

Agenda Item

5.1

Joint Commissioning Committee

**Plastic Surgery Commissioning Project:
Report on Outcome of the First Phase**

Dyddiad y Cyfarfod / Date of Meeting	16/09/2025
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Cyflwynydd yr Adroddiad / Report Presenter	Melanie Wilkey, Director of Commissioning for Specialised Services, NWJCC
Noddwr yr Adroddiad / Report Sponsor	Melanie Wilkey, Director of Commissioning for Specialised Services, NWJCC

Pwrpas yr Adroddiad / Report Purpose	For Approval Choose an item.
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Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/Group)		
Committee / Group / Individuals	Date	Outcome
Plastic Surgery Commissioning Project Board	28.07.25	Noted
Specialised Services Commissioning Group	07.08.25	Noted
Collaborative Commissioning Leadership Group	26.08.25	Noted

Acronyms / Glossary of Terms	
CCLG	Collaborative Commissioning Leadership Group
MWL	Mersey & West Lancashire NHS Trust
NWJCC	NHS Wales Joint Commissioning Committee
OPCS	Office of Population Censuses and Surveys Classification of Interventions and Procedures
SBUHB	Swansea Bay University Health Board
SSCG	Specialised Services Commissioning Group
WHSSC	Welsh Health Specialised Services Committee

1. SITUATION/BACKGROUND

1.1 Purpose

The purpose of this paper is to

- To report on the work undertaken to date and outcome of the first phase of the plastic surgery commissioning project to realign commissioning responsibilities for plastic surgery between the NHS Wales Joint Commissioning Committee (NWJCC) and health boards;
- To set out the practical challenges that have been encountered to using OPCS codes as the basis for commissioning and to outline the specific concerns raised by the provider of plastic surgery in south Wales regarding the feasibility of this approach;
- Given the challenges and concerns that have been raised with regard to commissioning on the basis of codes, to reflect on the feasibility and implications of re-aligning commissioning between specialised and non-specialised plastic surgery;
- To inform consideration of whether to proceed with the current project to re-align commissioning responsibility between NWJCC (specialised surgery) and health boards (non-specialised surgery) or to re-assess the options for future commissioning arrangements.

2. SPECIFIC MATTERS FOR CONSIDERATION

2.1 Background

Plastic surgery is currently centrally commissioned for the population of Wales by NWJCC. The main providers are Swansea Bay University Health Board (SBUHB) for south Wales and Mersey & West Lancashire NHS Trust for north Wales.

It was agreed in 2022 by the Welsh Health Specialised Services Committee (WHSSC) Management Group that the current commissioning arrangement should be realigned. This was for several reasons: the recognition that plastic surgery is a high volume specialty delivering a high proportion of non-specialised treatment, the reduced opportunity afforded by the centralised commissioning model to innovate and develop pathways across the large number of interfaces between plastic surgery and other specialties, and the significant geographic

variation in utilisation of plastic surgery across Wales and risk of inequity in access to best treatment.

In January 2023, the WHSSC Joint Committee considered two options for future commissioning arrangements: option 1 to de-centralise commissioning so that all plastics would be commissioned by each health board for its population; and option 2, to define specialised plastic surgery, which would be centrally commissioned by WHSSC (and now NWJCC), with all non-specialised plastic surgery to be commissioned by health boards for their respective populations. The Joint Committee (JC) agreed Option 2 as the preferred option, to separate commissioning responsibilities between NWJCC and health boards for specialised and non-specialised plastic surgery respectively. The preferred option was agreed subject to a number of considerations (listed in **Appendix 1**), including that the transition should be managed without destabilising the plastic surgery centres.

Following the JC decision, a project was established to undertake the work to define specialised plastic surgery and transfer commissioning responsibility for non-specialised plastic surgery to health boards. A project board and clinical working group were established. The project plan set out 2 phases: phase 1 to define specialised plastic surgery and to operationalise this as a set of OPCS codes as the basis for contracting; and phase 2 to explore opportunities for improving pathways and outcomes in a range of specific clinical areas. It was anticipated the work would take place over a 2-year period.

The project is approximately 12 months behind the initially intended timeline. This has been due to the complexity and time required to develop and agree a set of specialised OPCS codes. It has also been necessary to cancel some project board meetings since they would not have been quorate due to apologies from members.

During the process of developing the set of specialised OPCS codes, a number of concerns were raised by members of the clinical working group regarding the feasibility of using OPCS codes as the basis for contracting and commissioning. Subsequently a formal letter from SBUHB has been received by the NWJCC setting out the health board's concerns and suggesting that, in the light of these issues, re-consideration is given by the NWJCC over the preferred option for future plastic surgery commissioning arrangements.

2.2 Plastic Surgery Commissioning Project: Outcome of Phase 1 to Define Specialised Plastic Surgery

The scope of the work to define specialised plastic surgery focussed on adult plastic surgery. Paediatric plastic surgery, burns, major trauma related plastic surgery, and gender reassignment surgery would remain commissioned by NWJCC.

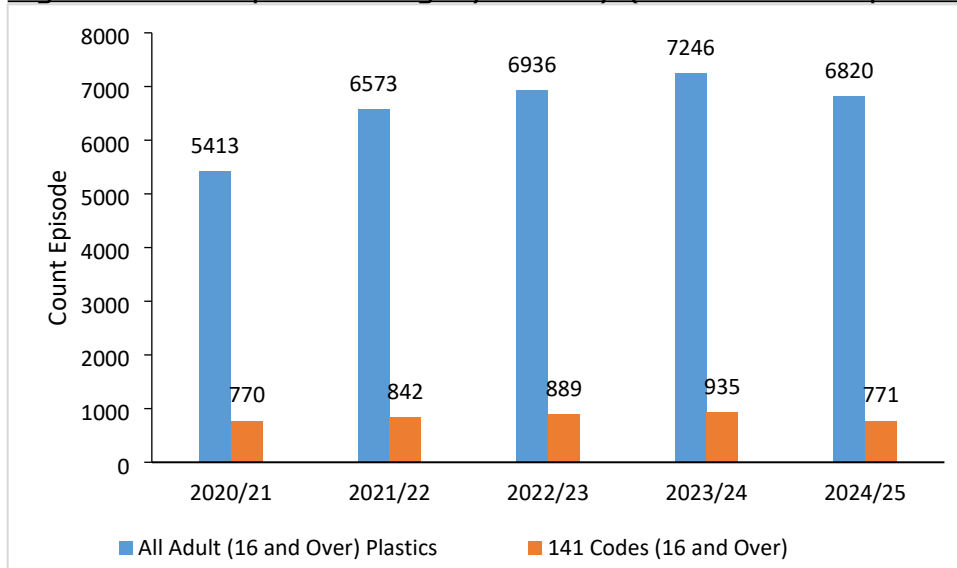
Specialised plastic surgery was broadly defined as surgery that only plastic surgeons perform. However, there was no pre-existing list of procedures regarded as specialised that could be used as a starting point. The following approach was taken by the clinical working group:

- To develop an initial draft list of specialised procedures organised by body site;
- To cross-check and validate the draft list with consultants from other specialties to identify any procedures to be added or removed;
- To match the resulting list of procedures to OPCS codes;
- To further refine the OPCS codes iteratively through analysis of activity data to ascertain the associated volumes of activity and the degree of overlap with other specialties¹ to arrive at a pragmatic set of codes to use as the basis for commissioning.

The outcome of this process resulted in a final proposed list of 141 specialised procedure codes (listed in **Appendix 2**); all other OPCS codes used by plastics services would be categorised as non-specialised (a list of these codes is also available). Applying the finalised list of 141 codes to historic activity shows the following:

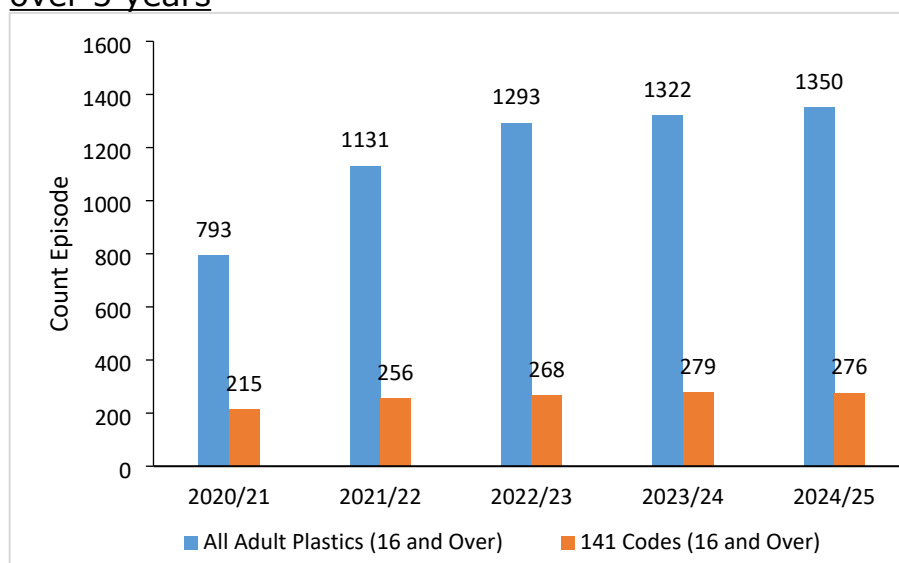
- South Wales: There were 935 specialised episodes in 2023/24 at SBUHB, equivalent to approximately 13% of all adult plastic surgery (Fig 1).
- North Wales: The specialised codes accounted for 21% of all adult activity at Mersey & West Lancashire Trust (Fig.2) in 2023/24, reflecting differences in case mix between the two services.

Fig 1: SBUHB: plastic surgery activity (all adult and specialised) over 5 years



¹ For each code, data was extracted to identify activity under any specialty (to assess whether the code was unique to plastic surgery); where there was activity recorded against other specialties, this code was removed (but flaps, autografts, micro-surgery, congenital deformity were protected as specialised); this process was conducted for each position in the procedure hierarchy (i.e. from primary up to 12th) to ensure that any plastics specific codes that tend to be used in non primary procedure positions would be identified and categorised as specialised.

Fig 2: Mersey & West Lancs: plastic surgery activity (all adult and specialised) over 5 years



Appendix 3 shows the estimated share of expenditure by commissioner health board (non-specialised surgery) and NWJCC (specialised surgery) at SBUHB based on 2023/24 outturn. This shows £16.6m expenditure on non-specialised surgery and £7.8m on specialised surgery. Specialised plastics therefore accounts for approximately 32% of overall expenditure in south Wales, greater than the share of activity, indicating that these procedures are of higher cost (estimated value of expenditure in north Wales and specialised and non-specialised surgery has not yet been calculated).

In summary, the set of 141 codes has been developed using a method aimed at identifying procedures specific to plastic surgery, has been shown to account for a minority of activity and also to be of higher cost. This suggests that the activity identified by these codes is consistent with the concept of a specialised service (low volume, high cost) and to this extent could provide a reasonable basis for commissioning specialised plastic surgery. However, a number of issues have been raised regarding commissioning on the basis of these codes. These are discussed in 2.4.

2.3 Practical Challenges and Stakeholder Concerns

As noted above, a number of practical challenges and concerns regarding the use of OPCS codes as the basis for commissioning plastic surgery were raised during discussions within the clinical working group and subsequently in a formal letter from SBUHB to NWJCC in December 2024. These issues are considered here grouped as either: i) those relating to the quality of coding - whether there are unique codes able to capture all specialised activity and exclude all non-specialised activity; or ii) those relating to administrative challenges such as coding capacity and backlogs, disaggregating the waiting list and performance management arrangements.

2.3.1 Quality of coding

The clinicians have advised that not all procedures which are specific to plastic surgery will have a unique OPCS code. For example, complex revisions (such as for a breast reconstruction where the first procedure was undertaken by a breast surgeon) are not uniquely coded. These are not captured in the proposed set of 141 specialised codes and would therefore be allocated to health board commissioning as non-specialised activity.

The extent to which there are specialised procedures that cannot be captured by currently available OPCS codes has not to date been audited and quantified. It is therefore not currently known whether this is a relatively small number of procedures or a more significant number. Secondly, it has not been explored as to what would be required to be able to prospectively record such activity so it could be included alongside the other specialised activity and charged to the specialised commissioner.

In addition to the possibility that the 141 codes will omit some specialised activity, they also capture some non-specialised activity. **Appendix 4** shows the extent of cross-over with other specialties. This indicates in particular a degree of cross over with dermatology where some of the same codes are being used. While this level of overlap is significantly less than in earlier iterations of the specialised codes, it indicates there may be scope for further refinement of these codes.

The above implies that the proposed 141 specialised codes do not capture with 100% accuracy the activity that is specialised. Therefore a view would need to be taken on whether 100% accuracy is required as the basis for commissioning, or whether it is sufficient that the codes capture the majority of specialised activity (with action agreed to improve the codes over time). If 100% accuracy is felt to be the required standard, then the work undertaken to date suggests that this is unlikely to be possible. This would mean reconsidering the preferred option for commissioning plastic surgery.

2.3.2 Administrative Challenges

A number of administrative challenges have been raised including coding capacity and timeliness, and management of waiting time performance.

Coding capacity and timeliness: There are backlogs in coding in both main plastic surgery providers, although this is a greater issue in SBUHB where the backlog is understood to be several months. Unless resolved, this would complicate the implementation of contracts based on the use of OPCS codes since there would be delays in allocating activity to the correct commissioner. This is a general issue affecting all services but might be a consideration in relation to the timing of any change to commissioning arrangements based on coding.

Waiting list reporting: To enable reporting of the waiting list to the correct commissioner, the waiting list would need to be disaggregated between patients waiting for specialised procedures and patients waiting for non-specialised

procedures. It is understood that currently OPCS codes are assigned after surgery, implying that measures would need to be put in place by the provider to enable waiting lists to be separately reported for specialised and non-specialised surgery.

Given there would be a single provider and multiple commissioners, consideration would also need to be given to whether collaborative arrangements should be put in place for performance management. This might be in the form of a lead commissioner role to lead performance management and escalation arrangements.

The above discussion indicates there are a number of practical challenges to commissioning plastic surgery on the basis of OPCS codes, both with regard to identifying specialised procedures and to administering a contracting and commissioning framework. It may be felt that in the light of these challenges, before proceeding further, it would be appropriate to reconsider the options for future commissioning arrangements.

2.4 Options for future commissioning arrangements

In the light of stakeholder concerns described above, the options for future commissioning arrangements are outlined and appraised below to inform consideration of whether to proceed with the current project to re-align commissioning responsibility between NWJCC and health boards, or to consider an alternative model.

There are 3 options to consider:

- **Option 1:** To adopt the proposed 141 specialised codes and transfer commissioning responsibility for non-specialised adult plastic surgery from NWJCC to health boards.
- **Option 2:** Transfer commissioning responsibility for all plastics from NWJCC to health boards.
- **Option 3:** Retain current commissioning arrangements.

2.4.1 Option 1: To adopt the proposed 141 specialised codes and transfer commissioning responsibility for non-specialised plastic surgery from NWJCC to health boards.

This option would include a transition and shadow contracting period for 12 months from April 2025 to March 2026, with the intention to fully transfer commissioning responsibility commencing from 1st April 2026. The transition period would include:

- Shadow reporting of activity and finance to each health board for non-specialised surgery / shadow reporting to JCC for specialised surgery.
- Clinical working group to explore the practical issues relating to coding quality and completeness to inform a mid-year review of the specialised codes by the project board.
- Finance Working Group to scrutinise and agree the financial transfer and baselines for implementation from April 2026.

- Work to agree the arrangements for wider aspects of commissioning including waiting list reporting, performance management, policy and specification development and review. Approach to be agreed by the Project Board.
- Implementation of phase 2 to explore pathway opportunities

2.4.2 Option 2: Transfer commissioning responsibility for all plastics from NWJCC to health boards

This option would require a decision by Joint Committee since it is a change to the decision previously made by the WHSSC Joint Committee. In this option, 2025/26 would also be a transition year with shadow reporting, with the intention to transfer commissioning responsibility from 1st April 2026. This option would include similar actions to be completed during the transition period as in option 1.

2.4.3 Option 3: Retain current commissioning arrangements

This option would require a decision by Joint Committee since it is a change to the decision previously made by the WHSSC Joint Committee. This option would include the planned phase 2 work to explore pathway opportunities. No further actions or changes would be required since this option retains the current position.

2.4.4 Options appraisal

Table 2 below summarises supporting considerations and challenges with regard to each of the options.

Table 2: Appraisal of options for future commissioning arrangements for plastic surgery

	Considerations
Option 1: Re-alignment / transfer of non-specialised plastics to health board commissioning	<p>Supporting considerations</p> <ul style="list-style-type: none"> • Implements WHSSC Joint Committee decision in 2023 to re-align commissioning responsibility to facilitate service development and improvement. • A draft set of specialised codes has been developed that capture the majority of specialised activity. • Project structure and plan in place to implement a transition and shadow reporting period (including action to address concerns regarding coding quality) <p>Challenges</p> <ul style="list-style-type: none"> • The proposed specialised codes do not currently capture all specialised activity and include some non-specialised activity. • Further work required to improve quality of coding to ensure as specific as possible to specialised plastic surgery. • Work required to agree processes for wider aspects of commissioning including waiting list reporting, performance management arrangements, policy review/development.
Option 2: Transfer of all plastics to health board commissioning	<p>Supporting considerations</p> <ul style="list-style-type: none"> • Reflects that the majority of activity undertaken in plastic surgery is non-specialised.

	<ul style="list-style-type: none"> • Consistent with the arrangements in England where adult plastic surgery is not commissioned as a specialised service. • Simplifies commissioning arrangements compared with option 1, avoiding the complexity of implementing specialised and non-specialised commissioning based on codes. • Retains the benefits in option 1 of aligning commissioning responsibility with clinical pathways for non-specialised activity. <p>Challenges</p> <ul style="list-style-type: none"> • Requires a decision by Joint Committee to transfer all plastics to health board commissioning. • Consideration required over whether to develop collaborative arrangements for aspects of commissioning including performance management and policy review/development. • Specialised activity (a minority of procedures) would be commissioned by health boards rather than JCC.
Option 3: retain current arrangements	<p>Supporting considerations</p> <ul style="list-style-type: none"> • Retains current arrangements, so no further action required to realign commissioning. • Would avoid diverting scarce clinical time towards further work on the coding of specialised plastic surgery (compared with option 1). • All aspects of commissioning remain with JCC as single commissioner (e.g. performance management, policy review/development). <p>Challenges:</p> <ul style="list-style-type: none"> • Requires a decision by Joint Committee to reverse the 2023 decision to realign commissioning responsibility and to retain current arrangements. • Retains arrangements whereby commissioning responsibility is not aligned with clinical pathways for non-specialised activity. As a result, there will continue to be reduced opportunity to innovate and develop pathways across the large number of interfaces between plastic surgery and other specialties. • Opportunity cost for the JCC: limited commissioning resource will be allocated to a high volume, non-specialised service, reducing capacity for services that require a centralised commissioning focus. • Not consistent with the arrangements in England where adult plastic surgery is not commissioned as a specialised service. • Retains arrangements where a high volume, largely non-specialised service is centrally commissioned.

2.5 Specialised Services Commissioning Group (SSCG)

This report was discussed at the SSCG on 7 August 2025. Members acknowledged the work that has been undertaken and the challenges that have been identified in the paper. Members agreed it was important to maintain a broad case mix for plastic surgery to support training. Members also agreed that current commissioning arrangements were not the most suitable for plastics surgery and that there needed to be a change whether that was to option 1 (transfer non-specialised to health boards) or to option 2 (transfer all plastics to health boards).

2.6 Collaborative Commissioning Leadership Group (CCLG)

This report was discussed at the CCLG on 26 August 2025. Given the practical challenges relating to coding (including backlogs and coding quality), the view of CCLG was to retain existing arrangements (option 3) at the current time while working towards the delegation to health boards of commissioning responsibility for non-specialised plastics (option 1). CCLG did not support transfer of all adult plastics to health board commissioning (option 2).

The view of NWJCC officers is that current arrangements are not delivering best value. Given the large number of non-specialised, secondary care pathways involving plastics, NWJCC as a central commissioner is not best placed to actively commission these pathways. Transferring commissioning responsibility to health boards will enable the NWJCC's specialised services commissioning function to focus on areas where it can add greater value. If the NWJCC is to consider commissioning new services and expanding its remit, this would be supported by transferring non-specialised services to secondary care commissioning.

If option 3 is preferred and current arrangements retained, JC may wish to consider if a programme of pathway development and improvement should be put in place for plastics. However, the delivery of such a programme would require resourcing and, if led by NWJCC, would need to be prioritised in the IMTP.

3. ASSESSMENT

Objectives / Strategy	
Dolen i Amcan (au) Strategol CBC / Link to JCC Strategic Objectives(s)	Maximise Value Facilitate Integration Choose an item.
Dolen i Ddeddf Llesiant Cenedlaethau'r Dyfodol – Nodau Llesiant / Link to Wellbeing of Future Generations Act – Wellbeing Goals 150623-guide-to-the-fg-act-en.pdf (futuregenerations.wales)	A Healthier Wales Choose an item. Choose an item.
Dolen i Hwyluswyr Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (Ilyw.cymru)) /</i> Link to Enablers of Quality	Data to Knowledge Whole-systems Perspective Choose an item.

(Duty of Quality Statutory Guidance (gov.wales))	
Dolen i Feysydd Ansawdd <i>(Canllawiau Statudol Dyletswydd Ansawdd (llyw.cymru)) /</i> Link to Domains of Quality (Duty of Quality Statutory Guidance (gov.wales))	Effective Efficient Equitable Person Centred Timely Safe
Effaith Amgylcheddol/ Cynaliadwyedd (5R) / Environmental /Sustainability Impact (5Rs)	No - Not Applicable

Impact Assessment		
Ansawdd <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Ansawdd? /</i> Quality <i>Have you undertaken a Quality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: Not required at this stage. This paper reports progress implementing the plastic surgery project and seeks advice for the next stage.
Cydraddoldeb <i>Ydych chi wedi ymgymryd â Sgrinio Asesiad o'r Effaith ar Gydraddoldeb? /</i> Equality <i>Have you undertaken an Equality Impact Assessment Screening?</i>	Yes: <input type="checkbox"/>	No: <input checked="" type="checkbox"/>
	Outcome:	If no, please include rationale below: Not required at this stage. This paper reports progress implementing the plastic surgery project and seeks advice for the next stage.
Cyfreithiol / Legal	There are no specific legal implications related to the activity outlined in this report.	

Enw da / Reputational	There is no direct impact on the reputation of the Joint Committee as a result of the activity outlined in this report.
Effaith Adnoddau <i>(Pobl / Ariannol) /</i> Resource Impact <i>(People / Financial)</i>	Yes (Include further detail below) There is a neutral resource impact associated with the changes in commissioning considered in this paper.

4. RECOMMENDATIONS

Members of the Joint Committee are asked to:

- To **note** the work undertaken to date on the first phase of the plastic surgery commissioning project to realign commissioning responsibilities for plastic surgery between NWJCC and health boards;
- To **discuss** the 3 options set out in the paper, namely option 1 to transfer non-specialised plastics to health board commissioning, option 2 to transfer all plastics to health board commissioning, and option 3 to retain current arrangements;
- To **note** the view and advice of the Collaborative Commissioning Leadership Group and advice of NWJCC officers;
- To **approve** an option for the future commissioning arrangements for plastic surgery.

5. NEXT STEPS

To take forward the decision agreed by Joint Committee for the future commissioning arrangements for plastic surgery.