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## SUMMARY

In the context of *Making the Connections Beyond Boundaries* and in order to ensure that objectives set out in *Designed for Life, Fulfilled Lives, Supportive Communities* and other major strategies are met, health services and social services commissioning arrangements need to be strengthened and more closely aligned. Making commissioning fully fit for purpose will have to be a developmental process over a number of years to ensure that the structures, models, skills and information are all in place, but a firm start must be made now.

The immediate need is to accelerate the implementation of service improvements, reconfiguration proposals and quality standards already agreed, and to start building a firm platform for implementation of the next round of Health, Social Care and Well-being Strategies and Children and Young People Plans in 2007/08 and after.

This guidance sets out:

- arrangements for establishing three Regional Commissioning Units (RCUs) to support Local Health Boards in commissioning;
- rules to govern commissioning behaviour in the NHS;
- proposals to develop national patient pathways for the major care streams together with the associated contract currencies and information requirements;
- proposals to improve skills to support commissioning;
- encouragement to make more use of powers under Section 33 of the National Health Services (Wales) Act 2006 (formerly section 31 of the Health Act 1999) (“Section 33 Flexibilities”) to improve joint working across health and social care boundaries (as further specified in the National Health Service Bodies and Local Authorities Partnership Arrangements (Wales) Regulations 2000 (S.I. 2000/2993));
- a requirement for Local Health Boards and Health Commission Wales to establish formal mechanisms for dealing with joint commissioning issues.

# 1. INTRODUCTION

## Background

1.1 In May 2005, *Designed for Life* identified an ambitious reform programme radically to transform health and social care in Wales. For the NHS this means:

- promoting health and well-being by addressing the determinants of ill health and dealing with inequality;
- adopting a citizen-centred model for the provision of public services across all sectors in Wales;
- delivering cost-effective care safely, sustainably, and as locally as possible in accordance with published quality standards throughout Wales;
- where possible, providing care in the home, or the community, rather than in hospital;
- reconfiguring services so that they provide an optimal balance of networked local hospital care and centres of excellence linked by technology; and
- achieving a balance across services through a combination of investment, standard setting, public and professional engagement, ensuring value of money and improved outcomes.

1.2 In February 2007, *Fulfilled Lives, Supportive Communities* was launched. It states that social services will be rebalanced to allow services to be provided earlier, tailored to individual needs and prevent or delay people moving to a higher level of need. It proposes a model that will mean:

- simpler access and assessment, and more developed self referral and self assessment;
- appropriate access out of normal hours;
- services that give people real say about when and how they are delivered including offering citizens' greater financial control;
- person-centred care services with dignity and respect for the individual and no tolerance of abuse;
- better information to service users and carers;
- more effective joint working with all partners and a action to address the barriers to better collaboration;
- stronger joint commissioning with health and other services;
- action to influence and develop services that deliver improved nutrition and food security for users and their carers;
- clearer outcome-based approaches to care planning;
- more informed and shared decisions about managing risks;
- clear, simple systems of complaint and redress.

- 1.3 Both these strategic documents identified commissioning as a vital element in achieving the objectives. The purpose of this document is to provide an overview of how a new commissioning process should develop and the range of issues that need to be considered by those involved in managing and/or participating in the process.
- 1.4 In the context of *Making the Connections Beyond Boundaries*, local services must be better aligned. This guidance will assist health service commissioners and local authorities in ensuring their services reflect this aim in the context of Health, Social Care and Well-being Strategies and Children and Young People Plans.

### **The Role of Commissioning**

- 1.5 Commissioning involves specifying, securing and monitoring services that are evidence-based, cost effective, of high quality and meet individuals' needs. It is important to distinguish commissioning from contracting. The former involves taking a long term view of demand, reviewing supply and then bringing the two together in a plan for evidence-based services to meet current and future needs on a sustainable basis. Contracting arrangements are over a much shorter time span and focus on the detail of the service to be delivered. Commissioning must therefore be led by senior managers, within agreed strategic frameworks.
- 1.6 The objectives of health and social care commissioning are to improve the health, social care and well-being of the population in line with government policies and local Health, Social Care and Well-being Strategies and Children and Young People's Plans. In this context its task is to clarify:
  - what the needs are;
  - what types of services are required to respond to need and quality standards;
  - what capacity and volume of services are required;
  - where services are to be located and provided;
  - who is the most efficient and effective provider;
  - how service gaps can be remedied;
  - how redundant or inefficient services can be improved or decommissioned and resources redeployed;
  - value for money in the use of public resources.
- 1.7 Commissioning needs to link to and strengthen the impact of other approaches such as unified assessment, care pathways, clinical networks and healthcare standards. A vital task will be to manage demand, so that service users receive the right service and scarce resources are not misapplied.

1.8 Across all the bodies, the aim will be to:

- make better use of existing capacity within commissioning agencies;
- improve the skills of commissioners;
- improve the use of resources through partnership working;
- improve the quality of information for commissioning;
- improve opportunities for clinicians and other professionals to contribute to the commissioning process;
- improve opportunities for users and carers to influence commissioning;
- ensure the full engagement of all relevant senior managers including finance and planning managers;
- ensure that all services commissioned at the very least reach minimum quality standards and that outcomes can better be assessed;
- ensure that services **across** a care pathway encompass all relevant provider agencies – e.g. NHS, social services, education, the voluntary sector, etc.

## **2. ROLES AND RESPONSIBILITIES**

### **The Principles**

- 2.1 Commissioning must drive improvements in quality and performance in a more determined way than hitherto. More explicitly it must remodel services where needed, tackle unacceptable practices, and improve quality, reflecting national quality standards. Commissioners will be expected to commission against published standards, implementing the recently issued *Healthcare Quality Improvement Plan*.
- 2.2 Commissioners must be able to provide a rationale for all services contracted for.
- 2.3 Commissioning needs to be led by senior managers. It must be rooted in strategic objectives and in planning. Planning must be informed by community and user views as well as by clinical and professional advice from a range of disciplines to address quality issues.
- 2.4 Commissioning strategies need to be monitored and reviewed on a regular basis to respond to changing needs, circumstances and advances in treatment and technologies.
- 2.5 Commissioning needs to be underpinned by good clinical, management and financial information.
- 2.6 Providers need to be engaged at each stage of the commissioning process.

### **The role of LHBs, HCW, Trusts and Regional Offices**

- 2.7 Acting with other relevant commissioners of care, LHBs will retain their current responsibility for the elements of commissioning for their resident populations – from planning through to contracting, and covering the whole care pathway. In each of the three regions LHBs will establish a Regional Commissioning Unit (RCU) to assist them in discharging their responsibilities for the commissioning of emergency and elective services in secondary care. Depending on its complexity, rehabilitative and intermediate care will be commissioned locally or via the RCU. LHBs may act separately, together or through the RCUs, depending on the issue, but in all cases will remain responsible for discharging all the elements of commissioning for their resident population, except in those areas falling to HCW.
- 2.8 LHBs and HCW will be accountable for their commissioning decisions; providers will be accountable for what they are commissioned to provide. This guidance does not propose any change in the current allocation of commissioning responsibilities between HCW and LHBs, though this will be reviewed during 2007/08.

- 2.9 Commissioners and providers must work more effectively and in partnership to co-create excellent citizen-centred services. This means that all must collaborate more openly and honestly. There must be a marked change in behaviour across all players, to improve services and eliminate deficits. This will include the following:
- commissioning must explicitly aim to achieve the objectives set out in the Health, Social Care and Well-being Strategy and the Children and Young People's Plan and to meet published standards;
  - all parties must be open with information relevant to contracts; any dispute will be referred to Regional Office for resolution;
  - agreement that PEDW will form the common data set for secondary care commissioning and that information from CHKS, as publicly funded information on public services, must be shared on a confidential basis between commissioners and providers;
  - GP referral data will be shared;
  - all changes in senior medical and dental staffing must be seen as an opportunity for service change and modernisation, and should be discussed by Trusts with their main Commissioner(s);
  - there must be greater involvement with service users and partners.
- 2.10 Performance management of the RCUs will be the responsibility of the LHBs. Performance management of the LHBs will remain the responsibility of DHSS. Work will be undertaken during 2007/08 in partnership with the service to ensure that accountability remains clear and that performance is properly managed.
- 2.11 The role of the Regional Office and of the Delivery Support Unit will need to be kept under review in line with the requirement for there to be strengthened performance management.
- 2.12 Commissioners and providers will be expected to agree commissioning agreements by 31<sup>st</sup> March in the year before the agreement become operational, and must urgently alert Regional Offices where this is an issue. This will be in place for the agreements to be reached in 2007-08. Regional Offices will deal with other inter-commissioner disputes from that time onwards.
- 2.13 Work is in hand on an ethical framework, to be issued in spring 2007, intended to aid all commissioners of health services in Wales by setting out the ethical principles that should underpin their decisions and help to ensure that local, regional and national patterns of service delivery are developed to consistently achieve the Healthcare Standards for Wales. Based around the fundamental principle of equal concern and respect, it then sets out and explains 8 substantive and procedural principles:
- treating populations and particular people with concern and respect;
  - minimising the harm that an illness or disease could cause;
  - fairness;

- working together;
- reciprocity;
- keeping things in proportion;
- flexibility;
- good decision-making – including openness and transparency, inclusiveness, accountability, reasonableness and appeal.

### **Regional Commissioning Units (RCUs)**

2.14 During 2007/08 and no later than October 2007 the LHBs in each region will have in place a Regional Commissioning Unit (RCU), whose role will be to provide advice to LHBs as well as negotiating and contracting for services.

2.15 Establishing a RCU in each region will enable LHBs to build up capacity and expertise, and to reduce the number of individual agreements and level of transaction costs. In creating the RCUs the LHBs must:

- draw on existing resources and configure them more effectively;
- secure the appropriate commissioning information and skills;
- rapidly agree effective and efficient working arrangements that give commissioning a much sharper cutting edge while maintaining clear lines of accountability;
- ensure that inter-regional issues are properly handled;
- ensure good practice is shared between RCUs.

2.16 The LHBs in the region will determine the arrangements for the RCU and take responsibility for its success. The LHBs establishing the RCU must sign off the RCU's accountability and governance arrangements, including:

- the annual processes;
- resourcing;
- efficiency gains and risk management plans;
- a protocol to support disinvestment and reinvestment;
- disputes procedures, covering failure to reach agreement and LHB withdrawal from previous agreements;
- performance management;
- the role of clinical networks, in accordance with their status and maturity;
- arrangements to ensure that LHBs cannot unilaterally undermine joint agreements; and
- compliance with equality statutory obligations.

2.17 Each RCU will be organised to support the LHBs. It will not be a separate body or tier but must work under the direction of the LHBs. Its role will be to:

- provide advice to LHBs and keep them informed of all issues relating to their responsibilities;
- negotiate with and contract for services from providers in line with the Secondary and Specialist Care Agreements;
- secure appropriate clinical advice and access to evidence for effective care;
- agree the allocation of resources with LHBs;
- develop arrangements for effective engagement with HCW.

### **Professional Advice and Managed Clinical Networks**

- 2.18 Commissioning must be informed by detailed and specialist knowledge of existing services and future requirements. Clinical support to the commissioning function is vital to effective commissioning and the monitoring of effectiveness. Clinical networks and the regional professional advisory committees must have a powerful role in supporting and informing commissioning.
- 2.19 Clinical advice for commissioning must reflect:
- national standards and guidance and clinical governance requirements;
  - the outcome of annual audits against national quality requirements and guidance and the outcome of national clinical audits;
  - deficiencies reported in inspection reports or accreditation processes;
  - national targets, including those set out in the Annual Operating Framework;
  - the outcome of demand and capacity analysis which in turn informs the need for additional investment or disinvestment;
  - surveys of patients' satisfaction with local services.
- 2.20 For all formally established networks governance arrangements including accountability must be clear. There should be a Network Board, with sufficiently senior clinical, managerial and lay representation and skills to fulfil the function at all levels of advising annual commissioning contractual arrangements. The Director of the Network and the Lead Clinician should be a resource for the RCU to use as part of the commissioning team for that particular service. The Chair of a Network should be an LHB Chief Executive and should champion the operational aspects of the Network in driving up the quality of services.
- 2.21 The Network Boards must be capable of prompt decision-making in formulating their advice to the RCU and then prompt follow-through of actions falling to them. The role, responsibility, time commitment, accountability and subsequent communication requirements for each network participant must be determined and described in a Network Establishment Agreement (see WHC (2005) 076). Any managerial

support staff for each network should be formally employed by a host LHB. Clinicians' time and input must be reflected in their employer job plans.

- 2.22 Clinical governance is the legal responsibility of the Chief Executives of LHBs and NHS Trusts, and does not pass to the network. However, networks must have in place a framework for dealing with clinical governance issues where they arise as part of the network function. There must be clear protocols for reporting clinical governance issues to the relevant Chief Executive (or nominated clinical governance lead). Individual health care professionals have the responsibility of conforming to the guidance of their individual registration authorities in the way that they conduct network business.

### **The Benefits**

- 2.23 The benefits to commissioners from the new arrangements will be to:
- enable the LHBs to build up capacity and expertise, through reducing the need to replicate activity 22 times;
  - strengthen LHBs' ability to drive change, through pooling their financial resources;
  - free up individual LHBs to focus on demand management, the chronic conditions agenda and modernising primary care;
  - better integrate commissioning of services commissioned by LHBs and HCW;
  - demonstrate improvements in quality and performance of services.
- 2.24 The benefits to NHS Trusts from the new arrangements will be to:
- make life simpler for providers through reducing the number of commissioners and contracts they must deal with;
  - speed and clarify the process of decision-making at commissioner level.

### **3. THE PROCESS**

#### **Triennial Planning**

- 3.1 The planning system will be based on the three-year cycles set out in *Designed for Life and Fulfilled Lives, Supportive Communities*. At the start of each cycle, the Department for Health and Social Services (DHSS) will issue a *Strategic Framework Statement* that will state planning assumptions for the next three years.
- 3.2 This will inform the development of the following round of Health, Social Care and Well-being Strategies and Children and Young People's Plans, which will cover a three year period.
- 3.3 LHBs and local authorities will need to develop and align planning functions to ensure that services are developed on the basis of local needs and in a co-ordinated way within the broader region. For the planning process, they will secure appropriate clinical and professional advice and user and community engagement.
- 3.4 Drawing on agreed plans, LHBs will need to work with the RCU in their area to identify:
  - demand that will be met;
  - capacity that will be required;
  - services required, analysed by level, cost and quality;
  - service specifications, securing the requisite clinical advice, and allowing such variances as they deem appropriate;
  - performance requirements.

#### **Commissioning Strategies**

- 3.5 Local authorities and LHBs must develop commissioning strategies to improve care outcomes for patients and local people, based on better defined and documented patient pathways linked with the unified assessment or, where applicable, the care plan for a child or young person, which will provide the foundation for commissioning and benchmarking best practice in Wales. Standardised pathways for patient care will ensure:
  - more consistent, citizen-centred care;
  - attention to planning the whole journey from the community to secondary care and back again;
  - clinical and social care engagement;
  - removal of stages of the pathway that are out-moded or add no value;
  - the development of better costing;
  - the incorporation of quality and clinical effectiveness into commissioning decisions; and

- more outcome-based commissioning.
- 3.6 During 2007/08 the Government will lead on developing model pathways for the major work streams e.g. for emergency and elective care and chronic conditions. The contract currencies and information required to support these will need to be identified, for example in relation to volume, speciality case mix, and variations in delivery and quality of care.
- 3.7 Each local authority and LHB should work closely together and with other partners in consultation with users, carers and their representatives to produce commissioning strategies for major service areas – such as children and young people, older people, mental health and learning disabilities. Local pathways should be developed with the collaboration of primary and secondary care clinicians, social care and voluntary service providers, and service users. Unnecessary stages will be eliminated. Further guidance on this will be published in 2007.

### **The NHS Annual Planning Cycle**

- 3.8 At the start of the annual commissioning round, the Welsh Assembly Government will issue to the NHS an Annual Operating Framework (AOF) for the coming year. It will act as a detailed set of expectations for each organisation, and will be sent to each Chief Executive in NHS Wales as accountable officers, and will set out:
- service delivery expectations;
  - the resource envelope; and
  - ministerial priorities.
- 3.9 The LHBs and NHS Trusts will then be required to draw up their service response, which will demonstrate how the AOF will be delivered. The service response will:
- identify detailed delivery for the first year, and information and assumptions for years two and three;
  - set out the impact of longer-term changes or of major capital developments over that period;
  - incorporate action to implement the Health, Social Care and Well-being Strategy, the Children and Young Person's Plans and the Modernisation Assessment (see below).
- 3.10 Health Commission Wales will also develop a service response describing the services LHBs require it to commission.
- 3.11 LHBs will by April 2008 have developed the following two agreements, which together will ensure improvements to health, and a shift in care closer to home.

## **The Community Partnership Agreement**

- 3.12 The primary purpose of this will be to identify how the NHS, working with the advantage of co-terminosity, will work with local government, the voluntary and independent sector to deliver improvements in primary, community, intermediate and social care. This must result in better planning and delivery of services, including potentially the pooling of funds and sovereignty, reflecting the recommendations of the Beecham Review. It must lead to:
- improved health;
  - better, more integrated community services;
  - the development of effective services for “hard to reach” or vulnerable citizens such as the homeless and substance users; and
  - close alignment of the NHS and the wider public sector.
- 3.13 During 2007/08 LHBs will be expected to review with partners current commissioning and management arrangements for community services including primary and intermediate care and chronic conditions management. This will be informed by the Beecham Report and the new Chronic Conditions Model and Framework for Wales, with a view to strengthening integrated working across primary, community and social services, and with education services for children. Local commissioning should be taken forward in close liaison with local clinicians and practitioners.
- 3.14 It is expected that in doing so both health and social services commissioners will look carefully at the possibility of making far more use of the Section 33 Flexibilities. These have been used very effectively in England to improve user outcomes, efficiency and staff morale. They are of particular value with regard to services for older people and children, and for those with mental health problems, learning disabilities and long-term conditions. They are very underused in Wales.

## **Secondary and Specialist Care Agreement**

- 3.15 The primary purpose of this will be to secure those services likely to continue to be provided by secondary care hospitals and to ensure a safe and effective interface with HCW commissioned services. The RCU will act on behalf of the LHBs in securing services to meet the Secondary and Specialist Care Agreement. It is anticipated that the RCUs will negotiate one contract with each provider identifying LHB-specific service schedules.
- 3.16 The RCUs and HCW will construct a formal mechanism whereby commissioning involving their joint interests can be considered and agreed. This will minimise the danger of patients being caught between the two commissioning interests.

## Balancing the Agreements

- 3.17 The division of services between the two agreements will be at the discretion of the LHBs. If LHBs took different views which would cause difficulties to the RCUs, it will be for Regional Offices to arbitrate. Taken together the impact of the two agreements taken together must increasingly be to:
- strengthen integrated working across all levels of health and social care for adults and children;
  - shift services closer to home and away from the secondary sector, with an appropriate transfer of resources, allowing that sector to focus on the delivery of high quality secondary services;
  - promote far better health promotion and demand management at all points in the pathway;
  - support independence and self care;
  - demonstrably improve outcomes for patients and local people;
  - improve care pathways for patients and local people;
  - remould services on the basis of clinical and professional advice and broad public engagement;
  - make best use of the skills of different professionals;
  - improve patient safety;
  - jointly commission services for children living away from home due to health and education or social care needs.
- 3.18 The introduction of these new arrangements must in no way impair the continuity of care through the patient journey. LHBs must take responsibility for ensuring that the integrity of the care pathway is protected. Equally as for the LHB/HCW interface, the introduction of RCUs will provide no excuse for fragmentation of care or services; indeed the expectation is for closer integration between all services including HCW commissioned services.

## Social Care Commissioning

- 3.19 *Fulfilled Lives, Supportive Communities* committed the Assembly Government to working closely with the voluntary sector to ensure that its unique contribution is recognised and developed, and with the independent care sector to ensure that its experience and resources are recognised and used to contribute to more effective, consistent and higher quality services across Wales. It acknowledged that both the voluntary and independent care sectors should be able to contribute to a stronger impetus for delivery and partnership through more effective engagement with local councils, Local Health Boards and others. The development of Local Independent Sector Provider Forums creates a good basis to help achieve these aims.

- 3.20 It sets out an intention to work with partners including the Social Services Improvement Agency, the National Leadership and Innovation Agency for Health as well as independent and voluntary organisations to develop a comprehensive commissioning framework for social services. For adults this will have strong links to commissioning for health services and housing where, increasingly, we expect to see accommodation and care support provided as part of packages. For children, the Children's Plan will set out how services will be commissioned for all children in need (including disabled children, looked after children and care leavers) so that all their needs are met and outcomes improved.

## **4 NEW COMMISSIONING CAPACITY**

- 4.1 Building commissioning expertise is vital to a successful transformation of health and social care in Wales. Even with the best governance arrangements, the effectiveness of Wales' commissioning arrangements in both health and social care depends upon the ability to discharge the function with expertise, judgement and confidence. There is a need both to strengthen formal training and the development of commissioning managers and clinicians in order to build the information infrastructure required to support sophisticated commissioning.
- 4.2 Joint training for commissioners, providers, managers and clinicians, will assist in achieving the mature environment of collaborative working required and speed the adoption of more integrated service arrangements. Accordingly, from March 2007 NLIAH will draw on examples of good practice in Wales and work with a recognised academic centre, NHS Wales and the WLGA Improvement Agency to set up a skills development programme for commissioners. In future graduating from a Commissioning Development Programme should increasingly be seen as a pre-requisite to taking up a senior role in commissioning organisation.
- 4.3 In addition, during 2007, action will be initiated to enhance information needed to improve commissioning and performance management, based in part on the work on model pathways referred to earlier. The aim will be to build a more comprehensive, accurate and informative picture of the well-being and healthcare performance of each community.

## **5 A DEVELOPMENTAL APPROACH**

- 5.1 The scale and importance of the changes required to build strong commissioning across the health and social care system mean that this will not be resolved quickly. Capacity and confidence need to be built on firm foundations and information and experience will take time to accrue.
- 5.2 It will be particularly important to ensure that developments relating to health and social services are handled separately where necessary but together where this offers benefits. There needs to be greater use of Section 33 Flexibilities, and the development process over the next year needs to be managed across the whole sector.
- 5.3 In 2007/08 cancer services should be a particular area for focusing on improvement because of the importance of making progress in achieving both the reorganisation of services required to reflect best practice and to meet national standards. This will be an important test also of how the LHBs and RCUs work with the networks and HCW in making improvements and how information is used to inform and monitor change.
- 5.4 This guidance will be reviewed in nine months time in the light of progress.

## 6 ACTIONS

### **For the Welsh Assembly Government and its agencies –**

1. DHSS will clarify the role of the Regional Offices in supporting the working of LHBs and RCUs under these new arrangements (2.12);
2. DHSS will issue *Ethical Framework for Commissioning* in spring 2007 (2.13);
3. NLIAH will in 2007/08 set up a skills development programme for commissioners (4.2);
4. DHSS will establish a Project to create the information support needed to improve commissioning and performance management (4.3);
5. DHSS will issue in 2007 more detailed advice on different elements of commissioning e.g. children and young people, older people, mental health and learning disabilities (3.6);
6. DHSS will clarify by April 2008 the allocation of commissioning responsibilities between HCW and LHBs (2.8).

### **For LHBs and Trusts with Local Authorities with other partners -**

1. From April 2007 commissioning must reflect the good practice requirements set out in this guidance (2.9);
2. By April 2008 commissioning must reflect the revised procedural arrangements set out in this guidance (sections 2 and 3);
3. In 2007/08 LHBs will be expected to review with partners current commissioning and management arrangements for primary and intermediate care (3.13);
4. Commissioners and providers will complete commissioning agreements by 31st March (3.12);
5. During 2007/08 the LHBs in each region will have in place a Regional Commissioning Unit (2.15);
6. Cancer services should be a particular focus for improvement (5.3).