

A Guide to the Commissioning Framework for Mental Health and Addiction

2015

Consultation document

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How to have your say

There will be many opportunities for feedback through national, regional and local consultation, workshops and forums.

There will be four regional workshops in Auckland, Hamilton, Wellington and Christchurch as well as the opportunity to provide a written submission.

You are invited to make a submission on this consultation document by visiting www.health.govt.nz/about-ministry/consultations and completing the online form.

You can also download the feedback form, complete, and email it to:
commissioningframework@moh.govt.nz

or print it out and post to:

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Submissions close at 5pm, Friday 13th November 2015.

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Executive summary

The Commissioning Framework for Mental Health and Addiction aims to place people at the centre of commissioning to achieve equitable outcomes, wherever people live and whatever their circumstances. It is part of an outcomes-focused approach intended to shift the focus from 'how' things are done to outcomes that will make a real difference for people experiencing mental health and/or addiction.

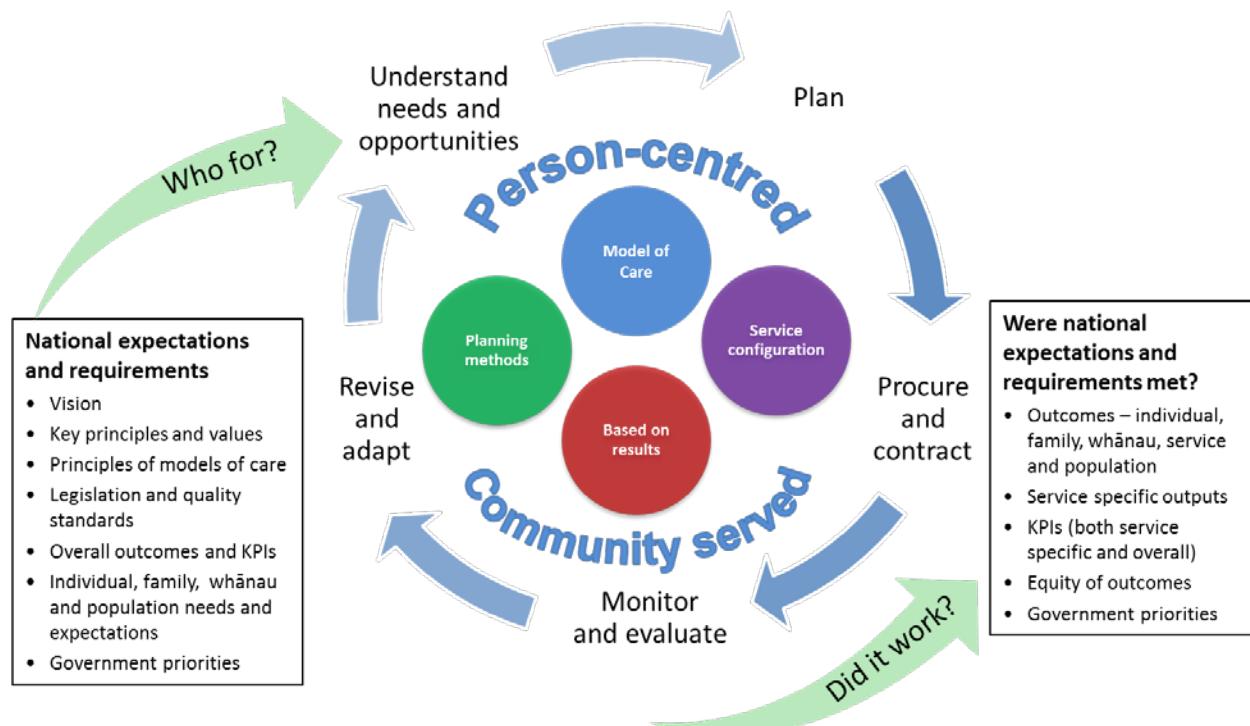
The Commissioning Framework provides a nationally consistent approach to commissioning that supports the direction set for delivering mental health and addiction services in *Rising to the Challenge* (Ministry of Health 2012) both now and in the future. It takes into account the social determinants of health by taking a much broader approach to health and wellbeing.

Commissioning is defined as:

the process of continuously developing services and committing resources to achieve the best health outcomes for individuals and the population, ensure equity and enhance experience within the resources available.

As outlined in the diagram below, the Commissioning Framework provides guidance and direction for those who are responsible for commissioning care to improve outcomes for mental health and addiction. Under this framework, they must understand national expectations and requirements clearly, be more flexible on how responses to needs are developed and delivered and be firm that the responses they commission are making a real difference and improving outcomes.

The Commissioning Framework for mental health and addiction



Note: KPIs = Key performance indicators

To deliver on its aim, the Commissioning Framework:

- considers **expectations and requirements** set at the national level to drive the overall system. Because it is dynamic, the framework can adapt to changes over time
- asks, '**Who is the response¹ for?**' This key question must be answered to inform the best commissioning approach. The framework has the flexibility to be applied at a national level (eg, to all those needing forensic mental health services), at a regional level (eg, to all youth in the Southern Region) and at the local level (eg, to all Māori youth living in Bay of Plenty)
- captures the dynamic nature of a **commissioning cycle** and the importance of continually reviewing, evaluating and adapting to achieve the expected outcomes
- uses an overarching **person-centred** approach and understanding of the **community served** to ensure responses complement and link into the existing resources of the community
- centres on the four key components of **planning methods, model of care, service configuration** and **based on results** linked to outcomes
- asks, '**Did it work?**' To answer this critical question, it is necessary to capture and measure outcomes. A National Outcomes Framework for Mental Health and Addiction will provide national-level population outcomes. Expected outcomes at the regional, local and service levels must first be clearly defined, measured and agreed to answer this question
- helps to answer, '**Were the national expectations and requirements met?**' The answer comes from information at national, regional and local levels. If the framework is followed, the national requirements and expectations will have fed into the approach and the question can be answered using the information defined as part of the 'based on results' component of the Commissioning Framework.

The Commissioning Framework for Mental Health and Addiction covers commissioning for the full range of publicly funded care, including health promotion, primary, specialist, district health board and non-governmental organisation care. It provides a high-level framework that can be applied across the whole continuum of mental health and addiction care and can adapt to changing national expectations and requirements.

¹ Here, **response** is used in a broad sense to reflect that commissioning will not always lead to the purchase of services but can also lead to different ways of responding to need and opportunity, across communities, agencies and funding streams.

Introduction

This guide sets out the rationale for developing the Commissioning Framework for Mental Health and Addiction, describes the Commissioning Framework and its key components, and explains how to use it.

The development of the Commissioning Framework is a specific action that comes from *Rising to the Challenge* (Ministry of Health 2012). The Ministry of Health has taken this opportunity to shape the framework with the sector to ensure it is fit for purpose and has relevance beyond 2017 (see Appendix A for more on the development process). It provides a national commissioning frame for implementing an outcomes-focused approach for mental health and addiction.

The framework is to be used by those responsible for commissioning mental health and addiction care. It supports a consistent approach to commissioning responses² across New Zealand, using the relevant information to purchase the responses that will meet the needs of the local population.

The framework describes the components that are critical to successfully commissioning mental health and addiction care. It also provides a national structure based on the key principles that mental health and addiction commissioning:

- is based on authentic partnerships that place people at the centre
- builds on the strengths of people, family, whānau and communities
- is a collaborative process that connects providers, agencies and government sectors to promote social inclusion and equitable outcomes
- enables innovative and effective care tailored to meet need
- promotes wellbeing, prevention and early intervention
- ensures the right help, when it is needed, across the continuum.

² In this document, **response** is used in a broad sense to reflect that commissioning will not always lead to the purchase of services but can also lead to different ways of responding to need and opportunity, across communities, agencies and funding streams.

Chapter 1: Why develop a framework?

In 2012 three key national documents were released that set out the direction for the mental health and addiction sector over the next five to ten years: *Blueprint II: How things need to be* along with its companion document *Blueprint II: Making change happen* (MHC 2012a, 2012b) and *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* (Ministry of Health 2012).

The overarching vision for *Blueprint II* is that ‘Mental health and wellbeing is everyone’s business’, taking a broad view that considers the roles of not only health but also social services (MHC 2012, p 6). It refers to district health board (DHB) planners and funders as the ‘architects’ of the New Zealand system and as critical to making change happen as the sector is shaped by the types of services purchased and how these are purchased.

Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017 sets the direction for delivering mental health and addiction services across the health sector. It outlines key priority actions aimed at achieving further system-wide change to make service provision more consistent and to improve outcomes. It also considers a planning and funding framework to support effective use of resources (see Appendix B for more on this background document).

In a recent report, the New Zealand Productivity Commission (2015) looks at how to make New Zealand’s government-funded social services more effective so that they improve people’s lives and raise social wellbeing. Its report highlights the importance of developing new approaches that better match services to those who need them and encourage service providers to innovate and continually improve their services.

One of the key findings in the commissioning section of the report is that ‘Effective commissioning is fundamental to well-functioning social services. It is a challenging task. It is not generally undertaken in New Zealand in a structured, consistent and effective way’ (New Zealand Productivity Commission 2015, p 313). This Commissioning Framework addresses this issue by providing a national structure that can be used to approach commissioning for mental health and addiction in a consistent way across New Zealand.

Key terms used in this document

Although definitions of **commissioning** differ, the literature agrees that it is more than traditional planning and funding and more than procurement processes. Commissioning encompasses all three of the goals of the NZ Triple Aim model: improved quality, safety and experience of care; improved health and equity for all populations; and best value for public health system resources (Figure 1).

Figure 1: The New Zealand Triple Aim for quality improvement



Source: Health Quality and Safety Commission

The following definition of commissioning is adapted from definitions used by the United Kingdom's National Health Service (NHS) World Class Commissioning national programme (Sobanja 2009) and South Australia's clinical commissioning guide (O'Brien 2013).

Commissioning is the process of continuously developing services and committing resources to achieve the best health outcomes for individuals and the population, ensure equity and enhance experience within the resources available.

O'Brien (2013) describes commissioning as an iterative and collaborative process that requires a deep understanding of the evolving needs of the community as well as of key priorities that need to be delivered. It requires that:

- services are designed and delivered to meet these needs and use the full capabilities of providers and community groups
- opportunities for collaboration and innovation are identified and maximised to challenge thinking and consider the best way to meet needs (O'Brien 2013).

Commissioning frameworks set out an ideal approach to using available resources to achieve the best outcomes in the most efficient, effective and sustainable way. **Successful commissioning** encompasses the full range of resources – not just money – and many different ways of improving outcomes through a range of approaches (Ministry of Justice UK 2013). Commissioning frameworks have been an important tool in the United Kingdom and Australia to support the shift from institutional care to community care.

Outcomes of the Commissioning Framework

The Commissioning Framework provides a nationally consistent approach to commissioning care that will not only support the achievement of *Blueprint II* (MHC 2012a, 2012b) and *Rising to the Challenge* (Ministry of Health 2012) but also maintain the system into the future. It has been developed to provide a frame and infrastructure to support a move towards an outcomes-focused approach.

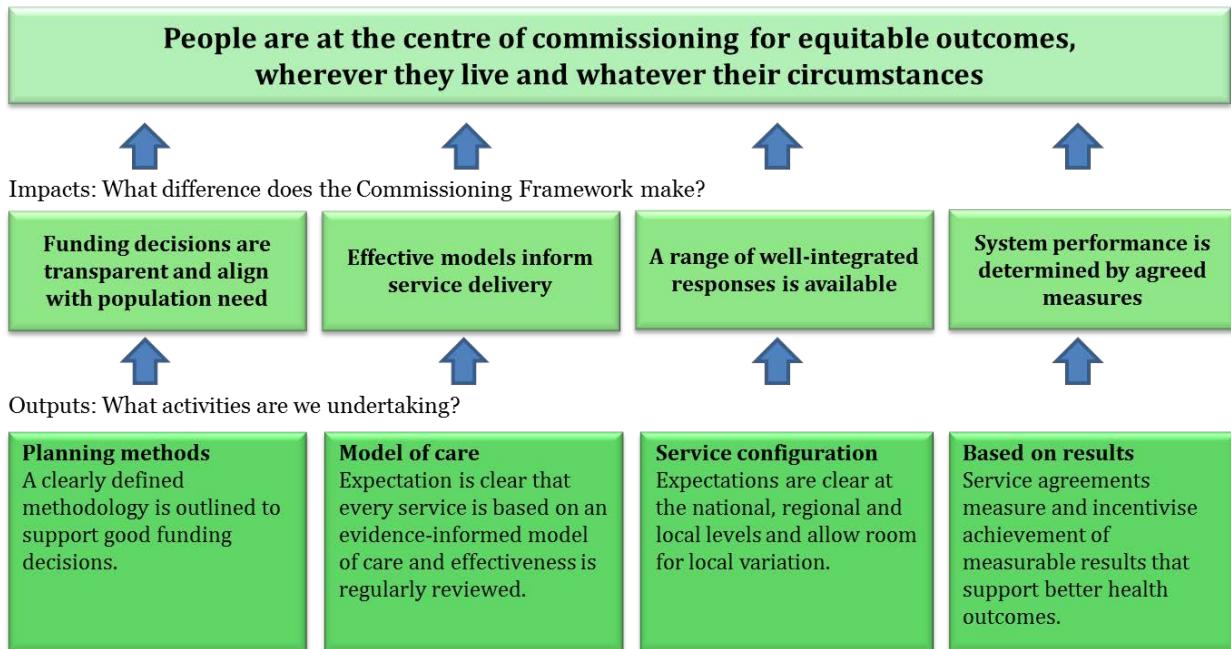
The Commissioning Framework for Mental Health and Addiction in New Zealand has been developed with reference to other national and international approaches (see Appendix D). It is intended to:

- provide a high-level national frame to allow for local variation linked to national outcomes and describe key principles that need to be included in local care, service design and provision
- identify which parts of the current system need to be more flexible and which parts need to be tightened to enable innovative and integrated approaches to be supported within the framework
- address the three goals of the Triple Aim and ensure that these are included in all commissioning activities
- describe the dynamic nature of commissioning and the need to continually revise and adapt approaches so that they are responsive to changing population need
- support the move from a national framework focused on inputs and outputs to one focused on outcomes
- ensure accountability for public funds and continuous quality improvement so that investment produces improved outcomes
- refocus resource to achieve the goals of delivering care closer to home and provide a national infrastructure that supports new ways of working.

The intervention logic diagram below (Figure 2) describes how the Commissioning Framework will produce the desired outcomes. The approach is based on advice from the State Services Commission and The Treasury in *Performance Measurement: Advice and examples on how to develop effective frameworks* (2008).

Figure 2: Intervention logic diagram

Outcomes: What are our goals for New Zealanders?



Benefits of the commissioning approach

We will know this Commissioning Framework is fit for purpose because it supports innovative and integrated approaches to meet people's needs, and agreed performance and outcome measures will drive continuous development and quality improvement.

The implementation of the framework will drive the activities as the key components at the centre of the Commissioning Framework. The impacts will contribute to the overall aim, in which people are at the centre of commissioning to achieve equitable outcomes, wherever they live and whatever their circumstances. Table 1 sets out the more specific impacts and the evidence that will demonstrate each one has been achieved.

Table 1: Impacts of the Commissioning Framework and how they will be demonstrated

Impact	How it will be demonstrated
Funding decisions are transparent and align with population need	National, regional and local priorities are clearly aligned to population need, and funding is invested in line with these priorities.
Effective models inform service delivery	Measures of effectiveness are regularly monitored and tracked over time. The model is reviewed and adapted in line with these findings as well as emerging evidence and research. Models emphasise prevention and early intervention.
A range of well-integrated responses is available	Districts can demonstrate the range of options available to meet the needs of their local communities and these options align with national requirements, expectations and priorities. Responses promote social inclusion, reduce health inequities and cross agency boundaries when needed.
System performance is determined by agreed measures	Agreements clearly outline how agreed results will be measured and include measures of all three goals of the Triple Aim.

Chapter 2: What the Commissioning Framework looks like

This chapter introduces the Commissioning Framework for Mental Health and Addiction. It sets out the framework's purpose, principles, values and scope before outlining the different features that contribute to it. Chapter 3 looks at its key phases and components in more detail.

Purpose

The Commissioning Framework for Mental Health and Addiction provides a national commissioning frame for implementing an outcomes-focused approach for mental health and addiction.

Key principles and values

New Zealanders with mental health or addiction issues must lead their own recovery, have personal power and take up a valued place in their family or whānau and communities. In addition, service users have a vital role in participating in and leading at all levels of the system they use, including planning, funding and delivery of services.

(Ministry of Health 2012, p 6)

Mental health and addiction commissioning:

- is based on authentic partnerships that place people at the centre
- builds on the strengths of people, family, whānau and communities
- is a collaborative process that connects providers, agencies and government sectors to promote social inclusion and equitable outcomes
- enables innovative and effective care tailored to meet need
- promotes wellbeing, prevention and early intervention
- ensures the right help, when it is needed, across the continuum.

Scope

This Commissioning Framework has been designed to apply to all commissioning that is done to improve outcomes for mental health and addiction, regardless of who is responsible for commissioning. It covers the full range of publicly funded mental health and addiction care, including health promotion, primary, specialist, DHB and non-governmental

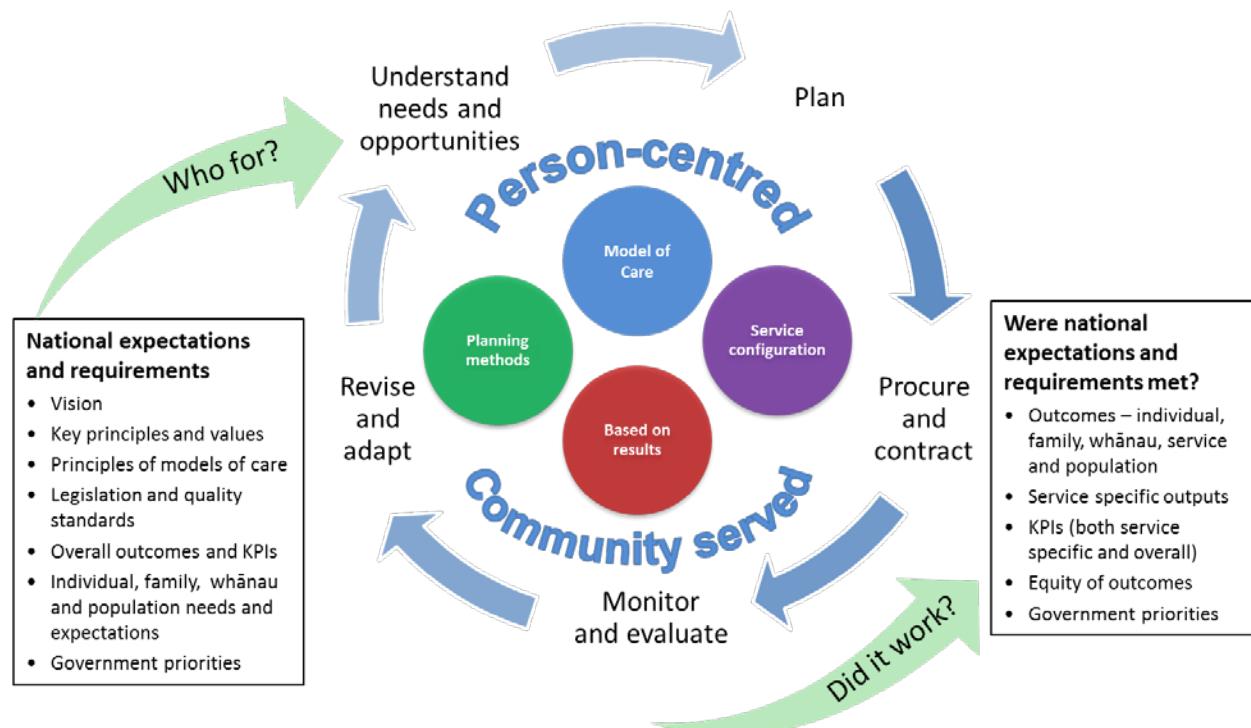
organisation (NGO) care. It also takes account of physical health and ensuring equitable access to health responses.

By applying the framework, those who are commissioning care will consider national expectations and requirements while they also mix and match service types, configurations, models of care and funding models to suit local need and support innovative and integrated approaches.

Features of the Commissioning Framework

Figure 3 outlines the essential features of the Commissioning Framework. The following sections focus on each of those features in turn.

Figure 3: The Commissioning Framework for Mental Health and Addiction



National expectations and requirements

National expectations and requirements

- Vision
- Key principles and values
- Principles of models of care
- Legislation and quality standards
- Overall outcomes and KPIs
- Individual, family, whānau and population needs and expectations
- Government priorities

The national expectations and requirements are the high-level, non-negotiable conditions that set the context for commissioning. Commissioning activity occurs within the wider health and state services environment and needs to align with government direction and overarching strategies and policy in relation to mental health and addiction.

The current vision, key principles and values for mental health and addiction are set out in *Rising to the Challenge* (Ministry of Health 2012). As national expectations change over time, these will feed into the Commissioning Framework so that it continues to be relevant over the longer term (see Appendix C for examples of current national expectations and requirements).

Principles of models of care

The Ministry of Health expects mental health and addiction services to develop models of care that:

- clearly state the nature of their services
- provide a basis for funding against which the effectiveness of those services can be measured.

The aim of a model of care is to describe best practice care and services within a system (or a part of that system) for a person or population group as they progress through the stages of a condition, injury or episode of care. Models of care should sit across a range of services, including primary and secondary services and those provided by NGOs and in the community. A model of care is not limited to health and disability services, and may include social and cultural services that support the delivery or outcomes of health care.

The following principles need to underpin any model of care for mental health and addiction to ensure the success of services.

- Service users and their family and whānau (including children) are at the centre of the model.
- A robust framework underpins service delivery, reflecting clinical and non-clinical aspects of care.
- The model focuses on resilience and recovery.
- It reflects holistic practice that is focused on wellbeing and includes responses from outside the health sector.
- The model has a systemic focus.
- Responses reflect evidence of best practice (defined as dynamic, evidence-informed, innovative and open to change).
- Data is used to inform practice.
- The model is responsive to co-existing problems.

- Responses are culturally competent as well as clinically competent and reflect whānau ora.
- The model is part of a range of information used to develop funding models.
- The model can relate to other models of care within the DHB and to models of care for regional services (eg, adult forensic mental health services).

Legislation and quality standards

The health and disability system operates within a statutory framework made up of over 20 pieces of legislation, which are updated periodically. Those commissioning care need to ensure all activity meets these legislative requirements. In addition, they must consider national standards, guidelines and requirements (see Appendix C).

Overall outcomes

To move the sector towards an outcomes-focused approach, the Ministry is developing a National Outcomes Framework for Mental Health and Addiction. This Outcomes Framework and associated measures (including reviewing and refining existing measures) will provide a national framework that will link local outcome measures to overarching health outcome measures. It will outline, at the national population level, the desired outcomes for mental health and addiction and how achievement of these will be measured.

With a National Outcomes Framework, the impact and outcomes of change can be measured at national system and population levels. It will also make it possible to:

- take a strategic and continuing view of change needed at population, system and provider levels to support service delivery to population groups
- align activities to outcomes across the mental health and addiction sector, and broader health and social service initiatives
- prioritise and guide investment decisions and align these with results-based accountability
- report and track the effectiveness of actions in delivering change to identified population groups using specifically designed outcome and indicator measures.

Part of the process of developing the Outcomes Framework is to work through current measures and key performance indicators (KPIs) to ensure that they all support an outcomes-focused approach. The existing set of data collected from DHB, NGO and primary care needs to allow the agreed population outcomes to be measured, providing a national picture of actual outcomes achieved.

Key performance indicators

The KPI Framework for New Zealand Mental Health and Addiction Services is a provider-led initiative, designed to drive quality and performance improvement across the sector (NDSA 2012). Using data from PRIMHD (the Ministry of Health's national database on mental health), a national picture of performance against key indicators can be benchmarked across the country.

The overall goal of the KPI Framework is to improve outcomes for people who use mental health and addiction services and support effective use of resources across the system. Planning is underway to extend the framework to the whole sector, including DHBs, NGOs and all mental health and addiction services.

Individual, family, whānau and population needs and expectations

The expectations of individuals, families, whānau and the wider New Zealand population are an important part of commissioning care that is acceptable and upholds the principles and values of the Commissioning Framework. At a national level, needs and expectations drive priorities and individuals, families, whānau and the population as a whole expect to be included in national, regional and local planning.

Involving these different groups early in the planning phase is critical, as is having mechanisms for engaging stakeholders to give their input into setting the priorities. By engaging early, those who are commissioning care gain an understanding of needs and also can manage expectations in line with the resources that are available. For more detail on involving individuals, families, whānau and communities and seeking their views, see ‘Component 1: Planning methods’ in chapter 3.

Government priorities

Better Public Services, one of the Government’s key priority areas, is about services working together to make a difference to New Zealanders. To deliver better public services that meet the needs of New Zealanders, government agencies must be innovative and responsive and take a whole-of-government approach to reaching these outcomes.

In the health sector specifically, the expectation is that the sector will become more innovative, efficient and focused on delivering what New Zealanders really want and expect. At the same time, public services will have a sharper focus on costs and ensuring value for money.

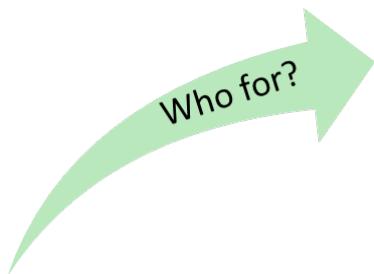
The wellbeing and health of New Zealanders will be improved by delivering services that are accessible, safe, individual- and family-centred, clinically effective and cost-effective. The Ministry has a multi-faceted strategy for providing these services, as is appropriate for a complex sector.

Since the current New Zealand Health Strategy was published in 2000, much has changed. The strategy is currently being updated to set a new vision and a road map for the health sector for the next three to five years. It is being developed in conjunction with two external reviews of:

1. health system funding, looking at the arrangements to support a high-quality health sector that integrates across the social sector and is sustainable in the long term
2. health system capability and capacity, which will contribute to an adaptable and responsive health and disability sector that supports the updated strategy.

For more on the update of the strategy and the associated reviews, go to:
www.health.govt.nz/about-ministry/what-we-do/new-zealand-health-strategy-update-and-associated-reviews

Who for?



around the answer to this question.

The very first question to answer when commissioning care is who the response is for. This may be at a national, regional, district or community level and may be determined geographically (eg, all those living in Waikato) or by population group (eg, all those with low-prevalence conditions and/or high needs) or through a combination of both (eg, all those living in Waikato with low-prevalence conditions and/or high needs). Defining the target group is critical as the entire commissioning process will be tailored

The answer may be made in response to a government priority or local needs or it may be investigating a suspected gap in care. For example, if the target group is Māori aged 12–19 years with mild to moderate mental health and/or addiction needs, then the approach to developing the key components will be very different from an approach where the area of focus is older people with high-prevalence conditions.

This framework has been designed to be applied at different levels so the answer may be broad at the national level, more specific at the regional level and very specific at the local level.

Person-centred

The Commissioning Framework aims to place people at the centre of the process of commissioning care for mental health and addiction to achieve equitable outcomes, wherever they live and whatever their circumstances. A person-centred approach has its primary focus on people, understanding their needs and aspirations and what matters to them. To deliver person-centred health care, the focus is on the person, their family, whānau and community and the outcomes they expect.

Improving mental health and wellbeing is everyone's business. Commissioning must support people to 'lead their own recovery, have personal power and take up a valued place in their family or whānau and communities' (Ministry of Health 2012, p 6). A person-centred approach is based on strong partnerships, empowerment and self-determination and responses that are designed around a person's needs rather than the needs of those providing services (MHC 2012b).

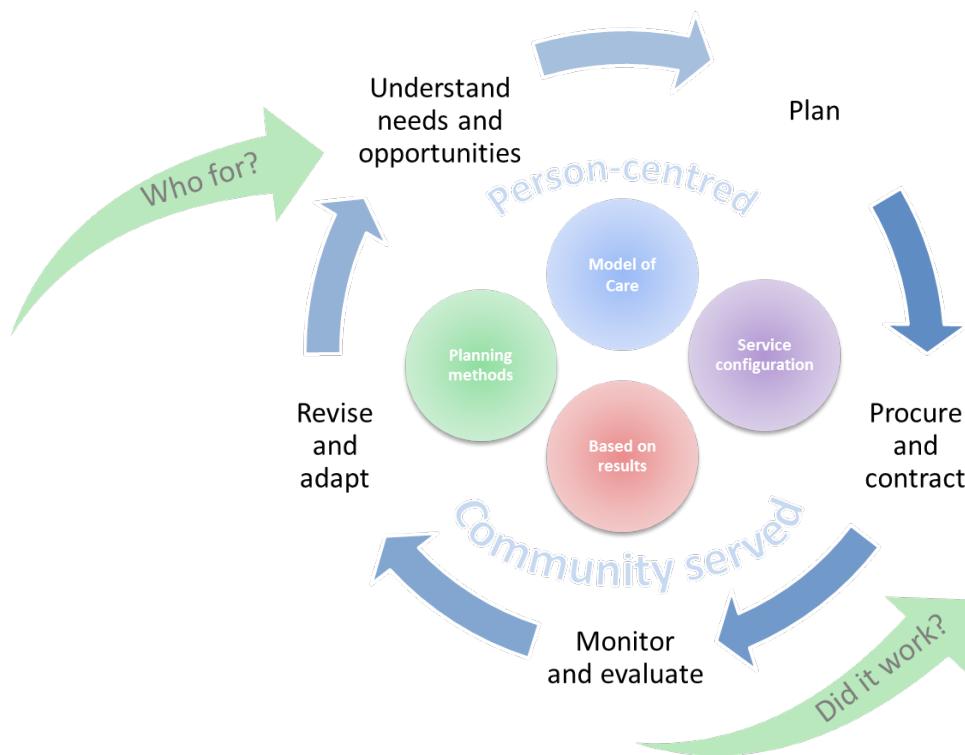
The whānau ora approach represents a fundamentally different way of developing responses by placing the whānau at the centre and empowering them to develop a plan for their future (Matheson and Neuwelt 2012). Whānau Ora commissioning emphasises the importance of relationships for successful commissioning and working with key stakeholders at all stages of the commissioning cycle (Te Puni Kōkiri 2013). Innovative approaches such as whānau ora present a different way of designing care and demonstrate how approaches centred on the person and their family and whānau can reorient health care (Matheson and Neuwelt 2012).

Community served

The commissioning approach needs to take into account the community being served and their needs, aspirations and strengths. Communities contain a rich tapestry of resources that all play a role in the mental health and wellbeing of their members, and health responses must complement and support these. To commission appropriate responses, those commissioning care must actively engage with the community throughout the commissioning cycle so that they have an ongoing dialogue about needs and opportunities. With active engagement, the commissioning process is transparent and approaches can flex and respond as priorities change.

Understanding the unique features of the community served is a critical part of addressing health inequalities. Mental health and wellbeing are strongly influenced by social determinants; low income, unemployment and a low standard of living all contribute to poorer outcomes for those with mental health and addiction issues. In New Zealand, some population groups, such as Māori and Pacific peoples, experience significant and unnecessary disparities of mental health and addiction outcomes (Ministry of Health 2012). Engaging early with these groups is essential so that approaches can be tailored to respond appropriately. By understanding and engaging with the community served, those commissioning care can encourage the development of innovative and integrated approaches that become part of the fabric of the community.

The five phases of the commissioning cycle



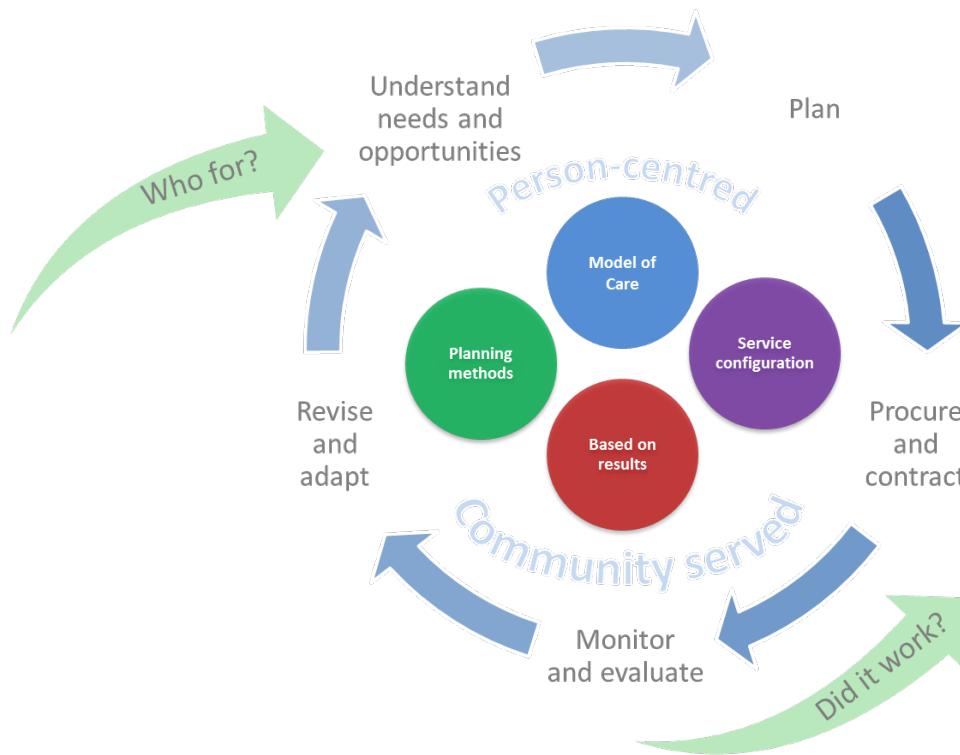
The cycle reflects that commissioning is a continuous and dynamic process of improvement. It consists of five phases.

1. **Understand needs and opportunities.** Accurately assess population need so that opportunities to improve outcomes can be identified.
2. **Plan.** Develop a solid plan based on the information gathered through the first phase.
3. **Procure and contract.** Determine the best approach as part of the plan.
4. **Monitor and evaluate.** Find out whether the response is on track to deliver expected results.
5. **Revise and adapt.** Identify opportunities for improvement.

Each of these phases is described in further detail in chapter 3. It is critical that those commissioning care can revise and adapt their approach in response to changing needs and priorities and that they ensure the responses are meeting expected outcomes as this allows the most effective use of resources to achieve those outcomes. Through the monitoring and evaluation phase, actual outcomes are compared with expected outcomes; if actual outcomes are below expectations, the approach must be revised or adapted.

As care is delivered, the results that were agreed on at the planning stage might need to be reviewed along with the measures themselves. The service agreement always needs to leave room to review and adapt as you go; otherwise the response can become rigid, inflexible and unable to achieve the agreed outcomes and results.

The four key components of commissioning



At the centre of the commissioning cycle are the four key components of the Commissioning Framework, which will support a shift towards an outcomes-focused approach for mental health and addiction.

1. **Planning methods:** A clearly defined methodology for planning supports good commissioning decisions. Planning methods are critical to the first two phases of the commissioning cycle to understand needs and opportunities and develop a plan to address those needs and enhance those opportunities.
2. **Model of care:** Every response needs to be based on an evidence-informed model of care. The model of care drives how the response is configured and underpins delivery to ensure that it will meet the needs of the community/people identified. The effectiveness of the model needs to be regularly reviewed.
3. **Service configuration:** Expectations are established at the national, regional and local levels while allowing room for local variation. Moving to an outcomes-focused approach involves co-designing how the response will be configured to meet the desired outcomes.
4. **Based on results:** Measuring the performance of the system needs to be based on agreed measures that include achievement of national and local outcomes as well as service outcomes. It must also include all three goals of the Triple Aim: improved quality, safety and experience of care; improved health and equity for all populations; and best value for public health system resources. Better health outcomes will be supported through service agreements that measure and incentivise achievement of measurable results.

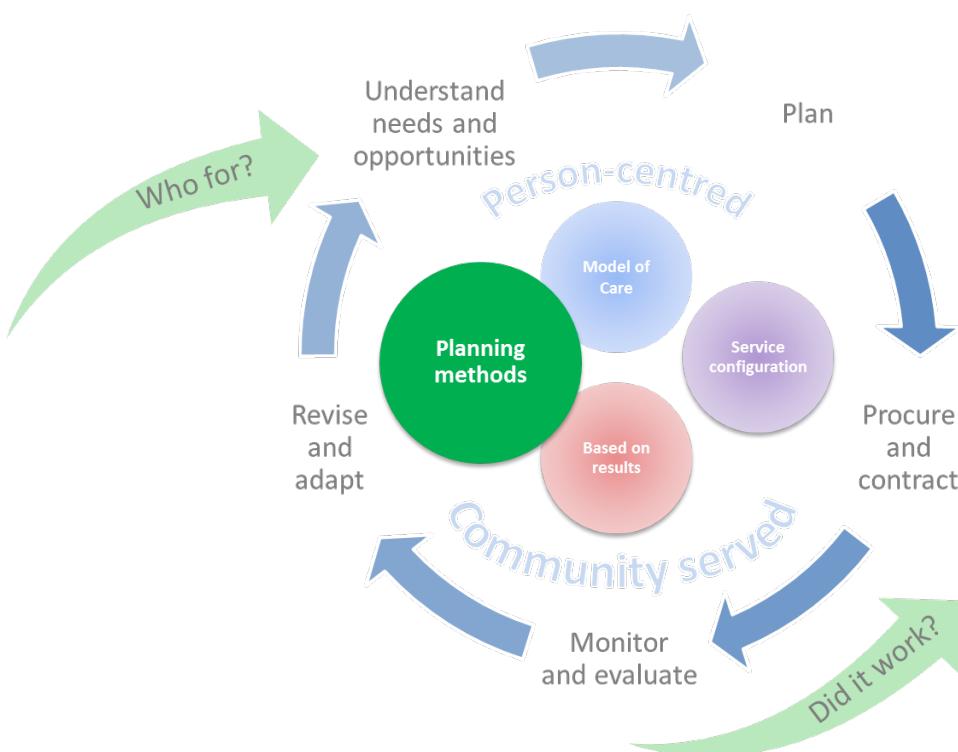
The following pages outline these four components; for more detail, see chapter 3. As this is a national framework, it provides guidance and support at a high level while encouraging innovative responses to local or specific needs and opportunities.

Component 1: Planning methods

Impact: Funding decisions are transparent and align with population need.

Demonstrated by: National, regional and local priorities are clearly aligned to population need and funding is consistent with these.

Activity: A clearly defined methodology is outlined to support good funding decisions.



Planning methods are particularly critical to the first two phases of the commissioning cycle: understanding needs and opportunities and developing a plan. To commission care that will improve the health of the population, those involved must understand the needs of the population and who the response is for. They must then also use this information to identify opportunities and plan how to address the needs and enhance the opportunities they have identified.

The planning methods must be based on the key principles of:

- equity of outcome
- collaboration
- innovation
- integration

- effectiveness
- accessibility.

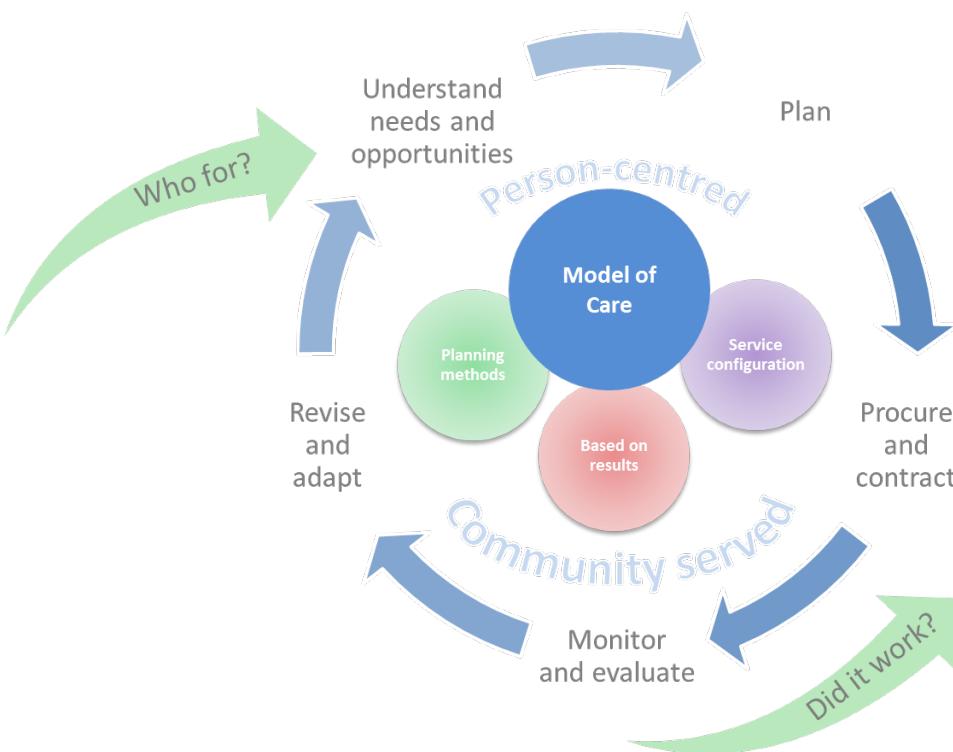
By working in partnership, agencies can share resources and increase their organisational capacity (Courtney 2007). Given the complex matrix of health services and the principle of including people, family, whānau and the community, working collaboratively is not only essential but also a very real way of using our resources most effectively. The development of a collaborative approach takes time and building trust is a key element of this process.

Component 2: Model of care

Impact: Effective models inform service delivery.

Demonstrated by: Measures of effectiveness are regularly monitored and tracked over time. The model is reviewed and adapted in line with these findings as well as emerging evidence and research. Models emphasise prevention and early intervention.

Activity: Expectation is clear that every service is based on an evidence-informed model of care and effectiveness is regularly reviewed.



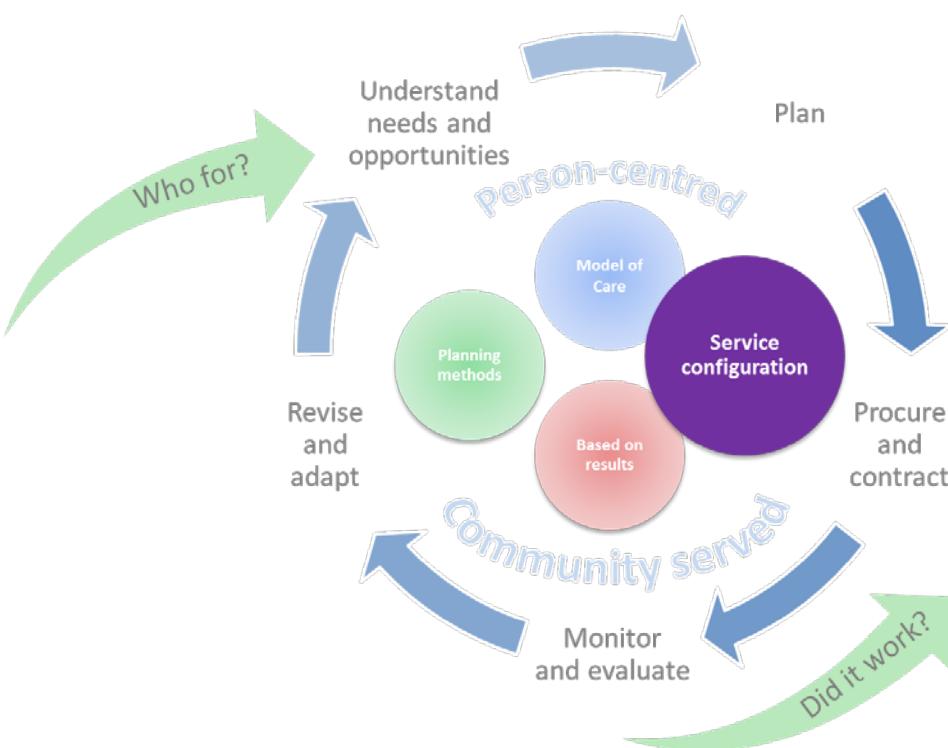
A model of care describes best practice and services or responses within a system (or a part of that system) for a person or population group as they progress through the stages of a condition, injury or episode of care. Models of care need to sit across a range of services, including primary, secondary and tertiary services, those provided by NGOs and in the community. A model of care is not limited to health and disability services; it may include social and cultural services that support the delivery or outcomes of health care.

Component 3: Service configuration

Impact: A range of well-integrated services and responses is available.

Demonstrated by: Districts can demonstrate the range of options available to meet the needs of their local communities and these options align with national requirements, expectations and priorities. Responses promote social inclusion, reduce health inequities and cross agency boundaries when needed.

Activity: Expectations are clear at the national, regional and local levels and allow room for local variation.



Moving to an outcomes-focused approach involves co-designing how the response will be configured to meet the desired outcomes. This means moving away from a sole focus on inputs and outputs and designing a response that can achieve the expected outcomes and identify whether people are better off after accessing the service.

Key principles for service configuration are that:

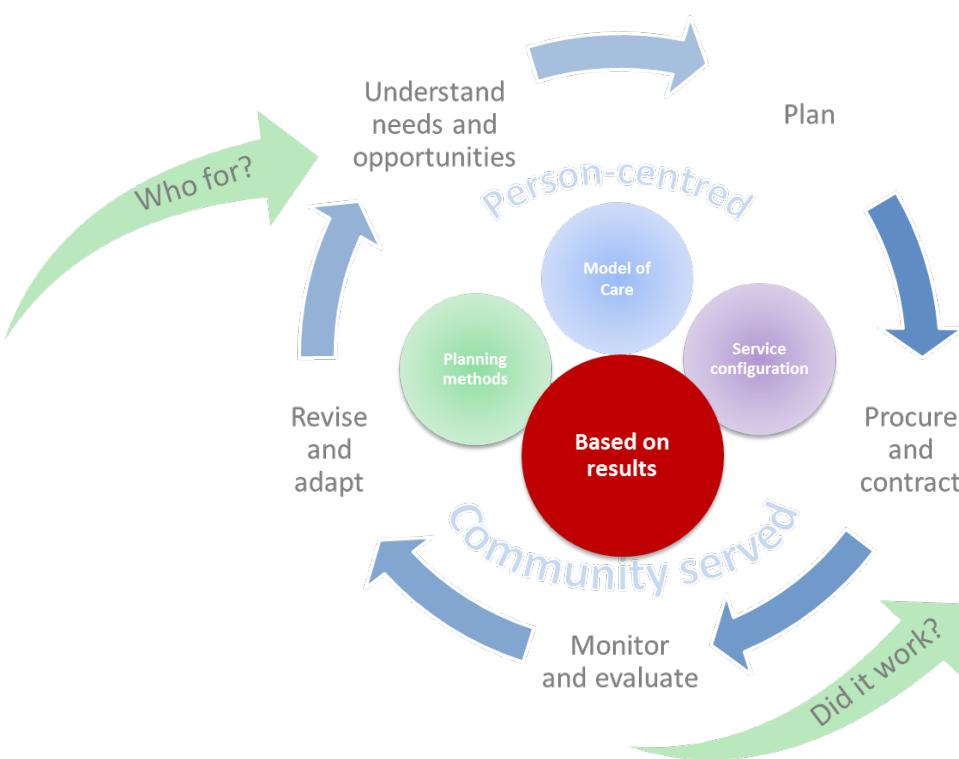
- those with lived experience of mental health and/or addiction are central to the process
- the approach is co-designed in collaboration with providers and those with lived experience
- mana whenua and Māori need to be involved
- co-existing addiction and mental health conditions are the norm
- community resources are prioritised.

Component 4: Based on results

Impact: System performance is determined by agreed measures.

Demonstrated by: Agreements clearly outline how agreed results will be measured and include measures of all three goals of the Triple Aim.

Activity: Service agreements measure and incentivise achievement of measurable results that support better health outcomes.



Defining what success looks like is essential if those commissioning care are to work out whether the expected results have been achieved. For services to be effective, clear performance measures must be agreed as part of the process of setting up the service. Expected results will include achievement of national, local outcomes and service outcomes as well as all three goals of the Triple Aim (improved quality, safety and experience of care; improved health and equity for all populations; and best value for public health system resources).

'Co-design' is the process of working collaboratively with other key stakeholders to develop a response to an identified need or opportunity. Part of the co-design approach is to agree on expected results while the response is being developed. Expected results need to address the three goals of the Triple Aim and include agreed measures for each of them.

Were national expectations and requirements met?



Did it work?

This is the key outcome question about what difference a response has made and how effective it has been. The tools used in the evaluation phase of the framework need to be able to answer this question and compare actual outcomes with desired outcomes.

Were national expectations and requirements met?

- Outcomes – individual, family, whānau, service and population
- Service specific outputs
- KPIs (both service specific and overall)
- Equity of outcomes
- Government priorities

The answer will come from the mix of national, regional and local measures that were agreed as part of the ‘based on results’ component of the framework. The national expectations and requirements will have fed into the approach and the local and expected service-specific outputs will have been developed as part of agreeing measures to address the three goals of the Triple Aim.

The monitoring and evaluation phase considers all of these aspects, helping to answer the question of whether the response met the national expectations and requirements. Recommendations then feed into the ‘revise and adapt’ phase of the framework and the cycle continues.

Outcomes – individual, family, whānau, service and population

Measuring outcomes and comparing them with the expected outcomes will provide information at these different levels. Agreeing on outcomes and how these will be measured will be part of the process of defining expected results.

Service specific outputs

Defining service specific outputs helps to address the Triple Aim, particularly in relation to identifying the best value for public health system resources. Co-designing the configuration of the response will include agreeing, measuring and monitoring these outputs.

KPIs (both service-specific and overall)

KPIs for the service or response will have been agreed as part of the ‘based on results’ component of the framework. There will also be overall KPIs for all service types (identified as part of the planning processes) to provide information on how well the wider system is functioning and whether the outcomes are being achieved.

Equity of outcomes

Equity is the absence of avoidable or remediable differences among groups of people (WHO 2015). Ensuring equity of outcomes is one of the aims of the framework and measuring the

impact of the intervention is critical to determining whether the response has addressed inequity. Those commissioning care need to consider equity at every stage of the commissioning process and identify how commissioning activity can reduce or eliminate inequitable outcomes. These activities include collaborating across sectors to address the social determinants of health (see ‘Component 1: Planning methods’ in chapter 3).

Government priorities

Government priorities will have been fed into the commissioning cycle to develop relevant measures and targets that can be used to identify whether the response is achieving the expected results. As these priorities change, the framework can adapt by including them in the planning processes at the local level and making national measures part of local measures.

Chapter 3: How to use the Commissioning Framework

This chapter supports use of the Commissioning Framework by describing the commissioning cycle in more detail. It covers both the five phases and the four key components of the cycle.

Success factors in the commissioning cycle

In following the commissioning cycle, those commissioning care must answer some hard questions about whether the planned approach is working and, if it is not, why not and what can be done to achieve the expected outcomes.

The following are key factors contributing to the success of all phases of the commissioning cycle (adapted from State Services Commission and The Treasury 2005).

- Have a good understanding of the environment you are operating in.
- Have a clear vision of why the response is needed, what it needs to achieve and how much it is achieving.
- Plan the work while keeping in mind a clear set of objectives, activities, outputs, outcomes and measures of success.
- Deliver what was planned – meeting budget and standards of timeliness, quality and accuracy, and following ethical practice.
- Take stock of progress by monitoring, measuring, reviewing and evaluating as you go.
- Learn from success and failure and modify what and how the response is delivered.
- Share results to help make commissioning transparent.
- Seek continuous improvement.

These key success factors reinforce that good commissioning is dynamic, responding to any changes in needs and conditions.

The five phases of the commissioning cycle

This section looks in more detail at the five phases of the commissioning cycle: understand needs and opportunities; plan; procure and contract; monitor and evaluate; and revise and adapt (which can include decommissioning).

Understand needs and opportunities

An essential first step of any commissioning process is that those commissioning care use appropriate planning methods to accurately assess population need. When they understand the needs of the population and community served and consider the services and

responses already in place, they can then identify opportunities to improve outcomes. Several methods can be used to understand needs and opportunities. For details on the critical information required, see 'Component 1: Planning methods' later in this chapter.

Plan

In the next phase of the commissioning cycle, those commissioning care draw on the knowledge gained from assessing needs and opportunities to prioritise investment and develop a plan. The plan needs to consider the national expectations and requirements and determine the most efficient and effective way of addressing the identified need within the resources available. The plan also needs to take into account the local landscape and how any new service or approach will fit into this landscape, as described in detail under 'Component 1: Planning methods' later in this chapter.

Procure and contract

Procurement covers all aspects of acquiring and delivering goods, services and works (eg, refurbishment and new construction). It starts with identifying the need and finishes with either the end of a service contract or the end of the useful life and disposal of the asset (MBIE 2015).

New Zealand is committed to open, transparent and competitive government procurement that:

- delivers best value for money (which is not always the cheapest price)
- does not discriminate against suppliers (whether domestic or international)
- meets agreed international standards.

Part of the planning process involves agreeing on the procurement approach and how best to configure the service or response needs. The approach chosen must be in line with the *Government Rules of Sourcing* (MBIE 2015) as well as with legislative requirements and other national guidelines (see Appendix C).

To download the *Government Rules of Sourcing* (MBIE 2015), go to:
www.business.govt.nz/procurement/for-agencies/key-guidance-for-agencies/the-new-government-rules-of-sourcing

To be effective and efficient in procuring goods and services, entities need to be clear about the overall objective of the procurement and select a procurement method that will give them best value for money. To do this effectively, public entities must have a detailed understanding of what they are procuring, the value and risk of the procurement, and how important the procurement is to achieving their overall goals and business strategy.

(Controller and Auditor-General 2008b, p 9)

Those commissioning care must understand and follow what is set out in legislation about funding approaches and requirements (ie, clinical requirements, standards, staffing). Where there is no legislative framework for funding, relevant contracts apply.

Having set some high-level measures as they developed a plan, at the procurement phase those commissioning care include those measures in the documentation for the response they are commissioning. (See more on procurement under ‘Component 1: Planning methods’ later in this chapter.)

Monitor and evaluate

This phase of the commissioning cycle is critical to understanding whether the commissioned response is on track to delivering the expected results (see ‘Component 4: Based on results’ later in this chapter). Those commissioning care may need to refine or update their original plan as the response is delivered and different priorities emerge. For example, it may become clear that there are other unmet needs that were previously unrecognised. The methods used to monitor and evaluate should draw on the initial assessment and determine if the identified needs have been met and if there are further opportunities to enhance outcomes for people.

The investment those commissioning care have made in developing solid working relationships in the planning phase will pay off in this phase. They need to be open and transparent in discussing how the service/response is performing so providers know how outcomes and results will be measured and there are no surprises.

Revise and adapt

By monitoring and evaluating the service/response against the expected outcomes and defined results in the previous phase, those commissioning care will identify opportunities for improvement in the model of care, configuration, quality or efficiency. They then need to act on these results to ensure resources are used most effectively. In this phase, they revise the four previous phases of the commissioning cycle to determine whether the response has met the needs and planning objectives and has achieved the expected outcomes and results.

This phase feeds back into the first phase of ‘understand needs and opportunities’. Revising the service/response will open up opportunities to adapt it to better meet the needs, which may lead to a new commissioning cycle or a recommendation that resources are used in a different way to achieve better outcomes.

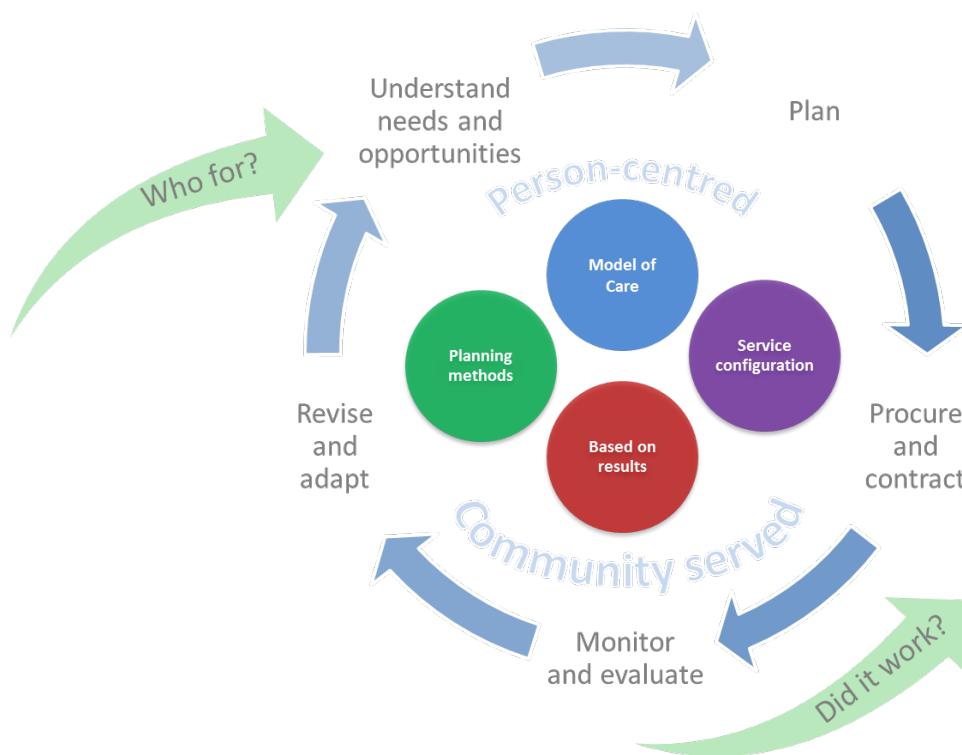
Decommissioning

In the ‘revise and adapt’ phase, those commissioning care may also identify the need to decommission services. Decommissioning is the process of planning and managing a reduction in service delivery or terminating a service because it has not achieved the expected results or is not compatible with changing priorities. Decommissioning needs to be carefully managed so that those receiving service experience minimal disruption. It is also necessary to consider the:

- impact of reducing/ending service on those currently receiving the service
- impact on the families, whānau and local community

- impact of reducing or ending the service on those who may need it in the future
- alternative options available to the community if the service is no longer available
- impact on compliance with legal, financial and statutory requirements
- impact on equity of health outcomes
- impact on key stakeholder relationships.

The four key components of commissioning for mental health and addiction



As outlined in chapter 2, the Commissioning Framework is made up of four key components that will support a shift towards an outcomes-focused approach to mental health and addiction. Each of these is described in detail in the following sections.

Component 1: Planning methods

In collaborative approaches to designing a response/service, multiple players can work together to solve ‘wicked problems’. Wicked problems are those that are complex, multi-faceted and difficult or impossible to solve because they involve incomplete, contradictory and changing requirements that are often difficult to recognise (Rittel and Webber 1973). Collaborative models allow for collective impact and the true application of co-design. If we are to ‘transform our model of care towards an integrated primary/community based response that leverages our hard won but limited capacity in specialist care’ (Health Workforce New Zealand 2011, p 8), then services need to be designed in a quite different way.

The Productivity Commission (2015) refers to the ‘shared goals’ service model, which reflects the view that complex social problems are best addressed by people and agencies working together to share information, resources and expertise. It recommends that:

commissioning services using a shared goals model need to set high-level goals within a broad performance-measurement framework that is acceptable to those participating and leaves them room to develop their own compatible, yet subsidiary goals and measures.

(New Zealand Productivity Commission 2015, p 143)

The literature identifies that critical factors to working in collaboration are:

- identification of a common goal
- leadership
- communication
- clarity
- accountability
- trust
- expectations.

To ensure responses are integrated, those commissioning care need to respond to multiple funding paths and line up data and research across health and social sectors. By thinking more broadly across sectors, they can take a person-centred approach, considering distress in the context of a person’s life, family, whānau and community. The community needs to be brought in to support efforts to deal with bigger social issues.

Social determinants and equitable outcomes

The World Health Organization (WHO) considers the ‘responsibility for promoting mental health and preventing mental disorders extends across all sectors and all government departments’ (WHO 2013, p 17). This is because a whole range of social and economic determinants – including income, employment, education, standard of living, health status and exposure to adverse life events – have a strong influence on mental health (WHO 2013; WHO and Calouste Gulbenkian Foundation 2014).

Understanding how social, economic and physical environments can contribute to the development of mental health issues is important for responses to intervene at critical points. How social factors impact on mental wellbeing and how people think about their life problems and psychological stressors need to inform the response. Evidence shows that activities such as wellbeing habits and cognitive skills such as mindfulness, or online cognitive behaviour therapy, can be effective in building resilience, reducing risks of common mental health problems and treating minor problems early before they reach the threshold for a diagnosis.

Considerable evidence, both internationally and in New Zealand, shows significant inequalities in health between socioeconomic groups, ethnic groups, people living in different geographical regions, and males and females (Acheson 1998; Howden-Chapman and Tobias 2000). Research shows that the poorer you are, the worse your health. In

addition, in countries with a colonial history, indigenous people often have poorer outcomes than other population groups.

In New Zealand, equity of outcome is a key consideration when commissioning services for mental health and addiction. As well as the lack of equitable outcomes for some population groups such as Māori and Pacific peoples, those with mental health and addiction issues demonstrate poorer outcomes than the general population. To address inequity of health outcome, those commissioning care must give greater weight to particular population groups and allow for this focus through whichever method they are using.

On Track: Knowing where we are going (Platform Trust and Te Pou o Te Whakaaro Nui 2015) proposes three principles that are important for improved health outcomes.

1. **Indigeneity** acknowledges a unique position for indigenous people and takes into account the self-determination of indigenous peoples to retain their cultural identify and avoid assimilation.
2. **Clinical and cultural competence** expects that all workers will be both clinically and culturally competent.
3. **Proportionate universalism** adjusts universal policies in proportion to the level of disadvantage or need of particular groups.

The first two principles are informed by the work of Professor Mason Durie. They support the importance of tino rangatiratanga (self-determination), which is a key thread of He Korowai Oranga, the refreshed Māori Health Strategy (Ministry of Health 2014b).

He Korowai Oranga

He Korowai Oranga, New Zealand's Māori Health Strategy, sets the overarching framework that guides the Government and the health and disability sector to achieve the best health outcomes for Māori. It was refreshed in 2014 so that it continues to be relevant into the future and builds on the initial foundation of whānau ora (healthy families) to include mauri ora (healthy individuals) and wai ora (healthy environments) (Ministry of Health 2014b).

A range of resources and tools supports the implementation of He Korowai Oranga. These include the Reducing Inequalities Intervention Framework and the Health Equity Assessment Tool (Equity Lens) (HEAT).

The Reducing Inequalities Intervention Framework can be used to review current practice and ensure that actions contribute to improving the health of individuals and populations and to reducing inequalities in health. It also highlights the importance of factors outside the direct control of the health sector in shaping the health of our population.

HEAT aims to promote equity in health in New Zealand. It consists of a set of 10 questions for assessing how policy, programme or service interventions will have an impact on health inequalities currently or in the future. The questions cover four stages of policy, programme or service development:

1. understanding health inequalities
2. designing interventions to reduce inequalities
3. reviewing and refining interventions

4. evaluating the impacts and outcomes of interventions.

These four stages need to feed into the planning process as well as into the other three key components of the Commissioning Framework: model of care, service configuration and based on results.

For more information on He Korowai Oranga, go to:
www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga

The *Māori Commissioning Report* (Te Pou Matakanā 2014) highlights the importance of looking at approaches that serve Māori and actively seek positive change within a kaupapa Māori framework. The review notes that although there is no definitive funding model designed specifically for Māori, Mason Durie has proposed several frameworks and guiding principles that can inform funding and help define funding outcomes from a kaupapa Māori perspective (Te Pou Matakanā 2014).

Overall health

Achieving ‘parity of esteem’ is an outcome the United Kingdom is working towards for mental health and addiction – an outcome best described as valuing mental health and physical health equally (NHS 2013). The NHS is calling for a new approach to commissioning to give people with mental health issues (including co-morbid mental health and physical health problems) the same access and quality of care and treatment as anyone else (Bailey et al 2013).

In its evidence review, *The Physical Health of People with a Serious Mental Illness and or/Addiction*, Te Pou o Te Whakaaro Nui (2014b) identifies that people in New Zealand with serious mental illness and/or addiction have significant physical health needs and a reduced life expectancy in comparison with the general population. It found that the well-documented international trends of poorer outcomes for those with serious mental illness and/or addiction are mirrored in New Zealand. Integrated care provides a way of working together to address this inequity and commissioning approaches must support these approaches.

The Equally Well initiative has been set up to address this issue. It is a group of organisations and individuals who are working together to improve physical health outcomes for people who experience mental health and/or addiction issues.

For more on Equally Well, go to:
www.tepou.co.nz/initiatives/equally-well-physical-health/37

Assessment of need

Health care needs assessment can be defined as ‘the assessment of the population’s capacity to benefit from health care services, prioritised according to effectiveness, including cost-effectiveness, and funded within available resources’ (Coster 2000, p 2).

A range of different methods can be used to assess population need. To choose one that is appropriate to a particular assessment, it is important to first clearly define the purpose and objectives of the assessment.

The five main types of needs assessment, which are fully described in Coster's report (2000), are summarised below.

- **Global approaches** are used at national, regional and district levels to understand the population need for health services and for what types of conditions. In the context of mental health and addiction, this involves analysing population-level data such as access rates, service use and waiting times and comparing these findings with expectations and national targets. This approach is service-orientated and can identify service gaps and inform prioritisation based on these gaps.
- **Community-based approaches** support strong involvement of users and the community and focus on small areas or specific population groups. These approaches draw on more qualitative data to involve the community. Community development 'recognises the social, economic and environmental models of ill health and links user involvement and (purchasing) to improve health and reduce inequalities' (Fisher et al 1999, cited in Coster 2000, p 20). This approach involves working with the community to define and address the issues that are important to them. Northland DHB has used it successfully to support better outcomes for people with mental health and/or addiction issues (see example 4 under 'Component 4: Based on results' below).
- **Epidemiologically based approaches** focus on the occurrence of a particular disorder in terms of person, place and time. They use prevalence and incidence data to identify the effectiveness and cost of services. These approaches can be useful for planning regional and tertiary services that are designed to address a particular mental health and/or addiction disorder.
- **Comparative approaches** compare different areas that have different approaches to service provision to understand how these differences are impacting on the health of people living in each of the areas. Comparative approaches can compare countries, regions, districts or communities.
- **Corporate approaches** are based on the demands, wishes and perspectives of interested parties, including consumers, clinicians, health agencies, politicians, media and providers. This approach is often taken as part of the process of developing national health strategies.

Understanding needs and opportunities

To assess population need and identify opportunities to use resources most effectively, those commissioning care may use a combination of different approaches to gain the full picture of need at a number of different levels. They need to match their approach or approaches to the purpose and clearly define them as they will use the information gathered to help them make commissioning decisions. It is also important to check data from this assessment against data from other sources (triangulation) so that those commissioning care can draw meaningful conclusions (Coster 2000).

The essential information for assessing needs and opportunities is:

- what the needs of the population are, taking into account social determinants of health including demography, prevalence, inequity of health outcomes for different population groups, rurality and socioeconomic factors
- current and emerging evidence of service effectiveness
- stakeholder views on current needs and opportunities in the community.

An assessment of needs and opportunities must provide detailed information about what is available to the target group. It should involve a broad approach to community resources, which considers areas of disconnect or gaps in service/response among health, social, community, government and non-government funded services.

Those commissioning care need to take an approach that can consolidate quantitative data (eg, population projections, number of people accessing service, service volumes, demand and throughput) with qualitative data (eg, quality of service, people's experience, whether people are better off). As the process of needs and opportunities assessment will inevitably create expectations, they must also manage such expectations carefully so stakeholders know how identified needs will be prioritised and reprioritised (eg, results may point to the need to decommission services).

Data related to the social determinants of health of the local community – such as data on demography, prevalence of ill health, inequity of health outcomes for different population groups, rurality and socioeconomic factors also needs to be collected. This data will highlight where inequity is evident and help those commissioning care to set priorities, giving greater weight to particular groups to address inequity.

Gathering information

Those commissioning care need to gather information through a process that is collaborative and inclusive and builds trust. The process needs to capture the views of communities, population groups, people who use or may need services, families and whānau, clinical leaders, health and social services across the spectrum and government agencies. Such views are critical if the assessment is to accurately capture the needs and opportunities and in this way provide accurate information to inform the development of the plan.

It is important to choose appropriate mechanisms for engaging stakeholders in the planning process as effective engagement will ensure the process is genuine. It is critical that the mechanism allows for early involvement in the planning phase so stakeholders are involved early, from the assessment of needs and opportunities, and have the chance to contribute to the setting of priorities. Consumers, families, whānau, community members, clinicians and service providers are all important in helping to identify needs and opportunities with their first-hand experience of the needs of the community.

Cultural considerations are another part of the decision on how best to collect data, as gathering data from a cultural perspective will provide a much richer picture of needs and opportunities. To develop responses that achieve equitable outcomes for all, it is necessary to design them in the context of the person and their family, whānau, community and culture.

Consumer involvement

People who have lived experience of mental health and/or addiction have a vital role to play in the planning process. Those commissioning care must plan to include a strong consumer voice and take a partnership approach throughout the commissioning process. To be true to the key principles and values of the Commissioning Framework (as set out in chapter 2), commissioning needs to be based on authentic partnerships that centre on people and build on their strengths. Involving consumers at all stages of commissioning can ensure that services are responsive to the needs identified.

The Health Quality and Safety Commission (HQSC) considers consumers as key partners in promoting change within health and disability. Its guidance document, *Partners in Care Framework* (HQSC 2012), emphasises the importance of consumer involvement.

To download HQSC's (2012) *Partners in Care Framework*, go to:
www.hqsc.govt.nz/our-programmes/consumer-engagement/publications-and-resources/publication/467

Using a diverse range of information sources

Using information from the household social survey will help build an understanding of the population profile. Statistics New Zealand publishes a range of measures of wages and income in New Zealand, providing helpful information about the socioeconomic status of the people living in particular parts of the country.

For a range of Statistics New Zealand data on income, go to:
www.stats.govt.nz/browse_for_stats/income-and-work/Income.aspx

Combining this information with Census data, health data, known prevalence data (see Oakley Browne et al 2006) and community pharmaceutical dispensing claims (PHARMS) data can provide a richer picture of the needs of people living in a particular area. The aim is to join up datasets to gain robust and integrated information from areas such as primary care, Child, Youth and Family, housing and the ministries of Social Development, Justice and Education. The choice of sources of data will be guided by the target group, for whom some information sources will be more helpful than others. For example, if youth is the target group, then Child, Youth and Family and Ministry of Education data will be relevant; on the other hand, with a target group of older adults, an important source of information will be older person Needs Assessment and Service Coordination services.

Cost-utility analysis (CUA) is a method used to help understand how effective new medicines are. It involves using 'quality-adjusted life years' (QALYs) to determine how much longer we live as well as how much better the quality of our lives are as a result of the new medicine, and comparing this with costs of the medicine (both the cost of treatment itself and other costs to the health sector) (PHARMAC 2012). CUA tells us how many QALYs are gained for every dollar spent and allows us to compare the results of different medicines. This approach has been applied to interventions in other areas of health (eg, smoking cessation programmes) and could be used to compare the cost-effectiveness of different interventions,

responses or services. This information, considered alongside information gathered from other sources, may be helpful to develop a richer picture of how resources can be used most effectively.

Service stocktakes can be used to quantify current service provision and to identify what services are available to the target group. Such stocktakes need to include social and community services as well as health-funded services as they are essential resources to support family and whānau wellbeing and effective service delivery. The results need a good structural analysis rather than just analysis of gaps.

Specific tools are available to assess need. For example, the Needs and Gap Analysis Tool is a useful tool developed by the Mental Health Commission (MHC 2014). It is designed to assess need and compare that need with access to identify gaps.

Knowing the People Planning (KPP) is an evidence-based management approach that can provide accurate and up-to-date information to help identify service gaps, develop local planning for services/responses for people with enduring mental health issues and make commissioning decisions.

KPP offers a practical way for mental health services to assess how well they are meeting the needs and wants of people using their services. It is based on a toolkit that helps service users, families, whānau and services identify the things that will help someone receive the best support possible.

For more on KPP, go to:

www.tepou.co.nz/outcomes-and-information/knowing-the-people-planning/31

Identifying opportunities

Looking for opportunities to improve, change or create one or more responses to be as effective as they can be is an important part of planning. There may be current services and responses that could be supported to work more closely together to close gaps. Service users and their whānau will also have ideas about how these resources could have better met their needs.

Prioritisation is another important part of planning and will provide guidance on how to effectively address the identified needs. Through the planning phase, those commissioning care need to work with key stakeholders to determine how to prioritise the identified needs and agree on which opportunities should be followed up.

The response to the needs and opportunities assessment may be to commission a service or, alternatively, it may be to allocate resource in a different way allowing for more personalised care. Those commissioning care need to understand intervention models but avoid setting predefined conditions on them so that the models can develop to be responsive to population need as identified through the assessment. They make their choice of the most appropriate model of care based on current and emerging evidence of most effective approaches, which must be tailored to the identified need. The assessment of need and the model of care need

to underpin the configuration of the service or response and options are weighed up based on demonstrated evidence of improving outcomes.

When considering the needs and opportunities, those commissioning care need to balance the needs of those who will require care in the health setting (specialist and primary) with the need to support preventative social and behavioural change in communities to reduce the impact of mental health and addiction issues. In deciding on this balance, they must be careful not to lose the gains made in providing access to high-quality services for those with the highest needs.

Procurement

Those commissioning care will use the needs and opportunities assessment to help identify the appropriate approach to procurement. The preferred approach is an open, competitive process; however, a direct approach may be appropriate in some instances (see Table 2).

A critical part of planning is working in partnership with the provider to agree how results will be measured. During the planning phase, it may not be possible to reach this agreement if the provider has not yet been determined due to procurement requirements. In this case, it may be appropriate to set some high-level measures, while indicating that these will be further refined with the preferred provider once that provider is identified.

The planning phase of the commissioning cycle includes developing investment plans, intervention logic and business cases to work through the benefits of a range of approaches. A business case sets out the needs, the care/service gap that has been identified, a range of proposed ways of giving people access to the care they need, and a procurement plan. Those commissioning care will work through how to configure the service/response and how to fund the provider to incentivise better outcomes for people (see ‘Component 4: Based on results’ later in this chapter for information on different funding options).

The Controller and Auditor-General (2006) offers the following advice when managing funding arrangements with NGOs.

- Be clear about how NGOs fit into the overall purpose and strategy.
- Recognise and manage the particular risks in each funding arrangement.
- Be committed to effective relationships with NGOs.

For more on the Controller and Auditor-General’s guidance on working with NGOs, go to:
www.oag.govt.nz/2006/funding-ngos

In addition, The Treasury (2009) has the following clear expectations of government agencies’ relationships with the community and voluntary sector.

- Recognise the objectives of both parties.
- Respect the autonomy of the voluntary sector.
- Communicate in an open and timely manner.
- Work constructively together.

- Recognise the responsibilities of each party to its stakeholders.

Key guiding documents related to procurement are:

- *Guidelines for Contracting with Non-government Organisations for Services Sought by the Crown* (The Treasury 2009)
- *Procurement Guidance for Public Entities* (Controller and Auditor-General 2008b)
- *Mastering Procurement: A structured approach to strategic procurement* (Ministry of Economic Development 2011)
- *Government Rules of Sourcing* (MBIE 2015).

Table 2 summarises some possible approaches to procurement and the circumstances in which each one might be taken.

Table 2: Some possible approaches to procurement

Approach	When this approach may be appropriate	Process
Competitive		
Closed Invitation to suitable suppliers to submit competitive quotes.	Low-value, low-risk goods and services	Request for quotation (RFQ) Request for tender (RFT) Request for proposal (RFP)
Open Invitation for all interested suppliers to submit competitive tenders.	Goods and services of low to medium value and risk	RFQ RFT RFP
Multi-stage (open then closed) Open invitation for all interested suppliers to respond. Agency assesses all responses and invites shortlisted suppliers to submit full tenders.	High-value, high-risk, complex or unique goods and services where there may be many potential suppliers	Expression/registration of interest (EOI/ROI) or pre-qualify. Shortlisted suppliers invited to submit proposals/tenders (RFP/RFT)
Direct approach		
Buy directly from any suitable supplier Agency must be able to demonstrate price is consistent with market rates.	Very low-value, low-risk purchases Typically goods	One-off purchase Procurement card Emergency procurement Qualified supplier list
Buy directly from pool of suppliers through a standing arrangement A group of eligible suppliers is established through an open, competitive process. Agency has ability to purchase from these suppliers for an agreed time at fixed rates or based on quotations.	High-value, low-risk goods or services	Syndicated contract All-of-government contract Panel contract Standing offer Collaborative or cluster arrangement
Buy selectively from a specific supplier Agency must be able to demonstrate price is consistent with market rates. Agency must be able to justify the decision not to use the open, competitive option.	Higher-value, higher-risk procurements where special circumstances apply (eg, highly complex specification), or only one source is available and this can be verified, or only one supplier has the capacity to deliver on time and this can be verified	Relational contract

Source: MBIE (2011, p 16)

Those commissioning care also need to be aware that the *Government Rules of Sourcing* (MBIE 2015) do not apply in some instances. Specifically, some procurement activity is covered by the non-procurement, opt-out or exemption provisions (MBIE 2015, Rules 12, 13, 15).

As part of the procurement process, potential providers will need to consider how they will design a service/response consistent with the model of care. The configuration of the service will have been defined at a high level (to provide clarity about what is being purchased); however, there are still opportunities after the procurement phase to re-design the service. Those commissioning care can invite potential providers to propose different options for configuration that may produce better outcomes. As the procurement phase is an opportunity to encourage innovative approaches, those commissioning care can share the needs and opportunities assessment so that potential providers can propose creative options to meet the identified needs.

Supporting integration

To best support integrated care, Addicott (2014) notes four essential lessons.

- Continually engage with providers, service users and the wider community to define problems and identify solutions.
- Develop transactional and relational approaches. Strong working relationships built on trust are key to successful integrated delivery of care.
- Align payment mechanisms and incentives across providers.
- Providers need to develop appropriate governance and organisational models to manage accountability.

Moreover, contracts are a way of recording agreement but the contract itself will not solve problems, develop integrated service/responses or fix poor relationships (Addicott 2014).

Example 1: Single point of entry for mental health in Nelson Marlborough

In the Nelson Marlborough district, a joint initiative across primary and specialist services was undertaken to improve access to and responsiveness of adult mental health services. From Stakeholder consultation feedback showed the pathway to access services was not clear, often resulting in delays, and some confusion and frustration about referral criteria.

In addressing these issues, the newly established Mental Health and Addictions Directorate reviewed both quantitative and qualitative data to understand rural and urban demographics and the current provision of PHO and specialist services. A steering group was established with input from the Consumer Collective to work through a proposal for a single point of entry across primary and specialist mental health, as seen in Carlsbad, New Mexico on an International Institute of Mental Health Leadership visit. This concept was widely consulted on using online surveys, and gathering feedback from consumers, general practitioners (GPs), NGOs (particularly Supporting Families), Police, emergency departments and other hospital departments.

How does it work?

The Single Point of Entry (SPOE) triages all referrals for adult mental health. To assist, Nelson Bays Primary Health Organisation (PHO) developed an electronic referral system aligned to the current GP Medtech system, which is then fed to the DHB. Telephone, written and walk-in referrals are also received. Once they are received (within approximately 30 minutes) all referrals are triaged and a decision is made about which service will meet their needs considering primary, specialist and NGO options. Any 'grey' or complex referrals are taken to the supporting multidisciplinary team. Specialist mental health services and two PHOs work collaboratively to ensure referred consumers get the services they need when they need it.

What difference has it made?

The Single Point of Entry simplifies and streamlines the referral process, thus improving the experience for the consumers as well as the referrer. It ensures rapid clinical triage and supports a multidisciplinary team approach, which means the system is more responsive and provides more options. SPOE provides a comprehensive pathway that enhances collaboration amongst the different parts of the system and greatly increases the speed of communication back to the consumer and referrer.

Robyn Byers (General Manager, Nelson Marlborough DHB) says the approach was based around the concept of the whakataukī (proverb), 'Nāu te rourou, nāku te rourou, ka ora te manuwhiri', which means, 'With your food basket and mine, we can feed the people'. It is this concept of sharing resources to improve the experience for consumers and referrers that has ensured the success of the approach.

Streamlined contracting

Streamlined contracting is the government-wide programme to develop and implement a streamlined contracting framework for government agencies and NGOs working together. The Contracting Framework will assist government agencies and NGOs to work in a more efficient, collaborative, coordinated and connected way. The Contracting Framework includes a focus on outcomes so that the things that make a difference – rather than simply activity – are measured.

The aim is to achieve greater consistency across government agencies, including shared performance measures across programmes to streamline reporting. The Contracting Framework is a group of documents and tools for government agencies to use when contracting with NGOs:

- Government Agency Agreement (GAA)
- Framework Terms and Conditions (FTC)
- Outcome Agreement (OA)
- Outcome Agreement Management Plan (OAMP)
- Decision Support Tool (DST).

After a preferred provider has been identified through an appropriate procurement process, the contract is established, based on the contract templates provided in the *Streamlined Contracting* toolkit. However, it is critical that the contract covers the agreed performance

measures, including outcome measures, developed using the results-based accountability methodology (see 'Component 4: Based on results' for more detail).

To download any of the documents and tools in the Contracting Framework, go to:
www.business.govt.nz/procurement/procurement-reform/streamlined-contracting-with-ngos/the-contracting-framework-1

Alliancing

Alliancing is a way of working that brings key stakeholders together to share the responsibility for health and social outcomes. Through alliance agreements, stakeholders can take a more integrated approach as well as promote clinical leadership. Alliance agreements are now in place with all 20 DHBs and the PHO/s operating in their districts. In some DHBs, additional alliance partners have joined these Alliance Leadership Teams and are working together to plan, prioritise and determine investment.

Alliance agreements have been proposed as a structure for delivering integrated health services and bridging the gap between primary and specialist services. While some districts are still establishing how these Alliance Leadership Teams will function, others are already including NGOs and other community partners. Canterbury and Wairarapa DHBs are using the alliancing approach to mental health and addiction planning for their populations.

The Mental Health Commission identified potential advantages of alliance contracting for mental health and addiction in its report *Mental Health and Addiction Funding: Mechanisms to support recovery* (MHC 2010). In particular, this approach can:

- provide an open-book, high-trust environment for commissioners and providers
- incentivise NGO and other community providers to work on system goals by sharing information, risks and gains.

Alliancing can support outcomes-focused approaches for mental health and addiction by supporting groups of NGOs, primary care providers and social services to work together on common goals and incentivise collaborative approaches to achieving these (MHC 2010).

Example 2: An alliancing approach to mental health and addiction in Canterbury

In Canterbury, the alliancing approach has been applied beyond primary care to encompass all areas of health, including mental health and addiction. The Mental Health and Addiction Alliance is one of the established groups that feeds into the Canterbury Clinical Network and the Alliance Leadership Team. As a leadership group, it brings together the perspectives from across the sector. Members include consumer and family leaders, chief executives, leading clinicians and senior managers from across the alcohol and other drugs and mental health sector.

How does it work?

The Mental Health and Addiction Alliance meets regularly and reports through to the Canterbury Clinical Network, which actively seek its views on all matters relating to mental health and addiction. Collective accountability and responsibility are core principles and an external chair gives it a degree of independence.

The group is working on three current priority areas: suicide prevention, access and responsiveness, and primary–secondary integration. The alliance process requires the sector to work together and work differently.

Usually the local priorities align with national priorities. The group's focus is on what is needed at a local level and agreeing how it can be done; it is less concerned with who is providing it. The group works together to identify where efficiencies can be made and what are the opportunities for improvement. Each member is there to bring their perspective, skills and experience to the tasks of shaping sector planning and solving complex problems.

Recommendations for change may mean that funding and contracts need to change; however, funding is not the focus of the group. Usually solutions are found within existing funding and contracting arrangements, with changes made through being flexible and supporting people and organisations to work differently as required. Although Planning and Funding continues to be responsible for planning and funding decisions, the Mental Health and Addiction Alliance has a direct influence on those decisions.

What difference has it made?

This initiative has brought much greater cohesiveness to sector planning and the approach to addressing sector issues. The Mental Health and Addiction Alliance has led the process of working together to reconfigure pathways so that they are more responsive to primary care. The approach encompasses a broader view than health alone, as demonstrated by the work with Ministry of Social Development services to integrate more closely with them.

Another example is the work to strengthen the acute response by understanding how the system works. With more accessible specialist advice (including via a direct phone line for general practitioners), demand for specialist care is more likely fall in the long term.

Toni Gutschlag (General Manager Mental Health, Canterbury DHB) says the main reasons why this approach is successful are that it:

- is locally led and focused
- brings together the right people with the right skills to participate at the right level
- is based on an absolute commitment to core principles and collective accountability
- does not focus on the dollars – all the resources are shared resources.

Component 2: Model of care

Those commissioning care develop an appropriate model of care based on evidence about what works. It is also important that they work in partnership, taking a multidisciplinary and inclusive approach, as all those who will be involved in service delivery need to understand the model and the principles that underpin it. Expectations of roles and responsibilities need

to be clear, and philosophical differences explored as these will impact on service delivery if not resolved. As the model of care will drive how the service is configured, it must be an evidence-informed, agreed model that will meet the needs of the community/people identified.

Overarching, broad models of care apply across areas – for example, a stepped care approach to primary mental health. The principles of these overarching models, such as being strengths-based and recovery-focused, are also important. Local models of how service will be delivered need to be developed so that local needs are addressed.

To be successful, models of care for mental health and addiction should:

- put service users and their families and whānau (including children) at the centre of the model
- establish a robust framework that underpins service delivery, reflecting clinical and non-clinical aspects of care
- focus on resilience and recovery
- reflect holistic practice that is focused on wellbeing and includes services from outside the health sector
- have a systemic focus
- promote services/responses that reflect evidence of best practice (defined as dynamic, evidence-informed, innovative and open to change)
- use data to inform practice
- be responsive to co-existing problems
- promote services/responses that are culturally competent as well as clinically competent and that reflect whānau ora
- be part of a range of information used to develop funding models
- be able to relate to other models of care within the DHB and to models of care for regional services (eg, adult forensic mental health services).

It is also necessary to design the model of care so that its impact and effectiveness can be evaluated. To allow such evaluation, some (but not necessarily all) of the elements it needs to include are:

- the goals and expected outcomes of the model
- the evidence and the intervention logic underlying the model
- if evidence is not readily available, the assumptions that underpin the model
- the philosophy on which the model is based
- whether performance indicators have been identified and agreed on
- the information (quantitative and qualitative) that needs to be collected throughout the lifetime of the model
- the implementation plan for the model
- which people with lived experience of mental health and/or addiction were part of the model's development and how they contributed.

Clinical leadership is important to agree on the overarching model of care to inform the planning and configuration of the service/response. The model must be able to meet the identified needs and make the most of the opportunities to achieve the desired outcomes. Good service planning will always include an evidence-informed model of care; however, the details of the model will be developed in partnership with the provider following the procurement phase.

Models of care are important at all phases of the commissioning cycle: they influence opportunities and planning, they need to be monitored and evaluated to check that they are working in the way that was expected, and they must be revised and adapted as appropriate to achieve expected outcomes. Regular monitoring and evaluation of new services also helps to identify whether those services are continually developing in the way they should.

Component 3: Service configuration

Many different funding models and service configurations are available, which can influence behaviour in both intended and unintended ways. Creating a menu of service and care types allows for a mix-and-match approach to choosing service configurations that suit the target population and the model of care. The Ministry of Health's National Service Framework (NSF) offers one such menu, although its options have been limited to date. With the move to an outcomes-focused approach, it is necessary to provide more flexibility in this area to allow for local variation and adaptation to local need.

A response that addresses the identified needs and maximises opportunities may involve providing a service, but not necessarily. For example, in some situations a better solution might be to tailor care around the needs of individuals and individualised funding.

The NSF provides the overarching framework of a range of effective, evidence-based service/intervention types. In this way, it contributes to a national picture of how funding is spent, ensuring accountability for public funds. At the same time, the current NSF specifies more detail than what is required and can be simplified.

The NSF needs to allow for a range of service and intervention types, including the option of individualised funding that allows people using services to decide how they will use the resources available to them. The approaches to purchasing services also need to be flexible to support innovation, and funding models need to focus on measuring outcomes as well as outputs.

If the NSF is simplified to reduce the detail of the service specifications and free up the way services are purchased, the 'how' of service delivery can be determined at the local level in response to the assessment of needs and opportunities. This approach will still give the Ministry of Health a national overview of the different types of services/interventions that are being purchased while allowing services to be flexible in how these services are configured.

The configuration of the service needs to be responsive to the demand and needs of the population. Ongoing monitoring of the funding model is also important to ensure that it is incentivising providers to achieve the desired outcomes. With a range of service configurations supported at the national level, services can be co-designed with key stakeholders and providers at the local level.

Through regular monitoring, those commissioning care can have ongoing dialogue with the provider about whether the measures are accurately measuring the expected outcomes and whether the service/response is on track. By building in evaluations, including developmental evaluations, as part of standard practice for new services, they gain regular opportunities to consider the effectiveness of each new service and determine whether it is demonstrating results and improving outcomes.

Example 3: Co-designing services in Capital & Coast DHB

Capital & Coast DHB embarked on a project to look at how its services could be used more effectively by people with high and complex mental health and addiction issues.

To understand how the current resources were being used, Capital & Coast DHB compiled and reviewed a range of information, which covered the local population's needs, best practice research and financial analysis, including national and regional comparisons.

The process

The first step was to develop a set of principles that aligned with government priorities and met the Triple Aim of improving the health of the population, enhancing the experience and outcomes of the service user, and achieving better value for money.

Capital & Coast DHB undertook a wide-ranging engagement process to identify the services required to address the gaps identified. This involved a series of workshops with providers, clinicians, government agencies, and service users and their families and whānau. Participants shared their experiences of the existing service model and identified areas for improvement.

Two general forums were also held with a range of stakeholders, including, clinicians, service users and their families and whānau, community organisations, the Mental Health Commissioner, the ministries of Social Development and Health, and the Department of Corrections. Also present were representatives for Māori, Pacific peoples, disability and youth.

These discussions helped develop the proposed service model for people with high and complex mental health and addiction issues, and a change of approach within existing services was advocated. Te Ara Pai – ‘Stepping Stones to Wellness’ – was developed as a flexible and integrated service model to better support a person and their recovery.

Te Ara Pai includes culturally appropriate services specific to Māori and Pacific clients, a mix of community support and rehabilitation services, and multidisciplinary meetings between clinicians, community support organisations and people using the service. As this model was significantly different from the approach it was replacing, it was expected to take two years to fully implement.

The next step was to develop a business case and evaluation framework to measure whether the model was successful, along with a transition plan for users of the existing service.

Using logic statements, clear definitions of outcomes were developed. These were used to describe how this work would help achieve the immediate and long-term goals identified in the engagement process and to develop key performance indicators. These statements helped people involved in the implementation to understand how their

work would contribute to the high-level outcomes. Financial modelling was also used to consider options, predict future volumes and identify financial implications.

What difference has it made?

Involving the sector early meant that the situation was well understood and the available options were explored together. Although this model is still in its beginning stages, Pauline Morrison, Senior Manager with the Service Integration and Development Unit is confident that the co-design approach has improved both the quality and efficiency of services.

A key consideration now is striking the right balance between pushing forward with further improvements and maintain stability in services that are still 'settling in'.

Component 4: Based on results

The method of measuring results and funding providers for the service/responses delivered can have a strong impact on provider behaviour. It is important to recognise how such incentives are influencing provider behaviour as they can change behaviour in unintended ways.

For example, if services receive less funding when they have client vacancies, providers are incentivised to keep services fully occupied at all times. Correspondingly, they may have a disincentive for transitioning clients out of the service when there are no clients ready to enter. Capacity funding (funding the service as if it is constantly full) is an alternative approach that not only makes services sustainable but also has the added advantage of ensuring services have capacity when needed.

Another example is financial incentives based on short-term outcome measures without taking into account the cyclical nature of mental health and addiction. For example, it is well recognised in addiction literature (Vaillant 1988) that people may relapse several times before achieving a sustainable positive outcome. One solution is to use a combination of client outcome measures and service outcome measures that are agreed in the co-design phase. Table 3 outlines a range of options for funding models and considerations that are relevant to each one.

Table 3: Funding model options

Model	Examples	Considerations
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Model	Examples	Considerations
Individualised funding	Packages of care, personal budgets	<p>This type of funding is tailored to the needs of the individual and is determined by an assessment of need. The term 'individualised funding' has also been used to describe arrangements where people manage their agreed budget and purchase interventions of their choice, either managing the budget themselves or having a host provider or an authorised guardian to manage it. Robust methods for assessing support needs are required to allocate funding in this way.</p> <p>The funding of packages of care in mental health and addiction has become more common over the last few years. Usually these are funded by hours of direct service delivery (sometimes further defined as clinical or non-clinical). Packages of care are usually delivered by a lead provider who provides the support staff but some are managed by a third party, with an option of purchasing hours or services from external agencies. Packages of care allow for more responsive and flexible approaches tailored to support the individual (including their family or whānau if deemed appropriate) and are better able to respond to changing needs. However, significant resource is required to allocate, review, coordinate, manage support and monitor/evaluate the outcomes of the support.</p> <p>This model is best suited to support people with multiple and complex needs. It allows for inter-agency funding arrangements to be developed.</p>
Programme	Workforce training programmes, skill development courses	<p>This type of funding is used when a set programme is purchased and the content, number of sessions and duration are expected to remain reasonably constant. It allows for preparation time, venue costs, materials etc to be factored into the overall cost of the programme. It works best for standardised and well-defined programmes.</p>
Input-based	FTE, beds	<p>This type of funding is currently the most commonly used. It is simple and easily measured and reflects the overall cost of delivery. Usually the provider is only paid when a permanent FTE staff is in place (which can disadvantage providers who are covering roles with casual workers). Payment is not related to outcomes (either population or clinical) and is not dependent on the quality or quantity of service delivered. This type of funding can be helpful to ensure sufficient staff are in place (where minimum staffing levels are specified) or a specified number of beds are provided.</p> <p>The type of FTE is also usually prescribed, which can create issues if the provider cannot recruit staff in a particular specialty. It can also restrict the use of cultural and peer support roles as these need to be specifically contracted for. Bed-based funding that is based on occupancy (or use) can incentivise providers to maintain high occupancy; however capacity funding (funding as if full) is an alternative approach that addresses this issue.</p>
Output-based	Number of visits or sessions (fee-for-service), number of assessments	<p>This type of funding can be used to manage fluctuating demand for service (eg, forensic assessments) and pays providers for what they deliver. It can encourage increased demand, promoted by the providers themselves, and can also stifle innovation by leading providers to offer only the type of intervention that is funded.</p>

Model	Examples	Considerations
Activity-based	Episode of care, residential days of care	<p>Providers are funded based on the activity they undertake, adjusted for complexity. Activity may be counted by the day (as in residential care) or as an episode of care. This type of funding incentivises shorter stays so manages flow but can lead to premature discharge/exit. To manage this issue, this approach can be combined with outcome measures and collaborative approaches across the continuum of care.</p> <p>This type of funding is used to reimburse hospitals in many European countries including England, Finland, France, Germany and Ireland, as well as in the United States of America and Australia; however, mental health/psychiatric care is excluded in most cases. It has been shown to lead to an increase in activity, a decline in length of stay and/or a reduction in the growth rate of hospital expenditure (O'Reilly et al 2012).</p> <p>This type of funding provides transparency between activity and funding but cannot cover all activities that providers undertake, such as training, liaison and health promotion.</p> <p>This approach is best suited to mental health and addiction when combined with other approaches that take outcomes for service users into account.</p>
Outcome-based	Number of people with improved Health of the Nation Outcome Scale (HoNOS) score	<p>Under outcome-based funding, contractual payments are linked to the achievement of agreed outcomes. This approach was piloted by Ministry of Social Development in relation to employment assistance. The evaluation report highlights the complexity of applying this approach. It also pointed to some of the challenges; for example, this model creates the incentive for providers to work with clients who are more likely to achieve the desired outcome rather than those with the highest need (Ramasamy and de Boer 2004).</p> <p>For mental health and addiction, desired outcomes are intertwined with social outcomes, reinforcing the need to collaborate across agencies working with people to understand how to capture all of the factors contributing to desired outcomes. Mental health and addiction outcomes are complex and highly interrelated and can occur simultaneously across the domains of people's lives. For this reason, this type of funding is best suited as part of a combined approach that takes into account all goals of the Triple Aim.</p>
Combination	Payment is made according to agreed measures of different elements of the service/response	<p>Combination approaches can take into account all goals of the Triple Aim and agree measures, measuring different aspects of performance (both system and service). Contracts that are based on results will have agreed measures of success including measures of outcome, quality, equity and value for money. Using this approach, agreements can reinforce integrated, collaborative approaches and identify contributions towards desired population outcomes.</p> <p>This type of funding is best suited to an outcomes-focused approach for mental health and addiction. Combined approaches allow performance to be measured across a number of different domains, thus giving confidence that resources are being used most effectively.</p>

Measuring success

The following three key questions (based on results-based accountability, as outlined in the next section) can help measure success.

1. How much?

In relation to spend, this question helps to determine value for money and, as such, address the Triple Aim goal of 'best value for public health system resources'. This measure of outputs is needed to determine how effectively resources are being applied. Current measures used include access rates, number of referrals, number of contacts, admissions and bed days; New Zealand data systems are also set up to capture this kind of quantitative data.

With a wider range of models and service configurations, more people may be able to get the help they need with the same amount of resource. For example, it may be possible to offer a less intensive response earlier to more people for the same amount of resource as a more intensive response delivered in a more acute phase. To gain a better understanding of performance, this data needs to be considered as just one part of performance measurement.

2. How well?

This question captures the quality of the service/response and addresses the ‘improved quality, safety and experience of care’ goal of the Triple Aim. The answer to it needs to be continually reviewed as part of a quality improvement system. Current measures include viewpoints and feedback from consumers and their families and whānau, staff satisfaction, incident and complaint reporting, assessment of quality framework, audit results, seclusion and restraint data.

3. Is anyone better off – did it work?

This question addresses the ‘improved health and equity for all populations’ goal of the Triple Aim. Given this focus on outcomes, service agreements need to set out an approach to capturing individual outcomes (both clinical and non-clinical) as well as the percentage of positive outcomes achieved for all those who access the service/response.

Agreed outcome measures must take account of the social determinants of health. Broader population measures might be made up of several contributing measures, of which the service/response may be only one. Current measures include outcome measures such as HoNOS, WHO quality of life, the Kessler Psychological Distress Scale (Kessler-10), the Patient Health Questionnaire (PHQ-9), readmission rates, mastery scales, and self-reported measures.

Results-based accountability

Results-based accountability (RBA) is a simple, practical way for organisations to evaluate the results of their programmes. The question, ‘How are our communities, whānau and clients better off as a result of our work?’ is central to RBA. The Ministry of Health is using this approach in its role as purchaser.

RBA was developed by Mark Friedman, author of *Trying Hard Is Not Good Enough* (2005). It is used internationally and, since the Ministry of Social Development introduced it in 2006, New Zealand has become one of the world leaders in its application and implementation. It is used widely across social service, health and disability, local government, community development, environmental development, recreation and commercial sectors.

RBA uses two types of accountability.

1. **Population accountability** is about improving conditions of wellbeing and quality of life for specific populations (eg, families with children under five years living in Motueka). It emphasises how multiple stakeholders can share accountability to achieve results and recognises that many different agencies and programmes will service a given population.

2. **Performance accountability** is about how well services are delivered, and whether they are making a difference to the people who receive them (how much, how well and is anyone better off).

Crucially, RBA links the target population with performance accountability. It shows how outcomes delivered to service users are linked to the outcomes or wellbeing of a whole population.

In RBA, the following seven questions guide organisations moving from planning to action to make life better for families, whānau, children/tamariki, and communities.

1. Who are our service users (or clients)?
2. How can we measure if our service users are better off?
3. How can we measure if we are delivering services well?
4. How are we doing on the most important measures?
5. Who are the partners that have a role to play in doing better?
6. What works to do better, including no-cost and low-cost ideas?
7. What do we propose to do (what is our action plan)?

Example 4: Community development in Northland

Northland DHB adopted a different approach to reviewing its contracts for service, by going on a journey of discovery with its community. It considered the government expectations and focus areas and what these mean for the people of Northland. As a new Planner and Funder, Trish Palmer sought to understand the current DHB services, what is funded, by how much and how those services are distributed across Northland. This information led her to discover that some parts of Northland had no services in their area, prices for the same service varied, access to specific services depended on where you live, availability of some services was seasonal and some services were seeing as many as 40 times more people for the same level of funding. Once she had a good understanding of the issues, finding some options to address them was the next step.

The process

Key questions guiding the process were: Would I use this service? Would I want my grandmother to use this service?

The changed approach put people at the centre and engaged/involved whānau. With a focus on outcomes, it aimed to leave people better off as a result of contacting the DHB's services, as well as to prioritise resources and value for money.

Values and guiding principles were agreed at the outset. These provided a 'go to place' if the group started to get lost. It was always a matter of checking back with the values – what matters to clients? From the beginning, the board agreed that any funding that was freed up through the process would be re-invested in mental health.

The RBA approach was chosen as it was considered to ask the right questions. All current providers were trained in RBA and performance data across all providers was shared. This sharing of data allowed providers to compare their performance, and non-performers could identify their non-performance for themselves. Providers were

expected to fully participate in the process and be part of decision-making and were not there just as representatives.

A number of forums seeking feedback from consumers and their families and whānau were held throughout the rohe (area). In addition, open stakeholder group discussions were held on what works, what does not and what could be done to leave us better off. Listening to people and understanding what they want highlighted that people were not asking for a lot – for example, they wanted to ‘be asked what we want or need’ and to ‘feel in control’.

The open planning discussions took place without competition or secrecy, and reached agreement on what was needed to meet the needs of the Northland population. Disinvestment decisions were made collectively and how this money would be re-invested and prioritised was discussed. Providers voluntarily agreed to report more so that results agreed through RBA process could be measured.

What difference has it made?

It has been an iterative process of working together to build trust and relationships. The visions of people and organisations have changed and there is an increased focus on the Kaupapa Māori approach. It has been a shared journey and the process has been as important as the outcomes. Trish Palmer says there have been some early adopters and some watchers but it is the engagement in development that leads to ownership.

Continued development of the Commissioning Framework

The Commissioning Framework identifies key parts of the existing framework that need to change in order to implement the new framework. To fully implement the Commissioning Framework, the National Outcomes Framework will need to be in place.

The national implementation plan will identify the actions that the Ministry of Health will undertake to support the Commissioning Framework, including a full review of the NSF to identify how outcomes-focused approaches can be supported. In developing the Commissioning Framework, it has become clear the NSF cannot support an outcomes-focused approach in its current form. It is necessary to review how services are purchased and make this approach more flexible so it is possible to move away from a sole focus on inputs and outputs.

The NSF needs to allow for a range of service and intervention types including the option of individualised funding that allows people using services to determine how they use the resources available to them. The way in which services can be purchased will become more flexible to support innovative and integrated approaches.

Reporting requirements generated as part of these service specifications will also no longer be fit for purpose and a shift to measuring outcomes may reduce the need for input-based data. The Performance Monitoring Reports have been retained to measure input information that cannot be captured through PRIMHD but this may be less relevant when focusing on outcomes.

Development of the workforce is another key to implementing the Commissioning Framework successfully. The framework also provides a basis for developing the workforce

so that those who are responsible for commissioning, planning and funding for mental health and addiction are equipped with the right skills and knowledge to enable the development of integrated and innovative approaches.

Those responsible for commissioning will need the right skills and expertise to implement this framework. They will be the drivers of the approach but all stakeholders need to understand where it is going and what this will mean for them.

The national implementation plan needs to give those commissioning care access to the resources, training and support they need to implement the framework. Access to resources, training and support will also be important for providers and consumers and their families and whānau, who will be involved at all stages of commissioning as part of implementing the framework.

To implement this framework, results must be clearly defined, agreed and measured. It will take time to develop measures based on the Triple Aim that will be able to answer the question, 'Did it work?' Expected outcomes need to be clearly defined and actual outcomes measured at national, regional, local and service levels. While there are existing measures that can be used, there will also need to be new measures developed and tested. While these are being developed, it will be necessary to retain some measures as results-based measures are established.

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Glossary of terms and abbreviations

Alliancing	A way of working that brings key stakeholders together to share the responsibility for health and social outcomes. Alliancing agreements are a method of enabling a more integrated approach as well as promoting clinical leadership.
Cluster	A group of public sector entities that collaborate before going to the market and then approach the market collectively
CUA	Cost-utility analysis; a form of financial analysis used to guide procurement decisions
DHB	District health board
EOI	Expression of interest. Similar to a registration of interest (ROI) in that it is used to identify suppliers interested in, and capable of, delivering the required goods or services. Potential suppliers are asked to provide information on their capability to do the work. It is usually the first stage of a multi-stage tender process.
GETS	Government Electronic Tender Service; a government website (www.gets.govt.nz) that provides information about New Zealand Government business opportunities
HoNOS	Health of the Nation Outcome Scale
HQSC	Health Quality and Safety Commission
JCPMH	Joint Commissioning Panel for Mental Health
KPI	Key performance indicator
KPP	Knowing the People Planning
MBIE	Ministry of Business, Innovation and Employment
NGO	Non-governmental organisation
NSF	National Service Framework
OPF	Operational Policy Framework
Panel contracts	Contractual arrangement with a group of suppliers to provide goods or services as and when required, under a schedule of rates for each supplier or on a quotation basis
PHO	Primary health organisation
PRIMHD	Programme for the Integration of Mental Health Data
Procurement	All the business processes associated with purchasing goods and services, spanning the whole cycle from the identification of needs to the end of a service contract or the end of the useful life and subsequent disposal of an asset

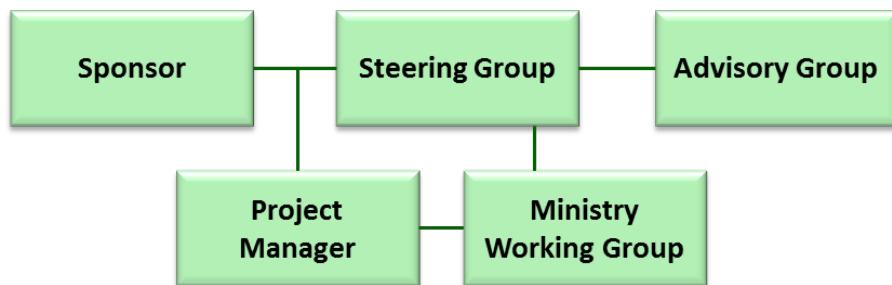
Public sector	All public entities in central and local government
QALYs	Quality-adjusted life years; a measure of disease burden, which considers both the quality and the quantity of life lived
RFP	Request for proposal; a formal means of seeking proposals from the market for goods or services where the public entity is open to supplier innovation – that is, where the outputs and outcomes, rather than the process the supplier follows to deliver them, are important
RFQ	Request for quotation; a formal means of seeking quotations from the market for goods or services where price is the main selection criterion, the requirement is for “stock standard” or “off the shelf” goods or services, and the procurement is low risk
RFT	Request for tender; a formal means of seeking tenders from the market to provide goods or services where the public entity’s specification or requirements are clearly defined and there is little room for flexibility or innovation
ROI	Registration of interest; similar to an expression of interest (EOI) in that it is used to identify suppliers interested in, and capable of, delivering the required goods or services. Potential suppliers are asked to provide information on their capability to do the work. It is usually the first stage of a multi-stage tender process.
Streamlined contracting	A project led by MBIE to develop and implement a streamlined contracting framework for government agencies and NGOs working together. The Contracting Framework will assist government agencies and NGOs to work in a more efficient, collaborative, coordinated and connected way. The Contracting Framework includes a focus on outcomes; measuring the things that make a difference rather than simply measuring activity. The Contracting Framework is a group of documents and tools: Government Agency Agreement (GAA), Framework Terms and Conditions (FTC), Outcome Agreement (OA), Outcome Agreement Management Plan (OAMP) and Decision Support Tool (DST).
Sustainability	The ability to meet the needs of today, without adversely affecting the needs of tomorrow. In a business sense, the key messages of sustainability tie in with what are considered sound business practices, such as building efficiency, minimising waste and maximising resources.
Value for money	Using resources effectively, economically and without waste, with due regard for the total costs and benefits of an arrangement, and its contribution to the outcomes the entity is trying to achieve. In addition, the principle of value for money when procuring goods or services does not necessarily mean selecting the lowest price but rather the best possible outcome for the total cost of ownership (or whole-of-life cost). Value for money is achieved by selecting the most appropriate procurement method for the risk and value of the procurement, and not necessarily by using a competitive tender.
WHO	World Health Organization

Appendix A: Developing the framework

In September 2014, the project to develop a commissioning framework for mental health and addiction was initiated. Since then, the Ministry of Health has involved the sector in the planning, development and consultation phases. The project was overseen by a Steering Group, whose Chair reported through to the Mental Health and Addiction Governance Group and provided regular updates.

This project is part of a programme of work to move toward an outcomes-focused approach for mental health and addiction. The project sponsor is Dr John Crawshaw, Director of Mental Health, the owner is Audrey Bancroft, Team Leader Mental Health and Addictions and the Project Manager and author of the framework is Sonya Russell. Figure A.1 presents the different individuals and groups involved in the project and their relationship to each other.

Figure A.1: Project structure



The membership of the Steering Group reflected the Ministry's commitment to working in partnership with DHBs, NGOs and PHOs. Members include those who are able to bring a national perspective.

Table A.1 shows the people and perspectives represented on the Steering Group.

Table A.1: Members of the Steering Group

Perspective	Name
Director of Mental Health	Dr John Crawshaw (Sponsor)
Mental Health & Addiction Service Improvement (Ministry of Health)	Audrey Bancroft (Owner) Sonya Russell (Project Manager)
DHB General Managers Planning and Funding	Julie Wilson Margaret Hill
Platform (National NGO forum)	Marion Blake
Primary Care	Andrew Swanson-Dobbs
System Integration (Ministry of Health)	Kate Charles

Populations Policy (Ministry of Health)	Tanya Roth
Consumer – Ngā Hau Whā	Victoria Roberts
Chairperson of the Advisory Group	Pauline Morrison

The Steering Group considered both international and New Zealand approaches to commissioning and a draft concept was developed.

Following a large sector workshop in November 2014 to test the draft concept and approach, an Advisory Group was established (Table A.2). The Advisory Group developed the key components and provided advice to the Steering Group on what needed to be included.

Table A.2: Members of the Advisory Group

Name	Perspective	Region
Audrey Bancroft	Ministry of Health – Project Owner	National
Clive Bensemman	Clinician, DHB provider	Northern
David Benton	Clinician (alcohol and other drugs), NGO, expert advisor	Midland
Hugh Norriss	Mental health and addiction management, planners and funders, NGO	National
Jim Dickinson	Families and whānau	Midland
Lesley Watkins	Planners and funders, families and whānau	Midland
Luke Rowe	Māori, NGO provider	Central
Marc Beecroft	Consumer (alcohol and other drugs)	Southern
Pauline Morrison	Planners and funders	Central
Rodger McLeod	Clinician, NGO	Central
Sal Faid	Consumer (mental health)	Southern
Sonya Russell	Ministry of Health – Project Manager	National
Stewart Eadie	Clinician, PHO	Northern
Terry Huriwai	Māori, expert advisor	National
Tess Ahern	Mental health and addiction management, planners and funders	Northern
Thomas Cardy	NGO	Southern
VACANCY	Pacific peoples	to be confirmed

A Ministry Working Group was also established. It included representatives from across different teams within the Ministry of Health, who brought their knowledge and skills and ensured alignment with other work programmes.

Consultation

Following approval from the Steering Group and the Mental Health and Addiction Governance Group, the draft framework will go out for sector consultation. The consultation process is expected to occur in September to October 2015 and will include regional open consultation workshops in each of the four regions (Southern, Central, Midland and Northern) as well as the opportunity to provide written feedback and verbal feedback through existing national, regional and local forums.

Appendix B: Background to key documents for mental health and addiction

The mental health and addiction sector in New Zealand has been undergoing significant change over the last two decades. In 1994 the Ministry of Health released New Zealand's National Mental Health Strategy, *Looking Forward: Strategic directions for the mental health services* (Ministry of Health 1994) and four years later the Mental Health Commission laid out the implementation plan for this strategy in the game-changing document, *Blueprint for Mental Health Services in New Zealand: How things need to be* (MHC 1998).

These two key national documents marked a turning point for mental health and addiction services in New Zealand and led the way down a new path as the sector shifted from an institutional base to a recovery approach with a strong community focus. These documents highlighted the importance of ensuring access to service for those with the highest need for mental health and addiction services.

The *Blueprint* laid out the expectations of access based on the prevalence of mental illness and addiction issues in the population. Among adults, this was the 3 percent of the population who are most seriously affected by mental illness and addiction issues (MHC 1998). This became known as 'the top 3 percent' in reference to the expected rate of adult access to mental health and addiction services. For children and youth, however, the expected rate needed to move to 5 percent by the year 2005 (Ministry of Health 1997).

With the release of the *Blueprint* came the acknowledgement that funding needed to be increased substantially if New Zealand was going to be able to meet the expected service levels it outlined. Over the next 10 years, there was significant investment into the sector, resulting in the development of a wide range of community services and innovative approaches, along with the opportunity to develop specialist services to better cater to the needs of the population. As a result, most DHBs have now reached the 3 percent target for access for the adult population.

The mental health and addiction sector is in a very different place now and it faces new challenges. In the current financially constrained environment, the focus has shifted to ensuring current resources are being used most effectively to offer support and interventions to more people while the sector continues to build on gains to date and improve outcomes for people with low-prevalence conditions and/or high needs.

In 2012, three key national documents were released that set out the direction for the mental health and addiction sector over the next five to ten years: *Blueprint II: How things need to be* along with its companion document *Blueprint II: Making change happen* (MHC 2012a, 2012b) and *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* (Ministry of Health 2012).

Blueprint II

Blueprint II is comprised of two documents. The first, *How things need to be*, sets out the broad view of the changes that are needed within the mental health and addiction sector. The second, *Making change happen*, is directed more at people working in the sector, providing a more practical guide to implementing the changes, an initial framework by which to measure the changes as they occur, and an overview of the roles across all areas of the *Blueprint II* from families and whānau to all of government. Table A.3 lists the eight priority actions identified in *Blueprint II*, which set out to achieve its vision.

Table A.3: Blueprint II priorities

Priority	Description
Providing a good start	Respond earlier to mental health and addiction issues in children and young people to reduce lifetime impact.
Positively influencing high-risk pathways	Provide earlier and more effective responses for youth and adults who are at risk or involved with social, justice, or forensic mental health and addiction services.
Supporting people with episodic needs	Support return to health, functioning and independence for people with episodic mental health and addiction issues.
Supporting people with severe needs	Support return to health, functioning and independence for people most severely affected by mental health and addiction issues.
Supporting people with complex needs	Support people with complex combinations of mental health issues, disabilities, long-term conditions and/or dementia to achieve the best quality of life.
Promoting wellbeing, reducing stigma and discrimination	Promote mental health and wellbeing to individuals, families and communities and reduce stigma and discrimination against individuals with mental illness and addictions.
Providing a positive experience of care	Strengthen a culture of partnership and engagement in providing a positive experience of care.
Improving system performance	Lift system performance and reduce the average cost per person treated while at the same time improving outcomes.

Source: MHC (2012a)

Rising to the Challenge

Rising to the Challenge: Mental Health and Addiction Service Development Plan 2012–2017 (Ministry of Health 2012) is the strategic policy document for the sector and outlines prioritised goals over a five-year period. It was approved by Cabinet and published in December 2012.

Rising to the Challenge aims to:

- increase value for money
- enhance integration
- improve client mental health and wellbeing, physical health and social inclusion
- expand access and decrease waiting times (Table A.4).

Rising to the Challenge's primary focus is to:

assist health services across the spectrum, from health promotion through primary care and other general health services to specialist mental health and addiction services, to collectively take action to achieve four overarching goals.

(Ministry of Health 2012, p 5)

The actions in *Rising to the Challenge* focus on four population groups that span the life course. At the same time, the document considers the ‘specific additional needs of groups most disadvantaged by disparities in outcome’ (Ministry of Health 2012, p 5). It also highlights the opportunities to implement a stepped care approach to better integrate primary and specialist services.

Table A.4: The ABCD overarching goals and desired results of *Rising to the Challenge*

Overarching goal	Results we wish to see
A Actively using our current resources more effectively	Increased value for money
B Building infrastructure for integration between primary and specialist services	Enhanced integration
C Cementing and building on gains in resilience and recovery for:	Improved mental health and wellbeing, physical health and social inclusion Disparities in health outcomes addressed
i. people with low-prevalence conditions and/or high needs (psychotic disorders and severe personality disorders, anxiety disorders, depression, alcohol and drug issues or co-existing conditions)	
ii. a) Māori b) Pacific peoples, refugees, people with disabilities and other groups	
D Delivering increased access for:	Expanded access and decreased waiting times in order to: <ul style="list-style-type: none">• avert future adverse outcomes• improve outcomes• support their positive contribution in the home and community of their choice
i. infants, children and youth	
ii. adults with high-prevalence conditions (mild to moderate anxiety, depression, alcohol and drug issues or co-existing conditions, and medically unexplained symptoms)	
iii. our growing older population	

Source: Ministry of Health (2012)

The Ministry of Health’s outcomes framework

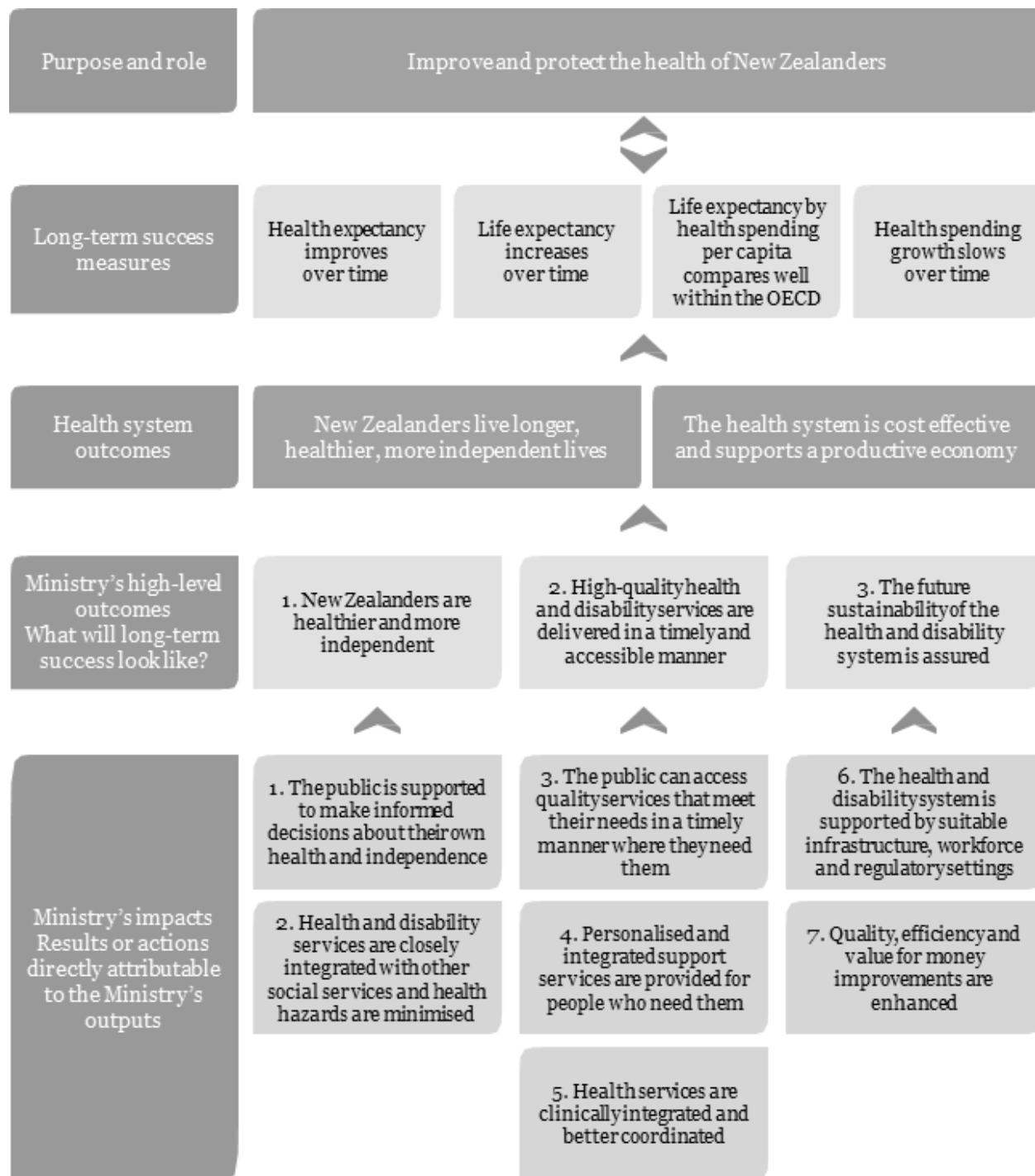
The Ministry’s outcomes framework (Figure A.2) contains two outcomes for the health system:

- New Zealanders live longer, healthier, more independent lives
- the health system is cost-effective and supports a productive economy.

These health system outcomes support the achievement of wider Government priorities and are not expected to change significantly over the medium term.

Many factors influence outcomes. In helping to achieve the outcomes for the health system, the Ministry will have a real impact on the lives of New Zealanders. The health and disability system is dynamic and integrated, and many of the Ministry’s activities contribute across a number of long-term outcomes and impacts. The Ministry’s work is directly aimed at achieving seven impacts, which contribute to the higher-level outcomes.

Figure A.2: The Ministry of Health's outcomes framework



Source: Ministry of Health (2014a)

Appendix C: Examples of current national expectations and requirements

The Commissioning Framework has been designed to adapt to changing national expectations and requirements. At the time of development, the examples of national expectations and requirements below applied to commissioning in the mental health and addiction sector. However, those commissioning care will need to keep up to date with any changes as national strategies, legislation, standards and requirements are reviewed and updated.

The vision, key principles and values for mental health and addiction are currently captured in *Rising to the Challenge* (Ministry of Health 2012).

Vision

The vision of *Rising to the Challenge* has three components as follows:

All New Zealanders will have the tools to weather adversity, actively support each other's wellbeing, and attain their potential within their family and whānau and communities.

Whatever our age, gender or culture, when we need support to improve our mental health and wellbeing or address addiction, we will be able to rapidly access the interventions we need from a range of effective, well-integrated services.

We will have confidence that our publicly funded health and social services are working together to make best use of public funds and to support the best possible outcomes for those who are most vulnerable.

(Ministry of Health 2012, p vi)

This Commissioning Framework will contribute to all three components of the vision. However, it is the framework's contribution to the third component that will be its most tangible outcome.

Legislation and quality standards

The health and disability system operates within a statutory framework made up of over 20 pieces of legislation. The following are the Acts and accompanying strategies that are most significant for the health sector.

New Zealand Public Health and Disability Act 2000

The New Zealand Public Health and Disability (NZPHD) Act establishes the structure underlying public sector funding and the organisation of health and disability services. It establishes district health boards and sets out the duties and roles of key participants, including the Minister of Health, Ministerial committees and health sector provider organisations. The NZPHD Act also sets the strategic direction and goals for health and disability services in New Zealand. These include improving health and disability outcomes, reducing disparities and providing a community voice.

The NZPHD Act requires DHBs to take a population health focus, with the overall objective of improving the health of those living in their district. Part 1 of the Act addresses how this legislation should be used to recognise and respect the principles of the Treaty of Waitangi, for the purpose of improving health outcomes for Māori. Part 3 of the Act includes the statutory objective for DHBs to reduce health disparities for Māori and other population groups and to reduce, with a view to eliminating these health outcome disparities. Part 3 also provides for mechanisms to enable Māori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

Health and disability strategies

The Minister of Health is responsible for strategies that provide a framework for the health system and for reporting on their implementation to Parliament. (In the case of the New Zealand Disability Strategy, this responsibility is shared with the Minister for Disability Issues.)

Four key strategies currently in place are:

- the New Zealand Health Strategy
 - the New Zealand Disability Strategy
 - He Korowai Oranga: Māori Health Strategy
 - the Primary Health Care Strategy.

Health Act 1956

The Health Act sets out the roles and responsibilities of individuals to safeguard public health, including the Minister of Health, the Director of Public Health and designated officers for public health. It contains provisions for environmental health, infectious diseases, health emergencies and the National Cervical Screening Programme.

Crown Entities Act 2004

Many of the organisations that provide health services are Crown entities. The Crown Entities Act provides the fundamental statutory framework for the establishment, governance and operation of Crown entities. It clarifies accountability relationships and reporting requirements between Crown entities, their board members, responsible Ministers and the House of Representatives.

Legislation relevant to mental health and addiction

Table A.5 sets out the Acts that apply to the mental health and addiction sector specifically.

Table A.5: Legislative requirements that apply to the mental health and addiction sector

Act	Summary
Accident Compensation Act 2001	The purpose of this Act is to enhance the public good and reinforce the social contract represented by the first accident compensation scheme by providing for a fair and sustainable scheme for managing personal injury that has, as its overriding goals, minimising both the overall incidence of injury in the community, and the impact of injury on the community (including economic, social and personal costs).
Alcoholism and Drug Addiction Act 1966	The aim of this Act is to consolidate and amend the Reformatory Institutions Act 1909 and to make better provision for the care and treatment of those with alcohol or other drug issues.
Crimes Act 1961	Section 23 of this Act sets out the conditions that apply to a defence of insanity.
Criminal Procedure (Mentally Impaired Persons) Act 2003	The purpose of this Act is to 'restate the law formerly set out in Part 7 of the Criminal Justice Act 1985 relating to mentally disordered persons who are involved in criminal proceedings, and to make a number of changes to that law', including changes to: <ul style="list-style-type: none"> • provide the courts with appropriate options for the detention, assessment and care of defendants and offenders with an intellectual disability • provide that a defendant may not be found unfit to stand trial for an offence unless the evidence against the defendant is sufficient to establish that the defendant caused the act or omission that forms the basis of the offence.
Health and Disability Commissioner Act 1994	The purpose of this Act is to promote and protect the rights of health consumers and disability services consumers, and, to that end, to facilitate the fair, simple, speedy and efficient resolution of complaints relating to infringements of those rights. This Act underpins the Code of Rights, which establishes the rights of consumers, and the obligations and duties of providers to comply with the Code.
Health and Disability Commissioner Amendment Act 2003	This Amendment Act came into force from 18 September 2003.
Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003	The purposes of this Act are to: <ul style="list-style-type: none"> • provide courts with appropriate compulsory care and rehabilitation options for people who have an intellectual disability and who are charged with, or convicted of, an offence • recognise and safeguard the special rights of individuals subject to this Act • provide for the appropriate use of different levels of care for individuals who, while no longer subject to the criminal justice system, remain subject to this Act.
Land Transport Act 1998	The key areas of relevance from this Act are the provisions concerning driver licences for patients under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Directors of Area Mental Health Services (DAMHS) are responsible for retaining the suspended driver licences of special patients and patients subject to compulsory inpatient orders, under section 19 of the Land Transport Act 1998. DAMHS are also responsible for returning licences to patients and for forwarding licences to the Director of Land Transport when a patient ceases to be a special patient or subject to a compulsory inpatient order. Licences are returned by DAMHS temporarily where patients are certified fit to drive on leave.
Mental Health (Compulsory Assessment and Treatment) Act 1992	This Act provides for the compulsory assessment and treatment of people who are considered to be 'mentally disordered' within the meaning of the Act.
Mental Health (Compulsory Assessment and Treatment) Amendment Act 1999	This Amendment Act came into force from 1 April 2000.
Misuse of Drugs Act 1975	Section 24 of this Act relates to the treatment of people dependent on controlled drugs.

Act	Summary
Privacy Act 1993	This Act outlines the principles and regulations for sharing of personal information and the role of the Privacy Commissioner.
Victims' Rights Act 2002	Section 37 of this Act concerns notice to be given to registered victims of the discharge, leave or escape, or death of an accused or offender who is compulsorily detained in a hospital.
Vulnerable Children Act 2014	This Act underpins the development of the Children's Action Plan, which aims to improve outcomes for vulnerable children and teenagers up to the age of 17 years who are at risk of abuse or neglect. This plan is cross-government and will lead to more collaboration between agencies and greater integration of services around these children.

Please note: The legislation referred to in this section was current at the time of publication. However, it is subject to change as reviews and updates occur regularly. Those commissioning care should refer to the link below for the most up-to-date legislative requirements.

For up-to-date information on mental health-related legislation, go to:
www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-related-legislation

Procurement requirements

The *Government Rules of Sourcing* (MBIE 2015) govern all government procurement. All public services (of which the Ministry of Health is one) must follow these rules. State services (including DHBs) are required to have regard to the rules as good practice guidelines.

The following are the five principles of procurement.

1.  Plan and manage for great results
2.  Be fair to all suppliers
3.  Get the right supplier
4.  Get the best deal for everyone
5.  Play by the rules

When purchasing publicly funded health services, the person commissioning care considers what is set out in legislation regarding funding approaches and requirements for services (ie,

clinical requirements, standards, staffing). Where there is no legislative framework for funding, contracts apply.

Quality standards

The Health and Disability Services (Safety) Act 2001 applies to all health and disability services. It is the legislation that underpins the certification of health care services. Hospitals, rest homes and providers of residential disability care that have five or more residents need to meet the Health and Disability Services Standards 2008 and achieve certification.

The Health and Disability Services Standards 2008 were developed in collaboration with many groups, including consumers, providers, government and non-governmental agencies and the Ministry of Health. They are made up of four overarching Standards as follows:

- Health and Disability Services (General) Standard (NZS 8134:2008)
- Health and Disability Services (Core) Standards (NZS 8134.1)
- Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134.2)
- Health and Disability Services (Infection Prevention and Control) Standard (NZS 8134.3).

For more on the Health and Disability Services Standards, go to:
www.health.govt.nz/our-work/regulation-health-and-disability-system/certification-health-care-services/health-and-disability-services-standards

The Health Quality and Safety Commission (HQSC) works with health professionals, providers and consumers to improve the quality and safety of care. Its vision is for a world-class and patient-centred health care and disability support system in New Zealand.

HQSC plays a key role in publishing information about the quality of health care in New Zealand to stimulate quality improvement. Its work in measurement and evaluation of health care enables transparency and accountability of public funds. Through the health quality evaluation programme, the Commission establishes baseline measures and indicators to assess the quality of the health and disability system (HQSC 2015). The *Atlas of Healthcare Variation* includes a selection of indicators from the *Key Performance Indicator Framework for New Zealand Mental Health and Addiction Services* report (NDSA 2012).

For more on mental health KPIs, go to:
www.ndsa.co.nz/OurServices/MentalHealth/KPIFramework.aspx

Appendix D: International and local approaches to commissioning

Commissioning frameworks are used extensively in the United Kingdom and in Australia. There is a range of different approaches taken, a few of which are discussed below. Commissioning is described as taking place at many different levels right across the system and varies according to local variations and the specialisation of services.

World Class Commissioning

The United Kingdom has developed a World Class Commissioning (WCC) programme as a statement of intent to head towards a new form of commissioning that has not yet been developed or implemented across any of the developed health care economies (Sobanja 2009). It has been developed with the aim of 'moving power from providers to patients or those that act on their behalf' (Sobanja 2009, p 1). WCC is a set of mutually reinforcing policies, development programmes and assurance systems put in place by the Department of Health in England.

All the commissioning frameworks in the United Kingdom link back to World Class Commissioning as the high-level framework document. It describes eight principles as follows:

1. understanding the needs of users and other communities by ensuring that, alongside other consultees, engagement is made with the third sector organisations, as advocates, to access their specialist knowledge
2. consulting potential provider organisations, including those from the third sector and local experts, well in advance of commissioning new services, and working with them to set priority outcomes for that service
3. putting outcomes for users at the heart of the strategic planning process
4. mapping the fullest practical range of providers with a view to understanding the contribution they could make to delivering those outcomes
5. considering investing in the capacity of the provider base, particularly those working with hard-to-reach groups
6. ensuring contracting processes are transparent and fair, facilitating the involvement of the broadest range of suppliers, including considering sub-contracting and consortia building, where appropriate
7. ensuring long-term contracts and risk sharing, wherever appropriate, as ways of achieving efficiency and effectiveness
8. seeking feedback from service users, communities and providers in order to review the effectiveness of the commissioning process in meeting local needs.

WCC takes the approach of a commissioning cycle, involving the phases of plan, do, review and analyse. This aligns very closely with the plan, do, study, act (PDSA) quality improvement approach that is endorsed by the Health Quality and Safety Commission in New Zealand and based on the model of improvement PDSA cycle (Langley et al 2009).

The vision of the UK programme is to demonstrate better outcomes in three key areas, which align very closely with New Zealand Triple Aim model. Table A.6 shows this alignment by comparing the stated outcomes of the WCC programme and the Ministry of Health's outcome framework described in the Ministry's Statement of Intent (Ministry of Health 2014a).

Table A.6: A comparison of the United Kingdom's World Class Commissioning and the Ministry of Health's outcome framework

UK World Class Commissioning	NZ Ministry of Health's outcome framework
Better health and wellbeing for all <ul style="list-style-type: none"> • People live healthier and longer lives. • Health inequalities are dramatically reduced. 	New Zealanders are healthier and more independent <ol style="list-style-type: none"> 1. The public is supported to make informed decisions about their own health and independence. 2. Health and disability services are closely integrated with other social services and health hazards are minimised.
Better care for all <ul style="list-style-type: none"> • Services are evidence-based, and of the best quality. • People have choice and control over the services that they use, so they become more personalised. 	High-quality health and disability services are delivered in a timely and accessible manner <ol style="list-style-type: none"> 3. The public can access quality services that meet their needs in a timely manner where they need them. 4. Personalised and integrated support services are provided for people who need them. 5. Health services are clinically integrated and better coordinated.
Better value for all <ul style="list-style-type: none"> • Investment decisions are made in an informed and considered way, ensuring that improvements are delivered within available resources. • Primary care trusts work with others to optimise effective care. 	The future sustainability of the health and disability system is assured <ol style="list-style-type: none"> 6. The health and disability system is supported by suitable infrastructure, workforce and regulatory settings. 7. Quality, efficiency and value for money improvements are enhanced.

Commissioning development

In the United Kingdom, a Joint Commissioning Panel for Mental Health (JCPMH) was launched in 2011. It is a collaboration between 17 organisations, co-chaired by the Royal College of Psychiatrists and the Royal College of General Practitioners (Dent 2013).

JCPMH aims to inform high-quality mental health and learning disability commissioning by:

- giving briefings on key values for effective mental health commissioning
- providing practical guidance and a framework for mental health commissioning
- supporting commissioners to commission care that delivers the best possible outcomes for health and wellbeing
- bringing together service users, carers, clinicians, commissioners, managers and others to deliver the best possible commissioning for mental health and wellbeing.

This panel has published several guides on commissioning including *Practical Mental Health Commissioning* (JCPMH 2011) and *Values-based Commissioning in Mental Health* (JCPMH 2013b). These guides are supported by a range of more specific guidance documents on commissioning for specialist areas.

Practical Mental Health Commissioning

This guide describes the commissioning framework and aims to guide commissioners on how they can commission services that support the strategic direction of the United Kingdom (JCPMH 2011). Although its focus is on the mental health system, it covers population health and the links between mental and physical health. The framework covers all ages and is intended as a high-level document that is supported by a range of more specific companion documents that go into further detail in relation to specific specialist areas and population groups. Companion documents include commissioning guidance that covers perinatal, primary mental health, forensic, alcohol and drug, and child and adolescent mental health services (JCPMH 2013a).

The framework is described as a scene-setting document, which is made up of three sections:

1. The changing commissioning landscape
2. What mental health commissioning looks like now
3. Going forward: what mental health commissioners need to know.

This document describes the changing landscape for commissioners in the United Kingdom as a result of changing government priorities and legislative changes. The principles and concepts that are described within it align closely with those that are expressed in *Blueprint II* and *Rising to the Challenge* although the context is quite different. Having been written for the UK context, it makes several assumptions that would need to be refined for New Zealand.

One of these assumptions is that there is a common understanding of commissioning, who does it and how it is done, including decision-making processes. Another assumption is that resource and expertise exist to conduct population needs assessments, which is not the case in New Zealand. The United Kingdom is implementing GP-led commissioning – again an approach that is very different to the current approach in New Zealand, where mental health funders predominantly sit within DHBs, with a limited interface with general practice.

Values-based Commissioning in Mental Health

This guidance document explains the principles and values of values-based commissioning (VbC) and how these can be applied to contribute to achieving better health and wellbeing outcomes and the objectives of the English mental health strategy (JCPMH 2013b).

Its 10 key messages are summarised below.

1. VbC rests on three equal pillars:
 - (a) patient and carer perspectives and values
 - (b) clinical expertise
 - (c) knowledge derived from scientific or other systematic approaches (evidence).

2. VbC is based on the principles of co-production, collaboration and shared decision-making.
3. VbC builds on existing commissioning models by ensuring that service users and patients are involved at every stage of the commissioning process, and at all levels of decision-making.
4. VbC is the practice of acting on and recognising the value of all those involved in the commissioning process. *VbC promotes the principle that people who use services and carers are the first point of call for information about decisions relating to health care and treatment.*
5. Clinical Commissioning Groups can implement VbC by:
 - (a) developing leadership
 - (b) developing strong links with peer networks and expertise
 - (c) providing formal support and capacity building
 - (d) fostering organisational commitment.
6. To achieve the four actions, VbC supports balanced decision-making within a framework of shared or negotiated values based on mutual respect and discussion.
7. VbC supports outcomes-based commissioning being underpinned by the principle that only the person using services or experiencing illness can truly attach value to health status.
8. VbC supports the development of new relationships, more choice and control in public service, innovation and engagement that supports the Government's Personalisation agenda.
9. VbC supports Payment by Results through building on strengths, self-management, the equality of relationships, recovery and social inclusion.
10. VbC can help achieve the six shared objectives in the English mental health strategy.

Table A.7 compares the objectives of the English mental health strategy with those of *Rising to the Challenge* (Ministry of Health 2012).

Table A.7: A comparison of the objectives of the English mental health strategy and *Rising to the Challenge*

English mental health strategy – shared objectives	<i>Rising to the Challenge</i> (page 9)
1. More people will have good mental health.	1. Young people have a healthy beginning and can subsequently flourish.
2. More people with mental health problems will recover.	2. All people can learn and draw strength from the challenges they face.
3. More people with mental health problems will have good physical health.	3. People with mental health or addiction issues can rapidly recover when they are unwell.
4. More people will have a positive experience of care and support.	4. Social isolation or exclusion as a result of adverse experiences and illness become a thing of the past.
5. Fewer people will suffer avoidable harm.	
6. Fewer people will experience stigma and discrimination.	

Primary mental health care services

JCPMH (2013a) has published guidance on practical mental health commissioning for primary mental health care. The guidance covers the scope of primary mental health care, why it is particularly important to commissioners and the current state, and it then describes what a good primary mental health care service should look like.

In describing why primary mental health care is important, the guidance document refers to several policy imperatives such as the provision of care closer to home, taking patient views into account and patient preference for being treated in primary care. The cost of mental health problems and population prevalence are presented along with a discussion on the importance of early intervention to improve outcomes and reduce costs.

The importance of addressing physical health care needs as well as mental health care needs through primary care is also discussed, with a key focus on aligning physical health care with mental health services. The expectation is that better management of long-term conditions and co-morbidity will reduce the demand on acute inpatient services. Key principles and patient-centred approaches are outlined to describe what a good primary mental health care service would look like.

Victims' Services Commissioning Framework

In a non-mental health example, the Ministry of Justice in the United Kingdom (2013) reviewed the Victims' Services Commissioning Framework. The introduction to the framework describes it as an introduction to help understand the 'evolving commissioning landscape' and to 'promote a shared commissioning language to support the best possible outcomes'. It is an advisory document that gives an overview of commissioning and the different information to be considered.

In this framework, the Ministry of Justice followed a similar approach to continuous quality improvement, working through four stages in a cycle with the community served in the middle. The four stages are understand, plan, do, review.

South Australian Health Clinical Commissioning Framework

Commissioning is considered a key change management tool to meet the objectives of South Australia's Health Care Plan (O'Brien 2013). This framework describes an overarching approach to commissioning for all health services in South Australia.

The framework builds on service planning and delivery and contracting activity already undertaken as well as on international best practice.

The intention is to clarify the commissioning process by:

- defining commissioning and developing a common language and understanding
- establishing a set of common commissioning principles that enable decision-making in the interests of the community, based on strategic objectives
- providing a clear explanation of the commissioning model and the sequence of activities typically involved in doing it well and the processes that support it

- describing who is responsible for doing what and how mechanisms for governance and challenge should function.

Commissioning values and principles, focused on achieving the best outcomes, are outlined . The values listed align closely with the Triple Aim and include provision of services that are accessible, safe, appropriate, well-integrated, high quality and efficient.

The commissioning model is based on the NHS commissioning cycle. It describes the three stages of commissioning as:

1. strategic planning
2. operational planning (including investing, disinvesting and service redesign)
3. monitoring and evaluation.

The framework goes on to describe each of these stages in further detail.

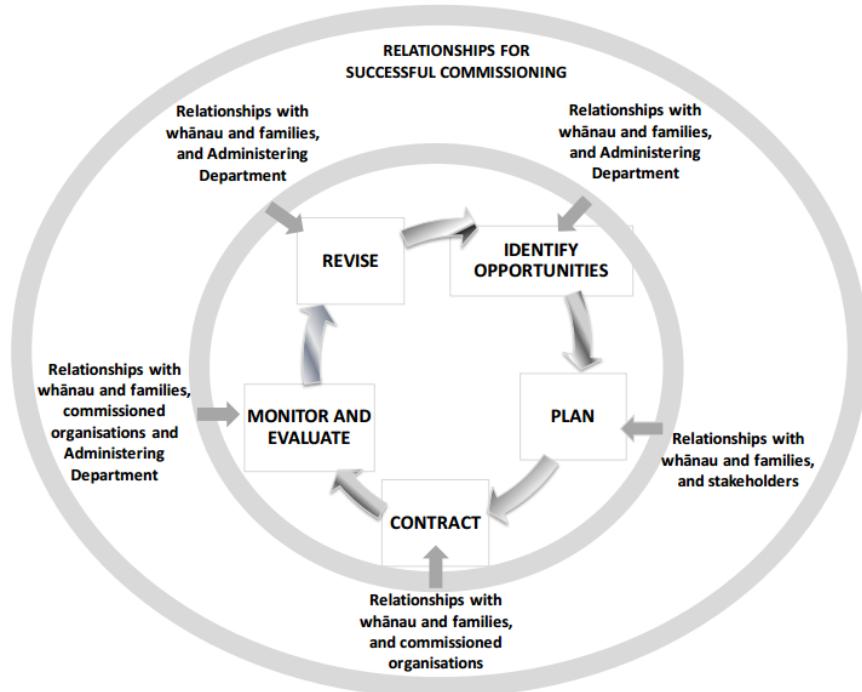
Whānau Ora commissioning

The Whānau Ora Results Commissioning Framework (Te Puni Kōkiri 2013) is depicted on a one-page table that has five high-level outcomes. Contracted commissioning agencies will determine commissioned activities to develop and support initiatives that will deliver measurable results for whānau and families that align with the Government’s high-level Whānau Ora outcomes.

In the context of Whānau Ora, commissioning is described as ‘the process of identifying the aspirations of whānau and families and investing in a portfolio of new or existing programmes or initiatives expected to best deliver progress towards Whānau Ora outcomes as well as the monitoring, evaluation and review of these investments’ (Te Puni Kōkiri 2013).

The Whānau Ora commissioning cycle shows the core activities expected from a commissioning agency as well as the relationships that are expected to underpin these (Figure A.3).

Figure A.3: Whānau Ora commissioning cycle



What do all these frameworks have in common?

All of the commissioning frameworks reviewed aim to achieve high-level outcomes and are designed to enable the implementation of key strategic objectives through commissioning. The commissioning frameworks in the United Kingdom link back to World Class Commissioning and draw on the values and principles detailed in this approach.

The frameworks reviewed are generally high-level. The UK frameworks also have a separate one-page ‘10 key messages’ document that accompanies them. This helps make the key points clear and easy to refer to. The mechanisms and contractual models are not generally discussed; instead, it is assumed that these need to be aligned to ensure outcomes are met.

Several of the frameworks depict a cycle of continuous review of needs, services, performance and outcomes. The HQSC endorses the PDSA cycle of quality improvement based on the approach presented by Langley et al (2009). This approach has been adapted to guide the development of the key components of the framework (model of care, planning methods, service configuration and based on results). By framing it in this way, planning and implementation can be supported as the system transitions to an outcomes-focused approach.

Making a submission

A Guide to the Commissioning Framework for Mental Health and Addiction (2015): Consultation document

Submissions close on Friday, 13 November 2015 at 5.00 pm.

The Ministry of Health must have your submission by this time. Our preference is to receive submissions electronically either by email or on-line. Please ensure that the Ministry of Health receives it before the closing time as any submissions received after this time will not be included in the analysis of submissions, even if they have been posted earlier.

In making your submission, please include or cite relevant supporting evidence if you are able to do so.

The following questions may help you to focus your submission. However, you do not have to answer the questions if you prefer to structure your submission in some other way.

General questions

1. Do you think the Commissioning Framework achieves its purpose of providing a national commissioning approach to enable an outcomes-focused approach to Mental Health and Addiction?
2. Do you think the Commissioning Framework will result in a better understanding of the needs of communities and a broader focus on health and wellbeing?

Section specific

3. Does Chapter One clearly describe a nationally consistent approach to commissioning care that will not only support the achievement of *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* but also shapes the system into the future?
4. Are the benefits of the commissioning approach clearly described?
5. Do you think that the Commissioning Framework's purpose, principles, values and scope are clearly described?
6. Are the essential features (national expectations and requirements, who for, person-centred, community served, five phases of the cycle, four key components and did it work?) of the Commissioning Framework clearly articulated?
7. Does the commissioning cycle capture the dynamic nature of commissioning and how activity flows?
8. Are the five phases of the commissioning cycle clear?
9. Are the four key components that will support a shift towards an outcomes-focused approach to mental health and addiction clearly described?

10. Do you have any other comments related to the Commissioning Framework for Mental Health and Addiction?

There are two ways you can make a submission.

Fill out the submission form on the following pages of this document. Also available on the Ministry of Health's website, <http://www.health.govt.nz/about-ministry/consultations> and complete the online form or email it to commissioningframework@moh.govt.nz

OR

Our preference is to receive submissions electronically however hard copies of completed submission forms can be posted to:

Sonya Russell
Senior Project Manager
Mental Health Service Improvement
Sector Capability and Implementation
Ministry of Health
Private Bag 92522
Auckland 1141

Please send only *one* copy of your submission and ensure you allow postal time so it is received by the closing date. The Ministry of Health will acknowledge all submissions and a summary of submissions will be posted on the Ministry of Health's website.

The Ministry of Health will hold a series of sector workshops at which interested parties can discuss this consultation document and ask questions to inform their written submissions. The dates, times and locations of these meetings will be published on the consultation section of the Ministry's website.

Note: Your submission may be requested under the Official Information Act 1982. If this happens, the Ministry of Health will be required to release your submission to the person who requested it.

Submission form

You do not have to answer all the questions or provide personal information if you do not want to.

This submission was completed by: (name) _____

Address: (street/box number) _____
(town/city) _____

Email: _____

Organisation (if applicable): _____

Position (if applicable): _____

Are you submitting this as (*tick one box only in this section*):

- An individual or individuals (not on behalf of an organisation)
- On behalf of a group or organisation(s)

If you are an individual or individuals, the Ministry of Health will remove your personal details from your submission, and your name(s) will not be listed in the published summary of submissions, if you check the following box:

- I do not give permission for my personal details to be released.

Please indicate which sector(s) your submission represents (*you may tick more than one box in this section*):

- | | |
|--|---|
| <input type="checkbox"/> Māori | <input type="checkbox"/> Families/whānau |
| <input type="checkbox"/> Pacific | <input type="checkbox"/> Consumer |
| <input type="checkbox"/> Asian | <input type="checkbox"/> District health board |
| <input type="checkbox"/> Education/training | <input type="checkbox"/> Local government |
| <input type="checkbox"/> Service provider | <input type="checkbox"/> Funder |
| <input type="checkbox"/> Non-government organisation | <input type="checkbox"/> Professional association |
| <input type="checkbox"/> Academic/research | <input type="checkbox"/> Other (<i>please specify</i>): _____ |

Introduction

The development of the Commissioning Framework is a specific action from *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* (Ministry of Health, 2012). We have worked with the sector to define the approach and to develop the framework.

This project is part of a programme of work to move towards an outcomes-focused approach for Mental Health & Addiction and is closely connected to the development of a National Population Outcomes Framework and associated measures- including the review and refinement of existing measures.

The Commissioning Framework project was initiated in September 2014. Following the sector workshop in November 2014, an Advisory group was established to develop the detail of the key components and provide advice to the Steering group.

We have now drafted this Commissioning Framework that describes the key components and provides a national approach to support better outcomes for Mental Health and Addiction. This draft document has been developed to provide guidance to the sector, and has been informed by relevant information from a range of sources that are important for commissioning. It also identifies some actions that need to be taken by the Ministry of Health to allow for innovative and integrated approaches to be supported within the national framework.

This is new and exciting work and we hope that it will generate discussion and there will be many opportunities for feedback through national, regional and local consultation, workshops and forums.

Questions - General

The Commissioning Framework for Mental Health and Addiction aims to place people at the centre of commissioning to achieve equitable outcomes, wherever people live, and whatever their circumstances. It is part of an outcome-focused approach intended to shift the focus from 'how' things are done, to outcomes that will make a real difference for people experiencing mental health and /or addiction.

Question 1

Do you think the Commissioning Framework achieves its purpose of providing a national commissioning approach to enable an outcomes-focused approach to Mental Health and Addiction? (If no, please specify)

Yes No

Comment:

Question 2

Do you think the Commissioning Framework will result in a better understanding of the needs of communities and a broader focus on health and wellbeing?

Yes No

Comment:

Questions – Section Specific

Chapter 1– Why develop a Framework?

In this section, we refer to three key national documents that were released in 2012 that set out the direction for the mental health and addiction sector over the next 5 to 10 years.

The 2015 New Zealand Productivity Commission report looked at how to make New Zealand's government funded social services more effective so they improve people's lives and raise social wellbeing. This Commissioning Framework has been developed to address this issue by providing a national structure that can be used to approach commissioning for mental health and addiction in a consistent way across New Zealand.

Question 3

Does Chapter One clearly describe a nationally consistent approach to commissioning care that will not only support the achievement of *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* but also shape the system into the future? (If no, please specify)

Yes No

Comment:

Question 4

Are the benefits of the commissioning approach clearly described? (If no, please specify)

Yes No

Comment:

Chapter 2 – What the Commissioning Framework looks like

This chapter introduces the Commissioning Framework for Mental Health and Addiction. It sets out the framework's purpose, principles, values and scope before outlining the different features that contribute to it.

Question 5

Do you think that the Commissioning Framework's purpose, principles, values and scope are clearly described? (If no, please specify)

Yes No

Comment:

Question 6

Are the essential features (national expectations and requirements, who for, person-centred, community served, five phases of the cycle, four key components and did it work?) of the Commissioning Framework clearly articulated? (If no, please specify)

Yes No

Comment:

Chapter 3 – How to use the Commissioning Framework

This chapter supports use of the Commissioning Framework by describing the commissioning cycle in more detail. It covers both the five phases and four key components of the cycle.

Question 7

Does the commissioning cycle capture the dynamic nature of commissioning and how activity flows? (If no, please specify)

Yes No

Comment:

Question 8

Are the five phases of the commissioning cycle clear? (If no, please specify)

Yes No

Comment:

Question 9

Are the four key components that will support a shift towards an outcomes-focused approach to mental health and addiction clearly described? (If no, please specify)

- Planning methods
- Model of Care
- Service Configuration
- Based on results

Yes No

Comment:

Question 10

Do you have any other comments related to the Commissioning Framework for Mental Health and Addiction?

Comment:

Thank you for your feedback – it is much appreciated