Annex 6

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.

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.

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

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

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.

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.

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

- 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.

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

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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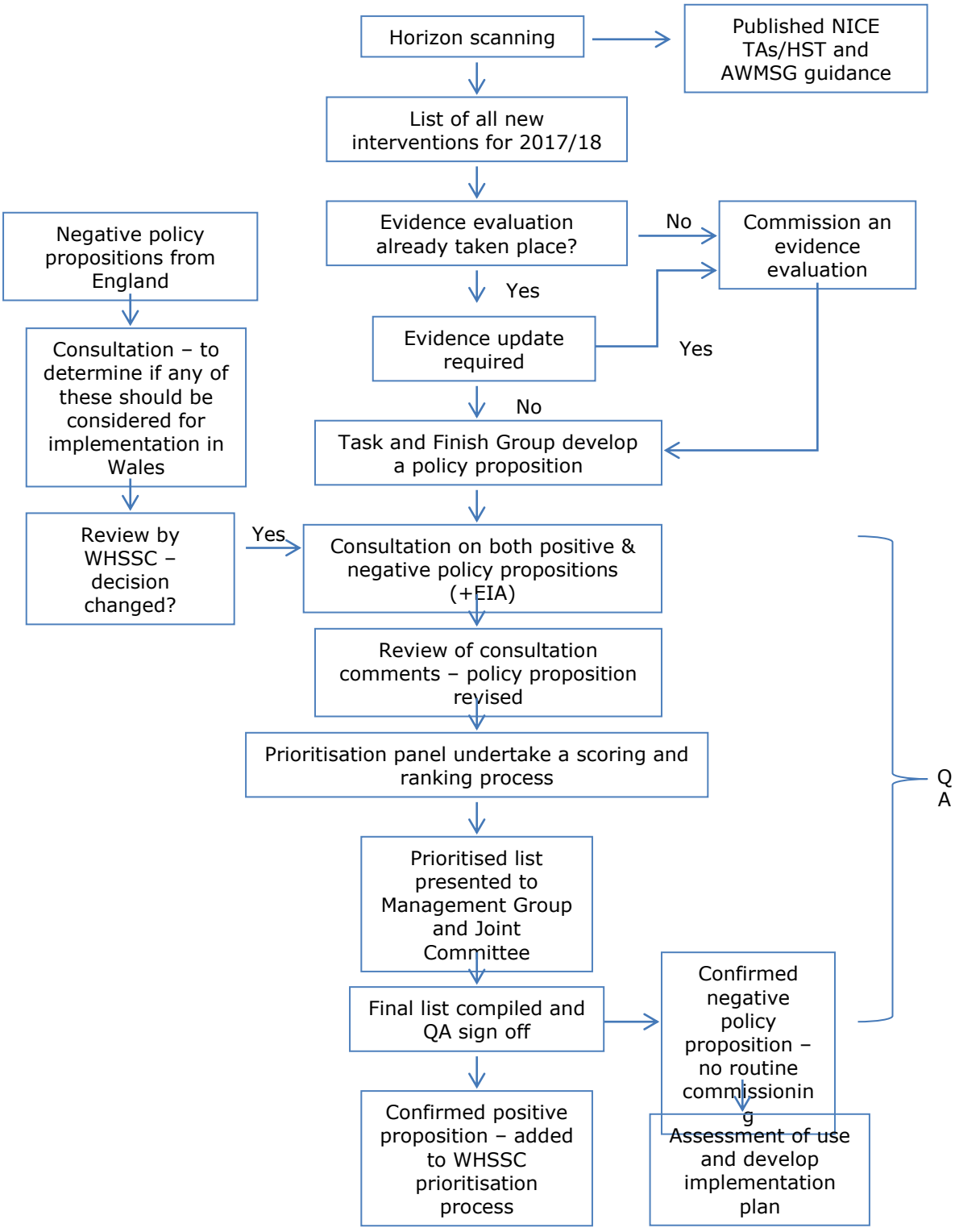
Appendix A: Overview of the prioritisation process for Wales



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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]

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- 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]