay	(293.4)	(304.1)	(10.7)	37.1
Non Operating Items	(12.0)	(13.2)	(1.2)	
Trust Top Up	68.1	158.1	90.0	
Provider Total	**0.0**	**0.0**	**0.0**	**72.7**
L&SC Total	**0.0**	**0.0**	**0.0**	**107.3**

Covid related costs

7. At the end of July, organisations had incurred £107.3m of Covid related costs, an increase of £23.1m since June. The tables below show a breakdown of the CCG and Trust monthly costs. We can see that CCG costs are increasing month on month, particularly for mental health and continuing care. Whereas trust costs appear to be reducing, particularly pay costs although this is impacted by a correction to sick pay at M04. We can also see testing and segregation costs increasing as the system moves into restoration and recovery.

Table 1b – CCG Covid related costs as at the end of month 4, July 2020:

CCGs - YTD Covid Related Costs	M01	M02	M03	M04	Total
	£m	£m	£m	£m	£m
Acute Services	0.2	0.1	0.1	0.1	0.5
NHS	0.0	0.0	0.0	0.0	0.0
Independent / Commercial Sector	0.2	0.1	0.1	0.5	0.9
Other	0.0	0.0	0.0	0.0	0.0
Mental Health Services	0.1	0.5	0.4	1.0	2.0
Community Health Services	0.3	0.8	0.2	0.5	1.8
Continuing Care Services	2.2	3.7	6.9	6.4	19.2
Primary Care Services	2.3	1.6	0.5	1.7	6.1
Primary Care Co-Commissioning	0.0	0.0	0.0	0.0	0.0
Other Programme Services	0.5	0.9	1.6	1.6	4.6
Running Costs	0.0	0.0	0.0	0.0	0.0
Hosted Services	0.0	0.0	0.0	0.0	0.0
TOTAL	**5.6**	**7.6**	**9.7**	**11.7**	**34.6**

Table 1c – Trust Covid related costs as at the end of month 4, July 2020:

Trusts - YTD Covid Related Costs		M01-02	M03	M04	Total
		£m	£m	£m	£m
Expand NHS workforce		2.8	2.2	1.9	6.9
Sick pay at full pay		4.7	1.2	(5.8)	0.1
Covid-19 virus testing		1.1	0.6	0.9	2.6
Remote management of patients		1.4	0.7	0.7	2.8
Plans to release bed capacity		3.2	0.9	0.2	4.3
Increase ITU capacity		3.5	1.5	1.1	6.1
Segregation of patient pathways		0.3	0.3	1.3	1.9
Enhanced PTS		0.3	0.2	0.1	0.6
Existing workforce additional shifts		5.8	4.7	4.3	14.8
Decontamination		1.4	0.2	0.3	1.9
Backfill for higher sickness absence		6.9	3.0	3.6	13.5
NHS 111 additional capacity		0.4	0.4	0.3	1.1
Remote working for non patient activities		1.1	0.3	0.9	2.3
National procurement areas		3.8	1.4	0.7	5.9
Other		4.5	0.8	0.8	6.1
Covid-19 Nightingale set up cost		1.8	0.0	0.0	1.8
TOTAL		**43.0**	**18.4**	**11.3**	**72.7**

Of which :	Pay	19.7	11.4	4.5	35.6
	Non Pay	23.2	7.1	6.8	37.1
		42.9	18.5	11.3	72.7

Financial risk

8. We outlined a number of financial risks in our previous report and updated that the future finance regime will mean the ICS is given a financial envelope to work within for the rest of the financial year and a Covid allocation to use flexibly rather than making retrospective claims.

9. Work is progressing to understand what is driving costs this year so that we can forecast what is likely to happen across the rest of the year and understand the limitations that a financial envelope may bring. This work is also required to enable us to understand our recurrent run-rate and the exit run-rate into 2021/22, to ensure we do not generate a run-rate that is not sustainable.

10. This work is continuing alongside phase 3 planning which is due in September and we expect to be in a position to update the Board in future reports.

Capital

11. The ICS has been given a capital envelope to work within for 2020/21 for our pre-Covid business as usual plans (shown as 'CDEL capital envelope for the ICS' in the table below) and we have worked with trust partners during the start of the year to refine these plans to ensure we are able to remain within this envelope. During the year new capital funding has been announced and the ICS has worked with trusts to develop bids to maximise the amount of capital at our disposal. The table below summarises the current anticipated capital allocations by Trust. Currently we are awaiting confirmation of two further bids in relation to critical care and CT scanners.

Table 1d – Capital Allocations:

CAPITAL FUNDING	BTH	ELHT	LSCFT	LTH	NWAS	UHMB	TOTAL
	£m	£m	£m	£m	£m	£m	£m
CDEL Capital envelope for the ICS	32.3	16.6	9.8	38.9	14.0	27.1	**138.7**
Other Central Programme PDC (STP wave 1/4, etc)	13.4	4.6	8.1	2.8			**28.9**
A&E	2.9	7.5		6.3		2.0	**18.7**
MH Dormitories			9.5				**9.5**
Critical Infrastructure Risk (CIR)	1.9	1.9	2.2	4.2	0.8	7.6	**18.6**
TRUST TOTAL	**50.5**	**30.6**	**29.6**	**52.2**	**14.8**	**36.7**	**214.4**

12. This is a substantial programme of work and therefore the ICS has agreed to develop an enhanced monitoring process for 2020/21 through the FIG and reporting to the ICS Board to ensure that we are able to spend these funds and gain maximum benefit for L&SC.

13. Since the last ICS Board meeting a range of Finance and Estates colleagues have met to develop this process. The following agreements were reached:

    - The creation of a jointly funded post to work across organisations to help identify and mitigate risks to ensure the ICS maximises its capital spend. Initially this will be recruited from a third party to ensure additional capacity is brought into the ICS system.
    - Trusts agreed to adopt and populate a standard template identifying the best, likely and worst scenarios. This will initially be based upon Trusts being able to identify internal opportunities to bring forward expenditure in line with existing future year priorities.

    This piece of work will be completed in the next four weeks following which consideration will be given to brokering any slippage across organisations within the ICS.

14. It is also proposed that if by the time of reporting Month 6 we cannot contain all slippage within the ICS then we need to consider brokering back to regional team in order to protect the overall resource allocated.

15. There is also a longer term work programme needed following publication of the Clinical Strategy to refresh the ICS Infrastructure Strategy, both Estates and Digital, to ensure that future years' Capital/Investment Programmes facilitate delivery of the Clinical Strategy.

ICS Central Functions

16. The table below provides an update on the financial position for central functions. The funding for the ICS which makes up these budgets is also subject to the new finance regime and whilst we anticipate that we will manage within our financial budgets for the year, there are still some aspects of the system contributions and national transformation funding that we are working on to understand if the funding is already in the system in which case we can extract these sums from existing trust block payments.

17. There is still some uncertainty on nationally funded budgets; further work is ongoing to establish the source of funding for these elements.

Table 1e – Central Functions budgets as at the end of month 4, July 2020:

ICS Central Functions	Year-to-date			Full Year Forecast		
	Budget	Actual	Under/(over) spend	Annual Budget	Forecast Outturn	Under/(over) spend
	£000	£000	£000	£000	£000	£000
ICS Core Budgets						
Clinical Portfolios	195	195	0	505	505	0
Enabling Functions	438	415	23	1,313	1,313	0
Executive Functions	720	578	142	2,142	2,142	0
Other Support Functions	109	109	(0)	326	326	0
	1,461	1,297	164	4,286	4,286	0
Nationally Funded Budgets	1,760	803	957	5,228	5,228	0
System Funded Budgets	146	144	2	437	437	0
TOTAL	**3,367**	**2,244**	**1,123**	**9,951**	**9,951**	**0**

Revised Scheme of Delegation

18. The ICS Executive has recently updated the ICS scheme of delegation to ensure appropriate management of ICS income and expenditure budgets. A copy of this document is available should anyone wish to read it in full but the extract below describes the delegated approval limits which have been put in place.

19. The Board is asked to approve the limit reserved for ICS Board approval.

ICS ROLE	AREA OF AUTHORITY	APPROVAL LIMIT
ICS Board	All cost centres	over £500,000
ICS Lead	All cost centres	£500,000
ICS Exec Lead for Finance	All cost centres	£250,000
ICS Executive	Assigned cost centres only	£100,000
ICS Programme Lead / Budget Manager	Assigned cost centres only	up to £20,000

Elaine Collier
ICS Head of Finance
27 August 2020

Joint Committee of Clinical Commissioning Groups (JCCCGs)

Title of Paper	**Special Educational Needs and Disabilities – Update for Lancashire**		
Date of Meeting	3rd September 2020	Agenda Item	7

Lead Author	Hilary Fordham	
Contributors	Zoe Richards, Senior Programme Manager for SEND for Health	
Purpose of the Report To update the JCCCG on the progress being made following the SEND Inspection Revisit outcome in Lancashire, and to highlight the priority areas of work resulting from the revisit.	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	X
Executive Summary	The Lancashire SEND inspection revisit took place 9th-12 March 2020. The Ofsted and CQC inspectors found sufficient progress has been made in 7 of the 12 areas, but that insufficient progress has been made in 5 of the 12 areas. These 5 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 1st October 2020. Although the revisit was conducted in March, the publication of the letter was delayed due to COVID-19, and it was published on 5th August 2020.	
Recommendations	JCCCG is asked to: a. Note the positive improvements highlighted by Ofsted and CQC. b. Note the position regarding the continuing areas of significant concern where insufficient progress was made. c. 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. d. Nominate 2 non-executive members to join the sub-committee of the Health and Wellbeing Board that will undertake the monitoring of the Accelerated Progress Plan, from the Fylde Coast and Central Lancashire.	

Joint Committee of Clinical Commissioning Groups (JCCCGs)

Next Steps					
Is this a level 1 or Level 2 decision?	Level 1	X	Level 2		
Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable		
Patient and Public Engagement Completed	Yes	No	Not Applicable		
Financial Implications	Yes	No	Not Applicable		
Risk Identified	Yes		~~No~~		
If Yes : Risk	• Inability to address the remaining areas of significant concern. • ASD waiting lists were a significant concern of the inspectors' revisit; this has been compounded by impacts of COVID-19				
Report Authorised by:					

Level 1: *where decision making authority is within the delegated authority of the Joint Committee as outlined within its Terms of Reference and where a decision(s) undertaken by the Joint Committee will be final and binding on all member CCGs.*

Level 2: *where health and social care commissioning areas and operational functions affect/impact on the population of Lancashire & South Cumbria (or wider) are considered by the Committee and any decision(s) undertaken by the Committee from the basis of endorsements and recommendations to the governing bodies of each member CCG, and other decision making bodies.*

Joint Committee of Clinical Commissioning Groups (JCCCGs)

SPECIAL EDUCATIONAL NEEDS AND DISABILITIES (SEND) UPDATE FOR LANCASHIRE

1. Introduction

1.1 The purpose of this report is to update the Joint Committee of the Clinical Commissioning Groups on the progress being made following the SEND Inspection Revisit outcome for Lancashire, and to highlight the priority areas of work resulting from the revisit.

1.2 Following the Lancashire County area SEND Inspection in November 2017, and subsequent report received in January 2018 that set out some very challenging findings, a Written Statement of Action was requested to address the 12 areas of significant concern. Delivery of the Written Statement of Action was monitored by DfE and NHSE/I with the expectation that progress would be made before a revisit inspection. JCCCG has received three updates since the Lancashire Inspection and this report provides the next update.

1.3 Ofsted and CQC inspectors revisited Lancashire from 9th to 12th March 2020 to review progress against the identified 12 areas of significant concern. The letter presenting the outcome from this revisit was published on 5th August 2020 and is attached.

1.4 The JCCCG is asked to support the on-going activity related to the Accelerated Progress Plan for Lancashire SEND.

2. Re-Visit Outcome

2.1 The inspectors recognised the improvements made, and during the verbal feedback of their findings they acknowledged the significance of the improvement journey. They particularly identified that sufficient progress has been made in 7 of the 12 areas of concern, which means that monitoring of these areas is no longer required as the partnership is now demonstrating:

- Strategic leadership and vision across the partnership
- Effective engagement with parent carers
- Improved systems and processes of identification of SEND
- Improved quality of EHC Plans
- Strategy to improve outcomes for CYP who have SEND
- Reduction in numbers of CYP with an EHC Plan who are permanently excluded
- Reduction in inequalities of provision based on location

2.2 For the 5 areas where further improvement is required, the inspectors recognised the good work that has taken place to date. These areas will now be monitored by DfE and NHSE/I through an Accelerated Progress Plan which is currently in development for submission by 30th September. These 5 areas are:

- Leaders had an inaccurate understanding of the local area
- There were weak joint commissioning arrangements that were not well developed or evaluated

- There was an absence of effective diagnostic pathways for autism spectrum disorders across the local area and no diagnostic pathway in the north of the area
- Transition arrangements in 0 to 25 healthcare services were poor
- The local offer was inaccessible and the quality of information published was poor

2.3 The areas where there has been sufficient progress made will no longer be monitored, however continuing improvements are required, and these will be captured within the Partnership's next iteration of the SEND Improvement Plan, to be overseen by the SEND Partnership Board. The Accelerated Progress Plan will form part of that Plan.

2.4 The Accelerated Progress Plan (APP) requires delivered outcomes within 12 months of the publication of the Ofsted letter, with key milestones at 3 months and 6 months. Much of the work to be delivered was underway at the time of the revisit in March, and will continue.

2.5 The APP will be monitored through a sub-committee of the Health and Wellbeing Board. The JCCCG is asked to nominate 2 Non-Executive members to join this sub-committee alongside the LCC Cabinet members for Health and Wellbeing and Children and Young People. It is suggested that they are drawn from Fylde Coast and Central Lancashire which will 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).

3. Key Priorities

3.1 Whilst the partnership works together to address the plan, there are a number of priorities for health as a result of the SEND revisit, some of which relate to commissioners, and others require active engagement and delivery by providers.

- Identify provider leads for two of the actions of the Accelerated Progress Plan – ASD and Transitions in Health care.
- Implement the ASD Pathway rapid recovery plan, including commissioning additional support, to help manage the increasing waiting lists across the ICS. This maybe via using an external company and a business case will be developed over the next few weeks and return to the Collaborative Commissioning Group for funding agreement.
- Implement a Data Quality Improvement Project for health, monitored by commissioners in respect of the required outputs from providers, to deliver timely, accurate and meaningful data that will inform decision-making
- Commission more consistent services for consumables, starting with continence products.
- Implement the plan for Transitions for 0-25 in Healthcare, monitored by CCGs to ensure providers engage both children's and adult services in the work required

3.2 Other areas will be delivered as a partnership:

- Joint commissioning arrangements, ensuring evaluation processes are in place.
- Further development of the Local Offer to improve its use.

- Develop the joint data dashboard to further improve understanding and enable more timely commissioning decisions.

3.3 Whilst much has been achieved, there is still considerable work to do to achieve a consistently good service for our children and young people in Lancashire and across the ICS in relation to the SEND agenda. The CCGs have already committed the following resources:

- Senior SEND Manager – Health
- Funding for a Project Manager and Local Offer Development Officer jointly with the Local Authority.
- Re-instatement of the support provided via the CSU, agreed by CCB
- CSU Business Intelligence support to undertake the Data Quality Improvement Project and ensure that accurate monitoring of data related to SEND is available and linked to Local Authority Data to enable timely monitoring and decision making.

4. Recommendations

4.1 The JCCCG is requested to:

a. Note the positive improvements highlighted by Ofsted and CQC.
b. Note the position regarding the continuing areas of significant concern where insufficient progress was made.
c. 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.
d. Nominate 2 non-executive members to join the sub-committee of the Health and Wellbeing Board that will undertake the monitoring of the Accelerated Progress Plan, from the Fylde Coast and Central Lancashire.

Hilary Fordham
Chief Operating Officer, MBCCG

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August 2020

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23 March 2020

Mrs Edwina Grant, OBE
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Preston
PR1 8RJ

Hilary Fordham, Chief Operating Officer, NHS Morecambe Bay Clinical Commissioning Group

Sian Rees, Interim SEND Improvement Partner, Local Area Nominated Officer

Dear Mrs Grant and Ms Fordham

Joint area SEND revisit in Lancashire

Between 9 March and 12 March 2020, Ofsted and the Care Quality Commission (CQC) revisited the area of Lancashire to decide whether sufficient progress has been made in addressing each of the significant weaknesses detailed in the written statement of action (WSOA) issued on 8 January 2018.

As a result of the findings of the initial inspection and in accordance with the Children Act 2004 (Joint Area Reviews) Regulations 2015, Her Majesty's Chief Inspector (HMCI) determined that a written statement of action was required because of significant weaknesses in the area's practice. HMCI determined that the local authority and the area's clinical commissioning groups (CCGs) were jointly responsible for submitting the written statement to Ofsted. This was declared fit for purpose on 25 April 2018.

The area has made sufficient progress in addressing seven of the 12 significant weaknesses identified at the initial inspection. The area has not made sufficient progress in addressing five significant weaknesses. This letter outlines our findings from the revisit.

The inspection was led by one of Her Majesty's Inspectors from Ofsted and a Children's Services Inspector from CQC.

Inspectors met with leaders, managers and frontline workers from the area for health, social care and education. More than 550 parents and carers contributed to the revisit. Inspectors spoke with children and young people with special educational needs and/or disabilities (SEND). Inspectors looked at a range of information about

the performance of the area in relation to the actions outlined in the WSOA. Inspectors sampled more than 20 education, health and care (EHC) plans.

Main findings

- The initial inspection found that:

  There was lack of strategic leadership and vision across the partnership.

  At the time of the inspection in November 2017, Lancashire was lagging well behind in its implementation of the SEND reforms. From the very highest levels of leadership, including elected members, there has been a genuine commitment to putting things right. There are strong working relationships across the partnership now. The provision for children and young people with SEND is a priority for elected members and leaders across health, social care and education. The needs of these children and young people are a 'golden thread' running through the work that leaders do. The partnership's plans and strategies reflect the area's ambitious vision for children and young people with SEND. While there is still a huge amount to do, the transformation across the area cannot be underestimated.

  Leadership is more stable now. Furthermore, leaders have made some key appointments. These include the three designated clinical officers (DCOs), a senior SEND programme manager and a SEND partnership improvement team. It is clear that the pace of improvement has speeded up as a result of these appointments.

  Leaders have worked tirelessly to deliver the improvements needed. They have made sure that children, young people and families have been at the heart of their work. Consequently, children and young people's needs are more effectively met and their outcomes are improving. No-one, however, is in any doubt about the considerable amount of work still to be done. Leaders have well-developed plans, which set out the next stage of the journey.

  The area has made sufficient progress to improve this area of weakness.

- The initial inspection found that:

  Leaders had an inaccurate understanding of the local area.

  Leaders have a better view of strengths and weaknesses across the partnership. Recently, more comprehensive and reliable datasets are informing area plans, such as the early years strategy. However, it has taken a considerable length of time to reach this point, and there is still much more to do.

  Following the 2017 inspection, action plans did not clearly indicate how leaders would measure success in resolving each of the significant weaknesses identified by inspectors. Leaders did not set out step-by-step targets to help them check

how well their plans were progressing at key points. This has made it hard for leaders to know whether actions are on track and effective. For example, there was and still is no system in place to collect the views of parents and carers at the point of service delivery. This means that leaders and managers do not find out how well new systems and services are working quickly enough. They rely on the results of the online personal outcomes evaluation tool (POET) survey. These results are published annually, which is too infrequent for the only measure of parental views, given the pace of change. Consequently, leaders do not always know whether their actions have made the positive difference for children, young people and their families that was intended.

The area has not made sufficient progress to improve this area of weakness.

- The initial inspection found that:

  There were weak joint commissioning arrangements that were not well developed or evaluated.

  At the initial inspection, leaders had not evaluated the impact of their actions or taken into account the views and lived experiences of children and young people with SEND and their families. This contributed to weak arrangements for joint commissioning.

  A well-established group of commissioners from across the partnership work well together now. They have made sure that they are better informed about children and young people's needs. Effective co-production is helping commissioners to decide what services they need to provide and where they need to provide them. Commissioners are now prioritising some of the more pressing issues, such as re-designing the short breaks offer and improving the speech and language therapy (SALT) service.

  However, these arrangements are not sufficiently well developed or evaluated. At the initial inspection, inspectors found weaknesses in the services for consumables, such as continence products. Twenty-eight months later, families still struggle to get these consumables. Furthermore, there remains inequitable special school nursing provision and gaps in specialist children's nursing services. Children and young people's access to public health nursing in special schools is not well understood and therefore not routinely used. Commissioners are currently reviewing these services. However, it is unacceptable that some children, young people and their families have not had access to these important healthcare services for over two years.

  The area has not made sufficient progress to improve this area of weakness.

- The initial inspection found that:

  There was a failure to engage effectively with parents and carers.

At the time of the initial inspection, parents' views and experiences of the provision for their children and young people were 'overwhelmingly damning'. Parents had lost trust. They lacked confidence and felt that there was no transparency.

The absence of a parent carer forum initially hampered leaders' efforts to get to work following the inspection. To plug this gap, leaders reached out to parents to help them draw up their improvement plans. The parents who have worked with leaders told inspectors about the positive difference that their contributions have made. For example, parents have helped leaders to co-produce the new neuro-developmental pathway. These parents feel valued, trusted and equal partners in driving improvements.

Parents have now established a parent carer forum with the support of a national charity for families with disabled children. The new forum is aware that its reach is limited and has plans in place to widen parent participation. The forum has put on lots of events for parents across the area, including workshops and coffee mornings, but take up for these events has not been high.

Three quarters of the 1700 parents who completed the POET last year rated the levels of support and help that their child received as good or better. This was an improvement on the previous year. Moreover, the number of complaints to the partnership from parents and carers has reduced considerably. These improved levels of parental satisfaction are reflected in the much-lower rates of mediation and tribunals than seen nationally.

Leaders are in no doubt that there is still much to do to gain the full confidence and trust of parents. A minority of parents continue to feel that their long-standing concerns have not been addressed.

The area has made sufficient progress to improve this area of weakness.

- The initial inspection found that:

  Systems and processes of identification were confusing, complicated and arbitrary.

  Inspectors found that children and young people's access to specialist healthcare services was limited by obstructive referral procedures. This is no longer the case. The new DCOs play a key role in finding out about and resolving any potential issues.

  There has been a wealth of information sharing with professionals and parents about the EHC assessment process. Professionals have had the opportunity to observe the EHC assessment panel in action. This has given them a real insight into how requests are made, advice is sought, assessments are carried out and decisions are reached. Professionals are now much clearer about the point at which assessments can be requested. When an assessment is turned down, parents and professionals are informed about the reasons for the decision.

There is more secure evidence to show that children who are looked after in Lancashire have their healthcare needs identified, assessed and met. While practice is still not where it needs to be, it is an improving picture.

The area has made sufficient progress to improve this area of weakness.

- The initial inspection found that:

  There were endemic weaknesses in the quality of education, health and care plans.

  Inspectors found that the quality of EHC plans was 'alarmingly poor'. The quality of these plans has improved considerably.

  There has been effective training and support for all those involved in the production of EHC plans. Professionals better understand how to work with children, young people and their parents to gather their views. Social care, health and education professionals now routinely provide advice for EHC assessments. Parents and professionals now have enough opportunity to check the draft plans. Clear quality assurance systems are now in place. This means that plans now accurately reflect children and young people's needs. Those parents whose child has recently been assessed for a plan are positive about the process.

  While there is some inconsistency in how the partnership's quality assurance standards are applied to final EHC plans, leaders are beginning to address the inconsistent use of these standards.

  Area leaders have reviewed many of the EHC plans issued before the new systems and processes were introduced. Quite rightly, they have prioritised the plans for the most vulnerable children and young people, such as those who are looked after or those in youth custody. They have also reviewed the plans for the children and young people who are at key points in their lives, for example school leavers and the children moving from primary to secondary school. However, some children and young people still have poor-quality plans. These will be reviewed within the next year to ensure that their needs are better met.

  The area has made sufficient progress to improve this area of weakness.

- The initial inspection found that:

  There was an absence of effective diagnostic pathways for autism spectrum disorders (ASD) across the local area and no diagnostic pathway in the north of the area.

  There are now diagnostic pathways for ASD in place across the county, including in the north of the area. However, long waiting times in some areas are limiting the effectiveness of these pathways.

Professionals co-produced the pathway in the north with children, young people and parents. This approach means that this service reflects their needs. However, the partnership underestimated the demand for this service. The service has been swamped by four times the anticipated number of referrals and, as a result, children and young people are waiting too long for an initial appointment. There is often little communication with these families about how long they should expect to wait for an appointment.

A new county-wide neuro-developmental pathway integrates assessment and support for ASD and attention deficit hyperactivity disorder. This single diagnostic pathway provides some consistency, while allowing providers to respond to local needs. Behavioural, sleep and sensory workshops are offered to families when they are referred to the pathway. These sessions are valued highly by the parents who have attended. Unfortunately, few parents have taken up this offer of support to help them better meet their child's needs. Leaders are looking at other ways to provide this support that may better suit parents, such as offering different times and locations.

Across Lancashire, leaders have put in measures to assure themselves that pathways are compliant with National Institute for Health Care and Excellence (NICE) guidance. This is regularly monitored. However, long waiting times for an initial appointment, combined with too little communication with families, are creating frustration and anxiety for some families.

The area has not made sufficient progress to improve this area of weakness.

- The initial inspection found that:

  There was no effective strategy to improve outcomes of children and young people with SEND.

  Previously, inspectors found that EHC plans were too focused on pupils' education outcomes, even when a child or young person had significant healthcare and/or social needs. Current plans provide helpful information about children and young people's health, education and social care needs and set out how their outcomes should improve.

  Leaders have taken urgent action to improve outcomes for children and young people with SEND since the inspection. Termly meetings between school improvement officers and headteachers have focused on the performance of this group of children and young people. These officers have held headteachers to account for how well their schools are improving the performance of this group.

  More of the youngest children with SEND are achieving a good level of development than previously. Leaders have a better understanding about the main barriers to learning experienced by this group. This is helping them to put the right provision in place as part of the early years strategy.

By the end of key stage 1, more children with SEND are meeting the expected standard in reading, writing and mathematics. At the end of key stage 2, there has been a decline overall. However, targeted support last year in Hyndburn and Lancaster has helped children with SEND in these areas to buck the trend. The outcomes for these children improved. This work has recently been extended so that more children with SEND across Lancashire benefit from the additional support.

The area is doing much more to improve the life chances of young people as they move into adulthood. The number of young people not in education, employment or training has reduced considerably. Leaders have also reduced the number of young people whose destinations are not known. 'Project Search' is an example of how the partnership is helping young people with SEND gain valuable academic and employability skills. This programme is enabling more young people every year to move successfully on to internships, apprenticeships and traineeships.

Leaders have reduced the number of children and young people with SEND who are electively home educated. More of these children and young people are having their needs met in schools now. This means that they are able to get the specialist help and support that they need more easily.

The area has made sufficient progress to improve this area of weakness.

- The initial inspection found that:

  Transition arrangements in 0 to 25 healthcare services were poor.

  Inspectors reported that transition arrangements across Lancashire were 'splintered'. At that time, there was no evidence of a strategy to ensure that young people transitioned effectively into adult services.

  There has been limited progress in resolving the weaknesses found at the initial inspection. Although there has been some activity, this has been piecemeal. For example, there are well-developed plans to extend the delivery of the existing child and adolescent mental health service (CAMHS) to young people up to 19 years old. The early years strategy sets out how young children, including those not in schools or settings, will be supported to be school ready.

  However, there are still not enough commissioned services for young people up to the age of 25. There is limited effective joint working between children's and adults' services. This results in poor experiences for young people.

  The area has not made sufficient progress to improve this area of weakness.

- The initial inspection found that:

There were a disconcerting proportion of children and young people with EHC plans who were permanently excluded from school.

At the initial inspection, the number of exclusions was at an unacceptable level and rising. This is no longer the case. Permanent exclusions for children and young people with SEND are now few and far between. Moreover, leaders have checked that children and young people who were permanently excluded in the past, are now in suitable provision.

The area set up a programme to support Year 6 children at risk of exclusion in Preston move successfully on to secondary school. None of the Year 6 children on this programme have been excluded since moving into Year 7. This successful programme is now being rolled out more widely across Lancashire.

The area has made sufficient progress to improve this area of weakness.

- The initial inspection found that:

There were inequalities in provision based on location.

At the initial inspection, there was inconsistency and variability in children and young people's needs being met. Children, young people and their families now have more equitable experiences.

Good practice has been shared across the area. For example, mainstream schools now seek advice and guidance from special schools. This means that mainstream colleagues are better equipped to meet the needs of some of their children and young people with SEND. There has also been a range of training and support. This has improved the knowledge and skills of frontline workers, such as special educational needs coordinators and CAMHS practitioners.

Leaders are adept at setting up small-scale projects in different districts to test out new ways of working. Once they are satisfied that these are making a positive difference, they then roll these out across the area. For example, in Blackpool, a group of primary mental health workers delivered early intervention and prevention work in schools. This successful model has since been replicated across the county.

There is now a more equitable service provided by specialist health services across the county. There are more opportunities for families to access services locally. This has reduced some of the pressure on families who were previously travelling long distances for appointments.

Leaders know that there is more to do. For example, the accessibility of SALT provision for young children is variable across the area. The special schools in Lancashire are not currently provided with a named public health nurse. However, they are able to access the service through a single point of contact. As a result, some children and young people may miss out on routine height and

weight measurements, dental checks and emotional health and well-being provision.

The health visiting team carry out the two- to two-and-a-half-year check using the ages and stages questionnaire. Any emerging concerns are picked up at this point. This means that support is in place well before children start school.

The area has made sufficient progress to improve this area of weakness.

- The initial inspection found that:

  The local offer was inaccessible, and the quality of information published was poor.

  Inspectors found that the local offer was not used effectively, parents' awareness of the local offer was poor and the information provided was not useful.

  Leaders have engaged well with parents, children and young people and other partners to redesign the local offer. Unfortunately, there have been delays in its delivery. This means that the new offer was only launched in January.

  Furthermore, this work is not yet complete. Parents do not find the information it provides useful. Leaders have a plan to add a directory of services to the local offer and also appoint an officer to keep the information up to date and relevant.

  The area has not made sufficient progress to improve this area of weakness.

The area has made sufficient progress in addressing seven of the 12 significant weaknesses identified at the initial inspection. The area has not made sufficient progress in addressing five significant weaknesses.

As not all the significant weaknesses have improved, it is for DfE and NHS England to determine the next steps. Ofsted and CQC will not carry out any further revisit unless directed to do so by the Secretary of State.

Yours sincerely

Pippa Jackson Maitland
Her Majesty's Inspector

Ofsted	Care Quality Commission
Andrew Cook Regional Director	Ursula Gallagher Deputy Chief Inspector, Primary Medical Services, Children Health and Justice
Pippa Jackson Maitland HMI Lead Inspector	Lucy Harte CQC Inspector

cc: Department for Education
Clinical commissioning group(s)
Director Public Health for the area
Department of Health
NHS England

Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

Title of Paper	Mental Health Phase 3 National Planning		
Date of Meeting	3 September 2020	Agenda Item	8

Lead Author – Peter Tinson		
Contributors – Roger Parr and Paul Hopley		
Purpose of the Report Outline the mental health planning and investment expectations and consequential requirement to increase investment.	Please tick as appropriate	
	For Information	
	For Discussion	
	For Decision	x
Executive Summary	Whilst meeting the Mental Health Investment Standard (MHIS) expectations CCG do not currently meet the Long Term Plan (LTP) investment expectations.	
Recommendations	It is therefore recommended that CCGs support the:- • investment of an additional £5.7m to meet these expectations. • 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.	
Next Steps		

Is this a level 1 or Level 2 decision?	Level 1	X	Level 2	

Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable
Patient and Public Engagement Completed	Yes	No	Not Applicable
Financial Implications	Yes	No	Applicable

Risk Identified	Yes	No
If Yes : Risk	If LTP investment expectations aren't met the mental health phase 3 planning submission will fail and may result in regulatory interventions.	
Report Authorised by:	Andrew Bennett	

Joint Committee of Clinical Commissioning Groups (JCCCGs)
Cover sheet

Level 1: *where decision making authority is within the delegated authority of the Joint Committee as outlined within its Terms of Reference and where a decision(s) undertaken by the Joint Committee will be final and binding on all member CCGs.*

Level 2: *where health and social care commissioning areas and operational functions affect/impact on the population of Lancashire & South Cumbria (or wider) are considered by the Committee and any decision(s) undertaken by the Committee from the basis of endorsements and recommendations to the governing bodies of each member CCG, and other decision making bodies.*

Phase 3 Mental Health Planning 2020/21

1. Introduction

Detailed phase 3 mental health planning guidance was published alongside the *Third phase of the NHS response to Covid-19* correspondence received from the NHSE Chief Executive and Chief Operating Officer on 31 July 2020.

2. Mental Health Planning

The guidance requires the submission of a number of bespoke mental health planning templates in accordance with the overarching phase 3 national planning timeline.

These templates seek to provide assurance that the planned spend both meets the Mental Health Investment Standard (MHIS) and Long Term Plan (LTP) investment expectations.

Whilst Lancashire and South Cumbria CCGs investment meets the MHIS expectation it does not meet the LTP expectations (see below) and consequently the mental health planning submission would fail.

Table 1 – Comparison of LTP expectations ('in year' column) and planned investment ('proposed' column) and variance

	2020/21		
	In year	Proposed	Variance
CCG Baselines			
Community perinatal	£2,127.6	£514.2	-£1,613.4
maternity outreach			
CYP community & crisis	£1,185.0	£268.9	-£916.1
CYP eating disorders	£362.9	£142.4	-£220.5
People with MH receive physical health checks/integrated primary/community care	£5,380.5	£3,182.0	-£2,198.5
Crisis single point of access/universal MH care	£2,149.7	£3,212.5	£1,062.8
Ambulance service mental health response	£799.0	£12.9	-£786.1
IAPT	£826.5	£1,338.0	£511.5
Therapeutic IP care	£258.8	£1,607.0	£1,348.2

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.

The above should also be considered within the context of an historic underinvestment in mental health services when compared to recognised national benchmarks.

The position was recently discussed by a number of Lancashire and South Cumbria Integrated Care System (ICS) executives, CCG mental health lead commissioners and Lancashire and South Cumbria NHS Foundation Trust (LSCFT) executives who agreed that the planning submission would be amended to reflect the delivery of all the LTP expectations and a paper prepared for JCCCG consideration on 3 September 2020. This effectively equates to additional investment of £5.7m. This recognises that the implementation of the Urgent Mental Health Pathway recommendations has resulted in an investment above LTP expectations in some areas, e.g. crisis pathway.

3. Investment Principles

CCG mental health lead commissioners and LSCFT colleagues have begun exploring a number of principles which would provide a framework for the investment of the resource:-

a) Robust phased delivery plans are developed, tested, agreed and monitored (recognising that they will be significantly influenced by workforce availability).
b) Investment will be directed towards the relevant system provider partner.
c) All partners will implement a transparent 'open book' approach to the investment.
d) Any under investment would be collectively prioritised for investment into other mental health services, e.g. to improve children's and young people's access to services, involving clinical colleagues as appropriate.
e) More broadly the mental health, learning disabilities and autism planning process for 2021/22 will fully explore efficiency opportunities across the system and review the latest available benchmarking comparisons.
f) System provider and commissioner leads will maintain an oversight of the above.

4. Recommendation

It recommended that:-

a) CCGs support the investment of an additional £5.7m to meet these expectations.
b) CCGs also 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.
c) CCGs provide feedback regarding the investment principles outlined above which are progressed by CCG lead mental health commissioners with LSCFT and other provider colleagues and with CCG Chief Finance Officers support.

Peter Tinson
Lancashire and South Cumbria Director of Collaborative Commissioning

Joint Committee of CCGs
3rd September 2020

Title of Paper	**Report from the Commissioning Reform Group**		
Date of Meeting	3rd September 2020	Agenda Item	10

Lead Author	Andrew Bennett	
Contributors	Members of the CRG	
Purpose of the Report	Please tick as appropriate	
	For Information	x
	For Discussion	x
	For Decision	
Executive Summary	The purpose of this report is to provide the Joint Committee of CCGs with an update of the business discussed by the Commissioning Reform Group during its meetings in July and August 2020. The report asks the Joint Committee to note that a number of further actions will now be taken with oversight from the Commissioning Reform Group.	
Recommendations	The Joint Committee of CCGs is asked to: 1. Note this report from the Commissioning Reform Group 2. Note that a workshop will be arranged by the Commissioning Support Unit to produce proposals for consolidated Quality and Performance reporting which can be considered by the Joint Committee. 3. Note that the Commissioning Reform Group will prepare further implementation plans about other functions which can be consolidated. 4. Note the actions now 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. 5. Endorse further work by the Commissioning Reform Group to develop an updated programme and timeline in	

	which the key actions and decision points related to commissioning reform are identified.			
Next Steps	CRG meets to review progress on the actions set out in this paper on September 8th 2020.			
Is this a level 1 or Level 2 decision?	Level 1		Level 2	x
Equality Impact & Risk Assessment Completed	Yes	No	Not Applicable	
Patient and Public Engagement Completed	Yes	No	Not Applicable	
Financial Implications	Yes	No	Not Applicable	
Risk Identified			No	
If Yes : Risk				
Report Authorised by:	Andrew Bennett			

Level 1: *where decision making authority is within the delegated authority of the Joint Committee as outlined within its Terms of Reference and where a decision(s) undertaken by the Joint Committee will be final and binding on all member CCGs.*

Level 2: *where health and social care commissioning areas and operational functions affect/impact on the population of Lancashire & South Cumbria (or wider) are considered by the Committee and any decision(s) undertaken by the Committee from the basis of endorsements and recommendations to the governing bodies of each member CCG, and other decision making bodies.*

Joint Committee of CCGs
3rd September 2020

Joint Committee of CCGs
Thursday 03 September 2020

Report from the Commissioning Reform Group

Introduction

The purpose of this report is to provide the Joint Committee of CCGs with an update of the business discussed by the Commissioning Reform Group during its meetings in July and August 2020. The report asks the Joint Committee to note that a number of further actions will now be taken with oversight from the Commissioning Reform Group.

The context for the report is as follows:

- The commissioning reform programme was paused by agreement in March 2020 as a result of the Covid 19 pandemic. However, a number of circumstances are now prompting this position to be reconsidered.
- Constructive correspondence and a number of separate meetings have taken place between CCG Chairs, ICP Chairs, CCG Accountable Officers, the ICS Chief Officer and Director of Commissioning during June and July. These have addressed issues including representation on the ICS Board, the governance of the Hospital and Out of Hospital Cells and the opportunities to review the development of the Integrated Care System (ICS) and local Integrated Care Partnerships (ICPs). Out of these discussions, it was agreed that it would be helpful for the Commissioning Reform Group to be convened to review the current position.
- Publication of the national Phase 3 planning guidance at the end of July 2020 which contains a number of important statements about the development of local systems and partnerships. The ICS is required to agree a System Reform implementation plan for Lancashire and South Cumbria with the Regional Director during September 2020.The guidance refers to "*Plans to streamline commissioning through a single ICS/STP approach. This will typically lead to a single CCG across the system."*
- Further to the Phase 3 letter, the Regional Director has also written to Chairs and Chief Officers confirming that actions now need to be taken to push forward with the development of systems and place-based partnerships.

Commissioning Reform Group

The terms of reference for the Commissioning Reform Group (CRG) were agreed by the Joint Committee before the pandemic. The CRG's purpose is to agree and oversee the implementation of a road map for commissioning reform in Lancashire and South Cumbria. Building on the workshops attended by CCG Chairs, Chief Officers, CSU and ICS Directors during 2019, CRG was renamed to reflect its responsibilities going forward and to create a formal accountability to the Joint Committee of CCGs. The meeting is now attended by Executive leads and Clinical/Lay representatives from each CCG, CSU Directors, ICS Leads

and the locality Director of NHSEI.

Meetings of the CRG have been held on the 14th July and the 11th August. The main areas of business to date are summarised below:

1. Consolidated Quality and Performance Report

Discussions here have been taking place between CCG Executives and CSU Directors, facilitated by the Chief Nurse for NHSEI in Lancashire and South Cumbria. CRG has been advised that there are opportunities to streamline and reduce duplication in existing quality and performance reports used by CCGs. In so doing, there are potential benefits in releasing management capacity, particularly in Business Intelligence functions which can be directed towards new priorities.

There remains a need to ensure reporting is agile enough to report at neighbourhood, CCG, ICP and system levels.

CRG endorsed a proposal made by leads that a workshop with relevant leads is now arranged to address some of the practical concerns raised to date and to ensure recommendations in this area meet the needs of the future system. It was emphasised that the workshop should produce recommendations which can be endorsed in due course by the JCCCGs.

2. Additional functions which could be consolidated

Building out of the discussions about Quality and Performance reporting, CRG members asked for further proposals to be developed in which functions could be remodelled across the system/ICPs to reduce duplication and release capacity. There was a particular focus on Contract management, Business Intelligence and Equality and Diversity.

Members of CRG acknowledged that:

- there appeared to be opportunities to release capacity by simplifying the requirements on key functions.
- there are variations in the approaches taken by individual CCGs
- there is an opportunity presented by the Phase 3 planning guidance to streamline functions and release resources to support system/ICP priorities linked to Covid recovery

Further work will now take place to develop an implementation plan in order that the CRG can make formal recommendations to the Joint Committee of CCGs.

3. ICP development in the context of wider system reform

The CRG has received presentations from ICP Programme Directors at both of its meetings. This group of colleagues have updated proposals they made prior to the pandemic. These proposals were intended to set out the positive connections between the development of place-based partnerships in each ICP, the opportunities for stronger provider collaborations and the rationale for commissioning reform. This comprehensive approach to system reform

was endorsed in the publication of the Phase 3 planning guidance.

CRG has therefore supported proposals from the ICP Programme Directors to:

- Draft a common narrative and timeline for the further development of ICPs across Lancashire and South Cumbria by the end of September 2020
- Ensure that system leaders across all of our key ICS partners are engaged in the next steps and reporting this through the ICS Board
- Identify Executive Sponsors (a Provider CEO, CCG Accountable Officer, Senior Clinician, Local Authority Executive and ICS Executive) to provide oversight of the next stage of this work
- Liaise with colleagues in NHSEI to establish if additional support could be offered for this programme of system reform

CRG will take stock of the progress on this work at its next meeting which is scheduled for September 8th 2020. It is also now imperative that a refreshed programme and timeline is developed by CRG in which the key actions and decision points related to commissioning reform are identified. These will be incorporated within the wider System Reform implementation plan required from the ICS.

Recommendations

The Joint Committee of CCGs is asked to:

- Note this report from the Commissioning Reform Group
- Note that a workshop will be arranged by the Commissioning Support Unit to produce proposals for consolidated Quality and Performance reporting which can be considered by the Joint Committee.
- Note that the Commissioning Reform Group will prepare further implementation plans about other functions which can be consolidated.
- Note the actions now being taken by ICP Programme Directors to develop a narrative for the further development of Integrated Care Partnerships in the wider context of system reform.
- Endorse further work by the Commissioning Reform Group to develop an updated programme and timeline in which the key actions and decision points related to commissioning reform are identified.

Andrew Bennett **Executive Director of Commissioning**

25th August 2020

Commissioning Reform Group (CRG)
Tuesday 14 July 2020, 08.30-10:30
MS Teams

MEETING NOTES

Attendees: Graham Burgess (chair) Amanda Doyle, Andrew Bennett, David Bonson, Dawn Haworth, Carl Ashworth, Cath Owen, Claire Richardson, Clare Thomason, Katherine Disley, Neil Greaves, Jim Hacking, Jerry Hawker, Jackie Moran, Sarah James, Karen Kyle, Richard Robinson, Doug Soper, Vicky Ellarby

Apologies: Roy Fisher, Denis Gizzi, Julie Higgins

Item	Notes
1.	**Introduction and apologies** Graham Burgess introduced the meeting and explained he was chairing on behalf of Roy Fisher who had a prior commitment. Apologies noted above.
2.	**Purpose of the Meeting** Andrew Bennett outlined the background to the meeting and noted that the meeting is taking place in the context of the current COVID response. Andrew introduced the Terms of Reference for the group which is a sub-group of Joint Committee. The terms of reference had been agreed by Joint Committee of CCGs in January 2020, prior to the COVID outbreak. The Commissioning Reform Group is an evolution of the previous executive Commissioning Oversight Group. The Terms of Reference were noted.
3.	**MLCSU Letter** Amanda Doyle introduced a letter received from Linda Riley at MLCSU, confirming the CSU's offer to proceed with development of an integrated performance and quality report for CCGs/JCCCGs and proposing that individual CCGs cease to produce their own Quality and Performance reports and move to utilise a collective framework. The letter confirmed that this would then release resources from within CCGs including CSU embedded Quality staffing capacity to support wider activities. It also identified a number of other potential service areas which could also move to a system wide approach which would release additional capacity. Agreed actions: • MLCSU to bring a draft performance and quality report to the next CRG meeting for consideration prior to being presented to JCCCGs in September for their endorsement. • MLCSU to develop proposals in discussion with CCG Accountable Officers relating to a single contracting function and to identify the capacity that this would release. • OH Cell to consider other potential areas where a single function could be established and would free up capacity • Further discussion to take place at the next meeting relating to freed-up capacity

	and how this might be re-allocated.
4.	**Outputs from Meeting of CCG AOs and ICP Programme Directors 2.7.20** Claire Richardson and Vicky Ellarby presented ICP Programme Directors' Proposal for Collaborative Working in response to COVID-19 pandemic. The proposals were supported.
5.	**Discussion and agreement of next steps** Agreed actions: • Jane Cass to share contact details with Claire and Vicky for colleagues at NHSE who are able to support and facilitate work around ICP development • AD, AB and ICP Directors to co-ordinate presentation of slides and engagement with ICPs, including providers and Local Authorities, ICS Board and Joint Committee, to gain endorsement of the proposed approach. • Work to implement the proposed approach to progress in parallel where possible • Further update on progress to be given at next CRG • Approach towards Primary Care Commissioning to be included on agenda for next CRG and Peter Tinson invited to speak to the item
6.	**Any other business** None
Date and time of next meeting: Tuesday 11th August 2020 10am-12noon	