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

An Integrated Commissioning Plan for Specialised Services for Wales 2019 - 2022

WHSSC

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

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Contents

Executive Summary

The focus of the Welsh Health Specialised Services Committee's (WHSSC) Integrated Commissioning Plan (ICP) 2019-22 is to continue to commission high quality services in line with the organisation's stated aim *"On behalf of the seven Local Health Boards; to ensure equitable access to safe, effective, and sustainable specialised services for the people of Wales."*

We know that more patients require specialised services due to an ageing population, as well as advances in medical technology, and we continue to strengthen our workforce and develop new collaborations to meet these demands. This provides us with the opportunity to increase engagement and co-production with patients, clinicians and the public 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 established Prioritisation Process and Risk Management Framework continue to help identify the priorities for WHSSC this year whilst the Quality and Performance Escalation Process is identifying pressures within the system that require integrated clinical and managerial support.

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 Local Health Boards (LHBs), 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.

1 Introduction

1.1 WHSSC's Role

WHSSC is responsible for commissioning a range of specialised services on behalf of the seven Local Health Boards in Wales. As an organisation WHSSC is split into five Directorates:

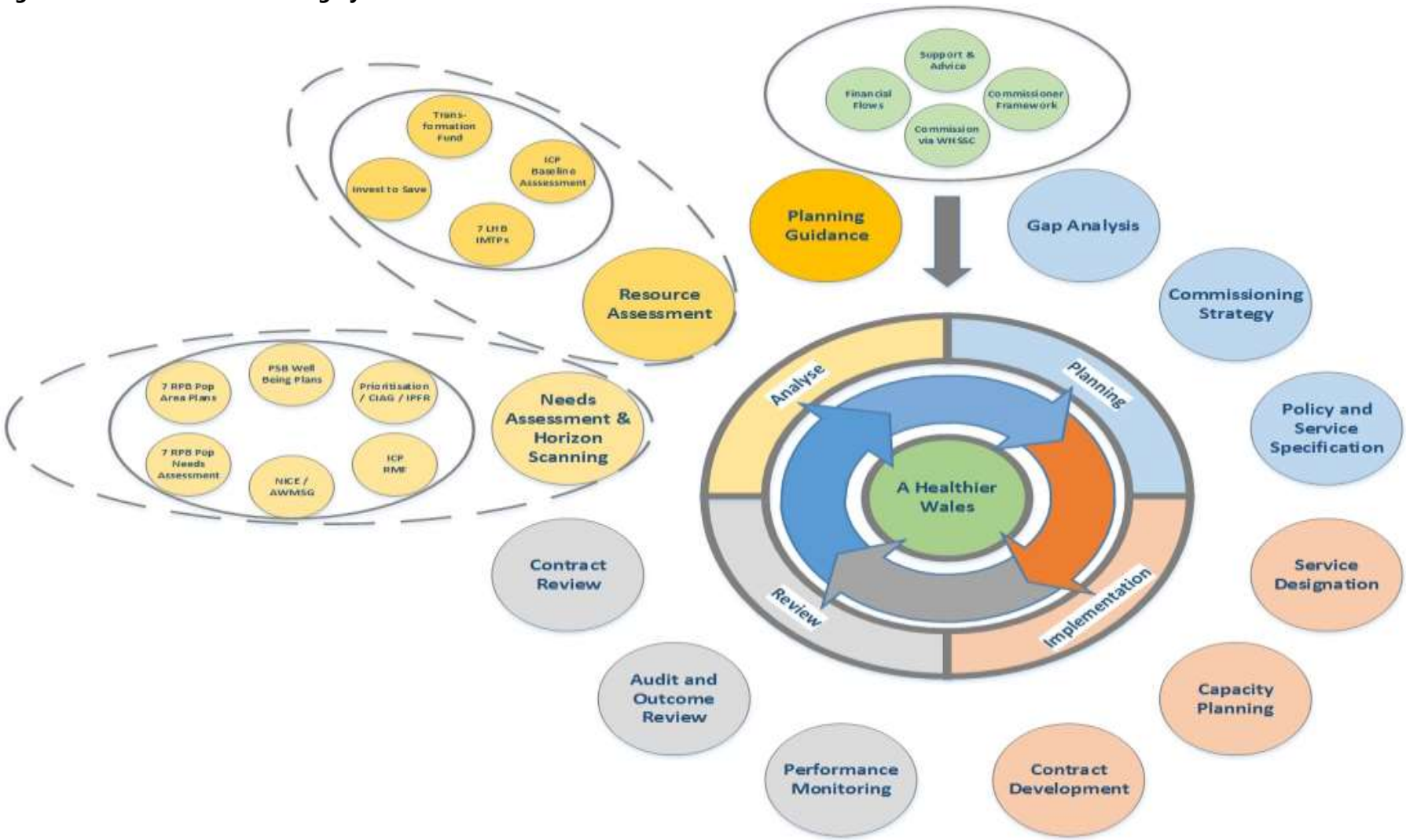
- Corporate
- Finance
- Medical
- Nursing and Quality
- Planning

However we recognise that to commission effective services we need to organise around the needs of patients and therefore operationally we use a commissioning team structure which cuts across these directorates. This means that the Welsh Health Specialised Services (WHSS) Team can ensure that our patients' outcomes and experiences when accessing specialised services is of a high standard. We do this through:

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

All of this work is undertaken on a cyclical basis with ongoing engagement with patients, service users and professionals. This is illustrated overleaf in Figure 1:

Figure 1 – WHSSC Commissioning Cycle



1.2 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. The WHSS Team works with specialised services providers to ensure that they are treating a certain number of patients per year in order to remain sustainable, viable and safe. If providers are unable to treat the required level of patients as is most commonly prescribed by a specialty's national standards, the WHSS Team looks at alternative options for commissioning such as a network arrangement or commissioning from a different provider. This ensures that care is both clinically and cost effective.

The range of services to be commissioned by WHSSC is agreed and delegated through the Joint Committee. An original list of services was agreed in 2012 and since this time there have been a number of transfers back to LHBs for planning and funding, as well as some transfers and new services added 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.

1.3 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.

*(Excluding EASC and NCCU)

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 context for Specialised Services

2.1 Strategy for Specialised Services

The approach to developing the strategy for Specialised Services was agreed at the WHSSC Joint Committee meeting in March 2018. Its development is underpinned by the Principles of prudent health care [1] and the Well-being of Future Generations (Wales) Act 2015, with the main aim of the strategy to make a long-lasting, positive change to current and future generations, and in doing so, setting out a twenty year vision for the commissioning of Specialised Services for Wales.

To formulate the strategy for consideration by both the WHSSC Joint Committee and Welsh Government, it was agreed that a formal consultation process will be undertaken which uses a blended approach of written/electronic feedback and feedback from stakeholder meetings. Focus groups will be established to capture patient and public feedback. In addition, the Joint Committee requested that the WHSS Team work closely with the major south Wales service providers to ensure that the WHSSC strategy was aligned to their proposed collaborative arrangements.

It was agreed that the timetable for this work could only be confirmed when other major public engagement processes led by WHSSC were completed. As described in more detail in Section 3: Progress in delivering the ICP 2018-21, one of the key pieces of work undertaken by the WHSS Team during 2018-19 has been the Public Consultation on the future provision of adult thoracic surgery services in south Wales.

The strategy will allow WHSSC to fulfil its aim, reducing health inequalities and provide effective and timely access as close to home as possible.

2.2 A Twenty Year View of Specialised Services

Since 1999 specialised services for Wales have been commissioned by a single dedicated national organisation. Up until this point, specialised services had been commissioned directly by the five Welsh Health Authorities, and prior to that by the Welsh Office. This model of commissioning led to geographical differences in access and difficulties in agreeing the development of new or improved services.

[1] http://www.prudenthealthcare.org.uk/ (2014)

Over the twenty year period of specialised services commissioning, there have been significant developments and progress in the way that specialised services have been commissioned in Wales. This unique perspective has enabled WHSSC to develop a comprehensive approach to commissioning specialised services, with the experience gained from long term planning, meaning that WHSSC is well placed to set a vision for the future commissioning of specialised services.

Examples of the changes that have taken place in a number of specialised services since 1999 are included in Annex 1.

2.3 A future view of Specialised Services

Although WHSSC is not a statutory body for the purposes of the Well-being of Future Generations (Wales) Act 2015, the Act provides valuable opportunities to capitalise on the knowledge and experience gained over the last twenty years, to make a long-lasting, positive change to current and future generations. This includes:

- Cross sector collaboration (horizon scanning, information sharing, service development, etc.);
- Co-production and engagement with service users;
- Identifying opportunities for whole systems solutions, such as value based healthcare;
- Quality and performance management.

WHSSC has started to work closely with the Office of the Future Generations Commissioner, to explore how it embed the five ways of working within its commissioning cycle. Table 1 summarises some of the barriers and opportunities to embedding the five ways of working:

Barriers	**Opportunities**
Existing governance arrangements can be restrictive.	**Flexibility of role** across 5 ways of working.
The services that WHSSC commission are often at the end of the patient care pathway, and it can be difficult to influence the earlier parts of the pathway which can have a significant impact on patient outcome.	**Collaborating with clinical networks and implementation groups**, as some of their work starts early in the patient's pathway.
Most of the existing measures for health services are	WHSSC ideally placed to do things **once for Wales**, lead strategic direction

performance/finance based and therefore short term.	in some areas and set out long term vision.
Current structures in NHS make it difficult to innovate. WHSSC have to negotiate with multiple organisations at a detailed level.	WHSSC has a **helicopter view of services**, which can be used to inform and influence patient pathway across organisations.
Limited evidence, particularly because of small patient numbers.	Sophisticated **horizon scanning** and **information sharing** between organisations.
Limitations with the consultation process when exploring opportunities for delivering services differently.	Identifying opportunities for more **co-production and conversations** with patients.
Lack of opportunities to engage with Regional Partnership Boards, and inability to influence funding opportunities.	**Whole systems and whole pathways**, and **ability to influence prevention**.
Organisational boundaries and funding/finance issues.	Exploring opportunities for **pathway and joint commissioning.**
Overall Opportunity	
Development of the Specialised Services Strategy.	

2.4 Quality

2.4.1 Quality Assurance Framework

This year will have seen the recruitment of a team of staff to strengthen the focus on quality monitoring and improvement on all of our commissioned services. The Quality Assurance team will have a pivotal role in the co-ordination of operational quality monitoring and interventions within commissioned services and help build upon the work of the specialised commissioning *Quality Assurance Framework (*QAF) (July 2014).

The QAF was designed to establish the basic infrastructure to support driving assurance and improvement of quality for specialised commissioned services. As such it sets out the systems and processes that needed to be in place, the roles and responsibilities of key staff in delivering these systems and processes and the tools that would be developed to support staff to deliver their responsibilities. Specialised commissioning can now move beyond the basic infrastructure to the next stage of driving quality assurance and improvement in our specialised commissioned services.

One of the ambitions over the forthcoming year is to review the QAF to address new challenges and set out further ambitions for quality in specialised commissioned services. To support the delivery of this ambition it will be designed to:

- Gain assurance regarding the quality of commissioned services.
- Monitor, identify and addressing variation in access and/or outcomes and inpatient experience.

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

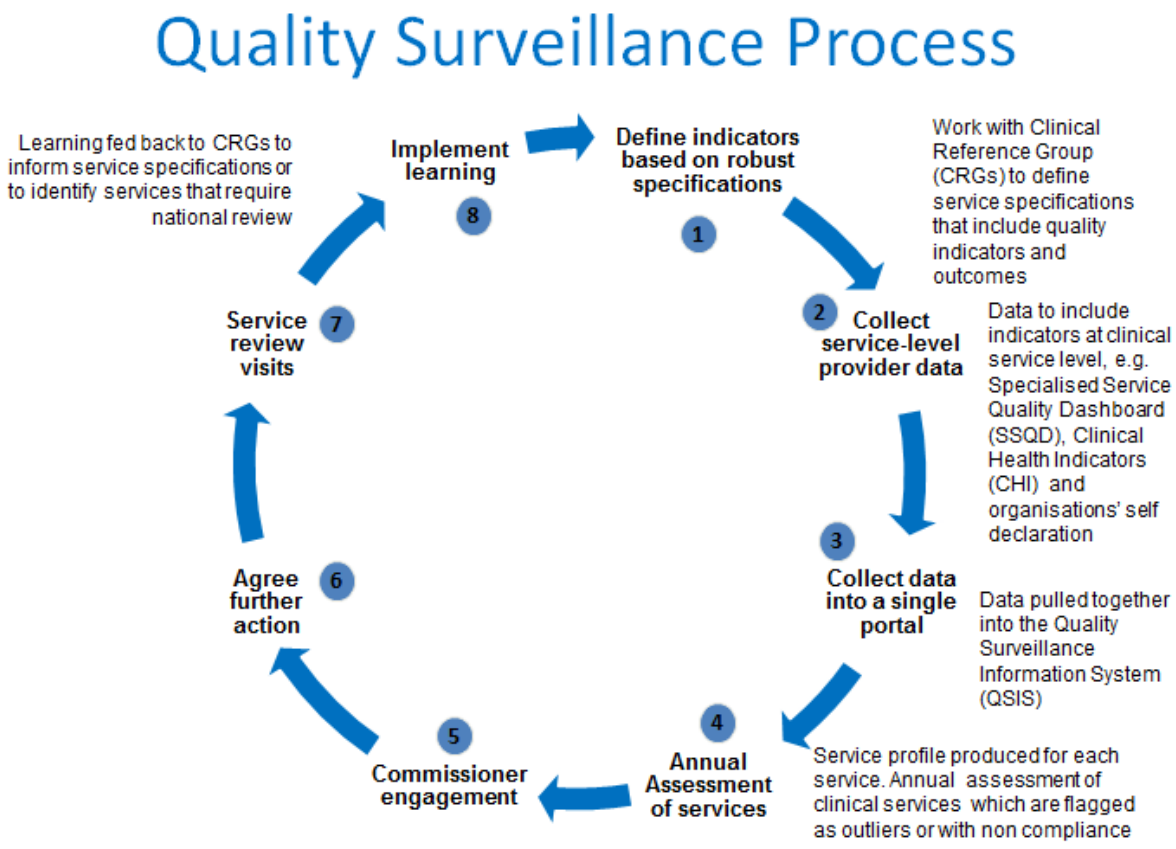
The Quality Assurance team will have a pivotal role working closely with the Medical Directorate and Commissioning Teams and will monitor quality activities such as:

- management and learning from serious incidents and never events
- co-ordination of investigations and responses to complaints and reported near misses
- contribution to the commissioning cycle including planning, contracting and quality assurance of provider services
- contribution to and being the specialised commissioning local representative for the agreed escalation process of quality concerns within their geographical area
- compliance with key legislation such as the *Nurse Staffing Levels (Wales) Act 2018* which although it does not have a direct impact on many of the WHSSC commissioned services with its focus on acute medical and surgical staffing levels, has key principles that can be applied.

Work has been ongoing with NHS England to utilise the tools that have been developed such as the Specialised Services Quality Dashboards (SSQD), and Quality Surveillance Information System (QSIS) in order to roll them out across NHS Wales.

The following diagram illustrates the Quality Surveillance process in place to effectively monitor the provider services commissioned from NHS England.

Figure 3: Quality Surveillance Process, NHS England



It is intended that this work will fully align with and facilitate the delivery of the Health & Care Standards in Wales and build upon the Seven step model for quality Improvement and adopted for specialised commissioning, which is illustrated in the diagram below.

Figure 4: Seven step model for Quality Improvement

The next phase of work will be to map out the quality assurance and improvement activities within the framework and align it to the Seven step model. 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.

2.5 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:

- ability to balance competing demands from secondary care within; acute hospitals which host specialised services
- historical patterns of service delivery;
- medical training requirements;
- 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;
- austerity and the drive towards economies of scale; and
- the impact of the UK leaving the European Union.

In the ICP, 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. This includes funding the serious concerns raised in the All Wales Cancer Review of Neuro-Oncology and working through the long term sustainability issues within the consultant workforce as part of the five year Neurosciences Strategy.

2.6 Equity of access

Equity of access to specialised services for the population across Wales is a key priority for WHSSC. It is acknowledged that there is too much variation at present and work is underway to identify inequity and put in place measures to reduce it. A major step forward in improving our understanding of this issue has been the development of our new management information system MAIR which is described in detail in section 3.5.1. This allows us to produce maps of variance and highlight areas of inequity.

In addition, addressing issues of inequity has been key in identifying priority areas for investment in previous plans. The Inherited Metabolic Disease service based in Cardiff received funding for their infrastructure in 2015-16. This has meant that the job plans of staff, now include quarterly clinics in north Wales which has led to repatriation of patients to services provided closer to their homes.

More recently, the funding for a new Spinal Rehabilitation Consultant has led to the introduction of outreach clinics across LHBs in south Wales rather than just out of the Spinal Injuries Centre based in Rookwood, Cardiff. This was in response to concerns raised directly by patients in west Wales where they described the difficulty of travelling long distances.

There are also examples of services where although effective specialised services are commissioned by WHSSC such as with Alderhey Children's Hospital, Liverpool, uptake of certain treatments, such as Ketogenic Diet for children with epilepsy, is lower than expected for the population based on prevalence of the condition. This will be explored during 2019/20.

2.7 Evidence and Evaluation

WHSSC is committed to ensuring that all of its commissioning decisions are based upon the most up relevant and up to date evidence of both clinical and cost effectiveness. Over the last few years new processes and methodologies have been introduced to ensure greater transparency and consistency in both prioritising new and existing interventions and service developments (section 4.2), and the review, update and development of commissioning policies (see below).

Over the last twelve months WHSSC has signed separate agreements with Cedar Healthcare Technology Research Centre (Cedar), an NHS academic evaluation centre which is part of Cardiff and Vale University Health Board (CVUHB) and Cardiff University and Health Technology Wales (HTW), a national organisation which undertakes health technology assessments (HTAs) of non-medical technologies on behalf of NHS Wales. These contracts ensure that every Executive and Commissioning team within WHSSC has access to dedicated evidence appraisal support.

In order to highlight and emphasise the link between evidence and final commissioning decision, the Medical Directorate within WHSSC is aiming to publish all historic and future evidence reviews on our website. We are also looking to increase access to these reviews in 2019-20 with a programme of publication within peer reviewed journals, including those with open access.

2.7.1 Cedar Healthcare Technology Research Centre

Cedar holds multiple contracts across academia and the NHS, including acting as an external assessment Centre to the NICE (National Institute of Health and Care Excellence) Medical Technologies Evaluation Programme.

Since September 2017, WHSSC has held a service level agreement (SLA) with Cedar to produce rapid evidence reviews to support our evidence based approach to both topic prioritisation and policy development, review and update. So far this financial year (2018-19) four evidence reviews were commissioned by WHSSC and completed by Cedar:

- Transcatheter aortic valve implantation (TAVI) for high risk surgical patients
- Cytoreductive Surgery with Hyperthermic Intraperitoneal Chemotherapy (HIPEC) for Peritoneal Carcinomatosis
- Cytoreductive Surgery with Hyperthermic Intraperitoneal Chemotherapy (HIPEC) for Pseudomyxoma Peritonei
- Lymphovenous Anastomosis (LVA) for mild and moderate primary or secondary lymphoedema.

The following topics have been recently been referred to Cedar as part of our on-going policy development programme, and scoping searches of the literature as part of the topic exploration phase are now underway:

- Ruxolitinib for the treatment of chronic graft-versus-host disease
- Wedge biopsy of ovarian or testicular tissue from pre-pubescent children receiving anticancer treatment
- The ketogenic diet for children and adults with seizures.

The SLA between WHSSC and Cedar was recently renewed and extended until March 2020.

2.7.2 Health Technology Wales

HTW's remit covers the identification (horizon scanning), appraisal and adoption of non-medical technologies. Its work informs commissioning and supports decision makers to make evidence-informed decisions on both technology investments and disinvestments. It is expected to monitor the adoption of their guidance, and guidance from other organisations, across all of the LHBs.

In 2018-19 WHSSC and HTW signed a joint memorandum of understanding (MoU) to develop closer links and share resources across mutually beneficial areas of non-medicine technology assessment and commissioning.

The objectives of the MoU are to:

- Formalise collaboration and partnership working and improve shared understanding of respective work programmes and processes

- Explore opportunities to collaborate on and/or co-produce evidence reviews
- Realise economies of scale and scope in non-medicine HTA and commissioning efforts.
- Promote knowledge exchange
- Enhance professional and personal development opportunities for the scientific, medical and secretariat staff in each body.

WHSSC was a key participant during the initial set up of HTW and is represented on their 'Front Door' and Assessment Groups, and their Appraisal Panel. WHSSC is now working with HTW to identify future topics to support the prioritisation process for 2019-20 and the on-going development and update of the WHSSC commissioning policy portfolio.

2.7.3 National Cell and gene therapy oversight group

The WHSS Team has been closely involved with the strategy development for cell and gene therapies in Wales and sits on the national oversight group. The Team have helped to develop the statement of intent for cell and gene therapies which include the advanced therapy medicinal products (ATMPs) which are a key feature of this ICP. Unlike conventional medicines these advanced therapies aim to selectively remove, replace and re-engineer a patient's own cells or genes to allow restoration of normal function and elimination of disease. Two ATMPs have recently been appraised by NICE for three separate indications. These will require implementation within 60 days of a positive Final Appraisal Determination (FAD) under the terms of the New Treatment Fund (NTF). The WHSS Team is therefore working closely with providers and the pharmaceutical company to make these highly complex treatments available to our population as soon as possible.

It is planned that adult cases will be delivered at Cardiff and Vale University Health Board (C&VUHB) and paediatric cases will be delivered by NHS England providers. This is an entirely new class of intervention that has the potential to offer curative treatment to individuals without further treatment options or offer earlier more effective treatment with better outcomes.

2.7.4 Public Health Expertise

WHSSC has not yet been successful in the appointment of an Associate Medical Director for Public Health. The WHSS Team will therefore commission specific pieces of work on an ad hoc basis from public health consultants. A current example is a piece of work examining the lower than anticipated demand for bariatric surgery in Wales. More generally WHSSC Associate Medical Directors are providing support.

2.8 Policy Development

The WHSSC Policy Group was established in November 2016 in response to a growing list of out of date published commissioning policies. The Group is currently chaired by the Managing Director and all teams within WHSSC are represented.

The Group has the following delegated powers and authority:

- Sign off and approval of policy proposals for further consideration by Management Group. Where there is no financial or service impact or where the funding requirement has already been identified within the ICP Management Group may approve for publication.

- If a policy is identified as having a financial or service impact or where a funding requirement has not been identified within the ICP the policy must be formally progressed via Management Group to the Joint Committee for final ratification.

WHSSC is committed to regularly reviewing and updating all of its policies based upon the best available evidence of both clinical and cost effectiveness (where available). The eventual aim is to produce a suite of policies, each containing a supporting evidence review, with a clear link between the evidence and the recommendations/indications in the policy.

The latest data (up to November 2018) are as follows and are based on a total of 70 extant policies:

- Policies within their review date (n=41; 58.5%)
- Policies outside their review date but under review/in development by the Commissioning Teams for update (n=27; 38.5%)
- Policies outside their review date and no action has yet been taken (n=2; 3%).

Significant work has also taken place (and is on-going) to develop new commissioning policies and service specifications in key clinical areas. Since April 2018 WHSSC has published 11 new or updated policies and there are 32 new commissioning policies currently in development. The details of these policies along with those published in 2018/19 are included in Annex 2.

2.8.1 Policy development methodology

In order to ensure WHSSC continues to produce clear, consistent and evidence based commissioning policies a new methodology guide has been produced. This guide primarily for use by WHSSC staff, explains how WHSSC

will develop and updates policies, from pre-scoping (preparation and planning) through to publication. It provides advice on the technical aspects of policy development and the methods used. It also recommends a clinically led approach using both the WHSSC Associate Medical Directors and colleagues in the service.

To accompany the methodology manual a suite of supporting documentation has been prepared including revised commissioning policy, position policy and service specification templates. The role of stakeholder engagement has been strengthened, including better coverage of policy consultation and greater transparency in responding to stakeholder feedback.

3 Progress in Delivering the ICP 2018-21

The WHSSC Integrated Commissioning Plan 2018-21, which was approved by Joint Committee in March 2018, had a number of areas for investment.

3.1 Areas of Investment in 2018-21

Additional funding was agreed for the following schemes in the 2018-21 ICP:

- Alternative and Augmentative Communication
- Cardiac Ablation for Atrial Fibrillation and Ventricular Tachycardia (south Wales)
- Porphyria (south Wales)
- Replacement of obsolete wheelchairs (south Wales)
- Transcatheter Aortic Valve Implantation
- New indications for Positron emission tomography CT
- 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)
- Use of 5-Aminolevulinic Acid (5ALA) in Brain Tumours

3.2 Performance Escalation Framework

The Performance Escalation Framework introduced in 2017-18 has become fully embedded in the WHSS Team's management of services. All services which have been under enhanced performance management arrangements in the form of Commissioning Quality Visits and Escalated Monitoring meetings, have demonstrated improvements in their service performances. These services include Bariatric Surgery, Paediatric Surgery and the north Wales Adolescent Mental Health Service (NWAS).

3.3 Long term Commissioning Strategies

3.3.1 Mental Health

3.3.1.1 Adult Medium Secure Services

The introduction of dedicated case management teams working with alongside the two NHS Wales services and gatekeepers has resulted in further significant reductions in out of area placements. The total number of adult medium secure out of area placements has fallen from circa70 patients to c.50 patients over the last three years.

These placements are made using a National Framework ensuring quality standards at providers and agreed pricing structures apply across Wales. A major impact of the Framework arrangements has been a gradual increase in the number of patients being placed further from home in high quality low cost providers. This tension needs to be examined as part of the Framework evaluation before the existing contract period expires in March 2021.

The overarching principle of people being treated as close to home as possible is being reinforced in England with a change in secure services bed capacity across the regions. This is being supported by performance targets and payment incentives that require commissioners to ordinarily place patients within 50 miles of the patients' home area. Early indications are beds will migrate from north to south and west to east.

This is likely to have a knock on impact to Wales as providers shift bed capacity across England to meet commissioning intentions and reduce placements of English patients in Welsh independent sector services. This could destabilise some Welsh providers who currently have high levels of English patients.

This is further exacerbated for people with Learning Disabilities due to lack of services in Wales. The five year transforming care programme in England is well underway with year four commencing in April 2019. It is intended that there will be a reduction of 20% in medium secure and 50% in low Eating Disorder (ED) beds by the end of the plan. NHS Wales will therefore need to develop a strategic response to these changes as a matter of urgency as placements are becoming ever more difficult and expensive to find.

3.3.1.2 Adult Eating Disorder Services

The Welsh Government's Framework for ED services is currently being reviewed and will inform WHSSC's response to the position of specialist inpatient beds. The option of building a dedicated inpatient unit in Wales was considered but discounted in 2013 following option appraisal by the ED Network. WHSSC had intended to revisit this position in 2018 but this work was put on hold pending the outcome of the Welsh Government review.

3.3.1.3 Child & Adolescent Inpatient Services

The number of Child and Mental Health Services (CAMHS) admissions to out of area placements has reduced to c.30 placements a year with about 50% requiring low secure beds. The majority of these low secure patients were

previously placed at Regis Healthcare in Wales but the provider was terminated from Framework in early 2018 due to serious quality concerns.

The CAMHS Network is currently reviewing options for potential best use of all NHS Wales CAMHS beds (including beds not currently used) and WHSSC will consider any recommendations in its future commissioning arrangements. There are considerable environment and workforce issues that need to be addressed before any further beds can be utilised. The CAMHS Framework has been extended to March 2020 and potentially March 2021 in order to align with the adult Frameworks.

3.3.1.4 Gender

It is anticipated that there will be a transfer of funding to WHSSC to commission the new adult gender identity service from C&VUHB from April 2019. Work has been completed by the Associate Medical Director for Gender with the London Gender Identity Clinic to support repatriation of the inpatient waiting list in readiness for the start of the new clinic in April, based in St David's Hospital, Cardiff. Work on the primary care element of the patient pathway is being taken forward by LHBs, including the development of local gender teams.

3.3.1.5 Peri-natal (Mother and Baby)

Funding for establishing a Peri-natal (Mother and Baby) Unit in south Wales has been approved within the Welsh Government's new Mental Health ring-fenced funding allocated to LHBs. The establishment of this service will significantly reduce the dependence on out of area referrals and improve access.

3.3.2 Thoracic Surgery

The strategic review of thoracic surgery provision for the population of south and parts of mid Wales has made significant progress over the last year. In January 2018, the WHSSC Joint Committee endorsed two recommendations: the recommendation from the Project Board that there should be a single thoracic surgery centre in south Wales, and the recommendation from the Independent Panel that the single centre should located at Morriston Hospital, Swansea.

It was subsequently agreed, in conjunction with the Community Health Councils of the six affected LHBs, to undertake a formal public consultation on the recommendation to locate the single thoracic surgery centre at Morriston

Hospital. This was conducted during July and August. In September, the Joint Committee received the outcome of the public consultation. This went forward in November to each of the six affected LHBs for decision: each Local Health Board supported the recommendation for a single centre located at Morriston Hospital.

In 2019-20, the strategic review will move into the implementation phase. The overarching governance framework for implementation was agreed by the Joint Committee in January 2019. ABMUHB is currently establishing an Implementation Project Board to lead the development of the new adult thoracic surgery service. It is anticipated that during 2019-20 the planning ground work will be undertaken, with transition to the new service over a longer timeline. The precise timeline for transition will be determined by the implementation plan and key constraints including the timeline required for capital case development and implementation.

3.3.3 Neurosciences Strategy

The development of a Neurosciences Strategy for south Wales was requested by the Joint Committee in May 2015 in response to a number of issues including: a number of neurosciences services that required financial support outside of the ICP process, recommendations still to be implemented from Service Reviews undertaken in 2008-09 and key developments on the horizon including Mechanical Thrombectomy.

The Strategy published in March 2018 was split into four main elements over the following time periods:

2013-18 Stabilisation and Development of Strong Foundations
2018-20 Service redesign and Recommissioning
2021-23 Delivering Higher Standards

A number of elements of the Strategy required investment and therefore year one of the Five year Strategy was moved to 2018-19. Whilst funding was still limited in this year, funding was identified to address the immediate risks in Spinal Rehabilitation with the addition of a second Consultant and to implement the NICE Guidance for 5-ALA.

Further funding identified in this ICP which will aid in the stabilisation of the following key neurosciences services: Neuro-Rehabilitation, Paediatric Neurology (through the funding of Paediatric MRI) and Interventional Radiology (through the funding of Thrombectomy). Recurrent funding has

also been approved for increased capacity within Neurosurgery, allowing the service to maintain its current RTT position.

3.4 Value Based Commissioning

Over the course of the 2018-21 Integrated Commissioning Plan for Specialised Services (2018-21 ICP), the WHSS Team has begun to work closely with its NHS Wales partners including Local Health Boards and Shared Services on developing a value based healthcare approach across the whole of the patient care pathway. This approach 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 was referred to as 're-commissioning' in the 2018-21 ICP, but in line with the Welsh Government's 'A Healthier Wales' vision that is widely being applied by LHBs, we will adopt the title of 'Value Based Commissioning' for this work.

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

- Referral Management - local case management to reduce referrals into NHS England, optimise use of local specialised services, repatriation of non-specialised care on a timely basis.
- Introduction of the Blueteq IT systems for prescribing high cost medicines
- Out Patient Management from working in partnership with NHS England and local services to reduce initial referral, use of alternative consultation methods including telemedicine and use of local specialist nursing to reduce follow up activity.
- Medicines Management – building on the exemplary work of the Renal Network looking at initiatives that use local specialist pharmacy expertise to ensure best value from optimisation of start/stop criteria, monitoring of market access arrangements.
- Inherited Bleeding Disorders – blood products procurement, home delivery and clinical trials income.

In addition WHSSC will be working in partnership with Welsh Government's value based healthcare team and the Value Based Procurement Team in Shared Services to develop a joint project. The first project will focus on the pathway of aortic stenosis / heart valve disease. The overall objective of this work is to design and procure the optimal value based pathway for patients with valvular heart disease. The key components of project include:

- Analysis of variation
- The range of products and differential cost
- The variety of processes across services and opportunities for improvement
- The measurement of patient outcomes including clinical outcomes and patient reported outcomes

WHSSC is also commencing work around the commissioning of the optimal stroke pathway which could represent a major opportunity to take an innovative approach to commissioning decision making. It will examine the health outcomes for investments throughout the pathway including prophylaxis and reflects the WHSS Team's commitment to the principles of a Healthier Wales.

The portfolio of value based healthcare projects will grow as it becomes embedded in the work of commissioning teams backed by the work of the associate medical directors and new quality team.

WHSSC is also working with individual LHBs on a bi-lateral basis to review local pathways into specialised services to identify and deliver opportunities for improving value. Work has commenced with Powys Teaching Health Board (PtHB) to agree a set of proposals which will offset their net financial requirement. Scoping work has commenced to develop similar opportunities for north Wales with BCUHB.

3.5 Workforce

Table 2: Update against the High Level Workforce Plan for 2018-21

Improvement Objective	Description	Lead	Outcome
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 • Ensure all vacancies are filled	Managing Director Managing Director	Ongoing. The last of the permanent Executive posts is now in place with the recently appointed Director of Planning taking up post in January 2019. A Finance Manager based in north Wales is being re-advertised following failure to recruit. The WHSS Team wte has remained the same as in 2017/18.

Improvement Objective	Description	Lead	Outcome
Improve the Quality Assurance function	• Implement the staffing structure to improve the quality assurance function	Director of Nursing and Quality	Completed. Quality team are appointed and will all be in post by Mar 2019.
Maximise staffing capability	• Develop and implement organisational development and learning programmes across the organization	Managing Director	Ongoing. Regular OD sessions for senior staff. Increased take up of management training provided by CTUHB, host organisation. Lunch and learn sessions being provided by Internal staff.
Maximise staffing capacity	• Ensure HR policies are appropriately applied to manage sickness and absence and that this is audited • Ensure >85% of staff have completed PDRs	Managing Director	Ongoing. Described in section 6.2.4 Ongoing. PDRs compliance is 100% for the WHSS core staff (non-seconded). We are continuing to work to improve compliance for seconded staff and ensure there is high performance on core skills training for all staff following in-year changes to the programme content.

3.6 Information

In the 2018-21 ICP, four Information and Communications priorities were set out. These are described below, with an update on the progress to date.

Table 3: Update on the Information and Communications Technology priorities 2018-21

Improvement Objective	Description	Lead	Update
Streamline and automate processes	To significantly reduce, duplication,	Committee Secretary	During 2018-19 we have migrated to a new electronic meeting

	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).		papers software package and expanded its use to more meetings. We have also begun a project to move to paperless systems for our IPFR process.
Improve access to information		Committee Secretary	A project is underway to re-develop the external website, increasing its content and making it more user-friendly. We have also undertaken development work on our Sharepoint Site ensuring that all Local Health Boards can access information about our work programme and committee business. This supported the policy development work we have been doing and allowed 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	Director of Finance and Director of Nursing and Quality	Implementation of the Quality Surveillance Information System (QSIS) for specialised services to NHS Wales providers by December 2019.

	systems for their collation, communication and analysis. (This is dependent upon the resources being available to improve the quality assurance function).		
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 Local Health	Director of Finance	This is described in detail in section 3.4.1

	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. This enables better trend analysis, control and planning.		

3.5.1 Development of MAIR - My Analytics and Information Reports

WHSSC has significantly developed its management information capability over 2018-19, including piloting and then releasing a new information system - MAIR.

A server database was created to amalgamate the over 200 patient level contract returns received from its healthcare providers. The resulting single dataset for reports, makes interrogation much quicker and more accurate, as previously all data queries had to be manually compiled.

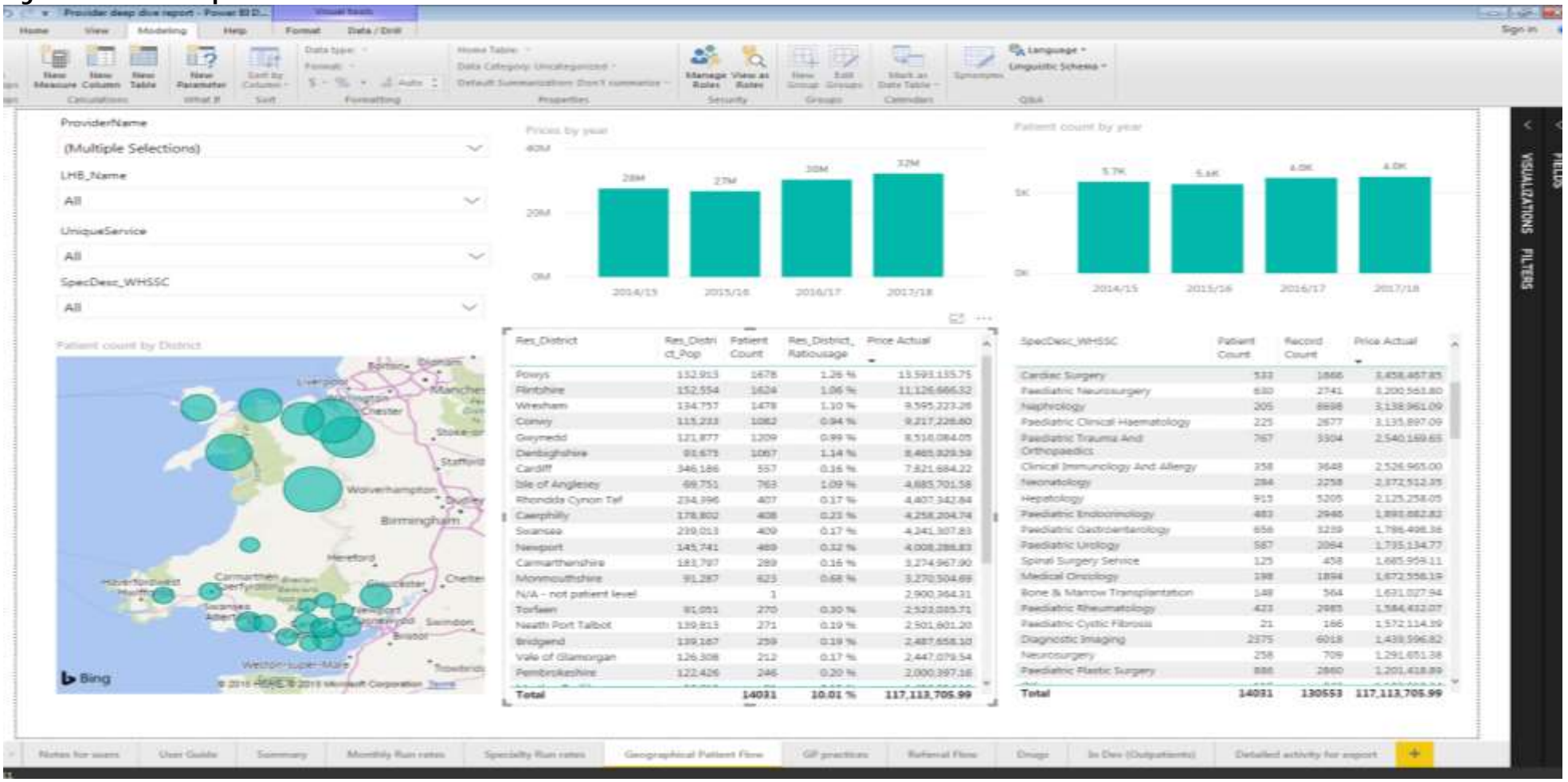
The reports from the MAIR system are simple to use and contain various visual displays and data manipulation, all of which are quickly filtered by LHB / Specialty / Point of Delivery / Financial year, etc., depending on the user's needs.

These visuals include:

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

In the interest of effective joint working across organisations, the reports have been made available to all Local Health Boards in December 2018, restricted to the patient records relating to their own residents. Local Health Boards can now view their own activity and referral data and if they wish join it up to their local primary/secondary care data.

Figure 5: MAIR example



Res_District	Res_District_Pop	Patient Count	Res_District_Ratiousage	Price Actual
Powys	132,913	1678	1.26 %	13,593,135.75
Flintshire	152,554	1624	1.06 %	11,126,666.32
Wrexham	134,757	1478	1.10 %	9,595,223.26
Conwy	115,233	1082	0.94 %	9,217,226.80
Gwynedd	121,877	1209	0.99 %	8,516,084.05
Denbighshire	93,673	1067	1.14 %	8,465,929.59
Cardiff	346,186	557	0.16 %	7,821,684.22
Isle of Anglesey	69,751	763	1.09 %	4,685,701.58
Rhondda Cynon Taf	234,396	407	0.17 %	4,407,342.84
Caerphilly	178,802	408	0.23 %	4,258,204.74
Swansea	239,013	409	0.17 %	4,241,307.83
Newport	145,741	469	0.32 %	4,008,289.83
Carmarthenshire	183,797	289	0.16 %	3,274,967.90
Monmouthshire	91,287	625	0.68 %	3,270,504.69
N/A - not patient level		1		2,900,364.31
Torfaen	91,051	270	0.30 %	2,523,085.71
Neath Port Talbot	139,913	271	0.19 %	2,501,601.20
Bridgend	139,167	259	0.19 %	2,487,658.10
Vale of Glamorgan	126,308	212	0.17 %	2,447,079.54
Pembrokeshire	122,426	246	0.20 %	2,000,397.16
Total		**14031**	**10.01 %**	**117,113,705.99**

SpecDesc_WHSSC	Patient Count	Record Count	Price Actual
Cardiac Surgery	533	1866	3,458,467.85
Paediatric Neurosurgery	630	2741	3,200,563.80
Nephrology	205	8698	3,138,961.09
Paediatric Clinical Haematology	225	2677	3,135,897.09
Paediatric Trauma And Orthopaedics	767	3304	2,540,169.65
Clinical Immunology And Allergy	358	3648	2,526,965.00
Neonatology	284	2258	2,372,512.35
Hepatology	913	5205	2,125,258.05
Paediatric Endocrinology	483	2946	1,893,682.83
Paediatric Gastroenterology	656	3239	1,786,498.36
Paediatric Urology	587	2084	1,735,134.77
Spinal Surgery Service	125	458	1,685,959.11
Medical Oncology	198	1894	1,672,558.19
Bone & Marrow Transplantation	148	564	1,631,027.94
Paediatric Rheumatology	423	2985	1,584,432.07
Paediatric Cystic Fibrosis	21	186	1,572,114.39
Diagnostic Imaging	2375	6018	1,439,596.82
Neurosurgery	258	709	1,291,651.38
Paediatric Plastic Surgery	886	2860	1,201,418.89
Total	**14031**	**130553**	**117,113,705.99**

The new MAIR system is in line with the 'Once for Wales' approach, in that it compiles the data into one dataset for use not only internally, but also by LHB. NWIS (NHS Wales Informatics Service) is currently working on a similar project (NDR – National Data Registry), but for the whole of Wales, targeted for December 2020 rollout, which would collate all of the NHS Wales data into one dataset. At that point, the data in the MAIR system will be incorporated into the national dataset and WHSSC will work closely with NWIS to include the specialist activity datasets in the NDR.

The MAIR system is a critical enabling resource in developing WHSSC's approach to value based healthcare as it enables powerful identification and mapping of variation – both in terms of cost and activity.

4 Development of the ICP

4.1 Principles

The ICP is designed to ensure that is aligned with previous Integrated Commissioning Plans and with the LHBs Integrated Medium Term Plans at both a service and financial level.

Over the six years of developing an Integrated Commissioning Plan a number of steps that have been built into its developmental process. These include:

- developing clear and accountable WHSSC commissioning priorities
- bringing forward the prioritisation of schemes requiring evidence appraisal
- ensuring that schemes for consideration at the Joint Clinical Impact Assurance Group (CIAG/Management Group process (this is explained in detail in section 4.3) have been risk assessed on the Risk Management Framework
- consideration of Health Board priorities for specialised services and;
- integrating scrutiny and good governance.

4.1.1 Improved interface with Commissioning Health Boards

Although the WHSS Team has worked with all commissioning LHBs through at least monthly Management Group meetings and the Joint Clinical and Managerial Prioritisation workshops, it has also strengthened its relations with Planning Leads in LHBs.

The WHSS Team is keen to provide synergy with the 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.

4.1.2 A Healthier Wales: Working across boundaries

In line with a Healthier Wales the WHSS Team is supporting a number of developments which cross organisational boundaries. Important examples include the development of the All Wales Gender Identity Pathway which includes primary care. This work is led by the WHSSC Director of Nursing and has involved the appointment of an Associate Medical Director for Gender Identity and a Project Manager. Whilst WHSSC does not commission the primary care element of this pathway it has been pivotal in providing leadership and co-ordination of the service.

A more recent example is work with the Youth Justice Board to look at the commissioning of the Forensic Adolescent Consultation Teams (FACTS) service to ensure that commissioning is designed to meet the needs of the clients and patients rather than those of traditional organisational boundaries. This offers an opportunity to move away from the traditional linear model of health care and integrate specialist services with social care.

The WHSS Team is also providing leadership for a range of services where there are underlying pathway issues outside the specialised services arena. This includes the aortic stenosis strategy and the stroke pathway value based health care projects which are described in section 3.3.

4.1.3 NHS Wales Delivery Plans

WHSSC continues to support LHBs in the delivery of the condition based NHS Wales Delivery Plans and is an active contributor to the Cancer, Critical Care, Heart Conditions, Neurological Conditions and Stroke Implementation Groups.

WHSSC has provided leadership to the Prolonged Disorders of Consciousness Group – one of the Critical Care Delivery Groups work-streams and provides commissioning input to the Long Term Ventilation work-stream. The Cardiac Commissioning Team have worked collaboratively with the Heart Implementation Group and the Cardiac Network on the revised TAVI policy which is due to be fully commissioned and implemented in 2019-20.

4.1.4 Innovation

WHSSC is examining opportunities to work more innovatively both within its commissioner role and with other organisations. As part of the development of the specialised services strategy, the WHSS Team will develop its innovation strategy and develop an organisational innovation hub during 2019-20. The WHSS Team will take advantage of the opportunities available, for example working with the Bevan Commission, to deliver innovative service improvement projects.

4.2 Horizon Scanning and Prioritisation

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.

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

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.

The process adopts the principles of prudent healthcare and supports implementation of the Well-being of Future Generations (Wales) Act. It sets out to reduce inappropriate variation using evidence based practices consistently and transparently with the public, patients and professionals as equal partners through co-production.

A comprehensive overview of the entire WHSSC prioritisation process algorithm for 2019-20 is presented in Annex 3.

4.2.1 Mandatory schemes

The horizon scanning exercise to identify new technologies for consideration within the 2019-22 ICP generated a list of mandated NICE and All Wales Medicines Strategy Group (AWMSG) guidance likely to publish in 2019-20. The list includes all NICE highly specialised technologies (HSTs), NICE Technology Appraisals (TAs) and AWMSG medicines.

All schemes that are mandatory were excluded from the prioritisation process and have been funded separately within the ICP (see section 5.3.1).

For NICE recommendations, a medicine should be available no later than 60 calendar days after the first publication of the Final Appraisal Determination (FAD) for Technology Appraisals (TAs) or the Final Evaluation Determination (FED) for Highly Specialised Technologies (HSTs). Cancer medicines recommended for an interim period by NICE for funding through the NHS England Cancer Drug Fund (CDF) should be made available within two months of the first publication by NICE of the FAD (provided the manufacturer offers NHS Wales the same or similar package as NHS England, including price).

For AWMSG recommendations, a medicine should be available no later than 60 calendar days after publication of the decision (following ratification of the recommendation by Welsh Government).

Currently all NICE HSTs due for publication in 2019-20 have a negative recommendation. However this may change during the latter stages of guidance development thus making it difficult to accurately predict the likely cost impact of these medications. Within the list of NICE TAs there are three ATMPs that have already published or are due to publish soon (see also Section 5.5). These carry a considerable up front cost.

4.2.2 Horizon scanning

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 2018-19 is presented in Annex 3.

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 August 2018 to inform this process.

The sources of information that WHSSC uses to horizon scan have now been formalised and these are presented in Annex 3. The first cut of this horizon scan identified >20 new technologies or treatments for WHSSC to consider. Following triage this was reduced to 9.

4.2.2.1 Reconsideration of interventions

There are a growing number of interventions and treatments that were previously given a low or medium priority by the WHSSC Prioritisation Panel which remain unfunded and outside of the ICP but may have a growing evidence base. Currently these are not routinely commissioned by WHSSC but can be accessed via Individual Patient Funding Requests.

WHSSC has now introduced an additional step in the prioritisation process with the creation of a 'static list' for low and medium priority topics. Topics on the static list may be transferred back to the active list for further appraisal if

new evidence becomes available that is likely to have a material effect on their priority. However all topics on the static list will be routinely reviewed every three years.

In June 2018 Management Group supported a revised process to re-consider any topic assigned as 'medium priority' by the Prioritisation Panel for a second time the following year. A total of five medium priority topics were re-assessed this year and were accompanied by an updated evidence review.

A summary of the new interventions and the medium priority topics reintroduced in to the process for consideration by the Prioritisation Panel are presented in Annex 3 and includes the source of each item.

4.2.3 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 June 2018. The final membership of the WHSSC Prioritisation Panel is presented in Annex 3 along with the methodology used.

Each of the interventions presented in Annex 3 were considered by the WHSSC Prioritisation Panel during two all-day meetings on 16 and 23 October 2018.

4.2.3.1 Results

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

- Susoctocog alfa for treating bleeding episodes in people with acquired haemophilia A (all ages). WHSSC have decided to exclude all haemophilia products as they are currently procured on a UK-wide basis
- Selective Dorsal Rhizotomy (SDR) for the treatment of spasticity in Cerebral Palsy [Children aged 3 – 9 years]. The Panel were not comfortable with prioritising this important topic without sight of the final NHS England commission through evaluation report. The Panel recommended that this intervention should be considered via IPFR until reassessed by the Panel in 2019
- Metreleptin for congenital leptin deficiency [all ages]. The evidence base was weak/uncertain and the expected volume of eligible patients

very small. The Panel recommended that this intervention should only be considered via IPFR.

The remaining topics were presented to the Panel and the results are shown in Annex 3.

Members agreed that the following four interventions be considered for inclusion in the 2019-22 ICP and undergo further prioritisation against the existing WHSSC schemes by the Clinical Impact Assessment Group (CIAG) (see section 5.3):

- Minimally invasive mitral valve surgery for 're-do' surgery
- Microprocessor controlled prosthetic knees
- Anakinra to treat periodic fevers and auto inflammatory diseases (all ages)
- Total pancreatectomy with islet auto transplant for chronic pancreatitis (adults).

4.2.3.2 Deprioritisation

For the first time, the process was used to carry out prioritisation of an intervention which is currently commissioned. This was undertaken because of an increasing evidence base underpinning Hyper thermic Intraoperative Peritoneal Chemotherapy (HIPEC). An evidence review was commissioned from CEDAR and this was prioritised alongside new interventions. The procedure was scored as being of lower priority than a number of the new interventions under consideration. The WHSS Team will now be working with clinicians to decommission this intervention, releasing funds for newer, more clinically effective interventions.

4.2.3.3 Prioritisation during 2019-20

The WHSS Medical Directorate is proposing to bring forward the horizon scanning and prioritisation process by three months in 2019-20 in order to align with the earlier Welsh Government submission dates for IMTPs/ICPs.

4.3 Joint Clinical Impact Assessment Group (CIAG) and Management Group Prioritisation

A joint workshop between representatives of the WHSSC Management Group and the Clinical Impact Assessment Group (CIAG) was held in early November to determine the relative prioritisation and 'clinical impact' of both new and existing interventions within specialised services for 2019-22. The prioritisation

of schemes was based on relative priority from a patient rather than financial perspective.

CIAG 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. Management Group were represented by one member of each Health Board. The Group acts in an advisory capacity only and was chaired by the WHSSC Managing Director.

The complete list of attendees is presented in Annex 4.

A list of 31 schemes had been drawn up from Prioritisation and schemes which had been assessed on the WHSSC Risk Management Framework.

The pre-determined criteria used in the CIAG workshop was on a slight variation to previous years consisting of:

- Burden of Disease
- Patient Benefit
- Increase in equity of access or decrease in inequity of access

Each scheme presented received a separate vote out of ten on the three elements of the criteria outlined above and each Clinician and Management Group member present received a vote.

To aid the Group with the decision making process, each scheme was supported by a statement prepared by the Lead Specialised Planner/Assistant Director for Evidence and Evaluation and a Clinical expert summary. A brief overview was presented on the day of the workshop with an opportunity for members to seek clarity on any queries.

The output from the workshop is presented in figure 6 below with full detail of the methodology used in the workshop presented in Annex 4.

4.3.2 Schemes not scored

Following discussions with the WHSSC Managing Director prior to the workshop two schemes – Neonatal Transport and Minimally Invasive Mitral Valve Redo Surgery (MIMVRS) were removed from the process. A further six schemes were removed by the CIAG Group from the process following presentation and discussion of the schemes at the workshop, but prior to voting. Details of the schemes removed and the reasons for why are outlined below:

Table 4: Summary of all schemes removed from the CIAG scoring process

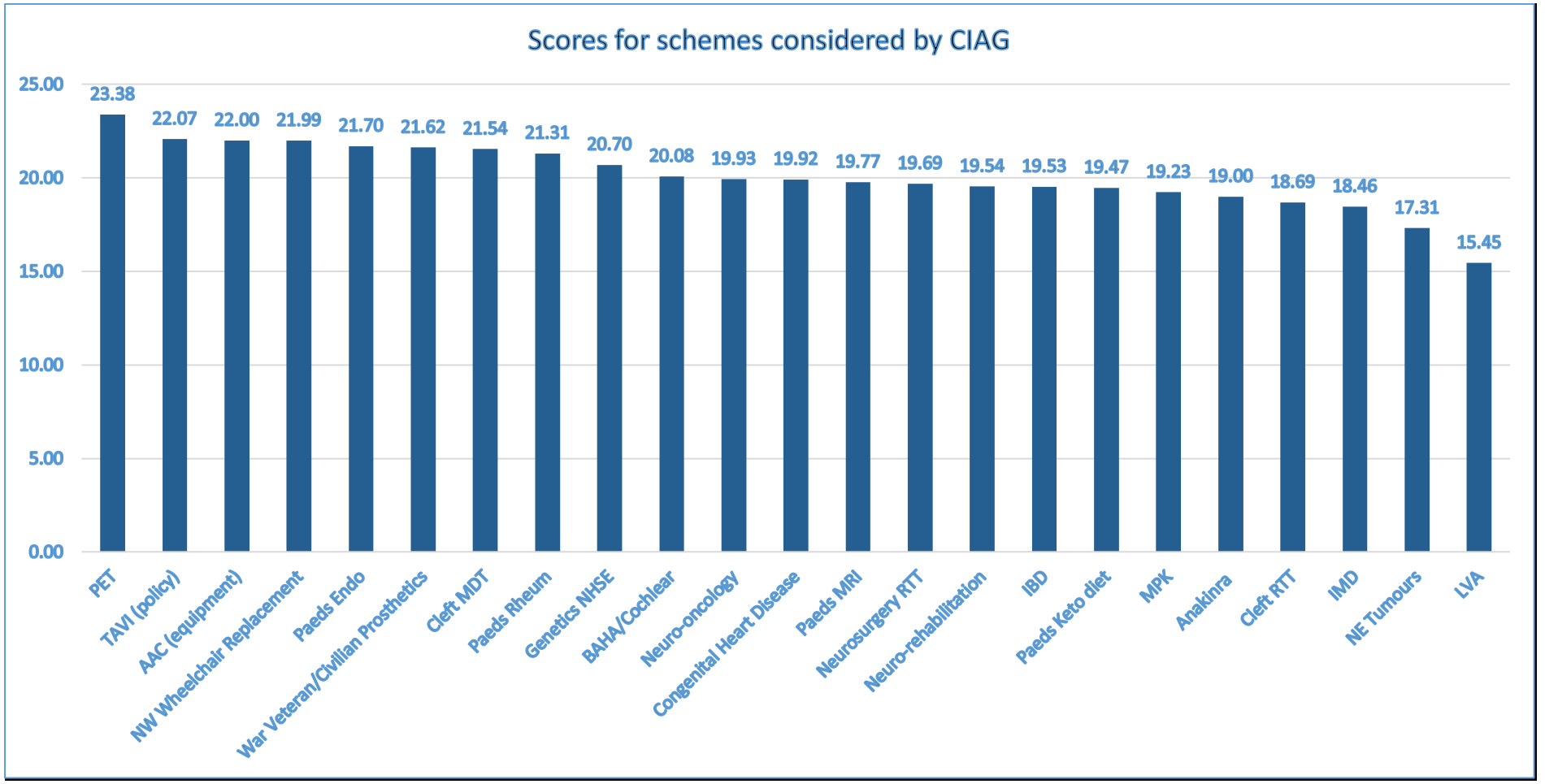
Scheme	Reason for removal from scoring process
Neonatal Transport	Already designated as a high clinical risk within the 2018-21 ICP which needs to be addressed in 2018-19.
Minimally Invasive Mitral Valve Redo Surgery (MIMVRS)	Primary MIMVS (which was agreed previously through Prioritisation) is not currently provided by NHS Wales due to capacity issues
Major Trauma Network	This stream of work has already been agreed by the Chief Executives and does not fit within this process for prioritising the order in which services should receive any available funding in 2019.
Major Trauma Revenue	As above.
Paediatric Oncology	Need to explore if increase in activity can be addressed through an increase in the baseline.
Total pancreatectomy with auto islet transplant	Due to low numbers, requests for this treatment should be made through the IPFR process. It was also noted that no providers had yet been procured to deliver this treatment
Thrombectomy	Similarly to Major Trauma, this procedure has been agreed by Chief Executives and Local Health Boards where possible are commissioning it from English Trusts.

4.3.3 Results

In comparison to the results from last year's workshop, the range of scores were much closer with nine schemes scoring >20 and a further six schemes scoring over 19.5. A number of the schemes considered in this year's workshop were also scored in previous years and in the majority of cases, their scores increased.

Two of the schemes scored for Neurosurgery and Cleft, Lip and Palate related to a requirement for additional resources in order to deliver improvements

against or sustain the Referral to Treatment (RTT) targets. It was agreed that these should be considered separately to the CIAG process but together as they each have a similar priority in meeting Welsh Government delivery


Scores for schemes considered by CIAG
25.00
20.00
15.00
10.00
5.00
0.00
23.38
22.07
22.00
21.99
21.70
21.62
21.54
21.31
20.70
20.08
19.93
19.92
19.77
19.69
19.54
19.53
19.47
19.23
19.00
18.69
18.46
17.31
15.45
PET
TAVI (policy)
AAC (equipment)
NW Wheelchair Replacement
Paeds Endo
War Veteran/Civilian Prosthetics
Cleft MDT
Paeds Rheum
Genetics NHSE
BAHA/Cochlear
Neuro-oncology
Congenital Heart Disease
Paeds MRI
Neurosurgery RTT
Neuro-rehabilitation
IBD
Paeds Keto diet
MPK
Anakinra
Cleft RTT
IMD
NE Tumours
LVA

4.4 Strategic Specialised Services Priorities

Schemes for the following services have been included within the 2019-22 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 resources required and the mitigation of risk following any investment.

4.4.1 Cystic Fibrosis

Whilst investment was made to the service in 2018 as outlined in section 3.1, to manage the patient cohort which had grown to in excess of 300, the further proposal to support the revenue consequences of the inpatient service expansion to manage this increased patient cohort was not received by the WHSS team from C&VUB in time to be considered in the prioritisation process. The importance of increasing the bed base within the Unit and mitigate the current cross contamination concerns for this vulnerable patient group through sharing bathrooms is recognised by WHSSC. Capital and infrastructure support from Welsh Government is required to allow this expansion in the bed base but the Provider has advised that this is expected in 2019-20.

4.4.2 Neonatal Transport

Neonatal Transport in south Wales is currently delivered for 12 hours per day, seven days per week. This service runs on a 1 week in 3 rotational basis between the three Neonatal Intensive Care Units (NICUs), Aneurin Bevan, Abertawe Bro Morgannwg and Cardiff & the Vale Local Health Boards. The All Wales Neonatal standards and a recent Independent Case Review has recommended that a 24 hour transport service is in operation for neonatal services.

It is proposed that a comprehensive review is undertaken of the current system in 2019-20 in order to inform the development of a 24 hour service. In the interim, the WHSS Team are working with Neonatal Transport providers to implement an interim 24 hour solution until the review is completed and can be considered as part of the 2020-23 ICP.

4.5 New Commissioned Services

4.5.1 Thrombectomy

It was agreed by the Joint Committee that WHSSC would commission Mechanical Thrombectomies services for NHS Wales from April 2019. Throughout 2018-19 the WHSS Team has been working to secure access to capacity from services in NHS England whilst provision has also been made to develop the service in C&VUHB to serve the population of mid and south Wales. The team are working in collaboration with the Welsh Government's Stroke Implement Group (SIG) and LHBs on the pathway required to both access Thrombectomy treatment and repatriate to a patient's local hospital following treatment.

4.5.2 Major Trauma

WHSSC has been designated by LHB Chief Executives as the organisation to develop the Commissioning Framework and Governance structure to support the delivery of the Major Trauma Network for south and west Wales led by the NHS Wales Collaborative. Fixed term roles in Planning and Finance have been funded by Welsh Government in order to progress the Strategy and Commissioning Framework required for the Major Trauma Centre and Network in south and mid Wales.

5 Finance

5.1 Context

Specialised services continue to evolve at an accelerated pace including the emergence of genomics and personalised medicine. The financial plan for 2019-20 to 2021-22 demonstrates that the core is being well managed and constrained within comparators. However, the plan also contains a number of exceptional issues that now need to be accounted for including:

- The re-alignment of contracts with NHS England to incorporate current and proposed changes to the tariff system.
- The incorporation of pay awards into the NHS England contracts.
- New Clinical Impact Advisory Group priorities.
- New mandated advanced therapeutic medicinal products and their associated service implications.
- Long standing strategic priorities including cystic fibrosis.
- New services which Local Health Boards wish WHSSC to commission including Thrombectomy.

The combined impact of the above taken together with expected standard growth in demand pressure, mandated drugs and RTT presents an affordability challenge.

5.2 Composition

Figure 7: WHSSC expenditure by Commissioner 2018-19 (£579m)

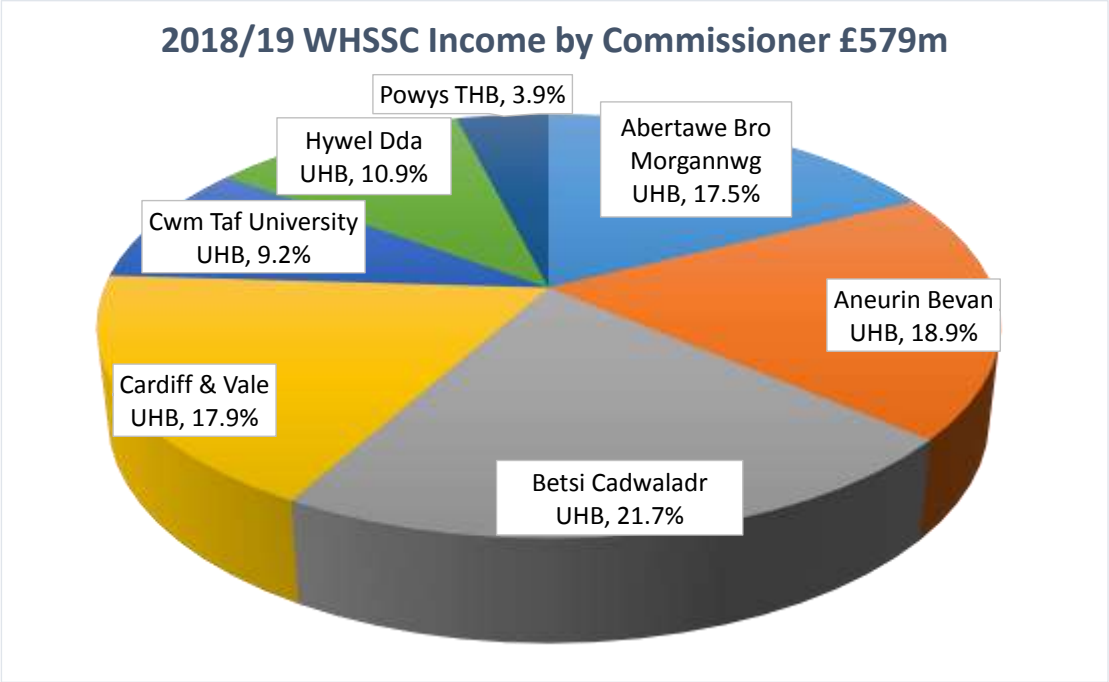
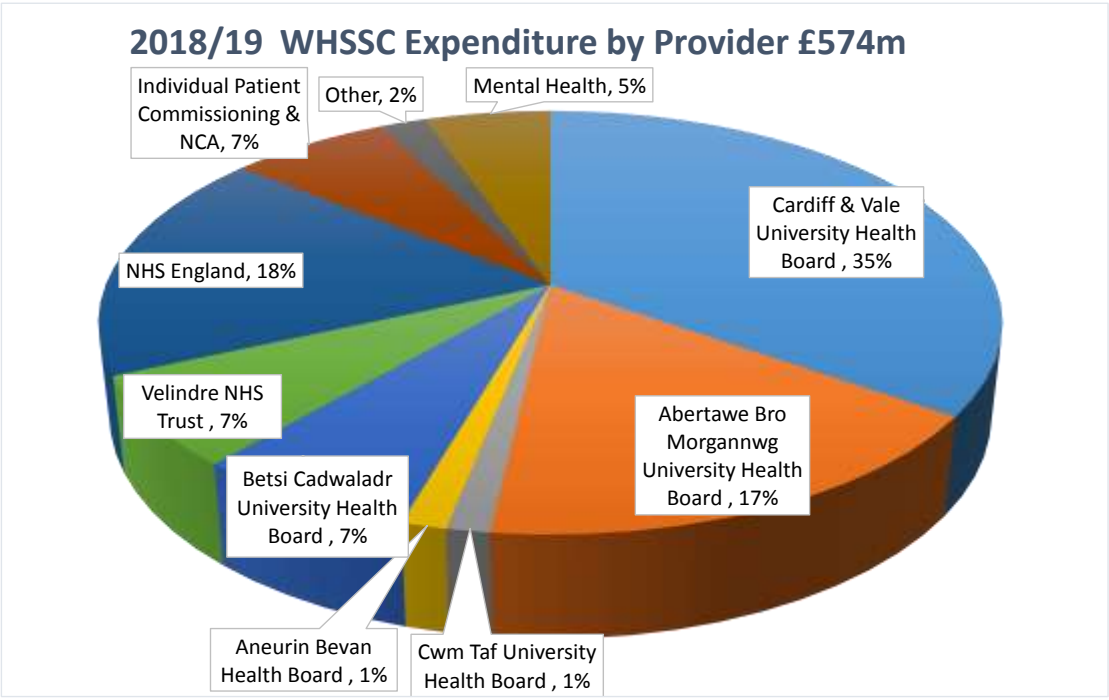


Figure 8: WHSSC expenditure by Provider 2018-19 (£574m)



5.3 Financial Plan Structure

The financial plan is set out in terms of income and expenditure allocated by Health Board for 2019-20 together with the forward look extending to 2021-22. The summary quantum impact is shown together with percentages of baseline for reference.

5.3.1 Underlying Position and Standard Growth

- Opening allocation – the starting point is the agreed allocation in December 2018-19 of £578.660m, the 2019-20 ring-fenced allocation for the genomic test directory and perinatal mental health are then added to derive the 2019-20 opening baseline of £581.568m.
- Forecast performance 2018-19 – the forecast performance for the year is an underspend of £4.581m (0.79%).
- Re-instatement of non-recurring write-back – the 2017-18 included a number of exceptional items linked to substantial uncertainty in terms of performance and HRG4+. The material benefit resulting in 2018-19 of £10.358m (1.78%) is assumed to be non-recurrent.
- Adjustments to non-recurrent performance – the forecast 2018-19 out-turn position has been adjusted to account for non-recurring performance variations including slippage and exceptionality. The net impact is £3.537m (0.61%). Example issues include assumptions in respect of cardiac surgery (re-instate 50% of underperformance recurrently) and plastics performance (re-instate £200k of underperformance to make current baseline is recurrent).
- Full Year Effect of Prior Year Investments - £1.634m (0.28%) is required to fund the full year impact of agreed investments. Example schemes include the first phase of Cystic Fibrosis investment for Multi- Disciplinary Team (MDT) expansion, BAHA/cochlear implants and the PICU 7th bed.
- New Service Pressures and Growth - £6.199m (1.07%) required for growth including:
    - £1.914m for growth in immunology drugs, Eculizumab drugs and cochlear implants
    - £2.950m for growth in dialysis, specialised cardiology and paediatric oncology.
    - £1.020m for neurosurgery and cleft lip and palate RTT activity requirements.
- Mandated High Cost Drugs - £1.995m (0.34%) required for NICE approved drugs which must be provided by NHS Wales including:
    - £0.675m for new specialised cancer drugs – including some for cancers with specific genetic mutations.

    - £1.2m for highly specialised drugs typically for rare diseases including muscular dystrophy and Batten disease (CLN2 disease).
- Mandated New Treatments - £4.381m (0.76%):
    - The Welsh Government's commitment to Advanced Therapies Treatment Centres (ATTC) means that Wales will be at the forefront of the introduction of ATMPs. The unit cost of these products is high at a list price in excess of £250,000 per case. In addition there are significant service costs associated with treatment preparation, initiation and managing immune response including intensive care.
    - The cost of treating the expected population is estimated at just over £8m per annum. It has been assumed that year 1 costs have been reduced to 80% to allow for some slippage in system capacity. In practice it is anticipated that capacity across the UK will be limited and centres will be cautious in the number of treatment cycles in progress at any time. This may reduce anticipated year 1 costs.
    - The full cost of ATMPs is subject to significant uncertainty. Service treatment costs have been provided for at circa 50% of drug cost but will be kept under review as evidence from the US/European health systems reported higher initial costs. The WHSS Team will work closely with providers to assess the resource impact of these new therapies on the whole care pathway and patient outcomes.

- Value Based Healthcare and Transformation Workstreams – saving £3.250m (0.56%):
    - As a commissioning organisation WHSSC does not have direct access to the provider cost base on which to secure traditional cost improvement savings. WHSSC continues to develop a programme of value based commissioning schemes which are designed to act in addition to provider internal CIPs.
    - At this point in the IMTP process a prudent financial assessment of schemes has identified £3.250m (0.56%) of savings including:
        - Inherited Bleeding Disorders - £0.800m from blood products procurement and clinical trials income.
        - Mental Health Services – a minimum of £0.500m from the continued success of case management of secure services.
        - Referral Management - £0.250m from local case management to reduce referrals into NHS England, optimise use of local specialised services, repatriation of non-specialised care on a timely basis.
        - Out Patient Management - £0.250m from working in partnership with NHS England and local services to reduce initial referral, use of alternative consultation methods including telemedicine and use of local specialist nursing to reduce follow up activity.

- Medicines Management - £0.250m from initiative using local specialist pharmacy expertise to ensure best value from optimisation of start/stop criteria, monitoring of market access arrangements including right price, repatriation, brand switching and procurement.
- Market Forces Factor - £0.150m (rising to £0.446m) from changes to the proposed market forces factors phased over 4 years. This is subject to the proposal being implemented consistent with the consultation within NHS England.
- Perinatal Repatriation - £0.350m from repatriation of out of Wales referrals contingent on the development of a Welsh service (funding source £7m ring-fenced Mental Health allocation for targeted developments).
- Inherited Metabolic Disorders - £0.500m from product switching.
- De-prioritisation - £0.200m from identification and de-prioritisation of low value interventions or spend.

5.4 Net Underlying Deficit, Prior Commitment, Growth and Mandated Treatments

The net financial requirement for the underlying position, including prior commitments and growth totals £20.273m (3.9%).

5.5 Clinical Impact Advisory Group (CIAG) Priorities

The financial plan sets out the £4.416m (0.78%) required to deliver the higher priorities that have been identified by the CIAG process:

CIAG Highest Priority (>20 Score) – the investment identified for the highest scoring priorities from CIAG is £3.443m. In addition to these priorities which are outlined below, the introduction of an extended range of tests available from the new test directory for cancer and rare diseases has been top-sliced and ring-fenced for funding. Additional income has been shown in table 5 for the genetics directory with matching expenditure assumed in the baseline.

Table 5: Cost of funding CIAG schemes scoring >20

CIAG Mean Score	Clinical Impact Schemes score > 20	2019/20 £m	2020/21 £m	2021/22 £m
23.38	PET new indications	0.300	0.500	0.500
22.07	TAVI	1.000	1.400	1.400
22.00	AAC	0.700	0.700	0.700
21.99	BCU P&M - wheelchairs	0.400	0.400	0.400
21.70	Paeds Endocrine	0.350	0.525	0.525
21.62	BCU ALAS - war veterans		0.100	0.100
21.54	Cleft lip and palate	0.250	0.392	0.392
21.31	Paeds Rheumatology	0.197	0.262	0.262
20.70	Genetic test directory (Funded by WG allocation)	0.000	1.432	3.646
20.08	BAHA & Cochlears replacement & maintenance	0.247	0.500	0.500
	Total	**3.443**	**6.211**	**8.425**

CIAG Medium Priorities (>19.5<20 Score)

The investment required to deliver medium priorities which are outlined below is £0.973m. The Inherited Bleeding Disorders scheme is also linked to a value based healthcare improvement project targeting efficiencies and savings.

Table 6: Cost of funding CIAG schemes scoring >19.5<20

CIAG Mean Score	Clinical Impact Schemes score < 20	2019/20 £m	2020/21 £m	2021/22 £m
19.93	Neuro-oncology	0.100	0.150	0.150
19.92	Adult Congenital Heart Disease	0.300	0.800	0.800
19.77	Paeds MRI	0.060	0.300	0.300
19.54	Neuro rehabilitation	0.113	0.150	0.150
19.53	IBD project trials saving + service model	0.400	0.930	1.290
		0.973	**2.330**	**2.690**

CIAG Lower Priorities (<19.5 Score)

Given the pressure on the overall plan a line has been drawn for those schemes scoring less than 19.5 in the CIAG/Management Group process on the basis of those which may be less unavoidable. These schemes include

paediatric ketogenic diet (the IPFR route is still available); the provision of micro-processor knees; Anakinra (not subject to NICE approval); inherited metabolic disease; neuro endocrine tumours (additional phase of investment); and Lymphovenous Anastomosis (LVA).

5.6 Strategic Specialised Priorities

£0.500m (0.09%) required for investment in three strategic priorities that have been under consideration across a number of planning cycles:

5.6.1 Cystic Fibrosis

£0.2m in year 1 rising to £1.046m for the new inpatient unit including increased capacity. The net increase in beds will have been moderated by the investment in the out of hospital pathway but will still be required to match the growth in the CF population.

5.6.2 Peri-natal (Mother and Baby)

Table 2 includes this new allocation for year 1. The costs are estimated at £0.575m rising to £1.150m to develop a new model of care including a Welsh in patient service. The plan is that will significantly reduce the dependence on out of area referrals and improve access. Repatriation savings are planned in section 5.4.

5.6.3 Neonatal Transport

An estimated £0.3m rising to £0.6m for the development of an extended hours retrieval service. The final model is under consideration to strike the right balance between operating hours, demand and safe clinical practice.

5.7 New Commissioned Services

£3.776m (0.65% required for new services that will transfer from Local Health Boards to WHSSC commissioning responsibility in 2019/20:

5.7.1 Thrombectomy

Through 2018-19 the WHSS Team has been working with LHBs to secure Thrombectomy capacity from services in England.

5.7.1.1 Provider costs

The financial plan includes the cost of commissioning increased access from providers on a sustainable basis:

South Wales North Bristol Trust – £0.820m for 32 cases rising to £1.640m for 64 cases per annum. Modelled costs are based on current offer levels which are in excess of national tariff costs and hence are still subject to negotiation. Assumed volumes are flat over three years as the plan is for the Cardiff service to step up its capacity gradually in line with improvements in local interventional neuroradiology capacity.

South Wales Cardiff – no impact in year 1 rising to £1.4m for 100 cases as the service is developed and volumes increase. Prices are based on national tariffs for modelling purposes.

North Wales Walton – £0.280m rising to £1.12m for 20 to 80 cases. Prices are based on national tariffs consistent with discussions with the Trust.

Powys University Hospitals North Midlands - £0.056m to £0.224m for 4 to 16 cases. Prices are based on national tariffs.

5.7.1.2 Supporting Local Health Board Pathways

The WHSS Team will be working with Local Health Boards to ensure that the pathway resources are in place to ensure appropriate identification and diagnosis of the patient, transfer of patient to the centre and prompt repatriation back post intervention.

5.7.1.3 Demand

It is anticipated that demand for the service will increase further beyond the three year period of the plan but that initially will be constrained by system capacity. The WHSS Team will be evaluating the emerging evidence base for the intervention and in particular the time for a successful outcome from occurrence to intervention.

5.7.2 Major Trauma south Wales

Financial estimates are highly indicative at this point. In aligning this ICP with capital development plans, it is assumed there will be no revenue requirements in 2019-20 with commissioning commencing in mid to late 2020. However should there become a requirement to pump prime the service, this will need to be managed within the quantum of the overall agreed ICP as an in year pressure. Early estimates of cost from providers in meeting all standards were indicated up to £10m but at this point Local Health Boards have not agreed any firm resource envelope. The WHSS Team will work with

the provider to develop an appropriate business case and financial/contracting model.

5.8 NHS Wales Financial Framework

The agreed direct financial uplift for all Welsh provider services is 2%. The net cost is £7.464m (1.28%). In line with the agreed framework the 2% has been provided for in full for all Welsh providers including Local Health Boards and Trusts.

The allocation letter sets out a clear expectation that Local Health Boards must direct a further 1% towards delivering Healthier Wales requirements. The WHSSC plan meets this requirement in full. The plan provides investment in new services and strategic investment of 1.05% set out in sections 5.5 to 5.7 above. In addition the plan provides for a further 1.07% plus 0.76% to fund new service growth, demand growth and new advanced therapy services.

5.9 Financial Risks currently outside of the funded Plan

There are a number of financial risks that following dialogue with Welsh Government and LHBs have been excluded from the ICP approved by LHBs on 22nd January 2018. The key risks all relate to financial framework for paying for activity delivered by providers within the English NHS system. Discussion continues between NHS Wales and NHS England regarding these issues but at this point the outcome remains uncertain.

5.10 NHS England Tariff

The financial plan includes the material impact of the investment required to ensure price alignment to the NHS England price structure for services provided by NHS England providers. The total cost of re-alignment is estimated to be £9.065m (1.56%) and includes the following:

- HRG4+ - NHS Wales has been in dispute with NHS England regarding the introduction of the 2017-18 two year tariff which was not subject to appropriate consultation and increased the net liability for NHS Wales by increasing materially specialised services prices. NHS Wales has not paid the tariff increase for 2017-18 and 2018-19. Whilst the 2017-18 position was resolved by NHS England directly funding affected Trusts, the position for 2018-19 remains in dispute. The annual value under dispute for specialised services is approximately £5.4m.
- Cost uplift – the recently published prescribed price uplift for 2019-20 is 3.8% less a 1.1% efficiency requirement giving a net increase of 2.7%. This

includes the impact of the pay awards for 2018-19 and 2019-20 assessed at 3.4%. NHS England received full funding for 2018-19 and 2019-20 on a provider basis rather than a population basis. In line with this the 2018-19 pay award was paid to English Trusts directly outside of tariff arrangements. For 2019-20 NHS England are proposing to include the pay award in tariff which would result in a cost to NHS Wales of circa £2.668m. The Welsh Government / NHS Wales position on this is that it would not be appropriate for Welsh commissioners to have to pay the pay award via tariff as NHS England have already been fully funded. This issue will be structurally difficult to resolve but a solution will need to be found.

- CQUIN – 1.25% of CQUIN (approximately half of the total) has been transferred into core prices. The introduction of CQUIN into tariff prices is disputed by NHS Wales as CQUIN has always been excluded from contracts with English Trusts. The net impact is circa £0.995m.
- Consultation – the NHS Wales position remains that the changes to the 2017-18 and 2018-19 together with the new changes to the 2019-20 tariff are not applicable as NHS England has failed to consult with NHS Wales regarding the changes and that they are either inappropriate (CQUIN and pay inflation) or would have a material financial adverse financial impact on Wales for no improvement in services (HRG4+).

5.11 Service Risks

The financial planning assumptions set out in the report and detailed schedules provides a prudent assessment of financial risk related to specialised services. There are some areas where financial provision has not been made at this point, for example, where service plans are not yet adequately developed or there is too much uncertainty as to whether a specific risk will materialise in year. The key areas of service risk are highlighted below for completeness.

- Major Trauma – no separate financial provision has been made in 2019-20 on the basis that delivery will commence late in 2020. The risk is that specific posts may be identified for pump priming consideration.
- Cystic Fibrosis – business cases for the home IV antibiotic scheme and in patient development were not received from the provider in time for consideration against priorities. Provision has been made for phased development of the in patient service with some priming in 2019-20 and step up through years 2 and 3. Provision for home IV remains at the 2018-19 level of circa £83k pending an evaluation from the service on their home IV trial that could be considered in future ICPs.
- Thrombectomy – provision has been made for an increase in thrombectomy access. The pathway will need to be developed in 2019-

20 in order to ensure structured and equitable access to the increased new tertiary capacity.

5.12 Summary Impact Assessment

The impact assessment of the 3 year ICP requirement is set out in the below table:

Table 7: WHSSC 2019-22 ICP 3 year Financial Summary

	2019/20 ICP Requirement £m	2020/21 Indicative Requirement £m	2021/22 Indicative Requirement £m
2019/20 Opening Baseline	581.568	581.568	581.568
Underlying Deficit & Growth	15.892	31.982	48.548
CIAG Schemes	4.416	8.541	11.115
Mandated AMTPs	4.381	6.924	6.924
Strategic Specialist Priorities	0.500	4.350	5.296
New Commissioned Services	1.156	9.840	13.040
NHS Wales assume 2% provider inflation	7.464	15.014	22.614
WHSSC Additional Requirement	33.809	76.651	107.537
Total WHSSC 3 Year Requirement	615.376	690.201	737.653
% Cumulative Uplift Required	5.81%	18.68%	26.84%

The financial requirement to deliver the submitted plan in 2019-20 is £33.809m including New Mandated ATMPs; CIAG Schemes; Strategic Priorities and New Commissioned Services.
The breakdown of the 2019-20 requirement by commissioner is set out below:

Table 8: WHSSC 2019-20 ICP Financial Summary by Commissioner

	Commissioner Split							
	Abertawe Bro Morgannwg UHB	Aneurin Bevan UHB	Betsi Cadwaladr UHB	Cardiff & Vale UHB	Bridgend (Cwm Taf UHB)	Cwm Taf UHB	Hywel Dda UHB	Powys THB
	£m	£m	£m	£m	£m	£m	£m	£m
2019/20 Opening Baseline	**73.036**	**107.395**	**127.517**	**100.098**	**28.213**	**55.956**	**66.220**	**23.132**
M8 18/19 - Forecast Performance	(0.548)	(0.945)	(1.435)	(2.249)	0.242	0.165	0.662	(0.472)
Reinstate Non Recurrent Writebacks	1.295	2.187	2.203	3.204	0.000	0.470	0.038	0.961
Adjustments for Non Recurrent Performance	0.386	0.646	0.770	0.801	0.166	0.314	0.309	0.145
Full Year Effect of Prior Year Investments	0.356	0.306	0.005	0.358	0.108	0.143	0.330	0.027
New Cost Pressures / RTT / Growth in IPC	0.805	1.293	0.680	1.382	0.308	0.760	0.767	0.205
Mandated High Cost drugs	0.154	0.537	0.268	0.418	0.129	0.262	0.159	0.068
Mandated ATMP	0.544	0.822	0.977	0.694	0.203	0.420	0.538	0.184
VBC workstreams	(0.403)	(0.607)	(0.766)	(0.509)	(0.140)	(0.306)	(0.382)	(0.137)
Underlying Deficit & Growth	**2.589**	**4.240**	**2.702**	**4.099**	**1.015**	**2.228**	**2.421**	**0.980**
CIAG Schemes	0.633	0.923	0.625	0.775	0.212	0.484	0.601	0.162
Strategic Specialist Priorities	0.089	0.117	0.000	0.116	0.031	0.066	0.067	0.014
New Commissioned Services	0.150	0.206	0.277	0.168	0.036	0.104	0.139	0.077
NHS Wales 2% provider inflation	**1.100**	**1.525**	**0.957**	**1.479**	**0.413**	**0.814**	**0.970**	**0.207**
2019/20 WHSSC Additional Requirement	**4.561**	**7.011**	**4.561**	**6.636**	**1.707**	**3.696**	**4.198**	**1.440**
% Total Uplift Required	**6.67%**	**6.96%**	**4.00%**	**7.02%**	**6.46%**	**7.03%**	**6.80%**	**6.68%**

5.13 Comparative position to NHS England

Given the recognised differential pace of service pressures impacting on specialised services it is important to continue to track historic and forecast positions to NHS England specialised services.

When the 2018-19 ICP was drafted the only published information indicated that specialised services in England would be uplifted by 4.5%. The final allocation confirmed for specialised services referenced in reports published in October 2018 confirm that the allocation was significantly higher at 7.52%. Allocations increased from £16.412bn in 2017-18 to £17.448bn in 2018-19. This is a material increase in resource which reflects the nature, pace and scale of the pressures being experienced nationally in specialised services both from demand and the cost of new interventions.

The finalised WHSSC ICP represents a specialist allocation uplift to commissioners of 6.24%. The indicative specialist allocation growth for NHS England for 2019-20 is 8.14%.

NHS England has published a 5 year draft budget for CCGs Specialist allocation which sets out a cumulative growth of 37% over the next 5 years:

Table 8: NHS England's Specialist Services Allocation 2019-2024

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

6 Workforce

6.1 Within Commissioned Services

6.1.1 Clinical Workforce issues

Difficulties in recruitment and retention of clinical staff within some specialised services is leading to the fragility of those services and an increasing risk to patients of service failure. 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 ICP through our prioritisation process. This is informed by provider risk registers and our own Risk Management Framework.

There are also important examples of how such workforce issues have been addressed through service innovation. The north Wales Adolescent Service (NWAS) has managed clinical staff shortfalls through the introduction of a Psychology led model and has managed to significantly reduce out of area placements ensuring not only that patients get care closer to home but that costs are reduced.

Changes in clinical practice with increasing sub-specialisation have also been important drivers in service change. This was a key issue for the recently agreed service reconfiguration of thoracic surgery services. Previously thoracic surgery was covered by cardiothoracic surgeons however there are no-longer what is known as "dual practice" surgeons and therefore our two centres do not have sufficient numbers of thoracic surgeons to run an out of hours rota. To mitigation this, it is intended that Thoracic Surgery are delivered services from a single site.

There are also significant 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 services. This has been evident most recently in paediatric surgery in south Wales.

New technologies also provides challenges, for example the introduction of Thrombectomy. This is a life changing treatment typically delivered by Interventional Neuro-Radiologists, a specialty where staff shortages mean that we currently struggle to meet existing patients' needs. The new Advanced Therapeutic Medicinal Products will also make new workforce demands, demands which as yet are not fully understood. We are therefore engaging with the newly established Health Education and Improvement Wales (HEIW) regarding the staffing shortfalls, notably in Cardiac Scrub nursing and Cardiac

Anaesthetics and looking to work on joint solutions for stabilising the workforce in Wales and increasing training opportunities.

6.2 Within WHSSC

6.2.1 Workforce and Organisational Development Plan

A summary of the High Level Workforce Plan for WHSSC for 2019-22 is presented in Table 2.

6.2.2 Staff Engagement

A major piece of work to develop the WHSS Team's corporate values was undertaken during the year and resulted in the launch of the values on the 5th July 2018 the 70th birthday of the NHS. The development of the values involved a continuous process of engagement using one to one conversations, detailed behaviour feedback, a listening tree to capture key themes and workshops.

The values agreed for the organisation are shown in the figure below.

Figure 9: Values of WHSSC launched in July 2018

Over the course of the last year further work has been undertaken to strengthen staff engagement throughout the organisation. As part of the process one to one meetings were held with the Managing Director during

September and October 2018 and feedback has been positive regarding the process.

Departmental meetings are held at least monthly and 'all staff' meetings are convened by the Managing Director every 2 months. These provide employees at all levels in the organisation opportunities to be updated and share information.

Encouragingly, the recent All Wales NHS Staff Survey had an excellent response rate within the organisation with 78% of non-medical staff (with the medical staff taking part in their primary employer HB) taking part. This showed high levels of staff satisfaction with their jobs:

- More people in WHSSC look forward to going to work than in NHS Wales in general (76% compared with 60%)
- More people in WHSSC are enthusiastic about their job than NHS Wales in general (85% compared with 73%)
- More people in WHSSC are proud to work for WHSSC than the NHS in general (80% compared with 72%). This was a big improvement from 2016 when only 40% of staff reported they were proud to work for the organisation.
- No-one felt that their role doesn't make a difference to patients

The survey did also identify some dissatisfaction with team working and an action plan is currently being developed with staff. A lower percentage of staff reported having experienced bullying than the NHS in Wales average (13% compared with 17%) although we still wish for this percentage to reduce further.

6.2.3 Training opportunities

The organisation has made a number of training opportunities available to staff. These include the Healthcare Financial Management Association (HFMA) modules for non-finance staff which are being undertaken by staff within the Clinical and Planning team and the Academi Wales Senior Leadership course which is being undertaken by staff at Assistant Director level. We also have a number of staff undertaking master's level qualifications. At Director level we are providing executive coaching and have provided professional development opportunities in Value Based Healthcare. One of our Associate Medical Directors is due to undertake a coaching qualification to allow us to provide an "in-house" resource for future staff development.

6.2.4 Staff sickness and absence

As a small organisation, sickness and other absences have a significant impact on the capacity of the WHSS Team. Short and long term sickness absence continues to be a focus with all Line Managers attending sessions arranged by Cwm Taf University Health Board (CTUHB) as our host organisation. This ensures high levels of awareness of the All Wales sickness policy and that staff have the necessary skills and knowledge to implement the policy.

The sickness rates for WHSSC are shown below:

Table 9: WHSSC Sickness Absence Rates

Rolling period Oct 2017 – Sep 2018		
Absence days (FTE)	Available days (FTE)	% Rolling rate (FTE)
1,210	19,715	6.14

Note: Excluding EASC and QAIT

6.2.5 Development of Clinical Leadership

Both the Good Governance Institute and Health Inspectorate Wales reviews (2015) included the need to strengthen clinical leadership, clinical credibility and clinical engagement within the WHSS Team. This has been core to our strategic focus and significant steps have already been undertaken to deliver this. The five Associate Medical Directors aligned to the commissioning teams 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, challenging the way in which Neonatal services are delivered in south Wales and addressing clinical and performance concerns in one of our CAHMS units.

Part time Medical and Deputy Medical Directors took up post in the first quarter of 2018-19. These are key appointments in taking forward the WHSS Team strategy. The Deputy post focuses on the prioritisation, evidence evaluation and rare diseases portfolio and the Medical Director on the performance management, quality outcomes and strategic review.

6.2.6 External Training and Development

The WHSS Team is keen to offer out unique all Wales strategic planning and commissioning experience 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.

The Associate Medical Director roles provide a stepping stone for those pursuing a career in medical leadership and were specifically advertised as three year posts with this in mind. Both the Medical Director and Managing Director are active in the regional Faculty of Medical Leadership and Management.

The WHSS Team was successful in its bid for a Welsh Clinical Leadership Fellow who took up post in August 2018 and is leading on a review of Pulmonary Hypertension Services. This is a complex initiative looking at an extremely high cost service of around £6m involving English providers and challenging patient pathways. WHSSC has also achieved training status for Public Health trainees. We are also actively engaged 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 fourteen 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. In addition the Finance Directorate has established apprenticeship posts.

7 Governance and Accountability Framework

7.1 WHSSC Joint Committee Structure

The WHSSC Joint Committee is established as a statutory Sub-Committee of each of the seven LHBs. It is led by an Independent Chair, appointed by the Minister for Health and Social Services. Its membership is made up of the Chair, three Independent Members, one of whom is the Vice Chair, the Chief Executives of the seven 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 the Chief Executive of CTUHB as WHSSC's host organisation. Under the terms of the establishment arrangements, CTUHB as the host organisation, 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.

7.1.1 Sub Committees

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

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

The Quality and Patient Safety Committee is chaired by an independent member, the Integrated Governance Committee is chaired by the Chair of the Joint Committee, and the Welsh Renal Clinical Network is chaired by the former Lead Clinician for the Network, who is also an 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 WHSSC website: www.whssc.wales.nhs.uk.

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

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

A review of the group was undertaken in 2017-18 by the Managing Director and Committee Secretary. As a result of this work the Assistant Director for Workforce and Organisation Development at CTUHB, as the host organisation for WHSSC, is taking forward a 9 month programme of OD with the group starting in the third quarter of 2018-19.

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 the host organisation for WHSSC, advises and assures the Joint Committee on whether effective arrangements are in place – through the design and operation of the Joint Committee's assurance framework – to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Joint Committee's delegated functions.

The WHSSC Committee Secretary and Director of Finance attend for the WHSSC components of the CTUHB Audit Committee.

7.1.2 Advisory Groups and Networks

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

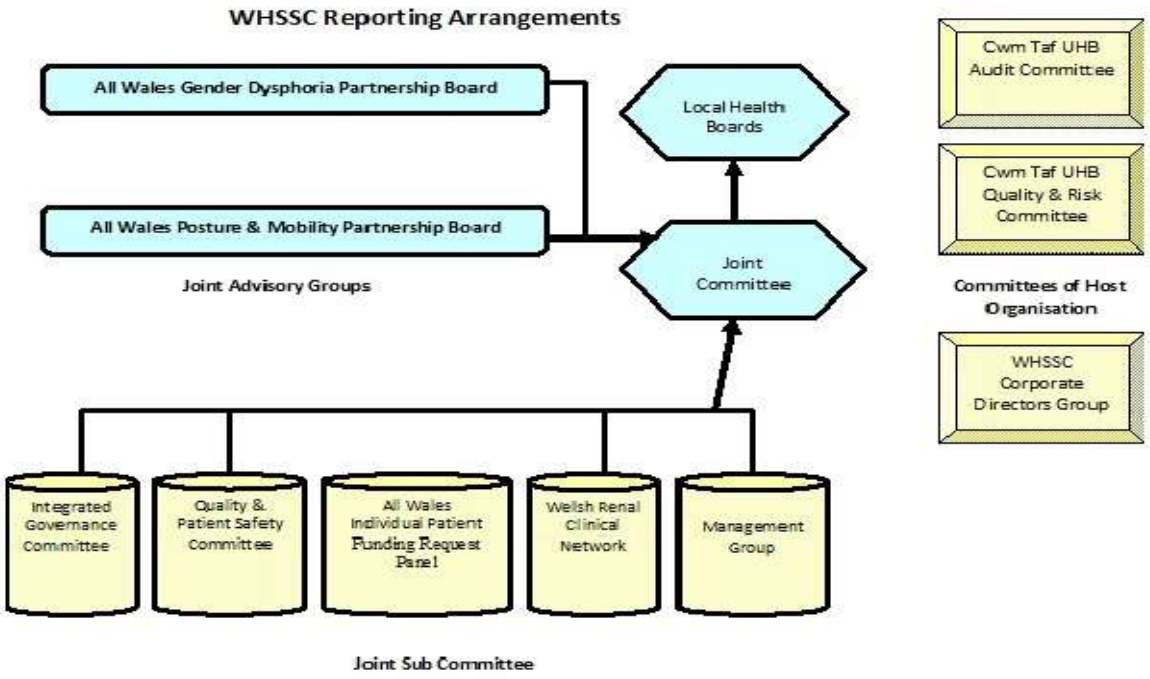
- All Wales Gender Identity Partnership Board
- All Wales Mental Health and Learning Disability Collaborative Commissioning Group (formally Wales Secure Services Delivery Assurance Group)
- All Wales Posture and Mobility Service Partnership Board

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 10: WHSSC Reporting Arrangements



7.2 Governance and Accountability Framework

The Joint Committee is due to receive a routine review of the Governance and Accountability Framework in the final quarter of 2018-19.

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 WHSSC.

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 (as the host Health Board for WHSSC), form the basis upon which the Joint Committee's governance and accountability framework is developed. Together with the adoption of a Values and Standards of Behaviour framework this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

7.3 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.

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

7.4 Risk Management

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

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

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

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

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

WHSSC has the following risk appetite statement that we intend to review in 2019-20:

Risk Appetite Statement

WHSSC is working towards an "open" risk appetite.

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

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

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

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Annex 2: WHSSC Policy work

Annex 3: WHSSC Prioritisation Process

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Annex 5: WHSSC Financial Tables

Annex 6: WHSSC NHS Planning Framework Appendix C