The Development of a Collaborative Framework for Commissioning Health and Social Care.

Abstract

Purpose

This paper presents an evaluation of a collaborative commissioning approach to improve quality and experience and reduce cost within integrated health and social care.

Methods

Multi-method approach using qualitative interviews, documentary analysis and non-participant observation.

Findings

The findings suggest that the approach provides a suitable framework for the collaborative commissioning of integrated health and social care services.

Implications

With health systems under significant scrutiny, the approach demonstrates effectiveness in securing quality improvements, achievement of recognised care standards and patient outcomes, while providing scope for financial gains and a goal for stakeholders to engage in effective communication. Further research is now needed to provide a definitive evaluation of its value outside of Wales.

Originality

This research presents an innovative method for collaborative commissioning and reveals activities that appear to contribute to more effective commissioning processes.

Keywords: Commissioning of care services; Health and social care; Integrated care; Multidisciplinary teamwork; NHS; Organisational development.

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Introduction

Integrating health and social care is a universal goal. So too is achieving that care within a finite resource; a consequence of economic austerity. Integrating services may improve patient satisfaction and experiences of care (Ham and Walsh, 2013; Ham and Curry, 2010a); it may also improve service efficiency (Ham and Curry, 2010a). However, the evidence is varied and success can depend on local context. Measuring its impact can be difficult, and results can take years to emerge (Bardsley et al., 2013). Nevertheless, sufficient evidence indicates that this is the right path to meet the changing needs of our population (Humphries and Wenzel, 2015).

When it comes to delivering benefits, the successful integration of services is dependent on having a shared purpose and a clear vision of what integrated care will achieve (Ham and Curry, 2010b). At the very least, a collaborative approach between clinical decision makers, managers and finance teams is required to ensure that resources are used most effectively to deliver the highest quality of care. Against this backdrop, it is clear that commissioning has an important role in developing integrated services.

In comparison to other UK nations, Wales enjoys some considerable advantages in its journey towards optimising integrated care (Lewis, 2015). The post-2009 structure unifies the planning and delivery functions of care on a geographical basis in seven Local Health Boards (LHBs) and three all-Wales NHS Trusts – the Welsh Ambulance Service, specialist cancer services and public health. The aim was to improve patient care by removing the artificial boundaries between LHBs and NHS Trust providers (the 'purchaser-provider split'), thus ending the internal market.

Despite this move, Wales has been seen to provide highly-fragmented, poorly co-ordinated care services. There is, however, a growing realisation that clear agreements detailing

care standards, pathways, expected performance, incentives/disincentives and finances can drive quality improvements and increase value in an integrated non-competitive environment. This has been given further traction by the Parliamentary Review of Health and Social Care in Wales (2018) which suggests that integrated commissioning is the right direction for Wales.

To realise these benefits, a collaborative project sponsored by NHS Wales and funded by a Welsh Government "Invest to Save" grant was developed in 2012. Previously, commissioning of commercial, non-NHS mental health and learning disability hospital services was undertaken separately by each LHB, or through the Welsh Health Specialised Services Committee. Monitoring of these independent provider units – many outside of Wales – was down to individual staff members or small teams within each LHB, with little or no collaboration. The advent of the commissioning framework, which evolved into CAREMORE®, resulted in reduced costs and quality assurance of psychiatric care provision (NHS Wales, 2016). This success led to the establishment of seven further frameworks (Table 1).

[insert Table 1]

CAREMORE® forms the structure for the national commissioning quality and delivery frameworks for NHS services and national commercial framework agreements for externally provided care services. The method allows LHBs and/or local authorities (LAs) to identify a specific population and create a detailed assessment of healthcare needs and the services required to meet these needs. These frameworks enable all parts of NHS Wales to acquire and performance manage services under pre-agreed standards, costs, terms and conditions of a contract, which are also in accordance with EU and UK Procurement Regulations. The core components are: Care standards; Activity; Resource Envelope; Model of care; Operational arrangements; Review of performance; Evaluation.

Given that CAREMORE® is becoming increasingly used within NHS Wales, an evaluation to explore its utility was necessary. This study aims to evaluate the development of the framework to date, and assess the extent to which the findings can be used to inform wider implementation. The specific evaluation questions posed are based on four criteria developed by Haynes (1999) that ask: 1) should it work – the underlying logic; 2) can it work and in what context; 3) does it work – are the expected outcomes likely to be achieved; and, 4) is it worth it – are the expected benefits greater than the costs incurred?

Methods

Pluralistic evaluation (Smith and Cantley, 1985) is based on the premise that criteria for judging the success of an initiative are situational and may be interpreted differently by various stakeholders. It explores a policy or service from different viewpoints, and is concerned with developing a portfolio of evidence from multiple stakeholders, and using multiple methods to analyse and evaluate data.

In line with pluralistic evaluation, a multi-method approach was adopted. A preliminary validation (Farr and Phillips, 2017) scrutinised relevant documents to ascertain the extent to which the framework had been effective and efficient. The wider team then analysed documents from each of the eight settings in which CAREMORE® had been implemented, observed local meetings and conducted semi-structured interviews with stakeholders.

In total, 14 interviews were completed (10 via telephone and 4 face-to-face) between July and September 2017. Stakeholders identified as "users" or "observers" of CAREMORE® were approached. Those interviewed included 1 NHS and 2 LA commissioners, 4 NHS and 1 LA providers, 1 NHS and 1 LA procurement representatives, 2 policy managers, 1 public health representative and 1 third-party observer from NHS England.

Interviews typically lasted for one hour and were recorded and transcribed verbatim. Verbal informed consent was obtained and recorded before each interview. Interviews were supplemented with a series of non-participant observations (undertaken by two researchers [AM and KN; January – July 2017]) and an analysis of local documents, to build an understanding of CAREMORE® and provide context for the interview analyses. Each observation was written up as a descriptive account.

Thematic analysis was performed on all data (Braun and Clarke, 2006). A coding frame for deductive analysis was developed and refined as appropriate. Interviews were independently coded by two researchers and significant findings were then considered in collaboration to identify recurrent themes, compare and contrast findings and detect divergent accounts. This was combined with inductive coding to ensure any issues not anticipated in the initial research questions but with implications for the research were identified. Emerging themes were explored within each case and then compared across frameworks to identify variation.

The study was approved by Swansea University Research Ethics Committee (ref: 100717) in July 2017.

Findings

Preliminary validation

CAREMORE® was assessed as having clear alignment with national and international policy. For example, there is close association between the core components of the framework and Welsh Government's Together for Health policy, which specifically addresses quality, and the Triple Aim focus on quality, cost, and value (Berwick et al., 2008). This gives weight to

the 'construct validity' of CAREMORE® and its appropriateness as a framework for collaborative commissioning.

CAREMORE® enabled transparency in setting care standards, monitoring of both quality and effectiveness of services and the implementation of governance structures to promote collaboration and sharing of good practice. The process of contracting care for patients involved setting service specifications, including quality standards and performance management, which did not exist before.

In the hospital framework, between 96 – 98% of required care outcomes were evidenced. Transparency in care quality led to 93% of new placements being allocated to a top-5-ranked provider. In terms of efficiency, since the Framework Agreement was introduced in 2012, there had been a reduction in expenditure of £7.92 million over the 4-year period (NHS Wales, 2016).

Stakeholder interviews

To enhance our understanding of CAREMORE®, we explored the following: Overall views and rationale for the implementation; the impact on the commissioning process, on stakeholders, and on collaboration; barriers and facilitators.

Overall Views of CAREMORE®

Participants described CAREMORE® as a structured approach to manage the complex task of commissioning healthcare services.

"CAREMORE®, to my mind, is a structured planning tool to allow you, when developing services, to keep a balanced view of all the important aspects" (Procurement 1)

Gathering the explicit detail needed to develop the Framework Agreement tended to highlight a paucity of available data within a service, particularly in relation to evaluation. While perceived as beneficial, the task was observed to be complex, time-consuming and sometimes frustrating for those involved.

Some NHS providers viewed CAREMORE® as an opportunity to justify and evidence their resource envelope and activity in an attempt to secure additional funding for their service. Few described CAREMORE® as a necessary hoop to jump through in order to "*get you money in the healthcare system*" (NHS provider 1).

CAREMORE® was compared to project management methodologies, such as PRINCE2, but considered bespoke, specifically for commissioning healthcare. No core areas were considered missing or providing redundant information. The 'Evaluation' component was praised as good practice, although two participants thought it was closely linked to the 'Review' component and struggled to distinguish between them.

The CAREMORE® products were identified as the plan on a page and the workbook. Feedback for these two management techniques was mixed. Some users praised the plan on a page for its simplification of extremely complex information. Although, they also acknowledged that the page sometimes spanned several pages, thus losing the simplicity of the communication. The more detailed workbooks were often described as quite "*dry*" and "*cumbersome*" (NHS provider 2). To ease administrative burden, there was a desire to streamline the underlying schedules. However, the work involved was perceived to match the task at hand and was no more paperwork than would be otherwise involved.

Rationale for the Implementation of CAREMORE®

Participants viewed the successful implementation of the secure hospital framework as a proof of concept, rendering CAREMORE® a tried and tested approach. Although, within the latterly implemented frameworks, where the need for change in response to crisis was less pressing, the implementation of CAREMORE® was felt to lack rationale. These participants felt that resource, training, and stakeholder engagement was limited which appeared detrimental to both relationships and motivation.

Crisis

A service in crisis was the most commonly reported rationale for implementation across the frameworks. Crisis was often defined as following a review or report of a service suggesting a need for improvement, such as the Secure Services Review into secure mental health facilities in Wales, or the Review of the Welsh Ambulance Service. Participants considered the structure of the National Collaborative Commissioning Unit (NCCU) a positive here; it was an external service able to provide opportunities and support for service improvement. However, resource availability within the NCCU and its governance, or authoritative limits, was a caveat.

Shaping the market

The return of an approach more aligned with commissioning was considered a positive opportunity to influence providers to react to population needs, and was especially apparent in the commercial sector. A strong emergent notion was that CAREMORE® provided people with the opportunity to ask, 'what good looks like'. Although, there was variation in how commissioning was perceived generally - some participants thought commissioning was "*just [purchasing] goods and other non-important services*" and "*this isn't 'us' [Wales]*" (LA

commissioner 1). This was commonly attributed to a lack of knowledge and awareness of commissioning.

Quality

Quality assurance and quality improvement were seen to be at the core of CAREMORE® and were the main draw. Where services were suggested to have been in crisis, this was often related to difficulties in achieving quality within a finite or already stretched resource envelope. The approach provided the resource and motivation to focus on quality, agreeing national targets and moving the focus away from purely financial-based or arbitrary targets. The national, all-Wales focus promoted consistency in information sharing and performance monitoring, which was considered lacking in the current system.

The Impact on the Commissioning Process

The impact on the commissioning process was examined to explore perceptions of the effectiveness and efficiency.

Increased Taxonomy

Using CAREMORE® appeared to create a more manageable commissioning process by bringing "*organisation and structure to an otherwise complex task*" (Procurement 2). Participants agreed that previous commissioning arrangements had lacked structure in terms of what data was collected and reported, thus, ultimately, it had little purpose. CAREMORE® was described as providing a reference point to ensure all key components of commissioning were considered systematically.

<u>Transparency</u>

Developing a framework was likened to "shining the light" - it forced organisations to look meticulously at what they were, or were not, doing. This was generally perceived positively, particularly within services that had been subject to criticism following recent failures.

"If there's one thing that it [CAREMORE®] has done is, it's focussed our attention on the bad things that we need to make better, if that makes any sense." (NHS provider 2)

However, increased transparency was not without its consequences. One participant described it as "*quite frightening*" (LA commissioner 2) to have uncovered numerous inefficiencies within the service with limited resource available to manage that. Additionally, two participants expressed fear about publically available information being taken out of context, particularly with regard to resource envelope allocation. This was balanced by a view that, given the more readily available information, stakeholders were now in a better position to provide context in response to any criticism.

<u>Accountability</u>

CAREMORE® introduced new governance structures to increase accountability and ensured that services justified and took responsibility for their activities. Reporting mechanisms were also improved. For some NHS providers, this provided a much-needed resource to focus on quality:

"One obvious [benefit] is being able to account for the service [we] provide. In the past, we haven't been able to do this because [they] will take money out of the service and "who cares?" That's different now. We have a ring-fenced amount of money within

12

the resource envelope to deliver a specified service, and we have a budget to work on

the quality - which is what we've needed" (NHS provider 1)

Clarity about who was accountable, to whom, and for what, was observed. Although, some participants felt that accountability was more comparable to "*a one-way street*" (Policy manager 1) and the current system lacked opportunity for providers to challenge commissioners, or hold them to account, when issues arose:

"One of the problems with accountability is that they're in charge and we're the

provider. That doesn't encourage us to sit at the table together and say 'right, we jointly

need to problem solve" (NHS provider 3)

Transformation

A cultural shift was described by NHS stakeholders, who identified a change in environment from one notoriously complex and stressful to one that, while still demanding, was more streamlined and cohesive. Further, some participants perceived that before CAREMORE®, services were stagnant and "*not adaptive to the needs of the population*" (policy manager 2). With the new commissioning framework came a change in practice and a formative approach to service delivery, largely enabled by the 'Review' and 'Evaluation' components. Generally, participants described becoming "*a bit more savvy*" (NHS provider 2) and had increased confidence that the model of care being implemented was the right one.

"As I say, it was a quantum leap in my view of how to commission and manage

[complex service change]" (Procurement 1)

The data available as a result of the new commissioning approach enabled meaningful conversations, and users were better able to highlight the most relevant areas of service in need of change:

"Data shifts the debate, without us just arguing. Really good things, like that, have started to occur. You get used to the numbers and the patterns and it starts talking you down to ask questions and look at where you are seeking to improve things" (NHS provider 2)

Transformation was also noted in the unique combination of improved quality and efficiency:

"What we've delivered through this methodology has been pretty effective. Delivering value for money. We've improved quality and we've improved patient services, there's no denying that. It's quite an unusual combination to actually improve quality and reduce costs. In terms of an outcome, that's pretty unique" (Procurement 1)

While participants agreed that the use of CAREMORE® for commissioning had improved quality, some found it more difficult than others to envisage where cost-savings would occur. It was agreed, however, that services were now likely to be more cost-effective as a result of this new approach.

The Impact on Stakeholders

Participants noted positive and negative impact on themselves in their professional roles. Positively, the approach provided a structure to ensure that the relevant component parts were considered. Participants also reported using a *"slimmed down"* (NHS commissioner 1) version to structure their thinking on both a local footing, and in other areas of their work.

The process of designing a framework required participants to think about how their service differed from other services, drawing clear boundaries and increasing their confidence around what they do, and do not, deliver.

CAREMORE® was credited for aiding communication among stakeholders and was sometimes used as a tool to enhancing mutual understanding. This was favourable because it introduced "*a consistency about how people are doing things*" (Policy manager 2).

The accessibility of data was seen to increase productivity:

"[Chief Exec] said to me, "you have a real skill in terms of bringing things together". I was able to do that because of the commissioning framework. I'd got the set of numbers and I could say exactly what was going on, in a way that hadn't been portrayed before" (NHS provider 2)

During the development period, participants took time to understand CAREMORE®, and gather the relevant data. This was time-consuming and participants would have liked more support. Nevertheless, within more established frameworks, this burden appeared to ease as the process became more embedded in standard practice.

The Impact on Collaboration

Generally, the approach was perceived to create a focal point for the right stakeholders to come together and actively manage service change. However, within integrated health and social care, collaboration was perceived as a more difficult aspect of CAREMORE®. There were suspicions of "*a health take-over*" (LA commissioner 2). One participant attributed unwillingness to collaborate between services as being due to ignorance about strategic aims:

"You have councillors saying, 'I'm not giving the Health Board any money!'' - It's because people don't understand" (Procurement 2)

Many attributed the reluctance to work together as a consequence of budget constraints, and recognised that LAs were also under a lot of pressure.

The collaborative aspects of CAREMORE® enhanced communication and reduced duplication by bringing together professionals and creating a shared vision for the service. Most participants believed their framework was collaboratively developed. Although, some in the latterly implemented frameworks perceived the collaboration as a heavy 'top-down' approach, with little room for flexibility and ownership. This led to feelings of despondency:

"It didn't feel collaborative, kind of one sided. After taking the time and trouble of coming up with [model of care], I actually just walked away from it. I've got better things to do with my time than draft multipage documents that will be thrown in the bin" (NHS provider 3)

A suggested solution was that the NCCU facilitate the collaboration between commissioners and providers. Others suggested having a nominated individual within the organisation to drive the interaction between the provider and commissioner.

Barriers

Limited resource was the most commonly reported barrier to implementation, and included; limited capacity to deliver service change within a finite and already stretched budget; limited engagement for those developing and implementing new Framework Agreements; and, limited capacity within the NCCU to provide the required stakeholder engagement.

Other barriers related to the complexity of the detail behind the CAREMORE® acronym, which could be "*off-putting to other colleagues*" (Policy manager 1). A suggestion from one provider was to streamline the number of schedules under each key component and adapt the language used to increase its accessibility.

"It's got a language that's kind of its own. There's strength in that but I wonder whether the focus on the schedules and things like that, at times, has disengaged the audience". (NHS provider 2)

Collaboration and the integration of health and social care both represented a "*major mind-set change*" (Procurement 1) and required one of two opposing approaches to tackle. Some individuals thought that, since the NCCU was not a statutory body, it did not have enough power to exert influence. The NCCU involvement occasionally created tension among stakeholders who saw them as *"trying to take over the world"* (Policy manager 2). Thus, involvement from Welsh Government or senior management within LHBs and LAs was required.

"There should be more senior engagement, to get around these people with entrenched views on 'this is how we've always done things'" (Procurement 1)

Where difficulty engaging local authorities was reported due to differences in governance structures, more directional instruction from Welsh Government was anticipated to go some way to resolve this.

Facilitators

Good project management was the main facilitator. It was important to have an external body to oversee the national approach and bring stakeholders together. The NCCU were perceived as being best positioned for this role:

"[NCCU] tend to take the lead because that's the way think, they work collaboratively on an all-Wales basis. Health Boards just think on a local footing. One Health Board

won't think about a neighbouring Health Board. We need them [NCCU] to see the much bigger picture" (NHS commissioner 1)

The NCCU may add further value if they were able to act as an impartial third party, providing support to those involved in the commissioning of healthcare services, although there was further acknowledgement that, in reality, this would need to be properly resourced.

Discussion

The complexity of healthcare commissioning provides great motivation to look for ways to improve how this is carried out and managed (Petsoulas et al., 2014). System pressures and a permissive national context in Wales have created an opportunity for commissioners to think differently and experiment with an alternative approach to commissioning and contracting. This research provides evidence that the advent of CAREMORE® has considerably changed how services are delivered. Moving away from previous commissioning methods permitted the development of standardised ways of working, improved processes to deliver high-quality and consistent care, and more efficient use of resources. Stakeholders worked collaboratively to create a shared vision for their service, setting national care standards, developing clear governance structures, and promoting consistency in information sharing and performance monitoring - all of which were previously lacking in Wales but are key factors of success (NHS Clinical Commissioners 2017).

The success of CAREMORE® is shaped by a number of contextual factors. For example, the increase in available and transparent data was a positive step forward in ensuring a more effective service – i.e. greater transparency leads to improved quality and efficiency - but it may highlight additional inefficiencies. This is important since, for services to work

differently there must be sufficient resource available to enable that to happen (NHS Clinical Commissioners, 2017). Although, broadly, initial costs were counterbalanced by a more efficient service once the framework had been implemented.

This study also points to the ongoing difficulties encountered in effectively engaging organisations with differing priorities (Bardsley et al., 2013; Gray and Birrell, 2016). More directional instruction was required to facilitate collaboration, particularly between health and social care. However, this 'top-down' approach is only successful if the culture, resource allocation and management are changed throughout the local system (Edwards, 2018). The gap between health and social care is well-entrenched and it is important for policy-makers to accept that these new working relationships may take time to establish. Evidence from international models such as New Zealand, US, Netherlands and South Korea suggest, perhaps, even decades. Furthermore, the methods transformational capacity seems highly dependent upon extraneous factors such as leadership within organisations and the NCCU. Thus, the importance of relationship building must not be underestimated.

Service improvement is a long-term strategy which requires measuring impact over a considerable length of time (Bardsley et al., 2013; Lewis, 2015). It is not uncommon for quality improvement initiatives to report some benefits, particularly at the start of an initiative, when engagement and motivation is high (Bardsley et al., 2013). A longitudinal assessment is now needed, with the 'Evaluation' component embedded as mandatory within the commissioning process, to ascertain the extent to which the quality improvement and transformation necessary to address future demand are delivered.

The difficulties involved in commissioning healthcare are not unique to the UK. Internationally no system, to date, has performed consistently well (Ham, 2008). Many of the problems encountered are however symptomatic of the nature of healthcare provision rather

than particular healthcare funding models. As such, CAREMORE® should be widely applicable to other countries. It is therefore now important to explore CAREMORE®'s potential outside of Wales, particularly given the different ways in which commissioning is carried out.

Study limitations

Given our sample size, it is difficult to generalise the nuances in the data by Framework. Further, the interpretive nature of qualitative data may limit the conclusions that can be drawn from this study. In mitigation, however, the pluralistic evaluation framework used to frame the data collection gives coherence and enhances the validity of our findings (Øvretveit, 2011). The method enabled a synthesised account of CAREMORE®'s impact on the commissioning process, making explicit the processes which had been successful in generating impact, and which can be used to take the approach forward. This was facilitated by the use of three qualitative methods for triangulation.

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TABLES

Table 1. National Collaborative Frameworks, Commissioning Value, and Commencement Dates

National Collaborative Frameworks	Annual Commissioning & Service Values £m	Framework commencement date
Internally Provided NHS Wales Services		
Specialist NHS Child and Adolescent Mental Health Service (CAMHS) – Quality & Delivery Improvement Framework	30	01/04/2015
National Collaborative Commissioning: Quality & Delivery Framework Agreement for Emergency Ambulance Services	136	01/04/2016
National Collaborative Commissioning: Quality & Delivery Framework Agreement for Non-Emergency Patient Transport Service	26	01/10/2017
National Collaborative Commissioning: Quality & Delivery Framework Agreement for Emergency and Medical Retrieval and Transfer Service	8	01/04/2017
Unscheduled Care Programme Delivery Plan 2016/17 then Quality & Delivery Framework Agreements	1,200[a]	*In development*
Externally Provided Services		
National Collaborative Mental Health & Learning Disability Hospital Services Commercial Framework Agreement (£10m of which is via WHSSC for Medium Secure Services)	55	01/02/2012
National Collaborative CAMHS (Low secure & acute) Commercial Framework Agreement	4	01/04/2015
Integrated Health & Social Care Collaborative Commissioning Programme – development of Commercial Framework Agreement for Mental Health & Learning Disability Younger Adult Care Homes [spend for all care homes circa £500m]	130	01/10/2016

Note. [a] Urgent & Emergency Care NHS Benchmarking Network commissioning and service value estimate.