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# Health Commission Wales: A Review

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A report on the findings and conclusions, including recommendations,  
for Mrs Edwina Hart AM MBE, Minister for Health and Social Services,  
Welsh Assembly Government.

**By:** Professor Mansel Aylward CB  
Chair: Wales Centre for Health and Independent Expert Panel

**Date:** June 2008

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# Foreword



Edwina Hart AM MBE, Minister for Health and Social Services, asked me to undertake this review of Health Commission Wales in my capacity as Chair of the Wales Centre for Health. There is no handbook for conducting reviews of this kind and no real guidance. Remaining sensitive to the issues I was asked to deal with has been my guiding principle and that of my review team. The objective has been to provide advice, including the making of recommendations, for the Minister in connection with her functions for the provision of specialised health services for the people in Wales.

This review has demonstrated the industry, commitment and devotion of the staff at Health Commission Wales to the tasks they undertake in difficult circumstances, and to the patients whom they serve. Complex decisions have to be made about the availability of, and access to, tertiary and highly specialised healthcare services for

individual patients. Such decisions must be based on sound evidence of efficacy and financial propriety. There is clearly a need for specialised services to be commissioned primarily at a national level. Decisions must be made in a way which patients and society in general understand in the context of an open and transparent decision making process.

A very large number of patients have evidently accessed successfully specialised services commissioned by Health Commission Wales without encountering any problems. Indeed the very great majority of these patients will have been unaware of the pivotal role played by Health Commission Wales in securing the specialist treatments for them. I know too the sterling efforts that many doctors make to ensure that their patients benefit from commissioned specialised healthcare services.

Although Health Commission Wales laboured under sustained inadequacies in staff resources, there were examples of excellently conducted commissioning, readily acknowledged by its stakeholders, when financial resources were available. Moreover the staff are admired by many stakeholders for their hard work and tenacity in a very trying environment.

However, even at an early stage of the review, common key themes began to emerge. When subsequently consolidated, they revealed that the organisational structure, governance and functioning of Health Commission Wales fall short of its fitness for purpose. Some disquieting findings in relation to fractured lines of commissioning across Local Health Boards and Health Commission Wales

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have surfaced which demand an early resolution. It is imperative that patients can move easily along pathways of treatment for their health conditions between different levels of commissioner. It may be argued that the best interests of patients have been compromised by dislocated commissioning and a mismatch between funding and commissioning responsibilities.

This report does not seek to assign blame or intentionally criticise individuals but it does convey some disconcerting messages about the commissioning of specialised and tertiary services in Wales. Systemic barriers to effective commissioning have led to some uneasy relationships between Health Commission Wales, Local Health Boards, stakeholders and patients.

During the organisation and analysis of evidence, a consultation was published by the Minister of Health and Social Services on proposals to change the structure of the NHS in Wales (Welsh Assembly Government 2008).

Consideration was given to this consultation particularly with regard to the abolition of the internal market and the proposed subsequent move from a commissioned to a planned service. The framing of some recommendations were made with this new context in mind.

It is my sincere wish that this report is accepted as an honest and open review of the challenges that have faced Health Commission Wales from its inception.

Finally, I would like to acknowledge most gratefully the time taken and the evidence given by the management and staff at Health Commission Wales, NHS and Welsh Assembly Government

officials, healthcare professionals, patient interest groups and patients themselves. Without their co-operation and involvement this review would not have reached informed and compelling conclusions to furnish advice and recommendations to the Minister for Health and Social Services.

Furthermore, I am greatly indebted to the review team and members of the independent expert panel. Without their dedication and industry I could not have carried out the full scope of the review.

**Professor Mansel Aylward CB**  
**Chair: Wales Centre for Health**

# Acknowledgements

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I am very grateful to the following people for their support and contributions to the review.

The review team:

- Keith Cox
- Mark Dickinson
- Rebecca Firks
- Jan Humphreys
- Angela Jones
- Chris Lines
- Joanne Menzies
- John Morley

The independent expert panel (Chair: Professor Mansel Aylward CB)

- Dr Kevin Fitzpatrick
- Dame Deirdre Hine DBE
- Mr Clifford L Jones OBE
- Professor Anthony Newman Taylor CBE
- Mrs Fran Targett

Administrative support:

- Eleanor Higgins,  
Personal Assistant to Professor Aylward CB
- Rebecca Milton,  
Personal Assistant to Professor Aylward CB

Legal Advice:

- Tessa Shellens,  
Legal Adviser, Morgan Cole Solicitors

All those who have given their time to provide evidence to the review.

# Executive Summary

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1. In September, 2007 Mrs Edwina Hart AM MBE, the Minister for Health and Social Services, asked me to undertake a review of the role and functions of Health Commission Wales and to provide advice, including making recommendations, on the provision of specialised and tertiary health services for the people in Wales. More than 150 people were interviewed and some on more than one occasion. Around 1800 documents were examined in evidence during the course of the review.
2. Although Health Commission Wales was established as an Executive Agency of the Welsh Assembly Government in April 2003, it lacks many of the expected orthodox governance arrangements. Most notable is the absence of a management board with an independent chair and non executive directors to provide effective support and challenge. As a result of these governance arrangements senior managers at Health Commission Wales were constrained in their ability to operate effectively and flexibly.
3. The governance arrangements of Health Commission Wales are different to all other specialised commissioning arrangements in the UK. In particular, other specialised commissioners are part of the NHS. Their finances are negotiated and pooled from primary care organisations for the provision of agreed, clearly defined services and outcomes. Health Commission Wales is fully subject to Welsh Assembly Government procedures even though they are expected to fulfil all the necessary functions of a commissioning body.
4. Audit arrangements have been established by Health Commission Wales. However, it does not have non executive directors on whom to call and sit on a properly constituted Audit Committee. A question is therefore raised about the degree of assurance that can be given to its Audit Group for all aspects of risk management, governance and internal control processes.
5. The initial resource mapping exercise conducted by the Welsh Assembly Government to identify a budget for Health Commission Wales was rushed and fragmented. The schedule of specialised services was poorly defined to assist this process. The resources, where identified, were top sliced from Local Health Boards' budgets and not risk pooled. Where they were not identified in this process, the budgets remained with Local Health Boards although the duty to commission the services rested with Health Commission Wales. Consequently, many Local Health Boards believed the funding mechanism lacked legitimacy.
6. Efforts were made by the Welsh Assembly Government to address these issues and complete the resource mapping exercise. Unfortunately this was not satisfactorily completed and has left some Local Health Boards in a position of commissioning a number of services by default, still holding the relevant budgets. The budget allocation for Health Commission Wales was therefore unsound, inadequate and almost certainly led to a mismatch between funding and responsibilities.
7. As a consequence, the boundaries between commissioning responsibilities of Health Commission Wales and Local Health Boards respectively are unclear and have led to conflict. These fractured lines of commissioning compromise the best interests of patients. It is essential that patients can move along pathways of care between Health Commission Wales and Local Health Boards with ease. However, in many cases this is not being achieved. In particular the review

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- highlighted disquieting issues relating to patients with eating disorders and to patients in medium secure and low secure mental health facilities.
8. Health Needs Assessments prepared by Local Health Boards do not address requirements for the specialised services commissioned by Health Commission Wales. The lack of expertise available to Local Health Boards in this area has obliged Health Commission Wales to formulate strategies and develop plans for specialised services in consultation with Regional Stakeholder Panels. Health Commission Wales' Framework Document which sets out the process for developing strategy and commissioning plans is therefore flawed. It has not been subsequently amended to address the disparity in expertise and knowledge of specialised services between Health Commission Wales and Local Health Boards.
  9. The requirement of Health Commission Wales to live within its budget and repay over £30million of an overspend has inevitably led to difficult choices having to be made by Health Commission Wales. Its restricted financial position, proposals for investment, priorities and efficiency savings featured prominently in discussions with the Welsh Assembly Government in the development of commissioning plans. Final decisions about funding issues rest with the Minister for Health and Social Services whose priorities have then to be implemented by the Chief Executive Officer of Health Commission Wales. This direct relationship with the Minister for Health and Social Services is not applicable to NHS bodies such as Local Health Boards where there is a statutory separation and no requirement for personal Ministerial approval of commissioning plans.
  10. Additional allocations and strategic assistance had been provided to Health Commission Wales by the Welsh Assembly Government. These were largely focused on the provision of funds for new or enhanced services. They did not provide a viable remedy for unanticipated increased expenditure by Health Commission Wales to meet the burgeoning costs associated with the Individual Patient Commissioning process or with the prolonged unnecessary maintenance of patients in medium secure mental health facilities.
  11. The inadequate staffing levels, coupled with its national remit, have left Health Commission Wales with limited capacity to develop and maintain effective and sustained relationships with all its providers and stakeholders. Communication and engagement with stakeholders consequently is inadequate for an organisation with such important responsibilities and accountabilities. Nonetheless, there are examples of sound engagement and good practice though they are not always consistently applied.
  12. Evident to many stakeholders is the extraordinary tenacity, commitment and diligence Health Commission Wales staff have shown over the years. However, an insubstantial level of administrative funding, and the need to adhere to the Welsh Assembly Government's employment processes, have contributed to the considerable stress and personal anxiety among staff. These concerns have been repeatedly raised by the Welsh Assembly Government's Occupational Health Service with colleagues in the Human Resources Division. Chief Executive Officers of Health Commission Wales have also raised these issues as matters for concern with the Department of Health and Social Services. There is a lack of evidence that these issues have been adequately addressed.
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13. There is a general lack of vocational training for commissioners in the planning, developing, contracting and reviewing of healthcare services. Although the National Leadership and Innovation Agency for Healthcare have recently introduced a sponsored module on commissioning, this training gap should be rigorously addressed by the Welsh Assembly Government.
  14. The heavy volume of referrals for Individual Patient Commissioning was unanticipated. The resulting financial burden on Health Commission Wales is around £12million per annum and consumes 25% of staff resources. This process is not sufficiently transparent, nor is it easily understood by stakeholders or accessible to patients or clinicians.
  15. All decision making in the Individual Patient Commissioning process ultimately rests with the Chief Executive Officer and is constrained by the need to achieve financial balance. The External Review Panel is not empowered to change a decision. It can only advise on adherence to due process and refer a decision to the Chief Executive Officer for reconsideration. This process is potentially vulnerable to legal challenge by means of judicial review. Furthermore, there is no process by which the validity of policies on which many of these decisions are made can be challenged.
  16. Informed by the findings and conclusions of this review, recommendations have been formulated. These are by way of advice to assist the Minister for Health and Social Services in connection with her functions in the provision of specialised and tertiary health services for people in Wales. The recommendations are primarily directed at improving planning, funding and provision of these services having regard to the Minister's proposals to change the structure of the NHS in Wales, which are currently subject to consultation.
  17. Recommendations reflect the need for the funding and planning services of specialised and tertiary services to be maintained primarily at a national level. Whatever arrangement is selected on the way NHS Trusts and Local Health Boards are required to cooperate, there is a compelling case for devolving an appropriate selection of specialised services to a more local level. Such an arrangement would strengthen the responsiveness of the NHS to local experiences of healthcare delivery and the needs of the local populations.
  18. Any future organisational arrangements must ensure that an all Wales approach to planning and funding specialised health services should secure an appropriate level of statutory separation from the Welsh Assembly Government. Befitting governance and organisational structures should be in place to preserve that arrangement. Due regard needs to be given to the extent of financial resources required to meet the magnitude and complexity of specialised and tertiary services required within reason in Wales.
  19. Particular consideration has also been given to Individual Patient Commissioning. A separate all Wales system should be introduced to hear appeals against decisions on individual patient requests for specialised and tertiary services and new or emerging treatments. Recommendations propose arrangements for establishing a properly constituted Independent Appeals Board.
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# 1. Background to the review

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- 1.1 The Review of Health Commission Wales was announced by the Minister for Health and Social Services in the National Assembly for Wales on 26 September 2007. The Minister appointed Professor Mansel Aylward CB, in his capacity as Chair of the Wales Centre for Health, to undertake the review.
- 1.2 Health Commission Wales often has to make very difficult decisions about the availability of, and access to, specialist services and newly emerging treatments within the NHS for individual patients. Such decisions must therefore be based on sound evidence of efficacy and financial propriety, made in a way that patients and society in general understand, and be underpinned by an open and transparent decision making process.
- 1.3 Concerns have been raised in public about the basis on which some decisions for individual patients requiring very specialised healthcare services and treatments had been made. Because public confidence in this aspect of the health service is so important, the Minister asked that an independent review be carried out of Health Commission Wales's role and functions.
- 1.4 Although the initial terms of reference indicated that the review should make particular reference to the mechanisms used to determine the healthcare treatment of individual patients, the review also needed to understand the framework in which Health Commission Wales operates its relationship with others and how it sets and meets its business objectives. This led to the initial terms of reference being extended to consider the wider environment in which Health Commission Wales operated to ensure a comprehensive understanding of the accountability, stakeholder relationships, finance and internal organisation which may impact on decision making processes.
- 1.5 The initial and extended terms of reference for the review are detailed in the Appendix 1.

## 2. Background to Health Commission Wales

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- 2.1 Health Commission Wales was established as an Executive Agency of the Welsh Assembly Government on 1 April 2003 following restructuring of the NHS in Wales.
- 2.2 Health Commission Wales is responsible for planning and contracting some national services as well as highly specialised services for patients in Wales. This is a very complex role and has to be done within a defined budget. The NHS is resourced from taxation. Its budget is defined within this context to ensure the most appropriate and effective use of its resources to benefit individuals and the population.
- 2.3 Health Commission Wales has responsibility for the commissioning of tertiary and other specialist services which require a population base greater than any individual NHS Trust. Health Commission Wales is also responsible for commissioning designated services on a national scale. These include blood and screening services and NHS Direct Wales. Health Commission Wales also has a role in giving advice to NHS Wales on the commissioning of specialised services.
- 2.4 Prior to the NHS restructuring in 2003, specialised health services were either commissioned by individual Health Authorities or were delegated to the Specialised Health Services Commission for Wales. This organisation had been set up as a joint arrangement between the then five Welsh Health Authorities and operated as a sub-committee of Dyfed Powys Health Authority.
- 2.5 On 1 April 2003 Dyfed Powys Health Authority ceased to exist. The future responsibility for commissioning all designated specialised health services for the residents of Wales was formally delegated to Health Commission Wales by the Welsh Assembly Government, including those specialised services formerly commissioned directly by Health Authorities.
- 2.6 In order to help identify and define the specialist services to be transferred to the newly created Health Commission Wales, the Welsh Assembly Government undertook a resource mapping exercise. This involved requesting NHS Trusts and Health Authorities to formally declare the level of specialised services each provided or commissioned, together with the estimated cost of those services. This information was then used to determine Health Commission Wales' baseline funding.
- 2.7 Health Commission Wales' role and responsibilities are overseen by the National Commissioning Advisory Board. The Board's primary function is to consider and advise on the National Commissioning Strategy and Annual Commissioning Plans. The Chair of the Board is appointed by the Minister for Health and Social Services and is responsible for ensuring that it functions properly and effectively. In addition to the Chair, the membership of the Board consists of representatives from NHS Trusts and Local Health Boards, the voluntary sector, the Association of Welsh Community Health Councils, the National Public Health Service for Wales, the Welsh Local Government Association and the cancer and cardiac networks.
- 2.8 Health Commission Wales also receives advice and guidance from many other panels, committees, groups, networks and stakeholders, such as the Individual

Patient Commissioning Panel, External Review Panel, Audit Group, Clinical Governance Committee and Regional Stakeholder Panels. The role of these and other key contacts are described in further detail in this report.

2.9 The Chief Executive Officer of Health Commission Wales is also the Accounting Officer and is appointed by, and directly accountable to, the Director of the Department of Health and Social Services within the Welsh Assembly Government. The Director of Finance, Director of Planning and Performance, the Medical Director and a recently appointed Nursing Director all report to the Chief Executive Officer.

2.10 Health Commission Wales employs around fifty full-time members of staff. These include specialist commissioners who are responsible for managing the commissioning of services within their specialised area. Although the individual commissioners may provide advice and guidance and make recommendations on policies and other matters, they are not ultimately responsible for the policies that Health Commission Wales adopts or the system in which it operates. The final decision making power rests with the Chief Executive Officer, advised by the management team and National Commissioning Advisory Board.

2.11 The responsibilities of Health Commission Wales are detailed in its Framework Document which sets out the role, processes and governance arrangements to be followed by the Executive Agency. The initial Framework Document was prepared by the Welsh Assembly Government, amended by Health Commission Wales in 2005, and approved by the Department of Health and Social Services Management Board. The Framework Document describes Health Commission Wales' main responsibilities as:

- Commissioning tertiary and other highly specialised services throughout Wales
- Giving advice to NHS Wales on the commissioning of specialised secondary and regional services.
- Providing expert guidance, support and facilitation in relation to acute services commissioning.
- Being the first source of arms length independent advice and guidance on difficult issues relating to specialised services.

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## Notable successes of Health Commission Wales

2.12 The review recognises that there have been a number of notable achievements accredited to Health Commission Wales. More care is properly provided in Wales and Welsh NHS capacity has been strengthened since its establishment. A sample of these, based on the evidence the review has received, is as follows:

- The achievement of Ministerial priorities for reducing waiting time targets by 31 March 2008.
- Neonatal Intensive Care Units: in partnership, Health Commission Wales has undertaken a review and presented plans to deliver services, meet standards and reduce risks to the Welsh Assembly Government.
- Paediatric neurosurgery: completed review with recommendations for the location and improvement of services to the Minister which were subsequently approved.
- Neurosurgery: substantial investment in neurosurgery in Swansea, Cardiff and Walton for North Wales. The extensive and well conducted neurosciences review is currently subject to the external review of neurosurgery for Wales. This is expected to report in July 2008.
- Paediatrics: investment in additional consultant posts in paediatric haematology and paediatric oncology. Recommencing paediatric nephrology services in Cardiff which had ceased in 2002.
- Tertiary referral management centre: introduced to ensure that where services are available locally in Wales, they are used in preference to services outside Wales.
- Medium secure services: investment in the Caswell Clinic to increase capacity from 33 to 60 beds, developing sub specialities to allow more patients to be treated locally.
- Children and adolescent mental health services: investment for reduction in clinical needs for admission, freeing up beds to ensure equity of access for the population of Gwent and West Wales. In addition, two successful public consultations in North and South Wales to develop in patient services, incorporating access to emergency beds in purpose built accommodation.
- North Wales: significant investment in services for the resident population at Royal Liverpool Children's Hospital, Liverpool and Central Manchester, Bodelwyddan, Chester and the Walton Neurosciences Centre.

## 3. How services are commissioned

- 3.1 The definition for commissioning used in this review is taken from the Welsh Assembly Government Welsh Health Circular (2007) 023:

*“Commissioning involves specifying, securing and monitoring services that are evidence-based, cost effective, of high quality and meet individuals’ needs. It is important to distinguish commissioning from contracting. The former involves taking a long term view of demand, reviewing supply and then bringing the two together in a plan for evidence-based services to meet current and future needs on a sustainable basis. Contracting arrangements are over a much shorter time span and focus on the detail of the service to be delivered. Commissioning must therefore be led by senior managers, within agreed strategic frameworks.”*

- 3.2 The commissioning of health services in Wales is divided into three main categories by the Welsh Assembly Government:

- **Primary (or tier one):** this covers everyday health services such as GP surgeries, dentists, pharmacists and opticians commissioned in Wales by Local Health Boards. Health Commission Wales has a role in the prevention of disease through the commissioning of screening services.
- **Secondary (or tier two):** this covers services such as hospitals, ambulances and mental health provision delivered primarily by NHS Trusts and by a range of other healthcare organisations. The commissioning of secondary care in Wales is a complex process involving a number of bodies such as NHS Trusts and Local Health Boards working together. Health Commission Wales

has a role in the commissioning of ambulance services and the Welsh Blood Service.

- **Tertiary (or tiers three and four):**

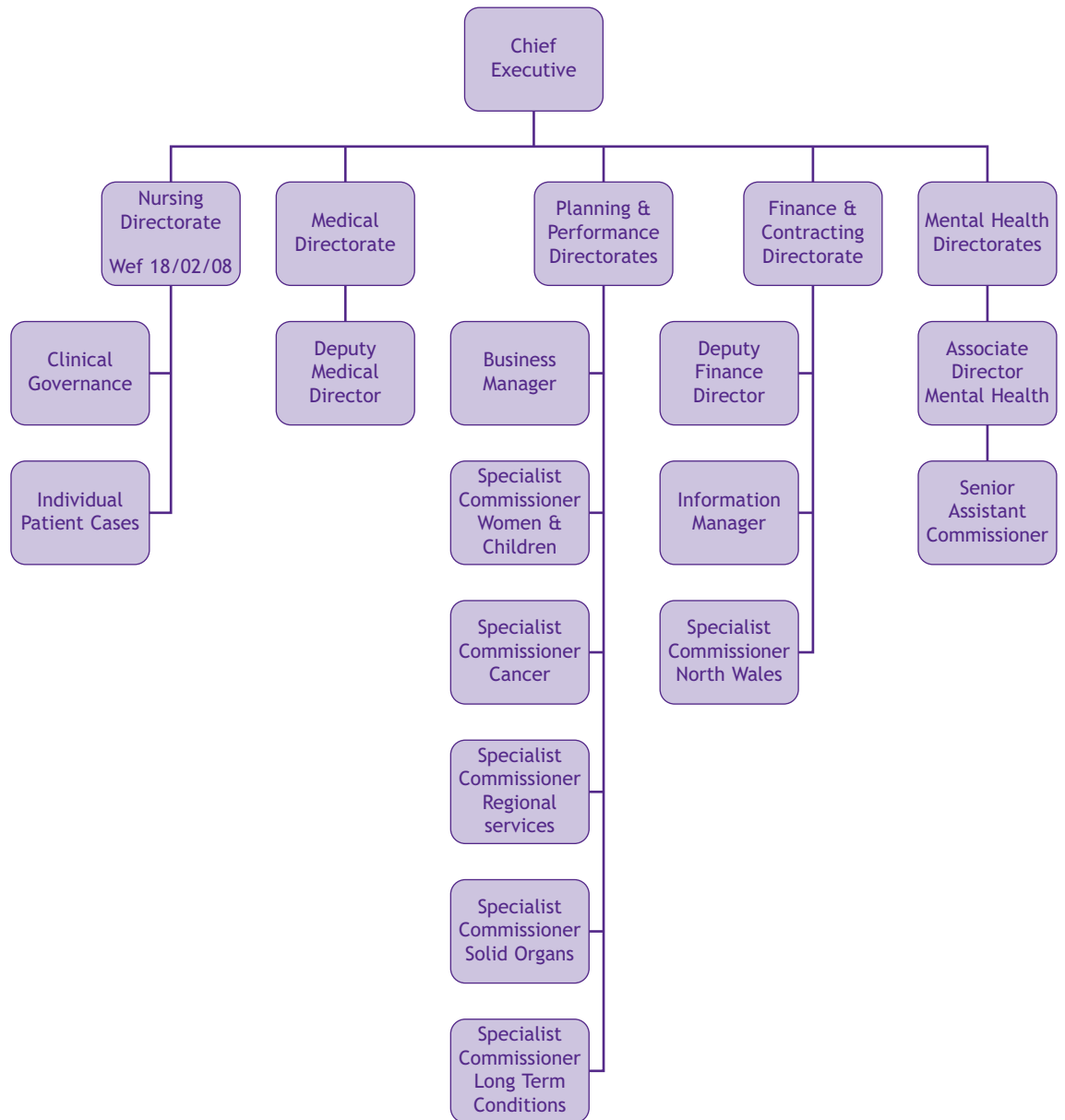
tertiary care refers to specialist services with the following characteristics:

- Where patient numbers are small and where a critical mass of patients, e.g. all Wales or sometimes UK, is needed to:
  - achieve the best outcomes and maintain clinical competence,
  - sustain the training of specialist staff and ensure succession planning,
  - ensure the integrity of audit of services
  - ensure cost-effectiveness in provision
  - ensure the best use of scarce resources such as rapidly changing technologies and expertise
- Where the service is developing rapidly and where this needs to be carefully managed and evaluated
- Where there are high profile ethical issues such as equity of access, high costs or political considerations.

- 3.3 Local Health Boards are responsible for commissioning both primary and secondary health care on behalf of their populations. There are 22 of them, co-terminus with Local Authority boundaries. Further details on their functions can be found in Appendix 5.

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- 3.4 Following the issue of the Welsh Health Circular (2007) 023 'NHS Commissioning Guidance' on 30 March 2007, Local Health Boards are establishing three Regional Commissioning Units to help fulfil their commissioning function.
- 3.5 Tertiary and other specialised services are commissioned by Health Commission Wales on an all Wales basis to ensure those services are delivered to patients who may require such needs.
- 3.6 The schedule of the specialised services for which Health Commission Wales has responsibility can be found in the Welsh Health Circular (2003) 063. This schedule was created by combining the lists of services provided by the former Specialised Health Services Commission for Wales and Health Authorities. It also took into account initially the English Specialised Services definition set at that time. Some national services were also added, namely emergency ambulance, blood and screening services and NHS Direct Wales. It was then reviewed over time to reflect changing circumstances.
- 3.7 In order to determine priorities, Health Commission Wales prepares a three year rolling Commissioning Strategy which should be based on the specialised healthcare needs identified by Local Health Boards and Local Authorities through their statutory Health Needs Assessment process. The strategy is considered as part of the Welsh Assembly Government's Business Planning Round. Priorities are agreed for implementation through Health Commission Wales' Annual Commissioning Plan which has to be approved by the Minister for Health and Social Services.
- 3.8 Health Commission Wales is organised into five directorates each with its own specific responsibilities to the organisation and to the commissioning of services in Wales. This structure is depicted in Figure 1.

Figure 1: Organisational Diagram



## 4. Review Methods: development, process and quality assurance

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- 4.1 The review's objectives had to be strictly defined within the context of the terms of reference. This was to ensure that the most appropriate evidence-based data were identified and gathered to realise viable conclusions and to formulate reasonable recommendations. The essential features of the work had to be well understood by the review team to select the precise methodology that would work best within the limits of the review's timeframe and capture a wide range of information from diverse sources.
- 4.2 The review had to address a number of issues to fulfil effectively the demands set by the terms of reference (Appendix 1).
- 4.3 Meeting the diverse demands of the terms of reference necessitated a combination of approaches. Developing an understanding of the background, constraints and environment within which Health Commission Wales operated, and organising the gathering of evidence and information from stakeholders, other informed parties and sources required freedom to evolve as the work progressed. A 'best evidence approach' was thus adopted which analysed and assessed the available literature and information gathered, both orally reported and in written form, to draw conclusions about the balance of evidence based on its quality, quantity and consistency (Slavin 1995).
- 4.4 This approach afforded the flexibility needed to tackle the variety of evidence and potentially diverse views with quality assurance. A rigorous approach was taken to analysing the data and assessing the strength of the evidence.
- 4.5 Further details of the methodology, including sources of evidence, data extraction, evidence rating and quality assurance is given in Appendix 4. The review team membership is listed in Appendix 2.
- 4.6 Throughout the review, broad and inclusive methods were used to engage with, and obtain evidence from, as wide a range of interested parties, stakeholders and other relevant sources as possible. Search strategies were also adopted to retrieve pertinent documents. This wealth of information was organised, analysed and assessed for its relevance to the basic questions imposed by the terms of reference. Exclusion of material was solely on the basis of lack of relevance to these basic questions.
- 4.7 The review also considered other relevant reports and reviews such as Ombudsman Reports on Health Commission Wales and the 2006 Department of Health review of commissioning arrangements for specialised services in England.
- 4.8 Greatest weight was given to evidence that met "Strong" and "Moderate" in the evidence rating system employed (Appendix 4). Information gathered under the 'Chatham House Rule' or in preliminary scoping of the methodology was only used to expand on relevant issues or develop review planning and emerging findings.
- 4.9 Evaluation and weighting of the evidence invariably involved judgements about quality and consistency. The evidence was considered independently by members of the review team followed by plenary discussion and presentation to, and discussion with, the Independent Expert Panel (Appendix 2).

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## Gathering and organisation of evidence

- 4.10 Views were sought from as wide a range of those individuals and groups who had working relationships with Health Commission Wales as possible. Also involved were those delivering specialised and tertiary healthcare services in Wales and in selected comparator regions in Scotland and England, and those who may have observations and experience of working practices and decisions made by Health Commission Wales. The Minister for Health and Social Services had also stressed that the review should engage as fully as possible, within the time and resource constraints, with the public in Wales. Considerable efforts were therefore made to achieve contact with these wide and diverse groups of individuals and organisations and to solicit information from them.
- 4.11 The underlying principles in structuring and executing the review have been to carry out an evidence-based and transparent process. Clear terms of reference were shared with Health Commission Wales and stakeholders at the outset. Contributions were actively encouraged to identify the strengths of Health Commission Wales as well as any limitations or areas for improvement. The evidence collected was considered for consistency and consensus and, wherever possible, triangulation of evidence from independent sources was sought before being accepted.

## Invitations to contribute

- 4.12 Letters were sent to groups or individuals either seeking direct written or oral contributions to the review or consent to access relevant information. These included patients, UK healthcare providers, representative groups registered with the Wales Council for Voluntary Action, Screening Services, NHS Direct Wales and the Welsh Blood Service. Patient letters were sent by Health Commission Wales on behalf of the review as the names of patients were confidential.
- 4.13 Interviews were given to BBC Radio Wales, BBC Wales TV and ITV Wales News following announcement of the Review on 26 September 2007. A press conference was held on 6 December 2007. Advertisements were placed in 11 newspapers across Wales over the following week. All correspondence and advertisements were bilingual.
- 4.14 In addition, a further exercise was completed to gather relevant literature and documentary evidence from Health Commission Wales and the Welsh Assembly Government. Clarification or additional information was also obtained from stakeholders in the form of documents, interview records and via correspondence.

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## Scale of response

- 4.15 More than 80 interviews took place, involving more than 150 people, some of whom represented more than one organisation. Some interviews required more than one session.
- 4.16 Initially, 20 interviews were carried out under the 'Chatham House Rule' to assist in scoping the review, developing the methodology and defining the objectives more precisely. 64 formal interviews were undertaken with the following groups of stakeholders:
- 22 NHS stakeholders
  - 15 Health Commission Wales staff (including former staff)
  - 5 members of boards and panels of Health Commission Wales
  - 5 patients or their representatives
  - Other organisations including Healthcare Inspectorate Wales, Children's Commissioner for Wales, Wales Audit Office, Public Service Ombudsman for Wales, the Welsh Local Government Association, and the Welsh Assembly Government.
- 4.17 The support for, and engagement with, the review was very strong. There were a wide range of stakeholders who came forward to contribute, some unsolicited, resulting in this stage of the review having to be extended by two months. The response from the general public was low and was principally confined to those patients and their representatives who had concerns about decisions made by Health Commission Wales which had affected them personally.

4.18 18 patients whose care had been the subject of decisions made by Health Commission Wales gave consent for their case records to be scrutinised to help inform the review. None of these cases were still under consideration by Health Commission Wales and it was agreed that any patient information would remain confidential and would be anonymised if referred to in the report.

4.19 The review team also logged (approximately) the following evidence:

- More than 1,800 documents
- 52 letters
- 50 emails to the review team mail box
- 23 calls to the 24 hour response line
- 1 comment on the online forum.

### How evidence and information was organised and assessed: The Balanced Scorecard

4.20 The review generated a substantial response and a plethora of information. To ensure that this was organised in a way that considered each aspect of the governance and performance of Health Commission Wales, the Balanced Scorecard methodology was adopted. The Balanced Scorecard is organised around four distinct perspectives: financial, customer (stakeholders), internal processes and innovation and learning. The model is flexible and can be adapted to the specific circumstances of any organisation and can include additional perspectives. It is widely used throughout the NHS as a performance measurement tool but its main purpose is in managing current and future performance (Kaplan and Norton 1996).

4.21 The Balanced Scorecard model was adapted to incorporate a governance domain. The Healthcare Standards for Wales, which promote clinical governance, were also considered under each domain (Welsh Assembly Government 2005). The five final domains are explained as follows:

- **Corporate Governance**  
The way in which Health Commission Wales is directed, controlled and managed. It includes the rules and procedures for making decisions and the process through which its objectives are set and performance monitored.
- **Finance**  
This considers the resources of Health Commission Wales, how they are generated and used best to achieve strategic objectives and the specialist healthcare needs of patients in Wales.
- **Stakeholder Engagement**  
This includes those individuals, organisations and groups, especially patients, patient groups, the wider public, clinicians and other organisations who depend on Health Commission Wales to fulfil their own needs or objectives and on whom, in turn, Health Commission Wales depends.
- **Internal Business Processes**  
Those processes that the organisation must excel at to achieve the greatest impact on stakeholder satisfaction and to achieve its financial objectives. To work and function effectively the individual components should be integrated seamlessly, working together as a whole system.

- **Learning and Growth**

The organisational development and personal development of staff needed to support and achieve the strategic objectives and inform the strategic direction of an organisation.

4.22 These domains comprised the environment in which Health Commission Wales operated and were essential to fully address the terms of reference of the review.

### **Addressing sample bias and fairness**

4.23 Reviews of public sector bodies that have to make complex, difficult and sensitive decisions about the availability of services for citizens are inevitably subject to sample bias. Adverse comment and complaints about the organisation subject to review are anticipated from those people who feel aggrieved by decisions that have not been in their favour. Responses to the review, particularly unsolicited, were expected to be dominated by adverse rather than favourable comment. This is much more likely if some of the organisation's decisions have featured in the media as matters of "public concern". The review sought balance by casting the net widely to involve a substantial number and wide range of potential respondents with knowledge of Health Commission Wales adopting a proactive strategy. Additionally, in soliciting comment and information whether in correspondence or in face-to-face interview, it was stressed that a rounded appreciation and assessment of the functions, role and delivery of Health Commission Wales was an objective.

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4.24 Whilst it was most certainly not an intention of the review to criticise individuals, in the interests of fairness, individuals who may feel that they are the subject of indirect criticism were given an opportunity to consider appropriate extracts of the developing report. They were able to provide written and/or oral submissions. These were taken into account in the preparation of the final draft of the report.

### Independent Expert Panel

4.25 To assist in reviewing and assessing the evidence, Professor Aylward appointed an independent expert panel with expertise and experience in the areas of: commissioning, governance, policy development, patient and public engagement, specialised service delivery and scrutiny. Their purpose was to provide a disinterested perspective of the evidence and to guard against subjective bias in the gathering and retrieval of evidence, data extraction,

evidence synthesis, strength ratings and analysis. They were also involved in reviewing iterations of the developing report and the final draft of the report.

4.26 The independent expert panel comprised (biographies are contained in Appendix 2):

- Professor Mansel Aylward CB (Chair)
- Dr Kevin Fitzpatrick
- Dame Deirdre Hine DBE
- Mr Clifford L Jones OBE
- Professor Anthony Newman Taylor CBE
- Mrs Fran Targett

4.27 The independent expert panel met on five occasions in Cardiff between February and April 2008. The panel helped scrutinise, review and interpret summaries of the evidence collected, together with appropriate original supporting documents. They also provided advice, articulating clear conclusions and recommendations.

## 5. Corporate Governance

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- 5.1 Corporate governance is the way in which organisations are directed, controlled and managed. It defines the distribution of rights and responsibilities among the different stakeholders and participants in the organisation, determines the rules and procedures for making decisions on corporate affairs including the process through which the organisation's objectives are set, and provides the means of attaining those objectives and monitoring performance. This is a key domain in addressing the terms of reference of the review as it considers the direction, control and management of Health Commission Wales and the impact on decision making.
- 5.2 The decision to establish Health Commission Wales on 1 April 2003 as an Executive Agency appears to have been taken following a submission from Welsh Assembly Government officials to the Permanent Secretary of the Welsh Assembly Government. This followed an informal discussion paper to the then Minister for Health and Social Services in which officials requested a steer on the key issues. Both papers outlined the need for an independent, arms length yet accountable organisation with responsibility for commissioning specialised health services in Wales. Four possible organisational models were put forward for consideration:
- A Special Health Authority
  - An Assembly Sponsored Public Body
  - A Host NHS Trust
  - An Executive Agency.
- 5.3 The advantages and disadvantages of each option were briefly outlined in the papers. It is not clear why the Executive Agency model was favoured over the other options, although it is possible that the other options represented a potential conflict of interest or they did not fit well with Welsh Assembly Government policies or could not be legally established in the time available.
- 5.4 Officials advised the Minister for Health and Social Services that the Welsh Assembly Government had the power under the Government of Wales Act, 1998 to establish an Executive Agency. The fact that this could be done relatively quickly and easily could have added weight to the adoption of the Executive Agency model option.
- 5.5 Executive Agencies were first introduced in 1988 as a means of delivering central government services. Due to their diversity in function and scale of operations, there is no typical Executive Agency model. Nevertheless, a common feature of all Executive Agencies is that they should operate at arms length from their parent departments and, within an agreed framework, have autonomy and freedom of action. Other common features include:
- A clearly defined business boundary
  - A focus downward and outward on delivery within an agreed framework of accountability
  - Financial and personnel flexibilities to get the job done
  - A Chief Executive Officer with personal responsibility and accountability for operating decisions
  - A published annual report and accounts, including a review of performance against targets.

5.6 In July 2002, Her Majesty's Treasury and the Prime Minister's Office of Public Services Reform jointly issued a report on Executive Agencies in the Twenty-first Century (HM Treasury 2002). The report considered how well the Executive Agency model had worked and made some important recommendations to help guide departments in their relationships with their agencies. Included in the recommendations were that all agencies should have:

- At least one discussion a year with their Minister
- A senior sponsor within their parent department to provide strategic direction and performance management
- A two-way 'no surprises' rule
- External challenge and support introduced via the agency's management board
- Clear roles for, and induction of, non executive directors
- A framework document reviewed at least every three years or as business plans roll forward.

5.7 In recommending the Executive Agency model for specialised health services in Wales, officials had identified and considered all these key corporate governance features. However, the reference to a management board was altered to an advisory board. The Treasury guidance did provide scope for a Ministerial Advisory Board as long as it provided effective governance of the organisation. The recommendation put before the Permanent Secretary included an advisory board, not a Ministerial Advisory Board.

5.8 When Health Commission Wales was established, although described as an Executive Agency, some of these common, key features associated with Executive Agencies had not been incorporated into the organisation. In particular, the creation and constitution of the National Commissioning Advisory Board did not meet the board model recommended by the Treasury guidance in which external support and scrutiny should be introduced from non executive board members.

5.9 The National Commissioning Advisory Board meets in public approximately six times a year and is expected to advise the Chief Executive Officer of Health Commission Wales on the National Commissioning Strategy and Annual Commissioning Plans. The Chair of the Advisory Board is appointed by the Minister for Health and Social Services and is independent of Health Commission Wales. The review was informed that National Commissioning Advisory Board meeting dates, agenda and minutes of meetings are not proactively published though they are selectively circulated to a variety of key bodies and are available to the public on request.

5.10 The National Commissioning Advisory Board, as its title suggests, is only advisory and its guidance, in practice, tends to be confined principally to commissioning matters. Consisting entirely of stakeholders, there are no independent non executive members, which would be expected of an independent body.

5.11 As a consequence, the National Commissioning Advisory Board has little influence over the strategic direction

and development of Health Commission Wales and lacks the external challenge and experience that independent members could bring.

- 5.12 A common feature of Executive Agencies is that they operate at arms length from their parent departments. However, a consistent theme emerging from the evidence collected during the course of this review is that Health Commission Wales, on some occasions, operates and behaves as if it is an integral part as the Welsh Assembly Government. Many stakeholders do not see it as anything other than part of the Welsh Assembly Government. Those who do understand its status as an Executive Agency accept that it does not always operate along the lines of the conventional model.
- 5.13 The integral working relationship between Health Commission Wales and the Welsh Assembly Government is evident in many of the practices and procedures inherent within the organisation. Health Commission Wales' business planning and resource allocation process forms part of the Welsh Assembly Government's own system. Policy matters such as recruitment, retention, terms and conditions, communications, IT and others are all those of the Welsh Assembly Government.
- 5.14 Health Commission Wales has undoubtedly been constrained by these arrangements in its management and flexibilities in both driving forward and developing its functions. The resource bidding process, for example, leaves Health Commission Wales being treated in the same way as any department in the Welsh Assembly Government. This means that it has to compete with priorities of other departments. The elements of the internally focused process do not appear fully to provide for the role of Health Commission Wales in the commissioning of front line NHS services. The review found it very difficult to unravel the precise way in which budgets were allocated to Health Commission Wales. For example, some bids for proposed service development were made by policy divisions in the Department of Health and Social Services on behalf of Health Commission Wales. The complexity and heterogeneity of these processes made it difficult for the review team to understand fully how resources were allocated.
- 5.15 It does seem, however, that Health Commission Wales enjoyed a more favourable position than other Commissioners in Wales because they were permitted to negotiate uplifts/additional funds directly with the Minister. This process could reflect their cost pressures and might secure their commissioning plan during the financial year. However there appears to be no discernable system to ensure that resources kept pace with, or reflected medical or technological advances.
- 5.16 The Welsh Assembly Government's policy and practices on the recruitment and retention of staff is another example of how failure to operate at arms length from the parent department has constrained effective management of Health Commission Wales. However, Health Commission Wales had no choice but to act in accordance with the structure established by the Welsh Assembly Government in which it was held to account.

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- 5.17 All staff are recruited by the Welsh Assembly Government so Health Commission Wales has to compete with other departments to fill vacancies. Delays and restrictions on recruitment have resulted in a large proportion of the staff of Health Commission Wales being agency sourced (22% in December 2007). Under Welsh Assembly Government rules, agency/casual staff are not normally retained after 40 weeks employment. Consequently there is a continual turnover of staff resulting in skills shortages and vacancies at all levels across the organisation (20% in December 2007). This is further compounded by the fact that, since staff can only be employed on Welsh Assembly Government/Civil Service terms and conditions, Health Commission Wales has considerable difficulty recruiting and employing health professionals directly who would normally be expected to be employed on NHS terms and conditions, although secondments are available in certain circumstances.
- 5.18 In its 2006/07 Management Letter, the Wales Audit Office recommended that Health Commission Wales should reduce their over reliance on agency staff. Health Commission Wales accepted this recommendation and reported that the problem had been signalled through all formal routes. Health Commission Wales is working with the Welsh Assembly Government to improve the position.
- 5.19 The constitutional failure to establish and maintain an arms length relationship between Health Commission Wales and the Welsh Assembly Government risks compromising the independence of the Minister and senior officials who would inevitably be brought much closer to the decision making processes. Health Commission Wales does not function as an Executive Agency. It does not have a management board and thus does not have non executive directors on whom to call.
- 5.20 A key corporate governance feature for Executive Agencies is the establishment of a formal effective Audit Committee. In accordance with recommended good practice, Health Commission Wales did establish an Audit Committee (however, it was called an Audit Group so as not to confuse it with the National Assembly for Wales' Audit Committee). This was considered particularly important by the Chair of the National Commissioning Advisory Board and supported by the Chief Executive Officer and Director of Finance.
- 5.21 Audit Committees provide assurance to the Board and Accounting Officer on risk management, governance and internal control. HM Treasury produces and maintains the Audit Committee Handbook which provides good practice and guidance on the role and purpose of Audit Committees including their membership, skills and scope of work.
- 5.22 The handbook states that an Audit Committee of at least three members should be established. The Chair of the Audit Committee should be an independent non executive member of the Board and at least one of the committee members should have recent and relevant financial experience. Where there are insufficient non executive Board members to form an Audit Committee, independent external members should be appointed.
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Executive members of the organisation should not be appointed to the Audit Committee. The role of the executive is to attend, to provide information, and to participate in discussions, either for the whole duration of a meeting or for particular agenda items. These good practice principles were also endorsed by the Wales Audit Office in a meeting with Health Commission Wales.

5.23 Because of the constraints on the ways in which Health Commission Wales was established Health Commission Wales was not able to apply all of these principles to its Audit Group. The Audit Group continues to be chaired by the Chief Executive Officer of Health Commission Wales. Two dedicated external members were later appointed. There is therefore a question about the degree of assurance that all aspects of risk management, governance and internal control within Health Commission Wales are functioning effectively.

5.24 During the course of this review, it was confirmed that, in support of Health Commission Wales, the Clinical Governance Support and Development Unit and the Governance in Health project team, both of which are part of the Welsh Assembly Government, had reported on its standards and governance issues.

5.25 In a joint minute to the Head of the Department of Health and Social Services dated 11 September 2007, the teams commented:

*“Health Commission Wales tries to do a good job in impossible circumstances”.*

The minute goes on to say:

*“the governance structure of Health Commission Wales is not a success; the relationship between HCW with the rest of the DHSS means that HCW cannot easily get on with their job properly since they are subject to WAG procedures, though they are expected to act as a commissioning body; the Board of Health Commission Wales has a lot of good will for the success of the organisation but does not really have a huge amount of influence; there may be insufficient strength in depth as far as commissioning expertise goes; the boundary between central commissioning and the commissioning role of LHBs is unclear and leads to conflict; the way in which they were established, particularly in the mismatch between their funds and their responsibilities has led to conflict and has helped to bring about a position where there are accusations of cost-shifting running round the system.”*

5.26 The review has learned from Health Commission Wales that after its healthcare standard assessment by Healthcare Inspectorate Wales, in October 2007 it sought advice from the Clinical Governance Support Unit on how improvements could be made. In consequence it has recently appointed a Nurse Director and a new Chair for their Clinical Governance Committee.

### **Comparison with other Specialist Commissioners in the UK**

5.27 The review also considered arrangements for providing the commissioning of specialist services elsewhere in the UK. Visits were made to Scotland and the North West of

England to explore and discuss arrangements there. A discussion was also held with the Director of the National Specialised Commissioning Group in England. Due to current organisational change in Northern Ireland it was not possible to glean sufficient information.

5.28 There were several illustrations of good practice provided by the other UK specialist commissioners and, although detailed information was provided, the review was unable to make a thorough assessment of these in the time available nor how they compared with the level of services currently provided by Health Commission Wales. However, the key features of other UK Specialist Commissioning bodies are summarised in Appendix 3. The key features include those recommended by Sir David Carter in his review of Specialised Commissioning in England (2006).

5.29 Of particular note are the common features of the other UK models of specialised services which are different in degree to those of Health Commission Wales. These include:

- All are part of the NHS
- All negotiate and pool budgets with other NHS organisations to meet service and patient need
- All provide scrutiny by non executive members of effective management boards
- The schedule of specialised services is clearly defined and agreed by , relevant stakeholders
- No individual patient decisions are made at this level. Agreed services are commissioned. Requests outside these services are considered by Primary Care Trusts in England and Health Boards in Scotland
- All have clear, formal, robust and participative horizon scanning and planning processes
- Regular audit of all services commissioned routinely including the equity of access, outcome measures, clinical governance and cost effectiveness.

## 6. Financial

6.1 This chapter considers the resources of Health Commission Wales, how they are generated and used to best achieve its strategic objectives and the specialist healthcare needs of patients in Wales. The resources available in relation to the duties of Health Commission Wales will inevitably influence decision making and it was therefore essential to address this area to meet the terms of reference of the review.

### Resource mapping

6.2 When Health Commission Wales was established it began with a commissioning budget of £368million. This commissioning budget was created following a resource mapping exercise carried out by the Welsh Assembly Government immediately prior to setting up Health Commission Wales.

6.3 The resource mapping exercise involved requesting former Health Authorities and NHS Trusts to formally declare the level of specialised services they provided, together with the estimated cost of these services. This exercise was carried out quickly, with evidence that some Health Authorities and NHS Trusts were given less than a week to respond. The eventual commissioning budget for Health Commission Wales was then created by ‘top-slicing’ Local Health Boards’ budgets by amounts equivalent to their estimates.

6.4 The budget was not ‘risk pooled’ as it was under the former Specialised Health Services Commission for Wales. This essentially meant that each former Health Authority came together to aggregate and share high cost, low volume services and therefore prevent any major unexpected cost pressures in

that year. They agreed a defined schedule of specialised services which was reviewed annually. This facilitated review and investment in appropriate high quality services and effective monitoring and evaluation of outcomes in a transparent, planned process.

6.5 It is clear from discussions with NHS Trusts, Local Health Boards and other stakeholders that the resource mapping exercise caused them a great deal of concern. In particular they felt that the exercise was rushed and ill-thought through resulting in a lack of engagement and consultation not only with NHS stakeholders but also with other important stakeholders such as patients, patient representative groups and clinicians.

6.6 There is little doubt that the initial resource mapping exercise was incomplete and therefore fundamentally flawed. It is one of the root causes of the problems which Health Commission Wales had to contend with at the outset and which it continues to battle with today. Not all those asked to respond to the resource mapping exercise did so and those which did found the definition of specialised services unclear, resulting in different interpretations. This was acknowledged in correspondence from officials shortly after the establishment of Health Commission Wales with a commitment to complete the process. Evidence heard has led the review to conclude that there is disagreement between the Welsh Assembly Government on the one hand and Health Commission Wales and Local Health Boards on the other, as to whether the resource mapping exercise had been completed satisfactorily.

6.7 As a result of this the budget allocation was initially unsound and almost certainly led to a mismatch between funding and responsibilities. This remains unresolved and is continuing to pose considerable obstacles to enable patients to move easily along pathways of treatment for their health conditions between different levels of commissioner. Additionally, the boundary between what is now the central commissioning responsibility of Health Commission Wales and the commissioning role of the Local Health Boards on a number of services is unclear and often leads to conflict. Management from both sides admit that much of their dealings with each other were spent on contending and defending responsibilities. These ‘fracture lines’, as they have been referred to, lie behind many of the contentious issues identified in this and in other reports, including those of the Ombudsman (2007). Examples of the effect this can have on the treatment of patients are shown in the Internal Business Processes chapter.

6.8 Medical and technological advances are such that what is regarded as a specialised service today may well be regarded as a routine procedure tomorrow. It is important therefore that any system for commissioning specialised services should contain a strategy for ‘stepping down’ those services which could be reclassified as mainstream, transferring responsibility back to Local Health Boards as appropriate. Similarly, as medical and technological advancements provide opportunities for the introduction of new services or treatments, any strategy should be flexible enough to

ensure that such advancements are properly investigated and evaluated.

6.9 Although the Health Commission Wales Framework Document provided a process by which the schedule of services could be amended there is no evidence that such a strategy was implemented. The failure to regularly review and step down services has restricted Health Commission Wales’ ability to respond to new services and treatments. Whilst it is accepted that the commissioning of novel and innovative procedures is a risky and costly practice, and that a balance must be drawn between cost and evidence of effectiveness, there nevertheless need to be strategies that keep pace with the continual medical and technological advancements.

### Budget

6.10 Early in the financial year 2004/05, Health Commission Wales overspent its commissioning budget by around £5million which continued to grow each year. This deficit included the overspend it inherited from the previous Health Authorities. Health Commission Wales expressed its concerns to the Welsh Assembly Government about the above and inadequate funds for Individual Patient Commissioning and growing demands in medium secure mental health commissioning.

6.11 In April 2005, Health Commission Wales was informed by the Welsh Assembly Government that it would receive £25.2million loan funding, provided that it met its then forecast deficit on completion of an approved Strategic Change and Efficiency Plan (SCEP). By

October 2005 Health Commission Wales was forecasting a deficit of between £18 - £25million. An emergency meeting was held in October 2005 with Welsh Assembly Government officials because Health Commission Wales forecast an increased deficit in 2005/06. The notes of the meeting record that the officials informed Health Commission Wales that there was no further money available to assist it in managing the deficit and that the present situation could not be allowed to continue. In particular, concerns were expressed that unless there were substantial improvements Health Commission Wales' annual accounts could be qualified. This could have had significant implications for the Welsh Assembly Government as this could have resulted in the accounts of the National Assembly for Wales also being qualified.

- 6.12 Health Commission Wales was told that it must reduce the level of the deficit and begin producing savings as originally stated in their SCEP. Health Commission Wales had been required to develop a further SCEP to address their increased deficit position. This was finally approved, with corresponding cover for their deficit, in a letter sent by the Welsh Assembly Government to the Chief Executive Officer in a letter in July 2006. As a result, there was considerable pressure on Health Commission Wales to achieve and maintain financial balance. Following the retirement of the first Chief Executive Officer, a new Chief Executive Officer was appointed in January 2006 and this was associated by many stakeholders with an even greater emphasis by Health Commission Wales on financial considerations. The new

Chief Executive Officer did, indeed, go about the task of achieving financial balance in a diligent, determined and systematic fashion. He also had the formidable challenge posed by an accumulating burden of developing new policies to take account of the new context.

- 6.13 Stakeholders repeatedly informed the review that they felt decisions made by Health Commission Wales were less about clinical need or the care of the patient, but more about cost containment. Stakeholders felt that the chairing of the Individual Patient Commissioning Panel by the Director of Finance rather than the Medical Director could be perceived as supporting this view. The Medical Director or his deputy were also members of the panel. The Director of Finance was also an expert commissioner in a number of service areas. This is further commented on in the Individual Patient Commissioning chapter.
- 6.14 Whilst it is essential that Health Commission Wales should consider cost implications when developing their commissioning policies (and they have confirmed that they were required to take this into account), an examination of some of these policies revealed that budgetary considerations not only featured heavily in the development of the policy but was also the determining factor whether a treatment or service was adopted or not. It is, however, acknowledged that there are great difficulties in attempting to address clinical need within a fixed budget. Difficult decisions have to be made within the limitations Health

Commission Wales was required to operate. The final decision making rested with the Chief Executive Officer. More detailed examples are given in the Internal Business Processes chapter.

- 6.15 Stakeholders also expressed concerns about the implications of the strategy Health Commission Wales had adopted to reduce their deficit. Many commented that Health Commission Wales attempted to save costs by reducing the levels of payments for commissioned services. This was perceived by some as merely shifting costs to other parts of the NHS. One service provider commented that there was little room for negotiating with Health Commission Wales because they would have their budgets agreed by Welsh Assembly Government prior to any meeting. This meant that discussions principally focused on cost savings. Health Commission Wales accepted that it had to carry out a balancing exercise between making savings and delivering new and expanded service provision.
- 6.16 It is however, incumbent on commissioners to make decisions which take account of available financial resources when operating within a fixed budget. As Accounting Officer for Health Commission Wales, the Chief Executive Officer had no authority to spend more than the allocated funds.
- 6.17 The financial position of Health Commission Wales was publicly criticised by the National Assembly for Wales Audit Committee in a press release which accompanied publication of the report into NHS Finances published in 2006. Health Commission Wales was the only organisation named

and emphasis was thus given to the requirement on Health Commission Wales to live within its allocated budget and to repay over £30million of debt. This inevitably led to difficult choices having to be made.

- 6.18 Resources required to deliver what was expected of Health Commission Wales were the subject of regular discussions with Welsh Assembly Government officials. Health Commission Wales attests that despite the submission of well argued and evidence-based bids for funding, only some were successful. The pressures on Health Commission Wales, its restricted financial position, priorities for investment, and proposals for priorities and efficiency savings featured prominently in discussions with the Welsh Assembly Government in the development of Commissioning Plans. In this context ultimate decisions about funding are the responsibility of the Minister for Health and Social Services. The Minister's priorities have then to be implemented by Health Commission Wales. Decisions as to which services are to be developed or restricted had to be made by the Chief Executive Officer of Health Commission Wales under the Minister's powers delegated to him. The direct relationship with the Minister and the accountability process to which the Chief Executive Officer of Health Commission Wales has to adhere, are not shared by NHS bodies such as Local Health Boards where there is statutory separation and no requirement for a personal Ministerial approval of Commissioning Plans.
- 6.19 Health Commission Wales has a close performance management relationship with the Welsh Assembly Government.

Plans and performance are subject to scrutiny, and financial plans and their implications for existing services and development of new services are the topics of detailed discussion and deliberations.

- 6.20 The budget of Health Commission Wales has been uplifted each year to meet the cost of inflation. These budgetary uplifts have not allowed Health Commission Wales to keep pace with the medical and technological advancements mentioned earlier, nor has it provided the opportunity to address the inadequate resource which was created at inception. As a consequence, Health Commission Wales is continually faced with shifting resources between priority services, resulting in disinvestment or enforced efficiencies in some services to fund others. The fact that inflation relating to healthcare services is normally much higher than the average cost of living inflation only serves to compound the problem.
- 6.21 There is a national precedent for requiring efficiency savings. The National Finance Agreement has acknowledged the under-funding of inflationary, and other cost pressures, and the requirement for NHS bodies to deliver efficiency savings to address this financial gap. By definition, efficiency savings are those that can be achieved by removing cost from the system. The movement of costs between organisations cannot be considered as efficiency savings for the NHS as a whole. Health Commission Wales argue that it has good evidence of the scope for efficiency savings in specific services. On the basis of that evidence, Cardiff and the Vale NHS Trust achieved a £2million efficiency saving for the last financial year. It does seem that the separation of Health Commission Wales from other commissioning bodies in Wales is a substantial disadvantage in this context. It is perhaps unsurprising that NHS organisations in Wales have demonstrated some reluctance to engage with proposals by Health Commission Wales effecting efficiency savings (as defined) where these were perceived to be detrimental to their budgets.
- 6.22 It is noted too that Health Commission Wales has begun repayment of the £33.5million loan which it has been allowed to accrue since 2004/05. The repayments began in 2007/08 with a repayment of £5.5million and will be followed by repayments of £7.7million in 2008/09, £11.7million in 2009/10 and a final repayment of £8.6million in 2010/11. The review was told by the Welsh Assembly Government that it acknowledged the associated difficulties and a recent decision has been made to fund Health Commission Wales for 2007/08 for cost pressures which is to a level broadly equivalent to the loan repayment for that year. It is further proposed that Health Commission Wales will be similarly funded for 2008/09. These ad hoc and late funding decisions do not permit adequate financial and service planning which can result in financial uncertainty for Health Commission Wales. This uncertainty, unless resolved, will inevitably bring further stresses to an already pressurised budget.
- 6.23 A review of the financial position at Health Commission Wales was carried out between April and June 2006 by an independent consultant (Meekings

2006). The report to the Director of Resources in the Department for Health and Social Services of the Welsh Assembly Government identified many of the financial and other issues identified in this report. The main findings were:

- Health Commission Wales faced a significant financial crisis. Although difficulties started in the first year, it did not react quickly enough to the developing situation.
- In the absence of forward looking strategies and as the financial problems grew, Health Commission Wales resorted to short term tactical proposals to save money in 2005/06.
- It had a focussed Strategic Change and Efficiency Plan moving forward which assumed a large savings plan to deliver over the next three years. This will inevitably have had an impact on the development and improvement of specialist services in the immediate future. It probably does not have the right staffing skill mix to deliver this ambitious plan.
- It probably did not get the right level of resource transfer for its inherited responsibilities. It is not helped by the lack of a non executive Board to give challenge, direction and corporate oversight.
- Separating Health Commission Wales from the rest of health commissioning is a substantial disadvantage and leads to tensions with Local Health Boards.
- Its relationship with the Welsh Assembly Government is a problem not having the level of operational independence necessary to make difficult decisions.

6.24 The issues raised in this report and its recommendations have not all yet been fully addressed. In response to this report, Health Commission Wales indicated that they had flagged up the growing financial crisis but it had considered it had received little support or recognition in resolving the situation. This view is not shared by officials in the Department of Health and Social Services. Moreover, Health Commission Wales have indicated that they have achieved their financial targets in 2006/07 and 2007/08, and they continue to develop and submit strategic investment plans for consideration by the Welsh Assembly Government in the budget planning rounds.

## 7. Stakeholders

7.1 Health Commission Wales engages with a wide range of stakeholders through many different mechanisms. Key stakeholders include:

- Health Commission Wales staff
- Regional Stakeholder Panels
- Clinicians, including clinical networks
- Welsh Assembly Government
- Local Health Boards
- NHS Trusts and other providers
- Community Health Councils
- Patients, carers and patient representative groups including the voluntary sector
- National Public Health Service for Wales
- Various other interested parties, such as those involved in clinical service reviews.

### External and internal communication

7.2 In order to ensure effective communication with its stakeholders, the Health Commission Wales' Framework Document identifies the need to develop a communication strategy in respect of both external and internal communications.

7.3 Health Commission Wales has not produced an external communications strategy but instead relies upon that of the Welsh Assembly Government's. Some Health Commission Wales staff have commented that by using the Welsh Assembly Government's strategy, such communications as press releases would normally be approved by the Minister and worded in such a way as to represent the Welsh Assembly Government's position and views rather than those of Health Commission Wales.

7.4 However, Health Commission Wales has produced an internal communications strategy which provides information relating to organisational structure, induction, performance reviews, team meetings, the National Commissioning Advisory Board, the internet and records management.

7.5 Testimonies from a number of Health Commission Wales employees indicate however, that the internal communication strategy may not be effective. Internal communication has been described as ad hoc, performance reviews as patchy and staff team meetings as inconsistent.

7.6 Health Commission Wales has undertaken some public and patient engagement through, for example, their extremely comprehensive Strategic Review of Neurosciences for Wales. This involved a series of service user focus groups facilitated through the Wales Neurological Alliance. Nevertheless, some stakeholders have commented that there is still only a limited level of public and patient engagement and there remains a lack of any formal mechanism of engagement undertaken by Health Commission Wales.

7.7 The assessment of Health Commission Wales's performance against the Healthcare Standards for Wales by Healthcare Inspectorate Wales showed:

*“evidence of a consistent approach across all services to public and patient engagement, or to sharing information on the processes of decision making was not provided. Again this is not to say that these issues are not considered or managed for a particular service but there is an absence of an agreed framework”* (Healthcare Inspectorate Wales 2007).

7.8 As a result of this report Health Commission Wales produced an improvement plan which includes action to produce a public and patient involvement strategy and agree priorities for 2008/09 in order to strengthen patient and public involvement.

7.9 The level of awareness of Health Commission Wales among the general public is difficult to assess. As part of this review advertisements were placed to encourage comments and feedback from as many stakeholders as possible. Based upon the very limited feedback received, it could be assumed that the public in Wales has a limited awareness and knowledge of Health Commission Wales' role and purpose. This lack of awareness may reflect the large number of patients who have successfully accessed services commissioned by Health Commission Wales without encountering any problems and who therefore remain unaware of Health Commission Wales' involvement in decision making from which they have benefited.

### Profile

7.10 Health Commission Wales does not have its own website. Instead it has a few pages featured on the Welsh Assembly Government website. A significant number of stakeholders have commented that, at the time of the review team's assessment, the website was difficult to navigate and not comprehensive.

7.11 A review in March 2008 of web pages relevant to Health Commission Wales appears to support these testimonies. The website does provide access to

information, but not the full range of information which a stakeholder might expect. The website provides contact details, information relating to making a complaint, the individual patient commissioning review process and the commissioning plans for 2007/2008. However, it does not provide access to agendas and minutes of National Commissioning Advisory Board meetings or to the majority of its commissioning policies. Indeed, 18 of its 24 policies are not published, including the Child and Adolescent Mental Health Services policy and Deep Brain Stimulation policy. In September 2006, the Health Commission Wales Management Team agreed to publish all emerging policies on the website (Health Commission Wales 2006). The review was informed that there is no resource dedicated to keeping the web pages up to date. Staffing issues are indeed of relevance here. The pressures under which Health Commission Wales operated and the level of funding allocated to it limited the activities which it could undertake. It may well be that the upkeep of the website fell foul of these limitations on its staff and resources.

7.12 It was also noted that not all information accessible on the English language web pages of Health Commission Wales is available on Welsh language web pages. For example the procedure for individual patient treatment and the low dose brachytherapy policy are not published in Welsh.

### Stakeholder boards and panels

7.13 A number of key stakeholders are represented on the National Commissioning Advisory Board. When preparing the National Commissioning

Strategy and Annual Commissioning Plans, Health Commission Wales also consults with the three Regional Stakeholder Panels (North Wales, Mid and West Wales, and South East Wales). Consisting of representatives from NHS Trusts, LHBs, Community Health Councils, Local Government, the voluntary sector and the Welsh Assembly Government, the panels meet annually and provide advice and guidance to the Board on the development of the commissioning plans.

7.14 It is understood that the frequency and effectiveness of the Stakeholder Panels varies considerably between the three regions. The review was informed that the South East Panel no longer exists and engagement is through the Local Health Board Chief Executive Officers Group and Regional Commission's Executive.

7.15 Nevertheless, there is evidence that Health Commission Wales does communicate and engage with NHS Trusts, clinical networks, clinicians and other stakeholders. Since its establishment for example, Health Commission Wales has undertaken 27 clinical service reviews, many of which appear to have involved engagement with a range of stakeholders. The review of Adult Cystic Fibrosis Services in South Wales undertaken in 2004 involved engagement and collaboration with Cardiff and Vale NHS Trust, professionals from cystic fibrosis units in the UK and the Cystic Fibrosis Trust. The review of Renal Services at Bridgend undertaken in 2004/2005 involved engagement and collaboration with Bro Morgannwg NHS Trust, North East Wales NHS Trust, Bridgend Local Health Board and South Wales Renal Managed Clinical Network.

7.16 The testimonies of some NHS Trusts, clinical networks and clinicians indicate that there are significant concerns in relation to levels of engagement and communication. Points of concern raised include poor engagement with clinicians in the development and implementation of policy and poor communication of these developments. However, Health Commission Wales has undertaken substantial engagement with clinicians in the development of certain policies, despite its inadequate staffing levels and the considerable number and range of clinical groups, networks and individuals with which it needs to engage. The observations of some NHS Trusts and clinicians about lack of engagement in certain circumstances may reflect dissatisfaction with a developed policy after discussion rather than failure of engagement. These issues in so far as they relate to policy development are discussed further in the Internal Business Process chapter.

### National Public Health Service for Wales

7.17 The National Public Health Service for Wales is required to provide public health services to Health Commission Wales under the Service Level Agreement between itself and the Welsh Assembly Government. It provides public health advice to Local Health Boards and Health Commission Wales for the commissioning of healthcare services, for the provision of national and regional specialist services and for specialist commissioning arrangements.

7.18 The relationship between the National Public Health Service for Wales and Health Commission Wales has been

described as difficult by both parties, with different expectations of timescales and scoping of work appearing to be the root cause of the problem. An initial Memorandum of Understanding was established between the organisations in 2003. It was reviewed by the National Public Health Service for Wales following organisational changes in October 2005. Several attempts were made to discuss and agree it with Health Commission Wales but it still remains unsigned. Health Commission Wales attest to this review that the draft Memorandum did not meet its requirements. The information received by the review is conflicting. Both the National Public Health Service and Health Commission Wales have divergent views on the reasons why meaningful discussions have not ensued.

### NHS bodies

- 7.19 The difficulties in the relationship between Health Commission Wales and Local Health Boards was seen to have taken a positive step forward, however, in the establishment of the Interface Management and Governance Project which met for the first time in January 2008. The project aims to provide a pragmatic and agreed management solution to address the issues surrounding the commissioning of specific health services. A list of 21 services where there is currently disagreement has already been identified.
- 7.20 A number of interviewed NHS stakeholders also feel that Health Commission Wales' status as an Executive Agency of the Welsh Assembly Government, rather than an NHS body, is a disadvantage because of

perceptions of political influence over the decision making process. Examples have been given by a broad range of stakeholders where decisions have been reversed where the only apparent change in circumstances is the involvement of politicians on behalf of patients.

- 7.21 There is strong consensus for specialised services to be commissioned at a national level to ensure that safe, accessible, efficient and effective services are maintained and developed. This national level commissioning includes the commissioning of services from providers outside Wales to ensure ease of accessibility, especially to residents in North Wales or where patient numbers are so low that it would not be safe or cost effective to provide the services in Wales. A significant number of stakeholders also consider that Health Commission Wales would be in a better position to carry out its functions if it were a part of the NHS.
- 7.22 Allied to the governance concerns is the vulnerability of Health Commission Wales to political influence. Examples have been given by a broad range of stakeholders where decisions have been reversed where the only apparent change in circumstances is the involvement of politicians on behalf of patients. It is of course a perfectly legitimate role for MPs and AMs to advocate strongly on behalf of their constituents.
- 7.23 There are examples of decisions by Health Commission Wales being modified following the issue of letters by politicians on behalf of their constituents. It may well be that such letters provided additional or new

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information which itself permitted a change of decision. The review is satisfied that Chief Executive Officers, management and staff showed integrity in the formulation of policies and in the decision making process.

- 7.24 However, a previous Chief Executive Officer of Health Commission Wales firmly and strongly attests that his decisions had never been swayed by political influence. If a decision has been changed it is the result of a direction within the powers of the Minister which he was obliged and perfectly content to accept.
- 7.25 On a number of occasions, decisions were made by Health Commission Wales not to commission certain treatments.

Many of the decisions were ratified by the Minister for Health and Social Services through the approval of the respective Commissioning Plan. It is evident too that throughout the history of Health Commission Wales, Ministers have decided to provide additional specific resource allocations to fund some treatments which initially Health Commission Wales had decided not to commission. These are legitimate decisions by the Minister to what they consider are their priorities. These decisions do not come within the scope of political influence.

## 8. Internal Business Processes

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8.1 The internal business processes are those that the organisation must excel at to achieve its financial objectives and to have the greatest impact on stakeholder satisfaction. They should be aligned to maximise efficiency in delivering the objectives, roles and functions. For an organisation to work effectively the individual components should be seamlessly integrated, working together as a whole system (Kaplan and Norton 1996).

### Leadership and direction

8.2 The Chair of the National Commissioning Advisory Board is appointed by, and is accountable to, the Minister for Health and Social Services. The Chair is responsible for leading the Board and for ensuring that it functions properly and effectively. The Board makes recommendations to the Director of the Health and Social Services Department and the Minister for Health and Social Services through the Chief Executive Officer. It also monitors the implementation of the National Commissioning Strategy and Annual Commissioning Plans.

8.3 The Chair is a non executive appointment and should not therefore be involved in any of the decision making processes. There is evidence that the Chair of the National Commissioning Advisory Board has attended decision making management meetings, running the risk of compromising the non executive status of the appointment. The role of the Chair is further clarified in Health Commission Wales' Framework Document.

8.4 The Chief Executive Officer is the Accounting Officer for Health Commission Wales and is appointed by, and directly accountable to, the Director of the Department of Health and Social Services. The Chief Executive Officer is responsible for the delivery of high quality specialised services in Wales and for implementing, monitoring and evaluating the National Commissioning Strategy and Annual Commissioning Plans. Direction from the Health and Social Services Department is given through regular meetings and quarterly performance reviews. The role of the Chief Executive Officer is also further described in the Framework Document of Health Commission Wales. Inevitably, different individuals have different styles of leadership. However, some stakeholders felt the focus and priorities of Chief Executive Officers varied quite considerably, particularly in the balance between clinical and financial governance.

8.5 The Chief Executive Officer is responsible for developing the National Commissioning Strategy and Annual Commissioning Plans, as advised by the National Commissioning Advisory Board. The process for strategy and plan development described in the Framework Document should involve all Local Authorities and Local Health Boards through the Health Needs Assessment processes to identify needs for specialised services. These needs should be aggregated at regional and then national level to inform the Chief Executive Officer. It appears that this process was not followed and the Chief Executive Officer drew up the strategy and plans through consultation with the Regional Stakeholder Panels.

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- 8.6 A former Chief Executive Officer of Health Commission Wales gave evidence that the process for developing plans as described in the Framework Document was unworkable.
- 8.7 Health Needs Assessments produced by Local Health Boards and Local Authorities do not specifically set out the requirements for the specialised services to be commissioned by Health Commission Wales. Local Health Boards lack expertise to undertake needs assessments for specialised services. Health Commission Wales has undoubted expertise and experience in commissioning such services and was obliged to formulate strategies and develop plans for specialised services in consultation with Regional Stakeholder Panels. The Framework Document itself was therefore flawed. It has not been amended to take into account the disparity in expertise and knowledge of specialised services between Health Commission Wales and Local Health Boards. This should have been anticipated at the outset. The strategies and plans were discussed with officials of the Department of Health and Social Services of the Welsh Assembly Government. The resultant documents including the Commissioning Plan were put before the National Commissioning Advisory Board before submission to the Welsh Assembly Government for agreement by the Minister for Health and Social Services.
- 8.8 The Director of Finance, Director of Planning and Performance, the Medical Director and a recently appointed Nurse Director all report to the Chief Executive Officer. Clinical leadership has primarily rested with the Medical Director with support from the Deputy Medical Director. Since these are the principal health professionals in the organisation, Health Commission Wales staff have relied heavily upon their advice and guidance.
- 8.9 The Nurse Director was appointed following the Healthcare Inspectorate Wales assessment, as explained in the Corporate Governance chapter. She has responsibility for nine of the 32 Healthcare Standards for Wales and shares this with the Medical Director for one other standard. Responsibility for the other Healthcare Standards is shared between the Chief Executive Officer and the other Directors.
- 8.10 Some staff dissatisfaction in the leadership was expressed in the 2006 staff survey (discussed in more detail in the Learning and Growth chapter) but it was not clear whether this was directed at Health Commission Wales' management or the wider management by the Welsh Assembly Government. It is understood that the interpretation of the then Chief Executive Officer was that it was directed at the Welsh Assembly Government.
- Development of policies**
- 8.11 Health Commission Wales develops policies to assist the decision making process in respect of requests for treatment or services. Policies are a predetermined set of criteria against which requests for treatments are judged, and help to ensure requests are dealt with quickly and equitably. Since the treatments and services to which the policies relate are highly specialised in nature, new or in stages of clinical evaluation, and due to the generally
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small numbers of patients who undergo such treatments, the evidence of effectiveness is often inconclusive. When developing policies therefore, Health Commission Wales must be informed by the knowledge of experts.

- 8.12 A range of stakeholders confirmed that they felt Health Commission Wales had done well in reviewing and developing some policies and services. Examples provided included in-vitro fertilisation services; community intensive therapy services in respect of Child and Adolescent Mental Health Services and repatriating paediatric nephrology services from Bristol to Cardiff.
- 8.13 However, some stakeholders have suggested that policy development has been influenced more by financial matters rather than by clinical evidence. The review has evidence that the qualifying bar for supporting a policy was raised with the intention of controlling expenditure. Stakeholders raised concerns on a number of the policies of Health Commission Wales, including those for eating disorders, deep brain stimulation, gender reassignment surgery, low dose brachytherapy and bariatric surgery.
- 8.14 The response of Health Commission Wales has been that the public health and medical part of the policy described as accurately as possible the evidence base and the available current evidence. The second and final policy position determined the relative priority accorded to the treatment of the specific condition in the context of the Commissioning Plan agreed by the Minister for Health and Social Services.

- 8.15 Policies were not open to a formal process of external scrutiny or challenge resulting in a lack of understanding and wider ownership of the policies. Furthermore, there was no clear process for challenging policies once they were made or for reviewing them in light of new evidence.
- 8.16 The review looked in detail at how two of these policies were developed. The policies were finalised at Directors Group level, put before the National Commissioning Advisory Board and approved by the Chief Executive Officer.

### Deep brain stimulation

- 8.17 Deep brain stimulation is a neurosurgical intervention for the management of severe movement disorders in patients whose symptoms are resistant to medical therapy e.g. Parkinson's disease, tremor and dystonia.
- 8.18 A policy for deep brain stimulation was put to the National Commissioning Advisory Board in June 2006. The policy described deep brain stimulation as a low priority in the Health Commission Wales Commissioning Plan 2006/07. The policy proposed that deep brain stimulation would not be funded for patients with Parkinson's disease, multiple sclerosis complicated with severe tremor, essential tremor and dystonia, except in exceptional circumstances. On the grounds that the withdrawal of treatment would be to the detriment of the patient the policy proposed the replacement of non functioning pulse generators if they had been initially funded by Health Commission Wales. The policy described

the procedure as one of high cost and low demand with a significant lack of evidence available on the cost effectiveness in improving long term quality of life. The policy was supported by the National Commissioning Advisory Board and subsequently adopted by Health Commission Wales.

**8.19** Examination of various papers relating to the development of this policy highlight a number of issues of note:

- The commissioning policy for deep brain stimulation was developed in response to the increasing number of requests for this high cost intervention (Health Commission Wales Management Team, 23 October 2006)
- The failure to fund this procedure may increase prescribing costs and if some patients were resistant to drug therapy their increased disability would require further community support i.e. nursing. Both fall to Local Health Boards to fund, yet there was no evidence of engagement with Local Health Boards on this matter.
- Although copies of the policy were distributed to relevant NHS Trusts, there was no evidence that Trusts or expert clinicians were engaged in the original policy development process to provide advice and insight in light of the apparent lack of published evidence on long term effectiveness of the procedure and cost effectiveness.
- No mechanism was discovered by which patients or patient groups could contribute to the process until a further review in September 2007.

**8.20** Evidence has been provided that inability for patients to access funding for deep brain stimulation treatment was associated with inability to continue working and a reduction in quality of life. Evidence presented to the review shows eight patients had contacted a charitable organisation for advice after having either been refused treatment or because their clinicians advised that the treatment was not available in Wales (Hatch 2008).

**8.21** During the recent review of this policy Health Commission Wales has since taken steps to engage with clinicians in South Wales and discuss the issues with representatives of the Parkinson's Disease Society and the Dystonia Society.

### Low dose brachytherapy

**8.22** Low dose brachytherapy is one of two more recently developed procedures for treating prostate cancer and consists of planting radioactive pellets in the prostate gland via the perineum under general or spinal anaesthetic. It is used in cases where disease is localised to the prostate gland.

**8.23** Options for the continued funding of brachytherapy were presented to the National Commissioning Advisory Board on 7 December 2005. The Board agreed to the proposal of funding the nine patients currently in the system and that further funding would be suspended on the basis of the grounds of affordability and equity. At that time Health Commission Wales paid £160,000 for this service with an average cost of treatment per patient of around £9,500.

- 8.24 A new commissioning policy for brachytherapy was presented to the National Commissioning Advisory Board on 6 June 2006. It proposed that Health Commission Wales would seek to obtain the necessary treatment from providers within an overall budget of £80,000. With an estimated 56 cases, this would result in an average cost of treatment per patient of less than £1,500.
- 8.25 NHS Trusts were unable to provide treatment at the price being negotiated and on 7 September 2006 the National Commissioning Advisory Board was informed that, as a result, Health Commission Wales would now only consider 'exceptional' cases for access to funding for brachytherapy.
- 8.26 Whilst the review noted that Health Commission Wales did not consider brachytherapy as a priority treatment for investment, patients felt that by withdrawing funding altogether, Health Commission Wales had not acted in the best interest of the patients.

### Fractured interface with Local Health Boards

- 8.27 Concerns have been expressed over the effect that the relationship problems between Health Commission Wales and Local Health Boards have had on the commissioning of some services. Particular concerns have been expressed over eating disorders and medium secure forensic mental health facilities.
- 8.28 There is a lack of community and secondary support services in Wales for patients with eating disorders to access. Local Health Boards are responsible for commissioning these services in the community. These services are inadequate in many areas. Health Commission Wales' policy limits access to specialist services for all but the most severely undernourished. Specialist services include psychiatric therapy and support. On occasions the condition of patients is such that by the time they access these services, they are unable to benefit from the nature of support on offer. If patients gain access to specialist services and respond to the treatments with a resulting sufficient gain in body mass index, they fall outside the provision of specialist services. They are discharged into the community which substantially lacks local psychiatric and community support. Further sustained improvement in patients health and wellbeing is thus at risk. Health Commission Wales recognises this anomaly and has requested that care plans are in place before patients are discharged from specialist services to redress the paucity of appropriate community based services for this group of patients. Moreover, Health Commission Wales have taken steps to pilot community schemes which should improve support services for patients with eating disorders.
- 8.29 The lack of adequate support and community services provided by Local Health Boards for people with eating disorders is viewed with concern by this review. It is imperative that patients can move easily along pathways of care and support for their health conditions between different levels of commissioner. Moreover, the adequacy of the services provided by the different levels of commissioner must primarily ensure that these fully meet the patients' needs during and following the transition.

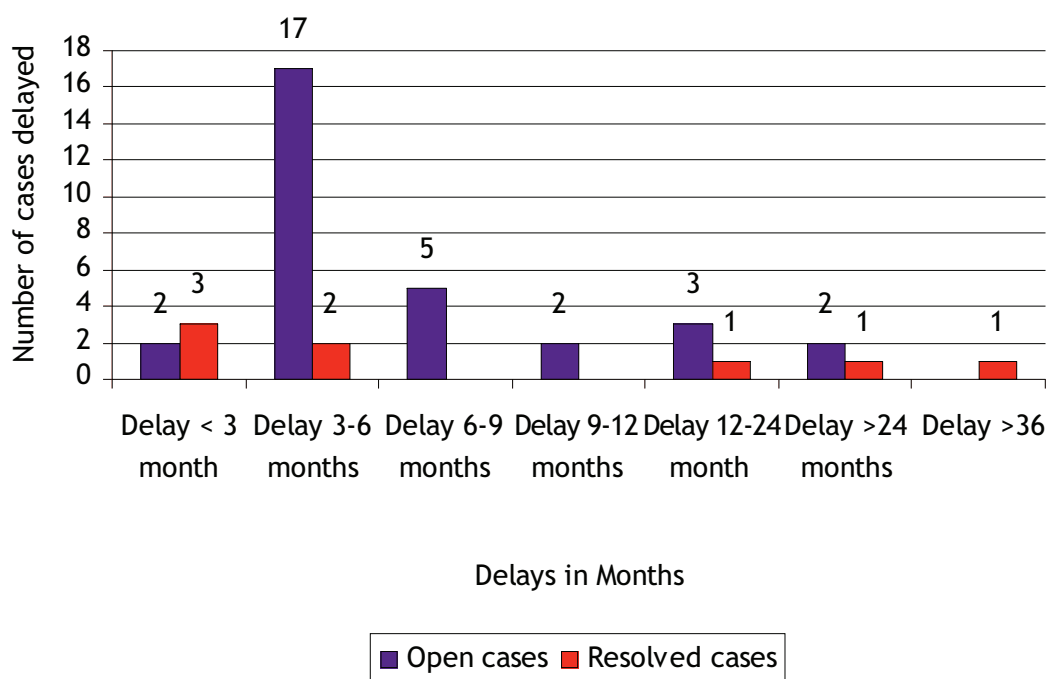
8.30 A serious situation also arises with medium secure forensic mental health facilities. Health Commission Wales is legally required to commission services for patients with these needs. When patients have improved and are ready to step down to low secure care (which is the responsibility of Local Health Boards) there are often insufficient places available to accommodate them. As a result patients may be kept in medium secure facilities for longer than necessary. These are often located at long distances from their homes. In one case identified by the review team it appears that a patient may have been inappropriately held in medium secure facilities for over three years.

8.32 The cost of inappropriately housing patients in medium secure facilities runs into millions of pounds each year. This cost is currently incurred by Health Commission Wales which has confirmed that this is a major cause of its overspend. Health Commission Wales has attempted to resolve this issue with Local Health Boards by invoicing them to encourage them to accept their commissioning responsibilities and recover funds. Patients continue to be placed inappropriately. No invoices issued by Health Commission Wales have been paid at the time of preparing this report.

8.31 The following graph shows the length of time and numbers of patients who may have been inappropriately held in medium secure facilities beyond three months:

8.33 There are, evidently, governance and financial concerns around step up and step down arrangements. Both Local Health Boards and Health Commission Wales have vigorously defended the stances they have taken, and the limitations imposed upon them by the

Graph: Length of stay of patients in medium secure mental health facilities after assessment to step down to low secure facilities



Source: Data provided by Health Commission Wales (March 2008).

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- existing commissioning set-up. This situation is unacceptable and is in need of urgent resolution. These delays in the transition of patients between medium and low secure facilities raise vital questions about whether there has been appropriate recognition and consideration of the rights of the patients involved, including possible breaches of the Human Rights Act. This is a totally unacceptable situation which must be urgently addressed by the Welsh Assembly Government.
- 8.34 Information on equity of patient access to specialised and tertiary services and equity of outcomes, which could be used to inform planning of services and prioritisation of investment, is not routinely available in an accurate or reliable form. These are difficulties also faced by other commissioners in the UK. It is, however, within the contractual power of Health Commission Wales to require such data from providers of services commissioned which, over time, could lead to improvements.
- 8.35 There are inadequate resources for information analysis in Health Commission Wales, with no separate team to research and inform the planning and policy development process. In addition, it has been difficult to get basic data to inform the review on trends, processing time and outcomes, including data from individual patient commissioning.
- 8.36 There is evidence that up to date research information is available to inform the policy development process. However, full engagement of clinical, professional and patient stakeholders is not always possible for reasons dealt with elsewhere in this report.
- 8.37 When services are fully reviewed and improved, outcome data is reported back to the Clinical Governance Committee, although notes of the meetings for 2007 showed that only outcome data relating to cardiac and cleft lip and palate were reported.
- 8.38 There is good evidence of current performance monitoring of services that have undergone review, for example neonatal intensive care, cardiac services and cleft lip and palate services. There is also good evidence on performance monitoring of Ministerial targets such as waiting times, to demonstrate improvements and compliance in line with investments.
- 8.39 However, this is not consistent across services. The Healthcare Inspectorate for Wales raised concerns that clinical governance was not yet, at the time of their report, at the core of Health Commission Wales business, with insufficient evidence to provide assurance that all providers were regularly monitored or that remedial action was taken in a timely manner where required (Healthcare Inspectorate Wales 2007). Health Commission Wales accepts that monitoring has had to be indirect, by exception, through the identification of clinical risks associated with patterns of care that are unsatisfactory or individual patient incidents.
- 8.40 Health Commission Wales has a national remit. Apart from Welsh NHS Trusts, Health Commission Wales commissions a range of private sector providers and a sizeable number of NHS and private providers in England. It is accepted by this review that Health Commission Wales labours under the burden of wholly inadequate staff resources. This substantially limits its capability to establish relationships with each of its providers.
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## 9. Individual Patient Commissioning

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- 9.1 Health Commission Wales receives a very large number of requests to refer patients to providers of specialised services that may fall outside criteria which form the basis of an existing contract with relevant providers. During 2007/08 around 2,300 referrals were made to Health Commission Wales which were dealt with under the Individual Patient Commissioning process. Of these, 59% were approved and 27% were not approved. The remainder were either deferred or cancelled.
- 9.2 These requests are either made to meet a patient's individual needs or to seek an exemption from an existing Health Commission Wales policy or a contract. Decisions for funding such requests are made by the Chief Executive Officer or a nominated deputy on behalf of Health Commission Wales. These requests fall under Individual Patient Commissioning; a process in which the internal Individual Patient Commissioning Panel of Health Commission Wales is frequently heavily engaged.
- 9.3 In the first instance, however, all such funding requests are considered by the "gatekeeper" or appropriate Health Commission Wales commissioner. Where insufficient information is supplied, or where the request for funding does not meet internal policy criteria, the request is referred to an Individual Patient Commissioning Panel. There is also opportunity for further information to be sought from the instigator of the request. Following the decision of the Individual Patient Commissioning Panel, the instigator of the request (most frequently a hospital consultant acting on behalf of the patient) will be informed. If the referring clinician or patient disagrees with the Individual Patient Commissioning Panel's decision, a review of that decision may be sought under Individual Patient Commissioning Review Procedures.
- 9.4 If, however, there does not exist a precise policy which addresses the details of the funding request there are internal processes which consider whether an appropriate policy should be formulated by means of which determination of the request may subsequently be made.
- 9.5 Health Commission Wales has also established a Mental Health Panel separately to consider all cases involving requests for treatments of patients with mental health problems.
- 9.6 In August, 2006 a report of an internal audit on Individual Patient Commissioning undertaken by the Welsh Assembly Government's Internal Audit Services was satisfied that controls over Individual Patient Commissioning requests in most respects were effective. The report also noted that Health Commission Wales, at that time, had comprehensive guidance in place in respect of Individual Patient Commissioning and review processes, which was available to all key interested parties. At that time the internal audit report found that commissioning policies had been established for eight out of 40 areas. Information provided to this review indicates that there are now 24 established policies. At the time when the internal audit was undertaken no external reviews had been executed. An External Review Panel was then in the process of being set up. The first meeting of the External Review Panel took place in September 2006.

9.7 The Review Procedure states:

*“As a consequence of the finite resources available, it is necessary to determine healthcare priorities as part of the commissioning process. Health Commission Wales is under an obligation to consider the reasonable requirements of patients across Wales for such services and to make judgements about the amount of resources that can be made available to meet these requirements. Health Commission Wales will not unfairly discriminate between patients, nor will it have “blanket bans” not to treat particular conditions, but it will not be possible to provide funding for every health need for which it has commissioning responsibility. Therefore the individual circumstances for each case will have to be considered alongside clinical effectiveness, cost effectiveness and affordability.”*

9.8 Moreover the Review Procedure places emphasis on the requirement for transparency and consistency in the decision making process and makes it incumbent on decision makers that they have followed due process and have been rigorous and fair in arriving at their decisions. The Review Procedure must therefore ensure that proper procedures have been followed; that decisions under Individual Patient Commissioning agreements fully consider all the relevant facts and arguments; and that decisions are clearly communicated.

9.9 An internal review conducted by the Individual Patient Commissioning Panel may be requested in two cases. The first is where it is judged that there is additional information which may alter

the original decision of the panel. The second is where there are overriding exceptional personal circumstances which may influence the decision to approve the patient’s access to the specialised healthcare treatment or services. The Individual Patient Commissioning Panel will review the funding request in the light of all available evidence and existing policies.

9.10 An External Review Panel can be convened and asked to review a decision where there is no additional information or supplementary evidence but the case is made that the earlier first tier decision had been reached without a full consideration of all the relevant facts and arguments. Dissatisfaction expressed by the instigating clinician or the patient with an outcome of an internal review may also be referred for further review by the External Review Panel.

9.11 The Public Service Ombudsman for Wales (2007) describes the External Review Process as follows:

*“The review procedure sets out that the External Review Panel will consist of three lay members. The External Review Panel will receive all documentation in relation to the review prior to the Panel meeting and will be able to request the attendance of HCW officers and request additional independent clinical advice taking into account the range of needs of the individual and the evidence of clinical efficacy and cost effectiveness in each case.”*

*“HCW’s review procedure stipulates that it will be the role of the External Review Panel to consider whether HCW followed rigorous and robust*

*processes in coming to a decision about the patient accessing funding for the requested treatment. Following its consideration of the request the External Review Panel can either uphold the original decision of the Panel, or decide not to uphold the original decision and recommend to HCW's Chief Executive that the case should be reconsidered by HCW taking into account the specific points raised by the Panel."*

- 9.12 However, the External Review Panel is not empowered to change the earlier decision. That can be effected only by the Chief Executive Officer or another person within Health Commission Wales who has been empowered to make such changes on behalf of the Chief Executive Officer. In essence, the External Review Panel can:
- Advise the Chief Executive Officer that the due process was not followed in reaching their decision about the patient's accessing funding for specialised healthcare treatment.
  - Consider the initial decision but were not empowered to substitute a different decision if they felt that the initial decision was flawed.
- 9.13 The remit was confined to referring the matter back to the Chief Executive Officer. The External Review Panel is primarily restricted to a consideration of the papers and information upon which the Individual Patient Commissioning Panel had based its decision. This external review process was designed with input from the office of the Public Service Ombudsman and other stakeholders including a representative of the Board of Community Health Councils.

9.14 A report by the Public Service Ombudsman for Wales published in October 2007, relating to his investigation of a complaint against the Welsh Assembly Government (Health Commission Wales), questioned the quality of the Individual Patient Commissioning Panel's decision making in this particular case. The Ombudsman considered that relevant considerations had not been taken into account by the Individual Patient Commissioning Panel which he regarded as maladministration and that in the particular circumstances of the investigation in question, the internal review Individual Patient Commissioning Panel had failed to address reasonable arguments advanced by the complainant (Peat 2007).

9.15 However, this review acknowledges that this criticism of Health Commission Wales relates to one specific case. It does not imply that there is a more general problem with decision making in the Individual Patient Commissioning processes executed by Health Commission Wales. Out of the 7,298 cases referred under Individual Patient Commissioning procedures from 2003 to March 2008, 38 have gone for external review and there have been five cases referred to the Public Service Ombudsman for Wales.

### Exceptionality

9.16 Health Commission Wales recognise that even though a patient may not meet the commissioning criteria there may be circumstances that are of an exceptional nature. This might mean that an individual patient should be treated outside the existing policies formulated by Health Commission Wales.

9.17 Health Commission Wales, in describing its consideration and interpretation of “exceptionality”, is quoted in the Ombudsman’s report:

*“Exceptionality, by its very nature, cannot be defined but the individual’s referring consultant will need to demonstrate to Health Commission Wales that the patient merits exceptional funding. In this context, ‘exceptional’ will mean the need for the individual’s clinician, not only to demonstrate how the patient differs from others with the same condition, but the clinician will also have to provide evidence to Health Commission Wales that she is likely to derive greater benefit from the treatment/investigation as compared to those other patients who might also benefit, but will not currently be offered the treatment/investigation under Health Commission Wales’ existing policy.”*

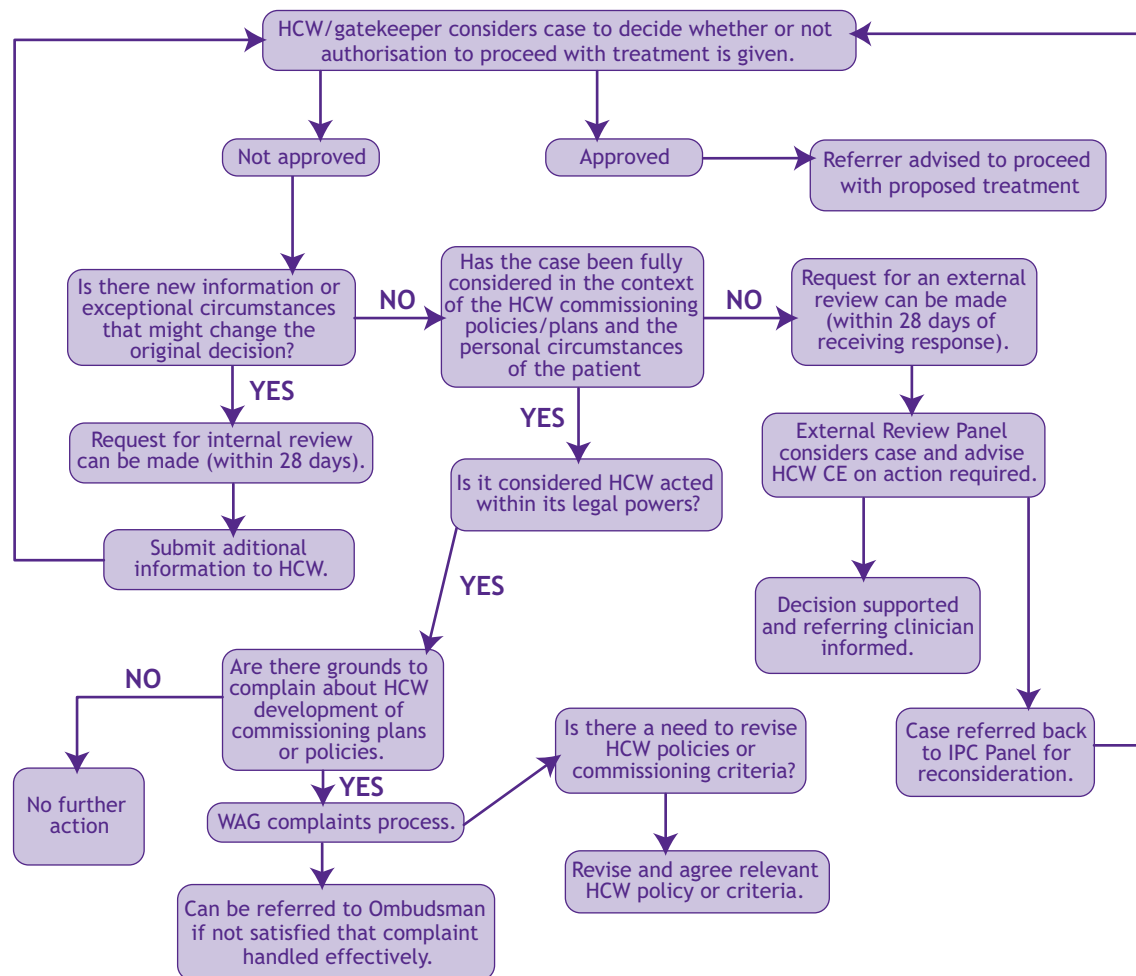
9.18 The Ombudsman also recommended that the Welsh Assembly Government ensures that it is made clear to members of the External Review Panel that they are able to refer any decision that they believe to be irrational, procedurally flawed or otherwise unfair back to the Chief Executive Officer of Health Commission Wales for review. This review however, accepts that the remit of the External Review Panel did permit the panel to refer an initial decision back to the Chief Executive Officer with advice.

9.19 Evidence presented by the External Review Panel in the Ombudsman’s case demonstrates that this was done but not accepted by the then Chief Executive Officer.

9.20 Although policies allow consideration of exceptional circumstances there is a general need to develop broad guidance to assist in the interpretation of what constitutes exceptionality by the Individual Patient Commissioning or External Review Panels. It is, however, understood by this review that it would be difficult to define exceptional circumstances as not every circumstance could be contemplated. Moreover, the customary definition of “exceptional” denotes that it includes the unusual, extraordinary and unexpected. However, other commissioners, such as the Vale of Glamorgan Local Health Board (2002), have provided evidence of broad guidance of criteria for consideration of exceptionality:

- Where new scientific or medical evidence would support application of an exemption
- Where old (weak) scientific evidence which has been reanalysed (and hence strengthened) would now support application of an exemption
- Where the cost effectiveness of care has improved significantly
- Where NHS treatment would be provided in all (or almost all) other parts of the UK
- Where a National Service Framework recommends care
- Where an individual is reclassified to a category into which they did not previously fall and as a result of this change it is perceived that care would be more likely to be effective
- Where an individual’s circumstances demonstrate that clearly linked clinical benefit or more appropriate and effective care would result.

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- 9.21 There are different legal interpretations of what is meant by exceptional circumstances. This is a most complex matter open to different qualifications and definitions. Attempts to facilitate its meaning and the application in context, such as provided by the Vale of Glamorgan Local Health Board (2002), must be encouraged.
- 9.22 The Individual Patient Commissioning Panel, until very recently, consisted of the following members:
- Director of Finance (Chair)
  - Tertiary Referral Centre Manager (Deputy Chair)
  - Medical Director or Deputy Medical Director
  - Specialist Commissioner
  - Specialised Commissioner or Assistant to present each case
  - Individual Patient Commissioning Administrator
  - The Clinical Governance Manager
- 9.23 There is also the Mental Health Panel which is chaired by the Director of Finance. The Medical Director, Senior Commissioner and Strategy Manager also attend.
- 9.24 The chairing of such a panel by an Officer who also performs the role of the Director of Finance within the organisation, is regarded by the review as inappropriate for the future. The exceptional reasons given by Health Commission Wales for this particular arrangement were that the personal qualities of the Director of Finance best suited him for this role. There was a lack of comparable expertise in the organisation. It is evident that he does have knowledge and expertise of the commissioning process and policy development, and is highly committed to Health Commission Wales. The review accepts that the Director of Finance undertook this role with complete integrity and ensured that cases were well discussed in reaching a particular view.
- 9.25 However, stakeholders have commented that the Director of Finance chairing the Individual Patient Commissioning Panel could be perceived as reflecting tight financial control over a process which should consider issues such as eligibility, assessment of need and effectiveness. The review understands the position in which Health Commission Wales found itself but it recommends for the future, that it is an inappropriate function to be performed by an Director of Finance in that role.
- 9.26 The flowchart depicts the Individual Patient Commissioning Panel, review and complaint procedures.



9.27 The flowchart is difficult to follow and it mixes up the review procedure with complaints and policy procedures.

9.28 The system for dealing with Individual Patient Commissioning requests that has since evolved is viewed as complex by many, not well understood by patients, and still consumes a disproportionate amount of Health Commission Wales’ human and financial resources. Interview records suggest that it is the Individual Patient Commissioning process which places most pressure on Health Commission Wales staff. The Individual Patient Commissioning process costs approximately £12million in patient care and occupies 25% of the time of the specialised commissioners and Medical Director.

9.29 The review received evidence from a number of patients and NHS stakeholders of the significant delays in receiving decisions from Health Commission Wales in respect of the Individual Patient Commissioning process. There were examples of delays spanning many months and the consequential effect that this has had on patients. There was also considerable pressure on Health Commission Wales’ staff in dealing with the complexity and volumes of Individual Patient Commissioning cases given the very limited staff resources.

9.30 Health Commission Wales does not routinely communicate directly with patients. It is, of course, appropriate to inform the person who made the

referral, thus Individual Patient Commissioning decisions are usually communicated to the referring clinician and copied to all parties involved in the referral process, including the patient's Local Health Board.

9.31 Health Commission Wales only communicate with patients when patients contact them directly; usually when the panel declines funding and the case consequently escalates to a review or beyond. Patients have commented that letters they have received from Health Commission Wales are just standard letters, extremely blunt and in no way explain why or how the decision was made.

9.32 Particular concerns were expressed about the lack of patient involvement in the Individual Patient Commissioning process as a whole, but particularly at the review stage. It may be argued that patients, or their representative, should be allowed to be present at external review when their cases are heard. As with all decisions made *in camera* this leaves the decision making process potentially vulnerable to challenge by means of Judicial Review.

9.33 The review has identified that the Individual Patient Commissioning process has a number of other limitations and weaknesses:

- Consideration is against existing policy even if the policy development in some cases is of variable quality
- Case representation is often difficult particularly when commissioners are out of the office or on annual leave
- The system is little understood by patients and others not familiar with the processes

- There is no process for appeal to an independent body. The review process is unclear to many stakeholders and patients
- The minutes of IPC panels rarely record more than the outcome and rarely the discussion or reason for the decision
- The External Review Panel was not established until September 2006
- There is no evidence that minutes of the External Review Panel are recorded
- The complaints procedure is that of the Welsh Assembly Government and is not designed for reviewing decisions in relation to individual patient commissioning in the context of a separate tier of the decision making processes.

9.34 David Lock, an acknowledged legal authority, in a recent commentary has given his opinion on the minimum standards for policies for commissioners (2007):

- Save in an emergency, rationing decisions should be made in accordance with clear written policies, specifically adopted and reviewed regularly.
- Policies should be as specific as possible and set up the tests to consider in order to decide which patients should and should not get specified treatment.
- The procedures for individual cases should include consultation with clinicians, patients, parents (in the case of children) and affected family members.
- You can have blanket bans. They are not unlawful.

- 
- If you do leave the exceptional case or exceptional clinical grounds exemption, make sure (a) you say it's on resources grounds, and (b) you decide if social factors are in or out.
- 9.35 Admittedly this is but one view, albeit from an acknowledged legal authority. Several of the points raised are generally reflected in the system that Health Commission Wales operates.
- 9.36 The lack of written guidance on the process for policy development, lack of stakeholder engagement, and lack of guidance on considering individual cases and exceptionality is of great concern. Furthermore, appeals cannot be made against a decision or policy; appeals can only be made against the process followed. The review has found that processes are not open to scrutiny and are not transparent.
- 9.37 Procedural documents provided by a Local Health Board show that appeals can be made against decisions made as well as the process of how decisions were made. The Appeal Panel has the restricted role of hearing appeals that fall into one or more of three strictly limited grounds upon which interested parties may appeal. An appeal on any other ground will not be considered (Vale of Glamorgan Local Health Board, 2006).

# 10. Learning and Growth

10.1 Learning and growth addresses the organisational development and personal development needed to support and achieve the strategic objectives and to inform the strategic direction of Health Commission Wales.

## Recruitment, retention, training and occupational health issues

10.2 Health Commission Wales' difficulties in recruiting and retaining staff have been highlighted earlier in this report. Being unable to make permanent appointments and having to rely on the Welsh Assembly Government system of employing agency staff on 40 week contracts has undoubtedly caused Health Commission Wales considerable difficulties. This impacts on business continuity and adds to the stress of the remaining staff. Health Commission Wales' management have commented on the critical problems caused by the staffing position and quoted examples where posts in whole teams have been vacant, most notably the Individual Patient Commissioning team. Health Commission Wales' staffing position as at December 2007, helps illustrate the problems faced by management:

Substantive	21 (39%)
Agency/fixed term	12 (22%)
Vacant	11 (20%)
Secondees	9 (17%)
Interim	1 (2%)
<b>Total Posts</b>	<b>54</b>

10.3 In reviewing the findings, the review acknowledges that there was clear evidence of a passion, belief and desire by the staff to deliver specialised services. If this was not consistently applied, it was entirely due to the constraints on the organisation. Many staff carried a heavy emotional burden as a consequence.

10.4 The numbers of Health Commission Wales' staff who volunteered contributions and evidence to this review (63%), together with a staff union's submission (submitted on behalf of all staff), further demonstrates their willingness, desire and commitment to provide a good service for patients.

10.5 This commitment, however, seems to have come at a price. There is evidence of staff consistently working long hours and although, there is very little sporadic sick leave, the Occupational Health Service of the Welsh Assembly Government had in total 15 consultations involving several staff who had suffered extended periods of stress related sick leave. Mental health issues dominated discussions with the Occupational Health Service and there is a frustration from staff that Health Commission Wales been unable to address the root cause of these issues - notably progress recruitment more rapidly - although they have implemented phased return to work and support in the workplace. It is understood that these issues have been identified and recorded on the Risk Register of Health Commission Wales.

10.6 There is evidence that the Welsh Assembly Government's Occupational Health Service had identified many concerns in regard to the staff of Health Commission Wales. These include stress and anxiety, recruitment, staff turnover, working long hours, covering sickness absences, absence of performance plans, blurred roles, lack of support from line managers, increased delegations and bullying behaviours. Evidence of staff worrying about individual patients has also been presented to the review. Members of the Human Resources

Department, which included the Occupational Health team, had worked closely together in an attempt to resolve these issues. Focus groups were offered to staff but none were taken up.

- 10.7 Staff consider that their workloads are often too high to accommodate time for training. They reported that access to training was varied with most requests for training being self motivated, opportunistic and not necessarily linked to personal targets.
- 10.8 Although short training sessions were provided by the Welsh Assembly Government in Cardiff, some staff felt this was inconvenient due to the time spent travelling and work building up in their absence. Though these issues were often seen as a disincentive to attend, where training was accessed from the Welsh Assembly Government, staff felt it was of a very high quality.
- 10.9 Staff induction varied considerably. A shortage of staff in Health Commission Wales trained in recruitment interviewing created obstacles to filling posts.
- 10.10 There is no recognised vocational training route for commissioners in Wales. The National Leadership and Innovation

Agency for Healthcare has recently introduced a sponsored module on commissioning and three staff from Health Commission Wales have accessed it. However, commissioning requires competency in a wide range of skills and the lack of general training in base line skills was of concern to the review. It is important to ensure that all commissioning staff have access to training in the full range of commissioning skills.

- 10.11 Health Commission Wales has Investor in People accreditation, although it is understood that the accreditation is that of the Welsh Assembly Government. Health Commission Wales itself does not appear to have been separately audited by Investor in People assessors.
- 10.12 Staff in Health Commission Wales are invited to take part in the Welsh Assembly Government’s annual staff survey. Part of the results from the 2006 survey which relate specifically to Health Commission Wales are shown in Tables 1 and 2 below. It is understood that 13 people from Health Commission Wales participated in the survey, giving a response rate of 30%.

Table 1: Health Commission Wales Staff Survey 2006

I believe I offer a high standard of service to our customers and to the public	90% favourable
I am proud to work for the WAG/Assembly Parliamentary Service	90% favourable
I have been not been subject to discrimination in work during the past 12 months	89% favourable
I enjoy my work	80% favourable
I am not subjected to unacceptable behaviours at work	78% favourable

Table 2: Health Commission Wales Staff Survey 2006

Good leadership is developed at all levels of the organisation	0% favourable
The organisation as a whole is well managed	10% favourable
Poor performance is dealt with effectively where I work	10% favourable
My division encourages me to seek feedback from our customers on the work that we do	11% favourable
My team is well managed	11% favourable

- 10.13 The results appear to indicate that the staff enjoy their work, are happy working for Health Commission Wales and/or the Welsh Assembly Government and believe they do a good job. The results however, also suggest that the staff who responded are extremely dissatisfied with the leadership and management, although it is not clear whether this relates to management in Health Commission Wales, the Welsh Assembly Government or both. The 2008 staff survey has been recently produced but the review has not been able to analyse the results fully.
- 10.14 The staff survey does seem to support evidence provided by staff during this review. Staff report that there is a good team spirit among the staff but they can often feel isolated and frustrated as a whole.
- 10.15 Other concerns raised by staff included the limited recognition of achievements on both a personal and organisational level, and the lack of capacity to communicate the successes of the organisation. Staff also expressed concern over the fractured lines of commissioning, resulting in patients becoming trapped between the responsibilities of Health Commission Wales and Local Health Boards. A positive comment was that the directors were supportive and operated a well received and well used 'open door policy' to all staff.
- 10.16 The review found Health Commission Wales has staffing levels which fall well below those which would enable it to deliver fully and effectively its commissioning role for specialised and tertiary services in Wales, and the full range of allied activities pertinent to that role.
- 10.17 There is evidence that Chief Executive Officers of Health Commission Wales have repeatedly raised with officials of the Welsh Assembly Government the inadequacies of staffing levels, the pressures under which staff have to work, vacancy levels and recruitment problems. Admittedly the Welsh Assembly Government itself, and particularly the Department for Health and Social Services, are no less burdened by having to make difficult decisions on financial grounds, to wrestle with priorities and to allocate funding in as equitable a manner as possible. The effective planning and funding of specialised and tertiary healthcare services must give due

regard to the magnitude and complexity of this most sensitive and essential undertaking.

10.18 The low level of administrative funding from the Welsh Assembly Government is partly responsible for the significant pressures on Health Commission Wales staff. Additional resources for Health Commission Wales have been provided by the Welsh Assembly Government as described in other parts of this report. However, these additional allocations largely focused on the provision of funds for new or enhanced services to be commissioned by Health Commission Wales. It has not been possible to identify any allocation of additional resources provided specifically to address staff and staffing related difficulties with the exception of the finance section. Very recently the review has been informed that Health Commission Wales has created additional resources for staffing including the Nurse Director.

10.19 It is understood by this review that the spend on staff by Health Commission Wales represented only around 0.4% of its budget allocation. Additionally, the demands on staff capacity caused by the evidently unanticipated volumes of referrals under the Individual Patient Commissioning process have aggravated the situation. They have imposed considerable burdens on staff and management at Health Commission Wales.

10.20 The review noted one other matter relating to learning and growth. The Specialised Health Services Commission for Wales, which provided the specialist commissioning services prior to Health

Commission Wales being established, provided a legacy document which outlined mistakes it had made and lessons it had learned. This was designed to assist Health Commission Wales in taking forward the commissioning specialist services role in Wales. Lessons learned included the need:

- For clinical networks
- For the designation and/or accreditation of specialised services
- To work collaboratively with the National Specialist Commissioning Advisory Group
- To establish and maintain close working relationships with English commissioners and providers
- To establish and maintain close working relationships with commissioners and providers in Wales
- To communicate with and listen to users
- To work closely with non NHS Agencies e.g. local authorities, social workers, the criminal justice system, prisons, the police, Home Office, Department of Health, charities and pressure groups
- To take account of the advice of all stakeholders and to involve them in the commissioning process.

10.21 There is evidence of good practice in many of these areas. However, the organisation has been constrained within its financial and governance arrangements. As a result it did not possess the flexibility or resources to address fully some of the areas for reasons we have described earlier in this report.

# 11. Conclusions

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- 11.1 The investigation carried out, in undertaking this review, has of necessity become a wide ranging inquiry to fully address the terms of reference. In this context the conclusions are inevitably broad ranging in nature.
- 11.2 Fundamental problems exist for Health Commission Wales as a result of faults in the way it was established. Although established as an Executive Agency the organisation falls short of the orthodox governance arrangements. Most notable is the absence of a management board with an independent Chair and non executive directors to provide effective support and challenge. The process of establishment failed to utilise fully the experience gained from the operation of Specialised Health Services Commission for Wales.
- 11.3 As a result of the governance arrangements senior management of Health Commission Wales were substantially constrained in their ability to operate effectively.
- 11.4 Health Commission Wales is fully subject to Welsh Assembly Government procedures though they are expected to fulfil all the necessary functions of a commissioning body. Audit and clinical governance arrangements have been established but it does not have a management board with non executive directors on whom to call and sit on a properly constituted Audit Committee. A question is therefore raised about the degree of assurance that can be given by its Audit Group to all aspects of risk management, governance and internal control processes.
- 11.5 The failure at its inception to adopt orthodox corporate governance arrangements expected of an Executive Agency constrained its ability to engage with a high number and wide range of healthcare providers and stakeholders, and limited its ability to establish sustained relationships with them.
- 11.6 The resource mapping exercise undertaken by the Welsh Assembly Government to identify a budget for Health Commission Wales was unsound and based on a rushed, flawed and fragmented process. The schedule of services was poorly defined to assist this process. The resources, where identified, were top sliced from Local Health Boards' budgets and not risk pooled. Where they were not identified in this process, the budgets remained with Local Health Boards although the duty to commission the services rested with Health Commission Wales. The funding mechanism lacked legitimacy for that reason and was perceived as such by Local Health Boards.
- 11.7 The incomplete resource mapping exercise was identified early on as an issue by the Welsh Assembly Government and efforts were initiated to address and complete the process. This was not satisfactorily completed and has left some Local Health Boards in a position of commissioning these services by default, still holding the budgets, in a situation where they may not possibly have the delegated power to do so. From these initial failings flowed many of the consequent problems experienced by Health Commission Wales.
- 11.8 The budget allocation for Health Commission Wales was therefore unsound and inadequate and almost certainly led to the mismatch between

funding and responsibilities. The boundary between the commissioning roles of Health Commission Wales and Local Health Boards is unclear and has led to conflict. These fractured lines of commissioning compromise the best interests of patients. It is imperative that patients can move easily along pathways of care between Health Commission Wales and Local Health Boards. In many instances this is not being achieved.

11.9 Some disquieting findings consequent to these fractured lines of commissioning across Health Commission Wales and Local Health Boards relate to services provided for patients with eating disorders and the experience of patients between medium secure and low secure mental health facilities.

11.10 There is a lack of community and secondary support services in Wales for patients with eating disorders. Local Health Boards are responsible for commissioning these services which are evidently inadequate. Health Commission Wales policy limits access to specialised services for those patients who are most severely undernourished. When such patients have accessed these specialised services and respond with a gain in body mass index they may fall outside the criteria set by Health Commission Wales and are discharged to the community. This deficiency in local services must be viewed with concern.

11.11 When patients accommodated in medium secure forensic mental health facilities, commissioned by Health Commission Wales, have improved and are ready to step down to low secure

care, which is the responsibility of Local Health Boards, there are often insufficient places locally available to accommodate them. Consequently patients may be kept in medium secure accommodation, often far from home, for far longer than necessary. These delays raise vital questions about whether there has been appropriate recognition of patients' rights and, indeed, possible breaches of the Human Rights Legislation. The financial cost is borne by Health Commission Wales who confirm that this has been a major cause of their overspend.

11.12 The governance arrangements of Health Commission Wales are different to all other specialised commissioning arrangements in the UK. In particular, other specialised commissioners are part of the NHS and have clear governance through management boards with independent Chairs and non executive members. Finances are negotiated and pooled from primary care organisations for the provision of agreed, clearly defined services and outcomes.

11.13 Given that Health Commission Wales labours under the burden of inadequate staffing levels and its national remit, it has limited capability to establish effective relationships with all of its providers and stakeholders. The communication and engagement with stakeholders is thus inadequate for an organisation with such important responsibilities and accountabilities. There are examples of sound engagement and good practice, although not always consistently applied. Communication is generally more responsive than proactive. Only

recently has a public and patient engagement policy been developed. There is evidence that Health Commission Wales was not fully consulted by all Local Health Boards in the development of their services and policies - yet another example of fractured lines of communication and commissioning embedded in the system.

- 11.14 There is a lack of clarity about leadership. In particular the extent to which it rested with the Welsh Assembly Government, Chair of the National Commissioning Advisory Board or the management of Health Commission Wales.
- 11.15 The heavy volumes of referrals for Individual Patient Commissioning were sadly unanticipated. The consequent financial burden on Health Commission Wales is around £12million per annum and consumes 25% of staff resources. There is clearly inadequate process and capacity for Individual Patient Commissioning. These processes are not sufficiently transparent, easily understood by stakeholders or accessible to patients or clinicians. The External Review Panel is not empowered to change an earlier decision as it can only advise on adherence to due process and refer a decision back to the Chief Executive Officer for reconsideration. Furthermore, there is no process by which the validity of policies can be challenged. All decision making in the process rests with the Chief Executive Officer who is also constrained by the requirement of Welsh Assembly Government to achieve financial balance. The process is potentially vulnerable to legal challenge by means of judicial review.
- 11.16 Health Commission Wales staff have shown extraordinary tenacity over the years since its establishment. Their commitment, loyalty, dedication and industry are clearly evident, though there has been a serious lack of structured and consistent appraisal and personal development of staff throughout the organisation. This is evident to many of their stakeholders.
- 11.17 An insubstantial level of administrative funding and the need to adhere to the Welsh Assembly Government's employment processes have put staff under considerable stress and personal anxiety. These issues have been raised by the Welsh Assembly Government's Occupational Health Service with colleagues in the Human Resources Division. This was also a concern of Chief Executive Officers of Health Commission Wales who had discussed these matters with the Department of Health and Social Services. There is a lack of evidence that these issues have been adequately addressed.
- 11.18 Planning, developing, contracting and reviewing health services require a broad skill base for commissioners and specific expertise to support their role. There is a general paucity of vocational training in this field. This should be rigorously addressed by the Welsh Assembly Government. It was noted that the National Leadership and Innovation Agency for Healthcare had recently introduced a sponsored module on commissioning. A small number of Health Commission Wales staff had enrolled on this model. This is a positive start in addressing this gap.
- 11.19 Emphasis was given by the Welsh Assembly Government to the

requirement that Health Commission Wales had to live within its allocated budget and to repay over £30million of an overspend. This inevitably led to difficult choices having to be made by Health Commission Wales. Pressures on Health Commission Wales, its restricted financial position, proposals for investment, priorities and efficiency savings featured prominently in discussions with the Welsh Assembly Government in the development of Commissioning Plans. The final decisions about funding issues rested with the Minister for Health and Social Services whose priorities have then to be implemented by the Chief Executive Officer of Health Commission Wales. The direct relationship with the Minister and her officials and the accountability processes to which the Chief Executive Officers had to adhere are not applicable to NHS bodies such as Local Health Boards where there is statutory separation and no requirement for personal Ministerial approval of Commissioning Plans.

11.20 The Framework Document for the establishment of Health Commission Wales set out the process for developing strategy and commissioning plans. This process was unworkable. Health Needs Assessments prepared by Local Health Boards do not address requirements for the specialised services to be commissioned by Health

Commission Wales. The lack of expertise available to Local Health Boards in this area obliged Health Commission Wales to formulate strategies and develop plans for specialised services in consultation with Regional Stakeholder Panels. The Framework Document was therefore flawed and has not been subsequently amended to address the disparity in expertise and knowledge of specialised services between Health Commission Wales and Local Health Boards.

11.21 To meet the justifiable healthcare needs of the people in Wales, due regard has not been given to the extent and nature of funding to meet the magnitude and complexity of commissioning specialised and tertiary healthcare services. Additional allocations and strategic assistance had been provided to Health Commission Wales by the Welsh Assembly Government. These were largely focused on the provision of funds for new or enhanced services to be commissioned by Health Commission Wales. They did not provide a remedy for unanticipated increased expenditure by Health Commission Wales to meet the burgeoning costs associated with the Individual Patient Commissioning process or the prolonged unnecessary maintenance of patients in medium secure forensic mental health facilities.

## 12. Recommendations

### Organisational, governance and financial arrangements

- 12.1 There is a clear need for specialised and tertiary services to be planned and funded at a national level. The role and functions of Health Commission Wales could usefully come together under an all Wales NHS umbrella organisation. On 2 April 2008, the Welsh Assembly Government issued a consultation paper on proposals to change the structure of the NHS in Wales. Proposals include abolishing the internal market by providing for the planning and funding of health services in Wales either directly from the Welsh Ministers or via a separately constituted National Health Service Board for Wales (the National Board). Three options are offered as models for establishing the National Board: Special Health Authority, a Civil Service Board, or an Advisory Board supporting a Welsh Assembly Government Chief Executive.
- 12.2 Were the selected model to be a Special Health Authority this would provide a suitable setting for locating the planning and funding of those tertiary and specialised healthcare services which require to be delivered at the national level.
- 12.3 Any other future organisational arrangements must ensure that an all Wales approach to planning and funding these specialised healthcare services should secure an appropriate level of statutory separation and the governance characteristics that would protect that arrangement. Particular attention would need to be given to recommendations 1 to 6, and to ensure that the existing support for NHS Wales in this area is not significantly disrupted.
- i To ensure effective planning and contracting for specialised services in Wales, Health Commission Wales should be replaced with a truly arms length organisation (hereafter referred to as the organisation) having the governance characteristics which provide for appropriate statutory separation. It should have a clear remit, sufficient and expert permanent staffing and a budget subject to regular review. This budget should be calculated on proper costing of the role and functions the organisation is expected to deliver to meet the justifiable healthcare needs of the people in Wales. Due regard must be paid to the extent and nature of the financial resources needed to address the magnitude and complexity of planning and funding specialised and tertiary healthcare services in Wales.*
  - ii In the allocation of a new budget the organisation should not be burdened with any overspend of predecessor organisations.*
  - iii The schedule of specialised services should be regularly strategically regularly reviewed to effect horizon scanning, innovation and mainstreaming of services as appropriate.*
  - iv There should be a clear budget strategy to meet the schedule of specialised services. Accurate baseline costing is essential with recognition that healthcare inflation considerably exceeds national inflation (Retail Price Index). A system should be*

*adopted which possesses the advantages brought by risk-pooling resources or an approach that delivers the same benefits.*

- v *When establishing new structures or reorganising existing structures it is imperative that there must be full stakeholder consultation.*
- vi *The transparency of the organisation's internal business processes should include formal board meetings held in public with published minutes. It should also publish an annual report that includes an accessible account of its achievements and performance, including comparison with other relevant organisations.*

### Specialised services at a national and local level

12.4 Whatever arrangement is selected on the way NHS Trusts and Local Health Boards are required to cooperate together effectively, serious consideration should be given to revisiting the wide range of specialised services commissioned at the national level.

12.5 A consensus should be reached on the definition for specialised service. This should be regularly updated and reviewed. A revision of the schedule of specialised services should identify precisely, those which can be devolved and included in the proposed revised planning system for the NHS in Wales that will replace the current commissioning framework.

12.6 Several existing specialised services are virtually already considered as mainstream delivery of hospital

services. It is acknowledged that the schedule was greater than necessary and that only some services needed to be commissioned at national level. Such an arrangement will strengthen the responsiveness of the NHS to local experiences of healthcare delivery and the needs of the local populations.

12.7 This will encourage planning at the local level and secure more adequate provision of services closer to the patient.

vii *The schedule of specialised services should be urgently revisited to identify those services that can be devolved to a local level and be included in the proposed revised planning system for the NHS in Wales. This will replace the existing commissioning framework. Furthermore, it will release capacity and expertise at the national level to focus more closely on emerging treatments, technologies and their evaluation along with greater freedom to engage more fully with a wide range of healthcare providers and stakeholders.*

viii *The national organisation planning, funding and contracting of specialised services should have, as a high priority, a comprehensive communication strategy. This must secure transparency in policy and decision making to inform patients' expectations and enable patients and other stakeholders to feel they are being treated fairly.*

ix *The system should ensure that patients can expect timely, high quality and transparent decision*

*making and management of complaints. The organisation fulfilling these functions should have processes and monitoring mechanisms to ensure the standards are being met.*

- x It should be recognised that due to the nature of some healthcare needs, effective treatments cannot always be provided in Wales. For the foreseeable future there will be a continuing need for the provision of such services by providers outside Wales. Citizens in North East Wales, in particular, are highly dependant on relationships with healthcare providers in North West England.*
- xi The organisation should work with service providers and other Specialised Commissioners in the UK to set standards, benchmark services, improve quality and effectiveness and reduce duplication of effort. This work should include horizon scanning and timely evaluation of new and evolving treatments.*
- xii In supporting this and recognising an arrangement that has worked well in food safety and health and safety at work (i.e. Home Authority Principle for food safety of national manufacturers and the Lead Authority Partnership Scheme for Health and Safety at Work), it is recommended that a similar arrangement be explored in the UK for the evaluation of providers of specialised healthcare services.*

## **Internal business processes and staffing**

- xiii To allow scrutiny and challenge of funding, policies should be published with the evidence on which they are based. Consideration should be given to using a system of policy development similar to that used by the All Wales New Medicines Strategy Group. This allows evidence to be presented from different stakeholders in a public forum and includes a transparent and timely appeals process. This balanced policy process should be based on properly founded evidence, priorities and criteria for consideration of exceptionality. An Ethical Framework for commissioning health services to achieve the Healthcare Standards for Wales is now available with substantive principles to assist in this process (Welsh Assembly Government 2007).*
- xiv Decisions must be based on evidence, made in a way which patients understand and be underpinned by an open and transparent review and independent appeals process.*
- xv The new organisation must have the capacity and competence to fulfil its remit with a majority of permanent, as opposed to agency, staff, selected for their experience and expertise, who are properly trained for their role and benefit from regular appraisals.*

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- xvi The internal communication strategy should be fully reviewed in consultation with staff, to ensure effective, timely and reciprocal communication within the organisation.*
  - xvii A rigorous process should be instituted for effective monitoring of quality and health outcomes underpinned by clinical audit and comparative datasets.*
  - xviii A vocational training programme should be introduced to ensure a minimum skill set in the planning and contracting for specialised services in Wales.*

### **Individual Patient Commissioning Appeals Process**

- xix A separate all Wales system should be introduced for appeals dealing with individual patient requests for specialised and tertiary services or new and emerging treatments. This should be a stand alone organisation - Individual Patient Independent Appeals Board - with a national remit, entirely independent from the planning and funding role. This Individual Patient Independent Appeals Board would be serviced by a secretariat and*

*administration team drawn from the National Board, irrespective of which model is finally selected. Within the board requests should be considered by a panel of independent experts and citizen representatives, appointed by the Minister for Health and Social Services.*

- xx An appeal process that considers the basis of the initial decision and the process by which it was achieved, should be introduced immediately. The appeal panel should be independent of the NHS and Welsh Assembly Government and its decisions binding upon it. The appeal panel should have the power to revise or amend the original decision. The composition of the panel should include legal, clinical and lay representation, at the minimum. Patients should be able to represent themselves or be represented at the appeal hearing.*
- xxi The budget for Individual Patient Commissioning should not be fixed; rather a floating budget should be introduced, underwritten by the National Board.*

# Appendix 1

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## Terms of Reference for the Review

The initial terms of reference was as follows:

1. To review the existing role and functions of Health Commission Wales, with particular reference to the mechanisms used to determine the health care treatment for individual patients who:
  - a. Require very specialised care; or
  - b. Where the evidence base for the care requested for an individual patient or group of patients is such that the evidence base is only partly developed and to make recommendations on any changes that are thought to be necessary.
2. To advise on the operation of an appeal mechanism which might be required as a consequence of decisions made relating to individual patients. Any appeals mechanisms must ensure that it operates in an open and transparent manner.
3. A report on the conclusions reached as a consequence of the review will be presented to Minister for Health and Social Services by the end December 2007.

Following further consideration and discussions, it was agreed by the Minister that the terms of reference should be extended to include the following aspects:

- Procedures for ensuring progressive improvement
- Ability to accommodate clinical innovation
- Comparing availability of services with other UK countries
- Transparency on all decisions and the decision making process

Because of the extended terms of reference, it was agreed that the report on the conclusions from the review should be presented to the Minister at the end of March 2008. This was subsequently extended to June 2008.

# Appendix 2

## The Independent Expert Panel

The panel consisted of the following members:

### **Professor Mansel Aylward CB MD FFPM FFOM Hon FFPH FRCP.**

Chair of Expert Panel, Chair of the Wales Centre for Health, Director of the Centre for Psychosocial and Disability Research at Cardiff University, and Royal Society of Medicine Academic Dean for Wales. Former Chief Medical Advisor, Medical Director and Chief Scientist at the Department for Work and Pensions, and Chief Medical Adviser and Head of Profession at the Veterans Agency, Ministry of Defence.

### **Dr Kevin Fitzpatrick PhD.**

National Leadership and Innovation Agency for Healthcare Partners in Healthcare, the Posture and Mobility Steering Group and Management Committee of St. David's Children Society. Former Disability Rights Commissioner for Wales.

### **Dame Deirdre Hine DBE FFPH FRCP.**

Chair of BUPA Foundation. Former Chief Medical Officer for Wales and former Chair of the Commission for Health Improvement. Past President of the BMA and of the Royal Society of Medicine, Vice President of Marie Curie Cancer Care and the British Lung Foundation

### **Mr Clifford L Jones OBE JP.**

Magistrate and lay member of Employment Tribunals Service. Former miner and Managing Director, Mine Manager at Tower Colliery, Deputy Chairman of Murrison Hospital NHS Trust, served on the council of Swansea University and Standards Committee at Merthyr Tydfil Borough Council.

### **Professor Anthony Newman Taylor CBE, FRCP, FFOM, FMedSci.**

Head of the National Heart and Lung Institute Faculty of Medicine, Imperial College and Professor of Occupational Medicine at Imperial College. Trustee of the Colt Foundation and Rayne Foundation, Chair of CODA, charity preventing Health Disease and Stroke. Former Chair of the Industrial Injuries Advisory Council.

### **Mrs Fran Targett.**

Director, Citizen's Advice Cymru, Member of the Wales Council for Voluntary Action Board, Chair of the Community Legal Services National Independent Provider Forum and the Equalities and Employment Rights Network Wales.

## Review Team Membership

Core Team:

- **Angela Jones** - Project Manager, Wales Centre for Health
- **Rebecca Firks** - Project Officer, Wales Centre for Health
- **John Morley** - Information Manager, Wales Centre for Health
- **Jan Humphreys** - Team Support Officer, Wales Centre for Health

Wider Support Team:

- **Keith Cox** - Director of Corporate Services, Wales Centre for Health
- **Joanne Menzies** - Media Officer, Wales Centre for Health
- **Chris Lines** - Head of Communications Wales Centre for Health and National Public Health Service for Wales
- **Mark Dickinson** - Director of Operations and Service Development, National Public Health Service for Wales

# Appendix 3

## Comparison of UK Specialised and Tertiary Commissioning Models

Organisational feature	Previous commissioning system
	Specialised Health Services Commission Wales
NHS	Yes
Statutory	No
Independent Board	No
Non Executives	Yes
Governance	Via HAs & Host HA
Commission on behalf of LHBs/HBs/PCTs	Yes
Budget negotiated/pooled	Yes
Schedule of services - resource mapped	Yes
Definition set & updates	Yes
Individual patient commissioning	No
Risk sharing arrangements	No
Individual patient commissioning appeal process	Via HA
Clear process for policy development	Yes
Multi disciplinary teams	Yes
Commissioning screening	No
Published annual prioritisation/report	Yes
Patient activity data available	Yes
Formal horizon scanning process	Yes
Designated specialised service providers	No
Work with clinical networks	Yes
Integrated care pathways - commissioning	No
Patient choice	No
Payment by results	No
National clinical databases	Not applicable
Audit of services	Yes
Public information on commissioning process & contacts	No
Patient and public involvement strategy	No
Overview & scrutiny/arbitration	HAs
Performance Management	HAs
Assessment of commissioning expertise	No
Profile: National targets & careers	No
Commissioner powers - safeguard	No
Competency of commissioners	No
De commissioning/ step down	No

Please refer to comments on page 25 when using this table

Current UK commissioning systems			Recommended in the Carter Review
Health Commission Wales	National Services Division Scotland	North West Specialised Commissioning Team England	
No	Yes	Yes	Yes
No	Yes	No	No
No	Yes NHS NSS	Via host PCT	No
No	Yes	Yes	No
Via WAG	Yes	Via All PCTs & Host	Yes
No	Yes	Yes	Yes
No	Yes	Yes	Yes
Limited	Yes	Yes	Yes
Yes but not updated	Yes	Yes	Yes
Yes	No	No	No
No	Yes	No	No
Yes	Via HB	Via PCT	No
No	Yes	Yes	Yes
Limited	Part	Yes	Yes
Yes	Yes	Yes	Yes
Yes/No	Yes	Yes	Yes
Yes	Yes	Yes	Yes
No	Yes (SMC)	Yes	Yes
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes
No	n/a	Yes - in progress	Yes
No	No	Limited	Limited
No	No	Yes	Yes
Not applicable	Not applicable	Yes	Yes
Some	Yes	Yes	Yes
No	Yes	Yes	Yes
In progress	In progress	Yes	Yes
Via WAG	Via HBs & NSS	Via all PCTs and Host	Yes
Via WAG	Via HBs & NSS	Via all PCTs and Host	Yes
No	No	Yes	Yes
No	No	Yes	Yes
No	Yes	Yes	Yes
No	No	No	No
No	Yes	Yes	No

### Acronyms:

HA - Health Authority

HB - Health Board

LHB - Local Health Board

NPHS - National Public Health Service for Wales

NSS - National Services Scotland

PCT - Primary Care Trust

SMC - Scottish Medical Consortium

WAG - Welsh Assembly Government

# Appendix 4

## Review Methods (Supplementary details)

1. The questions posed and the issues addressed for this review according to the terms of reference required consideration of a wide range of evidence, allied information and opinion from a substantial number and range of stakeholders, other interested parties, disciplines and literature. This required a flexible approach that was allowed to develop and consolidate as the review progressed. At the same time it was essential that a rigorous approach was adopted when it came to assessing and evaluating the strength of evidence and other data to furnish cogent and consistent findings that would form the basis of advice and recommendations to the Minister for Health and Social Services as set out in her letter to Professor Mansel Aylward CB, as Chair of the Wales Centre for Health, dated 26 September 2007.

2. The “best evidence synthesis” approach which was employed in the conduct of the review has been described in the main body of this report. This approach offered quality assurance together with flexibility and an emphasis on consistency to tackle heterogeneous evidence, opinion and complex issues relevant to the nature and process of commissioning specialised and tertiary health care services. Consistency refers to agreement, harmony and congruity of the evidence and opinions gathered from the diverse sources in documented oral and written forms.

3. The basic process was to develop and rigorously scrutinise emerging key themes and topics facilitated by adopting a balanced scorecard procedure which is described in the main body of the report.

4. A dedicated database was constructed. Interviews were recorded with the consent of interviewees. Comprehensive summaries of the interviews were prepared. These were offered to interviewees to ensure accuracy and amendment should they not accurately reflect the content of the information and opinions expressed by interviewees. The wealth of information was organised, analysed and assessed for its pertinence to the basic questions imposed by the terms of reference.

5. An evidence rating system was used for the strength of data which supported the formulation of key themes, conclusions and recommendations. The rating system adopted is illustrated in the table below.

Evidence Rating	Definition
<b>Strong</b>	Consistent and cogent findings provided by several and diverse sources.
<b>Moderate</b>	Generally consistent findings provided by fewer sources and not in discord with emerging general consensus.
<b>Weak</b>	Limited evidence provided by a single source without reasonable corroboration by the general consensus or supported from another independent and impartial source.
	Mixed or conflicting evidence providing inconsistent findings and lacking external validity.

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6. The entire material was progressively distilled into an evidence synthesis to reflect the overall balance of the evidence which would be used to address the issues and questions raised in responding to the terms of reference and formulating judgements, conclusions and recommendations.

7. To guard against subjective bias in the retrieval of data, evidence extraction and its synthesis, these

processes and evidence ratings were discussed and examined by plenary sessions of the independent expert panel. Drafts of the developing report and this final version were reviewed by members of the independent expert panel. Their feedback also contributed to the format, structure and text of the developing report and guided refinement of the final report.

# Appendix 5

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## Glossary of Key Terms

<b>Chatham House Rule</b>	<i>"When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed".</i> The world-famous Chatham House Rule may be invoked at meetings to encourage openness and the sharing of information (Chatham House, 2007).
<b>Commissioning</b>	<i>"Commissioning involves specifying, securing and monitoring services that are evidence-based, cost effective, of high quality and meet individuals' needs. It is important to distinguish commissioning from contracting. The former involves taking a long term view of demand, reviewing supply and then bringing the two together in a plan for evidence-based services to meet current and future needs on a sustainable basis. Contracting arrangements are over a much shorter time span and focus on the detail of the service to be delivered. Commissioning must therefore be led by senior managers, within agreed strategic frameworks".</i> (Welsh Assembly Government, 2007).
<b>Clinical Governance</b>	A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish.
<b>Corporate Governance</b>	Corporate governance is the way in which organisations are directed and controlled. It defines the distribution of rights and responsibilities among the different stakeholders and participants in the organisation, determines the rules and procedures for making decisions on corporate affairs including the process through which the organisation's objectives are set, and provides the means of attaining those objectives and monitoring performance.
<b>Executive Agency</b>	An executive agency, also known as a next-step agency, are parts of a government department that are treated as managerially and budgetary separate in order to carry out some part of the executive functions of the United Kingdom government, Scottish Government, Welsh Assembly and Northern Ireland Executive. Executive agencies are "machinery of government" devices distinct both non-ministerial government departments, on the one hand, and non-departmental public bodies (or "quangos"), on the other, each of which enjoy a real legal and constitutional separation from ministerial control.
<b>Health Authority</b>	The Health Authority (HA) is responsible, within the resources available, for identifying the health care needs of its resident population, and securing hospital and community health services to reflect those needs.

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<b>Home Authority Principle</b>	The importance of the Home Authority Principle is widely recognised by local authorities and central government. It provides a way for local authorities to work effectively in partnership with businesses within their local area to deliver robust and consistent enforcement and advice services across the UK. Further information can be found at: <a href="http://www.lacors.gov.uk/lacors/upload/5812.pdf">http://www.lacors.gov.uk/lacors/upload/5812.pdf</a>
<b>Lead Authority Partnership Scheme</b>	The Lead Authority Partnership Scheme (LAPS) sets out to raise the standard of health and safety management within a partner organisation or business and encourage consistency of enforcement across those LAs that engage with it. A partnership is formed between a LA (the future lead authority) and a business, organisation or intermediary group with multiple outlets across the country or a national membership. The authority works closely with that organisation to help develop and improve its health and safety arrangements and/or the guidance and advice it promotes through its membership. The lead authority then acts as a focal point of liaison on health and safety issues between other LAs, HSE and that organisation. Further information can be found at: <a href="http://www.hse.gov.uk/lau/laps">http://www.hse.gov.uk/lau/laps</a>
<b>Local Health Board</b>	The Local Health Board (LHB) is responsible, within the resources available, for identifying the health care needs of its resident population, and securing hospital and community health services to reflect those needs. It is normally co-terminus with a local authority.
<b>Methodology</b>	Approach taken to answer a research question.
<b>Nolan Appointed</b>	The nationally agreed guidance process for appointment to public bodies.
<b>Qualified Accounts</b>	Company accounts on which the auditor has expressed reservations about whether they represent a true and fair view of the company's financial condition.
<b>Specialised Services</b>	Specialised services are those with low patient numbers but which need a critical mass of patients to make treatment centres cost effective.
<b>Welsh Health Circular</b>	Formal mechanism of communication between the Welsh Assembly Government and the NHS in Wales. The communication can fall into the following categories: <ul style="list-style-type: none"> <li>• Direction - Legally binding and must be complied with.</li> <li>• Action - require specific action on the part of the recipient.</li> <li>• Information - draws attention of the recipient to relevant information.</li> <li>• Good practice - for guidance only to share good practice (Welsh Office, 1998)</li> </ul>

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# Appendix 6

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