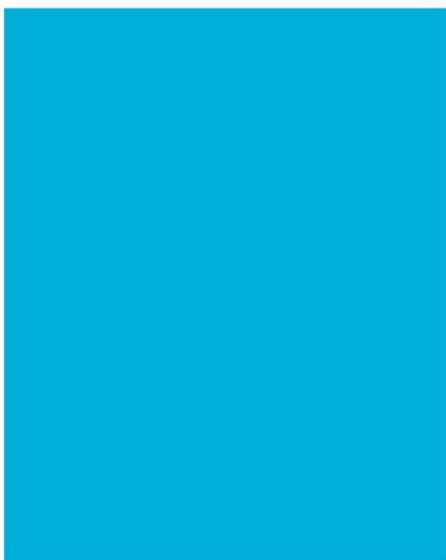
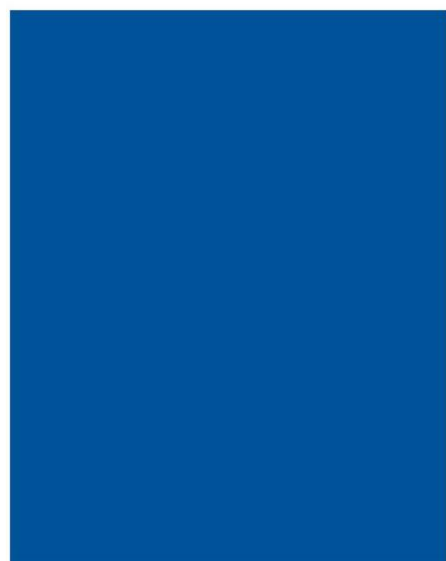


A framework for collaborative  
commissioning between  
clinical commissioning  
groups

DRAFT



# A framework for collaborative commissioning between clinical commissioning groups

*DRAFT*

First published: August 2012

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## **Technical appendices** (provided separately)

Technical appendix 1: Full spreadsheet of data tables for CCGs and providers

Technical appendix 2: Possible models for collaborative commissioning arrangements between CCGs

## **To follow**

Model collaborative agreement (September 2012)

# 1 Introduction

As set out in [Towards establishment: Creating responsive and accountable CCGs](#), to commission improvements in health and healthcare for their local populations and drive the integration of services around the needs of individuals, it will be important for CCGs to have appropriate robust collaborative arrangements between themselves and with other organisations.

This document addresses the collaborative commissioning of health care services across CCGs as opposed to where they will be working collaboratively with other, equally important partners, especially local authorities on joint commissioning and integrated commissioning. The National Learning Network for health and wellbeing boards has been exploring how the NHS and local authorities can work together to improve services and outcomes, including through joint commissioning.<sup>1</sup> Building on this, the NHS CBA and the Local Government Association are also taking forward a joint programme of work, and further information about this will be available shortly.

Where two or more CCGs commission a single service they could work together to ensure consistency in quality for their patients. In some cases, a large number of CCGs might commission a single service that is organised across a large geographical area (such as ambulance services) and in other cases, a group of CCGs who are geographical neighbours may wish to work together on a contract with a single provider to which the majority of their patients flow.

We have not re-iterated all of the key elements that CCGs would need to ensure were included in any great commissioning process and are making the assumption that CCGs will build these into all of their collaborative arrangements. For example, collaborative commissioning arrangements should ensure that the views of each practice population are sought and acted on and the views of individual patients are reflected in shared decision-making and commissioning decisions, including patients exercising choice. CCGs will also need to ensure that when commissioning across a wider geography, they engage with all of the relevant Health and Wellbeing Boards.

The Health and Social Care Act amends the NHS Act 2006 to make provision to enable CCGs to establish appropriate collaborative arrangements with other CCGs. This document particularly draws out the legal requirements for collaborative commissioning across CCGs and the specific considerations that need to be taken into account are detailed in annex 1.

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<sup>1</sup> The products are available to download on the Knowledge Hub <https://knowledgehub.local.gov.uk/home> (registration required) and on the NHS Confederation website <http://www.nhsconfed.org/Publications/Pages/lresources-health-wellbeing-boards.aspx>

This document then draws together relevant information that proposed CCGs might consider, and sets out steps that many will want to take in their preparation for authorisation and the 2013/14 contracting round. It builds on information set out in both the governance guidance for CCGs, [Towards establishment: Creating responsive and accountable CCGs](#) and in [Clinical commissioning group authorisation: Draft guide for applicants](#) and has been developed with input from CCG leaders and the Clinical Commissioning Coalition (NHS Alliance/NAPC), the national GP Working Group and a CCG led task and finish group. Providers have been engaged through the Foundation Trust Network via the NHS Confederation.

It is important to remember that each CCG retains accountability for the commissioning of services that meet the needs of their population and ensures that relevant quality standards are met, regardless of any practical or collaborative arrangement that is put in place. They should:

- ensure that they have considered which provider contracts and/or individual services should be included in collaborative commissioning arrangements and at what level;
- ensure that there are no 'orphan services', or contradictory arrangements;
- ensure that they have robust governance arrangements in place for collaborative commissioning; and
- ensure that they have decided what commissioning support they need to underpin their collaborative arrangements and where this will come from.

Determining which services and contracts to collaborate on will be key for CCGs. In order to assist these decisions, a database has been provided (technical appendix 1) which enables users to view the main providers for a CCG and the main commissioning CCGs for a provider. Using these in combination can help establish an understanding of the CCG-provider relationships within an area or health economy.

The tables demonstrate both the key CCG commissioners of services by provider and also the range of providers with which each CCG has previously arranged services. It is likely that different arrangements will be necessary for:

- CCGs who share a main provider (eg in urban areas where several CCGs send most of their patients to the same provider). Comprehensive arrangements for these *core collaborative* arrangements would be needed;
- a large group of CCGs who commission a service such as ambulance services. Their interest in the contract is equally spread between them but it may make up a relatively small proportion of any one CCG's overall commissioning business. *Linked collaborative* arrangements will be necessary; and
- a group of CCGs commissioning more specialist, low volume, services from one provider. Some CCGs, will have a far smaller proportion of the total activity and for these CCGs the business with that particular provider constitutes a small (although of course still significant) proportion of their overall business. Arrangements should be equally robust, although every CCG is unlikely to be as intimately involved in the day to day arrangements.

The collaborative models at technical appendix 2 describe for CCGs the possible scenarios. A model collaborative agreement is being developed and will be shared in September 2012.to support CCGs to develop these arrangements in a robust and effective way.

Some CCGs will choose to create and resource their collaborative arrangements themselves. Many will arrange support through a commissioning support service (CSS).

## 2 Background

[Developing clinical commissioning groups: Towards authorisation](#) set the clear expectation that CCGs would put in place:

*“Collaborative arrangements for commissioning with other clinical commissioning groups, local authorities and the NHS Commissioning Board, as well as the appropriate external commissioning support” (Domain 5)*

The Health and Social Care Act amends the NHS Act 2006 to make provision to enable CCGs to establish appropriate collaborative arrangements with other CCGs and this is the focus of this document.

What is clear is that individual CCGs always remain accountable for meeting their statutory duties, for instance in relation to quality and financial resources, and CCGs will want to ensure that any collaborative commissioning relationships and governance arrangements enable them to do so effectively. The progress being made will be assessed through the authorisation process and proposed CCGs should complete preparatory arrangements in readiness for the 2013/14 planning round.

The draft authorisation guide for applicants sets out in domain 5 that CCGs will be expected to work together where appropriate in order to effectively commission all the categories of care for which they are responsible, but also to share risk safely, transfer skills and secure commissioning support. They will increasingly wish to look beyond their own direct commissioning responsibilities to recognise where quality, access to and outcomes from local services may depend on commissioning services on a larger geographical footprint. For example, they may choose to collaboratively commission services for tuberculosis where effective control requires specialist care and collaboration with other organisations across geographical and organisational boundaries. Collectively CCGs will want to prioritise those service areas where improvement is most needed to ensure appropriate collaborative arrangements.

Domain 3.3G also requires CCGs to have arrangements in place to collaborate with neighbouring CCGs. A significant proportion of the evidence for the collaborative commissioning domain will be gathered and assessed through document assessment, with an overview, distillation and triangulation of findings, and a summary of possible key lines of enquiry for the site visit.

The requirements for authorisation are listed in [Clinical commissioning group authorisation: Draft guide for applicants](#) and includes:

#### Domain 3.3

- G. CCG has arrangements in place to collaborate with neighbouring CCGs in areas such as lead<sup>2</sup> commissioning where there is more than one CCG contracting with a provider.

#### Domain 5.1

- A. CCG has written agreements in place detailing the scope of the collaboration with other CCGs, with clear lines of accountability and decision-making processes.
- B. Mechanisms in place for CCG to collaborate with others where patient flow or provider configuration necessitates this.
- C. Examples of CCG collaboration with other CCGs and a multi-disciplinary range of clinicians.
- D. CCG can demonstrate collaboration with other CCGs sharing employed staff/teams where appropriate.

The approaches described in this paper are intended to be helpful to CCGs in developing their own arrangements for collaborative commissioning in their own unique geography and situations. The criteria and considerations described need the judgement and expertise of CCGs themselves. This is intended to be helpful in the journey towards authorisation, and beyond, in the collaborative commissioning domain.

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<sup>2</sup> Of course this document demonstrates a broad range of ways in which collaborative commissioning can be discharged, of which a single CCG taking a lead role is only one. What will be necessary is that CCGs can demonstrate that their arrangements are robust, including arrangements with CSSs, and that all relevant CCGs are appropriately involved.



# 3 When would collaborative commissioning be a good thing to do?

Collaborative commissioning between CCGs is the process whereby two or more CCGs work together in order to effectively commission some of the services for which they are responsible, but also to share risk safely, transfer skills and secure commissioning support.

Building on earlier work with proposed CCGs, [Towards establishment: Creating responsive and accountable CCGs](#) (page 44) suggested a range of benefits potentially available to CCGs from taking a collaborative approach where, for example their patients flow to the same provider and /or access the same service:

## **Clinical improvement:**

- Consistent, evidence based pathway development
- Effective and consistent performance management, clinical governance and risk management
- Service integration

## **Efficiency:**

- Leverage with providers
- Keeping transaction costs low
- Sharing (potentially scarce) expertise and capacity

## **Resilience and risk management:**

- Enabling diversity in CCG configuration and size
- Managing financial risks
- Managing regulatory and legal change
- Managing extended absence of key staff
- Improved risk management and intelligence systems
- Business continuity arrangements

What emerging CCGs and national primary care organisations also clearly identified was the need to retain local control, ensuring that member practices remain involved and able to influence decisions, whilst ceding authority where appropriate to any pan-CCG arrangement.

CCGs will therefore wish to make a local judgement, primarily based on their local knowledge about whether, on balance, it would be in the best interests of their patients to collaborate in a particular circumstance. In some instances it will be clear cut and in others it will be a finely

balanced judgement between retaining direct local influence and potential gains in quality, efficiency, and resilience.

The data tables provided in technical appendix 1 will assist CCGs to identify which other CCGs also have contracts with their main providers and the relative proportion of activity that they commission from each provider.

Starting with the commissioner tables, selecting a CCG in the top left hand box, will reveal the major providers from which it commissions services.

### Main Providers for a CCG

Select CCG below

Alpha CCG 99X

Provider (ordered by number of admissions)	Number of Admissions / spells (%)	Of which elective	% of Provider total	Number of Outpatients (%)	Of which first outpatients
Oscar NHS FT	28,470 (48%)	11,892	31.4%	274,659 (51%)	84,454
Papa NHS FT	24,431 (42%)	10,590	23.4%	230,019 (42%)	69,854
Quebec NHS Trust	1,028 (2%)	377	2.0%	4,892 (1%)	1,971
Romeo NHS FT	651 (1%)	323	21.0%	0 (0%)	0
Other	4,148 (7%)	2,146	n/a	33,786 (6%)	8,226
<b>Total</b>	<b>58,728 (100%)</b>	<b>25,328</b>	<b>n/a</b>	<b>543,356 (100%)</b>	<b>164,505</b>

Using the provider tables, by selecting the main providers identified above, a CCG can now identify the other CCGs that are potentially its core and linked commissioners and will help a CCG to identify which other CCGs it may wish to engage in discussions with about developing collaborative commissioning arrangements.

### Main commissioning CCGs for a Provider

Select Provider below

Oscar NHS FT RZX

CCG (ordered by number of admissions)	Number of Admissions / spells (%)	Of which elective	% of CCG total	Number of Outpatients (%)	Of which first outpatients
NHS Alpha CCG	28,470 (31%)	11,892	48.5%	274,659 (31%)	84,454
NHS Bravo CCG	25,303 (28%)	11,259	39.7%	226,096 (26%)	71,116
NHS Charlie CCG	10,884 (12%)	6,825	16.2%	113,709 (13%)	32,945
NHS Delta CCG	4,128 (5%)	2,665	5.1%	50,079 (6%)	12,649
NHS Echo CCG	3,505 (4%)	2,144	4.4%	38,714 (4%)	10,367

Whilst the focus of the collaboration will most likely include the full breadth of commissioning functions, existing and proposed contracts are, for many CCGs, a helpful place to start. In considering whether collaborative commissioning arrangements would be of benefit for patients over a specified geography, a number of key questions have been identified and are set out as a proposed checklist below.

<b>For contracts</b>	<b>Y/N</b>
Does the existing/ proposed contract cross more than one CCG?	
Are there economies of scale in establishing common contracting arrangements across CCGs with this provider? (in relation to transactional cost, time etc.).	
Are there enhanced collective negotiating powers that make local clinical issues more likely to be achieved. (i.e. would collaboration provide an opportunity for CCGs to focus on specific issues that could otherwise be drowned out?)	
Is there limited skill/knowledge in a CCG in relation to contracts for a particular service? Would going alone be as effective and efficient as collaborating?	
Are there appropriate support services (eg provided by one of the CCGs or from the local CSS) to support the contracting arrangements on a collaborative basis?	
Are there any risks locally that could be mitigated by taking a collaborative approach?	

### **For service specific contracts**

There are a number of named services that are part of contracts that CCGs may wish to jointly give more specific attention and leadership to. In some instances, CCGs will wish to develop specific collaborative arrangements for these services. The key criteria to take into account are:

- a. **Rarity** – the number of individuals who require the provision of the service or facility is low (per CCG)
- b. **Cost** – the cost of providing the service or facility is high
- c. Services that are **both** high cost and low volume
- d. **Variation** in need (at CCG level) and consequent high variability in spend both between similar CCGs and year on year (requiring financial risk management)

### **Securing quality, safety and service continuity**

When developing collaborative arrangements CCGs will want to ensure the development of, and access to, services of sufficient quality. Particular considerations include:

- a. Complexity of assessment and/or treatment intervention by multi disciplinary teams
- b. Caseload needed to offer safe and sustainable services (critical mass of activity)
- c. Evidence-based smaller number of expert centres and practitioners (with consequent need to ensure succession planning)
- d. Need for planning across a range of providers to avoid risk of abrupt loss of service
- e. Managed entry of innovative services at the leading edge of technology and/or research, in a limited number of places.

# 4 What arrangements are needed to ensure collaboration works?

For those contracts and services that are judged as likely to benefit from collaborative commissioning, there are a number of arrangements that CCGs may want to put in place to ensure that the way in which they then delegate their contracting responsibilities, and related tasks, is appropriate.

## Relationships

Regardless of the formality or breadth of the collaborative arrangement, the nature of the relationships established over time will be a significant determinant of success and CCGs will want to pay due attention to the relationship management aspects of their collaborative arrangements. Annex 2 describes the steps taken by CCGs in the North East as they approached establishing their collaborative arrangements.

Early discussions with proposed CCGs and national primary care organisations really highlighted that where CCGs are building on existing good relationships, they can use collaborative arrangements to move from transactional relationships to transformation. Where relationships between CCGs are more challenging, building trust and common cause is an absolute priority – no amount of governance and infrastructure will, on its own, deliver effective clinical relationships.

**Key questions to be considered early (and kept under review) are:**

- a. What local intelligence, particularly commissioning intentions and insight into local health needs, will be shared by each participating CCG to inform all subsequent discussions and decisions?
- b. What decisions will be made together?
- c. How are commissioning decisions going to be made?
- d. How are individual CCGs going to be involved in the decision-making?
- e. What, if any, delegation arrangements are needed? – within or across CCGs
- f. How will all parties know if the collaborative approach is working?
- g. What would happen if it all goes wrong (i.e. parties are not satisfied with the content of the contract) or if CCGs want to withdraw from the collaboration?

## **Governance**

Building from this, [\*Towards establishment: Creating responsive and accountable CCGs\*](#) sets out a series of good governance features which CCGs should address when considering collaboration of any sort. Many of these are central features of establishing a successful collaborative commissioning arrangement and would include:

### **Secure shared objectives**

Each participating CCG should understand how the collaborative commissioning arrangement will contribute to delivering their own objectives. The motives, which are likely to be less explicit than objectives, for each CCG taking part in a collaborative arrangement should also be compatible.

### **Explicit alignment of vision and values for the area of collaboration**

This may be a development of specific vision and values for the purpose of the collaboration or may be recognition that vision and values of the CCGs taking part are similar and/or compatible. Values would extend to expected standards for corporate and individuals' behaviours and the prevailing cultures within the CCGs.

### **An agreement regarding scope of collaboration**

CCGs must ensure that they operate within their legal powers. These are summarised in annex 1. There should also be clarity regarding what is not included within the scope of the collaboration. The CCGs may wish to consider whether they will share or pool risks, particularly in respect of financial and activity deviance, and agree how this will be managed.

### **Clarity regarding the extent to which decisions can be taken by the collaborative arrangement**

CCGs should refer to annex 1 for further information about what can be delegated and in what circumstances, to whom. Any arrangements for delegation should be appropriately documented.

### **Process for taking decisions**

CCGs should be clear in advance what responsibilities they have, individually and together, for ensuring full support for a collective decision. In all but the most minor and informal of arrangements, CCGs should set up a contract oversight board (or similar) on which each of the participating CCGs would be represented. Questions they may want to resolve could include:

- will voting be used and if so, how?
- will unanimous decisions be required or will a majority be accepted?
- how large a majority is required and will a majority decision be binding on all parties?
- might a consensus be sought in some circumstances and if so, when?
- what are the consequences when one CCG does not agree with the decision? Will a CCG be allowed to walk away, and if so in what circumstances? For example, CCGs may want to agree that a CCG may only walk away from a collaborative agreement in

circumstances where their exit does not have a direct or indirect negative impact on the other CCGs.

Arrangements should be detailed in terms of reference for such a 'board' and these should include agreements regarding membership, quoracy, meeting arrangements and dispute management. CCGs should ensure this is consistent with their collaborative agreement and a model collaborative agreement is currently being developed to support CCGs with this.

### **How the collaborative will report**

With the freedom to make decisions comes responsibility for ensuring that the decisions are both implemented and deliver the stated objective(s). Where this is the case, performance criteria may be set and reporting arrangements should be put in place so that each CCG as an accountable NHS Statutory body is always fully appraised of progress and risks.

### **An understanding of what happens when things go wrong**

This could range from a simple paragraph in terms of reference to a full disputes' resolution process that extends to detailing how, if necessary, the collaborative arrangements will be dissolved. It is critical that all parties should understand what happens when there is lack of agreement or disappointment regarding performance. There should be advance agreement regarding circumstances in which one CCG may wish leave the collaborative commissioning arrangement, and any conditions that should apply.

### **Governance of supporting functions**

In many cases CCGs will share, or secure from commissioning support services, a package of support functions for their collaborative commissioning activity. The governance arrangements for these support functions should make it clear which organisation is responsible for which functions. Most of all it should be clear that CSSs are not permitted to make any commissioning decisions and act only as the agent for CCGs. Appropriate procurement processes to secure commissioning support services should be considered and will need to reflect this.

### **The collaborative agreement**

In summary, formally established collaborative relationships should be underpinned by explicit and documented agreements. A collaborative commissioning agreement should describe the relationship and the systems and processes for operating it. The responsibilities of each of the CCGs, and the commissioning support service if appropriate, involved in the collaborative arrangement should be clearly set out. It should also describe the systems and processes for when things go wrong. The detail will depend on the model of collaboration the CCGs have chosen, how many CCGs are involved and the contract or service that they are collaborating on. A model collaborative agreement is being prepared and will be shared in the autumn.

## **Support for collaborative arrangements and sharing resources between CCGs**

Each CCG remains accountable for services commissioned for its population. In entering a collaborative commissioning relationship, whilst there remain a number of activities and responsibilities that can only be undertaken locally (such as defining the local need and activity modelling) other activities can be shared.

In particular, there are many administrative and co-ordinating activities that need to be undertaken to ensure best practice and good governance across the collaborative. Depending on the model of collaboration that the CCGs choose, these could potentially be undertaken by a commissioning support service or by one (or more) of the collaborating CCGs taking a key role on behalf of all of them. Examples of functions that CCGs might choose to share or commission from a CSS are outlined in annex 3.

In circumstances where one CCG takes a key role on behalf of others, either in co-ordinating and conducting the relationship with the provider or, undertaking the administrative and governance functions to enable and support the collaborative arrangement, the CCGs will wish to determine how this will be resourced. Similarly, where support is secured from a CSS, CCGs will wish to determine how the costs will be apportioned between the collaborating CCGs.

In many cases, CCGs will determine that a commissioning support service (CSS) will be best placed to provide shared support to their collaborative commissioning arrangement. It will be for the CCGs to determine the precise nature of any functions they wish to secure from a CSS.

# 5 Options for collaborative commissioning models

Working together, CCGs will wish to agree what arrangements they will put in place to govern and run their collaboration.

Key issues to be addressed include:

- a. Confirm which CCGs will participate in the collaborative commissioning arrangements and with what level of involvement?
- b. How will the collaborative relationship be structured?
- c. Who will contribute which expertise / capacity?
- d. What part might a CSS play?

A range of possible models are drawn in technical appendix 2 for CCGs to consider what might be appropriate for their local circumstances.

The models are designed to illustrate the range of possibilities that might exist for different collaborative commissioning circumstances and it is anticipated that CCGs are likely to implement more than one of these models. Which arrangement a CCG chooses will depend on local circumstances as well as the type of service/ contract that the CCGs are collaborating on, the number of CCGs involved and the relative sizes of the contracts involved.

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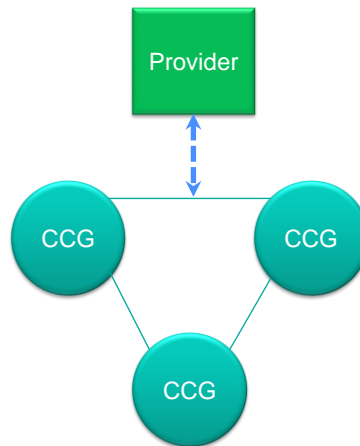
CCGs work together equally and severally, sharing responsibility between themselves for all aspects of the collaborative commissioning arrangements and the interface with providers. CCGs draw upon their collective resources for capacity and expertise.

**Benefits**

- CCG ownership is 'built in'
- CCGs develop mutual accountability

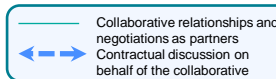
**Risks**

- Lack of leadership and focus
- Access to capacity and expertise is more limited
- Lack of clarity for support functions



CCGs might want to use this where two or more have broadly similar sized contracts with a single provider (eg in city conurbations) and provide the commissioning support from within themselves

CCGs remain accountable for decision making under all models



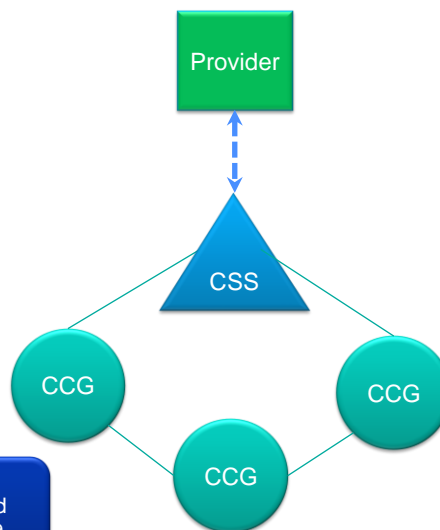
CCGs work together equally and severally with one another; and are supported by a CSS. The CSS (under the direction of CCGs) acts on behalf of the CCGs at the interface with the provider

**Benefits**

- CSS can ensure all CCGs' interest are accounted for
- Additional expertise and capacity available to CCGs

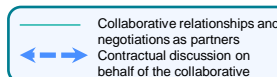
**Risks**

- 'abdication' of responsibility by CCGs
- 'mission creep' from CSS



CCGs might want to use this approach in circumstances where CCGs have different sized contracts with a single provider and also require specific support from a CSS

CCGs remain accountable for decision making under all models



CCGs work together, equally and severally sharing responsibility between themselves. Additional expertise and capacity is sourced from a CSS for specific tasks, projects or functions (under the direction of the CCGs)

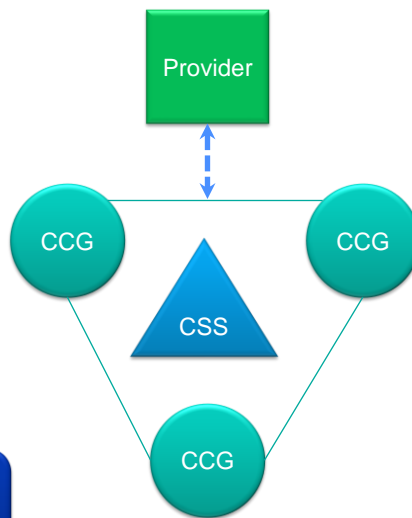
**Benefits**

- CCGs access additional expertise and capacity when needed.
- CCGs develop mutual accountability

**Risks**

- Lack of leadership and focus
- Lack of role clarity for CSS

CCGs might want to use this when two or more CCGs have broadly similar sized contracts with a single provider (eg in a single city or town) and require input from a commissioning support service.



CCGs remain accountable for decision making under all models

— Collaborative relationships and negotiations as partners  
 ↔ Contractual discussion on behalf of the collaborative

CCGs work together, agreeing arrangements between themselves. Each CCG takes a lead responsibility with one provider on behalf of them all; thus building in reciprocal and mutual accountability. The collaborative sources specific support from a CSS where it makes sense to do so

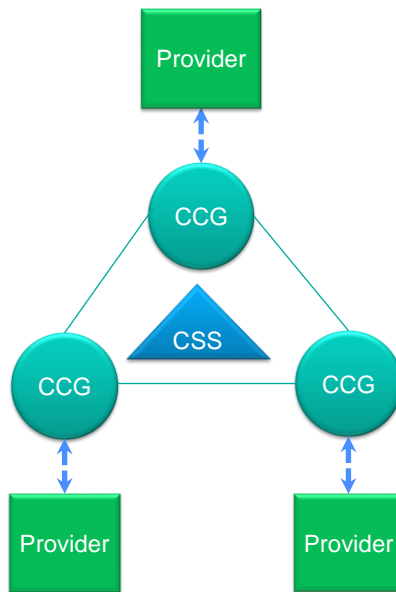
**Benefits**

- CCG ownership is 'built in'
- Mutual accountability

**Risks**

- Mission creep for the CSS
- CCGs focus primarily on one contract to the detriment of others
- Lack of CCG buy in to all providers

CCGs might want to use this in city conurbations where two or more CCGs commission from the same group of two or more providers



CCGs remain accountable for decision making under all models

— Collaborative relationships and negotiations as partners  
 ↔ Contractual discussion on behalf of the collaborative

One CCG takes lead responsibility on behalf of the others for the administration and management of collaborative arrangements and the interface with providers i.e. acts as the co-ordinator

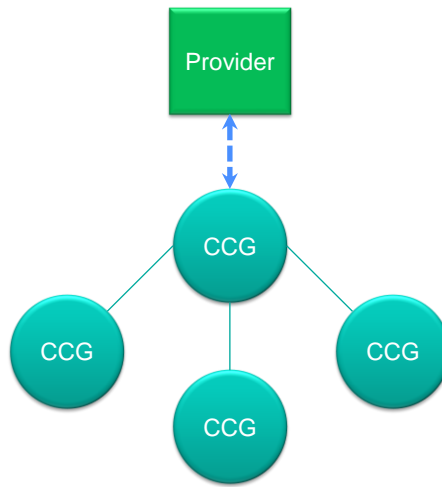
**Benefits**

- Single relationship, works well for providers

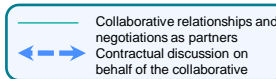
**Risks**

- Perception (or reality) of bias towards one CCG's interests and undermining of other CCG's commissioning intentions
- Provider influence generating "divide and rule" culture
- Lack of buy in from CCGs, other than the one leading

CCGs might want to use this approach when one of the participating CCGs has a significantly larger portion of the contract with a provider



CCGs remain accountable for decision making under all models



A CSS takes lead responsibility on behalf of the CCGs (under the direction of CCGs) for the administration and management of collaborative arrangements and the interface with providers i.e. acts as the co-ordinator.

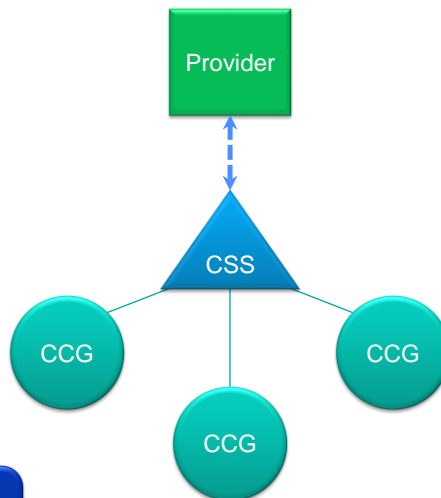
**Benefits**

- CSS can ensure all CCG's interests are accounted for
- Single relationship, works well for providers

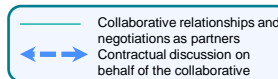
**Risks**

- 'mission creep' from CSS
- Individual CCG intentions overlooked
- Potential abdication of responsibility by CCGs

CCGs might want to use this in circumstances where a large number of CCGs collaborate such as when commissioning ambulance services



CCGs remain accountable for decision making under all models



# 6 Next steps for CCGs

Proposed CCGs will wish to consider their collaborative arrangements in a way which is locally appropriate to them. The processes described in this paper are intended to help CCGs successfully consider the collaborative arrangements they wish to pursue. During transition, CCGs should expect the support of SHAs and PCT clusters as appropriate.

## Pre-authorisation

The key evidence for authorisation is listed in [Clinical commissioning group authorisation: Draft guide for applicants](#) and includes:

### Domain 3.3

- G. CCG has arrangements in place to collaborate with neighbouring CCGs in areas such as lead<sup>3</sup> commissioning where there is more than one CCG contracting with a provider.

### Domain 5.1

- A. CCG has written agreements in place detailing the scope of the collaboration with other CCGs, with clear lines of accountability and decision-making processes.
- B. Mechanisms in place for CCG to collaborate with others where patient flow or provider configuration necessitates this.
- C. Examples of CCG collaboration with other CCGs and a multi-disciplinary range of clinicians.
- D. CCG can demonstrate collaboration with other CCGs sharing employed staff/teams where appropriate.

CCGs should therefore:

1. Decide which contracts and services the CCG would want to collaborate on (technical appendix 1).
2. Determine which other CCGs they will collaborate with in which instances (technical appendix 1).
3. Agree with the other CCGs in the collaborative, the approach they will take, the model they will use and what each CCG will contribute (technical appendix 2).
4. Determine what, if any, additional support might be needed for example from a CSS and determine how this will be funded (annex 3 and technical appendix 2).
5. Design, agree and implement the governance arrangements that enable the collaboration and ensure these arrangements are reflected in their constitution, plans and structure (a model collaborative agreement is currently being developed).

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<sup>3</sup> Of course this document demonstrates a broad range of ways in which collaborative commissioning can be discharged, of which a single CCG taking a lead role is only one. What will be necessary is that CCGs can demonstrate that their arrangements are robust, including arrangements with CSSs, and that all relevant CCGs are appropriately involved.

The thresholds for authorisation are the same for every wave. However we recognise that as the year progresses CCGs will have more time to plan for their application and that external factors will change (e.g. stage of annual planning cycle at time of application will affect how developed a CCG's draft commissioning intentions for 2013-14 can be), and assessment will take into account. The inclusion of draft documents within the submission list explicitly recognises that at the point of submission a CCG may not have finalised or signed off a document.

### **For the 2013/14 planning round**

By the end of October, in time for the start of the 2013/14 contracting round, all CCGs should have met the authorisation requirements above in order to be able to put in place the new arrangements by the end of March 2013.

# Annex 1. Legal and technical considerations for collaboration across CCGs

Under section 14Z3 of the NHS Act 2006, any two or more CCGs may enter into arrangements whereby:

- (a) one of the CCGs exercises any of the commissioning functions of another on its behalf,
- (b) the CCGs exercise any of their commissioning functions jointly.

“Commissioning functions” means the functions of CCGs in arranging for the provision of services as part of the health service<sup>4</sup>

## **Liability**

Where two or more CCGs engage in collaborative commissioning arrangements, the individual CCGs will retain liability for the exercise of their respective statutory functions for their areas. This cannot be delegated or shared, and the arrangements must recognise this.

Two or more CCGs could have a joint working committee as the hub of their collaborative arrangements, but such a committee could not make decisions directly of its own authority which would bind the CCGs, as legislation does not provide for this. Without alternative arrangements in place, the individual CCGs would have to ratify all decisions of such a committee.

However, a CCG can delegate the exercise of any function to a committee or sub-committee of the CCG, or to its governing body, or to any member or employee (under paragraph 3(3) of schedule 1A of the NHS Act 2006). Therefore a CCG could, for example, delegate to a designated employee the function of approving or agreeing decisions, on its behalf, relating to collaborative commissioning, and this could include approving or agreeing the decisions or recommendations of a joint committee.

Similarly, the CCG could delegate to a committee or sub-committee of the CCG, or member, or to its governing body, this function of approving decisions or agreeing actions relating to collaborative commissioning, without a formal joint committee. These delegated arrangements would have to be set out in the constitution of the CCG, as they will form part of the arrangements made for the discharge of the CCG’s functions: the constitution must specify the procedure to be followed by the CCG in making decisions.

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<sup>4</sup> This includes the function of a CCG asking the Board under section 14Z9 to exercise any of the CCGs functions under section 3 or 3A of the 2006 Act (or a function related to those functions).

## **Governance and transparency**

Each CCG which is a partner to the collaboration, should ensure that they have appropriate arrangements in place to ensure that the arrangements are in line with, and will contribute to meeting, the CCG's statutory duties and in particular, the group's commissioning responsibilities under section 3 of the NHS Act 2006 as amended by the 2012 Act (i.e. the CCG's duty to arrange for the provision of health services as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility).

The arrangements for collaboration, how they relate to the decision-making process of the CCG, and how they are covered by the governance of the CCG, should be set out in the constitution of each CCG.

The duty of the CCG under section 14O(4) of the NHS Act 2006, as inserted by the 2012 Act, (ie The CCG's duty to make arrangements for managing conflicts and potential conflicts of interest in such a way as to ensure that they do not, and do not appear to, affect the integrity of the group's decision-making processes) will apply to these arrangements and the constitution must specify the arrangements that have been made to discharge this duty.

The CCG constitution must specify the arrangements made by the group for securing that there is transparency about the decisions of the group and the manner in which they are made. This includes arrangements made for collaborative commissioning.

## **Financial governance**

Under section 14Z3 of the NHS Act 2006, any CCG entering into collaborative arrangements may:

- (a) make payments to another CCG, or
- (b) make the services of its employees or any other resources available to another CCG.

Collaborating CCGs may establish a pooled fund, comprising contributions by the groups, out of which payments may be made towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made. CCGs must ensure that their financial governance takes account of these financial arrangements.

## Annex 2. How emergent CCGs in the North East established their collaborative arrangements

A case study of the work undertaken by pathfinder CCGs coming together to determine their collaborative arrangements in the North East is described in brief on the following pages. The case study describes a possible method for working this through – but it's really important that the method is locally tailored to local systems. The relationships between the CCGs in the north east are strong and build on years and years of collaboration through the historical statutory organisation structures. Relationships between CCGs are the determining factor in the effectiveness of collaborations – without those in place, no method will succeed.

### **Stage 1: Do we have an appetite for collaboration?**

The north east steering group for CCG development (a combination of CCG leaders, PCT, SHA and local authority senior management) established a work stream for contracting and performance management arrangements. The work stream report described the conditions in which contracting can best thrive and led to CCG leaders in the north east taking a particular interest in the contracting round for 2012/13 as a pre cursor for future work.

### **Stage 2: What do we want to collaborate on?**

NHS North facilitated a CCG engagement event in the north east that asked CCG leaders to consider whether they would want to collaborate - and to consider this for all of the contracts that they would be managing from April 2013.

The event and its preparation included:

- In advance of the meeting, PCT clusters mapped out all contract types (20 contracts and contract groupings). The mapping included the finances associated with each contract or contracting group, by CCG. (This showed the level of funding and activity by CCG – to help the judgment about the relative importance to the local patch of the particular contract group).
- The bulk of the meeting was dedicated to CCG specific group work – considering each of the 20 contracts/ groupings in turn and agreeing a preferred collaborative configuration where appropriate. (Note: PCT contracting leads were available as 'experts' to help CCGs on the day, if needed).
- The CCG then voted (using an electronic voting system that played out live results) for their preferred configuration for contracting in 2012/13.
- The event resulted in a broad overview of the preferred configuration of collaboration across the north east. The vote was not considered anything more than an indicative shape of preferred contracting arrangements.



### Stage 3: Are we sure?

CCG conversations were held across the north east to confirm and re examine the voting preferences of the delegates at the May event and to amend as appropriate, particularly by looking at the mapping by neighbouring CCGs (you can't collaborate if no one else wants to).

### Stage 4: So who and how will we make it work?

NHS North convened a half day workshop on behalf of CCGs. The workshop comprised CCG leaders to consider the specific collaborations that could operate across the north east (i.e. to identify which CCGs would collaborate and which would be the co-ordinating commissioner for the 2012/13 contracting round).

The event worked through a series of decisions:

- Confirmation/amendment of the contracts on which each CCG wanted to collaborate.
- Agreement about which CCGs would be involved in each collaboration.
- Agreement about the contributions that each CCG will make by way of expertise/ capacity to the collaborative effort.

The workshop resulted in a clear set of collaborative arrangements for the 2012/13 contracting round which will be consolidated for 2013. It is felt that a similar approach can be used to consider services which would benefit from stronger collaborative arrangements for 2013.

### Example matrix contracts

CCG	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
A CCG	2	NA	NA	NA	4	1	1	2	NA	NA	NA	4	1	1	2	NA	NA	NA	4	1
B CCG	2	NA	NA	NA	4	NA	NA	2	NA	NA	NA	4	NA	NA	2	NA	NA	NA	4	NA
C CCG	2	NA	NA	3	4	1	1	2	NA	NA	3	4	1	1	2	NA	NA	3	4	1
D CCG	2	NA	NA	3	4	NA	NA	2	NA	NA	3	4	NA	NA	2	NA	NA	3	4	NA
E CCG	2	NA	NA	3	4	NA	NA	2	NA	NA	3	4	NA	NA	2	NA	NA	3	4	NA
G CCG	NA	2	NA	3	4	1	1	NA	2	NA	3	4	1	1	NA	2	NA	3	4	1
H CCG	NA	2	NA	3	4	NA	NA	NA	2	NA	3	4	NA	NA	NA	2	NA	3	4	NA
I CCG	NA	2	NA	3	4	NA	NA	NA	2	NA	3	4	NA	NA	NA	2	NA	3	4	NA
J CCG	NA	2	NA	3	4	1		NA	2	NA	3	4	1		NA	2	NA	3	4	1
K CCG	NA	2	NA	3	4	NA	NA	NA	2	NA	3	4	NA	NA	NA	2	NA	3	4	NA
L CCG	NA	NA	2	3	4	NA	NA	NA	NA	2	3	4	NA	NA	NA	NA	2	3	4	NA
M CCG	NA	NA	2	3	4	NA	NA	NA	NA	2	3	4	NA	NA	NA	NA	2	3	4	NA
N CCG	NA	NA	2	3	4	NA	NA	NA	NA	2	3	4	NA	NA	NA	NA	2	3	4	NA
O CCG	2	NA	NA	NA	4	NA	NA	2	NA	NA	NA	4	NA	NA	2	NA	NA	NA	4	NA
P CCG	NA	2	NA	3	4	1		NA	2	NA	3	4	1		NA	2	NA	3	4	1
Q CCG	NA	2	NA	3	4	NA	NA	NA	2	NA	3	4	NA	NA	NA	2	NA	3	4	NA
R CCG	NA	NA	2	3	4	NA	NA	NA	NA	2	3	4	NA	NA	NA	NA	2	3	4	NA
S CCG	NA	NA	2	3	4	NA	NA	NA	NA	2	3	4	NA	NA	NA	NA	2	3	4	NA
T CCG	NA	NA	2	3	4	NA	NA	NA	NA	2	3	4	NA	NA	NA	NA	2	3	4	NA
U CCG	2	NA	NA	NA	4	NA	NA	2	NA	NA	NA	4	NA	NA	2	NA	NA	NA	4	NA

1 INDIVIDUAL CCG  
 2 SMALL CLUSTERS OF CCGs  
 3 LARGER CLUSTERS OF CCGs (eg CURRENT PCT CLUSTERS)  
 4 REGIONAL (EG CURRENT SHA AREAS)  
 5 NATIONAL (OFTEN IN COLLABORATION WITH NHSCB)

## Annex 3. Generic functions to support collaborative arrangements

These functions and tasks lend themselves to being undertaken once on behalf of all CCGs in a collaborative commissioning arrangement.

- Ensuring that decision making complies with the agreed governance model for the collaboration, and supporting the governance of their meetings, decision-making processes and record keeping – a ‘company secretary’ function
- Supporting a close working and contractual relationship between the collaborating CCGs, operating with good communication, transparency, openness and maximum good faith
- Fulfilling the information and reporting requirements of the contract with the provider and the provision of complete and timely information to all the CCGs
- Under the agreed direction of the CCGs in the collaboration, undertaking agreed negotiations and agreeing variations of specifications and contract terms with the provider on behalf of all CCGs in the collaboration.
- Executing the agreed management of the contract with the provider.
- Collation of the demand, financial and investment and quality requirements of the participating CCGs before and during negotiations for the provider contract and during the life of it in order that a single conversation can take place with the relevant provider
- Monitoring the provider’s performance against agreed collective and individual CCG requirements. Ensuring accurate and timely reporting to CCGs, including actual activity against agreed indicative activity plans and with reference to specific information monitoring requirements, meeting specification and quality standards and meeting the 18 Week Referral to Treatment Target and other targets;
- Facilitating discussion between collaborating CCGs in line with their shared commissioning intentions with regard to proposals for service or pathway reconfiguration and potential disinvestment decisions that could impact on partner CCGs within the collaboration.
- Supporting or overseeing the implementation of decisions taken by the CCGs relating to a clinical quality review (or equivalent process).

In many circumstances, CCGs will wish to engage a commissioning support service (CSS) to undertake these tasks and functions on their behalf. The models in technical appendix 2 illustrate how the CSS might potentially construct its relationships with the CCGs in the collaborative and with the providers from which the CCGs are commissioning.

Alternatively, CCGs might choose to share the functions or decide that one CCG will undertake them on behalf of the others.

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