DEVELOPING THE INAUGURAL PLAN FOR THE NEW JOINT COMMISSIONING COMMITTEE

RESPONDENT DETAIL

- Questionnaire distributed to DOFs, DOPs and Management Groups from both EASC and WHSSC – Discussion with CEOS during development session in June

- There were 15 responses to the Questionnaire

  - 5 EASC Management Group Members
  - 3 WHSSC Management Group Members
  - 3 DOP members
  - 2 EASC DAG members
  - 1 ADOP member
  - 1 person representing a Health Board

- Organisations who responded

  - ABUHB, BCUHB, HDUHB, PTHB & WAST

Q1 PLANNING PROCESS

What did you particularly like/value about the planning processes, and plans, of the predecessor organisations of the Joint Commissioning Committee?

EASC

- Being aware of the bigger picture across Wales and having an appreciation of the wider issues experienced and the different approaches to addressing these.
- Collaborative approach based on overall purpose and patient flow.
- Collaborative approach based on a patient flow model with the purpose to shift left when it is clinical safe and appropriate to do so.
- Open communication.
- EASC allowed joint communication.

NCCU

- Collaborative discussions
- Collaborative approach based on overall purpose and patient flow.
- Collaborative approach based on a patient flow model with the purpose to shift left when it is clinical safe and appropriate to do so. And top cover on difficult projects like the pan-Wales roster review.
- Assurance around standards of providers - contactable
- Open Communication

WHSSC

- Extremely transparent process undertaken in a timely way that could meaningfully inform the plan
- Intentions and scope of future trends, also the previous insights in to what had been commissioned and decision making
- Excellent engagement with Management Group. Clear deadlines and process. Early iterations shared
- It gave both commissioning organisations and the main provider organisations an opportunity to contribute. It focused on risks. There was the opportunity for clinical input.
- Clarity of process, clear and robust approach to development of new specialised services
- Unable to comment.
- Gate keeping function
- The timetable is set out clearly and the plan is discussed and given due focus in a timely manner.
- Support.

Q2 IMPROVEMENT

Which areas would you want us to improve upon/do differently?

EASC

- Transparency of process and opportunity to input"
- "Communication processes. The accountability between HB/WAST for commissioning services based on population need now and longer term, and realistic service demand projections with defined and agreed tolerances . "
- "Commissioner led - setting the agenda, aligning the incentives, performance management assurance"
- "Earlier sight of the ICP and financial schedules to meet HB IMTP deadlines"
- "In comparison to WHSSC, the development of EASC's plan and its workings did not, from my perspective, have the same level of transparency and seemed less inclusive."
- "Overarching strategy, systems, opportunities for partnership arrangements, brokering with health boards "
- "Inconsistency of process and felt led by management team not commissioners. Need ownership and emphasis on decision making by the Health Board representatives. Very limited focus on commissioning for outcome and needed to see/hear more from provider in WAST as part of the process"
- "There was a sense of duplication in the various issues discussed, reflected in the management group papers that were distributed. The latter would regularly number in excess of 25, many of which overlapped in respect of the key issues e.g. system pressures, response times and ED handover delays. I think there is scope for these to be streamlined."
- "Higher profile for NEPTS"
- "Handover reduction."
- "Sight of the easc plan within the imtp deadlines. Early and clear communications on the available allocations from WG and the requirements attached to them. Increased focus on the competing priorities and acknowledgment greater consideration of the pressures on hb's to fund developments."
- "Identify as the commissioners rather than the service providers, Ensure as EASC group key stakeholders are present but it functions as a commissioners group rather than being told what is happening. Services that are commissioned via EASC have a guest place but an awareness they don't carry a deciding vote."
- "EASC appeared as a service commissioner for WAST rather than Health into WAST. Occasionally minutes did not reflect the discussions during the meetings. Difficult to articulate how funding is being utilised ie: EMRTS > ACCTS but no transaction from EMRTS funding for the service as an example reducing funding for Transfer and retrieval from EMRTS and move to ACCTS. Parallel discussions via different groups ie EASC - DAG, EASC - Chief execs. "

NCCU

- Transparency of process and opportunity to input
- Same as above.
- Early engagement, strategic direction, support with managing health board expectations/ conflicts of ask
- Never really clear on role/function of NCCU
- Higher profile for NEPTS
- Sometimes a bit more formality and structure around reporting on quality and performance, but not more reporting as such; however, I would consider the arrangements mature and robust.
- Greater visibility of work programme and progress. early sight of possible implications for HB's and clear timetables for sign off by HB's. Increased focus on the competing priorities and acknowledgment / considerations of the pressures on HB's to fund developments.
- "Work with ongoing national work streams as noted lots of duplication (Goal 4 & ICAP) as examples. Have conviction when doing reviews in that " if it doesn't work then stop it) In essence all EASC/NCCU/WHSSC need to ensure North Wales are fully factored into service design / modelling ie: Funding for the south wales Trauma network - North Wales did not receive any support financially or programme. ACCTS implemented as a sub section for EMRTS, North Wales was an after thought with service provision."

WHSSC

- Feedback from the DoF conversations about what is agreed through other peer groups e.g. ADoPs"
- "longer term projections of service demand and type to support planning, and any gaps in delivery which could support preventative interventions "
- "Clear strategic plans, decisions taken in the context of the whole"
- "In the context of the financial position of HBs, the WHSSC ICP has recently felt like a traditional investment plan with a large number of cases going through the CIAG process when HBs clearly don't have the funding available. It would be helpful to further prioritise cases that only the highest priority cases go through the CIAG process. "
- "In prior years, the initial stage of the process seems relatively short with tight deadlines for participating organisations, which effects the quality of those contributions. The time allowed for WHSSC officers to use the information seemed disproportionately long and generous in comparison."
- "Whilst good and robust process for adding services into WHSSC process needed to see more on how services evaluate and could be stepped down from WHSSC. Needed greater clarity on risk and escalation process from providers, issues sometimes came up late rather than early warning, perhaps due to provider/commissioner conflict. Could still be more emphasis on commissioning for outcome rather than contracting on cost and volume "
- "Increased focus on the competing priorities and acknowledgment / considerations of the pressures on hb's to fund developments."

Q3 IMTP DEVELOPMENT

There will first and foremost be a need to respond to the NHS Wales planning requirements in the development of the JCC IMTP.

We are however interested to hear of any aspirations you would specifically like to see reflected in the plan, particularly as a result of being a national Commissioning entity and the additional opportunities this brings.

- How we can have collective commissioning arrangements that are visible and provide opportunities to achieve the best value care "
- "Re commissioning. Are we clear about the overall strategy for investment - how do we benchmark - should we be spending 5, 10,15% or more on the relevant services - what's the right intended growth curve? If we have this then our planning can be set in a clear context. Then we push for quality and activity and vfm. Innovative pathways of care - remote consultations etc. Are we appropriately returning services to healthboard control as they become routine? Re provision Performance management in line with above Link with existing QA processes and avoid duplication "
- "Is there an opportunity to bring the voices of patients and their representatives, and the voices of the population into the process more?"
- "Strategy across system, opportunities for planning across, partnership arrangements across organisations,"
- "Collaboration of development, early indications of strategic development to enable planning"
- "Robust population need analysis - Commissioning based on population size/need Commissioning for Outcome- focus on outcome not cost/volume Secondary Prevention in all elements of commissioning "
- "In respect of EASC, to see the issues in the context of a joined up interdependent system, with all stakeholders playing their part and ensuring the emphasis is on tackling root causes rather than symptoms e.g. little point in reinventing 'front door' initiatives if the blockages are at other points of the urgent care system"
- "There are no WG targets around NEPTS. An area of focus is the long term strategy/ambition for NEPTS."
- "There is only really one main WG target for WAST, Red 8 minute 65%. The main aspiration would be around patient safety/harm and experience and what is being commissioned on this, recognising that the primary cause of the current levels is beyond WAST's control i.e. handover."
- "Efficiencies across the system"
- "It would be good to have a clear work plan and the economies of scale expected from the JCC, including input from HB's IMTP priorities. It is also important to review existing plans and how current resources are used rather than focussing on developments. This may well develop but clear structure on discussions of plans , recommending plans and roles and responsibilities for sign off and recommendation to Boards. "
- "As the title eludes to a National Commissioning entity plea is that is considered when planning/decisions are required."
- "Governance, assurance regarding governance process ie: how the meetings feed up and down. As commissioners, awareness/planning for services that are being commissioned are guests to the sessions rather than a permanent seat, which prevents wider conversations."

Q4 FINANCIAL CLIMATE

In the current financial climate, what is your advice on the balance of the following drivers that should inform our Commissioning Intentions and the framework for the IMTP (bearing in mind these will be agreed by the JCC):

A PLAN BASED ON DRIVING EFFICIENCY AND VALUE IN COMMISSIONED SERVICES

- Very High Priority
- These intentions need to explicit with transparency of any balancing potential longer term effects from shorter term gains on equity of access
- Set the overall ambition Accept the in year growth reality Then drive for value
- This should always be sought.
- Value is key
- Considering value strategically
- It would be better to focus on what services we no longer need to deliver and those that deliver better outcomes and trying to get 5p of improvement on some services
- Important, subject to previous comment on tackling root causes rather than symptoms
- These would flow from having defined what quality looks like - then, what are the best value services (including efficiencies) for delivering that level of quality.
- Agree
- Efficiency should be integral to all the commissioning decisions, this doesn't mean downgrading services but more improving value for money and making the most of current resources.
- Stop the need for duplication ie: EMRTS (Transfer and retrieval) ACCTS (Transfer) paying
- Commissioning - We need to identify what we are currently commissioning, what is the performance of current commissioning (If it does not work, why carry it on?)

A PLAN BASED ON SERVICE DEVELOPMENT AND MEETING STANDARDS

- Medium Priority - Quality would be paramount
- This is a given but some developments have to be phased
- see answer to 12 plus, This can only be done to the extent that our workforce and financial resources allow.
- Continuous improvement is key and delivery against standards
- Incorporated into strategic direction and reporting
- What do we really mean by standards? We need to strive to deliver the optimum we can to deliver patient outcomes but this may not mean meeting the gold royal collage standard. I think we should be comfortable with this and be more pragmatic on what standards we are prepared to meet
- Support service development where this is genuinely evidence based and assist in relieving known system pressures
- These would flow from having first defined what quality looks like.
- Agree
- All services should meet required standards but there maybe need to accept a 'silver' standard rather than 'gold' at times. this shouldn't negatively impact the services patients receive but may be the difference between having a service and not having that or another compensating saving elsewhere. Service developments may need to take a back seat, apart from where they are proven to be efficient, and long term benefits are accounted for. Need to consider how prevention is fitting into these cases.
- Focus on forward look and patient safety.
- A generic plan for commissioning rather than separating planning that results in an element of divide and conquer.

A PLAN PRIORITISED ON ASSESSMENT OF QUALITY, RISK, EVIDENCE & HORIZON SCANNING

- Medium Priority - Quality would be paramount
- Service quality and include longer planning timescales drawing on evidence of the opportunities that may 10 - 20 years away
- As above
- Evidence based plan with quality of services at its core, will provide greater value. Affordability constraints may mean that investments are phased over a period of time.
- Has to be included in strategic planning
- Needs to be incorporated into strategic planning
- Yes as derives better outcomes
- Strongly support if based on whole wider system examination
- A plan based on defining what a quality service looks like should be the primary focus, with all the other questions being related/fitting around this.
- I would see this as the primary driver with the other questions here fitting around this. So having identified what a quality 999 emergency ambulance care pathway looks like, based on evidence and horizon scanning this will start to drive out what services and standards are required, what efficiencies are required, what constitutes value and so on."
- Agree
- All of these are important but need to be weighed up against the same assessments with other HB services.
- A plan for all .
- Tier reporting for Quality/Risk and evidence (Evidence needs to be visible and not mixed between numbers)

A PLAN BASED ON ADDRESSING EQUITY OF WELSH RESIDENTS WITH OTHER NATIONS OF THE UK.

- Medium Priority
- A core principle should be equitable across the UK
- This is imperative
- Surely devolution means that Wales can choose for itself what it wants to prioritise and de-prioritise; and the service standards it wants to set.
- Benchmarking is essential
- Yes there should be strong benchmarking
- Yes - but addressing health inequality
- Supported, based on benchmarking and sharing of experience / best practice
- Important, but the primary focus should be on quality, risk etc. based on evidence from within the Welsh system, as every system is unique.
- Agree
- Again this is important but needs to weighed up against other HB priorities, not all of this will be an increase in funding, it could poor communications or poor choice of venue for example. Need to explore these things and the demand prior to investments.
- Supportive for North Wales as would prevent the current equity variance between North Wales and South Wales.

A PLAN BASED ON ADDRESSING THE PERFORMANCE CHALLENGES WITHIN COMMISSIONED SERVICES

- High Priority
- The measures need to be considered to assess outcomes and value for patients and the population
- This is about setting clear and deliverable expectations and managing closely
- How is this different from 12?
- Collaborative opportunities to put in place improvement plans within commissioned services and across the system
- Yes in collaboration
- Not based on this but does need to be a robust risk and escalation process- what are the leavers in our system?
- This should to some extent flow from addressing the priorities above
- As above, important, but evidence based quality the primary driver.
- Agree
- Agreed.
- As per previous comments.
- Needs to be in conjunction with Ministerial priorities and national reporting rather than a further metric.

OTHER, PLEASE SPECIFY BELOW

- It would be good for Quality Impact Assessments to be shared to understand the consequences of dis-investment etc
- Commissioning for Outcome as the number one driver

Q5 COLLABORATION

Please give us your advice on collaborating to ensure that our IMTP aligns well with NHS Wales commissioner and provider plans, and any processes you use within your organisations that we could learn from

- A lot can be learned from the engagement presentations HEIW undertake, where they schedule them and create the time for a good conversation"
- A clear framework with accountable timescales and delivery expectations
- DoP and ADoP awaydays?
- WHSSC did this well
- Collaborative development, consideration of timelines particularly for provider IMTP production
- Consider timelines for development, collaborative processes
- Start in July with commissioning intentions. Monthly meeting with Health Boards. We have used a quality impact assessment process in AB that has been positive in priority setting/ decision making.
- A significant element of our planning process is based on the principle of 'one version of the truth' in respect of data used, such that there is a common understanding of current position, baselines and expectations of change. Important that this principle is applied to EASC commissioning and oversight, to avoid differing interpretations and conclusions
- Early commissioning intentions (draft), informal dialogue and presentations from providers (early in second half of year) around how their plans align to the commissioning intentions
- We have previously had the draft commissioning intentions issued in the summer, which is helpful. This means that in September/October, as a provider, we can present on our planning intentions and assumptions, based on these commissioning intentions. We normally have a good process of dialogue (outside of formal committees) through the second half of the year, which works."
- Need a neat system of forums to enable this
- Clarity and transparency from talking about the future intentions to plans to implementation with HB's . This needs to include service side, planning, finance, workforce. Clear reporting and decision making structures and roles and responsibilities of groups feeding into the individual boards for decisions.
- National collaboration with Ministerial requirements.

Q6 IS THERE ANYTHING ELSE THAT YOU WANT TO SHARE?

- Thank you for the opportunity to input and share feedback. I appreciate the openness of this approach and hope feedback is received constructively
- We need to deal with the conflict of commissioner/provider. Do we need an independent commissioner not a collective board.
- No - thank you
- Meetings needs to have elements of F2F rather than constant teams approach.