Appendix 1

Commissioning Models Table

Model	Benefits	Issues / Concerns
Network Model - this is the current model of delivery which will be reviewed	 One member of staff to pull together work across all providers with clear structures and processes Gives an element of independence from the network and can see the bigger picture Providers feed into a central point but still make day to day decisions on their own services 	 There can be confusion over what is the co-ordinators responsibility and what is a service managers The co-ordinator is not a manager, nor do they oversee the network and therefore decision making sits with the individual organisation leads Whilst knowledge is shared, staffing and other skills are not shared amongst the network There are multiple clinical governance but no lead
Consortium	 Providers will share the same objectives Providers will pool resources It can offer new opportunities for staff The CAMISH 'brand' will reduce confusion amongst young people 	 If one provider is not performing well, all members of the consortium are responsible, this is particularly relevant for any finances that are not part of a block payment Decision making may be slower due to the number of parties involved, this may include decisions not being made due to no consensus Will need structure and a solid framework
Lead Provider	Quicker decision making process Lead provider carries the risk rather than risk being shared across several providers	 Commissioning have less control if something goes wrong with a subcontracted service. The lead provider will be responsible for any action as a result of under-performance We may limit the number of providers bidding and lose the successful collaboration we have made so far This would support the option of streamlined governance, IT and policies and processes as highlighted in the JTAI. Lead provider carries the risk rather than risk being shared across several providers