Agenda Item 7.0.

JOINT COMMITTEE OF CLINICAL COMMISIONING GROUPS
TERMS OF REFERENCE

Document Control			
Title	Lancashire and South Cumbria Joint Committee of Clinical Commissioning Groups (JCCCGs) – Terms of Reference		
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Amendment History		
Version	**Date**	**Changes**
4	31.12.16	Updated to standardise all TOR within HLSC
5	17.10.17	Outstanding amendments from Fylde and Wyre CCG incorporated.
6	24.10.17	Update of wording to bring in line with current environment.
7	28/08/2019	Update to bring in-line with current environment / NHS Long Term Plan
8	12/09/2019	Updated following JCCCG on the JCCCG on 05/09/2019

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1.	The Purpose of the Joint Committee of the Clinical Commissioning Groups
1.1	The purpose of the Joint Committee is to bring together the leadership of the eight Lancashire & South Cumbria Clinical Commissioning Groups (JCCCG) who have collectively committed to improve and transform health and care services across the area, delivering the highest quality of care possible within the resources available. The work of the Joint Committee is designed to deliver on the ambitions, commitments and priorities set-out in the NHS Long Term Plan and the Lancashire & South Cumbria ICS Strategy. The leadership of the eight Lancashire & South Cumbria commissioning groups (CCGs) will through the Joint Committee aim to: a. reduce unwarranted variation in the range and quality of services available to people living in different boroughs in Lancashire & South Cumbria by improving outcomes in areas that are below average and driving up outcomes overall; b. ensure key clinical standards are consistently met across the patch, so that all people receive the highest possible care and best outcomes. c. provide a joined-up approach to the commissioning of acute, community and mental health services, enabling the CCGs to work effectively with major health and care providers to ultimately improve quality of outcomes for patients; d. Work collectively to ensure progress towards and ultimately delivery of financial sustainability (agreed control totals) at both ICP and ICS levels. e. provide leadership in developing new ways of working as set-out in the NHS Plan including; a. supporting the continuing establishment of the Lancashire & South Cumbria ICS , b. options for moving towards "place based commissioning" c. development of integrated care partnerships
1.2	The primary purpose of the Joint Committee is to take collective commissioning decisions about services provided to the Lancashire & South Cumbria population.
1.3	Decisions will be taken by members of the joint committee in accordance with delegated authority from each CCG in-line with its Constitution, Scheme of Reservation & Delegation and the functions set-out in Schedule 1.
1.4	Guiding principles: The Lancashire and South Cumbria Joint Committee will adhere to the following principles already adopted by the Healthy Lancashire & South Cumbria (HLSC)Programme: • People and patients come first – delivering parity of esteem and outcomes – fairness and timeliness of access to support. • Delivering a clinically and financially sustainable health and care system across HLSC. • Clinically-led, co-design and collaboration across HLSC health & care system, delivering integrated support. • Aligning priorities across local health and care systems and organisations –

	managing sovereignty and risk. • Prioritised effort on greatest benefit – improving quality and outcomes efficiently and effectively. • Ensuring Value for Money. Getting it right first time. • Alignment of effort and resource across the system. • Built upon innovation, international evidence and proven best practice. • Subsidiarity with clear framework of mutual accountability.
1.5	The Joint Committee of CCGs will meet collaboratively with NHS England (NHSE) and NHS Improvement (NHSI)to make decisions in respect of those services within the Programme, which are directly commissioned by NHSE/NHSI.

2.	**Geographic Coverage**
2.1	The Joint Committee shall comprise the eight Clinical Commissioning Groups who collectively cover the geographic footprint of the Lancashire & South Cumbria Integrated Care System (ICS)
2.2	The Joint Committee of Clinical Commissioning Groups ('**JCCCGs**') is a joint committee of: • NHS Blackburn with Darwen CCG; • NHS Blackpool CCG; • NHS Chorley & South Ribble CCG; • NHS East Lancashire CCG; • NHS Fylde & Wyre CCG; • NHS Greater Preston CCG; • NHS Morecambe Bay CCG; • NHS West Lancashire CCG.
2.3	Specialised services commissioned by NHS England for the population of Lancashire & South Cumbria whilst outside the delegated authority of the Committee will be involved through a collaborative commissioning arrangement.
2.4	Services commissioned by Local Authorities for the population of Lancashire & South Cumbria whilst outside the delegated authority of the Committee will be involved through, wherever appropriate, a collaborative commissioning arrangement.

3.	**Accountability & Responsibility - Statutory Framework**
3.1	The NHS Act 2006 (as amended) was amended through the introduction of a Legislative Reform Order (LRO 2014/2436) to form joint committees. This means that two or more CCG's exercising commissioning functions jointly may form a joint committee as a result of the LRO amendment to s.14Z3 of the NHS Act. Joint Committees are statutory mechanisms which enable CCG's to undertake collective decision making.
3.2	The CCGs named in paragraph 1.5 above, have delegated the functions set out in Schedule 1 to the Joint Committee for commissioning services and functions as set-out and agreed within the Committee's annual work programme.
3.3	Joint committees are a statutory mechanism, which gives CCGs an additional option for undertaking collective strategic decision making. Whilst NHSE/NHSI will make decisions on Commissioning Specialised services separate from the Joint Committee, it has been decided that decisions on those services will be undertaken on a collaborative basis. This will allow sequential decisions to be undertaken allowing clarity of responsibility, but also

	recognising the linkage between the two decisions.
3.4	Individual CCGs and NHSE/NHSI will still always remain accountable for meeting their statutory duties. The aim of creating a joint committee is to encourage the development of strong collaborative and integrated relationships and decision-making between partners.

4.	**Role of the Joint Committee of CCGs**
4.1	The overarching role of the Joint Committee is to take collective commissioning decisions about services provided for the Lancashire & South Cumbria population. Decisions will be taken by members of the Joint Committee in accordance with delegated authority from each CCG. Members will represent the whole Lancashire & South Cumbria population and make decisions in the interests of all patients.
4.2	Decisions will support the strategy, aims and objectives of the Lancashire & South Cumbria ICS and will contribute to the sustainability and transformation of local health and social care systems. The Joint Committee will at all times, act in accordance with all relevant laws and guidance applicable to the CCGs.
4.3	The role of the committee will be to exercise the collective functions of the Clinical Commissioning Groups with respect to: a) Delegated decision making authority (level 1) on commissioning services across Lancashire & South Cumbria as agreed within the Committees Annual work programme and each member CCG Scheme of Reservation & Delegation. b) Making collective recommendations (level 2) to each member CCG Governing Body on commissioning services across Lancashire & South Cumbria which fall outside either the Annual work programme or member CCG Schemes of Reservation & Delegation. c) Making collective recommendations (level 2) to each member CCG Governing Body on developing new ways of working as set-out in the NHS Plan including; a. supporting the continuing establishment of the Lancashire & South Cumbria ICS b. future options for the configuration of Clinical Commissioning Groups c. development of integrated care partnerships
4.4	The Joint Committee will develop an annual work programme (Example in Schedule 3) which will be agreed and approved by the Governing Body of each member CCG. It will be the responsibility of executive leads and the JCCCG to ensure clarity over the scope of decision making associated with the work plan (Level 1 or Level 2)
4.5	The role described in 4.3 includes, but is not limited to the following activities which are aligned to those set-out in Appendix 1. • Acting to secure continuous improvement in the quality of commissioned services, including outcomes for patients, safety and patient experience. • Duty to promote the NHS Constitution • Due regard to the finance duties imposed on CCGs under the NHS Act 2006 including ensuring the means of meeting expenditure out of public funds.

	• Duty to ensure that process and decisions comply with the NHS Guidance on Planning, assuring and delivering service change for patients (including but not limited to Case for changes, service models and decision making business cases) • Statutory duties with respect to public engagement and consultation (including Local Authorities and associated committees) • Complying with public sector equality duty

5.	**Decision Making**
5.1	The primary purpose of the Joint Committee is to take collective commissioning decisions about services provided to the Lancashire & South Cumbria population.
5.2	Joint Committee members will make decisions in the best interests of the whole Lancashire & South Cumbria population, rather than the population of the Governing Body they are drawn from.
5.3	At all times, the Joint Committee, through undertaking the decision making function of each member CCG, will act in accordance with the terms of their Constitutions , Scheme of Reservation & Delegation and the functions set-out in Schedule 1.
5.4	The decision of the Committee will be binding on all member CCGs
5.5	**Decision making authority level definition:** ***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 form the basis of endorsements and recommendations to the Governing Bodies of each member CCG, and other decision making bodies.*
5.6	Any item or paper presented to the JCCCG which has not been previously agreed as part of the work programme will only be considered under Level 2 delegation.

6.	**Voting**
6.1	The Joint Committee will aim to make decisions by consensus wherever possible. Where this is not achieved, a voting method will be used. The voting power of each individual present will be weighted so that each party (CCG) possesses 12.5% of total voting power.
6.2	It is proposed that recommendations can only be approved if there is approval by more than 75% of the voting membership.

7.	**Membership**
7.1	Membership of the committee will combine both Voting and Non-voting members and will comprise of: -
7.2	Voting members: • The two individuals appointed to represent each of the member CCGs, subject to such voting being in compliance with paragraph 7 below on 'Voting'. (Whilst the JCCCG does not require a clinical majority, the CCG members should ensure it consists of clinicians, lay members and executives).

	• A vice chairman to be elected from the membership of the JCCCGs by the members and who will retain their CCG voting rights; • A CCG Audit Chair who will act as the Conflicts of Interest Guardian to be elected from the membership of the JCCCGs by the members and who will retain their CCG voting rights
7.3	Non-voting members: • The Independent Chair of the Joint Committee Non-voting attendees: • The Lancashire & South Cumbria ICS Lead; • The Lancashire & South Cumbria ICS Medical Director; • The Lancashire & South Cumbria ICS Executive Director of Commissioning • NHS England Representatives • A Healthwatch representative nominated by the local Healthwatch groups; • Such representation from the Combined and/or Local Authorities as the JCCCG deems appropriate; • Other such representation as the JCCCG deems appropriate;
7.4	Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Joint Committee. All deputies should be fully briefed and the secretariat informed of any agreement to deputise, so that quoracy can be maintained.
7.5	No person can act in more than one role on the Joint Committee, meaning that each deputy needs to be an additional person from outside the Joint Committee membership.

6.	**Meetings**
6.1	The Joint Committee shall adopt the standing orders of Blackpool CCG, insofar as they relate to the: a) notice of meetings b) handling of meetings c) agendas d) circulation of papers e) conflicts of interest Notice of Meetings and the Business to be transacted (1) Before each meeting of the JCCCG, a clear agenda and supporting documentation, specifying the business proposed to be transacted shall be sent to every member of the JCCCG at least six clear days before the meeting. The agenda and papers will also be published on the Healthier Lancashire and South Cumbria website. (2) No business shall be transacted at the meeting, other than that specified on the

	agenda, or emergency motions allowed under Standing Order 3.8. (3) Before each public meeting of CCG Governing Body meetings, a public notice of the time and place of the next Joint Committee meeting and the public part of the agenda shall be displayed on the CCG's website, at least three clear days before the meeting.

8.	**Quorum**
8.1	At least one voting member (or nominated deputy) from each CCG must be present for the meeting to be Quorate. It is the responsibility of each CCG to ensure that they have at least one voting member present at all Committee meetings. In the exceptional circumstances that a CCG cannot field a representative, the CCG must communicate this information to the independent chair in advance of the meeting.

9.	**Frequency of Meetings**
9.1	Frequency of meetings will usually be monthly, but as and when required, in line with priorities.

10.	**Meetings of the Joint Committee**
10.1	Meetings of the Joint Committee shall be held in public, unless the Joint Committee considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting. Therefore, the Joint Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings), whenever publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted, or for other special reasons stated in the resolution and arising from the nature of that business, or of the proceedings, or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.
10.2	Members of the Joint Committee have a collective responsibility for the operation of the Joint Committee. They will participate in discussion, review evidence and provide objective expert input to the best of the knowledge and ability and endeavor to reach a collective view.
10.3	The Joint Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.
10.4	The Joint Committee has the power to establish sub groups and working groups and any such groups will be accountable directly to the Joint Committee.
10.5	Members of the Joint Committee shall respect confidentiality requirements as set out in the Standing Orders referred to above, unless separate confidentiality requirements are set out for the Joint Committee, in which event these shall be observed.

11.	**Secretariat Provisions**
11.1	The agenda and supporting papers will be circulated by email, five working days prior to

	the meeting. The agenda and papers will be published on each member CCG website and the Healthier Lancashire and South Cumbria website.
11.2	Papers may not be tabled without the agreement of the Chair.
11.3	Minutes will be taken and distributed to the members within 14 working days after the meeting.
11.4	Minutes will be published in the public domain, unless there are discussions which need to be recorded confidentially - in which case there will be recorded separately and will not be made public.
11.5	Agenda and papers to be agreed with the Chairman seven working days before the meeting.

12.	**Reporting to CCGs and NHS England**
12.1	The Joint Committee will hold annual engagement events to review aims, objectives, strategy and progress. The Joint Committee will also publish an annual report on progress made against objectives.

13.	**Decisions**
13.1	The Joint Committee will make decisions within the bounds of the scope of the functions delegated.
13.2	The decisions of the Joint Committee shall be binding on all member CCGs, which are: Blackburn with Darwen CCG; Blackpool CCG; Chorley & South Ribble CCG; East Lancashire CCG; Fylde & Wyre CCG; Greater Preston CCG; Morecambe Bay CCG; and West Lancashire CCG.
13.3	All decisions undertaken by the Joint Committee will be published by the Clinical Commissioning Groups.

14.	**Conflicts of Interest**
14.1	The Committee shall hold and publish a register of interests. Each member and attendee of the committee will be under a duty to declare any such interests. Any interest related to an agenda item should be brought to the attention of the Chair in advance of the meeting or notified as soon as the interest arises and recorded in the minutes. Any changes to these interests should be notified to the Chair.
14.2	To further strengthen scrutiny and transparency of CCGs' decision-making processes, the Committee will have a Conflicts of Interest Guardian (akin to a Caldicott Guardian). This role should be undertaken by a nominated CCG audit chair, provided they have no provider interests, as audit chairs already have a key role in conflicts of interest management. The role of the Conflicts of Interest Guardian will be in-line with the requirements set-out in NHS England's " Managing Conflicts of Interest: Revised Statutory Guidance for CCG's 2017"

14.3	All members of the Committee and participants in its meetings shall comply with, and are bound by, the requirements in the relevant CCG's Constitutions, Policies, the Standards of Business Conduct for NHS staff and NHS Code of Conduct.

15	**Review of Terms of Reference**
15.1	These terms of reference will be formally reviewed by Clinical Commissioning Groups at least annually, taking the date of the first meeting, following the year in which the JCCCG is created and may be amended by mutual agreement between the CCGs at any time to reflect changes in circumstances as they may arise.

16.	**Withdrawal from the Joint Committee**
16.1	Should this joint commissioning arrangement prove to be unsatisfactory, the Governing Body of any of the member CCGs or NHS England can decide to withdraw from the arrangement, but has to give six months' notice to partners, with new arrangements starting from the beginning of the next new financial year.

17.	**Signatures**
Blackburn with Darwen CCG	**Blackpool CCG**
Chorley & South Ribble CCG	**East Lancashire CCG**
Fylde & Wyre CCG	**Greater Preston CCG**
Morecambe Bay CCG	**West Lancashire CCG**

Schedule 1 - Delegation by CCGs to Joint Committee

A. As required to achieve the purpose of the Joint Committee of CCG's, the following CCG functions will be delegated to the Joint Committee of CCGs ('**the JCCCGs**') by the member CCGs in accordance with their statutory powers under s.14Z3 of the NHS Act 2006 (as amended). s.14Z3 allows CCGs to make arrangements in respect of the exercise of their functions and includes the ability for two or more CCGs to create a Joint Committee to exercise functions. The delegated functions relate to the health services provided to the member CCGs by all providers they commission services from in the exercise of their functions.

B. The Lancashire and South Cumbria ICS focuses on achieving clinical quality standards in the services listed below provided by the NHS Trusts (and other providers) within the ICS. As part of this work, it is necessary to consider interdependencies between these services and any other services that are affected. The relevant services are:

a. All elements of the programme, including the Case for Change, evaluation criteria, options, communications plan and such like.

b. Such other services not set out above, which the CCG members of the JCCCGs determine should be included in the programme of work.

C. Each member CCG shall also delegate the following functions to the JCCCGs, so that it can achieve the purpose set out in (A) above:

a. Acting with a view to securing continuous improvement to the quality of commissioned services in so far as these services are included within the scope of the programme. This will include outcomes for patients with regard to clinical effectiveness, safety and patient experience to contribute to improved patient outcomes across the NHS Outcomes Framework.

b. Promoting innovation, in so far as this affects the services included within the scope of the programme, seeking out and adopting best practice, by supporting research and adopting and diffusing transformative, innovative ideas, products, services and clinical practice within its commissioned services, which add value in relation to quality and productivity.

c. The requirement to comply with various statutory obligations, including making arrangements for public involvement and consultation throughout the process. That includes any determination on the viability of models of care pre-consultation and during formal consultation processes, as set out in s.13Q, s.14Z2 and s.242 of the NHS Act 2006 (as amended) ('the Act').

d. The requirement to ensure process and decisions comply with the four key tests for service change introduced by the last Secretary of State for Health, which are:

- Support from GP commissioners;
- Strengthened public and patient engagement;
- Clarity on the clinical evidence base;
- Consistency with current and prospective patient choice.

e. The requirement to comply with the statutory duty under s.149 of the Equality Act 2010 i.e. the public sector equality duty.

f. The requirement to have regard to the other statutory obligations set out in the new sections 13 and 14 of the NHS Act. The following are relevant but this is not an exhaustive list:

13C and 14P - Duty to promote the NHS Constitution

13D and 14Q - Duty to exercise functions effectively, efficiently and economically

13E and 14R – Duty as to improvement in quality of services

13G and 14T - Duty as to reducing inequalities

13H and 14U – Duty to promote involvement of each patient

13I and 14V - Duty as to patient choice

13J and 14W – Duty to obtain appropriate advice

13K and 14X – Duty to promote innovation

13L and 14Y – Duty in respect of research

13M and 14Z - Duty as to promoting education and training

13N and 14Z1- Duty as to promoting integration

13Q and 14Z2 - Public involvement and consultation by NHS England/CCGs

13O - Duty to have regard to impact in certain areas

13P - Duty as respects variations in provision of health services

14O – Registers of Interests and management of conflicts of interest

14S – Duty in relation to quality of primary medical services

g. The JCCCGs must also have regard to the financial duties imposed on CCGs under the NHS Act 2006 and as set out in:

- 223G – Means of meeting expenditure of CCGs out of public funds
- 223H – Financial duties of CCGs: expenditure
- 223I - Financial duties of CCGs: use of resources
- 223J - Financial duties of CCGs: additional controls of resource use

h. Further, the JCCCGs must have regard to the Information Standards as set out in ss.250, 251, 251A, 251B and 251C of the Health & Social Care Act 2012 (as amended).

i. The expectation is that CCGs will ensure that clear governance arrangements are put in place, so that they can assure themselves that the exercise by the JCCCGs of their functions is compliant with statute.

j. The JCCCGs will meet the requirement for CCGs to comply with the obligation to consult the relevant local authorities under s.244 of the NHS Act and the associated regulations.

k. To continue to work in partnership with key partners e.g. the Local Authority and other commissioners and providers to take forward plans so that pathways of care are seamless and integrated within and across organisations.

l. The Joint Committee will be delegated the capacity to propose, consult on and agree future service configurations that will shape the medium and long terms financial plans of the constituent organisations. The Joint Committee will have no contract negotiation powers meaning that it will not be the body for formal annual contract negotiation between commissioners and providers. These processes will continue to be the responsibility of Clinical Commissioning Groups and NHS England under national guidance, tariffs and contracts during the pre-consultation and consultation periods.

D. The role of the JCCCGs shall be to carry out the functions relating to decision making on pertinent Lancashire and South Cumbria wide commissioning issues that arise from the programme. This includes, but is not limited to, the following activities:

- Determine the options appraisal process;
- Determine the method and scope of the engagement and consultation processes;
- Act as the formal body in relation to consultation with the Joint Overview and Scrutiny Committees established for relevant consultation by the applicable Local Authorities;
- Make any necessary decisions arising from a pre-consultation Business Case (and the decision to run a formal consultation process);
- Approve relevant consultation plans;
- Approve the text and issues on which the public's views are sought in all documentation associated with the formal consultation process;
- Take or arrange for all necessary steps to be taken to enable the CCG to comply with its public sector equality duties;
- Approve the formal report on the outcome of the consultation that incorporates all of the representations received in response to the consultation document in order to reach a decision;
- Make decisions about future service configuration and service change, taking into account all of the information collated and representations received in relation to

the consultation process. This should include consideration of any recommendations made by the ICS Board, or views expressed by the Joint Health Overview and Scrutiny Committee or any other relevant organisations and stakeholders.

At all times, the Joint Committee, through undertaking the decision making function of each member CCG will act in accordance with the terms of their constitutions. No decision outcome shall impede any organisation in the fulfillment of its statutory duties.

Schedule 2 - List of Members from each Constituent CCG

Clinical Commissioning Group	Representative
Blackburn with Darwen CCG	
Blackpool CCG	
Chorley & South Ribble CCG	
East Lancashire CCG	
Fylde & Wyre CCG	
Greater Preston CCG	
Morecambe Bay CCG	
West Lancashire CCG	

Schedule 3: EXAMPLE OF A WORK PROGRAMME AND DELEGATION LEVELS

Service/ Subject	Executive Sponsor	Description	Key Output	Level of Decision making
Urgent Care	David Bonson	Approve updated Urgent and Emergency Care strategy for Lancashire and South Cumbria which will be developed in response to the national strategy.	Strategy Document	Level 1
SEND	Julie Higgins	Collaborative work between CCGs and Lancashire County Council to deliver the 2019-2020 Lancashire SEND partnership improvement plan with specific delivery of a commissioning plan, evaluation and monitoring system, implementation of the neuro developmental diagnostic pathway; speech and language and occupation therapy service reviews; consistency in multiagency school readiness pathway		Level 2
Mental Health	Andrew Bennett	Agree action plan for commissioners which may arise from the external review of the urgent care mental health system in Lancashire being undertaken by Northumberland Tyne and Wear NHS Foundation Trust	Action Plan	Level 1
Individual Patient Activity (IPA)	Jerry Hawker	Agree a single commissioning and operating model across Lancashire & South Cumbria, appropriately resourced, with the right staff, in the right place at the right time across the ICS, ICPs and neighbourhoods. Agree a single governance, business intelligence and delegated financial framework with accountability to the ICS and JCCCGs	Proposed Commissioning Model	Level 1 Level 2
Cancer	Denis Gizzi	Agree recommendations for commissioners which arise from Cancer transformation programme	Set of Recommendations	Level 1
Cancer/ Workforce	Denis Gizzi	Agree the Outline Business Case for Oncology Advanced Clinical Practitioners	Outline Business Case	Level 2
Specialist weight management services	Clare Thomason	Approve a case for change for multi-agency action in relation to obesity and specialist weight management	Case for Change	Level 1
Stroke	Andrew Bennett	Agree options for the configuration of Hyper Acute and Acute stroke services	Case for Change	Level 1

		Review and approve outline business case. Decide on requirement and readiness to consult. Approve full business case Review outcomes of consultation Consider and approve commissioning approach and approve delivery plan	Outline Business Case Full Business Case	Level 1 Level 2
Commissioning Policies	Andrew Bennett	Agree updated commissioning policies developed collectively for all CCGs Agree updated medicines management policies developed collectively for all CCGs	Policy Documents	Level 1
Vascular	Talib Yaseen	Agree operating model for vascular services across Lancashire and South Cumbria.	Case for Change Service (operating) model	Level 1
Commissioning development	Andrew Bennett	Agree recommended operating models and implementation plans arising from Commissioning Development Framework programme	Commissioning Framework	Level 1
Children and Young People's Mental Health	TBA	Approve clinical model for CYP Mental Health services across Lancashire and South Cumbria Approve transition and implementation plan for clinical model	Clinical Model and implementation plan	Level 1
Children and Maternity	Arif Rajpura	Approve case for change for paediatric services	Case For Change	Level1
Primary Care	Amanda Doyle	Approval of ICS Strategy for Primary Care	ICS Strategy	Level 1
Planned Care	Andrew Harrison	Agree prioritised list of pathways and timeline for development of outcome based consistent clinical pathways across Lancashire & South Cumbria	Clinical Pathways	Level 1
Learning Disability	Andrew Bennett	Agree clinical model of non-secure, specialist inpatient provision for Learning Disabilities and Autism within the Lancashire and South Cumbria footprint	Clinical Model	Level 1
Integrated Commissioning (on LCC footprint)	Julie Higgins	Collaborative work between CCGs and Lancashire County Council to build a common platform for integrated commissioning at an ICP level: Initiation to proof of concept phase:- scope principles, commitment and approaches, for the integration agenda building on BCF; test two areas for "in view" budget	Integrated Commissioning platform	Level 2

		management leading to transformation for intermediate care and mental health section 117.		

Decision making authority level definition:

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 form the basis of endorsements and recommendations to the Governing Bodies of each member CCG, and other decision making bodies.*