Bundle WHSSC Joint Committee - In Public 6 January 2020

Agenda attachments

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1	Preliminary Matters
1.1	Welcome, Introductions and Apologies
2	Items for Decision and/or Consideration
2.1	Approval of WHSSC 2020-23 Integrated Commissioning Plan

This paper requests support for the approval of the Integrated Commissioning Plan (ICP) for Specialised Services 2020-23.

- 2.1 JC 2020-23 ICP covering paper .pdf
- Draft ICP 23rd December v0.3.docx
- Appendix 1 - Activity access rates by Health Board from MAIR system.docx
- Appendix 2 Prioritisation Panel.docx
- 060120 ICP Presentation for JC.pptx

3	Concluding Business
3.1	Any Other Business
3.2	Date of the Next Meeting

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

WHSSC Joint Committee Meeting held in public
Monday 06 January 2020 at 09:00

WHSSC, Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd CF37 5YL

Agenda

Item		Lead	Paper / Verbal	Time
1.	**Preliminary Matters**			
1.1	Welcome, Introductions and Apologies	Chair	Verbal	09:00 – 09:05
1.2	Declarations of Interest	Chair	Verbal	
2.	**Items for Consideration and/or Decision**			
2.1	Approval of WHSSC 2020-23 Integrated Commissioning Plan	Director of Planning	Att.	09:05 – 10:30
3.	**Concluding Business**			
3.1	Any Other Business	Chair	Verbal	
3.2	Date of next meeting - 28 January 2020, 09:30 - Conference Room, WHSSC, Unit G1 The Willowford, Main Avenue, Treforest, CF37 5YL	Chair	Verbal	

		Agenda Item	2.1
Meeting Title	**Joint Committee**	Meeting Date	06/01/2020
Report Title	Finalising the Integrated Commissioning Plan for Specialised Services 2020-23		
Author (Job title)	Assistant Director of Planning		
Executive Lead (Job title)	Director of Planning	Public / In Committee	In Committee

Purpose	This paper requests support for the approval of the Integrated Commissioning Plan (ICP) for Specialised Services 2020-23.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☒	☐	☐	☒

Sub Group /Committee		Meeting Date	
		Meeting Date	
Recommendation(s)	• **Approve** the Integrated Commissioning Plan for Specialised Services for 2020-23; • **Note** that the ICP will be submitted to Welsh Government for information if approved.		

Considerations within the report (tick as appropriate)								
Strategic Objective(s)	YES ✓	NO	Link to Integrated Commissioning Plan	YES ✓	NO	Health and Care Standards	YES	NO ✓
Principles of Prudent Healthcare	YES ✓	NO	IHI Triple Aim	YES	NO	Quality, Safety & Patient Experience	YES ✓	NO
Resources Implications	YES ✓	NO	Risk and Assurance	YES ✓	NO	Evidence Base	YES ✓	NO
Equality and Diversity	YES ✓	NO	Population Health	YES ✓	NO	Legal Implications	YES	NO ✓

Commissioner Health Board affected												
Aneurin Bevan	✓	Betsi Cadwaladr	✓	Cardiff and Vale	✓	Cwm Taf Morgannwg	✓	Hywel Dda	✓	Powys	✓	Swansea Bay	✓

Provider Health Board affected (please state below)
Betsi Cadwaladr, Cardiff and Vale, Cwm Taf Morgannwg, Swansea Bay University Health Boards

1. Situation

As a supporting organisation within NHS Wales, WHSSC has a duty to develop a three year Integrated Commissioning Plan (ICP) for Specialised Services on an annual basis.

This paper outlines the processes that have been used to develop the Integrated Commissioning Plan in conjunction with Health Boards and requests approval of the ICP for 2020-23

2. Background

The ICP has been developed with Health Boards within a shortened period of engagement due to the initially compressed Welsh Government timeframe. Velindre NHS Trust and the Welsh Blood Service have also had the opportunity to contribute to the ICP's development through for the first time, their submission of schemes for consideration in the Joint Clinical Impact Assessment Group (CIAG) and Management Group prioritisation process.

The first draft of the ICP taking account of the results of the CIAG prioritisation and the Prioritisation panel as well as strategic priorities and service risks, was circulated to Management Group and Welsh Government on the 19th October. Discussions took place with Management Group members on the 24th October and are due to be undertaken with Welsh Government in a formal Engagement meeting on 4th November, although a number of informal meetings have taking place with them over the last few months.

The main feedback from the Management Group discussions was that the plan in its current form was unaffordable and that further work was required to identify opportunities for further re-prioritisation. The WHSS team was tasked with identifying from the strategic priorities, service risks, prioritisation schemes and CIAG schemes that were included within the first draft of the plan:

- What is mandated
- Where priorities/schemes look to address inequity in terms of being available to patients in one part of Wales but not another, and where there is inequity for all Welsh patients compared to other home nations
- What the need is for 2020-21
- What the risk of not funding the schemes is (number of patients affected, what alternatives exist, harm impact). This could be illustrated through the completion of the risk management framework which includes the scores for the schemes from a commissioner and provider perspective.

Further information was also requested on the schemes that had been prioritised as high from the Prioritisation panel and it was requested that the CIAG schemes which had all been included in the first draft, were prioritised into high, medium and low. It was also felt that it would be useful to outline the schemes that had

been submitted by providers for consideration in the ICP but had not been circulated to them to raise awareness of the prioritisation that had already taken place.

3. Assessment

The Integrated Commissioning Plan 2020-23 can be found in Annex (i).

4. Recommendations

Members are asked to:

- **Approve** the Integrated Commissioning Plan for Specialised Services for 2020-23;
- **Note** that the ICP will be submitted to Welsh Government for information if approved.

5. Appendices / Annexes

Annex (i) Integrated Commissioning Plan 2020-23

Link to Healthcare Objectives	
Strategic Objective(s)	Development of the Plan Implementation of the Plan
Link to Integrated Commissioning Plan	This paper requests approval of the 2020-23 Integrated Commissioning Plan
Health and Care Standards	Safe Care Staff and Resourcing Governance, Leadership and Accountability
Principles of Prudent Healthcare	Care for Those with the greatest health need first Reduce inappropriate variation Choose an item.
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Improving Patient Experience (including quality and Satisfaction)
Organisational Implications	
Quality, Safety & Patient Experience	Specific section on Quality, Safety and Patient Experience within the ICP.
Resources Implications	Specific finance section within the ICP.
Risk and Assurance	Specific section outlining the risks within the ICP and a key consideration of the prioritisation through the development.
Evidence Base	The ICP is underpinned by a prioritisation process that is designed to examine the evidence inform of the best use of resources.
Equality and Diversity	There are no equality and diversity implications associated with this report.
Population Health	Impact of population health is included within the ICP.
Legal Implications	There are no legal implications associated with this report.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Management Group	24/10/2019	Workshop required prior to JC to better understanding the need and risks of the schemes within the ICP
Joint Committee	12/11/2019	Further information required on financial quantum before approval

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

An Integrated Commissioning Plan for Specialised Services for Wales 2020 - 2023

WHSSC

"On behalf of Health Boards, to ensure equitable access to safe, effective, and sustainable specialised services for the people of Wales."

Executive Summary

GIG CYMRU NHS WALES
Tîm Gwasanaethau Iechyd Arbenigol Cymru
Welsh Health Specialised Services Team

PARCH · RESPECT
PARTNERIAETH · PARTNERSHIP
GWELLA AC ARLOESI · IMPROVEMENT & INNOVATION

The continued focus of the Welsh Health Specialised Services Committee's (WHSSC) Integrated Commissioning Plan (ICP) 2020-23 is to commission high quality services in line with the organisation's stated aim *"On behalf of the seven Local Health Boards; to ensure equitable access to safe, effective, and sustainable specialised services for the people of Wales."*

The demand for specialised services continues to increase as advances in medical technology offer treatment where previously none were available. The development of ever more complex and innovative treatment whilst offering benefits to patients is however providing a growing financial challenge which is demonstrated in the financial summary.

A core element of our work in 2020-21 will be to increase our engagement and co-production with patients, to strengthen our services and patient pathways. In doing so, we hope to identify opportunities to release value from those pathways or through the re-commissioning of services. We are developing a number of new work-streams to support this including referral management and medicines management.

The established Prioritisation Process and Risk Management Framework continue to help identify the priorities for WHSSC this year whilst the Quality and Performance Escalation Process is identifying pressures within the system that require integrated clinical and managerial support. We are able to demonstrate a number of services where our escalation processes have had a positive impact for patients and this work will continue to be strengthened in 2020-21. In 2020-21 our quality improvement focus will be around mental health services where we are taking forward a number of service reviews.

We know that key to the success of our work is increased collaboration with Local Health Boards (LHBs), in both their provider and commissioner function and with NHS Trusts in Wales and England to ensure that we maximise opportunities to better aligning Integrated Medium Term Plans (IMTPs) with our ICP.

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WHSSC Profile

WHSSC is responsible for commissioning a range of specialised services for the population of Wales on behalf of the seven LHBs.

As an organisation it is split into five Directorates: Corporate, Finance, Medical, Nursing and Quality and Planning.

Recognising that to commission effective services we need to organise around the needs of patients, operationally we use a commissioning team structure which cuts across these directorates broadly categorised in the following areas:

- Cancer and Blood
- Cardiac Services
- Mental Health and Vulnerable Groups
- Neurosciences and Long Term Conditions
- Women and Children's Services

This collaborative professional working enables the Welsh Health Specialised Services Team (WHSST) to work towards ensuring that our patients' outcomes and experiences when accessing all specialised services is of a high standard through:

- Effective planning, commissioning and monitoring of the performance of specialised services. This begins with the WHSS Team establishing clear processes for the designation of specialised services providers and the specification of specialised services and then developing, negotiating, agreeing, maintaining and monitoring contracts with providers of specialised services. Key within this is co-ordination of a common approach to the commissioning of specialised services both within and outside Wales.
- All teams working to ensure there is assurance regarding clinical quality and outcomes through the quality framework for monitoring quality and a rolling programme of service reviews.
- Undertaking associated reviews of specialised services and managing the introduction of drugs and new technologies.
- Managing the LHBs pooled budget for planning and securing specialised services and putting financial risk sharing arrangements in place.

- Work with provider organisations to improve the process of public and patient involvement underpinning our work. We aim to do this through continuous engagement in addition to our more formal consultation processes; supporting generally the five ways of working of the Wellbeing Future Generations Act and specifically through 'Collaboration' and 'Involvement'.

WHSST Values

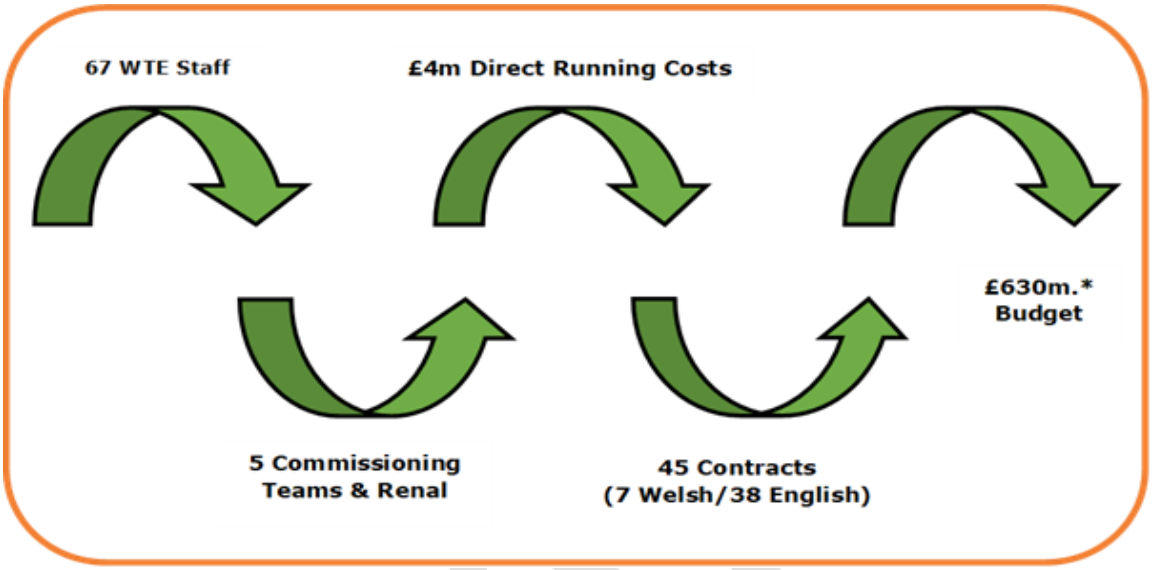
The core values of the organisation outlined in Figure 1 below, were developed by the all staff within the organisation and are an indication of how we would like to be measured by each other, by those who work with us, and by those who depend on us to deliver services. They are also the values we would expect to be upheld by those who will join our team in the future and have been integrated in our workforce processes from recruitment through to Personal Development Reviews.

Figure 1: Organisational Values

Workforce

Figure 2 overleaf sets out the key statistics including staffing levels, direct running costs* and number of contracts for healthcare services.
*(Excluding EASC and NCCU)

Figure 2: Key organisation statistics



The WHSST high level workforce plan for 2020-23 has the key aim of maximising workforce capacity through:

Table 1: WHSST high level workforce plan 2020-23

Objective	Action taken, by when
Strengthening of Executive team	All Executives posts are filled substantively, with the newest Director being in post since Jan 2019
Improving recruitment and retention	-One Finance Manager post for north Wales is still open following unsuccessful recruitment. -Two vacancies within the Quality Assurance Team due to external promotion are in the process of being advertised. -Vacancy rate is currently 5% (a vast improvement from 30% in 2017).
Expanding the workforce to lead on specific projects	- Developing new posts to increase commissioning effectiveness. Recent appointments include a Referral Manager Post and a PET project manager. - Future developments includes a Medicines Management Post and Blue Teq project manager.

	- Development of a Vulnerable Group work-stream supported by WG funding underway. This includes a planning role and a part time Associate Medical Director
Developing and implementing organisational development and learning programmes across the organisation	-Regular OD sessions are taking place for the Executive team, in part facilitated by the host organisation. -Roll out of an organisation wide OD programme is planned for 2020-21. -A number of staff are receiving assistance to study toward Masters Degrees and/or relevant professional qualifications. -Lunch and learn sessions are being provided by members of the WHSS Team. - Participation in the Embrace on-line Health and Wellbeing public sector pilot.
Ensure HR policies are appropriately applied to manage sickness and absence and that this is audited Ensure >85% of staff have completed PDRs	We are continuing to work to improve compliance for seconded staff and ensure there is high performance on core skills training for all staff following in-year changes to the programme content and recruitment of new staff.

Clinical Leadership

The five Associate Medical Directors (AMD) appointed during 2017-18, aligned to the commissioning teams, have continued to raise the profile of the WHSS Team amongst clinical colleagues. There continues to be part time medical and Deputy Medical Directors and a full time Director of Nursing & Quality Assurance in the WHSS Executive team. A sixth AMD joined us for the duration of a project to establish a Welsh gender service during 2019-20. AMD appointment were made for 3 years and we intend to review the effectiveness of the current model in anticipation of the 2020 recruitment round.

An additional Clinical Leader post is being developed to support the new vulnerable groups' portfolio which has a strong focus on mental health and seeks to meet the ministerial priorities of reducing inequalities and improving timely access.

An important development during 2019/20 is a review of the Clinical Gatekeeper role. WHSSC currently has 47 Clinical Gatekeepers covering 107

services and interventions who are key in ensuring patients receive the most appropriate and timely treatment. This work is being taken forward as part of the development of our referral management processes and will culminate in a workshop in January 2020 aimed at helping better define the role and identifying the support and training needs of gatekeepers.

Progress in Delivering the ICP 2019-22

The WHSSC Integrated Commissioning Plan 2019-22, which was approved by Joint Committee in January 2019, identified investment for a number of areas.

Additional funding was agreed for the following specialised services priorities in 2019-22:

- Cystic Fibrosis
- Paediatric Critical Care
- Fetal Medicine
- Neonatal Transport

The following new commissioned services

- Major Trauma
- Thrombectomy

The following areas prioritised in the Clinical Impact Advisory Group (CIAG) process which is described further in *the Increasing the value achieved from funding* chapter below.

- Positron Emission Tomography (PET) new indications
- Transcatheter Aortic Valve Implantation (TAVI)
- Programme for replacing obsolete wheelchairs (north Wales)
- Paediatric Endocrinology
- Cleft Lip and Palate Multi-disciplinary team
- Cleft Lip and Palate addressing waiting times
- Paediatric Rheumatology
- Genetic Test Directory
- Bone Anchored Hearing Aids (BAHAs) and Cochlear Replacement and Upgrades Programme
- Neuro-oncology – to address serious concerns raised in Peer Review
- Adult Congenital Heart Disease
- Paediatric Magnetic Resonance Imaging (MRI)
- Neuro-Rehabilitation
- Inherited Bleeding Disorders project trials savings and service model

As funding for these services was released throughout 2019-22, the assessment of their progress, impact and achievement of aims will be reviewed and reported on in 2020 allowing time for recruitment and implementation.

Development of the 2020-23 ICP

The WHSSC Commissioning Intentions were drafted to inform the development of NHS organisation IMTPs with regard to the commissioning and delivery of specialised services. The intentions underpin WHSSC's aim 'to ensure equitable access to safe, sustainable and effective specialised services for the people of Wales, as close to a patient's home as possible within available resources, on behalf of the seven Health Boards'.

WHSSC Commissioning Intentions 2020-23

1. Equitable access to safe, sustainable and effective specialist services as close to patients' homes as possible
2. Improving the experience and quality of care for individuals and families
3. Increasing the value achieved from funding of health and care through improvement, innovation, use of best practice and eliminating waste
4. Improving information on services in order to drive service change and improve quality of services
5. Evidencing proactive management of new treatments and services

Rather than referring directly to the need to adhere to the Wellbeing of Future Generations (Wales) Act 2015, the Act's five ways of working, outlined in Figure 3 below, are embedded within the intentions and the work that underpins them.

A number of strategic priorities are highlighted within the 2020-23 WHSSC ICP. Strategic priorities are service developments which are either currently mandated by organisations such as the National Institute for Health and Care Excellence (NICE) or have already been agreed as service priorities through previous ICPs or through the CIAG process. All require a service change but for a variety of reasons. These include the implementation of the new treatments, such as Advanced Therapeutic Medicinal Products (ATMPs) and Thrombectomy and working through the required step change in investment for services including Cystic Fibrosis and Intestinal Failure Services which are faced with challenging levels of growth. The highlighted priorities are described in more detail in this section and are key items of work for the relevant Commissioning Teams.

Advanced Therapeutic Medicinal Products (ATMPs)

The introduction of new ATMPs or gene therapies represents a major step change in the provision of potentially curative treatments for patients which had no previous alternative treatments. The ability to transform outcomes for patients has enormous potential but comes at a high financial impact.

The therapies approved to date have tended to be for low volume indications and rare diseases. Gene therapies for more common diseases which could have the potential to transform the whole configuration of service provision are not yet available but are anticipated in the future. For now the cost of ATMPs will largely be in addition to the costs of existing services as they often represent an additional line of treatment after failure of standard of care or are entirely new treatments.

WHSSC has been at the forefront of commissioning ATMPs and have recognised the need for a national strategic approach to their introduction. This includes the ability to forecast their material impact in order to enhance policy formulation and financial planning. The WHSSC team have developed a policy impact paper to highlight the issues at health board executive level and with Welsh Government.

Horizon scanning of ATMPs shows that internationally there is a huge product development pipeline of circa 1,000. However, many remain in trial phases and to date only 4 significant ATMPs have made it through regulatory and NICE approval. Research of international forecasts indicates that at least 40

ATMPs may be approved by 2022 hence, there is likely to be an acceleration at some point in the 2021/21 three year ICP cycle.

Funding will be held centrally within the Welsh Government NHS budget to recognise the impact of NICE mandated Advanced Therapeutic Medicinal Products.

Critical Care – Long Term Ventilation

The Minister for Health and Social Services recognising the growing demand for critical care beds for some of the sickest patients in our healthcare system, allocated specific funding to address the flow issues and increase bed capacity within NHS Wales critical care services. WHSSC was requested to commission one of the areas recommended by the Task and Finish Group on Critical Care – the expansion of the Long Term Ventilation (LTV) beds in University Hospital Llandough. This scheme which will provide benefits across all Health Boards in south and parts of mid Wales through the release of bed days in the acute critical care units following the transfer of non-acute patients into dedicated LTV beds, aims to see two additional beds opening within the existing footprint of the Critical Care Unit in early 2020 and increased therapy input to the care of the patients. Further work to the physical infrastructure is required to achieve the long term aim of the Unit becoming a bespoke ten bedded regional unit for Wales.

A visit to the leading UK Long term ventilation unit – Lane Fox, London informed the thinking around the clinical, workforce and commissioning models. Using this information and the requirements to meet the British Society for Rehabilitation Medicine (BSRM) for a level 1a service, which are also described in our Specialised Rehabilitation policies, a service specification will be drafted. It is anticipated that the establishment of a dedicated Long Term Ventilation Unit for south and parts of mid Wales will in addition to providing more appropriate care for their needs will also lead to financial efficiencies with the cost of an LTV bed being less than an acute critical care bed and the standardisation of care for these specialised patients improving their ongoing management through Continuing Health Care (CHC).

Cystic Fibrosis

The Wales Adult Cystic Fibrosis service (CF) provided by C&VUHB for patients across south and parts of mid Wales has been highlighted as a key risk in recent commissioning plans. This is because of the success of treatments for this disease and the increasing number patients surviving in adulthood. The

number of patients now exceeds the size/staffing of its service and this is compounded by the lack of a home prepared IV antibiotic service, available in all other CF Units in the UK.

A two phased approach to the total investment requested was agreed due to the substantial investment required within the original business case and the lack of clarity around the timeline for the submission of a capital business case to Welsh Government for the increased inpatient capacity.

The phase one proposal for increase in multi-disciplinary staff and non-recurrent funding to trial the provision of the Home IV services was approved in July 2018 with the request for the service to undertake further work on the increased ward model and full year costs of the home IV Service. A provision of funding was made for phase 2 in the 2019-22 WHSSC ICP but with the Business Justification Case (BJC) for the capital element required only submitted to Welsh Government in May 2019 following the tender for the project contract, the funding has not been utilised for the revenue implications of the new extended ward. Completion date for the new ward is predicted to be late summer 2020 although this is dependent on Welsh Government approval of the BJC and work starting.

An element of the phase two funding was approved for investment in the remaining MDT posts, home IV service and satellite clinics across south and parts of mid Wales, in order to deliver care as close to patient's home as possible whilst also responding to the increasing demand. This has resulted in the previously allocated resources for CF being insufficient to also cover the staffing requirements for the ward expansion when these come on line in 2020, requiring a change in the phased bed model or additional funding to be made available in the course of this ICP.

In November 2019 Welsh Government agreed funding to enable Welsh patients to have access where clinically appropriate to the Cystic Fibrosis Modulator Therapies, Orkambi and Symkevi as well as continued access to Kalydeco (Ivacaftor). Welsh Government have agreed non recurrent funding for the Adult and Paediatric services provided by Cardiff and Vales UHB to support the implementation of these therapies. WHSS are working with the services to determine the recurrent revenue costs of providing these therapies.

Gender Services

Until recently, all elements of the treatment pathway for this very vulnerable group of patients was only available from a Gender Identity Clinic in London where there is a two year waiting list. An integrated model which includes Local

Gender Teams (LGTs) and the Direct Enhanced Service (DES) has begun to mainstream gender services, enabling provision of care and support as locally as possible within Wales. The first clinic of the Welsh Gender Service was undertaken in September 2019 in Cardiff. Plans to develop satellite clinics will be included in the long term plan for Welsh Gender services. 2020-21 is the final year of the three year period of the funded interim Gender Identity Service for the population of Wales. During the next twelve months an assessment of the long term provision required is being developed which will be presented for consideration of recurrent funding from 2021-22. A need to introduce peer support in 2020-21 for those waiting to access Gender services ahead of the long term service being established has been raised. But the funding requirements for this need to be understood further.

Major Trauma

The commitment to develop a service model for a Major Trauma Network for south and parts of mid Wales was made by the Collaborative Executive Group (CEG) in 2014. WHSSC as the sole commissioning body in Wales with delegated responsibility for commissioning specialised services, a number of which would be delivered as part of a Major Trauma Centre, was requested by the CEG to lead the development of a commissioning framework, model and governance structure. In September 2018 Joint Committee members agreed the scope of the commissioning framework for Major Trauma (MT) as:

- An Operational Delivery Network (ODN) to be established to oversee the delivery of trauma services to the population of South, Mid and West Wales.
- The ODN and Major Trauma Centre at University Hospital Wales, Cardiff will be commissioned by WHSSC.
- EASC will commission WAST and the EMRTS.
- Health Boards will be responsible for local commissioning.
- Existing trauma commissioning arrangements for BCUHB will be retained.

The Major Trauma Programme Network Board, the team for which currently sit within the NHS Wales Health Collaborative prior to hosting transferring to Swansea Bay University Health Board (SBUHB), identified April 2020 as the proposed launch date for the service with an element of the operational development costs pump primed by non-recurrent funding from Welsh Government to help enable this.

At the January 2019 extraordinary meeting of the WHSSC Joint Committee members were asked to consider future funding options as due to the

absence of financial detail for Major Trauma, the 2019-21 ICP did not include any funding to pump prime the service ahead of the go live date. Members agreed to consider all requests on an exceptional basis with each funding request subject to the usual scrutiny by the WHSSC Management Group, prior to consideration by the Joint Committee.

Following a number of scrutiny processes including professional peer review from relevant Consultants across a number of Trauma Centres in England, funding for the identified in year requirements for the Major Trauma centre, the ODN and some of the requested Plastic Surgery requirements has been released and provided recurrently.

Welsh Government will providing funding for the Major Trauma centre, specialised services, pre hospital and network costs for the Major Trauma Network for South Wales, West Wales and South Powys. Health Boards will fund the Trauma Unit elements.

Mental Health Services Strategy

A Commissioning Strategy is being developed for Mental Health services with a focus on the patient pathways and opportunities for repatriation of patients and services from England. Mental Health services are delivered for NHS Wales by HBs across various sites, NHS providers in England and independent providers in both Wales and England leading to disjointed pathways for those accessing the services.

Work on the strategy is in its first phase, with the need to review existing services taking into account current tier 2 (for patients with mild-moderate mental health presentation) and tier 3 (for patients with moderate to severe presentation) service arrangements and the impact on the need for Tier 4 (specialised services) inpatient care. Consideration will also have to be given to a wide range of key drivers, some of which will be specific to a service area and others impacting across the full range of services. Key external drivers include:

- A number of Committee Inquiries and external reviews influencing Welsh Government policy and recommendations
- Changes to the commissioning landscape in England and the establishment of NHS England have meant that the previous opportunities for cross border joint planning have reduced.
- The Transforming Care Strategy for Learning Disabilities, an NHS England national strategy which is coming towards the end of the initial 5 year plan. This proposes a 20% reduction in medium secure beds and a 50%

reduction in low secure beds. This change takes place within an environment of low independent sector provision.
- New Models of Care Pilot Schemes are being rolled out across England with the effect of moving secure MH capacity around the country with a focus on placing patients closer to home and with financial incentives to do so.
- The establishment of MH provider collaboratives in England that will fundamentally change the delivery model for services in the future.

Key internal drivers are:
- Workforce recruitment issues particularly affecting Child and Adolescent Mental Health Services (CAMHS) services
- The Welsh Framework Agreements for accessing non NHS Wales beds being due for review in April 2020. This arrangement is dependent on an adequate supply of beds and provider competition which is currently reducing because of changes to commissioning within NHS England.
- Recent reviews of inpatient CAHMS services which identified the lack of Psychiatric Intensive Care/Assessment beds leading to potentially unnecessary out of area placements.
- A complex commissioning model for Forensic Adolescent Consultation Treatment Service (FACTS) which is leading to service delivery problems for children with very complex social and health care needs.
- A lack of national services for women and patients within Learning Disability in Wales

Key enablers: Underpinning this work is the close working relationship with the National Collaborative Commissioning Unit who are responsible for managing the Mental Health Framework for Secure Accommodation for Wales. A formal SLA established in April 2019 between WHSSC and the NCCU has led to, for the first time, the introduction of routine quality assessment of NHS Wales inpatient providers. Their expertise has also supported the WHSS Team in its quality escalation processes and assessment of new providers.

A second important enabler is funding from WG to establish a Vulnerable Groups Commissioning Team, consisting of a Clinical Lead and Project Manager which will support the existing Mental Health Commissioning Team with elements of this review.

The following areas have been identified as priority areas of the strategy:

Secure Learning Disability: The need to make recommendations on the development or otherwise of inpatient capacity for secure Learning Disability

beds within Wales. This will take into account the findings of individual patient reviews, requested by the Chief Nursing Officer and being carried out by the Quality Assurance & Improvement Service (QAIS) into the use of inpatient beds. The Review will also need take into account the impact of the NHSE commissioning strategy on private providers located in Wales as well as the current and potential future provision of enhanced community support from other providers including the third sector. It is relevant to note that previous legislative changes mean that currently increasing Welsh capacity for secure learning disability patients may not be possible.

Tier 4 CAMHS: To make recommendations on the future in-patient capacity and the potential for widening the scope of services and developing Psychiatric Intensive Care and assessment capacity within NHS Wales. This will be informed by the review of impatient demand undertaken by a task and finish sub group of the CAMHS Network Board and an examination the potential for developing new workforce models and recruitment and retention strategies.

Forensic Adolescent Consultation Treatment Service (FACTS): To make recommendations on the optimal commissioning model for the service and improvements in the patient pathway across traditional health and social care boundaries ensuring seamless care for children.

WHSSC has been provided with funding by WG to employ a Clinical Lead and Project Manager to lead on this work and other services for Vulnerable Groups.

Women's Services including Peri-natal (Mother and Baby Unit): In October 2017 the National Assembly's Children, Young People and Education Committee published a report following its inquiry into perinatal mental health care in Wales. It concluded that whilst it recognised that Wales's geography posed challenges for the provision of specialist Mother & Baby Unit (MBU) beds, their absence in Wales was not acceptable and needed to be addressed by the Welsh Government as a matter of urgency. The Cabinet Minister for Health, Health, Well-being and Sport supported this in his response stating that:

> "The current evidence base would suggest there is a need for inpatient care in southern Wales, though there would not be sufficient demand to provide a unit in North Wales alone….".

WHSSC was subsequently asked to develop a south and parts of mid Wales MBU which would help to drive forward service development in existing local Health Board (HB) Perinatal Mental Health pathways, leading longer term to a

standardised whole-pathway equitable approach to the delivery of Perinatal Mental health and wellbeing.

After issues in identifying a suitable location for the six bedded unit with capacity to increase to eight beds when sufficient demand required, it is likely that the MBU will be established in 2020/21.

Neurosciences Strategy

The WHSSC five year Neurosciences Strategy which was implemented within the 2018-21 ICP, is moving from the first stage of the strategy of stabilising and developing strong foundations within Neurosciences services to the second stage of service redesign and recommissioning. Re-commissioning is the term used within the WHSSC Integrated Commissioning Plan to describe the approach being taken to ensure that the organisation is making best use of resources by reviewing existing patient care pathways into and across specialised services, to identify the point at which greatest benefit for the patient can be achieved. This will require collaborative working across local, regional and national commissioning elements of the care pathway and in some cases, this will require a redesign of the existing commissioning arrangements for a specific condition, pathway or service

Investment has been made in the key areas of:

- Neurosurgery to increase elective capacity to meet Referral to Treatment (RTT) waiting times, increase the membership of the Neuro-oncology Multidisciplinary team and post-operative MRIs and the use of 5-ALA
- Interventional Neuro-Radiology with the investment in Thrombectomy
- Specialised Rehabilitation in both spinal and neuro rehabilitation and;
- Paediatric Neurology with the commissioning of additional Paediatric MRI capacity and the currently being worked through, repatriation of the Ketogenic Diet service from Bristol.

During 2020-21 we will work closely with the service to understand how the above investment has improved services and outcomes for patients and also on the longer term planning needs which require capital investment in theatre capacity for Neurosurgery to be in line with National standards and have a dedicated emergency Neurosurgery theatre and Specialised Rehabilitation in terms of the relocation of services form Rookwood to University Hospital Llandough.

Proton Beam Therapy

Proton Beam Therapy (PBT) is currently commissioned for adult and paediatric patients from providers both within the UK and overseas. Patients who may benefit from PBT are referred to the National Clinical Reference Panels for assessment against the commissioning policy criteria (these criteria are currently the same in Wales as in England) and, for eligible patients, recommendation of a suitable provider. Since December 2018, PBT has been provided within the UK by the Christie Hospital, Manchester. NHS England will gradually phase out the overseas programme in Germany and America as the Christie service increases its capacity and expertise. A second NHS service is scheduled to open in London in the next few years. Further to a procurement process in 2018, WHSSC also commissions PBT for selected adult patients from the Rutherford Cancer Centre, Newport.

Further indications for the use of PBT are currently being considered by NHS England and are likely to be introduced by them in 2020-21. To ensure equity of access for welsh patients many of whom are being treated in England, we are looking to make financial provision for increased activity, but also accounted for unit costs decreasing as volumes increase. We have been advised by Velindre NHS Trust (Velindre) that the volumes of paediatric and teenage and young adults patients switching from traditional radiotherapy to PBT is likely to increase by approximately nine referrals per annum, taking total referrals to thirteen.

There are significant strategic implications of this potential policy change on standard (photon based) paediatric radiotherapy services across the UK. If adopted, it will mean that a number of paediatric radiotherapy centres will no longer be viable because of the very small numbers of children requiring treatment. The WHSST has initiated dialogue with colleagues in Welsh Government (WG), Velindre and the Clinical Oncology Services Committee (COSC) to ensure that the NHS in Wales is proactive in agreeing a Welsh strategy to address this issue.

The first portfolio of PBT clinical trials was launched by NHS England in November 2019. These studies will be investigating the effectiveness of PBT compared to conventional radiotherapy across a range of cancer sites including oropharynx, breast, glioma and oesophageal cancer. It is hoped that eligible patients from Wales will be enrolled in these trials once funding arrangements have been formalised with Health Care Research Wales.

Single Cancer Pathway

WHSSC commissions a number of diagnostics and treatments used within Cancer services that health boards and Trusts will be identifying and reporting performance against, within the recently established single cancer pathway. Further investment in extending the indications for using PET is included within this ICP and WHSST are also taking the lead on the capital planning for expanding PET capacity with a dedicated Project Manager due to start in November 2019.

WHSST actively work with providers of a number of cancer site treatments to ensure that they are working and delivering cancer services effectively. These include Thoracic Surgery where we have increased surgical capacity in recent years, Neuro-oncology where in 2019 we addressed the serious concerns raised in a Cancer Network peer review allowing for the expansion of the MDT and post-operative scans and are working with Sarcoma leads and establishing links with England providers to improve the effectiveness and timeliness of MDT decision making.

Thrombectomy

It has been estimated that Mechanical Thrombectomy a treatment undertaken by Interventional Neuro Radiologists is an appropriate treatment for around 10% of (ischaemic) stroke cases which equates to around 500 interventions each year in Wales. As the numbers and model of delivery fall within the definition of a specialised service, it was agreed by the Joint Committee that WHSSC would commission Mechanical Thrombectomies services for NHS Wales from April 2019. Throughout 2019 the WHSS Team has been working to secure access to capacity from services in NHS England whilst provision has also been made to develop the service in C&VUHB from 2020-21 to serve the population of mid and south Wales. The team are working in collaboration with the Welsh Government's Stroke Implement Group (SIG) and LHBs on the pathway required to both access Thrombectomy treatment and repatriate to a patient's local hospital following treatment. Collaborative working is ongoing with Cardiff and English Trusts as the providers of the service, Welsh Ambulance Services Trust as the transport provider and Health Boards to ensure appropriate referral and discharge.

Strategic Priorities deliverables in 2020/21

- To commission any newly NICE or All Wales Medicines Strategy Group (AWMSG) approved ATMPs
- To develop and implement a service specification for the commissioning of Long Term Ventilation
- To work with C&VUHB on expanding the inpatient facilities in the Wales Adult Cystic Fibrosis centre
- To work with C&VUHB as the provider of the All Wales Gender Services in understanding the requirements for introducing a peer support service for patients in 2020-21 and the longer term requirements of establishing a recurrently funded service from 2021-22.
- To work with the south and mid Wales Major Trauma Network in establishing a Major Trauma Network from April 2020
- To establish the outcomes of the funding invested in Neurosciences services to date and further requirements to allow Neurosciences services in Wales to provide as a minimum, comparable standards to those provided in NHS England.
- To develop the Mental Health Commissioning Strategy and its key priority areas of Secure Mental Health, Tier 4 CAMHS, FACTS and Peri-natal Mother and Baby inpatient services.
- To understand the implications of any new indications for Proton Beam Therapy introduced in NHS England and agree an NHS Wales policy position
- To receive information on performance against the single cancer pathway for WHSSC commissioned services and include in performance reports to Management Group and Joint Committee
- To develop the Interventional Neuro Radiology service in C&VUHB to allow for the local delivery of Thrombectomy to patients in south and parts of mid Wales

Increasing equitable access to safe, sustainable and effective specialist services

Equity of access to specialised services for the population across Wales is a key priority for WHSSC. It is acknowledged that there is unwarranted variation at present and work is underway to identify inequity and work with Health Boards to put in place measures to reduce it. A major step forward in improving our understanding of this issue has been the development of our management information system MAIR which allows us to produce maps of variance and highlight areas of inequitable access to specialised services.

The need for equity of access underpins almost all of the strategic priorities listed in the previous section: South Wales is the only region in the UK currently without access to a Major Trauma Network and the Wales Adult Cystic Fibrosis service developments seek to bring the delivery of the service in line with that delivered within all CF Units in England.

As a commissioning organisation WHSSC does not have direct access to the provider cost base on which to secure traditional cost improvement savings. However, WHSSC continues to develop a programme of value based commissioning schemes which are designed to act in addition to provider internal cost improvement programmes.

Referral Management

The Referral Manager has recently taken up post with the objectives to reduce inappropriate referrals into NHS England through identifying episodes of care that could be provided closer to home, therefore improving the patient experience and optimising use of local specialised services. Work is already underway focussing on the utilisation of the London contracts as they are accessed by all Health Boards and due to the London weighting carry with them a premium cost.

This will involve working in partnership with NHS England and local services to reduce initial referrals, promote use of alternative consultation methods including telemedicine and encourage use of local specialist nursing to reduce follow up activity.

Use of Information

The information capability of WHSSC has continued to develop significantly in 2019/20 following the launch of the My Analytics and Information Reports (MAIR) System in 2018/19.

WHSSC has worked closely with Health Board teams to ensure that they now have access to the comprehensive information sets now available. Reports can be tailored by health board or provider, by specialty and point of delivery. Results can also be made available using a variety of visualisation tools including maps, charts, tables and pathways. This has enabled Health Boards to gain a deeper understanding of their demand patterns for specialised services. Health Boards can now identify clearly their patient flows by specialty and provider and compare their own access rates to other health boards thus helping to identify variation in access. Enabling this understanding is enabling both health boards and WHSSC to review patterns of utilisation and inform areas for targeted review which may not previously have been evident.

WHSSC is actively using the system to identify patterns of differential referral to English providers which has highlighted a number of repatriation opportunities. This will enable better and more equitable use of local tertiary services within Wales.

MAIR data is already available for the last four years and will be added to with new financial years. The information is also proving to be valuable in highlighting trends in differential activity growth which is informing the development of improved forecasting and contracting going forward.

Data available within MAIR includes:

- Spend, patient numbers, record numbers, gender, age bucket, etc. across the 4 years of data already amalgamated
- Variation - geographical maps showing the patient numbers across Wales, by LHB District and GP practice, along with local population numbers and GP/cluster list sizes and the associated usage ratios for comparison (see sample below)
- Referrer/Referring organisation codes and names, cross-referenced into the warehouse from data provided by NWIS
- Top 20 drug spends by drug name/grouping
- Patient pathway timeline – this pulls in all the activity in our data warehouse for the selected patient cohort, and displays a visual of all their events.

Commissioning Analysis - Health Board Access to and Utilisation of Specialised Services

Detailed trends of utilisation of specialised services for each Health Board for the four year period from 2015/16 to 2018/19 are included in Appendix 1 to this ICP. Trends are detailed by provider and by specialty.

The trends for each board by provider give a flavour of their own unique pattern of referral into specialised services. The information demonstrates:

- The flows in South Wales are highly consistent with the utilisation of CVUHB and SBUHB dominating as regional and supra-regional providers.
- Velindre is an important provider of regional cancer services.
- University Hospitals Bristol is an important provider of supra-regional specialised children's services notably for heart surgery and stem cell transplant.
- Mersey Care NHS Trust is a highly specialised national service provider of high secure mental health services and features in the top 6 providers for all Welsh Health Boards.
- Referral patterns for Powys reflect a complex flow into the specialised services in the Midlands together with significant flows into CVUHB and SBUHB. In addition Powys has flows to BCUHB for its northern population.
- BCUHB has a very different pattern of referral with the use of its own service dominating along with very close relationships with specialised providers based in the Liverpool and Manchester area.

The trends for health boards by specialty show a high degree of consistency across Wales:

- The top 6 specialties consistently include nephrology (dialysis and transplant), cardiac surgery, cardiology, forensic psychiatry and neurosurgery.
- Plastic surgery including burns also features highly in nearly all boards but there are some interesting exceptions which relate to the different local pathways for hand surgery and dermatology. These are consistent with the findings of WHSSC's plastic surgery review which identified potential opportunities for some health boards.
- Child and Adolescent Psychiatry featured highly in BCUHB as they have a higher utilisation rate of tier 4 CAMHS relative to South Wales. This is an area which is developing as WHSSC is supporting BCUHB in

managing more patients locally within BCUHB and BCUHB are developing improved models of tier 2 and 3 services which are complimenting and changing the balance of delivery.

Relative Activity/Access Rates by Health Board

Appendix 1 summarises activity access rates for elective and non-elective care by specialty. The data is presented by Health Board in terms of financial value and patient count. The data for patient count is also presented normalised by population size in order to inform the level of variation in access rates.

When comparing access rates for specialised services it is important to note the following when interpreting the information:

- Patient volumes on specialised services are generally much lower than general services and can therefore be volatile in terms of movement between financial years and between health boards. A small movement in patient volume can be material owing to relatively high unit cost.
- It is useful to normalise data by population but it should be noted that planning populations for specialised services are large, sometimes from 1m to 5m and hence results for smaller populations interpreted with caution.
- Specialised services usually sit at the end of patient pathways that are often complex with many points at which alternative interventions are possible and referrals on influenced by available local alternatives. This can explain some large variations between health boards who provide specialised services and those who refer into them. The local availability of specialty secondary care further informs variation.
- Access to highly specialised services which are quaternary and can be at some distance from Wales may be more exposed to a risk of variation given the complexity of the pathway and differences in referral relationships and awareness.
- Finally for some services WHSSC commissions a different pathway scope by agreement with health boards in order to simplify commissioning and contracting arrangements – an example is that WHSSC still contracts for neurology for North Wales and has only recently transferred the contracts for neurology from the CVUHB area. The difference between cancer commissioning responsibilities across Wales is significant.

The results of the comparison using 2017/18 financial values to determine the top 6 specialties highlights the following:

- Powys outlier – access per 100k population appears to show Powys population as low outlier in terms of activity rates. It is unclear why this pattern has been observed and may be variation due to the smaller population size. We are looking to work closely with Public Health colleagues from the HB to investigate this observation.
- Nephrology – this relates to renal dialysis and renal transplantation. Wales tends to have high access rates compared to England, particularly for transplantation where Welsh waiting times are notably shorter and annual demand closely aligned to capacity. There is some variation within Wales with the range from a high of 134 per 100k (SBUHB) to 56 per 100k (BCUHB) in relation to inpatient episodes. There are no significant variations in waiting time to dialysis. End stage renal failure is a chronic disease and closely related to the aging population. Early identification in primary care and management within a secondary care service will influence the numbers referred through for treatment.
- Cardiac Surgery – this includes open heart surgery and TAVI. Cardiac surgery provision more centralised at only 2 centres in Wales. Variation is from a high of 84 per 100k (SBUHB) to 44 per 100k (CVUHB).
- Forensic Psychiatry & Adult Mental Illness – this includes high secure and medium secure where patient volumes are low. All high secure provided in England with Medium secure provided in both North and South Wales with mixed economy of private and NHS provision. Pathway availability of low secure can have a marked impact on variation in utilisation of high and medium secure. There is a recognised higher utilisation expected in urban areas compared to more rural areas. However, in recent years medium secure volumes have been consistently falling overall. Combined variation from a high of 10 per 100k (CVUHB) to 5 per 100k (HDHB and ABUHB).
- Cardiology – this includes angioplasty, complex pacing (including implantable cardiac defibrillators (ICDs)) and electrophysiology. Angioplasty provision is now more dispersed at 4 centres in Wales. ICDs provision more dispersed now at 5 centres in Wales. Variation from high of 199 per 100k (HDHD) to low of 78 per 100k (BCUHB).
- Plastic Surgery – this includes plastic surgery and burns activity. Activity variation driven by pathway differences. There is a high volume impact linked to whether there is local secondary care access to dermatology as some skin cancer volumes can be undertaken by dermatology. There is a further pathway impact of local availability of hand surgery. Finally, local expertise in breast cancer surgery impacts on referral rates to plastic surgery. WHSSC has set out a strategy of tackling plastic surgery access variation by focussing on dermatology,

hand surgery and breast surgery as an opportunity for value improvement. Variation from a high of 616 per 100k (SBUHB – the supra-regional provider for South Wales) to a low of 113 per 100k for CVUHB (due to local availability of hand surgery service and dermatology).

- Neurosurgery – this includes traumatic head injury, cancer, neuro-spinal surgery, spinal implants. There is a pathway impact of local availability of spinal surgery together with referral for head injury monitoring. Variation from a high of 121 per 100k (BCUHB) to 53/56 per 100k (HDHB & SBUHB).

Needs Analysis

Our much improved understanding of activity data has further emphasised the lack of public health expertise within our organisation to support population needs analysis. This has repeatedly been identified by Stakeholders a a key weakness in our organisation. Previous attempts at Consultant recruitment were unsuccessful and obtaining external expertise of sufficient quality has also not been as anticipated. We are therefore taking a number of steps to address this:

- Taking up Public Health Wales on their offer to assist us with supporting population needs assessments
- Developing in house expertise building on the MAIR system
- As part of our engagement process with the Boards of HBs we have highlighted this issue and raised the profile of our work and strengthened relationships with Directors of Public Health (DPHs)
- We are in discussion with the Chief Medical Officer and DPHs to identify alternative opportunities for providing expertise to WHSSC.

Increasing access deliverables in 2020/21

One of the key deliverables is to identify and address inequity and inappropriate variation in access to specialised services. This work can specifically be undertaken through the referral management post and the use of MAIR by all commissioning teams.

The Referral Management Project Manager will:

- work with welsh providers on repatriating any unnecessary activity from English providers
- identify opportunities for providing follow up activity locally rather than through NHS England providers
- strengthen the Gatekeeping process

It is planned to further develop the capability and use of MAIR and the underpinning Power BI platform by:

- Developing further methods of standardising activity measures by population to make comparison between health boards more meaningful.
- Producing performance management dashboards.
- Developing methods to speed the addition of new time period data by greater standardisation in the way data comes in from multiple providers and utilisation automation tools.
- Developing further visualisation tools including heat mapping.
- Developing action specific plans with health boards to act on findings and opportunities identified.
- Exploring how quality and outcomes data can be incorporated.
- Improving the familiarisation of Health Boards with the variety of WHSSC's contracts by the production of deep dive reports.
- Strengthening Public Health expertise.

The quality of care that patients and their families receive, and their experience is central to the commissioning of specialised services. Quality is everyone's business and all of our staff strive to ensure that quality and patient centred services are at the heart of commissioning. This section of the ICP is designed to provide assurance that not only do we commission high quality clinical care but there are robust processes in place to monitor services and escalate to the Joint Committee if required as well as taking effective remedial action for services of concern.

Central to our approach is to develop open and transparent relationships with our providers, engage and involve the clinicians and work in partnership with stakeholders when planning and commissioning services. This year will have seen the recruitment of a team of staff to strengthen the focus on quality monitoring and improvement on all of our commissioned services. The 'Quality Team' will have a pivotal role in the co-ordination of operational quality monitoring and interventions within commissioned services and help build upon the work of the specialised commissioning *Quality Assurance Framework (*QAF) (July 2014).

The QAF was designed to establish the basic infrastructure to support driving assurance and improvement of quality for specialised commissioned services. As such it sets out the systems and processes that needed to be in place, the roles and responsibilities of key staff in delivering these systems and processes and the tools that would be developed to support staff to deliver their responsibilities. Specialised commissioning can now move beyond the basic infrastructure to the next stage of driving quality assurance and improvement in our specialised commissioned services. The work on developing the QAF is underway and being undertaken jointly with Health Boards and the Quality and Patient Safety Committee through a series of development days which commenced in October 2019, with the second planned for February 2020.

The Quality team work closely with the Medical Directorate and Commissioning Teams and have a pivotal role in monitoring the quality of commissioned services through the activities illustrated in Figure 4 overleaf.

Figure 4: Activities and mechanisms for monitoring the quality of commissioned services

Key areas of work include:

- **Compliance with legislation and regulation:** The Nurse staffing Act (2016) were applicable to specialist services, Putting things right (2011). Working with providers in management and learning from serious incidents and never events monitoring the timeliness and quality of investigations and responses to complaints and reported near misses. Compliance with key legislation such as the Welsh Government's Health and Social Care Bill (Quality and Engagement 2019), Safeguarding and Public Protection.
- **Quality planning:** via the ICP, contribute to the commissioning cycle including planning, contracting and quality assurance of provider services. Using quality data analysis, through public engagement and patient experience, based on understanding population health, principles of equality and diversity, workforce development and wellbeing.
- **Quality improvement**: e.g. clinical effectiveness via research, audit, implementation of NICE guidelines professional and service specific standards, learning, education & training, research & development, organisation-wide and national sharing of learning.
- **Quality assurance**: e.g. improvements using learning generated by internal and external scrutiny, including those undertaken by HIW, Community Health Council, and other regulatory, speciality, service

specific and professional standards, mortality review, evidence-based policies and protocols QSIS CQC.

- **Managing risk** e.g. assessing, understanding and articulating risk via risk registers, infection prevention and control, decontamination, clinical incident reporting and investigation, managing concerns, implementation of patient safety solutions alerts and notices applying learning.

Fundamental principles underpinning the Quality Assurance Framework will be

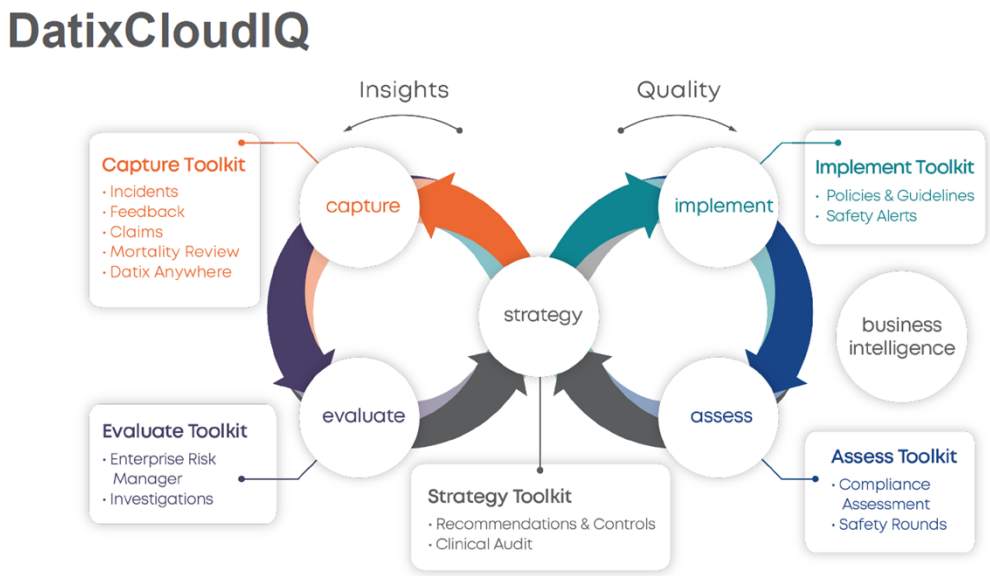
- Ensuring that the patient is at the centre of the services commissioned by WHSSC. Capturing the patient experience alongside quality indicators is key to inform quality improvements.
- Work in partnership with providers to agree Service specifications.
- Ensuring that the development of quality indicators is clinically-led and reflect the specialist nature of the service delivered.
- Develop and support tools /mechanisms for analysis and reporting of Quality Indicators.
- Ensure quality is seen as everybody's business across the organisation
- Reducing duplication and unwarranted variation.

Quality governance arrangements have also been strengthened over the year to provide clear oversight of actions and responses, either across regions, or via commissioning teams and clinical networks where applicable. Whilst further development is required to strengthen the interface with LHBs the role of the Quality & Patient Safety Committee is core to ensure a comprehensive picture is maintained about service quality for commissioned services and reported accordingly.

Over the past year there has been an emphasis on ensuring that the WHSSC Quality Patient Safety Committee has a level of independent scrutiny of internal processes with exception reporting back to the Joint Committee. In addition a series of development workshops with the Health Board's Quality Patient Safety Committees chairs and quality leads has strengthened the links and agreed reporting mechanisms to optimise assurance and shared learning.

We are also looking forward to working with Health Boards in implementing the newly launched Once for Wales Concerns Management System which is succinctly summarised below. This will bring consistency in reporting and a whole systems approach in supporting the quality cycle.

Figure 5: Once for Wales Concerns Management System



Interface with NHS England

A large percentage of the services WHSSC commission are in NHS England a close working relationship has developed to share intelligence and reporting methods. The Quality Surveillance Team (QST), previously the National Peer Review Programme supports the monitoring of quality of all specialised commissioning services in England. We work in partnership with NHS England specialised commissioning hubs where quality teams are responsible for monitoring on an on-going basis in collaboration with service specialists. Information on the quality of services is made available through a single portal known as the Quality Surveillance Information System (QSIS) that can be viewed by ourselves as the commissioner of the service.

Patient Experience

Patient experience is an important element of the quality cycle with patient and public engagement helping WHSSC to:

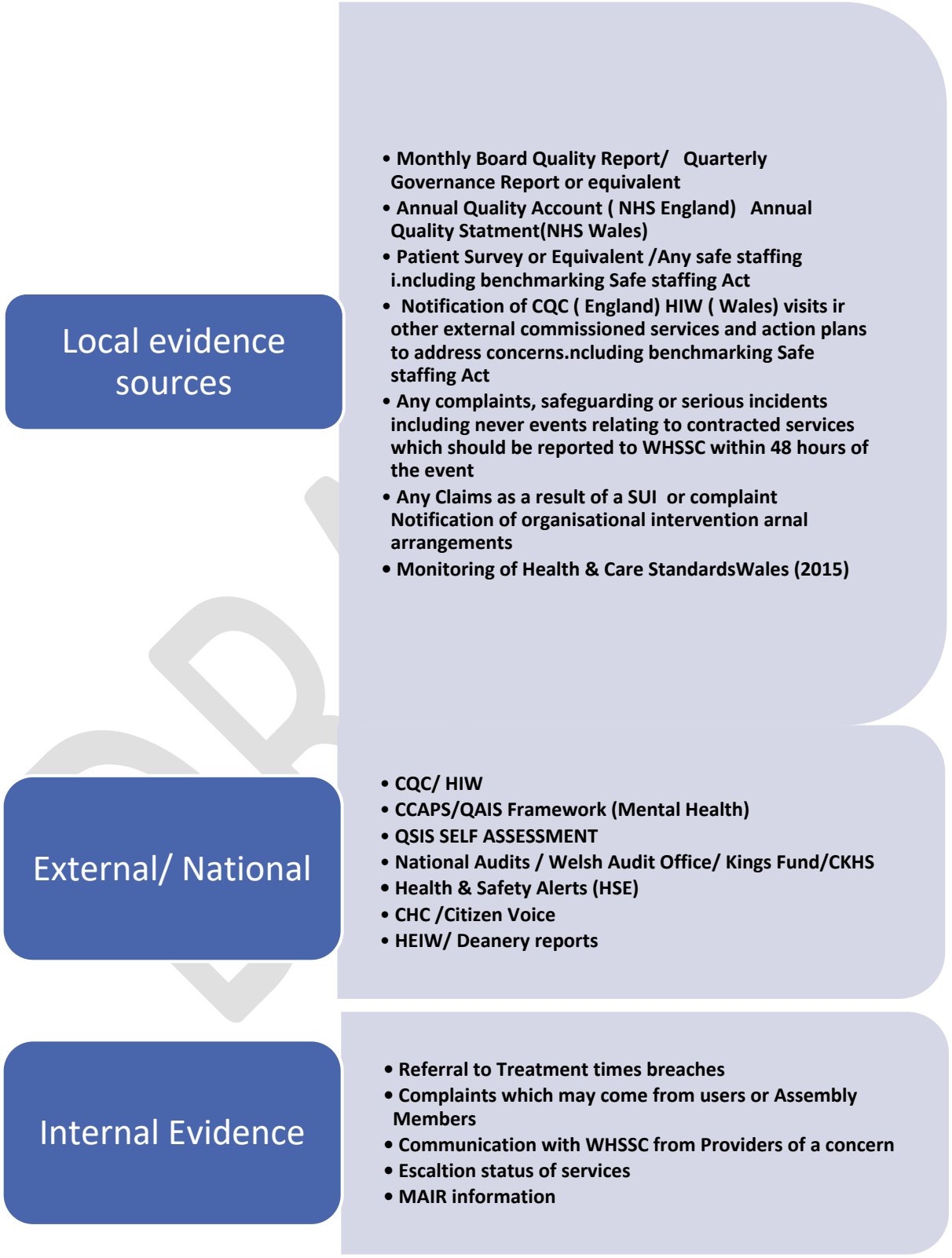
- Understand the patient's expectation of a particular service
- Put things right if the patient experience was not as expected or unplanned
- Understand differences in patient experience between locations and types of treatment
- Make changes where needed and highlight areas where changes have improved care

- Monitor the outcomes and benefits of treatment in terms of a person's physical, mental and social wellbeing
- Inform WHSSC how a service or particular treatment is being provided
- Plan future service provision

Patient stories are taken to the Joint Committee and Quality Patient Safety Committee. An example of patient feedback from one of our providers is that Swansea Bay University health Board reported a rise in the family and friends evaluation from 49,792 in 2016-2017 to 64,405 in 2017-2018 with 95% of respondents say they would recommend the Health Board.

Figure 6 overleaf illustrates the sources of intelligence that the organisation uses to effectively report the quality of both providers and the care that they provide to patients. It builds on quality reporting from the providers, gathers assurance from the regulators and provides a greater emphasis on the reporting back to the Health Boards for the services we commission on their behalf.

Figure 6: Information sources for reporting quality



Quality and Performance Escalation Framework

The Quality and Performance Escalation Framework is fully embedded in the WHSS Team's management of services. A number of the services which have been under enhanced performance management arrangements in the form of Commissioning Quality Visits and Escalated Monitoring meetings, have demonstrated significant improvement to allow them to be de-escalated. These include Paediatric Surgery which was placed into Escalation from a Quality perspective and Bariatric Surgery and Neurosurgery from a waiting list performance perspective.

The north Wales Adolescent Mental Health Service (NWAS) and CAMHS in south Wales remain in escalation due to unresolved quality concerns and Cardiac Surgery and Plastic Surgery remain due to increasing waiting list times.

Improving the patient experience and quality of care deliverables in 2020/21

The WHSS Quality Team has highlighted the following deliverables which will enables them to improve the services we commission and to demonstrate some of the changes that they have already made to improve patient outcomes and to ensure that patients receive a positive experience when they access services.

- Review the Quality Assurance Framework to address new challenges and set out further ambitions for quality in specialised services.
- Continue to monitor, identify and address variation in access and/or outcomes and patients experience.
- Continue to undertake peer review visits to test the accuracy of the information submitted and benchmark performance against the quality indicators.
- Continue to work with NHS England to utilise the tools that have been developed such as the Specialised Services Quality Dashboards (SSQD), and Quality Surveillance Information System (QSIS) in order to roll them out across NHS Wales.
- Strengthen and further develop our escalation process and aim for more services to be de-escalated where levels of improvements have been recorded.

Increasing the Value achieved from funding

Health care decision making requires balancing the demand of new, innovative technologies and services against finite resources. Within the field of specialised services, these innovations often represent treatments of high cost for low treatment numbers. This inevitably leads to commissioners of healthcare having to make difficult choices.

NHS Wales and WHSSC must ensure that investment decisions are:

- affordable and offer value for money
- supported by convincing evidence of safety and effectiveness, and
- made using a process that is consistent and transparent.

To achieve this WHSSC has developed a number of processes designed below, that enables it to compare competing proposals for new investment so that these can be prioritised and subsequently implemented. The methodology used in the prioritisation processes incorporates several elements from other published prioritisation processes, particularly those used by NHS England, the National Specialised Services Committee in Scotland[1] and the system favoured in Canada.

Horizon Scanning

The use of horizon scanning is now firmly embedded in WHSSC's commissioning practice. It aims to support planning and priority setting and to assist in the prioritisation and allocation of resources by identifying and monitoring new and emerging health technologies that are likely to have a significant impact on the delivery of healthcare. It has enabled WHSSC to provide reliable estimates of future expenditure in order to inform development of the ICP.

Horizon scanning can vary in its extent and complexity dependent upon the time and resource available and requires a systematic examination of all relevant information sources. WHSSC has robust and systematic horizon scanning arrangements in place with AWMSG for appraisal of medicines and Health Technology Wales (HTW) for any non- medicinal health technologies such as medical devices or surgical procedures. WHSSC recently signed a Memorandum of Understanding with HTW in order to formalise the strategic alliance, ensuring closer collaborative working and timely delivery of high quality reviews.

Prioritisation Panel

Since 2016 WHSSC has held an annual prioritisation process to consider *new* interventions and technologies identified via the previously mentioned horizon scanning. This has allowed us to compare competing proposals for new investment so that these can be prioritised within all other competing priorities and subsequently implemented.

This process adopts the principles of Prudent Healthcare[2] setting out to reduce inappropriate variation using evidence based practices consistently and transparently with the public, patients and professionals as equal partners through co-production.

The dual processes of horizon scanning and prioritisation helps to ensure that the NHS in Wales effectively commissions' clinical and cost effective services, by horizon scanning identifying the new interventions which may be suitable for funding, and prioritisation allowing them to be ranked according to a set of pre-determined criteria, including their clinical and cost effectiveness.
The scoring and ranking of new interventions was carried out by the *WHSSC Prioritisation Panel* (Appendix 2). Members were invited to score each

[2] Prudent Healthcare: https://gov.wales/topics/health/nhswales/about/prudent-healthcare/?lang=en

intervention against the following criteria in order to develop recommendations on their relative priority:

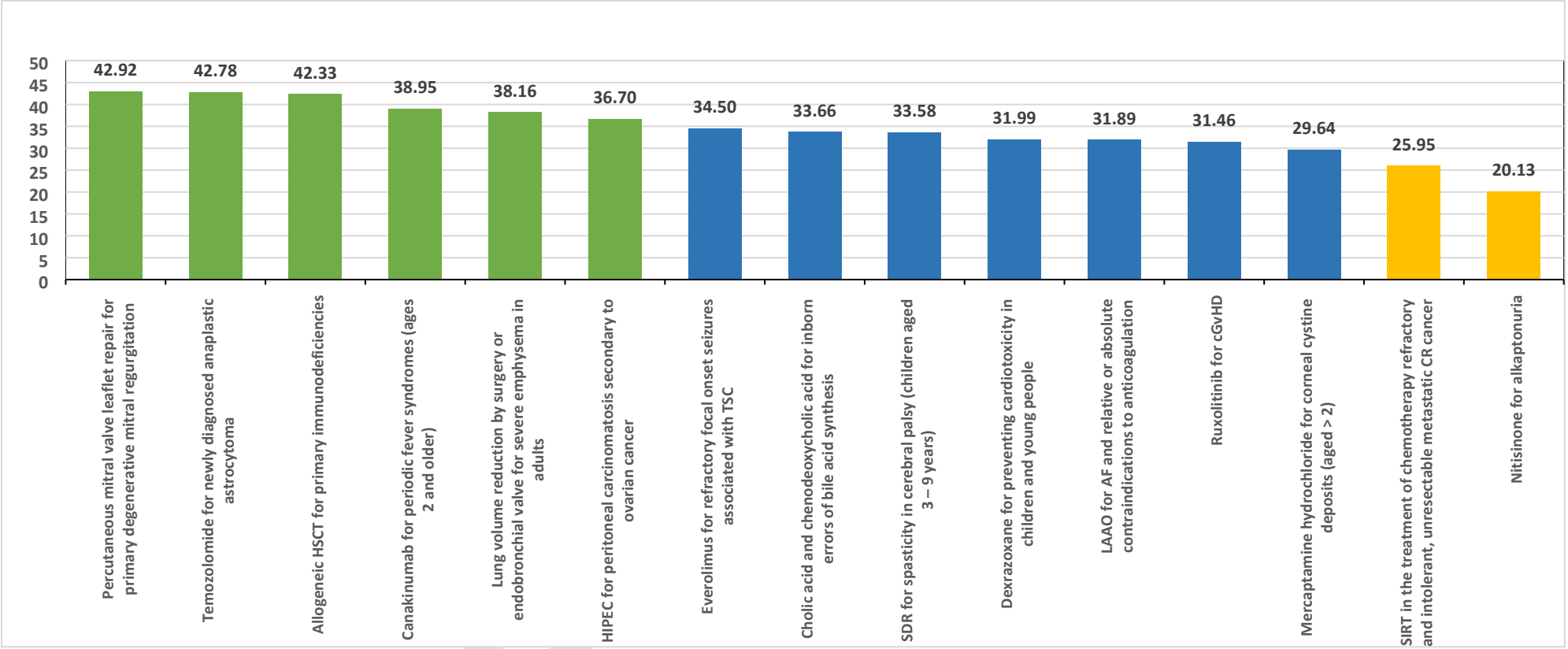
- Quality and strength of the evidence of clinical effectiveness
- Patient benefit (clinical impact)
- Economic assessment
- Burden of disease – nature (severity) of the condition
- Burden of disease – population impact
- Potential for improving/reducing inequalities of access.

The horizon scanning process for 2019 identified eleven new interventions for consideration and four medium topic priority topics that were sitting on the WHSSC static list for review this year. The scoring of these fifteen topics is shown in figure 7 below.

Interventions were categorised as high (***green***), medium (***blue***) or low (***orange***) priority for inclusion in the 2020-23 ICP. Members recommended that the following six 'high priority' interventions be considered for inclusion in the 2020-23 ICP:

- Percutaneous mitral valve leaflet repair for primary degenerative mitral regurgitation
- Temozolomide for adjuvant treatment for people with newly diagnosed anaplastic astrocytoma without 1p/19q codeletion following surgery and radiotherapy (adults)
- Allogeneic haematopoietic stem cell transplant for primary immunodeficiencies (all ages)
- Canakinumab for periodic fever syndromes: TRAPS, HIDS/MKD and FMF (ages 2 and older)
- Lung volume reduction by surgery or endobronchial valve for severe emphysema in adults
- Cytoreductive Surgery with Hyperthermic Intraperitoneal Chemotherapy (HIPEC) for the treatment of peritoneal carcinomatosis (PC) secondary to ovarian cancer.

Figure 7: WHSSC Prioritisation Panel Score 2019



Clinical Impact Advisory Group

The Clinical Impact Advisory Group was established following the recognition that there was a lack of clinical input into the prioritisation for new WHSSC services. The CIAG which attends an annual workshop with members of Management Group consists of one member from each Health Board, usually an Associate Medical Director with responsibility for Public Health or primary care.

The CIAG/Management Group workshop has evolved since it was first introduced in 2016. The notable difference in this year's workshop is the increase in the criteria used for scoring the schemes presented from three to four, which are:

- Patient benefit (clinical impact)
- Burden of disease – nature (severity) of the condition
- Burden of disease – population impact
- Potential for improving/reducing inequalities of access.

Schemes not scored

A high volume of schemes were submitted for consideration in the CIAG/Management Group workshop. A number of these were felt to be more appropriately addressed outside of the CIAG workshop, the reasons for which are outlined in the below table. These suggested removals from the CIAG processes were shared with members of CIAG and Management Group prior to the workshop, giving the opportunity in advance to consider whether our reasoning was appropriate, which it was considered to be.

Table 2: Summary of all schemes removed from the CIAG scoring process prior to presentation

Scheme(s)	Reason for removal from scoring process
▪ Genetics Tuberous Sclerosis clinic ▪ Paediatric Cochlear Implantation for north Wales ▪ Peptide Receptor Radionuclide Therapy (PRRT)	Schemes based on repatriation of patients so should be cost neutral or of minimal costs. To be worked through with the relevant organisations within the next financial year with the case for change presented at a Management Group meeting.
▪ BAHA and Cochlear scheme for north Wales	This scheme relates to implementation of the mandatory

	NICE guidance TA566 it is suggested that this scheme is not prioritised as will need to be implemented and the case for implementation is scrutinised through the usual Management Group process before any funding is agreed.
▪ Immunotherapy for Stage 3 Melanoma for South east Wales and Inherited Cardiac Conditions for patients in South west Wales	for patients in South west Wales and could be considered at regional forums. We are not aware of how the services are managed in other regions across Wales
▪ Renal Replacement Therapy	address growth only and is not requesting any infrastructure costs within this. It is suggested that whilst we need to have a better understanding of the growth in terms of the rates across the different Health Boards etc. that this could be managed through a paper/presentation to Management Group
▪ Gender	the scheme which is to introduce a peer support service within the newly established all Wales Gender service has been highlighted as a Ministerial priority so is being considered as a Strategic priority as was the case last year for Major Trauma and Thrombectomy.
▪ Anakinra	this treatment for periodic fevers syndrome was considered in last year's prioritisation and CIAG process but wasn't agreed for funding as it was below the line for what was affordable in our plan. There is now another treatment Canakinumab which can be used for the same indications that is licensed whereas Anakinra could only be used off licence. We are currently checking with one of the Consultant Immunologists in the

	Cardiff service that Canakinumab is the treatment that they would use but suggest that the Anakinra scheme is not prioritised on Thursday.

A further five schemes were removed by the CIAG Group from the process following presentation and discussion of the schemes at the workshop, but prior to voting. Details of the schemes removed and the reasons for why are outlined below:

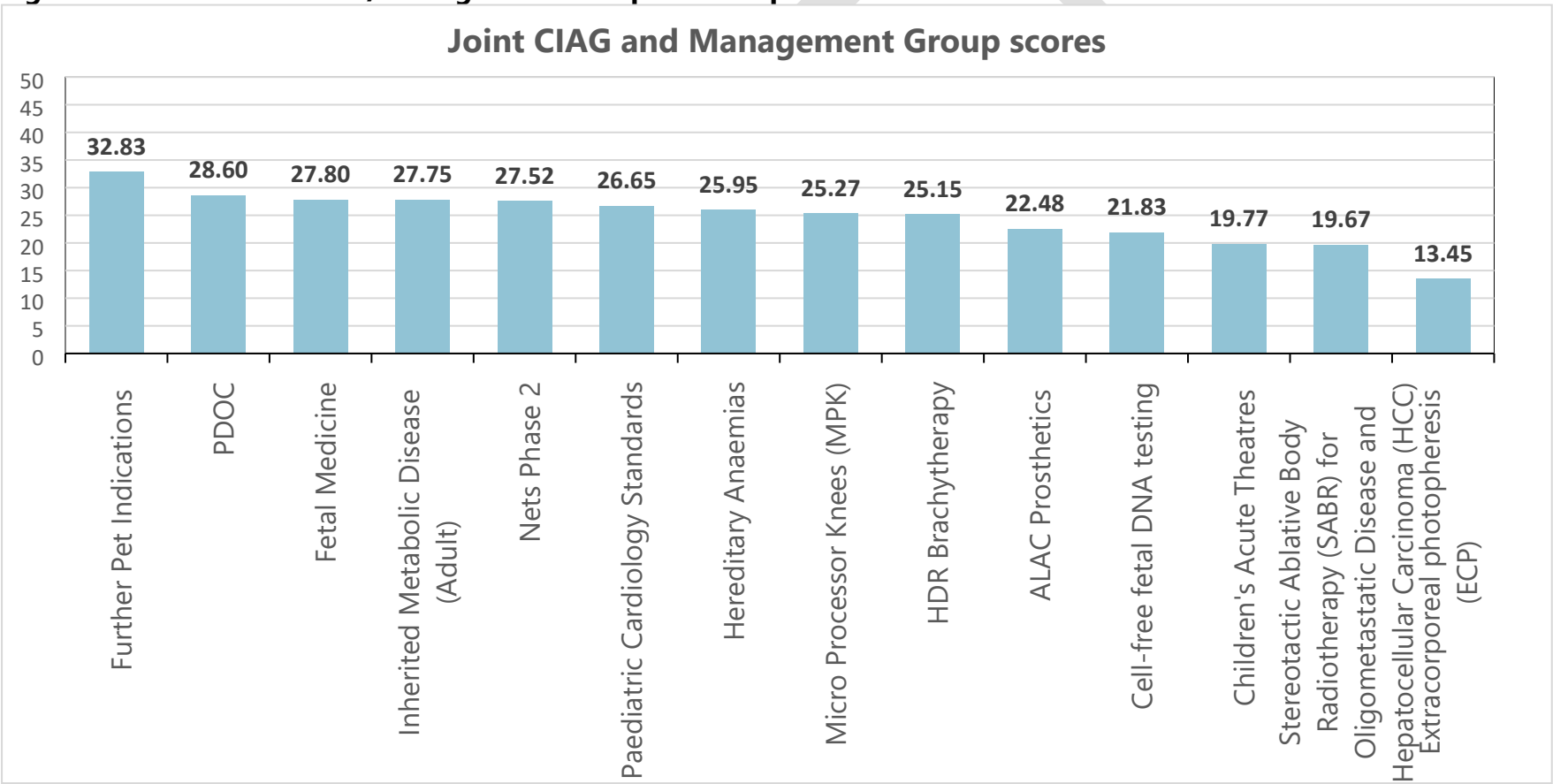
Table 3: Summary of all schemes removed from the CIAG scoring process following presentation

Scheme(s)	Reason for removal from scoring process
Expansion in red cell serology testing	Savings result from the introduction of this testing need to be understood in the overall Welsh Blood Service contract
Home Parenteral Nutrition (HPN) service for south and parts of mid Wales	Recognised that there were shortfalls in the Intestinal Failure service for south and parts of Mid Wales that were likely to require financial support in 2020-21 but a better understanding was required on the high level of growth in the service and the clear inequity in take up to commissioned service for patients in north Wales.
Paediatric Gastroenterology	Lack of clarity on the current model commissioned and the priorities of the service. Suggested inclusion in the ICP as a potential in year service risk.
Paediatric Metabolic Disease	Success of current model working with Birmingham needs to be understood as well as clarity on when the retired and returned post-holder will be fully retiring.
Sentinel Node Biopsy	To be confirmed

Results

The results of the CIAG/Management Group scoring are outlined below:

Figure 8: Results from CIAG/Management Group workshop October 2019



Value Based Commissioning

The following areas are currently being worked on using the Value Based Commissioning model:

- Referral Management and outpatient (follow up) management– as described previously in the *Improving access to specialised services* chapter.
- Introduction of the Blueteq IT systems for prescribing high cost medicines including the new CAR-T therapies. A Project Manager employed by AWMSG is due to start in March 2020.
- Medicines Management – building on the exemplary work of the Renal Network looking at initiatives that use local specialist pharmacy expertise, we have recently appointed a senior pharmacist to undertake a scoping exercise to identify efficiencies and opportunities for value based commission.
- Inherited Bleeding Disorders – blood products procurement, home delivery and clinical trials income.
- Procurement efficiencies – is a joint programme of work with NHS Wales Shared Services Partnership (NWSSP) and includes wheelchair procurement and transcutaneous aortic valves.

WHSSC will work with individual LHBs on a bi-lateral basis to review local pathways into specialised services to identify and deliver opportunities for improving value.

Prospective savings across the WHSSC contracts will be investigated during 2020-21 but are currently insufficiently certain to quantify. As identified, these savings opportunities will be presented to Management Group.

WHSSC has continued to build a comprehensive set of outcome measurement for a range of specialised services via audit programmes. WHSSC continues to actively promote outcomes monitoring by direct funding contribution to national databases for a range of specialised services to ensure providers are appropriately supported in this important function.

Examples of where WHSSC's audit approach is actively collecting and reviewing outcomes includes:

- Paediatric intensive care
- Specialised cardiac services including cardiac surgery, cardiology and transcatheter aortic valve insertion

- Renal services including home therapies, renal dialysis and renal transplantation (– this is one exemplar of what is possible in terms of outcomes measurement in practice and at large scale)
- Stem cell transplantation

Increasing the Value deliverables in 2020/21

- To strengthen the CIAG/Management Group process WHSSC is holding a meeting with participants from this year's workshop in early 2020 to discuss improvements that could be made including the provision of needs assessment data.
- In collaboration with HTW undertaking an audit of commissioning policies to ensure outcomes measurement requirements are appropriately defined.
- Improving the visibility and use of the outcomes information currently available.
- Reviewing the scope of current outcomes audit programmes to consider wider measures of outcomes beyond traditional hard clinical outcomes, including the greater use of patient reported outcomes.
- Reviewing the use of current national databases to ensure they are being used to optimum effect.
- Identifying additional specialised services to focus on developing and using outcomes measurement, paying particular attention to services where WHSSC has identified concerns regarding variation, growth and variability of standards. Examples will include immunology and intestinal failure.
- WHSSC will be developing approaches to outcomes measurement specific to the introduction and growth of new advanced therapeutic medical products so that they can be incorporated into all new approvals.

There are some areas where financial provision has not been made at this point, for example, where service plans are not yet adequately developed or there is too much uncertainty as to whether a specific risk will materialise in year. These potential in year service risks are outlined below.

Cardiac Surgery outsourcing

Long waits in breach of Welsh Government referral to treatment waiting times are being experienced in cardiology and cardiac surgery by the two welsh providers of the specialised services cardiac pathways. We know that such long waits are both clinically undesirable and cause enormous anxiety to patients with very poor patients, with very poor experience measures (PREMs). It is noted late referrals from Health Board cardiology services to Cardiac Surgery is contributing to the waiting times which needs to be addressed. Both providers of the specialised services – C&VUHB and SBUHB are shadow reporting component waiting times to better understand this and other issues including the appropriate reporting of pathway start dates.

To reduce the long waiting times for patients and mitigate the risks associated with long waits for treatment, a number of options have been explored with colleagues from SBUHB and C&VUHB to discuss options which include outsourcing. Liverpool Heart and Chest Hospital (LHCH) who provide treatment for patients from north Wales have agreed to support a number of patients from south & mid Wales but discussions will need to be held with NHS England in order to utilise this and understand what other capacity may be available to support.

Clinical Immunology

Clinical Immunology is a growth area which, given the underlying genetic nature of the disorders, is cumulative and has an ongoing recurrent investment requirement to deliver the level of service required. However, on the background of this steady growth there have been three additional growth pressures on the service. There has been growth in patient volumes, complexity and intensity of monitoring and associated expenditure over the last three years, for which the drug, blood product costs and procedures have been recurrently met. In addition, within the south and parts of Mid Wales service, we are seeing a growing demand for secondary antibody deficiency (SAD) which has now overtaken the numbers of primary antibody deficiency patients requiring immunoglobulin replacement therapy (IgRT) and thirdly the increase in paediatric and adult bone marrow transplantation for severe immunodeficiencies, with each patient requiring very detailed work-up,

transplant liaison, intense monitoring during the vulnerable post-transplant period before the new immune system is established and long term late effects monitoring.

Home Parenteral Nutrition

It was foreseen that there would be a significant increase in Home Parental Nutrition (HPN) following the tender exercise which resulted in Calea being re-awarded the welsh HPN contract from July 2018. There was a predicted increase in spend of 21% without taking account of the growth in patient numbers which are described in detail in the Intestinal Failure section below.

Intestinal Failure Services

There has been significant growth (30% since 2014) in the number of patients under the care of the intestinal Failure (IF) service based in Cardiff which serves the population of south and parts of mid Wales. This has led to it becoming the third largest IF service in the UK with 127 active home patients, behind the two largest IF centres (Salford and St Mark's Hospital) have designated 'Intestinal Failure Units' comprising 20-22 inpatient beds, approximately 250 HPN patients and operate a twice weekly HPN clinic. If growth continues at a similar rate to currently, the Welsh service will be comparable in size to Salford and St Marks.

Recent significant issues with the national Home Parental Nutrition (HPN) supplier (Calea) has highlighted and illustrated the significant clinical impact for patients without access to this service and its fragility. The risk to patients resulting from this is so high that the NHS declared a national emergency incident "at the highest level".

This has also highlighted the fragility of the service, run by one Consultant with a specialist interest and largely part time MDT members. The service is experiencing many of the issues encountered prior to the service being commissioned by WHSSC – that of delays and deteriorating patient health whilst waiting for specialist treatment in Cardiff. There have been significant delays for new HPN patients in the last 18 months from routine outpatient review, being admitted from home after an outpatient review or ward visit and in the transfer from another hospital as an acute admission for HPN assessment (this increases a patient's length of stay in their local hospital).

Discussion at the recent CIAG/Management Group workshop (described in more detail in the *Increasing Value* chapter) confirmed the need to understand

the reasons for the high levels of demand for the south and parts of mid Wales service as well as the disproportionately low uptake amongst patients in north Wales for accessing the specialist service in Salford, Manchester and HPN before investing in the service, but recognised the high risks needed to be addressed within 2020-21.

Paediatric Gastroenterology

As described in the CIAG section of the *Increasing Value* chapter, the Paediatric Gastroenterology was presented in the CIAG/Management Group workshop but not scored as it felt that further information was required to understand how the current funding of the south and parts of mid Wales service is utilised before any further commitment is made. Notwithstanding this, it is recognised that the current service is failing to meet many national standards including those from NICE and the Royal College of Paediatric and Child Health and Welsh Government RTT waiting times and has a fragile, due to small numbers, Consultant workforce.

Progress since 2019-22

The financial plan for the 2019-22 ICP represented a step change in the level of investment in specialised services recognising the importance of structural investment in key service priorities including:

- The introduction of a new class of mandated advanced therapeutic medicinal products or gene therapies together with their associated service implications.
- New services which Local Health Boards wish WHSSC to commission including the south and mid Wales Major Trauma Network and Thrombectomy.
- New Clinical Impact Advisory Group priorities.
- A re-alignment in the payment by results framework used as the basis of contracting with NHS England.

Further risks were highlighted in the 2019-22 ICP which were agreed for later agreement and implementation. These included:

- The full costs of the final agreement with NHS England for payment by results and other structural movements in the pricing framework. These changes were substantially funded by Welsh Government together with an investment by Health Boards equivalent to planned inflationary settlement levels of 2%. The net in year gap was met non-recurrently by a contribution from reserves.
- The costs of advanced recruitment to enable the planned commencement of a Major Trauma Centre (MTC) and Operational Delivery Network (ODN) in April 2020.

Financial Plan 2020-23

The financial plan for the 2020-23 ICP contains a further material increase from year to year which will incorporate the recurring financial impact of the above re-alignments together with the real terms growth in the plan.

The new real terms changes in the ICP for 2020-21 are anticipated to continue at an accelerated pace:

- WHSSC has successfully engaged with Welsh Government throughout 2019 to ensure that there is alignment between policy and funding arrangements for Advanced Therapeutic Medicinal Products (ATMPs) in

recognition of the exceptional scale of the investment required. Welsh Government has agreed to hold funding centrally for these so the costs have therefore been removed from the plan.

- The pace of launch of new high cost medicines approved via the NICE process is expected to continue to rise as the extensive pipeline of innovative new medicines reaches the market.
- The enhanced genetics service will be fully implemented which will also play an important role in service improvements arising from a better understanding of disease and treatment opportunities.
- The full scale of the cost of the business cases to deliver the new MTC and ODN had previously been incorporated into the plan but as with ATMPs, Welsh Government have agreed to provide funding for the Major Trauma centres.
- Expected continuation of higher than average growth rates in demand for specialised serviced including new services, demand growth, NICE approvals and additional CIAG priorities.
- Additional potential cost increases from further re-alignment of the English tariff system – notably, pay award full effect, pensions cost, clinical negligence (CNST) cost reform.
- Services are determining the recurrent revenue costs of providing the recurrent costs related to new high cost drugs for Cystic Fibrosis.

Risk sharing rebasing utilisation adjustment for 2020-21

- Rebasing adjustment – In line with the agreed risk sharing framework, the opening income assumption includes a rebasing utilisation adjustment. This updates the utilisation baselines based on a 2015-16 and 2016-17 two year average utilisation to the most recent available 2017-18 and 2018-19 two year average utilisation.
- Approximately 60% of the total £630m WHSSC funding of is distributed on utilisation based risk shares. An element of the volatility in health board contribution may be attributable to the framework moving forward by a clear two years with no common base year.

Underlying Position and Standard Growth

- Opening allocation – the starting point is the agreed allocation in September 2019-20 of £631.9.
- Forecast performance 2019-20 – the forecast performance for the year is an underspend of £3.9m (-0.61%).
- Re-instatement of non-recurring write-back – 2019-20 included a number of exceptional items linked to substantial uncertainty in terms of

performance and the HRG4+ settlement. The material benefit resulting in 2019-20 of £6.7 m (1.07%) is assumed to be non-recurrent.

- Adjustments to non-recurrent performance – the forecast 2019-20 out-turn position has been adjusted to account for non-recurring performance variations including slippage and exceptionality. The net impact is £2.0m (0.32%). Example issues include assumptions in respect of cardiac surgery (£0.6m) at Swansea Bay, Neonatal Care (£0.2m) and Haemophilia (£0.2m). The slippage in the Genetic Test Directory implementation (£0.8m) agreed in the 2019-20 plan has been reinstated.
- Full Year Effect of Prior Year Investments - £4.9m (0.78%) is required to fund the full year impact of agreed investments. Significant schemes are Cardiac Ablation (£0.5m), Adult Congenital Heart Disease (£0.3m) and the IBD project trials (£0.5m).
- New Service Pressures and Growth - £10.8m (1.72%) required for growth including:
    - £3.4m for growth in immunology drugs, Eculizumab drugs and cochlear implants
    - £1.5m for growth in dialysis
    - £1.0m for specialised Cardiology
    - £0.5m for Proton Beam Therapy
    - Growth assessment for High Cost Drugs of £1.2m (0.19%) is required for NICE approved drugs which must be provided by NHS Wales with an additional £1.8m (0.29%) for the Velindre Joint Commissioning group.

Value Based Healthcare work-streams – saving £2.8m (-0.44%)

At this point in the ICP process a prudent financial assessment of schemes has identified £2.8m of savings including:

- £0.6m from clinical trials income.
- Mental Health Services – a minimum of £1.0m from the continued success of case management of secure services
- Referral Management - £0.3m as described in the *Increasing Value from Funding* chapter earlier in this document
- £0.4m from further developing medicine management

Net underlying deficit, prior commitment, growth and mandated Treatments

The net financial requirement for the underlying position, including prior commitments and growth totals £18.0m (2.83%)

CIAG and Prioritisation Group Priorities

The anticipated phased cost of the approved high and medium schemes is £1.2m.

In addition, six new procedures approved by the Prioritisation panel amounting to £1.0m bringing the total cost of schemes to £2.2m (0.34%).

Strategic Priorities

Strategic priorities amount to £0.4 m (0.06%) relate to the Cystic Fibrosis New Ward infrastructure.

Investment in Thrombectomy Services across Wales amounts to £0.9m (0.15%)

NHS England Providers

£3.4m (0.54%) to cover additional costs from English Providers.

NHS Wales Financial Framework

The agreed direct financial uplift for all Welsh provider services is 2%. The net cost is £8.3m (1.31%). In line with the agreed framework the 2% has been provided for in full for all Welsh providers including Local Health Boards and Trusts.

Table 4: WHSSC 2020-21 ICP Financial Summary by Commissioner

	Aneurin Bevan UHB £m	Betsi Cadwaladr UHB £m	Cardiff & Vale UHB £m	Cwm Taf Morgannwg UHB £m	Hywel Dda UHB £m	*Powys THB £m	Swansea Bay UHB £m	2020/21 WHSSC Requirement £m
19 / 20 Income as Mth 6	**116.254**	**139.070**	**107.363**	**90.270**	**72.231**	**25.497**	**79.782**	**630.467**
Anticipated 2020/21 Allocation Funding	0.269	0.319	0.227	0.203	0.176	0.060	0.178	**1.432**
2020/21 Opening Baseline income	**116.523**	**139.389**	**107.590**	**90.473**	**72.407**	**25.557**	**79.960**	**631.899**
2 year average riskshare (2017/18 & 2018/19)	0.643	(0.663)	(0.294)	0.390	(0.739)	1.695	(1.032)	-
2020/21 Uitilisation adjusted baseline	**117.166**	**138.726**	**107.296**	**90.863**	**71.668**	**27.252**	**78.928**	**631.899**
Underlying Deficit (inc adj Baseline)	**2.402**	**(0.596)**	**1.006**	**1.281**	**(0.594)**	**1.716**	**(0.319)**	**4.896**
Underlying Deficit & Growth	**5.369**	**1.403**	**3.678**	**3.451**	**0.816**	**2.123**	**1.061**	**17.901**
CIAG & Prioritisation Schemes	0.418	0.348	0.383	0.346	0.289	0.079	0.316	2.179
Strategic Specialist Priorities	0.283	0.138	0.263	0.214	0.172	0.062	0.196	1.328
NHS England Provider 2%	0.318	2.070	0.237	0.201	0.186	0.191	0.204	3.406
NHS Wales 2% provider inflation	1.711	1.026	1.623	1.371	1.090	0.255	1.190	8.266
Total WHSSC increase 2020/21	**8.099**	**4.984**	**6.184**	**5.583**	**2.553**	**2.711**	**2.967**	**33.080**
TOTAL WHSSC 2020/21	**124.621**	**144.373**	**113.773**	**96.056**	**74.960**	**28.268**	**82.927**	**664.979**
% Total Uplift Required	**6.95%**	**3.58%**	**5.75%**	**6.17%**	**3.53%**	**10.61%**	**3.71%**	**5.24%**

*Includes growth in secondary care cancer products of £0.5m

Financial risks currently outside of the funded Plan

At the time or writing, the NHS England payment by results framework uplift has yet to be finalised. There is residual uncertainty regarding:

- Clinical Negligence – there may be a further material increase in Clinical Negligence costs associated with the revised discount rates used to assess claims.
- Pensions – for 2019/20 the 6.3% (14.38% to 20.68%) increase in pension costs was dealt with directly by NHS England on a provider basis meaning no impact was translated via the payment by results tariff. NHS England are looking at alternative options for dealing with this for 2020/21 and if the tariff option is chosen there would be a net impact for NHS Wales via tariff uplifts. Estimated risk range between +2.7% and 4.3% on a cost base of c£100m. It is understood that funding of such a change would be something for Welsh Government to consider via the allocations process and is not an inter-country funding issue.

NHS England Tariff

The financial plan includes the impact of the final agreement reached between NHS Wales and NHS England which included:

- HRG4+ - the transition to fully incorporate the £5.975m impact of 2017/18 HRG4+ implementation which included a structural re-alignment of prices with the effect of increasing the cost of some specialised services materially.
- 2019-20 tariff changes – the implementation of the further changes to the tariff set out below:

Table 5: Changes to tariff in 2019-20

19-20 Tariff Uplift	Total adjustment
PSF adjustment	2.81%
Allocated CNST	-1.07%
Cost uplift factor	3.83%
Centralised procurement	-0.36%
Efficiency factor	-1.10%
Sum of adjustments:	**4.11%**

The 3.83% cost uplift factor includes the pay award which had been previously dealt with on a direct provider basis. The impact of this tariff

uplift across the Specialised England LTAs is £2.065m with a further £3.478m required to fund the non-tariff cost uplift. This also covered the uplifts required in non-contract activity, mental health, renal and IVF contracts.

This total NHS England 19-20 uplift of £5.543m has been funded by 2% contribution from commissioners as a baseline uplift of £2.718m (partially offset with £1.493m of non-recurrent reserves) with the residual £2.825m funded by Welsh Government through a recurrent allocation.

In addition the plan at this stage includes a 2% uplift for the 2020/21 tariff inflation agreement. As indicated in the earlier section the final agreement is not yet known but is likely to include the following components:

- Core inflation – ranging from 2.6% to 3.1%
- Less an efficiency requirement – circa 1.1%
- Net inflator – ranging from 1.5% to 2%

Following concerns in previous financial years regarding the lack of consultation with NHS Wales, a new forum has been established between NHS England and NHS Wales in order that there is early warning and discussion of potential changes to the tariff system that could impact NHS Wales. Through this process there are no indications of further material changes that would create an adverse risk at this point.

Comparative position to NHS England

The uplift required by the WHSSC ICP should be considered against an appropriate comparator as it is recognised that specialised services historically experience higher growth pressure.

The latest comparator for NHS England specialised services confirms that allocations grew by over 7.5% to the start of 2019/20. Forecast levels from published allocations indicated 8.14% for 2019/20 and 6.79% for 2021/21. NHS England has published a 5 year draft budget for CCGs Specialist allocation which sets out a cumulative growth of 37% over the next 5 years:

Table 6: NHS England's Specialist Services Allocation 2019-2024

	2019/20	2020/21	2021/22	2022/23	2023/24
Indicative Allocation Growth	**8.14%**	**6.79%**	**6.95%**	**7.44%**	**7.68%**

Governance

WHSSC Joint Committee Structure

The WHSSC Joint Committee is established as a statutory Sub-Committee of each of the seven health boards. It is led by an Independent Chair, appointed by the Minister for Health and Social Services. Its membership is made up of the Chair, three Independent Members, one of whom is the Vice Chair, the Chief Executives of the seven health boards, Associate Members and a number of Officers.

Whilst the Joint Committee acts on behalf of the seven health boards in undertaking its functions, the responsibility of individual health boards for their residents remains and they are therefore accountable to citizens and other stakeholders for the provision of specialised services.

The Joint Committee is accountable for internal control. The Managing Director of Specialised and Tertiary Services Commissioning has the responsibility for maintaining a sound system of internal control that supports achievement of the Joint Committee's policies, aims and objectives and to report on the adequacy of these arrangements to the Chair of the Joint Committee and the Chief Executive of CTMUHB as WHSSC's host organisation. Under the terms of the establishment arrangements, CTMUHB as the host organisation, is deemed to be held harmless and have no additional financial liabilities beyond its own population.

The Joint Committee is supported by the Committee Secretary, who acts as the guardian of good governance within the Joint Committee.

Sub Committees

The Joint Committee has also established five joint sub-committees in the discharge of functions:

- All Wales (WHSSC) Individual Patient Funding Request Panel
- Integrated Governance Committee
- Management Group
- Quality and Patient Safety Committee
- Welsh Renal Clinical Network.

The Quality and Patient Safety Committee is chaired by an independent member, the Integrated Governance Committee is chaired by the Chair of the

Joint Committee, and the Welsh Renal Clinical Network is chaired by the former Lead Clinician for the Network, who is also an Affiliate Member of the Joint Committee.

Formal meetings of the Joint Committee are held in public and are normally held bi-monthly. The agenda and papers are available on the WHSSC website: www.whssc.wales.nhs.uk.

The **Integrated Governance Committee** provides assurance to the Joint Committee that effective governance and scrutiny arrangements are in place across WHSSC activities.

The **Management Group** is responsible for the operationalisation of the Specialised Services Strategy through the Integrated Commissioning Plan and provides a scrutiny function on behalf of the Joint Committee. The group underpins the commissioning of specialised services to ensure equitable access to safe, effective, sustainable and acceptable services for the people of Wales.

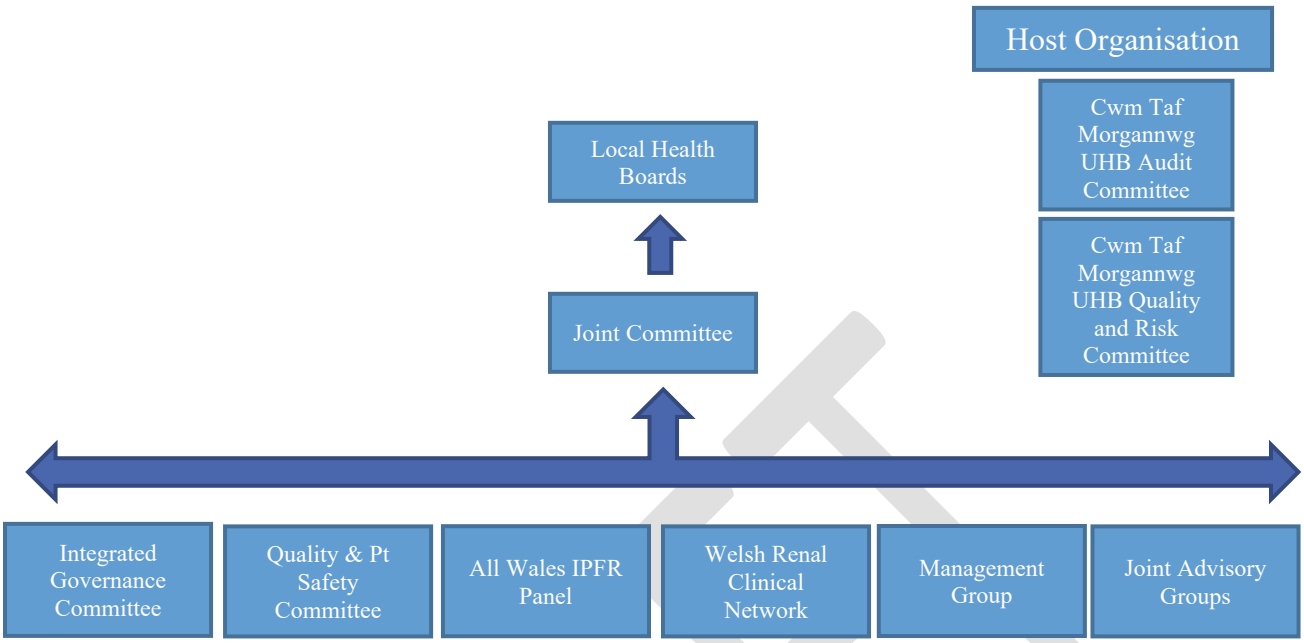
The **Quality and Patient Safety Committee** provides assurance to the Joint Committee in relation to the arrangements for safeguarding and improving the quality and safety of specialised healthcare services within the remit of the Joint Committee.

The **Welsh Clinical Renal Network** is a vehicle through which specialised renal services are planned and developed on an all Wales basis in an efficient, economical and integrated manner and provides a single decision-making framework with clear remit, responsibility and accountability.

The **Audit Committee** of CTMUHB, as the host organisation for WHSSC, advises and assures the Joint Committee on whether effective arrangements are in place – through the design and operation of the Joint Committee's assurance framework – to support the Joint Committee in its decision taking and in discharging its accountabilities for securing the achievement of its delegated functions. The WHSSC Committee Secretary and Director of Finance routinely attend for the WHSSC components of the CTMUHB Audit Committee.

The reporting arrangements for committees, boards and networks are illustrated in figure 9 below.

Figure 9 WHSSC Reporting Arrangements



Governance and Accountability Framework

The Joint Committee is due to adopt new specimen Standing Orders (issued by Welsh Government) and tailored Standing Orders in the third quarter of 2019-20.

The Joint Committee Standing Orders (Joint Committee SOs) form a schedule to each health board's own Standing Orders, and have effect as if incorporated within them. Together with the adoption of a scheme of decisions reserved to the Joint Committee; a scheme of delegations to officers and others; and Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of WHSSC.

These documents, together with a Memorandum of Agreement setting out the governance arrangements for the seven health boards and a hosting agreement between the Joint Committee and CTMUHB (as the host health board for WHSSC), form the basis upon which the Joint Committee's governance and accountability framework is developed. Together with the adoption of a Values and Standards of Behaviour framework this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

Access to advice

In addition to the advice available from our increased Medical Directorate, WHSSC accesses clinical advice for both strategic and operational purposes from a number of sources including:

- Patient representatives, organisations and third sector bodies representing the public and patients;
- Individual expert clinicians;
- Together for Health National Implementation Groups;
- National Specialist Advisory Group and Welsh Professional Advisory Committees;
- Professional bodies (e.g. Royal Colleges, standing groups, etc.);
- Clinical leads/advisors for other planning structures (e.g. networks and WHSSC commissioning teams);
- health board clinical directors; and
- All Wales Medicines Strategy Group/Welsh Medicines Partnership.

Links are also maintained with relevant bodies in England and Scotland.

Risk Management

Risk Management is embedded in the activities of WHSSC through a number of processes.

The Corporate Risk and Assurance Framework (CRAF) forms part of the WHSSC approach to the identification and management of risk. The framework is subject to continuous review by the relevant Executive leads, the Corporate Directors Group Board, the Joint Committee and the joint sub-committees.

The CRAF is informed by risks identified by the Commissioning Teams, Networks and Directorates. Each risk is allocated to an appropriate sub-committee for assurance and monitoring purposes, for example the Audit Committee or the Quality and Patient Safety Committee. The CRAF is received by the sub-committees as a standing agenda item. The Joint Committee receives the CRAF twice yearly.

A Risk Management Framework (RMF) has been embedded within the development of the ICP and is complimentary to, and utilises the same risk assessment methodology as, the CRAF.

Both the RMF and CRAF are available on request. As dynamic documents they have not been included as an annex to this Plan.

WHSSC has the following risk appetite statement that we intend to review in 2020-21:

Risk Appetite Statement

WHSSC is working towards an "open" risk appetite.

WHSSC has a **low** appetite for risk in support of obtaining assurance of commissioned service quality and is aiming to embed quality into every aspect of "business as usual".

WHSSC has **no** appetite for fraud/financial risk and has zero tolerance for regulatory breaches. WHSSC will take considered risks where the long term benefits outweigh any short term losses.
WHSSC has an appetite for performance managing services.

WHSSC has **no** appetite for any risk that prevents WHSSC demonstrating the highest standards of governance, accountability and transparency in accordance with the Citizen Centred Governance Principles.

Summary of Deliverables in 2020-23

This section provides a summary of the deliverables that we have outlined at the end of sections within the body of the ICP. When grouped together it is evident that whilst we have separated our deliverables into priority areas, there are interdependent actions. For example, the need for better establishment of outcomes featuring in the Strategic Priorities, Improving Experience and Quality of Care and Increasing the Value of Funding sections.

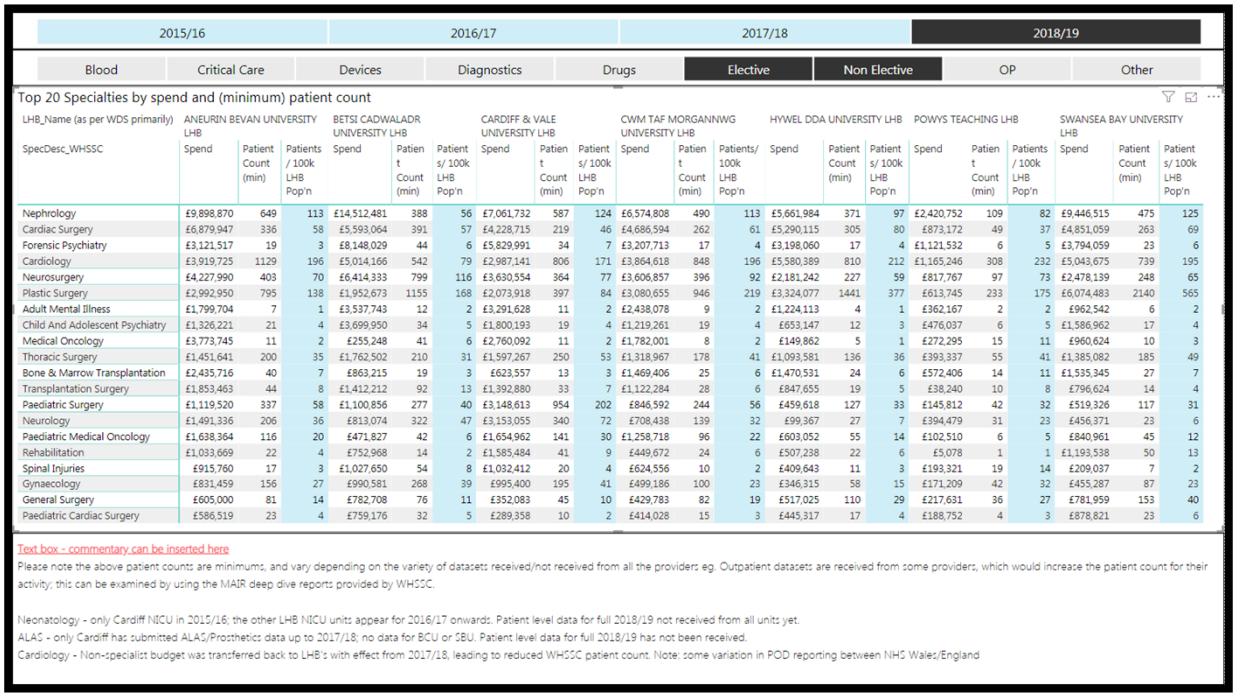
ICP Deliverables	Timelines
Strategic Priorities	
To commission any newly NICE or AWMSG approved ATMPs	Within three months of approval
To develop and implement a service specification for the commissioning of Long Term Ventilation	By March 2020
To work with C&VUHB on expanding the inpatient facilities in the Wales Adult Cystic Fibrosis centre	By March 2021
To understand the peer support requirements within the All Wales Gender service and the longer term requirements of establishing a recurrently funded service from 2021-22.	By March 2020
To work with the south and mid Wales Major Trauma Network in establishing a Major Trauma Network from April 2020	Winter 2020
To establish the outcomes of the funding invested in Neurosciences services to date and further requirements to allow Neurosciences services in Wales to provide as a minimum, comparable standards to those provided in NHS England.	By July 2020
To work with SBUHB in introducing a specialist mother & baby inpatient service for south & mid Wales	Awaiting outcome of capital discussions between WG and HBs (outside remit of WHSSC)

To understand the implications of any new indications for Proton Beam Therapy introduced in NHS England and agree an NHS Wales policy position	Awaiting final guidance from NHS England and then implementation will need to be agreed
To receive information on performance against the single cancer pathway for WHSSC commissioned services and include in performance reports to Management Group and Joint Committee	From January 2020
To develop the Interventional Neuro Radiology service in C&VUHB to allow for the local delivery of Thrombectomy to patients in south and parts of mid Wales	By March 2020
Increasing Access	
The Referral Management Project Manager will work with welsh providers on repatriating any unnecessary activity from English providers, to identify opportunities for providing follow up activity locally rather than through NHS England providers and strengthen the Gatekeeping process.	Ongoing from August 2019 Clinical Gatekeeper Engagement event 9th January 2020
To further develop the capability and use of MAIR and the underpinning Power BI platform.	Ongoing
To strengthen Public Health expertise	Ongoing discussions with Public Health Wales. Intial meeting took place Dec 2019 with further discussions on specific work arranged for January 2020.
Improving the Experience and Quality of Care	
To review the Quality Assurance Framework to address new challenges and set out further ambitions for quality in specialised services	By September 2020
To continue to monitor, identify and address variation in access and/or outcomes and patients experience.	Ongoing

To continue to undertake peer review visits to test the accuracy of the information submitted and benchmark performance against the quality indicators.	Ongoing, outcomes presented at quarterly Quality and Patient Safety meetings
To strengthen and further develop our escalation process.	By July 2020
Increasing the Value of Funding	
To strengthen the CIAG/Management Group process WHSSC is holding a meeting with participants from this year's workshop in early 2020 to discuss improvements that could be made including the provision of needs assessment data.	Meeting planned March 2020
Commence undertaking an audit of commissioning policies to ensure outcomes measurement requirements are appropriately defined, working collaboratively with Health Technology Wales on the methodology utilised for this.	By December 2020
To review the scope of current audit programmes to consider wider measures of outcomes beyond traditional hard clinical outcomes, including the greater use of patient reported outcomes.	By April 2020
To improve the visibility and use of the outcomes information currently available.	Crude mortality data will be made available in the WHSSC Power BI reports by March 2020.
To review the use of current national databases to ensure they are being used to optimum effect.	By April 2020
To identify additional specialised services to focus on developing and using outcomes measurement, paying particular attention to services where WHSSC has identified concerns regarding variation, growth and variability of standards. Examples will include immunology and intestinal failure.	From April 2020
To develop approaches to outcomes measurement specific to the introduction and growth of new advanced therapeutic medical products to incorporate into all new approvals.	Outcome measurements data is currently being collected across

	NHS England. Awaiting AWMSG appointment of Project Manager in early 2020 to drive implementation of Blueteq system which will collect this data.

Appendix 2: Activity/Access rates across Wales – 2018/19 (activity badged as Elective/NonElective inpatient activity)



2015/16 | 2016/17 | 2017/18 | 2018/19

Blood | Critical Care | Devices | Diagnostics | Drugs | Elective | Non Elective | OP | Other

Top 20 Specialties by spend and (minimum) patient count

LHB_Name (as per WDS primarily)	ANEURIN BEVAN UNIVERSITY LHB			BETSI CADWALADR UNIVERSITY LHB			CARDIFF & VALE UNIVERSITY LHB			CWM TAF MORGANNWG UNIVERSITY LHB			HYWEL DDA UNIVERSITY LHB			POWYS TEACHING LHB			SWANSEA BAY UNIVERSITY LHB		
SpecDesc_WHSSC	Spend	Patient Count (min)	Patients / 100k LHB Pop'n	Spend	Patient Count (min)	Patients/ 100k LHB Pop'n	Spend	Patient Count (min)	Patients/ 100k LHB Pop'n	Spend	Patient Count (min)	Patients/ 100k LHB Pop'n	Spend	Patient Count (min)	Patients/ 100k LHB Pop'n	Spend	Patient Count (min)	Patients / 100k LHB Pop'n	Spend	Patient Count (min)	Patients/ 100k LHB Pop'n
Nephrology	£9,898,870	649	113	£14,512,481	388	56	£7,061,732	587	124	£6,574,808	490	113	£5,661,984	371	97	£2,420,752	109	82	£9,446,515	475	125
Cardiac Surgery	£6,879,947	336	58	£5,593,064	391	57	£4,228,715	219	46	£4,686,594	262	61	£5,290,115	305	80	£873,172	49	37	£4,851,059	263	69
Forensic Psychiatry	£3,121,517	19	3	£8,148,029	44	6	£5,829,991	34	7	£3,207,713	17	4	£3,198,060	17	4	£1,121,532	6	5	£3,794,059	23	6
Cardiology	£3,919,725	1129	196	£5,014,166	542	79	£2,987,141	806	171	£3,864,618	848	196	£5,580,389	810	212	£1,165,246	308	232	£5,043,675	739	195
Neurosurgery	£4,227,990	403	70	£6,414,333	799	116	£3,630,554	364	77	£3,606,857	396	92	£2,181,242	227	59	£817,767	97	73	£2,478,139	248	65
Plastic Surgery	£2,992,950	795	138	£1,952,673	1155	168	£2,073,918	397	84	£3,080,655	946	219	£3,324,077	1441	377	£613,745	233	175	£6,074,483	2140	565
Adult Mental Illness	£1,799,704	7	1	£3,537,743	12	2	£3,291,628	11	2	£2,438,078	9	2	£1,224,113	4	1	£362,167	2	2	£962,542	6	2
Child And Adolescent Psychiatry	£1,326,221	21	4	£3,699,950	34	5	£1,800,193	19	4	£1,219,261	19	4	£653,147	12	3	£476,037	6	5	£1,586,962	17	4
Medical Oncology	£3,773,745	11	2	£255,248	41	6	£2,760,092	11	2	£1,782,001	8	2	£149,862	5	1	£272,295	15	11	£960,624	10	3
Thoracic Surgery	£1,451,641	200	35	£1,762,502	210	31	£1,597,267	250	53	£1,318,967	178	41	£1,093,581	136	36	£393,337	55	41	£1,385,082	185	49
Bone & Marrow Transplantation	£2,435,716	40	7	£863,215	19	3	£623,557	13	3	£1,469,406	25	6	£1,470,531	24	6	£572,406	14	11	£1,535,345	27	7
Transplantation Surgery	£1,853,463	44	8	£1,412,212	92	13	£1,392,880	33	7	£1,122,284	28	6	£847,655	19	5	£38,240	10	8	£796,624	14	4
Paediatric Surgery	£1,119,520	337	58	£1,100,856	277	40	£3,148,613	954	202	£846,592	244	56	£459,618	127	33	£145,812	42	32	£519,326	117	31
Neurology	£1,491,336	206	36	£813,074	322	47	£3,153,055	340	72	£708,438	139	32	£99,367	27	7	£394,479	31	23	£456,371	23	6
Paediatric Medical Oncology	£1,638,364	116	20	£471,827	42	6	£1,654,962	141	30	£1,258,718	96	22	£603,052	55	14	£102,510	6	5	£840,961	45	12
Rehabilitation	£1,033,669	22	4	£752,968	14	2	£1,585,484	41	9	£449,672	24	6	£507,238	22	6	£5,078	1	1	£1,193,538	50	13
Spinal Injuries	£915,760	17	3	£1,027,650	54	8	£1,032,412	20	4	£624,556	10	2	£409,643	11	3	£193,321	19	14	£209,037	7	2
Gynaecology	£831,459	156	27	£990,581	268	39	£995,400	195	41	£499,186	100	23	£346,315	58	15	£171,209	42	32	£455,287	87	23
General Surgery	£605,000	81	14	£782,708	76	11	£352,083	45	10	£429,783	82	19	£517,025	110	29	£217,631	36	27	£781,959	153	40
Paediatric Cardiac Surgery	£586,519	23	4	£759,176	32	5	£289,358	10	2	£414,028	15	3	£445,317	17	4	£188,752	4	3	£878,821	23	6

Text box - commentary can be inserted here

Please note the above patient counts are minimums, and vary depending on the variety of datasets received/not received from all the providers eg. Outpatient datasets are received from some providers, which would increase the patient count for their activity; this can be examined by using the MAIR deep dive reports provided by WHSSC.

Neonatology - only Cardiff NICU in 2015/16; the other LHB NICU units appear for 2016/17 onwards. Patient level data for full 2018/19 not received from all units yet.
ALAS - only Cardiff has submitted ALAS/Prosthetics data up to 2017/18; no data for BCU or SBU. Patient level data for full 2018/19 has not been received.
Cardiology - Non-specialist budget was transferred back to LHB's with effect from 2017/18, leading to reduced WHSSC patient count. Note: some variation in POD reporting between NHS Wales/England

Please note that the patient counts are minimums, as not all areas have patient level backing submissions (eg. Welsh Blood Service, Velindre NHS Trust), and relate to Elective/NonElective badged activity, as per the summary above. Some variation across the years for patient count will include:

- Neonatology – patient level for 2018/19 has not yet been received from CTMUHB, SBUHB or BCUHB as providers, so these patient counts are not reflected.
- ALAS – Wheelchair and prosthetics patient data has been received from Cardiff up to 2017/18 (not for 2018/19 yet); no data received from SBUHB or BCUHB.
- Cardiology – note there is some variation in POD reporting between NHS Wales/England. If ALL activity is reflected, the patients/100k population increases, but with a narrower range with BCUHB within that.

The following charts are specific to each Health Board.

Aneurin Bevan Health Board

Trend by Provider

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Providers by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
ProviderName	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
CARDIFF & VALE UNIVERSITY LHB	£32,545,747	3119	£32,157,991	2857	£32,743,984	2877	£35,903,131	2959
SWANSEA BAY UNIVERSITY LHB	£6,806,357	1141	£7,084,551	1229	£7,117,250	1238	£6,745,135	1172
VELINDRE NHS TRUST	£3,870,370	34	£2,032,474	23	£1,670,510	2	£3,720,733	3
ANEURIN BEVAN UNIVERSITY LHB	£2,494,172	2	£2,602,956	2	£2,478,415	1	£1,384,809	476
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	£1,083,015	175	£1,375,352	182	£1,577,530	196	£1,684,430	197
MERSEY CARE NHS FOUNDATION TRUST	£894,039	3	£838,126	3	£622,555	3	£665,950	2
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	£650,297	2	£718,000	2	£746,303	4	£839,000	2
CWM TAF MORGANNWG UNIVERSITY LHB	£583,223	14	£446,094	8	£785,657	13	£700,348	17
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	£724,687	65	£472,465	47	£490,781	66	£568,840	70
REGIS HEALTHCARE LTD	£496,800	4	£706,400	3	£292,800	3		
ST ANDREWS HEALTHCARE	£457,576	5	£300,708	2	£148,900	2	£534,771	3
OXFORD HEALTH NHS FOUNDATION TRUST	£274,835	6	£371,016	8	£349,408	6	£281,818	6
NORTH BRISTOL NHS TRUST	£222,509	28	£404,378	42	£270,459	36	£314,616	32
PRIORY LTD (Llanarth Court Site)	£223,930	2	£178,850	1	£317,030	3	£302,994	3
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	£173,438	34	£373,935	39	£292,976	35	£116,387	34
PRIORY LTD (Kneesworth House Site)	£323,540	2	£179,622	1	£183,230	1	£188,573	1
ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	£135,176	29	£211,371	26	£244,672	32	£268,067	30
ELLERN MEDE EATING DISORDER CENTRE			£172,605	1	£410,371	1	£156,000	1
CYGNET HEALTH LTD	£227,071	2	£181,770	1	£184,325	1	£121,514	2
ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	£151,264	24	£106,138	22	£229,890	26	£198,539	23
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	£113,287	33	£102,732	32	£228,353	29	£228,325	36
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	£281,041	29	£109,263	22	£193,690	21	£45,594	17
CHESWOLD PARK HOSPITAL			£162,260	1	£371,409	1		
ELYSIUM LTD (Chadwick Lodge Site)			£76,297	1	£177,379	1	£271,041	3
FLORIDA PROTON INSTITUTE	£98,454	2	£203,375	3	£105,886	1	£110,000	1
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	£120,803	33	£86,357	29	£91,283	28	£102,893	32
PRIORY LTD (Calverton Hill Site)			£235,355	2	£122,055	1		
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	£74,000	1	£65,000	1	£51,500	1	£142,000	1
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	£60,278	11	£97,746	11	£79,085	27	£91,044	22
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	£64,754	1					£235,312	2

By Specialty

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Specialties by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
SpecDesc_WHSSC	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
Nephrology	£8,425,443	595	£8,629,706	609	£9,315,007	627	£9,898,870	649
Cardiac Surgery	£7,757,850	401	£7,236,926	339	£6,754,550	323	£6,879,947	336
Cardiology	£4,963,904	908	£4,271,393	557	£4,882,431	614	£3,919,725	1129
Neurosurgery	£3,519,002	395	£3,893,734	376	£4,427,135	416	£4,227,990	403
Forensic Psychiatry	£3,833,937	26	£3,868,680	22	£3,643,579	22	£3,121,517	19
Plastic Surgery	£2,532,245	801	£3,073,539	870	£3,121,806	784	£2,992,950	795
Medical Oncology	£3,811,809	9	£1,955,745	10	£1,725,483	12	£3,773,745	11
Bone & Marrow Transplantation	£1,896,837	40	£1,615,414	36	£1,929,655	41	£2,435,716	40
Transplantation Surgery	£1,690,807	30	£1,732,562	29	£1,133,809	17	£1,853,463	44
Child And Adolescent Psychiatry	£2,011,031	19	£1,459,582	12	£1,588,331	17	£1,326,221	21
Adult Mental Illness	£1,609,090	6	£1,556,126	5	£1,296,121	5	£1,799,704	7
Neurology	£1,751,402	225	£1,589,913	265	£1,424,754	237	£1,491,336	206
Paediatric Medical Oncology	£1,759,718	81	£1,020,440	72	£1,277,966	95	£1,638,364	116
Thoracic Surgery	£1,073,789	184	£1,318,416	204	£1,296,929	195	£1,451,641	200
Paediatric Surgery	£1,144,205	344	£1,074,681	347	£1,160,282	327	£1,119,520	337
Rehabilitation	£496,855	1	£968,788	1	£812,341	24	£1,033,669	22
Gynaecology	£553,944	146	£668,837	160	£683,264	164	£831,459	156
Paediatric Cardiology	£462,026	52	£719,759	81	£653,773	62	£616,701	75
Paediatric Cardiac Surgery	£392,180	20	£644,823	30	£689,327	28	£586,519	23
General Surgery	£505,651	61	£523,227	60	£582,372	73	£605,000	81
Spinal Injuries	£353,054	13	£462,910	14	£388,569	14	£915,760	17
Paediatric Neurology	£428,483	64	£487,400	60	£502,470	51	£528,778	44
Paediatric Neurosurgery	£515,435	50	£415,306	39	£273,169	30	£355,903	38
Cardiothoracic Transplantation	£539,245	17	£394,017	13	£353,856	13	£260,578	11
Eating Disorders	£274,835	6	£371,016	8	£349,408	6	£281,818	6
Paediatric Plastic Surgery	£290,840	125	£252,747	119	£399,993	166	£270,014	115
Hepatobiliary & Pancreatic Surgery	£248,871	32	£268,539	37	£336,202	35	£254,645	33
Paediatric Cleft Work	£148,548	18	£186,997	23	£320,291	34	£292,455	29
Paediatric Burns Care	£239,019	23	£227,154	24	£266,322	60	£185,270	36
Paediatric Nephrology	£154,989	22	£264,509	28	£226,757	18	£188,506	17

By Provider

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Providers by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
ProviderName	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
BETSI CADWALADR UNIVERSITY LHB	£23,418,773	303	£23,048,532	389	£23,376,399	409	£24,428,718	416
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	£7,779,159	1231	£7,167,114	1148	£9,139,618	1095	£9,085,948	1070
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	£6,492,623	1233	£6,013,548	1240	£7,111,908	1507	£8,146,891	1362
THE WALTON CENTRE NHS FOUNDATION TRUST	£5,347,306	1155	£6,101,484	1170	£6,945,127	1227	£7,785,392	1135
MERSEY CARE NHS FOUNDATION TRUST	£2,472,042	10	£2,959,873	13	£3,736,400	14	£3,726,815	13
ST HELENS AND KNOWSLEY HOSPITAL SERVICES NHS TRUST	£1,913,034	1065	£1,890,927	1155	£2,030,493	1126	£2,260,049	1327
THE CHRISTIE NHS FOUNDATION TRUST	£1,335,126	123	£1,938,583	133	£1,856,644	128	£1,977,702	149
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	£1,307,520	201	£1,084,057	239	£1,538,546	228	£1,812,889	243
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	£1,267,424	69	£1,290,815	74	£891,616	57	£1,389,228	85
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	£1,098,500	49	£956,411	56	£634,440	49	£1,027,650	54
ELYSIUM LTD (Arbury Court Site)	£531,480	3	£568,045	6	£940,905	5	£972,872	7
ST ANDREWS HEALTHCARE	£1,006,112	7	£823,214	5	£494,145	3	£494,445	4
SWANSEA BAY UNIVERSITY LHB	£528,295	39	£834,466	53	£765,150	47	£632,973	30
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	£385,251	115	£528,917	119	£602,251	143	£596,429	144
PRIORY LTD (Llanarth Court Site)	£526,227	3	£728,794	4	£447,091	4	£178,850	1
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	£525,070	122	£370,887	102	£345,596	98	£323,358	84
CARDIFF & VALE UNIVERSITY LHB	£275,399	14	£398,948	16	£407,128	30	£425,762	77
SALFORD ROYAL NHS FOUNDATION TRUST	£397,884	109	£286,529	145	£244,131	122	£478,445	88
REGIS HEALTHCARE LTD	£241,600	2	£297,600	2	£562,800	4	£194,400	2
UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	£531,683	31	£470,044	29	£253,999	14	£37,290	1
THE HUNTERCOMBE GROUP	£747,636	5	£162,218	4	£279,853	2		
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	£230,571	57	£358,712	72	£298,665	66	£291,358	77
PRIORY LTD (Kneesworth House Site)	£188,490	1	£323,755	2	£372,177	2	£250,695	2
CYGNET HEALTH LTD	£42,462	2	£417,961	4	£266,503	7	£382,739	6
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	£312,549	21	£267,114	17	£270,998	17	£225,179	16
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	£221,693	5	£368,932	8	£287,034	6	£97,240	1
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	£220,482	88	£270,382	82	£216,806	81	£212,784	87
PRIORY LTD (Stockton Hall Site)	£265,420	2	£187,975	1	£187,975	1	£180,765	1
PRIORY LTD (Cheadle Royal Site)	£121,075	4	£182,209	6	£250,727	3	£181,940	2
ELYSIUM LTD (The Spinney Site)	£178,850	2	£178,850	1	£178,850	1	£178,850	1

By Specialty

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Specialties by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
SpecDesc_WHSSC	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
Nephrology	£13,445,268	292	£13,874,628	372	£14,279,108	387	£14,512,481	388
Forensic Psychiatry	£8,038,214	46	£9,454,190	46	£8,439,308	51	£8,148,029	44
Neurosurgery	£4,496,138	763	£4,987,212	783	£5,838,659	829	£6,414,333	799
Cardiac Surgery	£4,546,271	441	£4,556,730	474	£5,616,089	421	£5,593,064	391
Cardiology	£5,280,475	630	£4,267,543	552	£4,848,206	539	£5,014,166	542
Child And Adolescent Psychiatry	£5,419,047	49	£4,166,779	49	£4,260,317	35	£3,699,950	34
Adult Mental Illness	£2,472,042	11	£2,795,788	14	£3,547,328	13	£3,537,743	12
Plastic Surgery	£1,741,645	998	£1,740,691	1072	£1,744,139	1008	£1,952,673	1155
Neurology	£2,007,958	466	£1,908,463	425	£1,620,849	433	£813,074	322
Thoracic Surgery	£1,266,698	216	£1,176,006	196	£1,779,005	202	£1,762,502	210
Transplantation Surgery	£1,151,837	70	£1,260,958	73	£1,275,494	54	£1,412,212	92
Paediatric Surgery	£965,637	294	£863,868	323	£1,535,547	420	£1,100,856	277
Gynaecology	£995,641	262	£947,255	246	£968,514	257	£990,581	268
Paediatric Nephrology	£332,847	32	£389,148	30	£1,403,030	31	£1,402,039	36
Bone & Marrow Transplantation	£498,660	9	£1,007,457	19	£1,029,637	22	£863,215	19
Paediatric Medical Oncology	£901,769	56	£941,435	54	£575,226	61	£471,827	42
Clinical Haematology	£847,222	50	£680,660	50	£515,676	48	£615,252	54
General Surgery	£539,752	59	£590,024	73	£646,676	87	£782,708	76
Paediatric Neurosurgery	£454,395	60	£572,693	52	£717,468	63	£709,503	63
Paediatric Cardiac Surgery	£418,736	25	£482,767	30	£679,496	37	£759,176	32
Cardiothoracic Transplantation	£499,198	3	£490,028	4	£494,552	5	£453,264	4
Paediatric Urology	£408,589	142	£439,724	135	£444,287	205	£461,512	153
Rehabilitation	£167,600	8	£439,199	10	£368,906	10	£752,968	14
Paediatric Clinical Haematology	£397,966	16	£219,001	29	£430,248	58	£477,681	50
Clinical Oncology	£78,900	19	£605,903	21	£453,394	21	£219,529	27
Paediatric Trauma And Orthopaedics	£285,203	70	£357,688	70	£249,160	58	£417,026	74
Paediatric Ear Nose And Throat	£161,769	91	£371,600	87	£236,508	108	£414,271	103
Spinal Injuries			£133,984	1	£16,548	1	£1,027,650	54
Paediatric Gastroenterology	£271,041	93	£226,889	87	£242,981	112	£368,758	100
Paediatric Plastic Surgery	£206,812	129	£250,292	153	£330,099	161	£305,868	165

Cardiff & Vale UHB

By Provider

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Providers by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
ProviderName	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
CARDIFF & VALE UNIVERSITY LHB	£37,157,084	5052	£31,651,133	4000	£34,719,361	4149	£34,540,913	4314
SWANSEA BAY UNIVERSITY LHB	£6,939,726	778	£6,986,711	787	£6,930,342	847	£7,670,766	766
MERSEY CARE NHS FOUNDATION TRUST	£2,561,608	9	£2,514,378	10	£2,716,979	10	£2,841,689	9
VELINDRE NHS TRUST	£2,880,373	26	£1,541,020	21	£1,218,979	2	£2,712,919	2
CWM TAF MORGANNWG UNIVERSITY LHB	£1,567,243	15	£1,259,028	31	£1,287,080	33	£1,190,130	17
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	£846,687	81	£981,994	89	£1,182,533	70	£832,507	70
PRIORY LTD (Llanarth Court Site)	£1,146,848	8	£913,678	7	£752,643	6	£464,615	4
ST ANDREWS HEALTHCARE	£1,003,003	7	£501,057	4	£801,667	5	£904,187	6
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	£412,511	39	£645,892	27	£262,856	28	£230,764	38
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	£393,554	2	£359,000	1	£336,783	1	£419,500	1
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	£241,266	30	£377,951	37	£279,511	31	£284,482	33
OXFORD HEALTH NHS FOUNDATION TRUST	£275,851	6	£307,224	5	£149,681	6	£288,518	5
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	£292,481	59	£231,456	56	£277,920	46	£148,554	49
ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	£239,389	18	£100,061	25	£211,430	25	£171,999	20
NORTH BRISTOL NHS TRUST	£175,857	18	£109,956	11	£81,502	10	£154,167	16
ELYSIUM LTD (Thornford Park Site)	£74,636	1			£59,288	1	£330,179	3
PRIORY LTD (Bristol Site)	£205,508	3	£180,748	2			£65,680	3
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	£88,114	29	£109,863	28	£114,529	28	£118,502	35
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	£92,795	21	£92,362	21	£129,013	17	£92,471	15
CHESWOLD PARK HOSPITAL							£406,583	1
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	£38,945	1	£149,220	1	£182,074	1	£30,439	1
FLORIDA PROTON INSTITUTE	£38,770	1	£100,611	1	£158,883	2	£86,593	1
PRIORY LTD (The Dene Site)	£41,200	1	£187,975	1	£114,330	1		
PRIORY LTD (Calverton Hill Site)	£59,740	2	£187,975	1	£60,255	1		
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	£123,676	14	£38,398	12	£76,051	11	£65,358	13
NORTHUMBERLAND, TYNE AND WEAR NHS FOUNDATION TRUST							£296,712	1
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	£116,136	3	£57,101	1			£120,420	2
DIVING DISEASES RESEARCH CENTRE	£60,099	9	£77,963	6	£98,024	8	£14,252	4
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	£250,000	1						
PRIORY LTD (LDS/St Johns Site)	£193,980	1	£32,330	1				

By Specialty

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Specialties by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
SpecDesc_WHSSC	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
Nephrology	£5,778,185	525	£5,976,554	491	£6,877,362	570	£7,061,732	587
Forensic Psychiatry	£5,890,336	40	£5,296,778	34	£4,933,158	33	£5,829,991	34
Cardiac Surgery	£4,677,267	259	£3,945,867	201	£4,296,649	205	£4,228,715	219
Cardiology	£7,672,734	1937	£2,983,817	874	£3,213,528	826	£2,987,141	806
Neurosurgery	£3,714,992	399	£3,278,487	323	£3,747,630	346	£3,630,554	364
Adult Mental Illness	£2,955,162	11	£3,022,598	12	£3,235,836	12	£3,291,628	11
Paediatric Surgery	£2,395,935	869	£2,792,863	884	£3,028,875	894	£3,148,613	954
Neurology	£2,157,203	332	£2,830,009	333	£3,116,632	314	£3,153,055	340
Medical Oncology	£2,850,479	7	£1,402,739	6	£1,271,997	10	£2,760,092	11
Rehabilitation	£2,505,170	2	£1,721,630	2	£1,672,432	35	£1,585,484	41
Plastic Surgery	£1,598,457	382	£1,416,490	343	£1,629,486	380	£2,073,918	397
Paediatric Medical Oncology	£1,871,648	87	£1,515,895	86	£1,617,887	108	£1,654,962	141
Child And Adolescent Psychiatry	£1,813,527	15	£1,263,092	31	£1,597,502	35	£1,800,193	19
Transplantation Surgery	£1,333,146	25	£1,540,938	27	£1,640,738	27	£1,392,880	33
Thoracic Surgery	£1,017,828	190	£1,224,105	199	£1,511,365	231	£1,597,267	250
Paediatric Neurology	£1,296,932	153	£991,557	113	£915,569	112	£1,047,524	105
Gynaecology	£780,444	185	£962,570	227	£1,024,166	237	£995,400	195
Bone & Marrow Transplantation	£1,115,674	25	£1,149,706	27	£789,831	15	£623,557	13
Spinal Injuries	£756,493	20	£737,993	14	£860,932	26	£1,032,412	20
Paediatric Ear Nose And Throat	£742,995	450	£792,070	534	£788,732	556	£854,076	584
Paediatric Cardiology	£659,909	70	£637,767	73	£736,175	67	£797,166	86
Paediatric Nephrology	£660,455	71	£459,401	41	£543,110	45	£603,520	44
Paediatric Cardiac Surgery	£406,288	25	£466,532	26	£757,167	27	£289,358	10
Eating Disorders	£661,384	12	£535,142	7	£149,681	6	£354,198	8
General Surgery	£416,083	53	£552,610	65	£344,509	40	£352,083	45
Paediatric Gastroenterology	£469,711	100	£302,549	92	£292,491	65	£285,268	79
Paediatric Neurosurgery	£349,707	38	£416,004	38	£258,480	28	£323,941	31
Cardiothoracic Transplantation	£431,821	13	£504,808	15	£235,516	11	£155,230	10
Paediatric Burns Care	£280,388	32	£197,658	21	£254,894	56	£209,734	26
Hepatobiliary & Pancreatic Surgery	£202,884	26	£288,850	39	£177,814	21	£187,767	23

Cwm Taf Morgannwg UHB

By Provider

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Providers by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
ProviderName	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
CARDIFF & VALE UNIVERSITY LHB	£24,183,927	2309	£22,656,863	2130	£22,848,618	2165	£22,596,582	2247
SWANSEA BAY UNIVERSITY LHB	£10,370,425	1672	£10,952,933	1749	£11,067,341	1698	£11,661,620	1807
MERSEY CARE NHS FOUNDATION TRUST	£1,731,895	6	£1,676,252	6	£1,852,823	7	£2,423,874	8
VELINDRE NHS TRUST	£1,934,283	38	£1,008,223	18	£788,138	2	£1,754,071	2
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	£753,094	78	£656,232	83	£1,395,494	84	£965,938	87
CWM TAF MORGANNWG UNIVERSITY LHB	£660,016	17	£432,702	17	£732,439	20	£1,118,461	18
ST ANDREWS HEALTHCARE	£989,034	9	£776,351	6	£485,598	5	£274,864	3
PRIORY LTD (Llanarth Court Site)	£440,613	4	£470,030	4	£293,425	4	£80,495	2
BETSI CADWALADR UNIVERSITY LHB	£292,144	6	£277,089	4	£300,471	4	£270,010	7
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	£381,536	34	£362,059	32	£143,051	27	£184,932	36
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	£164,220	20	£187,100	16	£184,884	21	£53,935	16
ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	£177,523	23	£92,236	24	£170,657	26	£128,191	15
PRIORY LTD (Bristol Site)	£188,176	1	£56,329	1	£165,892	1	£141,751	1
OXFORD HEALTH NHS FOUNDATION TRUST	£229,622	3	£69,916	3	£116,924	1	£132,325	3
ELYSIUM LTD (Thornford Park Site)	£174,082	1	£155,996	1	£33,046	1	£177,379	1
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	£69,952	16	£99,747	26	£158,614	25	£162,214	17
NORTH BRISTOL NHS TRUST	£171,608	8	£93,027	5	£155,781	14	£13,274	6
ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	£54,887	12	£111,045	9	£118,097	10	£132,613	11
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	£89,866	14	£111,686	15	£117,694	15	£58,906	9
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	£77,782	20	£117,760	15	£94,995	10	£73,014	18
CYGNET HEALTH LTD					£93,074	1	£248,694	2
FLORIDA PROTON INSTITUTE	£98,275	1			£241,409	2		
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	£83,188	18	£97,815	23	£68,200	19	£63,275	20
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	£93,216	12	£59,027	14	£73,565	20	£54,147	16
REGIS HEALTHCARE LTD	£75,200	1	£4,800	1	£48,800	3	£100,800	2
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	£34,179	8	£56,226	7	£73,865	8	£43,984	14
ELYSIUM LTD (Chadwick Lodge Site)					£110,854	1	£89,398	1
DIVING DISEASES RESEARCH CENTRE	£75,271	9	£45,207	6	£1,335	1	£53,199	4
PRIORY LTD (LDS/St Johns Site)	£136,740	1						
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST			£63,137	1	£36,244	1	£35,558	1

By Specialty

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Specialties by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
SpecDesc_WHSSC	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
Nephrology	£6,146,304	435	£6,290,104	458	£6,497,753	460	£6,574,808	490
Cardiac Surgery	£4,980,314	269	£5,592,907	277	£5,045,463	255	£4,686,594	262
Cardiology	£5,557,760	889	£2,849,122	711	£3,247,425	720	£3,864,618	848
Forensic Psychiatry	£4,591,617	31	£4,041,408	22	£3,512,506	24	£3,207,713	17
Neurosurgery	£3,487,448	396	£3,360,416	331	£3,787,131	385	£3,606,857	396
Plastic Surgery	£2,560,216	851	£3,049,234	887	£2,472,560	890	£3,080,655	946
Adult Mental Illness	£1,746,142	7	£1,690,428	7	£1,852,823	7	£2,438,078	9
Medical Oncology	£1,884,108	6	£897,623	5	£815,471	9	£1,782,001	8
Bone & Marrow Transplantation	£691,965	19	£923,529	20	£2,127,438	35	£1,469,406	25
Thoracic Surgery	£1,155,003	210	£1,195,262	189	£1,377,548	185	£1,318,967	178
Paediatric Medical Oncology	£1,099,642	59	£1,117,600	58	£1,061,534	67	£1,258,718	96
Transplantation Surgery	£919,074	18	£945,723	20	£787,339	15	£1,122,284	28
Spinal Injuries	£1,072,741	21	£1,094,374	17	£611,499	12	£624,556	10
Child And Adolescent Psychiatry	£735,216	17	£468,572	19	£961,546	23	£1,219,261	19
Neurology	£949,361	194	£692,872	181	£840,307	163	£708,438	139
Paediatric Surgery	£679,922	208	£805,637	231	£836,905	219	£846,592	244
Rehabilitation	£368,506	56	£805,653	55	£754,570	25	£449,672	24
Paediatric Cardiology	£447,288	47	£561,671	58	£459,335	49	£453,364	52
Paediatric Cardiac Surgery	£388,283	24	£259,257	16	£847,249	32	£414,028	15
Gynaecology	£399,386	98	£396,823	103	£500,623	129	£499,186	100
Paediatric Plastic Surgery	£459,213	197	£520,088	227	£436,365	188	£363,462	159
General Surgery	£350,094	47	£490,259	61	£387,717	54	£429,783	82
Paediatric Neurology	£400,314	58	£342,275	41	£493,021	54	£292,428	36
Paediatric Neurosurgery	£385,456	41	£301,684	33	£228,818	24	£380,975	28
Eating Disorders	£466,845	5	£126,245	4	£282,816	2	£274,076	4
Cardiothoracic Transplantation	£366,211	12	£331,246	10	£129,000	9	£193,923	13
Paediatric Nephrology	£234,606	15	£241,882	26	£187,293	12	£256,792	22
Paediatric Burns Care	£260,817	24	£241,412	24	£230,409	25	£187,539	22
Hepatobiliary & Pancreatic Surgery	£259,898	36	£198,068	28	£181,505	23	£264,501	33
Paediatric Cleft Work	£191,162	20	£220,192	24	£186,859	17	£242,835	26

Hywel Dda HB

By Provider

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Providers by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
ProviderName	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
SWANSEA BAY UNIVERSITY LHB	£20,994,981	3149	£22,208,807	3105	£23,656,564	3180	£23,090,966	3233
CARDIFF & VALE UNIVERSITY LHB	£6,020,019	576	£6,476,816	538	£7,268,551	514	£7,058,399	538
MERSEY CARE NHS FOUNDATION TRUST	£1,192,052	4	£900,124	4	£396,621	2	£804,613	3
CWM TAF MORGANNWG UNIVERSITY LHB	£830,641	24	£612,970	15	£901,544	22	£562,702	11
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	£455,447	59	£894,329	73	£774,205	64	£746,103	64
HYWEL DDA UNIVERSITY LHB	£957,285	2	£501,308	1	£540,151	1	£548,860	1
ST ANDREWS HEALTHCARE	£631,171	6	£509,943	5	£519,480	3	£528,440	4
NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST	£325,149	1	£359,000	1	£336,783	1	£419,500	1
SOUTH WEST LONDON AND ST GEORGE'S MENTAL HEALTH NHS TRUST	£313,350	1	£420,690	2	£278,481	2	£147,867	1
REGIS HEALTHCARE LTD	£460,000	3	£491,200	4	£69,600	1		
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	£260,018	39	£140,692	32	£240,871	29	£172,252	37
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	£195,474	18	£118,181	19	£169,084	19	£159,627	20
PRIORY LTD (Calverton Hill Site)	£54,060	1	£193,450	1	£193,450	1	£193,450	1
FLORIDA PROTON INSTITUTE	£90,312	1	£274,311	2	£73,941	1	£186,919	2
VELINDRE NHS TRUST	£231,458	19	£202,682	19	£43,764	2	£123,223	2
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	£81,634	27	£153,473	28	£102,036	24	£141,557	26
ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	£144,406	16	£81,395	15	£116,949	16	£135,598	19
PRIORY LTD (Llanarth Court Site)					£58,832	1	£334,752	2
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	£48,585	24	£84,597	24	£180,215	27	£69,348	13
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	£98,838	25	£91,532	21	£90,139	29	£85,398	23
ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	£121,659	7	£69,433	7	£78,183	7	£68,621	7
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	£91,971	22	£40,798	17	£104,530	15	£66,483	17
OXFORD HEALTH NHS FOUNDATION TRUST	£63,502	1	£75,020	2	£126,023	2	£33,081	2
GREATER MANCHESTER MENTAL HEALTH NHS FOUNDATION TRUST	£209,364	1					£77,123	1
NORTH BRISTOL NHS TRUST	£27,802	6	£117,784	12	£87,689	9	£26,495	9
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	£250,000	1						
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST			£55,371	1	£167,452	3		
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	£90,500	6	£43,265	2	£63,240	3	£510	1
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	£26,172	8	£38,440	11	£75,548	9	£33,491	10
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	£18,320	8	£76,308	11	£17,343	5	£52,451	18

By Specialty

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Specialties by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
SpecDesc_WHSSC	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
Nephrology	£5,239,642	365	£4,967,354	335	£5,552,602	351	£5,661,984	371
Cardiac Surgery	£5,159,519	307	£5,519,225	299	£4,918,776	286	£5,290,115	305
Cardiology	£4,739,460	725	£4,744,587	734	£5,247,989	761	£5,580,389	810
Plastic Surgery	£3,286,774	1358	£3,458,855	1379	£3,743,656	1408	£3,324,077	1441
Forensic Psychiatry	£2,065,530	16	£2,969,934	16	£3,152,928	16	£3,198,060	17
Neurosurgery	£1,752,899	204	£2,190,639	228	£1,981,835	203	£2,181,242	227
Adult Mental Illness	£1,726,564	6	£1,342,645	6	£746,717	4	£1,224,113	4
Bone & Marrow Transplantation	£1,257,697	27	£1,163,007	24	£1,074,572	26	£1,470,531	24
Child And Adolescent Psychiatry	£1,719,862	27	£1,107,457	17	£972,028	23	£653,147	12
Thoracic Surgery	£638,855	130	£924,469	135	£1,123,156	154	£1,093,581	136
Transplantation Surgery	£1,010,698	22	£767,317	12	£1,130,438	18	£847,655	19
Paediatric Medical Oncology	£339,773	32	£709,242	39	£887,489	49	£603,052	55
Rehabilitation	£506,728	62	£483,599	64	£691,624	39	£507,238	22
Paediatric Surgery	£596,293	173	£510,679	159	£423,614	131	£459,618	127
General Surgery	£479,035	66	£404,645	56	£451,740	62	£517,025	110
Paediatric Cardiac Surgery	£186,024	11	£383,510	19	£625,233	20	£445,317	17
Spinal Injuries	£119,352	6	£340,612	8	£666,452	11	£409,643	11
Gynaecology	£400,697	93	£303,120	69	£393,856	71	£346,315	58
Paediatric Plastic Surgery	£405,013	191	£344,508	163	£337,327	161	£355,115	162
Eating Disorders	£376,851	2	£412,189	3	£391,191	3	£180,948	3
Paediatric Cardiology	£183,078	28	£306,131	43	£334,363	38	£198,519	25
Neurology	£333,702	29	£142,482	25	£171,690	27	£99,367	27
Clinical Oncology	£4,396	8	£371,533	6	£54,135	3	£270,157	8
Medical Oncology	£236,865	5	£110,244	10	£177,956	8	£149,862	5
Hepatobiliary & Pancreatic Surgery	£224,527	28	£192,674	23	£120,881	14	£109,830	12
Paediatric Burns Care	£167,773	24	£170,776	12	£126,196	30	£165,207	18
Cardiothoracic Transplantation	£218,883	8	£90,172	9	£229,816	8	£73,226	10
Trauma and Orthopaedics	£166,517	29	£109,398	25	£189,889	26	£137,648	24
Paediatric Neurology	£87,998	11	£148,991	12	£188,962	19	£160,652	13
Paediatric Neurosurgery	£187,960	22	£76,156	9	£194,628	20	£86,780	8

Powys THB

By Provider

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Providers by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
ProviderName	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
CARDIFF & VALE UNIVERSITY LHB	£2,291,359	212	£1,703,499	159	£1,794,153	194	£2,377,953	206
SWANSEA BAY UNIVERSITY LHB	£1,852,068	293	£1,580,369	312	£1,963,512	295	£2,171,441	300
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	£1,554,984	198	£1,713,708	253	£1,794,896	231	£2,182,196	249
UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	£1,262,972	213	£1,107,987	209	£1,250,606	219	£1,143,777	205
BETSI CADWALADR UNIVERSITY LHB	£1,179,674	31	£989,346	28	£1,390,791	35	£1,040,684	29
MERSEY CARE NHS FOUNDATION TRUST	£503,202	2	£558,751	2	£601,941	2	£362,167	2
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	£470,599	84	£250,936	66	£336,362	66	£226,997	54
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	£252,906	42	£246,948	35	£262,586	45	£309,283	48
ST ANDREWS HEALTHCARE	£175,314	1	£174,835	1	£73,942	2	£389,871	2
PRIORY LTD (Llanarth Court Site)	£358,904	2	£316,086	2	£125,440	1		
PRIORY LTD (Stockton Hall Site)	£179,340	1	£178,850	1	£178,850	1	£178,850	1
CWM TAF MORGANNWG UNIVERSITY LHB	£314,476	5	£258,649	6	£121,713	4	£9,007	1
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	£123,500	35	£218,739	38	£147,986	27	£176,967	27
VELINDRE NHS TRUST	£237,465	7	£123,820	4	£85,183	2	£196,850	2
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	£105,500	12	£126,232	13	£161,160	12	£126,480	17
HEART OF ENGLAND NHS FOUNDATION TRUST	£154,998	28	£95,039	21	£149,167	21	£115,308	19
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	£76,944	13	£75,117	17	£115,543	12	£214,116	8
WYE VALLEY NHS TRUST	£95,163	80	£108,510	102	£78,862	97	£100,475	114
THE WALTON CENTRE NHS FOUNDATION TRUST	£29,717	10	£60,336	12	£242,016	19	£36,309	13
NORTH BRISTOL NHS TRUST	£46,102	5	£167,104	6	£84,236	4	£44,214	4
REGIS HEALTHCARE LTD					£95,200	2	£164,800	1
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	£232,750	1	£6,418	2	£4,473	2	£1,256	2
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	£36,224	15	£96,885	23	£42,680	9	£61,826	12
TEES, ESK AND WEAR VALLEYS NHS FOUNDATION TRUST			£75,109	1	£155,998	1		
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	£67,125	13	£80,976	8	£24,705	9	£30,244	12
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	£21,382	9	£80,995	13	£18,722	7	£56,294	10
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	£58,196	6	£39,880	4	£35,188	3	£40,027	5
POWYS TEACHING LHB			£6,604	1	£158,410	1		
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	£18,074	3	£10,640	2	£73,419	7	£51,510	4
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	£36,030	6	£32,571	6	£24,887	8	£40,150	7

By Specialty

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Specialties by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
SpecDesc_WHSSC	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
Nephrology	£2,397,699	102	£2,264,420	117	£2,386,867	109	£2,420,752	109
Cardiology	£1,246,230	242	£846,379	255	£885,523	250	£1,165,246	308
Forensic Psychiatry	£1,068,992	8	£813,847	5	£947,845	7	£1,121,532	6
Cardiac Surgery	£980,474	109	£844,611	55	£1,026,930	66	£873,172	49
Neurosurgery	£579,944	77	£933,288	99	£807,167	96	£817,767	97
Plastic Surgery	£575,843	223	£669,701	279	£648,810	253	£613,745	233
Adult Mental Illness	£503,202	2	£558,751	2	£601,941	2	£362,167	2
Child And Adolescent Psychiatry	£314,476	5	£341,505	7	£746,437	11	£476,037	6
Neurology	£477,781	36	£426,181	37	£480,216	42	£394,479	31
Thoracic Surgery	£455,854	78	£333,749	65	£426,180	63	£393,337	55
Cardiothoracic Surgery	£230,971	25	£259,585	31	£327,451	27	£306,917	29
Bone & Marrow Transplantation	£191,780	6	£103,969	3	£166,366	5	£572,406	14
Medical Oncology	£233,752	9	£137,777	10	£133,952	14	£272,295	15
General Surgery	£199,576	29	£129,685	23	£226,497	41	£217,631	36
Trauma and Orthopaedics	£132,387	30	£190,764	28	£190,534	25	£190,405	37
Transplantation Surgery	£377,140	10	£122,665	8	£110,699	6	£38,240	10
Gynaecology	£129,715	38	£91,440	24	£132,998	34	£171,209	42
Paediatric Surgery	£137,814	50	£102,967	36	£135,748	46	£145,812	42
Hepatobiliary & Pancreatic Surgery	£125,992	20	£127,625	17	£146,798	23	£106,771	17
Paediatric Medical Oncology	£129,153	8	£85,504	7	£97,408	8	£102,510	6
Paediatric Neurosurgery	£130,902	18	£62,257	12	£84,363	10	£122,002	9
Paediatric Cardiac Surgery	£73,511	4	£18,249	1	£69,338	2	£188,752	4
Urology	£79,720	17	£87,776	17	£45,399	11	£77,515	15
Spinal Surgery Service	£79,137	4	£58,776	6	£83,320	8	£65,939	6
Spinal Injuries	£58,166	3	£28,384	1			£193,321	19
Paediatric Plastic Surgery	£56,850	25	£66,919	39	£78,441	37	£59,597	29
Paediatric Ear Nose And Throat	£48,775	28	£33,266	23	£128,320	40	£42,827	29
Rehabilitation	£36,621	5	£69,738	6	£134,610	3	£5,078	1
Gastroenterology	£65,905	17	£77,766	21	£65,610	18	£30,348	17
Eating Disorders	£56,390	1			£122,464	2	£56,942	1

Swansea Bay UHB

By Provider

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Providers by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
ProviderName	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
SWANSEA BAY UNIVERSITY LHB	£31,293,529	4146	£31,324,197	4210	£32,444,630	4178	£32,091,887	4214
CARDIFF & VALE UNIVERSITY LHB	£7,190,316	543	£7,993,244	534	£7,777,860	499	£8,321,065	565
MERSEY CARE NHS FOUNDATION TRUST	£1,244,163	5	£1,260,659	6	£941,798	5	£696,966	3
CWM TAF MORGANNWG UNIVERSITY LHB	£789,964	19	£883,101	18	£701,146	17	£858,959	13
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	£655,199	79	£563,602	54	£722,096	76	£1,173,438	69
VELINDRE NHS TRUST	£1,057,164	20	£539,239	13	£399,136	2	£913,370	2
ST ANDREWS HEALTHCARE	£688,800	5	£814,149	5	£811,060	6	£286,979	4
PRIORY LTD (Llanarth Court Site)	£542,073	4	£357,700	2	£129,360	2	£188,795	2
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	£115,199	34	£139,781	39	£247,552	34	£267,250	37
REGIS HEALTHCARE LTD	£140,800	1	£196,000	3	£264,800	1	£153,945	1
PRIORY LTD (LDS/St Johns Site)	£203,860	2	£187,975	1	£187,975	1	£74,160	1
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	£162,154	21	£72,994	18	£240,107	28	£130,061	20
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	£250,000	1					£250,000	1
BIRMINGHAM AND SOLIHULL MENTAL HEALTH NHS FOUNDATION TRUST	£15,283	1					£475,636	3
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	£124,773	32	£161,881	35	£106,647	24	£93,162	25
ROYAL BROMPTON & HAREFIELD NHS FOUNDATION TRUST	£135,835	16	£136,499	22	£156,802	18	£50,719	14
UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	£122,654	34	£125,087	31	£84,238	23	£121,843	23
PRIORY LTD (Kneesworth House Site)	£79,870	1	£178,850	1	£169,050	1		
OXFORD HEALTH NHS FOUNDATION TRUST			£73,999	1	£162,420	4	£190,531	4
PRIORY LTD (Calverton Hill Site)			£168,405	1	£168,405	1		
ROYAL PAPWORTH HOSPITAL NHS FOUNDATION TRUST	£80,834	8	£70,090	9	£96,144	7	£85,218	7
CYGNET HEALTH LTD	£149,388	1					£175,740	1
FLORIDA PROTON INSTITUTE	£47,747	1	£57,211	1	£111,730	2	£69,998	1
MID ESSEX HOSPITAL SERVICES NHS TRUST	£196	2	£261,096	1				
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	£96,919	8	£27,176	5	£24,253	14	£101,324	11
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	£37,252	13	£60,914	13	£106,406	10	£36,501	8
NORTH BRISTOL NHS TRUST	£71,023	5	£44,528	7	£67,309	6	£54,872	7
CALDERSTONES PARTNERSHIP NHS FOUNDATION TRUST	£189,082	1						
ELYSIUM LTD (Potters Bar Site)							£169,178	1
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	£8,303	3	£36,568	5	£71,939	8	£50,393	3

By Specialty

Blood | Critical Care | Devices | Diagnostics | Drugs | **Elective** | **Non Elective** | OP | Other

Top 30 Specialties by spend and (minimum) patient count

Fyear	2015/16		2016/17		2017/18		2018/19	
SpecDesc_WHSSC	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)	Spend	Patient Count (minimum)
Nephrology	£10,683,998	465	£11,039,239	478	£10,877,905	507	£9,446,515	475
Plastic Surgery	£5,469,825	1939	£5,446,172	2046	£5,645,207	1945	£6,074,483	2140
Cardiac Surgery	£5,144,805	299	£5,269,837	296	£5,206,174	302	£4,851,059	263
Cardiology	£4,590,529	713	£4,748,389	723	£4,937,513	714	£5,043,675	739
Forensic Psychiatry	£4,415,590	26	£4,455,306	24	£4,332,980	28	£3,794,059	23
Neurosurgery	£2,271,248	257	£2,383,474	239	£1,969,950	212	£2,478,139	248
Thoracic Surgery	£993,478	182	£1,147,580	174	£1,531,261	201	£1,385,082	185
Bone & Marrow Transplantation	£1,052,775	27	£1,441,430	30	£976,155	20	£1,535,345	27
Child And Adolescent Psychiatry	£979,484	20	£1,083,556	19	£967,144	18	£1,586,962	17
Adult Mental Illness	£1,273,693	7	£1,085,753	6	£931,944	5	£962,542	6
Transplantation Surgery	£1,047,701	18	£1,023,076	14	£1,197,358	18	£796,624	14
Rehabilitation	£800,042	139	£772,566	141	£847,774	94	£1,193,538	50
Medical Oncology	£954,208	8	£559,891	10	£460,139	9	£960,624	10
Paediatric Medical Oncology	£906,286	39	£613,574	42	£548,065	42	£840,961	45
Paediatric Plastic Surgery	£718,138	315	£708,942	316	£738,792	321	£715,329	294
General Surgery	£576,580	83	£552,196	81	£503,072	60	£781,959	153
Gynaecology	£507,963	106	£505,558	97	£633,071	119	£455,287	87
Paediatric Surgery	£340,072	116	£388,027	120	£423,125	118	£519,326	117
Paediatric Cardiac Surgery	£274,710	13	£172,848	11	£339,488	14	£878,821	23
Paediatric Cardiology	£371,991	40	£382,378	45	£447,642	41	£368,570	38
Neurology	£227,807	32	£468,465	34	£399,648	22	£456,371	23
Spinal Injuries	£442,032	14	£325,894	9	£569,797	15	£209,037	7
Paediatric Cleft Work	£321,087	40	£258,313	30	£143,213	14	£187,021	19
Paediatric Neurosurgery	£233,003	18	£191,200	15	£270,697	19	£185,579	15
Paediatric Burns Care	£174,668	29	£139,934	20	£192,195	60	£142,748	19
Hepatobiliary & Pancreatic Surgery	£124,064	19	£150,218	18	£119,220	14	£222,053	25
Paediatric Neurology	£110,422	10	£103,041	6	£180,157	17	£129,255	12
Eating Disorders	£21,196	1	£73,999	1	£162,420	4	£190,531	4
Paediatric Nephrology	£120,298	9	£56,851	6	£106,650	8	£134,270	6
Perinatal Psychiatry	£67,065	2			£14,749	1	£326,071	7

Appendix 2

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)

Welsh Health Specialised Services Committee (WHSSC)

WHSCC Prioritisation Process for the 2020/23 Integrated Commissioning Plan (ICP)

An Overview

Appendix 2

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Appendix 2

1. Introduction

NHS Wales and WHSSC must ensure that investment decisions are:

- affordable and offer value for money
- supported by convincing evidence of safety and effectiveness, and
- made using a process that is consistent and transparent.

To achieve this WHSSC has developed a process that enables it to compare competing proposals for new investment so that these can be prioritised and subsequently implemented.

Health care decision making requires balancing the demand of new technologies and services against finite resources. This inevitably leads to commissioners of health care making choices between many attractive alternatives and saying no to some things that are worthy and desirable.

Innovation within healthcare provides a stream of new treatments and interventions. Within the field of specialised services these often represent treatments of high cost for low patient numbers.

This process adopts the principles of Prudent Healthcare[1] and supports implementation of the Future Generations Act in Wales[2]. The process sets out to reduce inappropriate variation using evidence based practices consistently and transparently with the public, patients and professionals as equal partners through co-production.

Identifying topics for prioritisation

The dual processes of horizon scanning and prioritisation can help ensure the NHS in Wales effectively commissions' clinical and cost effective services, and makes new treatments available in a timely manner. Horizon scanning identifies new interventions which may be suitable for funding, and prioritisation allows them to be ranked according to a set of pre-determined criteria, including their clinical and cost effectiveness. This information when combined with information around demands from existing services and interventions will underpin and feed into the development of the WHSSC Integrated Commissioning Plan (ICP).

A comprehensive overview of the entire WHSSC prioritisation process algorithm for 2019/20 is presented in Figure 1 (see page 12).

[1] Prudent Healthcare: https://gov.wales/topics/health/nhswales/about/prudent-healthcare/?lang=en
[2] Well-being of Future Generations (Wales) Act (2015): https://futuregenerations.wales/

Appendix 2

Purpose

This document describes the methodology that WHSSC uses in order to determine the relative prioritisation of new interventions within specialised services for 2020/21. This methodology has been adapted from the model used by WHSSC over the last two years and incorporates several elements from other published prioritisation processes, particularly those used by NHS England[3], the National Specialised Services Committee in Scotland[4] and the system favoured in Canada[5].

[3] NHS England, Commissioning Operations, Specialised Commissioning (April 2016) Developing a method to assist investment decisions in specialised commissioning: next steps. https://www.england.nhs.uk/commissioning/spec-services/key-docs/
[4] National Specialist Services Committee, NHS Scotland (2015) Annual Prioritisation Round 2015-2018. http://www.nsd.scot.nhs.uk/services/specserv/
[5] CADTH. https://www.cadth.ca/

2. Horizon scanning and prioritisation of interventions by WHSSC for funding in 2020/21

2.1 Horizon Scanning

The use of horizon scanning is now firmly embedded in WHSSC's commissioning practice and has been applied successfully for the past three years.

Horizon scanning identifies and monitors new and emerging health technologies that are likely to have a significant impact on the delivery of healthcare. Horizon scanning aims to support planning and priority setting and to assist in the prioritisation and allocation of resources. It has enabled WHSSC to provide reliable estimates of future expenditure in order to inform development of the ICP.

Information sources

Horizon scanning can vary in its extent and complexity dependent upon the time and resource available and requires a systematic examination of all relevant information sources.

Since 2016, WHSSC has developed a much more robust and systematic horizon scanning function and arrangements are now in place with the All Wales Medicines Strategy Group (AWMSG) and Health Technology Wales (HTW) to identify future medical and non-medical technologies. Both organisations draw on the following existing published resources and this is supplemented by a close examination of other published sources of information (Table 1):

- NICE Health Tech Connect
- UK Pharma Scan
- Specialist Pharmacy Service (SPS)
- NIHRIO Technology Briefings
- Euro Scan

A horizon scanning exercise was carried out by the Medical Directorate at WHSSC between January and June 2019 to inform this process. A finalised record is available on request.

The horizon scanning process generated three lists.

i. Interventions where there is currently an obligation to fund (NICE TA/HST guidance and AWMSG guidance). Interventions for obligatory funding will require an impact assessment, policy development and Equality Impact Assessment (EIA) before progressing directly into ICP development. All of these have been excluded from the prioritisation process.

ii. All NICE TA/HST guidance and AWMSG appraisals which have been turned down. All of these have been excluded from the prioritisation process.

iii. New interventions that need to be considered through a process of prioritisation. These will be the interventions considered by the Panel.

Appendix 2

Table 1: List of information sources for horizon scanning

Organisation	Information source
• NICE Highly Specialised Technologies (HST) Guidance Work Programme. Positive assessments are currently obligatory to fund in Wales	https://www.nice.org.uk/guidance/indevelopment?type=hst
• NICE Technology Appraisal (TA) Guidance Work Programme. Positive assessments are obligatory to fund in Wales	https://www.nice.org.uk/guidance/published?type=ta
• Other NICE guidance. There are a range of different types of guidance produced by NICE which are not mandatory. Of these the Interventional Procedures Guidance (IPG) and Medical Technologies Guidance are the area's most likely to impact on specialised services	https://www.nice.org.uk/guidance/published?type=ip and https://www.nice.org.uk/guidance/published?type=mtg
• All Wales Medicine Strategy Group (AWMSG) Evidence Appraisal Work Programme: Positive assessments are obligatory to fund in Wales (subject to Cabinet Secretary approval)	http://www.awmsg.org/
• Health Technology Wales (HTW)	http://www.healthtechnology.wales/
• Interim Pathways Commissioning Group (IPCG). This group considers an unlicensed medicine or one outside of the normal treatment pathway identified via the 'One Wales' process.	https://www.awttc.org/pams/one-wales-interim-commissioning-process
• NHS England Commissioning through Evaluation (CtE) scheme	https://www.england.nhs.uk/commissioning/spec-services/npc-crg/comm-eval/
• WHSSC Commissioning Teams	Lead Planners and Associate Medical Directors, WHSSC
• Individual Patient Funding Requests (IPFR): The IPFR process often provides early indications of clinical demand for new treatments	Patient Care Team, WHSSC
• Provider Health Boards and Trusts: WHSSC formally approaches providers on an annual basis to identify new interventions for development	Health Boards and Trusts
• NHS England (NHSE) propositions. Many specialised services are delivered in England for the population of Wales and new service developments within England can stimulate demand from within Wales	NHSE Clinical Reference Groups (CRGs), Clinical Priorities Advisory Group (CPAG), Rare Diseases Advisory Group (RDAG)
• Scottish Medicines Consortium	https://www.scottishmedicines.org.uk/Home
• Northern Ireland and Social Care Board	http://www.hscboard.hscni.net/
• Clinicians with a special interest in a clinical condition may lobby for commissioning of emergent therapies	Individual clinicians
• Welsh Government strategic priorities.	Welsh Government

2.2 Prioritisation

The scoring and ranking of interventions by the WHSSC Prioritisation Panel is carried out using methodology described in the All Wales Prioritisation Framework (2011) (see Attachment 3 and All Wales Prioritisation Framework). The framework presents a fair and transparent process to ensure that evidence-based healthcare gain and value for money is maximised.

The following key principles have been applied:

- That the process is specific for Wales and therefore reflects the needs and priorities of our population.
- The process reflects current Welsh Government (WG) policy and in particular the principles of Prudent Health Care[6].
- That in line with the principles of Prudent Health Care[6] we do not (wherever possible) duplicate work already completed within the other UK nations around evidence evaluation and prioritisation.
- That where the process identifies interventions where the evidence for clinical or cost effectiveness is very weak or there are safety concerns, no routine commissioning should be recommended.
- The need to ensure appropriate and timely engagement and consultation with colleagues in NHS Wales during the entire prioritisation process.

All voting members of the Panel will be asked to score each intervention against a set of pre-determined criteria in order to develop recommendations on their relative priority. These criteria are described further in Section 6. Each intervention presented to the Panel will be supported by a comprehensive evidence review.

Group decision support systems (GDSS) (provided by the Swansea Centre for Health Economics[7]) are integrated into the process to facilitate decision-making, gain consensus and improve the use of time in the meeting. This method employs a voting system and a set of wireless handsets to enable parallel, simultaneous and anonymous individual input. Voting in this way allows final recommendations to be made in a collegial atmosphere, without conflict or disagreement.

Based on the combined mean scores you will be asked to split the list of topics to be discussed into 'high', 'medium' and 'low' for prioritisation within the ICP. Only those with a high priority will be included for consideration within the ICP.

[6] https://gov.wales/topics/health/nhswales/about/prudent-healthcare/?lang=en
[7] Swansea Centre for Health Economics

Appendix 2

Topics assessed to date

The WHSSC Prioritisation Panel is now well established and provides a robust and evidence based process for assessing new interventions. Since the WHSSC prioritisation process was revised in 2016 a total of 43 new propositions have been assessed by the Panel.

The results/recommendations are as follows:

- High priority for inclusion in the ICP (n=12)
- Medium priority for inclusion in the ICP (n=9)
- Low priority for inclusion in the ICP (n=11)
- Removed from the prioritisation process (n=11), for example subsequent NICE/AWMSG appraisal, already commissioned or recommended via IPFR.

Although the low and medium priority topics were not considered they were highlighted to the Commissioning Teams with many schemes featuring on the WHSSC Risk Management Framework (RMF). This framework sets out the risks of low and medium priority/unfunded schemes across the three domains of patient, provider and commissioner. The RMF aids in informing the schemes to be considered for inclusion in the ICP and also manages the risks for those schemes not funded.

Static list

Historically the high priority propositions have been forwarded for consideration within the WHSSC ICP whilst propositions ranked medium and low have remained unfunded and have not been reassessed for inclusion in a future ICP.

In 2019/20 WHSSC introduced an additional step in the prioritisation process with the creation of a 'static list' for low and medium priority topics. Topics on the static list may be transferred back to the active list for further appraisal if new evidence becomes available that is likely to have a material effect on their priority. However all topics on the static list will be routinely reviewed every three years. Topics assigned to the static list will be classified as 'not for routine commissioning' but can continue to be requested via IPFR.

The following was agreed:

- High priority topics – these will continue to be prioritised for consideration within the ICP by the WHSSC Management Group (MG) and Clinical Impact Assessment Group (CIAG).
- Low priority topics – these will go straight to the 'static list'.
- Medium priority topics – these will be considered by the Prioritisation Panel for a second time the following year. If the topic

is scored medium or low priority it will be immediately transferred to the 'static list'.

Therefore in addition to new topics identified this year via horizon scanning, you will also be asked to consider and score the medium priority topics from last years' prioritisation panel meeting.

Wherever possible an evidence update has been carried out for those topics scored as 'medium' and these will be presented to you during the Panel meetings.

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3. List of interventions to be prioritised (2020/21)

3.1 New interventions

The horizon scanning process has identified **11** new interventions for consideration (Attachment 4). These were presented and discussed at the first Panel meeting on the 17th September 2019.

3.2 Medium priority topics from the static list

A total of **4** medium priority topics currently sit on the WHSSC static list for review this year (Attachment 4). These were presented and discussed at the second Panel meeting on the 19th September 2019.

3.3 Evidence evaluations

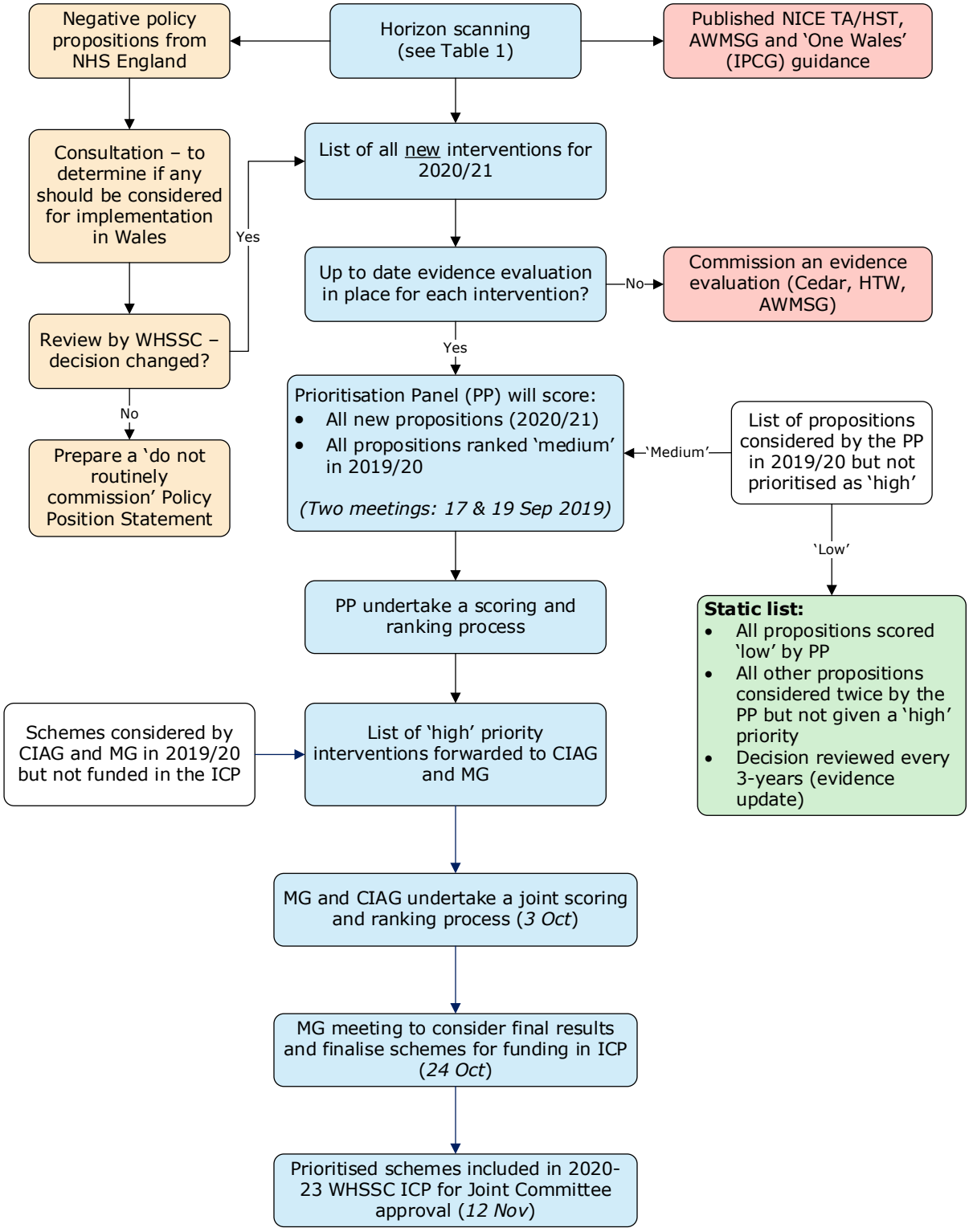
Each intervention/proposition presented to the Panel was supported by an evidence review. A presentation on how the evidence was retrieved and appraised was provided at the first Panel meeting.

The evidence review for each draft policy proposition was either carried out by colleagues at NHS England or by the team at Cedar (Cardiff University) or AWMSG.

For all the English policy propositions the Panel were presented with a copy of the Commissioning Policy document which contains a summary of the evidence. This should be sufficient information for you to score the clinical effectiveness of the intervention. However the full evidence reviews (including the evidence tables) are available on request from WHSSC.

Appendix 2

Figure 1. The WHSSC Prioritisation Process algorithm for 2020/21



4. Scoring

Each intervention was scored from 1 - 10 against all of the criteria described below. A high score indicates consistency with each of the criteria.

4.1 Criteria for prioritisation

The proposed criteria that will be used in prioritisation are:

- Quality and strength of the evidence of clinical effectiveness
- Patient benefit (clinical impact)
- Economic assessment
- Burden of disease – nature (severity) of the condition
- Burden of disease – population impact
- Potential for improving/reducing inequalities of access.

As a result of feedback received following last years' prioritisation process the criterion 'Burden of disease' has been split into two elements - nature (severity) of the condition and population impact – and these will be scored separately. In addition a summary table is now included with suggested 'weights' applied to each criterion (Table 2)

The review of priorities takes into account how the different criteria work together, including the balance of:

- clinical benefits and clinical risks
- the timing of the application with the urgency of the clinical need, what clinical alternatives are available, and the need to strengthen the evidence for clinical benefits
- cost per patient or treatment, clinical benefits per patient, and the robustness of the evidence for clinical benefits (clinical and cost-effectiveness of the treatment)
- overall cost impact and overall benefits from national commissioning (overall value for money of a national commissioning approach)

4.2 Equality and human rights

Although the criteria of 'equality and human rights' will not be explicitly scored in the prioritisation process, members are asked instead to carefully consider and be mindful of the impact of the *protected characteristics* within each of the proposals being presented.

WHSSC and NHS Wales must demonstrate that it understands the potential effect of adoption of clinical commissioning policies on people with characteristics that have been given protection under the Equality Act (2010)[8], especially in relation to their health outcomes. We must also

[8] Equality Act 2010 | Equality and Human Rights Commission

consider both the Social Services and Well-being (Wales) Act (2014)[9] when considering the well-being for people who need care and support (and carers who need support) and the Human Rights Act (1998)[10].

Therefore WHSSC should have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the act.
- Advance equality of opportunity between people who share a protected characteristic and for those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

These are often referred to as the three aims of the general equality duty and apply to the following protected characteristics:

- Age
- Disability
- Sex (gender)
- Gender reassignment
- Pregnancy and maternity
- Race
- Belief (or non-belief)
- Sexual orientation
- Marriage and civil partnership

[9] http://www.legislation.gov.uk/anaw/2014/4/pdfs/anaw_20140004_en.pdf
[10] The Human Rights Act | Equality and Human Rights Commission

5. Output from the Prioritisation Panel

Once the Prioritisation Panel has considered all the interventions (both new and those included from the static list) and assigned each a mean score, these will be tabulated and presented back to the Panel at their second meeting. Although members will be permitted to discuss the final results, a re-vote on any intervention or a change to the order of the results will be at the discretion of the Chair.

Members will then be asked to split the final prioritised list into 'high', 'medium', 'low' and 'no routine commissioning' based on their overall % score. These data when combined with information around demands from existing services and interventions will underpin and feed into the development of the WHSSC Integrated Commissioning Plan (ICP) for 2020-23 (see figure 1).

5.1 Recommended for 'no routine commissioning'

For any intervention where the Panel considers the evidence base to be too weak (or uncertain) (and therefore there should be no routine commissioning), a negative policy proposition will be taken out to public consultation and an EIA carried out. The policy will be reviewed in the light of this consultation and if the negative position is still supported then the process will be quality assured by the Prioritisation Panel before being accepted.

The Panel may also be faced with a proposition where the evidence base is weak (or uncertain) and the expected volume of eligible patients is expected to be very small (<1 per year). In these circumstances the Panel will also have the option to recommend that the intervention is considered via the IPFR route.

In those circumstances where a decision for no routine commissioning is endorsed, WHSSC will be required to carry out an assessment of current use of the intervention, quality assure the process and where necessary develop an implementation plan. The development of an implementation plan may be required if some patients are already receiving the treatment or are on the patient pathway through the IPFR route or because the Health Board has funded the treatment.

6. Definitions for each of the assessment criteria

A summary of each criterion and suggested weighting is provided in Table 2.

A) Quality and strength of the evidence of clinical effectiveness

You will be asked to form recommendations on the relative prioritisation of the policy proposals using the principle of clinical effectiveness. You should only accord priority to treatments or interventions where there is adequate and clinically reliable evidence to demonstrate clinical effectiveness. This criterion considers (i) the *quality* of the evidence to support the use of the intervention and (ii) the *strength* of evidence available.

Briefly the levels of quality of the evidence can be summarised as follows:

1. Randomised trials (high)
2. Observational studies (medium)
3. Case series/case reports (low).

However the quality may be compromised by several factors including:

- Limitations in the design and implementation of available studies suggesting high likelihood of bias
- Indirectness of evidence
- Unexplained heterogeneity or inconsistency of results
- Imprecision of results (wide confidence intervals)
- Publication bias.

It should be noted that for much of highly specialist care the quantity and quality of the available evidence can be sparse.

Each policy proposition includes an evidence evaluation which provides a comprehensive critique of the clinical studies identified in the evidence review. This will include an assessment of bias and the generalisability of the evidence to help Panel members.

The quality of the evidence on the effectiveness of the intervention is described using established methods for grading research evidence. Commissioning policies developed by NHS England and Cedar have usually been developed using GRADE (The Grading of Recommendations Assessment, Development and Evaluation) methodology[11].

[11] The Grading of Recommendations Assessment, Development and Evaluation. http://www.gradeworkinggroup.org/

B) Patient benefit (clinical impact)

This is defined as the potential for the technology to have an impact on patient-related health outcomes (from no expected change in outcomes to major potential improvements in outcomes). This criterion considers the balance of harms and effects based on the evidence presented in the evaluation.

Direct patient benefit may be demonstrated in one or more of the following ways. A drug, medical device or intervention could be life-saving, life-extending, life-improving (where the improvement in symptoms or functional capacity is detectable by the patient) or it provides reduced risk of developing a condition or disease.

Will this intervention have a positive effect on mortality, longevity and health related quality of life compared to the currently available treatment(s)?.

The Panel should also consider the potential for the intervention to have an impact on patient related health outcomes.

The potential benefit of each proposed investment can be described using the following metrics:

- Survival
- Progression free survival
- Mobility
- Quality of life
- Pain
- Anxiety/depression
- Replacement of more toxic treatment
- Dependency on care giver/supporting independence
- Safety

Some health metrics record clinical benefits rather than direct patient benefits, but these can be used as surrogate measures of patient benefit if it can be demonstrated that they provide an accurate, early indication of the direct patient benefit.

Where direct evidence of patient benefit is not available it may be inferred from the available clinical evidence. However, this should take into account the quality of the evidence for any clinical or patient benefit.

Members should not include in their consideration of patient benefit the following factors, societal benefit, the absolute cost of the intervention or considerations of affordability, any financial savings arising from it, the number of patients needed to be treated to give rise to the patient benefit, the prevalence of the underlying condition/illness.

The clinical benefit offered by the intervention is described in the independent review of the clinical evidence of each policy proposition.

C) Economic assessment

The treatment or intervention should demonstrate *value for money* and the role of the Panel is to try and assess the impact of the technology on healthcare spending in Wales.

The panel should consider the following key factors:

- Has evidence of a cost utility analysis been presented? If yes, has this demonstrated that the new intervention is cost effective compared to the existing treatment or intervention?
- Affordability
    - What are the costs of the intervention, including initial acquisition costs and running costs compared to the current 'gold standard' treatment?
    - Are there opportunities for cost savings by introducing this new technology?

Again it should be recognised for that for highly specialised treatments and interventions, evidence of cost effectiveness may be sparse or completely lacking. The Panel should take this into account when trying to assess the whether the new intervention has the potential for improved efficiency and cost effectiveness in the treatment of the condition/disease.

D) Burden of disease

Assessing this criteria involves the consideration of two main issues: the (serious) nature of the condition and the size of the population effected (individual, small cohort or large population). Panel members this year will be invited to vote on both of these criteria separately.

The following serves as guidance to Panel members in assessing the overall 'burden of disease' and highlights some of the considerations each Panel member will need to take.

D1) Serious condition

Regulatory bodies such as NICE and the FDA interpret the term *serious* follows:

'…. *a disease or condition associated with morbidity that has substantial impact on day-to-day functioning. Short-lived and self-limiting morbidity will usually not be sufficient, but the morbidity need not be irreversible if it is persistent or recurrent. Whether a disease or condition is serious is a matter of clinical judgment, based on its impact on such factors as survival, day-to-day functioning, or the likelihood that the disease, if left untreated, will progress from a less severe condition to a more serious one*'.

To satisfy this criterion, an intervention must be intended to have an effect on a serious condition or a serious aspect of a condition, such as a direct effect on a serious manifestation or symptom of a condition or other intended effects, including the following:

- A diagnostic product intended to improve diagnosis or detection of a serious condition in a way that would lead to improved outcomes.
- A product intended to mitigate or prevent a serious treatment-related side effect (e.g., serious infections in patients receiving immunosuppressive therapy).
- A product intended to avoid or diminish a serious adverse event associated with available therapy for a serious condition (e.g., product that is less cardiotoxic than available cancer therapy).
- A product intended to prevent a serious condition or reduce the likelihood that the condition will progress to a more serious condition or a more advanced stage of disease.

D2) Population impact

This is defined as the number of people (the size of the population) who are likely to benefit or be affected by the intervention or recommendation. Technologies that affect a large percentage of the population should score higher on this criterion. The Panel should also consider the issue of population impact separately when scoring each intervention in terms of access and reducing inequity (see section E).

E) Potential for improving/reducing inequalities of access

Members of the Prioritisation Panel must have regard to the need to reduce inequalities between patients when accessing health services and considering the outcomes achieved. The Panel may wish to identify potential health inequalities that may be present with the adoption of a specific policy proposition, and provide WHSSC with advice on how to commission services with a view to reducing health inequalities. This may influence the Panel's recommendation on the relative prioritisation of a specific policy proposition.

Introduction of new highly specialised treatments have the potential to affect equity, for example many specialised technologies are only available in a small number of major treatment centres.

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In addition there is inequity for some patients in Wales who are currently unable to access treatments and services already routinely commissioned across the other devolved administrations within the UK.

The Panel is asked to consider the following:

- whether introduction of the new treatment/intervention would help NHS Wales reduce inequalities between people in the general population in their ability to access these services and increase their potential for improved outcomes
- what will implementation of this policy mean for the individual patient/group of patients and the wider community?
- will this service or intervention contribute to reducing or widening health equalities within Wales?

This criterion should also consider the current availability of (effective) treatments contained within the concept of 'unmet need'. An unmet clinical need is a condition whose treatment or diagnosis is not addressed adequately by available therapy. An unmet clinical need includes an immediate need for a defined population (i.e. to treat a serious condition with no or limited treatment) or a longer-term need for society (e.g., to address the development of resistance to antibacterial drugs).

- Is there currently no available therapy to treat this condition?
- If a therapy already exists for this condition has an improved effect on an outcome(s) of the condition compared with available therapy been demonstrated?

In some disease settings, an intervention that is not shown to provide a direct efficacy or safety advantage over available therapy, may nonetheless provide an advantage that would be of sufficient public health benefit to qualify as meeting an unmet clinical need.

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Table 2: WHSSC prioritisation criteria

Criterion	Definition (weight)	Suggested scores	Score definition
Quality and strength of the evidence of clinical effectiveness	This criterion considers the quality and strength of the available evidence to support the use of the intervention [15%]	8-10	High quality evidence presented to support intervention
		5-7	Moderate quality evidence presented to support intervention
		2-4	Low quality evidence presented to support intervention
		1	No/negligible evidence to support intervention
Patient benefit (clinical impact)	Potential for the intervention to have an impact on patient-related health outcomes (benefits and harms) [15%]	8-10	Major potential to improve clinical outcomes
		5-7	Moderate potential to improve clinical outcomes
		2-4	Little potential to improve clinical outcomes
		1	No expected improvement in clinical outcomes
Economic assessment	Impact of the intervention on healthcare spending [25%]	8-10	Demonstrates significant value for money / cost effectiveness
		5-7	Demonstrates moderate value for money / cost effectiveness
		2-4	Demonstrates limited value for money / cost effectiveness
		1	Demonstrates little/no value for money / cost effectiveness
Burden of disease – nature of the condition	The (serious) nature of the condition involved [15%]	Refer to section D1 p18	

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Burden of disease – population impact	The size of the population that would be affected (or would benefit) by the intervention [15%]	9-10	>50 eligible patients per year
		7-8	10-50
		4-6	1-10 per year
		1-3	< 1
Potential for improving/reducing inequalities of access	The intervention has the potential to introduce, increase or decrease equity in health status [15%]	9-10	Major potential to decrease (improve) inequalities of access
		6-8	Minor potential to decrease inequalities of access
		5	Will not affect inequality of access
		3-4	Minor potential to increase inequalities of access
		1-2	Major potential to increase inequalities of access

WHSSC

"On behalf of Health Boards, to ensure equitable access to safe, effective, and sustainable specialised services for the people of Wales."

Finalising the Integrated Commissioning Plan 2020-23

Joint Committee

6th January 2020

Elements of 2020-23 ICP

- Strategic Priorities (inc. ATMPs, Cystic Fibrosis, Major Trauma, Mental Health Services Strategy, Thrombectomy)
- Six Prioritisation Panel interventions
- High and Medium CIAG priorities (inc. PET, Fetal Medicine and Inherited Metabolic Disease N.Wales)
- Service Risks (Cardiac Surgery outsourcing, Clinical Immunology, Home Parenteral Nutrition, Intestinal Failure, Swansea Bay UHB Prosthetics)

Updates to ICP since November meeting

- Incorporated Welsh Government feedback
- More explicit references to broader strategic context/ministerial priorities/Wellbeing Future Generations Act
- Timelines on ICP deliverables
- Reference to introduction of new Cystic Fibrosis treatments
- Low scoring priorities from CIAG process removed
- Confirmed financial position for ATMPs and Major Trauma

WHSSC uplift by Health Board (& risk-share effect)

	Aneurin Bevan UHB £m	Betsi Cadwaladr UHB £m	Cardiff & Vale UHB £m	Cwm Taf Morgannwg UHB £m	Hywel Dda UHB £m	*Powys THB £m	Swansea Bay UHB £m	2020/21 WHSSC Requirement £m
19 / 20 Income as Mth 6	**116.254**	**139.070**	**107.363**	**90.270**	**72.231**	**25.497**	**79.782**	**630.467**
Anticipated 2020/21 Allocation Funding	0.269	0.319	0.227	0.203	0.176	0.060	0.178	**1.432**
2020/21 Opening Baseline income	**116.523**	**139.389**	**107.590**	**90.473**	**72.407**	**25.557**	**79.960**	**631.899**
2 year average riskshare (2017/18 & 2018/19)	0.643	(0.663)	(0.294)	0.390	(0.739)	1.695	(1.032)	-
2020/21 Uitilisation adjusted baseline	**117.166**	**138.726**	**107.296**	**90.863**	**71.668**	**27.252**	**78.928**	**631.899**
Underlying Deficit (inc adj Baseline)	**2.402**	**(0.596)**	**1.006**	**1.281**	**(0.594)**	**1.716**	**(0.319)**	**4.896**
Underlying Deficit & Growth	**5.369**	**1.403**	**3.678**	**3.451**	**0.816**	**2.123**	**1.061**	**17.901**
CIAG & Prioritisation Schemes	0.418	0.348	0.383	0.346	0.289	0.079	0.316	2.179
Strategic Specialist Priorities	0.283	0.138	0.263	0.214	0.172	0.062	0.196	1.328
NHS England Provider 2%	0.318	2.070	0.237	0.201	0.186	0.191	0.204	3.406
NHS Wales 2% provider inflation	1.711	1.026	1.623	1.371	1.090	0.255	1.190	8.266
Total WHSSC increase 2020/21	**8.099**	**4.984**	**6.184**	**5.583**	**2.553**	**2.711**	**2.967**	**33.080**
TOTAL WHSSC 2020/21	**124.621**	**144.373**	**113.773**	**96.056**	**74.960**	**28.268**	**82.927**	**664.979**
% Total Uplift Required	**6.95%**	**3.58%**	**5.75%**	**6.17%**	**3.53%**	**10.61%**	**3.71%**	**5.24%**

***Includes growth in secondary care cancer products of £0.5m**

Uplift excluding Riskshare adjustment								
Total WHSSC increase 2020/21	**7.456**	**5.647**	**6.478**	**5.193**	**3.292**	**1.016**	**3.999**	**33.080**
TOTAL WHSSC 2020/21	**123.978**	**145.036**	**114.067**	**95.666**	**75.699**	**26.573**	**83.959**	**664.979**
% Total Uplift Required	**6.40%**	**4.05%**	**6.02%**	**5.74%**	**4.55%**	**3.97%**	**5.00%**	**5.24%**

Recent progress against financial gap

- Investment in Major Trauma, ATMPs, Peri-natal (Mother and Baby)

Stage	WHSSC requirements for 2020-21 £m	%	Total
Joint Committee - 12-11-20	**74.348**	**11.77%**	**11.77%**
ATMPs	-23.553	-3.73%	8.04%
Major Trauma	-11.986	-1.90%	6.14%
Peri-natal (Mother & Baby)	-1.150	-0.18%	5.96%
Activity growth reduction	-1.350	-0.21%	5.75%
Additional VBC Schemes	-1.100	-0.17%	5.57%
Thrombectomy PYE	-0.982	-0.16%	5.42%
Other adj	-1.147	-0.18%	**5.24%**
Joint Committee - 6-1-20	**33.080**	**5.24%**	

- Ask now - 5.2%

NHS England/NHS Wales comparators

	2019-20	**2020-21**	2021-22
WHSSC	6.28%	**5.24%**	TBC
England Specialist Services	8.14%	6.95%	7.44%
Welsh Allocation	6.46%	4.67%	TBC
(Source: Allocation letter Table A1)			

- English growth provision in 2020-21 7.0 % compared to WHSSC 5.2%
- English growth provision in 2019-20 8.1% compared to WHSSC 6.3%
- Health Boards funded an additional 4.7%