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

WHSSC Joint Committee Meeting held in public
Tuesday 30 May 2017 at 9.30am

Health and Care Research Wales - Castlebridge 4,
19-15 Cowbridge Rd E, Cardiff CF11 9AB

Video Conferencing: 51 2111

Agenda

Item	Lead	Paper/ Oral
Preliminary Matters		
1. Welcome, Introductions and Apologies - To open the meeting with any new introductions and record any apologies for the meeting	Chair	Oral
2. Declarations of Interest - Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for the meeting	Chair	Oral
3. Patient Story - To hear a patient story.	Director of Nursing and Quality Assurance	Oral
4. Accuracy of Minutes of the Meeting held 28 March 2017 - To **agree** and **ratify** the minutes.	Chair	Att.
5. Action Log and Matters Arising - To **review** the actions for members and consider any matters arising.	Chair	Att.
6. Report from the Chair - To **receive** the report and consider any issues raised.	Chair	Att.

Item	Lead	Paper/ Oral
7. Report from the Acting Managing Director - To **receive** the report and consider any issues raised.	Acting Managing Director, WHSSC	Att.
Items for Decision and Consideration		
8. WHSSC Integrated Commissioning Plan 2017-20 - To **support** **Contact:** - Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
9. Provision of Specialised Neurosciences in NHS Wales - To **note** and **support** **Contact:** - Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.

Routine Reports and Items for Information

10. Delivery of the Integrated Commissioning Plan 2016/17 - To **note** **Contact:** Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
11. Performance Report - To **note** current performance and the action being undertaken to address areas of non-compliance. **Contact:** Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
12. Financial Performance Report - To **receive** the report and consider any specific corrective action to reduce any forecast overspending. **Contact:** Director of Finance – stuart.davies5@wales.nhs.uk	Director of Finance, WHSSC	Att.
13. Reports from the Joint Sub-committees - To **receive** the report and consider any issues raised. **Sub Committees** **13.1** WHSSC Quality and Patient Safety Committee **13.2** All Wales Individual Patient Funding Request Panel **13.3** WHSSC Integrated Governance Committee **13.4** Welsh Renal Clinical Network **13.5** WHSSC Management Group **13.6** Audit Committee	Joint Sub Committee and advisory group Chairs	Att.

Item	Lead	Paper/ Oral
Concluding Business		
14. Date of next meeting - 27 June 2017, 09.30am - Health and Care Research Wales, Castlebridge 4, 15 - 19 Cowbridge Road East, Cardiff, CF11 9AB	Chair	Oral

The Joint Committee is recommended to make the following resolution:
"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"
(Section 1 (2) Public Bodies (Admission to Meetings) Act 1960)".

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

Minutes of the Welsh Health Specialised Services Committee
Meeting of the Joint Committee
held on 28 March 2017, 9.30am

Boardroom, Welsh NHS Confederation, Ty Phoenix, 8
Cathedral Road, Cardiff, CF11 9LJ

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Members Present

Ann Lloyd	(AL)	Chair
Lyn Meadows	(LM)	Vice Chair
Chris Turner	(CT)	Independent Member/ Audit Lead
Gary Doherty	(GD)	Chief Executive for Betsi Cadwaladr UHB (via videoconference)
Sharon Hopkins	(SH)	Interim Chief Executive, Cardiff and Vale UHB
Steve Moore	(SM)	Chief Executive, Hywel Dda UHB
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB
Carol Shillabeer	(CS)	Chief Executive, Powys THB
Allison Williams	(AW)	Chief Executive, Cwm Taf UHB
Stuart Davies	(SD)	Acting Managing Director of Specialised and Tertiary Services Commissioning, WHSSC
Carole Bell	(CB)	Director of Nursing and Quality, WHSSC
Sian Lewis	(SL)	Acting Medical Director, WHSSC

Associate Members

Tracey Cooper	(TC)	Tracey Cooper, Chief Executive, Public Health Wales
John Williams	(JW)	Chair of Welsh Renal Clinical Network

Apologies:

Steve Ham	(SH)	Chief Executive, Velindre NHS Trust
Alex Howells	(AH)	Acting Chief Executive, Abertawe Bro Morgannwg UHB
Chris Koehli	(CK)	Interim Chair of Quality and Patient Safety Committee
Marcus Longley	(ML)	Independent Member

In Attendance

Elizabeth Gallagher	(EG)	Neonatal Network Manager (Item 10)
Hamish Laing	(HL)	Medical Director, Abertawe Bro Morgannwg UHB
Ian Langfield	(IL)	Acting Director of Planning, WHSSC
Kevin Smith	(KS)	Committee Secretary and Head of Corporate Services, WHSSC

Minutes:

Juliana Field	(JF)	Corporate Governance Officer, WHSSC

The Meeting opened at **9.25am**

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JC076 **Welcome, Introductions and Apologies**

AL opened the meeting and welcomed members and the public to the meeting.

Apologies were received from Alex Howells, Marcus Longley, Chris Koehli and Steve Ham. It was noted that Hamish Laing was in attendance at the meeting on behalf of Alex Howells.

JC077 **Patient Story**

CB presented two patient stories on behalf of Jackie and Elizabeth who had received cochlear implants. Members noted the circumstances which lead to the treatment and the impact it had on their respective lives.
Members asked CB to extend their thanks to Jackie and Elizabeth for sharing their stories.

JC078 **Declarations of Interest**

There were no declarations to note.

JC079 **Accuracy of Minutes of the meetings held 17 January 2017**

Members approved the minutes of the meeting held on 17 January 2017 as a true and accurate record.

JC080 **Action Log and Matters Arising**

Action Log

Members reviewed the action log for the year and noted the updates provided.

It was requested that the way in which actions were recorded and monitored be changed in the future to provide greater granularity around each action and its closure.

Matters Arising

GD raised a question regarding the minute around Risk Sharing and the actions taken. Members agreed that, given the current financial sensitivities relating to the development of Health Board plans, this would be discussed in the private session of the meeting.

JC081 **Report from the Chair of WHSSC**

Members received and noted the report from the Chair of WHSSC as presented.

Clarification was provided that due to unforeseen circumstances the Chair

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was unable to attend the Welsh NHS Confederation Annual Conference.

Chair's Action
Members noted the urgent action taken in relation to universal screening of blood products for Hepatitis E Virus, and ratified the decision.

Members **resolved** to:

- **Note** the contents of the report; and
- **Ratify** the Chair's action referred to in the report.

JC082 **Report from the Acting Managing Director of WHSSC**
Members received the report which provided an update on key issues that had arisen since the last meeting. The following areas were highlighted.

Collective Commissioning
Members were advised that the Management Group had received papers on 1) Inherited Bleeding Disorders (IBD), and 2) Endoscopic Mucosal Resection (EMR) and Radio Frequency Ablation (RFA) for Oesophageal Cancer.

It was noted that the Management Group members agreed to defer the decision made in 2015 relating to the transfer of resource to WHSSC to bring IBD under a single commissioner in the 2017-18 WHSSC workplan, that the proposal for WHSSC to take on full commissioning responsibility for EMR/RFA was not supported and that the proposal to fund an additional staff member in support of these activities, from anticipated costs savings, was also not supported. SD had written to Chief Executives advising them that, as a result of these decisions, the responsibility for these services now lay with Local health Boards.

Members questioned the governance process in relation to the Management Group overturning a decision made by the JC in 2015. It was noted that the decision was taken to defer the scheme, rather than to abort it, as there was insufficient resource available to progress it at the current time.

It was noted that the issues around the availability of resources to deliver work had been a recurrent theme and that it was important to ensure that such constraints were made clear when WHSSC was asked to take on such additional projects.

Funding Release: Bone Anchored Hearing Aids (BAHA) and Cochlear growth South Wales
Members noted that the Management Group had approved funding to support the delivery of the 52 week waiting time standards and maintenance requirements for cochlear implants and BAHA in South Wales. Members were informed that assurances had been received by the Group that the schemes would be completed by the end of the financial year.

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Members raised the issue of ensuring that, going forward, there is an improved demand and capacity planning review for all services, which will improve visibility of recurrent capacity issues and ensure that there is value for money.

The Chair supported the requirement to have an explicit value for money assessment for every service commissioned or invested in, and clarity of actions to be taken where value for money was not achieved.

NHS England consultation – Congenital heart disease
It was noted that Management Group had received a paper summarising the situation and that minimal impact was expected for Welsh patients.

Individual Patient Funding Requests (IPFR): Independent Review
Members noted that the Independent Review had been published in January.

The Chair expressed disappointment that the review panel had not met the Chair of the WHSSC IPFR panel, given her expert knowledge. Members noted that the Chair of the WHSSC IPFR panel had provided a written response to the review.

The Cabinet Secretary's response, on 21 March, had accepted all of the review's recommendations.

Members enquired as to whether or not the response to the review provided by the Chair of the WHSSC IPFR panel could be circulated to members for information. It was agreed that Chair would speak with the Chair of the WHSSC IPFR panel in relation to this.

Action:

- **Chair to speak with the Chair of the WHSSC IPFR Panel regarding the possibility of circulating her response to the Independent Review Panel to WHSSC Joint Committee Members.**

Members **resolved** to:

- Note the content of the report.

JC083 **WHSSC Integrated Commissioning Plan 2017-20**
It was noted that that a Technical Plan had been provided to members which was to be reviewed as part of a presentation to be received in the Joint Committee's private session.

JC084 **Neonatal Intensive Care Unit Medical Workforce Employment**

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Models
Members received a paper which presented an option appraisal of three potential employment models to support a sustainable neonatal medical workforce across South Wales and described the governance arrangements required for these models.

Members noted the work undertaken by the Task and Finish Group and thanks were extended in particular to Cathy Brooks, Head of Workforce Planning, Aneurin Bevan UHB.

SL provided an overview of the options presented within the paper and the recommendation that the Alliance model to be taken forward by the Task and Finish Group. Members discussed the options presented and supported the recommendation for the Alliance model. It was suggested that consideration be given to contracts for professionals recruited from overseas, who required an organisation specific permit to work, being placed with NHS Wales Shared Services Partnership to facilitate flexibility within the service.

Members discussed the requirement to monitor the success of the Alliance model and to report back in 12 months time. It was agreed that this report would be presented to the South Wales Workforce Group in the first instance and that any issues arising would be reported back to the Joint Committee.

Members **resolved** to:

- **Note** the Task and Finish Group reaffirming their recommendation that an Alliance workforce model is best suited to managing Neonatal workforce issues
- **Approve** that the functions of the Alliance model be taken forward by the South Central Alliance Neonatal Task and Finish Group, with revised terms of reference and membership.

JC085 **Wales Neonatal Network – Standards 3rd Edition**
Members received a report which presented the final draft of the revised All Wales Neonatal Standards – 3rd Edition 2017 (the standards) and discussed the process of peer review in assessing the units against these revised standards, and recommend that the standards and baseline assessment are submitted to Welsh Government for approval.

EG provided an overview of the paper and background to the development of the standards, sought further comments from members and requested support for the planned baseline assessment and process for referring to Welsh Government.

Members discussed the proposed standards and it was noted that further

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clarity was required as to which were mandatory, safety requirements or aspirational and the potential financial impact of compliance with the standards. It was also suggested that clarity be provided regarding the governance and leadership of the entity in which the service/network sits and the processes by which they are linked.

A discussion was held around the requirement for the Network to work in an integrated manner with commissioners rather than assuming sole responsibility and a challenge was presented that some of the standard's domains may already sit as part of Health Boards' overarching responsibility rather than individual neonatal units (e.g. fire safety).

It was suggested that further consideration be given to the section relating to peer review and how this could be taken forward across all delivery groups and networks, and how work might be linked through the Collaborative, not just in relation to standards but also looking at value for money and other issues which challenge the system.

A query was made around the level of discussion that had taken place with the Deanery regarding impact on training. It was noted that EG had raised this with the Network's clinical lead who was currently in the process of reviewing this.

It was agreed that EG would provide members with an update on any amendments made following consideration of the points discussed.

Members **resolved** to:

- **Note** the revised Wales Neonatal Standards - 3rd Edition March 2017;
- **Support** in principle the revised standards and the planned baseline assessment against the standards of each neonatal unit in Wales; and
- **Support** the suggested process for referring the standards to Welsh Government for approval, subject to the results of the baseline assessment and sight of a further revised draft of the standards.

JC086 **Thoracic Surgery**

Members received the paper which included updates on the Thoracic Surgery Review and the Additional Capacity Project. The paper included a 'short form' version of the report of the Royal College of Surgeons (RCS) Invited Review of Thoracic Surgery in Wales.

Thoracic Surgery Review

Members received an overview of and background to the purpose of the RCS Invited Review, noting that it was anticipated that the review would provide an overview of strategic service issues together with insight into best standards that could be achieved in Wales. This would inform the development of the Service Specification.

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It was noted that it had been the intention of WHSSC to publish the full report from the RCS; however, on receipt of the report a number of issues had been raised that were outside of the commissioned scope of the review, which it was considered should be dealt with separately to the commissioned strategic report.

Discussions had been held with the RCS about the publication of the report and WHSSC's concerns about the inclusion of personally identifiable, unsubstantiated information within the body of the report. It was agreed that there was a real need to be able to publish the reports conclusions in respect of service design and best practice standards in order to ensure transparency in the future commissioning decisions.

The Chair informed members that, at her request, a 'short form', abridged version of the report would be published, as presented to the meeting, which would include the strategic outcome of the review. However, the full report, which included confidential person identifiable information, would not be published. Assurances would be provided to the Joint Committee in private session that appropriate action was being taken in regard to the matters contained within the more confidential content of the full report.

It was explained that the RCS had suggested that a redacted version of the full document be published. The Chair explained that the WHSSC Team did not feel that this was the right approach, as it was likely to dilute focus on the strategic service issues. The Chair also explained that she had received a letter from the RCS earlier in the day requesting that the 'short form' report contained in the meeting papers be replaced by a redacted version of the full report.

Members questioned whether opinions and quotations contained within the report had been triangulated or otherwise verified and whether contributors to the report had been given an opportunity to review the document for accuracy. It was explained the RCS methodology relied on triangulation of opinions and quotations but that WHSSC had been informed that contributors had not been given an opportunity to review the report for accuracy.

AW offered her full support for the Chair's actions and noted that from reading the report it was clear that the pertinent commissioning elements had been identified and that the action taken by the Chair regarding publication of a 'short form' version of the report was wholly appropriate. The other members present confirmed that they also supported the approach taken by the Chair.

Members noted that KS would be drafting a response to the letter received from the RCS regarding the publication of the 'short form' report and would

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reference the discussions at this meeting.

Members discussed what learning could be drawn from this experience. It was noted that for any future reviews consideration should be given to including guidance within the terms of reference on how any findings identified outside of scope required should be managed.

Members received an overview of the work carried out by the Project Board over recent months and, in particular, the development of the Service Specification. It was noted that due to quoracy issues written confirmation had been received from each member of the Project Board to confirm agreement of the Service Specification, including the tracked changes, as presented to the Joint Committee.

Assurance was provided that the work required in the Service Specification would be delivered within the current financial envelope. The need to test that the additional non-recurrent funding in 2016-17 had achieved its intention was noted.

It was noted that the Specification included a requirement for minimum volumes. It was suggested that there was an opportunity to include a provision for benchmarking value for money through the specification using productivity targets if this was not to be expressly included through SLAs or elsewhere.

IL confirmed that the Project Board included representation from the Management Group.

It was suggested that on page 11 of the Service Specification consideration be given to the use the term 'sufficient' when referring to 'access to dedicated high dependency beds' and 'access to the intensive care unit'.

Members discussed the provider and commissioner responsibilities for efficiency improvements the need to ensure that there is clarity on this for both parties through the SLA and that the payment system used to fund the service reflects this.

Assurances were provided around the need to ensure demand and capacity planning is carried out for the service and the issues resulting in the requirement for additional capacity are clearly addressed.

Members noted that advice had been sought regarding the requirements for consultation and that clarification had been received that this could be dealt with through an engagement process.

Members noted the proposed revised process and timeline to completion of the Thoracic Surgery Review as detailed in the report.

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Additional Capacity Project
It was noted that additional capacity for south east Wales patients had been achieved through weekend working at Cardiff & Vale UHB, where the initiative had begun in February and was scheduled to complete after two months. Additional capacity for south west Wales had been identified from an English provider; the pathway had been developed, providers assessed, patient information developed and detailed discussions had begun with the selected provider on 15 March with capacity about to come on line.

Members noted that SL had chaired a clinically led group to discuss the pathway for south west Wales patients and lessons learned from previous outsourcing programmes.

Members **resolved** to:

Thoracic Surgery Review
- **Receive** the RCS 'short form' report;
- **Approve** the thoracic surgery Service Specification;
- **Approve** the proposed process for completing the review, in particular, the approach to stakeholder engagement and the role of the independent panel.

Additional Capacity Project
- **Note** the progress implementing the Additional Capacity Project.

JC087 **Neurosciences Strategy**
Members received the report which provided an overview of the five-year Commissioning Plan for Specialised Neurosciences.

It was noted that the final report would be presented at the May 2017 Joint Committee meeting. Members noted the progress made to date within a number of areas.

The report identified three key schemes. The three schemes represented a cross section of the specialised neurosciences programme and would be the main focus for 2017-18 to support the stabilisation of neuroscience services. The services were identified as (1) provision and utilisation of Specialised Rehabilitation Services; (2) provision of Paediatric Neurology; and (3) delivery of Neuro-Radiology.

Members discussed the requirement to ensure that a whole picture for neurosciences was available; given fragilities in the service it was felt important to ensure that any solution was sustainable across the whole service. Members noted that there had been significant investment in neurosciences and it was requested that information be provided which

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gave clarity on progression within the service and commissioner/provider responsibilities. It was noted that the final report in May 2017 would provide the current service mapped against best standards, identify any gaps and comparisons with other major providers of neuroscience services to make sure there is a baseline for comparison. It was suggested that further consideration be given to value of outcomes and that spinal surgery not get overlooked.

Members expressed disappointment that Public Health Wales was unable to provide any needs assessment. It was noted that WHSSC Team was looking at alternative ways of dealing with this.

TC explained that Public Health Wales were looking at a strategic review of its services and SD and SL would be included as part of the discussions.

It was agreed that the final paper would be circulated with sufficient time to allow members to raise any questions and provide feedback prior to the May 2017 meeting.

Members **resolved** to:

- **Note** the overview of the five year Commissioning Strategy for Specialised Neurosciences.
- **Support** the Neurosciences and Complex Conditions Programme Team initially focusing on the three outlined areas.

JC088 **Delivery of the Integrated Commissioning Plan 2016-17**

Members received the paper which provided an update on the delivery of the Integrated Commissioning Plan for Specialised Services 2016-17 at the end of January 2017.

AW requested that feedback on all additional investments made in 2016-17 be presented to the Management Group for scrutiny.

Members **resolved** to:

- **Note** the progress made in the delivery of the 2016-17 ICP;
- **Note** the funding release proforma schedule;
- **Note** the risk management summary.

JC089 **Performance Report**

Members received the report for December 2016, which provided a summary of the key issues arising and detailed the action being undertaken to address areas of non-compliance.

Members noted performance issues in Cardiac Surgery, Plastic Surgery, Paediatric Surgery, Neurosurgery, and Bariatric Surgery. It was further

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noted that there had been a decline in performance against the Posture Mobility 26 week Referral to Treatment target which had been attributed to staff absence.

Members noted the appointment of a planning analyst who had been seconded to the Team to establish a consistent approach to the reporting process. It was noted that new escalation process had been established within WHSSC and that any services/ concerns regarded as high risk were reported directly to the Cabinet Secretary for Health, Well-being and Sport.

AW requested that an explanation of the deterioration in Cardiac Surgery be reported to the Management Group for further scrutiny, particularly given the extra investment approved for this service. SD reported that there had been some recent recruitment of theatre staff.

Members **resolved** to:

- **Note** the current performance and action being undertaken to address areas of non-compliance

JC090 **Financial Performance Report**

Members received the finance report for Month 10 and noted the year to date under spend of £6,110k and forecast year end under spend of £5,165k.

Members **resolved** to:

- **Note** the current financial position and forecast year-end position.

JC091 **WHSSC Joint Committee Annual Business Cycle**

Members received the paper which outlined the Joint Committee's Annual Business Cycle for 2017-18.

Members **resolved** to:

- **Note** the content of the report, including the schedule of meetings for 2017-18

JC092 **Reports from the Joint Sub-committees and Advisory Group Chairs'**

Members received the following reports from the Joint Sub-committees and Advisory Group Chairs':

Sub Committees

WHSSC Quality and Patient Safety Committee

Attention was drawn to the long standing concern that BCUHB's Blood & Marrow Transplant service had failed to achieve JACIE accredited status and that de-commissioning the service was being considered. GD had discussed

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the issues with the service and reported that he was hoping that a flexible and innovative approach could be developed with the Christie.

All Wales Individual Patient Funding Request Panel
Members noted the update from the meeting held 25 February 2017.

Welsh Renal Clinical Network
Members noted the update from the meeting held 2 February 2017.

WHSSC Management Group
Members noted the update from the meetings held 26 January 2017 and 23 February 2017.

Advisory Groups
Wales Neonatal Network Steering Group
Members noted the update from the meeting held 28 February 2017.

All Wales Posture and Mobility Partnership Board
Members noted the update from the meeting held 6 March 2017, and were invited to attend the service Audit Day which was scheduled for 6 June 2017.

JC093 **Date and Time of Next Meeting**
It was confirmed that the next meeting of the Joint Committee would be held on 30 May 2017.

The public meeting concluded at approximately **11.10am**

Chair's Signature: .....

Date: .....

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

2016/17 Action Log
Joint Committee Meeting

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
22.11.2016	JC020	**JC055 - Financial Performance Report** Next iteration of the finance performance report to provide additional detail regarding 'other sundry income' and the recurrent and non-recurrent position.	Director of Finance	Jan 2017	Update report received	CLOSED
28.03.2017	JC021	**JC082 - Individual Patient Funding Requests (IPFR): Independent Review** Chair to speak with the Chair of the WHSSC IPFR Panel regarding the possibility of circulating her response to the Independent Review Panel to WHSSC Joint Committee Members.	Chair	April 2017		OPEN

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

		Agenda Item	6
Meeting Title	**Joint Committee**	Meeting Date	30/05/2017
Report Title	Report from the Chair		
Author (Job title)	Committee Secretary		
Executive Lead (Job title)	Chair	Public / In Committee	Public

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Purpose	The purpose of this paper is to provide Members with an update of the key issues considered by the Chair since the last report to Joint Committee.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the contents of the report		

Considerations within the report (tick as appropriate)

Strategic Objective(s)	YES ✓	NO	Link to Integrated Commissioning Plan	YES ✓	NO	Health and Care Standards	YES ✓	NO
Principles of Prudent Healthcare	YES	NO ✓	Institute for HealthCare Improvement Triple Aim	YES	NO ✓	Quality, Safety & Patient Experience	YES	NO ✓
Resources Implications	YES	NO ✓	Risk and Assurance	YES	NO ✓	Evidence Base	YES	NO ✓
Equality and Diversity	YES	NO ✓	Population Health	YES	NO ✓	Legal Implications	YES	NO ✓

1.0 Situation

1.1 The purpose of this paper is to provide Members with an update of the key issues considered by the Chair since the last report to Joint Committee.

2.0 Background

2.1 The Chair's report is a regular agenda item to Joint Committee.

3.0 Assessment

3.1 **Meeting with Cabinet Secretary**
I met with the Cabinet Secretary on 27 April 2017. Amongst other things we discussed Thoracic Surgery, Neurosciences, Gender Identity Services, Neonatal Intensive Care, Paediatric Review and General sustainability of high-risk services.

3.2 **Attendance at Health Board Meetings**
Stuart Davies and I attended C&VUHB's Board Meeting on 30 March 2017 and CTUHB's Board meeting on 5 April 2017.

3.3 **All Wales Chairs Meeting**
I attended the All Wales Chairs Meeting on 16 May 2017.

4.0 Recommendations

Members are asked to:

- **Note** the contents of the report; and
- **Ratify** the Chair's action referred to in the report.

5.0 Appendices/ Annex

There are no appendices or annexes to this report.

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance
Link to Integrated Commissioning Plan	Approval process
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	Not applicable
Institute for HealthCare Improvement Triple Aim	Not applicable
Organisational Implications	
Quality, Safety & Patient Experience	No implications identified at this time.
Resources Implications	No implications identified at this time.
Risk and Assurance	No implications identified at this time.
Evidence Base	No implications identified at this time.
Equality and Diversity	No implications identified at this time.
Population Health	No implications identified at this time.
Legal Implications	No implications identified at this time.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Not applicable		

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

		Agenda Item	7
Meeting Title	**Joint Committee**	Meeting Date	30/05/2017
Report Title	Report from the Acting Managing Director		
Author (Job title)	Acting Managing Director, Specialised And Tertiary Services Commissioning, NHS Wales		
Executive Lead (Job title)	Acting Managing Director, Specialised And Tertiary Services Commissioning	Public / In Committee	Public

Purpose	The purpose of this report is to provide the Members with an update on key issues that have arisen since the last meeting.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the contents of this report.		

Considerations within the report (tick as appropriate)

	YES	NO		YES	NO		YES	NO
Strategic Objective(s)	✓		Link to Integrated Commissioning Plan	✓		Health and Care Standards	✓	
Principles of Prudent Healthcare		✓	Institute for HealthCare Improvement Triple Aim		✓	Quality, Safety & Patient Experience	✓	
Resources Implications		✓	Risk and Assurance	✓		Evidence Base		✓
Equality and Diversity		✓	Population Health	✓		Legal Implications		✓

1.0 Situation

1.1 The purpose of this report is to provide the Members with an update on key issues that have arisen since the last meeting.

2.0 Updates

2.1 **Associate Medical Director Appointments**
WHSSC have recently appointed four Associate Medical Directors to support the newly developed commissioning teams within WHSSC. They will take up post in the next few months. The new appointments will cover the following portfolios:

- Cancer and Blood Services: Mr Kerryn Lutchman-Singh
- Cardiovascular Services: Mr Paul Flynn
- Neuroscience Services: Dr Shakeel Ahmad
- Women and Children's services: Dr Helen Fardy

The recruitment process for an associate medical director to cover the Mental Health portfolio is still underway.

2.2 **Risk Sharing**
The Finance Working Group met on 12th May 2017 to discuss the recommendations from the Directors of Finance Group and specifically the methods that could be used to implement in practice. The methodology agreed is being written up and will be shared. Revised calculations will now be undertaken.

The implementation period consistent with the recommendation from the DOFs Group remains a three year period subject to any extension arising from a decision by Joint Committee regarding the limit on maximum additional cost to any one Health Board.

2.3 **Neuroradiology**
WHSSC continues to work to seek assurance regarding the plans to ensure continuity of service whilst recruitment and retention issues are being resolved. Enhanced performance management arrangements are in place following an occurrence in mid-May when no operators were available and an urgent case had to be transferred out of Wales.

2.4 **Neurorehabilitation**
WHSSC is working with ABMUHB to resolve a range of concerns regarding the service. A detailed action plan and response has been requested.

2.5 **Thoracic Surgery: Additional Capacity To Achieve Cancer Targets**
WHSSC established the Thoracic Surgery Additional Capacity Project in December 2016 to develop and implement proposals to achieve waiting time targets for lung cancer patients. In January 2017, the Joint Committee

agreed to provide the additional funding required. The initiative has achieved the following to date:

South East Wales

- A WLI was agreed with CVUHB to provide additional activity on weekends during February and March.
- The initiative was successful in treating and eliminating the backlog on the waiting list for primary lung resection.
- No patients breached the cancer waiting times targets in March.
- It is expected that no patients will breach in April (awaiting validation).
- The position is monitored through the WHSSC-CVUHB thoracic surgery performance meetings.

South West Wales

- A referral pathway to external provider (University Hospital North Midlands) from South West Wales has been agreed. However, referrals have not yet commenced as a result of delay due to:
  - Technical difficulties at Stoke with the video conferencing link required for MDT participation
  - A period of sick leave for the lead surgeon at Stoke
- Stoke have advised that the lead surgeon is expected to return in week commencing 29th May.
- The commissioning framework is in place, including:
  - Referral pathway and patient selection process
  - Contract arrangements and reporting requirements
  - Information for patients
  - Arrangements agreed for weekly monitoring of referrals
  - Patient experience questionnaire
- The impact of the initiative will be monitored through the WHSSC-ABMUHB thoracic surgery performance meetings.

2.6 **Cardiac Surgery**

WHSSC has continued to work with the DSU to ensure appropriate pathway start dates are in place for the cardiac surgery service. A final report is due from the DSU by mid summer. Meanwhile the attention given to this issue is already starting to take effect with improved information sharing on start dates. This is having an impact on the management of waiting lists and will remain a risk until after the full impact is known and works through.

2.7 **Neonatal Transport**

Dedicated neonatal transport services in South Wales are provided by Cymru Inter Hospital Transfer Service (CHANTS) and are commissioned to operate for 12 hours per day, 7 days per week. The Neonatal Standards require a 24/7 dedicated transport service and so this standard is not currently met in South Wales. Previously, in recognition of this, a proposal was presented to the WHSSC Management Group in September 2013, for investment to deliver a 24 hour service through CHANTS, however this was not deemed to be a cost effective due to the relatively small number of babies that require this service. There has since subsequent discussion with the service based in

Bristol, NEST, around their ability to provide an out of hours service in South Wales, however this has ultimately identified that they could only deliver this on a very ad-hoc basis that is not deemed to be appropriate. CHANTs are now developing an updated proposal to deliver a 24/7 service, however it should be noted that there is no funding provision for this within the WHSSC ICP. To support this work, they are retrospectively auditing journeys that were requested first thing in the morning to determine whether these would have been undertaken overnight, had a service been available. They will also prospectively collect information around any incidents arising as a result of a lack of 24/7 service. The outcome of this work will determine any future proposals to develop this service.

3.0 Recommendations

3.1 Members are asked to:

- **Note** the contents of the report.

4.0 Annexes and Appendices

4.1 There are no annexes or appendices to this report

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance
Link to Integrated Commissioning Plan	This report provides an update on key areas of work linked to Commissioning Plan deliverables.
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	Not applicable
Institute for HealthCare Improvement Triple Aim	Not applicable
Organisational Implications	
Quality, Safety & Patient Experience	The information summarised within this report reflect issues relating to quality of care, patient safety, and patient experience.
Resources Implications	There is no direct resource impact from this report.
Risk and Assurance	The information summarised within this report reflect financial, clinical and reputational risks. WHSSC has robust systems and processes in place to manage and mitigate these risks.
Evidence Base	Not applicable
Equality and Diversity	There are no specific implications relating to equality and diversity within this report.
Population Health	The updates included in this report apply to all aspects of healthcare, affecting individual and population health.
Legal Implications	There are no specific legal implications relating within this report.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Not applicable		

7

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

		Agenda Item	8
Meeting Title	**Joint Committee**	Meeting Date	30/05/2017
Report Title	Approval of the Integrated Commissioning Plan for Specialised Services 2017-20		
Author (Job title)	Acting Director of Planning/Acting Assistant Director of Planning		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	Public

Purpose	This paper requests support for the approval of the Integrated Commissioning Plan for Specialised Services 2017-20 (ICP). The paper describes the recommendations regarding the ICP Risk Management Framework and asks the Corporate Directors to consider this Framework in order to approve the ICP.			
RATIFY ☐	APPROVE ☐	SUPPORT ☒	ASSURE ☐	INFORM ☒

Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	**Members are asked to** • **Support** the Integrated Commissioning Plan for Specialised Services for 2017-20; • **Support** the implementation of the ICP Risk Management Framework and advise on the most appropriate officers within each Health Board to outline risks and advise on mitigation; and • **Note** that the ICP will be submitted to Welsh Government for information.		

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Considerations within the report (tick as appropriate)

	YES	NO		YES	NO		YES	NO
Strategic Objective(s)	✓		Link to Integrated Commissioning Plan	✓		Health and Care Standards	✓	
Principles of Prudent Healthcare	✓		Institute for HealthCare Improvement Triple Aim	✓		Quality, Safety & Patient Experience	✓	
Resources Implications		✓	Risk and Assurance			Evidence Base	✓	
Equality and Diversity	✓		Population Health	✓		Legal Implications		✓

1.0 Situation

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

This paper:

- Is informed by the Technical Plan that was agreed at the March meeting of the Joint Committee;
- Provides an update on the actions taken since the March meeting of the Joint Committee;
- Describes the wider processes that have been used to develop the Integrated Commissioning Plan in conjunction with Health Boards;
- Outlines the ICP Risk Management Framework that has been developed to assess, monitor and mitigate the risks identified for each of the unfunded schemes and highlighted streams of the workplan; and
- Requests approval of the ICP for 2017-20

2.0 Background

The ICP has been developed with the full engagement of Health Board Commissioners through a series of Management Group workshops. Provider Health Boards and Velindre NHS Trust have also had the opportunity to contribute to the process following the publication of the approved commissioning intentions in September 2016.

Since the draft ICP was presented to the January meeting of the Joint Committee and cleared for submission to Welsh Government, the majority of Health Boards have significantly reduced the specialised services provisions declared in their January IMTP submissions in order to manage their own deficits. As it was clear that the WHSSC ICP was no longer affordable to the majority of Health Boards, a Technical Plan was developed in response, with the objectives to confirm Health Boards revised financial positions and describe the risk management framework for unfunded schemes.

At the Joint Committee held on 28th March 2017, Members approved a Technical Plan, which represented a reduction of over £6million from the draft ICP. The Technical Plan was submitted to Welsh Government on 31st March 2017.

The Acting Managing Director wrote to CEOs on 11th April and advised of this submission, along with details of the further work proposed to confirm financial agreement with all Health Boards. These proposals included taking actions to reduce Cardiology over-performance in C&VUHB and tracking the benefits of the delivery of investment in BMT Phase 3.

3.0 Assessment

3.1 Planning Assessment

The need for Specialised Services for the Welsh population is described in the ICP and shows that the demand for specialised services will continue to increase over the next few years. Issues of service sustainability, equity of access and clinical workforce challenges also continue to be evident in the specialised services that WHSSC commissions. These issues are reflected in the ICP as they are likely to continue in the medium term future.

During the Management Group workshops from October 2016 through to January 2017, a total of fifty schemes were reviewed and risk assessed. Nineteen schemes were subject to further scrutiny and relative prioritisation through the Clinical Impact Assessment Group (CIAG). The outcomes of the CIAG were presented to the Management Group workshop on the 16th March. However, during this same period, Health Boards positions have deteriorated further, and it was clear that they would not be able to fund in line with their original intentions. As a consequence, it was necessary to explore a series of options with the Joint Committee in order to ensure that the plan matched the level of funding available from the Health Boards.

At the Joint Committee held on 28th March 2017, Members approved a series of revisions to the ICP, which reduced the overall requirement to £16.9million for the Health Boards. This was submitted as a Technical Plan to Welsh Government on the 31st March.

3.2 Included within the Plan

The Technical Plan formed the basis of the ICP, which now includes the following six elements:

1	Baseline assessment of recurrent position	
2	**Full year effect of 2016/17 developments and benefits realization.**	
3	Unavoidable IPC growth and contract inflation pressures	
4	Mandated schemes	• Hepatitis E Testing - Mandated UK Tests • Ivacaftor in paediatrics (age 2-5 years) • Migalastat for Fabry's disease – Mandated • Eliglustat for Gaucher's disease – Mandated • Progressive LAL deficiency - 18/19 pressure • Rare diseases - Pegvisomant for acromegaly
5	Schemes which have received prior commitment	• Thoracic capacity to achieve cancer targets • Genetics Micro arrays for CGH backlog • Genetics UKGTN • Genetics NSCLC • Genetics Stratified Medicine
6	Unavoidable FYE of growth	• Renal Replacement Therapy Demand

As set out in the table, the ICP includes the recurring impact of the service developments approved as part of the 2016/17 ICP, which includes a number of important emerging service sustainable issues which were considered in year, and have been reaffirmed for 2017/18. These investments are set out in the table below:

Table 3 – WHSSC 2016-17 Investments

Service	Commissioning Intention
Prosthesis service - prosthetics for war veterans	Investment to sustain service performance and the achievement of delivery.
Cystic fibrosis	Use of Ivacaftor for approved indications
Malignant Melanoma *	NICE Mandated
Elosulfase Alfa *	Elosulfase alfa for treating mucopolysaccharidosis type IVa (MPS IVa) in line with managed access agreement
Ataluren NS DMD *	Ataluren for treating Duchene muscular dystrophy resulting from a nonsense mutation in the dystrophin gene in people aged 5 years and older who can walk, - in line with managed access agreement
Thoracic surgery	To commission sufficient surgery at ABMU and C&VU, to achieve the 2012 LUCADA upper quartile resection rate for Wales.
Neuroendocrine Tumours (NETs)	To commission the service model agreed by the NETs Task and Finish Group.
Fetal cardiology	Investment to address quality and sustainability issues.
Paediatric surgery	Investment in capacity at C&VU to meet backlog, recurrent demand and capacity gap.
BAHAs and Cochlears	Investment to meet increased demand in BCU and C&VU.
BMT Phase 3	Three year phased investment to address demand and sustainability issues.
PET-CT	Investment to widen indications for PET
Paediatric Cardiology RTT	Investment in capacity at C&VU to meet backlog, recurrent demand and capacity gap
Liver ablation	Investment in ABU US/RF Liver ablation service to include microwave ablations service
Genetics	Investment to commission UKGTN tests approved 2015/16 for commissioning in 2016/17
Genetics	Investment to commission additional range of stratified medicine tests
Neurovascular	Investment to address sustainability issues.
Interventional neuroradiology	Investment to address quality and sustainability issues.
Neurosurgery	Investment to address quality and sustainability issues.
Clinical Immunology	Investment in infrastructure to meet increasing demand
Posture and Mobility (Wheelchairs)	Investment to meet increasing demand
High Secure	Investment in gatekeeping role to include clinical case monitoring all patients in independent sector placements.
Medium Secure - patients with learning disabilities	Investment in gatekeeping role to include clinical case monitoring all patients in independent sector placements.

Work will be undertaken throughout the course of 2017/18 to ensure that each of these schemes has been fully implemented in line with the original commissioning intention, and that the benefits have been realised. Particular attention will be given to those investments designed to improve service performance.

3.3 Excluded from the Plan

Due to the changes in the Health Boards positions, it has not been possible to include the following schemes in the ICP:

- Recommendations from the WHSSC Prioritisation Panel, inc. new device technologies
- Cardiac ablation for AF and VT
- Posture & Mobility - Replacement of wheelchairs
- PET policy - new indications
- Cochlear and BAHA
- PET Capacity to achieve target access rate
- Cystic Fibrosis
- Cleft Lip and Palate
- BCU Artificial Limb and Appliance Service – service impact of enhanced prosthetic provision for war veterans
- Fetal Medicine
- Neuromodulation
- Spinal Rehabilitation
- Neuro Rehabilitation
- Cleft Lip and Palate RTT
- Additional Paediatric Intensive Care Unit Capacity 7th Bed
- Neurosurgery RTT Clear backlog
- IVF sustain 26 week RTT
- South Wales Neuro-oncology
- Neonatal Intensive Care Unit
- Neuroendocrine Tumours
- Transcatheter Aortic Valve Implantation Policy Review
- Ketogenic Diet
- Alternative Augmentative Communication (AAC)
- ICU/HDU
- Implementation of the Thoracic Surgery Commissioning Strategy
- Renal Replacement Therapy Demand
- Genetics Micro arrays for Comparative Genomic Hybridisation

There are varying degrees of risk associated with each of these unfunded schemes, however unless any further savings can be identified, it will not be possible to fund these schemes. Therefore, they will be managed through the ICP Risk Management Framework described in section 3.5.

3.4 Assessment of Risk

The technical plan has an increased level of inherent risk from draft ICP, in the following areas:

- Equity of Access
- Inappropriate variation
- Capacity
- Quality

- RTT and Waiting Times
- Commissioning Strategies

Each of these areas is discussed in greater detail within the technical plan.

3.5 ICP Risk Management Framework

Following the agreement of the Technical Plan, an ICP Risk Management Framework has been developed with the WHSSC Management Group in order to assess, monitor and mitigate risk using the open source model. The Framework includes all of the risks associated with the non implementation of schemes including:

- All unfunded schemes from financial plan
- Schemes within strategic reviews (Cardiac / Paediatric)
- Work-plan schemes which may present in 17/18

As previously outlined in the Technical Plan, it outlined that for each scheme, there are three domains under which risk will present:

- Patient (Resident Health Board) - assessed by Resident Health Board
- Provider - assessed by Specialised Provider
- Commissioner (Health Board + WHSSC) - assessed by WHSSC Commissioning Team

Risks for each of the domains will be scored using a standard impact x likelihood risk assessment methodology, using a 5 x 5 matrix. Risks scoring higher than 16 will be reviewed by the Management Group on a monthly basis, and those scoring less than 16 will be reviewed on a quarterly basis. Management Group will assess, monitor and mitigate risk using the open source model, and where necessary will escalate extreme or high risks, which do not respond to mitigation, to the Joint Committee for resolution.

The aim is to utilise existing processes to support the development of the ICP Risk Management Framework. Therefore, each organisation will use risk scores from their current risk registers to provide the score for the 'Patient' and / or 'Provider' domains on the ICP Risk Management Framework. The WHSSC risk register will also be used to populate the ICP Risk Management Framework, for the 'Commissioner' domain.

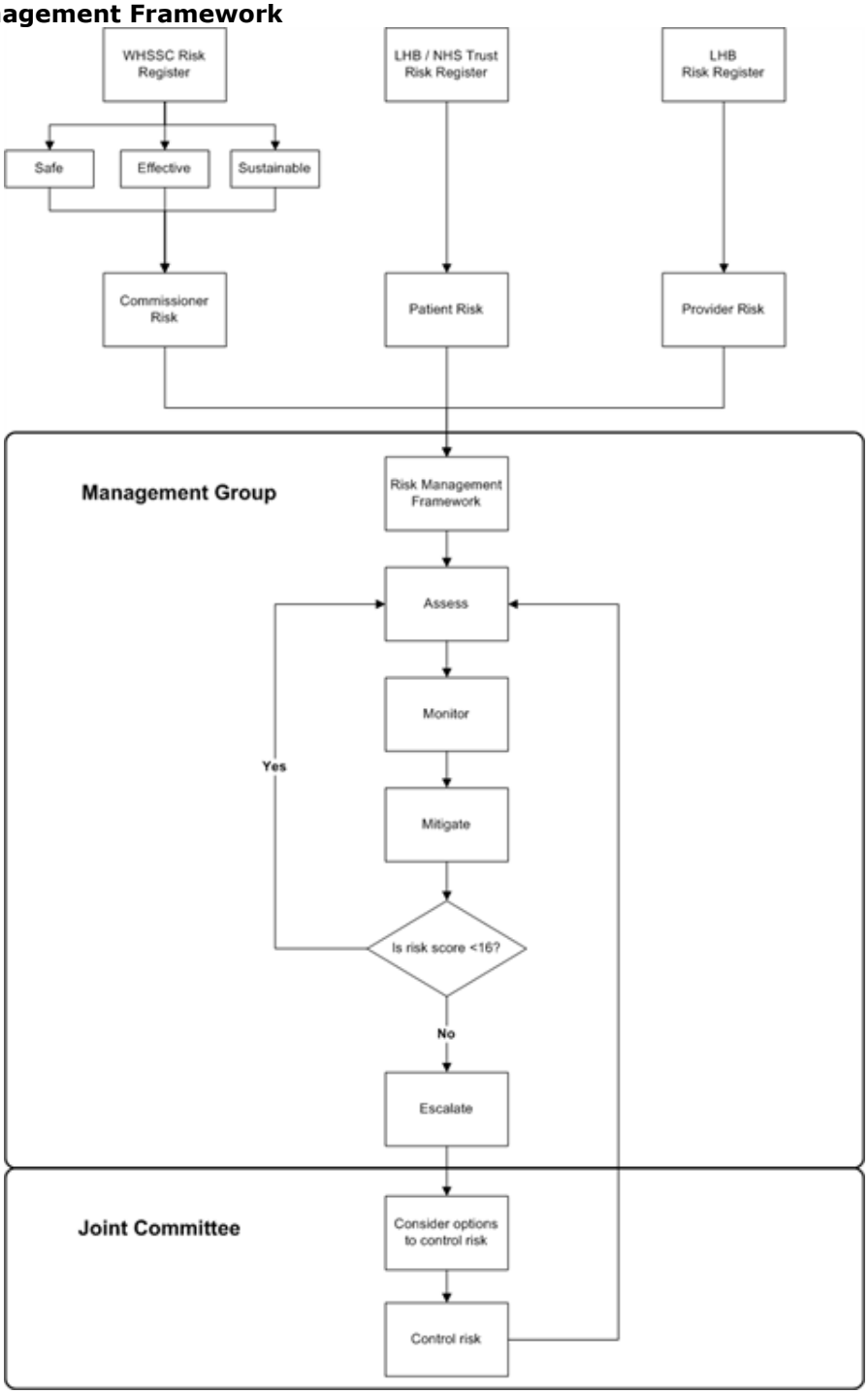
It is essential that the level of risk perceived, and mitigation of the risks across the three domains, is developed in partnership with both Provider and Commissioner Health Boards. This will ensure that the triangulation of the risks is reflective of the whole Healthcare system.

Each organisation, either as in its role as provider or resident health board, will be responsible for developed mitigating actions to reduce the risk score. For WHSSC in it's role as a commissioning organisation, there is little active mitigation available to manage the risk, beyond the performance and quality management processes. The main Commissioner action to mitigate risk would be to seek to re-

commission services where there are quality concerns, but this would not necessarily meet the demands of patients within NHS Wales nor be financially cost neutral.

The ICP Risk Management Framework is illustrated in the diagram below.

ICP Risk Management Framework



3.6 Emerging Risks

Since the submission of the Technical Plan at the end of March the following priorities have already been received from Welsh Government:

- PET – extension of policy
- BAHAs / Cochlears – 26 week RTT – Press release
- Radio Frequency Ablation
- Lynch syndrome
- Mini mitral valve

Cystic Fibrosis facilities has also been raised as an issue by the Chair of C&VUHB to Welsh Government, the latter's response being to organise a meeting between themselves and WHSSC.

A number of these areas were highlighted as a priority within the ICP and are currently being risk assessed as part of the ICP Risk Management Framework due to not being allocated funding. The same process will be used to assess the risks of schemes through utilisation of the ICP Risk Management Framework for any further priorities that emerge from Welsh Government or in year service changes.

3.7 Quality and Performance Management

WHSSC will continue to develop the quality and performance management processes over the course of 2017/18. These will in turn support the mitigation required to address high or extremely high risks, and these will be further enhanced through the introduction of a new four stage escalation process:

- **Stage I – Enquiry**
  Any quality concern will enter the process at this stage. The evidence will be reviewed and an informal enquiry into the concern will be undertaken. Immediate patient safety issues will be urgently escalated to a designated member of the nursing and medical directorate to lead on the enquiry.

- **Stage II – Investigation**
  If the stage I enquiry identifies the need for further investigation, the lead party will initiate an investigation process which may include:
  - Attendance at provider performance meetings
  - Attendance at provider action planning meetings
  - Triangulation of data with other quality indicators
  - Advice from external advisors

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

on the degree of concern, further evidence collection may be commissioned prior to the visit.

- **Stage IV – Escalated Monitoring Meeting**
  Where there is evidence that the Action Plan emanating from a Stage III visit has failed to meet the required outcomes as agreed by the Commissioning Advisory Group, the meeting will identify the next steps:
  1. Further action planning
  2. Penalties
  3. De-commissioning
  4. Outsourcing

3.8 Finance

The draft ICP submission in January based on the month 8 financial forecasts set out an uplift requirement of 4.3% to fund the baseline, known growth and the schemes prioritised by the management group.

During the development of the ICP post January submissions of the draft plans, the scale of the Health Boards IMTP planning deficits emerged, which further impacted on the resources available to meet the required provision for specialist services, with most HB's significantly reducing the specialist service provisions declared in the January IMTP submissions in order to reduce their respective planning deficits.

In view of this uncertainty and pressures within NHS Wales, WHSSC has undertaken a programme of work to identify mitigating savings that can be offset against the pressures, revised forecast assumptions using the latest available information and recovered recurrent funding, where there are delays in provider implementation of 2016-17 approved developments.

The starting point for the financial plan is a rollover of the 2016-17 opening baseline adjusted for known in year allocation adjustments and transfer of services. The impact of the following categories has been calculated to derive the carried forward underlying deficit required to fund the recurrent baseline for 2017-18.

- **Forecast year end outturn** - Based on month 10 financial reporting, This is mitigated to a degree by forecasting techniques that factor in previous 3 year trends and current provider capacity positions.
- **Reinstatement of non recurrent write backs** - Arising from prudent 2015-16 year end provisions, predominately for IPC approvals and English forecast activity that did not materialise post year end.
- **Assessment of recurrent and adjustments for non recurrent performance** - Judgement of in year recurrent performance has been undertaken and reviewed in conjunction with programme teams and providers, considering forecast demand and capacity.

- **Full year impact of developments** - Developments approved in 2016-17 have been assessed and adjusted for any additional pressures or provider capacity delays in implementation. This includes the full year impact of funded 'high risk amber' sustainability investments in Neurosciences and Immunology which were not originally resourced in the 2016-19 ICP, however the overall full year impact is within the year 2 ICP indicated provision.
- **Indicative growth provisions** have been included to address known demand growth in contracts for PET scanning and Haemophilia blood products. As per the year 2 of the 2016-19 ICP further patient growth in low volume, high cost drug packages for rare blood and inherited metabolic disorders have been factored into the rollover position. Additional provisions for in year emerging issues such as private sector contract inflation in Mental Health and Renal have also been included.
- **Mitigating savings** of £1.4m have been identified which part offset some of the growth pressures. These include procurement savings from blood products, high cost drug dosage reductions, and the part year impact of savings realised from the successful implementation of the All Wales Blood Service in May 2016 and repayment of the WG loan ahead of schedule.
- In order to produce a financial plan that was balanced to Health Board provisions a further plan for £0.25million of **localised savings** has been included for ABUHB and CTUHB commissioners, this reflects the anticipated efficiencies that can be achieved from value based work reviewing referral pathways and treatment variation in the Specialist Cardiology baseline at CVUHB provider. It is focused on testing the increase in usage of high cost cardiac devices in 2016-17 and exploring device costs.
- This revised plan also assumes £0.5million of the **new treatment fund** will be accessed in year 1 to resource mandated new technologies approvals for a small number of patients where the commissioning responsibility and expenditure mechanism falls within WHSSC.

Financial Impact 2017/18 by Commissioner

	ABM UHB £m	Aneurin Bevan UHB £m	Betsi Cadwaladr UHB £m	Cardiff & Vale UHB £m	Cwm Taf UHB £m	Hywel Dda UHB £m	Powys THB £m	2017/18 Total £m
2017/18 Opening Allocation	**93.775**	**101.621**	**118.366**	**92.871**	**48.139**	**57.710**	**21.574**	**534.056**
M10 Forecast Performance	(0.206)	(0.800)	(3.575)	(0.111)	0.117	0.018	(0.609)	(5.165)
M11 Forecast Adjustments	(0.115)	(0.022)	0.065	(0.093)	(0.027)	(0.100)	(0.141)	(0.434)
Reinstate Non Recurrent Writebacks	0.612	0.612	2.460	0.753	0.366	0.457	0.452	5.712
Adjustments for NRP	0.291	1.152	1.365	1.507	0.187	0.082	0.178	4.760
Full Year Effect of 16/17 Developments	1.065	1.444	0.262	1.510	0.856	0.638	0.151	5.928
Growth in IPC, Contract Activity & Inflation	0.619	0.887	1.819	0.787	0.547	0.445	0.249	5.353
Underlying Deficit & Growth	**2.267**	**3.274**	**2.396**	**4.353**	**2.046**	**1.541**	**0.279**	**16.154**
Mitigating Savings	(0.152)	(0.407)	(0.238)	(0.215)	(0.216)	(0.106)	(0.066)	(1.401)
Red Schemes - Mandated	0.043	0.049	0.059	0.039	0.025	0.033	0.011	0.258
Red Schemes - WG directed & prior commitments	0.143	0.048	0.047	0.053	0.028	0.119	0.023	0.459
Red Schemes - Unavoidable growth	0.133	0.150	0.183	0.120	0.077	0.101	0.036	0.800
Total Savings & Recommended Schemes	**0.167**	**(0.161)**	**0.050**	**(0.004)**	**(0.086)**	**0.146**	**0.003**	**0.116**
HB Uplift Required to Fund Baseline & Recommended Schemes	**2.434**	**3.113**	**2.446**	**4.349**	**1.959**	**1.687**	**0.282**	**16.269**
HB Commissioner Contribution to 2% provider inflation	1.491	1.438	0.902	1.426	0.738	0.824	0.177	6.996
2017/18 WHSSC Total Requirement for Commissioners	**97.700**	**106.172**	**121.714**	**98.646**	**50.836**	**60.221**	**22.032**	**557.321**

3 Year Outlook – WHSSC Integrated Commissioning Plan 2017/20

	2017/18 Total £m	2018/19 Total £m	2019/20 Total £m
2017/18 Opening Allocation	534.056	534.056	534.056
Recurrent Position	10.801	11.215	11.215
Growth in IPC, Contract Activity & Inflation	5.353	8.122	12.082
Underlying Deficit & Growth	**16.154**	**30.841**	**47.801**
Total Savings & Recommended Schemes	**0.116**	**0.738**	**0.738**
HB Uplift Required to Fund Baseline & Recommended Schemes	16.269	31.579	48.539
HB Commissioner Contribution to 2% provider inflation	6.996	6.996	6.996
2017/18 WHSSC Total Requirement for Commissioners	**557.321**	**572.631**	**589.591**

Value Based Commissioning

The implementation of the ICP will include the development of a value based commissioning framework designed to identify and secure improved value, increased efficiency and opportunities for decommissioning. The framework uses the same principles and approaches inherent in the all Wales efficiency framework but focused through the lens of commissioning.

The framework recognises that there will be different commissioning value opportunities arising which will vary across the service portfolio. Commissioning opportunities will differ according to whether they are commissioned from different health systems and the nature of the activity. A critical issue that will help unlock the potential that exists is the importance of working across the whole pathway. It is essential therefore that this work is jointly undertaken in full partnership with and participation of health boards.

4.0 Recommendations

Members are asked to:

- **Support** the Integrated Commissioning Plan for Specialised Services for 2017-20;
- **Support** the implementation of the ICP Risk Management Framework and advise on the most appropriate officers within each Health Board to outline risks and advise on mitigation; and
- **Note** that the ICP will be submitted to Welsh Government for information.

Link to Healthcare Objectives	
Strategic Objective(s)	Development of the Plan Implementation of the Plan Governance and Assurance
Link to Integrated Commissioning Plan	This paper requests approval of the 2017-20 Integrated Commissioning Plan
Health and Care Standards	Safe Care Effective Care Governance, Leadership and Accountability
Principles of Prudent Healthcare	Reduce inappropriate variation Care for Those with the greatest health need first Only do what is needed
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	The organisational priority of the development of the Quality Assurance Framework is described in the ICP.
Resources Implications	The ICP includes a Financial Plan.
Risk and Assurance	The ICP includes an assessment of risks and a description of the ICP Risk Management Framework as an assurance mechanism for managing the risks.
Evidence Base	The ICP is underpinned by a prioritisation process that is designed to examine the evidence inform of the best use of resources
Equality and Diversity	There are no equality and diversity implications associated with this report.
Population Health	There are no additional implications for population health associated with this report.
Legal Implications	There are no legal implications associated with this report.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Not applicable		

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

An Integrated Commissioning Plan for Specialised Services for Wales 2017 – 2020

8

Status	Draft
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Executive Summary

This is the fourth integrated commissioning plan for specialised services for Wales that the Welsh Health Specialised Services Committee (WHSSC) has published. This Plan describes the work that WHSSC will do in 2017-20 to:

- commission safe, effective and sustainable specialised services for Wales; and,
- continue to develop the organisation.

The Integrated Commissioning Plan for Specialised Services for Wales 2017-20 (ICP) is a commissioner-led plan, which seeks to balance the requirements to assure quality, reduce risk and improve health outcomes for the people of Wales.

The ICP has been developed following several years of significant investments in specialised services across NHS Wales, against an increasingly challenging financial environment. In recognition of this, the core objectives for this plan are to:

- Focus on the consolidation and benefits realisation from the ongoing investment plan;
- Refine the medium term priorities as identified during the development of the ICP;
- Continue the development of the overall service strategy for specialised services, including the individual specialty strategies, needs assessments, and the map of service delivery across NHS Wales; and
- Implement a value based framework to review opportunities for increasing value across specialised services and related pathways.

The pace of change in specialised services continues to present a significant challenge for Health Boards to be able to respond to:

- Increasing demand for current interventions;
- Differences in relative access rates across Wales;
- Accelerating pace of innovation, particularly related to stratified medicine, and interventional procedures;
- Cumulative growth of patients requiring high cost treatments; and
- Changing standards which influence critical mass, sustainability and shape of services, maintaining alignment with the direction of NHS England and national professional requirements.

Although the ICP includes a funding uplift of £16.9 million for specialised services in 2017-18, it is recognised that this increase is not sufficient to cover every one of these challenges. Therefore an integrated risk management framework will be developed to assess, monitor and mitigate the risks identified for each of the unfunded schemes, which have been developed in response to these challenges.

The Plan comprises six core elements:

- Baseline assessment of recurrent position;
- Full year effect of 2016/17 developments and benefits realization;
- Unavoidable ICP growth and contract inflation pressures;
- Mandated schemes;
- Schemes which have received prior commitment; and
- Unavoidable full year effect (FYE) of growth.

In addition, there are a number of schemes which the Joint Committee may wish to reserve for future decisions, pending the release of funding through locally owned savings schemes and the improving value programme. These include:

- Implementation of the Thoracic Surgery Commissioning Strategy;
- Renal Replacement Therapy Demand; and
- Genetics Micro arrays for Comparative Genomic Hybridisation.

1. An Integrated Plan for Commissioning Specialised Services

This Chapter is the introduction to the Plan and describes the range of services delegated to WHSSC to commission, and WHSSC's role, aim, and purpose.

1.1. WHSSC's Role

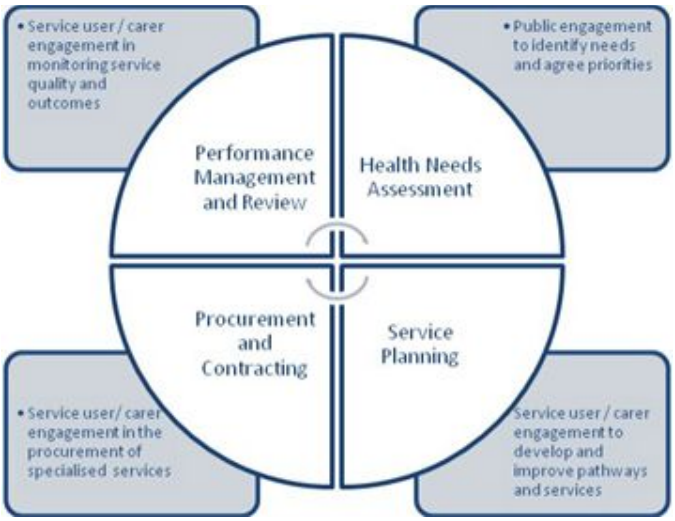
WHSSC is a Joint Committee of the seven Local Health Boards (LHBs) in Wales. The seven LHBs are responsible for meeting the health needs of their resident population; they have delegated the responsibility for commissioning a range of specialised services to WHSSC.

WHSSC's role is to:

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

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

Diagram 1 – WHSSC Commissioning Cycle



1.2. WHSSC's Aim

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

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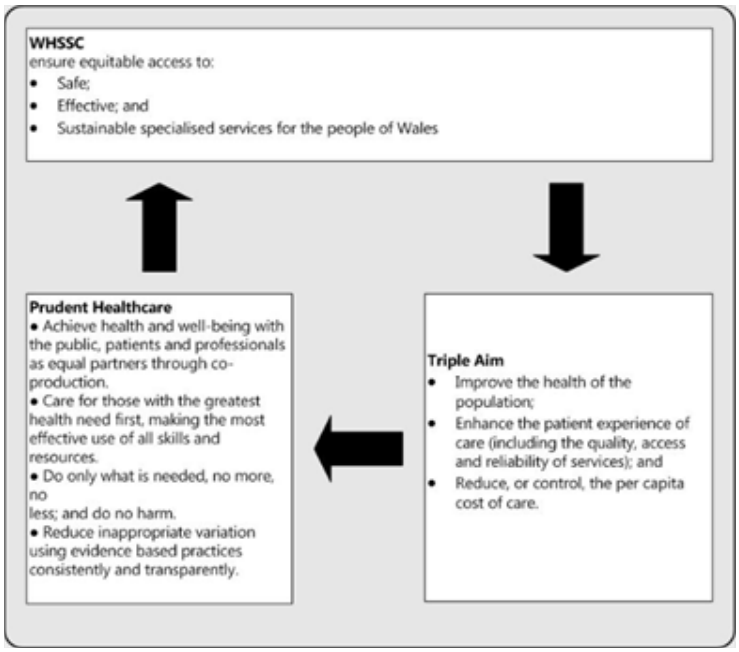
In order to achieve this aim, WHSSC works closely with each of the LHBs (in both their commissioner and provider roles) as well as with Welsh NHS Trusts, providers in NHS England and the independent sector. The commissioning of specialised services is informed through the application of the Prudent Healthcare Principles and the Institute of Healthcare Improvement Triple Aim, as illustrated in the following diagram.

Diagram 2 – Prudent Healthcare and Triple Aim



1.3. Features of Specialised Services

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

The range of services delegated by the seven LHBs to be commissioned by WHSSC is agreed through the Joint Committee. An original list of services was agreed in 2012. Since then there have been a number of transfers back to local planning and funding, as well as some additions to WHSSC's responsibilities. The services delegated to WHSSC can be categorised as:

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

The range of services delegated for commissioning by WHSSC for 2017-18 is shown in the following table.

Table 1 – Range of Services commissioned by WHSSC

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

1.4. Purpose of the Integrated Commissioning Plan 2017-20

The purpose of the Integrated Commissioning Plan (ICP) is to set out WHSSC's strategy and aim for commissioning specialised services over the next three years.

2. The Strategic and Policy Context for Specialised Services

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

2.1. A Strategy for Specialised Services

The NHS Wales Planning Framework for 2017-18 sets out a requirement for all NHS organisations to have a strategy which sets out the long term vision and provides the context within which key strategic decisions can be taken on the shape of services and use of resources. The strategy for specialised services (NHS Wales Specialised Services Strategy) was written in 2012; work is underway to update this to ensure that it reflects the challenges presented by the current economic climate and reflects the opportunities provided by recent changes in secondary legislation within Wales i.e. *The Social Services and Wellbeing (Wales) Act 2014* and *The Wellbeing of Future Generations (Wales) Act 2015*.

The recent appointment of a substantive Managing Director will be key to the further development of the strategy; it is expected that Dr. Sian Lewis will take up post in August 2017. In the interim, the strategy published on the WHSSC website is extant, and the following sections set out the context and key issues which will shape the development of the new strategy.

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

- Clinically informed and led – changes in the breadth and depth of clinical advice will make for a more informed and engaged strategy;
- Engaged – the development of the strategy will engage with a wide range of interested parties;
- Patient centred – the views of patients and patient groups will inform the strategy and patient experiences taken into account;
- Quality and Standards based – the strategy will be centred around ensuring there are clear standards in place for specialised services and robust assessment of services to those standard to ensure quality remains paramount;
- Needs based – the strategy will be informed by needs assessments that connect at both national and local levels and reflect the needs of the Welsh population;

- Performance – ensuring providers are delivering required standards, access times and access levels;
- Sustainable – the strategy will ensure that there is a clear resulting strategic plan of how the Welsh population will access sustainable quality services for the long term. The goal of maintaining and developing high quality specialised services in Wales wherever possible will remain but not at the expense of quality or sustainability; and
- Networked – the importance of ensuring the right networks and pathways are in place to ensure the right local balance of care and reliable and quick access to the most appropriate service wherever this is.

2.2 Historical Context

The purpose of this section is to provide the context against which specialised services have been commissioned in Wales and the challenges for commissioning and provision over the next three years.

2.2.1 Development of Specialised Services Commissioning in Wales

The commissioning of specialised health services was devolved from the Welsh Office to the five Welsh Health Authorities in the early part of the 1990s. Each Health Authority established different models for commissioning the various specialised health services and either undertook their own commissioning or established alliances such as the South Wales Cardiac Consortium.

There was no agreed strategy across Wales for access to or development of specialised health services. As a consequence there was:

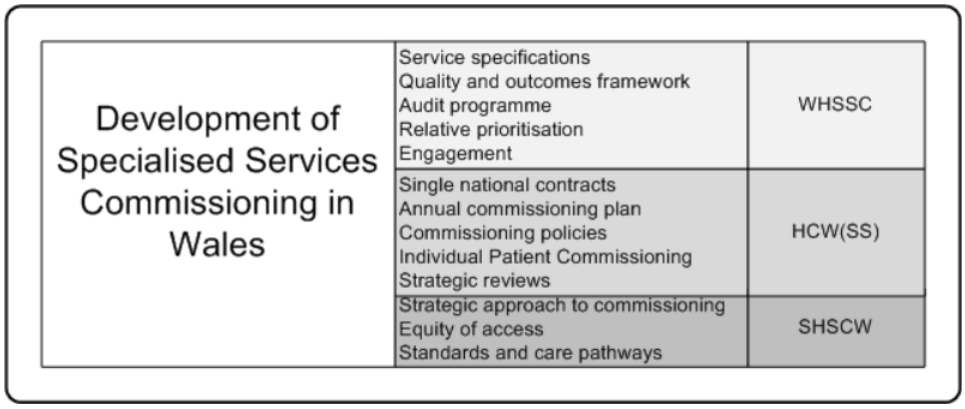
- A lack of clarity about access to new services and technologies;
- Geographic differences in access; and
- Absence of agreed service specifications and difficulties in agreeing the development of new or improved services.

2.2.2 National Commissioning of Specialised Services

Since 1999, arrangements have been in place to commission specialised services at a national level. This function was first led by Specialised Health Service Commission for Wales, then Health Commission Wales and was delegated to WHSSC from 1 April 2010.

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

Diagram 3 - Development of Specialised Services Commissioning in Wales 1999 - 2017



2.2.3 Forward View

The purpose of this section is to set out the broad vision and direction for specialised services over the next three years in order to contextualise the themes in the Plan. The forward view is summarised into the following domains and themes:

- Prudent Healthcare across the commissioning spectrum;
- Direction of commissioning intent; and
- Direction of need, demand and activity.

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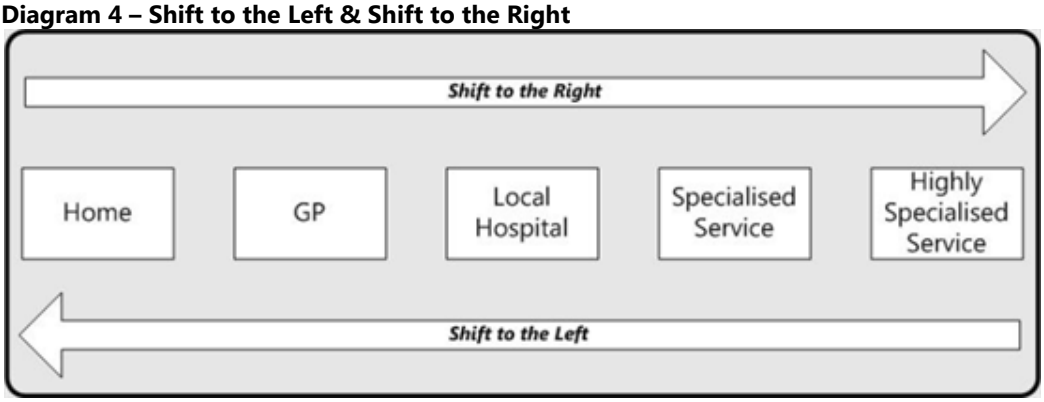
2.2.4 Prudent Healthcare across the Commissioning Spectrum

The challenge over the next three years will be to ensure that resources are used at the most appropriate part of the care pathway, in order to achieve the greatest benefit to the patient. This means that as well as delivering some care more locally at an earlier stage in the pathway (Shift Left), it may also be necessary for some patients to access specialised care at a much earlier stage of the pathway (Shift Right). Movement in both of these directions will need to be underpinned, through development of clear pathways across services in order to keep the needs of the patient at the centre.

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

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



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

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

2.2.5 Other Lessons Learned for the future Planning and Commissioning of Specialised Services

The history of commissioning specialised services in Wales has demonstrated that commissioning specialised services needs a balanced range of approaches to respond to the diversity of the challenges and opportunities that present:

- ***Strategic based plans*** based on assessment of need and gap analysis against agreed standards has been the most successful in delivering enduring improvements in services
- ***Commissioner led repatriation plans*** based on identification of opportunities for developing local service hubs and spokes that link to new or established networks. These are driven by analysis of referral patterns and the development of sub-specialist interests in order to improve local provision and help sustain local services
- ***Incremental demand growth –*** working with local tertiary providers to maximise the delivery from local services in order to deal with steady incremental growth in demand. This has an important role to play in delivering cost-effective service availability but needs to be carefully

managed to ensure planned stepped changes happen at the at the right time and pace, in combination with strategic demand assessment

- ***Stabilisation initiatives –*** whilst effective commissioning seeks to minimise service risks it is inevitable that there are occasions when services reach a tipping point in terms of sustainability and urgent action is need to stabilise, rationalise and sustain services. This is best done with a view to the strategic context including service interdependencies
- ***Rapid Evaluation and Response –*** this is particularly useful as a way of evaluating and introducing new technologies that may emerge between plans. It involves evaluating the evidence of new services, often highly specialised and determining whether implementation can be recommended. This may involve recommending more detailed access policies to target to best effect based on the evidence pending full evaluation.

2.3 Strategic Context

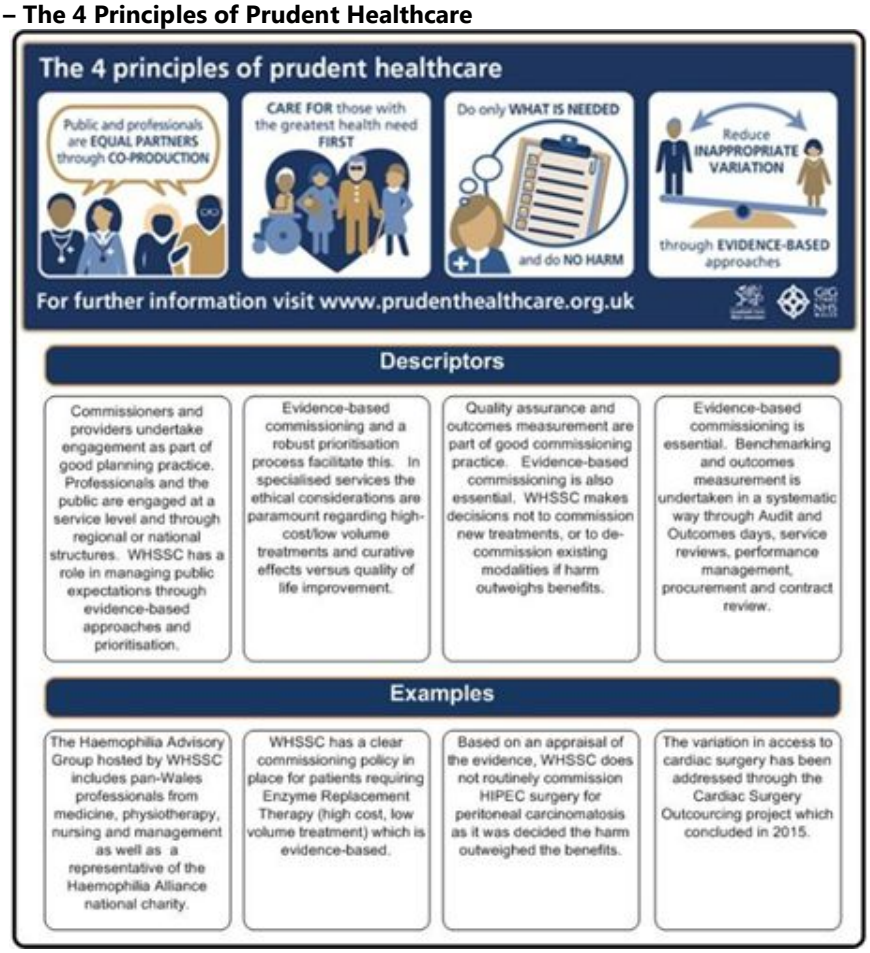
2.3.1 Quality and Outcomes

The ICP has a central theme of quality and outcomes. A key goal for the organisation over the last two years has been the implementation of the approved Quality Assurance Framework.

2.3.2 Prudent Healthcare

The four principles of Prudent Healthcare are now widely understood in the NHS in Wales. In developing this Plan, WHSSC has taken the opportunity to ensure that the practical application of Prudent Healthcare has been applied to each scheme that is included in the ICP.

Diagram 5 – The 4 Principles of Prudent Healthcare



2.3.3 Sustainability of Services

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

- Medical training requirements;
- Ability to balance competing demands from secondary care within acute hospitals which host specialised services;
- Historical patterns of service delivery;
- Publication of new or revised standards or accreditation requirements;
- Need to maintain good clinical outcomes and avoid occasional practice;
- Concerns regarding workforce pressures or inability to recruit;
- Growth in demand;
- Prudent Healthcare; and
- Austerity and the drive towards economies of scale.

In this Plan, WHSSC has considered the delivery and sustainability issues which need to be addressed during the short term. Further issues of medium to long term

sustainability will be identified through the current and future work to develop service specific commissioning strategies

2.3.4 Equity

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

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

2.3.5 Clinical Workforce Issues

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

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

2.4 Taking Wales Forward

The NHS Wales Planning Framework for 2017-18 outlines the key policy requirements from the Welsh Government programme for government – *"Taking Wales Forward"*.

The programme sets out an ambition for Wales to be:

- Prosperous and Secure
- Healthy and Active
- Ambitious and Learning
- United and Connected

From a health perspective, the provision of health care in Wales should focus on:

- Primary care, ensuring the patients receive prompt, cost effective and high quality care as close to home as possible;
- Timely care, reducing the time that patients wait before treatment;
- Mental health, at all levels of care, and also within the workplace; and
- Improving integration between health and social services.

2.5 Health Needs Assessment

Health Needs Assessment (HNA) is the process by which WHSSC considers the requirements for the commissioning of specialised services at a national level to identify both health needs and inequalities.

HNA is a critical process that informs:

- Commissioning and planning of services;
- Inequalities assessments; and
- The evidence evaluations required to support clinical interventions.

Currently Public Health Wales provide data to support WHSSC in this process. This arrangement is supported by a Service Level Agreement. It has become apparent during 2016 that this agreement does not fully address the needs of WHSSC and does not fit well with the planned strategy of PHW or indeed the existing skill sets. Therefore, by mutual agreement WHSSC has given notice of termination of the Service Level Agreement. This will take effect from May 2017. WHSSC is currently exploring new sources for obtaining appropriate expert advice.

2.5.1 Evidence Appraisal

The WHSSC evidence appraisal method uses a structured approach for each specialised service assessment. The initial work focuses on an analysis of the epidemiology including the expected number of people who may require the intervention, or procedure related to the specific (often rare) disease.
The incidence of new patients per year and the prevalence (total numbers of patients with the disease or condition in the Welsh population) are examined. This analysis also includes disease severity and acuity at stage of presentation, premature mortality (including patient years of life lost) and where available, data on survival and quality of life. This dataset for each service facilitates the development of population-based modelling and impact assessment.

The needs assessment also includes evidence-based analysis of the subpopulations meeting the clinical criteria, supporting the selection of patients that are likely to benefit for the interventions. Alternative treatment pathways are considered

including population numbers and predicted outcomes. This allows a more holistic view of both the clinical and the cost consequences of any proposed development. By using this approach the applied needs assessment for specialised services is directly connected to evidence-based clinical policies, with condition-based commissioning and clinical evaluation of outcomes.

2.5.2 Impact of demographic change

There are a number of different trends affecting the Welsh population. The table below summarises the increasing life expectancy for both men and women.

Table 2 - Life expectancy by gender and year

Year	2002-04	2003-05	2004-06	2005-07	2006-08	2007-09	2008-10	2009-11	2010-12
Male	75.8	76.13	76.63	76.77	76.97	77.18	77.62	77.95	78.2
Female	80.29	80.54	80.96	81.17	81.34	81.53	81.78	82.16	82.22

Source: Stats Wales

Alongside this the birth rate in Wales is changing. In 2014 the National Community Child Health Database recorded 33, 648 live births to Welsh residents, an increase of 4% on the number of births in 2004 (32,351) but a fall of 1% since 2013 (33,822) and of 7% from their peak in 2010.

The net effect is that the 'shape' of our population has changed. This is summarised in the Office for National Statistics figures below. Diagram 6 shows the age pyramid for Wales from the 2011 census and Diagram 7 shows the pyramid for England and Wales compared to the 2011 census to demonstrate the changing profile.

Diagram 6 – Age Pyramid for Wales (2011 census)

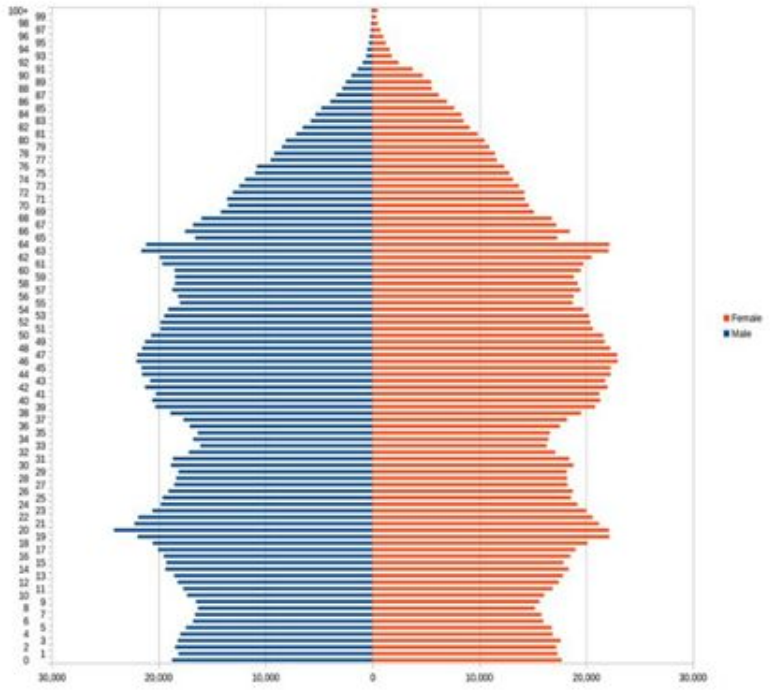
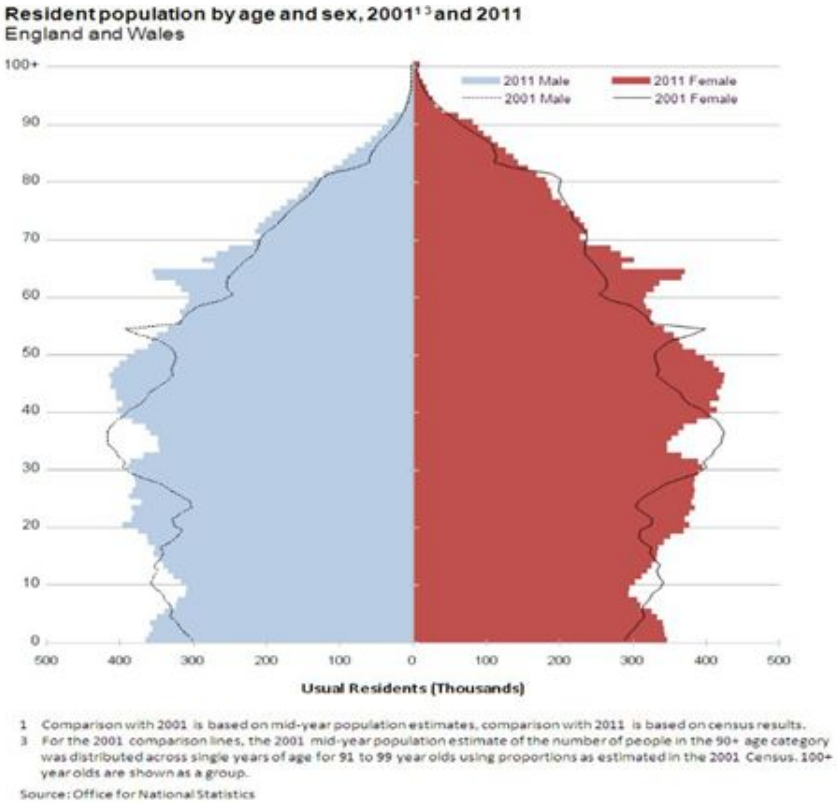


Diagram 7 – Age pyramid for England and Wales (2011 compared to 2001 census)



1 Comparison with 2001 is based on mid-year population estimates, comparison with 2011 is based on census results.
3 For the 2001 comparison lines, the 2001 mid-year population estimate of the number of people in the 90+ age category was distributed across single years of age for 91 to 99 year olds using proportions as estimated in the 2001 Census. 100+ year olds are shown as a group.

Source: Office for National Statistics

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2.5.3 Patterns of disease

Within this changing population there is also a changing pattern of disease. Deaths from myocardial infarction for example have halved in Wales over the last 30 years whilst deaths from alcohol related causes have increased by a third between 2001-03 and 2007-09. Alongside these changes related to lifestyle issues, changes related to more effective treatments are being seen. Cancer survival is one of those areas and the overall survival figures from cancer are shown in the table below.

Table 3 - Increases in 1 and 5 year cancer survival over time in Wales

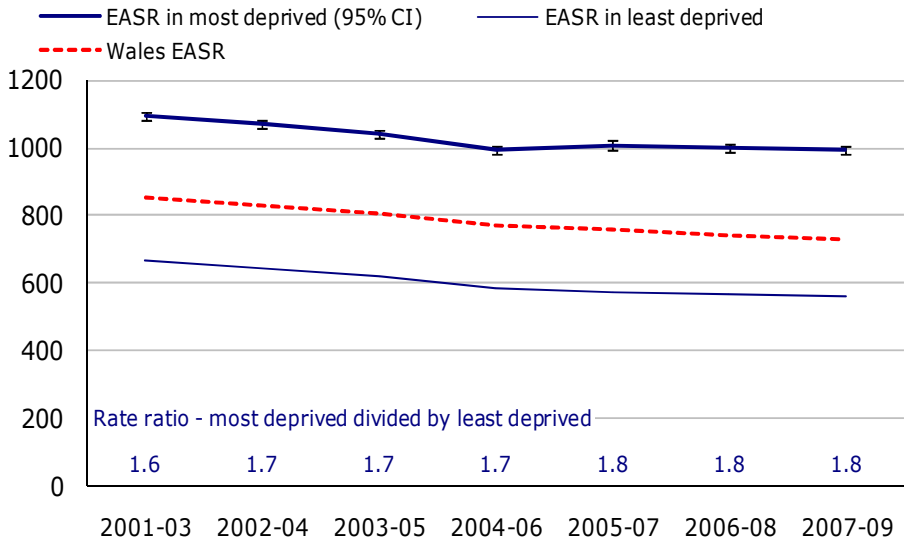
	1 year survival		5 year survival	
	2000-2004	**2008-2012**	**2000-2004**	**2008-2012**
Male	62.3%	69.1%	46.1%	50.9%
Female	67.3%	71.8%	53.1%	55.6%

Source: Wales Cancer Intelligence Unit 2013

2.5.4 Health Inequalities

Although overall life expectancy has improved, the degree of improvement is variable across Wales and the data demonstrates that this is closely related to the level of deprivation. The graph below shows the European Age Standardised Rate (EASR) for mortality of the most and least deprived areas in Wales. The EASR ratio has increased between 2001 and 2009 and this indicates that health inequality as increased.

Diagram 8 -Mortality rates from all causes for males in Wales



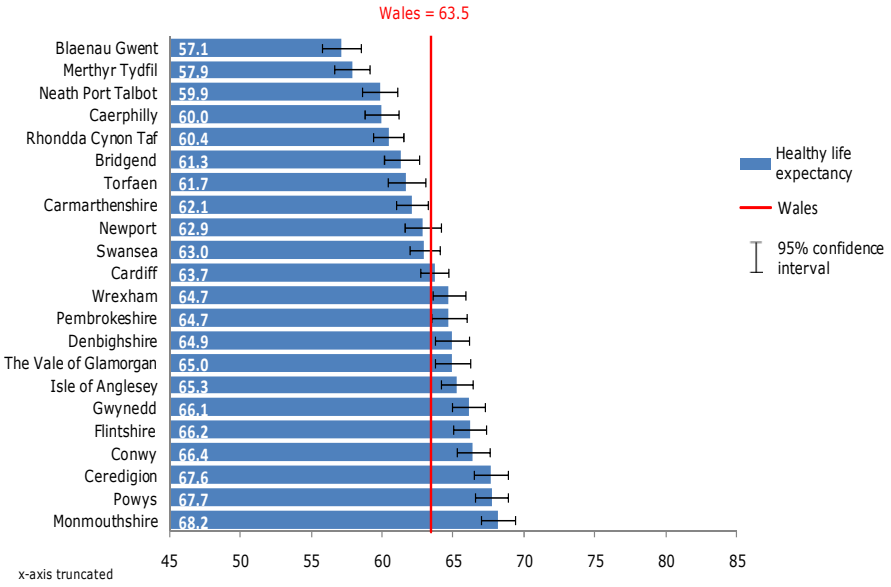
Source: Public Health Wales Observatory

2.5.5 Healthy life expectancy

Deprivation affects mortality rates but it is also closely related to ill-health and reduction in quality of life. The following diagram below is shows the Public Health

Wales Observatory data on healthy life expectancy by local authority. There is significant variation between local authority areas; again this is strongly associated with deprivation.

Diagram 9 - Healthy life expectancy of males 2005-2009 by local authority

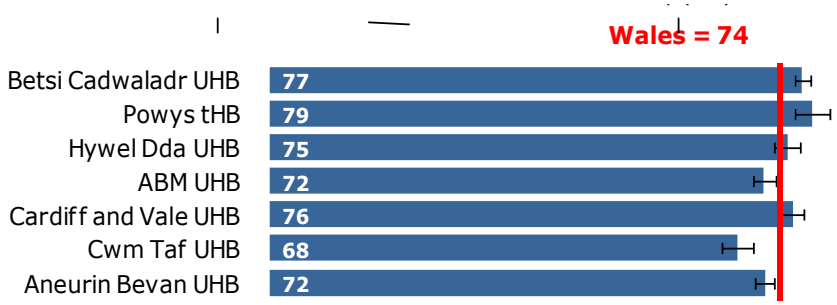


Source: Public Health Wales Observatory

2.5.6 Mental Health

It is also known that not only is there variation across Wales in the incidence of physical ill health; there is also variation in mental health. In common with the determinants of physical health, mental ill health is strongly associated with deprivation.

Diagram 10 - Adults free from a common mental disorder by Health Board 2013-14 (%)



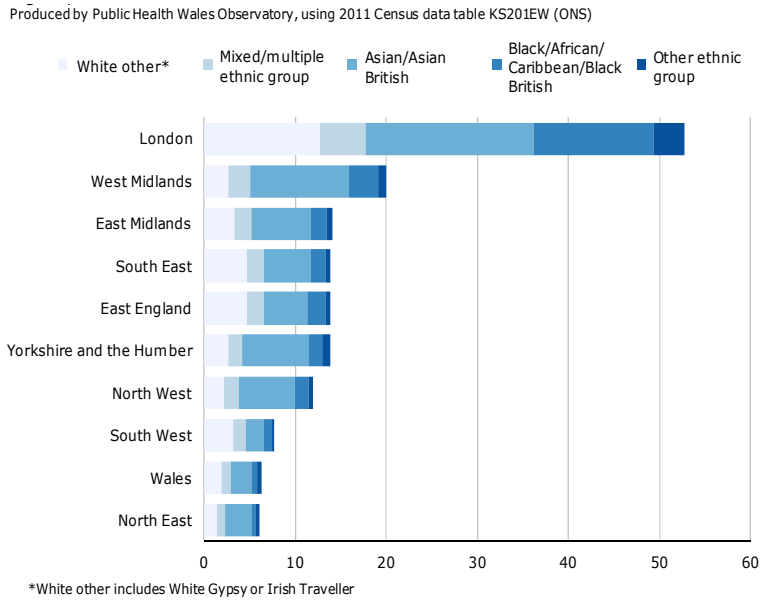
Source: Public Health Wales Observatory

These data show that there is significantly higher reporting of mental ill health in CTUHB compared with PtHB.

2.5.7 Ethnicity

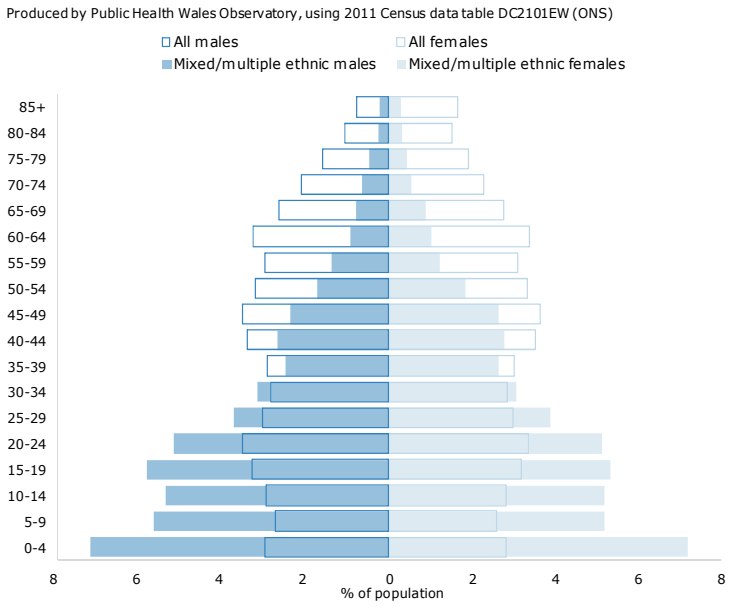
Compared to the rest of the UK Wales is much less ethnically diverse. This is illustrated below by Public Health Wales Observatory data from the 2011 census.

Diagram 11 – Population by ethnic group excluding White British or Irish, percentage, Wales and English regions, 2011



In addition ethnic minority groups have a younger age profile compared with white British or white Irish populations within Wales.

Diagram 12 – Age distribution of the total population and the Mixed/multiple ethnic population, percentage, males and females, Wales, 2011



2.5.8 The Implications for Specialised Services Commissioning

The demographic projections for the Welsh population, when applied to specialised services, have differing impacts depending on the type of commissioned service. **Overall, WHSSC estimates an increase in demand for specialised services of between 3% and 5% over the next ten years.** However, there are specific effects of changes in population size, age, birth rate, small increases in ethnic minority populations and the effects of cultural practices including consanguineous marriages which could impact on this projection for some specific specialised services.

The ageing population is altering the age/sex structure across the national population and has its greatest effects in the larger volume specialised services which include cardiac and renal services. In turn this is affected by improvements in clinical techniques which mean that more elderly patients with severe heart disease are now appropriate candidates for re-vascularisation, valve surgery and interventional management of valve disease even when there is high co morbidity from other chronic diseases. The specific needs assessment related to cardiac disease has confirmed the demographic effect of ageing with a predicted increased demand of up to 5% over the next 5-10 year period and the altered thresholds for interventions despite higher risk. In relation to renal disease there are other population effects including increased rates of obesity and higher rates of transplant compared to the rest of the UK even before legislative changes affecting organ donation were introduced. All of these factors are likely to increase demand relative to the rest of the UK.

For rare diseases (defined as disease frequency of fewer than 500 patients per million population) the effects of population growth or demographic changes are small. Assessment of the potential demand over the next ten years concludes that increases will be related to improved disease ascertainment through screening and application of genetic diagnostic techniques, with important effects on early diagnosis in childhood.

The earlier diagnosis of rare diseases is likely to continue to improve and this will improve quality of life and survival rates due to the commencement of patients on appropriate pathways of care at an early stage with early use of medical, surgical and therapeutic interventions and management. This is also likely to change the cost profile with the increased use of these technologies as well as an increasing pool of survivors over time. The cumulative effect will increase costs or, for some diseases, avoid cost through the prevention of disease progression.

There are a set of clinical services designated as highly specialised services which are almost all for rare diseases. In these populations, the number of elderly patients is typically very small because of the often lethal natural history of the disease. Hence the demographic change towards an ageing population does not have a direct effect

in increasing demand. However, because of the changing birth rate and the successes of new treatments, allowing individuals to live into adulthood, there are increased numbers of high risk pregnancies and increased transmission of genetic diseases.

Evidence from the annual audits of the 75 UK highly specialised services confirms the survival effects associated with better high cost treatment of inherited metabolic disorders and the altered survival curves for pre- and post-treatment of severe blood disorders. In addition, organ transplant outcomes are also improving. The number of patients in Wales who use any one of the 75 services is small; however improved survival rates increase the prevalence of each disease slowly each year. Although the volume of usage is low, these services are high cost.

In summary, the Health Needs Assessment shows that the demand and costs for specialised services will continue to rise for two major reasons:

1. the ageing population with higher risk factors (e.g. obesity) leading to increasing demand for some high-volume specialised services such as cardiac surgery, renal services and some specialised cancer services; and
2. better diagnosis and treatment of patients with rare diseases leading to improve survival and therefore a slowly increasing number of patients who require treatment.

2.6 Horizon Scanning, Evidence Appraisal and Prioritisation

The use of horizon scanning, clinical evidence appraisal and prioritisation is now firmly embedded in WHSSC's commissioning practice. This provides the opportunity to assess new research and development and to consider the use of technology and innovation in the provision of specialised health services for the Welsh population. These processes are designed into the development of the ICP, but are also used on an ongoing basis throughout the year in assessing new treatments and technologies and in the development of Commissioning Policies and Service Specifications.

A review of the WHSSC processes, methodology and governance for horizon scanning, evidence evaluation and prioritisation to inform the development of the ICP was completed in 2016 and the recommendations have been actioned to support the development of the ICP. The complete WHSSC horizon scanning and prioritisation methodology for 2017-18 is presented in Annex 1.

The sources of information that WHSSC uses to horizon scan have now been formalised and these are presented in Section 2.1 of Annex 1. The first cut of this horizon scan, carried out between July and September 2016, identified over 70 new technologies or treatments for WHSSC to consider. Following triage this was reduced to 27.

2.6.1 WHSSC Prioritisation Panel

The scoring and ranking of new interventions was carried out by a Prioritisation Panel using methodology described in the All Wales Prioritisation Framework (2011) (see: All Wales Prioritisation Framework). The framework presents a fair and transparent process to ensure that evidence-based healthcare gain and value for money is maximised. Membership of the WHSSC Prioritisation Panel was based on recommendations in the All Wales Framework and recruitment was completed by the end of October 2016. The final membership of the WHSSC Prioritisation Panel is presented in the following table.

Table 4 – Membership of the WHSSC Prioritisation Panel (2016/17)

Representation	Name	Title
Chair	Sian Lewis	Acting Medical Director, WHSSC
Health Professional Forum	Susan Cervetto	Appraisal Pharmacist, All Wales Therapeutics and Toxicology Centre (AWTTC)
Medical Professional	Stuart Linton	Consultant Rheumatologist, ABUHB
Medical Professional	Emma Mason	Consultant in Acute Medicine, ABUHB
Public Health Professional	Michael Thomas	Consultant in Public Health, Public Health Wales
Nursing Professional	Wendy Morgan	Assistant Director Quality & Safety, PtHB
Ethical and Legal Advisor	Vivienne Harpwood	Chair, PtHB
Lay member	Glan Rees	
UHB Stakeholder Forum	Trevor Davis	CTUHB
Attendees in an Advisory Capacity		
Health Economics Advisors	Sam Groves Pippa Anderson	Swansea Centre for Health Economics
Legal Advisor	Vivienne Harpwood	Chair, PtHB
Finance Advisors	Stuart Davies James Leaves	Director of Finance, WHSSC Finance Manager, WHSSC
Equality Advisor	Sally Thomas	Head of Equality, Diversity and Human Rights, BCUHB
WHSSC	Andrew Champion	Assistant Director of Evidence Evaluation , WHSSC

All 27 interventions were subsequently considered by the WHSSC Prioritisation Panel over the course of three all-day meetings (5 December 2016, 22 December 2016 and 4 January 2017).

The Panel meetings were co-ordinated within the process for the development of the Plan and the final results of the prioritisation process reported to Management Group Workshop on 5th January 2017.

The outcome report from the prioritisation process is now in preparation and will be available on the WHSSC website following publication of the 2017-20 ICP in May 2017.

2.6.2 The Clinical Impact Assessment Group (CIAG)

Whilst the WHSSC team has always worked closely with clinical colleagues around the development of schemes included in the ICP, historically there has been limited independent clinical evaluation. This lack of impartial clinical assessment has presented challenges in determining the relative priority of schemes against available resources. Therefore a further prioritisation process was introduced this year to review schemes and make recommendations on relative priority from a purely clinical perspective.

A Clinical Impact Assessment Group was convened in January 2017 to carry out this work. 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. The list of Group members is presented in Table 5. Members were appointed as individuals and not to represent the views of any stakeholder organisation they may be affiliated to. In addition, all members were asked to complete and sign a declaration of interest form prior to appointment.

The Group was asked to assess and score a list of 19 schemes on the basis of their clinical impact against a set of pre-determined criteria (see Annex 2). This list comprised schemes previously risk-rated with a Quality and Patient Safety score (QPS) >16 i.e. the highest scores, and those investments required to meet Welsh Government targets around waiting times (regardless of their QPS score). All schemes categorised as mandatory were excluded from this process.

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

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

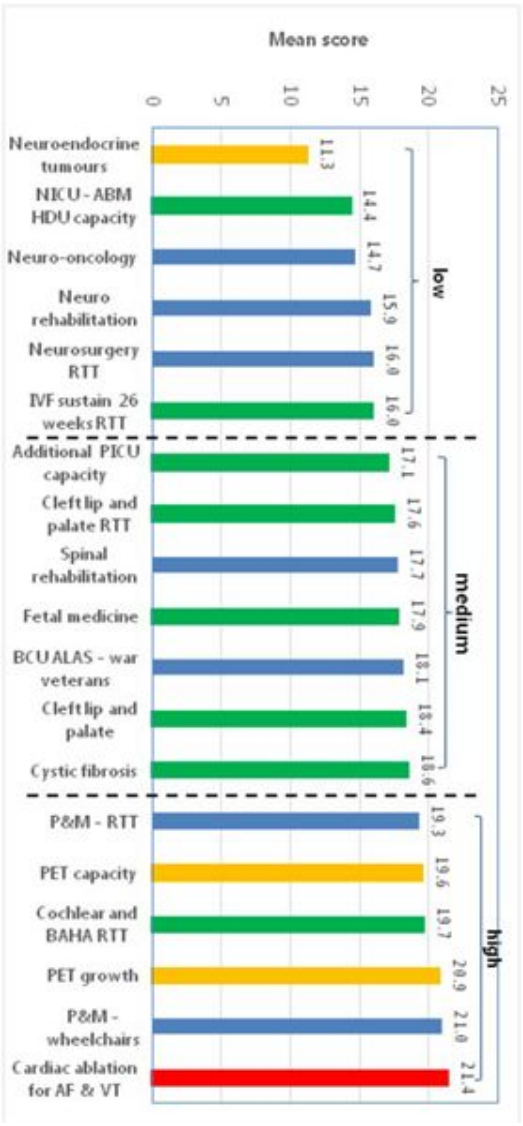
The output from the Group was presented as three separate categories of scheme for investment - high, medium or low clinical impact (Diagram 13). This information was then incorporated within existing prioritisation work and used to develop final recommendations regarding schemes for inclusion in the ICP.

A comprehensive overview of the methodology used by CIAG is also presented in Annex 2.

Table 5 – Membership of the WHSSC Clinical Impact Assessment Group (2016/17)

Representation	Name
Sian Lewis (Chair)	Acting Medical Director, WHSSC
Liam Taylor	Deputy Medical Director, ABUHB
Naveed Akram	Clinical Director (Quality and Safety) ABMUHB
Fraser Campbell	Assistant Medical Director (Primary Care) BCUHB
Christopher Fegan	Consultant Haematologist, CVUHB
Kelechi Nnoaham	Director of Public Health, CTUHB
Mark Barnard	Associate Medical Director, HDUHB
Stuart Bourne	Deputy Director of Public Health, PtHB
Attendees in an Advisory Capacity	
Andrew Champion	Assistant Director of Evidence Evaluation and Effectiveness, WHSCC
Kamala Williams	Acting Assistant Director of Planning, WHSSC and Specialised Planner for Cardiac Services
Claire Nelson	Specialised Planner - Neurosciences and Complex Conditions
Luke Archard	Specialised Planner - Cancer and Blood
Chris Coslett	Specialised Planner – Women, Children and Rare Conditions

Diagram 13: Outputs of CIAG – schemes for investment rated as high, medium or low clinical impact



2.7 The Good Governance Institute Review 2015

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

Major areas of recommendation included:

- The provision of a programme to develop and agree a national strategy for specialised services in Wales;

- Health Boards agreeing their reservation and delegation powers to ensure that any strategy and framework allows WHSSC to operate within a properly governed accountable system;
- The development of a framework for how WHSSC operates and takes decisions;
- Reviewing the resources within the organisation to deliver a challenging and complex service; and
- Addressing the reputation of WHSSC to develop the credibility and authority that an effective commissioner needs.

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

The action plan contained 29 actions, excluding those beyond the control of the Joint Committee, of which 20 were completed by December 2016.

The incremental improvements made during 2016-17 include:

- Appointment of a substantive Managing Director with clinical experience;
- Establishment of a specific group to consider operational risk management and development of a procedure to ensure risk management is embedded across the organisation;
- Consideration of quality framework domains in all contracts;
- Regular attendance by the Chair at the LHB Chair's group;
- Review commissioned into the joint sub-committees and their functions. Further work in this area is part of the planned work programme for 2017-18; and
- Role profiles agreed for the Independent Members of the Joint Committee.

The Managing Director, Designate, and Committee Secretary have begun a review of Management Group which will take into the account the views of all Joint Committee members and the existing members of Management Group. It is anticipated that this will result in a report to the Joint Committee with recommendations in the summer of 2017.

The Joint Committee has agreed that a number of the outstanding actions require additional resource in order to achieve progress.

It is anticipated that the remaining actions will be completed during 2017-18.

2.8 The Policy Context

2.8.1 NHS Wales Planning Framework for 2017-18

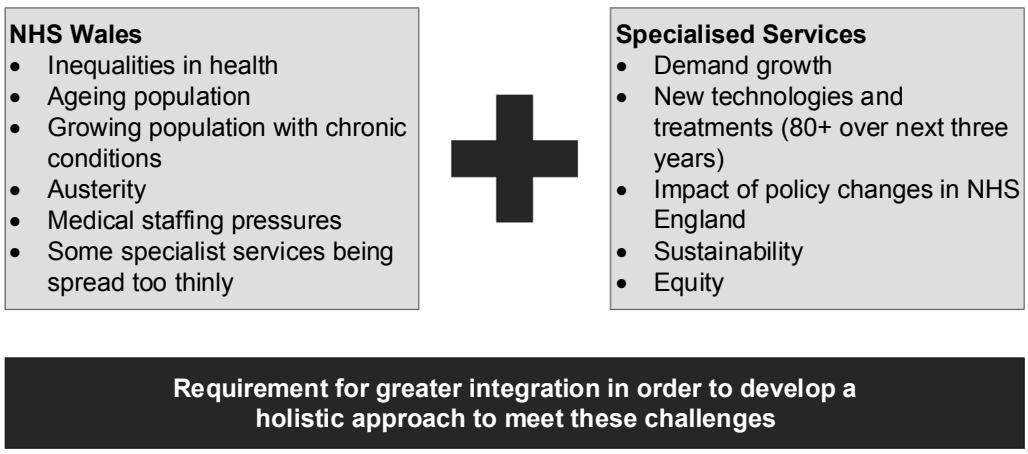
The NHS Wales Planning Framework for 2017-18 states:

"A central tenet of healthcare in Wales is integration and co-operation between organisations. This is intended to share expertise, avoid duplication and ensure that we do things "once for Wales". "

It specifies that whilst it is not a statutory requirement under the NHS Finance (Wales) Act 2014, WHSSC should produce a three year plan and long term strategy, which needs to be approved by the Joint Committee. The approved plan should then be incorporated into the statutory organisations' IMTP for Board approval.

Therefore, the ICP has been developed in collaboration with LHBs in order to take account of the challenges facing NHS Wales, as well as the more specific challenges facing specialised services (Diagram 14).

Diagram 14– Challenges facing NHS Wales and specialised services



There are multiple interfaces between specialised services, tertiary care, secondary care, primary and community care and WHSSC endeavours to ensure that, in the planning phase of the commissioning cycle, a whole pathway approach is taken through a variety of engagement methods.

Whole systems planning is undertaken on a service-specific basis, and this approach has been adopted in order to develop an ICP which is informed through a series of service-specific commissioning strategies. During the course of 2016-17 work has been ongoing on the development of

commissioning strategies for specialised neurosciences services, and thoracic surgery. On completion these strategies will provide clear recommendations with phased commissioning decisions over the next five years.

Planning is underway to commence the development of commissioning strategies for specialised children's services and cardiac services in 2017-18. In view of the current financial position, consideration will need to be given to the orientation of these strategies and how these align with Health Boards IMTPs and the WHSSC risk management framework. These will be reassessed in line with emerging priorities, and submitted to the Joint Committee for further consideration.

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

As a commissioning organisation, WHSSC supports NHS Wales to achieve compliance with the measures in the NHS Outcome Framework and Measures Guidance 2016-17, by ensuring these are central to WHSSC's 2017-18 Commissioning Intentions (Annex 3). The achievement of actions required in the Together for Health Delivery Plans and the National Priorities of Child and Maternal Health and Mental Health are also reflected in the Commissioning Intentions, as WHSSC has a direct role to play in ensuring delivery in these areas of specialised services.

2.9 The Social Services and Wellbeing (Wales) Act 2014

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

The Act places a requirement on health boards and local authorities to jointly undertake an assessment of the local populations care and support needs. The population assessment will inform the development of their IMTPs, which will in turn be reflected through the ICP where there are clear interfaces between specialised services and social care. However, as the first local well-being plans will not be published until mid 2018, this will not feature as a part of this year's ICP.

2.10 The Wellbeing of Future Generations (Wales) Act 2015

The Wellbeing of Future Generations Act will have a far-reaching impact on all NHS bodies. Whilst WHSSC is not named as a 'public body' for the purposes of the Act, WHSSC will, through good planning practice and engagement, support Health Boards and Trusts to meet their obligations under the

legislation. This to make sure that, when making their decisions, the impact these could have on people living their lives in Wales in the future is taken into account.

2.11 Informed Health and Care

The Welsh Government published its five year strategy for the use of digital technology within NHS Wales and social services *"Informed Health and Care: a digital health and social care strategy for Wales"* in December 2015.

As organisations develop their strategic outline programme for their areas, WHSSC will work with commissioner and provider LHBs in order to ensure that there is alignment with specialised services to ensure that there is equitable access to safe, effective and sustainable services for all Welsh patients.

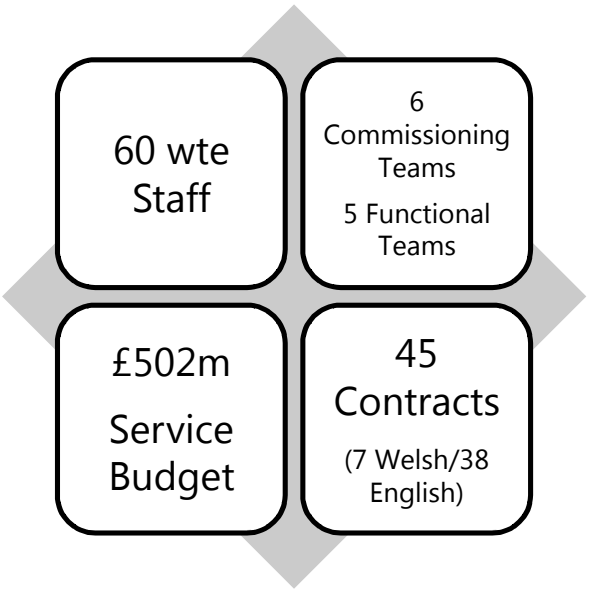
2.12 Equality Act 2010

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

2.13 WHSSC as an Organisation

In order to explain the relative scale of WHSSC compared to the services that it commissions on behalf of the LHBs, Diagram 15 below sets out the key statistics for the staffing levels, direct running cost budget, commissioning budget and contracts.

Diagram 15 – WHSSC in Numbers



Around two-thirds of WHSSC staff are directly engaged in commissioning work.

2.14 Financial Context

The following charts show the main source of funding received from Health Boards in 2015-16, together with the expenditure on services provided within NHS Wales.

Diagram 16 – Analysis of Income of WHSSC 2015/16 – Total £506m

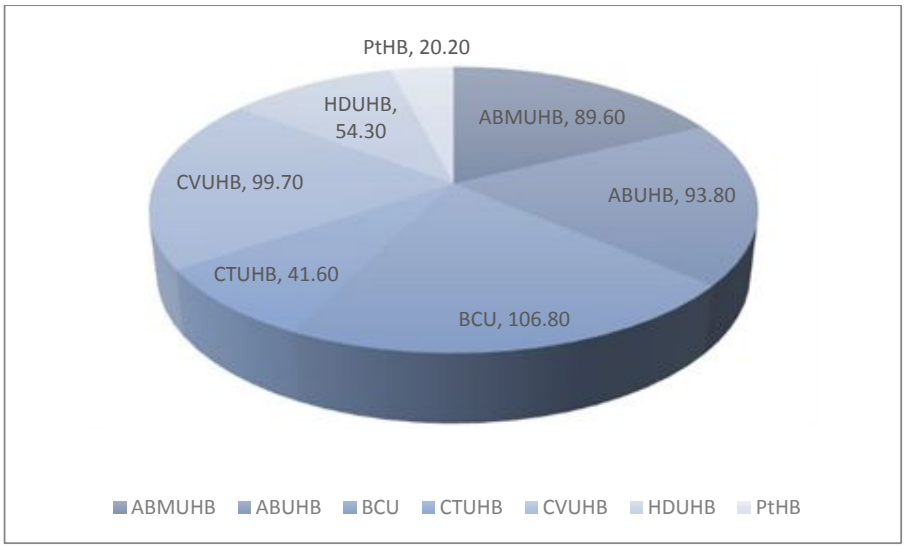


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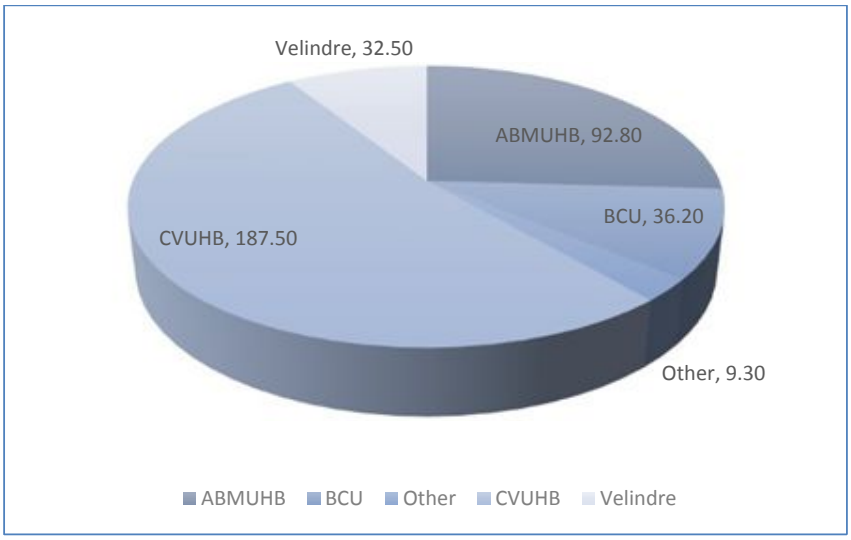
Diagram 17 – WHSSC Expenditure on Specialist Services Provided Within Wales 2015/16 – Total £358.3m



3 Quality and Outcomes

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

3.1 Quality Assurance Framework

In July 2014, the Joint Committee supported the proposal to enhance the WHSSC approach to quality by ensuring that quality was central to all commissioning and performance management arrangements. The Quality Assurance Framework was formally endorsed by the Joint Committee in January 2015.

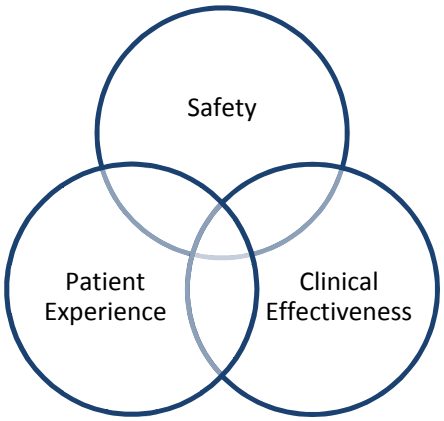
The development and implementation of a robust approach to quality assurance and improvement remains a priority for the organisation and continues to be a major focus of work. WHSSC recognises that providing high quality patient centred care is central to the aim of the organisation.

Monitoring the quality of both providers and services is essential in providing the assurance of contracted services. This involves the monitoring of patient outcomes and experience. WHSSC continues to work in partnership with providers, regulators and service users to ensure that the patient experience is captured and that commissioned services meet their needs.

The Quality Assurance Framework ensures that the contracting process utilises quality schedules, standards and clinical quality indicators to support effective healthcare delivery, quality improvement and innovation across the health system for specialised services.

The three dimensions of quality used within the Quality Assurance Framework are shown in the following diagram:

Diagram 18 – Dimensions of Quality within the Quality Assurance Framework



Applying this definition ensures that WHSSC commissions services based on the three overriding dimensions:

Safety:	Assurance that patients will not come to harm and that services have systems in place to protect and safeguard them
Clinical Effectiveness:	Confidence that all healthcare provided will be based on the best available evidence that clinically addresses patients' needs and delivers the best outcomes
Patient Experience:	Ensuring that patients are treated with compassion, dignity and respect at all times, receiving care that is personal and meets their needs

There are a number of key principles underpinning the Quality Assurance Framework Implementation Plan including:

- Ensuring that the patient is at the centre of the services commissioned by WHSSC. Capturing the patient experience alongside quality indicators is key to inform quality improvements. This involves working collaboratively with patients and service users in line with the Welsh Government framework for Assuring Service User Experiences 2015;
- Working in partnership with providers to agree quality indicators that reflect the specialist nature of the service delivered;
- Ensuring that the development of quality indicators is clinically-led;
- Ensuring that quality is seen as everybody's business across the organisation; and

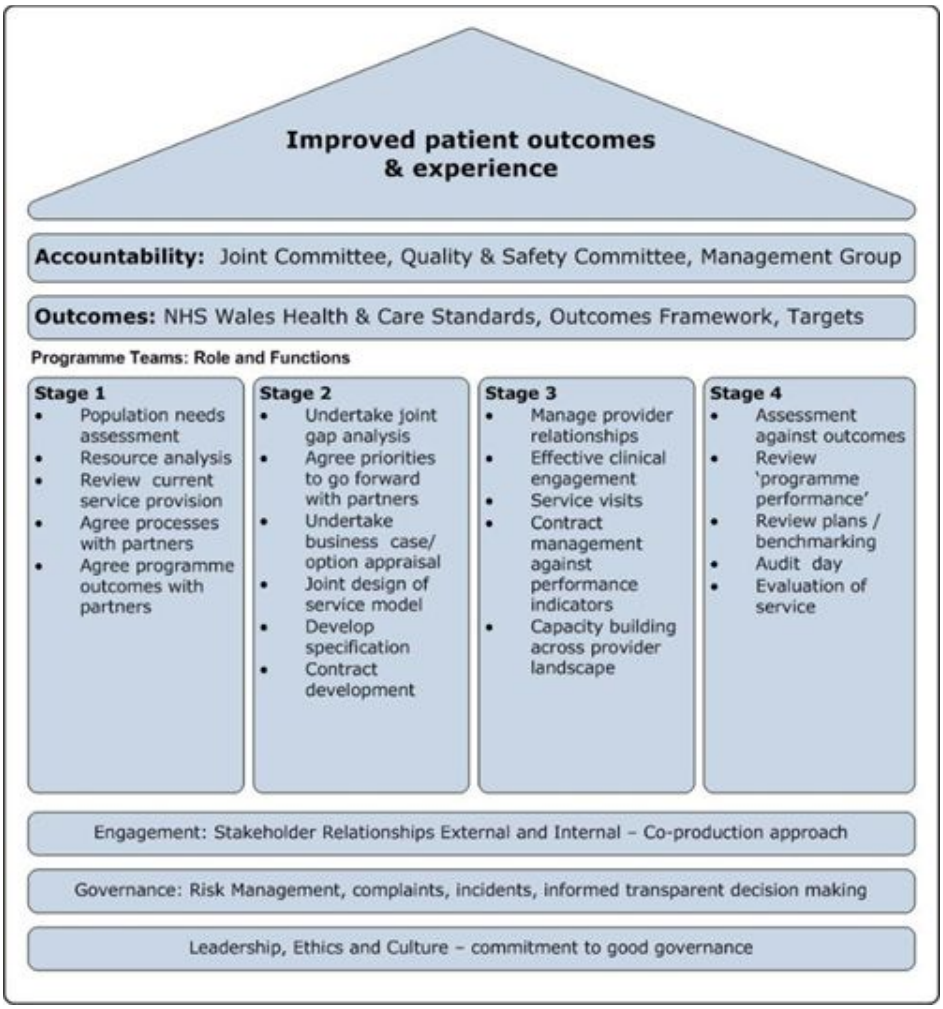
- Reducing duplication and unwarranted variation is critical to the success of the implementation plan.

WHSSC commissions services from a range of providers, within NHS Wales and NHS England. Providers in north west England provide a range of specialised services for the population of north Wales. Commissioning services from England adds an additional layer of complexity to monitoring quality as these providers are required to comply with NHS England standards. As such work has been done over the past year to streamline this process to ensure that no additional burden is placed on providers and data already captured and measured is fed into the system.

The Quality Surveillance Team (QST) Portal was launched last year; it measures performance against quality standards and provides a seamless interface to the statutory and regulatory quality functions. Specialised Services Quality Dashboards (SSQD) are designed to provide assurance on the quality of care by collecting information about outcomes from healthcare providers. They are a key tool in monitoring the quality of services enabling comparison between service providers and supporting improvements. Whilst the portal remains in the development stage, WHSSC is in the process of working with NHS England to access the available information.

The following diagram represents the implementation of the WHSSC Quality Assurance Framework.

Diagram 19: Implementation of the WHSSC Quality Assurance Framework



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

Diagram 20: Proposed quality audit cycle

3.1.1 Development and Implementation of the Quality Assurance Framework

Whilst a number of appointments have been made in order to strengthen the clinical team within WHSSC, including a substantive Executive Director of Nursing and Quality and new Associate Medical Directors, further work needs to be done to ensure that WHSSC becomes a clinical driven organisation focusing on patient outcomes and experience.

Both the Health Inspectorate Wales and the Good Governance Institute reports (2015) outlined a number of concerns and made a number of recommendations in relation to the quality framework and the processes required to support its implementation.

The GGI Review recognised that WHSSC could not assure Joint Committee members of the quality of commissioned services. It also identified the need to ensure that quality data is increasingly used to populate performance data and that minimum data is collected, analysed, reported and debated. Recommendation 20 of the review stated that:

- A directorate responsible for quality should be identified, with the Director of Nursing post being its lead. Sufficient resource should be provided to support data analysis and quality improvement.

In addition the HIW Review documented concerns regarding the current resource at WHSSC's disposal to implant and deliver the quality framework to ensure it is used to its potential. Recommendation 1 stated that WHSSC

should consider the resource implications necessary to enable the quality framework to be implemented and managed appropriately and effectively.

This work has been completed and is described in more detail within the workplan section.

Table 6: Progress on implementation of Quality Assurance Framework to date

Year	Actions
2014-15	• Appointment of an interim Director of Nursing and Quality to lead the development of a Quality Assurance Framework • Engagement of key stakeholders to inform the development of the Quality Assurance Framework • Quality Assurance Framework approved by the Joint Committee in January 2015
2015-16	• Discussions completed with providers regarding the inclusion of quality assurance in future contracts. • Limited quality indicators included in 2015-16 provider contracts. • Appointment of a substantive Executive Director of Nursing and Quality to provide executive leadership on the implementation of quality assurance across the organisation. • Phased approach agreed at Joint Committee to initially test the implementation model across a number of providers and service groups. This will include further prioritisation and roll out based on internal and LHBs' risk registers. • Mapping exercise undertaken to benchmark quality assurance across Wales and England to ensure unnecessary duplication is avoided and gaps are identified. • Formal connection made with NHS England Quality Team in Specialised Commissioning and agreement reached to work in partnership to share good practice and reduce unnecessary duplication. • Refreshed the Quality Assurance Framework in light of new Health and Care Standards, Quality and Outcomes Framework and Operating Framework. • Full implementation plan agreed by the Joint Committee in January 2016.
2016-17 To date	• Quality section on all contracts amended to reflect the requirement set out in the framework • Development of draft patient and pubic engagement strategy completed. Further engagement with stakeholder groups planned for forthcoming year. • Quarterly high level assurance report produced and monitored via the Internal Performance and Quality and Patient Safety Committee. • Development of a close working relationship with the Quality Surveillance Team that supports the monitoring of quality of all specialised commissioning services in England. • Access to a single portal known as the Quality Surveillance Information System (QSIS) • Peer review visits undertaken • Ongoing work with HIW to understand how as commissioners of services the organisation can gain access from information gathered on inspections undertaken for assurance purposes. • Patient story presented at beginning of each Joint Committee

Year	Actions
	• All seven LHBs have published their Annual Quality Statements with reference made to the commissioning of specialised services. • Following the self assessment a development day for both Quality and Patient Safety Committee members and the chairs of the Local Health Board Quality and Patient Safety Committees took place on the 2[8] September. This proved to be extremely useful in determining the work-plan for the forthcoming year as well as strengthening the links and communication between all parties. • Good progress is being made to develop a set of service scorecards and key performance indicators against the quality domains for specialised services. This work will be progressed through programme teams once fully functional as well as presenting the findings on an annual basis through the Audit & Outcome Days.

3.2 Healthcare Inspectorate Wales Report 2015

In 2014-15 HIW undertook a review of the clinical governance arrangements that WHSSC had in place, and how these related to patient outcomes. The report was prompted by concerns that had been raised about the management of waiting lists for elective cardiac surgery for Welsh patients, a service for which WHSSC has delegated commissioning responsibility. Whilst HIW examined the systems and processes that were in place for commissioning good patient outcomes in cardiac surgery, the findings and recommendations from the review were intended to be used to improve our clinical governance arrangements across all of our services.

In 2014 the GGI was also commissioned by WHSSC to undertake a review of its governance processes and procedures. The final report and recommendations from GGI were received in October 2015. In undertaking their review HIW had sight of the GGI recommendations and took them into account as part of their review. HIW recognised that during the period of time between GGI's fieldwork being completed and WHSSC receiving the report and recommendations, WHSSC had already started the process to make changes to strengthen its governance processes and procedures and that this had been recognised by the Joint Committee in September 2015.

HIW acknowledged that whilst WHSSC was in a period of transition, and working towards placing a much greater emphasis on quality, this focus had not always been present in the way that WHSSC operated in the past. HIW added that WHSSC previously had an inconsistent approach to the collection of information, as well as ineffective governance arrangements to assure the Joint Committee of the quality of care being provided to patients.

HIW also made a number of observations in relation to the level of independent scrutiny and objectivity provided by the Joint Committee and

these echoed the GGI recommendations. HIW made further recommendations around the need for meaningful clinical engagement. The full report is available on the HIW website (www.hiw.org.uk) and was received by the Joint Committee in January 2016. Progress against the resulting action plan became a 'business as usual' activity from March 2017 but continues to be monitored by the relevant assurance Joint Sub-Committees

3.4 Audit and Outcomes Days

Since 2015-16, WHSSC has continued to develop its programme of annual Audit and Outcome Days; the programme for 2016-17 is shown below.

Table 7: Programme of Audit Days 2016-17

Specialised Service	Date	Status
Bariatric Surgery	May 16	Completed
Haemophilia / IBD	Jun 16	Completed
Posture & Mobility and Prosthetics	Jun 16	Completed
IVF	Sep 16	Completed
Renal National Audit Day	Sep 16	Completed
Neonatal	Oct 16	Completed
Thoracic Surgery	Oct 16	Completed
Inherited Metabolic Diseases (ERT)	Oct 16	Completed
Blood and Marrow Transplant	Nov 16	Completed
Cardiac	Nov 16	Completed (Network)
Plastic Surgery	Nov 16	Postponed
Specialised Rehabilitation	Nov 16	Completed
Cystic Fibrosis	Nov 16	Completed
Congenital Heart Disease (Paeds & Adult)	Jan 17	Completed
PET-CT	Jan 17	Planned
Clinical Immunology	Feb 17	Postponed
Deep Brain Stimulation	TBC	TBC

The Audit and Outcomes Days have a number of benefits accrued from bringing together specialists from centres in Wales and England, including the:

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

Following each Audit and Outcomes Day a report is prepared for the WHSSC Quality and Patient Safety Committee to outline the major learning points and

to identify an action plan for any issues which need to be addressed. This year, issues which have been raised in Audit and Outcomes Days that have been used to inform the development of the ICP include access to thoracic surgery, BMT, cardiac ablation and IVF waiting times.

4 Progress in Delivering the Integrated Commissioning Plan 2016-19

This Chapter outlines the process for assuring delivery of the Integrated Commissioning Plan 2016-19 and progress to date in delivering the specialised services workplan. The Chapter also describes development work WHSSC has been undertaking in collective commissioning, performance management and workforce and organisational development.

Following approval of the Integrated Commissioning Plan 2016-19 by the Joint Committee, the delivery of the ICP was an organisational priority for WHSSC in 2016-17. Whilst the established systems and processes were used to facilitate scrutiny and approval of funding to be released from the ICP, the level of additional information sought by members of the Management Group increased beyond the dataset originally agreed. This process proved to be very resource intensive over the course of the year, and a number of funding releases had to be considered on multiple occasions before the release of funding was approved. As a consequence the increased focus on the funding release process has reduced capacity available to take forward other schemes within the work plan. Detail on outstanding schemes is reported to Management Group via the monthly ICP Delivery Reports. The position relating to outstanding schemes at 31st March 2017 is included as Annex 4.

During 2016-17, there were 23 areas in which the Joint Committee agreed additional investment in order to ensure access to new technologies as well as addressing specific performance, sustainability and service quality issues. These are set out in Table 14, Section 6.

4.1 Use of Systems and Processes for Implementation

WHSSC continues to use the following tools and processes for commissioning:

- Commissioning Intentions;
- Contracting Offer;
- Templates for Provider Business Cases;
- Process for scrutiny of business cases and release of funding from the ICP;
- Quality Impact Assessment Process and Tool;
- Clinical Commissioning Policies;
- Quality & Outcome Measures;
- Service Specifications;
- Performance Indicators; and

- Guidance for Audit and Outcome Days.

Monthly performance reports on the implementation of the ICP are considered by the Corporate Directors Group and Management Group. Completed schemes are described. Off-track schemes are identified along with the remedial action required to address them.

4.2 Delivery of the 2016-19 ICP

4.2.1 Implementation of Service Reviews and Phased Plans

Due to increasing familiarity with the opportunities offered by a 3-year planning cycle, there are now eight service areas where completed service reviews or medium-term plans are in their implementation phase. Some of these are being implemented using a phased approach over several years. The areas represent a particular challenge in prioritising the ICP due to the collaborative nature of the governance structures and the importance of maintaining continuity.

Table 8: Service reviews being implemented

Commissioning Programme	Service
Cancer and Blood	Plastic surgery Bone marrow transplant Thoracic surgery Neuroendocrine tumours service Hepatobiliary surgery
Cardiac	Cardiac surgery Bariatric surgery
Neurological and Complex Conditions	Prosthetic services

4.2.2 Commissioning Strategies due to complete in 2017-18

Over the last nine months, work has been ongoing to develop commissioning strategies for a number of services. The table below provides a summary of the current status of each project.

Table 9: Commissioning Strategies

Commissioning Programme	Service	Status
Cancer and Blood	Thoracic surgery in south Wales	Ongoing – due to conclude in Autumn 2017
Neurological and Complex Conditions	Specialised Neurosciences: • Neurosurgery • Neuro-diagnostics (including Neuropathology and Neuroradiology) • Neurorehabilitation	Ongoing – due to conclude in May 2017 Initial findings to be considered as part of 2017-18 financial plan
Mental Health	• Gender dysphoria	Ongoing – due to conclude

Commissioning Programme	Service	Status
	services (Tier 4) • Perinatal services • Specialised adult eating disorders services	in March 2018 Ongoing – due to conclude in December 2017 Ongoing – due to conclude in March 2018

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

4.2.3 Requirement to undertake and develop Commissioning Strategies

Despite the challenges of continuity within the framework of agreement of single-year plans, WHSSC has continued to develop further the expertise in developing commissioning strategies for specialised services, to inform recommendations on a whole pathway basis. This includes addressing issues of equity of service provision and access to services across the whole population. The development of commissioning strategies for PET CT, Specialised Cardiac Services, and Tertiary Paediatric Services, were originally scheduled for 2017-18; however each of these will now be considered against the Risk Management Framework, in order to determine specific specialty priority areas to be progressed in year.

4.2.4 Collective Commissioning

The collective commissioning framework clarifies the types of collective commissioning, including:

- Financial flows only – no service planning;
- Advice and support on the most appropriate commissioning model for a particular service;
- Development of a service commissioning framework – commissioning intentions, service specifications and contracting model; and
- Full commissioning and funding of service which would benefit from a national approach on a time-limited basis.

Collective Commissioning was undertaken for the following services for 2016-17:

- Cardiac MRI – Advice and Support;
- Gender Dysphoria (Non specialised) – Advice and Support;
- Interstitial Lung Disease MDT – Full Commissioning;
- Augmentative and Alternative Communication- Full Commissioning; and
- Neonatal Intensive Care – Financial Flows.

The following table provides an update on the progress of each of these schemes:

Table 10: Progress of Collective Commissioning by scheme

Scheme	Progress
Cardiac MRI	Policy and specification produced. Formal consultation exercise to be completed. Progress reports to the All Wales Heart Diseases Implementation Group. Exercise underway to review activity since 2015-16 to date. Quarterly meetings of the All Wales CMRI commissioning Group. Discussions underway to explore opportunities for the Cardiac Network to take this work forward for NHS Wales.
Gender dysphoria (non specialised elements of service)	Stakeholder engagement event held 18th October. Further work required to develop Health Board level services.
Interstitial lung disease	WHSSC is currently passing funding from the Respiratory Diseases Implementation Group (RDIG) to CVUHB.
AAC	Policy and service specification completed, preliminary evaluation concluded and monitoring arrangements put in place. Full evaluation to be presented at Joint Committee in September 2017.
Neonatal intensive care – financial flows	Baseline assessment has shown insufficient funds to support new model. Further work is ongoing.

In addition Joint Committee supported further scoping work to be undertaken during 2016-17 on a number of services leading to recommendations for collective commissioning:

- Paediatric radiology;
- Major trauma ;
- Radio frequency ablation and oesophageal endotherapy;
- Rare neurological diseases including motor neurone disease; and
- Specialist respiratory disease.

Due to capacity constraints WHSSC has not been able to complete the collective commissioning work programme as planned. This is likely to be further impacted over the course of 2017-18 following the development and

implementation of the risk management framework. Following approval from the Joint Committee, a project manager has been appointed to support the scoping work for collective commissioning, in order to identify the capacity requirements to deliver this work.

The table below provides an update on the status of each of these schemes:

Table 11: Update on Collective Commissioning schemes not yet completed

Scheme	Progress to date	Planned work
Paediatric radiology	Scoping paper completed, to be considered as part of the commissioning strategy for tertiary paediatric services.	Individual schemes from the commissioning strategy for tertiary paediatric services to be prioritised under the risk management framework.
Major trauma	Work not commenced awaiting advice from Collaborative Commissioning Group.	On hold pending outcome of the Major Trauma Review .
Radio Frequency Ablation and Oesophageal Endotherapy	Following consideration of a proposal to develop collective commissioning arrangements for an EMR and RFA service within South Wales, the WHSSC Management Group were unable to support a recommendation to Joint Committee that the service should be delegated to WHSSC for collective commissioning. Therefore EMR and RFA continue to be commissioning responsibility of LHBs. WHSSC has written to LHBs setting out the position.	No further work planned.
Rare Neurological Diseases including Motor Neurone Disease	Work not commenced.	Scoping to identify capacity requirement
Specialist Respiratory Disease	Work not commenced	Scoping to identify capacity requirement
Surgical management of gynaecological cancers	Work not commenced	Scoping to identify capacity requirement

4.3 Horizon Scanning, Evidence Appraisal and Prioritisation

The use of horizon scanning, clinical evidence appraisal and prioritisation is now firmly embedded in WHSSC's commissioning practice. This allows the opportunity to assess new research and development and to consider the use of technology and innovation in the provision of specialised health services for the Welsh population. The processes are designed into the development of the ICP, but are also used on an ongoing basis throughout the year in assessing new treatments and technologies and in the development of Commissioning Policies and Service Specifications.

4.4 Performance Management

The performance management approach described in the last ICP has been embedded within the organisation. A new performance report was introduced in May 2016 and further work is ongoing to develop the WHSSC performance management framework.

Provider performance is closely monitored and enhanced performance measures are put in place where required. There are monthly internal performance management meetings, with reports against the dashboards being provided to Corporate Directors Group, Management Group and the Joint Committee.

Work is being advanced with the NHS Wales Informatics Service regarding the development of an information system to improve the flow of activity to support performance management arrangements.

In 2016-17, WHSSC has implemented enhanced performance management arrangements in the following services:

- Bariatric surgery (ABMUHB);
- Cardiac surgery (ABMUHB, CVUHB and LHCH);
- Posture and mobility (wheelchairs) (ABMUHB, BCUHB, and CVUHB);
- Plastic surgery (ABMUHB);
- Paediatric surgery (CVUHB);
- PET-CT (Cardiff University);
- Neurosurgery (CVUHB); and
- Thoracic surgery (ABMUHB and CVUHB).

However, whilst there have been some improvements over the course of the last year, there are still significant delivery issues in the following services:

- Bariatric surgery (ABMUHB);
- Plastic surgery (ABMUHB);

- Neurosurgery (CVUHB); and
- Thoracic surgery (ABMUHB and CVUHB).

WHSSC is currently escalating action on each of these issues with the providers and reports are being provided to the Management Group and the Joint Committee on the progress of these actions.

In 2017-18, the performance management processes will be enhanced through the introduction of a new escalation process. The process includes the following stages:

Stage I – Enquiry
Any quality concern will enter the process at this stage. The evidence will be reviewed and an informal enquiry into the concern will be undertaken. Immediate patient safety issues will be urgently escalated to a designated member of the nursing and medical directorate to lead on the enquiry.

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

- Attendance at provider performance meetings
- Attendance at provider action planning meetings
- Triangulation of data with other quality indicators
- Advice from external advisors

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

Stage IV – Escalated Monitoring Meeting
Where there is evidence that the Action Plan emanating from a Stage III visit has failed to meet the required outcomes as agreed by the Commissioning Advisory Group, the meeting will identify the next steps:

1. Further action planning
2. Penalties
3. De-commissioning
4. Outsourcing

4.5 Risk Management

The top organisational risks (scored 15 and above) are delegated where appropriate to key sub committees of the Joint Committee and these in summary fall into the following areas:

- Access
- Delivery of waiting times targets
- Sustainability

The following table sets out a summary of the current key risks as at March 2017, and as such it does not take account of the subsequent impact arising from the technical plan. These risks will come into alignment with the risk management framework over the next few months. This will be included in future reports to the Joint Committee.

Table 12: Risks as of March 2017

Risk Reference	Description of risk identified	Score (last reported)	Current Score	Overall Trend	Last Review By Directorate/ Programme Team
Neuropathology NC/015	Sustainability of the Neuropathology service	20	20	⇨	21/04/2017
Lung cancer CH/020	Excessive lung cancer waiting times	20	20	⇧	30/04/2017
Bariatric Surgery CH/021	Long waiting times for high risk bariatric surgery patients	20	16	⇧	30/04/2017
Retroperitoneal sarcoma CH/023	No service for South Wales patients for retroperitoneal sarcoma.	New	16	⇨	23/04/2017
Spinal rehabilitation NC/001	Un-sustainability with the mid and south Wales spinal rehabilitation service	16	16	⇨	21/04/2017
Functional Neurosurgery NC/012	Ability of provider to deliver Neuromodulation service	16	16	⇨	21/04/2017

Risk Reference	Description of risk identified	Score (last reported)	Current Score	Overall Trend	Last Review By Directorate/ Programme Team
Core Neurosurgery NC/016	Understaffed in medical establishment although additional funding received	New	16	⇨	21/04/2017
South Wales ALAC service NC/019	Inability to cover specialist staff during maternity leave	New	16	⇨	21/04/2017
Immunology NC/020	Increased outpatient waiting times for patients with primary immunodeficiency	20	16	⇨	21/04/2017
Infection Control risks on Burns ITU NC/021	Acinobacter found in three patients	16	16	⇨	21/04/2017
Plastic Surgery RTT CH/018	Failure of provider to deliver 26wk/ 36 wks RTT for plastic surgery	16	16	⇨	30/04/2017
Bariatric Surgery CT/011	Ability of provider to deliver the Bariatric Surgery commissioning plan in 2015/16	16	16	⇨	30/04/2017
Cardiac Ablation CT/013	Limited access to curative treatment for arrhythmia for south Wales patients	16	16	⇨	15/04/2017
Revascularisation CT/014	Revascularisation delivery is outside the 96 hours	16	16	⇨	15/04/2017
Cystic Fibrosis WC/016	Growing cohort of patients with limited inpatient facilities	New	16	⇨	30/04/2017
TAVI and surgical AVR CT/017	Not currently commissioning in line with latest evidence and best practice	New	15	⇨	15/04/2017

Although the risks scores are updated and reviewed by Commissioning Teams and an Executive Director monthly, the updated version of the CRAF is not expected until July.

4.6 Workforce and Organisational Development

The Corporate Directors Group has continued to focus on organisational development progress over the last year. Elements from the Aston Model have been used for this.

In addition to this, ongoing work continues to look at each Directorate's objectives and how they align across the organisation. This enables collaborative working within teams, resulting in the commissioning of high quality patient care.

During 2016-17 WHSSC considered clinical support staffing within the Medical and Nursing Directorates with a focus on improvements to clinical quality of the services it commissions.

WHSSC will be conducting a further review of all posts within the organisation. The aim is to identify any gaps and to ensure effective use of resources. The review will also examine the current establishment against staffing in post and current workforce knowledge and skills. From this future organisational development and learning plans will be developed.

The organisation has participated in CTUHB's Graduate Trainee Scheme since April 2016. WHSSC is keen to offer opportunities to NHS Wales' staff to gain skills and experience in planning and commissioning, either on a short term or longer term basis and can offer family-friendly flexible working conditions for skilled staff.

The appointment of a substantive Managing Director was previously identified as crucial to the leadership and stability of the organisation. The appointment of Dr Sian Lewis was announced in December 2016 and it is anticipated that she will commence in post from August 2017, although she is currently engaged as Acting Medical Director.

The recruitment of four part time Associate Medical Directors to support the commissioning teams was recently announced; the process continues to recruit a further Associate Medical Director to support the Mental Health Team.

4.6.1 Commissioning Teams

The WHSSC planning functions have been delivered through a specialty based programme team model since 2010. Over the last seven years, the teams have

developed a greater commissioning focus, and following the appointment of the Associate Medical Directors, the clinical focus of the teams has been strengthened. Following an internal review of the membership and functions of the teams, they have been re-launched as commissioning teams.

The following table sets out the core functions of the commissioning teams. These functions will be reviewed by the Corporate Directors Group on an annual basis.

Table 13: Commissioning Team Functions

Commissioning Team Functions
• Support development of ICP, through: o Development of service specific commissioning strategies, including health needs assessment o Identification, assessment, and evaluation of commissioner and provider schemes o Assure and evaluate implementation of schemes o Alignment of national projects i.e. Welsh Government Implementation Groups
• Development of: o Service specifications inc. quality and key performance indicators o Commissioning policies o Commissioning intentions
• Development and review of: o Service directory o Referral pathways
• Organisation and leadership of audit and outcome events
• Support the Patient Care team in the assessment of IPFRs
• Performance monitoring and management of specialised services– including regular monitoring, monthly management meetings, and clinical summits.
• Risk assessment and management related to the commissioning of specialised services
• Support contract management team in the management of contracts with providers of specialised services

4.6.2 Staff Development

Over the course of the last year, work has been undertaken to strengthen staff engagement throughout the organisation. Key priorities continue to be the achievement of PDR targets and the completion of core skills training by all staff. PDR compliance at November 2016 was 85%. This is a significant improvement on the position reported in November 2015 and is within the organisational target of 85-100%.

4.6.3 Staff Sickness and Absence

As WHSSC is a small organisation, sickness and other absences have a significant effect on the capacity of the organisation. Short and long term

sickness absence continues to be a focus of management effort; however the rates are below the Welsh Government target rate of 4.5%.

Table 14 - WHSSC Sickness Absence Rates

Oct 2016			Rolling period Nov 2015 – Oct 2016		
Absence days (FTE)	Available days (FTE)	% Rate (FTE)	Absence days (FTE)	Available days (FTE)	% Rolling rate (FTE)
21	1,529.75	1.37	467.66	19,391.14	2.41

Note: Excluding EASC and QAIT

WHSSC has experienced relatively high levels of staff turnover during the last 12-18 months and is continuing to direct its efforts on recruitment to fill all vacancies and develop OD strategies targeted to reduce turnover.

5 Development of the 2017-20 Plan

This Chapter describes the process for developing the *Integrated Commissioning Plan 2017-20* and progress to date.

5.1 Principles

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

- Developing clear WHSSC commissioning priorities;
- Accelerating the relative prioritisation of schemes requiring evidence appraisal;
- Building in the risk-assessment of schemes regarding service issues and sustainability;
- Allowing sufficient time for examining opportunities for savings and repatriation and to consider the application of prudent healthcare to specialised services;
- Consideration of Health Board priorities for specialised services; and,
- Integrating scrutiny and good governance.

The ICP outlines NHS Wales' priorities for commissioning specialised services between 2017-18–2019-20. The implementation of the refreshed Quality Assurance Framework will continue to be a priority for WHSSC in 2017-18 and this will be reflected throughout the ICP. The ICP seeks to address the key commissioner risks in specialised services and will describe mechanisms for providing quality assurance as well as for quality improvement.

5.2 Engagement

WHSSC is described as an NHS Support Organisation in the NHS Wales Planning Framework. There is a duty on NHS Support Organisations "to engage fully with NHS stakeholders to develop robust and realistic plans which are aligned to the individual IMTPs". WHSSC has a good track record of engagement with other NHS organisations in the development of its ICP. The process of developing the ICP for 2017-20 has included extensive engagement:

- with Local Health Board commissioners through a series of 7 structured workshops with the Management Group members;
- with individual Health Boards;
- with Health Board and Trust providers through meetings and opportunities to submit written documents and supporting information;
- with Health Boards through the Joint Committee; and
- through the re-convened Horizon Scanning and Evidence Evaluation Prioritisation Panel and the Clinical Impact Assessment Group.

The ICP must align with LHBs IMTPs. In terms of the financial plan, consistency and alignment is essential and this has been re-iterated to LHBs in the final stages of developing the financial plan.

Wider engagement with the public and other stakeholders will be undertaken by LHBs in the context of their own IMTPs.

5.3 Process

The ICP is developed through WHSSC developing commissioning intentions (Annex 4), setting priorities and undertaking risk assessments, providers submitting responses, a series of Management Group workshops, horizon scanning, evidence appraisal and prioritisation.

There are four main inputs into the service element of the ICP, these being:

- Horizon scan/prioritisation panel results;
- Commissioner priorities;
- Provider priorities; and
- NHS Wales strategic priorities

The process is designed to allow consideration of all of these inputs and for the four input streams to be synthesised and risk-rated together through the Management Group workshops. The draft ICP was submitted to the January meeting of the Joint Committee and cleared for submission to Welsh Government.

Following the submission of the draft ICP, the majority of Health Boards had to significantly reduce the specialised service provisions declared in their January IMTPs submissions in order to manage their own plan deficits. As a consequence it was clear that it would not be possible to fund all of the schemes identified within the development process, and that further work would be necessary to identify the relative priority for implementing schemes and to provide advice on the impact of non-implementation. A Clinical Impact Assessment Group (CIAG) was established to undertake this work.

The CIAG met in January 2017 to assess and score a subset of 19 schemes on the basis of their clinical impact against a set of pre-determined criteria. The membership was drawn from Health Board Medical Director's Offices.

Members were appointed as individuals and not to represent the views of any stakeholder organisation to which they may be affiliated.

All of the schemes that had been identified as mandatory (e.g. NICE and AWMSG) were excluded from this process. The group ranked each of the schemes into the following categories – high, medium and low. The outputs were then used to reassess schemes from the draft ICP, and as a consequence, a number of schemes were re-categorised.

The outcomes of this work were presented to the Management Group workshop on the 16th March. However, during this same period, it had been necessary for Health Boards to make further reductions in their provisions for specialised services, in order to reduce the deficits within their own IMTPs. As a consequence, following discussion at the March meeting of the Joint Committee it was concluded that the level of funding available from Health Boards was not sufficient to cover all of the new schemes identified through the development of the plan, including the outputs of the Prioritisation and CIAG processes, and therefore an ICP risk management framework is being developed to assess, monitor and mitigate the risks identified for each of the unfunded schemes, and to escalate risks where appropriate to the Joint Committee for resolution. This framework is described in more detail in section 6.5.

The theme and objectives of each workshop are described in the table below.

5.4 Management Group Workshops

The Management Group workshops ensure that the ICP was developed through a collaborative process with Local Health Board commissioners and that it is owned by LHBs. One-to-one meetings with provider LHBs and Trusts were also held and opportunities were given for written submissions and submission of supporting information. An overview of the engagement workshops is contained in the following table.

Table 15: Timetable of Management Group workshops

Workshop	Content
Workshop 1 8th September 2016	**Theme: Preparing for open source model and delivery of 2016-19 ICP** • Process for developing the ICP 2017-20 • Introduction to open source model • Review of 2016-19 ICP schemes • Finance and contracting framework

Workshop	Content
Workshop 2 13th October 2016	**Theme: Commissioning intentions** • Actions to implement 2016-17 WHSSC ICP economic benefits schemes. • Review 2016-17 WHSSC ICP and schemes and agree approach to those not planned for completion in year. • Review WHSSC Programme Team commissioning priorities for 2017-18. • Note Horizon Scanning and prioritization process for new interventions. • Agree principles, process and information required to support the development of ICP proposals
Workshop 3 10th November 2016	**Theme: Developing the plan** • Note schemes identified to date; • Receive an update on Integrated Commissioning Proposal T&F Groups and confirm next steps; • Receive an update on the development of other schemes; • Receive an update on evidence evaluation • Process for considering schemes - Financial framework, impact assessment and categorization.
Workshop 4 8th December 2016	**Theme: ICP preliminary assessment** • Consider and agree recommendations from WHSSC internal review of ICP schemes. • Receive preliminary baseline assessment and consider financial framework issues
Workshops 5 and 6 4th and 5th January 2017	**Theme: ICP categorisation parts 1 and 2** • To agree the schemes for inclusion in the ICP 2017-18 • To receive and consider recommendations from the WHSSC Executive Team – Removed and work plan schemes. • To categorise the schemes not yet ranked.
Workshop 7 12th January 2017	**Theme: ICP submission to Joint Committee** • To review the WHSSC 2017-20 ICP submission to Joint Committee. • To note the categorisation of schemes for inclusion in the 2017-20 ICP. • To note the financial framework. • To note the recommendations regarding funding of the 2017-20 ICP which will be made to Joint Committee • To agree further action required
Workshop 8 9th February 2017	**Theme: ICP final submission** • To receive feedback from Joint Committee; • To note mechanism for addressing feedback from Welsh Government; • To note arrangements to ensure alignment of ICP and HB IMTPs; • To receive an update on the establishment of a Clinical Impact Assessment Group; • To receive an update on the financial framework; • To note process and timescale for final submission; • To note WHSSC proposals for developing 2018-21 ICP.
Workshop 9 16th March 2017	**Theme: ICP March submission** • To receive feedback from the Clinical Impact Assessment

Workshop	Content
	Group (CIAG) meeting. • To note WHSSC recommendations regarding the schemes for inclusion in the 2017-20 ICP. • To review the WHSSC ICP financial framework. • To note arrangements for the risk management of unfunded schemes. • To receive an update on Welsh Government feedback relating to WHSSC 2017-20 ICP January submission. • Health Boards to provide feedback on the status of their IMTP submissions. • To note key elements WHSSC 2017-20 ICP March submission. • To discuss arrangements for 2018-21 ICP development.
Workshop 10 27th April 2017	**Theme: Risk Management Framework** • To note the Technical Plan submitted to Welsh Government • To note feedback received to date • To receive and develop the risk management framework

5.5 Commissioning Products

The products that are considered in the workshops to develop the ICP are:

- ***Commissioning Intentions*** – The Commissioning Intentions for 2017-20 have been approved by the Joint Committee.
- ***Commissioner priorities*** – WHSSC used the Commissioning Intentions to describe the top commissioning priorities in each commissioning programme area. The priorities have been shared with the Management Group as the Local Health Board commissioners, and with provider LHBs and Trusts. These are used to prioritise the ICP and to ensure it is commissioner-led.
- ***Horizon Scanning –*** WHSSC has undertaken a technical horizon scanning exercise to compile and assess a list of new drugs, interventions and technologies expected in 2017-20. These will be assessed and prioritised through the relative prioritisation process. WHSSC has also undertaken a service issues horizon scan and these issues will be prioritised through risk-rating and the Management Group workshops.
- ***Baseline Review –*** A financial assessment of the contract baseline will be undertaken. Each commissioning programme will undertake a comprehensive review of the contract baseline and service baseline, to identify where there are recurrent pressures or underspends for consideration by Management Group.
- ***Savings and Repatriation –*** WHSSC and LHBs have considered the opportunities for making savings and repatriation in specialised services.
- ***Review of 2016-19 Prioritisation Process Green Schemes*** – The list of Green Schemes that were not prioritised for inclusion in the 2016-19 ICP has been reviewed by WHSSC and Management Group and it has been

agreed which of these will be included for re-consideration for the 2017-20 ICP.

- ***Health Board and Trust issues*** – In addition to the work that is being undertaken internally, information has been requested from LHBs and NHS Trusts providers in order to ensure a collaborative approach is undertaken for NHS Wales. This includes submission of the relevant sections of Local Health Board risk registers, demand and capacity plans, strategic service development plans and the use of an open source model to develop integrated commissioning proformas.
- ***Risk Assessment*** – all of the individual service schemes that are considered in the development of the Plan (whether identified through horizon scanning, by commissioners or by providers) are risk-rated by WHSSC and peer-reviewed through the Management Group workshops.
- ***Clinical Impact Assessment Group*** - assessment and relative ranking of a subset of 19 schemes (excluding mandatory schemes) on the basis of their clinical impact against a set of pre-determined criteria. The group ranked each of the schemes into high, medium and low categories.
- ***ICP Risk Management Framework*** – assessment of risk associated with non implementation of ICP schemes. The framework has three domains – patient (resident Health Board), commissioner and provider.

5.6 Integrated Commissioning Plan Approval

The ICP was developed in partnership with the LHBs and included a number of Management Group Workshops and individual meetings with the respective LHBs.

All LHBs are required to agree the *Integrated Commissioning Plan 2017-20* which will then form part of their IMTPs. The NHS Wales Planning Framework does not take into account the difficulties of the concurrent development of the ICP and the LHBs IMTPs and there is always a difficult balance to find regarding process. It is recommended that in future years the ICP has a later deadline than Health Boards IMTPs in order to make this a smoother process.

The Joint Committee will meet to consider this plan on the 30th May 2017. The plan contains the following elements:

- Baseline assessment of recurrent position;
- Full year effect of 2016-17 developments and benefits realisation;
- Unavoidable IPC growth and contract inflation pressures;
- Mandated schemes;
- Schemes which have received prior commitment; and
- Unavoidable FYE of growth.

The timeline used for the approval process for the ICP 2017-20 is set out in the following table.

Table 16: Timeline for the approval process of the ICP 2017-20

Stage	Timescale	WHSSC MGM	WHSSC JC	Welsh Government
ICP submitted to Management Group for comment	12th January 2017	✓		
ICP submitted to Joint Committee	17th January 2017		✓	
ICP submitted to Welsh Government	27th January 2017			✓
Technical Plan submitted to Joint Committee for approval	28th March 2017		✓	
Technical Plan submitted to Welsh Government	31st March 2017			✓
Final version ICP submitted to Joint Committee for approval	30th May 2017		✓	
Final version ICP submitted to Welsh Government	31st May 2017			✓

Key: MGM Management Group
JC Joint Committee

6 Commissioning Specialised Services 2017-20

This Chapter describes the results of the integrated process for planning specialised services commissioning over the next three years.

Following the re-categorisation of schemes, the Plan now includes the following six elements:

Table 17: Composition of the 2017-20 ICP

1	Baseline assessment of recurrent position	
2	**Full year effect of 2016-17 developments and benefits realization.**	
3	Unavoidable IPC growth and contract inflation pressures	
4	Mandated schemes	• Hepatitis E Testing - Mandated UK Tests • Ivacaftor in paediatrics (age 2-5 years) • Migalastat for Fabry's disease – Mandated • Eliglustat for Gaucher's disease – Mandated • Progressive LAL deficiency - 2018-19 pressure • Rare diseases - Pegvisomant for acromegaly
5	Schemes which have received prior commitment	• Thoracic capacity to achieve cancer targets • Genetics Micro arrays for CGH backlog • Genetics UKGTN • Genetics NSCLC • Genetics Stratified Medicine
6	Unavoidable FYE of growth	• Renal Replacement Therapy Demand

The net result of these revisions is an overall requirement of £16.9 million for the Health Boards, which compares favourably to the £23 million requirement set out in the draft ICP.

In addition to these six elements, there are a number of schemes which the Joint Committee may wish to reserve for future decisions, pending the release of funding through locally owned savings schemes and the improving value programme. These include:

- Implementation of the thoracic surgery commissioning strategy
- Renal replacement therapy demand
- Genetics Micro arrays for Comparative Genomic Hybridisation

The following new schemes are not included within the 2017-18 financial plan:

- Recommendations from the WHSSC Prioritisation Panel, inc. new device technologies;
- Cardiac ablation for AF and VT;
- Posture & Mobility - Replacement of wheelchairs;

- PET policy - new indications;
- Cochlear and BAHA;
- PET Capacity to achieve target access rate;
- Cystic Fibrosis;
- Cleft Lip and Palate;
- BCU Artificial Limb and Appliance Service – service impact of enhanced prosthetic provision for war veterans;
- Fetal Medicine;
- Neuromodulation;
- Spinal rehabilitation;
- Neuro rehabilitation;
- Cleft lip and palate RTT;
- Additional paediatric intensive care unit capacity (7th b)
- Neurosurgery RTT clear backlog;
- IVF sustain 26 week RTT;
- South Wales Neuro-oncology;
- Neonatal intensive care unit;
- Neuroendocrine tumours;
- Transcatheter aortic valve implantation policy review;
- Ketogenic diet ;
- Alternative augmentative communication (AAC); and
- ICU/HDU.

There are varying degrees of risk associated with the unfunded schemes; however, unless any further savings can be identified, it will not be possible to fund these schemes. Therefore, they will be managed through the risk management framework described in Chapter 6.

The impact associated with not taking these individual schemes will vary across each of the LHBs, this will be reflected within the risk management framework, but will also need to be included within each LHB's IMTP, as part of the risk stratification for specialised services accessed by their population. Similarly the impact on each LHB's delivery against the NHS Outcomes and Delivery Framework should be included within their IMTP.

The plan includes the recurring impact of the service developments approved as part of the 2016-17 ICP, which includes a number of important emerging service sustainable issues which were considered in year, and have been reaffirmed for 2017-18. These investments are set out in the following table:

Table 18: WHSSC 2016-17 Investments

Service	Commissioning Intention
Prosthesis service - prosthetics for war veterans	Investment to sustain service performance and the achievement of delivery.
Cystic fibrosis	Use of Ivacaftor for approved indications
Malignant Melanoma *	NICE Mandated
Elosulfase Alfa *	Elosulfase alfa for treating mucopolysaccharidosis type IVa (MPS IVa) in line with managed access agreement
Ataluren NS DMD *	Ataluren for treating Duchene muscular dystrophy resulting from a nonsense mutation in the dystrophin gene in people aged 5 years and older who can walk, - in line with managed access agreement
Thoracic surgery	To commission sufficient surgery at ABMU and C&VU, to achieve the 2012 LUCADA upper quartile resection rate for Wales.
Neuroendocrine Tumours (NETs)	To commission the service model agreed by the NETs Task and Finish Group.
Fetal cardiology	Investment to address quality and sustainability issues.
Paediatric surgery	Investment in capacity at C&VU to meet backlog, recurrent demand and capacity gap.
BAHAs and Cochlears	Investment to meet increased demand in BCU and C&VU.
BMT Phase 3	Three year phased investment to address demand and sustainability issues.
PET-CT	Investment to widen indications for PET
Paediatric Cardiology RTT	Investment in capacity at C&VU to meet backlog, recurrent demand and capacity gap
Liver ablation	Investment in ABU US/RF Liver ablation service to include microwave ablations service
Genetics	Investment to commission UKGTN tests approved 2015/16 for commissioning in 2016/17
Genetics	Investment to commission additional range of stratified medicine tests
Neurovascular	Investment to address sustainability issues.
Interventional neuroradiology	Investment to address quality and sustainability issues.
Neurosurgery	Investment to address quality and sustainability issues.
Clinical Immunology	Investment in infrastructure to meet increasing demand
Posture and Mobility (Wheelchairs)	Investment to meet increasing demand
High Secure	Investment in gatekeeping role to include clinical case monitoring all patients in independent sector placements.
Medium Secure - patients with learning disabilities	Investment in gatekeeping role to include clinical case monitoring all patients in independent sector placements.

Work will be undertaken throughout the course of 2017-18 to ensure that each of these schemes has been fully implemented in line with the original commissioning intention, and that the benefits have been realised. Particular attention will be given to those investments designed to improve service performance.

6.1 Horizon Scanning and Prioritisation

The use of horizon scanning, clinical evidence appraisal and prioritisation is now firmly embedded in WHSSC's commissioning practice. This is set out in detail in **Section 2.4**. The complete WHSSC horizon scanning and prioritisation methodology for 2017-18 is presented in Annex 1.

6.2 Commissioner Priorities

To ensure that the ICP is commissioner-led, in addition to the technical horizon scan, the WHSSC team identified the commissioner service priorities for 2016-17 and service horizon scanning issues. The priority setting and service horizon scan were undertaken by the commissioning teams taking into consideration the principles outlined in the Commissioning Intentions and include consideration of:

- Quality and outcomes;
- NHS Delivery and Outcomes Framework Measures (RTT/cancer waiting times targets, mental health measures);
- National priorities (maternal and child health and mental health in particular); and
- South Wales Reconfiguration Plans (south Wales programme).

6.2.1. NHS Wales Delivery Plans

WHSSC has an important role to play in supporting Health Boards to deliver the condition-based NHS Wales Delivery Plans. Delivery Plans are currently being updated and WHSSC will review and respond to the relevant priority areas identified once this work has been completed.

6.3 Provider Priorities

Due to the collaborative nature of the development of the WHSSC ICP, Local Health Board commissioners and providers were also invited to submit their priorities for specialised services for consideration. These were invited in the context of WHSSC's Commissioning Intentions, provider risk registers, Delivery Plans, RTT and cancer waiting times targets.

6.4 A Commissioner Led Plan

In total there were 175 schemes identified for consideration in the development of the 2017-20 ICP as outlined above schemes were identified by the WHSSC Commissioning Teams; via Horizon Scanning or by Health Boards/Trusts.

6.5 Risk Management Framework

The approach outlined in the previous chapters has enabled WHSSC to reduce the requirement from Health Boards by over £46 million, however the consequence is that there are a greater number of risks inherent within the

baseline planning assumptions than in previous years. In addition to this, there are further risks related to each of the unfunded schemes which have been identified as priorities.

For each of these schemes, there are three domains under which risk will present:

- Patient (Resident Health Board) - assessed by Resident Health Board
- Provider - assessed by Specialised Provider
- Commissioner (Health Board + WHSSC) - assessed by WHSSC Commissioning Team

The aim is to use existing risk registers from each of the organisations to feed into the risk management framework, e.g. the current 'Effective' score from WHSSC risk register maps directly to the 'Commissioner' score in the risk management framework.

Commissioning Teams have undertaken a baseline assessment of the 'Commissioner' risk score for each of the schemes. WHSSC has now written out to each of the LHBs via their members on the Management Group, in order to obtain the risk scores for the 'Patient' and 'Provider' domains. The current ICP risk management framework which represents the position as at the end of May is attached as Annex 5.

The WHSSC Management Group will continue develop the risk management framework, and will use it to assess, monitor and mitigate risk using the open source model, and to escalate as appropriate any risks which require resolution by Joint Committee.

Further information on the risk management framework is included within Chapter 10.

6.5 Work Plan

In addition to the schemes included within the financial plan, there are a number of schemes which will be progressed through the workplan over the next year.

The following table sets out the draft work plan for 2017-18. This work plan will be reviewed following the agreement of the ICP, and will be considered against the Risk Management Framework, in order to determine the priority areas to be progressed in year.

Table 19: Draft Work Plan

Prog Team	ICP17-Ref	Service	Description	Commissioning Intention
C&B	ICP17-005*	Proton Beam Therapy	Implementation of service specification and commissioning policy	To commission a PBT service that meets the WHSSC service specification and policy to maximise patient benefits from treatment.
C&B	ICP17-013*	SBRT	Revise the SBRT commissioning policy	Commissioning through Evaluation - oligo metastasis and liver
C&B	ICP17-015*	High Dose Rate Brachytherapy for Prostate Cancer	Introduction of a new HDR Boost Brachytherapy Service for south east Wales based at Velindre Cancer Centre. The equipment for performing HDR prostate implants was purchased via a Wales Healthcare Technology Fund award in 2013/14, so this proposal is for the staffing of this service.	
C&B	ICP17-020*	Plastic surgery	To achieve and maintain max 36 weeks RTT in ABMUHB through i) performance management; and ii) pathway review and implementation of agreed changes.	To commission a sustainable service able to meet increasing demand within acceptable waiting times.
C&B	ICP17-029*	Bariatric surgery	Sustainable service model for south Wales	To increase access to bariatric surgery in line with the 5 year phased growth plan agreed in the WHSSC ICP.

Prog Team	ICP17-Ref	Service	Description	Commissioning Intention
Cardiac	ICP17-033*	Cardiac surgery	Introduce component waits for cardiac surgery. Welsh Government directive.	Equity of access and patient safety
Cardiac	ICP17-037*	Percutaneous Coronary Intervention (PCI)	Repatriation of PCI from CVUHB to CTUHB. To improve access and treatment times for CTUHB residents.	Equity of access
N&CC	ICP17-040*	Neuropathology	Scheme was included in 2016-17 plan but rolled by CVUHB whilst they work through the options for sustaining a Neuropathology service with a sole Consultant following a number of unsuccessful recruitment attempts.	To ensure that Neuropathology is adequately resourced to support a tertiary Neurosciences centre in south Wales.
W&C	ICP17-057*	Pre Genetic Implantation Policy	PGD Policy is due for review, consideration with regards to if this should be available for single people in line with IVF policy	To commission PGD for the population of Wales.
Cardiac	ICP17-078*	Left appendage occlusion	Develop commissioning policy	In the absence of a policy requests are being dealt with via IPFR. A policy is required to ensure WHSSC position is in line with current evidence and to promote equitable access to treatment

Prog Team	ICP17-Ref	Service	Description	Commissioning Intention
C&B	ICP17-090*	Hepatobiliary-Pancreatic surgery in south Wales	Impact assessment and implementation of recommendations from Hepato Pancreato Surgery Review (inc. consideration of transfer of service to WHSSC)	To commission a sustainable service able to meet increasing demand within acceptable waiting times.
C&B	ICP17-093*	Haemato - oncology	Review by Finance Working Group with regard to proposals for improving efficiency of the haemato-oncology pathways inc. potential transfer of services.	To work collaboratively with Health Boards to commission an effective, sustainable and cost effective service, across the whole pathway, for patients who require haemato-oncology services.
C&B	ICP17-095*	TIPSS - Transjugular Intrahepatic Portosystemic Shunts	Interventional radiology procedure currently outside WHSSC's commissioning remit. Collective commissioning.	Demand and capacity pressures in this support service. Business case required.
Cardiac	ICP17-096*	Cardiac surgery	Achieve and sustain 36 week RTT performance (Performance management - within existing resources)	Equity of access and patient safety
N&CC	ICP17-103*	Neuro rehabilitation	Implementation of network model of delivering Neuro-rehabilitation in south Wales	To revisit the recommendations of the Neurosciences Steer Review for a network approach to deliver Neuro-Rehabilitation across south Wales

Prog Team	ICP17-Ref	Service	Description	Commissioning Intention
C&B	ICP17-130*	Lymphovenous Anastomosis	Commissioning plan	To commission access to LVA in accordance with evidence of effectiveness and patient demand.
C&B	ICP17-132	PET	Commissioning plan (to set out commissioning intentions and ensure capacity to achieve the required level of population access to PET)	To implement PET commissioning plan to ensure appropriate and equitable access, based on evidence, to maximise patient benefits from radical treatment for cancer
Cardiac	ICP17-135	Cardiac services	Development of tertiary cardiac services strategy	To inform planning decisions
Cardiac	ICP17-136	Ventricular Assisted Devices (VADs)	Develop commissioning policies for the following indications - for Bridge to Transplant (BTT), Bridge to Recovery (BTR) and Destination Therapy (DT)	In the absence of a policy, requests are being dealt with via IPFR. A policy is required to ensure WHSSC position is in line with current evidence and to promote equitable access to treatment
Cardiac	ICP17-137	CRT for the management of advanced heart failure	Develop commissioning policy	Equity of access
MH	ICP17-141	Medium Secure	Learning Disability Capacity	Demand & Capacity Review
MH	ICP17-142	Eating Disorders	External support for Tier 4 Options Appraisal	Capacity & Contract Review Review of the whole pathway
MH	ICP17-143	Gender Dysphoria	Clarify pathway and review GIC provision	Pathway Review & Revised Policy
MH	ICP17-144	Perinatal	Clarify pathway and commissioning arrangements	Pathway Review & Revised Policy
MH	ICP17-145	High and medium secure	Evaluate case management arrangements	Optimise use of resources

Prog Team	ICP17-Ref	Service	Description	Commissioning Intention
N&CC	ICP17-149	Paediatric Epilepsy	Historically have commissioned from GOSH, but NHS England have designated Bristol as a specialist centre as well. UHW, Cardiff also working on developing a service for over 3s which helps to sustain UHW, Cardiff Paediatric Neurosurgery.	To establish a commissioning strategy for paediatric patients requiring epilepsy treatments.
N&CC	ICP17-150	Interventional Radiology - Stroke	New clot retrieving treatments for stroke are being introduced which require the input of Interventional Radiologists and similar treatments to those used in Neuro-Interventional cases in terms of cost and theatre time.	To understand the demands both physically and financially of clot retrieval treatments for stroke patients on our commissioned Neuro-Interventional Radiology service.
N&CC	ICP17-151	Adult MRI capacity	Inadequate MRI capacity to undertake timely diagnoses and post surgery MRIs following tumour surgery.	To commission safe and sustainable Neurosurgical services which include timely diagnosis and optimum treatments of patients.
N&CC	ICP17-152	Paediatric GA MRI capacity	There are waits of up to a year for Neurosurgery patients under 8 to receive a General Anaesthetic MRI.	To commission safe and sustainable paediatric Neurosurgical services which include timely diagnosis and optimum treatments of patients.

Prog Team	ICP17-Ref	Service	Description	Commissioning Intention
W&C	ICP17-155	Cryopreservation of Gametes	An increasing number of patients are accessing the gender dysphoria pathway, it is highly likely this cohort of patients will also request cryopreservation of gametes. Thus, the providers will see a significant increase in demand for this service.	To commission services to meet the fertility/ cryopreservation policy
W&C	ICP17-159	Porphyria	No out of hours Acute Porphyria service currently commissioned in Wales. NHS England commission a service on behalf of England and Scotland, Wales could potentially buy in to this.	Provision of appropriate services for patients out of hours
W&C	ICP17-166	Genetic testing for inherited cardiac disorders	Develop commissioning policy	Equity of access
C&B	ICP17-177	BMT (North Wales)	Requirement for JACIE accreditation for the BCUHB BMT service	To commission a high quality, safe service that meets JACIE and WHSSC service specification quality standards.
C&B	ICP17-181	Contact Radiotherapy for rectal cancer	Low-energy contact X-ray brachytherapy (the Papillon technique) for early-stage rectal cancer	Low-energy contact X-ray brachytherapy (the Papillon technique) for early-stage rectal cancer - repatriation Further detail to be confirmed

Prog Team	ICP17-Ref	Service	Description	Commissioning Intention
C&B	ICP17-184	Implementation of NICE guidance on Fetal DNA testing for anti D immunoglobin	Fetal RHD Genotype Testing	NICE recommendation is for high throughput NIPT for fetal RhD. This is intended as a cost effective option to guide antenatal prophylaxis with anti-D immunoglobin.
C&B	ICP17-185	Compliance with IVDD regulations for reagents	Implementation of directive on in vitro diagnostic device regulation.	To enable WBS to move from in house prepared or diluted reagents to those which are CE marked as a requirement of new forthcoming regulation.
C&B	ICP17-187	Hb testing improvement to reduce donations lost to failed screening	Implementation of improved Haemoglobin (Hb) testing for people making a blood donation	Hb testing improvement to reduce donations lost to failed screening.
Cardiac	ICP17-188	PCI	Repatriation of 100 PCIs to ABUHB	Repatriation
N&CC	ICP17-190	Spinal rehabilitation	Question of effectiveness of current model of delivering spinal rehabilitation in Mid and South Wales. Proposal from RJAH for step down level of care	Ensure that Spinal Rehabilitation is being delivered effectively to patients across Wales
N&CC	ICP17-192	Specialised Rehabilitation	Specialised Rehabilitation New Facilities	Specialist Rehabilitation New Facilities - move to a modern two storey facility at University Hospital Llandough (UHL)
N&CC	ICP17-196	Rare Neurological Diseases	Rare Neurological Disease Service Sustainability	To ensure pathways for rare Neurological diseases are well defined and assessed for sustainability, across a wide variety of providers to ensure the successful delivery of high quality care and support not just today but into the future.
W&C	ICP17-203	Congenital Heart Disease (CHD)	Self assessments against the CHD standards are likely to identify	Commissioning of CHD services in line with the standards

Prog Team	ICP17-Ref	Service	Description	Commissioning Intention
			gaps across services in Wales that may require resources to address. Phase 2 of the adult CHD business case to be progressed.	
W&C	ICP17-211	Neonatal	24 Hour Neonatal Transport Service	To formalise the commissioning for the extension to 24 hour neonatal transport service
N&CC	ICP17-214	Clinical Immunology	Finance and contracting-separation primary and secondary services.	To understand if the service can be clearly defined as primary and secondary immuno-deficiency separately and if this is an effective way of managing the service both financial and clinically.
C&B	ICP17-218	Inherited Bleeding Disorders	Haemophilia service commissioning arrangements are currently highly fragmented. To ensure consistency and equity in provision, unified commissioning arrangements are needed.	To align haemophilia commissioning under WHSSC as a single commissioner to enable effective service commissioning to ensure consistency, equity and sustainability of the whole service.
C&B	ICP17-219	BMT (North Wales) - access to donor transplant	To improve access to donor BMT in BCUHB.	To increase access rates to donor BMT for North Wales; to commission a high quality and equitable BMT service across Wales.
N&CC	ICP17-221	Neurosciences	Final evaluation for Selective Dorsal Rhizotomy (SDR) by the NHS England Commissioning through Evaluation	To implement the recommendations of the CtE programme for SDR.

Prog Team	ICP17-Ref	Service	Description	Commissioning Intention
			programme will be available in Summer 2017. This could have recommendations that the procedure is funded.	
W&C	ICP17-222	Tertiary Paediatric services	Development of tertiary paediatric services strategy	To inform planning decisions
MH	ICP17-223	Specialised Services	Commissioning support for Specialised Services provided by NHS England	
All	ICP17-259	Audit databases etc	Review financial contribution to audit databases to assess VFM	To ensure that we are receiving and appropriately utilising the information form the Audit databases that we are financially contributing to.

6.6 Workforce and Organisational Development Plan

WHSSC has a small workforce of around 60 whole time equivalent (wte) staff allocated across five functional Directorates and six Commissioning Teams including the Renal Clinical Network. Of this total, around two-thirds are engaged in core commissioning. The GGI report acknowledged that WHSSC has a small staffing resource and that, as a result, there is a need to ensure that staff are engaged and that training is provided to ensure that the staffing resource is used to its best effect. As highlighted in **Section 4.6**, during 2016-17 work has been done to consider clinical support staffing within the Medical and Nursing Directorates, and a further workforce review will be conducted during 2017-18 to identify any gaps, ensure the efficient deployment of staff and develop OD and learning plans.

The Joint Committee has again acknowledged that the organisation has expertise in commissioning and that, in 2016-17, staffing resources have been deployed to support collective work on behalf of LHBs to commission services which are outside WHSSC's delegated remit. This recognition of the expertise within the organisation is welcomed and WHSSC is keen to continue to develop organisational capacity by continuously improving the capability of

staff and ensuring that the workforce is engaged, motivated and working collaboratively together. Proposals to undertake further collective commissioning work are being reviewed to ensure that any additional staffing resources required are considered and approved in conjunction with the agreement to undertake the work.

As signalled previously, the Quality Assurance and Improvement Team, who undertake work specifically related to forensic mental health and learning disabilities services, have transferred to CTUHB and therefore no longer form part of the WHSSC workforce.

As explained in **Chapter 3**, the implementation of the Quality Assurance Framework is a top priority in 2017-18. Action will be taken to appoint additional capacity to undertake the quality assurance work required to implement the ICP. It is likely that this will entail the appointment of an additional two wte QA practitioners, and two wte support staff, largely from existing resource.

During 2016 the Neonatal and CAMHS Network staff formally transferred to Public Health Wales, this entailed a reduction of six wte staff from the previous WHSSC establishment. However there are no other plans to reduce the core commissioning staff establishment within WHSSC, and indeed a small increase is expected in order to support the quality improvement work as described above.

The workforce plan also reflects actions being taken to recruit to all vacancies and to manage sickness absence.

A summary of the High Level Workforce Plan for WHSSC for 2017-20 follows.

Table 20: High Level Workforce Plan for 2017-20

Improvement Objective	Description	Manager	Timescale
Maximise staffing capacity	• Ensure the review of the establishment is complete and this is used to inform further iterations of the workforce plan, including the identification of any gaps	Managing Director	June 2017
	• Ensure all vacancies are filled	Managing Director	Ongoing
Improve the Quality Assurance function	• Implement the staffing structure to improve the quality assurance function	Director of Nursing and Quality	June 2017
Improve engagement and efficiency by ensuring good teamwork	• Develop and implement OD and learning programmes across the organisation	Managing Director	Ongoing
Maximise staffing capacity	• Implement the collective commissioning framework to enable prioritisation of staffing resources	Director of Planning	June 2017
	• Ensure HR policies are appropriately applied to manage sickness and absence and that this is audited	Managing Director	Ongoing
	• Ensure 90% of staff have completed PDRs	Managing Director	Ongoing
Maximise staffing capability	• Rollout project management approach and continue to improve planning practice	Director of Planning	September 2017
	• Rollout the organisational training plan	Committee Secretary	Ongoing

6.7 Information and Communications Technology

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

Information & Communications Technology provides an opportunity to improve the effectiveness of the way in which WHSSC operates and the priorities for 2017-20 will be to focus on streamlining and automating systems and processes. They key areas of improvement are described in the following table.

Table 21: Information and Communications Technology priorities 2017-20

Improvement Objective	Description	Manager	Timescale
Streamline and automate processes	To significantly reduce, duplication, error and process inefficiencies by automating and streamlining current working practices through the better use of Information, Communication and Technology which include the complete roll out of the Electronic Staff Record, E-Expenses and electronic payslips.	Committee Secretary	June 2017
Improve access to information	To improve the way in which staff access information resulting in improvement in efficiencies and reduction of staff time. This will include the ongoing development of the Sharepoint Site and the Internet Site ensuring that all Health Boards can access information about our work programme and committee business.	Committee Secretary	June 2017
Quality Measures	Develop a suite of quality measures to be used in contract monitoring and performance management and automate systems for their collation, communication and analysis. (This is dependent upon the resources being available	Director of Finance and Director of Nursing and Quality	September 2017

	to improve the quality assurance function and the recruitment to the Head of Information post).		
Commissioning Support	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. (This is dependent upon appointments to the Information Team which are currently vacant).	Director of Finance	September 2017

6.8 Equality Impact Assessment (EQUIA)

When developing the ICP, WHSSC has a statutory duty to ensure that due regard is paid to the impact on the groups with protected characteristics as laid out in the Equality Act 2010. Preliminary EQUIA screening has been undertaken on the schemes put forward for consideration in the 2017-20 ICP. Full EQUIAs will be completed on all schemes following submission of the final version of the Plan to Joint Committee in May 2017.

7.0 Finance

This Chapter describes the financial framework for the commissioning of specialised services in 2017-20 and the financial impact assessment of the Plan.

7.1 Financial Framework

The starting point for the development of the 2017-18 financial framework is year two of the three year Integrated Commissioning Plan agreed for 2016-17 to 2018-19. This plan sets out the expected requirement for specialised services, which includes the recurring impact of the approved 2016-17 plan together with a provision for activity changes and growth, service improvement and planned developments to deliver service strategies. The 2016-19 ICP indicated a required funding uplift of 4.4% for specialised services in year 2.

It is recognised that the 2017-18 allocation letter to Health Boards set out a different approach to the balance between resources issued to Health Boards and retained resources at Welsh Government. This has adversely impacted on the ability of Health Boards to cover the original WHSSC plan for 2017-18.

The draft ICP submission in January based on the month 8 financial forecasts set out an uplift requirement of 4.3% to fund the baseline, known growth and the schemes prioritised by the management group.

During the development of the ICP post January submissions of the draft plans, the scale of the Health Boards IMTP planning deficits emerged, which further impacted on the resources available to meet the required provision for specialist services, with most HB's significantly reducing the specialist service provisions declared in the January IMTP submissions in order to reduce their respective planning deficits.

In view of this uncertainty and pressures within NHS Wales, WHSSC has undertaken a programme of work to identify mitigating savings that can be offset against the pressures, revised forecast assumptions using the latest available information and recovered recurrent funding, where there are delays in provider implementation of 2016-17 approved developments.

Continuing the theme from the 2016-17 plan, it is important to track the relative level of resources allocated to specialised services in NHS England as it provides a sense check on direction and relative pace of change. This is essential as nearly all highly specialised services are delivered within NHS England providers, many of which will include mandated developments and

new technologies which Welsh residents will access. The reported allocation totals for NHS England specialised services for 2017-18 will need careful interpretation following material changes in the national tariff which will increase the price of specialised services. WHSSC has raised this issue with Welsh Government colleagues as a significant risk. The initial financial planning assumption for this version of the plan is not to provide for the proposed price increases until there is an agreed allocation adjustment from NHS England to NHS Wales.

7.2 Financial Plan Structure and Assumptions

The structure of the financial plan and key assumptions are summarised as follows:

The starting point is a rollover of the 2016-17 opening baseline adjusted for known in year allocation adjustments and transfer of services. The impact of the following categories has been calculated to derive the carried forward underlying deficit required to fund the recurrent baseline for 2017-18.

- **Forecast year end outturn** - Based on month 10 financial reporting, This is mitigated to a degree by forecasting techniques that factor in previous 3 year trends and current provider capacity positions.
- **Reinstatement of non recurrent write backs** - Arising from prudent 2015-16 year end provisions, predominately for IPC approvals and English forecast activity that did not materialise post year end.
- **Assessment of recurrent and adjustments for non recurrent performance** - Judgement of in year recurrent performance has been undertaken and reviewed in conjunction with programme teams and providers, considering forecast demand and capacity.
- **Full year impact of developments** - Developments approved in 2016-17 have been assessed and adjusted for any additional pressures or provider capacity delays in implementation. This includes the full year impact of funded 'high risk amber' sustainability investments in Neurosciences and Immunology which were not originally resourced in the 2016-19 ICP, however the overall full year impact is within the year 2 ICP indicated provision.
- **Indicative growth provisions** have been included to address known demand growth in contracts for PET scanning and Haemophilia blood products. As per the year 2 of the 2016-19 ICP further patient growth in low volume, high cost drug packages for rare blood and inherited metabolic disorders have been factored into the rollover position. Additional provisions for in year emerging issues such as private sector contract inflation in Mental Health and Renal have also been included.

- **Mitigating savings** of £1.4m have been identified which part offset some of the growth pressures. These include procurement savings from blood products, high cost drug dosage reductions, and the part year impact of savings realised from the successful implementation of the All Wales Blood Service in May 2016 and repayment of the WG loan ahead of schedule.
- In order to produce a financial plan that was balanced to Health Board provisions a further plan for £0.25million of **localised savings** has been included for ABUHB and CTUHB commissioners, this reflects the anticipated efficiencies that can be achieved from value based work reviewing referral pathways and treatment variation in the Specialist Cardiology baseline at CVUHB provider. It was focus on testing the increase in usage of high cost cardiac devices in 2016-17 and explore device costs.
- This revised plan also assumes £0.5million of the **new treatment fund** will be accessed in year 1 to resource mandated new technologies approvals for a small number of patients where the commissioning responsibility and expenditure mechanism falls within WHSSC.

7.3 Financial Plan - Impact of 2016-17 Performance and 2017-18 pressures

The financial position reported at month 10 and used for planning purposes was a forecast Specialised Services under spend of £5.165m. This was reviewed at month 11 and a further £0.434m of material improvements in the CVUHB and ABMUHB provider Cardiology and Cardiac Surgery contracts were adjusted into the plan.

Wales

- The CVUHB provider over performance of £2.2m is a major driver in the overall Welsh provider forecast of £2m. This particularly impacts south east Wales commissioners (ABUHB, CVUHB, CTUHB). The forecast overspends in services such as Specialist Cardiology £1.4m, Adult Cystic Fibrosis £0.4m, Haemophilia £0.4m and Spinal care are initially provided for recurrently reflecting demand growth. This position included £1m underperformance on the interim additional Cardiac Surgery capacity required for south west Wales and this has been deemed recurrent and the baseline reduced accordingly. *Cardiology overperformance will be the subject of review under the value based commissioning programme planned for 2017-18.*
- ABMUHB provider contract forecast overspend of £0.4m can be attributed to over performance in Cardiology £0.6m, Thoracic Surgery £0.2m and Cardiac Surgery £0.3m. With the Cardiac Surgery performance a result of a significant expansion in TAVI cases which

poses a risk for the 2017-18 plan if growth continues. Despite this over performance the outlook for west Wales Commissioners is broadly breakeven. *Cardiology overperformance on TAVI and ICDs will be the subject of review under the value based commissioning programme planned for 2017-18*.

- BCUHB provider contract remains stable with over performance in ICD's assumed recurrent and a provision for growth in current PET indications made of £0.2m.
- CTUHB provider contract has experienced a significant non recurrent underperformance of £0.7m in Tier 4 CAMHS provision, however this has been returned to baseline recurrently recognising increased unit occupancy towards the latter quarter of 2016-17.
- Velindre provider contract is broadly within baseline for the core cancer service LTA, however growth in the pass through drug treatments for new 2016-17 Melanoma approved technologies and horizon scanning for pending 2017-18 approvals have been provided for in the full year effect of the Melanoma pathway scheme. The methodology used to forecast this 2017-18 impact of £1.5m has been derived collaboratively from the establishment of the Velindre Joint Commissioning group. The position excludes the outcome of an arbitration commenced by Velindre for the 2017-18 financial year related to pay inflation provision.
- The 2017-18 Welsh Government allocation letter has indicated provider inflation agreement of 2% be intra traded between LHB's and Trusts, this inflation will be applied to 2016-17 opening baselines net of any pass through costs. This is a net £6.996m contribution for commissioners and distributive effect is highlighted in the plan.

England

- The English provider contract forecast overspend position of £0.42m is cast on tailored forecasting by provider, factoring in 3 year trend analysis and provider volatility. A further growth provision of £0.9m is provided for English activity growth which equates to an uplift in rollover baselines of 1.4%.
  The 2016-19 ICP included high levels of investment required and made by BCU (9% growth) and Powys (8% growth) in the English provider growth. The outlook for 2016-17 is that the position appears to have stabilised and the financial provision holding at a recurrent breakeven baseline position.
  However, at this stage, negotiations between NHS England and NHS Wales are ongoing as to the impact of HRG4+ price inflation on Welsh Commissioners and whether any allocation adjustment will be offered as mitigation. Early assessment of the impact of HRG4+ on Specialist

Services providers is contract price inflation of approximately 10%. To date there is a known minimum gap of circa £5m increased prices for a small number of providers. Prices increases have been particularly high in specialised cardiac services and highly specialised paediatric services. An impact assessment on remaining providers is ongoing and is highly sensitive to casemix. The high end risk is extrapolated as up to £10m.

- The Individual Patient Commissioning overspend of £1.2m is deemed recurrent and is caused by two low volume high cost interventions in particular:
    - In year growth in Proton Beam Therapy of £0.7m. This remains a further risk in 2017-18 as demand continues. The forecast for 2018-19 is for unit prices to decrease as new UK providers come on line. However, this is likely to be offset by increases in demand as the evidence base and indications for PBT expands.
    - £1.2m pressure in recognition that anticipated Enzyme Replacement Therapy drug savings are unattainable due to emerging clinical evidence of adverse patient safety when switching drug regimes. The net costs of treating rare chronic conditions with very high cost drugs continues to grow as new patients are identified.

- Mental Health budgets are broadly reinstated to the baseline 2016-17 baseline with contract inflation provided for High Secure providers of £0.64m
- The 2017-18 will be the first financial year that the Renal Network will not be able to live within initial ringfenced resources. The outturn for 2016-17 was a small under spend of £0.3m against the ring fenced budgets, this has not been reinstated in full with £0.45m of Renal Transplant underperformance viewed as recurrent. However, new provision has been made for renal network pressures including growth in renal replacement therapy of £0.8m and independent sector provider dialysis contract inflation of £0.7m both of which are regarded as unavoidable. The overall position across the renal network will be reviewed in line with dialysis performance. In addition, funding has been set aside for additional transplantation for North Wales of £0.153m and the non recurrent transportation risk provision of £0.303m.

7.4 Choices and Risks 2017-18

Once factoring in the forecast year end under spend, adjustments for non recurrent write backs and performance, the underlying recurrent financial

position is a requirement of £4.9m, of which £3.6m is attributed to the three south east Wales commissioners.

Adding to this the £5.9m full year effect of 2016-17 developments and comprehensive unavoidable growth provisions of £5.3m the additional requirement before any new technology developments, emerging RTT pressures or sustainability issues are considered is £16.2m which is equivalent to an overall uplift of 3%. This reduces to 2.8% when offsetting the mitigating savings identified of £1.4m.

As described in Chapter 5, the plan development process for new developments and pressures had four distinct inputs:

- WHSSC recommendations;
- Management Group workshop rankings;
- Prioritisation Panel assessment of new technologies; and
- Clinical Impact Assessment Group (CIAG) review.

In March 2017 the Joint Committee were presented with four ICP options to consider for approval, each option containing an aggregated level of risk:

- Technical Plan (Requirement of £19.030m)
- Interim Funding Plan (Requirement of £18.225m)
- Confirmed Funding Plan (Requirement of £16.993m)
- Reverse Funding Plan (Requirement of £15.134m)

Option 3, the confirmed funding plan was approved (subject to further work with CTUHB and ABUHB) which was balanced within the overall Health Board confirmed funding provision for specialised services. This option was refined through further evaluation post Joint Committee, reducing the overall requirement to £16.269m and ensuring alignment with all HB individual provisions.

This revised requirement represents a £6.7m reduction from the January submission of the ICP and the consequence of this position is a greater number of risks inherent within the baseline planning assumptions, less flexibility to respond to changes and a growing number of priorities deemed as high risk but not resourced.

The value based commissioning framework detailed in the next section is designed to help identify opportunities for improved value including disinvestment, re-allocation and cost reduction. Early opportunities that could be realised from this framework can be utilised to offset the affordability gap

presented within the highest unfunded risks or the emerging pressures that have been identified in this planning round and may materialise in year.

7.5 Value Based Commissioning Framework

The implementation of the ICP will include the development of a value based commissioning framework designed to identify and secure improved value, increased efficiency and opportunities for decommissioning. The framework uses the same principles and approaches inherent in the all Wales efficiency framework but focused through the lens of commissioning.

The framework recognises that there will be different commissioning value opportunities arising which will vary across the service portfolio. Commissioning opportunities will differ according to whether they are commissioned from different health systems and the nature of the activity. A critical issue that will help unlock the potential that exists is the importance of working across the whole pathway. It is essential therefore that this work is jointly undertaken in full partnership with and participation of health boards.

Targets for technical efficiency will include:

- Higher volume services provided by Welsh providers – securing improvements in length of stay and operational efficiency to deliver the best from current investment; reducing delayed transfers into and out of specialised services;
- Reviewing comparative prices and securing improvements
- Exploiting opportunities for standardisation and national procurement for pass-through cost components.
- Optimising prescribing – assessment of sustained benefit; baseline measurement; volume; wastage; switching; centralisation

Diagram 21 – Technical Efficiency Opportunity

8

The commissioning potential from **targets for allocative efficiency** have the greatest potential but are more challenging to achieve and will include:

- New technologies and interventions – prioritisation and evidence review to target best value and health gain;
- Pathways – reviewing to ensure equity and clarity; ensure more effective alternatives at both ends of pathway;
- Referral management – ensuring improved value of referrals by gatekeeping, MDTs, informed patient choice;
- Health gain – exploring approaches to access thresholds; consistent application of policies to target best effect and INNU; and
- Access rates – comprehensive comparison of access rates differentials between health boards and with other countries to identify opportunities including disinvestment.

Diagram 22 – Allocative Efficiency Opportunity

7.6 Capital Programme Requirements

The following service improvements are linked to the capital programme developments in Welsh Health Boards and Trusts over the period of the ICP:

- Cystis Fibrosis development Llandough Hospital (CVUHB);
- Neonatal intensive care capacity University Hospital of Wales (CVUHB) and Singleton Hospital (ABMUHB);
- Relocation of Spinal and Neuro-Rehabilitation services from Rookwood to Llandough Hospital (CVUHB);
- Positron Emission Tomography (PET) scanning capacity – requirement for additional fixed site in Swansea (ABMUHB); plus additional capacity

for south east Wales either at University Hospital of Wales (CVUHB) or Velindre; either fixed site or increased mobile facilities in north Wales (BCUHB);
- BMT improved ward facilities in University Hospital of Wales (CVUHB); and
- Thoracic surgery – if the strategic review currently in progress recommends a single centre for south Wales then capital works likely to be required at either University Hospital of Wales (CVUHB) or Morriston Hospital (ABMUHB).

7.7 Risk Sharing

The financial position set out in the ICP at this point currently excludes any changes to risk sharing.

In the 2016/17 financial year the Joint Committee considered and approved in principle a revised risk sharing framework subject to resolution of a range of technical issues and questions. The remaining technical issues were considered by the Directors of Finance Group in April 2017 resulting in a clear consensus position. This advice is being presented to the Joint Committee on 30th May 2017 with the following recommendations:

- The introduction of a new risk sharing framework was supported and that the impact of change should be neutralised to an appropriate point of time in order to reflect uncertainties in the original baseline and previous decisions.
- The selection of any neutralisation point would be a compromise but the end of 2013/14 financial year is agreed as a reasonable compromise as it addressed some of the concerns around the age and accuracy of information, honoured the material components of agreed contract rebasing and retained some referral management improvement benefits.
- The introduction of the new framework would be phased in over a three year period subject to the impact of an agreed cap as indicated below.
- A cap should be agreed by the Joint Committee for the maximum additional adverse annual movement for any one health board and should be in the range of a minimum £0.5m and a maximum £1m to ensure that the overall financial position of individual health boards is not compromised.
- The recommended calculation method would be amended to ensure that the income contributions from health boards are fully accounted for in any gap analysis.

Subject to agreement by the Joint Committee WHSSC will progress via the established Finance Sub Group to implement the proposed changes commencing in the 2017/18 financial year.

The new risk sharing framework allocated financial risk on the basis of three risk pools which share differing levels of financial risk broadly aligned to the degree of volatility and avoidability. The underlying principle is an increased moved towards aligning income and usage. The three pools are:

- Utilisation Pool – for the majority of services including high volume and lower unit cost where population utilisation is more stable over time. This pool includes cardiac surgery, thoracic surgery, cardiology and neurosurgery.
- Club Pool – for high cost and low volume services which are unpredictable, unavoidable and can vary for no reason between health boards. This pool includes very high cost drugs and IPFR.
- Pay As You Go Pool – for use in exceptional circumstances where an individual health board wishes to repatriate services on a planned basis and needs the funding to follow the activity more quickly.

Health Boards will continue to share in year risk and utilisation shares will be updated at the end of each financial year to inform next year contributions. The key difference to the historic risk sharing arrangement is that for the utilisation pool the contributions of health boards will now eventually align in full to match relative utilisation as opposed to only marginal changes.

7.8 Summary Financial Plan

Table 22: Financial Impact 2017/18 by Commissioner

	ABM UHB £m	Aneurin Bevan UHB £m	Betsi Cadwaladr UHB £m	Cardiff & Vale UHB £m	Cwm Taf UHB £m	Hywel Dda UHB £m	Powys THB £m	2017/18 Total £m
2017/18 Opening Allocation	**93.775**	**101.621**	**118.366**	**92.871**	**48.139**	**57.710**	**21.574**	**534.056**
M10 Forecast Performance	(0.206)	(0.800)	(3.575)	(0.111)	0.117	0.018	(0.609)	(5.165)
M11 Forecast Adjustments	(0.115)	(0.022)	0.065	(0.093)	(0.027)	(0.100)	(0.141)	(0.434)
Reinstate Non Recurrent Writebacks	0.612	0.612	2.460	0.753	0.366	0.457	0.452	5.712
Adjustments for NRP	0.291	1.152	1.365	1.507	0.187	0.082	0.178	4.760
Full Year Effect of 16/17 Developments	1.065	1.444	0.262	1.510	0.856	0.638	0.151	5.928
Growth in IPC, Contract Activity & Inflation	0.619	0.887	1.819	0.787	0.547	0.445	0.249	5.353
Underlying Deficit & Growth	**2.267**	**3.274**	**2.396**	**4.353**	**2.046**	**1.541**	**0.279**	**16.154**
Mitigating Savings	(0.152)	(0.407)	(0.238)	(0.215)	(0.216)	(0.106)	(0.066)	(1.401)
Red Schemes - Mandated	0.043	0.049	0.059	0.039	0.025	0.033	0.011	0.258
Red Schemes - WG directed & prior commitments	0.143	0.048	0.047	0.053	0.028	0.119	0.023	0.459
Red Schemes - Unavoidable growth	0.133	0.150	0.183	0.120	0.077	0.101	0.036	0.800
Total Savings & Recommended Schemes	**0.167**	**(0.161)**	**0.050**	**(0.004)**	**(0.086)**	**0.146**	**0.003**	**0.116**
HB Uplift Required to Fund Baseline & Recommended Schemes	**2.434**	**3.113**	**2.446**	**4.349**	**1.959**	**1.687**	**0.282**	**16.269**
HB Commissioner Contribution to 2% provider inflation	1.491	1.438	0.902	1.426	0.738	0.824	0.177	6.996
2017/18 WHSSC Total Requirement for Commissioners	**97.700**	**106.172**	**121.714**	**98.646**	**50.836**	**60.221**	**22.032**	**557.321**

Table 23: 3 Year Outlook – WHSSC Integrated Commissioning Plan 2017/20

	2017/18 Total £m	2018/19 Total £m	2019/20 Total £m
2017/18 Opening Allocation	534.056	534.056	534.056
Recurrent Position	10.801	11.215	11.215
Growth in IPC, Contract Activity & Inflation	5.353	8.122	12.082
Underlying Deficit & Growth	**16.154**	**30.841**	**47.801**
Total Savings & Recommended Schemes	**0.116**	**0.738**	**0.738**
HB Uplift Required to Fund Baseline & Recommended Schemes	16.269	31.579	48.539
HB Commissioner Contribution to 2% provider inflation	6.996	6.996	6.996
2017/18 WHSSC Total Requirement for Commissioners	**557.321**	**572.631**	**589.591**

8

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

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

8.1 Overall Approach to Risk Management

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

The aim of the Risk Management Policy is to:

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

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

The Corporate Risk and Assurance Framework forms part of the WHSSC approach to the identification and management of strategic risks. The framework is subject to continuous review by the Executive Director lead, Corporate Directors Group, Management Group, Joint Committee and joint sub-committees.

It is for the Joint Committee to determine whether there is sufficient assurance in the rigour of internal systems to be confident that there are adequate controls over the management of principal risks to the strategic objectives.

The CRAF is informed by risks identified by the Programmes, Networks, Directorates or Executives. Each risk is allocated to an appropriate committee for assurance and monitoring purposes, for example Joint Committee, Audit Committee or 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. The Corporate Governance Manager is also a member

of the CTUHB Quality and Risk Committee (formerly the CTUHB Corporate Risk Committee).

To support the CRAF WHSSC has a risk appetite statement:

Risk Appetite Statement

WHSSC is working towards an "open" risk appetite.

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

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

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

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

8.2 Risk Management of the Integrated Commissioning Plan

8.2.1 Risks to Quality, Outcomes and Sustainability of Services

During 2016-17 the approach to the risk management of the ICP has been developed. All schemes which were not approved for inclusion in the ICP have been risk-assessed on a monthly basis and exception reports have been provided to the Management Group for consideration where the risks have changed. This risk profile has been used to inform the development of the 2017-20 ICP.

8.2.2 Risks to Delivery of Key Targets and Priorities

As outlined in **section 4.6**, over the course of 2016-17 enhanced performance management arrangements have been implemented for:

- Bariatric surgery (ABMUHB);
- Cardiac surgery (ABMUHB, CVUHB and LHCH);
- Posture and mobility (wheelchairs) (ABMUHB, BCUHB, and CVUHB);
- Plastic surgery (ABMUHB);

- Paediatric surgery (CVUHB);
- PET-CT (Cardiff University);
- Neurosurgery (CVUHB); and
- Thoracic surgery (ABMUHB and CVUHB).

8.2.3 Risks to Delivery of the ICP 2017-20

There are similar risks in this ICP to those described in the previous ICP; the unknown impact of new in-year NICE approvals, and unavoidable service pressures that emerge throughout the course of 2017-18. The current advice is that during 2017-18, NICE in-year approvals may include competitor high-cost drugs and this may provide opportunities to mitigate other unforeseen pressures.

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

9 Governance and Accountability Framework

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

The Joint Committee reviewed the Governance and Accountability Framework in November 2015. In reviewing the current arrangements, the Joint Committee acknowledged that there is still further internal work to do to take into account the outcome of the HIW Review and the GGI Review.

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

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

9.1 NHS Wales Core Principles (2016)

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

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

They state:

- We put patients and users of our services first
- We seek to improve our care
- We focus on wellbeing and prevention
- We reflect on our experiences and learn
- We work in partnership and as a team
- We value all who work for the NHS.

9.2 Access to advice

WHSSC requires access to clinical advice for both strategic and operational purposes. In addition, WHSSC's strategic work requires public health support.

A number of sources of advice are used including:

- Patient representatives, organisations and third sector bodies representing the public and patients;
- Individual expert clinicians;
- 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 directors; and
- All Wales Medicines Strategy Group/Welsh Medicines Partnership.

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

The Joint Committee is established as a statutory Sub-Committee of each of the LHBs. It is led by an Independent Chair, appointed by the Cabinet Secretary for Health, Well-being and Sport, and membership is made up of three Independent Members, one of whom is the Vice Chair, the Chief Executives of the 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 the adequacy of these arrangements to the Chair of the Joint Committee and Chief Executive of CTUHB. Under the terms of the establishment arrangements, CTUHB is deemed to be held harmless and have no additional financial liabilities beyond their own population.

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

9.2.1 Joint sub-committees

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

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

The Quality and Patient Safety Committee is chaired by an Associate Member, the Integrated Governance Committee is chaired by the Chair of the Joint Committee and the Welsh Renal Clinical Network is chaired by the Lead Clinician for the Network, who is also an Associate Member of the Joint Committee.

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 the specialised services commissioning operational body responsible for the implementation of the Specialised Services Strategy. The group underpins the commissioning of specialised services to ensure equitable access to safe, effective, sustainable and acceptable services for the people of Wales.

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

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

The **Audit Committee** of the CTUHB, as host organisation, advises and assures the Joint Committee on whether effective arrangements are in place – through the design and operation of the Joint Committee's assurance framework – to support them in their decision taking and in discharging their

accountabilities for securing the achievement of the Joint Committee's Delegated Functions.

The relevant officers from WHSSC are in attendance for the WHSSC components of the CTUHB Audit Committee.

9.2.2 Advisory Groups and Networks

The Joint Committee has also established five 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
- Wales Child and Adolescent Mental Health Services (CAMHS) and Eating Disorders (ED) Planning Network Steering Group
- Wales Neonatal Network Steering Group

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

The **All Wales Mental Health and Learning Disability Collaborative Commissioning Group** advises the Joint Committee on issues regarding the development of secure mental health services for Wales. The group ensures that there is a co-ordinated approach to secure services across Wales and that the benefits of working collaboratively are realised.

The terms of reference of this group have been reviewed and Carol Shillabeer, Lead Chief Executive for Mental Health Services has agreed to chair the Group. In year, at the request of Welsh Government, the group's name was changed from the Secure Service Delivery Group to the Mental Health and Learning Disabilities Collaborative Commissioning Group to ensure there is no confusion between this NHS Group and the Welsh Government's Secure Service Advisory Group.

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

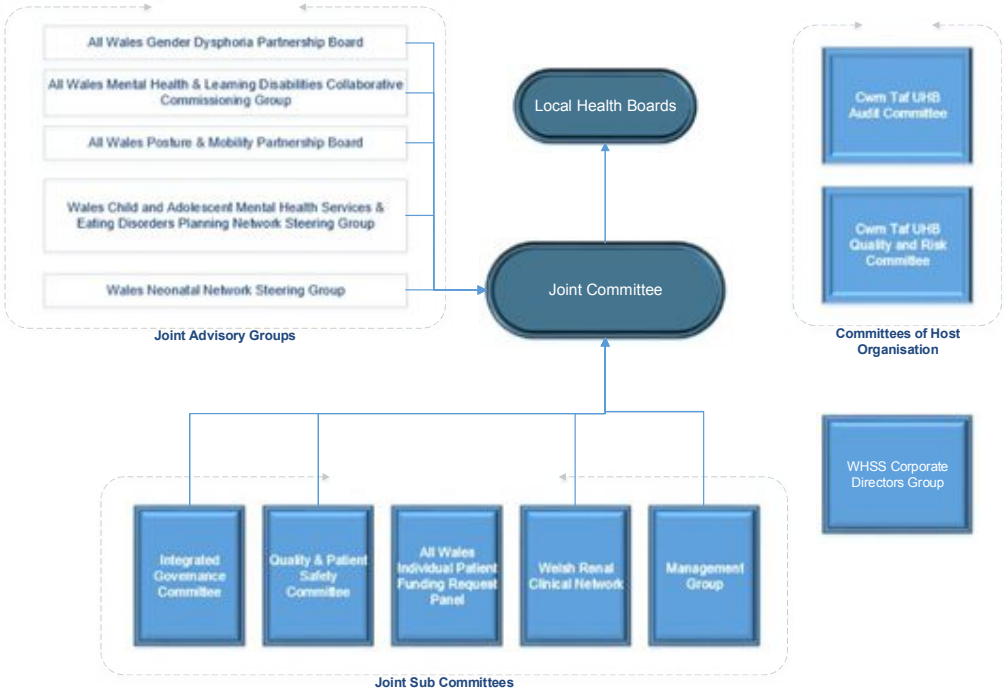
delivering in line with the All Wales Service Specification and advises the Joint Committee on the commissioning strategy for Posture and Mobility services, including identification of, and supporting opportunities for embedding coproduction as a core principle of the commissioning strategy.

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

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

Formal meetings of the Joint Committee are held in public and are normally held bimonthly. The agenda and papers are available on the website: www.whssc.wales.nhs.uk. Diagram 24 below shows the reporting arrangements.

Diagram 23 – WHSSC Reporting Arrangements



9.2.3 Other Governance Drivers

Good Governance Institute Governance Review

The GGI was commissioned to undertake a review of the governance review of WHSSC in July 2014.

The final report was received in October 2015 and was considered by the Joint Committee in January 2016. At that time the Joint Committee acknowledged that the there had been a number of notable improvements in addressing some of the issues highlighted in the report and approved the further work required, which was incorporated into an action plan.

It was accepted that many of the recommendations in the report were structural, some would require the support from the Joint Committee and also required changes to the Regulations and Directions.

The action plan contained 29 actions, excluding those beyond the control of the Joint Committee, of which 20 were completed by December 2016.

The Managing Director, Designate, and Committee Secretary have begun a review of Management Group which will take into the account the views of all Joint Committee members and the existing members of Management Group. It is anticipated that this will result in a report to the Joint Committee with recommendations in the summer of 2017.

The Joint Committee has agreed that a number of the outstanding actions require additional resource in order to achieve progress.

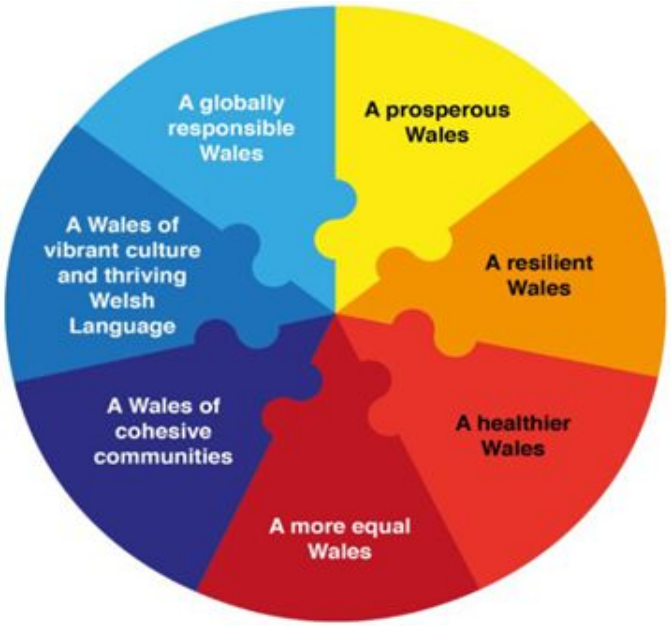
Progress against the resulting action plan became a "business as usual" activity from March 2017 but continues to be monitored by the relevant assurance Joint-Sub Committees.

Health Inspectorate Wales Clinical Governance Review

HIW have undertaken a Clinical Governance review of WHSSC, in order to understand the clinical governance arrangements that WHSSC has in place and how these relate to patient outcomes.

The Well-being of Future Generations (Wales) Bill 2014 The Wellbeing Act 2015 requires public bodies to seek to achieve seven long-term goals as part of carrying out sustainable development. The Welsh Ministers must measure progress against the goals and report annually. These goals are:

Diagram 24 – The Well-being of Future Generations



The Act references the five ways of working and WHSSC will continue its development work to contextualise these to the commissioning cycle. Examples may be:

- **Long-term thinking** - balancing short-term needs with safeguards to meet long-term needs – e.g. strategic reviews to inform the three year Plan;
- **Prevention -** actions to prevent problems getting worse – e.g. Shift to the Left**;**
- **Integration** - considering how our objectives may impact on those of others – e.g. impact on LHBs and LAs;
- **Collaboration** - working with other bodies (which may include third sector organisations) that can help us meet our goals – e.g. working with LHBs and LAs and patient groups; and
- **Involvement** - involving people and communities with an interest in helping us meet our objectives, and reflecting the diversity of the people in our area – e.g. engagement with clinicians, service users, and third sector.

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

In November 2015 the Joint Committee approved the revised Governance and Accountability Framework.

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

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

10 Monitoring, Delivery and Assurance

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

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

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

Over the next three years WHSSC will continue to improve its performance management and assurance processes through a combination of benchmarking, peer review and the use of internal and external audit reviews.

10.1 Monitoring Delivery and Assurance of Provider Performance

Over the three years, WHSSC will continue to develop its provider performance management arrangements, and this will include regular focused meetings with providers to review and evaluate delivery against the following areas of performance:

- Patient experience and outcomes;
- Quality indicators;
- Service performance indicators; and
- Financial performance.

10.2 Monitoring Delivery and Assurance of the Service Quality, Patient Experience and Outcomes

This is discussed in full in **Chapter 3**.

10.3 Financial Plan

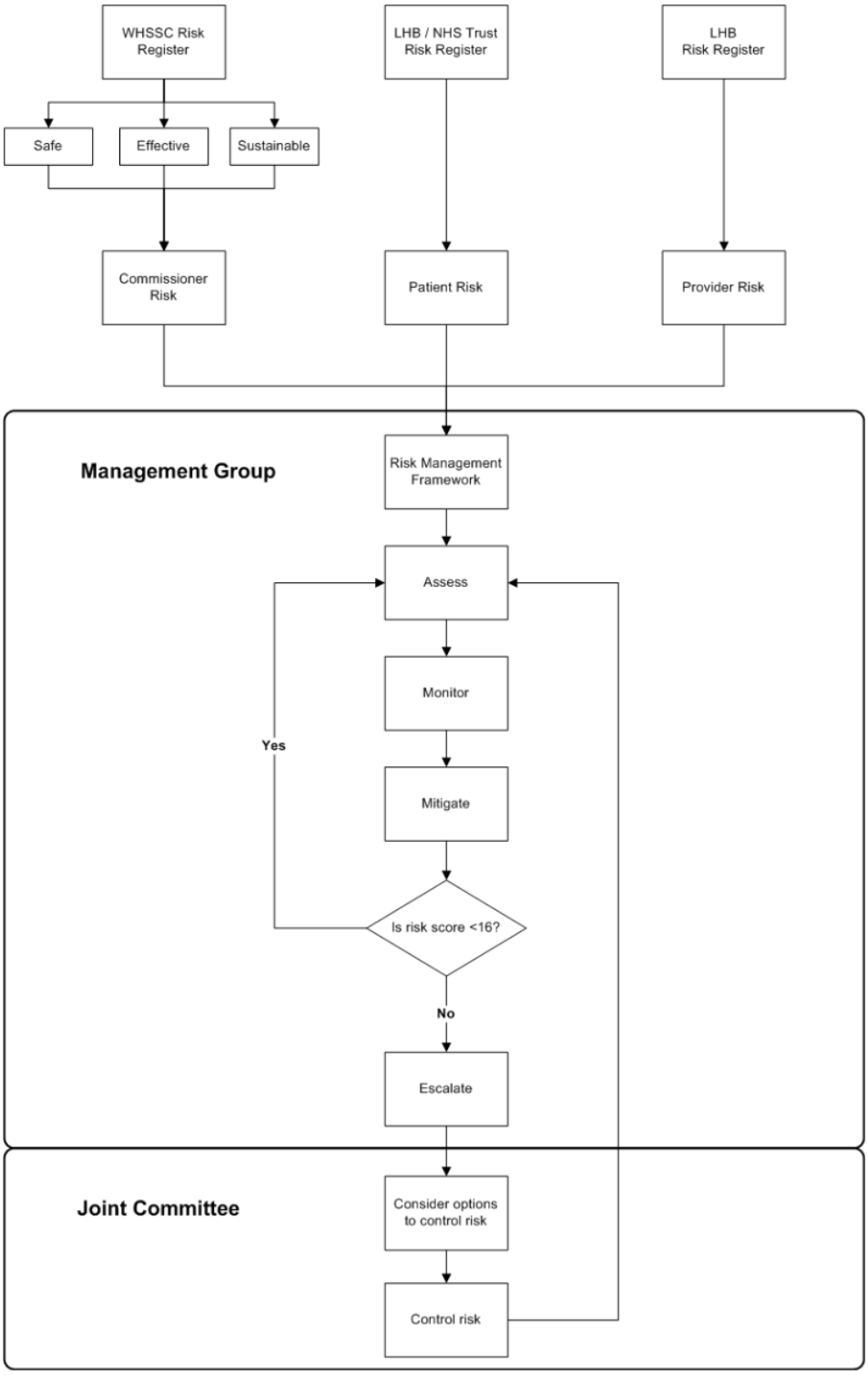
The financial plan is monitored on a monthly basis by the Corporate Directors Group and Management Group. The role of the Management Group is to apply scrutiny to decisions that are made to release funding from the ICP and to authorise the release of funding from the ICP. In 2017-18 this will be further developed to provide further information on the service impact of the ICP. The Joint Committee is accountable for the overall financial performance of the organisation.

10.4 ICP 2017-20 Risk Management Framework for the Integrated Commissioning Plan

The progress against the delivery of the ICP and associated risks will continue to be monitored through the process described in **Section 6.5** with monthly reports to the

Corporate Directors Group and Management Group and reports to each Joint Committee meeting.

Diagram 25 – WHSSC ICP Risk Management Framework



The approach outlined in the previous chapters has enabled WHSSC to reduce the requirement from Health Boards by over £6 million, however the consequence is that there are a greater number of risks inherent within the baseline planning assumptions than in previous years. In addition to this, there are further risks related to each of the unfunded schemes which have been identified as priorities.

For each of these schemes, there are three domains under which risk will present:

- **Patient (Resident Health Board)** - assessed by Resident Health Board
- **Provider** - assessed by Specialised Provider
- **Commissioner (Health Board + WHSSC)** - assessed by WHSSC Commissioning Team

Risks for each of the domains will be scored using a standard impact x likelihood risk assessment methodology, using a 5 x 5 matrix. Risks scoring higher than 16 will be reviewed by the Management Group on a monthly basis, and those scoring less than 16 will be reviewed on a quarterly basis. Management Group will assess, monitor and mitigate risk using the open source model, and where necessary will escalate extreme or high risks, which do not respond to mitigation, to the Joint Committee for resolution.

The aim is to utilise existing processes to support the development of the risk management framework. Therefore, each organisation will use risk scores from their current risk registers to provide the score for the 'Patient' and / or 'Provider' domains on the risk management framework. The WHSSC risk register will also be used to populate the risk management framework, for the 'Commissioner' domain.

11 List of Annexes

Annex 1 – WHSSC horizon scanning and prioritisation methodology
Annex 2 – WHSSC clinical impact assessment group methodology
Annex 3 – WHSSC's Commissioning Intentions 2017-18
Annex 4 – Outstanding schemes from 2016-19 ICP as of 31st March 2017
Annex 5 – ICP Risk Management Framework as of May 2017

12 Glossary of Terms

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

	>1million
Velindre	Velindre NHS Trust
WAST	Welsh Ambulance Service NHS Trust
WHSSC	Welsh Health Specialised Services Committee
WHSST	Welsh Health Specialised Services Team
Wte	Whole time equivalent

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Overview of the WHSCC Prioritisation Process 2017/18

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1. Introduction

NHS Wales and WHSSC must ensure that investment decisions are (i) affordable and offer value for money, (ii) supported by convincing evidence of safety and effectiveness and (iii) made using a process that is consistent and transparent. To achieve this WHSSC has developed a process that enables it to compare competing proposals for new investment so that these can be prioritised and subsequently implemented.

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. Therefore ensuring best value for money and that the NHS in Wales can effectively commission services, making new treatments which offer clinically and cost effective interventions available, in a timely manner, requires the dual processes of *horizon scanning* and *prioritisation* (see section 2). Horizon scanning identifies new interventions which may be suitable for funding and prioritisation allows them to be ranked in terms of clinical and cost effectiveness. This information when combined with information around demands from existing services and interventions will underpin and feed into the development of the WHSSC Integrated Commissioning Plan (ICP).

This paper describes the methodology that WHSSC will be using in order to determine the relative prioritisation of specialised services for 2017/18. This methodology has been adapted from the model used by WHSSC last year and incorporates several elements from other published Prioritisation Processes, particularly those used by NHS England [1, 2].

Your role in this process

All Panel members will be asked to form recommendations on the relative prioritisation of clinical commissioning policies which are proposed for routine commissioning by WHSSC in 2017/18.

Your eventual recommendations will be considered by the Joint Committee at WHSSC which will be asked to make a final decision on new investments in specialised services in January 2017.

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2. Horizon scanning and prioritisation of new interventions by WHSSC for funding in 2017/18

2.1 Horizon Scanning

Horizon scanning requires a systematic examination of all relevant information sources in order to identify new and emerging technologies (see below). A comprehensive horizon scanning exercise was carried out by the All Wales Therapeutics and Toxicology Centre (AWTTC) and WHSCC in May 2016 to inform this process. A finalised record is available from the Medical Directorate at WHSSC.

Information sources accessed:

- NICE Highly Specialised Technologies (HST) work programme
- NICE TA work programme
- Other NICE guidance. There are a range of different types of guidance produced by NICE which are not mandatory. Of these the Interventional Procedures Guidance (IPG) and Medical Technologies Guidance are the areas most likely to impact on specialised services
- All Wales Medicines Strategy Group (AWMSG) evidence appraisal work programme
- Interim Pathways Commissioning Group (IPCG). This group considers an unlicensed medicine or one outside of the normal treatment pathway identified via the 'One Wales' process.
- Individual Patient Funding Requests (IPFR). The IPFR process often provides early indications of clinical demand for new treatments
- Provider Health Boards and Trusts
- NHS England propositions (see section 2.5)
- Scottish Medicines Consortium
- Northern Ireland and Social Care Board
- Clinicians with a special interest in a clinical condition may lobby for commissioning of emergent therapies
- Schemes considered for inclusion in the 2016/17 ICP but excluded on the basis that an evidence appraisal would be required
- Welsh Government strategic priorities.

The horizon scanning process generated three lists.

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

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

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

2.2 Prioritisation of new interventions

The following key principles have been applied:

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

2.3 The method of prioritisation

The principle steps within a prioritisation process are (i) evidence evaluation; (ii) policy development including equality impact assessment; (iii) scoring to develop a ranking of interventions. It is worth noting that NHS England have established a new and very comprehensive, prioritisation process for 2016 [1]. The output of this process has been considered within the development of the revised prioritisation process in Wales for 2016-17.

A prioritisation process also exists in NHS Scotland and this is managed by their National Specialised Services Committee [2]. We have also considered international prioritisation processes during development of this methodology including the system favoured in Canada [3].

2.4 The Prioritisation Process in Wales

Below describes the steps required. A schematic overview of the process is presented in Appendix A.

1. **Cross referencing to other UK policy positions where a cost avoidance case has already been made.** These are policy propositions given a positive recommendation by the Clinical Priorities Advisory Group (CPAG) in England. (https://www.england.nhs.uk/2016/07/spec-services-investment/). We have assumed that these will be applied in Wales and will therefore not be part of the prioritisation process (see Appendix B).
2. **Cross referencing to other UK policy positions where an evidence evaluation has been made**. This is to ensure that

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where a recent evidence evaluation has been carried out this is not unnecessarily duplicated in Wales.

3. **Identifying those remaining interventions where a full evidence evaluation is required** or where updating an existing evidence evaluation is needed.
4. **Commissioning an evidence evaluation**
5. **Developing a policy proposition based on the evidence evaluation**. This policy proposition may either be positive or negative. A WHSSC Policy Governance Group will oversee this work. Negative policy propositions will be handled through the separate process described below.
6. **Carry out a formal consultation on the policy proposition (including the evidence evaluation) and undertake an EIA.** Both positive and negative propositions will be issued for consultation.
7. **Undertake a scoring and ranking process**. This work will be carried out by the 'Prioritisation Panel' based on methodology described in the All Wales Prioritisation Framework (2011) (see: Attachment 4).
8. **Undertake a quality assurance (QA) review of the process**
9. **Assuming satisfactory sign off via the QA process products will feed into the wider WHSSC prioritisation process** which includes the development of existing services and interventions. Only following completion of this stage will the decision regarding routine commissioning be made.

2.5 Policy Prioritisation Process in England (2016)

The outcome of the recently completed prioritisation process in England is summarised below:

- **N = 12** were categorised as 'in year service development'. These were defined as 'cost-saving or cost neutral' and given a positive recommendation (see Appendix B and: https://www.england.nhs.uk/2016/07/spec-services-investment/)

- **N = 36** were endorsed with a negative policy position i.e. not for routine commissioning (see Appendix C and https://www.england.nhs.uk/2016/07/spec-services-investment/). These were identified during the evidence evaluation and policy development process when the evidence for clinical and cost effectiveness was felt to be insufficient for that intervention to be considered within the prioritisation process.

  Given the rigour of this process and quality assurance step to which Wales has direct access WHSSC decided that all negative policy propositions from England i.e. no routine commissioning was considered for implementation within Wales via stakeholder consultation. The consultation process asked stakeholders to assess

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whether there are any additional factors within Wales which might impact on our decision to implement the policy proposition which were not considered within the English context.

The consultation process is now complete. A panel within WHSSC is now reviewing whether the output of the consultation process changes the decision not to routinely commission. Any overturned policies will then be fed into the WHSSC prioritisation process.

- **N = 18** English policies to be routinely commissioned. These have been included in the current WHSSC Prioritisation Process for the Panel to consider (Attachment 5).

  The Clinical Policies Advisory Group (CPAG) in England has already considered these 18 policies during 2016 as part of their own prioritisation process. Policies with the greatest clinical benefit and lowest cost attracted the highest priority recommendation (level 1), while those with lowest clinical benefit and high cost attracted the lowest (level 5). The score for all of 18 interventions can be found here: https://www.england.nhs.uk/2016/07/spec-services-investment/

  There is sufficient funding available in the expanded specialised commissioning budget for 2016/17 to enable the proposals in levels 1-4 of cost/benefit priority to be routinely commissioned. This means that they will be made available to patients who meet the clinical criteria set out in each policy.

  However, this investment remains subject to the outcome of a judicial review which will determine whether NHS England has the power to commission the use of antiviral drugs for the prevention of HIV, given before exposure (known as PrEP, or Pre-exposure Prophylaxis) to individuals who are at high risk of contracting the virus – specifically, men who have condomless sex with multiple male partners.

  Should the High Court decide that NHS England does have the power to commission this preventative service, a clinical commissioning policy on PrEP will need to be finalised, publicly consulted on, and then given a relative priority ranking against the other proposals listed below. This means that the policies in each priority level may change and some of the services provisionally set to be funded could be displaced and not therefore funded.

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3. List of new interventions to be prioritised (2017/18)

The horizon scanning process has identified **27** new interventions for consideration (Attachment 5) which were identified from the following sources:

- IPFR (n = 2)
- Schemes considered for inclusion in the 2016/17 ICP but excluded on the basis that an evidence appraisal would be required (n = 4)
- WHSCC policy review (n = 3)
- NHS England policies to be routinely commissioned following their recent Prioritisation Process (n = 18)

3.1 Evidence evaluations

Each draft Policy Proposition presented to the Panel will be supported by a comprehensive evidence review. A presentation on how the evidence was retrieved and appraised will be provided at the first Panel meeting on the 23rd November 2016. This presentation will also include a brief overview of health economics and the concept of cost utility analyses and cost effectiveness.

The evidence review for each draft Policy Proposition was either carried out by colleagues at NHS England or by the team at Cedar Health Technology Research Centre (Cardiff).

For all the English policy propositions (n = 18) you will presented a copy of the Commissioning Policy document which contains a summary of the evidence. This should be sufficient information for you to score the clinical effectiveness of the intervention. However the full evidence reviews (including the evidence tables) are available on request from WHSSC.

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4 Preparation prior to each Prioritisation Panel meeting

Before each meeting you will be expected to consider each commissioning policy proposal against the five criteria described in this paper (see section 6). You will be asked to score each policy against these criteria to form recommendations on the relative prioritisation of these policy proposals.

At the first meeting Panel members will be asked to agree a relative weighting algorithm for each of these criteria. The 'weighted scores' for each of the interventions under consideration will then calculated and used to rank the topics. This part of the process will be led by Dr Sam Groves (Welsh Health Economics Support Service (WHESS)) using a group decision support system (GDSS) and will be presented in more detail at the first Panel meeting.

You are asked to use your own knowledge and experience when considering each policy. You are not required to submit your preliminary views in advance of each meeting. Instead you should you record your preliminary views in your notes ready for discussion at the meeting. For each proposal you will have the opportunity to discuss the facts as defined in the papers so that any misunderstandings or questions are cleared.

You will be asked to score each intervention (from 1 - 10) against all of the criteria described below. A high score indicates consistency with each of the criteria.

4.1 Criteria for prioritisation

The proposed criteria that will be used in prioritisation are:

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

The review of priorities will take into account how the different criteria work together, including:

- The balance of clinical benefits and clinical risks

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

5 Expected output from the Prioritisation Panel

Once the Prioritisation Panel has considered all the interventions identified via the horizon scanning process and assigned each a mean score, these will be tabulated and presented back to the Panel at their final meeting. Although members will be permitted to discuss the final results, a re-vote on any intervention or a change to the order of the results will be at the discretion of the Chair.

Members will then be asked to split this list into 'high', 'medium', 'low' and 'no routine commissioning' based on their overall % score. These data when combined with information around demands from existing services and interventions will underpin and feed into the development of the WHSSC Integrated Commissioning Plan (ICP) for 2017-20.

5.1 Recommended for 'no routine commissioning'

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

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

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6. Definitions for each of the assessment criteria –a guide for Panel members

This document only serves as a guide to Panel Members – each Panel member must consider their own conclusions and be able to discuss these with other Panel members as part of the prioritisation process.

A] Burden of disease

Assessing this criteria involves a wide consideration of a number of different issues including the (serious) nature of the condition, the size of the population effected (individual, small cohort or large population) and the current availability of (effective) treatments contained within the concept of unmet need. The following serves as guidance to Panel members in assessing 'burden of disease' and highlights some of the considerations each Panel member will need to take.

A1] Serious condition

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

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

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

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

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A2] Unmet clinical need

An unmet clinical need is a condition whose treatment or diagnosis is not addressed adequately by available therapy. An unmet clinical need includes an immediate need for a defined population (i.e. to treat a serious condition with no or limited treatment) or a longer-term need for society (e.g., to address the development of resistance to antibacterial drugs).

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

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

A3] Population impact and reducing health inequalities

This is defined as the number of people who are likely to benefit from the intervention or recommendation? Things to consider include:

- What will implementation of this policy mean for the individual patient/group of patients and the wider community?
- Will this service or intervention contribute to reducing or widening health equalities within Wales?

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

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B] Patient benefit

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

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

Will this intervention have a positive effect on mortality, longevity and health related quality of life?

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

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

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

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

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

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

C] Quality of the clinical evidence

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

However it should be recognised that for much of highly specialist care the quantity and quality of the available evidence can be sparse.

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

The quality of the evidence on the effectiveness of the intervention is described using established methods for grading research evidence. Commissioning policies developed by NHS England have been developed using Scottish Intercollegiate Guidelines Network (SIGN) methodology. The evidence reviews provided by Cedar have used GRADE.

D] Quality of the economic assessment

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

The panel should consider the following

- Has a cost utility analysis been presented? If yes, has this demonstrated that the new intervention is cost effective compared to the existing treatment or intervention?
- Affordability. What are the costs of the intervention, including initial acquisition costs and running costs?

In England in 2016 they assessed the 'incremental cost' of each proposal defined by the 'cost per patient who benefits' over five years from the drug, medical device or intervention. In some cases, not all patients who receive a drug, device or intervention will benefit from it. Thus, a focus on the number of patients of who benefit from it, rather than a focus on the number of patients who are estimated to receive it, offers a more accurate description of cost effectiveness. However, NHS England adopted

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a "cost per patient" approach for 2016/17 where the information contained in the reviews of clinical evidence for the policy proposals did not enable them to identify the "cost per patient benefitting".

E] Equality and human rights

WHSSC and NHS Wales must demonstrate that it understands the potential effect of adoption of clinical commissioning policies on people with characteristics that have been given protection under the Equality Act (2010), especially in relation to their health outcomes. We must also consider both the Social Services and Well-being (Wales) Act (2014) when considering the well-being for people who need care and support (and carers who need support) and the Human Rights Act (1998).

[Professor Harpwood to add further detail here]

Therefore WHSSC should have due regard to the need to:

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

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

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

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References

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

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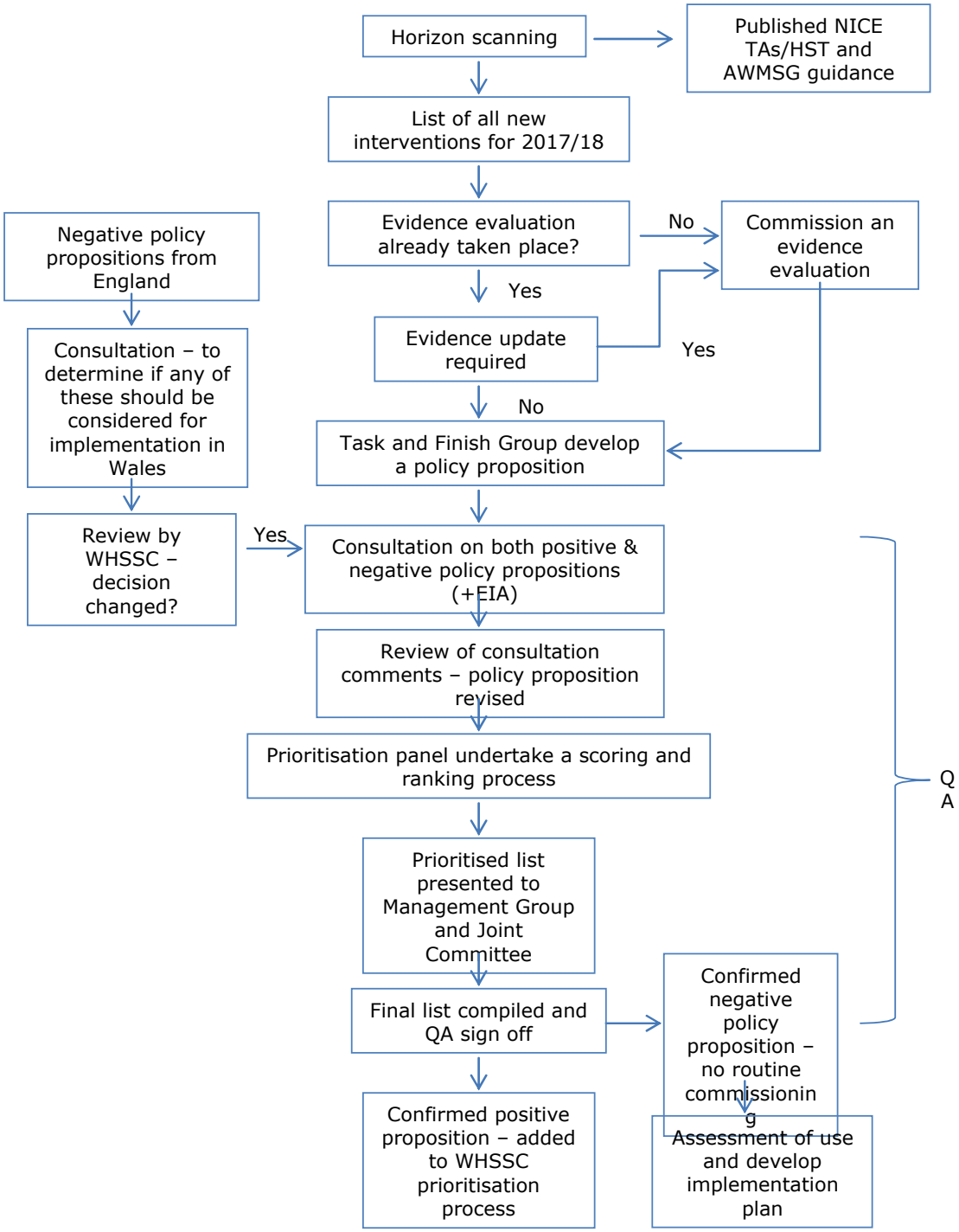
Appendix A: Overview of the prioritisation process for Wales



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Appendix B. NHS England English policy proposals for 'in year service development' 2016/17. These are defined as 'cost-saving or cost neutral' [including reference number]

- Bone conducting hearing implants for hearing loss (all ages) [D09X02]
- Cinacalcet for complex primary hyperparathyroidism [A03X04]
- Immune tolerance induction for haemophilia (all ages) [F02X04]
- Palliative radiotherapy for bone pain [B01X03]
- Prophylactic treatment of hereditary angioedema (HAE) types I and II [F06X04]
- Radiotherapy after primary surgery for breast cancer [B01X04]
- Rituximab for cytopaenia complicating primary immunodeficiency [F06X02]
- Rituximab for dermatomyostitis and polymyostis in adults [A13X05]
- Rituximab for immunobullous diseases [A12X05]
- Surgical sperm retrieval for male infertility (previously commissioned at CCG level) [B14X07]
- Tenofovir alafenamide containing treatments for HIV [F03X08]
- Ureothroplasty for benign urethral strictures in adult men (previously commissioned at CCG level) [B14X06]

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Appendix C. Policy propositions categorised as 'not for routine commissioning' in 2016/17 published by NHS England [including WHSCC consultation reference number – CPXX]

- Extra corporeal membrane oxygenation (ECMO) service for adults with cardiac failure [CP102]
- Everolimus for prevention of organ rejection following heart transplantation [CP103]
- Personalised External Aortic Root Support (PEARS) for surgical management of enlarged aortic root (adults) [CP104]
- Selexipag in the treatment of Pulmonary Arterial Hypertension [CP105]
- Chemosaturation for liver metastases from ocular melanomas [CP106]
- Proton Beam Therapy for cancer of the prostate [CP107]
- Robotic assisted lung resection for primary lung cancer [CP108]
- Robotic assisted surgery for oesophago-gastric cancers [CP109]
- Robotic assisted surgery for bladder cancer [CP110]
- Robotic assisted trans-oral surgery for throat and voice box cancers [CP111]
- Amifampridine phosphate for the treatment of Lambert-Easton Myasthenic Syndrome [CP112]
- Autologous chondrocyte implantation for osteochondral lesions of the talus (adults) [CP113]
- Dornase alfa inhaled therapy for primary ciliary dyskinesia (all ages) [CP114]
- Intravenous immunoglobulin for acute disseminated encephalomyelitis and autoimmune encephalitis [CP115]
- Pasireotide for acromegaly as third-line treatment (adults) [CP116]
- Teriparatide for the treatment of osteogenesis imperfecta (adults) [CP117]
- The use of Stereotactic Ablative Radiotherapy (SABR) in the treatment of previously irradiated tumours of the pelvis, spine and nasopharynx [CP119]
- The use of Stereotactic Ablative Radiotherapy (SABR) as a treatment option for patients with Renal Cancer [CP120]
- The use of Stereotactic Ablative Radiotherapy (SABR) in the treatment of Oligometastatic disease [CP121]
- The use of Stereotactic ablative Radiotherapy (SABR) in the treatment of Prostate Cancer [CP122]
- Ziconotide (intrathecal delivery) for chronic refractory cancer pain [CP123]

Annex 1

- The use of Stereotactic Ablative Radiotherapy (SABR) as a treatment option for patients with Hepatocellular carcinoma or Cholangiocarcinoma [CP124]
- Argus II retinal prosthesis [CP125]
- Tocilizumab for giant cell arteritis (adults) [CP126]
- Deep brain stimulation for central post stroke pain [CP127]
- Fampridine for multiple sclerosis (adults) [CP128]
- Infliximab for the treatment of hidradenitis suppurativa [CP129]
- Continuous aztreonam lysine for cystic fibrosis (all ages) [CP130]
- Stereotactic Radiosurgery (SRS) for adults with Parkinson's tremor and Familial Essential Tremor [CP131]
- Temperature-controlled laminar airflow device for persistent allergic asthma (children) [CP132]
- Gastroelectrical stimulation for gastroparesis [CP133]
- Renal denervation for resistant hypertension [CP134]
- Eculizumab in the treatment of recurrence of C3 glomerulopathy post-kidney transplant (all ages) [CP135]
- Everolimus for subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis complex [CP136]
- Riociguat for pulmonary arterial hypertension [CP137]
- Second allogenic haematopoietic stem cell transplant for relapsed disease [CP138]

Overview of the WHSCC Clinical Impact Assessment Process 2017/18

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1. Introduction

Each year WHSSC has a duty to develop a three year Integrated Commissioning Plan (ICP) which outlines NHS Wales' priorities for commissioning specialised services for the next three years. Development of the plan is a complex process involving a large number of key stakeholders and draws on expertise from many health sectors across the NHS.

NHS Wales and WHSSC must ensure that new investment decisions are (i) affordable and offer value for money, (ii) supported by convincing evidence of safety and effectiveness and (iii) made using a process that is consistent and transparent. To achieve this WHSSC has developed a prioritisation process that enables it to compare competing proposals for new investment so that these can be prioritised and subsequently implemented.

WHSSC is now looking to adapt this methodology and pilot a bespoke prioritisation process which will rank schemes identified for inclusion in the ICP on the basis of their clinical impact.

This paper describes the methodology that WHSSC will be using in order to determine the relative 'clinical' prioritisation of schemes for specialised services in 2017/18.

1.1 The WHSSC Integrated Commissioning Plan (ICP) 2017-20

The ICP for Specialised Services for Wales 2017-20 is a commissioner-led plan, which seeks to balance the requirements to quality assurance, risk reduction and improvement to health outcomes for the people of Wales with the challenging financial pressure that is evident in specialised services. The needs of the Welsh population for specialised services are described in the ICP.

WHSSC produces the ICP by:

- using a tested impact assessment model
- developing commissioning intentions
- setting priorities and undertaking risk assessments,
- using provider submitted information
- horizon scanning, evidence appraisal and prioritisation of new interventions
- running seven Management Group workshops to agree a final list of schemes. Management Group is made up of management representatives from each of the HBs.

During the course of the Management Group Workshops 175 schemes were assessed using a three stage process, which included programme team peer review, review by the Executive Team at WHSSC and finally

Management Group review. All of the individual schemes were 'risk-rated' and peer-reviewed through the Management Group workshops.

The resulting draft ICP sets out the broad categorisation of these schemes into three categories:

- Red – for example mandatory guidance (NICE or AWMSG) and 'high risk' schemes
- Amber – 'moderate' risk schemes
- Green – 'low' risk which are not to be considered within the 2017-20 ICP

The results of this process were reviewed by the Management Group on the 12th January. Whilst there was a broad level of consensus on the majority of schemes to include in the ICP there was significant variance on many others.

1.2 The CIAG

At a Joint Committee meeting on the 17th January the initial prioritisation of new and existing schemes requiring investment was presented for consideration.

It was noted that because of the compressed timescales this prioritisation process had received limited clinical input. This lack of independent clinical advice presented challenges in determining relative priority of schemes against whatever resource is available. Therefore a further prioritisation process was suggested to review schemes and make recommendations on relative priority from a purely 'clinical' perspective.

A Clinical Impact Assessment Group (CIAG) was proposed with membership drawn from each HB via their Associate Medical Director with responsibility for Primary Care. The Group will act in an advisory capacity only and will be chaired by the WHSSC Medical Director. Participants were recruited during February 2017 and the final list of Group members was subsequently agreed (Table 1).

Table 1. Membership of the WHSCC Clinical Impact Assessment Group (CIAG) 2017/18

WHSSC Clinical Impact Assessment Group	
Name	**Title/Representation**
Sian Lewis (Chair)	Acting Medical Director, WHSSC
Liam Taylor	Deputy Medical Director, Aneurin Bevan UHB
Naveed Akram	Clinical Director (Quality and Safety) Abertawe Bro Morgannwg UHB
Fraser Campbell	Assistant Medical Director (Primary Care) Betsi Cadwaladr UHB
Christopher Fegan	Consultant Haematologist, Cardiff and Vale UHB
Kelechi Nnoaham	Director of Public Health, Cwm Taf UHB
Mark Barnard	Associate Medical Director, Hywel Dda UHB
Stuart Bourne,	Deputy Director of Public Health, Powys Teaching HB
Attendees in an Advisory Capacity:	
Andrew Champion	Assistant Director of Evidence Evaluation and Effectiveness, WHSCC
Sam Groves	Health Economics Advisor, Swansea Centre for Health Economics
Kamala Williams	Acting Assistant Director of Planning, WHSSC and Lead Planner for Cardiac Services
Claire Nelson	Specialised Planner - Neurosciences and Complex Conditions
Luke Archard	Specialised Planner - Cancer & Blood
Chris Coslett	Specialised Services Planning Manager – Women, Children and Rare Conditions

The Group will be asked to score a list of 19 schemes (see Table 2) against a set of pre-determined criteria (see section 6). The resulting output of the Group will be three categories of scheme for investment - high, medium or low clinical impact. This information will be 'layered over' existing prioritisation work and used to develop final recommendations regarding schemes for inclusion in the ICP.

1.2 Schemes to be considered and scored by the CIAG

All schemes that were categorised as red have been excluded from this clinical prioritisation process on the basis that they are mandatory and will have to be funded within the plan.

In order to keep the process of clinical prioritisation manageable within the existing timescales WHSSC took a pragmatic decision to only include those remaining schemes that were risk-rated with a Quality and Patient Safety score (QPS) >16 i.e. those with the highest scores, and all those investments required to meet Welsh Government targets around waiting times (these are known as RTTs 'referral to treatment times') regardless of their QPS score. A risk score is derived from the level of impact that would be felt should the scheme not be approved. QPS measures the extent of the illness or intervention and the overall quality of the service.

1.2.1 Terms of Reference

The draft terms of reference (Attachment 2) will be presented to the Group at their first meeting. The main elements are:

- CIAG is not a decision making body
- It has been established to undertake a process of prioritisation of specialised services to inform commissioning decisions by Joint Committee and WHSSC
- The Medical Director will Chair the Group
- Membership will be drawn from Health Board Medical Director's Offices and each Health Board has been asked to nominate the Associate Medical Director with responsibility for Primary Care
- Members have been selected for their expertise and are appointed as individuals. They are not appointed to represent the views of any stakeholder organisation to which they may be affiliated
- Members are expected to abide by the principle of collective responsibility, stand by the recommendations of the Group and support them in public.

1.2.2 Your role in this process

All Group members will be asked to form recommendations on the relative prioritisation of schemes which are proposed for inclusion in the WHSSC ICP for 2017/18.

Your recommendations will be considered by the Joint Committee at WHSSC to help inform their final decision on new investments in specialised services. This process is expected to be completed by the 31 March 2017.

2. Process

The following sections briefly outline the basic process and principles that the Group will follow. The methodology has been adapted from that previously used by the WHSSC Prioritisation Panel when scoring new interventions for consideration in the ICP, and will be piloted here for the first time.

2.1 The method of prioritisation

The principle steps within a prioritisation process are (i) evidence gathering and evaluation; (ii) policy (or scheme) development including equality impact assessment; (iii) scoring to develop a ranking of interventions.

The following key principles will be applied:

1. That the process is specific for Wales and therefore reflects the needs and priorities of our population.
2. The process reflects current Welsh Government (WG) policy and in particular the principles of Prudent Health Care.
3. That in line with the principles of Prudent Health Care we do not (wherever possible) duplicate work already completed within the other UK nations around evidence evaluation and prioritisation
4. The need to ensure appropriate and timely engagement and consultation with colleagues in NHS Wales during the entire prioritisation process

The information and recommendations from the Group on clinical impact (when combined with information around demands from existing services and interventions) will underpin and feed into the development of the WHSSC Integrated Commissioning Plan (ICP).

3. List of schemes to be prioritised (2017/18)

A list of **19** schemes has been put forward for the Group to consider. These are presented in Table 2 and cover the following four clinical programme team areas:

- Neurosciences and complex conditions
- Cardiac services
- Women, children and rare diseases
- Cancer and blood

Each scheme will be presented in turn at the meeting by the lead specialist planner (2-3 minutes) followed by a brief Group discussion and scoring (10 minutes).

Table 2

Reference number	Scheme	Category	QPS score
ICP17-193	Neurosciences (spinal rehabilitation)	Sustainability	20
ICP17-195	Neurosciences (neuro rehabilitation)	Sustainability	20
ICP17-148	Neuro-oncology	Capacity	16
ICP17-147	Neurosurgery RTT	RTT	16
ICP17-191	BCU ALAS - Capacity for war veterans	Capacity	16
ICP17-194	Posture and Mobility - replacement of wheelchairs	Safety	16
ICP17-197	Posture and Mobility - sustainable RTT achievement	RTT	16
ICP17-031/2	Cardiac ablation for AF and VT	Capacity	16
ICP17-066	Cleft lip and palate	Sustainability	16
ICP17-199	Cleft lip and palate RTT	RTT	12
ICP17-051	Fetal medicine	Sustainability	20
ICP17-154	Cystic Fibrosis	Capacity	16
ICP17-165	Additional PICU capacity - 7th bed	Capacity	16
ICP17-210	NICU - ABM HDU capacity	Capacity	16
ICP17-202	IVF sustain 26 week RTT Wales	RTT	16
ICP17-257/258	Cochlear and BAHA - achieve 26 week RTT	RTT	-
ICP17-132	PET capacity to achieve target access rate	Capacity	16
ICP17-180	PET policy - new indications (growth)	Capacity	20
ICP17-003	Neuroendocrine Tumours	Capacity	16

3.1 Supporting information for Group members

To help the Group with the decision-making process, each scheme will be supported by a statement prepared by lead specialist planner (Attachments 4-23). They will consist of the following package of information (where available):

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

4 Preparation prior to the CIAG meeting

Before the meeting you will be expected to consider each scheme statement (Attachment 4) against the criteria described in this paper (see section 6). You will be asked to score each scheme against these criteria to form recommendations on the relative prioritisation of all the schemes.

The 'scores' for each of the schemes under consideration will then be calculated and used to rank the topics. This part of the process will be led by Dr Sam Groves (Welsh Health Economics Support Service (WHESS)) using a group decision support system (GDSS) and will be presented in more detail at the meeting.

You are asked to use your own knowledge and experience when considering each scheme. You are not required to submit your preliminary views in advance of each meeting. Instead you should you record your preliminary views in your notes ready for discussion at the meeting. For each scheme you will have the opportunity to discuss the facts as defined in the papers so that any misunderstandings or questions are cleared.

You will be asked to score each scheme (from 1 - 10) against all of the criteria described below. A high score indicates consistency with each of the criteria.

4.1 Criteria for prioritisation

The proposed criteria that will be used in prioritisation are:

- Burden of disease
- Patient benefit (potential for positive health impact / improved safety / clinical outcomes)
- Equality and human rights (potential for improved / reducing inequalities of access)

The review of schemes will take into account how the different criteria work together, including:

- The balance of clinical benefits and clinical risks
- The balance of the timing of the application with the urgency of the clinical need, what clinical alternatives are available, and the need to strengthen the evidence for clinical impact
- The balance of clinical benefits/impact per patient and the robustness of the supporting evidence
- The balance of overall clinical impact/benefits from national commissioning perspective.

5 Expected output from the CIAG

Once the Group has considered the schemes and assigned each a mean score these will be tabulated and presented back to the Group at the close of the meeting. Although members will be permitted to discuss the final results, a re-vote on any intervention or a change to the order of the results will be at the discretion of the Chair.

Members will then be asked to split this list into 'high clinical', 'medium clinical impact' and 'low clinical impact' based on their overall % score. Using this approach will ensure a spread between the three groups i.e. not all will come out as 'high clinical impact'. Based upon these results and Group discussion a narrative summary of proceedings will also explain risks of non-implementation and opportunities for mitigation

The clinical impact analysis will then allow the production of a report which overlays the scores for clinical impact against the existing prioritisation outputs from WHSSC and Management Group. Finally these data when combined with information around demands from existing services and interventions will underpin and feed into the development of the WHSSC Integrated Commissioning Plan (ICP) for 2017-20.

6 Definitions for each of the assessment criteria –a guide for Panel members

This document only serves as a guide to Group Members – each Group member must consider their own conclusions and be able to discuss these with other Group members as part of the prioritisation process.

A] Burden of disease

Assessing this criteria involves a wide consideration of a number of different issues including the (serious) nature of the condition, the size of the population effected (individual, small cohort or large population) and the current availability of (effective) treatments contained within the concept of unmet need. The following serves as guidance to Group members in assessing 'burden of disease' and highlights some of the considerations each Group member will need to take.

A1] Serious condition

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

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

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

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

A2] Unmet clinical need

An unmet clinical need is a condition whose treatment or diagnosis is not addressed adequately by available therapy. An unmet clinical need includes an immediate need for a defined population (i.e. to treat a serious condition with no or limited treatment) or a longer-term need for society (e.g., to address the development of resistance to antibacterial drugs).

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

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

A3] Population impact and reducing health inequalities

This is defined as the number of people who are likely to benefit from the intervention or recommendation? Things to consider include:

- What will implementation of this policy mean for the individual patient/group of patients and the wider community?
- Will this service or intervention contribute to reducing or widening health equalities within Wales?

[Members of CIAG must have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved. The Group may wish to identify potential health inequalities that may be present with the adoption of a specific policy proposition and provide WHSSC with advice on how to commission services with a view to reducing health inequalities. This may influence the Group's recommendation on the relative prioritisation of a specific scheme.]

B] Patient benefit

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

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

Will this intervention have a positive effect on mortality, longevity and health related quality of life?

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

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

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

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

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

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

C] Equality and human rights

WHSSC and NHS Wales must demonstrate that it understands the potential effect of adoption of clinical commissioning policies on people with characteristics that have been given protection under the Equality Act (2010), especially in relation to their health outcomes. We must also consider both the Social Services and Well-being (Wales) Act (2014) when considering the well-being for people who need care and support (and carers who need support) and the Human Rights Act (1998).

Therefore WHSSC should have due regard to the need to:

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

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

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

Annex 3: WHSSC STRATEGIC COMMISSIONING INTENTIONS 2017/18

Aim

These Intentions provide notice to Health Boards and NHS Wales Trusts about the changes and planned developments in the commissioning and delivery of specialised services.
The ICP is structured to support the purpose of the Welsh Health Specialised Services Committee (WHSSC), which is:

"on behalf of the seven Health Boards; to ensure equitable access to ***Safe,***

Quality and Patient Safety –WHSSC will implement the Quality and Outcomes Framework for Specialised Services agreed by Joint Committee in January 2015.

Patient experience –Patient experience will be captured using a variety of methods in conjunction with the Quality Framework.

Clinical risk – WHSSC will work with Health Boards to review their corporate risk registers in order to identify and develop plans to address any clinical risks that have been identified, within the services that they provide, or that their resident population access from another provider.

Effective,

Evidence-based commissioning – WHSSC will consider all proposals for new developments on the basis of the available evidence for clinical- and cost-effectiveness.

Delivery Measures (formerly Tier 1 targets) and National Priorities – Providers are required to ensure that they have approved plans to meet and sustain the agreed Delivery Measures[1] and National Priorities**.**

Clinical Innovation – WHSSC will work closely with Welsh providers to review the potential for implementing clinical innovation where it is evidence-based and cost-effective.

and ***Sustainable*** *specialised services for the people of Wales."*

Wellbeing of Future Generations – In line with the Well-being of Future Generations (Wales) Act 2015, WHSSC will work with all stakeholders to ensure that each of the five sustainable development principles – long term thinking, prevention, involvement, collaboration and integration, are reflected all of the services that it commissions on behalf of Health Boards.

Managing within Resources – WHSSC has a duty on behalf of NHS Wales to utilise its allocated resources effectively and efficiently and to manage specialised services

[1] As set out in the NHS Wales Outcomes Measures Framework 2015

within the resources agreed by NHS Wales.

- There will be no additional funding for inflationary or cost pressures.
- Providers will be expected to ensure that any local cost improvement plans for specialised services are clearly identified, and confirm that the plans will have no adverse impact on the quality or performance of the service.

Demand – WHSSC will expect Health Boards to ensure that appropriate referral pathways are in place, including primary and secondary care provision, in order to ensure that all referrals into specialised services are managed in accordance with the agreed pathways of care.

Service risk - WHSSC will work with providers to review corporate risk registers to identify and develop plans to address risks identified by Health Boards relating to the delivery and / or sustainability of specialised services.

Annex 4: Outstanding schemes from the 2016-19 Integrated Commissioning Plan as of March 2017

ICP Reference Number	Financial Table	Programme Team	Service	Commissioning Intention	Comments
ICP16-030	9a	Cancer & Blood	Bariatric Surgery Phase 2	Bariatric surgery is provided for the population of South Wales by ABMUHB. Joint Committee has agreed to the 5 year phased commissioning plan to increase access up to the clinically recommended level.	Agreed as 2015/16 development. Capacity is not available to implement in 2016-17. This scheme will not be achieved. In addition, commissioner concerns re the proposed service model, in particular the management of high risk patients, are addressed.
ICP16-042	9a	Neurological and Complex Conditions	Communication Aids	Augmentative and Alternative Communication (AAC) project. WG funding to develop service hub at Rookwood Hospital with staff also located at BCU. AAC project to include recommendations on future funding arrangements to be considered in ICP 2017/18.	An extension to the evaluation period was supported by Joint Committee in September 2016. Stakeholder event being planned for Feb 17. Additional funding requirements to be discussed in Board meeting 29 Nov 16. Board meeting took place on 29th Nov, agreed discussions need to take place with WG around future funding. Agreed future funding and evaluation would be discussed at JC in September.
ICP16-127	9b	Women and Children	Sebelipase Alfa - LAL *	Sebelipase alfa is a potentially life-saving treatment for babies with rapidly progressive LAL deficiency, and there is a compelling clinical need.	Final Appraisal Determination (FAD) not yet published nor date provided
ICP16-128	9b	Women and Children	Asfotase Alfa - HPP *	Background: NICE (HST): After the first evaluation consultation NICE has issued the following advice: Asfotase alfa is not recommended, within its marketing authorisation, for long-term enzyme replacement therapy in paediatric-onset hypophosphatasia to treat the bone manifestations of the disease. Expected publication date TBC.	Final Appraisal Determination (FAD) not yet published nor date provided

ICP Reference Number	Financial Table	Programme Team	Service	Commissioning Intention	Comments
ICP16-131	9b	Women and Children	BAHAs and Cochlears	Take steps to implement the centralisation of services at the UHB	Met with C&V UHB, they are keen to progress. Meeting with ABMU, they accept the principle of centralisation but question the decision making around Cardiff being the preferred site. Each centre has provided a summary of position against BCIG standards. Process to progress to be agreed. Now deferred until 2017/18.
ICP16-029	9c	Cancer & Blood	Bariatric Surgery Phase 3	To implement phase 3 of the bariatric surgery 5 year phased growth plan for all Wales.	Phase 3 will not be implemented in 2016-17 due to provider capacity constraints.
ICP16-040	9d	Neurological and Complex Conditions	Neuropathology	To commission a sustainable Neuropathology Service.	C&VUHB have indicated that this issue could be managed through improved links with Bristol. The most recent advertising of the post has seen interest from two high calibre candidates.
ICP16-051	9d	Women and Children	Fetal Medicine	Service poses a quality and sustainability concern. Concerns have been raised by the service itself, other Health Boards and Public Health Wales as to how the service is delivered. ***Lack of Fetal Brain MRI provision in South and Mid Wales (2015/16 Green scheme)	Agreed with C&V that not a priority for 2016/17, to be taken forward as part of 2017/18 planning.
ICP16-117	9d	Cancer & Blood	Proton Beam Therapy - Child	NHS England's Commissioning Policies are currently used by the UK-wide National Proton Clinical Reference Panel to make recommendations for the clinical suitability of Welsh patients to access Proton Beam Therapy (PBT). WHSSC needs to review its commissioning position for PBT and produce revised, up to date commissioning policies for people in Wales.	Assessed in 2017/18 Prioritisation Panel.

ICP Reference Number	Financial Table	Programme Team	Service	Commissioning Intention	Comments
ICP16-118	9d	Cancer & Blood	Proton Beam Therapy - TYP	NHS England's Commissioning Policies are currently used by the UK-wide National Proton Clinical Reference Panel to make recommendations for the clinical suitability of Welsh patients to access Proton Beam Therapy (PBT). WHSSC needs to review its commissioning position for PBT and produce revised, up to date commissioning policies for people in Wales.	Assessed in 2017/18 Prioritisation Panel.
ICP16-084	9d	Women and Children	Paediatric Cardiology	Ensure that the service meets the NHS England CHD standards - as the service is part of a network with Bristol. Also, outpatient component gap for this service and the consultant base is short on sessional time to support activities. This poses a risk to delivery and sustainability.	To be managed through Risk Management Strategy pending decision of Joint Committee. CHD service specification currently being drafted. Self assessment already circulated by CHD Network and Welsh service providers to return, this will help to identify gaps in services across South Wales.
ICP16-119	9d	Cancer & Blood	Proton Beam Therapy - Adult		Assessed in 2017/18 Prioritisation Panel
ICP16-115	9d	Cardiac	VAD - BTR	Implantation of a left ventricular assist device for destination therapy in people ineligible for heart transplantation NICE interventional procedure guidance [IPG516] Published date: March 2015	Recommendation from JC that English policy and service specification should be adopted as an interim position. Recommendation agreed at November Management Group, permanent policy to be developed as appropriate. Assessed in 2017/18 Prioritisation Panel
ICP16-121	9d	Cardiac	VAD - BTT	Ventricular Assist Devices (VADs) as a bridge to heart transplantation or myocardial recovery (All Ages) - NHS England service specification A18/S(HSS)/b - commissioned in England?	Recommendation from JC that English policy and service specification should be adopted as an interim position. Recommendation agreed at November Management Group, permanent policy to be developed as appropriate. Assessed in 2017/18 Prioritisation Panel

ICP Reference Number	Financial Table	Programme Team	Service	Commissioning Intention	Comments
ICP16-044	9d	Neurological and Complex Conditions	Neuromodulation/ pain service	Change to the Pain Service model that that could utilise existing baseline and performance funding in a different way with mutual benefit. Spinal Implants - development of an Multidisciplinary Team model.	Given priority to other Neurosciences schemes, this has rolled forward to 17/18.
ICP16-016	9e	Cancer & Blood	Endobronchial Valve Replacement (EBVR)	To commission sufficient surgery to meet RTT targets	Will be taken forward as a 17/18 ICP scheme.
ICP16-130	9e	Cancer & Blood	Plastic Surgery	Evaluation and recommendations for future funding of LVA service	Evaluation of first 12 months to include policy review. Indication that one of the criteria in the policy may require amendment (2 episodes of cellulitis in 12 months) to ensure sufficient eligible patients for screening. The paper was considered by Management Group and they supported extension of the trial period, but did not approve changes to commissioning policy.

				WHSSC preliminary patient scores							Health Board scores								
PT	Scheme Reference No.	Service Area	Scheme Description	*Pat* - ABU	*Pat* - ABMU	*Pat* - BCU	*Pat* - CTU	*Pat* - CVU	*Pat* - HDU	*Pat* - PT	*Pro* - ABU	Pat - ABM	*Pro* - ABMU	*Pro* - BCU	*Pro* - CTU	*Pro* - CVU	*Pro* - HDU	*Pro* - PT	*Com* - WHSS
C&B	Evidence Appraisal	Bone marrow transplant	Plerixafor for Paediatric BMT	16	16	16	16	16	16	16									12
C&B	Evidence Appraisal	Bariatric surgery	Obesity Surgery (Paeds)	12	12	12	12	12	12	12									9
C&B	Evidence Appraisal	Extra Corporeal Photopheris	ECP - Graft Vs Host	12	12	12	12	12	12	12									12
C&B	ICP17-001a	Thoracic surgery	Implement Thoracic Commissioning Plan	16	16	6	9	16	16	6	16								16
C&B	ICP17-003*	Neuroendocrine tumours	NET service development - Phase 2	9	9	6	9	9	9	9	12								12
C&B	ICP17-132	Positron emission tomography	Commissioning plan (to set out commissioning intentions and ensure capacity to achieve the required level of population access to PET)	16	16	6	16	16	16	16									12
C&B	ICP17-180	Positron emission tomography	To review the policy to bring the commissioned indications for Wales in line with the evidence base for PET CT.	16	16	16	16	16	16	16									12
C&B	Workplan		IBD	9	6	12	6	6	9	9									12
Cardiac	Evidence Appraisal	Cardiac surgery	Mitral Valve Repair (Primary)	12	12	12	12	12	12	12									12
Cardiac	Evidence Appraisal	Cardiac surgery	LVAD (Bridge to transplant)	16	16	16	16	16	16	16									16
Cardiac	Evidence Appraisal	Cardiac surgery	LVAD (Bridge to recovery)	16	16	16	16	16	16	16									16
Cardiac	ICP17-031*	Cardiac ablation	Develop service at ABMUHB	1	16	1	1	16	16	1									16
Cardiac	ICP17-032*	Cardiac ablation	Increase access at CVUHB	16	1	1	16	16	1	1									16
Cardiac	ICP17-036*	Transcatheter aortic valve implantation	Review existing policy and consider expansion of access criteria	9	9	9	9	9	9	9									15
LHB	Evidence Appraisal	Inherited anaemia	Iron Overload in Inherited Anaemias																
MH	Workplan	Gender Dysphoria	Development and implementation of Gender Pathway	9	9	9	9	9	9	9									12
MH	Workplan	Perinatal Services	Perinatal pathway and commissioning arrangements	9	9	9	9	9	9	9									12
MH	Workplan	Medium Secure	Lack of capacity for LD	16	16	16	16	16	16	16									20
N&CC	ICP17-044*	Neuromodulation	Implementation of formal MDT for delivering Neuromodulation pain service and consistent management of Neuro-stimulators	9	9	1	9	9	9	9									12
N&CC	ICP17-087*	Alternative augmentative communication	Evidence evaluation - future funding and potential for funding requirements in latter quarter of 2017/18	20	20	20	20	20	20	20									20
N&CC	ICP17-147	Neurosurgery	Funding to support achievement of RTT which has not been achieved for the past 3 years. This will require scoping of the demand and capacity requirements on beds and theatre lists.	12	12	1	12	12	12	12									20
N&CC	ICP17-148	Neurooncology	Peer Review of Cardiff and Walton services took place in November which for South Wales service highlighted shortfalls in MDT members particularly Radiologists and AHPs.	16	16	1	16	16	16	9									12
N&CC	ICP17-191	Prosthetics	Inadequate capacity to manage growing numbers of war veterans	1	1	16	1	1	1	1									20
N&CC	ICP17-193	Spinal injury rehabilitation	Spinal Rehabilitation - service sustainability and the achievement of standards due to poor staffing levels particularly one Spinal Rehabilitation Consultant against recommendation of three for size of Unit.	16	16	1	16	16	16	9									20
N&CC	ICP17-194	Wheelchairs	Posture and Mobility Service – Manufacturer Discontinuation of Models used within the Powered Wheelchair Fleet	9	9	1	9	9	9	9									15
N&CC	ICP17-195	Neurological rehabilitation	Neuro Rehabilitation Service – sustainability and standards due to poor staffing levels	16	16	1	16	16	16	9									20
N&CC	ICP17-198	Adult critical care	Adult Critical Care expansion	6	6	1	6	6	6	6									12
Renal	ICP17-167	Renal replacement therapy	Requirement to meet ongoing growth in Renal Replacement Therapy																

PT	Scheme Reference No.	Service Area	Scheme Description	*Pat* - ABU	*Pat* - ABMU	*Pat* - BCU	*Pat* - CTU	*Pat* - CVU	*Pat* - HDU	*Pat* - PT	*Pro* - ABU	Pat - ABM	*Pro* - ABMU	*Pro* - BCU	*Pro* - CTU	*Pro* - CVU	*Pro* - HDU	*Pro* - PT	*Com* - WHSS
W&C	Evidence Appraisal	Rare disease	Ritixumab IGG4	8	8	8	8	8	8	8									12
W&C	Evidence Appraisal	Rare disease	Pasireotide (Cushings disease)	12	12	12	12	12	12	12									6
W&C	ICP17-051*	Fetal medicine	Current service model unsustainable however due to a service review that is currently under way a revised business case has not been progressed. This will need to be taken through the 2017/18 planning process	8	8	4	8	8	8	4									12
W&C	ICP17-063*	Paediatric endocrinology	Repatriation of service currently provided by UH Bristol and expansion as there is unmet demand.	6	6	3	6	6	6	6									12
W&C	ICP17-066*	Cleft lip and palate	Requirement to invest in the CLP MDT in order to support service sustainability and ongoing delivery against standards	9	9	2	9	9	9	6									12
W&C	ICP17-154	Cystic Fibrosis	Capital business case to be developed by C&V UHB for expanded facilities at UHL, including additional beds. A bid is likely to be made for additional resources as required to staff the additional capacity should the capital case progress	12	12	1	12	12	12	8									16
W&C	ICP17-156	Genetics	Increasing demand for Microarray-based comparative genomic hybridisation (array CGH). Despite the introduction of demand management by the service requests for testing is significantly higher than funding available and waiting times are continuing to grow.	10	10	10	10	10	10	10									20
W&C	ICP17-165	Paediatric critical care	C&V UHB have raised concerns around service delivery with 6 PICU beds and are developing a business case for a 7th	15	15	5	15	15	15	10									16
W&C	ICP17-199	Cleft lip and palate	Potential backlog of adults awaiting revisional surgery - awaiting ABMU corporate confirmation of this.	6	6	1	6	6	6	6									20
W&C	ICP17-200	In vitro fertilisation	Fertility policy due to be reviewed in October 2016. All Wales Fertility Advisory Group established to review and they have recommended adding 3rd cycle. These changes would potentially have a cost associated.	1	1	1	1	1	1	1									4
W&C	ICP17-201	In vitro fertilisation	Achieve 26 weeks RTT for assisted fertility patients by treating the back log of patients currently suspended pending completion of 12 month mandatory wait.	2	2	2	2	2	2	2									2
W&C	ICP17-202	In vitro fertilisation	Sustain 26 weeks RTT for assisted fertility patients.	2	2	2	2	2	2	4									20
W&C	ICP17-205	Genetics	Due to the advances in genetics, there is increasing demand for stratified medicine across health disciplines. This could potentially include expanded indications for genetic testing for Lynch Syndrome	12	12	12	12	12	12	12									12
W&C	ICP17-210	Neonatal intensive care	Expansion of Neonatal Capacity in South Wales	10	10	6	10	10	10	8									12
W&C	ICP17-213	Genetics	Genomics Taskforce - The services provided are required to be updated and future-proofed to ensure that the Welsh population have equitable access to genetic and genomic services that are demonstrated to have increasing value in healthcare.	6	6	6	6	6	6	6									8
W&C	ICP17-257	Bone anchored hearing aids and cochlear implants - S Wales	Achieve and maintain 26 weeks RTT for adult and paed services	12	12	1	12	9	12	6									12
W&C	Review	Paediatric Gastroenterology	Paediatric Gastroenterology	12	6	3	12	12	6	8									12
W&C	Review		Paediatric Rheumatology	9	6	1	9	9	6	6									20
W&C	Workplan	Neonatal intensive care	Neonatal Transport	12	12	6	12	12	12	8									20
W&C	Workplan		Ciliary dyskinesia	12	12	3	12	12	12	8									9
W&C	Workplan		Paediatric Congenital Heart Disease	9	9	3	9	9	9	6									16
W&C	Workplan		Paediatric Infectious Diseases	6	6	1	6	6	6	4									6

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

		Agenda Item	9
Meeting Title	**Joint Committee**	Meeting Date	30/05/2017
Report Title	Current provision of Specialised Neurosciences in NHS Wales to inform the Commissioning Strategy		
Author (Job title)	Specialised Planner, Neurosciences		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	**Public**

Purpose	This paper sets out the current provision of Specialised Neurosciences which will inform a five year Commissioning Strategy for Specialised Neurosciences by the end of 2017.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Not Applicable	Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the current provision of Specialised Neurosciences for patients in NHS Wales which will inform the Five year Commissioning Strategy; • **Support** the urgent establishment of network arrangements with NHS England providers for Neuro-Radiology; • **Support** the establishment of an operational delivery network for Specialised Rehabilitation in South Wales; • **Support** the collective approach to the commissioning of Paediatric Neurology in both North and South Wales; and • **Support** the proposal to implement a service specification for Specialist Spinal Surgery and a Phased implementation of application of this to the listing of specialist spinal patients within Neurosurgery.		

Considerations within the report (tick as appropriate)

	YES	NO		YES	NO		YES	NO
Strategic Objective(s)	✓		Link to Integrated Commissioning Plan	✓		Health and Care Standards	✓	
Principles of Prudent Healthcare	✓		Institute for HealthCare Improvement Triple Aim	✓		Quality, Safety & Patient Experience	✓	
Resources Implications	✓		Risk and Assurance	✓		Evidence Base	✓	
Equality and Diversity	✓		Population Health	✓		Legal Implications		✓

9

1.0 Purpose

The purpose of this report is to present the Five year Commissioning Strategy for Specialised Neurosciences to the WHSSC Corporate Directors Group.

The paper sets out:

- the background for initiating the Five year Commissioning Strategy for Specialised Neurosciences;
- an assessment of the implementation of recommendations from the Steers, Axford and Price-Morris Reviews of Neurosciences for patients within NHS Wales;
- the details of the three work-streams established including the membership, terms of reference and outputs;
- how services are currently commissioning and delivered for patients in NHS Wales;
- a map of the current provision of Specialised Neurosciences in terms of activity and financial costs; and
- recommendations on the future delivery and commissioning of Specialised Neuroscience services.

2.0 Background

WHSSC were asked by Joint Committee in 2015 to develop a clear strategy for specialised Neuroscience services for patients from NHS Wales, in order to set the direction for specialised and non-specialised services in this area. This was in response to:

- The emergence of a number of Neurosciences service issues that required financial support outside of Integrated Commissioning Plans;
- Three Service Reviews: Steers (2008), Axford (2009) and Price-Morris (2009) which highlighted areas within Neurosciences that required development;
- The fragility of the Neuro Interventional-Radiology service in Cardiff;
- The number of Neurosciences schemes proposed for inclusion in the WHSSC Integrated Commissioning Plans;
- Continued inability of the inpatient Neurosurgery service in Cardiff to deliver the 26 week referral to treatment (RTT) target – the service has not been able to achieve a 36 week referral to treatment (RTT) target within the last five years.
- Key developments on the horizon within Neurosciences, most notably with the introduction of Medical Thrombectomy (clot retrieval) for the treatment of strokes.

In June 2016 Joint Committee members approved the Project Initiation Document (PID) which described the development of a Specialised Neurosciences Strategy. The PID is attached as Annex 1. It was acknowledged that the Strategy would only take into consideration those services commissioned directly by WHSSC and clarification was sought as to what these services were. The WHSSC commissioned services were broadly outlined as:

- Neurosurgery
- Interventional Radiology
- Neuro-rehabilitation
- Spinal Rehabilitation
- Paediatric Neurosciences including Paediatric Neurosurgery, Paediatric Neurology and Paediatric Neuro-Rehabilitation.

2.1 Recommendations from previous reviews

2.1.1 Steers and Axford

In 2007, the Welsh Assembly Government commissioned James Steers to undertake a review of neurosciences in Wales. The final report was published in three parts, North Wales, South & Mid Wales and All Wales, in September 2008.

Following the publication of the Steers Review, Dr Alan Axford was asked by the Minister for Health and Social Services to make specific recommendations for implementing the Steers findings for Mid & South Wales.

Dr Axford made 19 key recommendations which were taken forward through the Mid & South Neurosciences Implementation Programme. The 1st phase of this programme focused on the transfer of neurosurgery to a single site at the University Hospital of Wales, Cardiff. This had been precipitated by the removal of neurosurgery training from Morriston and the transfer was completed in 2010, with a small number of neurosurgeons opting not to transfer to UHW, rather to remain at ABMUHB as part of the spinal surgery service. WHSSC does not commission any of the activity undertaken by the neurosurgeons at ABMUHB. Furthermore, the service at ABMUHB is not designated as a neurosurgery unit, and as such the surgeons do not participate in the National Neurosurgery Audit programme (NNAP).

The 2nd phase of the implementation programme commenced in December 2010 with the aim of implementing the wider Axford recommendations for spinal surgery, neurology, rehabilitation and diagnostics by September 2011.

An update report describing the achievements of the 2nd phase of this work was presented to Management Group in September 2011. The report highlighted the achievements of the 2nd phase of work as –

For Spinal Surgery

- Implementation of a formal 24/7 provision of acute spinal surgery across Mid & South Wales.

For Adult Rehabilitation and Supportive Care

- Development of detailed proposals for a network to provide community based rehabilitation support for patients with acquired neurological and spinal injuries across Mid & South Wales.
- The mapping of Adult rehabilitation services for spinal cord and acquired brain injury across all Mid and South Wales NHS organisations.

Neurology

- Agreement across the 6 HBs to appoint two additional consultant neurologists for Mid & South Wales with appointments expected by December 2011.
- Needs assessment completed by Public Health Wales.
- Development of a model for neurology services and network across Mid & South Wales.

Diagnostics and Transport

- Sustainable neuro-radiology service across Mid & South Wales secured through closer working between neuro-radiology services in ABM UHB and C&V UHB.
- Established on-call neuro-radiology advice systems in place (separately for East and West): with work in progress to provide a single on-call rota across South Wales.

2.1.2 Price-Morris

The Minister for Health and Social Services also asked Mr Elwyn Price-Morris to make specific recommendations for implementing the Steers findings for North Wales. The Price-Morris report set out 26 key recommendations, outlined in Annex 2 of which four were highlighted as key:

- A North Wales Neurology Service should be established within an appropriate location for patient access from which medical neurology, stroke management and neurophysiology would be delivered with enhanced services at other main sites.
- A managed clinical network for neurosciences for North Wales should be established linking Bangor, Glan Clwyd and Wrexham together with the existing tertiary centres.
- An in-patient neuro-rehabilitation centre should be established in North Wales.
- A non-complex spinal injury surgery service should be established in North Wales.

Of the four key Price-Morris recommendations, both the managed clinical network for Neurosciences and a non-complex spinal injury pathway have been implemented.

Unlike the original Steers recommendations which were directed to organisations other than Health Boards including WHSSC and Welsh Government, the Price-Morris recommendations focussed on actions to be taken by Betsi Cadwaladr.

2.1.3 Conclusion of the Strategic Reviews

Following the conclusion of the strategic reviews of neurosciences services in both North and South Wales, it is evident that few of the recommendations have been effectively implemented. Those that remain prominent issues today include:

- Establishment of an integrated spinal and Neuro-Rehabilitation network;
- Appointment of a consultant in Rehabilitation Medicine to lead the development of a North Wales Neuro-Rehabilitation service and specialist in-patient service;
- Establishment of specialised community outreach teams for acquired brain injury and spinal injury;
- Establishment of a network to plan and deliver neurology services; and
- Integration of Neuro-Radiology services across Abertawe Bro Morgannwg UHB and Cardiff and Vale UHB.

One of the initial pieces of work recently undertaken by the Working Groups (described in 2.4) was to assess the recommendations from the Axford and Steers Reviews in terms of whether they had been implemented and if not, still needed to be. The full set of recommendations and progress against them following discussion in the three working groups, is outlined in Annex 3.

2.2. Needs Assessment

WHSSC initially envisaged in its Project Initiation Document for the Neurosciences Review that Public Health Wales (PHW) would be able to carry out a Needs Assessment for Neurosciences for the population of Wales and provide the following –

1. Current activity and access information (including consideration of the patient pathways);
2. Predicted levels of demand based on population demographics (and any changes since the last review);
3. Assessment of unmet need based on current activity or inequity of access
4. Published evidence regarding population numbers and optimal service models;

5. Horizon scanning of new technologies, procedures within the specialised neurosciences domain over the next five to ten years.

In a meeting between WHSSC and PHW, PHW advised that they could provide the following –

- Neurosciences activity which would be broken down into a number of fields including hospital accessed including English Trusts, residence of patient by Health Board, primary and secondary diagnosis of patient and treatment by procedure code;
- A review of published evidence of population numbers (epidemiology) including: incidence, mortality, prevalence and survival; and
- A review of optimal service models both nationally and internationally.

2.2.1 Information provided

Public Health Wales have been able to provide Neurosciences activity by Finished Consultant Episode (FCE) which provides us with a dataset for Inpatient and Daycase activity undertaken. Unfortunately further data was not readily available to them. Such information is considered to be an integral part of a Commissioning Strategy and we have tried to source this data by other means including from national databases such as UK Rehabilitation Outcomes Collaborative (UKROC).

One National Database the UK Rehabilitation Outcomes Collaborative (UKROC) were unable to provide data on the Rehabilitation Units in Wales and how they benchmark with other Units across the UK advising that neither Welsh Unit has submitted any information for such comparative information to be produced.

Until this data is available, we have made reference to the Public Health Wales Needs Assessment published in December 2015 which provides an overview of the burden of neurological conditions across Wales and description of the service provision and utilisation.

2.3 Working Groups

Three of the four working groups outlined in the Project Initiation Document – Neurosurgery, Neuro-diagnostics and Neuro-rehabilitation have held a series of meetings. Nominations for the initial three groups came from Health Boards who were written to with advice as to who had been involved with scoping work to date.

As the priorities for the Strategy are being developed and the contracting information for Neurosciences fully established, the fourth working group for

Finance is in the process of being set up with a terms of reference drafted (Annex 4) and nominations being sought from Health Board Finance and Commissioning representatives. A baseline assessment which detailed contracting and financial arrangements for all Specialised Neurosciences was presented to the April Management Group meeting (Annex 5). This paper also outlines the investments that have been made in Specialised Neurosciences since the Steers Review and subsequent transfer of Neurosurgery from Swansea to Cardiff. The purpose of the Finance Group is to ensure that all funding mechanisms align with commissioning responsibilities and reflect the five year Commissioning Strategy.

Due to the geographical spread and the differences in arrangements between South and North Wales, separate working groups were requested to be established for North Wales and a list of nominations for these groups provided by Betsi Cadwaladr UHB's Director of Neurosciences. Almost all the nominees have been consulted with on an individual or organisational basis, but have not been brought together in the suggested Groups. It was felt by a number of the nominees themselves that they had very different issues to highlight i.e. the three nominations for the BCUHB Neurosurgery working group consisted of: a Neurosurgeon from the Walton Centre, a Paediatrician based in BCU and the Clinical Director for Neurosurgery and Neurology from Alderhey and it would be helpful to meet with their separate teams/Management Leads when the need arose.

Similarly, due to distance and limited dedicated staff for Neurosciences, representatives from Hywel Dda UHB and Powys tHB did not attend the working group meetings but were included in the correspondence for the Groups and met with separately in their Health Boards. It was suggested by the Executive Lead for Neurosciences for Hywel Dda who is also Programme Director of the Mid Wales Healthcare Collaborative, that WHSSC attend a future meeting of the Mid Wales Healthcare Collaborative to feedback details of the Strategy once agreed.

2.4 External support to Strategy

The British Society of Rehabilitation Medicine and Society of British Neurological Surgeons who were involved in the previous reviews of Neurosciences have agreed to participate in the development of five year Strategy for Neurosciences. We will be calling on their expertise where relevant, on specific priorities.

The Royal College of Radiologists advised that they do not provide a consultancy role other than to undertake full service reviews. Contact with the National Imaging Programme Board who agreed with their members to help identify potential partners, was not forthcoming.

2.5 Assessment of current services

The assessment of current services focuses on the three main specialities of –

- Neurosurgery
- Neuro-diagnostics
- Neuro-Rehabilitation

Meetings with stakeholders for each of the three specialities and sub specialities took place in order to gain an understanding of their current status and priorities for the next five years. Their responses are outlined below, grouped under the three headings of Neurosurgery, Neuro-diagnostics and Neuro-Rehabilitation. The details of the individuals and organisations that have been consulted with are outlined in Annex 6.

3.0 Assessment

Through engagement with stakeholders from across all Health Boards, relevant NHS Trusts in England and Third Sector representatives, the Neurosciences and Complex Conditions programme team have been able to:

- provide an update on the progress made since the three reviews;
- Identify the best practice and are starting to share this where relevant across services;
- develop a schedule of schemes that outlines the priorities for services and workplan for the WHSSC Programme Team over the next five years.

The increased engagement particularly with English providers has led to changes to contracts, notably with Robert Jones Agnes Hunt. There has been a reduction in the bed day rates due to managing patients more effectively. We are working with the Walton Centre to introduce a bed day rate within Neuro-rehabilitation which will again reduce spend.

There have been improvements made to the Gate-keeping arrangements, so that Lead Consultants for their specialities are being made aware of referrals outside of their service. This is encouraging improved retention of patients locally which will consequently avoid increased costs of sending patients to NHS England.

During 2016-17 there have also been changes to the Neurosurgery contract within Cardiff, moving from a block contract of emergency and electives to a more reflective case-mix contract. The contracting details were presented to the Joint Committee in March 2017. Increased engagement with relevant Consultants on this work is leading to improved coding of cases ensuring that the contract is truly reflective of the work undertaken.

3.1 Schedule of schemes

Engagement through individual discussions and the meetings of the three work-streams set up specifically for Neurosurgery, Neuro-diagnostics and Neuro-Rehabilitation, has led to the development of a schedule of schemes for the five year duration of the Strategy which is outlined in Annex 7. The 54 schemes which are broken down into the three focus areas, can also be categorised into 42 work-plan and 12 requiring financial input, although it is likely that as the work-plan is undertaken, that more schemes will need to be quantified financially.

The schemes include recommendations from the Steers, Axford and Price-Morris reviews, which are still felt to be outstanding and requiring implementation.

It is anticipated that the schedule will continually evolve and although we have undertaken horizon scanning, within the five years there are likely to policy developments and other external influences which will need to be considered for inclusion.

3.2 Priorities for 2017-18

A number of priorities were submitted for inclusion within the WHSSC 2017-20 Integrated Commissioning Plan with the proposal that this would be year one of the five year Strategy. These priorities were:

- Neuro-Rehabilitation;
- Spinal Rehabilitation;
- Neuro-oncology; and
- Neuro-modulation.

However, with no funding allocated for highlighted priorities for Neurosciences and minimal funding for any Programme team proposals within 2017-18, we are viewing this 2017-18 as year zero of the five year Strategy and focussing on key priorities that can be worked through with minimal financial requirements.

Whilst all the specialties and sub specialties of Neurosciences are outlined in this Strategy, it has been identified that there are a number of issues which impact on wider pathways across Wales and span across both WHSSC and Health Board Commissioning. This work will be undertaken alongside the development of the Strategy can be rolled out to other areas which have been highlighted through the discussions with Stakeholders and working group meetings. There is also the opportunity to strengthen the proposals for those areas that we know are in urgent need of funding to bring the services up to national standards and in line with services provided in NHS England.

The ongoing consultation identified four immediate areas of focus which represent a cross section of the Specialised Neurosciences programme. Focussing on these areas in 2017/18 will help to stabilise not only these services directly, but also other specialised Neurosciences services commissioned by WHSSC and individual Health Boards. The schemes have been selected from the 54 schemes that have been discussed to date, which when worked through over the next five years, will help in sustaining Specialised Neurosciences for NHS Wales:

1. Provision and utilisation of Specialised Rehabilitation Services
2. Provision of Paediatric Neurology
3. The delivery of Neuro-Radiology
4. Provision of Spinal Surgery

3.3 Specialised Rehabilitation Services

Scoping work and assessments of specialised rehabilitation services provided to patients from NHS Wales, including benchmarking against the British Society of Rehabilitative Medicine standards, present a picture of overwhelmed services, which are unable to meet demand and provide timely rehabilitation. The principle reasons for this are inadequate staffing levels and inability to discharge patients back to Health Boards following the completion of specialised rehabilitation. The reasons behind the inability unable to discharge patients back to Health Boards range from lack of appropriate beds for these patients due to lack of provision of DGH beds within C&VUHB and BCUHB to perception of appropriately trained staff to manage the patients locally in other Health Boards.
This does not appear to be the case in Powys, where the Consultant Therapist led model does appear to have the repatriation of patients to as close to home as possible as a prime motive and have developed skills in tracheostomy care for example, in order to achieve this.

3.3.1 South Wales provision of Neuro Rehabilitation

Within South Wales, acute and post acute neuro-rehabilitation is provided in Rookwood and Neath Port Talbot Hospital.

The Neuro-Rehabilitation Unit in Rookwood which consists of 18 beds, is due to relocate to Llandough Hospital in 2018. WHSSC has provided commissioning support to the re-provision of Neuro and Spinal Rehabilitation in Llandough in order to mitigate the poor physical infrastructure issues experienced in Rookwood. This is viewed as a short term solution whilst a more appropriate location for delivering Specialised Rehabilitation services is found. The Llandough proposal requires current services to be delivered differently due to the changing model which will include an increase of single rooms rather than nightingale wards and the services being provided over two floors. WHSSC has been made aware that there will be additional revenue consequences of managing the transfer of patients from the ward area to therapy rooms within this new footprint, but the detail of this has not yet been fully described. WHSSC are being involved in the planning process for this transfer so will be able to highlight the revenue requirements through the Integrated Commissioning Plan process.

The Neath Port Talbot Rehabilitation Unit consists of 12 beds which is below the recommended guidance for minimum number of beds for a Unit, by the British Society for Rehabilitation Medicine. This supports the model recommended in the Axford review of the two Units in South Wales working in collaboration, although such network arrangements have yet to be established. Concerns have been raised over the utilisation of the Neath Port Talbot rehabilitation capacity for other patients, notably for Intrathecal pump trials and spasticity management which is not commissioned by

WHSSC. This highlights potential issues with the charges made to the bed day contract and more importantly, inappropriate use of the WHSSC specialised rehabilitation capacity. These issues are currently being raised by WHSSC with Senior Management in Abertawe Bro Morgannwg UHB.

3.3.2 Lack of Level 2 Rehabilitation in North Wales

For patients from North Wales, access to level 2 rehabilitation is limited to what is commissioned from NHS England, as the Price-Morris review recommendation for an inpatient rehabilitation centre to be established in North Wales has yet to be implemented. When funding was made available by Welsh Government through the Neurological Conditions Implementation Group for rehabilitation schemes that would benefit patients who had suffered from both stroke and neurological conditions, BCUHB submitted a proposal for a level 2 Rehabilitation Unit to be established in Llandudno. Unfortunately the sum of the bid was higher than the total monies available. BCUHB were however allocated a portion of funding for capital and a Project Manager to scope out the work required to establish a Rehabilitation Unit.

In terms of the English contracts, delays in discharging patients to appropriate beds results in higher spend and a threat of limiting the number of Welsh patients who can be accommodated by a provider at any one time.

WHSSC's annual Audit Day for Specialised Rehabilitation in November 2016 saw all of the NHS England providers present highlighting the issue of delays in patients being appropriately repatriated. This was leading to longer than necessary lengths of stay and patients distance from their family and friends which is recognised as key for improvements in rehabilitation.

3.3.3 Lack of cohesion in Commissioning of Rehabilitation

There are also delays for patients from Powys and BCU UHB under the care of NHS Trusts in England when determining if required specialised rehabilitation placements will be funded by Health Boards or WHSSC. This is due to rehabilitation provision being commissioned by both Health Boards and WHSSC depending on the site.

There is a proposal within 2017/18 to work with the relevant Commissioning Leads in BCUHB and Powys tHB on exploring the consolidation of the specialised rehabilitation contracts that they hold, including with Clatterbridge Rehabilitation Centre as part of the Wirral University Teaching Hospitals NHS Foundation Trust and University Hospitals of North Midlands NHS Trust. Apart from resolving the issue outlined around unclear lines of responsibility for commissioning, there could also be financial efficiencies from such consolidation.

3.3.4 Effect of rehabilitation delays in South Wales

For the South Wales services, such bottlenecks also have an effect earlier in a patient's pathway, with cancellations of elective admissions and patients waiting in excess of the referral to treatment targets for Neurosurgery.

Measures have already been taken through the revision of the Specialised Rehabilitation policy to re-affirm WHSSC's commissioning intentions and introduce a system which will highlight patients who have completed their specialised rehabilitation but due to delayed discharges remain in a specialised unit. However, the amendment of the policy only goes part way to produce whole system change.

There are opportunities of improving patient flow throughout the whole Neurosciences system by reducing the time to discharge once a patient's rehabilitation is complete. Improved flow would allow patients to receive rehabilitation earlier in their pathway which is proven to be more effective and consequently reduces the burden of disease on both health and social care. Further investigation in the current flow for Rehabilitation of North Wales patients is required with a view to redesigning the delivery model of Rehabilitation following this work. Proposals have been received from both the Sid Watkins Unit, the Walton Centre and Robert Jones Agnes Hunt Orthopaedic Hospital to increase their level 2 provision which makes up for the shortfall of this capacity within BCUHB.

The Neurosurgery service in Cardiff would also benefit from improved flow to the Rehabilitation wards with the service regularly having to cancel surgery due to unavailability of beds. A scheme to reduce the long waits within Neurosurgery through increased theatre capacity was proposed for inclusion in the 2017/18 ICP. However as one of the main reasons for not being able to meet the targets is unavailability of beds and this scheme does not address this specific issue, the decision was taken to remove the scheme from the ICP until the wider capacity issues begin to be addressed.

3.3.5 Spinal Injuries Rehabilitation

3.3.5.1 Spinal Injuries Unit, Rookwood

The Spinal Injuries Unit in South Wales consists of 26 beds and between 110-120 referrals each year managed by one Spinal Injuries Consultant who is also the Clinical Lead for Rookwood. The bed numbers were reduced from 36 in 2010/11 in order to establish community rehabilitation teams. The impact of these community teams is not known and will be assessed.

The Axford Review advised that there should be additional Consultant support in the spinal unit, as the reliance of one Consultant made cover of the Unit itself vulnerable and did not allow for outreach working. This is echoed in national benchmarking which the Unit underwent alongside other

Spinal Injury Units in England, which showed that due to limited numbers of staff across the whole Multi-disciplinary team, the service was only able to help 44% of patients with spinal cord injuries.

3.3.5.2 Robert Jones Agnes Hunt, Oswestry

The Spinal Injuries Unit consists of 44 of beds and in 2015/16 received 5 referrals from Welsh Hospitals, 4 from BCU and 1 from Hywel Dda. A case was submitted by Robert Jones Agnes Hunt as part of the 2017/18 IMTP process, for additional beds in a 'step-down' facility. This was in order to try and manage the increase in the number of delayed discharges the service was encountering from both English and Welsh patients.

3.3.6 Updating of Specialised Rehabilitation Policy

The Specialised Rehabilitation Policy which applied to the services of Neuro-Rehabilitation, Spinal Rehabilitation and Neuropsychiatry was due for review in July 2016. Following discussions with Stakeholders in formulating this Strategy, a session of the Specialised Rehabilitation Audit Day in November 2016 was allocated to discuss the policy. All providers of Specialised Rehabilitation were present and all Health Boards had been invited to attend the Day.

Two changes to the Policy were proposed by WHSSC for discussion:

1. to split the policy into two in order to represent Rehabilitation and Neuro-psychiatry separately; and
2. to introduce a time limit for WHSSC funded specialised rehabilitation which would help to highlight the patients experiencing a delayed transfer of care to Health Boards. The relevant clinical team would advise after a 12 week period if the patient still required specialised rehabilitation and if not, the patient's Health Board would be advised and given 8 weeks to find a suitable placement for the patient or be charged for the ongoing specialised rehabilitation that was deemed as unnecessary.

A similar process for highlighting of delays in repatriation is applied in low secure mental health services and led to significant reductions in the number of patients with delayed discharges.

Formal consultation of the policy has been completed and the policy is due to be ratified at the June meeting of the Management Group.

3.3.7 Neuropsychiatry

The Neuropsychiatry service that has recently moved to Llandough Hospital is a tertiary service for the whole of the South of Wales. The service is unique being the only one in Wales but also because it treats patients with Neuropsychiatry, Neuro-behavioural and Neuropsychological conditions. In NHS England these three services are often managed separately with dedicated staff and facilities for each. The service only has one Consultant medical post, a Consultant Neuro-psychiatrist, although it has recently recruited to a part time junior registrar post to provide support.

WHSSC commissions 10 inpatient beds and also funds the out-patient service at the Llandough site. Despite the service having new facilities, compared to the previous site in Whitchurch, the layout is quite isolating, without the communal lounge which encouraged integration and communication.

The patients referred require more than neuropsychiatry support as they are primarily transferring from neuro-rehabilitation centres. In order to replicate the level of care that patients at the neuro-rehabilitation centres receive, the Directorate advise there is a need for more equipment and an increase in staffing although this has not been formally outlined in a business case.

Therapies staff are also shared between sites and it is felt that their infrastructure is not sufficient to provide a robust and comprehensive package of care for very complex patients. We are looking at benchmarking this service in terms of staffing but as stated previously, Neuropsychiatry services are delivered very differently across the country.

The primary concern of the service is timely discharge and the impact that this has on the flow of patients in and out of the facility which does have a waiting list. We have recently part funded, along with the resident Health Board for a patient to receive inpatient treatment in a private facility due to being inappropriate for a rehabilitation bed, but unable to access a bed on this Unit.

The contracting mechanisms for Neuropsychiatry are also historical and no longer reflect way in which the service is delivered. Whilst those that require inpatient care appear to be of an increasingly higher acuity, there is also a shift from day care provided on site to support provided in local communities. Work is required to benchmark these changes in activity before making any contract adjustments.

3.3.7.1 North Wales Neuropsychiatry provision

There is currently no clear pathway in place for the Neuropsychiatry treatment for patients from North Wales. Whilst patients from North Wales are able to access the service from Llandough hospital, over recent months

only one Individual Patient Funding Request has been received for a North Wales patient to access this service. It is currently unclear how many patients are in need of this service from North Wales and therefore further exploration is required. Discussions with relevant clinicians including the Clinical Lead for the North Wales Brain Injury service advise that there is certainly unmet demand for this speciality.

Assessment of whether a service based in Llandough is appropriate for patients in North Wales given the distance and the fact that for many other such specialist services, contracts are in place with providers in North England also needs to be taken into consideration.

The Clinical Director for Mental Health in BCU has advised that although they the Health Board has Consultant Psychiatrists with an interest in Neurological conditions, dedicated Neuropsychiatry support is required. Until recent years, there was a part time Consultant Neuro-psychiatrist who worked between BCU and Bangor University but following the post-holder's re-location to Cardiff University, no replacement has been made.

3.4 Provision of Paediatric Neurology

The provision of specialised Paediatric Neurology in South Wales is vulnerable with 50% of the Consultant body due to retire within the next five years and the services being commissioned by both WHSSC and a Health Board, which restricts a pan South Wales approach to recruitment and retention. As Paediatric Neurology is a fundamental element of Paediatric Neurosciences, any shortfalls within it, will have a profound effect on the whole Paediatric Neurosciences system and the ability to deliver it within Wales. It is proposed that a collective commissioning approach be taken to Specialised Paediatric Neurology in South Wales between ABMUHB and C&VUHB and in North Wales between BCUHB and Alderhey.

Elements of Paediatric Neurology and interdependent Paediatric Neurosurgery service are provided to NHS Wales from England in a piecemeal fashion and repatriation of these services with limited financial requirements would go towards stabilising the workforce and provide the added benefit of more local services to patients.

3.4.1 Paediatric Neurology in South and Mid Wales

Specialised Paediatric Neurology is commissioned from the Children's Hospital of Wales, Cardiff and Alderhey Children's Hospital. An additional Paediatric Neurologist funded by ABM UHB undertakes specialist clinics in both ABM UHB and Hywel Dda UHB which avoids the need for a number of patients to access the Cardiff service. However, this post-holder has recently retired and returned to work part-time which is likely to increase the demand on an already under-resourced Specialist Centre.

3.4.2 Paediatric Neurology for patients in North Wales

In North Wales, Paediatric Neurology support is provided by Alderhey in terms of both inpatient care and outreach clinics and ongoing locally by Consultant Community Paediatricians. The long standing Lead Paediatrician with a special interest in Neurology retired completely from the service in April 2017, but has been replaced with another Paediatrician with an interest in Neurology. There have been discussions around a joint Consultant Paediatric Neurologist post between BCU and Alderhey which has the potential to minimise admissions to Alderhey and reduce patients overall length of stay, with specialist support provided within North Wales.

3.5 The delivery of Neuro-Radiology services

Specialised Neuro-Radiology services are provided in both ABM UHB and C&V UHB although at a reduced level from when Neurosurgery was provided on both sites.
All the activity undertaken within ABMUHB is Health Board commissioned.

Although Neuro-Radiology is considered a specialised service with only C&VUHB and ABMUHB employing Consultants with this sub specialty training, there are no Neuro-Interventional Radiologists employed by ABMUHB. WHSSC does not currently commission Neuro-diagnostics but given that this is a essential element of the Neuro-Interventional Radiologist and it is categorised as specialised work, the commissioning of Neuro-diagnostics does need to be considered by WHSSC. As part of this consideration, WHSSC would need to understand why the C&VUHB is the only Radiology Department in the country which directs all Head scans to be reported by a Neuro-Radiologist. Given the current shortfall in such specialists, this creates a risk for the reporting of what elsewhere is a department wide activity.

WHSSC is only responsible for commissioning Neuro-Radiology as part of a Neurosurgery episode with the remaining and majority of work undertaken in C&VUHB commissioned by Health Boards.

For patients in North Wales, dedicated Neuro-Radiology is accessed through the Walton Centre although scans are undertaken in North Wales where possible with results accessed by the relevant staff in the Walton.

3.5.2 Neuro-Radiology in Cardiff

WHSSC is only directly responsible for funding the Consultant Neuro-Interventional Radiologist post that was agreed in 2015/16 in C&VUHB. This was following the resignation of one of two Consultant Interventional Radiologists. This resignation had resulted in the Interventional Radiology service temporarily being suspended in Cardiff and provided in Bristol. The WHSSC funded post increased the number of Neuro-Interventional

Radiologists to three which aimed to stabilise the Neuro-Radiology service and the intrinsically linked WHSSC commissioned Sub-Arachnoid Haemorrhage service. A case to fund the support staff to work alongside the Consultant post which was part of the original case in 2015/16 was approved as part of the 2016/17 IMTP. This removed the need for the service to displace Radiological lists for other services such as ERCP in order to utilise the additional Neuro-Interventional Radiologist's time to carry out interventions.

In March 2017 we were advised that resignations had been received from two of the three Consultant Neuro-Interventional Radiologists, leaving one substantive post-holder. Although advised that the post-holders end dates were at the end of May/beginning of June, due to leave entitlements both post-holders finished working for C&VUHB week ending 12th May. A Locum Consultant was recruited prior to these post-holders leaving, with a second Locum Consultant currently being secured. Currently this loss of staff leaves the Neuro-Radiology rota for South East Wales extremely vulnerable with lack of cover on a recent weekend and Monday and this week, requiring the Health Board to confirm support from NHS England. Bristol as the nearest provider of Neuro-Interventional Radiology was unable to help over the weekend due to a Major Incident associated with the recent cyber attacks, but arrangements were put in place with Birmingham where one patient was successfully transferred for treatment. Contigency arrangements for this current week of the Locum absence are still to be confirmed by C&VUHB.

3.5.2.1 On call rota

The Steers Review highlighted the need to establish a single on call rota across South Wales but this has not been introduced to date. The C&VUHB rota which provides cover for South East Wales, is a 1 in 6 rota for Neuro-Radiology so when all in post, consists of three Neuro-Interventional Radiologists and three Neuro-Diagnostic Radiologists who do not undertake Interventional procedures. Any such procedures that are required when the Diagnostic only Consultants are on call, were prior to the recent resignations, undertaken by the three Interventional Radiologists on a goodwill basis.

Given the sustainability issues that have arisen revisiting of the Steers recommendation needs to be considered, along with formal networking arrangements with either Bristol or Birmingham to ensure that Neuro-Interventional provision is available seven days a week.

The Walton Centre runs a dedicated Neuro-Interventional rota and the benefits and effectiveness of this should also be looked into.

3.5.2.2 Imaging capacity in South Wales

Insufficient imaging capacity in C&VUHB, the only tertiary provider of Neurosciences in South Wales, has been raised by a number of individuals during the scoping work for this Strategy.

The Cardiff service which has three adult Magnetic Resolution Imaging (MRI) scanners and one paediatric MRI scanner across its two main sites has the oldest MRI scanners within Wales, with all the adult scanners being obsolete. Waiting times for standard diagnostics such as cerebral arteriograms are over 6 months which is unacceptable, particularly when comparing with the waiting times of equivalent diagnostics in Cardiology. It is estimated that it undertakes 66% of all Neuro MRIs within Wales.

A paper submitted to the National Imaging Programme Board (NIPB) in September 2012 highlighted the increase in demand on radiology services and that resources were stretched. The paper also highlighted that a seven-day scanning service at major acute hospitals has yet to be implemented across Wales. We are aware that Cwm Taf is the only Health Board in South East Wales outside of Cardiff that have a 24 hour on call rota for Radiographers.

The South Wales Imaging Collaborative (SWIC) undertook a review of Radiological equipment in 2015, the purpose of which was to provide an all-Wales view of the usage of imaging equipment and to determine what capacity was available to move toward a seven-day imaging service. The report highlighted the increased use of equipment will lead to the increased need to replace machines in the coming years, the data shows that 87% of imaging department machines/scanners will require replacement by 2017.

The National Audit Office's report *"Managing high value equipment in the NHS in England"* (2011)[1] examined the management of three types of high value equipment in the NHS, including MRI and CT scanners. It stated that value for money was not being achieved in the planning, procurement and use of high value equipment. There certainly does not appear to be a collective approach from NHS Wales and Welsh Government in establishing a clear programme for the purchasing of MRI scanners.

3.5.2.3 Utilisation of CUBRIC

The Cardiff University Brain Research Imaging Centre (CUBRIC) has the same number of MRI scanners but of a far higher specification than the Cardiff NHS service. The potential for NHS Wales to utilise these facilities is being explored.

3.5.3 Introduction of Clot Retrieval/Mechanical Thrombectomies

[1] Department of Health "Managing high value equipment in the NHS in England" (2011) https://www.nao.org.uk/ wp-content/uploads/2011/03/1011822.pdf

One of the main developments within Interventional Radiology is the emerging technologies in clot retrieval treatments for strokes. The treatment for acute stroke was approved by NICE in Feb 2016 and led to the publication of Interventional Procedures guidance "Mechanical Clot Retrieval for treating acute ischaemic stroke".

The procedures are undertaken by the Interventional Radiologists although there are discussions around Cardiologists increasingly undertaking this work in the future. Although stroke services and treatments are not commissioned by WHSSC, the treatment is high cost and similar to interventions used within Neuro-Radiology and is using the skill set and capacity of Consultants that are primarily employed for Interventional Neuro-Radiology.

The service has been developed locally in Cardiff and Vale UHB by existing Neuro-interventional Radiologists and Stroke Consultants for patients from across the six Health Boards in South and East Wales, with Health Boards charged on an individual patient basis following the undertaking of the emergency procedure. The procedure has not been introduced as a WHSSC commissioned service although a proposal from C&VUHB and strongly supported by the Clinical Lead of the Stroke Implementation Group was submitted for inclusion in this year's ICP. It is unlikely given the limited resource that has been invested and the recent staff departures, that all those who would benefit from the treatment are receiving it.

In order for the service to be formally commissioned by WHSSC it would require agreement by Joint Committee.

3.5.3.1 Access to treatment by North Wales patients

Patients in North Wales have had limited access to this treatment in the Walton Centre to date, with the Centre reporting at the end of March 2017, that they had undertaken less Thrombectomies during the year on both English and Welsh patients, than the Cardiff service. However, NHS England's announcement in early April 2017 that they will be commissioning mechanical thrombectomies from the twenty-four Neurosurgery centres across England will certainly change this. The treatments are expected to be phased in later in the year which gives time to understand the effect that this will have for patients in North Wales and the increased inequity that this will bring with the service not being formally commissioned for patients in Mid and South Wales.

Whilst the expansion of the provision in England has to be viewed as positive, such an increase in the recruitment of Neuro-Interventional Radiologists to undertake these procedures is likely to impact conversely on

the ability of the Cardiff service to recruit from an already limited number of specialists.

3.5.4 Reviews of Neuro-Radiology in Cardiff

The Radiology service in Cardiff in its entirety has undergone a number of reviews in recent years, with the highest profiled Service Review conducted by NHS England. This concluding that whilst the service has the potential to be leaders in health provision with an excellent calibre of clinical staff, sub-specialisation has achieved clinical excellence at a cost of providing a DGH service to the local population. Whilst mindful not to repeat this work, it is recommended that a Peer Review process is used to undertake an over-arching review of the two Specialised Neuro-Radiology services to understand the priorities for the service.

3.6 Scoping of other Neuroscience specialities

3.6.1 Neurosurgery

Benchmarking undertaken by the Society of British Neurosurgeons (SBNS) has shown that for the population and levels of activity undertaken in Cardiff, there should be at least 14 Consultant Surgeons and three theatres with the capacity to work seven days a week. Currently in the C&VUHB service there are 9.5wte Consultant Surgeons and two theatres which run for two sessions a day, five days a week.

Phase one of the Core Neurosurgery case which was agreed in 2016/17 looked to address the immediate staffing shortfalls in junior medical staff and nurse practitioner support. Phase 2 of the Core Neurosurgery case which C&VUHB is currently developing is looking to improve the sustainability of core neurosurgery by increasing both the theatre and bed capacity of the service. Given the known capacity shortfalls in Theatres in C&VUHB and likely need of a capital build to increase the theatre capacity for Neurosurgery, it is imperative that the planning for this resource commences. Although efficiencies could be made with existing resource such as running three session days, this would not be a long term solution. The impact of introducing a third session day in other specialties has shown that it doesn't create the equivalent throughput of a session in the morning or afternoon as a number of lists already over-run into this period and also there are case-mix limitations to avoid over-runs into the night.

As a Welsh Government priority 1 target that has not been achieved in the Cardiff Neurosurgery Service for at least the last five years, it is imperative that a scheme to address the deteriorating performance against the maximum target of 36 week Referral to Treatment (RTT) target is included in the priorities for 2017/18.

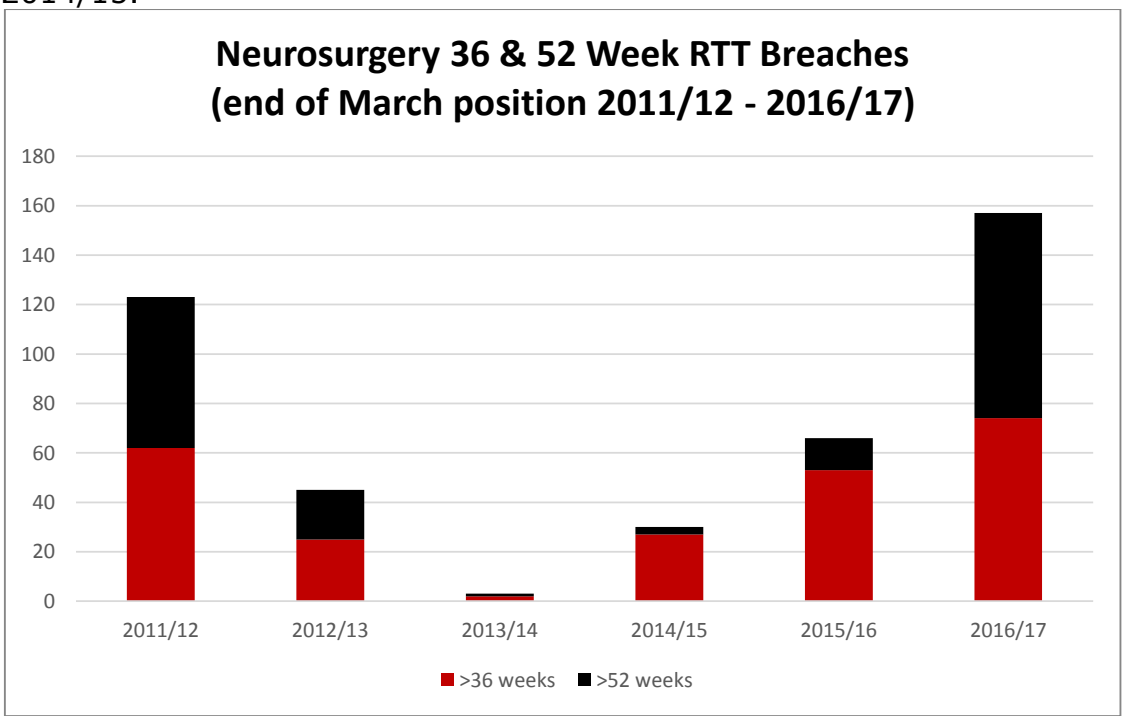
On average, 98% of patients from North and Mid Wales who undergo their neurosurgical treatment in NHS England are receiving treatment within the 26 week RTT target.

With a significant number of patients waiting over 52 weeks for surgery, solutions needs to be identified that will reduce the waiting list backlog and sustain at least a 36 week maximum wait for Neurosurgery patients, working towards the maximum wait of 26 weeks RTT in line with the Welsh Government guidance and the maximum waits experienced by North and Mid Wales patients in NHS England.

The graph below shows the C&VUHB Neurosurgery performance against the 36 week RTT target over the last five years.

Whilst the overall over 36 week waiting list position in 2016/17 was only a slight deterioration on the end of 2015/16, the number of patients waiting over 52 weeks was significantly higher than in previous years, with the longest wait over 120 weeks.

The table below shows the number of Neurosurgery patients waiting over 36 weeks split by >36 weeks-51 weeks and >52 weeks. There has a been a significant deterioration in the waiting list volume and position since 2014/15.



Monthly performance meetings with the Specialised Services Clinical Board have advised that the long waits can be attributed to delays in receiving Surgery and Radiology (predominantly in the form of cerebral angiograms) interventions and additional capacity in both these areas needs to be

sought. An increase in Neurosurgery emergencies and delayed transfers of care have led to cancellations of elective surgery due to bed unavailability, however, these difficulties have only worsened an existing capacity shortfall.

3.6.1.2 North Wales

The Walton confirmed that currently they are the only service within the UK meeting the NHS England target of spinal surgeries undertaken within 18 weeks of referral. The service is also meeting this target for Welsh patients. It is important to note that this is in a context where they have no Accident and Emergency and therefore for do not suffer the adverse affects of high levels of emergency cases As they are a stand alone facility they also do not have medical outliers.

3.6.2 Paediatric Neurosurgery

Within the Cardiff service there are three paediatric Neuro-surgeons undertaking on average, 100-150 cases a year. The Lead Surgeon advises that the elective: emergency split is 90:10 when it should be 70:30. The service provides 2 outreach clinics a month in Swansea.

The service is looking to develop in three areas that will bring a number of benefits, notably repatriating activity from England which in turn, increases the service's elective throughput and sustainability.

- **Baclofen pumps**. Spasticity activity is currently carried out in Bristol and Birmingham. The service has the surgical expertise in both Neurosurgery and Orthopaedics to provide Baclofen pumps and with the recent addition of a part time Consultant Paediatric Neurologist, there is potential capacity within the Paediatric Neurology team to input into the required Multi-disciplinary team.
- **Simple cranio-facial work**. Activity is currently carried out in Birmingham but repatriation of this work would reduce the travel time for patients and increase the sustainability of the service.
- **Paediatric epilepsy surgery** is currently commissioned from Great Ormond Street although Bristol is another of the four centres designated as a Children's Epilepsy Surgical Service (CESS) by NHS England. The Cardiff service has the expertise and equipment required to undertake such surgery on children over 3 years old, although investment would be required to increase capacity in job plans and infrastructure. The demand for the service is estimated to be 35 patients investigated each year for treatment, with 20 of these going on to surgery which for 75% of cases, can resolve the illness.

The main problem area for the service is lack of General Anaesthetic (GA) MRI capacity, with the current waiting list of up to a year for under 8s (children over 8 are able to tolerate an MRI without a GA). There is a need

to explore opportunities for increasing MRI throughput as well as look at increasing the number of lists. There is a dedicated paediatric MRI scanner within the Children's Hospital which is not currently commissioned five days a week, so there is the capacity for additional lists if staffing levels were increased. We are advised that Manchester's Children's Hospital changed the model of delivering MRI from general anaesthetic to sedation which increased throughput on existing lists, but required a different staffing model which we need to understand.

3.6.3 Neuro-Oncology

The all Wales Cancer Network undertook their first peer review of a tertiary cancer, within Neuro-oncology in November 2016.

A number of key issues and significant resource shortfalls in the South were identified as the outcome of the review. The review noted significant inequity in the services provided to patients in the North of Wales who access the Walton Centre to patients in South and West Wales who access their services from UHW, Singleton Hospital and Velindre. The stark difference in staffing and provision available at the Walton compared to that in the South was evidenced as part of the peer review.

The review also identified a number of key risks in particular:

- Limited CNS resource does not support the service and the level of risk increases due to absence of the South West CNS form all MDT's.
- Radiological delays impede the planning of essential treatment and causes delays to patient care.
- No Allied Healthcare Professional (AHP) input impacts on the treatment for patients, absence from the MDT also delays recovery and increases length of hospital stay.

In light of the findings and subsequent risks, a proposal has been included in the 2017/18 IMTP to seek to stabilise the service with formal arrangements and inclusion of duties within job planning. It also seeks to increase the level of CNS support in the South West region to ensure attendance at the MDT and better support for patients. The scheme also seeks to ensure AHP attendance at the MDT with a dedicated support within the service.

This scheme is the first phase of addressing these issues and there are subsequent schemes being discussed by the Working Groups and representatives from North Wales.

The all Wales Cancer Network are due to undertake their first peer review of a tertiary cancer, within Neuro-oncology in November 2016. This will involve the only Welsh Neuro-oncological service in Wales based in Cardiff and the Walton Centre which serves the North Wales population. WHSSC

are participating in this review as the commissioner for Neuro-oncology services for both providers.

The review, like those that have already taken place for common cancers, will consist of two elements; a requirement for the MDTs to respond to a range of qualitative and quantitative questions in advance of a site visit where the members of the MDT are 'interviewed' by a number of peers. Following this visit, the Cancer Network will construct a written board which in turn should generate a response by way of an action plan from the relevant Health Board and WHSSC in the case of a specialised service which they commission. These documents are in the public domain with the expectation that they are updated at least annually.

The report is likely to highlight the shortfalls that the service in Cardiff has already identified to WHSSC as part of this scoping work. The shortfalls include –

- Lack of access to a Neuro-oncology Clinical Nurse Specialist in West Wales. This issue was raised in a patient survey undertaken by the Brain Tumour Charity.
- Limited allied health professional input – no cover for neuro-psychologist, no speech therapy support in Theatres which is best practice. Lack of dedicated preparation time in job plan of one of the attending Radiologists.

3.6.4 Deep Brain Stimulation

For patients in South and Mid Wales, the Deep Brain Stimulation service from pre-operative to post-operative care is currently provided on a prior approval basis from North Bristol NHS Trust. Whilst the referrals to the service are closely monitored through a Consultant Neurologist Gatekeeper, there are efficiencies than could be gained by undertaking elements of the pre and post operative care of patients in Local Health Boards. Whilst WHSSC is supportive of this proposal, the details of it have yet to be worked through and feature as one of the schemes on the Neurosciences Strategy workplan.

3.6.5 Spinal Surgery

Although a Spinal Neurosurgery Service exists in Swansea, following the transfer of Neurosurgery from Swansea to Cardiff, WHSSC does not commission any Neurosurgery from ABM UHB.

Whilst WHSSC does not have a service specification or policy for Spinal Surgery, NHS England published a Complex Spinal Surgery service specification in 2013.

It stated that "delivery of complex spinal surgery services must recognise the shared involvement of both orthopaedic and neurosurgical specialties"[2]. Although Spinal Surgery undertaken by a Neurosurgeon is commissioned by WHSSC, Spinal Surgery carried out by an Orthopaedic Surgeon is commissioned by Health Boards and is managed under the Surgical Clinical Board rather than the Specialised Services Clinical Board in C&VUHB. Both the separate commissioning and management arrangements were highlighted as a concern during a meeting of the Neurosurgery working group.

The NHS England service specification details the procedure codes for specialised and standard spinal procedures. When cross checking the C&VUHB waiting list against these codes, 70 cases currently listed would be considered standard rather than specialised. As the longest waits currently on the C&VUHB Neurosurgery waiting list are predominantly patients awaiting spinal procedures, introduction of a similar specification would have a significant impact on both the volume and times of the waiting list.

The Spinal work-stream of the South Wales Collaborative has been developing a draft service model based on the NHS England service specification outlined abovel. Although the document was discussed at one of the WHSSC Neurosurgery working groups, it had not been signed off by all Consultants involved and could not be shared outside of the Spinal work-stream.

Discussions with United Hospitals Birmingham NHS Trust also advised that they have introduced a number of alternative treatments such as Pain Management and Physiotherapy support in order to ensure that only patients for whom there is no alternative to manage their pain, undergo spinal surgery under the care of Neurosurgeons. We understand that this intervention work is commonly applied to Orthopaedic pathways and will explore this being utilised within Neurosurgical lists in C&VUHB.

3.6.6 Skull based Surgery

Prior to one of the most recent Consultant appointments in Cardiff, skull based surgery for patients in South Wales, was undertaken in London and Cambridge as well as Cardiff. This activity has been repatriated with plans to also repatriate the activity from Sheffield to Velindre following the establishment of a Stereotactic Radiosurgery (SRS) service in 2014/15. Cardiff is funded directly by Velindre who are funded by WHSSC for SRS activity, for the Consultant Surgeon's time.

[2] NHS England *"NHS Standard Contract for Complex Spinal Surgery"* (2013) https://www.england.nhs.uk/wp-content/uploads/2013/06/d14-comp-spinal-surg.pdf

A phased approach to repatriation from Sheffield to Velindre was agreed with completion due in 2016/17. However, the number of SRS cases carried out in Sheffield increased from 15 in 2015/16 to 28 in 2016/17. It is hoped that with the recent appointment of a substantive Neuro-Vascular Consultant in C&V that repatriation will be completed in 2017/18 but a meeting with Velindre and the relevant Neurosurgeons is being convened to understand their recent underperformance.

Demand for skull based surgery is high with many cases requiring a three session theatre list, when all theatre lists within Neurosurgery are only funded for two sessions a day. There is little flexibility and opportunity within the system to undertake additional lists due to the limited theatre capacity described in previously.

There is a requirement for skull based cases to be monitored in theatre by a Neurophysiologist, but there are insufficient Neurophysiologists in Cardiff to undertake this work. A theatre company representative is currently aiding in the monitoring of cranio-nerve surgery undertaken free of charge, but this support will not continue indefinitely.

Best practice for patients undergoing cranial and neuro-oncology cases is to receive imaging 72 hours post surgery. This has not possible due to lack of MRI capacity which is raised as a wider issue.

The insufficient level of Neurophysiology support and post surgery imaging is believed to have arisen from the fact that the current Consultant's role utilised funding from a retired Consultant of a different subspecialty and there was less requirement for these elements. A case for effectively commissioning a skull based service has not presented to WHSSC for consideration.

3.6.7 Epilepsy Surgery

There is currently one part time Epilepsy Neurosurgeon in the Cardiff service funded by the NHS and Cardiff University respectively. This service was repatriated from Queen's Square, University College London's Hospital and required set up costs for additional staffing in order to be established. Currently the service is not undertaking the levels of Surgery undertaken.

An estimated 50% of patients assessed go forward for surgery. WHSSC only fund the assessment for those patients that go on to have surgery. This restricted assessments for only those who showed potential for surgery in their initial referral letter, has therefore hidden demand.

Assessments undertaken by the Neurosurgeon, Neurologist and Neurophysiologists include EEG and Telemetry, the latter carried out on the inpatient ward for a five day 24 hour recording and analysis.

Currently patients that require intracranial electroencephalogram (EEG)as part of their epilepsy diagnosis and treatment, undergo two separate surgeries; the first to attach the electrodes and the second surgery to remove them only or to remove and perform the epilepsy surgery. The department has received a donation of a *Neuromate Robot* to carry out Stereo EEG. The Robot which reduces the need for two separate surgeries saving theatre time and bed days and is less invasive for patients has just begun to be utilised.

3.7 Major Trauma Centre

As both the location and commissioning arrangements for the Major Trauma Centre have yet to be decided, the impact that this would have on Neurosurgery in Cardiff and Neuro-Rehabilitation in both Cardiff and Neath Port Talbot is not fully described in this outline document.

Given that the Department has already seen their Neurosurgery waiting list position deteriorate due to the increase of emergency patients who commonly have a longer length of stay, compared to elective patients, there is concern that the predicted increased numbers of patients will cause the waiting times to deteriorate further if additional capacity is not identified. Similarly for Neuro-rehabilitation, we have already described that the current service is overwhelmed due to staffing shortfalls and difficulties in discharging patients following completion of their specialised rehabilitation.

3.8 Neuropathology

Following the retirement of a Consultant Neuropathologist in 2013, there has only been one Neuropathologist in Wales, employed 50:50 by Cardiff University and the NHS respectively. Patients in North Wales are served by the Neuropathology service in the Walton.

The issues within Neuro-pathology are due to a limited medical workforce in this area rather than a lack of financial resources. There are a limited number of Neuro-pathologists being trained and posts have historically been part academic and research orientated, although research has decreased in recent years and it is not an area that attracts private practice. There have been a number of attempts to recruit to an additional Consultant post, with difficulty in navigating the GMC system and lengthy recruitment process highlighted as two areas that have exacerbated an already difficult process.

There have been recent internal developments within the Cardiff service in order to meet the standards of the Laboratory Inspection with a new dedicated Neuro-pathology laboratory and additional support staff planned. This will help to make the service more attractive to Consultant candidates

but until an appointment is made, options for strengthening the service further by collaborating with Bristol are being explored.

4.0 Next steps

Over the course of next six months we will use this detailed provision of Specialised Neurosciences services in NHS Wales to inform the five year Commissioning Strategy. We will clearly outline our commissioning intentions for Neurosciences services in NHS Wales; it is clear from this paper outlining the current provision that the services that we are currently commissioning are not delivering at the desired levels of quality and sustainability. This Strategy will be ready for implementation from 2018-19 when we aim to be in a position to financially support those services identified as high risk in the 2017-20 Integrated Commissioning Plan.

Through the financial working groups we will establish if our current contracts are providing value for money or if innovative ways of delivering them need to be considered. The work to date has identified areas of good practice and we will work with providers and Health Boards to roll these out.

As part of the final Strategy we will set out our work-plan on an annual basis for the course of the five years and details of the ongoing monitoring of the work.

Alongside the Strategy, we will begin work on the priorities outlined in this paper, notably:

- Respond to the urgent need to establish network arrangements with NHS England providers for Neuro-Interventional Radiology and request a review from the Royal College of Radiologists into how Neuro-Radiology can be effectively and sustainably delivered in South Wales.
- Ensure that the Neath Port Talbot Rehabiliation Unit is providing a service in line with standards, we will seek to create an Operational Delivery Network with service provided in Rookwood Cardiff.
- Appropriately commission specialist spinal surgery through publishing a service specification outlining our commissioning intentions for this specialty and work with providers to implement the necessary changes to listing patients for surgery under the care of Neurosurgery.

5.0 Recommendations

Members are asked to:

- **Note** the current provision of Specialised Neurosciences for patients in NHS Wales which will inform the Five year Commissioning Strategy;

- **Support** the urgent establishment of network arrangements with NHS England providers for Neuro-Radiology;
- **Support** the establishment of an operational delivery network for Specialised Rehabilitation in South Wales;
- **Support** the collective approach to the commissioning of Paediatric Neurology in both North and South Wales; and
- **Support** the proposal to implement a service specification for Specialist Spinal Surgery and a Phased implementation of application of this to the listing of specialist spinal patients within Neurosurgery.

Link to Healthcare Objectives	
Strategic Objective(s)	Development of the Plan Organisation Development Governance and Assurance
Link to Integrated Commissioning Plan	The Neurosciences Commissioning Strategy is to inform future Integrated Commissioning Plans.
Health and Care Standards	Staff and Resourcing Effective Care
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Reduce inappropriate variation Only do what is needed
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Improving Patient Experience (including quality and Satisfaction) Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	The Commissioning Strategy has been written with the Quality, Safety and Patient Experience at the forefront.
Resources Implications	Whilst this paper does not have any direct resource implications, its presentation of a number of Neurosciences services being significantly under-resourced, particularly in comparison with similar services in NHS England, recommends that resources are put into Neurosciences services.
Risk and Assurance	There is risk to patient safety as a number of services within Neurosciences for patients across Wales are not sustainable.
Evidence Base	A gap analysis was undertaken on the South Wales service compared to the English service specification which highlighted deficits in the provision of Neurosurgery compared to English counterparts such as the Walton Centre.
Equality and Diversity	There are clear inequities with the services that patients receive geographically in terms of Neurosurgery with the service received by patients in North Wales in the Walton Centre and in South Wales received in Cardiff. There are also notable reduce inequities between West and East Wales in accessing other services such as acute neuro-rehabilitation.
Population Health	There are no known effects on Population Health associated with this paper.
Legal Implications	There are no known legal implications associated with this paper.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	17/05/2017	Include recommendations for each of the five years of the Strategy

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

PROJECT INITIATION DOCUMENT

Project name	Developing a Commissioning Strategy for Specialised Neurosciences	
Programme	Neuroscience	
Product number	M1	
Release	Version	1.1
	Date:	19 January 2017

Author:	Assistant Planner – Neurosciences and Complex Conditions
Owner:	Assistant Director of Planning
Client:	Acting Director of Planning
Document Number:	

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Developing a Commissioning Plan for Specialised Neurosciences
PID *1.1* *19 January 2017*

Document History

Revision History Date of last revision: 19/01/2017

Revision date	Previous revision date	Summary of Changes

Approvals This document has been approved by:

Name	Date of Issue	Version
Corporate Directors Group	16/05/2016	0.1
Management Group	26/05/2016	0.1
Joint Committee	28/06/2016	1.0

Developing a Commissioning Plan for Specialised Neurosciences
PID *1.1* *19 January 2017*

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1 Purpose

This document has been produced to capture and record the basic information needed to correctly direct and manage the project. The Project Initiation Document (PID) addresses the following fundamental aspects of the project:

- the aims and objectives of the project;
- the expected benefits and outcomes of the project;
- the roles and responsibilities of those involved in managing the project; and
- the arrangements and timings to implement and manage the project.

When approved by the Project Board this PID will provide the "Baseline" for the project and will become "frozen". It will be referred to whenever a major decision is taken about the project and used at the conclusion of the project to measure whether the project was managed successfully and delivered an acceptable outcome.

2 Background

2.1 General

WHSSC is responsible for commissioning a range of specialised neurosciences services including:

- Neurosurgery;
- Interventional Neuro-radiology;
- Neuro-rehabilitation; and
- Spinal Injuries Rehabilitation

Over the last year, a number of issues have been raised regarding the neurosurgery service in South Wales. These include:

- Neurosurgery inpatient waiting times- currently the service in South Wales is not able to achieve the 26 week RTT, with a significant number of patients still waiting longer than 36 weeks;
- Functional Neurosurgery – the delay in replacing the previous lead neurosurgeon for the functional neurosurgery programme resulted in the need for the provider to use an English centre to manage new and existing patients. Following the appointment of a Locum Consultant, there will be a need for further work in order to identify the most appropriate model for the provision of a high quality resilient functional neurosurgery programme;
- Spinal Neurosurgery – following the consolidation of neurosurgery services onto a single site at UHW, there is still a requirement for further clarity on the remit of the spinal surgery service in Morriston Hospital, and in particular its interface with the Neurosurgery and Trauma and Orthopaedic service in UHW. Furthermore, in view of the imminent conclusion of the Major Trauma Centre project, there will be a need to understand how the service in Morriston and UHW interface with the new Major Trauma Centre; Trauma Units and District General Hospitals and

- Interventional Neuroradiology and Vascular Neurosurgery – following the resignation of a Consultant Interventional Neuro-Radiologist there was a need for the provider to use an English centre to manage new and urgent patients. Two additional Consultant Interventional Neuro-Radiologists were appointed to stabilise the service, although dedicated support staff are also required to ensure that the service runs at full capacity.

In addition there are a number of other all-Wales strategic issues which will require resolution over the coming years, including:

- Paediatric Neurosurgery – the impact of developments in NHS England, and the future relationships of the Welsh service with the new clinical networks;
- Adult and Paediatric Epilepsy Surgery – following investment in the South Wales service, further clarity is required on the development of a relationship with the service provided by North Bristol NHS Trust, and the in particular explore the opportunities for developing a local Paediatric Epilepsy Surgery Programme;
- Neuropathology – ensuring the provision of a sustainable service for South Wales;
- Neuro-rehabilitation, Spinal Rehabilitation and Neuropsychiatry – following on from the outcome of the Major Trauma Centre project in South and Mid West Wales, it will be necessary to agree a plan and service model for delivering these services in order to fully align the patient care pathways and ensure the best possible patient outcomes. There is a particular issue regarding neuropsychiatry services, as in the absence of a local inpatient service for patients in North Wales, it is not clear whether patients are able to access the specialist care they require following acute rehabilitation.
- Stereotactic Radiosurgery – the development of the service in Velindre presents an opportunity to repatriate further activity from NHS England (in addition to the cohort of North Wales patients that have already been repatriated to the Walton Centre) and explore opportunities for further development of the Velindre and Walton Centre services across a wide range of indications; and
- Stock-take of neurosurgery services against NHS England service specification – a stock-take of services was undertaken during Spring 2014, and the results were presented to the Management Group. The stock-take revealed gaps between the infrastructure and services provided to Welsh patients against the service specification. Further work is required in order to assess the significance of these gaps, and to make recommendations on the most appropriate way to address them.

2.2 Planning Responsibilities

The roles and responsibilities of each group are outlined in the project structure.

With regard to risk, the Project Board has three main responsibilities:

- Notifying the Programme Manager of any external risk exposure to the project
- Making decisions on the Programme Manager's recommendations to address risks.
- Striking a balance between the level of risk and the potential benefits that the project may achieve. Whilst we will be looking at flows to England, where pathways are working well, we will not be looking to disrupt and change them.

3 Project Definition

3.1 Project aim and objectives

The overall aim of the project is to undertake an assessment of the current provision of specialised neurosciences services for patients in Wales, including an evaluation of progress against the recommendations from the previous reviews of neurosciences services conducted between 2007 and 2010, in order to inform the development of a clear commissioning plan for specialised neurosciences services for the next five to ten years.

The following objectives have been identified:

- Refresh of the original stock-take documents – to provide a consistent baseline for the scoping exercise and project;
- Assessment of the current status of:
  - Neurosurgery at our largest providers Cardiff and Walton and all other Centres we access, including each of the neurosurgery sub-specialities:
    - Paediatric neurosurgery
    - Neuro-oncology
    - Functional Neurosurgery
    - Spinal surgery
    - Traumatology
    - Skull based surgery
    - Neurovascular surgery;
  - Interventional and diagnostic Neuro-Radiology;
  - Neuropathology;
  - Neuro-rehabilitation (acute and post acute);
  - Neuropsychiatry; and
  - Spinal injuries rehabilitation
- Assessment of health needs for Wales – Health needs assessment including predicted demand for neuroscience service over the next 5 and 10 years;
- Evaluation of progress against the recommendations from the previous reviews of neurosciences services conducted between 2007 and 2010;
- Development of plan document – including:
  - Vision for Neurosciences Service for Wales
  - Demand
  - Current Services

  - Gap analysis
  - Commissioning intentions, including:
    - Contract volume
    - Quality indicators
    - Performance indicators
    - Audit requirements
- Identify as part of the scoping exercise Neurology services, commissioned by Health Boards, that inter-relate with other specialised neuroscience services; and
- Identify areas of good practice and to learn from them.

4 Defined method of approach

The following forums will be utilised as reporting mechanisms for the project:

Project Board – The products and recommendations of the review will be considered by WHSSC Management Group.

Project Management Team – Regular updates, and draft recommendations for approval will be considered by the Programme Team for Neurosciences and Complex Conditions on a by monthly basis.

In addition four working groups, and eleven task and finish groups will be convened as required to progress the development of the key products. We are seeking external advisory support from key organisations including the Society of British Neurological Surgeons, to consider what has not been achieved since the previous reviews in 2009 and 2011 and to identify the key priorities for each of the services.

4.1 Project scope

The remit of the project will be to undertake a review of the structure and demand for Specialised Neurosciences Services delegated by Health Boards, to be commissioned by WHSSC. Whilst the review will not cover the non-specialised services commissioned directly by Health Boards, it will identify and scope interface issues in order to be submitted for consideration by the Neurological Conditions Implementation Group.

4.2 Project deliverables (products)

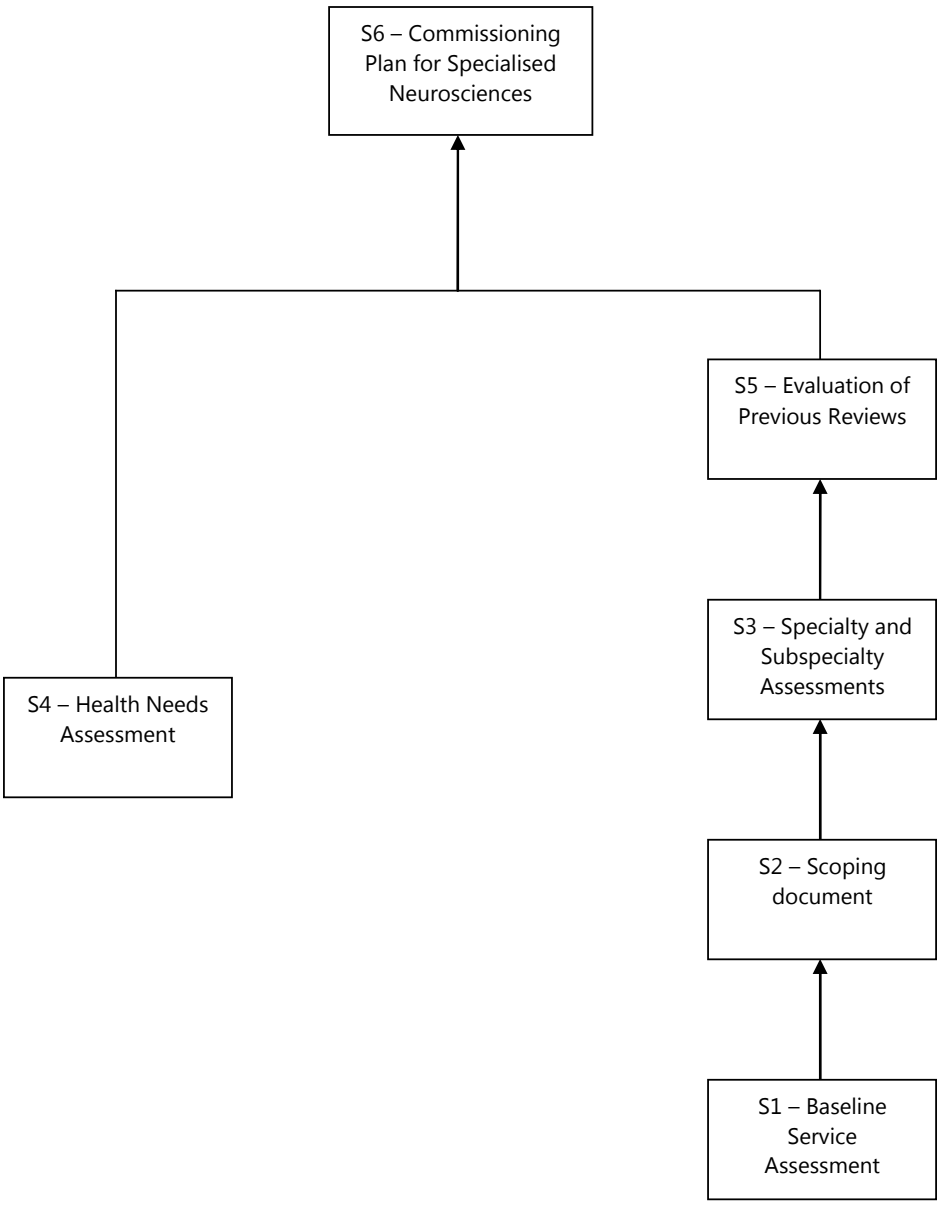
The table below specifies the project deliverables, including completion dates, dates for submission into the WHSSC Management Group and WHSSC Joint Committee.

	Product Title	***Completion Date***	***MGM Date***	***JC Date***	***Development/Author***	***Quality Assurance***
M1	Project Initiation Document	09/05/2016	26/05/2016		Assistant Planner	WHSSC Management Group
M2	Risk Log	09/05/2016	09/05/2016		Project Lead	WHSSC Management Group
Implementation 2016/17						
S1	Baseline service assessment	11/07/2016			Project Lead	WHSSC Management Group
S2	Scoping document	11/07/2016	28/07/2016		Project Lead	Project Management Team
S3	Detailed specialty and subspecialty assessment	10/10/2016	27/10/2016	22/11/2016	Subspecialty Task & Finish Group Specialty Working Group	WHSSC Management Group
S4	Health needs assessment	10/10/2016	27/10/2016	22/11/2016	Public Health Wales	WHSSC Management Group
S5	Evaluation of progress from previous reviews	09/01/2017	26/01/2017	28/03/2017	Subspecialty Task & Finish Group Specialty Working Group	WHSSC Management Group
S6	Commissioning Plan document	06/02/2017	23/02/2017	28/03/2017	Specialty Group Chairs & Project Lead	Project Management Team

Detailed descriptions of the products are included in Appendix B.

4.3 Product Breakdown Structure

The product breakdown structure shows a hierarchical structure with the end product at the top and its component parts shown at progressively higher levels of detail underneath.



4.4 Constraints

The project must be delivered within existing resources and the agreed timescales.

4.5 Assumptions

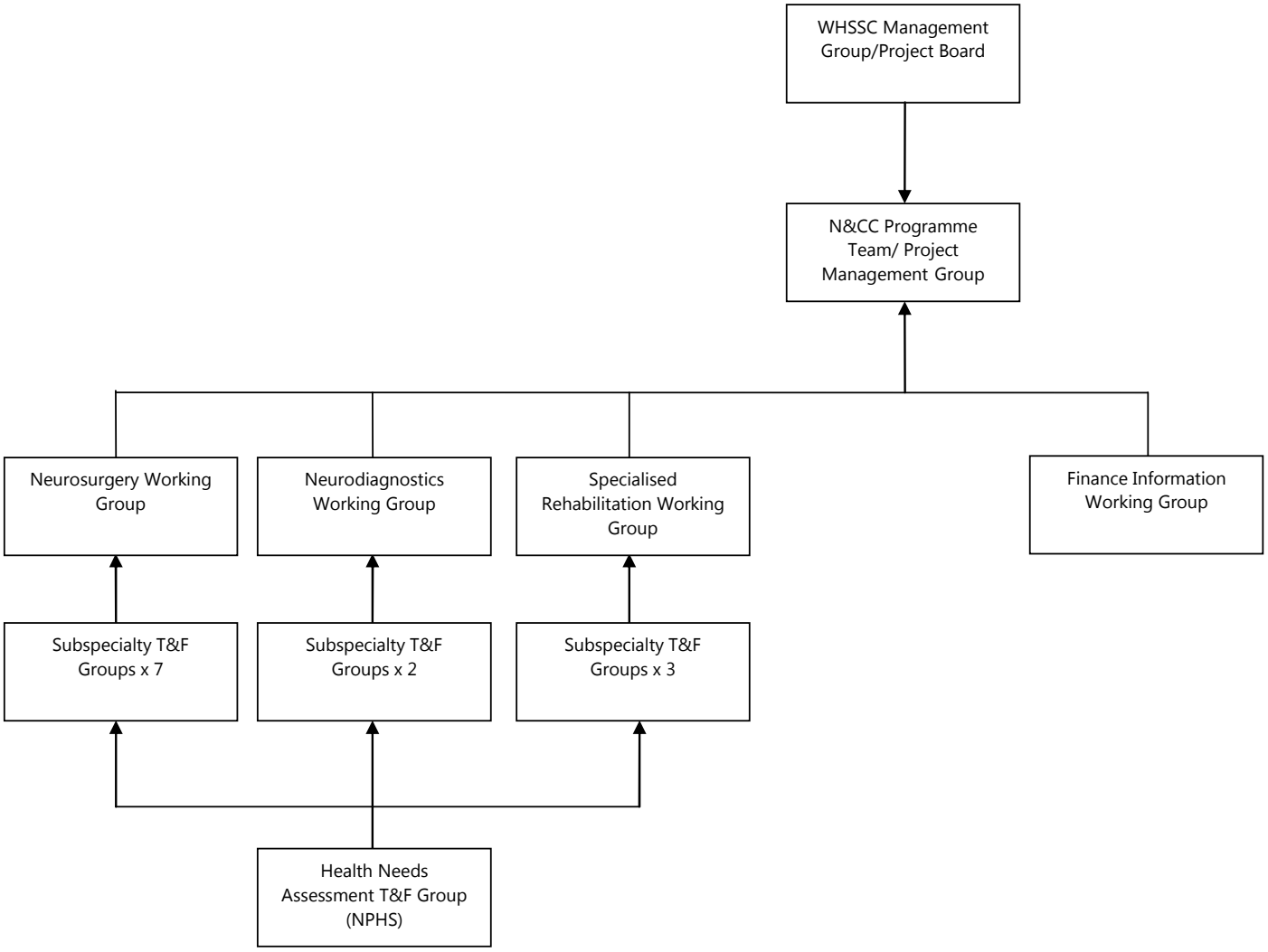
Assumptions made in the planning of this project are:

- The plan document will set out recommendation for improving service quality and resilience (identified through Health Needs Assessment and Specialty and Subspecialty Assessment) within resources currently available to Health Boards;
- Recommendations on the future plan for neurosciences services will be subject to agreement from the Joint Committee.

4.6 Project Organisation structure

The Project has been commissioned by the Acting Director of Specialised and Tertiary Services.

The diagram below illustrates the overall structure of the project.



The primary roles of each of the groups are:

4.7 Project Board

The WHSSC Management Group will act as the Project Board. It will provide the strategic lead to the project and will agree the detailed actions necessary to deliver the objectives. The Project Board will sign off the key products developed by the working groups. The Project Board meets on a monthly basis.

The specific responsibilities of the Project Board include:

- Oversight of the overall management of the development of the plan;
- Ensuring that regular reports are provided to all stakeholders;
- Monitoring progress reports from the various work streams;
- Approving the final report and EQIA report to the Joint Committee; and
- Responsible for overseeing the correlation between the working groups, ensuring that the products of each group are developed in parallel whenever possible.

4.8 Project Management Team

The Neurosciences and Complex Conditions Programme Team will act as the Project Management Team, and will be responsible for supporting the project and co-ordinating the four working groups. In addition to the support provided through the Programme Team, a dedicated Project Lead will be responsible for leading the project on a day to day basis.

Name	**Project Role**	**Organisation**
Ian Langfield	Project Director (Chair)	WHSSC
Claire Nelson	Project Lead	WHSSC
Kimberley Meringolo	Project Manager	WHSSC
Stacey Taylor	Finance Lead	WHSSC

4.9 Working Groups

There will be four working groups comprising of three Specialty Working Groups and one Finance and Information Working Group.

Three **Speciality Working Groups** (Neurosurgery, Neuro-Diagnostics and Rehabilitation) will focus on:

- Development of detailed assessment of the current status for each of the specialties and subspecialties, including the inter relationship across specialties and subspecialties;
- Assessment of the outcomes of the health needs assessment, and implications for each specialty and subspecialty; and

- Evaluation of progress in the implementing recommendations from previous reviews of neurosciences services conducted between 2007 and 2010; and
- Development of a commissioning plan for each specialty area, which is underpinned by a subspecialty assessment and plan developed by the Subspecialty Task and Finish Group.

The Specialty working groups will be chaired by a clinician, and will include clinical representation (Medical, Nursing and Therapies) as well as stakeholder and service user representation.

The groups will be supported by a number of task and finish groups which will be responsible for undertaking an assessment of each subspecialty, and the development of subspecialty commissioning plan. The subspecialty groups are specified below:

Neurosurgery Specialty Working Group

- Paediatric Neurosurgery task and finish group
- Neuro-oncology task and finish group
- Functional Neurosurgery task and finish group
- Spinal Surgery task and finish group
- Traumatology task and finish group
- Skull based surgery task and finish group
- Neuro-Vascular task and finish group

Neuro-Diagnostic Specialty Working Group

- Interventional/diagnostic Neuro-Radiology task and finish group
- Neuropathology task and finish group

Rehabilitation Specialty Working Group

- Neuro-rehabilitation task and finish group
- Spinal injuries rehabilitation task and finish group
- Neuropsychiatry task and finish group

The task and finish groups will be established by an accountable to the chair of the relevant specialty working group.

The **Finance and Information Working Group** will undertake an analysis of the current income and expenditure for the neurosciences services, and develop proposals for introducing a cost and volume contract model.

4.10 Working Group Membership

Neurosurgery Specialty Working Group		
Name	**Project Role**	**Organisation**
Claire Nelson	Project Lead, Chair	WHSSC

Kimberley Meringolo	Project Manager	WHSSC
Sarah Mills		Cwm Taf UHB
Collette Kiernan		Cwm Taf UHB
John Martin		Cardiff and Vale UHB
Ravindra Nannapaneni		Cardiff and Vale UHB
Emma Jones		Cardiff and Vale UHB
Navin Verghese		ABMUHB
Andrew MacNab		ABMUHB
Christopher Rickards		ABMUHB
Celia Satherley		ABUHB
Ken Dawson		ABUHB

Neurodiagnostic Specialty Working Group		
Name	**Project Role**	**Organisation**
Claire Nelson	Project Lead, Chair	WHSSC
Kimberley Meringolo	Project Manager	WHSSC
Sarah Mills		Cwm Taf UHB
Collette Kiernan		Cwm Taf UHB
Kathy Ikin		Cardiff and Vale UHB
Matt Temby		Cardiff and Vale UHB
Andrew Wood		Cardiff and Vale UHB
Robert Powell		ABMUHB
Rob Donkin		ABUHB
Richard Williams		ABUHB
Charlotte Lawthom		ABUHB
Fady Joseph		ABUHB

Rehabilitation Specialty Working Group		
Name	**Project Role**	**Organisation**
Claire Nelson	Project Lead, Chair	WHSSC
Kimberley Meringolo	Project Manager	WHSSC
Sarah Mills		Cwm Taf UHB
Malin Falck		Cwm Taf UHB
Collette Kiernan		Cwm Taf UHB
Sreedhar Kolli		Cardiff and Vale UHB
Seth Mensah		Cardiff and Vale UHB
Jennifer Thomas		Cardiff and Vale UHB
Tom Hughes		Cardiff and Vale UHB
Karen Bonham		Cardiff and Vale UHB
Susan Causon		Cardiff and Vale UHB
Samantha Miggins		Cardiff and Vale UHB

Richard Cuddihy		Cardiff and Vale UHB
Jo Pearse-Jones		Cardiff and Vale UHB
Jessica Quirke		Cardiff and Vale UHB
Jenny Moses		Cardiff and Vale UHB
Emma Cooke		Cardiff and Vale UHB
Lorraine Donovan		Cardiff and Vale UHB
Gwen Phillips		Cardiff and Vale UHB
Sajida Javaid		ABMUHB
David Abankwa		ABMUHB
Syed Alam		ABUHB

Finance and Information Working Group		
Name	**Project Role**	**Organisation**
Stacey Taylor	Management Accountant, Chair	WHSSC
Claire Nelson	Project Lead	WHSSC

5 Reporting Mechanisms

All of the working groups report directly to the Project Executive Group. This Group will be responsible for providing monthly update reports to the WHSSC Management Group.

6 Project tolerances

The overall project timescale has a tolerance of one month.

Appendix A – Product Descriptions

Identifier Title	S1 Baseline Service Assessment
Purpose	This will describe the current performance of the Neuroscience services against the Service Specification and NHS England guidance.
Composition	The product will: • Assess the current status of Neurosciences • Revise the current service specification • Benchmark against NHS England guidance
Format and Presentation	Microsoft Word supported by Microsoft Excel tables.
Allocated to	Project Lead
Quality Criteria	The following criteria will be used to assess the product: • Is the document comprehensive i.e. does it cover all services accessed by Welsh patients? • The activity within the document will be validated by Health Boards where appropriate.
Quality check method to be used	Quality Review by Project Management Team and Project Board.
Date for submission to Executive Group	11 July 2016 for CDG 28 July 2016 for Management Group

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Identifier Title	S2 Health Needs Assessment
Purpose	To identify the demands on Specialised Neurosciences Services over the next 5-10 years.
Composition	*The product will:* • Assess the health needs of Wales and predicted demand over the next 5 and 10 years; • Evaluation of progress against recommendations from previous reviews • Current referrals and care pathways • Epidemiology
Format and Presentation	Microsoft Word supported by Microsoft Excel tables.
Allocated to	Public Health Wales and WHSSC Medical Directorate.
Quality Criteria	The following criteria will be used to assess the product: • Is the document comprehensive ie. Does it cover all Welsh patients? • Does it align with forecast demands for other areas of Healthcare such as the South Wales Trauma Network?
Quality check method to be used	Quality Review by Programme Team and Project Board.
Date for submission to Executive Group	11 July 2016 for CDG 28 July 2016 for Management Group

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Identifier Title	S3 Detailed Specialty and subspecialty assessment
Purpose	To map the activity for Neurosciences sub specialities that are accessed by Welsh patients.
Composition	The document will set out the sub specialties within Specialist Neurosciences and where they are delivered for Welsh patients, detailing current activity and service pressures.
Format and Presentation	*Microsoft Word document.*
Allocated to	*Subspecialty task and finish group and Specialty working group*
Quality Criteria	The activity within the document will be validated by Health Boards and Trusts where appropriate.
Quality check method to be used	Quality Review by Project Management Team and Project Board.
Date for submission to Executive Group	10 October 2016 for CDG 27 October 2016 Management Group

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Identifier Title	S4 Neurosciences Strategy Update
Purpose	
Composition	The document will provide an update on the direction of travel and emerging priorities for the overall commissioning strategy
Format and Presentation	*Microsoft Word document.*
Allocated to	*Specialty working groups*
Quality Criteria	The activity within the document will be validated by Health Boards and Trusts where appropriate.
Quality check method to be used	Quality Review by Project Management Team and Project Board.
Date for submission to Executive Group	16 January 2017CDG 18 January 2017Joint Committee 26 January 2017 Management Group

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Developing a Commissioning Plan for Specialised Neurosciences
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Identifier Title	S5 Commissioning Plan document
Purpose	The purpose of this report is to provide recommendations to the Joint Committee for the commissioning of Specialised Neurosciences services for patients in NHS Wales for the next five to ten years.
Composition	The document will provide recommendations on the following: • Service specification • Quality and performance indicators including outcome measures • Service model • Resource model
Format and Presentation	Microsoft Word document
Allocated to	Project Lead, WHSSC
Quality Criteria	The following criteria will be used to assess the product: • Does the document meet the primary objectives of the project? • Is the document comprehensive i.e. does it cover all Welsh patients?
Quality check method to be used	Quality Review by WHSSC Joint Committee
Date for submission to Executive Group	6th February 2017 for Corporate Directors Group, 23rd February Management Group 28th March 2017 Joint Committee

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Appendix B - Initial Risk Log (M2)

Identifier	Description	Impact (1-10)	Probability (1-10)	Risk I x P	Counter-measures	Owner	Author	Date Identified
R1	Key staff in WHSSC are not able to commit the necessary time to work on the project.	10	2	20	Product descriptions will be used to clarify expectations and what is required of individuals from the outset.	Project Lead	Claire Nelson	May 2016
R2	Key staff in WHSSC change roles or leave the organisation.	8	2	16	The project will be defined to a level of detail that should simplify handover should the risk materialize.	Project Lead	Claire Nelson	May 2016

Annex 2: Recommendations from Price Morris Review for North Wales

1. Recruit three generically skilled neurology specialist nurses as soon as possible to work alongside disease specific specialist nurses to form multi-disciplinary teams and integrated services between primary, community, social and secondary care.
2. Increase on a phased basis, the consultant neurology workforce form the current 3 wte to the Steer's recommended 6 wte. The posts will work exclusively in North Wales but will be trained at The Walton Centre to ensure the highest possible skills development. This will allow adequate provision of specialist neurology care to a population size of North Wales.
3. Create an interim service solution (4 to 5 years) due to workforce planning issues and to give sufficient time to construct a sustainable service.
4. Identify and then commence training of neurophysiology technicians from the local population as soon as possible.
5. Recruit a consultant neurophysiologist as soon as possible to lead the development of services in North Wales, with another consultant appointment to follow ideally the year after.
6. Following from the above, establish a neurophysiology centre as an appropriate location, to form a 'hub' with a satellite 'spoke' services at the other two general hospitals.
7. Ensure that North Wales has the appropriate level of CT scanning across the main hospital sites according to clinical need. This is essential for the clinical management of a range of acute conditions including neurological trauma and emergencies such as stroke. It will also reduce the need to transfer seriously ill patients.
8. Increase, on a phased basis the number of CT scanner at each major acute site in North Wales to improve capacity and access. Extending working hours will not of itself address the issue of single CT scanners and critical failure risk nor will it be sufficient to cope with future planned activity (elective and emergency).

9. Build on the increases in neurocritical care capacity at The Walton Centre which have been made already, in accordance with the findings of the Steers Report further capacity needs must be assessed. Both The Walton Centre and the North Wales Critical Care Network predict that the current planned increase may not be sufficient to allow access to all North Wales patients who might benefit from neurocritical care. To assess this potential shortfall the North Wales Critical Care Network is working with The Walton Centre to prospectively monitor referrals and demand, from which plans for future capacity will be developed.
10. Conclude the introduction of guidelines on the management of acute head injury, spontaneous subarachnoid haemorrhage, acute neurovascular events, acute spinal injury and Cauda Equine compression. As part of which ensure that links with senior staff at The Walton Centre continue to be in place to facilitate timely decisions on management.
11. Plan through local service provision that supports the safe and timely transfer of patients returning to North Wales from The Walton Centre.
12. Build on the creation of the three newly created Stroke Units that now fulfil the basic Royal College criterion and the Welsh Health Circular recommendations for Acute Stroke Units, by further developing them to function fully according to the current guidance and recommendations.
13. Recruit Specialist Stroke Consultants to give clinical leadership to the implementation of the North Wales Stroke LDP and co-ordinate service development and delivery against the uniform clinical pathway. Improved access and capacity of specialist therapy staff is needed in support.
14. Having established the principle of a North Wales specialist in-patient rehabilitation stroke unit for young adults and those patients requiring specialist care, detailed planning must now be undertaken in association with the recommendations of the Rehabilitation work-stream culminating in business cases.
15. Establish an early Supportive Discharge Team in each Stroke Unit thereby enabling specialist rehabilitation to be delivered at home.
16. Expand imaging capacity to meet the Stroke Sentinel Standard for CT access in support of rapid assessment, clinical decision making and appropriate delivery of Thrombolytic Therapy.

17. Put in place further training of staff in Thrombolytic Therapy and preparation of a business case for a dedicate thrombolytic service.
18. Appoint a North Wales Consultant in Rehabilitation Medicine to lead the development of a North Wales neuro-rehabilitation service and specialist in-patient service; develop relationships with the University of Bangor to strengthen and enhance academic links to support the development of the s3ervice; and work with North Wales Stroke Physicians to develop a co-located complex stroke rehabilitation service. The need for a second consultant would be considered later.
19. Establish, under the North Wales Neurosciences Network, a North Wales Steering Group for progressive, degenerative neurological conditions to oversee the development and implementation of services, pathways and processes for patients with progressive degenerative neurological conditions, and to advise the Network on palliative care issues.
20. Establish, with the Third and Independent Sectors, a Task and Finish Group to consider in more depth the opportunities for these partners in the provision of neuro-rehabilitation and palliative care services. The Task and Finish Group should assess and review current pathways for specialist out-of-area rehabilitation services and recommend any necessary changes to ensure appropriate care and value for money. It should also review step-down facilities providing transitional rehabilitation for patients being discharged from specialist services, and recommend any changes necessary to improve patient care and the support of their carers and families.
21. Create, within the primary context of palliative and continuing care, the new role of a North Wales Development Worker for progressive degenerative neurological conditions, possibly Third Sector led.
22. Establish Multi-disciplinary Team meetings across North Wales for progressive degenerative neurological conditions to support anticipatory management of complex and rapidly progressive cases ensuring proactive and timely services from diagnosis to death.
23. Enhance respite services as a partnership development with local government ad the Third sector.

24. Undertake further work on a fuller options appraisal on the next two high scoring option of referring all patients to a single tertiary provider and referring patients to a mix of tertiary providers according to the presenting clinical need.
25. Explore a range of services that specialist centres can provide in North Wales accepting that this does not include surgery at this time.
26. Undertake further work to develop guidelines on the appropriate management and surgical referral of patients with back pain and sciatica.

Annex 3: Progress against recommendations from Axford Review for South and Mid Wales as agreed by the three working groups

	Health Board/ WHSSC/ WG	Achieved / Not achieved	Comments	Update following working group meeting
1. Appoint 2 additional neurologists, 1 in Cwm Taf and 1 in Hywel Dda LHBs, to enable the establishment of effective local services working as part of an integrated clinical network.	HB	Achieved	In response to the Axford Review two additional Consultant Neurologists were appointed for South Wales and in 2014 a post became funded between Cardiff and the Vale and Cwm Taf. This post provided an additional 4 sessions in Cwm Taf and 3 SPAs apportioned on the same basis. This arrangement is outside of WHSCC neurology contract. The Neurologist is based in the Royal Glamorgan Hospital and specialises in epilepsy. A local review of neurology services is being undertaken and will inform future development of neurology support in Cwm Taf.	In 2010 Neurology and Neurophysiology services were transferred back to HBs and were no longer WHSSC commissioned services. As part of the scoping work of this review it has become apparent that both services are experiencing difficulties and there is appetite for them to return to WHSSC as a commissioned service. In light of the tight deadline for the commissioning plan it is proposed that these areas are considered outside of the current project.
2. Support the integration of the current neurophysiology services to work to common protocols and guidelines.	HB	Not achieved	Work plan is being undertaken by Assistant Director of Therapies in C&VUHB. WHSSC are liaising with HB to discuss work required.	Dr Clive Morgan, Assistant Director of Therapies in C&VUHB who has been leading on this work on behalf of the Director of Therapies, to work with the Neuro-diagnostic specialty working group and to present his findings on the current service and potential actions that could be taken forward to stabilise the service.

	Health Board/ WHSSC/ WG	Achieved / Not achieved	Comments	Update following working group meeting
3. Support the stroke improvement work being undertaken by LHBs and the Stroke Services Improvement Programme needs to continue to ensure clear links through all aspects of neurosciences.	HB	Ongoing	Stroke was highlighted as a key area for improvement by Welsh Government when they published their 'Together for Health Stroke Delivery Plan' in December 2012. The plan set out Welsh Government's expectations of the NHS in Wales to tackle stroke in people of all ages, wherever they live in Wales. The Stroke Implementation Group that was established by Welsh Government is taking this work forward.	The Stroke Implementation Group is taking forward the Stroke Improvement Programme, Dr Phil Jones is the Chair of this Group. There are regular joint meetings between the Neurological Conditions Implementation Group and the Stroke Implementation Group. Clot Retrieval is in the WHSSC plan for 2017/18.
4. Establish a rehabilitation network which integrates spinal and neuro-rehabilitation that supports patients at acute sites and in the community, reaching out from the two current specialist centres in Cardiff and Swansea, to ensure that patients are rehabilitated closer to home.	WHSSC & HBs	Not achieved	A network has not yet been established for rehabilitation across South Wales and will be considered by the Neuro-Rehabilitation working group.	Following the Axford review Dr. Gareth Llewelyn, Consultant Neurologist AB, was looking to establish an All Wales Rehabilitation Network however there was limited appetite from North Wales for the network, as a consequence it did not develop further. There is not any one collaborative under the broad term rehabilitation, however condition specific and specialty specific, generally had professional networks. These are not necessarily formal but were invaluable.

	Health Board/ WHSSC/ WG	Achieved / Not achieved	Comments	Update following working group meeting
5. Strengthen supportive and palliative care for people with neurological conditions to be delivered by multi-disciplinary teams with a specialist interest in neurological conditions.	HBs	Ongoing	This work will be considered by the three specialty working groups due to the cross specialty work required.	Awaiting a response from the Palliative Care Team around any issues that are still outstanding.
6. Urgently establish a single neurosurgical service, with all emergency and intra-cranial activity being undertaken at the University Hospital of Wales, with non-complex spinal surgery and outpatient, diagnostic services and day case neurosurgery activity continuing at both Morriston Hospital	WHSSC & HBs	Achieved	2010.	The transfer of services did take place however issues are still being discussed around what surgical work is being carried out at Morriston hospital, as currently WHSSC do not commission any neurosurgery there. There are two Neurosurgeons based at Morriston Hospital as part of the overall spinal surgical team. The three Paediatric Neurosurgeons based in Cardiff are undertaking monthly clinics in ABM including a joint clinic with the Paediatric Neurologist. A draft report has been written by the Spinal Network that was looking at what work should and could be carried

	Health Board/ WHSSC/ WG	Achieved / Not achieved	Comments	Update following working group meeting
and the University Hospital of Wales. Neurosciences Implementation Programme 2/15 Position Statement & Recommendations – September 2009.				out at Morriston Hospital, with a clearly defined patient pathway.
7. Strengthen and expand spinal surgical capacity at Morriston Hospital to provide improved local access for patients in Mid and West Wales.	HB	Achieved	http://www.wales.nhs.uk/sitesplus/863/news/16949	Elective procedures at Morriston Hospital have expanded however emergencies are not taking place. Currently the service is reporting that they are within the 36 week RTT target however one consultant is due for retirement and therefore this is likely to change. This recommendation also features in the draft Spinal Network report noted under recommendation 6.
8. Co-locate complex spinal surgery and intra cranial neurosurgery within an expanded unit on the University Hospital of Wales site.	WHSSC & HBs	Achieved	In 2010.	The co-location of services did take place however the expanded unit was not actually an expansion. A reconfiguration of space took place at UHW however the department has only seen an increase of 8 beds overall, there are no additional theatres or staffing. The Morriston

	Health Board/ WHSSC/ WG	Achieved / Not achieved	Comments	Update following working group meeting
				and Cardiff services were not combined from a capacity perspective.
9. Establish a Mid and South Wales 24/7 acute spinal service.	HBs	Not achieved	This action will be considered by the Neurosurgery Specialty Working Group.	This recommendation interlinks with the update for recommendations 6 through to 8.
10. Establish 24/7 neuroradiology on call advice systems enabled by high definition teleradiology. This will require appropriate 24/7 scanning service at major acute hospitals.	HBs	Ongoing	Technology is in place. 24/7 scanning not yet available everywhere.	Currently all hospitals in Wales have the capacity and equipment to carry out CT scans out of hours, however not all hospitals can carry out an MRI scan out of hours. Consideration needs to be a consultant to report on the scan as well as the equipment and radiographer. A number of patients are bypassing a number of hospitals to reach the UHW site for an MRI scan out of hours. This is putting increased pressure on the already aged equipment and current staffing capacity. This is not a sustainable approach and needs urgent consideration.

	Health Board/ WHSSC/ WG	Achieved / Not achieved	Comments	Update following working group meeting
11. LHBs must work together to ensure that there is a well-developed trauma system between hospitals and that the major trauma centres effectively support emergency departments in district general hospitals.	HBs	In progress	The South Wales Collaborative is leading on discussions to set up a major trauma network in South Wales.	The Major Trauma review is currently underway. When information is available on the outcome and impact on Neurosciences services it will need to be considered as there are a number of cross cutting issues and interfaces.
12. LHBs should work with critical care networks to align future needs for critical care services.	HBs	In progress with Health Boards	Critical care network to respond re annual planning process.	The Critical Care team have been invited to attend each of the three specialty working groups.
13. LHBs must work with the Welsh Ambulance Service to ensure appropriate and efficient transport services for patients.	HBs	In progress with EASC	This is not a WHSSC Commissioned service and will is being progressed by EASC.	No further updates.
14. LHBs must work with the post-graduate Dean to ensure training for junior medical staff is	HBs	Ongoing		Recent changes by made by the Deanery are having a dramatic impact on the service as a whole. The changes implemented mean that 7 out of 10 sessions need to be carried out

	Health Board/ WHSSC/ WG	Achieved / Not achieved	Comments	Update following working group meeting
of the highest quality.				off ward and only a 1 in 11 on-call rota can be used. The Deanery are very proactive in checking compliance with trainees. As a consequence Cardiff and Vale UHB submitted a business case as part of the 2016/17 IMTP process to increase the number of Junior Doctors and Nurse Practitioners to neutralise the impact.
15. LHBs should work with the two universities in Swansea and Cardiff to capitalise on academic and research opportunities.	HBs	In progress with Health Boards		Discussions have already taken place around the potential for clinical capacity new CUBRIC site at Cardiff University.
16. LHBs should establish a project team across Mid and South Wales to ensure that these service models are fully implemented.	LHBs	Not achieved		A project team chaired by Mark Dickinson was established however the remit of the group was to look at the outcomes and not the implementation of the recommendations.
17. LHBs should plan and implement effective	LHBs	In progress	Local Health Boards are required to implement effective engagement with all stakeholders, patients and	

	Health Board/ WHSSC/ WG	Achieved / Not achieved	Comments	Update following working group meeting
engagement with all stakeholders, communities, patients and the public to ensure that the opportunities for excellent neurosciences services proposed in this report are fully understood.			the public in order to inform their annual Health Board Neurological Conditions Delivery Plans.	
18. In endorsing the service models in this report the Minister may wish to ensure that new models are continually evaluated, taking into consideration views of patients and that this is formally reported to her at regular intervals	WG	In progress	Whilst not specific, there is a Welsh Government Neurological Conditions Group which has representatives from all Health Boards, WHSSC and third sector organisations through the Welsh Neurological Alliance.	
19. The Implementation	LHBs	Not achieved	The Implementation Board ceases to exist.	

	Health Board/ WHSSC/ WG	Achieved / Not achieved	Comments	Update following working group meeting
Board should continue to have a role in the on-going planning of neurosciences for Mid and South Wales				

Annex 4 -WHSSC - Neuroscience Strategy Finance Commissioning Working Group

Terms of Reference

1.0 Background

During the 2016/17 IMTP process, the Joint Committee requested a Five Year Commissioning Strategy be developed relating to the Neurosciences portfolio.

The WHSSC Joint Committee has received numerous reports during 2016/17, providing progress on the work completed to date. The Management Group received a paper at the April 2017 meeting detailing a financial baseline assessment of the Neurosciences portfolio. This identified a number of areas where further work is required. To this end, it has been recommended that WHSSC work with Health Boards and initiate a Finance Commissioning Working Group to work through the detail of the report to inform the Financial Plan to support the strategy.

Proposed terms of reference are detailed:

2.0 Purpose

To advise Joint Committee on the commissioning financial issues that affects Health Boards and to discuss matters prioritised through the working groups of the Neurosciences strategy, advising on future financial implications for Neurosciences.

3.0 Objectives

The main purpose of the group will remain i.e.

- To review the current activity and costs of individual services and make comparisons
- To undertake benchmarking exercises and look for opportunity to make efficiencies
- To cost the relative components of the Five Year Strategy
- Review activity levels for appropriateness compared to relative access levels
- Make recommendations to Joint Committee on the levels of investment required to sustain services appropriately.

DRAFT

4.0 Reporting Arrangements

The group will report directly to the WHSSC Joint Committee via the WHSSC Management Group.

Links will be developed with all relevant NHS working groups and projects.

5.0 Membership

The membership of the group should consist of:

WHSSC Assistant Director of Finance (Chair)
WHSSC Assistant Director of Planning
WHSSC Finance Manager - Contracting
WHSSC Administration Support

Aneurin Bevan UHB Representative
Abertawe Bro Morgannwg UHB Representative
Betsi Cadwaladr UHB Representative
Cardiff and Vale UHB Representative
Cwm Taf UHB Representative
Hywel Dda UHB Representative
Powys Teaching Local Health Board Representative

Appropriate deputies may be sent when members are unable to attend. These deputies must be briefed and provided with the documentation relevant to the meeting by the group member.

6.0 Quorum

To be quorate 50% of the members must be present.

7.0 Frequency of Meeting

The group should schedule to meet once monthly.

Papers should be shared with member, 3 working days prior to the meeting.

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

		Agenda Item	
Meeting Title	**Management Group**	Meeting Date	27/04/2017
Report Title	Five year commissioning strategy, finance update		
Author (Job title)	Neurosciences Programme Team		
Executive Lead (Job title)	Director of Planning	Public / In Committee	In Committee

Purpose	The purpose of this report is to outline the current WHSSC contracting arrangements for Neurosciences. The report will also outline the investments made in Specialised Neurosciences since the Steers Reviews and subsequent transfer of Neurosurgery from Swansea to Cardiff.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Corporate Directors Group Board	Meeting Date	18/04/2017
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the financial position presented within the report.		

Considerations within the report (tick as appropriate)

	YES	NO		YES	NO		YES	NO
Strategic Objective(s)	✓		Link to Integrated Commissioning Plan	✓		Health and Care Standards	✓	
Principles of Prudent Healthcare	✓		Institute for HealthCare Improvement Triple Aim	✓		Quality, Safety & Patient Experience	✓	
Resources Implications	✓		Risk and Assurance	✓		Evidence Base	✓	
Equality and Diversity	✓		Population Health	✓		Legal Implications		✓

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1.0 Purpose

The purpose of this report is to outline the current WHSSC contracting arrangements for Neurosciences. The report will also outline the investments made in Specialised Neurosciences since the Steers Reviews and subsequent transfer of Neurosurgery from Swansea to Cardiff.

2.0 Background

The Joint Committee/Management Group have received papers describing the workplan of the Neurosciences Five Year Strategy in previous meetings.

A schedule of 54 schemes was presented to the March Joint Committee meeting along with the 12 schemes highlighted as finance/contracting issues that the five year strategy will focus on. It was agreed that a baseline assessment including contracting and financial arrangements would be provided in the April meetings, prior to the presentation of the final Strategy to Joint Committee in May.

The work of the strategic groups has aimed to map activity across the main providers and establish details on existing pathways. From this, funding has been mapped to the main service/speciality/sub-speciality areas.

Overall the WHSSC spend was circa £39.834m in 2015/16, on specialist Neurosciences across five main providers across England and Wales. This excludes spend approved through Individual Funding Requests, such as Paediatric Telemetry in Oxford. Work is also ongoing to quantify the level of spend on paediatric neurosciences.

The table below gives a high level summary of commissioning referral pathways to providers and the level of spend provided to each centre in 2015/16.

Strategic Group	Specialty/ Sub Specialty	Commissioners	Providers	Total Spend 2015/16 £'m
Neurosurgery including Paediatric Neurosurgery	Neurosurgery	South Wales inc Powys	Cardiff and Vale	£15.369
		BCU	Walton	£7.856
		Powys	University Hospital Birmingham	£0.234
			University Hospital North Midlands	£0.152
	Major Trauma	Powys	University Hospital North Midlands	£0.122
		BCU and South Wales	Commission Direct	
	Epilepsy	All	Cardiff and Vale	£0.261
			King's College Hospital	£0
	Neuro-modulation	South Wales	Cardiff and Vale	£1.298

	(spinal implants)			
			University Hospital Bristol	Sub contracted through CVUHB
		BCU	Walton	£0.342
	SRS	All	Sheffield Teaching	£0.084
		South Wales	Velindre	£0.544
		BCU	Walton	£0
	DBS	South Wales	North Bristol	£0.112
		BCU/Powys	Walton	£0.114
	Paeds Neurosurgery	SW	Cardiff and Vale	
			University Hospital, Bristol	
			University Hospital Birmingham,	£0.077
			GOSH	
		NW	Alder Hey	
	Paeds Epilepsy	SW	GOSH	
		All	Birmingham Children's	
			University Hospital Bristol	
		BCU	Alder Hey	
	Paeds Rehab		University Hospital Bristol Cardiff and Vale Alder Hey	£0.072
Neuro-diagnostics	Interventional Radiology		Cardiff and Vale Walton	£1.073
	Pathology (not directly commissioned by WHSSC apart from some send out tests to NHS England.)		Cardiff The Walton	
	Physiology		Not commissioned by WHSSC	
Rehab	Neuro-rehabilitation		Cardiff and Vale	£3.195
			ABMU	£1.858
			University Hospital North Midlands (BCU commissioned)	0
			Walton	£0.174
	Spinal- rehabilitation	SW	Cardiff and Vale	£3.059
		All	Robert Jones and Agnes Hunt	£1.125
	Neuro-psychiatry	All	Cardiff and Vale	£2.713

3.0 Assessment

The initial findings have been presented by each sub-specialty for Neurosciences that WHSSC Commission and have been considered individually for the purpose of the paper. It is often difficult to make like for like comparisons when considering the different services and providers. There are a number of different contract models in place and therefore caution needs to be applied when looking at the raw totals. It is also important to consider the detail in a context of population size. The South Wales population is two thirds to one third in the North of Wales.

3.1 Neurosurgery

3.1.1 Cardiff Neurosurgery

Cardiff and Vale UHB provide the only WHSSC commissioned Neurosurgery service for the South Wales population, following the Axford recommendation for the transfer of Neurosurgery from ABM UHB which took place in 2011/12. Although Neurosurgeons remained in ABM UHB, primarily undertaking Spinal Surgery, this activity is commissioned at Health Board level, with WHSSC only commissioning Neurosurgery in Wales from the Cardiff service.

Table 1 shows the overall expenditure since 2010/11. The increase in the C&VUHB expenditure between 2010/11 and 2011/12 can be explained by the transfer of services from ABMUHB to C&VUHB.

In 2015/16 The Cardiff and Vale contract was rebased which resulted in Neurosurgery being uplifted by circa. £2m.

Table 1: Cardiff and Vale UHB Neurosurgery outturn (£m) 2010/11-2015/16

10/11	11/12	12/13	13/14	14/15	15/16
12,679	13,403	13,300	13,244	13,048	15,369

The Cardiff and Vale Neurosurgery contract is currently reported using an indicative elective/ non elective/daycase split. This includes associated activity for all neurosurgery cases including those reported on a "through cost" such as Neuro-modulation and interventional radiology. **Table 2** shows the activity reported for the last three years.

Table 2: Cardiff and Vale UHB Neurosurgery activity reported for the last three years

FCE Outturn									
Cardiff and Vale	**2013/14**			**2014/15**			**2015/16**		
	EL	**EM**	**DC**	**EL**	**EM**	**DC**	**EL**	**EM**	**DC**
Neurosurgery	788	1,151	101	545	1,053	140	637	1,175	124

The current contract does not drill down to the procedure code and therefore, it was agreed in 2015/16 that a shadow contract be introduced before the implementation of a full case mix contract in 2017/18. The table in Annex A

represents the individual procedures for the new case mix contract along with the marginal price per procedure. This should allow for more comparability to other Neurosurgical centres in the future and more granularities regarding case-mix. It should also incentivise the provider to code more appropriately aligning activity, quality and outcome monitoring.

For the purposes of this paper the funding position as of 2015/16 has been used, however to note, during 2016/17 Management Group approved an investment into the core neurosurgery service and neurovascular service at Cardiff and Vale. A breakdown of the investments made is provided in Annex B. Historically there have been no other recurrent investments in Neurosciences other than the small funding allocation to Interventional Neuro-radiology in 2015/16 as noted in paragraph 3.2.9. The only fluctuations in spend have been down to annual assessments of the contractual baseline.

3.1.2 English Providers

WHSSC holds contracts with a number of providers in England to provide Neurosurgery services to mainly Powys and BCU residents. Whilst a number of Powys residents access Neurosurgery in Cardiff, they also access care across the border in English Centres, in University Hospital Birmingham as well as flow to University Hospital North Midlands.

Betsi Cadwaladr residents access their elective Neurosurgical care at the Walton Centre, Liverpool which is commissioned by WHSSC. BCUHB are responsible for commissioning the emergency activity that is undertaken in the Trauma Centre in North Midlands Hospital which will includes Neurosurgical activity such as head traumas.

A summary of overall expenditure at the Walton Centre is set out in **table 3a.** This is essentially a full cost model with no protected investments for infrastructure. Therefore non delivery equates to non payment of activity. The full cost price will reflect a different service delivery model compared to South Wales and the quality standards required.

Table 3a

	2014	2015	2016
Elective	2,638,409	2,530,846	2,656,172
Non-Elective	2,107,772	1,943,435	1,745,761
ITU/HDU	1,677,737	1,439,111	1,598,287
OPFA	377,294	397,366	455,157
OPFU	916,100	894,648	866,439
Implants	560,700	613,768	469,169
Haemostatics & Blood Products	47,200	84,795	65,434

Total	**8,325,210**	**7,903,969**	**7,856,420**

The contracts are based on Payment by Results (PBR) and Healthcare Resource Groups (HRGs). A summary of overall expenditure at the other mentioned providers is set out in **table 3b**.

Table 3b: The overall expenditure since 2013/14

Provider	POD	2014	2015	2016
UHB	**Elective**	£34,540	£80,879	£104,035
UHB	**Non-Elective**	£108,089	£107,975	£101,526
UHNM	**Elective**	£90,991	£95,787	£55,932
UHNM	**Non-Elective**	£139,352	£107,172	£80,762

Indicatively, using a count of HRG's, **table 4a** below splits the activity related to the Walton Centre.

Activity

	2014	2015	2016
Elective	1067	1,012	965
Non-Elective	697	816	640
ITU/HDU	1,200	1,024	1,152
OPFA	1231	1,317	1,513
OPFU	3433	3,418	3,348
Total	**7,628**	**7,587**	**7,618**

Table 4b splits activity into Elective and Non- Elective PODs for the other providers. In addition to this, costs will be incurred in relation to outpatient appointments and follow ups, case activity and "cost per case" activity which may fall outside the PBR mechanism and charged at local prices. The five year strategy should explore and confirm how the new case-mix contract used for South Wales residents can effectively be compared to the other centres and recommend appropriate additions or amendments.

Table 4: Activity reported against Elective and Non Elective since 2014

Provider	HRG count	2014	2015	2016
UHB	**Elective**	13	22	17

UHB	**Non-Elective**	16	17	13
UHNM	**Elective**	10	13	12
UHNM	**Non-Elective**	21	18	14

3.2 Neurosurgery sub-specialties

3.2.1 Major Trauma

North Midlands Hospital is one of the 22 designated Major Trauma Centres in England, and patients from North Wales with a head trauma access services here. Whilst this is currently sits outside the remit of WHSSC commissioned services, a small level of expenditure has been identified in the University North Midlands contracts for Powys residents. The commissioning arrangements for the soon to be confirmed Major Trauma Centre in South Wales have yet to be agreed.

3.2.2 Epilepsy

Epilepsy surgery was repatriated back from King's College London to Cardiff and Vale UHB for South Wales patients in 2013/14. In light of this transfer, there is an allocated budget within the C&VUHB Neurosurgery contract for Epilepsy Surgery; the current baseline is £522k. The budget is for the surgical procedure only and does not allow for the diagnostic elements as this would fall under neurology. Due to fluctuations in the numbers and that the conversion rate between diagnostic tests and surgery is not 100%, there is an inflated cost per case to allow for the testing in this instance.

The 2015/16 outturn at Cardiff and Vale equated to £261,000 being 9 cases whilst the outturn in 2016/17 was £290,000 being 10 cases. Currently, there are no cases identified as being treated in Kings, however, cases may have been considered on an individual basis which we will establish when we analyse the complete 16/17 IPFR data.

The recurrent baseline for 2016/17 onwards will need to take into account the underlying position as future baselines are reassessed.

3.2.3 Neuro-modulation

For South Wales patients this service is undertaken in Cardiff and Vale UHB. In 2014 there was a gap in the service following the retirement of the Consultant Neurosurgeon and as a consequence the service was accessed from Bristol for an interim period. This service is paid for as part of the case-mix contract but with additional non pay costs for the implants funded on an actual cost basis.

This service relates to mainly spinal cord stimulators and baclofen pumps. The procedure costs for these services are charged within the Neurosurgery contracting mechanisms with device costs being charged separately across the board. In Cardiff and Vale for 2015/16 the device costs out-turned at £1.298m for 70 patients. The device costs will range from £5k to £45k depending on the

complexity of the patient. The outturn for the Walton Centre for the device costs equated to £342k for 30 patients. Individual costs of implants range from £2k to £55k again dependent on complexity.

3.2.4 Stereotactic Radiosurgery

Historically this service has been commissioned from Sheffield Teaching Hospitals NHS Trust but in April 2015, activity began to be undertaken in Velindre Cancer Centre, Cardiff. With a planned approach the expectation was that two thirds of the activity from Sheffield would be repatriated in 2015/16, equating to approximately £350,000, with the remaining £173,000 of the planned £518,000 to be released from Sheffield to be made available in future years. In addition to this funding, the 2015/16 Integrated Commissioning Plan included an allocation to support the management of Cerebral Metastases. This provided Velindre with a baseline of £350,000 for SRS and £216,000 for Cerebral Metastases with further funding available if they were able to deliver the activity.

For 2015/16, 34 Benign SRS patients had been completed and a total of 41 patients had been treated for cerebral metastases for a total outturn of £543,884. The 2015/16 outturn position at Sheffield was £84k for 14 inpatients.
Activity has not been repatriated from Sheffield to Velindre at the predicted levels, with a noted delay in Velindre operating on Arteriovenus Malformations (AVMs). A meeting with Velindre to confirm forecasted activity for 2017/18 is planned for late April, in time to inform the Sheffield contract.

There is also a small flow of activity to the Walton Centre but no costs can be identified in 2015/16.

3.2.5 Deep Brain Stimulation

The flow for South Wales patient is currently through the North Bristol provider via a gatekeeper situated in ABHB. These currently get paid though the IFR budget. For 2015/16 the expenditure at Bristol was £112,402 for a total of 10 patients being treated. The cost per case varies between £16,183 and £8,317. The totals spend in the Walton for 2015/16 in relation to DBS is £113,539.

3.2.6 Paediatric Neurosurgery

The current contracting mechanism for the paediatric services varies depending on provider. Within Wales, WHSSC commissions Paediatric Neurology and Neuro-Rehabilitation on a cost and volume and spend basis respectively. However, this is commissioned on a HRG basis within the English Providers.

If prioritised, the strategic review should map paediatric activity across all centres to allow for appropriate benchmarking to be made. Costs for these services are not easily identifiable and are not currently monitored separately within WHSSC contracts.

The South Wales population access paediatric Neurosurgery services at Cardiff and Vale UHB and University Hospitals Bristol. As Paediatric Neurosurgery is a subset of Neurosurgery rather than Paediatric Surgery, it is considered as part of the Neurosciences portfolio and contract not Women and Children.

Powys residents again access this service or those offered in Birmingham's Children Hospital. The North Wales paediatric population access services at Alderhey Children's Hospital.

3.2.7 Paediatric Epilepsy

There is a contract with Great Ormond Street Hospitals Trust (GOSH) for highly specialised services and Paediatric Epilepsy, for which GOSH is one of the four specialist centres along with Bristol, Birmingham and Alderhey designated by NHS England to deliver Children's Epilepsy Surgery Services (CESS). Referrals for Paediatric Epilepsy Surgery are managed through the Paediatric Neurosciences Gatekeeper.

3.2.8 Paediatric Neurology

WHSSC commission the Specialist Paediatric Neurology service based in the Children's Hospital for Wales, C&VUHB.

Specialist Paediatric Neurology is also available in ABMUHB with the presence of a Consultant Paediatric Neurologist who provides specialist Paediatric Neurology support to patients in ABMUHB and Hywel Dda UHB. However, this is commissioned by Health Boards rather than WHSSC.

3.2.9 Neuro-Interventional Radiology

WHSSC only commissions Neuro-Interventional Radiology service through the Neurosurgery contract. The case mix contract that was established in shadow form in 2016/17 accounted for 150 Neuro-Interventional Radiology cases.

Due to a significant gap in the service following the departure of one of the Consultant Neuro-Interventional Radiologists in 2014/15, WHSSC funded a Consultant Neuro-Interventional Radiologist post in order to help stabilise the service by increasing the Consultant body to three. Whilst the service had a lone Consultant in post, interim arrangements to commission the service from North Bristol NHS Trust were put in place.

In the contract with Cardiff and Vale, ISATs are paid for on a through cost basis.

Outturn £			
Cardiff and Vale	**2013/14**	**2014/15**	**2015/16**
ISAT - Coils - interventional radiology	1,194	1,161	1,073

During 2016/17 and investment was made in this service, a breakdown of the investment is tabled in Annex C. Essentially this investment became a high priority to sustain the specialist radiology service at Cardiff and Vale.

3.2.10 Neuro-Rehabilitation

The only residual service remaining in ABM UHB that WHSSC commissions is Neuro-rehabilitation at Neath Port Talbot, with 13 beds. The ABMUHB service provides for the ABM and Hywel Dda populations with the remainder of South Wales going to Cardiff and Vale UHB (Rookwood Hospital) where WHSSC commissions 14 beds. Again, the majority of care of the Powys population and BCU is provided in English Centres.

Neuro-rehabilitation is currently contracted on a block basis in Cardiff and Vale. The future contracting mechanism for Neuro-rehabilitation within Wales should be consistent on a cost and volume basis. This will form part of the final strategy.

The contracts are described in Inpatients, Daycases and Outpatients in a cost and volume arrangement. A summary of the contract baselines is shown below:

Cardiff and Vale	Baseline (£)	Bed days	15/16 Activity Outturn variance	MR (£)	Day Care	15/16 Activity Outturn variance	MR (£)	New OP	15/16 Activity Outturn variance	MR (£)
Neuro-rehabilitation	£3,198,775	7910	-4117	Block arrang ement				177	-2	85

ABM	Baseline (£)	Inpati ents	15/16 Activity Outturn variance	MR (£)	Day case s	15/16 Activity Outturn variance	MR (£)	OP	15/16 Activity Outturn variance	MR (£)
Rehab – inpatients	£1,540,677	4629	-142							
Rehab – daycases	£13,304			89	148	146	89			
Rehab - outpatients	£304,492							380	-36	484

The English Centres that currently provide services to Wales consist of The Walton Centre, University Hospital Birmingham, University Hospital North Staffordshire, and Bristol Hospital.

Expenditure at the Walton Centre is on an increasing trend as the service develops. The table below states expenditure for the last three years.

		2014	2015	2016
Walton	**Rehabilitation**	13,649	193,462	174,413

On agreement of the new policy which is currently being finalised post consultation, contracting relationships will need to be put in place to ensure Health

Boards are being charged for the appropriate acuity of patient within their commissioning responsibility.

3.2.11 Spinal Rehabilitation

WHSSC Commissions 22 Spinal rehabilitation beds at Rookwood Hospital, at Cardiff and Vale for South Wales and Mid Wales patients. The outturn for the service commissioned at Cardiff and Vale is detailed below for the last three years:

Provider	Outturn £			
		2013/14	2014/15	2015/16
Cardiff and Vale	Spinal Injuries	2,343	2,329	3,059

The activity is accounted for on a cost and volume basis which under and over performance attracting marginal rates. The table below described the outturn activity for last three years:

FCE Outturn									
Cardiff and Vale	2013/14			2014/15			2015/16		
	Bedday	Out-patients	Daycare	Bedday	Out-patients	Daycare	Bedday	Out-patients	Daycare
Spinal Injuries	6,053	437		5,762	411		7,476	538	

For North Wales residents and occasionally all Wales residents, Robert Jones and Agnes Hunt (RJAH) provide a Spinal injuries service. RJAH has a specialised 44 bedded spinal unit. This is at a local price and is currently a "block" arrangement with tolerance. The expenditure and activity for 2015/16 is stated in the table below:

Robert Jones and Agnus Hunt	£ Baseline	IP	15/16 Act Outurn variance	£MR - performance not payable	OP	15/16 Act Outurn variance	£MR - performance not payable
Spinal Injuries - BLOCK	924,504	1,849	651	500			
Spinal Injuries - BLOCK	200,506				576	-30	348

3.3.12 Neuropsychiatry

WHSSC commissions 10 inpatient beds and also funds the out-patient service at the Llandough site and is a tertiary service of the whole of the South and Mid Wales population.

There is currently no clear pathway in place for the Neuropsychiatry treatment for North Wales patients. Patients from South Wales access the service from Llandough hospital however over recent months only one Individual Patient Funding Request has been received for a North Wales patient to access this

Cardiff and Vale	£ Baseline	Bed days	15/16 Act Outurn variance	£MR	Day Care	15/16 Act Outurn variance	£MR	New OP	15/16 Act Outurn variance	£MR	OP FU	15/16 Act Outurn variance	£MR
Neuro-psychiatry	2,713,361	4006	-336	119	1562	153	82	45	-5	463	164	181	51

service. It is currently unclear how many patients are in need of this service from North Wales and therefore further exploration is required.

3.3 Considerations

The drafting of this paper has highlighted a number of considerations that will be considered and prioritised on completion of the strategy in May 2017. The current work plan includes the schemes to be considered moving forward. These can be seen in **Annex D.**

4.0 Recommendations

Members are asked to:

Note the financial position presented within the report

Link to Healthcare Objectives	
Strategic Objective(s)	Development of the Plan Organisation Development Governance and Assurance
Link to Integrated Commissioning Plan	The Neurosciences Strategy is to inform future Integrated Commissioning Plans.
Health and Care Standards	Effective Care Staff and Resourcing
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Reduce inappropriate variation Only do what is needed
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Improving Patient Experience (including quality and Satisfaction) Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	The Commissioning Plan is being written with the Quality, Safety and Patient Experience at the forefront.
Resources Implications	There will be resource implications as it is evident that Neurosciences in South Wales is under-resourced compared to the service in the Walton Centre that serves North Wales and a number of developments have been delayed awaiting the outcome of this commissioning plan.
Risk and Assurance	There is risk to patient safety as a number of services within Neurosciences for patients across Wales are not sustainable.
Evidence Base	A gap analysis was undertaken on the South Wales service compared to the English service specification which highlighted deficits in the provision of Neurosurgery compared to English counterparts such as the Walton Centre.
Equality and Diversity	Investment in this service would reduce the inequities with the service received by patients in North Wales in the Walton Centre and reduce inequities between West and East Wales in accessing other services such as acute neuro-rehabilitation.
Population Health	None
Legal Implications	None

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	18/04/17	Supported subject to amendmendments

9

Annex A

Case Mix Category	Activity Baseline				Marginal Price
	DC	IPEL	IPNEL	Total	£
Admitted Patient Care (APC) [FCEs]:					
Brain tumours or cerebral cysts - cat 2 and below	<5	16	56	72	1,374
Brain tumours or cerebral cysts - cat 3 and 4	-	139	145	284	1,772
Cerebral degenerations or miscellaneous disorders of nervous system	-	56	77	133	1,440
Diagnostic vascular radiology	26	15	48	88	465
Extradural spinal conditions / procedures	-	184	72	256	1,568
Functional neurosurgery	<5	7	-	9	1,040
Haemorrhagic cerebrovascular disorders	<5	-	53	53	1,180
Haemorrhagic cerebrovascular disorders with intracranial procedures	-	11	36	47	2,330
Interventional neuroradiology	12	61	74	148	904
Intracranial procedures for trauma	-	-	120	120	1,833
Intradural spinal conditions / procedures	<5	31	37	72	1,705
Multiple trauma	-	-	32	32	1,927
Muscular, balance, cranial or peripheral nerve disorders or epilepsy	<5	27	60	88	1,303
Non-transient stroke or cerebrovascular accident, nervous system infections or encephalopathy	-	-	25	25	2,317
Other Diagnoses with intracranial procedures	<5	64	48	114	1,926
Other Diagnosis	-	4	12	16	466
Other neurosurgery episodes	31	16	53	100	877
Other spinal conditions / procedures	-	3	21	24	730
Other vascular	-	16	5	21	1,486
Paediatric Neurosurgery Episodes	8	47	110	165	1,029
Planned procedures not carried out	8	69	6	84	230
Uncoded	<5	23	62	88	1,987
TOTAL	**102**	**788**	**1,152**	**2,040**	

Key: DC – Day case, IPEL - In-patient elective, IPNEL – In-patient non-elective

Annex B

Core Neurosurgery – Phase 1

The purpose of this investment was to sustain service deliverability and to prioritise work in relation to the repatriation of patients whom no longer require specialist beds.

		Business Case		Forecast	
Staff Group	**WTE**	**2016/17 PYE (£k)**	**2017/18 FYE (£k)**	**2016/17 PYE (£k)**	**2017/18 FYE (£k)**
Pay:					
Nurse Practitioners	4.00	125	200	-	150
Clinical Fellows / Clinical Research Fellows	3.00	149	255	150	255
Anaesthetics Support		20	26		20
Sub-total	**7.00**	**293**	**481**	**150**	**425**
Non-pay:					
Other non-pay e.g. Training		7	19		19
Total		**300**	**500**	**150**	**444**

Neurovascular Service

In addition, a further investment was made into the neurovascular service. This funding was only approved for release in December and whilst the Consultant post has recently been appointed, the full MDT is still being finalised and we will feedback on its outcome in due course. A breakdown of the investment is provided below:

		Business Case		Forecast	
		PYE 2016/17	**FYE 2017/18**	**2016/17**	**2017/18**
	WTE	**£k**	**£k**	**£k**	**£k**
Pay					
Consultant Neurovascular Surgeon	1.00	130	130	75.83	130
Medical Secretary	0.50	10	13	6	13
Consultant Core Neurosurgeon	0.17	16	21		20
Consultant Interventional Radiologist	0.17	16	21		20
Consultant Radiologist with SRS interest	0.17	16	21		20
B6 ANS	1.00	32	43		35
MDT Coordinator	1.00	20	27		25

		Business Case		Forecast	
		PYE 2016/17	**FYE 2017/18**	**2016/17**	**2017/18**
Sub-total	**4.00**	**240**	**277**	**82**	**262**
Non-Pay					
Set-up costs		5	-		-
Other non-pay e.g. Training		5	8	3	8
Total		**250**	**285**	**85**	**270**

Annex C

Investment in Interventional Neuro-radiology (16/17)

Staff Type	Requirement	Business Case	16/17 Forecast	17/18 Forecast
		£k	£k	£k
Radiology nurses	1.6WTE Band 6 nurses includes annual leave factor, Saturday enhancements and on-call cover	90	52	82
Radiographer	1.0WTE Band 6 radiographer includes annual leave factor, Saturday enhancements and on-call cover	63	32	63
Admin and clerical	0.2WTE Band 3 plus annual leave factor	5	3	5
Portering	0.2WTE Band 3 plus annual leave factor and Saturday enhancements	7	6	7
Total		**165**	**92**	**157**

Annex D

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan	Workplan or funded scheme
Gatekeeping arrangements	All	Need to consider the current gatekeeping arrangements and potential changes that are needed following new appointments in specific areas such as Neurovascular.		Contracting	**Workplan**
Coding issues	Neurosurgery	Work to ensure coding is accurate for Neurosurgical procedures carried out in Cardiff and Vale. This will ensure correct allocation of funding in line with the new case mix contract and make comparison with funding provided to England services more transparent.	Mr Nannapaneni has agreed to be the Clinical Lead for this work, the Neurosciences Directorate currently pulling notes of uncoded procedures.	Contracting	**Workplan**
Pipeline Embolisation Devices	Neurosurgery/Neuro-diganostic	Amend the Pipeline Embolisation Device Policy to reduce the need for prior approval for the less complex and costly devices.	This is a terminology issue there are no cost implications.	Contracting	**Workplan - Service Specification**
Formalise DBS contracting arrangements with North Bristol	Neurosurgery	Currently pay on a case by case basis, formalise arrangements with North Bristol for improved reporting and exploring the potential additional work that could be carried out in		Contracting	**Workplan**

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan	Workplan or funded scheme
		Wales (pre-operative and post-operative care).			
Commissioning arrangements for Specialised neuro-radiology including both diagnostic and interventional elements	Neuro-diagnostic	Confirm resources currently utilised for specialised neurosciences and what is actually commissioned.	Will need to understand from Health Baords if they wish to commission centrally or maintain current commissioning mechanisms.	Contracting	**Scheme proposed for funding - potential service specification**
Paediatric Neuro-rehabilitation	Neuro-rehabilitation	Prepare for Neurological Conditions Implementation Group evaluation (after 3 years) to determine the continuation of funding.		Contracting	**Scheme proposed for funding**
Patient Pathways for Powys and Betsi Cadwaladr patients	All	Work with Powys to track where their patients are being treated and whether WHSSC or Health Board contracts are funding them.	There is a crossover of specialised constracts for both Powys and Betsi Cadwaladr with WHSSC and HBs. Need to identify the most effective model.	Contracting	
Paediatric Spasticity/Intrathecal Baclofen pumps	Neurosurgery	These procedures are currently carried out in Bristol and can potentially be repatriated.	Due to capacity constraints can only be achieved once additional theatre for Neurosurgery has been approved or the agreed use of the the theatre within the Children's Hospital for	Contracting	**Workplan with potential for a proposal for funding**

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan	Workplan or funded scheme
			Wales.		
Deep Brain Stimulation	Neurosurgery	Repatriation of service from England back to Wales.	Dependant on theatre capacity before full repatriation can take place, likely that pre-operative and post-operative treatment can be carried out in Wales which will be explored at the DBS Audit Day.	Contracting	**Workplan**
Paediatric Cranio-facial procedures	Neurosurgery	The less complex procedures could be repatriated back to Wales from Birmingham.	As above, need additional theatre in place for this work to be repatriated.	Contracting	**Workplan with potential for a proposal for funding**
Arteriovenous Malformation Surgery	Neurosurgery/ neuro-diganostic	Currently send 15-20 cases per year to Sheffield, have begun undertaking trials in Cardiff. Equipment already in place and would be carried out by Vascular Neuro-surgeon.	Currently Radiology not commissioned to do this therefore scheme would need to consider both neurosurgery elements and neuro-diagnostic if looking to repatriate.	Contracting	**Workplan with potential for a proposal for funding**
Utilisation of CUBRIC	Neuro-diagnostic	Use of the Cardiff University facilities to carry out clinical diagnostic work. Could use 3T scanners for functional imaging.	Look at feasibility cost of outsourcing.	Contracting	**Workplan - Contracting arrangements**

Annex 6
Individuals and Organisations interviewed as part of the process

Neurosurgery

- Mr. Paul Leach, Consultant Neurosurgeon, C&VUHB
- Miss Caroline Hayhurst, Consultant Neurosurgeon, C&VUHB
- Mr. Chirag Patel, Consultant Neurosurgeon, C&VUHB
- Mr. John Martin, Consultant Neurosurgeon and Clinical Director for Neurosurgery, C&VUHB
- Professor William Gray, Consultant Neurosurgeon C&VUHB
- Mr. Pablo Goetz, Consultant Neurosurgeon, C&VUHB
- Mr. Imran Bhatti, Consultant Neurosurgeon C&VUHB
- Dr. Ram Kumar, Consultant Paediatric Neurologist and Service Group Lead for Neurology and Neurosurgery, Alder Hey Children's NHS Foundation Trust
- Dr. Val Kilmach, Consultant Paediatrician and Neurosciences Clinical Lead for Paediatrics in BCUHB
- Mr. Paul May, Consultant Neurosurgeon and Divisional Clinical Director, The Walton Centre and the President of the Royal College of Neurosurgeons
- Dr. Andrew Nicolson, Consultant Neurologist and Medical Director, The Walton Centre
- Mr. Andy Brodbelt, Consultant Neurosurgeon and Clinical Director for Neurosurgery, The Walton Centre
- Craig Heffell, Highly Specialist Clinical Physiologist, Neurosciences.

Rehabilitation

- Dr. Sreedhar Kolli, Consultant in Spinal Injuries and Rehabilitation, C&VUHB
- Dr.Jenny Moses, Clinical Psychologist, C&VUHB
- Dr. Sajida Javaid, Consultant Rehabilitative Medicine, ABM UHB
- Mr. Joy Chowdhury, Consultant Spinal Surgeon, RJAH
- Dr. Gwen Phillips, Neuropsychologist and Clinical Lead for Neuropsychiatry
- Neuropsychiatry MDT, C&VUHB
- Sandra Morgan, Assistant Director of Therapies and Clinical Sciences, HDUHB
- Dr. Ellie Marsh, Consultant Rehabilitative Medicine, C&VUHB
- Dr. Andrea Lowman, Consultant Rehabilitative Medicine, C&VUHB
- Dr. Seth Mensah, Neuro-psychiatrist, C&VUHB
- Dr. Alex Ball, Consultant in Rehabilitation Medicine, University Hospital North Midlands
- Dr. Salah Elghenzai, Care of the Elderly Consultant/Stroke, BCUHB
- Dr. Rudi Coetzer,
- Dr. Craig Roberts, Consultant Clinical Psychologist, North Wales Brain Injury Service, BCUHB

Neuro-Diagnostics

- Dr. Mike Bourne, Clinical Diagnostics and Therapies Board Director, C&VUHB
- Matt Temby, Clinical Diagnostics and Therapies Head of Delivery C&VUHB
- Dr. Alistair Lammie, Consultant Neuropathology, C&VUHB
- Dr. Andrea Liu, Consultant Neuro-Radiologist, C&VUHB
- Dr. Shawn Halpin, Consultant Neuro Interventional Radiologist, C&VUHB
- Dr. Andrew Wood, Consultant Radiologist and Clinical Director for Radiology, C&VUHB
- Emma Cooke, Head of Physiotherapy and Speech and Language Therapy, C&VUHB
- Darrell Baker, Head of Pharmacy, C&VUHB
- Dr. Sacha Niven, Consultant Neuroradiologist, The Walton Centre

Review in General

- Annette Morris, Director of Neurosciences, BCUHB
- Dr. Tom Hughes, Consultant Neurologist & Clinical Lead for Stroke, C&VUHB
- Urtha Felda, Interim Chair of the ALAS Stakeholder Group and Relations Officer for the MS Society in Wales
- Sheffield Teaching Hospitals NHS Trust (to discuss Stereotactic Radiosurgery patients)
- Robert Jones and Agnes Hunt Orthopaedic Hospital (to discuss Spinal Injuries and Rehabilitation)
- Alison Shakeshaft, Director of Diagnostics and Therapies, ABUHB
- Dr. Gareth Llewelyn, Consultant Neurologist and Clinical Director for Neurosciences, ABUHB
- Celia Satherley, Directorate Manager for Neurosciences ABUHB
- Andrea Richards, Directorate Manager for Neurosciences, C&VUHB
- Wales Neurological Alliance Executive Committee
- North Wales Partnership
- North Wales Neurosciences Board
- Michelle Price, Consultant Therapist Neuro-rehabilitation, Powys THB
- Peter Skitt, County Director Lead for Neurosciences, Hywel Dda UHB
- Louise Cullum, Service Delivery Manager Neurosciences, Hywel Dda UHB
- Emma Cooke, Head of Physiotherapy Services, C&VUHB

Individuals that have engaged through the sub-specialty working groups*

- Sarah Mills, Commissioning Manager, Cwm Taf UHB
- Dr. Robert Powell, Consultant Neurologist, ABMUHB
- Michelle Herbert, WNA
- Kathy Ikin, Directorate Manager, C&VUHB
- Karen Bonham, Speech and Language Therapist, C&VUHB
- Dr. David Abankwa, Consultant in Rehabilitation Medicine, ABMUHB
- Collette Kiernan, Head of Therapies, CTUHB
- Janet Ivey, Occupational Therapist, CTUHB
- Samantha Miggins, Senior Physiotherapist, C&VUHB
- Jo Pearse-Jones, Clinical Specialist, C&VUHB
- Carol McCudden, Wales Neurological Alliance
- Dr. Jenny Thomas, Consultant in Rehabilitation Medicine, C&VUHB/Clinical Lead for Rehabilitation for Major Trauma Network
- Angela Chaulk, Head of Occupational Therapy, C&VUHB
- Dr. Syed Alam, Consultant Physician, ABUHB
- Dr. Jessica Quirke, Clinical Psychologist, C&VUHB
- Lorraine Donovan, Senior Nurse, Neurosciences, C&VUHB
- Dr. Richard Cuddihy, Consultant Clinical Psychologist, C&VUHB
- Dr. Malin Falck, Consultant Clinical Psychologist, CTUHB
- Ana Sivapatham, Wales Neurological Alliance
- Mr. Navin Verghese, Consultant Spinal Surgeon, ABMUHB
- Mr.Ravi Nannapaneni, Consultant Neurosurgeon, C&VUHB
- David Maggs, Wales Neurological Alliance
- Dr. Andrew MacNab, Consultant in Unscheduled Care, ABMUHB
- Emma Jones, Vascular Nurse Specialist, C&VUHB
- Dr. Christopher Rickards, Consultant Neurologist, ABMUHB
- Dr. Ken Dawson, Consultant Neurologist, ABUHB
- Celia Satherley, Directorate Manager, ABUHB
- Mr. John Howes, Consultant Spinal Surgeon, C&VUHB

A number of other listed individuals have also been involved in the working groups, however these names have not been duplicated but are listed in the meeting minutes.

To be Seen

Val Attwood, Associate Director of Commissioning, BCUHB
John Hindle, Consultant BCUHB

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan
Year 0 (2017/18)				
Neurosurgery RTT	Neurosurgery	Funding to support achievement of RTT which has not been achieved for a number of years. In an interim pl an for extended lists in theatres and Radiology.	Further work will be required scoping demand and capacity requirements for beds and theatre lists.	RTT
Neuro-oncology	Neurosurgery	Outcomes of Peer Review between Cardiff and the Walton service has highlighted the need for additional formal support for the MDT, nurse specialist within the South West area and AHP's as a priority.	The outcomes of the peer review were very stark and highlighted the significant inequities between the services for patients in South Wales and North Wales.	Standards
Neuro-modulation (pain management)	Neurosurgery	Implementation of formal MDT for delivering Neuromodulation pain service and consistent management of Neuro-stimulators.	The cost of the scheme needs further consideration.	RTT
Bladder and Bowel nurse led clinic (for neuro-rehabilitation patients)	Neuro-rehabilitation	Improve bowel and bladder care for patients with spinal cord injuries.	Continuation of successful trial which resulted in an NHS Wales award.	
Spinal Rehabilitation MDT (phase 1)	Neuro-rehabilitation	Spinal Rehabilitation service sustainability and the achievement of standards.	Service is extremely fragile with only one spinal rehabilitation consultant in Rookwood and inadequate levels of MDT support.	Standards
Neuro-rehabilitation MDT (phase 1)	Neuro-rehabilitation	Neuro Rehabilitation Service – sustainability and standards.	Service is extremely fragile with only one WTE neuro-rehabilitation consultant in Rookwood and inadequate levels of MDT support.	Standards
Clot retrieval/Mechanical Embolisation	Neuro-diagnostic	Following scoping work commissioning of a safe and sustainable service.	Currently being undertaken for patients across 6 Health Boards in Cardiff on an individual patient basis. Pts from North Wales being treated in the Walton are being picked up through the contract.	National Body
Gatekeeping arrangements	All	Need to consider the current gatekeeping arrangements and potential changes that are needed following new appointments in specific areas such as Neurovascular.		Contracting
Establish Neurosciences Network for South Wales	All	Assess if elements of good practice in the North Wales Neurosciences Board that could be replicated for South Wales.		
Neurosurgery	Neurosurgery	Service specification setting out the pathway, repatriation and Delayed Transfer of Care (DTOC).	Currently there is no service specification in place outlining the commissioning intentions for this service.	
Coding issues	Neurosurgery	Work to ensure coding is accurate for Neurosurgical procedures carried out in Cardiff and Vale. This will ensure correct allocation of funding in line with the new case mix contract and make comparison with funding provided to England services more transparent.	Mr Nannapaneni has agreed to be the Clinical Lead for this work, the Neurosciences Directorate currently pulling notes of uncoded procedures.	Contracting

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan
Paediatric Epilepsy	Neurosurgery	Write a service specification that covers paediatric services not only at Great Ormond Street Hospital where we historically commission but the other centres commissioned in the NHS England model. in line with NHS England guidance. Currently only have service specification available for adult epilepsy.	This was identified following different referring practices being carried out in Wales.	NHS England
Paediatric Epilepsy	Neurosurgery	Historically have commissioned from GOSH, but NHS England have designated Bristol as a specialist centre as well. Cardiff also working on developing a service for over 3s which helps to sustain Cardiff Paediatric Neurosurgery.	No theatre capacity currently to repatriate. Have written to Women and Childrens Board to query the empty theatre that was due to be dedicated to Neurosurgery and emergencies, awaiting a response. Removing the paediatric cases from the adult theatres will free up valuable theatre capacity.	RTT
Pipeline Embolisation Devices	Neurosurgery/Neuro-diganostic	Amend the Pipeline Embolisation Device Policy to reduce the need for prior approval for the less complex and costly devices.	This is a terminology issue there are no cost implications.	Contracting
Formalise DBS contracting arrangements with North Bristol	Neurosurgery	Currently pay on a case by case basis, formalise arrangements with North Bristol for improved reporting and exploring the potential additional work that could be carried out in Wales (pre-operative and post-operative care).		Contracting
Specialised Rehabilitation	Neuro-rehabilitation	Policy was due for review in Autumn 2016.	Consultation underway, due to be ratified June 2017.	Standards
Paediatric Neuro-rehabilitation	Neuro-rehabilitation	Service specification currently being developed by the South Wales service, but will encompass the Alderhey service.		Standards
Neuro-psychiatry provision in North Wales	Neuro-rehabilitation	No contracting arrangements in place or clear pathways for patients from North Wales.	Dependant on the outcome of the specialised rehabilitation policy review in 2017.	Standards
Major Trauma	All	Need to consider the outcome of the major trauma review and the potential implications on the service.	Commissioning model for Major Trauma Network has not yet been decided.	
Year 2 - 5				
Retirement of Consultant staff.	All	Retirement of key members of staff during the duration of the five year plan. Need to ensure succession planning is in place so service are not destabilised.	Staff from Neurosurgery, Radiology Paediatric/Adult Neurology and Neurophysiology.	RTT
Theatre Capacity	Neurosurgery	Demand and Capacity work is needed in order to clearly understand theatre requirements. Deficits in capacity were highlighted by the SBNS as an area of concern during National meeting held in Wales, in the summer of 2016.	This was included within the original 2016/17 Core Neurosurgery business case as phase 2.	RTT

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan
Spinal Surgery	Neurosurgery	Clarify pathways for out of hours emergency and non-emergency work. This is an outstanding recommendation from the Axford review.	Work has been undertaken by the Spinal Surgery Network, with plans to share recommendations with WHSSC shortly.	Standards
Neurosurgery consultant numbers	Neurosurgery	Currently Cardiff do not have the numbers of neurosurgeons for the size of the population, raised by the Society of British Neurosurgeons as a concern.	Need to address additional theatre capacity and scanning facilities before additional posts can be considered.	Standards
Neuro-oncology, nurse specialist support in South Wales service.	Neurosurgery	Overwhelmed with intrinsic tumours, do not have skull based support.	This was noted within the outcomes of the Peer review	Standards
Neuro -oncology (North Wales) post-operative treatment.	Neurosurgery	Currently no service in Wales for post-operative treatment. Patients receive surgery in the Walton and post operative cancer treatment in Clatterbridge but no formal oncology service from BCU.	Features in the outcomes for the peer review.	Standards
Neuro-oncology dedicated consultant neurosurgeons	Neurosurgery	Identified in peer review that in other services of a similar size there are dedicated neuro-oncology consultants. Currently Cardiff and Vale feature all consultants on MDT list as it is done rotationally with two neurosurgeons with an interest.	Other Centres in the UK with a similar population have dedicated neuro-oncology consultants. Need to explore services in other centres.	Standards
Post operative MRI scan within 72 hours.	Neurosurgery/neuro-diganostic	Scheme is dependant on a number of factors in particular increase in MRI capacity at UHW.	Undertake benchmarking as initial findings show that Cardiff carry out a third less post-operative scans than Southampton which is similar in size.	Standards
Selective Dorsal Rhizotomy	Neurosurgery	Consider the findings of the NHS England commissioning through evaluation that is due to report in 2018. Will require a service specification dependant on the outcome.	This is linked with the service specification included in year 1.	NHS England
Intra-operative monitoring	Neurosurgery	Not currently available in Cardiff, have equipment but no staff.		Standards
Neuro-physiology presence at open craniotomy, skull based and spinal tumour surgeries.	Neurosurgery	Insufficient numbers of Neuro-physiologists to attend theatre in order to monitor the cranio-nerve during surgery.		Standards
Adult Telemetry	Neurosurgery	Currently have the space, and equipment to carry out the service but insufficient staffing capacity to carry out clinics.	Need to understand the requirements and demand for this service.	Standards
Paediatric Telemetry	Neurosurgery	There is space available in the Children's Hospital for Wales and charity funding has purchased equipment however there is no technician within the current workforce.	Currently this service is provided in Bristol, the repatriation costs are insufficient for a technician. Need to establish a better understanding of current demand.	Standards

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan
Neuro-physiology	Neuro-diagnostic	WHSSC to Strengthen fragile service. Explore whether WHSSC can support the work undertaken by the Assistant Director of Therapies on behalf of Directors of Therapies to strengthen service.	Need to understand current service and numbers, previously commissioned by WHSSC.	Standards
Commissioning arrangements for Specialised neuro-radiology including both diagnostic and interventional elements	Neuro-diagnostic	Confirm resources currently utilised for specialised neurosciences and what is actually commissioned.	Will need to understand from Health Baords if they wish to commission centrally or maintain current commissioning mechanisms.	Contracting
Paediatric MRI	Neuro-diagnostic	Additional sessions in the Childrens Hospital for Wales as MRI sessions available but require funding for staffing.	Outline current waits.	Standards
Neuro-pathology	Neuro-diagnostic	Two phase business case, additional support staff to make Consultant post more attractive and a post without sub-speciality requirement which will be a training opportunity.	Current service very fragile with only one neuro-pathologist in Wales, arrangements have been put in place by Cardiff and Vale for Bristol to provide in and out reach support.	Standards
Spinal Rehabilitation MDT (phase 2)	Neuro-rehabilitation	Following implementation of phase one further work will be required to strengthen the in-reach and potential out-reach elements of the service.		Standards
Neuro Rehabilitation MDT (phase 2)	Neuro-rehabilitation	Following implementation of phase one further work will be required to strengthen the in-reach and potential out-reach elements of the service.		Standards
Prolonged Disorder of Consciousness	Neuro-rehabilitation	Understand requirements to increase in capacity to have in-reach and out-reach service.	Currently commission four beds however due to level of care required by patients and that the majority of patients having a tracheostomy, there is insufficent capacity at Rookwood. Increases in staff capacity would allow for potential in-reach and out-reach service.	Standards
Paediatric Neuro-rehabilitation	Neuro-rehabilitation	Prepare for Neurological Conditions Implementation Group evaluation (after 3 years) to determine the continuation of funding.		Contracting
Information Technology/Virtual communication	All	Explore with each health board what capacity there is available to strengthen communication and the sharing of information.		Standards
PROMS/PREMS	All	Assess how this form of outcome data can inform Audit and outcomes day and commissioning of services.		Standards
Attendance the Mid Wales Healthcare Collaborative	All	WHSSC to attend the quarterly meeting of the collaborative to feed in and to hear of emerging developments. This is similar to attendance to the North Wales Neurosciences Board.		National Body

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan
Patient Pathways for Powys and Betsi Cadwaladr patients	All	Work with Powys to track where their patients are being treated and whether WHSSC or Health Board contracts are funding them.	There is a crossover of specialised constracts for both Powys and Betsi Cadwaladr with WHSSC and HBs. Need to identify the most effective model.	Contracting
Paediatric Spasticity/Intrathecal Baclofen pumps	Neurosurgery	These procedures are currently carried out in Bristol and can potentially be repatriated.	Due to capacity constraints can only be achieved once additional theatre for Neurosurgery has been approved or the agreed use of the the theatre within the Children's Hospital for Wales.	Contracting
Deep Brain Stimulation	Neurosurgery	Repatriation of service from England back to Wales.	Dependant on theatre capacity before full repatriation can take place, likely that pre-operative and post-operative treatment can be carried out in Wales which will be explored at the DBS Audit Day.	Contracting
Paediatric Cranio-facial procedures	Neurosurgery	The less complex procedures could be repatriated back to Wales from Birmingham.	As above, need additional theatre in place for this work to be repatriated.	Contracting
Arteriovenous Malformation Surgery	Neurosurgery/neuro-diganostic	Currently send 15-20 cases per year to Sheffield, have begun undertaking trials in Cardiff. Equipment already in place and would be carried out by Vascular Neuro-surgeon.	Currently Radiology not commissioned to do this therefore scheme would need to consider both neurosurgery elements and neuro-diagnostic if looking to repatriate.	Contracting
MRI Scanners	Neuro-diagnostic	Requires capital investment from National Imaging Board/WG. Cardiff and Vale has oldest MRI in Wales.	Write letter to National Imaging Board/WG setting out concerns.	Standards
Utilisation of CUBRIC	Neuro-diagnostic	Use of the Cardiff University facilities to carry out clinical diagnostic work. Could use 3T scanners for functional imaging.	Look at feasibility cost of outsourcing.	Contracting
Palliative Care	Neuro-rehabilitation	Gain a better understanding the timing and nature of palliative and supportive care interventions for patients with brain and spinal cord tumours.	Strengthen supportive and palliative care for people with neurological conditions to be delivered by multi-disciplinary teams with a specialist interest in neurological conditions was originally included within the Axford report, however this has not been fully implemented.	
Rookwood move	Neuro-rehabilitation	Current plans in place for services at Rookwood to transfer to Llandough due to condition of facilities. No plans in place for expansion.	The Capital investment requirements for this move would be the responsibility of the HB/WG however there are potential staffing issues as a consequence of the move which would have revenue implications.	Standards
Rehabilitation for Tracheostomy patients	Neuro-rehabilitation	Explore the demand for tracheostomy rehabilitation beds.	Currently Neath Port Talbot are not able to take rehabilitation patients with a tracheostomy and Rookwood can only take a maximum of 4.	

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan
Network rehabilitation units in South Wales	Neuro-rehabilitation	Establish a South Wales rehabilitation network in order to ensure service meets standards and provides optimal patient care.	Recommendation from the Steers review.	Standards

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

		Agenda Item	10
Meeting Title	**Joint Committee**	Meeting Date	30/05/2017
Report Title	Delivery of the Integrated Commissioning Plan 2016/17 Progress at the end of March 2017		
Author (Job title)	Assistant Planning Manager/Acting Assistant Director of Planning		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	Public

Purpose	This paper provides an update on the delivery of the Integrated Commissioning Plan for Specialised Services 2016/17 at the end of March 2017, including the: • Funding Release Schedule; • Progress against the Work Plan; and • Risk Management Summary.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Management Group	Meeting Date	27/04/2017
	Corporate Directors Group	Meeting Date	18/04/2017
Recommendation(s)	Members are asked to: • **Note** the progress made in the delivery of the 2016/17 ICP; • **Note** the funding release proforma schedule; • **Note** the risk management summary.		

Considerations within the report (tick as appropriate)

	YES	NO		YES	NO		YES	NO
Strategic Objective(s)	✓		Link to Integrated Commissioning Plan	✓		Health and Care Standards	✓	
Principles of Prudent Healthcare	✓		Institute for HealthCare Improvement Triple Aim	✓		Quality, Safety & Patient Experience	✓	
Resources Implications	✓		Risk and Assurance	✓		Evidence Base		✓
Equality and Diversity	✓		Population Health	✓		Legal Implications		✓

10

DELIVERY OF THE INTEGRATED COMMISSIONING PLAN 2016/17
Progress at the end of March 2017

1.0 Situation

1.1 The Joint Committee has delegated authority to the Management Group to approve the implementation of the following 'Amber' schemes with the Integrated Commissioning Plan (ICP) for Specialised Services:

- Unavoidable Activity growth / RTT Amber Graded Schemes
- Economic Benefits to Health Boards Amber Graded Schemes

1.2 The paper provides an update for the delivery and implementation of the work plan 2016/17 (as at the end of March 2017) to enable the Group to undertake this role. This includes the following items:

- The progress against the work plan 2016/17
- The development of the risk management monitoring; and
- The funding release schedule (Annex i)

2.0 Background

2.1 In August 2015 Management Group approved the process to monitor the delivery of the ICP and supported the use of funding release proformas. The table below details which Group has the designated authority to approve the funding release for the different schemes of work listed in the ICP.

Group	Approval Authority
Corporate Directors Group	Black and Red Schemes
Management Group	Amber Schemes • Unavoidable Activity growth / RTT Amber Graded Schemes • Economic Benefits to Health Boards Amber Graded Schemes
Joint Committee	Amber Schemes • Risk Rated

Details of funding release approvals authorised by the Corporate Directors Group (CDG) will be made available at the following Management Group Meeting. The approvals to date are listed in Annex (i).

2.2 In addition, the Management Group approved the risk management plan and the submission of exception reports when required. Both the work plan and risk management plan are reviewed by the Corporate Directors Group on a monthly basis, in order to monitor delivery and performance of the ICP.

Any delivery issues identified through this process will be raised with the relevant Health Boards and the issue, with details of the mitigating action taken, will be reported to the Management Group.

3.0 Assessment

3.1 Audit and Outcome Days

A programme of clinical audit and outcome days is undertaken by WHSSC to ensure the quality and patient experience of specialised services commissioned on behalf of Wales. As at the end of February the progress on the delivery of these events is reported below:

Specialised Service	Date	Status
Bariatric Surgery	May 16	Completed
Haemophilia / IBD	Jun 16	Completed
Posture & Mobility and Prosthetics	Jun 16	Completed
IVF	Sep 16	Completed
Renal National Audit Day	Sep 16	Completed
Neonatal	Oct 16	Completed
Thoracic Surgery	Oct 16	Completed
Inherited Metabolic Diseases (ERT)	Oct 16	Completed
Blood and Marrow Transplant	Nov 16	Completed
Cardiac	Nov 16	Completed (Network)
Plastic Surgery	Nov 16	Postponed
Specialised Rehabilitation	Nov 16	Completed
Cystic Fibrosis	Nov 16	Completed
Paediatric Cardiology	Jan 17	Completed
Congenital Heart Disease (Paeds & Adult)	Jan 17	Completed
PET-CT	Jan 17	Completed
Clinical Immunology	Feb 17	Planned
Deep Brain Stimulation	TBC	TBC

3.2 Progress Against the Work Plan 2016/17

The work plan has been reviewed by the Programme Teams as at the end of February and progress is reported below.

3.2.1 Completed Schemes of Work

The following is a full list of schemes of work which have been completed:

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-048	Neurological and Complex Conditions	Prosthesis service - prosthetics for war veterans	Requirement to sustain performance and the achievement of delivery. *** WHSSC asked to undertake a review of the all Wales position as a matter of urgency.	Funding Release Proforma	Funding release letter has been sent to Cardiff.
ICP16-110	Women and Children	Cystic fibrosis	Use of Ivacaftor for indication	Funding Release Proforma	3 patients identified in South Wales paediatric and adult population
ICP16-114	Women and Children	Sapropterin *	NICE: Not on their proposed list of TAs or HSTs. England: Commissioning Policy in England (The use of Sapropterin in Children Reference:E06/P/a, published July 2015) - NHS England will not routinely commission sapropterin for children with Phenylketonuria.	Funding Release Proforma	Not endorsed at AWMSG in November 2015
ICP16-120	Cancer & Blood	Malignant Melanoma *	NICE Mandated	Contractual Allocation	NICE Mandated

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-124	Cancer & Blood	Susoctocog *	Background: AWMSG and NICE: Not referenced on AWMSG or NICE website. [Was referenced in last years' WHSSC Horizon scanning document as an AWMSG pending approval]. Baxalta (manufacturer) gained EU marketing authorization in November 2015. WHSSC has also taken advice from Dr Peter Collins, Consultant Haematologist at Cardiff Centre on patient numbers and treatment pathway - which indicated drug is currently going through UK national tender to determine unit price.	Contractual Allocation	Advice from Medical Directorate that this drug has not been evaluated by NICE or AWMSG. Currently, the drug is not scheduled for evaluation by NICE or AWMSG.
ICP16-125	Women and Children	Elosulfase Alfa *	Background: NICE (HST): Elosulfase alfa, within its marketing authorisation, is recommended for funding for treating mucopolysaccharidosis type IVa (MPS IVa) according to the conditions in the managed access agreement for elosulfase alfa. Published December 2015. Ministerial Announcement - drug available in Wales - 16/3/2016.	Funding Release Proforma	Fully implemented

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-126	Neurological and Complex Conditions	Ataluren NS DMD *	Background: NICE (HST): Ataluren, within its marketing authorisation, is recommended for treating Duchenne muscular dystrophy resulting from a nonsense mutation in the dystrophin gene in people aged 5 years and older who can walk, only when: · the company provides ataluren with the discount agreed in the patient access scheme · the conditions under which ataluren is made available are set out in a managed access agreement between the company and NHS England, which should include the conditions set out in sections 5.12–5.15 of this guidance. Expected publication date July 2016.	Funding Release Proforma	The policy has been approved by Management Group and is published on the WHSSC website
ICP16-001	Cancer & Blood	Thoracic surgery	To commission sufficient surgery, at full cost, to achieve the 2012 LUCADA upper quartile resection rate for Wales.	Funding Release Proforma	Implementation plans have been received in November 2016 from both ABMUHB and CVUHB.

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-003	Cancer & Blood	Neuroendocrine Tumours (NETs)	To commission the service model agreed by the NETs Task and Finish Group.	Funding Release Proforma	The funding release for Phase 1 investment was considered by MG in October 2016 and approved. Further work will need to be undertaken to develop the second phase of the business case to support the advancement of the service. An implementation and evaluation group will be created to oversee this work as well as monitoring progress and examining the outcomes of the first phase. The group will also ensure that the recommendations from the task & finish group have been met and this will include the agreement of an All Wales policy for Somatostatin Analogue which remains outstanding. Funding release letters have been sent.
ICP16-050	Women and Children	Fetal cardiology	Service poses a quality and sustainability concern. Currently failing to meet the NHS England CHD standards.	Funding Release Proforma	Funding release letter sent out July 2016, implementation plan received from C&V UHB for full implementation by end December 2016.

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-053	Women and Children	Paediatric surgery	Sustainability concerns as there are workforce issues with the middle grades within Paediatric Surgery - Deanery. Increased capacity at the UHB is required to meet backlog, recurrent demand and capacity gap impacting recurrent financial requirements.	Funding Release Proforma	Health Board appointing at risk and backfilling lists from April 16. Funding release approved by MGM in July 2016, implementation now being monitored against agreed waiting list profile.
ICP16-064	Women and Children	BAHAs and Cochlears	Management of increasing growth in demand.	Funding Release Proforma	Agreement reached with C&V UHB to reviewed contract model. Funding release approved non-recurrently by MGM in January 2017. Letter to be drafted and further work required on value for money assessment for recurrent approval.
ICP16-081	Women and Children	BAHAs and Cochlears	Performance management of growth in the service in North Wales ***Awaiting proforma / risk register / demand and capacity information for further consideration	Funding Release Proforma	Funding release approved at August MG

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-004	Cancer & Blood	BMT Phase 3	To commission a sustainable BMT service in South Wales.	Funding Release Proforma	There has been a stream of planning and commissioning work over the last few years which has resulted in a three year phased approach to making the service sustainable and to be able to cope with the increasing demand. The funding release for Phase 3 was considered by MG in Nov 2016 and approved. Funding release letter has been sent to CV UHB.
ICP16-009	Cancer & Blood	PET-CT	To revise the PET Policy on an annual basis to ensure equitable services with England and to contribute towards improving cancer outcomes in Wales	Funding Release Proforma	The PET-CT policy was first published in 2013 and was revised in 2015 to ensure it contained the most up to date evidence-based guidance. The revisions to the policy help to ensure that there is an equitable commissioning position within NHS Wales compared to the rest of the UK, facilitated by the increased number of indications routinely funded.
ICP16-052	Women and Children	Paediatric Cardiology RTT	Increased capacity at the UHB is required to meet backlog, recurrent demand and capacity gap impacting recurrent financial requirements.	Funding Release Proforma	Funding release letter sent out July 2016, implementation plan received from C&V UHB.

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-028	Cancer & Blood	Liver ablation	US/RF Liver ablation service to include microwave ablations service	Funding Release Proforma	Funding release proforma approved in December 2016. Funding release letter to be finalised.
ICP16-055	Women and Children	Genetics	To commission UKGTN tests approved 2015/16 for commissioning in 2016/17	Funding Release Proforma	Funding release proforma approved October 2016, funding release letter sent.
ICP16-056	Women and Children	Genetics	Stratified medicine tests	Funding Release Proforma	Funding release proforma approved October 2016, funding release letter sent
ICP16-021	Cancer & Blood	Plastic Surgery Proforma available	LVA service funded by WG. WG priority	Funding Release Proforma	The paper was considered by Management Group and they supported extension of the trial period, but did not approve changes to commissioning policy.
ICP16-038	Neurological and Complex Conditions	Neurovascular	To commission a sustainable neurovascular service in South Wales.	Funding Release Proforma	Funding release was approved in December 2016. Funding release letter to be sent.
ICP16-039	Neurological and Complex Conditions	Interventional neuroradiology	Phase 2 - To commission a sustainable Interventional Radiology Service	Funding Release Proforma	Funding release was approved in December 2016. Funding release letter to be sent.
ICP16-041	Neurological and Complex Conditions	Neurosurgery	To commission a sustainable Neurosurgery service in South Wales. Deanery changes to medical workforce would leave the service vulnerable with minimal cover overnight and leave the on call unsustainable. Insufficient theatre capacity for higher surgical training could also result in a loss of training numbers.	Funding Release Proforma	Funding release was approved in December 2016. Funding release letter to be sent.

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-043	Neurological and Complex Conditions	Clinical Immunology	The service continues to grow and the UHB is keen to discuss the resource implications of this for 2016/17.	Funding Release Proforma	Funding release was approved in December 2016. Funding release letter has been sent to service.
ICP16-047	Neurological and Complex Conditions	Posture and Mobility (Wheelchairs)	To manage growth in the volume of wheelchair issues and to achieve the current delivery measures.	Funding Release Proforma	Funding release was approved in December 2016. Funding release letter has been sent to service.
ICP16-058	Women and Children	NICU	To increase NICU capacity ***Implement the neonatal service model agreed for South and Mid Wales as part of the South Wales Plan (2015/16 Green schemes)	Funding Release Proforma	To be managed through Risk Management Strategy pending decision of Joint Committee. Confirmed with C&V that this scheme is no longer required.
ICP16-066	Women and Children	Cleft lip and palate service	Improve infrastructure within cleft lip and palate service in order to meet national standards ***Further scoping required. ABMU to advise. Possible equity issue for patients in North Wales (2015/16 Green scheme)	Funding Release Proforma	To be managed through Risk Management Strategy pending decision of Joint Committee. SBAR provided by service but currently awaiting Exec approval from within ABMU. Funding release taken to Management Group in November but not approved, to be considered again through 2017/18 ICP.
ICP16-069	Mental Health	High Secure	Expand gatekeeping role to include clinical case monitoring all patients in independent sector placements.	Funding Release Proforma	Funding Release Letters sent to ABM/BC UHBs
ICP16-070	Mental Health	Medium Secure - patients with learning disabilities	Expand gatekeeping role to include clinical case monitoring all patients in independent sector placements.	Funding Release Proforma	Funding Release Letters sent to ABM/BC UHBs

3.2.2 Schemes not yet completed

The table below summarises the position for each of the schemes for which funding has not yet been released:

ICP Reference Number	Financial Table	Programme Team	Service	Commissioning Intention	Comments
ICP16-030	9a	Cancer & Blood	Bariatric Surgery Phase 2	Bariatric surgery is provided for the population of South Wales by ABMUHB. Joint Committee has agreed to the 5 year phased commissioning plan to increase access up to the clinically recommended level.	Agreed as 2015/16 development. Capacity is not available to implement in 2016-17. This scheme will not be achieved. In addition, commissioner concerns re the proposed service model, in particular the management of high risk patients, are addressed.
ICP16-042	9a	Neurological and Complex Conditions	Communication Aids	Augmentative and Alternative Communication (AAC) project. WG funding to develop service hub at Rookwood Hospital with staff also located at BCU. AAC project to include recommendations on future funding arrangements to be considered in ICP 2017/18.	An extension to the evaluation period was supported by Joint Committee in September 2016. Stakeholder event being planned for Feb 17. Additional funding requirements to be discussed in Board meeting 29 Nov 16. Board meeting took place on 29th Nov, agreed discussions need to take place with WG around future funding. Agreed future funding and evaluation would be discussed at JC in September.
ICP16-127	9b	Women and Children	Sebelipase Alfa - LAL *	Sebelipase alfa is a potentially life-saving treatment for babies with rapidly progressive LAL deficiency, and there is a compelling clinical need.	Final Appraisal Determination (FAD) not yet published nor date provided
ICP16-128	9b	Women and Children	Asfotase Alfa - HPP *	Background: NICE (HST): After the first evaluation consultation NICE has issued the following advice: Asfotase alfa is not recommended, within its marketing authorisation, for long-term enzyme replacement therapy in paediatric-onset hypophosphatasia to treat the bone manifestations of the disease. Expected publication date TBC.	Final Appraisal Determination (FAD) not yet published nor date provided

ICP Reference Number	Financial Table	Programme Team	Service	Commissioning Intention	Comments
ICP16-131	9b	Women and Children	BAHAs and Cochlears	Take steps to implement the centralisation of services at the UHB	Met with C&V UHB, they are keen to progress. Meeting with ABMU, they accept the principle of centralisation but question the decision making around Cardiff being the preferred site. Each centre has provided a summary of position against BCIG standards. Process to progress to be agreed. Now deferred until 2017/18.
ICP16-029	9c	Cancer & Blood	Bariatric Surgery Phase 3	To implement phase 3 of the bariatric surgery 5 year phased growth plan for all Wales.	Phase 3 will not be implemented in 2016-17 due to provider capacity constraints.
ICP16-040	9d	Neurological and Complex Conditions	Neuropathology	To commission a sustainable Neuropathology Service.	C&VUHB have indicated that this issue could be managed through improved links with Bristol. The most recent advertising of the post has seen interest from two high calibre candidates.
ICP16-051	9d	Women and Children	Fetal Medicine	Service poses a quality and sustainability concern. Concerns have been raised by the service itself, other Health Boards and Public Health Wales as to how the service is delivered. ***Lack of Fetal Brain MRI provision in South and Mid Wales (2015/16 Green scheme)	Agreed with C&V that not a priority for 2016/17, to be taken forward as part of 2017/18 planning.
ICP16-117	9d	Cancer & Blood	Proton Beam Therapy - Child	NHS England's Commissioning Policies are currently used by the UK-wide National Proton Clinical Reference Panel to make recommendations for the clinical suitability of Welsh patients to access Proton Beam Therapy (PBT). WHSSC needs to review its commissioning position for PBT and produce revised, up to date commissioning policies for people in Wales.	Assessed in 2017/18 Prioritisation Panel.

ICP Reference Number	Financial Table	Programme Team	Service	Commissioning Intention	Comments
ICP16-118	9d	Cancer & Blood	Proton Beam Therapy - TYP	NHS England's Commissioning Policies are currently used by the UK-wide National Proton Clinical Reference Panel to make recommendations for the clinical suitability of Welsh patients to access Proton Beam Therapy (PBT). WHSSC needs to review its commissioning position for PBT and produce revised, up to date commissioning policies for people in Wales.	Assessed in 2017/18 Prioritisation Panel.
ICP16-084	9d	Women and Children	Paediatric Cardiology	Ensure that the service meets the NHS England CHD standards - as the service is part of a network with Bristol. Also, outpatient component gap for this service and the consultant base is short on sessional time to support activities. This poses a risk to delivery and sustainability.	To be managed through Risk Management Strategy pending decision of Joint Committee. CHD service specification currently being drafted. Self assessment already circulated by CHD Network and Welsh service providers to return, this will help to identify gaps in services across South Wales.
ICP16-119	9d	Cancer & Blood	Proton Beam Therapy - Adult		Assessed in 2017/18 Prioritisation Panel
ICP16-115	9d	Cardiac	VAD - BTR	Implantation of a left ventricular assist device for destination therapy in people ineligible for heart transplantation NICE interventional procedure guidance [IPG516] Published date: March 2015	Recommendation from JC that English policy and service specification should be adopted as an interim position. Recommendation agreed at November Management Group, permanent policy to be developed as appropriate. Assessed in 2017/18 Prioritisation Panel
ICP16-121	9d	Cardiac	VAD - BTT	Ventricular Assist Devices (VADs) as a bridge to heart transplantation or myocardial recovery (All Ages) - NHS England service specification A18/S(HSS)/b - commissioned in England?	Recommendation from JC that English policy and service specification should be adopted as an interim position. Recommendation agreed at November Management Group, permanent policy to be developed as appropriate. Assessed in 2017/18 Prioritisation Panel

ICP Reference Number	Financial Table	Programme Team	Service	Commissioning Intention	Comments
ICP16-044	9d	Neurological and Complex Conditions	Neuromodulation/ pain service	Change to the Pain Service model that that could utilise existing baseline and performance funding in a different way with mutual benefit. Spinal Implants - development of an Multidisciplinary Team model.	Given priority to other Neurosciences schemes, this has rolled forward to 17/18.
ICP16-016	9e	Cancer & Blood	Endobronchial Valve Replacement (EBVR)	To commission sufficient surgery to meet RTT targets	Will be taken forward as a 17/18 ICP scheme.
ICP16-130	9e	Cancer & Blood	Plastic Surgery	Evaluation and recommendations for future funding of LVA service	Evaluation of first 12 months to include policy review. Indication that one of the criteria in the policy may require amendment (2 episodes of cellulitis in 12 months) to ensure sufficient eligible patients for screening. The paper was considered by Management Group and they supported extension of the trial period, but did not approve changes to commissioning policy.

3.3 Financial Summary

As reported in the month 12 financial monitoring, 2016/17 developments are underspent by £3.278m. This includes £0.581m of expenditure for the high risk amber schemes approved which were unfunded in the 2016-19 ICP:

			2016/17			2017/18		
Planning Ref	Category	Scheme	2016/17 ICP £m	2016/17 Forecast Expenditure £m	2016/17 Total Slippage £m	2017/18 ICP £m	2017/18 Forecast Expenditure £m	2017/18 Forecast Slippage £m
ICP16-030	Black - Pre approved	Bariatrics Stage 2	0.084	-	(0.084)			
ICP16-048	Black - Pre approved	Prosthetics service sustainability for war veterans	0.300	0.121	(0.179)	0.300	0.210	(0.090)
ICP16-110	Red - Mandated	Cystic fibrosis - Ivacaftor NONG551D (AWMSG)	0.459	0.192	(0.267)	0.612	0.612	-
ICP16-120	Red - Mandated	Malignant Melanoma Pathway Drugs	1.500	0.758	(0.742)	1.750	1.769	0.019
ICP16-124	Red - Mandated	Susoctocog - Haemophilia	0.380	-	(0.380)	0.950	-	(0.950)
ICP16-125	Red - Mandated	Elosulfase Alfa - VIMZIM ERT	0.660	0.155	(0.505)	0.880	0.880	-
ICP16-126	Red - Mandated	Ataluren NS Duchene Muscular Dystrophy	0.400	0.053	(0.347)	0.750	0.200	(0.550)
ICP16-128	Red - Mandated	Asfotase Alfa - HPP ERT	0.450	-	(0.450)	0.900	0.900	-
ICP16-001	Amber - Unavoidable	Thoracic surgery infrastructure & activity	0.800	0.797	(0.003)	2.500	2.100	(0.400)
ICP16-003	Amber - Unavoidable	Neuroendocrine Tumours (NETs)	0.187	0.007	(0.180)	0.375	0.349	(0.026)
ICP16-050	Amber - Unavoidable	Fetal cardiology	0.095	0.095	-	0.189	0.138	(0.051)
ICP16-053	Amber - Unavoidable	Paediatric surgery	0.500	0.500	-	0.862	0.862	-
ICP16-081	Amber - Unavoidable	BAHA & Cochlears growth North Wales	0.290	0.240	(0.050)	0.500	0.340	(0.160)
ICP16-064	Amber - Unavoidable	BAHA & Cochlears growth South Wales	0.500	0.582	0.082	0.750	0.667	(0.083)
ICP16-047	Amber - Unavoidable	Posture and Mobility - ALAS (Wheelchairs)	0.500	0.373	(0.127)	0.500	0.373	(0.127)
ICP16-004	Amber - Unavoidable	BMT Phase 3 infrastructure & activity	1.150	0.700	(0.450)	2.400	2.101	(0.299)
ICP16-105	Amber - Unavoidable	Clinical Immunology non pay growth	0.400	0.400	-	0.800	0.800	-
ICP16-009	Amber - Unavoidable	PET CT new indications	0.062	0.062	-	0.170	0.062	(0.108)
ICP16-052	Amber - Unavoidable	Paediatric Cardiology RTT	0.187	0.087	(0.100)	0.187	0.173	(0.014)
ICP16-028	Amber - Unavoidable	Liver ablation	0.105	0.028	(0.077)	0.105	0.065	(0.040)
		Total Funded ICP schemes	**9.009**	**5.150**	**(3.859)**	**15.480**	**12.601**	**(2.879)**
ICP16-056	Economic Benefits	Genetics - Stratified Medicine		0.102	0.102		0.218	0.150
ICP16-038	Amber - Sustainability	Neurovascular		0.085	0.085		0.280	0.280
ICP16-041	Amber - Sustainability	Neurosurgery		0.150	0.150		0.375	0.375
ICP16-039	Amber - Sustainability	Interventional neuroradiology		0.092	0.092		0.207	0.207
ICP16-043	Amber - Sustainability	Clinical Immunology (infrastructure)		0.152	0.152		0.400	0.400
		Additional Funding Required for High Risk Schemes	**-**	**0.581**	**0.581**	**-**	**1.480**	**1.412**
		Total Reported 16-17 Developments	**9.009**	**5.731**	**(3.278)**	**15.480**	**14.081**	**(1.467)**

£2.691m of slippage is against mandated drug schemes and is reported based on actual IPFR approvals and for expenditure reported in the Velindre monitoring for the Melanoma drugs.

The revised full year effect of 2017/18 developments is a reduction of £1.467m against the 2016-19 ICP year 2 provision. This assumes that the genetics, high risk neurosciences schemes and clinical immunology infrastructure will be funded recurrently, these are forecast to cost £1.4m in 2017/18.

3.4 Risk Management Summary

Management Group approved the use of exception reports for the management of risk for schemes not included within the ICP in August 2015 ('Green' and 'Purple'). It was agreed that exception reports will be submitted when risks meet the following thresholds:

- Where a scheme has a 'red' rating in one or more of the three domains (Quality and Safety, Patient and Public Sensitivity, and Service Sustainability); and,
- Where a scheme moves from 'green' to 'amber' ratings in one or more of the three domains.

Further work has recently been undertaken to refine the risk management plan and is available on SharePoint as a live document.

4.0 Recommendations

Members are asked to:

- **Note** the progress made in the delivery of the 2016/17 ICP.

5.0 Annexes

- Annex i – Funding Release Schedule

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Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Development of the Plan Implementation of the Plan
Link to Integrated Commissioning Plan	This paper provides an update on the delivery of the ICP and the ICP risk management plan for schemes as at the end of January 2017.
Health and Care Standards	Governance, Leadership and Accountability Safe Care Effective Care
Principles of Prudent Healthcare	Reduce inappropriate variation Only do what is needed Public & professionals are equal partners through co-production
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Improving Patient Experience (including quality and Satisfaction) Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	The ICP Delivery Report highlights the risks to quality, safety and patient experience resulting in delays/changes to the implementation of schemes and the action being taken to address.
Resources Implications	Any in year change for individual schemes likely to result in a change in resource requirement will be highlighted in the ICP Delivery Report.
Risk and Assurance	The ICP Delivery Report will summarise risk assessment and mitigating action for off track ICP schemes.
Evidence Base	• Funding Release Schedule (Annex (i)); • Risk Management Plan (available on Sharepoint) • Work Plan Monitoring Schedule (available on Sharepoint)
Equality and Diversity	There are no equality and diversity implications associated with this report.
Population Health	There are no additional implications associated for population health in this report.
Legal Implications	There are no legal implications associated with this report.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	18/04/2017	Supported subject to minor amend
Management Group	27/04/2017	Noted

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Annex i

Funding Release Schedule

Planning Ref	Category	Scheme	Proposed Date of submission to CDG/MGM	Actual/ Revised Date of submission to CDG/MG:	Outcome
ICP16-021	Black - Pre approved	Plastics - LVA (For evaluation after 6 months)	TBC		
ICP16-030	Black - Pre approved	Bariatric Surgery Phase 2	TBC		
ICP16-042	Black - Pre approved	Communication Equipment (WG Allocation in 2016/17)	N/A	N/A	
ICP16-048	Black - Pre approved	Prosthetics service sustainability for war veterans	TBC	July	Approved
ICP16-110	Red - Mandated	Cystic fibrosis - Ivacaftor NONG551D (AWMSG)	TBC	June	Approved
ICP16-114	Red - Mandated	Saproterin - phenylketonuria	TBC	N/A	Removed as not approved by AWMSG
ICP16-120	Red - Mandated	Malignant Melanoma	Contractual Allocation made		
ICP16-124	Red - Mandated	Susoctocog – Haemophilia	TBC	N/A	Currently the drug is not scheduled for evaluation by NICE or AWMSG.
ICP16-125	Red - Mandated	Elosulfase Alfa - VIMZIM ERT	TBC		Approved
ICP16-126	Red - Mandated	Ataluren NS Duchenne Muscular Dystrophy	TBC	August	Approved
ICP16-127	Red - Mandated	Sebelipase Alfa - LAL ERT	TBC		
ICP16-128	Red - Mandated	Asfotase Alfa - HPP ERT	TBC		
ICP16-131	Red - Cost Neutral	BAHAs and Cochlears – Centralisation	Deferred to 2017/18		
ICP16-008	Red - Repatriation	Haemophilia (long lasting blood products)	January		
ICP16-001	Amber - Unavoidable	Thoracic surgery infrastructure & activity	June	May	Approved (June)
ICP16-003	Amber - Unavoidable	Neuroendocrine Tumours (NETs)	October	October	Approved
ICP16-050	Amber - Unavoidable	Fetal cardiology	May	May	Approved
ICP16-053	Amber - Unavoidable	Paediatric surgery	May	June	Approved
ICP16-081	Amber - Unavoidable	BAHA & Cochlears growth North Wales	June	August	Approved
ICP16-064	Amber - Unavoidable	BAHA & Cochlears growth South Wales	October	January	Approved
ICP16-047	Amber - Unavoidable	Posture and Mobility - ALAS (Wheelchairs)	October	December	Approved
ICP16-004	Amber - Unavoidable	BMT Phase 3 infrastructure & activity	October	October	Approved
ICP16-105	Amber - Unavoidable	Clinical Immunology non pay growth	July	October	Approved
ICP16-043	Amber – Risk Rated	Clinical Immunology (infrastructure)	September	October	Approved (November)
ICP16-009	Amber - Unavoidable	PET CT new indications	May	May	Approved
ICP16-029	Amber - Unavoidable	Bariatric Surgery Phase 3 (all Wales)	N/A	N/A	Implementation in 2017/18
ICP16-052	Amber - Unavoidable	Paediatric Cardiology RTT	May	May	Approved
ICP16-028	Amber - Unavoidable	Liver ablation	October	December	Approved

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

		Agenda Item	11
Meeting Title	**Joint Committee**	Meeting Date	30/05/2017
Report Title	February 17 Performance Report		
Author (Job title)	Performance Analyst / Assistant Planning Manager		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	Public

Purpose	The attached report provides members with a summary of the key issues arising from the February 2017 Performance Report and details the action being undertaken to address areas of non-compliance.			
RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☐	INFORM ☒

Sub Group /Committee	Corporate Directors Group Board	Meeting Date	18/04/2017
	Management Group	Meeting Date	27/04/2017
Recommendation(s)	Members are asked to: • **Note** current performance and the action being undertaken to address areas of non-compliance.		

Considerations within the report (tick as appropriate)

Strategic Objective(s)	YES ✓	NO	Link to Integrated Commissioning Plan	YES ✓	NO	Health and Care Standards	YES ✓	NO
Principles of Prudent Healthcare	YES	NO ✓	Institute for HealthCare Improvement Triple Aim	YES	NO ✓	Quality, Safety & Patient Experience	YES ✓	NO
Resources Implications	YES	NO ✓	Risk and Assurance	YES	NO ✓	Evidence Base	YES	NO ✓
Equality and Diversity	YES ✓	NO	Population Health	YES ✓	NO	Legal Implications	YES	NO ✓

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WHSSC Performance Report

February 2017

WHSSC

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3. Key Messages 1

1. Integrated Provider / Commissioner Dashboard

Domain	Improved Performance	Sustained Performance	Decline in Performance	Trend
Safety	0	0	1	⇨
Effectiveness	7	3	6	⇧
Staff & Resources	2	0	2	⇨
Leadership	4	1	0	⇨
Total	**13**	**4**	**9**	⇧

2. Provider Dashboard

Indicator Ref.	Provider	Measure		Target	Tolerance Levels			Dec-16	Jan-17	Feb-17	Previous Movement	Latest Movement	Comments
					Red	Amber	Green						
S01		Quarterly	Number of new Serious Incidents reported to WHSSC by provider within 48 hours	100%	<50%	50-99%	100%	21%			⇧	⇩	Reported Quarterly
E01	All	Monthly	Cardiac surgery patients to be waiting < 36 weeks	100% within 36 weeks	<100%	N/A	100%	97%	98%	95%	⇧	⇩	E02 to E04 does not contain English data due to availability of RTT. To be updated in March report
E02	All	Monthly	Plastic surgery patients to be waiting < 36 weeks	100% within 36 weeks	<100%	N/A	100%	97%	95%	96%	⇩	⇧	
E03	All	Monthly	Paediatric surgery patients to be waiting < 36 weeks	100% within 36 weeks	<100%	N/A	100%	93%	90%	90%	⇩	⇨	
E04	All	Monthly	Neurosurgery patients to be waiting < 36 weeks	100% within 36 weeks	<100%	N/A	100%	92%	91%	88%	⇩	⇩	
E05	All	Monthly	Bariatric surgery patients to be waiting < 36 weeks	100% within 36 weeks	<100%	N/A	100%	61%	60%	62%	⇩	⇧	
E06	All	Monthly	Thoracic surgery patients to be waiting < 36 weeks	100% within 36 weeks	<100%	N/A	100%	99%	99%	98%	⇨	⇩	
E06D	All	Monthly	Urgent Lung resection within 62 days - All Wales	95% within 62 days	<90% within 62 days	90-95% within 62 days	=,>95% within 62 days	43%	-	-			
E06E	All	Monthly	Non-Urgent Lung resection within 31 days - All Wales	95% within 31 days	<90% within 31 days	90-95% within 31 days	=,>95% within 31 days	50%	-	-			
E07	All	Monthly	Cancer patients to receive a PET scan within 10 days from referral to electronic receipt of image and report by the referring clinician - National	95% within 10 days	<90% within 10 days	90-95% within 10 days	=,>95% within 10 days	99%	98%	98%	⇩	⇨	
E08	All	Monthly	Delivery of 26 week RTT target for adult posture & mobility service - National	90% within 26 weeks	<85% within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	87%	85%	84%	⇩	⇩	
E09	All	Monthly	Delivery of 26 week RTT target for paediatric posture & mobility service - National	90% within 26 weeks	<85% within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	96%	98%	98%	⇧	⇨	
E10	All	Monthly	CAMHS OOA placements	14	>16	>14, <16	=,<14	11	11	10	⇨	⇧	
E11	All	Monthly	CAMHS NHS Beddays - National	95% with +/-5% tolerance	<85%,>105%	< 90%, >100%	90% - 100%	93%	95%	83%	⇧	⇩	
E11i	All	Monthly	CAMHS NHS Home Leave - National	25% - 35 % of Beddays	<20%, >40%	<25%, >35%	25%-35%	43%	40%	28%	⇧	⇧	
E12	All	Monthly	Adult Medium Secure NHS Beddays - National	100% with +/-5% tolerance	<90%, >110%	< 95%, >105%	95% - 105%	96%	97%	86%	⇧	⇩	
E13	All	Monthly	IVF patients waiting for Outpatient Appointment	100% within 26 weeks	<100%	N/A	100%	86%	98%	99%	⇧	⇧	
E13i	All	Monthly	IVF patients waiting to commence treatment	0 patients waiting	>1	N/A	0	156	169	150	⇩	⇧	
E13ii	All	Monthly	IVF patients accepted for 2nd cycle waiting to commence treatment	0 patients waiting	>1	N/A	0	51	53	45	⇩	⇧	

**E02 to E04 does not contain English data due to a month's delay in availability of English RTT data. Updates will be applied to the March report.*
E11i an increase in Home Leave during December is normal as patients are allowed home over Christmas period whenever clinically appropriate.
E06D and E06E no data received for January or February.

3. Key Messages

3.1 Provider

3.1.1 Safety

Data for the safety measure (number of new serious incidents) is reported on a quarterly basis.

3.1.2 Performance

Cardiac Surgery – Performance at Abertawe Bro Morgannwg UHB (ABMUHB), Cardiff & Vale UHB (CVUHB) continues to perform below planned levels.

WHSSC is continuing to hold monthly Directorate meetings with ABMUHB and CVUHB following close monitoring of the weekly activity submitted by both Health Boards. Although there has been a gradual decrease in total waiting list at ABMUHB there has been a slight increase in the number of 36 week RTT breaches. Similarly at CVUHB there has also been an increase in breaches but this has been a consequence of efforts to improve the accuracy of pathway start data included in referral information to the Health Board.

At the last SLA review meeting held with LHCH on the 23rd March the Trust advised that the further surgeon currently training to undertake mini mitral valve surgery should be ready to commence solo surgery by July/August 2017. As a consequence waiting times should reduce but WHSSC were informed that realistically improvements would be seen by the end of the calendar year.

Plastic Surgery – As the provider of plastic surgery to South Wales patients ABMUHB continue to report 36 week breaches; the sub specialties of breast surgery and hand surgery have patients with the longest waiting times.

The Health Board's plastic surgery delivery plan 2016/17 has set a target to reduce the number of 36 week breaches to 40 by year end but his target is now not expected to be achieved (current forecast: 59 breaches). This is due to the service reporting lost capacity due to unscheduled care pressures.

WHSSC has escalated the performance management arrangements for plastic surgery by establishing monthly executive level performance meetings commencing in April 2017.

Paediatric Surgery – In CVUHB the percentage of patients waiting over 36 weeks remained at 10% in February but a number of operational pressures impacted on this. However, the position is anticipated to improve in March.

As per the business case, the ward nursing staff are now fully established and the 2nd additional operating list will commence in April 2017, earlier than originally anticipated in the business case.

Correspondence has been received from the Chief Operating Officer at CVUHB confirming that the focus initially during 2017/18 will be on reducing waiting times to below 52 weeks. The focus for the remainder of the year will then be to deliver the 36 week target.

The profile provided by CVUHB is demonstrating that all patients waiting over 52 weeks will be treated by the end of Quarter 1 2017/18 and a further profile demonstrating the delivery of the 36 week RTT target during 2017/18 is awaited.

Neurosurgery – The waiting list position has deteriorated at CVUHB with 143 patients waiting over 36 weeks at the end of February of which 64 were waiting over 52 weeks. The position has deteriorated further in the reported March position.

Frequent dialogue is taking place between WHSSC and CVUHB to identify and address the difficulties within the service. The service is facing increasing numbers of emergency patients who have a longer length of stay than elective patients which in turn is increasing the number of bed related cancellations.

Neuroradiology – this service will be reported as part of the 2017/2018 monthly WHSSC Performance reports.

Bariatric Surgery – At a regional level in South Wales, 48% of patients were waiting in excess of 36 weeks at the end of January, which represents a slight improvement on December. For North Wales, 100% of patients were treated within the 36 weeks maximum target (service provided by Salford Royal NHST).

In order to address the clinical risks associated with long waiting times for patients listed for bariatric surgery at Morriston Hospital, it was agreed that ABMUHB would implement a plan to ensure more timely access to treatment for these patients, including outsourcing for additional capacity. The request for an update from ABMUHB on the current status of this plan and the number of patients that will be treated has been escalated to the Chief Executive, ABMUHB. A response is currently awaited.

WHSSC has also written to ABMUHB to confirm the intention to take forward a tender for future service provision for South Wales.

Thoracic Surgery – The percentage of patients waiting less than 36 weeks for thoracic surgery has remained at 98% in February; patients breaching the 36 week target were all located in South East Wales.

PET Scans – The target that 90% of scans are received within 10 days from referral to receipt of image was achieved in January for both North Wales and South Wales.

Posture and Mobility – The paediatric service is achieving the 90% target nationally; however, for the adult service both BCUHB and CVUHB have seen deterioration in performance resulting in underperformance nationally.

WHSSC are aware that this position has deteriorated due to staff vacancies across two of the three sites and is not likely to recover and achieve the national target until at least April 2017. Comprehensive presentations were provided by each provider of this service at the All Wales Posture and Mobility Partnership Board, where future plans for recovery were clearly set out and assurance provided.

Lung Cancer – Note: data not yet available for January and February.

This data has been provided previously by the Cancer Network. WHSSC is currently discussing with the Network the most appropriate source for continued access to the data.

The Thoracic Surgery Additional Capacity Project was established to develop plans to reduce the waiting times for lung resection in South Wales. CVUHB has provided additional capacity through weekend working over an 8 week period commencing on 11th February to address the current backlog of patients in South East Wales.

For patients in South West Wales, additional capacity is being commissioned from University Hospitals North Midlands NHS Trust.

CAMHS – The overall number of CAMHS inpatients in the two NHS Wales units increased to 22 in February, compared to 21 in January 2017. The number of patients in out of area placements reduced from 11 placements in January to 10 at the end of February 2017.

Medium Secure – The number of patients in Caswell Clinic (ABMUHB) remains in line with the 95% target (58 beds). There are currently 20 patients on the 20 bedded ward at Ty Llewellyn as at the end of January and the closure of the 5 bed ward for refurbishment had resulted in a temporary increase in out of area admissions.

IVF - The number of patients waiting for IVF treatment reduced in February 2017 as did the number of patients waiting for their 2nd cycle. The percentage of patients waiting over 26 weeks for 1st outpatient appointment has reduced significantly from 14% in December to 1% in February.

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Implementation of the Plan
Link to Integrated Commissioning Plan	This report monitors the delivery of the key priorities outlined within WHSSCs Integrated Commissioning Plan.
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	Not applicable
Institute for HealthCare Improvement Triple Aim	Not applicable
Organisational Implications	
Quality, Safety & Patient Experience	The report will monitor quality, safety and patient experience.
Resources Implications	There are no resource implications at this point
Risk and Assurance	There are no known risks associated with the proposed framework There are reputational risks to non-delivery of the RTT standards.
Evidence Base	Not applicable
Equality and Diversity	The proposal will ensure that data is available in order to identify any equality and diversity issues.
Population Health	The core objective of the report is to improve population heath through the availability of data to monitor the performance of specialised services.
Legal Implications	There are no legal implications relating to this report.

Report History:

Presented at:	Date	Brief Summary of Outcome
Corporate Directors Group Board	18/04/2017	Supported subject to minor amendments
Management Group	27/04/2017	

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

		Agenda Item	12
Meeting Title	**Joint Committee**	Meeting Date	30/05/2017
Report Title	Financial Performance Report – Month 1 2017/18		
Author (Job title)	Finance Manager – MH, DRC, IPFR & MM		
Executive Lead (Job title)	Director of Finance	Public / In Committee	Public

Purpose	The purpose of this report is to set out the estimated financial position for WHSSC for the 1st month of 2017/18. There is no corrective action required at this point. The financial position is reported against the 2017/18 baselines following provisional approval of the 2017/18 Technical Plan by the Joint Committee in March 2017.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee		Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the current financial position and forecast year-end position.		

Considerations within the report (tick as appropriate)

	YES	NO		YES	NO		YES	NO
Strategic Objective(s)	✓		Link to Integrated Commissioning Plan	✓		Health and Care Standards		✓
Principles of Prudent Healthcare		✓	Institute for HealthCare Improvement Triple Aim		✓	Quality, Safety & Patient Experience		✓
Resources Implications	✓		Risk and Assurance	✓		Evidence Base		✓
Equality and Diversity		✓	Population Health		✓	Legal Implications		✓

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1.0 Situation

1.1 The purpose of this report is to provide the current financial position of WHSSC together with outturn forecasts for the financial year.

2.0 Background

The financial position is reported against the 2017/18 baselines following provisional approval of the 2017/18 Technical Plan by the Joint Committee in March 2017.

3.0 Assessment

3.1 The financial position reported at Month 1 for WHSSC is an underspend to year-end of £602k.

The movements are across various budget headings, including Welsh contracts, Development funding and Mental Health.

3.2 Appendix A contains a full report of the Income and Expenditure values which make up this total, with further detail and explanations.

4.0 Recommendations

4.1 Members of the appropriate Group/Committee are requested to:

- **Note** the current financial position and forecast year-end position.

5.0 Appendices / Annex

- Appendix A – full report of the details behind the reported financial position. This includes:
  - WHSSC Expected Expenditure breakdown across LHB's/budget headings. This reconciles to the total reported to WG.

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Development of the Plan
Link to Integrated Commissioning Plan	This document reports on the ongoing financial performance against the agreed IMTP
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	Only do what is needed
Institute for HealthCare Improvement Triple Aim	Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	Not applicable
Resources Implications	This document reports on the ongoing financial performance against the agreed IMTP
Risk and Assurance	This document reports on the ongoing financial performance against the agreed IMTP
Evidence Base	Not applicable
Equality and Diversity	Not applicable
Population Health	Not applicable
Legal Implications	Not applicable

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**

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

Finance Performance Report – Month 1

1. Situation / Purpose of Report

The purpose of this report is to set out the estimated financial position for WHSSC for the 1st month of 2017/18 together with any corrective action required.

The narrative of this report excludes the financial position for EASC, which includes the WAST contracts, the EASC team costs and the QAT team costs, and have a separate Finance Report. For information purposes, the consolidated position is summarised in the table below.

Table 1 - WHSSC / EASC split

	Annual Budget	Budgeted to Date	Actual to Date	Variance to Date	Movement in Var to date	Current EOYF	Movement in EOYF position
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
WHSSC	557,055	46,421	46,321	(100)	(100)	(602)	(602)
Sub-total WHSSC	**557,055**	**46,421**	**46,321**	**(100)**	**(100)**	**(602)**	**(602)**
WAST	139,213	11,601	11,601	0	0	0	0
EASC team costs	350	29	23	(6)	(6)	(77)	(77)
QAT team costs	672	56	59	3	3	67	67
Sub-total WAST / EASC / QAT	140,235	11,686	11,683	(3)	(3)	(10)	(10)
Total as per Risk-share tables	697,290	58,107	58,004	(103)	(103)	(612)	(612)

Please note that as LHB's cover any WHSSC variances, any over/under spends are adjusted back out to LHB's. Therefore, although this document reports on the effective position to date, this value is actually reported through the LHB monthly positions, and the WHSSC position as reported to WG is a nil variance.

2. Background / Introduction

The financial position is reported against the 2017/18 baselines following provisional approval of the 2017/18 Technical Plan by the Joint Committee in March 2017. The remit of WHSSC is to deliver a plan for Health Boards within an overall financially balanced position. However, the composite individual positions are important and are dealt with in this financial report together with consideration of corrective actions as the need arises.

The overall financial position at Month 1 is an underspend of £103k to date, with a forecast year-end underspend of £602k.

The majority of NHS England is reported in line with the previous month's activity returns (Months 11/12 of 2016/17). WHSSC continues to commission in line with the contract intentions agreed as part of the IMTP and standard Pbr rules, and declines payment for activity that is not compliant with the business rules related

to out of time activity. WHSSC does not pay CQUIN payments for the majority of the English activity.

The inherent increased demand led-financial risk exposure from contracting with the English system remains but it is planned that this will have been mitigated to a greater extent in 2017/18 as financial baselines have been uplifted to more realistic levels based on historic activity. Reported variances are currently in line with this intention.

3. Governance & Contracting

All budgets have been updated to reflect the 2017/18 provisional IMTP, including the full year effects of 2016/17 Developments. Inflation has been allocated to the position, but work on this will be ongoing in future months. The IMTP sets the baseline for all the 2017/18 contract values. This will be translated into the new 2017/18 contract documents.

Distribution of the reported position has been shown using the 2016/17 risk shares based on 2015/16 outturn utilisation, and work is ongoing to move these to the 2016/17 outturn utilisation in future months. The Finance Working Group is working on validating prospective changes to the risk-sharing process, and any update will be shared with Management Group for agreement. Until there is formal agreement from Joint Committee on a change to the risk sharing process the current system will remain in operation.

4. Actual Year To Date and Forecast Over/(Underspend) (summary)

Financial Summary (see Risk-sharing tables for further details)	Annual Budget	Budgeted to Date	Actual to Date	Variance to Date	Previous month Var to date	Current EOYF Variance	Previous month EOYF Var
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NHS Wales							
Cardiff & Vale University Health Board	187,596	15,633	15,628	(5)	0	(60)	0
Abertawe Bro Morgannwg University Health Board	96,362	8,030	8,032	2	0	25	0
Cwm Taf University Health Board	7,452	621	621	0	0	0	0
Aneurin Bevan Health Board	8,833	736	736	0	0	0	0
Hywel Dda Health Board	1,486	124	124	0	0	0	0
Betsi Cadwaladr University Health Board Provider	38,137	3,178	3,150	(28)	0	(340)	0
Velindre NHS Trust	38,027	3,169	3,169	0	0	0	0
Sub-total NHS Wales	**377,894**	**31,491**	**31,460**	**(31)**	**0**	**(375)**	**0**
Non Welsh SLAs	95,774	7,981	8,019	37	0	0	0
IPFR	28,737	2,395	2,395	0	0	0	0
IVF	4,375	365	365	(0)	0	(0)	0

Financial Summary (see Risk-sharing tables for further details)	Annual Budget £'000	Budgeted to Date £'000	Actual to Date £'000	Variance to Date £'000	Previous month Var to date £'000	Current EOYF Variance £'000	Previous month EOYF Var £'000
Mental Health	32,718	2,726	2,656	(71)	0	(280)	0
Renal	5,261	438	438	0	0	0	0
Prior Year developments	6,035	503	503	0	0	0	0
2016/17 Plan Developments	2,796	233	243	10	0	(125)	0
Direct Running Costs	3,465	289	243	(46)	0	175	0
Phasing adjustment for Developments not yet implemented ** see below	0	0	0	0	0	0	0
Total Expenditure	**557,055**	**46,421**	**46,321**	**(100)**	**0**	**(602)**	**0**

The reported position is based on the following:

- NHS Wales activity – based on Month 12 data or Annual Plan values if deemed to vary from the 2016/17 outturn.
- NHS England activity – Month 11 data as very few Month 12 final returns received at the point of month-end; please note that most have been received since the risk-sharing on working day 3 and work is ongoing to analyse the final performances against the 2016/17 Balance Sheet Reserves.
- IVF – one NHS Wales contract, with some NHS England activity and IPFR approvals. As of reporting Month 1, no invoices for actual 2017/18 activity would have been received, so IVF was reported to budget at this point.
- IPFR – reporting is usually based on approved Funding Requests; reporting dates based on usual lead times for the various treatments, with unclaimed funding being released after 36 weeks. As of reporting Month 1, no invoices for actual 2017/18 activity would have been received, so IPFR was reported to budget at this point.
- Renal – a variety of bases; please refer to the risk-sharing tab for Renal for more details on the various budgets and providers.
- Mental Health – live patient data as at the end of the month, plus current funding approvals. This excludes High Secure, where the 2 contracts are being finalised.
- Developments – variety of bases, including agreed phasing of funding. Financial impacts of approved funding releases are currently accounted for in the forecasts.
  ** Please note that Income is collected from LHB's in equal 12ths, therefore there is usually an excess budget in Months 1-11 which relates to Developments funding in future months. To keep the Income and Expenditure position equal, the phasing adjustment is shown on a separate line for transparency and is accrued to date to avoid a technical underspend.

5. Financial position detail - Providers

5.1 NHS Wales – Cardiff & Vale contract:
Various over and underspends from the Month 12 data have been extrapolated, along with some actual positions to Month 1, to a total reported year-end position of £60k underspent. Notes on the various sub-headings will be expanded to the usual detail for Month 2 onwards as 2017/18 activity reporting starts to flow in.

5.2 NHS Wales – ABM contract:
Various over and underspends from the Month 1 data have been extrapolated to a total reported year-end position of £25k overspent. Notes on the various sub-headings will be expanded to the usual detail for Month 2 onwards as 2017/18 activity reporting starts to flow in.

5.3 NHS Wales – BCU contract:
Variances on only Angioplasty, ICD's and Haemophilia have been reported to date. This is risk-shared wholly to BCU.

5.4 NHS Wales – Cwm Taf contract:
Reported to break-even position at this point pending 2017/18 data.

5.5 NHS Wales – Aneurin Bevan contract:
Reported to break-even position at this point pending 2017/18 data.

5.6 NHS Wales – Hywel Dda contract:
Reported to break-even position at this point pending 2017/18 data.

5.7 NHS Wales – Velindre contract:
Reported to break-even position at this point pending 2017/18 data.
The reported position includes provision for a net 2% inflation offer from commissioners.

5.8 NHS England contracts:
Total £37k overspend to month 1. The English position has been reported prudently, with estimates for the Month 1 activity in most cases.

Notes on the various sub-headings will be expanded to the usual detail for Month 2 onwards as 2017/18 activity reporting starts to flow in.

Detailed explanations and trends on all the English providers are noted on the appropriate tab of the financial Risk-sharing tables sent to all LHB's on the 3rd working day; please see them for any further details. Triangulation of alternative methods of forecasting informs the degree of risk at any time and are reviewed each month. The current reported forecast outturn position is prudent compared with straight line forecasting.

5.9 IPFR:
Reported to break-even position at this point pending 2017/18 data.

Notes on the various sub-headings will be expanded to the usual detail for Month 2 onwards as 2017/18 activity reporting starts to flow in.

5.10 IVF:
Reported to break-even position at this point pending 2017/18 data.

5.11 Mental Health:
Various budgets totalling an underspend to date of £71k and a year-end forecast underspend of £280k. These budgets include:

- Adult Mental Health has a small underspend reported, based on current and expected patients. This area received growth funding the Annual Plan and is expected to be sufficient for 2017/18.

  The new Case Management teams are now progressing to recruitment, and it is expected that the increased clinical support in this area will reduce patient numbers going forward as staff come into post. The delay in recruiting led to underspends back into the 2016/17 position for both the BCU and ABM teams.

- South Wales CAMHS and All-Wales FACTS inpatient budgets have continued low activity and currently have a combined underspend of £71k to date and £167k year-end.

- BCU CAMHS inpatient budget has an unexpected overspend of £26k for Month 1. This is due to 5 admissions within April, which is an unusually high volume. One has been discharged since reporting, but there has been a further admission in May anyway.

  The current year-end position of £45k overspent assumes that an average of 2 patients will be discharged for the remaining months and that activity will reduce.

- High Secure block contracts at Ashworth & Rampton – both these contracts are currently being finalised. Ashworth is based on a rolling 3 year patient number average in comparison to NHS England patients, and is currently expected to be set for 2017/18 at £10,434k, a saving against the Annual Plan of £339k. However, Rampton had given prior notice to move from the 3 year average basis to an actual patient basis, which would increase the spend to an overspend of £260k on this line based on current patient levels.

5.12 Renal:
Reported to break-even position at this point pending 2017/18 data.

5.13 Reserves:
Reserves from the 16/17 Balance Sheet will be analysed over the coming months as final 16/17 charges are received. Any developments will be reported as soon as possible.

5.14 Developments:
There is a total of £8,831 funded developments in the 2017/18 position, £6,035k of which relates to developments from prior years. Further details will be provided in future months as 2017/18 develops.

5.15 Direct Running Costs (Staffing and non-pay):
The running cost budget is currently £46k underspent. This is due to the significant staffing vacancies the organisation is currently running with; some should be appointed to shortly and there is some minimal Agency spend in the meantime. The year-end position is expected to come back into break-even by year-end due to appointments.

Non-pay overspends include the Cwm Taf hosting fee, which is expected to be a year-end overspend.

Please note that the lease on the current Caerphilly office expires in March 2018, and new premises are being sourced. A provision for Dilapidations was entered in the 2016/17 Annual Accounts for £96k.

6. Financial position detail – by Commissioners
The financial arrangements for WHSSC do not allow WHSSC to either over or underspend, and thus any variance is distributed to LHB's based on a clearly defined risk sharing mechanism. The following table provides details of how the current variance is allocated and how the movements from last month impact on LHB's.

Table 3 – Year to Date position by LHB

	Allocation of Variance							
	Total £'000	Cardiff and Vale £'000	ABM £'000	Cwm Taf £'000	Aneurin Bevan £'000	Hywel Dda £'000	Powys £'000	Betsi Cadwaladr £'000
Variance M1	(100)	(8)	(28)	(17)	(12)	(38)	(14)	17
Variance M0	0							
Movement	(100)	(8)	(28)	(17)	(12)	(38)	(14)	17

Table 4 – End of Year Forecast by LHB

	Allocation of Variance							
	Total £'000	Cardiff and Vale £'000	ABM £'000	Cwm Taf £'000	Aneurin Bevan £'000	Hywel Dda £'000	Powys £'000	Betsi Cadwaladr £'000
EOY forecast M1	(605)	97	(131)	202	(32)	(318)	(50)	(370)
EOY forecast M0	0							
EOY movement	(605)	97	(131)	202	(32)	(318)	(50)	(370)

Material reporting positions or movements include:
At this point, there are no significant variances in the position to date. The usual detail by specific commissioners will be provided in future months when there is more data behind the monthly position to report on.

7. Income / Expenditure Assumptions

7.1 Income from LHB's
The table below shows the level of current year outstanding income from Health Boards in relation to the IMTP and in-year Income adjustments. There are no notified disputes regarding the Income assumptions related to the WHSSC IMTP.

Please note that Income for WHSSC/EASC elements has been separated, although both organisations share one Bank Account. The below table uses the total Income to allow reconciliation to the MMR returns; please refer to the Income tab on the monthly risk-sharing file to see all the details relating to the Commissioner Income if necessary.

Table 5 – 2017/18 Income Expected and Received to Date

	2017/18 Planned Commissioner Income £'000	Income Expected to Date £'000	Actual Income Received to Date £'000	Accrued Income - WHSSC £'000	Accrued Income - EASC £'000	Total Income Accounted to Date £'000	EOY Comm'er Position £'000	EOY total expected income £'000
ABM	117,570	9,798	9,511	286	0	9,797	(124)	117,447
Aneurin Bevan	129,864	10,822	10,819	3	0	10,822	(35)	129,829
Betsi Cadwaladr	157,821	13,152	12,901	191	59	13,151	(382)	157,439
Cardiff and Vale	115,662	9,638	9,185	454	0	9,639	103	115,765
Cwm Taf	64,193	5,349	5,108	241	0	5,349	202	64,395
Hywel Dda	79,610	6,634	6,440	194	0	6,634	(327)	79,283
Powys	32,570	2,714	2,677	20	17	2,714	(50)	32,520
Public Health Wales						0		0
Velindre						0		0
WAST						0		0
Total	**697,290**	**58,107**	**56,642**	**1,390**	**76**	**58,107**	**(612)**	**696,678**

Additional columns relating to Other Sundry Income and secondment recharge invoices will be shown to reconcile the total anticipated Income as per the I&E expectations submitted to WG as part of the monthly Monitoring Returns Ie. Both risk-shared Commissioner Income plus sundry non-recurring income through invoices. This should help reconciliation between WHSSC and other organisations' I&E tables, and expedite clarifying any differences, as per WG requests.

Invoices over 11 weeks in age detailed to aid LHB's in clearing them before Arbitration dates:

None

7.2 Expenditure with LHB's

A full breakdown of the expected expenditure across LHB's and budget headings is included as Annex A. This is an additional table to previous years.

These figures are also reported in the I&E expectations submitted to WG as part of the monthly Monitoring Returns. This Annex should help reconciliation between WHSSC and other organisations' I&E tables, and expedite clarifying any differences, as per WG requests.

8. Overview of Key Risks / Opportunities

The key risks remain consistent with those identified in the annual plan process to date.

The additional risk and opportunities highlighted in this report are:

- Phasing of Development funding as projects start; possible slippage in start dates may lead to non-recurrent in-year savings.
- Growth in all activity above that projected in the IMTP.
- Dealing with in year service risks associated with amber rated schemes which are yet to be funded. Please note the forecast outturn now includes provisions of £188k for amber schemes.
- The risk of inflation funding expectation gaps with Velindre Trust.
- The risk of Velindre Trust performance variation, which is unknown owing to the lack of financial returns from the Trust.

9. Public Sector Payment Compliance

The WHSSC payment compliance target is consolidated and reported through the Cwm Taf monitoring process.

10. Responses to Action Notes from WG MMR responses

None

11. Confirmation of position report by the MD and DOF:

Stuart Davies,
Acting Managing Director, WHSSC

Stacey Taylor,
Deputy Director of Finance, WHSSC

Annex A - 2017/18 Expected Expenditure

	2017/18 Baseline contract £'000	2017/18 Contract EOYF variance £'000	IPFR £'000	IVF £'000	Mental Health £'000	Renal £'000	Develo-pments & Reserves £'000	WHSSC/ EASC/QAT Running Costs £'000	2017/18 Sub-Total Other Spend £'000	2017/18 Total expected spend £'000
ABM	96,362	25	243	2,940	332	513		1	4,054	100,417
Aneurin Bevan	8,833	0	30			140		(130)	40	8,874
Betsi Cadwaladr	38,137	(340)	1,931		167	583	0	4	2,345	40,483
Cardiff and Vale	187,596	(60)	10,440			1,350	5,157	119	17,006	204,602
Cwm Taf	7,452	0	0			0		591	591	8,043
Hywel Dda	1,486	0	39			526		0	565	2,051
Powys			0			0		0	0	0
Public Health			8			0		(73)	(64)	(64)
Velindre	38,027	0	687			109	714	(88)	1,422	39,449
WAST (managed by EASC)	139,213	0	0			60		0	60	139,273
Total	**517,107**	**(375)**	**13,379**	**2,940**	**500**	**3,280**	**5,870**	**426**	**26,020**	**543,126**

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

Agenda Item 13.1
WHSSC Joint Committee
30 May 2017

Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Chris Koehli**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**10 May 2017**

Summary of key matters considered by the Committee and any related decisions made

Learning from the Peer Review of the Burns Service
Members received a presentation from the Burns Service at ABMUHB providing an update on the multi-drug resistance organism (MDRO) outbreak.

Members recommended that the Burns Service continue to implement its action plan. Members noted that risk remained whilst the actions were outstanding and therefore recommended that the risks should be reflected within the provider risk register. It was agreed that the actions should be monitored through the regular SLA meeting with the provider.

It was agreed that the following points would be raised at the Joint Committee:
- Current risks;
- Recommendation that the Joint Committee work with provider to resolve the remaining areas for action; and
- Joint (Welsh Government and the wider United Kingdom) learning from serious infection control incidents

Serious concerns
Members received updates on:
- Sarcoma Service: Members were assured that the Acting Medical Director had taken appropriate action regarding this issue and agreed that further updates would be provided as appropriate;
- Heater Cooler Units: Members received assurance that appropriate actions had been taken to address the concern. This item was closed as a current risk by the committee; and
- Thoracic Surgery Review: Members supported the actions proposed by WHSSC officers to obtain assurance from the provider. It was agreed that work should continue to collect information on outcomes including clinical practice; and that assurance would be required from the provider on the issues that were raised in the public report and in the provider's confidential report that had been requested by WHSSC.

Serious Concerns Report
Members received the serious concerns report with 2 new Serious Incidents recorded within WHSSC. A verbal update was provided on 2 further incidents

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that had been reported since the publication of the meeting papers. Two closure forms were received.

Health and Care Standards
Members received a report presenting the organisational self assessment for 2016-2017 against the Health and Care Standards.

Governance Action Plan
Members received a paper providing an explanation of the findings of an 'Annual review' of the Governance Action Plan that was developed to address the recommendations made within the HIW Governance report, the GGI Governance report, the cardiac surgery outsourcing project and Judicial Review.

Concerns Overview Report
Members received and discussed the concerns overview report.

Corporate Risk and Assurance Framework
Members received a paper providing Members with the risks faced by WHSSC at the end of the financial year 2016/17. Members noted the progress to refine the risk management process within WHSSC.

Report from WHSSC Performance Group
Members received the WHSSC Performance Report as at December 2016.

Report from the WHSSC Policy Group
Members received an oral update on the work of the WHSSC Policy Group.

Updates from the programmes and network
Members received updates from the programmes and network.

Quality and Safety Committee Briefing to Joint Committee
Members received the briefing for information.

Key risks and issues/matters of concern and any mitigating actions

Burns Service

- Risks remain in the unit whilst the agreed actions continue to be outstanding;
- Members recommended that the Joint Committee work with the provider to resolve the remaining areas for action; and
- Members recommended that there should be joint learning (Welsh Government and the wider United Kingdom) from serious infection control incidents.

BMT Service in north Wales

- All evidence has been submitted by the BMT unit for north Wales to JACIE for accreditation. The outcome is awaited and therefore the risk remains at this time.

Repatriation to DGHs of patients who have been treated in specialist centres • Delayed repatriation of patients back to the local DGH has an impact on bed availability in specialist units. Members requested that LHBs consider options that could be put in place to receive patients back in a timely manner.
Matters requiring Committee level consideration and/or approval
None
Matters referred to other Committees
None
Confirmed Minutes for the meeting held 28 February 2017 are available from http://www.whssc.wales.nhs.uk/quality-and-patient-safety-committee-con

Date of next meeting	16 August 2017

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

Agenda Item 13.2
WHSSC Joint Committee
30 May 2017

Reporting Committee	**All Wales Individual Patient Funding Request (IPFR) Panel**
Chaired by	**Professor Vivienne Harpwood**
Lead Executive Director	**Director of Nursing & Quality Assurance**
Date of last meeting	**26 April 2017**

Summary of key matters

The Panel meeting was quorate in relation to Health Board representation but not from a clinical perspective. Therefore, the recommendations of the Panel had to be ratified by at least one of the clinical representatives who were unable to attend.

The Panel considered 14 requests in April 2017. This consisted of:

- 11 requests were considered at the meeting
- 3 Virtual Panels for urgent requests

The action log of the All Wales IPFR Panel was reviewed and updates provided.

Updates were provided where clinical reports had been received on patients previously agreed funding by the Panel.

Key risks and issues/matters of concern and any mitigating actions

Clinical and Health Board Quoracy

The lack of clinical representation and need for ratification of recommendations at the April Panel caused delay in relaying decisions.

A letter has been sent from the All Wales Panel Chair to Health Board Medical Directors and copied to Chief Executives asking for confirmation of their clinical representative and nomination of at least 2 clinical deputies by 5 June 2017.

Individual Patient Funding Request Review 2016

The All Wales IPFR Network is working with AWTTC to implement the recommendations of the Review report.

This includes revision of All Wales IPFR policy and amendment of the decision making guide to focus on significant clinical benefit, evidence base considerations , reasonable value for money and ethical factors i.e. remove " exceptionality".

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Matters requiring Committee level consideration and/or approval
• None
Matters referred to other Committees
• Internal Performance and Risk Group – Commissioning, Service and Policy development gaps are reported monthly.

Date of next meeting	**31 May 2017**

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

Agenda Item 13.3
WHSSC Joint Committee
30 May 2017

Reporting Committee	**Integrated Governance Committee**
Chaired by	**WHSSC Chair**
Lead Executive Director	**Committee Secretary**
Date of last meeting	**10 May 2017**

Summary of key matters considered by the Committee and any related decisions made.

Members of the Committee received and reviewed the WHSSC Annual Governance Statement and the Health and Care Standards Self-Assessment providing comment and supporting the presentation of the documents to the May 2017 Cwm Taf Audit Committee.

Members discussed the Governance Arrangements for the Child & Adolescent Mental Health Service and Eating Disorders Network and the Neonatal Network following their transfer to the NHS Collaborative. Members requested that the WHSSC team undertake further work to understand how these groups and other Clinical Networks provide guidance and support to WHSSC and the mechanisms through which these services/support are provided.

Members reviewed the Corporate Risk and Assurance Framework and noted the ongoing work to develop this into a more robust/dynamic document. A discussion was held regarding the risk management process and risk appetite. It was suggested that the team considered a system through which risks were deescalated following successful implementation of control measures.

Key risks and issues/matters of concern and any mitigating actions

Concern was raised around the procedures for Individual Patient Funding Requests (IPFR) and issues presented by an increase in requests relating to Positron Emission Tomography scans. Members agreed that they would monitor this closely and requested an update report from the IPFR panel to the next Integrated Governance Committee Meeting.

Matters requiring Committee level consideration and/or approval

- None

Matters referred to other Committees

- None

Confirmed Minutes for the all meetings held are available on request

Date of next meeting	15 August 2017

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

Agenda Item 13.4
WHSSC Joint Committee
30 May 2017

Reporting Committee	**Welsh Renal Clinical Network**
Chaired by	**Chair, Welsh Renal Clinical Network**
Lead Executive Director	**Director of Finance**
Date of last meeting	**8 May 2017**

Summary of key matters considered by the Committee and any related decisions made.

- The implementation of the SE Wales dialysis contract is proceeding. The new Newport Renal Unit was officially opened by Vaughan Gething on 30th March 2017 and the last unit under this contract in North Gwent will be operational 11th July.
- A Lead Nurse has been appointed to the WRCN whose remit will include the development of an inspectorate role for assessing dialysis units in conjunction with HIW.
- The end of year position for WRCN 16/17 reflected an underspend of £231K against the all Wales Renal ring-fenced budget

Key risks and issues/matters of concern and any mitigating actions

- ABMU transport has presented a cost pressure during 16/17 and will continue to be a risk 17/18 until the transport tender can be resolved
- A review of the renal element of the Cardiff LTA has been undertaken and WRCN board have approved non recurrent changes to activity baselines to reflect the current use of the ongoing under spend in transplant activity. The transplant has baseline has been revised downwards from 160 transplants to a 100. The Cardiff dialysis baseline has been revised upwards by £525K to account for the ongoing over performance. This leaves a forecast net under spend position of £390K which will be used to off set the growth requirements submitted to the WHSSC ICP

Matters requiring Committee level consideration and/or approval

- All WRCN policies are to be revised and rebranded to bring them in to line with WHSSC templates. It is acknowledged that these will need to remain on the WRCN website for patient information going forwards

Matters referred to other Committees

None

Annexes: None

Date of next meeting	**7 August 2017**

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

Agenda Item 13.5
WHSSC Joint Committee
30 May 2017

Reporting Committee	**Management Group**
Chaired by	**Acting Managing Director, WHSSC**
Lead Executive Director	**Committee Secretary**
Date of last meeting	**27 April 2017**

Summary of key matters considered by the Committee and any related decisions made.

1. Bariatric Surgery

Members **received** a report providing an update on the development of the service specification for bariatric surgery and outlining the next steps in relation to ensuring a sustainable, high quality and equitable service is commissioned for the population of South Wales.

Following discussion it was **agreed** that:

- The service specification would be presented to the Management Group to be held in July 2017;
- Band removal would be added to service specification;
- Legal advice would be sought with regards to recompense from the private provider for band removal when undertaken on the NHS; and
- The aftercare arrangements would be included in the service specification.

Members **resolved** to:

- **Note** the progress to date and timeline for completing the bariatric surgery service specification.
- **Note** the implementation of performance management arrangements.
- **Support** the proposed next steps for taking forward a tender process for the future provision of the service.

2. Transcatheter Aortic Valve Implantation (TAVI)

Members received a report providing an overview of the issues relating to the commissioning of TAVI services.

Following discussion the Chair asked Members to confirm approval of the reintroduction of prior approval. ABMU noted that they do not support the reintroduction; CVUHB supported the reintroduction in principle but noted the need for a phased approach; and all other LHBs supported the reintroduction.

Following discussion it was **agreed** that:

- Interim position guidance would be developed and circulated;
- Further papers would be received by Management Group; and
- A sub group of patients who underwent a TAVI procedure as an

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emergency would be reviewed.

Members **resolved** to:

- **Approve** the re-implementation of requirement for prior approval for all TAVI cases and to review the IPFR form to support this;
- **Note** the work planned to support a review of the TAVI policy; and
- **Note** the ongoing work to review the pricing of TAVI across service providers.

3. Update: Out of Hours Neonatal Transport Service

Members received a report providing an update on the work to introduce an out of hours neonatal transport service.

Following discussions it was agreed that data would be gathered by WHSSC on the number of occasions where the service had not been provided and whether adverse incidents had been reported.

Members **resolved** to:

- **Note** the current position with regards the development of an out of hours neonatal transport service; and
- **Note** the potential financial risk, since this is not currently identified within the 2017/18 financial plan and has not been through the ICP prioritisation process.

4. Five-year Commissioning Strategy for Neurosciences: Finance Update

Members received a report outlining the current WHSSC contracting arrangements for Neurosciences. The report outlined the investments made in Specialised Neurosciences since the Steers Reviews and the subsequent transfer of Neurosurgery from Swansea to Cardiff.

It was **agreed** that a working group would be established to assist with the further work needed prior to a further paper being presented to Management Group.

Members **resolved** to:

- **Note** the financial position presented within the report.

5. Delivery of the Integrated Commissioning Plan 2016/17: Progress at the end of March 2017

Members received a report providing an update on the delivery of the Integrated Commissioning Plan for Specialised Services 2016/17 at the end of March 2017, including the Funding Release Schedule, the progress against the Work Plan and the Risk Management Summary.

It was **agreed** that the paper would be updated to include the outcome of the prioritisation panel.

Members **resolved** to:

- **Note** the progress made in the delivery of the 2016/17 ICP;
- **Note** the funding release proforma schedule; and
- **Note** the risk management summary.

6. Financial Performance Report: Month 10 2016/17

Members **agreed** to receive the financial performance report outside of the meeting.

7. Performance Report: February 2017

Members **received** the report which presented a summary of the key issues arising and detailed the actions being undertaken to address areas of non-compliance.

It was **agreed** that outcome data and assurance on investment would be gathered and that information would be brought back to the future meetings.

Members **resolved** to:

- **Note** the current performance and the action being taken undertaken to address areas of non-compliance.

Key risks and issues/matters of concern and any mitigating actions	
• None	
Matters requiring Committee level consideration and/or approval	
• None	
Matters referred to other Committees	
• None	
Confirmed Minutes for the meeting held 30 March 2017 are available on request	
Date of next meeting	29 June 2017

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

Agenda Item 13.6
WHSSC Joint Committee
30 May 2017

Reporting Committee	**Cwm Taf UHB Audit Committee**
Chaired by	**Cwm Taf UHB Audit Committee Chair**
Lead Executive Director	**Committee Secretary**
Date of last meeting	**15 May 2017**

Summary of key matters considered by the Committee and any related decisions made.

Members of the Committee received and reviewed the WHSSC Annual Governance Statement, providing comment and supporting the presentation of the final form document to the May 2017 Cwm Taf UHB Audit Committee. The Committee noted that the section 5.2 of the Statement, regarding Health & Care Standards, was yet to be drafted but that the Committee would be receiving assurance in this regard from an Internal Audit Report on WHSSC's application of the Standards.

Members of the Committee received and reviewed the Internal Audit Report on WHSSC's application of the Health & Care Standards, which reported 'Reasonable Assurance'. It was noted that as this was the first year that WHSSC had self assessed its performance against the Standards it was not yet possible to be assured that they were embedded and that the situation may develop over the coming year. Two recommendations were noted, one medium level and one low level.

Key risks and issues/matters of concern and any mitigating actions

- None

Matters requiring Committee level consideration and/or approval

- None

Matters referred to other Committees

- None

Confirmed Minutes for the meetings held on 13 February and 3 April 2017 are available on request from the Committee Secretary.

Date of next meeting	31 May 2017

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