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Welsh Health Specialised Services Committee (WHSSC)

An Integrated Commissioning Plan for Specialised Services for Wales 2018 – 2021

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Contents

Executive Summary

This is the fifth Integrated Commissioning Plan (ICP) for specialised services for Wales that the Welsh Health Specialised Services Committee (WHSSC) has published. The purpose of the ICP is to set out WHSSC's strategy and aim for commissioning specialised services over the next three years.

The focus of this Plan is to continue to commission high quality services and introduce innovative treatments in the increasingly challenging financial climate. We know that more patients are requiring specialised services due to an ageing population and advances in medical technology.

Our enhanced teams are strengthening our existing workforce and providing us with the opportunity to engage clinicians throughout our processes, ensuring that we meet the requirements of the prudent healthcare agenda whilst still driving the development of patient pathways and services. The embedded Prioritisation process and Risk Management Framework have helped to identify the priorities for WHSSC this year whilst the developing Quality and Performance escalation process is identifying pressures within the system that require integrated clinical and managerial support.

The financial summary demonstrates the challenge and considerable cost pressures relating to existing services. The ICP emphasises that if we are to introduce any innovation and developments we will be reliant on opportunities to release value from elsewhere in the patient's pathway or through the re-commissioning of services.

We know that key to the success of our work is increased collaboration with Health Boards, both providers and commissioners and NHS Trusts in England to ensure that we maximise opportunities to better align Integrated Medium Term Plans (IMTPs) with our ICP. In addition we will build on our experience of co-production with patients and the public and embed this into routine business.

The Plan comprises of the following core elements:

- baseline assessment of recurrent position
- full year effect of 2017/18 developments and benefits realization
- unavoidable ICP growth and contract inflation pressures
- schemes which have received prior commitment
- unavoidable full year effect (FYE) of growth
- mandated schemes
- schemes with a Clinical Impact Assessment Group (CIAG) score higher than 20, and exception risks.

1 Introduction

This chapter describes WHSSC's role, aim and the range of services delegated to WHSSC.

1.1 WHSSC's Role

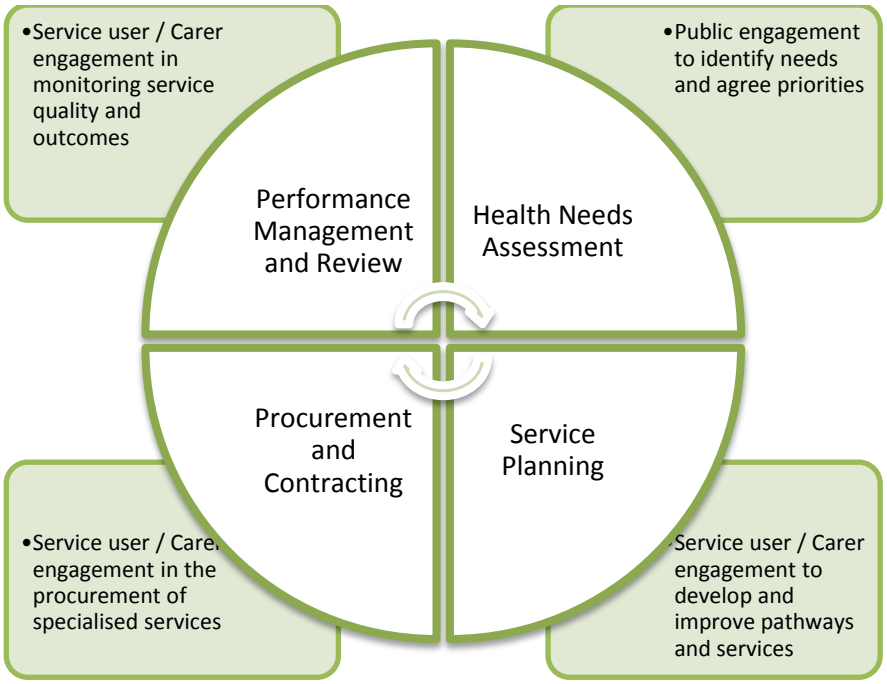
WHSSC is a Joint Committee of the seven Local Health Boards (LHBs) in Wales. The seven LHBs are responsible for meeting the health needs of their resident population, they have delegated the responsibility for commissioning a range of specialised services to WHSSC.

WHSSC's role is to:

- plan, procure and monitor the performance of specialised services
- establish clear processes for the designation of specialised services providers and the specification of specialised services
- ensure there is assurance regarding clinical quality and outcomes through the contract mechanisms and a rolling programme of service review
- ensure that patients are central to commissioned services and that their experience when accessing specialised services is of a high standard
- develop, negotiate, agree, maintain and monitor contracts with providers of specialised services
- undertake associated reviews of specialised services and manage the introduction of drugs and new technologies
- co-ordinate a common approach to the commissioning of specialised services outside Wales
- manage the pooled budget for planning and securing specialised services and put financial risk sharing arrangements in place, and
- ensure a formal process of public and patient involvement underpins its work.

All of this work is undertaken on a cyclical basis with ongoing engagement with patients, service users and professionals. WHSSC's commissioning cycle is shown in figure 1.

Figure 1 – WHSSC Commissioning Cycle



1.2 WHSSC's Aim

The aim of WHSSC is *"On behalf of the seven Health Boards; to ensure equitable access to safe, effective, and sustainable specialised services for the people of Wales."*

Over the course of the 2018-21 Integrated Commissioning Plan for Specialised Services (ICP), WHSSC will work closely with its NHS Wales partners to use a value based healthcare approach across the whole of the patient care pathway in order to ensure that investment is made in the most effective part of the care pathway, in order to achieve the greatest benefit to the patient. This process is referred to as 're-commissioning', and will be described in greater detail in section 2.2.2.

1.3 Features of Specialised Services

Specialised services generally have a high unit cost as a result of the nature of the treatments involved. They are a complex and costly element of patient care and are usually provided by the NHS. The particular features of specialised services, such as the relatively small number of centres and the unpredictable nature of activity, require robust planning and assurance arrangements to be in place to make the best use of scarce resources and to reduce risk. Specialised services have to treat a certain number of patients per year in order to remain sustainable, viable and safe. This also ensures that care is both clinically and cost effective.

The range of services delegated by the seven LHBs to be commissioned by WHSSC is agreed through the Joint Committee. An original list of services was agreed in 2012.

Since this time there have been a number of transfers back to local planning and funding, as well as some additions to WHSSC's responsibilities. The services delegated to WHSSC can be categorised as:

- Highly Specialised Services provided in a small number of UK centres
- Specialised Services provided in a relatively small number of centres and requiring planning at a population of >1million, and
- Services which have been delegated by LHBs to WHSSC for other planning reasons.

1.4 WHSSC as an organisation

Figure 2 aims to show the relative scale of WHSSC compared to the services that it commissions on behalf of the LHBs. It sets out the key statistics for the staffing levels, direct running costs, number of commissioning and functional teams and number of contracts for healthcare services.

Figure 2: WHSSC Key statistics

Around two-thirds of the Welsh Health Specialised Services (WHSS) Team are directly engaged in commissioning work.

2 The Strategic and Policy Context for Specialised Services

This chapter describes the historical, strategic, policy, health, legislative and financial context for planning the commissioning of specialised services for the Welsh population and also for WHSSC as an organisation.

2.1 A Strategy for Specialised Services

The NHS Wales Planning Framework for 2018/21 sets out a requirement for all NHS organisations to have a strategy which sets out their long-term vision. The document provides the context within which key strategic decisions can be taken on the shape of services and use of resources. The current strategy for specialised services (NHS Wales Specialised Services Strategy) was written in 2012, and is now under review following a number of significant changes to the organisation over the last year.

Whilst many of the underlying features of the existing strategy are likely to remain, the intention is that the updated strategy will have some important differences to provide a more comprehensive outlook. For example:

- Clinically informed and led – changes in the breadth and depth of clinical advice will make for a more informed and engaged strategy.
- Engagement – the development of the strategy will engage with a wider range of interested parties.
- Patient centred – the views of patients and patient groups will inform the strategy and patient experiences taken into account.
- Quality and Standards based – the strategy will be centred around ensuring there are clear standards in place for specialised services and robust assessment of services to those standard to ensure quality remains paramount, including assessment of Compliance of commissioned services against the Welsh Language Act.
- Needs based – the strategy will be informed by needs assessments that connect at both national and local levels and reflect the needs of the Welsh population.
- Evidence based- ensuring that our strategy is informed by published evidence and is line with the principles in Prudent Health Care.
- Performance – ensuring providers are delivering required standards, access times and access levels.
- Sustainable – the strategy will ensure that there is a clear resulting strategic plan of how the Welsh population will access sustainable quality services for the long term. The goal of maintaining and developing high quality

specialised services in Wales wherever possible will remain but not at the expense of quality or sustainability.

- Networked – the importance of ensuring appropriate networks and pathways are in place to ensure the right local balance of care and reliable and quick access to the most appropriate service wherever this is. The broad vision and direction for specialised services over the next three years is to focus on re-commissioning of services across primary, secondary and specialised services.

2.2 Historical Context

2.2.1 National Commissioning of Specialised Services

Arrangements have been in place to commission specialised services at a national level since 1999. In April 2010, the function was delegated to WHSSC.

Since its establishment, WHSSC has built upon the experience of its predecessor organisations to develop a comprehensive approach to commissioning specialised services which incorporates all of the key developments over the last 18 years. This is illustrated in Figure 3.

Figure 3 - Development of Specialised Services Commissioning in Wales 1999 – 2018

Development of Specialised Services Commissioning in Wales	• Service specifications • Quality and outcomes framework • Audit programme • Relative prioritisation and clinical impact assessment • Engagement • Performance management and escalation framework	WHSSC
	• Single national contracts • Annual commissioning plan • Commissioning policies • Individual patient commissioning • Strategic reviews	HCW(SS)
	• Strategic approach to commissioning • Equity of access • Standards and care pathways	SHSCW

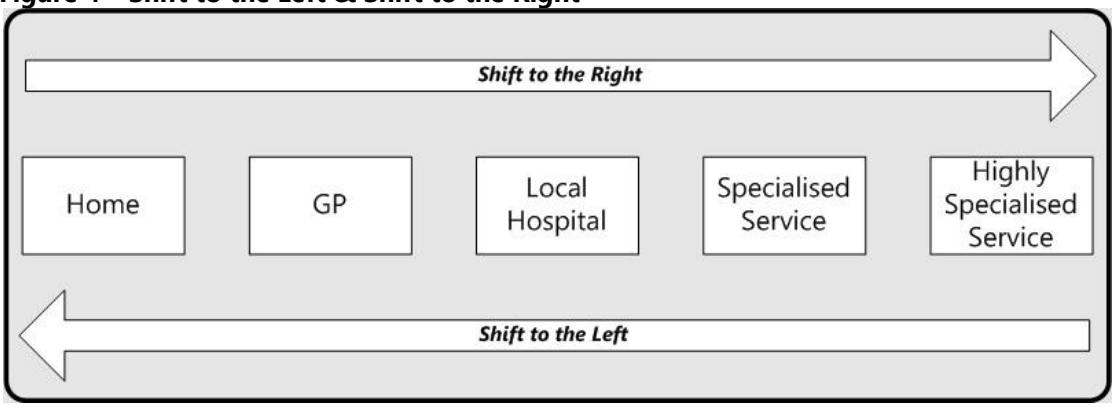
2.2.2 Re-commissioning across Primary, Secondary and Specialised Services

The financial climate remains challenging for NHS Wales and therefore it is essential that all organisations are able to make the best use of their resources in order to make a difference to the health and wellbeing of the nation. In order to do this, it will be necessary to review existing patient care pathways into and across specialised services, to identify the point at which greatest benefit for the patient can be achieved.

This means that as well as delivering some care more locally at an earlier stage in the pathway (Shift Left), it may also be necessary for some patients to access specialised care at a much earlier stage of the pathway (Shift Right). Movement in both of these directions will need to be underpinned by the development of clear pathways across services in order to keep the needs of the patient at the centre (Figure 4).

- Shift Left
    - Earlier intervention in a range of services is not only possible but desirable to improve overall outcomes
- Shift Right (secondary to tertiary)
    - Prompt escalation to the right definitive treatment is possible to improve overall outcomes
- Shift Left (highly specialised to tertiary)
    - This involves the shift in the balance of care from UK wide, highly specialised centres to local tertiary centres for a range of complex chronic conditions. This will be an important area for strategic development in order that most care can be available more locally to patients and the role of Wales based services is strengthened, improving sustainability.

Figure 4 – Shift to the Left & Shift to the Right



This will require collaborative working across local, regional and national commissioning elements of the care pathway, using the principles of Triple Aim, Prudent Healthcare and a Value Based Healthcare approach. In some cases, this will require a redesign of the existing commissioning arrangements for a specific

condition, pathway or service. For the purposes of brevity within this Plan we describe this process as 're-commissioning'.

In addition to the considerations outlined above, there is an underlying trend and evidence base to support specialised services being provided in fewer centres underpinned by network arrangements. A core element of this relates to sustainability, which is characterised by:

- minimum volumes consistent with improved outcomes
- balance between emergency and elective intervention in a service and the associated requirements for compliant rotas and sustainable working patterns;
- range of sub-specialisation
- training approval requirements, and
- service interdependency within centres – for example, related specialities, specialised diagnostics, interventional radiology, levels of intensive care.

2.3 Strategic Context

2.3.1 Quality and Outcomes

The ICP has a central theme of quality and outcomes. A key goal for the organisation over the last three years has been the implementation of the approved Quality Assurance Framework. This is described further in section 3.

2.3.2 Sustainability of Services

In common with specialised services commissioners in NHS England, the difficulties of commissioning sustainable highly specialised services is a common theme in discussions between the WHSS Team and providers. The influencing factors include:

- medical training requirements
- ability to balance competing demands from secondary care within acute hospitals which host specialised services
- historical patterns of service delivery
- publication of new or revised standards or accreditation requirements
- need to maintain good clinical outcomes and avoid occasional practice
- concerns regarding workforce pressures or inability to recruit
- budget impact of new drugs and technologies
- growth in demand
- Prudent Healthcare, and
- austerity and the drive towards economies of scale.

In this Plan, the WHSS Team has considered the delivery and sustainability issues which need to be addressed in the short term. Further issues of medium to long term sustainability will be identified through the current and future work to develop service specific commissioning strategies.

2.3.3 Equity

A priority for commissioning specialised services for the future is to ensure equity of service provision and access to services across the whole Welsh population. It is acknowledged that there is too much variation at present. More research and information is required to understand the variation across the major groups of specialised services (e.g., cardiac, neurosciences, cancer, renal and mental health) and this is a feature of future Audit and Outcomes days.

Inequity may relate to issues both of geography and deprivation. Specialised services are by their very nature, centralised, and understanding the Welsh access rates and the potential barriers to access services will inform models of care for the future, and improve population health. This is already taken into account within our prioritisation processes and has been built into recent service reviews. This will however need to be strengthened in the development of different care pathways, for example those built upon hub and spoke models which will need local investment and the development of local expertise.

2.3.4 Clinical Workforce Issues

The difficulties of recruitment and retention of clinical staff within some specialised services is leading to the fragility of services and an increasing frequency of service risk issues. Over the last few years this has been more apparent in smaller services in South Wales, rather than in the larger providers in North England which provide services to North Wales. Where urgent issues have been foreseen, they have been taken into account in the development of the Plan through reflection in the Commissioner Priorities and use of the provider risk registers.

There are also serious issues with the quality of training for junior medical staff and the impact of training decisions on the ability of providers to continue to deliver safe services. This has been evident most recently in neonatal services in South Wales.

2.4 The Policy Context

2.4.1 NHS Wales Planning Framework for 2018-21

Commissioning Intentions - The NHS Wales Planning Framework for 2018-21 sets out a requirement for plans to set out commissioning intentions and delivery milestones for clinically led transformation over the next three years, including the development of a strengthened approach to commissioning tertiary and specialised services.

The framework is clear that it is vital to secure the best possible services that deliver value for money, and identify when services are not required, could be better provided elsewhere or are not providing the expected outcomes or value, that they should be decommissioned. The Plan addresses these requirements through:

- Escalation Framework – the framework sets out a clear process for monitoring and managing performance of providers, including various stages of escalation which culminate in decommissioning if the provider is unable to deliver the appropriate level of quality, performance or activity. This is described further in section 4.3.
- Re-commissioning – the application of a value based healthcare approach combined with the principles of Triple Aim and Prudent Healthcare, will enable the assessment of patient care pathways into and across specialised services, to identify whether the current pattern of investment achieves the best outcome or value. This is described further in section 2.2.

Collective working – The NHS Wales Planning Framework for 2018/21 emphasises the need for collaborative and collective planning. It sets a requirement for Plans to reflect work undertaken at a local, regional and national level between organisations and ensure that there is clarity around joint working across the patient pathway. The Plan addresses these requirements through:

- Re-commissioning – as outlined above and described in section 2.2
- Collective Commissioning cycle – as described in the 2017-20 ICP which can be found here http://www.whssc.wales.nhs.uk/strategies-and-plans

In order to ensure that NHS Wales organisations are able to reflect the WHSSC work plan including areas of joint working, the commissioning intentions were agreed and issued in September 2017. These are included in Annex 1.

An extensive programme of baseline review, horizon assessment, risk assessment and prioritisation concluded in December 2017 and the results were shared with NHS Wales organisations in January 2018, in order to facilitate inclusion within their IMTPs.

2.4.2 Prosperity for All

"Prosperity for All" is the cross-government national strategy which sets out the priorities of this Government, and lays the foundations for further action over the longer term. The NHS Wales Planning Framework sets out clear requirements for organisations to develop plans that meet the wellbeing objectives aligned to the strategy. The objective to deliver quality health and care services fit for the future is core to the role of WHSSC in commissioning safe, effective and sustainable services.

2.4.3 Parliamentary Review of Health and Social Care

The Parliamentary Review into the Long-Term Future of Health and Social Care in Wales published its final report in January 2018. The report sets out a case for change in the way that health and social care services are organised. The report is clear that the current traditional models of health and social care are not sustainable,

and sets out the case for new model of care, underpinned by a new quadruple aim, which is to:

- improve the population's health and wellbeing, with a focus on prevention
- improve the experience and quality of care for individuals and families
- enrich the well-being, capability and engagement of the health and social care workforce, and
- increase the value achieved from funding health and care through improvement, innovation, use of best practice and eliminating waste.

This quadruple aim is consistent with the re-commissioning approach set out in this plan, i.e. the application of a value based healthcare approach combined with the principles of Triple Aim and Prudent Healthcare.

The report also emphasises the benefit of a coproduction model, and the need to ensure that as well as greater influence and involvement in the planning, delivery and evaluation of services, the people of Wales, staff, service users and carers should have clearer shared roles and responsibilities. The WHSS Team has successfully undertaken a public engagement exercise to inform the decision making process around thoracic surgery services and will be seeking to further develop the models of co-production that already exist in our All Wales Artificial Limb and Appliance Service Partnership Board and Gender Identity Partnership Group. WHSS Team will explore further opportunities for coproduction over the course of the next three years.

2.4.4 NHS Wales Outcomes Framework 2016-17 and Delivery of National Priorities

As a commissioning organisation, WHSSC is supporting NHS Wales to achieve compliance with the measures in the NHS Outcome Framework and Measures Guidance 2016-17, by ensuring these are central to WHSSC's 2018-21 Commissioning Intentions (Annex 1). The achievement of actions required in the Together for Health Delivery Plans and the National Priorities of Child and Maternal Health and Mental Health are also reflected in the Commissioning Intentions, as WHSSC has a direct role to play in ensuring delivery in these areas of specialised services.

2.4.5 The Social Services and Wellbeing (Wales) Act 2014

The Social Services and Wellbeing Act places duties on statutory bodies to improve services, work together with the public to promote well-being and give people a greater voice in and control over their care. Whilst WHSSC is not a statutory body for the purposes of the Act, it will, through good planning practice and engagement, support statutory bodies to meet their obligations under the legislation.

The Act places a requirement on health boards and local authorities to jointly undertake an assessment of the local populations care and support needs. The

population assessment will inform the development of their IMTPs, which will in turn be reflected through the Plan where there are clear interfaces between specialised services and social care. However, as the first local well-being plans will not be published until mid-2018, this will not feature as a part of this year's ICP.

2.4.6 The Wellbeing of Future Generations (Wales) Act 2015

The Wellbeing of Future Generations Act will have a far-reaching impact on all NHS bodies. The Act references the five ways of working and WHSSC will continue its development work to contextualise these to the commissioning cycle. Examples of this act are shown in figure 5.

Figure 5 – The Well-being of Future Generations

Ways of Working	**Long-term thinking**	**Prevention**	**Integration**	**Collaboration**	**Involvement**
Description	balancing short-term needs with safeguards to meet long-term needs	actions to prevent problems getting worse	considering how our objectives may impact on those of others – e.g. impact on HBs and LAs	working with other bodies (which may include third sector organisations) that can help us meet our goals	involving people and communities with an interest in helping us meet our objectives, and reflecting the diversity of the people in our area
WHSSC workstream	**Strategic Reviews**	**Shift to the Left**	**Collective Commissioning**	**Re-commissioning**	**Engagement**
Examples	Thoracic Surgery Project; Inherited Bleeding Disorders Project; etc.	Cardiac Ablation; PET CT scanning; etc.	Mechanical thrombectomy; Specialised Gender Services Project; etc.	Aortic Valve stenosis strategy; Spinal Implants; etc.	All Wales Posture and Mobility Partnership Board; NET Patient Foundation; NHS Wales Gender Identity Partnership Group.

Whilst WHSSC is not a statutory public body, it will ensure that the development of specialised services commissioning takes into account the goals and objectives of the respective Health Boards.

2.4.7 Public Health (Wales) Act 2017

The Public Health (Wales) Act received Royal Assent on 3 July 2017. The Act covers a range of areas, such as the development of a national strategy for preventing and reducing obesity levels in Wales. As commissioners of Tier 4 Bariatric Surgery, we will ensure that our policy and service specification are reviewed to take account of the emerging strategy.

2.4.8 Nurse Staffing Levels (Wales) Act 2016

The Nurse Staffing Levels (Wales) Act 2016 sets out the overarching duty for services to provide sufficient nursing staff in order to allow time to deliver patient care. The Statutory Guidelines were issued, and will apply to acute medical and surgical wards from April 2018 onwards. As part of the SLA contract, WHSSC will expect all Welsh providers of specialised services to demonstrate that they are compliant with the act.

This will be monitored through the regular quarterly performance and quality management process.

2.4.9 Equality Act 2010

WHSSC also has duties under the Equality Act 2010 which requires Health Boards and Trusts to pay 'due regard' to the need to eliminate discrimination, harassment and victimisation, promote equality of opportunity and promote good relations for people and groups with protected characteristics. These duties are discharged by WHSSC when developing service commissioning plans and in the development of the ICP, through good planning practice and engagement. Consideration and assessment of equality impact is inbuilt into our prioritisation, service reviews and policy development. An integral part of this Plan will be to develop an Equality Plan for Specialised Services. This ICP will need to form part of each Local Health Board's Strategic Equality Plan to ensure that there is alignment.

2.4.10 NHS Wales Core Principles (2016)

The NHS core principles, which have been developed in partnership by the Welsh Government, NHS Wales Employers and trade unions, are the foundation of how staff should work across and within NHS Wales.

The core principles put the public and patients first and have been developed to ensure the NHS delivers the best possible care to those with the greatest health needs first. They also put an emphasis on wellbeing and preventative healthcare and supporting NHS employees' continuing professional development.

WHSSC aims to work in partnership and as a team and demonstrate how each member of staff is valued. In turn this will be reflected in the work that we do when commissioning services, putting patients and recipients of the service first and seeking wherever possible to improve the care commissioned and learn from experiences.

2.4.11 Welsh Language (Wales) Measure 2011 and Welsh Language Standards

Whilst as an organisation WHSSC is under the umbrella of our host organisation Cwm Taf University Health Board (CTUHB) for a number of the statutory requirements of the Welsh Language (Wales) Measure 2011 and Welsh Language Standards such as the implementation of a Welsh Bilingual Strategy and Welsh Language training for staff, there are ways in which WHSSC itself is demonstrating compliance with the requirements.

WHSSC recognises the importance of patients being able to receive care in their first language and we seek assurance that the providers that we commission from are able to comply with the Welsh Language standards as part of our Service Level Agreement (SLA) contracts with them.

The WHSS Team understands that it has a unique role within NHS Wales in the way that it develops policies and service specifications with consultation, to guide the commissioning of services. It has an ongoing programme developing bi-lingual documents to explain these processes and how it consults and advise on how those consulted can respond in their preferred language. Equality Impact Assessments

2.5 Health Needs Assessment

At the highest level the key demographic challenges for specialised services remain unchanged from that included in last year's ICP with an expected **increase in demand for specialised services of between 3% and 5% over the next ten years.** However, there are specific effects of changes in population size, age, birth rate, small increases in ethnic minority populations and the effects of cultural practices including consanguineous marriages which could impact on this projection for some specific specialised services.

2.5.1 General Population Changes

We know that the ageing population is altering the age/sex structure across the national population and that this has its greatest effects in the larger volume specialised services which include cardiac and renal services. In turn, this is affected by improvements in clinical techniques which mean that more elderly patients are now appropriate candidates for treatment even when they have high co morbidity from other chronic diseases.

2.5.2 Rare Diseases

For rare diseases (defined as disease frequency of fewer than 500 patients per million population) the effects of population growth or demographic changes are small. This is because the number of elderly patients is typically very small due to the often lethal natural history of the disease. However, assessment of the potential demand concludes that increases will be related to improved disease ascertainment through screening and application of genetic diagnostic techniques with particularly effect on early diagnosis in childhood.

The earlier diagnosis of rare diseases will improve quality of life and survival rates due to the commencement of patients on appropriate pathways of care at an early stage with early use of medical, surgical and therapeutic interventions and management. This is likely to change the cost profile with the increased use of these technologies as well as an increasing pool of individuals living into adulthood that had not previously.

Evidence from the annual audits of the 75 UK highly specialised services confirms the survival effects associated with better high cost treatment of inherited metabolic disorders and the altered survival curves for pre and post treatment of severe blood disorders. In addition, organ transplant outcomes are also improving.

The number of patients in Wales who use any one of the 75 services is small, however, improved survival rates increase the prevalence of each disease slowly each year. Although the volume of usage is low, these services are high cost.

The cumulative effect, will for some diseases, increase costs and for others, avoid costs through the prevention of disease progression.

2.5.3 Health Needs Assessment specific to Specialised Services Commissioning

Currently WHSSC does not have a formal arrangement for accessing health needs analysis. An SLA with Public Health Wales (PHW) was terminated by mutual agreement in the summer of 2017 because it did not meet the needs of either organisation. The WHSSC strategy is now to appoint a part time Associate Medical Director for Public Health Medicine who can provide advice and co-ordination with Public Health Teams within PHW and the LHBs. Their role will also be to advise on the longer term strategy for Public Health input into WHSSC commissioning. This role is currently vacant and will be re-advertised in the last quarter of 2017/18. We are working with the Faculty of Public Health medicine to ensure the post is attractive and we are able to successfully recruit.

In addition the WHSS office has just achieved training status for Public Health Medicine and a trainee will take up post in September 2018. In the short term the Associate Medical Directors are directly working with Public health teams such as Congenital Anomaly Register & Information Service (CARIS) to ensure that commissioning models are underpinned by relevant health needs analysis.

2.5.4 Cedar Healthcare Technology Research Centre

Cedar is an NHS-academic evaluation centre which is part of Cardiff and Vale University Health Board (CVUHB) and Cardiff University. It is an external assessment Centre to (National Institute of Health and Care Excellence) NICE in the Medical Technologies Evaluation Programme.

WHSSC holds an SLA with Cedar to produce rapid evidence reviews to support our evidence based approach to policy development, review and update. Since September 2017 we have commissioned reviews for Transcatheter aortic valve implantation (TAVI) high risk patients and Cryo reductive surgery and Hyperthermic intraperitoneal chemotherapy (HIPEC).

2.5.5 Health Technology Wales

Health Technology Wales (HTW) was established in 2017 to facilitate the timely adoption of clinically and cost effective health technologies in Wales. Its remit covers all health technologies that are not medicines, for example medical devices and surgical procedures. HTW critically appraise the best available international evidence about the clinical and cost effectiveness of a health technology.

Topic selection is coordinated by a 'Front Door' process where proposals are assessed for appraisal or signposted to other organisations within NHS Wales. Suitable topics are then appraised by HTW, the outputs reviewed by their Assessment Group and signed off for publication by their Appraisal Panel.

WHSSC was a key participant during the initial set up of HTW and is now represented on both their Front Door and Assessment Groups. During 2017/18 colleagues at WHSSC suggested a number of topics for appraisal including corneal crosslinking for keratoconus.

Preliminary discussion has recently taken place about establishing a Strategic Alliance between WHSSC and HTW to facilitate joint working across common areas of interest. These include horizon scanning and prioritisation, uptake and implementation of technologies and disinvestment. Further work on this closer collaboration is planned for 2018/19.

3 Quality and Outcomes

This chapter describes the progress made on the development and implementation on the Quality Assurance Framework and actions required as a result of external governance reviews.

3.1 Quality Assurance

Healthcare services are facing the combined challenges of rising demand, escalating costs, advancing science, changing expectation and adverse economic climate. Specialised services are no exception, and it is difficult to meet each of these challenges whilst maintaining and improving quality.

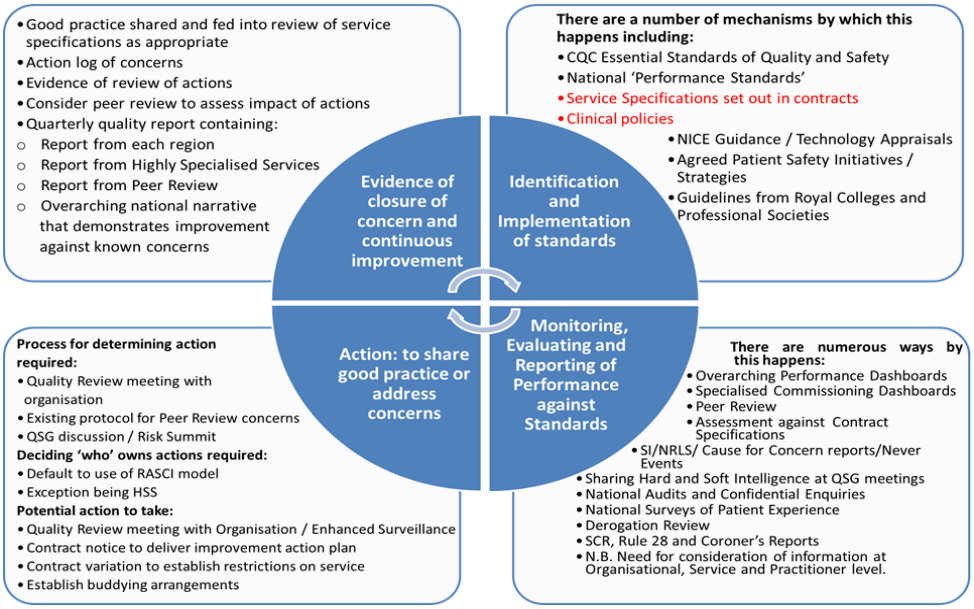
In January 2015 the Joint Committee approved the Quality Assurance Framework to ensure that quality was central to all commissioning and performance management arrangements. Building on the existing definition of quality, the three dimensions of quality namely **Safety, Effectiveness** and **Patient Experience** need high performing providers and commissioners to work in partnership to ensure inequalities in health outcomes are the focus for quality improvement. This has been a clear driver over the past year and has seen an improvement in the reporting of quality measures from all of the providers.

Quality should permeate everything we do – from the way we plan and commission care to the way we work with services to drive improvement and innovation. The seven steps from NHS England's National Quality Board sets out how WHSSC aims to maintain and improve the quality of care that people experience (Figure 6).

Figure 6: Seven steps to improve quality

The Quality Assurance Framework and the seven steps ensure that the contracting process utilises quality schedules, standards and clinical quality indicators to support effective healthcare delivery, quality improvement and innovation across the health system for specialised services. Further detail on the four components of the Quality Assurance Framework are described in the figure 7.

Figure 7: Components of the quality assurance framework



The quality improvement approach to serious incidents and never events is underpinned by the encouragement of reporting. Therefore the reporting of an incident by a provider is not in itself a concern.

In addition there are a number of key principles underpinning the Quality Assurance Framework Implementation Plan including:

- 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. This involves working collaboratively with patients and service users in line with the Welsh Government framework for Assuring Service User Experiences 2015
- working in partnership with providers to agree quality indicators that reflect the specialist nature of the service delivered
- ensuring that the development of quality indicators is clinically-led
- ensuring that quality is seen as everybody's business across the organisation, and
- reducing duplication and unwarranted variation is critical to the success of the implementation plan.

WHSSC commissions services from a range of providers within NHS Wales and NHS England. Commissioning services from both countries could potentially add an additional layer of complexity to monitoring quality. However, over the last year a great deal of cross border working has taken place to strengthen relationships and share information which this has resulted in improved transparency and benchmarking across services.

NHS England's Quality Surveillance Team's (QST) Portal measures performance against quality standards and provides a seamless interface to the statutory and regulatory quality functions. The QST continue to develop the functionality of both the Specialised Services Quality Dashboard (SSQD) Portal and the Quality Surveillance Information System (QSIS) Portal to support the ambition to pull together better information on patient outcomes, cost/value and quality to enable and inform change.

Specialised Services Quality Dashboards (SSQD) are designed to provide assurance on the quality of care by collecting information about outcomes from healthcare providers. They are a key tool in monitoring the quality of services enabling comparison between service providers and supporting improvements. Whilst WHSSC uses the portal for quality reporting of NHS England providers, discussions are ongoing as to the feasibility of Welsh providers having access and inputting data into the portal. This will provide consistency across specialised services and give WHSSC and Health Boards access to information for internal assurance purposes and reporting.

3.2 Audit and Outcomes

Figure 8 illustrates the quality audit cycle which is made up of eight steps for assurance purposes. It is designed to facilitate collaborative working and to enable clear and effective communication between WHSSC and providers to enhance patient care and experience with measured and agreed patient and provider outcomes.

Figure 8: Quality audit cycle

WHSSC continues to host a number of Audit and Outcomes Days which bring specialists together from the provider organisations across England and Wales to achieve the following:

- provision of assurance through the review of quality and performance indicators
- promotion of learning through the sharing of best practice
- networking, and
- identifying specific topics for future audit.

The details of the Audit and Outcomes Day undertaken over the last 12 months are included in Annex 2. The cycle is overseen by the WHSSC Quality and Patient Safety Committee.

3.3 Policy development

One of the key corporate risks in 2016 was the number of commissioning policies that were then out of date. In addition there was no strategy in place to address this. In recognition of this the WHSS Team have established a policy review group and appointed a Policy Project Manager. The process has been revised and suit of bilingual supporting documents developed. This means that the number of policies outside their review date has reduced from 53.1% (34/64) in April 2017 to 39.2% (31/79) in March 2018. Of the 31 policies currently outside their review date, 20 (25.4%) are under review and 7 (8.7%) are in development leaving 4 (5.1%) where no action has yet been taken.

4 Progress in Delivering the ICP 2017-20

This chapter outlines the process for assuring delivery of the Integrated Commissioning Plan 2017 -20 and progress to date in delivering the specialised services workplan. The chapter also describes the development work WHSSC has been undertaking in collective commissioning, performance management and workforce and organisational development.

The approved ICP for 2017-20 looked very different to previous WHSSC ICPs, due to the lack of financial resources available to Health Boards.

During the last year the organisation has focussed on embedding the Risk Management Framework and developing Commissioning strategies for a number of services. These are outlined below.

4.1 Risk Management Framework

The Risk Management Framework first described in the 2017-20 Technical Plan and subsequent ICP, was conceived following WHSSC being required to significantly reduce the funding requirements from Health Boards. This led to a greater number of risks inherent within the plan. The Framework aimed to set out the risks of unfunded schemes, schemes within Strategic Reviews and work-plan streams across the three domains of Patient (Resident Health Board), Provider and Commissioner, linking respectively with the three domains of the WHSSC aim – Safe, Sustainable and Effective.

Throughout 2017-18, WHSSC have worked with Management Group and provider Health Boards to complete the Patient and Provider domains for each of the schemes within the Framework. The Commissioner domain scored by the relevant Commissioning Team, moderated by other Commissioning Teams and shared with Management Group. The summary of scores has shown areas of inconsistency with how individual Health Boards perceived patient risk for their respective population but this could be attributed to the mitigation that they have in place. Better understanding of this mitigation could allow best practice to be shared across Health Boards and further reduce the risk scores.

Where necessary, Management Group have escalated a number of risks that have not responded to mitigation, to the Joint Committee for resolution. The escalation process for managing these risks is outlined in Annex 3 and the latest risk management framework scores outlined in Annex 4.

All the risks featuring on the Risk Management Framework are present on the relevant Commissioning Team/Directorates Risk Registers. It is not the case that all

risks on the risk register are on the Risk Management Framework as not all risks require funding as the mitigation i.e. Neuro Interventional Radiology.

4.2 Schemes from the Prioritisation process

A number of schemes from the Prioritisation process were featuring on the Risk Management Framework after not being allocated funding in the 2017-20 ICP. Following presentation of the schemes to Management Group by the Assistant Director for Evidence, Evaluation and Effectiveness in preparation for scoring the patient element of the Risk Management Framework, it was agreed that given the small number of potential patients requiring the treatments and an extreme likelihood that anyone presenting for the treatments through Individual Patient Funding Requests (IPFR) have been or would be approved, funding was agreed for:

- Complex Obesity Surgery for post pubertal Paediatrics for severe obesity. Estimated number of eligible patients in Wales per annum is estimated to be 1-2 at a cost of £15,000 per patient.
- Use of Plerixafor for stem cell mobilisation in children and young people with Lymphoma and paediatric type solid tumours. Previously Plerixafor was only commissioned for adults in Wales. Estimated number of eligible patients in Wales per annum was 1-2 at a cost of £6,000 per patient. Three patients were funded for this through IPFR in 2016/17.
- Pasireotide for Cushings Disease which is caused by a tumour of the pituitary gland that secretes high level of adrenocorticotropic hormone (ACTH). Estimated eligible number of patients in Wales is 1-2 per annum at an average cost of £12,500.

4.3 Workplan Achievements

In addition to the schemes highlighted above, the following workplan schemes have been completed for 2017/18 and are described in table 1.

Table 1 – Workplan Achievements in 2017/18

Programme	Description
Cancer and Blood	Bone Marrow Transplantation (BMT): Implementation of the investment, first approved in 2016/17, in the quality and capacity of the BMT service for south Wales, in particular the recruitment of nursing and therapy staff to ensure quality standards are achieved.
	The BMT service in Ysbyty Gwynedd, BCUHB, achieved JACIE accreditation in the summer 2017.
	Thoracic surgery review: WHSSC has made significant progress taking forward the strategic review of thoracic surgery in South Wales. This has included implementing a public engagement exercise during the Autumn 2017 to inform the development of recommendations on the future service model. In January, the Joint Committee supported the recommendation for a single centre based at Morriston Hospital. Currently work is taking place to develop the implementation plan and to scope the requirements for public consultation.

Programme	Description
	Graft versus host disease: Funding was approved within the WHSSC plan 2017/18 to extend the policy for Extracorporeal Photopheresis to treat chronic GvHD to include additional sites within the body.
	Proton Beam Therapy (PBT): Commissioning policies have been developed and approved to define access criteria for PBT for children and adults. In addition, the service specification for PBT for patients from Wales has been finalised and approved.
	Positron emission tomography (PET): Additional indications for head and neck cancer were approved for inclusion in the PET CT policy during 2017/18.
	Bariatric surgery for Children and Teenagers and Young Adults: Funding was approved within the WHSSC plan 2017/18 to commission bariatric surgery for children and young people.
	Bariatric surgery: The bariatric surgery service specification has been developed and consultation completed. The specification is currently being finalised.
	Bariatric surgery: Waiting times for bariatric surgery have significantly reduced during 2017/18. No patients are currently waiting in excess of maximum waiting times targets.
	Thoracic surgery sustainability and capacity: A locum thoracic surgeon has been appointed to Cardiff & Vale UHB to provide additional capacity and resilience in the service in the interim period while the strategic review is completed and the new service model implemented.
Cardiac	Commissioned the Delivery Unit to undertake an All Wales Cardiology to Cardiac Surgery Transfer Review to understand and improve the accuracy of Pathway Start dates to reduce waits for patients. Completion of an Action Plan to deliver the agreed actions with oversight from HCIG and Joint Committee.
	Completed a service specification for Cardiac Magnetic Resonance Imaging (CMRI) in line with the collective commissioning framework. Service Specification being taken forward by HB's supported by Cardiac Network.
	Achievement of Cardiac Surgery RTT at ABMU with a reduction in number of patients breaching at CVUHB.
	Completed a review of the current evidence for the provision of Trans-catheter Aortic Valve Implantation to ensure equity of access for Welsh patients.
Mental Health	Expansion of secure LD Gatekeeping expertise.
	New NICE guidelines issued for eating disorder services and Welsh Government Framework to be reviewed.
	New interim Gender Pathway agreed and business case received from Cardiff & Vale UHB for establishment of Welsh Gender Team.
	Initial options appraisal for Perinatal services completed and commitment from Welsh Government to establish inpatient beds in Wales.
	Case management function for secure patients contributed to significant reduction in patient numbers and lengths of stay.
Neurological and Complex Conditions	Commissioned a sustainable service model for Clinical Immunology in South and Mid Wales.
	Publication of the Paediatric Neuro-Rehabilitation service specification.

Programme	Description
	Appointment of Consultant Neuro-Vascular Surgeon and supporting staff to allow for implementation of a NICE compliant Neuro-Vascular MDT.
	Commissioned robust core Neurosurgery to ensure a sustainable junior medical staff model supported by nurse practitioners and allow for the introduction of pre-assessment.
	Achievement of RTT 26 weeks for Wheelchairs in the South Wales service following investment.
	Commissioned a more equitable and sustainable Prosthetics service for South East Wales.
Women and Children	Reviewed the Specialised Services Policy for Fertility Services in Wales.
	Supported specialised paediatric services at the Children's Hospital for Wales and have seen a significant reduction in the numbers of patients breaching the 36 week referral to treatment target.
	Supported the implementation of NIPT screening for Down's, Edward's and Patau's syndromes.
Renal	Completion and publication of the Renal Delivery Plan.
	Development and implementation of service specifications for each area of service: CKD, vascular access, home HD, Unit HD, PD, Conservative management and EOL care, transplantation, AKI and transport.
	Award and implementation of South East Wales dialysis contract. New units opened in Pontypool, Newport and Cardiff South delivering more local capacity, improved environment and facilities and higher nurse: patient ratio.
	Contract refresh of national home therapies framework to ensure service consistency and VFM opportunities across Wales.
	Collaboration with Cardiff and Vale to develop and submit business case for the service model redesign and refurbishment of the UHD main unit.
	Collaboration with ABMU for refurbishment and expansion of the UHD main unit.
	Collaboration with Powys LHB to develop a business case for the expansion of Llandrindod Wells UHD Unit to ensure provision of more local UHD capacity and local access to clinics, reduction of travel time for patients and reduction in costs for ECR/out of area travel and treatment for Powys residents.
	Collaboration with BCUHB to redesign service model for UHD and undergo procurement exercise to refresh existing units, increase regional capacity for UHD and replace Wrexham unit which is in urgent need of repair including a replacement water treatment plant.
	Development of IT national systems for automated reporting and audit across Wales
	Development and implementation of e-alert system to generate AKI alerts across Wales.
	Design and implementation of reporting suite for AKI and regular rolling performance reporting to LHBs via RRAILs.
	Development and agreement of service standards for transport and collaboration with EASC to develop new commissioning model for NEPTs.

Programme	Description
	Collaboration with WAST to improve the safety of the transport service by introducing new standards and monitoring of the service specifically relating to reduction of missed or lost hours of treatment missed.
	Appointment of WRCN Lead nurse to further develop QPS agenda, inspectorate role for UHD units, national development of nursing workforce, consistency in standards and service provision.
	Development and delivery of new Renal Module with Swansea University for renal nurses across South East and West Wales.
	Appointment of WRCN Lead Pharmacist to develop national protocols for key high cost drugs, review and refresh drugs contracts to ensure VFM and continued delivery of cost savings, and to develop the workforce nationally to deliver consist standards of service.
	Appointment of Youth Worker for South East and West Wales working with young adults to provide advice, support and patient engagement which has led to an improvement in treatment compliance and a significant reduction in the loss of transplanted organs as a result.

4.4 Collective Commissioning

Over the course of 2017/18, the WHSS team has commenced scoping work on the following areas of the collective commissioning work programme:

- Paediatric Radiology
- Gynaecological Cancers
- Paediatric Rheumatology
- Rare Neurological Diseases

Further work will be undertaken on the following new services and emerging issues over the course of 2018/19:

- Mechanical Thrombectomy
- Major Trauma

This outcomes of this work be will presented to the Joint Committee over the course of 2018/19, in order to inform the development of the next ICP.

4.5 Commissioning Strategies

WHSSC has continued to develop commissioning strategies for a number of specialised services listed below, in order to inform recommendations on a whole pathway basis and address issues such as equity of service provision and access to services across the whole population.

Commissioning Strategies:

- Thoracic surgery
- Specialised neurosciences
- Gender dysphoria

- Perinatal services
- Specialised adult eating disorders services

The aim of the Commissioning Strategies is to provide a five year commissioning plan which will inform the development of WHSSC's ICPs and Health Boards IMTPs over that period.

4.5 Quality and Performance Escalation Framework

Although WHSSC's Quality Management Framework (QMF) describes the overarching approach used to maintain high quality care and provide assurance to its Joint Committee it also needs to be assured that its performance management processes for those commissioned services are effective. In addition, it is only by performance managing those services effectively that WHSSC can assess whether its strategic goals are being achieved.

During 2017-18, the quality and performance management processes have been enhanced through the introduction of a new escalation process. The process includes the following stages:

Stage I - Enquiry
Any quality or performance concern will enter the process at this stage. The evidence will be reviewed and an informal enquiry into the concern will be undertaken.

Stage II – Investigation
If the stage I enquiry identifies the need for further investigation, the lead party will initiate an investigation process which may include:

- attendance at provider performance meetings
- triangulation of data with other quality indicators
- advice from external advisors

Stage III – Commissioning Quality Visit
If the stage II enquiry identifies the need for further investigation, a commissioning quality visit will be undertaken. The nature and focus of the visit will vary depending on the circumstances of the issue in question. In instances where there is insufficient evidence available to make a judgement on the degree of concern, further evidence collection may be commissioned prior to the visit.

Stage IV – Escalated Monitoring Meeting
Where there is evidence that the Action Plan emanating from a Stage III visit has failed to meet the required outcomes as agreed by an escalation scrutiny group (the format for which is currently being developed) the meeting will identify the next steps from the following:

- further action planning
- penalties
- de-commissioning
- outsourcing

The stages of the Escalation process are also shown diagrammatically in Annex 5.

4.6 Enhanced Performance Management arrangements 2017-18

In 2017-18, WHSSC has implemented enhanced performance management arrangements in the following services at the following stages of the Escalation process (Table 2).

Table 2 – Services in Escalated Performance Management

Service	Provider	Stage
All Wales Lymphoma Panel	C&V	Stage 2
Cardiac Surgery	ABM, C&V	
Paediatric Intensive Care	C&V	
Posture and Mobility (Wheelchair Service)	BCU, C&V	
Plastic Surgery	ABM	
Thoracic Surgery	ABM, C&V	
CAMHS (North Wales Adolescent Service)	BCU	Stage 3
Paediatric Surgery	C&V	
Neurosurgery	C&V	
Bariatric Surgery	ABM	Stage 4

4.7 Workforce and Organisation Development

The Joint Committee has again acknowledged that the organisation has expertise in commissioning and in 2017-18, staffing resources have been deployed to support collective work on behalf of LHBs to commission services which are outside WHSSC's delegated remit. This recognition of the expertise within the organisation is welcomed and WHSSC is keen to continue to develop organisational capacity by continuously improving the capability of staff and ensuring that the workforce is engaged, motivated and working collaboratively together. Proposals to undertake further collective commissioning work are being reviewed to ensure that any additional staffing resources required are considered and approved in conjunction with the agreement to undertake the work.

4.7.1 Workforce

During 2017-18 the Corporate Directors Group has continued to review all posts within the organisation. The aim was to identify any gaps and to ensure effective use of resources. The review also considered the current establishment against staff in

post and current workforce knowledge and skills. This is helping to shape future organisational development and learning plans. It has been decided that a new programme tailored to WHSSC's specific needs should be developed. The Managing Director and Committee Secretary are currently evaluating alternative models and service providers to progress this.

The appointment of a substantive Managing Director was previously identified as crucial to the leadership and stability of the organisation. The appointment of Dr. Sian Lewis, as substantive Managing Director, became effective in September 2017.

Progress has been made during the year on organisational change to facilitate recruitment of staff to form the Quality Assurance Team. It is anticipated that the recruitment process will commence in early 2018/19.

4.7.2 Staff Engagement

Over the course of the last year, work has been undertaken to strengthen staff engagement throughout the organisation. Departmental meetings are held at least monthly and 'all staff' meetings are periodically convened by the Managing Director or Chair giving employees at all levels in the organisation opportunities to interact. In addition, the physical presence of almost all WHSSC staff in a single building in South Wales makes engagement relatively easy.

4.7.3 Personal Development Reviews

The achievement of PDR targets and the completion of core skills training by all staff are key priorities for WHSSC. We are working with all staff not just Line Managers, to understand the importance of personal development reviews being undertaken.

4.7.4 Staff Sickness and Absence

As WHSSC is a small organisation, sickness and other absences have a significant effect on the capacity of the organisation. Short and long term sickness absence continues to be a focus, with all Line Managers attending sessions put on by CTUHB to ensure that they are aware of the changes to the All Wales Sickness policy and have the skills to implement them. Table 3 shows the sickness absence rates for WHSSC.

Table 3 - WHSSC Sickness Absence Rates

Rolling period Nov 2016 – Oct 2017		
Absence days (FTE)	Available days (FTE)	% Rolling rate (FTE)
939.42	17,918.30	5.2

Note: Excluding EASC and QAIT

4.7.5 Commissioning Teams

The WHSSC planning functions have been delivered through a specialty based programme team model since 2010. In 2017, the clinical focus of the teams was

strengthened through the appointment of Associate Medical Directors, and they were re-launched as commissioning teams.

The range of services delegated for commissioning by WHSSC for 2018-19 by Commissioning Team is shown in table 4.

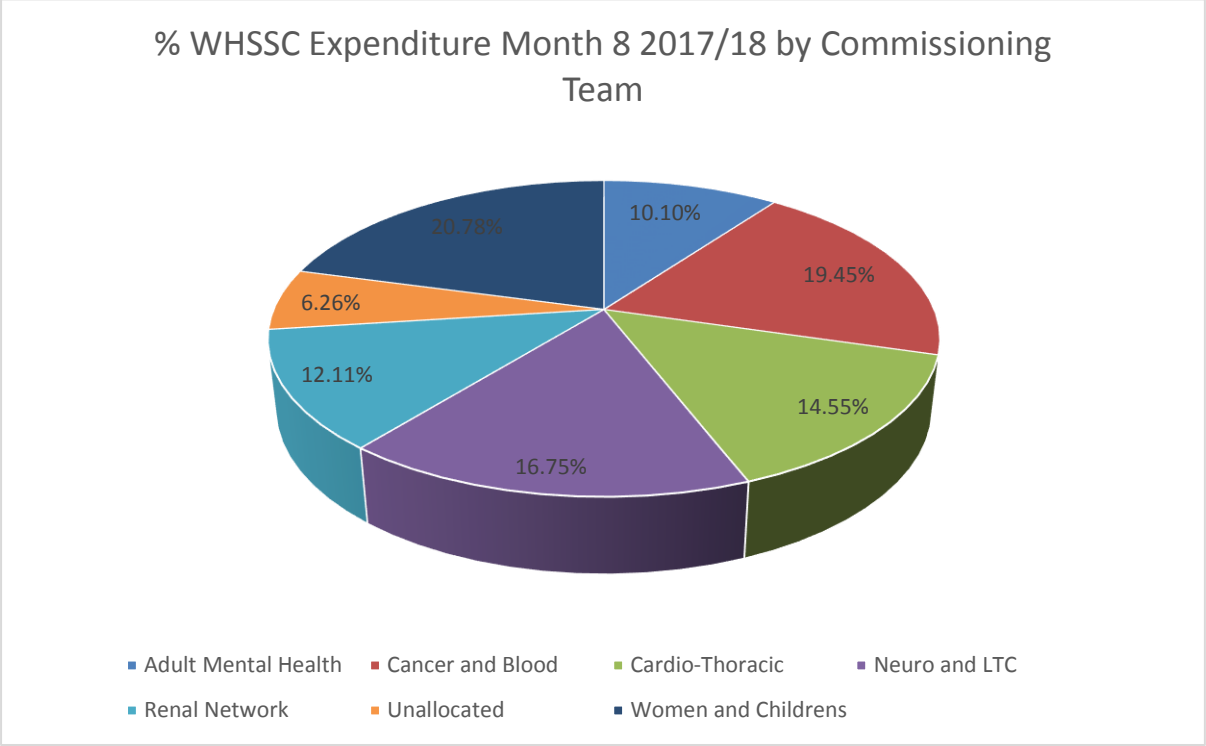
Table 4 – Range of Services commissioned by WHSSC

Commissioning Team	Services
Cancer and Blood	Rare cancers Specialised services for all cancers Inherited bleeding disorders Blood and marrow transplant Hepatobiliary surgery Thoracic surgery Plastic surgery
Cardiac	Cardiac surgery Adult congenital heart disease Specialised cardiology services Bariatric surgery
Women and Children	Specialised paediatric services Paediatric intensive care Neonatal intensive care Specialised fertility services Inherited metabolic diseases Genetics
Mental Health	High and medium secure forensic services Tier 4 and forensic child and adolescent mental health services Gender identity services Specialised adult eating disorders Specialised perinatal services Other specialised mental health services
Neurological and chronic conditions	Neurosurgery (Adult and Paediatric) Neuro-rehabilitation Neuropathology Interventional neuroradiology Neuropsychiatry Paediatric Neurology Environmental controls Communication aids Prosthetic services Posture and mobility services Spinal injury rehabilitation Clinical immunology
Renal	Renal dialysis

Commissioning Team	Services
	Renal transplant

WHSSC's budget split by Commissioning Team is shown in figure 9. WHSSC's largest Commissioning Team - Women and Children's, represents approximately 20.78% of WHSSCs (£116m) total expenditure with the smallest team being Mental Health representing approximately 10.10% (£56m). Individual Commissioning Teams budgets are still an area of discussion as priorities are being aligned to resources; therefore, it is likely that these budget areas are redefined over the next year.

Figure 9: WHSSC expenditure by Commissioning Team



4.7.6 Development of Clinical Leadership

Both the Good Governance Institute (GGI) and Health Inspectorate Wales (HIW) reviews included the need to strengthen clinical leadership, clinical credibility and clinical engagement within the WHSS Team. This is now core to our strategic focus and significant steps have already been undertaken to deliver this. In September 2017 five part-time Associate Medical Directors took up post, each aligned to one of the commissioning teams. They have already had a significant impact in raising the profile of the WHSS Team amongst clinical colleagues. Examples include the work that is underway regarding delivery and improving access to Thrombectomy services and addressing clinical and performance concerns in one of our CAHMS units.

More recently appointments were made to the part time Medical and Deputy Medical Director roles. These are key appointments in taking forward the WHSS

Team strategy. The Deputy post will focus on the prioritisation, evidence evaluation and rare diseases portfolio and the Medical Director on the performance management, quality outcomes and strategic review elements of the role. It is anticipated they will take up post in the last quarter of 2017/18.

As already outlined the only vacancy in the current structure is the Associate Medical Director in Public Health.

4.7.7 Recruitment of the Quality Team

In addition to the appointment of an Executive Director of Nursing and Quality and new Associate Medical Directors the organisation has identified funding to support the extension of the clinical team to support the quality function of the organisation. The need for the development was explicit in the recommendations of both Health Inspectorate Wales and the Good Governance Institute reports (2015). Recruitment is planned to commence from early 2018 and posts should be fully functional by the start of the new financial year. These posts will strengthen the function of the Commissioning teams and build on the current work driving the focus on improved patient delivered outcomes and experience even further.

4.7.8 External Training and Development

WHSSC offers unique all Wales strategic planning experience. It is our intention that this is opened up as a resource for the wider NHS in Wales. This philosophy has helped drive the restructuring of the Medical Directorate and the development of training opportunities throughout the organisation. Specifically within the medical directorate the Associate Medical Directorate roles provide a stepping stone for those pursuing a career in medical leadership. They were specifically advertised as three year posts with this in mind.

Related to this role the WHSS Team has developed a bid for the Wales Deanery to host a Welsh Clinical Leadership Fellow and has just been awarded training status for the Public Health trainees. We are also actively engaging with the host Health Board to explore opportunities for honorary roles within the WHSS Team.

The organisation has participated in CTUHB's Graduate Trainee Scheme since April 2016. This has led to twelve Graduate Managers undertaking placements with us and gaining an understanding of Specialised Services and how they are commissioned. Trainees from the NHS Wales Graduate Training Scheme have also undergone placements with WHSSC from both a General Management and Finance perspective.

WHSSC is keen to offer opportunities to NHS Wales' staff to gain the unique skills and experience in planning and commissioning that WHSSC can offer.

4.8 Information and Communications Technology

WHSSC is continuing to work to increase its access to, and use of, high quality health intelligence systems. The organisation will do this by strengthening collaboration with a number of existing providers and developing new relationships when required. Initial contact has been made with a number of academic units in Wales to understand the opportunities to ensure that commissioning activities are underpinned by a strong evidence base and are therefore in line with the principles of prudent healthcare.

Information & Communications Technology provides an opportunity to improve the effectiveness of the way in which WHSSC operates and the priorities for 2018-21 will be to focus on streamlining and automating systems and processes. They key areas of improvement are described in table 5.

Table 5: Information and Communications Technology priorities 2017-20

Improvement Objective	Description	Lead	Timescale
Streamline and automate processes	To significantly reduce, duplication, error and process inefficiencies by automating and streamlining current working practices through the better use of Information, Communication and Technology (this has already included the roll out of the electronic Board pads, electronic staff records, E-expenses and electronic payslips).	Committee Secretary	Ongoing
Improve access to information	Following the recent appointment of a Business Support Officer, to improve the way in which staff access information resulting in improvement in efficiencies and reduction of staff time. This will include the ongoing development of the Sharepoint Site, the Intranet Site and the Internet Site ensuring that all Health Boards can access information about	Committee Secretary	Ongoing

	our work programme and committee business. This will also support the policy development work and allow electronic participation to be offered for consultation processes.		
Quality Measures	Develop a suite of quality measures to be used in contract monitoring and performance management and automate systems for their collation, communication and analysis. (This is dependent upon the resources being available to improve the quality assurance function).	Director of Finance and Director of Nursing and Quality	September 2018
Commissioning Support	Following the recently announced appointment of the Head of Information, develop service dashboards to enable consistent and easy access by all staff to financial and activity information on a service basis, and to ensure intelligence is available regarding equity of access. The Commissioning Intelligence Portal has been developed by NWIS led by WHSSC and implemented in 2017/18. The implementation project will continue to develop the functionality of the system working with health boards to meet their local needs for secondary care as well. The system ensures systematic access and analysis of all care delivered by NHS England and then extended to NHS Wales.	Director of Finance	September 2018

	This enables better trend analysis, control and planning.		

5 Development of the 2018-21 Plan

This chapter describes the process for developing the *Integrated Commissioning Plan 2018-21* and progress to date.

5.1 Principles

The ICP is demonstrably commissioner-led and the process for developing it is designed to ensure that there is continuity with previous ICPs. The aim of the process is to ensure that there is full alignment between the ICP and the Local Health Board Integrated Medium Term Plans, both at a financial and service level. The lessons learned from the previous three years of the ICP cycle are built into the process. These include:

- developing clear WHSSC commissioning priorities
- accelerating the relative prioritisation of schemes requiring evidence appraisal
- building in the risk-assessment of schemes regarding service issues and sustainability
- allowing sufficient time for examining opportunities for savings and repatriation and to consider the application of prudent healthcare to specialised services
- consideration of Health Board priorities for specialised services, and,
- integrating scrutiny and good governance.

5.1.1 Improved interface with Commissioning Health Boards

Although WHSSC has worked with all Commissioning Health Boards through the ongoing Management Group meetings, this is not always evident within individual Health Board Integrated Medium Term Plans (IMTP) as there are only limited references to WHSSC and specialised services. We are keen to provide synergy with wider NHS structures such as Regional Planning Boards, and work with them to identify those services and areas that we currently commission but which may benefit from a different commissioning approach.

WHSSC recognises that it needs to develop closer relations with the Planning Departments in particular. As part of the development of this year's ICP, WHSSC has met with each Health Boards IMTP Leads in order to share commissioning intentions and gain knowledge of priorities for that Health Board. We know that patients from North Powys and Betsi Cadwaladr University Health Board (BCUHB) have specific needs in how specialised services are delivered and we are looking to provide tailored organisational arrangement to support these.

WHSSC wish to expand working with partners in NHS Wales and NHS England during 2018-21 to identify opportunities for re-commissioning, in order to ensure that resources are used to achieve the greatest benefit to patients across the care pathway.

5.1.2 NHS Wales Delivery Plans

WHSSC continues to support Health Boards in the delivery the condition-based NHS Wales Delivery Plans, and is an active contributor to the Cancer Implementation Group, Heart Conditions Implementation Group, and Neurological Conditions Implementation Group. The WHSS team is also working closely with the Stroke Implementation Group on plans for improving access to and provision of Mechanical Thrombectomy.

5.2 Horizon Scanning and Prioritisation

5.2.1 Introduction

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. 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 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 ICP.

The use of horizon scanning and prioritisation is now firmly embedded in WHSSC's commissioning practice and has been applied successfully for the past three years. The processes, methodology and governance for horizon scanning, evidence evaluation and prioritisation is reviewed annually and revised when appropriate. The full methodology for 2017-18 is presented in Annex 6.

5.2.2 Horizon scanning

Horizon scanning requires a systematic examination of all relevant information sources in order to identify new and emerging technologies. A horizon scanning exercise was carried out by the Medical Directorate at WHSSC between May and October 2017 to inform this process.

The sources of information that WHSSC uses to horizon scan have now been formalised and these are presented in Section 2.1 of Annex 6. The first cut of this horizon scan identified 38 new technologies or treatments for WHSSC to consider.

Following triage this was reduced to 9. This represents a significant reduction compared to last year when 27 new interventions were considered. This difference was largely due to a much smaller number of topics assessed this year by the Clinical Prioritisation Assessment Group in NHS England.

A summary of the new interventions identified for consideration by the Prioritisation Panel are presented in table 6 and includes the source of each item.

Table 6: Interventions to be considered by the Prioritisation Panel (2018/19)

Indication	Intervention	Source
Bevacizumab (Avastin)	Vestibular schwannoma in neurofibromatosis type 2	Turned down by the IPCG 'One Wales' process
Nitisinone (Orfadin)	Alkaptonuria	
Stereotactic radiosurgery/ radiotherapy	Pituitary adenomas [adults]	NHS England policies to be routinely commissioned following their recent Prioritisation Process
Nusinersen	Genetically confirmed Spinal Muscular Atrophy (SMA) type 1	
Mechanical thrombectomy	Acute ischaemic stroke	
Balloon pulmonary angioplasty (BPA)	Chronic thromboembolic pulmonary hypertension (all ages)	
Second allogeneic haematopoietic stem cell transplant (HSCT)	Relapsed disease (all ages)	Schemes considered for inclusion in the 2017/18 Prioritisation Process but excluded on the basis that an evidence appraisal would be required
Eculizumab	Recurrence of C3 glomerulopathy post-kidney transplant (all ages)	
Riociguat	Pulmonary arterial hypertension	

5.2.3 Prioritisation

The scoring and ranking of new interventions was carried out by a Prioritisation Panel using methodology described in the All Wales Prioritisation Framework (2011) (see: 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. Membership of the WHSSC Prioritisation Panel was based on recommendations in the All Wales Framework and recruitment was completed by the

end of October 2017. The final membership of the WHSSC Prioritisation Panel is presented in Annex 7.

Each of the interventions presented in table 6 were considered by the WHSSC Prioritisation Panel during one all-day meeting on 30 November 2017.

5.2.4 Methodology

All voting members of the Panel were asked to score each intervention against the following five criteria in order to develop recommendations on their relative priority:

- Burden of disease (nature of the condition, the size of the population effected and the current availability of treatments).
- Patient benefit (potential for positive health impact / improved safety / clinical outcomes).
- Quality of the clinical evidence (clinically reliable evidence to demonstrate clinical effectiveness).
- Quality of the economic assessment (value for money with a potential for improved efficiency/ cost effectiveness in delivery of health services).
- Equality and human rights (potential for improved / reducing inequalities of access).

At the meeting Panel members were first asked to agree a relative weighting algorithm for each of these criteria. The 'weighted scores' for each of the interventions was then calculated and used to rank the topics following voting.

Group decision support methods were integrated into the process to facilitate decision-making, gain consensus and improve the use of time in the meeting. This support was provided by Dr Sam Groves (Welsh Health Economics Support Service (WHESS)). This method employed a voting system and a set of wireless handsets to enable parallel, simultaneous and anonymous individual input. Voting in this way allowed weights for criteria to be agreed and final recommendations to be made in a collegial atmosphere, without conflict or disagreement.

5.2.5 Results

Prior to voting the Panel agreed to remove the following three topics from the process:

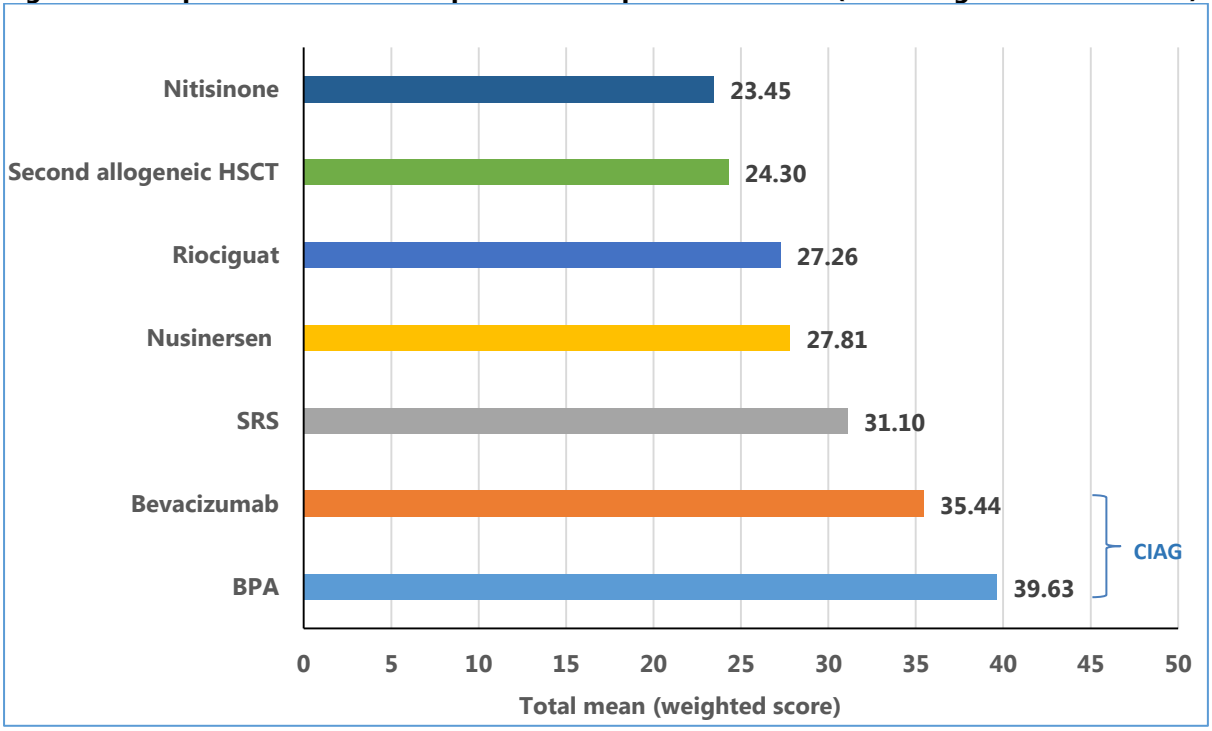
- Stereotactic radiosurgery/ radiotherapy for the treatment of pituitary adenomas (adults). This indication is already commissioned by WHSSC.
- Mechanical thrombectomy for acute ischaemic stroke. This intervention requires very specific planning and has high set-up costs.
- Eculizumab in the treatment of recurrence of C3 glomerulopathy post-kidney transplant (all ages). The evidence base was weak/uncertain and the expected

volume of eligible patients very small. The Panel recommended that this intervention is considered via IPFR.

The remaining topics were presented to the Panel and the results are shown in figure 10. Members agreed that the following two interventions be considered for inclusion in the 2018-21 ICP and further prioritisation against the existing WHSSC schemes by the Clinical Impact Assessment Group (CIAG) (see section 5.3):

- Balloon pulmonary angioplasty (BPA) for chronic thromboembolic pulmonary hypertension (all ages).
- Bevacizumab (Avastin) for the treatment of vestibular schwannoma in neurofibromatosis type 2.

Figure 10: Output from the WHSSC prioritisation process 2018/19 (total weighted mean scores)



The Medical Directorate at WHSSC are proposing to bring forward the horizon scanning and prioritisation process by three months in 2019/20 in order to better align with ICP development and the current NHS England prioritisation process.

5.3 Joint Clinical Impact Assessment Group and Management Group Prioritisation

The development of the 2017-20 ICP saw WHSSC introduce a prioritisation process to review schemes and make recommendations for inclusion on relative priority from a purely clinical perspective. Membership was drawn from Health Board Medical Director's Offices. Each Health Board was asked to nominate their Associate Medical Director with responsibility for Primary Care. Members were appointed as individuals

and not to represent the views of any stakeholder organisation they may be affiliated to. In addition, all members were asked to complete and sign a declaration of interest form prior to appointment.

Despite the success of the CIAG in bringing a strong clinical perspective to the priorities within the ICP, there was criticism from WHSSC Management Group members over the lack of integration between the CIAG's prioritisation of schemes and the Management Group prioritisation which had occurred earlier in the ICP process. There were also suggestions that the Clinical prioritisation had taken precedence. In order to dispel any concerns over the prioritisation process, it was agreed for 2018-21 that a Joint meeting would take place between the CIAG and Management Group members.

5.3.1 Methodology

The Group, the membership for which is outlined in Annex 8, was asked to assess and score a list of 13 schemes previously un-assessed by CIAG, on the basis of their clinical impact the pre-determined criteria. This list comprised schemes risk-rated >16. All schemes categorised as mandatory were excluded from this process.

The pre-determined criteria used by the CIAG in the previous year was used for the Joint meeting:

- Burden of Disease
- Patient Benefit (potential for positive health impact/improved safety/clinical outcomes)
- Equality and Human Rights (potential for improved/reduced inequalities of access)

Each scheme presented received a separate vote out of ten on the three elements of the criteria outlined above.

Every Clinician present received a vote and there was one vote assigned to each Health Board from a Management Group perspective. This ensured that the voting was not dominated by Management Group members or a particular Health Board as Management representatives ranged from 1 to 3 between Health Boards.

To help the Group with the decision-making process, each scheme was supported by a statement prepared by the lead Specialist Planner and consisted of the following package of information (where available):

- Service overview
- Patient population and growth
- Summary of the issue / risk
- Proposal
- Mitigation

- Clinical Expert Summary

The output from the Group is presented in figure 11 with the information planned to be used to develop final recommendations regarding schemes for inclusion in the ICP.

The full detail of the methodology used by CIAG is also presented in Annex 9.

5.3.2 Schemes not scored

Following the presentation and rigorous discussion of the schemes, the Group agreed to remove a number of schemes from the process, prior to voting. Details of these and the reasons for removing are outlined below:

- Bariatric Surgery – unclear need for further investment
- Neonatal Transport – further work required on the governance issues
- Neuro-modulation – should be explored through the value work, and
- Paediatric Endocrinology – service model needs clarifying.

5.3.3 Results

Figure 11 outlines all the schemes prioritised through the WHSSC CIAG process in 2016/17 that were not progressed during 2017/18 due to funding constraints (in blue), along with the schemes prioritised by the Joint CIAG Management Group process in 2017/18 (in green).

The schemes are ranked by the mean score of the three pre-determined criteria. We understand that the schemes which came out with the lowest scores are due to reasons of either not being considered core WHSSC services or their requirements for investment are still in the developmental stage.

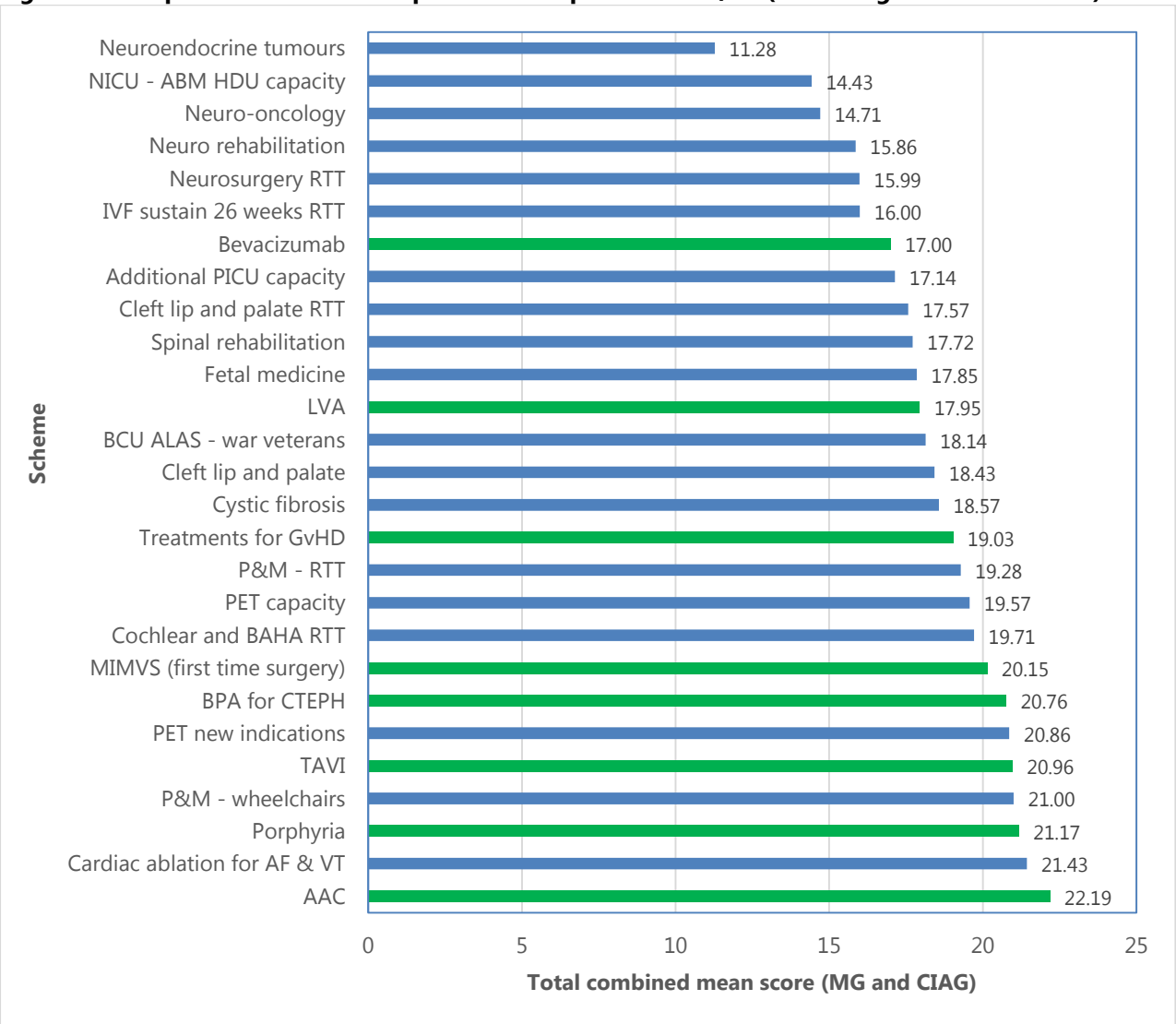
All schemes scored by the CIAG/Management Group this year and during the development of the 2017-20 ICP which due to funding constraints did not allow for the funding of any of the schemes prioritised and therefore are rolled over for consideration in the 2018-21 ICP are included in figure 11.

Two of the schemes included namely Cochlear and Bone Anchored Hearing Aid (BAHA) Referral to Treatment and Lymphatic Venous Anastomosis (LVA) have been highlighted as ministerial priorities and the funding required for them has been included in the baseline of the 2018-21 ICP.

Welsh Government announced in April 2017 that WHSSC would be working with Health Boards in a phased approach, to reduce the waiting time targets for adult Cochlear Implant and BAHA Surgery from the current 52 week RTT target to 26 weeks for standard cases and 36 weeks for complex cases over the next three years. During 2018/19 the target is to reduce the waiting time by 50%. In regard to LVA, the

evaluation period of the service has recently been extended from two to three years and is due for completion in 2018/19.

Figure 11: Output from the WHSSC prioritisation process 2018/19 (total weighted mean scores)



The CIAG schemes can be categorised into three broad groups:

1. Schemes with a Clinical Impact Score higher than 20 – As the highest maximum score is 30, these eight schemes are perceived to have the greatest clinical impact.
2. Exception risks – there are two schemes which scored less than 20, but are considered to be very high risk:
    - Spinal Rehabilitation (South Wales) – this service is extremely fragile, as it is delivered by a single consultant and with relatively few Units across the UK we know that there would be extreme difficulties in this service being delivered elsewhere for Welsh patients.

    - PICU capacity (South Wales) – WHSSC has become aware of difficulties in accessing PICU beds, and an increase in the rates of refused admissions over the last few months.
3. RTT schemes – there are a number of schemes which relate to a requirement for additional resources in order to deliver improvements against the RTT targets. These schemes have been grouped into a single table as they each have similar priority in meeting Welsh Government delivery requirements.
4. Schemes with a Clinical Impact Score lower than 20 – These schemes are perceived to have a lower clinical impact, and therefore are not considered to be as high a priority as the schemes included within the first three groups.

5.4 Schemes included within the 2018-21 ICP provision

The following schemes are included within the 2018-21 ICP provision:

- Alternative and Augmentative Communication (All Wales)
- Cardiac Ablation for Atrial Fibrillation and Ventricular Tachycardia (South Wales)
- Porphyria (South Wales)
- Replacement of obsolete wheelchairs (South Wales)
- Transcatheter Aortic Valve Implantation (All Wales)
- New indications for Positron emission tomography CT (All Wales)
- Percutaneous balloon pulmonary angioplasty for chronic thromboembolic pulmonary hypertension
- Minimally invasive mitral valve surgery (first time surgery) (South Wales)
- Spinal rehabilitation (South Wales)
- Additional Paediatric Intensive Care capacity (South Wales)

5.5 Re-commissioning

Re-commissioning is the application of a value based healthcare approach combined with the principles of Triple Aim and Prudent Healthcare. The purpose of this approach is to assess patient care pathways into and across specialised services, in order to identify whether the current pattern of investment achieves the best outcome or value.

There are two categories of recommissioning schemes within the ICP:

- Workplan – schemes which can be progressed without any additional support as part of Commissioning Teams core workplan.
- Focused Re-commissioning – schemes which require additional support across directorates and Commissioning Teams.

Schemes in both categories must fulfil each of the following criteria:

- Deliverable within a three year time frame (ICP)
- Quality and Performance data

- Availability of benchmarking data
- Good evidence base
- Clearly documented patient pathways into and out of Specialised Services
- All or most of the resources are mapped to WHSSC.

Further detail on the recommissioning schemes is included in Annex 10.

5.6 Service Issues not included within the 2018-21 ICP provision

5.6.1 Key Risks expected to emerge in year

Schemes for the following services have not been included within the 2018-21 ICP provision, but have been recognised as risks which are expected to present in year and may present a cost pressure. Further work is required on each of these schemes, in order to fully identify the resource requirement and outcome.

5.6.1.1 Cystic Fibrosis

A proposal was received from CVUHB for consideration in the WHSSC 2018-21 ICP to support the revenue consequences of the expansion of the South and Mid Wales service based in CVUHB. A draft proposal was prioritised by the CIAG but it did not score over 20 largely because the proposal was not felt to be sufficiently aligned to the risk identified. Based on current Health Board provisions it is not supported for funding.

Whilst we have not yet seen the latest iteration of the capital/infrastructure case, we are advised by CVUHB that there is an urgent need to increase inpatient capacity because of the growing patient cohort which will exceed 300 in 2018/19. They have forecast costs of approximately £700,000. Further work has been requested from the C&VUHB and it is anticipated that this work will be completed for consideration at the May meeting of the WHSSC Joint Committee.

5.6.1.2 Neonatal Transport

Neonatal Transport in South Wales is currently delivered for 12 hours per day, 7 days per week. This service runs on a 1 week in 3 rotational basis between the 3 Neonatal Intensive Care Units (NICUs), Aneurin Bevan, Abertawe Bro Morgannwg and Cardiff & the Vale Health Board. The All Wales Neonatal standards recommends that a 24 hour transport service is in operation for neonatal services.

Whilst this has been articulated by the Neonatal Network, we have not received a proposal from the provider organisations to facilitate this, and further clarity is required to ensure that utilisation of the current resource is fully optimised. It is proposed that a comprehensive review is undertaken of the current system in order to inform the development of a 24 hour service, which can be considered as part of the 2019-22 ICP. In the interim Aneurin Bevan University Health Board is leading work to optimise current provision, and identify solutions for managing urgent out of hours transport requests. Once this work has been completed, a proposal will be

submitted for consideration to the next available meeting of the WHSSC Joint Committee.

5.6.1.3 Fetal Medicine

A proposal was received from C&VUHB for consideration in the WHSSC 2018-21 ICP to fund additional capacity within the Fetal Medicine service. This scheme was not considered a priority through the CIAG process

A different issue relating to the sustainability of the service has since emerged, and we have asked the Health Board to review and develop a proposal for consideration within the year by the WHSSC Joint Committee.

5.6.2 New services

5.6.2.1 Mechanical Thrombectomy

It has been agreed by Joint Committee that WHSSC undertake a collective commissioning approach to planning how a Mechanical Thrombectomy service would be commissioned and procured for NHS Wales. The work will be undertaken in early 2018/19 commissioning to allow for inclusion in the WHSSC Integrated Commissioning Plan 2019-22. Parallel work is underway in NHS England (NHSE) who in November 2017 agreed a policy and service specification for INR services and Thrombectomy.

5.6.2.2 Major Trauma

The proposal for a Major Trauma Network for South and West Wales led by the NHS Wales Collaborative. As part of the development for this new service model, WHSSC has been informed that is has been selected to develop the commissioning framework and governance structure to support the delivery of the service model across the network.

5.7 Workforce and Organisational Development Plan

A summary of the High Level Workforce Plan for WHSSC for 2018-21 is presented in table 7.

Table 7: High Level Workforce Plan for 2018-21

Improvement Objective	Description	Lead	Timescale
Maximise staffing capacity	• Ensure the review of the establishment is complete and is used to inform further iterations of the workforce plan, including the identification of any gaps	Managing Director	March 2018
	• Ensure all vacancies are filled	Managing Director	Ongoing

Improvement Objective	Description	Lead	Timescale
Improve the Quality Assurance function	• Implement the staffing structure to improve the quality assurance function	Director of Nursing and Quality	June 2018
Improve engagement and efficiency by ensuring good teamwork	• Develop and implement organisational development and learning programmes across the organization	Managing Director	Ongoing
Maximise staffing capacity	• Implement the collective commissioning framework to enable prioritisation of staffing resources • Ensure HR policies are appropriately applied to manage sickness and absence and that this is audited • Ensure >85% of staff have completed PDRs	Director of Planning Managing Director Managing Director	June 2018 Ongoing Ongoing
Maximise staffing capability	• Rollout project management approach and continue to improve planning practice • Rollout the organisational training plan	Director of Planning Managing Director	September 2018 Ongoing

6 Finance

This chapter describes the financial framework for the commissioning of specialised services in 2018-21 and the financial impact assessment of the Plan.

6.1 Financial Context

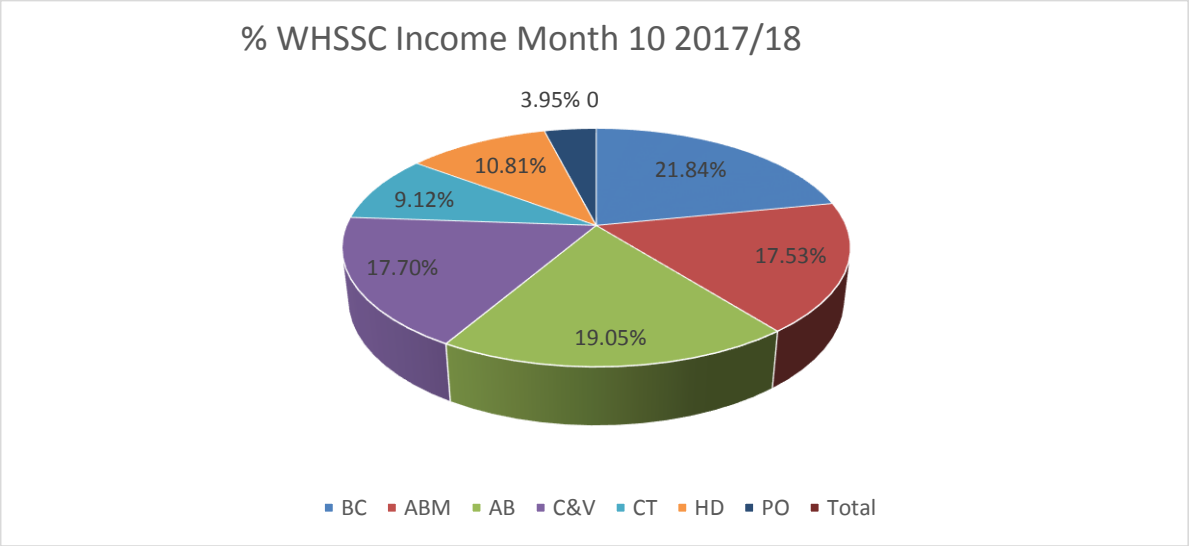
Over 68% (£390m) of WHSSC's spend is within the NHS in Wales, with 33% (£189m) of its overall spend with Wales' major tertiary care provider being Cardiff and Vale UHB. WHSSC has a contractual relationship with all except one NHS Wales organisation and over 40 NHS England Trusts.

The WHSSC financial outlook at month 10 is a forecast underspend of £0.286m for 2017/18 (0.05% of budget). The total budget for WHSSC made up circa 12.9% of the overall NHS Hospital and Community Health Services (HCHS) allocation set by Welsh Government in 2017/18.

The biggest financial risk associated with this position continues to be the HRG4+ price increase for services delivered in England and unplanned growth in volume access to these services. The most significant risk regarding Welsh services is the continued high rate of growth in specialised cardiology spend and the cumulative impact of growth in very high unit cost drugs.

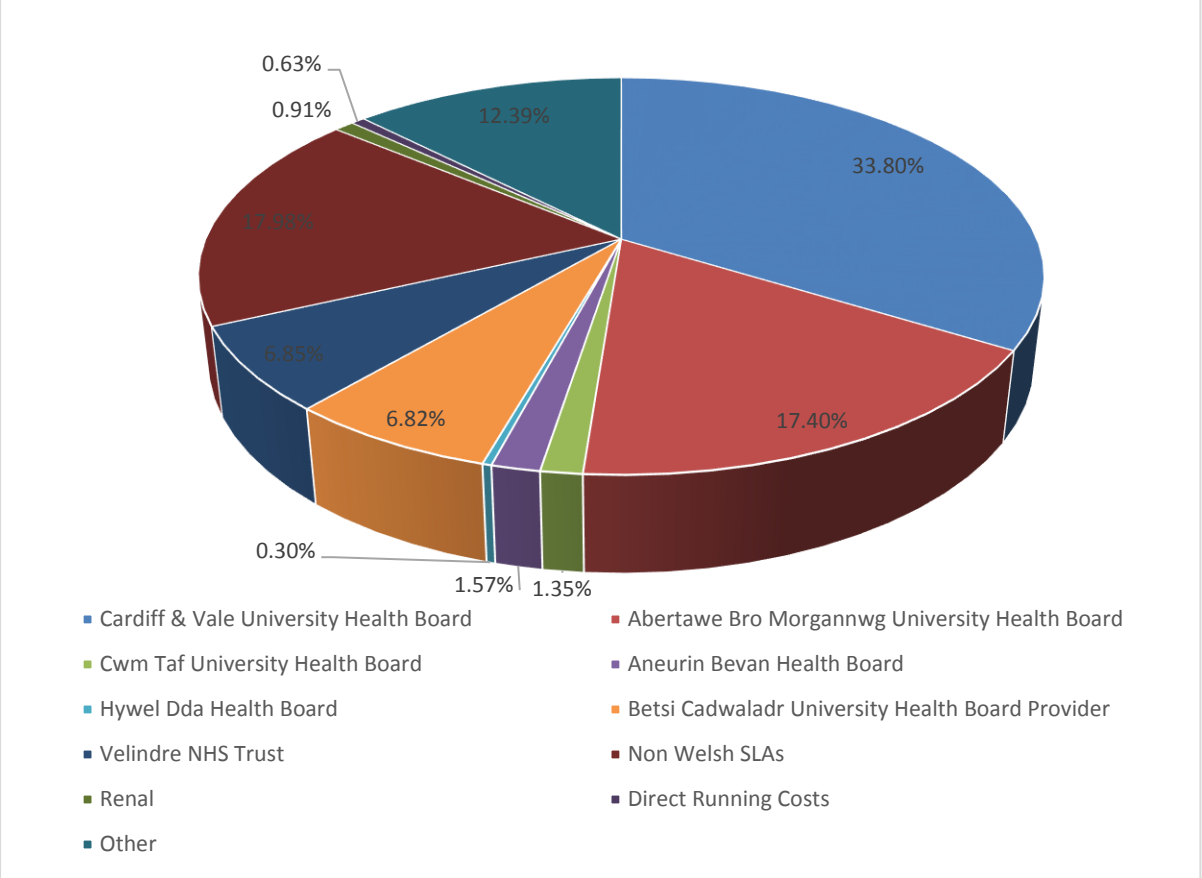
Figure 12 illustrates the income of WHSSC at month 10 of 2017/18 by Health Board.

Figure 12 – Analysis of Income 2017/18 Month 10 – Total £556.547m



The anticipated forecast expenditure for the same period is shown in figure 13.

Figure 13 – % WHSSC Forecast Expenditure Month 10 2017/18



6.1.1 Financial Framework

In line with agreed IMTP methodologies used in previous years, the initial draft of the baseline assessment for January's submission was constructed from the month 8 forecast financial position. However given the significant movements in the Welsh provider performance and a clearer position in English activity growth the March submission has been rolled forward based on the month 10 forecast.

The 2017/18 uplift approved in March 2017 was 3.9%.

The Welsh Government 2018/19 allocation letter included a higher element of top slicing from Health Boards which may limit impact on the ability of Health Boards to recognize cost pressures, including growth in specialist services. In this context, the December 2017 issue of the allocation letter does not at this point recognize any uplift for the disputed price increases as a result of Healthcare Resource Group (HRG) 4+ in England. At the timing of writing this plan the HRG4+ price increase remains unresolved with no agreement between NHS England and NHS Wales.

The WHSS team has undertaken a number of reviews throughout 2017/18 to identify and "slow down" emerging growth pressures as a result of investments approved though management group in previous IMTP rounds. A full assessment of these investments has been carried out and revised full year impacts have been adjusted

for in this plan. In addition, there were a number of recurrent growth assumptions made in previous plans which required some scrutiny before applying direct to baselines. The over-performance that continues to materialize in these areas implies Health Boards intent to continue to fund these services at these increased levels. As WHSSC progresses work on the Re-commissioning Agenda, these areas will be considered to reassure that value is maintained in commissioning these services at the specialist end of the pathway.

WHSSC has also engaged with reviewing schemes for disinvesting for 2018/19 and a number of schemes have been reviewed as well as workshops being held with clinical colleagues. These will also be included in the long list for consideration in the Re-commissioning Agenda.

6.2 Financial Plan Structure and Assumptions

The starting point for this submission is the month 10 forecast financial position. The key components of the financial summary detailed in the attached spreadsheets are:

- the agreed opening allocations based on the agreed 2017/18 position, adjusted for the transfer of Angiography services back to Aneurin Bevan provider
- the month 10 forecast outturn financial position of (£0.286m). This has been adjusted initially to exclude all English SLA variances which are then subject to separate consideration, due to the differential impact of HRG4+. Excluding the English performance the adjusted position is an underspend of (£5.299m)
- the month 10 forecast English SLA position is a £5.013m overspend. Of which circa £2.6m is driven by the non PbR price component and the volume growth elements of the English activity, together with a number of specific provisions for contract negotiations ongoing
- based on an updated assessment against 16/17 outturn and the methodology applied in reporting the impact of HRG4+, it is estimated that circa £2.4m is included within the rollover position
- the maximum impact assessment of English SLA HRG4+ cost is £6.3m, therefore there is an additional risk of £3.9m above the reported position. This additional impact is excluded in full, pending any agreement with Welsh Government on our financial relationship with NHS England and any additional allocations to compensate for the increased cost. This impact also has a highly differential impact on Health Boards
- due to the uncertainty in the resolution of a HRG4+ settlement any further 2018/19 English SLA price & activity growth has not been included
- re-instatement of the Non Recurrent write back position. This removes the in-year release of £5.2m from the rollover position
- adjustment for Non Recurrent Performance. A prudent view has been taken regarding areas experiencing under or over performance and the extent to which they are likely to be recurrent. These assumptions have been subject to

open scrutiny in the ICP process to agree a shared view which needs to relate to agreed commissioning intentions. The key assumptions with regards to materiality include:

  - over performance in South Wales Cardiology is deemed recurrent. Cardiac Surgery under performance has been put back to baselines pending further value review. There will be no further referral from ABMU to Cardiff for cardiac surgery capacity shortfalls
  - TAVI over performance has been limited to current performance pending wider consideration of a policy development scheme
  - South Wales BMT baseline assumes further slippage into 2018/19 and that baseline will be reviewed to match demand assessment
  - the BCU CAMHS out of area placements baseline has been reduced down to £1m, as the high number of placements in 17/18 is assessed as non-recurrent.

- the full year effect of prior year investments. This is the residual of 2016/17 investments which experienced slippage in 2017/18 but are planned to be fully committed from April 2018:
  - this includes the non-recurrent impact of the commitment to reduce Cochlear Implant RTT to 26 weeks in line with the Welsh Government commitment.
- new cost pressures and growth. This includes the full year impact of patients receiving high cost drug treatment commenced in 2017/18 together with a new part year impact of estimated new starters during 2018/19 in line with incidence indications
- mandated high cost drugs. This is consistent with the assessment shared at the Joint CIAG/Management Group workshop plus the Velindre joint commissioning group intelligence for the Melanoma pathway
- value based commissioning work-streams. These mitigating savings include more developed work streams that will continue into 2018-19 and have proven deliverability in the shorter term. As part of the ICP process, there is a parallel Re-commissioning work-stream formulating value based options for consideration. Themes have been identified and prioritised, and schemes will be developed in 2018-19 to inform future ICP's from 2019-20 onwards.
- As in 2017-18, the commissioner contribution to 2018-19 Welsh provider inflation of 2% has been applied to 17-18 Welsh SLA opening baselines. This equates to £7.226m with pass through costs for high cost drugs excluded from the calculation
- apart from high cost & Melanoma drug growth, no provision has been made for Velindre TCS project board costs or the Velindre radiotherapy expansion business case. The methodology agreed at the Velindre Joint Commissioning group is that Health Boards calculate their whole liability for these cases if approved, which includes the element that would flow through WHSSC, therefore this would be a double count if included in both WHSSC and Health

Boards IMTP provisions. Health Boards are therefore advised to check their assumptions to ensure consistency with the joint commissioning group methodology.

The underlying rollover position requires an uplift of £15.157m (2.73% including the mandated high cost drugs). Mandated high cost drugs should be eligible for central WG funding but to ensure there is no double counting, no income is assumed at this stage. Including the provider inflation the rollover provision required increases to £22.383m (a 4.03% uplift).

The exceptional provision for HRG4+ is equivalent to a 1.1% increase on the baseline which is material in the context of the general allocation uplift. Given the national importance of this matter and its uneven distribution, it would be expected that central funding may be considered for this by Welsh Government.

6.2.1 Financial Impact of CIAG and MG Prioritisation process

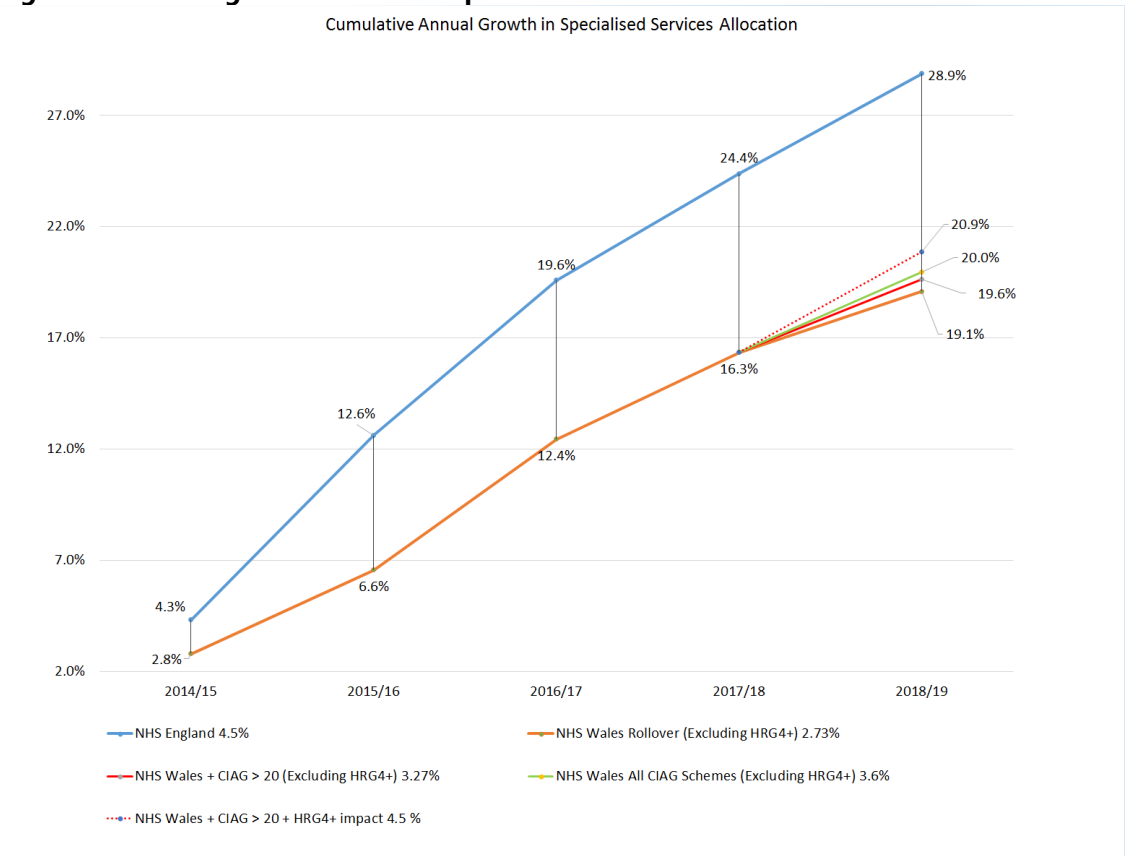
The impact of a range of issues considered under the CIAG and Management Group prioritisation process is included as follows in order of priority:

- CIAG schemes scoring >20 including 2 exceptional risks – these have been assessed as costing £2.961m. At this point two exceptional risks, for PIC capacity and spinal rehabilitation, have been included which did not score higher than 20 but are felt to be exceptional given the impact on other critical services and the degree of risk inherent
- CIAG RTT schemes – these have been grouped together as they all technically have equal standing in terms of Welsh Government priority. The total cost is estimated to be £0.995m
- CIAG schemes scoring <20 – these have been assessed as costing £4.484m. The resulting uplift increases to. These schemes have not been prioritised for investment in 2018/19, and include the adult cystic fibrosis scheme.

6.3 Allocation context

Figure 14 clearly demonstrates the disparity in allocation of funding for Specialised Services between NHS Wales and NHS England and the widening gap in Specialised Service growth between NHS England and NHS Wales over the last 5 years.

Figure 14: NHS England NHS Wales Specialised Services Allocation Growth Differential



Since 2013/14, the cumulative gap in annual growth has increased to a range of between 8-10% depending on the funding uplift approved for Wales in 2018/19.

If growth had remained on parity with NHS England during this period, the additional 8% growth over 5 years would equate to a recurrent baseline increase of £45m above the closing 2017/18 allocation.

Due to the differential impact to health boards of HRG 4+ and the ongoing tripartite discussions with WG and NHS England, the proposed NHS Wales Specialised allocation initially excludes the current assessment of the HRG4+ impact of £6.4m to derive the various funding levels of rollover growth (2.73%), rollover growth plus CIAG schemes scoring above 20 (3.27%) and rollover growth plus all CIAG schemes put forward (3.6%).

Only at the point at which HRG4+ impact is provided for in addition to the 8 CIAG schemes with scores above 20 and the emerging exceptional risks are funded, would the allocation growth for 2018/19 be on parity with the 4.5% annual settlement for NHS England Specialised Services.

Any settlement in Wales below 4.5% will result in the 5 year cumulative gap widening above 8%.

Figure 15 represents the growth in WHSSC allocation in relation to 5 year cumulative growth in NHS Wales HCHS and prescribing allocations. For illustration purposes this includes the initial settlement for 2018/19 allocations for health boards and then total NHS Wales settlement including £43m top slice and indicative £118m retained allocations.

Figure 15: Comparison of HCHS allocations 2013/14-2018/19

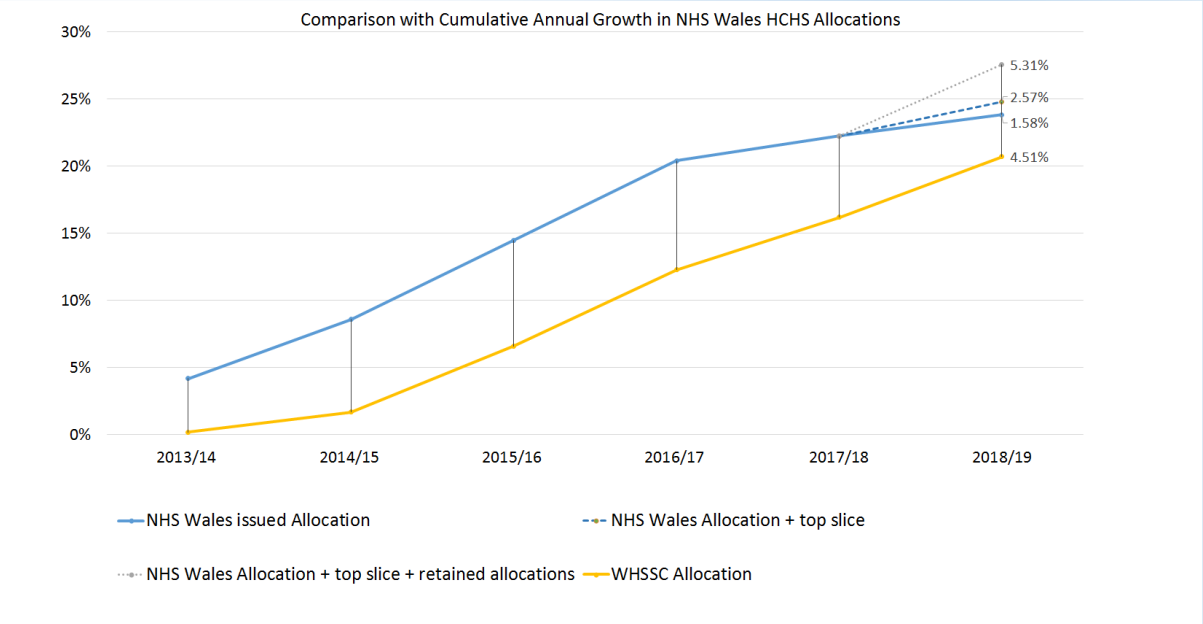


Table 7 tabulates the information represented in figures 13 and 14.

Table 7: Allocation growth in the last five years

	Annual Allocation 2012/13 £m	Annual Allocation 2013/14 £m	Annual Allocation 2014/15 £m	Annual Allocation 2015/16 £m	Annual Allocation 2016/17 £m	Annual Allocation 2017/18 £m	Annual Allocation 2018/19 £m
WHSSC Allocation (excluding WAST)							
Total Allocation	472	473	480	503	532	552	581
Incremental Annual Growth (%)		0.20%	1.50%	4.90%	5.70%	3.90%	5.14%
Welsh Health Board HCHS & Prescribing Discretionary Allocation							
Total Allocation	3,424	3,569	3,724	3,942	4,236	4,314	4382
Incremental Annual Growth (%)		4.20%	4.40%	5.90%	5.90%	1.84%	1.58%
NHS England Specialised Services Allocation							
Total Allocation	11,800	12,960	13,520	14,634	15,658	16,413	17151
Incremental Annual Growth (%)		9.80%	4.30%	8.20%	7.00%	4.82%	4.50%

6.4 Risk Sharing

In January 2018 the Joint Committee formally agreed a new risk sharing framework to commence implementation from 2018/19. The nature of the agreed framework means that there will be minimal impact in the 2018/19 financial year which will effectively be a neutral year.

In designing a new model the key principles underpinning the agreed model included:

- establishing a credible base year for neutralisation that can be justified to boards
- overcoming the volatility associated with changes in utilisation of specialised services
- revisiting the risk sharing appetite of health boards
- using data points that can align with inclusion into IMTP timetables without destabilising health board positions in year.

The proposed new model which best meets these principles and realities of impact assessment is set out below:

- Neutrality will be established based on the latest available data using average positions for 2015/16 and 2016/17.
- The risk sharing contributions for the new financial year, starting with 2018/19, will be adjusted to account for utilisation in the previous two complete financial years. For 2018/19 financial year the IMTP contribution will be based on the average of 2016/17 and 2015/16 financial years.
- In 2019/20 the IMTP contributions will be based on the positions for 2016/17 and 2017/18. Hence, 2019/20 will be the first year when the contributions will start to vary from the neutral baseline year. The impact on boards will be dampened by the fact that average utilisation is used with 2016/17 being common to both years.
- In 2020/21 the IMTP contributions will be based on the positions for 2017/18 and 2018/19. Hence 2020/21 will be first year when the full impact of risk sharing utilisation variances will have a full impact.
- Risk Appetite Review – the final proposed component of the new system is that, informed by internal consultation and advice by the WHSS Team, members of the Finance Sub Group will review the allocation of services to the utilisation and shared pools. Any changes to pooling must be established at the start of the process in order that there is fairness and transparency.

Under the agreed framework risks are allocated to the following pools:

- Utilisation Pool – this is the predominant pool where health boards will be allocated shares according to their respective patterns of usage of a service.

- Club/Shared Pool – this pool is used for risks which are shared using population or capitation based methods. It is designed to be used for services which are either high cost low volume or are for services not routinely commissioned. These risks are pooled because individual health boards have little control over usage patterns.
- Pay as you Go/Live Pool – this pool is used to enable service reconfiguration/transfer or repatriation. It is used in limited circumstances by prior agreement.

Finally, Health Boards are able to agree changes in the allocation of financial risk on a temporary basis via the WHSSC risk sharing process. These changes will be agreed with WHSSC and the individual health boards.

6.5 Summary Financial Plan

Tables 9 summaries the financial impact for 2018/19 by commissioner, and table 10 summaries the 3 year financial impact for WHSSC. Full financial tables are included in annex 11.

Table 9: Financial Impact 2018/19 by Commissioner

	Commisioner Split						
	Abertawe Bro Morgannwg UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff & Vale UHB	Cwm Taf UHB	Hywel Dda UHB	Powys THB
	£m	£m	£m	£m	£m	£m	£m
2018/19 Opening Allocation	**97.578**	**104.996**	**121.531**	**98.535**	**50.780**	**60.129**	**21.916**
M10 Forecast Performance (excluding English SLA's)	(0.412)	(0.724)	(2.951)	(0.328)	(0.272)	(0.046)	(0.565)
M10 English SLA forecast (excluding HRG4+ full impact)	0.478	0.167	2.887	0.579	0.367	0.318	0.218
Reinstate Non Recurrent Writebacks	0.504	1.229	1.794	0.567	0.229	0.287	0.559
Adjustments for Non Recurrent Performance	0.634	0.674	1.176	1.498	0.764	0.491	0.228
Full Year Effect of Prior Year Investments	0.212	0.239	0.070	0.221	0.124	0.147	0.042
New Cost Pressures / Growth in IPC	1.026	1.383	1.176	1.010	0.761	0.730	0.206
Mandated High Cost drugs	0.160	0.352	0.137	0.264	0.171	0.085	0.040
VBC workstreams	(0.678)	(0.727)	(0.735)	(0.670)	(0.442)	(0.299)	(0.196)
Underlying Deficit & Growth	**1.924**	**2.593**	**3.554**	**3.141**	**1.702**	**1.712**	**0.530**
CIAG Schemes - Score > 20 + Exception Risks	0.577	0.645	0.336	0.562	0.333	0.411	0.097
Commissioner Contribution to 2% provider inflation	**1.604**	**1.492**	**0.815**	**1.493**	**0.772**	**0.853**	**0.198**
2018/19 WHSSC Additional Requirement	**4.105**	**4.730**	**4.705**	**5.195**	**2.807**	**2.977**	**0.825**
2018/19 Total WHSSC Requirement	**101.684**	**109.725**	**126.236**	**103.730**	**53.586**	**63.106**	**22.742**
Residual risks not funded:							
Full HRG4+ price impact & most prudent volume growth	0.362	0.534	3.501	0.477	0.199	0.232	0.546
CIAG Schemes - RTT Schemes	0.217	0.214	0.069	0.197	0.139	0.131	0.028
CIAG Schemes - Score < 20	1.841	0.428	0.160	0.589	0.427	0.930	0.110

Table 10: 3 Year impact excluding HRG4+

	2018/19 WHSSC Requirement *Firm* £m	2019/20 WHSSC Requirement *Indicative* £m	2020/21 WHSSC Requirement *Outline* £m
2018/19 Opening Allocation	555.465	555.465	555.465
Rollover Baseline	10.348	10.348	10.348
Full Year Effect of Prior Year Investments	1.055	1.055	1.055
New Cost Pressures / Growth in IPC	6.292	11.333	16.243
Mandated High Cost drugs	1.208	2.500	4.500
VBC Workstreams	(3.747)	(3.400)	(3.400)
Future Years Growth		11.750	26.000
Underlying Deficit & Growth	**15.157**	**33.586**	**54.746**
CIAG Schemes - Score > 20 + Exception Risks	2.961	4.602	4.902
Commissioner Contribution to 2% Provider Inflation	**7.226**	**7.226**	**7.226**
2018-21 WHSSC Additional Requirement	**25.344**	**45.414**	**66.874**
2018-21 Total WHSSC Requirement	**580.809**	**600.879**	**622.339**
% Uplift Required	**4.6%**	**3.5%**	**3.6%**

6.6 Health Board 18/19 IMTP provisions for Specialised Services

The line of best fit recommended by Management group and provisionally agreed at Joint Committee is an uplift of £16.8m, which excludes HRG4+ impact risk. This was within the January IMTP provisions of five out of the seven health boards.

The movement in the ICP requirement January submission has further aligned the line of best fit to be closer to all seven health board declared provisions. There are no material differences identified between the WHSSC requirement and commissioners provisions at the monthly management group ICP engagement workshops (Table 12).

Table 12: Health Board January IMTP provisions against updated WHSSC ICP requirement excluding HRG4+ impact & welsh provider inflation

Commissioner	Baseline Assessment of Recurrent Position	Mandated Drugs, Growth Pressures & Savings	CIAG Schemes > 20 & Exceptional risks	RTT	CIAG Schemes < 20	% Uplift Required to line of best fit
Abertawe Bro Morgannwg	£2.5m provision					2.56%
Aneurin Bevan	£3.3m provision					3.08%
Betsi Cadwaladr	£4.1m provision					3.20%
Cardiff & Vale	£4.0m provision					3.76%
Cwm Taf	£2.0m provision					4.01%
Hywel Dda	£2.2m provision					3.53%
Powys	£0.7m provision					2.86%
Total Net	**£11.4m**	**£3.7m**	**£3.0m**	**£1m**	**£5.5m**	**3.26%**

6.7 Financial Risks Considered Outside of the WHSSC ICP

There are two financial risks that have not been explicitly funded in the current ICP at this point. The first relates to the issue of HRG4+. The second relates to a small number of service issues that remain risks but for there is no current agreement for investment or the degree of certainty is not high enough to warrant inclusion.

6.7.1 HRG4+

At this point there is no agreement in place between NHS England and NHS Wales regarding how to move to HRG4+ prices for English providers. Whilst discussions continue this remains a risk for the financial plan. In agreeing the plan the Joint Committee were presented with the financial plans both inclusive and exclusive of HRG4+. The adverse financial impact of including HRG4+ at this point would have materially undermined the ability of Health Boards to fund the developments agreed in this plan. The decision of the Joint Committee was to approve a plan excluding the HRG4+ risk at this point. This matter has also been discussed with Welsh Government officials and whilst there is currently no agreement for additional funding in place, the submission of a plan excluding HRG4+ has been accepted in principle. This risk will be subject to ongoing assessment as the dialogue with NHS England continues.

The materiality of the net additional risk is approximately £3.9m. This represents a gross price risk of £6.3m offset by prudent provisions built into the budgets forecast for contracts with English providers. These prudent provisions have arisen by not

assuming budget decreases where reported contract performance variations less HRG4+ price components resulted in a potentially negative movement. Whilst this provides for some cushion at an overall plan level the unequal distribution of risk and performance variation means the net impact is not equal across all boards.

The unequal distribution of HRG4+ risk emphasises the importance of a central solution to an exceptional issue that is outside of the control of any one Health Board.

6.7.2 Residual Service Risks

This plan sets out the comprehensive risk management process by which WHSSC are working with Health Boards to assess, manage and control a range of service risks for which specific investment is not yet indicated. This may be because of the degree of uncertainty around either the solution or the final impact of the risk. This process has proved to be effective in managing risk and keeping risk visible during 2017/18, developing on earlier approaches.

There are 4 specific risks which have been highlighted as more significant or which have a higher probability of some financial impact in year, in decreasing order of materiality:

- Adult Cystic Fibrosis – the risk is that the service in South Wales is close to maximum capacity of 300 patients, potentially limiting the ability of the service to meet the needs of new patients or admit patients requiring in-patient care on a timely enough basis. The quantum of risk is up to £0.7m for 2018/19 based on an investment proposal from the provider. There is considerable uncertainty whether this proposal addresses the risk set out above as it focuses on strengthening/development of an MDT and development of community pharmacy.
- Interventional Neuroradiology – there continues to be concern regarding the sustainability of the South Wales service provided by CVUHB. Currently there is only one interventionalist operating out of the establishment of three and a recent failure to recruit to a substantive vacancy. Any period of leave for the single handed consultant means a cessation of service for which it is increasingly difficult to secure cover from Bristol. The quantum of risk is estimated to be circa £0.5m based on the excess cost to the Welsh health economy of paying for activity in England whilst significantly under-utilising fixed resources at CVUHB. WHSSC continues to work with CVUHB and North Bristol Trust to develop a managed process and longer term network relationship. An additional layer of risk in this area is the need to develop additional clot retrieval capacity for the Welsh population which is currently severely constrained by both local and national shortages of INR consultants. WHSSC is working with Health Boards to develop capacity solutions for this new service.

- Neonatal Transport – the risk is that the current South Wales transport service, provided between three health boards on a rotational basis, does not provide a 24/7 service. This may result in babies being held in local neonatal units longer than necessary. The quantum of risk if up to £0.377m for 2018/19 based on the original estimate from the network. There is uncertainty regarding whether current retrieval funds are being efficiently or appropriately deployed. In addition there is uncertainty regarding case volumes and the evidence of benefit/harm associated with time of retrieval.
- Fetal Medicine – the risk is around the sustainability of the current South Wales service, which results in service interruption and transfer to University Hospital Bristol. This risk could impact on prompt detection and diagnosis of fetal abnormalities and their subsequent management in the appropriate care setting. This service is not currently directly commissioned by Health Boards from CVUHB with WHSSC commissioning the UH Bristol component. The quantum of risk is not possible to assess at this point as no investment proposals have been received.

7 Key Delivery Risks to the Integrated Commissioning Plan 2017-20

This chapter outlines the risks to the delivery of the ICP and the process for monitoring and managing them.

7.1 Overall Approach to Risk Management

Under the hosting agreement with CTUHB, WHSSC complies with the Health Board's Risk Management Policy and Risk Assessment Procedure.

The aim of the Risk Management Policy is to:

- ensure that the culture of risk management is effectively promoted to staff ensuring that they understand that the 'risk taker is the risk manager' and that risks are owned and managed appropriately
- utilise the agreed approach to risk when developing and reviewing the Resource and Operational Plan
- embed both the principles and mechanisms of risk management into the organisation
- involve staff at all levels in the process, and
- revitalise its approach to risk management, including health and safety.

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 strategic risks. It summarises the key 'live' risks that WHSSC recognizes and details actions being taken to mitigate them. The CRAF is informed by risks identified by the Commissioning Teams, Networks, Directorates or Executives and any risks scoring 15 or above in any domain, are escalated to the CRAF. A summary of the December 2017 Corporate Risk Assurance Framework is included in Annex 12.

The framework is subject to continuous review by the Executive Director lead, Corporate Directors Group, Management Group, Joint Committee and joint sub-committees. It is for the Joint Committee to determine whether there is sufficient assurance in the rigour of internal systems to be confident that there are adequate controls over the management of principal risks to the strategic objectives.

Each risk is allocated to an appropriate 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. WHSSC is also represented on the CTUHB Quality, Safety and Risk Committee (formerly the CTUHB Corporate Risk Committee).

To support the CRAF WHSSC has a risk appetite statement:

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 **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.

As part of WHSSC's continuing processes to develop and strengthen risk management into its core business, an escalation process has been put in place. This process sets out how risks will be escalated through the governance structures.

The current risk management framework which represents the position as at the end of November 2017 is attached as annex 4.

7.2 Risk Management of the Integrated Commissioning Plan

7.2.1 Risks to Quality, Outcomes and Sustainability of Services

During 2017-18 the ICP risk management framework has further developed, and is now an embedded part of the ICP development process. All schemes which have not been approved for inclusion in previous ICPs are risk-assessed on a monthly basis and exception reports have been provided to the Management Group for consideration where the risks have changed. This risk profile has been used to inform the development of the 2018-21 ICP.

7.2.2 Risks to Delivery of Key Targets and Priorities

As outlined in section 4.3, over the course of 2017-18 enhanced performance management arrangements have been implemented for:

- All Wales Lymphoma Panel

- Bariatric surgery
- Cardiac surgery
- Posture and mobility (wheelchairs)
- Plastic surgery
- Paediatric surgery
- PET-CT
- Neurosurgery, and
- Thoracic surgery.

7.2.3 Risks to Delivery of the ICP 2018-21

There are similar risks in this ICP to those described in the previous ICP. The unknown impact of new in-year NICE approvals, and unavoidable service pressures that emerge throughout the course of 2018-19.

In previous years, there have been risks associated with over performance of contracts held with NHS England providers which has greatest impact for BCUHB and PTHB. Following discussion with both Health Boards, it has been agreed that they will manage any risk within their own IMTPs.

8 Governance and Accountability Framework

This chapter outlines the current governance and accountability arrangements for commissioning specialised services, and for WHSSC as an organisation.

8.1 WHSSC Joint Committee Structure

The WHSSC Joint Committee is established as a statutory Sub-Committee of each of the LHBs. It is led by an Independent Chair, appointed by the Cabinet Secretary for Health, Well-being and Sport. Its membership is made up of the Chair, three Independent Members, one of whom is the Vice Chair, the Chief Executives of the seven LHBs, Associate Members and a number of Officers.

Whilst the Joint Committee acts on behalf of the seven LHBs in undertaking its functions, the responsibility of individual LHBs 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 Chief Executive of CTUHB. Under the terms of the establishment arrangements, CTUHB is deemed to be held harmless and have no additional financial liabilities beyond their own population.

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

8.1.1 Sub Committees

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

- All Wales Individual Patient Funding Request Panel (WHSSC)
- 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 Lead Clinician for the Network, who is also an Associate Member of the Joint Committee.

Formal meetings of the Joint Committee are held in public and are normally held bimonthly. The agenda and papers are available on the 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 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.

A review of the group was undertaken in 2017-18 by the Managing Director and Committee Secretary from which it is anticipated recommendations will be developed during the last quarter of 2017-18 for changes to the roles and responsibilities of the group. This will also take into account recommendations from the Parliamentary Review (2018).

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 CTUHB, as host organisation, 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 them in their decision taking and in discharging their accountabilities for securing the achievement of the Joint Committee's Delegated Functions.

The Committee secretary and Director of Finance from WHSSC are in attendance for the WHSSC components of the CTUHB Audit Committee.

8.1.2 Advisory Groups and Networks

The Joint Committee has also established two joint advisory groups in the discharge of functions

- All Wales Gender Identity Partnership Board

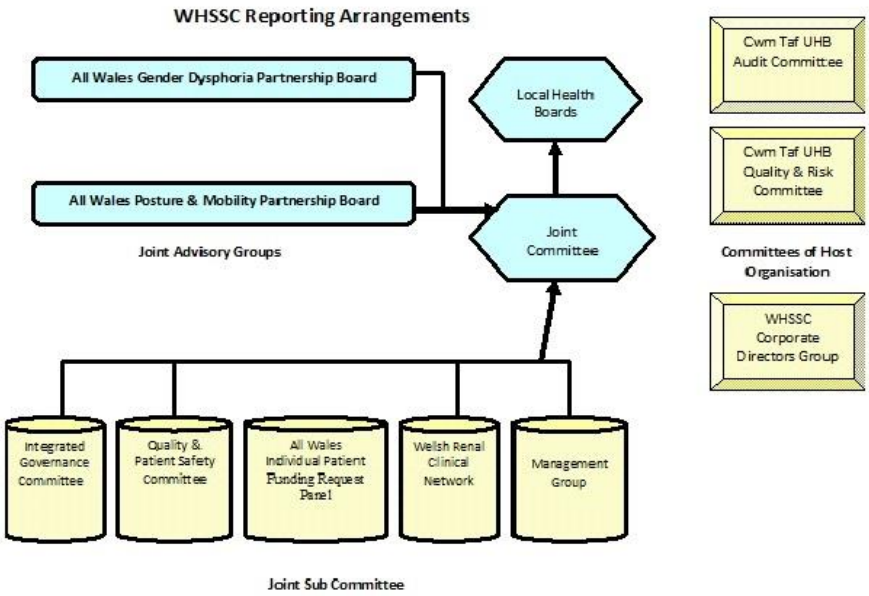
- All Wales Mental Health and Learning Disability Collaborative Commissioning Group (formally Wales Secure Services Delivery Assurance Group)
- All Wales Posture and Mobility Service Partnership Board

The **All Wales Gender Identity Partnership Board**, established in July 2013, supports the development of a future NHS Wales Strategy for Gender Dysphoria services within current NHS Wales funding parameters and reviews the audit of assessment and surgical services against quality indicators and key performance indicators. The scope of the Partnership Board extends beyond the services currently commissioned by WHSSC.

The **All Wales Posture and Mobility Services Partnership Board** monitors the service's delivery against the key performance and quality indicators, in order to provide assurance to the Joint Committee that the service is delivering in line with the All Wales Service Specification and advises the Joint Committee on the commissioning strategy for Posture and Mobility services, including identification of, and supporting opportunities for embedding coproduction as a core principle of the commissioning strategy.

The reporting arrangements for committees, boards and networks are illustrated in figure 16.

Figure 16: WHSSC Reporting Arrangements



8.1.3 Changes to the current WHSSC Structure

Following the transfer of hosting arrangements and staff to Public Health Wales in October 2016, governance arrangements for the following two groups transferred from WHSSC to the NHS Wales Health Collaborative with effect from January 2018:

- The **Wales Child and Adolescent Mental Health Services (CAMHS) and Eating Disorders (ED) Planning Network Steering Group**. The group's remit is to plan CAMHS and ED services in order to improve access, effectiveness and quality of services from a patient perspective.

- The **Wales Neonatal Network Steering Group** advises on issues regarding the development of neonatal services in Wales. The group ensures that there is a co-ordinated approach to Neonatal care across Wales and that the benefits of working collaboratively are realised.

A memorandum of understanding has been agreed, regarding the working arrangements between WHSSC and all of the networks hosted by the Collaborative.

8.1.4 Review of Management Group function

A review of Management Group Structure and function is underway. Currently this is a formal sub-committee of WHSSC. A number of previous reviews have identified tensions within this arrangement, and the Managing Director is engaged with members of the Joint Committee and Management Group to look at news ways of working which build on the strength of the existing arrangements, this also opens up opportunities for more effective working in the future.

This will report back to the Joint Committee in the last quarter of 2017/18.

8.2 Governance and Accountability Framework

The Joint Committee will be reviewing the Governance and Accountability Framework in 2018. In reviewing the current arrangements, it is anticipated that the Joint Committee will acknowledge that this is part of a process of continuous improvement that will include a more detailed review later in 2018.

The Joint Committee Standing Orders (Joint Committee SOs) form a schedule to each LHB'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 the Joint Committee.

These documents, together with a Memorandum of Agreement setting out the governance arrangements for the seven LHBs and a hosting agreement between the Joint Committee and CTUHB (the Host UHB), 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.

8.3 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
- LHB clinical director, and
- All Wales Medicines Strategy Group/Welsh Medicines Partnership.

We are working with the Association of CHCs for Wales to explore how the patient voice can be strengthened in our planning work. Links are also maintained with relevant bodies in England and Scotland.

8.4 Other Governance Drivers

In July 2014 the Good Governance Institute (GGI) was commissioned to undertake a review of the governance arrangements of WHSSC. The final report was received in October 2015 and was considered by the Joint Committee in January 2016. At that time the Joint Committee acknowledged that here had been a number of notable improvements in addressing some of the issues highlighted in the report and approved the further work required, which was incorporated into an action plan.

It was accepted that many of the recommendations in the GGI report were structural, some would require the support from the Joint Committee and some required changes to the Regulations and Directions and were therefore beyond the control of WHSSC. The recommendations also needed to be considered alongside the consultation on the Green Paper 'Our Health, Our Health Service', which provided an opportunity to highlight issues as part of the response to that consultation.

In 2014-15 Health Inspectorate Wales (HIW) undertook a review of the clinical governance arrangements that WHSSC had in place, and how these related to patient outcomes. The review was prompted by concerns that had been raised about

the management of waiting lists for elective cardiac surgery for Welsh patients, a service for which WHSSC has delegated commissioning responsibility. Whilst HIW examined the systems and processes that were in place for commissioning good patient outcomes in cardiac surgery, the findings and recommendations from the review were intended to be used to improve WHSSC's clinical governance arrangements across all of its services.

HIW had sight of the recommendations made by GGI when completing its report which was also considered by the Joint Committee in January 2016 and resulted in agreed actions that were combined into the action plan arising from the GGI report.

Progress against the combined action plan became a 'business as usual' activity from March 2017 but continues to be monitored by the relevant assurance joint sub-committees.

9 Monitoring, Delivery and Assurance

This chapter lays out the processes for monitoring and assuring the delivery of the ICP.

Monitoring the delivery of this ICP can be divided into four components:

- Provider Performance
- Service Quality, Patient Experience and Outcomes
- Financial Plan, and
- Delivery of the *Integrated Commissioning Plan 2017-20* itself.

As demonstrated in previous sections, WHSSC has and continues to strengthen its performance management section 4.3, risk management section 4.1 and assurance processes section 3 and 9.

9.1 Financial Plan

Financial performance against the plan is monitored on a monthly basis by the Corporate Directors Group, Management Group and Welsh Government. The role of the Management Group is to apply scrutiny to planned development funding decisions and to authorise the release of funding from the ICP. The Joint Committee is accountable for the overall financial performance of the organisation.

10 List of Annexes

Annex 1 – WHSSC Commissioning Intentions

Annex 2 – Audit & Outcomes Days 2017-18

Annex 3 – Escalation process for Risks

Annex 4 – Risk Management Framework scores

Annex 5 – Performance Escalation Framework

Annex 6 –Prioritisation Methodology

Annex 7 – WHSSC Prioritisation Panel membership

Annex 8 - Clinical Impact Assessment Group and Management Group Prioritisation workshop membership

Annex 9- Clinical Impact Assessment Group and Management Group Prioritisation workshop Methodology

Annex 10 – Recommissioning Schemes

Annex 11 – Financial Tables

Annex 12 – Corporate Risk Assessment Framework

11 Glossary of Terms

ABMUHB	Abertawe Bro Morgannwg University Health Board
ABUHB	Aneurin Bevan University Health Board
BCUHB	Betsi Cadwaladr University Health Board
CRAF	The WHSSC Corporate Risk and Assurance Framework
CVUHB	Cardiff & Vale University Health Board
CTUHB	Cwm Taf University Health Board
GGI	The Good Governance Institute or GGI Limited
HCW (SS)	Health Commission Wales (Specialist Services)
HDUHB	Hywel Dda University Health Board
Highly Specialised Services	Services provided in a small number of UK centres
Host UHB (or Host organisation)	CTUHB in its capacity as the host organisation of WHSSC
ICP	The WHSSC Integrated Commissioning Plan for Specialised Services for Wales 2017-20
IMTP	Integrated medium term plan, as required of each Local Health Board
Joint Committee	Committee of the seven Health Board Chief Executive Officers
Local Health Boards	The seven Welsh local health boards together, being AMBUHB, ABUHB, BCUHB, CVUHB, CTUHB, HDUHB and PTHB
Management Group	A joint sub-committee of the Joint Committee comprising the Executive Team and representatives from each of the Local Health Boards that is broadly responsible for operationalisation of the ICP under delegated authority from the Joint Committee
PTHB	Powys Teaching Health Board
RTT	Referral to treatment
Schemes	Service specific schemes planned and commissioned by WHSSC
Specialised Services	Services provided in a relatively small number of centres and requiring planning at a population of >1million
Velindre	Velindre NHS Trust
WHSSC	Welsh Health Specialised Services Committee
WHSS	Welsh Health Specialised Services