Attain

Improving health and wellbeing

Review of Strategic Commissioning for Children and Young People's Emotional Wellbeing and Mental Health Services in Essex

11 December 2018

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1. BACKGROUND

Attain have been commissioned by the three Local Authorities and seven Clinical Commissioning Groups in Essex to undertake a review of the Essex-wide strategic commissioning and contracting arrangements for children and young people's Emotional Wellbeing and Mental Health Services (EWMHS). The principal purpose of this is to enable commissioners to decide how to approach reprocurement of services in preparation for expiry of the current contract.

This document provides a brief history of these arrangements, a summary of the commissioners' and the provider's views, a review of key documents, a brief analysis of other collaborative arrangements, an overview of options, some further observations based on Attain's prior experience of collaborative commissioning, and a number of recommendations for the future.

The review has taken place alongside a separate review of the clinical effectiveness of services, undertaken by Apteligen. The respective leads of each review have co-operated to ensure that the two reviews together provide a complete analysis of the collaborative arrangements while avoiding duplication.

1.1. Terms of Reference

The key terms of reference of this review are to:

- Review the existing commissioning and contracting arrangements.
- Engage with commissioners to understand how well the Collaborative Commissioning Forum is functioning.
- Develop options for future commissioning and contracting arrangements.
- Conduct options appraisal and identify preferred options in relation to:
  - Future geographical footprint for the service
  - Future funding model
  - Future commissioning arrangements.

The final report is to include the following outputs:

- Clear recommendations based on the outcomes of the options appraisal for each of the elements outlined above.
- Development of a high level implementation plan should the recommendations be adopted by the commissioning partners.

1.2. Approach

The review has been based on:

- Structured interviews with representatives of all ten commissioning organisations.
- A structured interview with representatives of the service provider.
- Desktop analysis of key documents.
- Comparison with good practice based on other collaborative models.

Initial feedback was discussed at the Collaborative Commissioning Forum on 19 November and delegates also discussed the potential forward work programme.

1.3. History of the Collaborative

In 2014, the three Local Authorities and seven Clinical Commissioning Groups in Essex agreed to collaborate to jointly commission a single Children and Young People's Emotional Wellbeing and Mental Health Service. This would replace a number of previous contracts and providers delivering Child and Adolescent Mental Health Services (CAMHS) at tiers 2 and 3 of the traditional four-tier model[1]:

- Tier 1 – universal services provided by practitioners who are not mental health specialists, such as GPs, health visitors, school nurses, teachers, social workers, youth justice workers and voluntary agencies. Practitioners will be able to offer general advice and treatment for less severe problems, contribute towards mental health promotion, identify problems early in their development, and refer to more specialist services.

- Tier 2 – specialist community and primary care services such as primary mental health workers, psychologists and counsellors working in GP practices, paediatric clinics, schools and youth services. Practitioners offer consultation to families and other practitioners, outreach to identify severe or complex needs which require more specialist interventions, assessment (which may lead to treatment at a different tier), and training to practitioners at Tier 1.

- Tier 3 - usually a multi-disciplinary team or service working in a community mental health clinic or child psychiatry outpatient service, providing a specialised service for children and young people with more severe, complex and persistent disorders. Team members are likely to include child and adolescent psychiatrists, social workers, clinical psychologists, community psychiatric nurses, child psychotherapists, occupational therapists, art, music and drama therapists.

- Tier 4 - tertiary level services for children and young people with the most serious problems, such as day units, highly specialised outpatient teams and in-patient units. These can include secure forensic adolescent units, eating disorders units, specialist neuro-psychiatric teams, and other specialist teams (e.g. for children who have been sexually abused), usually serving more than one district or region.

The collaborative approach was intended to address issues of equity, access, fragmentation, variability in outcomes and poor service user experience.

In order to achieve this, the commissioners established an EWMH Redesign Project Board and a Collaborative Commissioning Forum (CCF) and entered into a two-part Collaborative Commissioning Agreement (CCA). Part 1 set out the arrangements for procurement of the service, while Part 2 established the arrangements for ongoing commissioning and contract management. Further details of the CCA are given in section 3.1.

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[1] Adapted from https://webarchive.nationalarchives.gov.uk/20100202120904/http://www.dcsf.gov.uk/everychildmatters/healthandwellbeing/mentalhealthissues/camhs/fourtierstrategicframework/fourtierstrategicframework/

Following a procurement process, a three year contract, with an optional two year extension, was awarded to North East London NHS Foundation Trust (NELFT), who had proposed an integrated "tierless" model which brings together the previous Tier 2 and Tier 3 services. This contract commenced on 1 November 2015.

The initial contract, and the extent of the collaborative arrangement, was based on historic Tier 2 and 3 expenditure, amounting to around £13.8m a year as at October 2014. The commissioners have subsequently invested substantial Local Transformation Plan (LTP) funds and the CCF currently manages total expenditure of around £20.5m, of which £19.2m (94%) is for services delivered by NELFT.

Discussion of proposals for LTP funding has formed a major part of CCF business over the last two years, however funds for 2019/20 are already fully committed and therefore it is likely that the focus of the meeting will change.

The commissioners have recently agreed to extend the NELFT contract and will need to decide by February 2019 how to approach reprocurement in readiness for contract expiry in 2020. A high level timetable for reprocurement is set out below:

Milestone/Stage	Date
Strategic commissioning review complete	Dec 18
Service evaluation complete	Jan 19
Recommendations reviewed by CCF and individual commissioners	Feb/Mar 19
Approval to proceed	Mar 19
Pre-procurement	Apr – Jul 19
Approval of procurement documentation	Aug 19
Procurement	Sep 19 – Mar 20
Mobilisation	Apr – Sep 20
Service start	Oct 20

1.4. Lead Commissioning Team

The collaborative is supported by a jointly funded lead commissioning team, hosted by West Essex CCG. This team has a budget of £312,478 of which half is shared between commissioners on a straight ten-way split and half in proportion to commissioners' shares of the NELFT contract.

The establishment of the team is as follows:

Post	Band	WTE
Strategic Lead	8d	1.00
Commissioning Manager	8b	1.00
Administrative Support	5	1.00
Clinical/Quality Management	8a	0.60
Financial Management	8a	0.50
BI support	7	0.05
Contract Support	8b	0.05

There is also a small provision for strategic financial management and a contribution to overheads.

The lead team carries out a wide range of functions on behalf of commissioners, including managing the NELFT contract, servicing CCF meetings, leading development and update of the strategy, developing proposals for LTP investments, managing and reporting on the LTP budget, reporting to NHS England and managing step-up/down between EWMHS and Tier 4 services.

2. SUMMARY OF INTERVIEWS

A series of structured face to face and telephone interviews were held during September, October and November 2018. These included all ten commissioners and the provider of the EWMHS service.

Commissioners were asked about:

- Their knowledge of the background to the collaborative arrangements and the extent to which they had personally been involved in the CCF.
- Their objectives in terms of children and young people's mental health and the collaborative arrangements.
- The strengths and weaknesses of the collaborative arrangements.
- The effectiveness of decision making processes.
- How well they thought LTP funds were being used.
- Other collaborative arrangements they were party to, or had been in the past.
- Their thoughts on potential future arrangements regarding footprint, funding and commissioning and contracting arrangements.
- Any specific requirements or "red lines".
- Anything else they wished to raise in relation to the arrangements.

The following sections summarise the key themes and issues which arose.

2.1. Commissioners

In total, 21 representatives of the 10 commissioning organisations were interviewed. A brief discussion of the issues raised is given below, followed by a summary of the key issues and the frequency with which they were raised. References to the number of commissioners raising an issue refers to the number of organisations and not the number of individuals.

All of the interviewees were familiar with the background to the collaborative arrangements, although only around half had been involved since the outset. Of the rest, five had only been involved in the CCF for a year or less, and the remainder for around two years. Some of those interviewed said that they do not regularly attend the CCF.

With regard to objectives, all commissioners stated that the Local Transformation Plan *Open Up, Reach Out*, which was updated in November 2017[2] was a good representation of their strategic objectives, although some felt that it does not fully recognise specific local issues. All commissioners also said that their principal objective in collaborating was to achieve equity and economies of scale,

All commissioners felt that the collaborative had achieved considerable early success in reducing inequity and developing a common offer for the county. Progress has also been made towards breaking down barriers, for example between health services and schools, although some organisations said that there is

[2] http://www.essex.gov.uk/Health-Social-Care/Families-and-childrens-social-care/Documents/Open-up-reach-out-year3.pdf

more work to do on that. Working at scale is recognised as a strength and a number of commissioners also said there is a good mix of skills on the CCF but two identified a need for more clinical input. Two commissioners also commented that there was a lack of service user engagement, and felt that this needs to be addressed.

While most commissioners said that access to services had been improved, for example through self-referral and the single point of access, four commented on the adverse impact this has had on waiting times.

It was clear from the interviews that the CCF has experienced some difficulties and a number of attempts have been made to address these, including discussions at Chief Officer level and a series of away days. This has led to some changes being made, and many commissioners mentioned that there had been improvements. One of the key issues is the need for unanimity in decision making. Most commissioners feel that the decision making process does not work well and needs to be reviewed. In particular some commissioners have said that the need to satisfy internal governance processes means that there is insufficient time to discuss proposals internally between issue of papers and the date of CCF meetings. This leads to unplanned delays in decision making at the CCF, which can be a cause of frustration, particularly for the lead commissioner who is responsible for progressing the programme of work. Even though the Collaborative Commissioning Agreement is clear that representatives should have delegated authority to make decisions, some interviewees said that they did not have that authority, and a small number said that they felt that the CCF should only make recommendations and not decisions.

Despite an apparent growth in the number of representatives in recent months, some commissioners said that there is still a lack of continuity in the membership and often a lack of seniority or delegated authority. This sometimes means that attendees are given organisational decisions in advance with no latitude for discretion, so there is little scope for discussion and decision. Some representatives also feel that an imbalance in seniority can result in some views being overlooked.

Almost all commissioners questioned the need for unanimous decision making and felt that there should be more scope for localisation.

Around half of commissioners said that the CCF has become transactional, with most of the focus being on spending LTP funds. Some felt that the pressure to ensure that funds are committed may mean that commissioners are not achieving the best possible value for money. Around half of the commissioners said that the quality of spending proposals is variable, with business cases sometimes being presented on a take-it-or-leave-it basis rather than providing a range of options. A scoring matrix has been developed to facilitate appraisal of proposals. Five commissioners said that the CCF needs to return to being a more strategic forum.

Other issues raised included the lack of a forward business plan for the CCF and a divergence of views about the role of the lead commissioner. While some commissioners are happy for the lead to act on their behalf, others want to be more involved, and would prefer the lead to act more in a co-ordinating role. Further reference is made to this issue in the Document Review section. Three commissioners also said that they wanted more opportunity to engage directly with the provider, but all were clear that they did not want to duplicate the lead commissioner's role.

Some commissioners also felt that they were not as well informed as they should be, for example on contract performance and wanted more time allocated to discuss this.

Most of the commissioners interviewed had relatively little experience of other collaborative commissioning arrangements, although some were mentioned such as the Adult Mental Health commissioning, which has recently been restructured, children's Continuing Healthcare and the Essex Transforming Care Partnership Board for Learning Disabilities, which has the same partners as the EWMHS collaboration. Three commissioners said that the Transforming Care Partnership Board experienced fewer difficulties in decision making and that this was due to a more senior membership and allowing more time for individual commissioners to discuss proposals before Board sign-off.

Others mentioned some emerging STP-wide arrangements but did not feel that there were any particular lessons which could be learnt from them and applied to the CCF.

There are different views on whether the collaborative should continue on a county-wide basis or at all, however most commissioners feel that the benefits of collaboration should outweigh the challenges, provided that the CCF can operate more effectively and that the autonomy and governance of individual organisations is respected. Further details are given in the Options section.

All commissioners stated that they would be happy to continue with the current funding arrangements if a county-wide approach is retained, provided that there is scope for more localised investment, and most said that they wanted to continue with a block contract, with some of the price linked to outcomes.

A summary of the key issues raised and the frequency (in terms of the number of organisations mentioning them) are shown below:

Issue	Frequency
Working Well:	
Clear strategic objectives	10
Strengths of the collaborative arrangements	10
Using outcomes-based block contract	8
Improvement Opportunities:	
Need for more localisation	9
Need to review the decision making process	9
Need more focus on contract performance and outcomes	7
Need more time for internal governance before CCF decisions	7
CCF needs to be more strategic	5
Increased waiting times	4
Need for more clinician and/or service user engagement	4
Need to review value for money of LTP investments	4

It should be noted that work is already in place to address some the issues raised above, such as the creation of a clinical network, which is due to begin meeting on a monthly basis from January, and the establishment of contract pre-meetings. More detail on this is given in the Recommendations section. Additionally, it can be seen that many of the difficulties experienced by commissioners have related to reaching agreement on

the LTP funding. Given that this has now been fully committed, the focus of discussions will shift towards reprocurement and therefore these issues will be of less relevance in the immediate future.

2.2. Provider

The provider, NELFT, gave a helpful overview of the history of the service and how they had mobilised and brought together the previously disparate clinical teams. They also highlighted some key strengths of the service, including improvements in equity, an emphasis on early intervention, breaking down organisational barriers, maintaining an overview of children and young people who move within the county, and innovations such as paid service user participation.

NELFT is not a member of the CCF but has begun attending a Part 2 session to update commissioners on matters such as service developments. The provider representatives feel that the lead commissioning arrangement works well in respect of contract management, with the meetings being well managed and effective. They do not feel that having wider attendance from commissioners would be productive and having separate meetings with each commissioner would not be practical, at least not at a senior level.

In respect of the broader commissioning agenda, it was noted that the move to unanimous decision making had delayed some proposals. The provider also noted that achievement of economies of scale was largely dependent on having a common service model across the county so the scope for local variation was limited.

Overall, NELFT representatives feel that they have good relationships with the commissioners and attend a range of forums across the county to engage with individual organisations.

3. DOCUMENT REVIEW

3.1. Collaborative Commissioning Agreement

The Collaborative Commissioning Agreement (CCA) is in two parts. This review focusses on Part 2 of the agreement, which relates to ongoing commissioning and management of the contract, as Part 1 is no longer relevant. Commissioners will however need to review Part 1 if they decide to continue to collaborate when services are reprocured.

The agreement is based on the NHS England Model Collaborative Commissioning Agreement (Single contract option)[3], with some differences as set out below:

- Under the model agreement, the collaborative forum does not have delegated authority to make decisions which are binding on commissioners, but makes recommendations based either on consensus or simple majority vote. The EWMHS CCA states that the forum has delegated authority to make decisions, and that it is assumed that representatives have the appropriate level of delegated authority to act on behalf of their organisation.
- The CCA also distinguishes between a number of "reserved matters", which require unanimous decisions, and other matters which may be decided by a weighted majority vote, with each Local Authority having a 16.6% vote and each CCG having a 7.14% vote.
- Under the CCA, each commissioner is to be given 5 days' notice of decisions to be made at the collaborative forum, with some additional provisions for unforeseen decisions.
- The CCA contains additional clauses on resourcing, termination, force majeure, waiver and complaints handling, which supplement the content of the model agreement.

The CCA defines the respective roles of the lead commissioner and the associate commissioners as set out in Appendix A and summarised below:

Individual commissioners remain responsible for a range of matters, including:

- performing and exercising their statutory duties and functions for the commissioning of health services or (in relation to those commissioners that are local authorities) their health related functions
- making decisions relating to their policy, for committing commissioning resources and for making commissioning decisions for their health economy
- modelling demand for the commissioned services, specifying indicative activity levels for inclusion in the commissioning contract, monitoring actual activity against indicative levels and raising any queries or concerns about performance against demand with the lead commissioner unless such actions are agreed as the responsibility of the lead commissioner.
- reviewing and, where appropriate, contesting reconciliation accounts received from the provider and making payments to the provider, in accordance with the payment provisions set out in the commissioning contract;

[3] The current version is available at https://www.england.nhs.uk/wp-content/uploads/2016/06/cca-1617-single-upd.docx

- where instructed by the lead commissioner, applying any financial adjustments or withholdings (and each commissioner acknowledges that where so instructed by the lead commissioner, it will make any adjustments, deductions or withholdings in accordance with those instructions)
- dealing with individual funding requests, service user complaints, and serious untoward incidents
- specifying any prior approval schemes and, in respect of any service specification, applicable exclusion or acceptance criteria (where different from others under the commissioning contract)
- managing referrals
- initiating dispute resolution, unless dispute resolution is initiated by the lead commissioner on behalf of all commissioners.

Commissioners are also required:

- to nominate a commissioner representative, with delegated authority to act on its behalf in relation to the collaborative and the commissioned cervices;
- to provide all relevant information to the lead commissioner promptly, so as to assist the lead commissioner in the management of the commissioning contract.

The lead commissioner is appointed to carry out responsibilities in relation to the commissioning contract (ie the NELFT contract). Where these relate to routine contract management, information and reporting, the lead commissioner may undertake those actions without further consultation with the commissioners.

Where the lead commissioner proposes to take any actions under the commissioning contract that affect the commissioning strategy, procurement, commissioning responsibilities or decisions of the commissioners, including actions relating to the variation, termination or suspension of the commissioned services, prices under the commissioning contract or any other actions in respect of the commissioning contract that affect the statutory commissioning responsibilities of the commissioners including but not limited to any reserved matters (such actions being lead commissioner actions), the lead commissioner may take that lead commissioner action only after receiving the approval of each commissioner in accordance with clause 7 of the CCA, which sets out the process for gaining agreement to lead commissioner actions, and for dealing with non-agreement.

Other responsibilities of the lead commissioner include:

- managing activity, including notifying the provider of activity planning assumptions, monitoring activity and reviewing activity reports, dealing with activity queries and activity management meetings, and agreeing activity management plans
- agreeing service development and improvement plans and/or data quality improvement plans with the provider
- agreeing service variations
- agreeing information and reporting requirements, and managing information breaches
- agreeing local prices, managing agreements or proposals for local variations and local modifications, making and receiving payments (where commissioners' payments under the commissioning contract are aggregated), including CQUIN payments
- agreeing local quality requirements and quality incentive scheme indicators, and variations to national sanctions and national CQUINs as applicable

- implementing financial adjustments or sanctions resulting from breaches of any provider obligations including those relating to activity management plans, operational standards, data quality improvement plans and service quality improvement plans
- managing complaints
- appointing of an auditor
- conducting review meetings, and undertaking contract management, including the issuing of receipt of contract queries and agreeing any remedial action plan or related contract management processes
- disseminating information to commissioners in relation to the commissioning contract
- dealing with termination, suspension and disputes on behalf of the commissioners

Some elements of the CCA, principally sections 5.1 to 5.9 regarding the functions, membership and operation of the CCF, have been superseded by CCF Terms of Reference dated 20 June 2018. Neither document however correctly defines the current decision making processes in the CCF.

Neither the CCA nor the CCF Terms of Reference fully reflect the range of work undertaken by the lead commissioning team, which extends beyond contract management to a number of activities as mentioned in section 1.4.

As noted above, there were different views among commissioners about the extent to which the lead commissioner should have delegated authority and it would probably be helpful to review this when the CCA and CCF Terms of Reference are refreshed.

3.2. Strategy

Open Up, Reach Out is a comprehensive document and clearly articulates the strategy, which is based on improving access and equality, building capacity and capability in the system and building resilience in the community.

Ten outcomes are defined in the strategy:

1. Improvements in mental health for children and young people in Southend, Essex and Thurrock, using better methods to monitor and measure progress.
2. A joined-up system with no barriers.
3. Reduction in inequality - no discrimination, no stigma.
4. Easier access to services with shorter waiting times.
5. Other services working with children and young people are enabled to promote and support good emotional wellbeing and mental health.
6. Better advice, support, training and guidance for parents, teachers and others.
7. Fewer visits to A&E.
8. Priority for assessment of children and young people from vulnerable groups, including proactive outreach.
9. Young people aged 14-25 to get the right support and, if necessary, a smooth transition to adult services.
10. Opportunities for children and young people to influence services, not just for their own care but also as part of collaboration between services and young people.

Given that all ten commissioners stated that this document reflects their commissioning objectives, there is clearly alignment of strategy. As noted above however, almost all commissioners feel that there are additional local issues due to the demographics and needs of particular communities which need to be addressed in addition to those in the strategy.

3.3. NELFT Contract

As noted above, the NELFT contract accounts for almost 95% of the collaborative's expenditure and is therefore a key vehicle for achievement of the strategic objectives.

The contract uses the standard NHS contract format, updated in May 2018, as mandated by NHS England. The contract commenced on 1 November 2015 for a period of three years, with an optional two year extension. This extension has been enacted, which means the contract is due to expire on 31 October 2020.

The pricing mechanism is block, with an element linked to outcomes as described below. This limits risk for commissioners but may disadvantage the provider at times of rising demand. The contributions of each commissioner are split between EWMHS, LTP funds and Learning Disabilities as shown below (these figures are based on month 7 forecast outturn):

Commissioner	EWMHS	LTP	LD	Total
Essex CC	1,844,918			1,844,918
Southend BC	204,226			204,226
Thurrock BC	196,445			196,445
NHS Basildon and Brentwood CCG	1,676,065	818,224	65,151	2,559,440
NHS Castle Point and Rochford CCG	888,596	548,377	34,542	1,471,515
NHS Mid Essex CCG	927,922	579,241	36,070	1,543,233
NHS North East Essex CCG	1,015,938	492,980	39,491	1,548,409
NHS Southend CCG	1,832,488	1,082,230		2,914,718
NHS Thurrock CCG	2,287,570	1,083,059		3,370,629
NHS West Essex CCG	2,575,056	923,714		3,498,770
Total	**13,449,224**	**5,527,825**	**175,254**	**19,152,303**

The contract contains a number of detailed service specifications, an indicative activity plan, a wide range of local quality requirements, a local CQUIN scheme, a local incentive scheme (which replaces national CQUIN), a range of reporting requirements, a data quality improvement plan, service development and improvement plans, and requirements for service user, staff and carer surveys.

The contract does not specifically refer to *Open Up, Reach Out,* however a number of the strategic objectives are reflected in the contract as key performance indicators, on which payment of part of the contract price is dependent under the local incentive scheme:

KPI 1: Number and % of service users who have improved their validated outcome measurement score between commencement of treatment, and at 6 months (or case closure if before 6 months)

KPI 2: Number and % of service users reporting satisfaction with services received

KPI 3: Referral to treatment waiting times by locality
KPI 4: Referral to assessment waiting times for new cases by locality
KPI 5: Total number of crisis assessments undertaken in A+E for each locality, including out of hours
KPI 6: DNA rate in each locality

The contract states that 6% of the price is linked to achievement of these KPIs. This is lower than the 15% aspiration stated in the CCA. While there is good evidence[4] that linking contract price to outcomes can achieve both better outcomes and reduced cost, there is no particular evidence as to what the most appropriate percentage is. This also has to be weighed against the risk of destabilising the provider, particularly when, as noted above, there has been a significant rise in demand over the period of the contract.

The contract is compliant with best practice and no issues of concern were noted.

3.4. CCF Minutes

The minutes of the Collaborative Commissioning Forum meetings from April to September were reviewed and the October and November meetings were observed. These show that the forum meets regularly but is not always well attended and it is frequently the case that not all member organisations are represented.

The meetings are well documented. The main area of concern is that there is usually a very full agenda, with limited time to discuss each issue and, as commissioners have noted, there is no dedicated time to discuss contract performance. The contract meeting minutes, action log and performance reports are however distributed to commissioners on a regular basis. These are extensive and comprehensive.

3.5. Contract Management Minutes

The contract meeting minutes from May to October were reviewed. These show that there are regular meetings and that these are well attended. There appears to be comprehensive discussion of performance and quality, and decisions and actions are well documented.

The main area of concern to note is the performance against waiting time KPIs, which have been amber or red since April and are in some cases declining. An action plan to address this has been approved by the CCF.

4 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/448283/Mental_Health_Outcomes_LPE.final.pdf

4. EXAMPLES OF OTHER COLLABORATIVE ARRANGEMENTS

There are numerous examples of other collaborative commissioning arrangements around the country. These vary considerably in their scope, the number of partners, the complexity of their structures and their decision making processes. There do not appear to have been any comprehensive studies of the relative effectiveness of different models, however this section highlights some alternative approaches which may be of interest to the CCF.

Ten examples have been reviewed in detail and links to relevant documents are included at Appendix B. Some of these may no longer be active but they provide some relevant examples of alternative approaches:

- Cheshire and Merseyside Collaborative Commissioning Forum (12 partners).
- Collaborative Commissioning Agreement for Commissioning Emergency Ambulance Services from South Central Ambulance NHS Foundation Trust (7 partners).
- Collaborative commissioning arrangements between four London CCG for services provided by Bart's Health NHS Trust (4 partners).
- NHS Bristol, North Somerset and South Gloucestershire CCGs Partnership Group (3 partners).
- Kent and Medway CCGs (8 partners).
- Lancashire Collaborative Commissioning Board (13 partners).
- NHS England and CCG Specialised Commissioning Oversight Groups (variable).
- South East London Collaborative Framework (6 partners).
- South Yorkshire and Bassetlaw STP (25 partners, of which 5 are CCGs).
- Yorkshire, Humber and Lincolnshire collaborative commissioning of NHS 111 services (23 partners).

As can be seen, the number of commissioners varies from 3 to 23. There is also considerable variation in the scope of services, with three being single-contract arrangements and the rest being for either a broader range of defined services or for all services.

A wide range of structures exists across these examples. Some, such as the Yorkshire Humberside and Lincolnshire NHS111 collaboration and the South Central Ambulance commissioners, have a single forum comprised of member organisations' staff. Others, for example the South East London CCGs and the Bart's commissioners, have jointly funded lead commissioning teams or programme offices as well as committees of partners' staff. At the most complex end of the scale are those which have multi-tiered organisational structures, such as the South Yorkshire and Bassetlaw STP. This has a range of bodies, including a Strategic Oversight Group, a Collaborative Partnership Board, an Executive Partnership Board and a Joint Committee of Clinical Commissioning Groups.

In general, as might be expected, the complexity of the structures is broadly related to the scope of services within the collaborative arrangements. The single-contract examples will of course be of most relevance to the CCF.

Taking into account the issues raised by CCF members, the area of most interest is the decision making processes within these arrangements. Again, these vary considerably. The South Central Ambulance Commissioning Agreement does not make any reference to joint decision making but states that each

commissioner remains responsible for committing resources and making commissioning decisions. Given that contract management is essentially a rules-based process, this is probably appropriate.

A number of the arrangements listed are only empowered to make recommendations to the partner organisations. These include the NHS Bristol, North Somerset and South Gloucestershire CCGs Partnership Group, the Cheshire and Merseyside Collaborative Commissioning Forum and the Kent and Medway CCGs. The Specialised Collaborative Commissioning Oversight Group Agreements only allow members to make non-binding recommendations to NHS England.

Those which have decision making responsibilities manage these in a variety of ways. The Bart's commissioners have delegated authority, subject to financial envelopes specified by their CCGs. The Lancashire Collaborative Board defines three decision making mechanisms to be used as appropriate:

- Individual members may participate in collective decisions in accordance with their delegated authority.
- Delegated authority may be requested and received from members in relation to individual projects.
- The Board may recommend to members a decision for ratification.

Similarly, the Yorkshire Humber and Lincolnshire NHS 111 commissioners have three levels of decision making, set out in a scheme of delegation:

- Decisions reserved to each party ("CCG Decisions")
- Decisions which are delegated by each party to a Lead Officer acting in collaboration with the other Lead Officers ("Joint Strategic Commissioning Board Decisions")
- Decisions which are delegated to the Lead Commissioner/Contractor by each Party ("Lead Commissioner/Contractor Decisions")

The South East London Committee in Common for Strategic Decision Making takes decisions in public on behalf of the CCGs, but only after consideration of the issues by each CCG Governing Body and engagement of the CCG membership. The South East London Chief Officers Group can make decisions based on the scheme of delegation passed to individual chief officers by individual CCG constitutions.

Finally, the South Yorkshire and Bassetlaw STP makes decisions through its Joint Committee of Clinical Commissioning Groups, which is formally constituted as a committee of each CCG with delegated authority.

It appears from this that the common features of collaborative arrangements with decision making powers are:

- A distinction between different types of decision, with some having to be referred back to partners' internal governance arrangements and some not.
- A clear scheme of delegation with specified financial limits.

The majority of the examples reviewed specify decision making by consensus, while the Yorkshire Humber and Lincolnshire NHS 111 collaboration seeks unanimity, with any lack of agreement referred to a dispute resolution process.

Further reference to these approaches and how they may be applicable to the CCF is made in the Recommendations section.

5. OPTIONS

As noted above, the terms of reference for the review included developing and appraising a range of options. For many of these, however, there is either a clear view from commissioners or an emerging consensus. It was not therefore felt necessary to fully define and analyse options. Instead a brief summary of the key issues is given below.

5.1. Footprint

There are a number of ways in which the future footprint of services could be defined and the associated commissioning and contracting arrangements would naturally follow. These are:

5.1.1. County-Wide

This would mean continuing with the current arrangements, with a single contract for all ten commissioners. As has been noted above, this would have a number of benefits in terms of equity and economies of scale. The main disadvantage would be continued boundaries within two of the STP areas, but neither of the CCGs concerned considers this to be major issue. Inevitably there would continue to be tensions between a county-wide approach and specific local issues but it should be possible to address this.

It should also be noted that a county-wide approach to children and young people's mental health services may not align to commissioning arrangements for adult mental health. Commissioners may however consider that the need for alignment with education services overrides this.

Four commissioners stated that a county-wide approach was their preference and three have indicated that they would support this, subject to having some scope for localisation. Three commissioners are still considering their options.

5.1.2. Sustainability and Transformation Partnerships

Commissioning on an STP basis would mean West Essex collaborating with the Hertfordshire CCGs and North East Essex working with the Ipswich and Suffolk CCGs. In each case this would potentially involve other Local Authorities, while the Mid and South Essex CCGs would continue to work with Essex County Council, Southend Borough Council and Thurrock Council.

Given the need for schools and health services to work closely together, this appears to be an unnecessarily complex situation and there is little support for this approach. Neither West Essex CCG or North East Essex CCG currently have strong collaborative commissioning arrangements within their STPs, while Essex County Council are clear that council taxpayers' money should stay within the county. This option would also not address differences between the three Local Authorities.

Two commissioners said that they were considering an STP approach but as above would support county-wide commissioning with localisation.

5.1.3. Local Authority Footprints

Splitting the current arrangement into three would allow Southend and Thurrock more autonomy however this would be detrimental to the economies of scale which arise from a single contract. It is also possible that

the two areas would be disadvantaged by reverting to local commissioning, as they only hold 15% and 9% respectively of the total budget (assuming that Castle Point and Rochford CCG would join Southend). This approach is however being considered by three commissioners.

5.1.4. Individual CCGs

This would be the most fragmented approach, with commissioning taking place separately in West, Mid, North East and South Essex, with Basildon and Brentford, Southend, Castle Point and Rochford and Thurrock either working together or separately. This would undoubtedly result in lost economies of scale and potentially a return to the fragmentation and inequality which existed prior to collaboration. None of the commissioners is currently considering reverting to individual CCG footprints.

5.1.5. Other Issues

In addition to the issues highlighted above, any move away from a single contract may cause difficulties in reprocurement, with multiple processes having to take place simultaneously. In particular:

- The market is unlikely to have the capacity to respond to multiple opportunities.
- This will mean less choice for commissioners as providers will pick the most lucrative or attractive areas to bid for.
- Those areas which the market considers to be less attractive may not get any bids returned.

It may be possible to stagger the timelines so that areas procure at different times and the contract is extended for those areas going last, however this brings with it a likelihood of increased cost and potential TUPE implications. Splitting up the service may also be difficult from a TUPE perspective with regard to management staff who work across multiple sites.

None of these issues are insurmountable, but commissioners should nevertheless be aware of them.

5.2. Funding

Funding for the current arrangement is based on historic spend, plus LTP funding. It is likely that future arrangements would continue on that basis, subject to a decision on the future footprint. All commissioners have said that they are happy with the current arrangement.

If there was to be a move from the current funding arrangement there are various alternatives which could be considered, as described below.

5.2.1. Activity Based Funding

This would mean that each commissioner's contribution would be based on their actual activity, possibly with an overall percentage adjustment to balance back to the contract value. At present, this approach would not be possible as service lines within the contract are not individually priced. For the same reason, it is not possible to say what the impact on individual commissioners would be although it is likely that there would be gainers and losers. It is also not clear how activity would be attributed to Local Authorities as opposed to NHS commissioners.

5.2.2. Episodic Payment

Commissioners will be aware that adult mental health services can be commissioned on an episode of care basis using care cluster currencies. This approach is not currently mandated and does not apply to children and young people's services. If that position was to change and the contract had to be based on episodic payment, it would be possible for commissioner shares to be based on their actual costs. Again, the impact of this cannot currently be assessed. It should be noted however that commissioner contributions could still be made on a full or partial risk share basis using historic shares.

5.2.3. Capitation Based Funding

A capitation based payment system would potentially more accurately reflect the relative needs of each commissioner's population, however it would not be possible to use a single methodology across all commissioners as the populations are of course shared by Local Authorities and CCGs. Assuming that the relative Local Authority and CCG total contributions were preserved, it would be possible to rebase the main element of the contract as shown in the table below. This splits the total Local Authority contribution pro-rata to mid-2017 ONS population estimates and the total CCG contribution pro-rata to 2018/19 weighted capitation. The effect is shown below and compared with the current payment. For the CCGs, the 'current payment' is on the basis of the financial risk share agreement which was in place across the North and South of the county at the time of CAMHS reprocurement in 2014:

Local Authorities	Mid-2017 ONS Pop Estimate	Rebased Payment	Current Payment	Gain/(Loss)
Essex CC	1,468,177	£1,811,119	£1,844,918	£33,799
Southend BC	181,808	£224,275	£204,226	£(20,049)
Thurrock BC	170,394	£210,195	£196,445	£(13,750)
Total	**1,820,379**	**£2,245,589**	**£2,245,589**	**£(0)**

CCGs	2018/19 Wtd Capitation	Rebased Payment	Current Payment	Gain/(Loss)
Basildon and Brentwood CCG	277,159	£1,638,853	£1,676,065	£37,212
Castle Point and Rochford CCG	186,101	£1,100,422	£888,596	£(211,826)
Mid Essex CCG	372,052	£2,199,961	£1,832,488	£(367,473)
North East Essex CCG	377,507	£2,232,215	£2,287,570	£55,355
Southend CCG	199,440	£1,179,299	£927,922	£(251,377)
Thurrock CCG	168,364	£995,542	£1,015,938	£20,396
West Essex CCG	314,110	£1,857,343	£2,575,056	£717,713
Total	**1,894,733**	**£11,203,635**	**£11,203,635**	**£0**

This shows that there would be very little impact for Local Authorities but potentially significant gains and losses for some CCGs.

5.3. Commissioning and Contracting

As noted above, the commissioning and contracting arrangements would naturally follow the footprint, either with or without a lead commissioner. Most commissioners have said that the lead commissioning arrangement is the right one and do not wish to duplicate the functions of the lead. There are others

however who feel that they should be more involved in commissioning and that they have expertise to offer which is not being well utilised.

As can be seen from the examples at section 4, there are various ways of collaborating, ranging from simply working together, to having defined shared responsibilities, or having some or all responsibilities delegated to a jointly funded team. At present, the CCA only defines the contract management role of the lead team, although as noted in practice they undertake far more than this.

West Essex CCG have said that they are happy to continue hosting a lead commissioning team and while two other commissioners said that they would also be happy to take on the lead role, there does not appear to be any definite desire to change the current arrangement.

There are however a number of ways in which the reprocurement of services could be structured:

- A lead commissioner acting with delegated authority and a single contract.
- A lead commissioning acting as a co-ordinating commissioner with a single contract.
- A lead commissioner acting with delegated authority with multiple lots and multiple contracts.
- A lead commissioner acting as a co-ordinating commissioner with multiple lots and multiple contracts.
- A number of commissioners acting with delegated authority across multiple lots and multiple contracts.
- A number of commissioners acting as co-ordinating commissioners across multiple lots and multiple contracts.
- Each commissioner procuring and managing separate contracts.

As noted above, this will to a large extent be dependent on the decision regarding footprint. A detailed comparison of the options would require a comprehensive financial analysis which is beyond the scope of this report, however it is clear that having a single contract should achieve economies of scale. If that was the preferred approach, having a lead commissioner would avoid unnecessary duplication and given that there are only a small number of collaborative arrangements across the county, and therefore limited opportunity to share lead responsibilities, it seems sensible to have a jointly funded team to undertake the lead role.

Given that contract management is largely rules-based, it would be efficient to continue to delegate authority to the lead commissioner as under the current CCA. If the lead commissioner was to have a co-ordinating role, this would result in changes to current staff roles and HR consultation on the implications of this would be required. West Essex CCG have advised that they would not support this if they were to continue to act as the lead commissioner.

5.4. Summary

The conclusions of the review of options are:

- The approach most likely to deliver economies of scale is a single county-wide contract.
- Seven commissioners have said they will support this, subject to having more scope for localisation.
- Three commissioners have not yet decided their preferred approach and may decide to leave the collaborative.

- If the county-wide approach continues, all commissioners would agree to continue the current funding model.
- With a single contract, a lead commissioner with delegated authority for contract management is likely to be the most efficient arrangement.

6. FINDINGS, OBSERVATIONS AND RECOMMENDATIONS

In undertaking the review, in addition to the terms of reference set out above, consideration has been given to four questions:

1. Do the commissioners know what they want to achieve?
2. Are they achieving it?
3. Do they know whether they are achieving it?
4. Is there a plan to remedy non-achievement if required?

The first question can clearly be answered with a yes, as the commissioning strategy is well defined in *Open Up, Reach Out* and while there are additional local nuances, individual commissioners understand what these are.

It is also clear that the collaborative arrangement has achieved a lot although it does not appear to have been an easy journey. This is perhaps not surprising; although there is alignment of strategic objectives it is probably unlikely that ten partners will always agree on everything. Overall progress against the strategy appears to be good, however one area of concern is waiting times, as has been flagged up in section 3.5.

As well as the issues raised in interviews, it was noted through attendance at the CCF that the agenda is extremely broad, covering strategic decisions, operational matters and contract management. The membership is very large but in many cases still not sufficient to address all of the issues being discussed.

A lot of time seems to have been spent trying to reach agreement on relatively minor issues, where it may have been more appropriate for the partners to have taken different approaches.

It should be noted however that the nature of the agenda is likely to change, as next year's LTP funds have already been committed and the need to agree spending proposals will diminish significantly.

The focus on contract management is minimal, even though this is the key mechanism for delivery of the commissioners' planned outcomes. It also seems that many commissioners are not well sighted on whether objectives are being achieved. Performance reports, contract meeting minutes and the contract management action log are comprehensive but are circulated for information only. It is likely that some commissioners do not review these thoroughly, particular those who have a wide portfolio. The need to give these more focus is however recognised and it was agreed at the November CCF meeting that there should be dedicated commissioner pre-meetings. It may also be helpful for the lead team to produce a highlight and exception report, which could be tailored by individual commissioners to brief colleagues and elected members.

With regard to the fourth question, a remedial action plan to improve waiting times has been agreed with the provider. There should continue to be regular review of progress to assess firstly whether clinical risk is being appropriately managed and secondly whether there is an underlying imbalance in demand and capacity which needs to be addressed.

Taking everything above into account, it appears that the best way forward would be to continue to collaborate on a county-wide basis with a lead commissioning team in order to retain the benefits and economies of scale which have been achieved. All commissioners have expressed a preference to retain the

current funding arrangement and to continue with an outcomes-based block contract, and there is no compelling reason to change this.

There is however a clear need to improve the functionality of the CCF, to ensure better oversight of strategic delivery and contract performance, and to allow variation at local level where appropriate.

The following recommendations are intended to enable this:

1. The business of the CCF should be separated into strategic and operational issues, with more senior representation for the former, allowing commissioning and contract managers to focus on day to day performance. In order to avoid duplication and to reduce the burden on the lead team, this could be achieved for example by having a quarterly strategic meeting, with the two monthly meetings in between being split between contract management and service review (eg to evaluate recent LTP investments).

2. In order to support this, and to enable delegates to prepare in advance for decisions, a detailed forward programme of work should be developed. The most pressing issue is to agree on whether to continue with the county-wide approach in preparation for reprocurement of services and it is recommended that a senior level meeting is held in February to make this decision.

3. The strategic meetings should focus on key decisions and overall delivery of the planned outcomes. A strategy dashboard, together with a high level programme plan and risk and issues log would ensure that senior representatives are properly briefed. The timetable should reflect the need for partners to satisfy internal governance processes before committing to a decision, unless partners can recommit to formally delegating authority to representatives.

4. If the Strategic CCF is to continue to be a decision making body, the scheme of delegation and list of reserved matters should be reviewed and the delegated authority of each member recorded, including any financial limits. Agreement is also required on dispute resolution, whether this is through an escalation/mediation process, a return to majority voting or, where possible, agreement to disagree.

5. The division of responsibility between the lead commissioner and the other commissioners needs to be reviewed in relation to non-contract issues and recorded in the Terms of Reference of both the Strategic CCF and the Operational CCF.

6. The extent of local variation and decision making needs to be agreed. For example, while there is benefit in having a single service model for the NELFT contract, it may be more appropriate for user engagement, identification and support of vulnerable children, prevention and crisis management to be developed locally. This could take place within an overarching strategic approach and potentially with service user representation at Strategic CCF meetings.

7. The Strategic CCF should specifically review the impact of long waits, taking into account any recommendations of the Apteligen review and advice from the clinical network.

8. The Operational CCF, and the clinical network, should not be decision making bodies but should make recommendations and escalate issues of concern to the strategic meeting.

9. Production of a monthly highlight and exception report for the NELFT contract would enable commissioners to focus on key issues for discussion at the contract management pre-meetings. This would also assist individual commissioners in briefing their colleagues and/or elected members.

10. Commissioners should recognise that collaborative working can be difficult, especially across such a large number of organisations. Having too much focus on areas of disagreement can be demotivating. Commissioners may wish to consider finishing each meeting with a ten minute "good news" slot to celebrate what is being achieved for children and young people in Essex, and to reinforce the benefits of working together.

7. FORWARD WORK PROGRAMME AND IMPLEMENTATION PLAN

Implementation of these recommendations does not require changes to the collaborative structures or funding arrangements and therefore implementation should be straightforward. The principal requirement is to reach agreement on the key points and then to structure the business of each meeting accordingly. A suggested sequence of steps and timeline for the next twelve months is set out on the following page.

This timetable depends on commissioners' agreement to the recommendations set out in this document. If commissioners are not able to reach agreement on these proposals, an alternative plan will be required.

Action	Date	Forum
Review and discuss recommendations of this report	Dec 18	CCF
Discuss findings of the clinical review and recommendations of the clinical network	Jan 19	CCF
Initial discussion on pre-procurement	Jan 19	CCF
Initiate contract pre-meetings	Jan 19	CCF
All commissioners to discuss strategic and clinical reviews internally	Jan/Feb 19	
Contract pre-meeting	Feb 19	CCF
Confirm agreement to collaborate on a county-wide basis	Feb 19	CCF
Confirm separation of strategic and operational issues	Feb 19	CCF
Allocate outstanding actions to Strategic CCF or Operational CCF	Feb 19	CCF
Confirm decision making and dispute resolution processes	Feb 19	CCF
Confirm scheme of delegation and authority of the lead commissioner	Feb 19	CCF
Confirm extent of local variation	Feb 19	CCF
Determine whether action is required on specific issues raised by reviews	Feb 19	CCF
Update Collaborative Commissioning Agreement Parts 1 and 2	Feb/Mar 19	Lead Team
Develop terms of reference for the Strategic CCF	Feb/Mar 19	Lead Team
Develop terms of reference for the Operational CCF	Feb/Mar 19	Lead Team
Develop strategy dashboard	Feb/Mar 19	Lead Team
Develop contract highlight and exception report	Feb/Mar 19	Lead Team
Sign off CCA and terms of reference for SCCF and OCCF	Mar 19	SCCF
Approval to proceed with reprocurement	Mar 19	SCCF
Contract pre-meet and review of selected LTP investments	Apr 19	OCCF
Contract pre-meet and review of selected LTP investments	May 19	OCCF
Review revised working arrangements	Jun 19	SCCF
Review progress against the strategy	Jun 19	SCCF
Review pre-procurement progress and agree future contract term	Jun 19	SCCF
Discuss issues raised by the OCCF and Clinical Network	Jun 19	SCCF
Contract pre-meet and review of selected LTP investments	Jul 19	OCCF
Contract pre-meet and review of selected LTP investments	Aug 19	OCCF
Review progress against the strategy	Sep 19	SCCF
Review pre-procurement and approve commencement of procurement	Sep 19	SCCF
Discuss issues raised by the OCCF and Clinical Network	Sep 19	SCCF
Contract pre-meet and review of selected LTP investments	Oct 19	OCCF
Contract pre-meet and review of selected LTP investments	Nov 19	OCCF
Review revised working arrangements	Dec 19	SCCF
Review progress against the strategy	Dec 19	SCCF
Review procurement process	Dec 19	SCCF
Discuss issues raised by the OCCF and Clinical Network	Dec 19	SCCF

SCCF – Strategic Collaborative Commissioning Forum
OCCF – Operational Collaborative Commissioning Forum

APPENDIX A - ROLES AND RESPONSIBILITIES

The following sections are taken from the Collaborative Commissioning Agreement.

Lead Commissioner

6.10 Each Commissioner appoints the Lead Commissioner to carry out the responsibilities in respect of the Commissioning Contract set out in Schedule 3 Part B as its agent, subject to the terms of this Agreement.

6.11 The Commissioners acknowledge that, regarding those of its roles and responsibilities that relate to routine contract management, information and reporting, the Lead Commissioner may undertake those actions as reasonably required and in accordance with objectives and principles of this Agreement, but without further consultation with the Commissioners regarding routine contract management matters.

6.12 Where the Lead Commissioner proposes to take any actions under the Commissioning Contract that affect the commissioning strategy, procurement, commissioning responsibilities or decisions of the Commissioners, including actions relating to the variation, termination or suspension of the Commissioned Services, Prices under the Commissioning Contract or any other actions in respect of the Commissioning Contract that affect the statutory commissioning responsibilities of the Commissioners including but not limited to any Reserved Matters (such actions being Lead Commissioner Actions), the Lead Commissioner may (subject to clause 6.14) take that Lead Commissioner Action only after receiving the approval of each Commissioner in accordance with clause 7.

6.13 Each Commissioner appoints the Lead Commissioner as its agent to sign variations to the Commissioning Contract on its behalf but only in accordance with clause 7.

6.14 If a Suspension Event occurs and the Lead Commissioner reasonably believes that it is necessary to suspend any Service in accordance with General Condition 16 of the Commissioning Contract with immediate effect, the Commissioners agree that the Lead Commissioner may call a meeting of the Collaborative Forum under clause 5.8 to discuss the proposed suspension of the affected Service and to agree any further measures in respect of the Commissioned Services.

7 Lead Commissioner Actions

7.1 Where the Lead Commissioner intends to take any Lead Commissioner Action, the Lead Commissioner must circulate details of the proposed Lead Commissioner Action (including, in the case of variations to the Commissioning Contract, the proposed variation) to all Commissioners (including Collaborative Forum members and their deputies) in sufficient time to allow the prior approval of that action by the Commissioners under this clause 7.

7.2 The Lead Commissioner must inform all Commissioners, when circulating details of a proposed Lead Commissioner Action under clause 7.1, of the timescale required for a response by each Commissioner to the proposed Lead Commissioner Action, taking into account any timescales allocated to the relevant action under the Commissioning Contract.

7.3 Each Commissioner must respond in writing to the Lead Commissioner, within the timescale set by the Lead Commissioner under clause 7.2, either confirming that it agrees the proposed Lead Commissioner Action, or rejecting it. If a meeting of the Collaborative Forum is held within the set timescale, then the Commissioner may give their response at the meeting with their confirmation recorded in the minutes of the meeting.

7.4 Where all Commissioners have confirmed their agreement to the proposed Lead Commissioner Action under clause 7.3, the Lead Commissioner will proceed to implement the Lead Commissioner Action (where appropriate, by signing the relevant variation, notice or other applicable documentation) on behalf of all Commissioners. Each Commissioner acknowledges that in those circumstances the Lead Commissioner may implement the Lead Commissioner Action, and that it has authorised the Lead Commissioner to do so, either through express approval, or through refraining from exercising its ability to reject the proposed Lead Commissioner Action under clause 7.3.

7.5 Where any Commissioner rejects a Lead Commissioner Action, the Lead Commissioner can call a majority vote either virtually or other pre agreed method or at the next Collaborative Forum, subject to the matter not being a Reserved Matter.

7.6 Each Commissioner acknowledges that, in respect of its rights and obligations under the Commissioning Contract, it is bound by a variation to the Commissioning Contract or other Lead Commissioner Action implemented by the Lead Commissioner in accordance with this clause 7, whether or not it has given express approval to that action.

7.7 If the response of one or more Commissioners under clause 7.3 is that it rejects the proposed Lead Commissioner Action, the Lead Commissioner may not proceed to implement the Lead Commissioner Action, but must call a meeting of the Collaborative Forum to discuss the options in relation to the Commissioning Contract. If, as a result of that meeting, a modified Lead Commissioner Action is proposed, the process in this clause 7 will apply to that new proposal and any subsequent proposal until a consensus is reached. Where a consensus is not reached within a reasonable time, the Lead Commissioner may refer the issue to Dispute Resolution.

10 Obligations of each Commissioner

10.1 Each Commissioner remains responsible for:

10.1.1 performing and exercising its statutory duties and functions for the commissioning of health services or (in relation to those Commissioners that are local authorities) their health related functions to meet the reasonable requirements of those service users for which it is responsible;

10.1.2 making decisions relating to its policy, for committing commissioning resources and for making commissioning decisions for its health economy; and

10.1.3 liabilities arising as a result of the exercise of its functions.

10.2 Each Commissioner will be separately and solely responsible for payment to the Provider in respect of the Commissioned Services, in accordance with the contribution apportioned or attributed to that Commissioner, in accordance with the Prices, payment terms and

specifications agreed under the Commissioning Contract as replicated in Schedule 6 to this Agreement.

Schedule 3 Roles and responsibilities

Part A: Roles and Responsibilities of all Commissioners

1. Signing the Commissioning Contract, and Support Organisation appointment

1.1 All Commissioners will sign the Commissioning Contract, for which each Commissioner acts as separate principal.

1.2 Where any Commissioner has appointed a Support Organisation to act as its agent, in respect of any of its functions under a Commissioning Contract, that Support Organisation may (subject to paragraph 1.2.3) carry out any of the roles attributed to that Commissioner in this Schedule 3, but each Commissioner acknowledges that:

1.2.1 no Support Organisation may be a signatory to the Commissioning Contract;

1.2.2 each Support Organisation acts as agent for the relevant Commissioner, and no powers are delegated by any Commissioner to the Support Organisation in respect of the Commissioned Services; and

1.2.3 where the Commissioners, or any Commissioner, enters into an agreement with any Support Organisation, the functions attributed to that Support Organisation, and the Support Organisation's authority to act on behalf of the relevant Commissioner or Commissioners, is as set out in that agreement.

1.3 Where any commissioning function or activity of a Commissioner is exercised by another Commissioner on its behalf, or where any commissioning function or activity is exercised jointly by the Commissioners, each Commissioner acknowledges that it retains statutory responsibility for those functions or activities.

2 Actions of Each Commissioner under the Commissioning Contract

2.1 Each Commissioner undertakes, on its own account in relation to the Commissioning Contract and to enable the Lead Commissioner to carry out its functions under Schedule 3 Part B, to carry out all actions required in relation to its rights and obligations under the Commissioning Contract in relation to its population, including:

2.1.1 modelling demand for the Commissioned Services, specifying indicative activity levels for inclusion in the Commissioning Contract, monitoring actual Activity against indicative levels and raising any queries or concerns about performance against demand with the lead Commissioner unless such actions are agreed as the responsibility of the lead Commissioner.

2.1.2 reviewing and, where appropriate, contesting reconciliation accounts received from the Provider and making payments to the Provider, in accordance with the payment provisions set out in the Commissioning Contract;

2.1.3 where instructed by the Lead Commissioner, applying any financial adjustments or withholdings (and each Commissioner acknowledges that where so instructed by

the Lead Commissioner, it will make any adjustments, deductions or withholdings in accordance with those instructions);

2.1.4 assessing, and approving or rejecting, individual funding requests;

2.1.5 managing Service User complaints, and dealing with Serious Untoward Incidents;

2.1.6 specifying as applicable any Prior Approval Schemes and, in respect of any Service Specification, applicable exclusion or acceptance criteria (where different from others under the Commissioning Contract);

2.1.7 managing referrals; and

2.1.8 initiating Dispute Resolution, unless Dispute Resolution is initiated by the Lead Commissioner on behalf of all Commissioners.

3 Confidentiality

3.1 Each Commissioner shall:

3.1.1 keep confidential any information obtained in connection with this Agreement and personal data subject to the Data Protection Act; and

3.1.2 take appropriate technical and organisational measures against unauthorised or unlawful processing of such personal data and against accidental loss or destruction of or damage to such personal data.

3.1.3 keep confidential any information, including commercially sensitive information, acquired through their conduct of this Agreement and will take all reasonable steps to ensure that their employees do not divulge such information to a Third Party, without the express consent of all Commissioners and the Service User (where relevant), except:

3.1.4 in accordance with the requirements for external audit;

3.1.5 where it is required to do so by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable law;

3.1.6 where such information is already in the public domain; or

3.1.7 where such information is obtained by a Third Party who is lawfully authorised to disclose such information.

4 Actions in support of the Collaborative and the Lead Commissioner

4.1 Each Commissioner undertakes:

4.1.1 to nominate a Commissioner Representative, with delegated authority to act on its behalf in relation to the Collaborative and the Commissioned Services;

4.1.2 to provide all relevant information to the Lead Commissioner promptly, so as to assist the Lead Commissioner in the management of the Commissioning Contract.

4.2 Each Commissioner further undertakes to carry out any additional roles and responsibilities assigned to it as agreed by the Commissioners and set out in Schedule 5D of the Commissioning Contract and in Table 1 below.

Part B: Roles and Responsibilities of the Lead Commissioner

1 Roles and Responsibilities of the Lead Commissioner

1.1 The Lead Commissioner undertakes to perform the roles and responsibilities allocated to the Lead Commissioner under the Commissioning Contract, including those set out in paragraphs 2 to 4 of this Schedule 3 Part B.

1.2 The Lead Commissioner further undertakes to perform any additional roles and responsibilities assigned to it as agreed by the Commissioners and set out in Schedule 5D of the Commissioning Contract and in Table 1 below.

2 Management of the Commissioning Contract

During the term of the Commissioning Contract, to carry out those functions, rights or obligations attributed to the Lead Commissioner under the Commissioning Contract (subject to clause 6.5 and clause 7), including:

2.1.1 managing Activity, including notifying the Provider of Activity Planning Assumptions, monitoring Activity and reviewing Activity Reports, dealing with Activity Queries and Activity Management Meetings, and agreeing Activity Management Plans;

2.1.2 implementing any Prior Approval Scheme;

2.1.3 agreeing Service Development and Improvement Plans and/or Data Quality Improvement Plans with the Provider;

2.1.4 agreeing Service Variations;

2.1.5 agreeing information and reporting requirements, and managing Information Breaches;

2.1.6 agreeing Local Prices, managing agreements or proposals for Local Variations and Local Modifications, making and receiving payments (where Commissioners' payments under the Commissioning Contract are aggregated), including CQUIN payments;

2.1.7 agreeing Local Quality Requirements and Quality Incentive Scheme Indicators, and variations to National Sanctions and National CQUINs as applicable;

2.1.8 implementing financial adjustments or sanctions resulting from breaches of any Provider obligations including those relating to Activity Management Plans, Operational Standards, Data Quality Improvement Plans and Service Quality Improvement Plans;

2.1.9 managing complaints;

2.1.10 appointing of an auditor; and

2.1.11 conducting Review Meetings, and undertaking contract management, including the issuing of receipt of Contract Queries and agreeing any Remedial Action Plan or related contract management processes.

3 Reporting under the Commissioning Contract

3.1 Disseminating to each Commissioner relevant information provided by the Provider in respect of the Commissioning Contract, including in relation to:

3.1.1 Monthly Activity Reports;

3.1.2 Service Quality Performance Reports;

3.1.3 reconciliations of payment against actual Activity, including allocations against individual Commissioners in respect of Activity and payment;

3.1.4 reports under any Data Quality Improvement Plan or Service Development and Improvement Plan;

3.1.5 contract management provisions including Contract Query Notices and Remedial Action Plans;

3.1.6 any financial adjustments or sanctions in respect of the Commissioned Services;

3.1.7 proposed Variations, and

3.1.8 any other information received from the Provider in relation to that Commissioner, or reasonably required by any Commissioner in respect of its Commissioned Services.

3.2 Providing such other relevant information to Commissioners in relation to the Commissioning Contract as reasonably agreed by the Commissioners.

4 Termination, suspension and disputes

4.1 Subject to clause 6.5 implementing the following actions on behalf of the Commissioners:

4.1.1 initiating suspension of the Commissioning Contract, or any Commissioned Service, following a Suspension Event;

4.1.2 serving notice to terminate the Commissioning Contract, or any Commissioned Service, in accordance with the terms of the Commissioning Contract; and

4.1.3 initiating and conducting Dispute Resolution (unless in any case an individual Commissioner elects to initiate Dispute Resolution on its own account).

5 Table of additional agreed Roles and Responsibilities in relation to the Commissioning Contract

The Commissioners have agreed that the following additional roles, in relation to the Commissioning Contract, will be undertaken by individual Commissioners, as set out in this table:

Commissioner (Insert name of the CCG against each of the identified roles)	**Identified role** (Lead Commissioner or Commissioner)	**Additional responsibilities**
West Essex Clinical Commissioning Group	Lead Commissioner	Provision, appointment and payment of the secretary
Mid Essex Clinical Commissioning Group	Commissioner	
Southend Clinical Commissioning Group	Commissioner	
Thurrock Clinical Commissioning Group	Commissioner	
Castle Point and Rochford Clinical Commissioning Group	Commissioner	
North East Essex Clinical Commissioning Group	Commissioner	
Basildon and Brentwood Clinical Commissioning Group	Commissioner	
Essex County Council	Commissioner	
Thurrock Borough Council	Commissioner	
Southend-on-Sea Borough Council	Commissioner	

APPENDIX B – LINKS

Documents relating to the other collaborative arrangements reviewed can be found through these links:

https://www.westcheshireccg.nhs.uk/document_uploads/governing-body/CCF_ToR_V1.3_030518.pdf

https://www.westhampshireccg.nhs.uk/download.cfm?doc=docm93jijm4n680.pdf&ver=1004

http://www.newhamccg.nhs.uk/Downloads/About-us/papers/13%20November%202013/3.1%20Barts%20-%20Collaborative%20Commissioning%20-%20CQC%20-%20Winter%20Planning.pdf

http://archive.northsomerset.bnssgccg.nhs.uk/media/medialibrary/2015/08/MOU_in_relation_to_collaborative_commissioning_arrangements_between_BNSSG_CCGs._23.01.15_2.pdf

www.westkentccg.nhs.uk/_resources/assets/attachment/full/0/296101.pdf

https://www.greaterprestonccg.nhs.uk/download.cfm?doc=docm93jijm4n1709.pdf

https://www.telfordccg.nhs.uk/who-we-are/publications/ccg-governance-board/governance-board-papers/2015/may-1/1547-08-3-appendix-3-wm-collaborative-commissioning-ccg-discussion-paper-21-4-15/file

https://www.greenwichccg.nhs.uk/About-Us/Documents/Collaborative%20Framework%20v%202%201.pdf

http://www.smybndccgs.nhs.uk/application/files/1514/8037/0832/South_Yorkshire_and_Bassetlaw_Sustainability_and_Transformation_Plan.pdf

https://www.hambletonrichmondshireandwhitbyccg.nhs.uk/documents/6631319/8152881/Item+17+Appendix+4+MOU+for+111+Services+Amended+230316.pdf/9aa91c51-94c3-43c2-bef7-f7a087a735ea

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