

WHSSC Joint Committee Meeting held in public

Tuesday 27 September 2016

1.30pm – 5.00pm

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

Agenda

Members

Ann Lloyd	(AL)	Chair	-
Lyn Meadows	(LM)	Independent Member	-
Maria Thomas	(MT)	Independent Members and WHSSC Audit Lead	-
Daniel Phillips	(DP)	Acting Managing Director of Specialised and Tertiary Services Commissioning, WHSSC	-
Paul Roberts	(PR)	Chief Executive, Abertawe Bro Morgannwg UHB	-
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB	-
Gary Doherty	(GD)	Chief Executive for Betsi Cadwaladr UHB	-
Adam Cairns	(AC)	Chief Executive, Cardiff and Vale UHB	-
Allison Williams	(AW)	Lead Chief Executive for WHSSC and Chief Executive, Cwm Taf LHB	-
Steve Moore	(SM)	Chief Executive, Hywel Dda LHB	✓
Carol Shillabeer	(CS)	Chief Executive, Powys THB	-
Carole Bell	(CB)	Director of Nursing and Quality, WHSSC	-
Stuart Davies	(SD)	Director of Finance, WHSSC	-
Sian Lewis	(SL)	Acting Medical Director, WHSSC	-

Associate Members

Tracey Cooper	(TC)	Chief Executive, Public Health Wales	-
Steve Ham	(SH)	Interim Chief Executive, Velindre NHS Trust	-
Chris Koehli	(CK)	Interim Chair of Quality and Patient Safety Committee	-
John Williams	(JW)	Chair of Welsh Renal Clinical Network	-

Item	Lead	Paper/ Oral
Preliminary Matters		
1. Welcome, Introductions and Apologies <ul style="list-style-type: none"> - To open the meeting with any new introductions and record any apologies for the meeting 	Chair	Oral
2. Declarations of Interest <ul style="list-style-type: none"> - Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for the meeting 	Chair	Oral



Item	Lead	Paper/ Oral
3. Patient Story <ul style="list-style-type: none"> To hear a patient story 	Director of Nursing and Quality Assurance	Oral
4. Accuracy of Minutes of the meetings held 28 June 2016 and 23 August 2016 <ul style="list-style-type: none"> To agree and ratify the minutes 	Chair	Att.
5. Action Log and Matters Arising <ul style="list-style-type: none"> To review the actions for members and pick up on any matters arising. 	Chair	Att.
6. Chair's Report <ul style="list-style-type: none"> To receive the report and consider any issues raised 	Chair	Att.
7. Report from the Acting Managing Director <ul style="list-style-type: none"> To receive the report and consider any issues raised 	Acting Managing Director, WHSSC	Att.
Items for Decision and Consideration		
8. Neonatal trainee allocation and future workforce planning <ul style="list-style-type: none"> To support the recommendation from the independent Panel and approve the recommendations within the workforce plan Contact: - Acting Medical Director – sian.lewis100@wales.nhs.uk	Acting Medical Director, WHSSC	Att.
9. Horizon scanning and prioritisation of new interventions by WHSSC for funding in 2017/18 <ul style="list-style-type: none"> To note the content of the report, support the recommendation that the approach offers a clear and transparent process and support the proposal relating to the policy consultation process. Contact: - Acting Medical Director – sian.lewis100@wales.nhs.uk	Acting Medical Director, WHSSC	Att.
10. Development of the ICP 2017/20 including Commissioning Intentions <ul style="list-style-type: none"> To approve the proposed process and approve the draft strategic commissioning intentions for specialised services 2017/18. Contact: - Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.



Item	Lead	Paper/ Oral
11. Thoracic Surgery Review <ul style="list-style-type: none"> To support the project structure and project board terms of reference. Contact: - Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
12. Update on the Implementation of the Plan <ul style="list-style-type: none"> To note the current position of the Amber Higher Risk Schemes Contact: - Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
Routine Reports		
13. Joint Committee Annual Self Assessment <ul style="list-style-type: none"> To note the information presented within the report. Contact: - Acting Committee Secretary – Cathie.Steele@wales.nhs.uk	Acting Committee Secretary, WHSSC	Att.
14. Delivery of the Integrated Commissioning Plan 2016/17 <ul style="list-style-type: none"> To note the progress made, the funding release proforma schedule and risk management summary. Contact: Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
15. Concerns Overview Report <ul style="list-style-type: none"> To receive assurance that there is ongoing review of concerns management process to continually improve and strengthen processes. Contact: Director of Nursing and Quality – Carole.Bell@wales.nhs.uk	Director of Nursing and Quality Assurance	Att.
16. Performance Dashboard <ul style="list-style-type: none"> To note the use of the new interim 2016/17 performance dashboard and note current performance. Contact: Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
17. Finance Report <ul style="list-style-type: none"> To receive the report and consider any specific corrective action to reduce any forecast overspending. Contact: Director of Finance – stuart.davies6@wales.nhs.uk	Director of Finance	Att.
Item for Information		
18. Reports from the Joint Sub-committees and Advisory Group Chairs' <ul style="list-style-type: none"> To receive the report and consider any issues raised 	Joint Sub Committee and advisory group	Att.



Item	Lead	Paper/ Oral
Sub Committees 18.1 Integrated Governance Committee 18.2 Quality and Patient Safety Committee 18.3 All Wales Individual Patient Funding Request Panel 18.4 Welsh Renal Clinical Network 18.5 Management Group Advisory Groups 18.6 Wales Neonatal Network 18.7 Gender Dysphoria Partnership Board 18.8 Mental Health and Learning Disability Collaborative 18.9 All Wales Posture Mobility Service Partnership Board 18.10 Wales Children and Adolescent Mental Health Service and Eating Disorders Network Steering Group	Chairs	
Concluding Business		
19. Date of next meeting - 22 November 2016, 9.30am, Bowel Screening Wales.	Chair	Oral

The Joint Committee is recommended to make the following resolution:

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



Minutes of the Welsh Health Specialised Services Committee Joint Committee held in Public

on 28 June 2016

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

Present Members

Ann Lloyd	(AL)	Chair
Maria Thomas	(MT)	Independent Members and WHSSC Audit Lead
Daniel Phillips	(DP)	Acting Managing Director of Specialised and Tertiary Services Commissioning, WHSSC
Allison Williams	(AW)	Lead Chief Executive for WHSSC and Chief Executive, Cwm Taf LHB
Paul Roberts	(PR)	Chief Executive, Abertawe Bro Morgannwg UHB
Judith Paget	(JP)	Chief Executive, Aneurin Bevan LHB
Gary Doherty	(GD)	Chief Executive for Betsi Cadwaladr
Adam Cairns	(AC)	Chief Executive, Cardiff and Vale UHB
Steve Moore	(SM)	Chief Executive, Hywel Dda LHB
Carol Shillabeer	(CS)	Chief Executive, Powys THB
Carole Bell	(CB)	Director of Nursing and Quality, WHSSC
Stuart Davies	(SD)	Director of Finance, WHSSC
Sian Lewis	(SL)	Acting Medical Directors, WHSSC

Associate Members

John Williams	(JW)	Chair of Welsh Renal Clinical Network
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Apologies:

Sian Marie James	(SMJ)	Independent Member
Tracey Cooper	(TC)	Chief Executive, Public Health Wales

In Attendance

Elizabeth Gallagher	(EG)	Neonatal Network Manager, WHSSC
Ian Langfield	(IL)	Acting Director of Planning, WHSSC
Cathie Steele	(CES)	Acting Committee Secretary, WHSSC

Minutes:

Juliana Field	(JF)	Corporate Governance Officer, WHSSC
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The Meeting opened at 09.32am



JC001 **Welcome, Introductions and Apologies**

The Chair opened the meeting and welcomed members.

Apologies were received from Sian Marie James and Tracey Cooper.

JC002 **Declarations of Interest**

As it was the first meeting of the financial year 2016/17 members were asked to complete and return an annual declaration of interests form.

No declarations were received for any item on the agenda for this meeting.

Action:

- **All members and associate members to complete a declaration of interest form and return to the Corporate Governance Officer for WHSSC.**

JC003 **Accuracy of Minutes of the meeting held 22 March 2016**

Minutes

The minutes of meeting held on 22 March 2016 was reviewed and **approved** as a true and accurate record.

JC004 **Action Log and Matters Arising**

Member reviewed and updates were made to the action log.

AC joined the meeting

Matters Arising

There were no matters arising.

JC005 **Thoracic Surgery Commissioning**

IL introduced the paper which set out progress and work undertaken.

Members **noted** that a funding release had been approved by the Management Group subject to additional work around contract arrangements and ensuring value for money. It was further noted that the project initiation document had also been approved by Management Group and members of the Joint Committee were asked to support the use of an invited review as core methodology for advice in relation to this piece of work.

Members **noted** that a report on the service model would be presented



to the Joint Committee for decision in January 2017.

Members held a discussion in relation to comments raised by the Management Group around value for money, the level of investment required for the proposal, demand and capacity and the decision making process of the Management Group. Members **agreed** that assurance would be through the Management Group. Members supported further work to ensure value for money for all services commissioned. Members **agreed** that they would, as part of the normal annual governance arrangements, receive the reviewed terms of reference for all sub committees at the next meeting, including decision making.

Actions:

- **Assurance report to be provided to Management Group in July 2016**
- **Further work to be taken to ensure value for money for all services commissioned**
- **Terms of Reference for Sub-committees would be reviewed as part of the annual governance arrangements at the Joint Committee meeting in September 2016.**

Members resolved to:

- **Note** the agreement to release funding from the ICP for the thoracic surgery schemes to improve rates of resection and service quality in 2016/17;
- **Support** the use of the Royal College of Surgeons Invite Review process for expert clinical advice on the model of provision for thoracic surgery;
- **Support** the project to review the thoracic surgery service model to inform the development of a commissioning plan for long term service sustainability; and
- **Note** that the final recommendation on the future service model for thoracic surgery for Wales will be presented for approval to Joint Committee in January 2017.

JC006 **Developing a Commissioning Plan for Specialised Neurosciences**
IL provided an overview of the paper. Members **noted** that the Management Group had supported the project initiation document and that the plan only took into consideration those services commissioned directly by WHSSC. Clarification was sought and provided around the services commissioned through WHSSC.

Members suggested that it would be helpful to have a review to set out the position in the short term and the considerations required which will contribute to the process. It was further suggested that Heath Boards would appreciate guidance from the WHSSC Team around membership of the working group and whether support to the group would be

required through an expert reference group.

Members were keen to ensure that expectations were appropriately managed regarding the scale and role of Welsh Government involvement as well as the more boarder infrastructural requirements/availability to support specific services.

Members **resolved** to:

- **Support** the proposed project initiation document for developing the commissioning plan for neurosciences; and
- **Note** the establishment of the Project Management Group and Working Groups, and the intention to seek nominations for membership.

JC007

Commissioning of Organ Donation Services from NHS Blood and Transplant

SD presented the report and members noted that the Welsh Government had confirmed that it intended to transfer the commissioning responsibility for the service provided by NHS Blood and Transplant (NHSBT) for organ donation and transplantation to WHSSC.

Members received assurance that the financial resource transferred to WHSSC for this work was more than sufficient and that NHSBT were currently holding an under spend from previous year of approximately £120,000.

Members **noted** that once the transfer had taken place a contract would be enacted between WHSSC and NHSBT. It was also anticipated that a Memorandum of Understanding or similar document would produced between the Welsh Government and WHSSC to manage any residual interests where Ministers may require consultation to ensure clarity of process. Members further **noted** that responsibility would remain with WHSSC rather than the Welsh Clinical Renal Network due to the level of involvement required.

Following a short discussion around risk sharing where there is an increase growth in demand, it was **agreed** that should this happen WHSSC and the LHBs would not be able to fund this without additional resource and that this should be clearly communicated to Welsh Government.

Members held a brief discussion regarding timescales and horizon scanning to understand potential future impact of taking on this work. Members noted that there was a firm three year horizon for this work and that this would be raised in the correspondence to Welsh Government confirming the decision taken by the Joint Committee.

Action:

- **Chair to write to the Welsh Government to confirm support and include information regarding risk share and horizon scanning.**

Members **resolved** to:

- **Approve** the transfer of commissioning responsibility from Welsh Government to WHSSC on behalf of Health Boards;
- **Approve** the allocation of funding to WHSSC consistent with the increase in allocation already received from Welsh Government;
- **Inform** the allocated budget is consistent with the requirements of the NHSBT income plan and that there are no immediate or anticipated cost pressures. There is an agreed process with Home Nation commissioners for any further innovation or development; and
- **Inform** the planned development of a Memorandum of Understanding or similar process which will be agreed between Welsh Government and WHSSC which will set out respective responsibilities.

JC008

Update on Implementation of the Plan

Members received a brief introduction in which it was noted that WHSSC had held discussions with Welsh Government regarding potential additional funding for the high risk amber schemes. Members **noted** that there was some potential for funding proton beam therapy through the innovation fund and possible new technology fund which would release funding already committed within the plan to pick up residual risk.

Members **noted** the information provided on page three of the report which outlined the slippage and full year effect from 2016/17. IL provided members with an overview of the funding proposals for each scheme as detailed within the plan and those which needed to be reviewed by Management Group for further discussion around risk.

A query was raised regarding committing slippage and the impact on the recurrent spending in the three year plan and where assurances could be drawn in relation to the impact on the three year plan. It was acknowledged that the Management Group had undertaken robust scrutiny of the proposals. However, members held a discussion noting that their commitment must be the most urgent priority for which they would require provider input to establish. It was agreed that Cardiff and Vale Health Board would confirm the greatest risk for the service.

Members **agreed** that as this was not something which could wait until

the next Joint Committee meeting in September 2016, the Chair would write to all members regarding the outcome for explicit approval by the Joint Committee and for report on the agreed priority to be provided to Management Group for approval.

Actions:

- **Cardiff and Vale Health Board to provide WHSSC with information regarding the service with the highest priority**
- **Chair to write to members to inform them of the outcome**
- **Report on highest priority to go to Management Group for decision.**

A brief discussion followed in which it was agreed that the Chair would raise issues with the drug fund with the Cabinet Secretary at their next meeting and that WHSSC needed to work with providers to be confident of the whole care pathway.

Members resolved to:

- **Note** the current position of the Amber Higher Risk Schemes;
- **Approve** the consideration of slippage from new developments and funding released through other sources to fund Amber Higher Risk Schemes on a case by case basis;
- **Approve** the delegation of the Neurosurgery schemes to the WHSSC Management Group for decision; and
- **Note** that recommendations on the remaining schemes will be made to the Joint Committee scheduled for September.

JC009

Transfer of Networks

CES provided a brief introduction to the paper which set out the proposed governance arrangements following the transfer of the Neonatal and Child and Adolescent Mental Health Service & Eating Disorder Networks to Public Health Wales.

Members **noted** that the current governance arrangements would continue until the transfer of networks and asked for support in relation to a review of the terms of reference.

Members **resolved** to:

- **Note** the contents of the report;
- **Note** the delay to the planned TUPE transfer;
- **Approve** the continuation of the governance and reporting arrangements for the Neonatal and CAMHS/ED Networks; and
- **Support** a review of the Network Steering Groups terms of reference, as advisory groups to the Joint Committee, to strengthen governance arrangements.

JC010 **Chair's Report**

Members **noted** that the Chair had a meeting planned with the Cabinet Secretary week commencing 4 July 2016. Members noted items to be discussed on the review of the Bristol Paediatric Heart Surgery and PET scanning would be discussed. The meeting also presented the Chair with an opportunity to present the current issues faced by WHSSC and the fragility of services.

Members **resolved** to:

- **Note** the content of the report

JC011 **Acting Managing Director's Report**

DP introduced the report highlighting the following key areas to note.

Independent Review of Children's Cardiac Service in Bristol

Members **noted** that the Report was expected to be published on Thursday 30 June 2016. A discussion was held regarding the focus of the report and the ways in which lessons could be learnt.

Cardiac MRI Training

Members **noted** the update received by the Management Group in May 2016 and the work undertaken by the Directors of Finance Group.

Members **noted** that Wales were an outlier in terms of training and had received 93% negative feedback from trainees. It was recognised that there were clear recommendations in place to address the feedback received and members that it had been agreed that cardiac MRI training should be included on both the Health Board and WHSSC risk registers.

Members resolved to:

- **Note** the content of the report.

JC012 **Concerns Overview Report**

CB introduced the report which provided members with an overview of complaints received by WHSSC and serious incidents reported to WHSSC by provider organisations.

Members **noted** that a total of seven serious incidents has been closed and that there were notable differences in number of concerns received both before and after the Welsh Assembly elections held in May 2016.

Members **noted** that there had been a review of the issues through the lessons learnt process that further consideration was required regarding amendments to the policy for specialist fertility treatment in relation to same sex couples IVF and the work on Gender Variance.

A query was raised around timescales and timelines of closing incidents and complaints. Members discussed the processes in place and CB provided members with assurance that WHSSC had a good working relationship with the provider quality teams. It was suggested that future iterations of the report included the reason for delayed closure to ensure members were fully informed of the position. Members noted that work was continuing around the development of an escalation framework for management of serious incidents.

Members **resolved** to:

- **Note** the report; and
- **Receive** assurance that there are appropriate concerns management procedures in place within WHSSC.

JC013 **Performance Dashboard**

Members received an overview of the report noting that this was a summary of performance for March 2016; the April 2016 information was to be presented to Management Group on Thursday 30 June 2016.

Members **noted** the areas performance management arrangements in place for Cardiac, Paediatric, Neurology, ALAS and the activity rates for Bariatric Surgery and Cancer services. Members noted that a paper in relation to Adult Medium Secure Services was to be presented to the Management Group on Thursday 30 June 2016.

Members **resolved** to:

- **Note** the use of the new interim 2015/16 performance dashboard;
- **Support** the progress in developing the commissioning teams and quality framework to further input into the dashboard; and
- **Note** the current performance and the action being undertaken to address areas of non-compliance.

JC014 **Finance Report**

Members received an overview of the finance report for Month 1 and noted that this was based on trend of March rather than actual data from April 2016, due to availability of information.

The overall financial position at Month 1 was an underspend of £394,000; with a forecast year-end underspend of £694,000. Members noted that SD was working with Betsi Cadwaladr University Health Board to develop shared methodology for English performance.

Members discussed the commitment of slippage and associated levels of risk and assurances were provided regarding benefits and work being carried out by the Directors of Finance Group in relation to this.



An enquiry was made in relation to the impact of Individual Patient Funding Requests (IPFR) on the budget and whether more information regarding this would be available in September 2016. Members noted that there was a clear understanding of the impact of IPFRs and that a detailed regular report on this was considered as part of the WHSSC internal processes.

Members **resolved** to:

- **Note** the current financial position and forecast year-end position; and
- **Agree** any specific corrective action to reduce any forecast overspending.

JC015 **Report from the Sub-committee and Advisory Group Chairs'**

a) Management Group

Members **noted** the update from the meetings held 28 April 2016 and 26 May 2016. Members also **received** the confirmed minutes of the meeting held 24 March 2016 and 28 April 2016

b) Quality and Patient Safety Committee

Members **noted** the update from the meeting held 2 June 2016 and **received** the confirmed minutes of the meeting.

c) Welsh Renal Clinical Network

Members **noted** the update from the meeting held 19 April 2016.

Members **noted** that the revised Adult Mental Health and Learning Disabilities Group held its first meeting; with good attendance from all Health Boards. A report from the Group would be presented at the next Joint Committee meeting in September 2016.

Members **resolved** to:

- **Note** the updates from the Sub-committee and Advisory Group Chairs.

JC016 **Annual Accounts and Annual Governance Statement**

Members noted that the Annual Accounts and Annual Governance Statement were received, scrutinised and approved by the Audit Committee.

Thanks were extended to all involved in the development of the two.

JC017 **Annual Corporate Risk and Assurance Report**

Members received, for information, the Corporate Risk and Assurance Framework Annual Report.

Members Resolved to:

- **Note** the update provided with the report.



JC018 **Date and Time of Next Meeting**

It was confirmed that the next meeting of the WHSSC Joint Committee would be held on Tuesday 27 September 2016, 1.30pm, Welsh NHS Confederation, Cardiff.

This concluded the Joint Committee meeting held in Public at approximately 10.38am

Chair's Signature: **Date:**



Minutes of the Welsh Health Specialised Services Committee Extraordinary Meeting of the Joint Committee

held on 23 August 2016, 08.30am

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

Present Members

Ann Lloyd	(AL)	Chair
Lyn Meadows	(LM)	Independent Member (via telephone)
Maria Thomas	(MT)	Independent Member/ Audit Lead
Daniel Phillips	(DP)	Acting Managing Director of Specialised and Tertiary Services Commissioning, WHSSC
Paul Roberts	(PR)	Chief Executive, Abertawe Bro Morgannwg UHB
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB
Adam Cairns	(AC)	Chief Executive, Cardiff and Vale UHB
Allison Williams	(AW)	Lead Chief Executive for WHSSC and Chief Executive, Cwm Taf LHB
Steve Moore	(SM)	Chief Executive, Hywel Dda LHB
Carol Shillabeer	(CS)	Chief Executive, Powys THB
Carole Bell	(CB)	Director of Nursing and Quality, WHSSC
Stuart Davies	(SD)	Director of Finance, WHSSC
Sian Lewis	(SL)	Acting Medical Director, WHSSC

Associate Members

Tracey Cooper	(TC)	Tracey Cooper, Chief Executive, Public Health Wales
Chris Koehli	(CK)	Interim Chair of Quality and Patient Safety Committee

Apologies:

Gary Doherty	(GD)	Chief Executive for Betsi Cadwaladr UHB
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In Attendance

Geoff Lang	(GL)	Executive Director of Strategy, Betsi Cadwaladr UHB (on behalf of Gary Doherty)
Cathie Steele	(CES)	Acting Committee Secretary, WHSSC
Elizabeth Gallagher	(EG)	Neonatal Network Manager

Minutes:

Juliana Field	(JF)	Corporate Governance Officer, WHSSC
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The Meeting opened at 08.36am



JC019

Welcome, Introductions and Apologies

AL opened the meeting and welcomed Lyn Meadows as a newly appointed Independent Member of the Committee who had joined the meeting via teleconference from Betsi Cadwaladr University Health Board.

Apologies were received from Gary Doherty; Geoff Lang was in attendance on Gary's behalf.

JC020

Declarations of Interest

There were no declarations to note.

JC021

Neonatal Service Reconfiguration

AL gave a brief introduction to the paper. Members noted the thanks passed to Professor Vivienne Harwood who had agreed to take up the position of independent chairperson for the panel.

SL provided an overview of the report noting that a meeting of the Independent Panel had been planned for 12 September 2016 to review and assess the two units (Royal Gwent or Singleton Hospitals) against the criteria which are proposed for agreement. Members were advised that the assessment process would be supported by the Swansea Centre for Health Economics and would be based on the work of EVIDEM (Evidence and Value: Impact on Decision-Making) Collaboration.

Members received a summary of the stakeholder engagement process and noted that since publication of the paper an additional four responses had been received. These responses were consistent with, and echoed those provided at appendix 2 and would be made available to members on request.

Section 3.3 of the paper highlighted the significant issues raised during the engagement process. SL provided an overview of these which included:

Timescales

Members were reminded that the deanery's intentions around training were initially communicated to Health Boards in January 2012 and that there had been a delay to the original target of July 2014 due to a lack of progress around workforce planning. The Deanery sent further correspondence in April 2015 confirming their intentions to change training in September 2016 for tier 1 and September 2017 for tier 2. This went to the NHS Wales Collaborative and in September 2015 they felt that unable to take the decision forward. WHSSC officers were asked to take the issue forward in March 2016.

Clinical Outcomes

Although several stakeholders had suggested that clinical outcomes should be used as part of the criteria, SL advised that this was not included as it was outside the scope of work. It was expected that any concerns would be addressed through the individual health board processes and as commissioners, Welsh Health Specialised Services Committee (WHSSC) had not been made aware of any clinical concerns from quality systems, for example from MBRRACE. It was further noted that outcomes are complex by nature and trying to establish these in relation to training skill mix was difficult to determine.

SL advised that within the feedback there had been strong support for the use of an independent panel and importance was placed on ensuring true independence.

Members noted the assessment process and the key principles behind the methodology as detailed within section 3.4 of the paper. SL advised that the weighting for each criterion would be determined by the Independent Panel as this had been the advice from the Swansea College of Health Economics (SCHE). This however would be based on the ranking identified from stakeholder engagement. The scoring for each unit would then be presented to the Joint Committee in September 2016 as part of the recommendation from the Panel.

It was noted that views had been sought from stakeholders as well as advice taken from external bodies around measurement of criteria to ensure a robust approach. This would also be supported by expertise from SCHE.

There was a high degree of consistency between stakeholders around criteria one and two with sustainability indicated as the most important in 26 of the 37 responses.

SL advised that no consistent themes had been identified for the inclusion of additional criteria to that presented in table 5 of the paper.

Members were reminded of the original membership of the Independent Panel noting the withdrawal from Welsh Government and The Royal College of Paediatrics and Child Health. Members noted their disappointment at the withdrawal of the Royal College of Paediatrics and Child Health and acknowledged they awaited confirmation in relation to the additional two members from the Royal College of Nursing and NHS Centre for Equality and Human Rights.

Members were invited to discuss the paper and provide comment.



Clarification was sought regarding the panel process point five which stated that "Criteria can be revisited and rescored in the light of ongoing discussion and understanding". It was raised that this could be perceived a process which could be adjusted. Assurances were provided that each panel member would score independently of each other and that dependent on the scale of variation between scores a discussion would be held by Panel Members and a rescoring would be undertaken. It was advised that this process had a strong academic evidence base and was common practice within decision making process of this type. Further assurances were provided as steps had been taken to achieve true independence of the panel this also reduced the likelihood of bias and that the role of the Panel Chair would be a key factor to this.

It was agreed that information would be provided around the scoring process including where there had been a requirement to rescore, within the narrative of the report to the Joint Committee in September 2016.

It was further agreed to provide scores and weighting promptly to Chief Executives following the meeting in the interests of transparency.

A query was raised in relation to the long term risk of non-sustainability being a broad criterion and whether this would be taken into consideration the number of level two and level three neonatal cots in each unit; additionally to this whether consideration would also be given to the stability of the general paediatric services units. It was supported that these areas would be considered for inclusion within the evidence pack to Panel members and that considerations around general paediatric units would be reinforced with the workforce group.

It was anticipated that the first draft of the workforce plan would be available 31 August 2016.

A suggestion was made in respect of the Constitution of the Panel and whether there was a requirement for a Chief Executive to be a member as an accountable officer; it was not envisioned that this would be a Chief Executive from NHS Wales but would provide a different perspective for the Panel.

Members recommended that the impact on patient safety be considered. A detailed discussion was held in relation to the work proposed within the paper being discussed and further work required ahead of the Joint Committee meeting in September 2016. Members were in agreement that there was a clear need to ensure that any proposed model was thoroughly assessed and that this was required for the decision to be made in September 2016. It was further reinforced

that the outcome of this process did not predetermine which of the units should be a neonatal intensive care unit.

Additional clarification was sought in relation to the full process and the decision requirement of this meeting and that of the Joint Committee in September 2016. It was confirmed that the current meeting was to agree the criteria against which the deanery training units would be assessed to determine which will deliver training. In September 2016 members would be provided with information regarding workforce arrangements and sustainably to agree the model going forward. A query was raised regarding the assumption that there would be three neonatal intensive care units, and had consideration had been made of the possibility that, in terms of sustainability, it would not be possible to maintain three units, and what the contingency would be in this instance. It was noted that if this did happen there would then be a need for full consultation. Members discussed the required process should this happen and assurances were provided that the project team had considered and were working to develop ways to mitigate.

A query was raised with some anxiety in relation the evidence packs being made available to the panel and the assurance processes around this. SL confirmed that stakeholder feedback, external advice and expertise at Swansea Centre for Health Economics would help to ensure information was relevant and accurate.

Members agreed that the evidence packs for the panel would also be circulated to the Members of the Joint Committee for information and completeness. Comments could then be made available for the panel to consider.

Action:

- **SL to ensure Members of the WHSSC Joint Committee are included in the circulation of the evidence packs to the independent panel.**

It was noted that in section 2.2 of the paper that "... there was not a requirement for full public consultation;...". Following discussion it was clarified that the engagement related to this stage and that reconsideration of whether engagement was required would be made following advice from the Community Health Councils (CHCs). Members discussed the wording and agreed that it was in reference to this stage of the process only. Therefore it was agreed that the wording would be clarified to ensure it was clear that if required for this engagement could be undertaken at a later time in the process. A suggestion was made that SL contact the CHCs to ensure that they were fully informed of the history relating to the Deanery decision which has led to the current position.



Action:

- **SL to contact the CHCs to ensure that they are fully informed of the process and the history relating to the Deanery decision which has led to the current position.**

Members enquired as to how concerns and queries raised through the engagement were being addressed as this information had not been provided. It was noted that concerns relating to the workforce were considered by the Workforce group and more general queries were considered by the project team.

Members commended the team on their objectivity, openness and transparency of the process to date, acknowledging the difficulties of this work and the timescales required.

A short discussion followed regarding the work required during September 2016 to progress this work and the necessity to ensure that engagement with staff continues as well as ensuring communications teams are updated and that there is a shared message regarding the process. It was noted that a newsletter was being developed to support management of expectations of stakeholders.

It was suggested that, although the decision is not one of service change, using a criterion which highlights a potential service change may create vulnerability within the system and an opportunity for possible challenge. It was agreed that SL should seek legal and governance advice to ensure this does not compromise the development of recommendations.

SL discussed the negativity associated with using 'non-training unit' to describe the unit without post graduate trainees from March 2017. It was agreed that this was fine for the purpose of any documentation, but for ongoing communication a different form of words should be used. SL is to discuss at the Workforce Task and Finish Group.

AL provided a summary of the meeting confirming that:

- U Members receive a report from the panel regarding the way the process was conducted including the issues around scoring variance, reasons for variance and an explicit explanation around scoring;
- Programme team to consider the relationship of staffing models with general paediatrics;
- A Chief Executive to be appointed to the Independent Panel;
- Amendment of the submitted document to confirm that public consultation is not required at the present time;



- Clarity to be provided around ongoing engagement ensuring there are opportunities for wider scrutiny of the work being undertaken by the project team;
- Confirmation that there are two pieces of work being undertaken first the decision making process and second relating to the workforce solution. and location and the issues relating to patient safety and service sustainability which will come together for presentation to the Joint Committee in September 2016;
- A communication plan be prepared to maintain openness and transparency throughout the process and to respond honestly to any concerns.

Members **resolved** to:

- **Approve** the revised criteria for use by the independent assessment panel on September 12th 2016; and
- **Approve** the necessary changes to the membership of the independent assessment panel

This **concluded** the Joint Committee Meeting held in Public at approximately
09.35am

Chair's Signature:

Date:



2016/17 Action Log (September 2016) Joint Committee Meeting

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
22.03.16	JC001	WHSSC15/81 – Specialised Services Strategy DP and AW to agree a plan for escalating the development of the strategy.	Acting Managing Director	April Sept 2016	Workshops arranged Agenda Item 9. 28.06.2016 – Issues regarding internal resource, anticipated early September 2016 for work to commence around that from National Audit Office. Report to be presented to Integrated Governance Committee 20.07.2016 in preparation for Workshops. Ensure feeds into Team Wales discussions on 01.07.2016 to create visibility at WG level. 27.09.2016 – Update to be provided at meeting	OPEN
22.03.16	JC003	WHSSC15/82 – Risk Sharing Review SD to lead a pricing review of Specialised Services.	Director of Finance	April 2016	Verbal update to be provided at the meeting to be held 28 June 2016. 28.06.2016 Work in progress, clear proposal re pricing put forward, need to agree risk share, work underway with C&V and ABM. 27.09.2016 – Update to be provided at meeting	OPEN

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
22.03.16	JC004	WHSSC15/82 – Risk Sharing Review AL to write to Welsh Government, outlining the difficulties in agreeing the risk sharing on the basis of the current allocation methodology.	Chair	April 2016	Letter sent to Welsh Government setting out the agreement at the Joint Committee. 28.06.2016 Following Joint Committee a response was received from Welsh Government. 27.09.2016 Proposals for implementation are being developed.	OPEN
28.06.16	JC008	JC002 – Declarations of Interest All members and associate members to complete a declaration of interest form and return to the Corporate Governance Officer for WHSSC	All	29 July 2016	Action Completed	CLOSED
28.06.16	JC009	JC005 – Thoracic Surgery Commissioning Assurance report to be provided to Management Group in July 2016 around value for money, the level of investment required for the proposal and demand and capacity.	Acting Director of Planning	20 July 2016	Update provided to Management Group. – Action Completed	CLOSED

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
28.06.16	JC010	JC005 – Thoracic Surgery Commissioning Further work to be taken to ensure value for money for all services commissioned	Director of Finance	20 July 2016	Paper presented to Management Group August 2016 – Action Completed	CLOSED
28.06.16	JC011	JC005 – Thoracic Surgery Commissioning Terms of Reference for Sub-committees would be reviewed as part of the annual governance arrangements at the Joint Committee meeting in September 2016.	Acting Committee Secretary	12 July 2016	Terms of Reference of Sub-Committees and advisory Groups reviewed by Integrated Governance Committee 20.07.2016. – Action Completed	CLOSED
28.06.16	JC012	JC007 – Commissioning of Organ Donation Services from NHS Blood and Transplant Chair to write to the Welsh Government to confirm support and include information regarding risk share and horizon scanning.	Chair	Nov 2016	27.09.2016 - Draft memorandum of understanding has been developed with Welsh Government to clarify delegation to WHSSC through Health Boards. Paper with memorandum of understanding to be presented to November Joint Committee for approval.	OPEN
28.06.16	JC012	JC008 – Update on Implementation of the Plan Cardiff and Vale Health Board to provide WHSSC with information regarding the service with the highest priority	Chief Executive Cardiff and Vale Health Board	June 2016	Action Completed	CLOSED

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
28.06.16	JC012	JC008 – Update on Implementation of the Plan Chair to write to members to inform them of the outcome	Chair	June 2016	No action required – Action Completed	CLOSED
28.06.16	JC012	JC008 – Update on Implementation of the Plan Report on highest priority to go to Management Group for decision.	Acting Director of Planning	20 June 2016	Completed – Action Completed	CLOSED
23.08.16	JC013	JC031 - Neonatal Service Reconfiguration SL to ensure Members of the WHSSC Joint Committee are included in the circulation of the evidence packs to the independent panel.	Acting Medical Director	Sept. 2016	Completed – Action Completed	CLOSED
23.08.16	JC014	JC031 - Neonatal Service Reconfiguration SL to contact the CHCs to ensure that they are fully informed of the process and the history relating to the Deanery decision which has led to the current position.	Acting Medical Director	Sept. 2016	SL wrote to CHCs. Evidence packs circulated to CHCs for information. – Action Completed	CLOSED



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Welsh Health Specialised
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		Agenda Item	6
Meeting Title	Joint Committee	Meeting Date	27/09/2016
Report Title	Chair's Report		
Author (Job title)	Acting Committee Secretary		
Executive Lead (Job title)	Chair	Public / In Committee	Public

Purpose	The purpose of this paper is to provide Members with an update of the issues considered by the Chair since the last report to Joint Committee.			
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RATIFY <input type="checkbox"/>	APPROVE <input type="checkbox"/>	SUPPORT <input type="checkbox"/>	ASSURE <input type="checkbox"/>	INFORM <input checked="" type="checkbox"/>
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Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	

Recommendation(s)	Members are asked to: <ul style="list-style-type: none"> Note the contents of the report. 		
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Considerations within the report (tick as appropriate)

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

1.0 Situation

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

2.0 Background

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

3.0 Assessment

3.1 Neuro-endocrine Tumour

A patient stakeholder event took place on 15 September 2016. Professor Mark Pritchard NET lead from Royal Liverpool attended with positive discussions and support for business case. The full business case will not be ready for this month's Management Group but a verbal update will be given and the business case will follow once revised following the stakeholder event.

A number of concerns have been received by Cardiff & Vale University Health Board (CVUHB) from individual patients and the SWNPSS. They also include clinicians from other Health Boards. As a consequence to provide independent assurance the Medical Directors from the respective Health Boards/NHS Trusts have formally approached the Welsh Cancer Network to perform a Peer Review of services for Neuro-Endocrine Tumour (NET) services in South Wales. The Terms of Reference are in the process of being agreed and the review is due to be completed by early December 2016.

3.2 WHSSC Executive Director Appointments

The Host Health Board is continuing to progress the permanent appointment of the Managing Director.

Applications for the Medical Director have been received and an interview date is currently being arranged.

Interviews for the Committee Secretary have been held and an offer of appointment, subject to the routine checks, has been made.

3.3 Chairs to Joint Sub Committees and Advisory Groups of the Joint Committee

I previously reported that I was seeking nominations for the Chair of the Gender Dysphoria Partnership Board.

I can confirm that Tracey Myhill has been appointed to the role of Chair of the Partnership Board.

3.5 **Chair's Action**

I have not taken Chair's action since the last meeting of the Joint Committee.

4.0 **Recommendations**

Members are asked to:

- **Note** the contents of the report

5.0 **Appendices / Annex**

There are no appendices or annexes to this report.



Link to Healthcare Objectives		
Strategic Objective(s)	Governance and Assurance	
Link to Integrated Commissioning Plan	None	
Health and Care Standards	Governance, Leadership and Accountability	
Principles of Prudent Healthcare	Not applicable	
Institute for HealthCare Improvement Triple Aim	Not applicable	
Organisational Implications		
Quality, Safety & Patient Experience	No implications identified at this time.	
Resources Implications	Recruitment of the substantive Managing Director, Medical Director and Committee Secretary will have a resource implication to the organisation e.g. advertising of posts.	
Risk and Assurance	The Quality and Patient Safety Committee provides assurance to the Joint Committee. The vacancy of substantive Chair to this committee may impact on the ability of the committee to provide assurance. This risk has been mitigated by the Vice Chair covering the role in the interim.	
Evidence Base	No implications identified at this time.	
Equality and Diversity	No implications identified at this time.	
Population Health	No implications identified at this time.	
Legal Implications	No implications identified at this time.	
Report History:		
Presented at:	Date	Brief Summary of Outcome
Not applicable		



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		Agenda Item	7
Meeting Title	Joint Committee	Meeting Date	27/09/2016
Report Title	Report from the Acting Managing Director		
Author (Job title)	Acting Managing Director, Specialised And Tertiary Services Commissioning, NHS Wales		
Executive Lead (Job title)	Acting Managing Director, Specialised And Tertiary Services Commissioning	Public / In Committee	Public

Purpose	The purpose of this report is to provide the Members with an update on key issues that have arisen since the last meeting.			
RATIFY <input checked="" type="checkbox"/>	APPROVE <input type="checkbox"/>	SUPPORT <input type="checkbox"/>	ASSURE <input type="checkbox"/>	INFORM <input checked="" type="checkbox"/>

Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: <ul style="list-style-type: none"> Note the contents of this report. 		

Considerations within the report (tick as appropriate)

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

1.0 Situation

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

2.0 Updates

2.1 All Wales Lymphoma Panel

Informal feedback of the impact of the investment into the All Wales Lymphoma Panel (AWLP) has been received. This specifically relates to the UHW site where there were particular problems around reporting times and attendance of the histopathologists at MDT meetings. Clinicians have reported "a marked improvement in reporting times for all cases of lymphoma. This has dramatically reduced the diagnostic pathway time lines and has more importantly had a noticeable impact on the patient experience". This will be more formally assessed through KPIs at the end of the year.

2.2 Cardiac Surgery

The £6.6 million expansion of cardiac critical care at Morriston Hospital was unveiled by the Cabinet Secretary on the 9 August 2016. The development has increased bed capacity with two new ICU and two new HDU beds. The service also includes an automated pharmacy and dispensing system and onsite lab. This is a major development which in addition to increasing capacity will also improve the quality of care for patients undergoing cardiac surgery at Swansea.

2.3 Equality Impact Assessment of Amber Funding Schemes

Equality Impact Assessments (EQIAs) have been completed for the three schemes identified for full assessment, Proton Beam Therapy - Adult, Teenage and Young Person and Children. For each scheme the recommendation of the EQIA assessment is that due regard has been taken of the duty to assess the impact on the protected groups of not undertaking this scheme in 2017/18.

A further three schemes that were identified as requiring peer review, Fetal Medicine, NICU and Paediatric Cardiology, have been re-screened and full EQIAs will be completed for Fetal Medicine and Paediatric Cardiology.

The remaining 19 schemes, categorised as 9d and 9e in the 16 -19 ICP, have been peer reviewed and assessed as not requiring full EQIAs.

2.4 Thoracic Surgery

As the Joint Committee is aware, WHSSC commissioned the Royal College of Surgeons, through the Invited Review mechanism, to review current thoracic surgery provision, particularly in South Wales, and provide advice to WHSSC

to inform the development a commissioning plan for the future of the service.

The Invited Review team was appointed in July 2016 and undertook its visit to Wales on 3 days from Monday 12th to Wednesday 14th September 2016. A wide range of stakeholders were interviewed, including service providers (full MDT), referrers, Cancer Network, relevant professional bodies, Community Health Council, and commissioners. At the conclusion of the interviews, preliminary verbal feedback was provided to WHSSC Executive Directors. This will be supported by a formal letter within the next week to outline the main findings. The full report is expected within approximately 6 weeks.

2.5 **Augmentative and Alternative Communication (AAC) Project**

Members will be aware that the establishment of an All-Wales specialist service for complex aids for Augmentative and Alternative Communication (AAC) was announced by the Minister for Health and Social Care in June 2016, to be developed from the existing Electronic Assistive Technology Service (EATS) at Rookwood Hospital. The Welsh Government supported the development with recurrent ring-fenced funding for five posts to do the necessary work in assessment and provision and 2 years non-recurrent money for the purchase of equipment. The Welsh Government undertook to consider further funding for equipment in the light of an evaluation of the first two years operation. The service commissioning was undertaken by WHSSC and a Service Specification and Commissioning Policy were agreed by the Joint Committee in March 2017.

The outcomes of the evaluation work show that the service is on a development trajectory in line with the agreed specification. It is regarded as patient centred, producing high quality assessments and the new developments – employing more assessment staff and being able to buy specialist equipment for long term patient loan – are addressing precisely the shortcomings identified by Welsh Government commissioned reports in 2011 and 2013 and echoed in the latest user feedback and comments of stakeholders.

Modelling future demand and costs on the basis of less than 6 months data will be subject to significant uncertainty. The experience of AAC hubs commissioned in England in April 2015 has shown that their referral patterns have not stabilised after 18 months. Therefore it is proposed that the evaluation period is extended to allow the service to stabilise and ensure that there is sufficient data available for analysis.

As it will not be possible to fully utilise the budget for 2016-17, and it is not clear whether there will be further funding available from Welsh Government, it is proposed that the forecast underspend is rolled over to meet the projected need for 2017-18.

Management Group Members considered a full paper and report at the meeting held on 25 August 2016. Members resolved to support the

extension of the evaluation period for the specialist AAC service and support the carry forward of a forecast underspend of non recurrent budget.

3.0 Recommendations

- 3.1 Members are asked to:
- **Note** the contents of the report.

4.0 Annexes and Appendices

- 4.1 There are no annexes or appendices to this report



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



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		Agenda Item	8
Meeting Title	Joint Committee	Meeting Date	27/09/2016
Report Title	Neonatal trainee allocation and future workforce planning: Recommendations for neonatal intensive care units in south Wales.		
Author (Job title)	Acting Medical Director		
Executive Lead (Job title)	Acting Medical Director	Public / In Committee	Public

Purpose	The purpose of this paper is to: <ul style="list-style-type: none"> • Make a recommendation to the Joint Committee regarding the future allocation of trainees from the Wales Deanery to Neonatal Intensive Care Units (NICUs) in south Wales • Provide an assessment of risk regarding future staffing models and recruitment • Seek approval for the recommendations identified in the workforce plan developed by the Neonatal Workforce Task and Finish Group 			
RATIFY <input type="checkbox"/>	APPROVE <input checked="" type="checkbox"/>	SUPPORT <input checked="" type="checkbox"/>	ASSURE <input type="checkbox"/>	INFORM <input type="checkbox"/>

Sub Group /Committee	Not applicable	Meeting Date	
Recommendation(s)	Members are asked to: <ul style="list-style-type: none"> • Support the recommendation from the independent panel regarding the future allocation of medical trainees to NICUs in south Wales taking into account the assessment of risk included within the neonatal workforce plan • Approve the recommendations within the workforce plan prepared by the Neonatal Workforce Task and Finish Group 		

Considerations within the report (tick as appropriate)

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

1.0 Situation

- 1.1 In January 2016 the South Wales Collaborative asked the Joint Committee to make a decision regarding the future allocation of medical trainees to NICUs in south Wales. In addition the Committee was asked to ensure that this was underpinned by a sustainable staffing model which maintained services in the 3 units.
- 1.2 In March 2016 the Committee established a programme board to deliver a decision making process and a workforce and recruitment plan.
- 1.3 In June 2016 it was agreed by the Committee that an independent panel would be put in place to inform the decision. The panel would carry out an assessment of evidence based on criteria developed through a stakeholder engagement process.
- 1.4 It was also agreed that a workforce task and finish group would be set up which would develop a workforce and recruitment plan. It was subsequently agreed that the group would be chaired by the Director of Workforce at Aneurin Bevan University Health Board (ABUHB).
- 1.5 In August 2016 the Committee agreed the membership of the independent panel and the criteria to be used.

2.0 Background

- 2.1 **Constitution of the panel and development of the evidence pack**
- 2.2 The independent panel was convened on the 12th of September. The membership had been agreed at the August 2016 extraordinary meeting of the Joint Committee and consisted of 50% lay and 50% clinical members. The chairman was a lay member who is also the chairman of Powys Teaching Health Board (PTHB).
 - The panel were provided with an evidence pack 4 days in advance of the meeting. The evidence pack was also shared with members of the Joint Committee and the Neonatal Programme Board at the same time and comments subsequently received were fed into the panel meeting.
 - Evidence within the pack had been shared with the Programme Board during its development and Programme Board members were asked for suggestions regarding the types of evidence that should be used.
 - Independent verification of activity data was carried out by the Badgernet (UK database of neonatal activity) team in England and the chair of the data-managers group of neonatal networks.
 - Evidence compiled by the Swansea Centre for Health Economics (SCHE) was used in the packs however the report provided was not included because it was felt that the style did not meet the needs of the lay members.
- 2.3 The membership of the panel was designed to provide expertise and perspectives which would supplement the evidence provided in the pack.

2.4 **Workforce Planning Task and Finish Group**

- 2.5 To deliver the necessary workforce plan, including recruitment planning and risk assessment, a task and finish group was established chaired by the Director of Workforce at ABUHB. The group was made up of health board human resources (HR), management and clinical representatives. In addition it included members of the neonatal network.
- 2.6 The T&F group agreed a work-plan which identified the need for both short term and longer term planning. The group recognised that timescales were such that document provided to the Joint Committee for the 27th of September would focus on short term planning and that proposal around longer term more strategic planning would need to be developed for the November Joint Committee meeting.
- 2.7 A detailed workforce assessment was undertaken including a prediction of March 2017 staffing levels. Recruitment proposals have been developed as well as a risk assessment. This work was undertaken by the HR representatives of the 3 provider health boards supported by clinical and management staff.
- 2.8 The workforce plan is attached (Appendix 1).

3.0 **Assessment**

3.1 **The independent panel: process and outcome**

- 3.2 At the panel meeting the chairman asked for declarations of interest and confirmed there were no material conflicts requiring action.
- 3.3 The first part of the meeting involved an overview of services including the structure of the NHS in south Wales and the location and current staffing position of NICUs.
- 3.4 The following points were clarified to the panel:
 - That services within the 3 NICUs needed to be maintained and there was no planned service change
 - The University Hospital of Wales would remain a Deanery training site because of the specialist exposure it provided
 - A choice needed to be made between allocation of Deanery trainees to either Singleton Hospital in Swansea or the Royal Gwent Hospital in Newport and affected 9 individuals (4 on tier 2 and 5 on tier 1).
 - A workforce group had been established to develop staffing plans and they were provided with a draft copy of the report
- 3.5 Panel members raised concerns regarding the balance of lay to clinical members and were reassured that it was 50% of each group. They also raised concern that the ranking of the criteria had been set by stakeholders and felt that this should be the responsibility of the independent panel. It was agreed therefore that weighting according to both the stakeholder ranking and to panel ranking would be undertaken.
- 3.6 Panel members clarified the wording around the criteria during the process ensuring there was full understanding and agreement.
- 3.7 Scoring went ahead for each of the criteria in turn and a total mean score was calculated. The results showed that irrespective of methodology, the weighting and scoring process produced the clear decision that *Singleton*

Hospital NICU in Swansea should retain postgraduate training, rather than Royal Gwent Hospital in Newport.

The scores are shown in the table below where the higher number prioritises the site for the allocation of trainees.

	Total mean without weighing	Total mean with stakeholder weighting	Total mean with independent panel weighting
Royal Gwent	19.20	18.5	19.27
Singleton	25.8	27.76	27.92

3.8 Minutes of the panel meeting are attached (Appendix 2)

3.9 A key feature of the process is that each panel member votes anonymously and does not have to explain their individual scores. It is therefore not possible with any certainty to identify the critical deciding factors for this pattern of scoring. However WHSSC officers noted that key points of discussion included:

- The catchment population of Singleton (SH) is larger than that of the Royal Gwent Hospital (RGH)
- The acuity of babies (as measured by gestational age and days of ventilation) was higher in SH compared with RGH
- If SH could not sustain services for babies of less than 27 weeks gestation approximately 30 babies would require transfer to Cardiff. This compared to 20 babies from the RGH. In addition travel times would be significantly longer for SH families compared with RGH.
- Both units are smaller than those generally found in England and trainees would get greater experience of critically ill babies in SH compared with RGH

3.10 **Workforce plan risk assessment**

3.11 There are 2 aspects to the risk assessment. First an assessment of the scale of risk of predicted vacancies levels compared to that which has been present in the recent past and to longer term vacancy levels. Secondly the risks related to the delivery of the optimal staffing levels as identified in the plan.

3.12 Likely vacancy levels in March 2017 compared to long term historical rates:

- As part of this assessment we did not carry out a detailed analysis of historical vacancy levels however we know that Bliss (a charity supporting sick and premature babies) reported in 2016 that *'Six years ago a committee of Welsh Assembly Members found considerable evidence of problems in the recruitment, retention and training of staff that were a major challenge for neonatal services. However, since the committee's report these issues have not been resolved'*.

3.13 Likely vacancy levels in March 2017 compared to rates in July 2016 and September 2016:

- NICU gaps in July 2016 were a minimum of 12.6 across the 3 sites
- NICU gaps in September 2016 were 7.9 across the 3 sites. This appears to have improved due to successful Medical Training Initiative (MTI) recruitment at UHW and RGH
- The worst case scenario of gaps for March 2017 i.e. no recruitment of additional MTIs or Advanced Neonatal Nurse Practitioners (ANNPs) will be 7.8 gaps.
- The best case scenario for March 2017 i.e. full recruitment and retention of MTIs (or equivalent ANNPs) and successful hybrid consultant recruitment will mean over recruitment of MTI's by approximately 3 and hybrid consultants by 2.

3.14 Risks of being unable to deliver optimal staffing levels:

- A range of risks have been identified in the plan (appendix 1). Importantly however one of these risks materialised during its development. The British Association of Physicians of Indian Origin (BAPIO) supported MTI recruitment has been delayed by 1 month and will now take place in October 2016. This means that it is almost certain that recruits will not take up post until April/May 2017 i.e. 6-8 weeks following changes to trainee allocation. The impact of this is that in March/May 2017 vacancies rates could remain at existing levels.

3.15 **Overall assessment of risk related to the allocation of trainees to SH:**

- It is demonstrated in the workforce plan and summarised above that vacancies levels in March 2017, across the region, are similar or lower than historical levels.
- Because of its less successful approach to recruitment SH is the least resilient site and would be least tolerant of the relocation of medical trainees. The worst case scenario for SH i.e. no trainees and no successful future recruitment would mean 9.4 vacancies and for RGH would mean 4 vacancies.
- The risk of service failure associated with allocation to SH is therefore lower than if trainees were allocated to RGH.
- To reduce existing, very high, risks of service failure means that an ongoing pro-active approach to recruitment is critical i.e. we aim to deliver optimal staffing levels.

3.16 **Workforce plan recommendations:**

3.17 During development of the plan a number of key enabling actions were identified. The plan therefore contains a number of recommendations for the Joint Committee. These include both issues related to delivery of short term staffing models as well as longer term strategic planning. The recommendations are listed below:

- That there is a commitment at health board level to collaborative working around workforce planning and recruitment
- That the joint and co-ordinated recruitment plans are underpinned by dedicated HR support in each of the 3 units

- That it is signalled, to those at all levels in the provider organisations, that the risks of over recruitment should be tolerated within limits
- That a more integrated employment model which may benefit the overall resilience of staffing in the 3 units and should be explored
- That units should be identified as either 'Heath Board Training Units' or 'Deanery Training Units'
- That opportunities for rotation of Deanery trainees to all sites should be explored
- That provider organisations are made aware of the likelihood in March/April 2017 that vacancies levels will remain a challenge and mitigation should be put in place
- That financial modelling is taken forward by WHSSC following the agreement of a workforce plan
- That a second paper describing the development of a strategy for creating a sustainable workforce model is brought to the Committee in November 2016
- That the Workforce Task and Finish Group remains in place until September 2017 and continues a monitoring and escalation function

3.18 **Conclusion:** The independent panel came to a clear recommendation regarding the allocation of trainees and the risk assessment does not identify any reasons not to support the recommendation of the panel. Indeed the workforce plan offers a significantly improved vacancy position and options for strengthening the long term sustainability of services across the 3 NICUs.

4.0 Recommendations

- 4.1 That the committee supports the recommendation of the independent assessment panel and allocates Wales Deanery neonatal trainees to Singleton Hospital from March 2017.
- 4.2 That the committee approves the recommendations of the Task and Finish Workforce Group, as described above, to ensure the delivery of both short and longer term sustainable staffing models to maintain 3 NICUs in south Wales.

5.0 Appendices / Annexes

- 5.1 Appendix 1: Workforce plan addressing vacancies in tier 1 and tier 2 staffing rotas in Neonatal Intensive Care Units in South Wales- March 2017 onwards.
- 5.2 Appendix 2: Trainee Allocation in Neonatal Intensive Care Units in South Wales. Independent Panel Minutes.



Link to Healthcare Objectives		
Strategic Objective(s)	Governance and Assurance Organisation Development	
Link to Integrated Commissioning Plan	Not Applicable	
Health and Care Standards	Staff and Resourcing Safe Care	
Principles of Prudent Healthcare	Care for Those with the greatest health need first Public & professionals are equal partners through co-production	
Institute for HealthCare Improvement Triple Aim	Not applicable	
Organisational Implications		
Quality, Safety & Patient Experience	There is no planned service change	
Resources Implications	There are potential resource implications and this will be taken forward the a WHSSC finance working group	
Risk and Assurance	A workforce risk assessment has been undertaken	
Evidence Base	Independently verified activity date Independently verified data on the quality of training BAPM standards 2014 All Wales Neonatal Standards 2012 Survey data of consultant training programmes Travel times from publically available sources Training plans from clinical leads Historical staffing levels from Neonatal Network capacity reviews	
Equality and Diversity	There is no planned service change.	
Population Health	N/A	
Legal Implications	The potential for judicial review has been considered however there is no planned service change and workforce analysis suggests the service model can be maintained. In addition the advisory process has been transparent and based on best practice.	
Report History:		
Presented at:	Date	Brief Summary of Outcome
Not applicable		

Recruitment Plan for Neonatal Intensive Care Programme Board Draft 5

Annex (i)

Assumptions - agreement of Deanery trainees on 12th September and recruitment plan activated 28th September

Notes

Objective	Actions	Lead	Duration	Completion Date	Complete or date if different	24-Aug-16	26-Aug-16	28-Aug-16	30-Aug-16	01-Sep-16	03-Sep-16	05-Sep-16	07-Sep-16	09-Sep-16	11-Sep-16	13-Sep-16	15-Sep-16	17-Sep-16	19-Sep-16	21-Sep-16	23-Sep-16	25-Sep-16	27-Sep-16	01-Oct-16	01-Nov-16	01-Dec-16	01-Jan-17	01-Feb-17	01-Mar-17
Recruitment Plan for MTI (5 months)	Establish Baseline Position including rotas/cots/service spec/workforce model and present to	Task and Finish Group	2 weeks	31 st August																									
Notes	Link with Bapio through service leads and HR leads to inform sites and MTI training numbers for neoates	HR leads linked to BAPIO	1- 14 days	5th September																									
	Issue letter of intent to BAPIO	BAPIO steering group	2 days	7th September																									
	Develop tripartite memorandum of understanding between HealthBoards and BAPIO	BAPIO steering group	2 days	9th September																									
	Tirpartite agree relocation pacakage	BAPIO steering group	2 days	11th September																									
	Get deanery and Royal College approval	Medical HR Reps	14 days	14th September																									
	Overseas indentification of suitable candidates	BAPIO	14 days	14th September																									
	Bapio review CV's and provide list	BAPIO	2 days	10th September																									
	Health Boards review and prepare final short list	HB with Medical HR	4 days	14th September																									
	Agreement on locaiton of 2nd training site	Workforce Task and Finish Group to BAPIO	2 weeks	28th September																									
	Confirmation required and agreement of funding arrangements	Workforce sub group and Medical Workforce GroupFinance Leads (UHB & WHSCC)	2 days	30th September																									
	Agree principles for rotation	Workforce sub group/and programme board	2 days	30th September																									
	Individual healthboards present BC for additional costs associated with MTI recruitment in accordance agreed Funding Arrangements	Service Leads	7 days	7th October																									
	Interviews arranged in medical schools	BAPIO	4 days	8th October																									
	Offer made, agreed employment pack	BAPIO and HB representatives	2 days	12th October																									
	MTI Obtain Visa	MTI supported by BAPIO	3 months	12th January																									
	Med HR Obtain GMC registration and visa and arrange accommodation	Medical HR Reps	3 months	14th January																									
	doctor arrives in UK			14th February																									
	OH screening	Medical HR Reps	1 week	18th February																									
	Doctor meets with workforce HR for employment checks	Medical HR Reps	1 week	25th February																									
	BAPIO assign a mentor in each hospital	BAPIO	1 week	25th February																									
	Doctor commences support tier rota	HB's	1 week	1st March 2017																									
	Recruitment Plan for HB recruitment of MTI/CF	Health Boards commence recruitment process and advertise posts either through RC or overseas links	HB	2 days	11th September																								
		Get deanery and Royal College approval	HB	14 days	14th September																								
		indentification of suitable candidates	HB	14 days	14th September																								
		HBreview CV's and provide list	HB	2 days	10th September																								
		Health Boards review and prepare final short list	HB	4 days	14th September																								
	Interviews arranged in medical schools	HB	4 days	8th October																									
	Offer made, agreed employment pack	HB	2 days	12th October																									
	MTI Obtain Visa	MTI supported by RC	3 months	12th January																									
	Med HR Obtain GMC registration and visa and arrange accommodation	Medical HR Reps	3 months	14th January																									
	doctor arrives in UK (if overseas)			14th February																									
	OH screening	Medical HR Reps	1 week	18th February																									
	Doctor meets with workforce HR for employment checks	Medical HR Reps	1 week	25th February																									
	Doctor commences support tier rota	HB's	1 week	1st March 2017																									
1	Establish Baseline Position including rotas/cots/service spec/workforce model and present to	HB's		12-Aug-16																									
2	Assess Current SIP for each HB at each tier	HB's		12-Aug-16																									
3	Assess Turnover and Leavers impact on baseline for each HB (end of fixed term contracts)	workforce sub group through WOD leads		24-Aug-16					WorkforceSub group meeting																				
4	Assess contribution factors to loss of workforce due to maternity, sickness, part time participation rates etc	workforce sub group through WOD leads		24-Aug-16					WorkforceSub group meeting																				
5	Assess Potential Recruitment Pipeline for each HB	workforce sub group through neonatal nurse		24-Aug-16					WorkforceSub group meeting																				
6	QA and validate workforce gaps	workforce sub group		24-Aug-16					WorkforceSub group meeting																				

Assumptions - agreement of Deanery trainees on 12th September and recruitment plan activated 28th September

	Objective	Actions	Lead	Duration	Completion Date	Complete or date if different	24-Aug-16	26-Aug-16	28-Aug-16	30-Aug-16	01-Sep-16	03-Sep-16	05-Sep-16	07-Sep-16	09-Sep-16	11-Sep-16	13-Sep-16	15-Sep-16	17-Sep-16	19-Sep-16	21-Sep-16	23-Sep-16	25-Sep-16	27-Sep-16	01-Oct-16	01-Nov-16	01-Dec-16	01-Jan-17	01-Feb-17	01-Mar-17
7		Develop a tracker of workforce mapped against demand and supply	workforce sub group		24-Aug-16					WorkforceSub group meeting																				
8		Assess the current and March 2017 Gaps across the 3 HB's	workforce sub group		24-Aug-16					WorkforceSub group meeting																				
9		Agree principles of cross site working and utilisation of existing resources	workforce sub group		24-Aug-16					WorkforceSub group meeting																				
10		Agree gaps for target recruitment through workforce sub group	workforce sub group/project group		24-Aug-16					WorkforceSub group meeting																				
12		Agree which organisation to host recruitment	workforce sub group		28th September																									
13		Agree JD for 8a for each healthboard	workforce sub group		28th September																									
14		Agree standard JD with HB's for band 8b	workforce sub group		28th September																							ANNP clinical group meeting		
15		Develop and agree advert for ANP recruitment - S Wales approach including need to work flexibly if required	workforce sub group		28th September																									
16		Agree financial implications	Workforce sub group & UHB finance leads		5th October																									
17		Agree interview dates with HB Nurse leads to place in advert	TBC	2 days	7th October																									
18		Vacancy identified and host HB enters vacancy onto TRAC with proposed interview dates	workforce sub group	1 day	8th October																									
19		Post advert	workforce sub group	2 days	10th October																									
20		shortlisting of candidates	Service Leads	5 days	15th Cotober																									
21		Interview with candiates	Service Leads/ host HB	1- 2 days	17th October																									
22		Notify recruitment of interview outcome	workforce sub group	2 days	19th October																									
23		HB's Send Conditional Offer letter	HB's	5 days	24th October																									
24		Commence employment		up to 3 months	Early Feb 17																									
25	Monitoring																													
26		Monthly update on recruitment process and any impact on MTI tier 1 recruitment			monthly until March 2017				update																					
27		Clinical fellows - same as above																												

notes
5

Project Plan for Neonatal Intensive Care Programme Board																												
	Objective	Outcomes	Tasks	Lead	Completion Date	Complete or date if different	16-Aug-16	23-Aug-16	30-Aug-16	06-Sep-16	13-Sep-16	20-Sep-16	27-Sep-16	04-Oct-16	11-Oct-16	18-Oct-16	25-Oct-16	01-Nov-16	08-Nov-16	15-Nov-16	22-Nov-16	29-Nov-16	06-Dec-16	13-Dec-16	20-Dec-16	27-Dec-16	03-Jan-17	10-Jan-17
Phase 1																												
Develop Workforce Planl for Three NICU	Develop Workforce Plan	Estimate the recruitment gaps for ANNP and medical staff for March 2017	Establish Baseline Position including rotas/cots/service spec/workforce model	HB's	12-Aug-16																							
			Assess Current SIP for each HB at each tier	HB's	12-Aug-16																							
			Assess Turnover and Leavers impact on baseline for each HB (end of fixed term contracts)	HB's	12-Aug-16																							
			Assess contribution factors to loss of workforce due to maternity, sickness, part time participation rates etc	HB's	12-Aug-16																							
			Assess Potential Recruitment Pipeline for each HB	HB's	12-Aug-16																							
			QA and validate workforce Plan for March 2017	Workforc e Task and Finish	31-Aug-16																							
			Develop a tracker of workforce mapped against demand and supply	HR leads	31-Aug-16																							
		Agree staffing model	Review best practice in staffing models	Workforc e sub group	16-Aug-16																							
			Develop and agree medical rotas and workforce profile for each tier at each HB	Workforc e Task and Finish	16-Aug-16																							
			Agree principles of cross site working and utilisation of existing resources	Workforc e Task and Finish	25-Aug-16																							
			Identify and agree posts for HB rotation and timescales of placements	Workforc e Task and Finish	25-Aug-16																							
			Agree gaps for target recruitment	Workforc e Task and Finish	31-Aug-16																							
			Develop workforce plan, recruitment plan and employment model	Workforc e sub group	31-Aug-16																							
			Identify Financial Implications for each HB	finance lead	31-Aug-16																							
	Develop report for panel		High level workforce plan and report to support resource implications of 2 site model of deanery trainees	E Gallaghe r	05-Sep-16																							
	Develop a recruitment Plan	To develop a recruitment Plan in order to ensure service sustainability	Recommend a recruitment targets for MTI/CF	HB leads	31-Aug-16																							
			Recommend principles of ANNP banding/job descriptions across HB's	HR leads/We ndy	28th September																							
			Recommend a recruitment targets for ANNP	HB Workforc e leads	28th September																							
	Develop a range of options for the neonatal network in future which will deliver a sustainable service model	To propose an employment model which offers a more sustainable workforce plan	To identify a range of options for the neonatal network in the future which will deliver a sustainable service model from ranging from greater collaboration , lead organisations for certain functions i.e. recruitment to one employer managing the network.	Service/W orkforce	October/November																							
			To risk assess each of the above options		31-Aug-16																							
			To propose an employment model which offers a more sustainable workforce plan based of a risk assessment of all the options considered		31-Aug-16																							
Phase 2					28th September 2016																							
Coordinate the implementation of the agreed Workforce Model Across the Three NICU's until March 2017 and escalate contingency plans	Implement Recruitment Plan	Implement recruitment process	Implement MTI recruitment and target resource requirements to BAPIO		28th September -																							
			Implement ANNP band 8a and band 8b recruitment		10th October																							
			Implement recruitment of CF		2nd October 2017																							
			Develop a staff engagement and consultation document		October																							
	Monitor recruitment Plan	Monitor Recruitment Process	Escalate Failure to recruit MTI		10th October																							
			Escalate slippage on recruitment timescales		weekly																							
			Esclate Failure to recruit hybrid consultants		12th October																							
			Esclate failure to recruit ANP		12th November																							
			Develop contingency plan and workforce plan for March 2017		30th November																							
	Develop Contingency Plans																											

SUMMARY REPORT		AB, ABM and CV University Health Boards
Neonatal Intensive Care Workforce Planning Task and Finish Group		Date: 19th September 2016
Subject	Workforce plan addressing vacancies in Neonatal Intensive Care Units in South Wales- September 2016 onwards.	
Prepared by	Workforce Task and Finish Group	

1 Purpose

The Task and Finish Group were asked to develop a workforce plan predicated on regional/collaborative working to address existing issues of recruitment and retention and to mitigate the impact of the withdrawal of medical trainees from either the Royal Gwent Hospital or Singleton Hospital in March 2017. It will address both short term solutions and longer term sustainability.

This plan, which has also been informed by the Neonatal Network, will be considered by the Joint Committee of the Welsh Health Specialised Services Committee (WHSSC), together with a recommendation from an independent panel, enabling the Committee to make a final decision regarding the allocation of trainees from March 2017 onwards.

Within the short time available through collaborative working, a plan has been developed which specifically covers the following:

- The current staffing situations at the Royal Gwent and Singleton Hospitals and the University Hospital of Wales (UHW) neonatal units
- The impact on staffing levels at these units after the change in trainee allocations for September 2016 and March 2017
- The staffing requirements to sustain three sites and meet BAPM standards and Deanery rota compliance
- A recruitment plan to address the staffing gaps in the short term
- An assessment of new workforce roles and models which may assist in the delivery of both short and longer term sustainable staffing
- A proposal for collaborative recruitment between health boards, which might create a more sustainable workforce plan and service provision
- An outline approach to financial planning around new staffing models
- An assessment of the risks associated with the plan
- A proposal of principles which should underpin the future workforce planning and recruitment strategy for neonatal services in south Wales

2. Background

In July 2016 Bliss (a charity supporting the families of sick or premature babies) reported in the executive summary of their annual assessment of neonatal services that;

'Six years ago a committee of Welsh Assembly Members found considerable evidence of problems in the recruitment, retention and training of staff that were a major challenge for neonatal services. However, since the committee's report these issues have not been resolved'

They went on to report that;

'In Wales over half of neonatal units did not have enough medical staff to meet minimum standards for safe, high quality care'

It is therefore against this backdrop of long term recruitment challenges that the forthcoming change in the allocation of medical trainees needs to be viewed. This change in allocation is being taken forward by the Wales Deanery with the aim of creating a more attractive training experience and addressing recruitment and retention challenges amongst training grade doctors. This reconfiguration means that from March 2017, trainees will only be allocated to 2 of the 3 units in South Wales. Because UHW provides specialist care such as foetal medicine and paediatric surgery, it offers experience which cannot be found at the other NICUs and this will therefore remain a Deanery training site. Therefore there is a choice between sending Deanery trainees to either the Royal Gwent or Singleton Hospitals. The decision regarding this allocation will be made by the Joint Committee on the 27th of September 2016 and this workforce and recruitment plan will help inform that decision.

3. Key principles

During the development of this work, five key principles were identified which will support the implementation of sustainable NICU work force models across three units in south Wales:

1. Joint and co-ordinated recruitment supported by dedicated human resources support in each of the three units
2. A willingness to accept that the risks of over recruitment are outweighed by the risks to patients of under recruitment, and that this needs to be signalled clearly to those at all levels in the provider organisations. This recognises that the existing variable cost pressures outweigh the financial risk of over recruitment
3. That longer term the flexibility of a more integrated employment model may benefit the overall resilience of staffing in the three units
4. That longer term staffing model may look different to those used in March 2017 e.g. the proportion of hybrid consultants and ANNPs is likely to increase
5. That whatever the staffing model in the units, training will be a key element of the work of that unit and that in future the terminology should relate to 'Heath Board Training Units' and 'Deanery Training Units'
6. That opportunities for the rotation of trainees, both Wales Deanery and MTIs to all sites should be encouraged

4. Medical standards required to work in a neonatal unit (BAPM Standards)

The British Association of Peri-natal Medicine (BAPM) identified in its Framework for Practice (June 2014) optimal staffing levels for neonatal units. Optimal was

defined as providing a combination of the lowest mortality and morbidity, the best cost effectiveness and the best baby and parent experience. NHS Wales has committed to these standards in the All Wales Neonatal Standards 2nd edition.

This means that for the Royal Gwent and Singleton Hospitals the workforce requirements are as follows:-

Tier 3

24/7 consultant on-call rota; **minimum 7 WTE**

Staffing: Consultants all of whom should have a Certificate of Completion of Training (CCT) in Paediatrics (Neonatal Medicine) or Equivalent.

Tier 2

Separate neonatal rota 24/7; **minimum 8 WTE**

Staffing: Senior medical trainees (ST4-8), senior non-training grade doctors, Advanced Neonatal Practitioners (ANNPs), resident neonatal consultants (known as 'hybrid' consultants).

Tier 1

Separate neonatal rota 24/7; **minimum 8 WTE**

Staffing: Junior medical trainees (ST1-3), Enhanced Neonatal Nurse Practitioners, ANNPs, junior non-training grade doctors

5. Staffing position in the three units as of September 2016

In June 2016, the Joint Committee approved a pragmatic solution for the allocation of trainees for the forthcoming September. The interim arrangement which is now in place is described below:

- Royal Gwent Hospital (RGH): 5 tier 1 trainees with no allocation of Tier 2 trainees (4 trainees in post)
- Singleton Hospital (SH): 4 tier 2 trainees with no allocation of Tier 1 trainees (3 trainees in post).
- UHW: 7 tier 1 trainees and 7 tier 2 trainees (6 and 7 trainees in post respectively)

The vacancy situation as of September 2016 for the 3 units is shown the table. The full analysis of staff in post and vacancies is shown in **Appendix A**.

	SH	UHW	RGH	Total NICU Gaps	Comments
Tier 2 vacancies	1.8	0	0	1.8	RGH are using substantive consultants to fill vacancies. SH has a locum tier 2 starting in October 2016 for 2 months.
Tier 1	1.7	1.4	2	5.1	SH expects to appoint

	SH	UHW	RGH	Total NICU Gaps	Comments
vacancies					a Clinical Fellow and ANNP in October 2016 UHW and RGH have already undertaken a highly successful programme of MTI recruitment covering both tier 1 and tier 2 vacancies. UHW has 1 trainee returning from Mat. leave in November .
Supplementary rota vacancies	NA	1	NA	1	UHW has 1 medical vacancy. This rota only applies in UHW and relates to the higher workload.
Total	3.5	2.4	2	7.9	

Note: Gaps consist of a mixture of long term sickness, secondment, vacancies or maternity leave, but exclude short term sickness. The position also reflects that in RGH, hybrid and non-hybrid consultants have agreed to cover tier 2 gaps. UHW will have a gap of 2.4 but SH will have a gap in the rota of 1.8 WTE, and this will partly temporarily be addressed when a locum takes up post for 2 months, which will reduce the gap to 0.8 WTE. *Tier 2 vacancies have the biggest impact on service delivery.*

6. Staffing position in the 3 units with effect from March 2017

Each health board was requested to forecast their vacancy position from March 2017 and the detailed analysis is shown in **Appendix A**. Forecasting is based on the following assumptions:

- UHW: all allocated trainees are available to participate in the rota
- SH: no trainees are allocated
- RGH: no trainees are allocated
- All sites: assumptions around successful local recruitment plans
- All sites: assumptions around the development of qualified ANNPs

6.1 Impact on staffing levels at RGH and SH if there is no trainee allocation and no further recruitment action is undertaken from March 2017

The table below describes the additional Medical Staff/ANNP staff which will be required to maintain rotas and safe staffing level in accordance with the All Wales Standards and BAPM (2014) Framework. It assumes that there will be no trainees allocated to RGH and SH. An assessment is provided for both units as their current circumstances vary depending on the number of hybrid consultants'

MTIs/ANNPs and clinical fellows that are known to be available through current local recruitment processes.

March 2017	SH	UHW (includes trainee allocation)	RGH	Total NICU Gaps	Comments
Tier 2 vacancies	4.6	0	0	4.6	Assumes no trainee allocation at SH or RGH. RGH will use substantive consultants with additional sessions and ANNPs to fill vacancies. SH assumes hybrid consultant recruitment is unsuccessful.
Tier 1 vacancies	4.8	0	4	8.8	Assumes no trainee allocation at SH or RGH. RGH have already undertaken a highly successful programme of MTI recruitment.
Supplementary rota vacancies	N/A	1.4	N/A	1.4	UHW ANNP on secondment. UHW have already undertaken a successful programme of MTI recruitment.
Total	9.4	1.4	4	14.8	
Total assuming 9 Deanery trainees are available*				5.8 (*7.8 if vacancies levels in Sept 2016 maintained)	

The total workforce gap across the health boards is 14.8 WTE staff but does not assume Deanery junior allocation to either RGH or SH. The following would therefore be required:

- Successful additional recruitment of a total of 11 WTE MTIs
- The expected increased availability of ANNPs through completion of training

- ABMUHB to successfully recruit 3 senior clinical fellows (but assumes ABMUHB will fail to recruit to hybrid consultants posts based on recent experience)

The allocation of Deanery trainees would potentially reduce the vacancy position by 5 WTE at Tier 1 and 4 WTE at Tier 2 depending which site is chosen as the second Deanery training site. **NB. in September 2016, 2 out of 9 trainee posts were vacant and it is reasonable to assume that this vacancy rate will continue.* The impact of trainee allocation on vacancy levels at either RGH or SH is shown below (this includes the assumption that 2 of 9 posts are vacant):

March 2017 to meet 1:8 compliance	SH vacancies	SH vacancies if trainees allocated	RGH vacancies	RGH vacancies if trainees allocated	Opportunities related to trainee allocation
Tier 2 vacancies (Assumes only 3 of 4 trainees available)	4.6	1.6	0	+3	This would allow consultants at RGH to move off the tier 2 rota and reduce the need for consultant hybrid consultants at SH and CF for tier 2.
Tier 1 Vacancies (Assumes only 4 of 5 trainees available)	4.8	0.8	4	0	This would reduce the number of MTI required.
Supplementary rotas showing vacancies of ANNP and MTI	N/A	0	N/A	0	
Total	9.4	0.8	4	+3	

+ indicates the rota would include more than the required BAPM minimum standards.

Depending on the site to which trainees are allocated, there could be more staff than are needed for a 1:8 rota. However, in the case of RGH, this situation could allow consultant staff to move off the Tier 2 rota.

7.0 Addressing the workforce gaps

The Workforce Sub-Group has explored a number of roles which may assist in sustaining medical rotas in the short term. **Appendix B** reflects the in-depth assessment of roles which may assist in providing a longer term solution to the

shortages or resources to support Tier 1 and Tier 2 rotas. Below is a brief summary of these roles.

7.1 Advanced Neonatal Nurse Practitioners (ANNPs)

The role of the ANNP has been integrated extremely successfully within Tier 1 rotas at all health boards and integrated onto Tier 2 rota at Singleton. The advantages are that they provide rota stability and the commissioning of their training is in within the control of health boards. However, there are currently only three in training who will have completed their training by 2018. A key issue is that the training is designed to take place over 1 year, however typically training for nurses from Wales actually takes 2 years. This is due to a variety of reasons including personal and family commitments, the need for health boards to plan for the release of staff and the subsequent back-fill arrangements and a financial penalty for staff who are unable to undertake out of hours work during training.

It has been traditionally assumed that for ANNPs to have the skills and competence to work at a Tier 2 level, they need to have worked at a Tier 1 level for five years and there is currently no programme of career development to support this progression. There do however appear to be units in the UK where a much faster progression has been developed and this needs to be investigated. At present there is no programme of external recruitment. There are currently 10 ANNPs who are qualified at Tier 1 and only 2 ANNPs working at Tier 2, but there are plans to increase the number of ANNPs on the Tier 2 at RGH before March 2017.

7.2 Medical Training Initiatives

There are 2 types of MTI schemes; college based through the RCPCH and health board based. A number of organisations have successfully recruited through both schemes and the All Wales Strategic Medical Workforce Group is now working closely with the British Association of Physicians of Indian Origin (BAPIO). This has led to a recent collaboration between health boards in Wales around a multi-specialty recruitment campaign for Wales. Within this there are plans for the recruitment of 11 WTE MTI posts to address the vacancy gap for March 2017. A key advantage to these posts is that typically they provide a two year commitment to a post or rotation. It is however unclear at this stage what the expected drop-out rate is from these posts.

Health boards have also indicated that the risks of using solely BAPIO are reduced, through continued exploration and recruitment where possible from existing links with the Royal Colleges.

It is expected that recruitment through this process will take a minimum of five months. Assuming this process starts in September 2016 a conservative estimate is that MTIs will be in post in April 2017.

7.3 Consultant Hybrids

This role has been used elsewhere in the UK and was first introduced in Aneurin Bevan University Health board (ABUHB) in 2015 to support the vacancies in Tier 2 junior doctor rotas. The role requires the recruitment of CCT holders (those

eligible to apply for consultant posts) in neonates, to work flexibly to support the junior doctor rota. ABUHB has successfully recruited to these roles however Abertawe Bro-Morgannwg University Health Board (ABMUHB) has recently advertised for two posts and has failed to recruit. It has been suggested that the ABMUHB job description could be made more attractive and they are now working with ABUHB to redesign the role.

Another option now in place in ABUHB is the use of existing consultant workforce through increased contracted sessions (via a job planning process) providing support over the next two years.

7.4 Clinical Fellows

Clinical fellows are doctors who are not currently part of a Deanery training programme, but who wish to have particular experience in a speciality. These posts are seen as developmental posts and there has been some success in their recruitment. Recruitment will therefore continue in anticipation that they will be required for March 2017.

There is also the potential for academic and teaching fellow posts. However, these posts do require either a research or training element to their role and their contribution to the rota is therefore reduced. These posts however have proved attractive in other specialities and provided high calibre applicants. These will be considered in the next stage of development of the workforce strategy.

7.5 Other roles

Other roles that are being explored, which may offer a longer term sustainable solution, include the emerging role of the Physician Associate (PA). These posts may have a role supporting medical staff and are likely to evolve over the long term. However, there are limitations to their skills that would restrict their capacity to be included on a medical rota. Training programmes for Physicians Associate roles will start in Wales in 2016 and the numbers across the UK are expected to double in the next two years. This is an area which may offer opportunities in the future.

8. Recruitment plan

The workforce plan has identified a number of vacancies to which we will need to recruit by March 2017. The table below summarises the posts to which we are currently undertaking active recruitment:

	Location and recruitment process
Consultant/Hybrid	2 Singleton local recruitment.
Clinical Fellows	3 Singleton local recruitment.
MTI	11 open adverts via BAPIO/UHB recruitment. This number might reduce following the decision on the allocation of trainees.
ANNP	An open advert via joint recruitment process.

The principle short term objectives are:

- To recruit to 11 MTI posts across South Wales (this position may be reviewed following the decision on trainee allocation)
- To externally recruit ANNPs through appropriate banding eg. to offer 8b posts to attract from outside Wales those interested in career development and who have the skills to operate at a Tier 2 level
- To continue to recruit clinical fellows i.e. non-training grade doctors
- To enable SH to recruit to hybrid consultant posts through improvement of the existing job descriptions

The recruitment plan in **Appendix C** sets out the recruitment cycle for each staff group to achieve recruitment numbers by March 2017. The process shows the time taken to prepare, advertise, shortlist and for overseas MTI recruitment, the timescales for GMC, Visa, ILEATS for overseas MTI staff. This process can take five months which should meet the March 2017 deadline. However, delays in the process are often outside UHBs' control in terms of Visa, GMC and ILEATS processes. The experience from other health boards is that the average recruitment timescales for MTIs is between five and seven months. This poses a risk to rotas for March 2017 and contingency plans will need to be developed should there be slippage in the timescales.

The recruitment process for ANNPs will run in parallel with medical recruitment through a national advert to attract interest from the UK. The health boards have agreed that a collaborative approach will be taken for recruitment, with one organisation taking the lead for processing the recruitment, but all organisations will participate in the selection process.

9. Long term sustainability

Having a sustainable medical and nursing workforce across the network is critical to delivering services at the three units. The three health boards therefore will work together on the following:

- Joint recruitment of designated MTI and Clinical Fellow vacancies, with one organisation taking the lead in respect of the recruitment process on behalf of the three organisations
- Joint recruitment to designated ANNP vacancies, with one organisation taking the lead in respect of the recruitment to designated vacancies on behalf of three organisations
- Ensuring a collaborative approach to educational commissioning of ANNP training programmes to meet future needs
- Sharing of good practice in respect of:
 - The current arrangements for the recruitment and retention of ANNPs. This includes for example consistency around enhanced payments for additional hours
 - MTI arrangements across the network (particularly the importance of developing long term links with hospitals and universities abroad and the infrastructure that is required to provide pastoral support, training and education for MTIs when they are in post). Also critically important will be maintenance of the training reputation of units

- Development of academic clinical fellow posts linked with local universities
- Further exploratory work will then be undertaken with health boards to understand the options for:
 - Joint recruitment for neonatal nursing vacancies across the network with one organisation taking the lead for the recruitment process on behalf of the three organisations
 - A collaborative approach across the network to using the existing workforce more flexibly i.e. joint approaches to temporary staffing i.e. a network nurse bank and medical locums.
 - The introduction of a single employer model for neonatal services in South Wales

10. Financial planning

There are a number of key factors affecting the likely cost impact of new staffing models:

1. Deanery training posts are partially funded from a central training budget i.e. 50% of basic salary. Replacing trainees with non-training doctors therefore has an immediate cost impact
2. ANNP salary costs are lower than those of doctors working on the same rota although the hours of work are less. The overall impact varies between individuals
3. Increasing the number of nurses on the ANNP programme has indirect backfill costs and evidence suggests that to increase the attractiveness of the programme there should be new financial incentives
4. Development of innovative posts such as academic fellows has a cost impact because of the reduced availability for routine work compared with other staff on service contracts
5. Costs related to a more active and co-ordinated recruitment programme across the three provider health boards

However the cost pressures described above are dwarfed by the variable costs currently necessary to deliver services. It is estimated during the financial year 2015/16 variable costs across the three units were greater than £700K.

It has already been agreed by the Joint Committee that once the workforce plan is finalised, including agreement around options such as single employer models, that further financial planning will be undertaken by WHSSC to build on the recently agreed contracting framework system.

11. Risk assessment

There a number of significant risks and impacts to the workforce plan and recruitment plan have been assessed and included in **Appendix D**.

During the development of this plan, however a key risk has materialised with regards to recruitment timescales. BAPIO supported MTI recruitment has been delayed by 1 month and will now take place in October 2016. This means that it is almost certain that recruits will not take up post until April/May 2017 i.e. 4-6 weeks following changes to trainee allocation. The impact of this is that in March/May 2017 vacancies rates are likely to remain at least at existing levels.

Other significant risks include:

- Failure to recruit through limited national and international supply
- Reliance on the good will of existing staff
- Unpredictable loss of workforce through sickness, turnover and maternity.
- Reduced attractiveness of a non-deanery training site for any future consultant workforce
- Age profile of workforce is not an immediate risk but a number of consultants may choose to retire in the next 3 years (**Appendix E**)
- Insufficient numbers of ANNP in training programmes
- Failure of health boards to collaborate to ensure a future sustainable workforce with cross site working, rotations and shared protocols
- Lack of alignment of commissioning of nurse education and service planning

In understanding the scale of risk, predicted vacancies need to be seen in the context of the current level of risk in the system. To help understand this, the vacancy levels for July 2016 are provided below for comparison.

July 2016	SH	UHW (includes trainee allocation)	RGH	Total NICU Gaps	Comments how rotas covered
Tier 2 vacancies	4.8	2	0	6.8	SH covered the rotas through a mixture of locums, additional ANNP hours and consultants.
Tier 1 vacancies	2.8	2	0	4.8	SH covered the rotas through a mixture of locums and additional ANNP hours.
Supplementary rota vacancies	N/A	1	N/A	1	MTI commenced Aug 2016.
Total	7.6	5	0	12.6	

- **This shows that the NICU gaps in July 2016 were a minimum of 12.6 across the 3 sites**
- **This compares with NICU gaps in September 2016 of 7.9 which has been addressed through MTI recruitment at UHW and RGH**
- **This compares with a worst case scenario for March 2017 i.e. no recruitment of additional MTIs or ANNPs of 7.8**
- **This compares with a best case scenario for March 2017 i.e. full recruitment and retention of MTIs (or equivalent ANNPs) of over recruitment of MTI's by 3 and hybrid consultants by 2**

Mitigating actions have also been put in place to ensure the risk is reduced where possible. These include:

- Diversifying recruitment by taking forward ANNP recruitment alongside MTI recruitment
- Planning for a 'worst case scenario' with potential over recruitment
- Close monitoring of the recruitment process and ongoing collaboration between health boards to seek solutions should the recruitment process be unable to meet requirements. This will for the next year be undertaken by the Task and Finish Workforce Group. Depending on the future agreed recruitment and employment models, this arrangement may be superseded
- Health boards will continue to use their local arrangements and escalation policies including:
 - Use of locums and short term cover arrangements
 - Review of local protocols and rotational arrangements
 - Investigating the potential for an ANNP bank
 - Investigating opportunities for trainee allocation with the South West England Deanery
 - Investigating opportunities regarding an interim position of trainee allocation with the Wales Deanery for March/April 2017
- Health boards will benefit from the collaborative arrangements developed through this process.

11. Next steps

Whilst this paper offers relatively detailed short term proposals, it does not currently include detail regarding the development of longer term more sustainable work force plans. The collaborative working to date however provides a strong platform on which we can build and develop ongoing sustainable solutions. This will require further work and it has been agreed by the Workforce Group that a second paper will be produced for the 31st of October reflecting the decision of the Joint Committee on the 27th of September. This will include progress on implementation as well as proposals for more strategic workforce planning.

12. Recommendations

It is therefore recommended that:

- The key principles are accepted and;
 - There is ongoing commitment at health board level to continued, close collaborative working.
 - Joint and co-ordinated recruitment supported by dedicated human resources support is taken forward in each of the three units
 - It is signalled, to those at all levels in the provider organisations, that the risks of over recruitment should be tolerated within limits and that this position will be under continuous review
 - A more integrated employment model which may benefit the overall resilience of staffing in the three units should be explored.
 - Units should be identified as either 'Heath Board Training Units' or 'Deanery Training Units'

- Opportunities for rotational programmes are explored
- Provider organisations are made aware of the likelihood in March/April 2017 that vacancies levels will remain a challenge and mitigation may be required
- Financial modelling is taken forward by WHSSC following the agreement of this workforce plan
- A second paper describing the development strategy for creating a sustainable workforce model is brought to the Committee in November 2016
- The Workforce Task and Finish Group remains in place until September 2017 and continues a monitoring and escalation function.

In the meantime recruitment plans currently in train will proceed (i.e. Eleven MTI posts, open ANNP recruitment and two hybrid consultant posts at ABMUHB). This position will however remain under continuous review and in particular may need to be revised following the allocation decision.

9. Appendices

Appendix A – Workforce Analysis of Gaps

Appendix B - Alternative Staffing Models

Appendix C -Recruitment Plan

Appendix D -Risk Assessment

Workforce Analysis of Gaps

Tier 1 rota with effect from September 2016 to March 2017							
Role	AB	Gap	ABM U	Gap	Cardiff (2 rotas)	Gap	Comments
ANNP's	1.3		2.4		4	0	ABM has an additional 0.8 ANNP from October
Clinical Fellows	1		3.6		3	0	ABM has an additional CF from October. UHW Dr delayed on arrival
Deanery trainees	4	1			5.6	1.4	1 trainee returning from mat leave November

MTI's					2	1	MTI delayed arrival
Specialty doctors							
Total Staff in Post	6.3		6	0	14.6	2.4	
Workforce Gap to meet 1:8 rota compliance		-1.7		- 2		2.4	

Tier 2 rota with effect from September 2016 to March 2017							
Role	AB	Gap	ABMU	Gap	Cardiff	Gap	Comments
ANNP's			1.6				
Clinical Fellows	2				1		ABM has a locum tier 2 starting in October for 2 months
Deanery trainees			3	1	7.4	-0.04	
MTI's							
Specialty doctors	3		1				
Consultant/ hybrid consultants	3		0.6				AB have an agreement with 3 consultants to cover for 2 years
Total Staff in Post	8		6.2	1	8.4	-0.4	
Workforce Gap to meet 1:8 rota compliance		0		1.8		0.4	

Tier 1 rota with effect from March 2017								
Role	A	Gap	ABMU	Gap	Cardiff	Gap	Tota	Comments

	B				(2 rotas)		I Gap	
ANNP's	2	0	3.2		5			
Clinical Fellows					4			
Deanery trainees					7	0.4	0.4	
MTI's	2	4		5	2		9	All these post are reliant on either BAPIO or local MTI recruitment . These posts may not be filled until after March 2017
Total Staff in Post	4		3.2		18			
Workforce Gap to meet 1:8 rota complianc e	4		4.8		1.4			

Tier 2 rota with effect from March 2017								
	AB	Gap	ABMU	Gap	Cardiff	Gap	Total Gap	Comments
ANNP's	0.7	0	1.6					
Clinical Fellows	1	0	1	3	1	0	3	Based on the assumption we can recruit CF's
Deanery trainees					7.4	+ 0.4		
MTI's								
Specialty doctors	3	0	0.8	0	0	0	0	

consultant / hybrid	3.3	0	0.6 to 1.8 (depends on successful recruitment)					ABM These are based on local recruitment and may not be filled
total	8	0	4-5		8.4	+0.4		
Workforce Gap to meet 1:8 rota compliance		0		3		+0.4		

Appendix B

Alternative Staffing Models to Support Neonatal Units

A variety of different healthcare professional are now able to perform the tasks that were traditionally performed by trainees. Clinical Fellow posts, for instance, are non-training posts that carry similar pay and conditions to trainees. It is these posts that are most often submitted by health boards into the RCPCH Medical Training Initiative (MTI). Specialty doctor posts are similar to clinical fellows but tend to be permanent appointments.

Advanced Neonatal Nurse Practitioners (ANNPs) have successfully worked alongside (and taken the place of) doctors in NICUs for the last 15 years or so. Other professionals who have the potential to take on the traditional roles of doctors are physicians' associates and midwives.

- **Advanced Neonatal Nurse Practitioners (ANNPs)**

ANNPs are now able to perform identical tasks to doctors and carry equal responsibility in all but one aspect of medical work, the certification of death. They have been integrated extremely successfully into the medical rotas at both Gwent and Singleton NICUs, and provide a very high standard of work.

There are major advantages to ANNPs working on the medical rota. These include:

1. *Their high levels of clinical and technical skill.*

ANNPs will generally be able to take a comprehensive history, perform a thorough examination of a baby, assess the baby's condition, arrange appropriate investigations, document their findings on the notes and in electronic databases, prescribe treatments and perform all the common neonatal procedures.

2. *Their familiarity with the unit working practices and guidelines.*

Most ANNPs have an intimate knowledge of their unit, its personnel and the way things work. Many have worked as nurses on the same NICU for many years.

3. *Continuity of care.*

ANNPs are not subject to the need to change jobs every 6 to 12 months as is the case with trainees. They can therefore provide the continuity service the NICU needs, especially during times of induction and familiarisation of new trainees.

4. *Their knowledge of both nursing and medical issues.*

ANNPs have knowledge and experience of both nursing and medical roles. This may be an advantage eg during teaching activities, and allow them to develop specialist interests that may straddle both disciplines, eg family integrated care, developmental care, teaching.

5. *Rota stability.*

ANNPs tend not to move away from the units where they have settled, unlike trainees who rotate every 6 to 12 months and whose posts may or may not be filled by the deanery.

The employment of ANNPs on medical rotas has not been without its challenges, and it is important that comprehensive and urgent solutions to these issues are sought on a national basis in Wales. These challenges include:

1. *The relatively low number of nurses who want to be ANNPs.*

Not all nurses want to undergo the 1 to 2 year training programme that ANNPs have to get through before they are allowed to practice independently. The course is academically demanding, and passing all the assessments and examinations takes considerable commitment in terms of time and effort.

The course that ANNPs in Wales have attended is based in Southampton University, and involves several residential periods, with placements on tertiary level NICUs. The need to travel to Southampton puts nurses off ANNP training. A questionnaire survey of nurses in November 2012 by the Neonatal Network shows that nurses would be more likely to attend an ANNP course in Wales (see appendix 1). Setting up a Welsh university ANNP course was not thought to be a viable proposition as the numbers would be too small to sustain such a course in Wales. There may be some benefit to repeating this questionnaire to establish current attitudes toward ANNP training, as the role has developed further in recent years. Factors that may further incentivise ANNP training could be explored further.

2. *Depletion of experienced and skilled nurses from the nursing cohort of the NICU.*

Most ANNPs have been nurtured from the nurses that already work in the unit and this presents challenges in terms of backfilling vacancies that arise when nurses undertake ANNP training later qualify. The pool of qualified children's nurses in Wales should be expanded to ensure that vacated nursing posts can be filled.

For these reasons the acquisition of a large team of ANNPs may take several years.

3. *Cross contractual difficulties.*

ANNPs will work in similar roles to doctors on the NICU, and may be fully part of the medical on call rota, yet their pay and conditions are governed by the "Agenda for Change" contract. This can present logistical problems in terms of payment of unsocial hours, leave arrangements, a restriction on hours to 37.5 hours per week, arrangements for payment for additional hours worked, monitoring start and finish times, and provision of rest periods.

All these will have to be negotiated with the ANNPs individually or as a group. Specific examples of professional difficulties that might arise include the payment of locum doctors, who may be paid more at an hourly rate than an ANNP for the same role, even though the work done by the ANNP may be of equal (if not higher) standard. There is an urgent need to establish national guidance on these issues so as to ensure fairness and consistency across Wales.

4. *Salary scales.*

ANNPs are paid from band 7 to band 8b. Adequate salaries to reflect their level of skill and responsibility are important to establish, especially if Wales is going to attract ANNPs from elsewhere. Typically ANNPs in Wales are paid at band 8a for first tier duties and band 8b for 2nd tier duties. These are seen as attractive salaries and the maintenance of these pay bands will benefit the recruitment of ANNPs. Suitable nurses may be encouraged to undertake ANNP training whatever their present band is. They do not need to achieve band 6 or 7 status first. The employment of hybrid consultants to fulfil middle grade duties may be much more expensive, however.

5. *Breadth of medical knowledge/capabilities.*

ANNPs are generally hugely experienced and skilled, but may not have the breadth of knowledge gained from a medical degree and subsequent postgraduate medical training. In practice this may not be a problem for NICUs, but issues may arise for instance when the resident cover for particular shifts may be completely provided by ANNPs, with the consultant being the only doctor on duty.

Death certificates must be completed by registered medical practitioners. This is the law and it is unlikely to change in the near future. The certification of death would have to be done by the consultant if he/she is the only doctor on duty at times when the resident cover is provided by ANNPs. In practice this may not present much difficulty - the consultant would likely be in attendance

anyway if the death was unexpected, and for an expected death, the certificate does not usually need to be completed urgently.

ANNPs must undertake additional training after qualification in order to be able to prescribe blood products. This may take several months, but local training is available.

Health boards may feel that there should always be a resident doctor on duty in addition to the ANNPs, but there is little specific guidance on this from the various advisory bodies (RCPCH, BAPM). There are examples of units that are entirely staffed out of hours by ANNPs (though these tend to be local neonatal units rather than NICUs) and also neonatal transport services that are almost entirely staffed by ANNPs. Until further advice is forthcoming on this issue, health boards may consider it prudent not to have junior rotas completely made up of ANNPs, but to have approximately equal numbers of doctors and ANNPs on the rotas as a whole.

6. Loss of ANNPs to other units.

This does not appear to have been a significant problem in Wales, but there are a large number of vacant posts around the UK that ANNPs could apply for, even after their home health board has provided funding to allow them to train. Health boards may wish to consider incentivising or formally agreeing the return of their qualified ANNPs to their home unit following qualification.

7. Professional regulation of ANNPs.

The Nursing Midwifery Council (NMC) is the regulatory body for ANNPs whereas for doctors it is the GMC. There is limited guidance relating specifically to the regulation of ANNPs working on medical rotas. The Welsh Government (WAG) had undertaken work in respect of governance arrangements for Advanced Nurse Practitioners, an important part of which is the maintenance of a comprehensive portfolio of their practice, as this is important evidence that ANNPs are maintaining their skills and availing themselves of appropriate CPD opportunities.

For ANNPs who are building up a portfolio of skills in order to work on the 2nd tier rota, the RCPCH curriculum for level 1 training in neonatology can be used as a suitable tool for judging whether an ANNP has the necessary skills to work at middle grade level.

8. Provision of time for supporting professional activities.

ANNPs should be given dedicated time for duties that are not directly clinical in nature. Suitable roles for ANNPs may include teaching roles, involvement in governance activities and research. Formal job planning is necessary to ensure time is included within the working week to fulfil these roles.

9. Cross health board working.

ANNPs working on local neonatal units or special care baby units should continue to have opportunities to visit, or work on NICUs. This may present difficulties when two or more health boards are involved. Sessions on NICUs can be undertaken as supporting professional activity (SPA) sessions; alternatively an honorary contract would allow ANNPs from smaller units to work paid shifts on the NICU, and vice versa. Consideration could be given to the formation of a Welsh "ANNP bank", and current ANNPs could be surveyed to ask whether they would be interested in this.

10. *Study leave.*

Nurses do not tend to have a dedicated study leave budget in the same way as doctors, but for ANNPs to maintain their clinical skills and knowledge, study leave to fund CPD activities is essential. A study leave budget solution is required for ANNPs to enable them to practice to the same level as doctors.

The Wales ANNP Forum

There is already an ANNP Forum that meets regularly under the auspices of the Wales Neonatal Network and this would be an ideal forum for discussing these issues. Links with senior HR managers may help the development of guidance to address these challenges.

• **Medical Training Initiative (MTI)**

This is a scheme that provides junior doctors from outside the European Union the opportunity to work and train in the UK for a period of 2 years. There are two types of MTI scheme: a "college-based" (in our case the RCPCH) MTI and an individual health board (or "Trust-based") MTI.

The All Wales Strategic Medical Workforce Group (AWSMWG) is working closely with the British Association of Physicians of Indian Origin (BAPIO) to lead, in conjunction with Health Boards in Wales, a recruitment campaign for MTIs for Wales (see Appendix 2). BAPIO have excellent links with both public and private institutions in India and their intention is to go out to these institutions and interview selected candidates in October 2016 with a view to commencing their posts in March/ September 2017. Six health boards have signed up to the scheme and a number of neonatal posts have been submitted from Wales. A Memorandum of Understanding has been drafted outlining the roles and responsibilities of the parties involved.

Advantages of recruiting doctors under the MTI scheme include:

1. *Not having to sit the PLAB examination*

The ability of Non-EU doctors to forego the Professional and Linguistic Assessments Board (PLAB) examination in order to be registered with the GMC. Registration with the GMC is mandatory in order to practice in the UK and in the past, the only way to become registered was by passing the PLAB exam. This is an expensive examination, the 2nd part of which is sat in the UK.

The MTI however is sponsored by the RCPCH and this means GMC registration can be granted without the PLAB exam providing a list of conditions are met.

2. MTI - eligible doctors are experienced paediatricians

They have already undergone a three year postgraduate qualification in their own country.

3. MTI - eligible doctors are usually highly motivated

Applicants wish to develop their skills further in the UK before returning home to undertake more advanced roles. They may wish to train in specialist skills (eg echocardiography) or undertake higher degrees (eg MSc Neonatal medicine) and these added opportunities may make posts highly attractive to overseas applicants.

4. Their ability to progress to middle grade roles

These doctors are expected to spend between 3 and 6 months on 1st tier rotas before moving up to middle grade rotas pending satisfactory progress.

5. High level of quality assurance

A significant quantity of evidence of eligibility is required by the RCPCH which ensures that there is a high level of quality assurance in the recruitment process.

Challenges associated with the recruitment of doctors under the MTI scheme may include:

1. Cultural adaptation to the NHS.

Problems may arise especially in relation to communication skills and customs/practice. This is being addressed by BAPIO who offer a specific induction programme to help doctors to adapt to UK working. The process of recruitment and selection is crucial to the success of the scheme. Non-face to face interviews (eg by Skype) may be used to select candidates but arranging for health boards to visit countries where there are interested applicants may be preferable.

2. The scheme is limited to two years.

The sponsorship of these posts by the RCPCH is linked to the acquisition of a tier 5 visa which allows Non-EU doctors to work in the UK for 2 years with the aim of returning to their home country at the end of this time.

3. Time taken to process an application.

Because of the rigorous checking process that is required, a large amount of evidence is required from the applicants to prove that they have the required training and qualifications. This takes 4 months or more, and applicants may give up due to quantity and complexity of work involved. Assistance may be

given to applicants with this process and locum agencies have been successfully employed to support applicants by some health boards in Wales. Further means of support with accommodation, relocation packages, purchasing air tickets etc will encourage applicants to carry out their intention to move to the UK to work.

4. Doctors may not progress quickly enough to become middle grade competent.

There are examples of MTI doctors being recruited directly on to middle grade rotas without the necessary skills, and this has led to significant difficulties for health boards. The RCPCH does not require MTI doctors to progress to the middle grade after 6 months, but will allow departments to make their own judgments on the doctors' readiness for more senior roles.

MTI posts should be as attractive as possible and rotational posts may be a good way of increasing the value of these posts to applicants. Regional Wales rotations could be developed for both MTI and clinical fellow posts. Possible neonatal rotations may include spending time in Newport or Singleton NICUs and rotating to the Cardiff NICU to gain surgical experience. Other combinations could include neonatology and general paediatrics – this would benefit MTI doctors, for instance, who wish to prepare for the MRCPCH examination which is still a highly valued postgraduate qualification in many countries, or a neonatal post combined with other specialties such as paediatric respiratory medicine.

- **Clinical Fellows**

Clinical Fellow posts are occupied by doctors who are not currently part of a training programme, but who wish to have experience in a particular specialty. These posts may attract doctors who are undecided on a long term career path, or doctors who have finished their training and are waiting for a consultant post. Such posts should be offered along with clear guidance on what the expected role is, and doctors should be encouraged and supported to maintain a portfolio of learning. They should be seen as developmental posts rather than simply filling in slots in rotas. An opportunity to complete a higher degree, or to undertake training in a specific specialty skill such as cardiac ultrasound or neuro-developmental assessment, may add greatly to the appeal of this kind of post.

- **Academic Fellow posts**

A small number of academic fellow posts already exist in paediatrics, and are normally appointed via the deanery. Health boards may link with universities to create clinical fellow posts that include a research element. These would be attractive to doctors who may wish to pursue an academic career path or build on their academic experience. Such posts take time to organise and require close liaison between clinical and academic staff to ensure that both elements of the post are adequately supervised and organised.

- **Teaching Fellow Posts**

A number of posts have been created in the UK in the past with a specific undergraduate teaching component. These may appeal to doctors who enjoy teaching and who want to develop their educational skills. There may be opportunities for additional funding from medical schools to support teaching in the clinical environment (eg SIFT funding)

- **Physicians Associates**

Graduates may now train in the UK to become Physicians Associates (PAs) by undertaking a higher degree/diploma in Physicians Associate studies. An example is the course provided by Worcester University. This is a 2-4 year course depending whether undertaken full or part time. A diploma course is currently being developed at Swansea University.

These are relatively new courses, but it is envisaged that PAs will be trained in many skills traditionally required by doctors, including history taking, examinations and technical procedures. Whilst PAs cannot entirely replace doctors, and there is little guidance from the regulatory bodies on their employment within the neonatal environment, there is significant potential for employing them in the future to reduce the burden of doctors' work in the NICU, such that fewer tasks might be required of the doctors and ANNPs.

- **Midwives**

Midwives are increasingly being trained and employed to perform the newborn examination, which has traditionally been a large part of the work of neonatal trainees. Newborn examinations are an important means of detecting potentially treatable abnormalities early in life, but tend to be seen by trainees as a high volume, low educational-value activity. On many 1:8 1st tier medical rotas, 1 week in 8 may be spent covering the postnatal ward, and the bulk of this work is newborn examinations. However when midwives perform this examination, there is evidence that they can do this to an equal standard to doctors, and in some respects may perform better than doctors. It will be neither possible nor desirable to remove doctors from the postnatal ward altogether, but if this part of the doctors' work can be covered by midwives, this will at least take some pressure off the medical rota.

Conclusion

It is clear that ANNPs present a potentially very successful solution to medical staffing difficulties, but in order to improve recruitment and ensure that we retain our ANNPs in Wales, it is crucial that regional guidance for health boards is produced so that solutions can be found to the challenges listed in this paper. There is a great deal of inconsistency and uncertainty within and between health boards and comprehensive guidance is urgently required.

Smaller neonatal units may benefit greatly from the development of ANNPs, and rotational posts linking smaller units with larger NICUs may be mutually beneficial to both. The formation of a Welsh ANNP bank could be considered.

The AWSMWG/BAPIO collaboration promises to be an excellent example of a regional initiative to address junior doctor shortages and neonatal units may wish to avail themselves of the opportunity this offers to attract high quality MTI applicants with the additional support that BAPIO brings.

It is important that MTI and clinical fellow posts are as attractive as possible and the added value of a higher degree (eg MSc Neonatal medicine), or training in specialist skills may be important to recruitment. Wales rotational posts may be developed for MTI and clinical fellow posts; these may include time in non-surgical and surgical neonatal units, or neonatal and general paediatrics posts for the benefit of doctors wishing to prepare for the MRCPCH examination.

Appendix C – Recruitment Plan to include spreadsheet

Appendix D – Risk Assessment

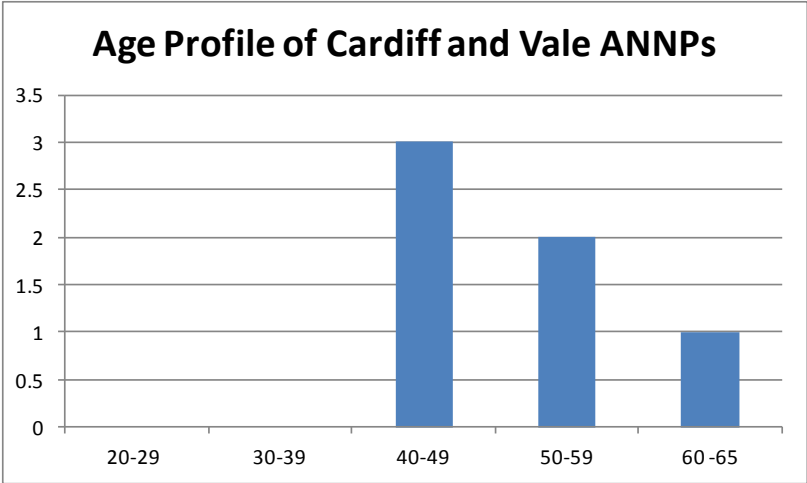
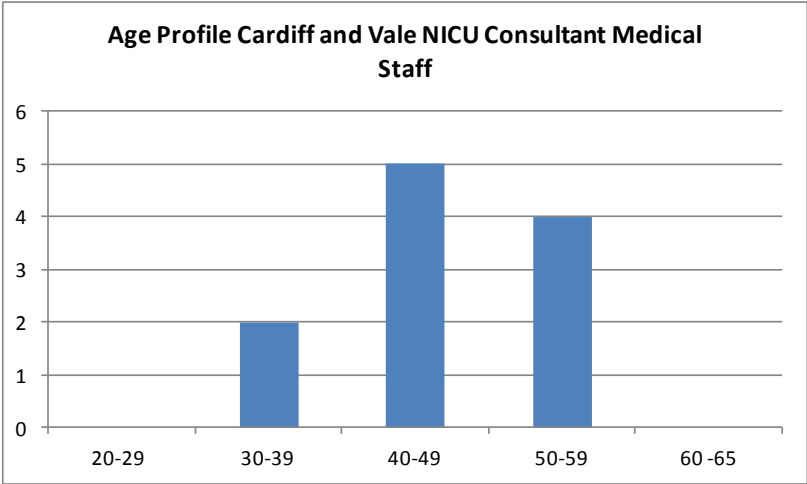
Risk Assessment for March 2017				
Risk	Impact	Risk Score	Actions required to reduce risk	Controls required to monitor risk
Failure of staff recruited to commence employment before March 2017	<ul style="list-style-type: none"> Inability to fill rotas at sites Mar-May 	High	<ul style="list-style-type: none"> Have pre prepared JD's and Averts Ensure advertisements are advertised within timescales within recruitment plan. Ensure tracking and administration time for recruitment processes to mitigate delays in processing time. Ensure ongoing close working with BAPIO through health board leads 	<ul style="list-style-type: none"> Task and Finish group meeting w/c 12th October 2016 to establish recruitment position and escalate action plan. Monthly monitoring of recruitment against resource requirements for March 2017 Escalated through Health boards risk management and escalation procedures Escalated through Shared Services
Failure to recruit Clinical Fellows	<ul style="list-style-type: none"> Inability to fill tier 2 rota at ABM 	High	<ul style="list-style-type: none"> Health boards collaboratively recruit for ANNPs band 8b in parallel with MTI recruitment Use of Medical and Agency Locum Review local arrangements to review existing consultants job plans to sustain services 	<ul style="list-style-type: none"> Task and Finish group meeting w/c 12th October 2016 to establish recruitment position and escalate action plan. Monthly monitoring of recruitment against resource requirements for March 2017 Escalated through health boards risk management and escalation procedures
Failure to Recruit hybrid consultant workforce	<ul style="list-style-type: none"> Inability to fill tier 2 rotas through local recruitment to ABMU 2 rota 	High	<ul style="list-style-type: none"> Amend job descriptions to ensure attractive to applicants Health boards collaborative approach to recruit for ANNPs band 8b in parallel with MTI recruitment Use of Medical and Agency Locum Review local arrangements to review 	<ul style="list-style-type: none"> Task and Finish group meeting w/c 12th October 2016 to establish recruitment position and escalate action plan. Monthly monitoring of recruitment against resource requirements for March 2017

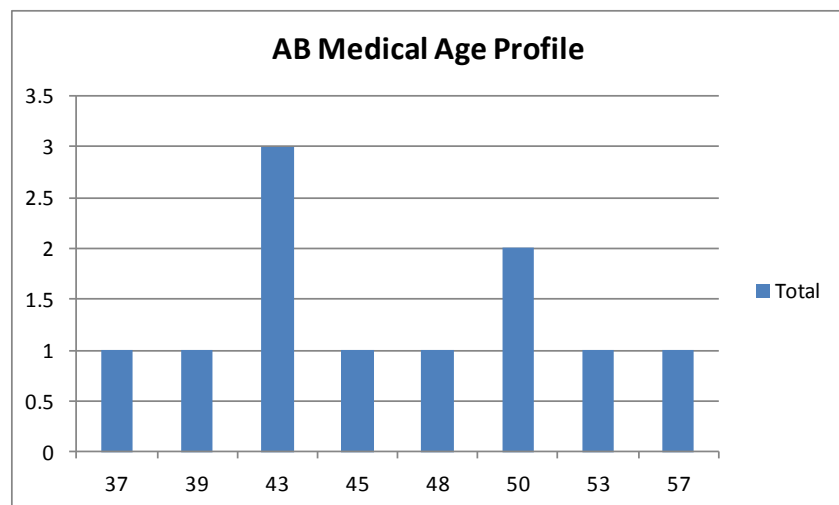
			existing consultants job plans to sustain services	<ul style="list-style-type: none"> Escalated through health boards risk management and escalation procedures
Failure to recruit ANNP band 8a following failure to recruit MTI	<ul style="list-style-type: none"> Inability to fill tier 1 rota at AB/ABMU 	High	<ul style="list-style-type: none"> Have pre prepared JD's and Averts All new graduates from Southampton have accepted posts, therefore recruitment will need to be opened widely across the UK through Journals and through NHS jobs Advertise these posts at the same time as the MTI post Long term ensure mechanism for backfill for ANNP training 	<ul style="list-style-type: none"> Task and Finish group meeting w/c 12th October 2016 to establish recruitment position and escalate action plan. Monthly monitoring of recruitment against resource requirements for March 2017 Escalated through Health Boards risk management and escalation procedures
Failure to recruit ANNP band 8b following failure to recruit Consultant hybrid or MTI/CF	<ul style="list-style-type: none"> Inability to fill tier 2 rota in the absence of either hybrid consultants or MTI/CF 	High	<ul style="list-style-type: none"> Have pre prepared JD's and Averts In the short term will need to recruit externally through journals and NHS jobs. 	<ul style="list-style-type: none"> Task and Finish group meeting w/c 12th October 2016 to establish recruitment position and escalate action plan. Monthly monitoring of recruitment against resource requirements for March 2017 Escalated through health boards risk management and escalation procedures
Failure to develop a collaborative relationship between provider organisations	<ul style="list-style-type: none"> Inability to develop sustainable models and short term contingencies 	High	<ul style="list-style-type: none"> Ensure high level commitment via the joint committee Joint working through the Task and Finish Group Exploration of a joint employment model 	<ul style="list-style-type: none"> Ongoing monitoring via the Task and Finish Group
Potential to Over recruit ANNP	<ul style="list-style-type: none"> Financial implications for health 	Low	<ul style="list-style-type: none"> Ensure staff are offered posts to meet service sustainability with collaborative plan to meet future 	<ul style="list-style-type: none"> Monthly monitoring of recruitment against resource requirements for March 2017 and beyond March

	boards		sustainability. <ul style="list-style-type: none"> Ageing workforce of existing ANNP will reduce the risk in the long term 	2017
Potential to over recruit MTI/CF	<ul style="list-style-type: none"> Financial implications for health boards Increased capacity for training which may put additional pressure on service 	Low	<ul style="list-style-type: none"> Ensure staff are offered posts to meet service sustainability with collaborative workforce plan to meet longer term future sustainability. 	<ul style="list-style-type: none"> Monthly monitoring of recruitment against resource requirements for March 2017 and beyond March 2017
Failure to recruit substantive consultants after March 2017 to work in non deanery training site	<ul style="list-style-type: none"> Consultant doctors may not find non deanery training site attractive employment Inability to sustain rotas Impact on service delivery 	Medium	<ul style="list-style-type: none"> Ensure that the training identity for non deanery trainees is recognised for overseas MTI/CF and ANNP training 	<ul style="list-style-type: none"> Turnover rates Number Recruited against target Staff engagement surveys
High turnover of hybrid consultants	<ul style="list-style-type: none"> Consultants may chose to take up substantive consultant positions as 	High	<ul style="list-style-type: none"> Hybrid consultants is a potential short term solution until alternative workforce models can be implemented Continue to train ANNP to work at tier 2 level 	<ul style="list-style-type: none"> Monthly monitoring of recruitment against resource requirements for March 2017 Escalated through health boards risk management and escalation procedures

	they arise		<ul style="list-style-type: none"> Recruitment of Clinical Fellows for tier 2 Recruitment of tier MTI with potential to train to tier 2 after 6 months, pending skills. 	<ul style="list-style-type: none"> ANNP training programmes
Turnover of Staff, retirements sickness and Maternity leave	<ul style="list-style-type: none"> Inability to sustain rotas Impact on service delivery 	Medium	<ul style="list-style-type: none"> Unpredictability of short term and long term absence will potentially need to be managed through locum and agency Potential to explore improved sharing of resources through offering overtime and additional sessions at other health boards. 	<ul style="list-style-type: none"> Monthly monitoring of recruitment against resource requirements for March 2017. Monitoring of turnover, age profile Consider additional training of ANNP. Escalated through health boards risk management and escalation procedures

Appendix E





Welsh Health Specialised Services Committee
Trainee Allocation in Neonatal Intensive Care Units in South Wales
Independent Panel Minutes
Monday 12 September 2016

Present

Panel Members

Member Name		
Vivienne Harpwood (VH)	Lay (Chairman) – Chair Powys THB	
Dr Rebecca Mann (RM)	Clinical - Consultant NHS England	
Dr Brendan Harrington (BH)	Clinical – Consultant BCUHB	
Gordon Donaldson (GD)	Lay - Public	
Alison Davies(AD)	Clinical – Royal College of Nursing	
Natalie Grice (NG)	Lay - Parent	
Helen Kirrane (HK)	Lay - Bliss	
Mandy Cooke (MC)	Clinical – Nursing BCUHB	
Teresa Griffin (TG)	Clinical – Network Manager Thames and Wessex	
Liz Jenkins (LJ)	Lay – Equality and Human Rights Representative CTUHB	

Apologies:

None received		
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In Attendance

Name		
Dr Sian Lewis (SL)	Senior Responsible Officer	
Buffy Gallagher (BG)	Programme Manager	
Dr Sam Groves (SG)	Facilitator – Swansea Centre for Health Economics	
Dr Andrew Champion (AC)	WHSSC Observer	
Christopher Coslett (CC)	WHSSC Observer	

Minutes:

Jacqui Davies	(JD)	Business Support Officer Neonatal Network
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1. Welcome and introductions

VH opened the meeting and welcomed all members of the panel, thanking them for agreeing to take part in this important piece of work. Introductions were made. Members were asked for declarations of interest and the following were reported:

NG: Journalist, Wales BBC Online

VH: Chair, Powys Teaching Health Board

SL: Member of GMC Quality Scrutiny Group and Expert Advisory Group for UK Standards in Education & Training

The interests were noted with no action required.

2. Background and overview

SL provided an overview of the background and context, including the structure of the NHS in South Wales and the location and current staffing position of the neonatal intensive care units (NICUs). She explained that the central issue for discussion concerned the allocation of trainees to these units and emphasised that maintaining 3 NICUs was part of the South Wales Programme. The University Hospital of Wales had been selected as a training unit by the Postgraduate Deanery. Therefore the recommendation to be made by the panel

concerned the most appropriate site to which trainee doctors should be allocated, the choice to be made being between Singleton Hospital in Swansea and the Royal Gwent Hospital in Newport. It was noted that the work was designed to maintain the three NICUs in South Wales, and the only issue under consideration was the allocation of trainees. The draft workforce plan, which had yet to be finalised, was presented to the panel.

There was a general discussion, during which it was explained that while education changes did not entail service change, decisions of this type could not be cost neutral.

The legal framework for the decision making process was outlined by the Chair, and members of the panel were urged to keep in mind the terms of reference throughout the deliberations. The purpose of the meeting was to decide on the allocation of trainee doctors to either Singleton NICU or Royal Gwent NICU. It was confirmed that the recommendations based on the views of the panel would be final, and the Chair stressed that any recommendations would be embargoed until the 21st September.

SL provided a detailed background which included a timeline since January 2012 when the Deanery first informed Health Boards of their intention to change the allocation of trainees.

3. How the criteria were agreed

SL explained the process by which the four criteria for voting had been agreed, and elucidated the weighting system. There followed an explanation of the voting system and its qualities of anonymity, efficiency and equity. Concerns about independence and transparency were expressed by GD, but it was emphasised that the panel contained the correct balance of lay and independent members.

BH noted that 50% fewer sick babies were treated at the Royal Gwent Hospital than at Singleton, which meant that the opportunities for training future doctors were correspondingly fewer there. RM pointed out that the recommended model for future NICUs in the UK would require a resident consultant to provide enhanced support for trainees, and that 25% of units in the UK currently have such arrangements in place.

There was some discussion about the ranking of the criteria following stakeholder engagement, and it was accepted that the independence of the panel should be respected. There was a suggestion by BH, which the panel accepted, that although the stakeholder ranking was an important consideration, the ranking of the criteria by the independent panel should not be influenced by

it, and should reach a decision of its own. RM suggested two separate columns for the ranking process, one based on the stakeholders' views and the other on those of the panel members. SL stated that this approach would be acceptable and that the reasons for it could be reflected in the narrative that would be supplied to the Joint Committee.

Following further discussion about the wording used for the scoring, and more detailed explanation of the scoring system by SG, the evidence for each of the four criteria was examined in detail by the panel.

4. Result

SG presented the panel with the outcome of the scoring, and the relevant criteria were weighted according to both stakeholder ranking and individual opinions of panel members. The higher number prioritises that site for the

	Total mean without weighing	Total mean with stakeholder weighting	Total mean with independent panel weighting
Royal Gwent	19.20	18.5	19.27
Singleton	25.8	27.76	27.92

allocation of trainees from the Wales Deanery.

The results showed that irrespective of methodology, the weighting and scoring process produced the clear decision that Singleton Hospital NICU in Swansea should retain postgraduate training, rather than Royal Gwent Hospital in Newport. The recommendation of the panel was accordingly to that same effect.

5. Summary

The Chair summarised the day, and congratulated the team who had managed the meeting for their careful preparatory work and for the rigorous approach they had taken to the presentation of the evidence. VH referred again to the terms of reference to ensure that all panel members were content that the outcomes they had delivered were based on the evidence. The panel members agreed with the summary and resolved to make a recommendation that Singleton NICU should retain post graduate trainees and the Royal Gwent Hospital should have an alternative model. The Chair reiterated the need for the recommendation to be embargoed until September 21st.

(VH/SL 17.09.16)



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

		Agenda Item	9
Meeting Title	Joint Committee	Meeting Date	27/09/2016
Report Title	Horizon scanning and prioritisation of new interventions by WHSSC for funding in 2017/18		
Author (Job title)	Acting Medical Director		
Executive Lead (Job title)	Acting Medical Director	Public / In Committee	Public

Purpose	To invite members to review a new horizon scanning and prioritisation process for WHSSC and to request feedback on the draft document.			
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RATIFY <input type="checkbox"/>	APPROVE <input type="checkbox"/>	SUPPORT <input checked="" type="checkbox"/>	ASSURE <input type="checkbox"/>	INFORM <input checked="" type="checkbox"/>
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Sub Group /Committee	Management Group	Meeting Date	30/06/2016
		Meeting Date	

Recommendation(s)	<p>Members are asked to:</p> <ul style="list-style-type: none"> • Note the contents of this report; • Support the recommendation that this approach offers a clear and transparent process of prioritisation when comparing competing proposals for new investment; and • Support the proposal that the policy consultation process should not delay the commissioning of evidence evaluation which will be required irrespective of the final process adopted. 		
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Considerations within the report (tick as appropriate)

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

1.0 Situation

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

2.0 Background

Innovation within healthcare provides a stream of new treatments and interventions. Within the field of specialised services these often represent treatments of high cost for low patient numbers. Therefore ensuring best value for money and that the NHS in Wales can effectively commission services, making new treatments which offer clinically and cost effective interventions available, in a timely manner, requires the dual processes of horizon scanning and prioritisation. Horizon scanning identifies new interventions which may be suitable for funding and prioritisation allows them to be ranked in terms of clinical and cost effectiveness. This information when combined with information around demands from existing services and interventions will underpin and feed into the development of the WHSSC Integrated Commissioning Plan (ICP). Below is a proposal for taking forward these processes in 2016/17 for the development of the 2017/18 ICP.

2.1 Horizon Scanning

Horizon scanning requires a systematic examination of all relevant information sources in order to identify new and emerging technologies. These are summarised in Table 1. A comprehensive horizon scanning exercise was carried out by AWTTTC and the Medical Directorate at WHSCC in May 2016 to inform the process outlined in this report. The finalised list is available from the Medical Directorate at WHSSC.

Table 1. Proposed list of information sources for horizon scanning

Organisation	Information source
<ul style="list-style-type: none"> NICE Highly Specialised Technologies (HST) Guidance Work Programme. Positive assessments are currently obligatory to fund in Wales unless they are considered not to be implementable based on advice from WHSSC. This is an important group because of the very significant cost of these types of treatment (circa £250k per patient) NICE Technology Appraisal (TA) Guidance Work Programme. Positive assessments are obligatory to fund in Wales Other NICE guidance. There are a range of different types of guidance produced by NICE which are not mandatory. Of these the Interventional Procedures Guidance (IPG) and Medical Technologies Guidance are the areas most likely to impact on specialised services 	<p>https://www.nice.org.uk/guidance/development?type=hst</p> <p>https://www.nice.org.uk/guidance/published?type=ta</p> <p>https://www.nice.org.uk/guidance/published?type=ip and https://www.nice.org.uk/guidance/published?type=mtg</p>



<ul style="list-style-type: none"> • All Wales Medicine Strategy Group (AWMSG) Evidence Appraisal Work Programme: Positive appraisals are obligatory to fund in Wales • Interim Pathways Commissioning Group (IPCG). This group considers an unlicensed medicine or one outside of the normal treatment pathway identified via the 'One Wales' process. • Individual Patient Funding Requests (IPFR): The IPFR process often provides early indications of clinical demand for new treatments • Provider Health Boards and Trusts: WHSSC formally approaches providers on an annual basis to identify new interventions for development • NHS England Propositions. Many specialised services are delivered in England for the population of Wales and new service developments within England can stimulate demand from within Wales • Scottish Medicines Consortium • Northern Ireland and Social Care Board • Clinicians with a special interest in a clinical condition may lobby for commissioning of emergent therapies • Welsh Government strategic priorities. 	<p>http://www.awmsg.org/</p> <p>IPCG</p> <p>WHSSC</p> <p>Health Boards and Trusts</p> <p>NHSE Clinical Reference Groups (CRGs), Clinical Priorities Advisory Group (CPAG), *Rare Diseases Advisory Group (RDAG)</p> <p>https://www.scottishmedicines.org.uk/Home</p> <p>http://www.hscboard.hscni.net/ Individual clinicians</p> <p>Welsh Government</p>
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*It is anticipated that RDAG will become an advisory group to NHS Wales

Horizon scanning will generate three lists. Firstly, new interventions where there is currently an obligation to fund and secondly, new interventions that will need to be considered through a process of prioritisation (see below). Interventions for obligatory funding will require an impact assessment, policy development and Equality Impact Assessment (EIA) before progressing directly into ICP development. The third list will comprise all NICE TA/HST guidance and all AWMSG appraisals which have been turned down. All of these will be excluded from this process.

2.2 **Prioritisation of new interventions**

The following key principles have been identified:

1. That the process is specific for Wales and therefore reflects the needs and priorities of our population.
2. That the process reflects current Welsh Government (WG) policy and in particular the principles of Prudent Health Care. During the development of this prioritisation process we will need to respond rapidly to any new initiatives or recommendations from WG, for example the proposed New Treatment Fund.
3. That in line with the principles of Prudent Health Care we do not (wherever possible) duplicate work already completed within the other UK nations around evidence evaluation and prioritisation.

4. That where the process identifies interventions where the evidence for clinical or cost effectiveness is very weak or there are safety concerns, a parallel process for no routine commissioning should be developed.
5. The need to ensure appropriate and timely engagement and consultation with colleagues in NHS Wales during the prioritisation process. There should also be input from the WHSSC programme team during horizon scanning, evidence review and evaluation.

Also, importantly, we are sensitive to the interdependencies of our clinical services with those in England and our reliance on English providers for a number of specialised services. This means that when there are differences in commissioning decisions there are clear implementations plans to manage the patient pathway.

2.3 The method of prioritisation

The principle steps within any prioritisation process are that of evidence evaluation, policy development including equality impact assessment and scoring to develop a ranking of interventions. It is worth noting that NHSE have established a new and very comprehensive, prioritisation process for 2016. This has involved a significant investment in evidence evaluation and potentially provides an important resource for use in Wales. The output of this process has therefore been considered within the development of the prioritisation process in Wales for 2016-17. Further information on this process can be found by accessing the following web link (<https://www.england.nhs.uk/commissioning/cpag/>).

A prioritisation process also exists in NHS Scotland and this is managed by their National Specialised Services Committee.

Proposed prioritisation process in Wales:

The horizon scanning process described above will identify those interventions where there is an obligation to fund as well as those where there is discretion. This prioritisation process only deals with the latter group. Below describes in more detail the steps required. A schematic overview of the process is presented in Appendix A.

- **Step 1: Cross referencing to other UK policy positions where a cost avoidance case has already been made.** These are policy propositions given a positive recommendation by the Clinical Priorities Advisory Group (CPAG) in England, see: (<https://www.england.nhs.uk/2016/07/spec-services-investment/>). We have assumed that these will be applied in Wales and will therefore not be part of the prioritisation process described in this report. However any interventions identified within this category will require an impact assessment and then progress directly into Integrated Medium Term Plan (IMTP) development. In parallel a process of consultation and EIA will occur to ensure this is appropriate within the Welsh context.

- **Step 2: Cross referencing to other UK policy positions where an evidence evaluation has been made.** This is to ensure that where a recent evidence evaluation has been carried out this is not unnecessarily duplicated in Wales.
- **Step 3: Identifying those remaining interventions where a full evidence evaluation is required** or where updating an existing evidence evaluation is needed.
- **Step 4: Commissioning an evidence evaluation** (the process for this has yet to be determined)
- **Step 5: Developing a policy proposition based on the evidence evaluation.** This policy proposition may either be positive or negative. (There are currently no standing committees to do this. The proposal is for a 'task and finish' group will be set up to do this work). Negative policy propositions will be handled through the separate process described below.
- **Step 6: Carry out a formal consultation on the policy proposition (including the evidence evaluation) and undertake an EIA.** Both positive and negative propositions will be issued for consultation.
- **Step 7: Undertake a scoring and ranking process.** This work will be carried out by a 'Prioritisation Panel' using methodology described in the All Wales Prioritisation Framework (2011) (see: <http://www.cardiffandvaleuhb.wales.nhs.uk/sitesplus/documents/1143/3%2018.pdf>). The proposed membership of the Prioritisation Panel is presented in section 5.8)
- **Step 8: Undertake a quality assurance (QA) review of the process**
- **Step 9: Assuming satisfactory sign off via the QA process products will feed into the wider WHSSC prioritisation process** which includes the development of existing services and interventions. Only following completion of this stage will the decision regarding routine commissioning be made.

2.3.1 Negative policy propositions from England

A total of 32 interventions have been endorsed with a negative policy position during the 2016 round of prioritisation i.e. **no routine commissioning** (see <https://www.england.nhs.uk/2016/07/spec-services-investment/>). These were identified during the evidence evaluation and policy development process when the evidence for clinical and cost effectiveness was felt to be insufficient for that intervention to be considered within the prioritisation process. The evidence evaluation and the policy proposition were then considered by the NHSE Specialised Services Clinical Panel. The Clinical Panel then had the option either to endorse the negative proposition or ask for reconsideration. Very occasionally the panel which also reviewed positive policy positions changed the proposition to a negative position. Once the panel agreed the negative policy proposition, this and the evidence evaluation went out to public consultation. Alongside this EIA was carried out. The policy was reviewed following the consultation and the final

version including the evidence evaluation, consultation process and EIA are quality assured by the CPAG at which WHSSC is an observer.

Given the rigor of this process and quality assurance step to which Wales has direct access we therefore propose that all negative policy propositions from England i.e. **no routine commissioning** undergo consideration for implementation within Wales. This process of consideration will comprise 3 steps:

- A consultation process to assess whether there are any additional factors within Wales which might impact on our decision to implement the policy proposition which were not considered within the English context. This might relate to:
 - The demographics of our population
 - Our service delivery model
 - Protected categories within Wales

The consultation process has now started. During August and September 2016 we will be releasing all 32 policy propositions for stakeholder consultation in a series of 'waves', each containing a maximum of 7 policies. Each 'wave' will be issued one week apart. The first wave was sent out on the 24 August. Each consultation wave will be accompanied by a structured proforma where feedback can be submitted. Copies of all policies and consultation material are available on the WHSSC website.

Following consultation a panel within WHSSC will review whether the output of the consultation process changes the decision not to routinely commission. Any overturned policies will then be fed into the WHSSC prioritisation process.

- A review within WHSSC of whether the output of the consultation process changes the decision not to routinely commission
- A quality assurance process to ensure the output of the consultation process has been given due regard and the final position is endorsed

2.3.2 Negative policy propositions from Wales

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

2.3.3 No routine commissioning

In those circumstances where a decision for **no routine commissioning** is endorsed WHSSC will be required to carry out an assessment of current use of the intervention, QA the process and where necessary develop an implementation plan. The criteria for triggering the development of an implementation plan are yet to be determined. However the development of

an implementation plan may be required if some patients are already receiving the treatment or are on the patient pathway through the IPFR route or because the Health Board has funded.

3.0 Assessment

3.1 Delivering the Prioritisation Process

This will involve:

1. Identifying resources to commission the evidence evaluations for interventions not scrutinised elsewhere. Current indications are there will be 5 interventions requiring evidence appraisal. A list of potential providers who can provide high quality and rapid evidence evaluations has been developed.
2. Identifying resources to develop policy propositions for interventions not developed elsewhere. Current indications are there will be approximately 10 interventions requiring policy development.
3. Establishing a 'Task and Finish Group' and a 'Prioritisation Panel' (according to the All Wales Prioritisation Framework) and agreeing membership and meeting schedules. This work is currently underway and will be completed by the 2 November 2016.
4. Establishing a group (according to the All Wales prioritisation Framework) to provide quality assurance of the process or identifying another committee to perform the function such as Quality and Patient Safety. WHSSC and the Prioritisation Panel will need to react to any emerging issues that present once the ICP is nearing completion and sign off.
5. From 2017 onwards the prioritisation process within WHSCC will take place between April and September.

4.0 Recommendations

The process described offers a clear and transparent approach to prioritisation within Wales. It also wherever possible reduces duplication of work with other UK nations. It is recommended that this approach is consulted upon with stakeholders including the Community Health Council, Welsh Government and UHB Commissioners.

Members are asked to:

- **Note** the contents of this report;
- **Support** the recommendation that this approach offers a clear and transparent process of prioritisation when comparing competing proposals for new investment; and
- **Support** the proposal that the policy consultation process should not delay the commissioning of evidence evaluation which will be required irrespective of the final process adopted.

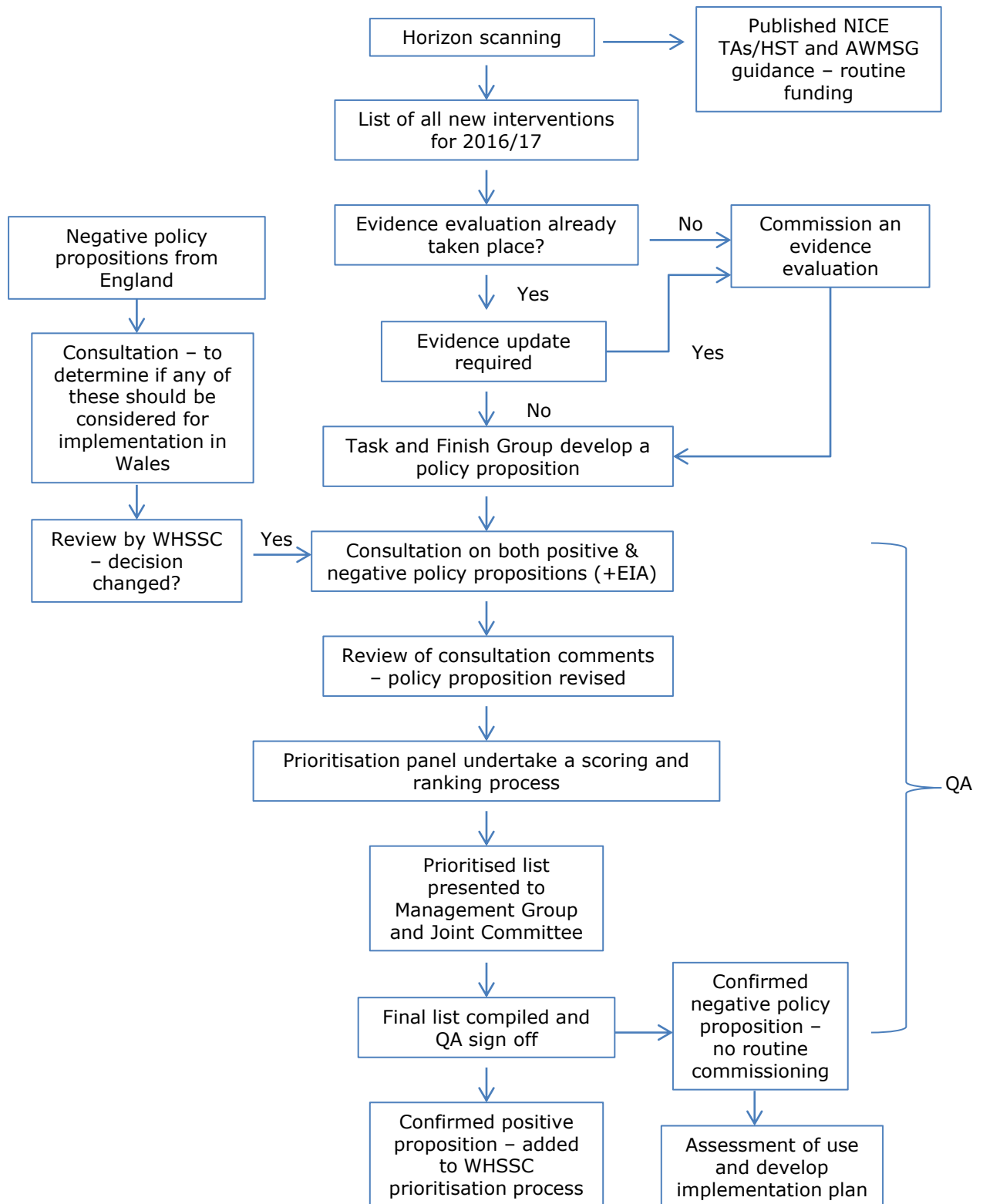
5.0 Appendices

Appendix A Overview of the draft prioritisation process



Link to Healthcare Objectives		
Strategic Objective(s)	Development of the Plan Organisation Development Governance and Assurance	
Link to Integrated Commissioning Plan	The outcome of the prioritisation process, when combined with information around demands from existing services and interventions, will underpin and feed into the development of the WHSSC Integrated Commissioning Plan.	
Health and Care Standards	Governance, Leadership and Accountability Effective Care	
Principles of Prudent Healthcare	Only do what is needed Reduce inappropriate variation Public & professionals are equal partners through co-production	
Institute for HealthCare Improvement Triple Aim	Not applicable	
Organisational Implications		
Quality, Safety & Patient Experience		
Resources Implications	All positive propositions will be added to the overall WHSSC protestation process for investment.	
Risk and Assurance	Will be managed in line with the agreed ICP risk management process.	
Evidence Base	Any evidence evaluation (of safety and effectiveness) carried out as part of this process will enhance future investment decisions.	
Equality and Diversity	All policy propositions will be subject to a full EIA.	
Population Health	There are no additional implications for population health in this report.	
Legal Implications	There are no legal implications associated with this report.	
Report History:		
Presented at:	Date	Brief Summary of Outcome

Appendix A: Overview of the prioritisation process for Wales





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

		Agenda Item	10
Meeting Title	Joint Committee	Meeting Date	27/09/2016
Report Title	Development of the Integrated Commissioning Plan for Specialised Services 2017-2020		
Author (Job title)	Acting Director of Planning		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	Public

Purpose	This paper includes a series of proposals for ensuring closer integration between NHS Wales provider and commissioner organisations in the development of the <i>Integrated Commissioning Plan for Specialised Services 2017-20</i> , and sets out the draft commissioning intentions to guide the development of the plan.			
RATIFY <input type="checkbox"/>	APPROVE <input checked="" type="checkbox"/>	SUPPORT <input type="checkbox"/>	ASSURE <input type="checkbox"/>	INFORM <input type="checkbox"/>

Sub Group /Committee	Corporate Directors Group Board	Meeting Date	15/08/2016
	Management Group Meeting	Meeting Date	25/08/2016
Recommendation(s)	<p>Members are asked to :</p> <ul style="list-style-type: none"> • Approve the proposed process and draft timeline for the development of the integrated commissioning plan for specialised services for 2017-20; and, • Approve the draft <i>Strategic Commissioning Intentions for Specialised Services 2017/18</i>. 		

Considerations within the report (tick as appropriate)

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

DEVELOPMENT OF THE INTEGRATED COMMISSIONING PLAN FOR SPECIALISED SERVICES FOR 2017-20

1. PURPOSE OF REPORT

This paper includes a series of proposals for ensuring closer integration between NHS Wales provider and commissioner organisations in the development of the *Integrated Commissioning Plan for Specialised Services 2017-20*, and sets out the draft commissioning intentions to guide the development of the plan.

2. BACKGROUND

2.1 Integrated Commissioning Plan for Specialised Services 2016-19

The *Integrated Commissioning Plan for Specialised Services 2016-19* (ICP) was approved at the Joint Committee meeting in March 2016. The plan was developed through detailed engagement with Health Boards both individually and collectively through the WHSSC Management Group and Joint Committee. The organisation has since concentrated on delivery of the plan, in line with the monitoring arrangements previously agreed by the Management Group in August 2015.

In developing the ICP for 2016-19, service growth and service development schemes with a financial impact were subject to evidence appraisal and a clinical prioritisation exercise. A risk-rating mechanism was also agreed collectively with the Management Group. Schemes that were risk-rated as Black, Red and Amber were supported to be funded in 2016/17 following business case scrutiny. Schemes rated Green and Purple were not supported in 2016/17 and it was agreed these will be considered in the development of the ICP for 2017-20.

2.2 Developing the ICP

The process for developing the ICP for 2016-19 comprised seven main stages:

1. **Commissioning Intentions** – These were developed with the support of the Management Group and approved at the September meeting of the Joint Committee.
2. **Commissioner Priorities** – Following the approval of the Commissioning Intentions, the WHSSC finance and planning teams identified the top commissioning priorities in each programme. This was informed through the WHSSC programme team risk registers, and the provider risk registers.
3. **Horizon Scanning** – Technical horizon scanning exercise was led by the Medical Directors team to compile and assess the list of new drugs, interventions and technologies expected over the course of the plan.
4. **Baseline Review** – The WHSSC finance and planning teams undertook a comprehensive review of the contract baseline and service baseline, to identify

where there are recurrent pressures or under spends for consideration by Management Group.

5. **Savings and Repatriation** – the WHSSC finance and planning teams and the Health Board commissioners considered the opportunities for making savings and repatriation in specialised services.
6. **Review of Previous ICP Green Schemes** – The list of Green Schemes that were not prioritised for inclusion in the ICP were reviewed by the WHSSC team and Management Group and was agreed which of these would be included for re-consideration for the new plan.
7. **Risk Assessment** – all of the individual service schemes that were considered in the development of the Plan (whether identified through horizon scanning, by commissioners or by providers) were risk-rated by the WHSSC team and peer-reviewed through the Management Group workshops.

Following approval of the plan, further work was undertaken before any additional funding is released to providers. This included:

1. **Proposal (Business case)** – developed by the provider to address the risk identified.
2. **Assessment** – the proposal was assessed by the WHSSC finance and planning teams to see whether it was in line with the commissioning intention and the value included within the ICP, addressed the risk, and represented value for money.
3. **Funding Release Proforma** – following discussion with the provider and once the WHSSC finance and planning teams were satisfied that that proposal met all of the criteria; the funding release proforma was completed and submitted to Management Group for approval.
4. **Funding release letter** – this was issued to the provider following the approval of the funding release proforma by the Management Group.

2.3 2017-20 Integrated Commissioning Plan

Whilst the updated *NHS Wales Planning Framework* has yet to be published, it is understood that it is likely to bring forward the timetable for submission of the final plan to Welsh Government from March 2017 to January 2017. Therefore, this paper has been prepared in order that the planning process for the Integrated Commissioning Plan can commence as soon as possible. Once the framework has been published, the process will be reviewed and amended as necessary in order to ensure alignment.

3. ASSESSMENT

The current Funding Release process is highly resource intensive and time consuming. The level of scrutiny applied to each scheme has increased over the last 12 months, and as such the finance and planning teams have to provide additional information over and above that which is included on the approved template. Such a process is not sustainable as the cumulative effect of servicing the funding release process is impacting on the capacity available to undertake

core planning functions, including policy and specification development, performance management and delivery of the programme team workplan.

3.1 Proposed Process

In order to improve the planning process and address future capacity constraints associated with funding release proformas following the approval of the next ICP, it is proposed that the process is front loaded and that an open source methodology is employed which is consistent with the integrated healthcare model of NHS Wales.

The proposed process would comprise the following stages:

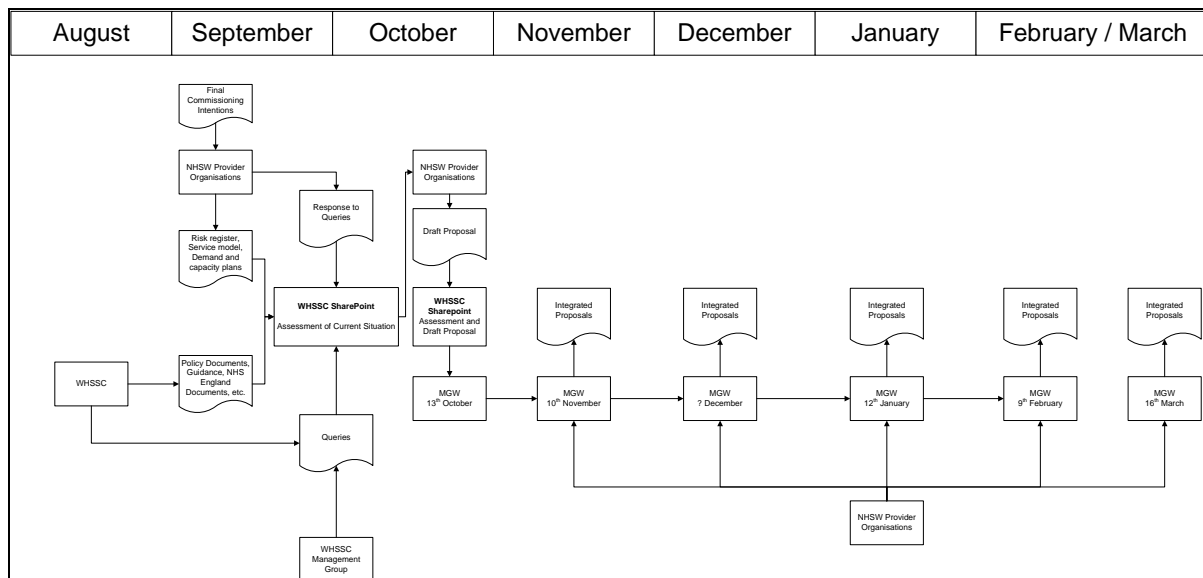
1. **Strategic Commissioning Intentions** – These are developed with the support of the Management Group and approved at the September meeting of the Joint Committee (annex i). Draft Strategic Commissioning Intentions are included within this paper.
2. **Commissioner Priorities** – Following the approval of the Strategic Commissioning Intentions, the WHSSC finance and planning teams identify the top commissioning priorities in each programme. This is informed through the WHSSC programme team risk registers, and the provider risk registers. These are issued to the providers to inform the development of proposals. This will also include any provider related issues identified through horizon scanning and the reassessment of green schemes from 2016/17.
3. **Integrated Proposal Development** – In order to ensure that there is an integrated approach and common understanding of the risk and the proposal, an open source technique will be used. This will involve the use of the SharePoint portal, and a series of facilitated workshops during which Providers, members of the Management Group and the WHSSC finance and planning teams will review each of the draft proposals, and work in partnership to develop an agreed integrated proposal. The process would include the following steps:
 - a. **Assessment of Current Situation** - Providers will upload the relevant documents to the WHSSC SharePoint – including risk register, description of current service model, demand and capacity plans.
 - b. **National and Local Context** – WHSSC will upload any relevant documents relating to the service including policies, service specifications, and documents from other bodies including NHS England, Professional Organisations, etc
 - c. **Open Forum** – Following the publication of the documents to the WHSSC SharePoint – there will be a two week period in which members of the Management Group will be able to review and query the documents. All queries and responses will be collated and uploaded to the WHSSC SharePoint for future reference.
 - d. **Draft Proposal** – Using the feedback from the open forum, the providers will develop draft proposals to address each of the risks.

These draft proposals will form the foundation for the integrated proposal

- e. **Integrated Proposal** – Over the next ten weeks, members of the Management Group and the WHSSC finance and planning teams will work with the providers to develop agreed integrated proposals using a common template for each of the identified risks. The template will include outcome measures, in order to ensure that progress of the scheme can be monitored throughout the year. This work will be supported through a number of workshops which will include wider representation as required.

4. **Risk Assessment** – all of the integrated proposals that have been considered in the development of the Plan (whether identified through horizon scanning, by commissioners or by providers) are risk-rated and prioritised for inclusion in the plan by the Management Group.

This process is illustrated in the diagram below (annex ii):



Following approval of the plan, each provider will be informed of the funding and timescale for implementing schemes, and a monthly monitoring report will be submitted to the Management Group outlining progress.

Using this process will have the following advantages:

1. Improved accuracy of the financial values for service pressures, development and growth schemes within the ICP.
2. Reduced delay in implementing schemes following approval of the ICP.
3. Released capacity to support the implementation and monitoring of the plan, and the delivery of the programme work plans.
4. Improved engagement across NHS Wales.
5. Better alignment across provider and commissioner organisations.

3.2 North Wales

It is recognised that as a consequence of the current model of provision, under which the majority of specialised services for BCU and PTHB residents are provided by NHS England, the process to date has had a greater focus on specific issues within South Wales services. Therefore, in parallel with the workshops taking forward the integrated proposals, it is proposed that a series of workshops will be convened for BCU and Powys in order to provide a greater focus on developing detailed commissioning plan for the services provided to their residents by NHS England.

3.3 Timelines

Indicative timelines are set out in the diagram in annex ii, however subject to approval of the proposed process and commissioning intentions by the Joint Committee, a detailed timetable will be submitted to the next meeting of the Management Group.

3.4 Strategic Commissioning Intentions

The purpose of the strategic commissioning intentions is to provide notice to Health Boards and NHS Wales Trusts about the changes and planned developments in the commissioning and delivery of specialised services.

The draft strategic commissioning intentions (annex i) have been derived from the previous versions, and have been restructured in order to provide greater clarity and alignment with purpose of WHSSC:

"on behalf of the seven Health Boards; to ensure equitable access to safe, effective and sustainable services"

The intentions also align with ongoing work to further improve the WHSSC approach to the risk assessment of specialised services.

4. RECOMMENDATION

Members are asked to:

- **APPROVE** the proposed process and draft timeline for the development of the integrated commissioning plan for specialised services for 2017-20; and,
- **APPROVE** the draft *Strategic Commissioning Intentions for Specialised Services 2017/18*.

5. ANNEXES

Annex i – Draft Strategic Commissioning Intentions

Annex ii – Indicative time line



Link to Healthcare Objectives		
Strategic Objective(s)	Development of the Plan Governance and Assurance	
Link to Integrated Commissioning Plan	N/A	
Health and Care Standards	Governance, Leadership and Accountability Effective Care Effective Care	
Principles of Prudent Healthcare	Care for Those with the greatest health need first Only do what is needed Reduce inappropriate variation	
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Improving Health of Populations Reducing the per capita cost of health care	
Organisational Implications		
Quality, Safety & Patient Experience	Quality, Safety and Patient Experience are identified in WHSSC’s Strategic Commissioning Intentions which underpin the development of the ICP.	
Resources Implications	A financial framework is in place to support the development of the ICP.	
Risk and Assurance	The WHSSC ICP development process is supported by an agreed risk and assurance process. All individual schemes undergo scrutiny for risk and assurance.	
Evidence Base	Evidence evaluation is central to the WHSSC ICP development process.	
Equality and Diversity	EQUIA are completed for all schemes considered in the WHSSC ICP development process.	
Population Health	WHSSC ICP process takes account of impact of schemes on population health	
Legal Implications	None identified	
Report History:		
Presented at:	Date	Brief Summary of Outcome
Corporate Directors Group Board	15/08/2016	Supported
Management Group Meeting	25/08/2016	Supported

DRAFT WHSSC STRATEGIC COMMISSIONING INTENTIONS 2017/18

Aim

These intentions provide notice to Health Boards and NHS Wales Trusts about the changes and planned developments in the commissioning and delivery of specialised services.

The Integrated Commissioning Plan (ICP) is structured to support the purpose of the Welsh Health Specialised Services Committee (WHSSC), which is:

*"on behalf of the seven Health Boards; to ensure equitable access to
Safe,*

Quality and Patient Safety – WHSSC will implement the Quality and Outcomes Framework for Specialised Services agreed by Joint Committee in January 2015.

Patient experience – Patient experience will be captured using a variety of methods in conjunction with the Quality Framework.

Clinical risk – WHSSC will work with Health Boards to review their corporate risk registers in order to identify, and develop plans to address any clinical risks that have been identified, both within the services that they provide, or that their resident population access from another provider.

Effective,

Evidence-based commissioning – WHSSC will consider all proposals for new developments on the basis of the available evidence for clinical- and cost-effectiveness.

Delivery Measures and National Priorities – Providers are required to ensure that they have approved plans to meet and sustain the agreed Delivery Measures¹ and National Priorities.

Clinical Innovation – WHSSC will work closely with Welsh providers to review the potential for implementing clinical innovation where it is evidence-based and cost-effective.

Delivery risk – WHSSC will work with providers to review corporate risk registers to identify and develop plans to address risks identified by Health Boards relating to the delivery of specialised services.

¹ As set out in the NHS Wales Outcomes Measures Framework 2015

and **Sustainable** specialised services for the people of Wales.”

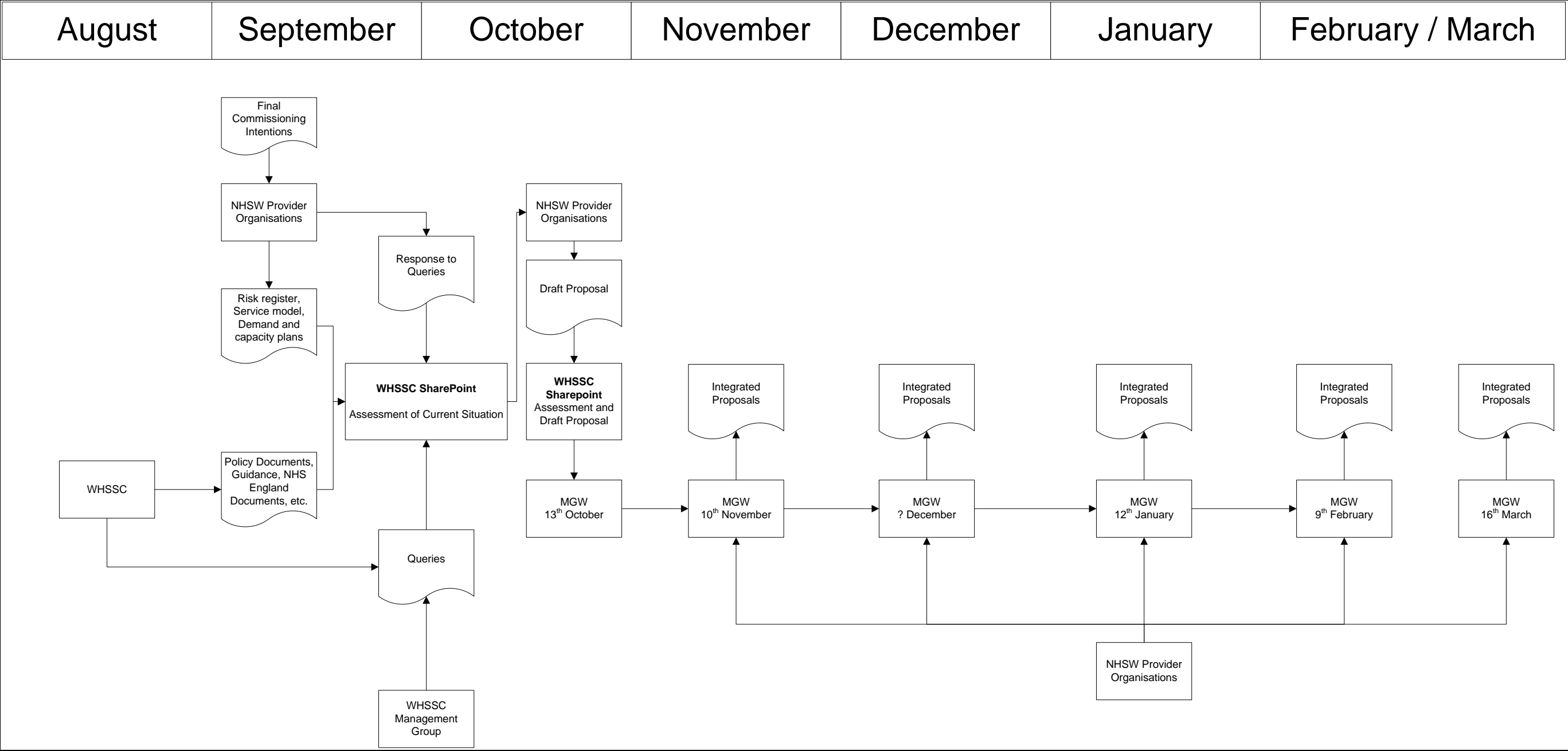
Wellbeing of Future Generations – In line with the Well-being of Future Generations (Wales) Act 2015, WHSSC will work with all stakeholders to ensure that each of the five sustainable development principles – long term thinking, prevention, involvement, collaboration and integration, are reflected in all of the services that it commissions on behalf of Health Boards.

Managing within Resources – WHSSC has a duty on behalf of NHS Wales to utilise its allocated resources effectively and efficiently and to manage specialised services within the resources agreed by NHS Wales.

- There will be no additional funding for inflationary or cost pressures.
- Providers will be expected to ensure that any local cost improvement plans for specialised services are clearly identified, and confirm that the plans will have no adverse impact on the quality or performance of the service.

Demand – WHSSC will expect Health Boards to ensure that appropriate referral pathways are in place, including primary and secondary care provision, in order to ensure that all referrals into specialised services are managed in accordance with the agreed pathways of care.

Service risk - WHSSC will work with providers to review corporate risk registers to identify and develop plans to address risks identified by Health Boards relating to the sustainability of specialised services.





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Arbenigol Cymru (PGIAC)
Welsh Health Specialised
Services Committee (WHSSC)

		Agenda Item	11
Meeting Title	Joint Committee	Meeting Date	27/09/2016
Report Title	Thoracic Surgery Review		
Author (Job title)	Specialised Services Planning Manager		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	Public

Purpose	The purpose of this paper is to: <ul style="list-style-type: none"> - Update Joint Committee on the progress of the Thoracic Surgery Review, in particular the Royal College of Surgeons Invited Review; - Seek support for the project structure and terms of reference for the Project Board. 			
RATIFY <input type="checkbox"/>	APPROVE <input type="checkbox"/>	SUPPORT <input checked="" type="checkbox"/>	ASSURE <input type="checkbox"/>	INFORM <input checked="" type="checkbox"/>

Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: <ul style="list-style-type: none"> • Note the progress to date of the thoracic surgery review; • Support the project structure and Project Board terms of reference. 		

Considerations within the report (tick as appropriate)

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

1.0 Situation

1.1 The purpose of this report is to:

- Update Joint Committee on the progress of the Thoracic Surgery Review, in particular, the Royal College of Surgeons Invited Review; and
- Seek support for the project structure and the terms of reference for the Project Board.

2.0 Background

2.1 As Joint Committee is aware, independent, external advice to the Thoracic Surgery Review has been commissioned from the Royal College of Surgeons through the Invited Review mechanism. The report from the Invited Review will provide key advice to inform the wider project to develop a commissioning plan for Thoracic Surgery in Wales.

2.2 WHSSC formally requested the Invited Review in June 2016. The Invited Review team was appointed in July and undertook its visit to Wales on 3 days from Monday 12th to Wednesday 14th September 2016 during which they visited Morriston Hospital and University Hospital of Wales. Alongside the RCS Invited Review, arrangements have been made to establish the Project Board and to further develop the structure for delivering the project to develop the commissioning plan.

3.0 Assessment

3.1 Royal College of Surgeons Invited Review Visit

A wide range of stakeholders were interviewed by the RCS Team, including service providers (involving the full MDT), referring clinicians, Cancer Network, relevant professional bodies, Community Health Council, and commissioners. At the conclusion of the interviews, preliminary verbal feedback was provided to WHSSC Executive Directors. This will be supported by a formal letter expected within the next week to outline the main findings. The full report is expected within approximately a further 6 weeks.

The Project Board is scheduled to meet at the end of September. It will consider the letter from the RCS Invited Review and next steps for taking forward the project to develop proposals for the commissioning plan to present to Joint Committee in January 2017.

3.2 Invited Review Feedback: Safety Concern

Joint Committee should be aware that the initial feedback included an immediate patient safety concern affecting both centres: the Invited Review team were concerned that there did not appear to be a clear or published arrangement for providing out of hours cover for either thoracic trauma or

thoracic in-patients. The WHSSC Medical Director has raised this as an urgent issue with Medical Directors in both Health Boards. A copy of the cover arrangements and agreed rotas has been requested to ensure that the services currently being commissioned are safe and sustainable while the review is completed and the new commissioning plan for thoracic surgery is developed. An update on the responses will be provided at the Joint Committee meeting.

3.3 **Project Structure**

The project initiation document sets out the proposed project structure.

- The outputs from the project will be reported to the Joint Committee which will agree and sign off the recommendations from the Project Board.
- The Project Board will provide oversight of the conduct of the project and will sign-off the method of approach for delivery of the products.
- A steering group, chaired by the WHSSC Director of Planning, will manage the operational delivery of the project.
- Working groups will develop the work and report to the steering group.
- The project will interface with other relevant strategic initiatives, in particular the on-going work of the NHS Wales Collaborative to review major trauma provision in Wales.

3.4 **Project Board Terms of Reference**

The specific terms of reference of the Project Board are to:

- Agree the Project Initiation Document: Thoracic Surgery – Development of a Commissioning Plan for Wales.
- Receive and consider the advice of the Royal College of Surgeons Invited Review.
- Agree the framework for the appraisal of options for the future service model for Thoracic Surgery.
- Agree the report to Joint Committee to recommend a commissioning plan for Thoracic Surgery in Wales.
- Agree the implementation plan for the preferred model for Thoracic Surgery in Wales.

The Project Board's membership includes the range of key stakeholders:

- Patient representatives
- Welsh Cardiothoracic Surgery
- Welsh Thoracic Society
- Cancer Network
- Provider representatives from ABMUHB and CVUHB
- Commissioner representatives from each Health Board
- WHSSC Director of Planning (Chair)
- WHSSC Medical Director
- WHSSC Finance Manager
- WHSSC Care Quality

It is proposed that the Project Board will meet 4 times between September 2016 and February 2017.

4.0 Recommendations

4.1 Members are asked to:

- **Note** progress to date of the thoracic surgery review:
- **Support** the project structure and project board terms of reference.

5.0 Appendices / Annexes

5.1 Annex (i) Project Board Terms of Reference



Link to Healthcare Objectives		
Strategic Objective(s)	Implementation of the Plan	
Link to Integrated Commissioning Plan	Work plan objective to review model of service provision. Access to thoracic surgery for lung resection to improve patient outcomes in Wales is identified as one of the top 3 risks for WHSSC.	
Health and Care Standards	Effective Care Safe Care Timely Care	
Principles of Prudent Healthcare	Reduce inappropriate variation	
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations	
Organisational Implications		
Quality, Safety & Patient Experience	This paper provides an update on progress of the project to review Thoracic Surgery provision in Wales and develop a commissioning plan. The aims of the project include ensuring the service is safe, of high quality and provides the best possible patient experience.	
Resources Implications	Resource implications are outside the scope of this particular update report. However, they are included within the scope of the project.	
Risk and Assurance	This paper provides information that describes action to date to take forward the Thoracic Surgery Review. The paper notes early feedback from the RCS Invited Review regarding out of hours provision and action taken to address the concern raised.	
Evidence Base	This paper does not consider issues relating to the evidence base for thoracic surgery.	
Equality and Diversity	This paper does not consider issues relevant to equality and diversity.	
Population Health	The project to review Thoracic Surgery provision aims to produce recommendations that will benefit population health in Wales.	
Legal Implications	No legal issues are identified in this paper.	
Report History:		
Presented at:	Date	Brief Summary of Outcome
Not applicable		



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Welsh Health Specialised
Services Committee (WHSSC)

Thoracic Surgery Review

Project Board

Terms of Reference

1.0 Introduction

This document sets out the terms of reference for the Project Board for the Thoracic Surgery review.

2.0 Accountability

The Project Board will report through the WHSSC accountability structure to the Joint Committee of the 7 Health Boards in Wales.

3.0 Terms of Reference

The purpose of the Project Board is to oversee the process for the conduct of the review and to agree the report and recommendations to the Joint Committee.

The terms of reference of the Project Board are to:

- Agree the Project Initiation Document: Thoracic Surgery – Development of a Commissioning Plan for Wales.
- Receive and consider the advice of the Royal College of Surgeons Invited Review.
- Agree the framework for the appraisal of options for the future service model for Thoracic Surgery.
- Agree the report to Joint Committee to recommend a commissioning plan for Thoracic Surgery in Wales.
- Agree the implementation plan for the preferred model for Thoracic Surgery in Wales.

4.0 Membership

The Project Board will be chaired by the Director of Planning, WHSSC.

The membership is comprised of the following:

- Patient representatives
- Welsh Cardiothoracic Surgery
- Welsh Thoracic Society
- Cancer Network
- Provider representatives from ABMUHB and CVUHB
- Commissioner representatives from each Health Board
- WHSSC Director of Planning (Chair)
- WHSSC Medical Director
- WHSSC Finance Manager
- WHSSC Care Quality

5.0 Frequency of meetings

Four meetings will be held between September 2016 and March 2017.

Meeting	Date	Key Purpose
Meeting 1	September 2016	<ul style="list-style-type: none">• To agree PID• To consider RCS letter outlining main findings from the Invited Review.• Consider outline approach for options appraisal.
Meeting 2	November	<ul style="list-style-type: none">• To consider full report from RCS Invited Review.• To agree approach to options appraisal.
Meeting 3	December 2016 / January 2017	<ul style="list-style-type: none">• To agree report and recommendations to Joint Committee.
Meeting 4	February 2017	<ul style="list-style-type: none">• To agree implementation plan.

6.0 Recommendations

Recommendations from the Project Board to the Joint Committee will wherever possible be based on consensus. Where there are differing views, these will be made clear within the reports to Joint Committee. Final decisions will be made by the Joint Committee.



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Arbenigol Cymru (PGIAC)
Welsh Health Specialised
Services Committee (WHSSC)

		Agenda Item	12
Meeting Title	Joint Committee	Meeting Date	27/09/2016
Report Title	Update on the Implementation of the Plan		
Author (Job title)	Acting Director of Planning		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	Public

Purpose	To provide an update to members on the status of the higher risk 'amber' schemes, and to notify members of the timeline for considering economic benefit amber schemes.			
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RATIFY <input type="checkbox"/>	APPROVE <input checked="" type="checkbox"/>	SUPPORT <input type="checkbox"/>	ASSURE <input type="checkbox"/>	INFORM <input checked="" type="checkbox"/>
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Sub Group /Committee	Corporate Directors Group Board	Meeting Date	12/09/2016
	Management Group	Meeting Date	22/09/2016

Recommendation(s)	<p>Members are asked to:</p> <ul style="list-style-type: none"> • Note the current position of the Amber Higher Risk Schemes • Note the prudent assessment of recurrent slippage on planned investments for 2017/18 onwards of £2.195m pa • Approve delegation of the highest risk amber schemes (3 related neurosurgery schemes, clinical immunology and cleft lip and palate) totalling a maximum of £1.877m pa to the WHSSC Management Group for decision, on a case by case basis; and • Note that an update on the remaining schemes will be made to the November Joint Committee meeting. 			
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Considerations within the report (tick as appropriate)

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

1.0 Situation

- 1.1 The Integrated Commissioning Plan 2016-19 (ICP) was approved by the Joint Committee on the 22nd March.
- 1.2 The ICP includes an additional £9m for mandatory new service developments, unavoidable demand and delivery of RTT.
- 1.3 The ICP does not include funding for a number of schemes which have been categorised as higher risk, and are currently valued at £2.3m.

2.0 Background

- 2.1 At the last meeting of the Joint Committee, a paper was presented on the current status of the higher risk schemes, which included a calculation of the current slippage from new developments, together with a proposal to use this to fund the higher risk schemes. Members resolved to:
 - **Approve** the consideration of slippage from new developments and funding released through other sources to fund Amber Higher Risk Schemes on a case by case basis;
 - **Approve** the delegation of the Neurosurgery schemes to the WHSSC Management Group for decision; and
 - **Note** that recommendations on the remaining schemes will be made to the Joint Committee scheduled for September.
- 2.2 In addition it was agreed that Cardiff and Vale Health Board would confirm the greatest risk for the neuroscience service, as it was agreed that it would not be possible to wait until September to approve funding
- 2.3 This paper provides an update on the work undertaken to date, as well as an update on the current level of slippage that is available from new developments.

3.0 Assessment

- 3.1 Following discussion between WHSSC and Cardiff and Vale Health Board, it has been subsequently confirmed that the highest priority for the service and the Health Board was to address the shortfall in junior doctor cover for the neurosurgery service.
- 3.2 **Schemes approved by Management Group** – the core neurosurgery scheme was approved by the Management Group at the meeting on the – however whilst members approved funding for the clinical fellow posts, they did not approve funding for the advanced nurse practitioner posts.
- 3.3 **Ongoing work** – Further work is ongoing with the Management Group on the following schemes:

Core Neurosurgery

- 3.2 A paper was presented to the July Management Group seeking agreement for the staffing complement referenced in section 2.3 however only the clinical/clinical research fellows were resourced.
- 3.3 An increase in the clinical registrars is a positive and a requirement in order to address the Deanery changes however the need for nurse practitioners is of equal need to ensure a safe and sustainable service for patients. Having nurse practitioners resourced to carry out a 7 day a week service ensures continuity of care for patients, improving not only the care provided but also the patient experience. It is the nursing element that provides the sustainability of the service as the medical staff employed are on fixed term rather than permanent contracts and whilst not training posts, are still not senior and require Consultant support and training.

Neuro-radiology

- 3.4 Cardiff and Vale submitted a business case as part of the 2016/17 IMTP for the remaining support staff that were originally included within the 2015/16 business case for the Neuro-radiology service. Currently the Health Board is scheduling lists 5 days per week, however due to the shortages noted the cancellation of vascular, ERCP and Neuro-radiology lists is taking place. As well as the risks associated with cancelling other patients at short notice the management of subarachnoid haemorrhage should be carried out within 48 hours, as recommended by NCEPOD and the service is at high risk of not meeting this standard. WHSSC have requested further information on the neuro-radiology activity from the two Consultant posts appointed in 2015/16 in order to understand whether there will be a further increase in activity on the appointment of support staff, or an ability to undertake neuro-radiology lists without impacting on non specialised radiology activity.

Neurovascular

- 3.5 The Health Board submitted a business case in order to formalise current arrangements for a safe and sustainable Neurovascular service. The case asked for a consultant neurovascular surgeon as well as the components for a formal MDT. This is the rationale for the inclusion of the 0.17 WTE core neurosurgeon and interventional neuro-radiologist within the case. We are awaiting the proposed job plan for the consultant post and an understanding of why the MDT was not formalised in the job plan of the two new neuro radiologists appointed following the approval of the 2015/16 business case from the HB. On receipt of this information a formal paper will be presented to Management Group.
- 3.6 More information is required on each of the cases before formal submission to Management Group for consideration. We are awaiting confirmation from the HB the priority of each of the outstanding Neurosciences cases.

- 3.7 In the interim, WHSSC is due to facilitate a workshop in Cardiff and Vale which will provide members of Management Group and appropriate clinical representation from each Health Board, the opportunity to understand the delivery of tertiary Neurosciences in Cardiff. This will give members an opportunity to see the range of services and sub specialties that are delivered and how the different elements link together. It will highlight the gaps that are currently in the services, the risks associated with these gaps and what actions the service will need to take should further funding not be released.
- 3.8 If these issues are not resolved there is a risk that services will need to be outsourced to NHS England at full cost, as happened in April 2015 due to the shortages in Consultant Neuro-radiologists.

Clinical Immunology Infrastructure

- 3.9 The ICP includes £0.4m for clinical immunology treatments, in recognition of the increased demand for the service following earlier diagnosis of patients with primary immunodeficiency syndromes. However, the infrastructure required to deliver the increased activity was assigned to the higher risk category within the ICP, and as a consequence is not funded.
- 3.10 Significant work was undertaken by the programme team on these proposals over the summer period in order to clarify the exact funding requirements. Following further scrutiny and discussion, these values have reduced significantly, and funding release proformas have been prepared for the September meeting of the Management Group, in order that the Group can make a recommendation on the schemes to Joint Committee.

Cleft Lip and Palate

- 3.11 Further discussion is ongoing with ABM Health Board regarding the nature and priority of the Cleft Lip and Palate scheme, in order to inform further discussion at Management Group.
- 3.12 **Completed work** – Following dialogue with Cardiff and Vale Health Board in its capacity as provider, the following schemes will now be deferred for consideration as part of the development of the 2017-20 ICP:

- NICU
- Neuropathology
- Paediatric cardiology standards
- Fetal medicine

In the interim, these schemes will continue to be monitored as part of the existing risk management strategy.

3.13 Managed through IPFR

Proton Beam Therapy

3.14 Access to treatment through Proton Beam Therapy for children and teenage and young people is currently being managed through the IPFR process. WHSSC continues to have discussion with Welsh Government regarding potential availability of health innovation funding to cover the cost of these schemes.

3.15 **New Treatments Fund** – Since the last meeting of the Joint Committee, there has been further clarification from Welsh Government on the new fund for high cost treatments. On the 12th July the Cabinet Secretary for Health informed the Senedd, that a £80m fund will be established by December to provide 12 months of funding for new treatments which have been determined to be cost effective. In view of this announcement it would appear that this fund will not be available to fund the high cost drugs included within the WHSSC ICP, and therefore it is now unlikely that the existing funding currently committed can be released towards the residual risks described in this paper.

3.16 The total costs of the schemes are summarised in the table below:

Table 1

Scheme	Risk Score	2016/17 £m	2017/18 £m	Management
Proton Beam Therapy - Child	44	0.550	1.100	Potential funding through WG Innovation
Proton Beam Therapy - TYP	44	0.330	0.550	
Sub Total		0.880	1.650	
Neurovascular	56	0.243	0.280	Potential funding through: 1. Slippage on new developments 2. Possible contributions from High Cost Drugs Fund
Neurosurgery	45	0.258	1.000	
Interventional neuroradiology	40	0.155	0.207	
Sub Total		0.656	1.487	
NICU	44	0.255		Provider no longer taking these schemes forward as 16/17 issues
Neuropathology	49	0.050	0.100	
Paediatric Cardiology Standards	41	0.091	0.182	
Fetal Medicine	44	0.060	0.120	
Sub Total		0.456	0.402	
Clinical Immunology (infrastructure)	40	0.225	0.300	Review priority with Management Group
CLP service	40	0.054	0.107	
Sub Total		0.279	0.407	

3.17 However, taking into account the management of the schemes as described in the preceding section, the key risks which require approval are summarised below:

Table 2

Scheme	Risk Score	2016/17 £m	2017/18 £m	Management
Neurovascular	56	0.140	0.280	Potential funding through: 1. Slippage on new developments 2. Possible contributions from High Cost Drugs Fund
Neurosurgery	45	0.258	1.000	
Interventional neuroradiology	40	0.104	0.207	
Sub Total		0.502	1.487	
Clinical Immunology (infrastructure) ¹	40	0.202	0.400	Review priority with Management Group
Sub Total		0.704	1.887	

3.18 **Slippage** - The table below sets out the current slippage forecast for Red and Amber Schemes:

Table 3

Table 9c Scheme	2016/17 £m	Recurrent Slippage £m
Susoctocog - Haemophilia	(0.380)	(0.950)
Ataluren NS Duchene Muscular Dystrophy	(0.248)	(0.350)
PET	-	(0.108)
Fetal and Paediatric Cardiology	(0.100)	(0.065)
Paeds Surgery		(0.129)
Thoracic Surgery	(0.003)	(0.593)
Total Slippage	(0.731)	(2.195)

The recurrent slippage of £2.195m forecast at this stage for known developments that have been approved, would be sufficient to cover the schemes outlined in table 3.

3.19 In addition to the slippage for new schemes, there is a discrete element of slippage relating to the cardiac surgery service in South Wales. Whilst the three year arrangement is still in place in order to support both units achieving the 36 week RTT, the current level of demand is much lower than previously planned. As a consequence it will not be necessary to commission

the proposed additional activity in 2016/17, and therefore it may be possible to release approximately £1m funding to support the higher risk schemes. Further work will be undertaken in order to determine the recurrent effect. Updates on this work will be presented at future meetings.

- 3.20 **Write-back Opportunity** – As the financial year progresses there will be greater certainty regarding the value of any write-back of financial provision from last year. Whilst the scale of this potential differs significantly by Health Board it could present a potential source of non-recurrent funding for higher risk schemes, subject to the overall financial position.
- 3.21 **Economic Benefits to Health Boards** – The ICP includes a number of schemes which will have economic benefits for Health Boards pending an investment in specialised services. The schemes have been included as cost neutral within the ICP in order to reflect the economic benefits that they will provide. Further work will be undertaken on these schemes over the next few months by the WHSSC Management Group.

Table 4

Economic Benefits to Health Boards Amber Graded Schemes	Risk Score	2016/17 £m	2017/18 £m
Cardiac ablation (AF and VT) - Expansion of EP services	48	0.131	0.262
Cardiac ablation (AF)	48	0.131	0.262
Genetics - UKGTN	37	0.030	0.030
Genetics - Stratified Medicine	37	0.150	0.150
LVA evaluation	34	0.042	0.084
Endobronchial Valve Replacement (EBVR) NICE IPG465	33	0.172	0.172
Total offsetting savings realised within Health Boards		(0.656)	(0.960)

4.0 Recommendations

4.1 Members are asked to:

- **Note** the current position of the Amber Higher Risk Schemes
- **Note** the prudent assessment of recurrent slippage on planned investments for 2017/18 onwards of £2.195m pa
- **Approve** delegation of the highest risk amber schemes (3 related neurosurgery schemes, clinical immunology and cleft lip and palate) totalling a maximum of £1.877m pa to the WHSSC Management Group for decision, on a case by case basis; and
- **Note** that an update on the remaining schemes will be made to the November Joint Committee meeting.



Link to Healthcare Objectives		
Strategic Objective(s)	Implementation of the Plan Governance and Assurance	
Link to Integrated Commissioning Plan	The ICP identifies a number of schemes which are recognised as higher risk but are currently affordable.	
Health and Care Standards	Effective Care Safe Care Staff and Resourcing	
Principles of Prudent Healthcare	Care for Those with the greatest health need first Reduce inappropriate variation	
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Improving Health of Populations Reducing the per capita cost of health care	
Organisational Implications		
Quality, Safety & Patient Experience	Without investment there is a risk that a number of these services will not be sustainable within Wales and therefore patients will be required to travel to alternative centres.	
Resources Implications	If the service is provided outside of Wales the cost will increase substantially.	
Risk and Assurance	There is risk to patient safety as the current services are not sustainable.	
Evidence Base	There are separate evidence bases for each of the schemes covered in this paper.	
Equality and Diversity	Investment in these services would reduce the inequitable access across Wales	
Population Health	None	
Legal Implications	None	
Report History:		
Presented at:	Date	Brief Summary of Outcome
Corporate Directors Group Board	12.09.2016	Supported
Management Group	22.09.2016	



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Arbenigol Cymru (PGIAC)
Welsh Health Specialised
Services Committee (WHSSC)

		Agenda Item	13
Meeting Title	Joint Committee	Meeting Date	27/09/2016
Report Title	WHSSC Joint Committee Self-Assessment 2015-16		
Author (Job title)	Corporate Governance Officer		
Executive Lead (Job title)	Acting Committee Secretary	Public / In Committee	Public

Purpose	The purpose of this paper is to provide members with information relating to the outcome of the Joint Committee's annual self-assessment.			
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RATIFY <input type="checkbox"/>	APPROVE <input type="checkbox"/>	SUPPORT <input type="checkbox"/>	ASSURE <input type="checkbox"/>	INFORM <input checked="" type="checkbox"/>
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Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	

Recommendation(s)	<p>Members are asked to:</p> <ul style="list-style-type: none"> Note the information presented within the report. 		
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Considerations within the report (tick as appropriate)

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

1.0 Situation

- 1.1 The purpose of this paper is to provide members with information relating to the outcome of the Joint Committee's annual self-assessment.

2.0 Background

- 2.1 Section 8.3 of the Standing Orders for WHSSC provides guidance in relation to reviewing the performance of the Joint Committee, its joint sub-Committees, Expert Panel and Advisory Groups. In which it states that:

"The Joint Committee shall introduce a process of regular and rigorous self assessment and evaluation of its own operations and performance and that of its joint sub-Committees, expert panels and any other Advisory Groups. Where appropriate, the Joint Committee may determine that such evaluation may be independently facilitated."

- 2.2 To support this and to ensure good governance practice Members of the Joint Committee were asked to complete an anonymous self-assessment questionnaire to understand the Committee's effectiveness and highlight any areas for improvement.
- 2.3 The questionnaire was split into four areas: Composition, Establishment and Duties; Effectiveness; Compliance with the Law and Regulations Governing the NHS; and Individual Effectiveness. There was also an opportunity for members and deputies to provide free text comment in relation to anything that worked well or required improvement/clarity.

3.0 Assessment

- 3.1 The initial questionnaire was circulated on 30 June 2016 with responses requested by 8 July 2016. However, due to external factors there was a low response rate and the Chair requested the questionnaire be resent to members to undertake the process again to try and ensure a response rate which is more representative and therefore provide more meaningful information.

3.2 Response Rate

The survey was distributed to all Members and Associate members of the Joint Committee; this was a total of 16 individuals. 13 responses were received. This represents an **overall response rate of 81%**

3.3 Composition, Establishment and Duties

This section of the assessment related to the structural framework of the Joint Committee. 8% of those who responded did not feel that Committee meetings were well attended and consistently attended. There was some uncertainty amongst members in relation distribution of assignments to Members and whether the Committee undertook regular assessment of its effectiveness.

In addition to this 100% of members were either not sure or disagreed with the statement relating to appropriate induction and training for members undertaking their role on the Joint Committee. Members may wish to note that this was reflected through WHSSC and was a common theme in the self-assessments undertaken by both the joint sub-committees and advisory groups. This is an area in which the WHSSC team are considering as part of a wider piece of work.

The responses to all other statements were mostly positive including operating within and familiarity of the guidelines set out in the Governance and Accountability Framework and the appropriateness of the knowledge and background of Independent Members.

3.4 **Effectiveness**

This section of the assessment related to the work carried out by the Joint Committee. The majority of responses were positive with the main areas of disagreement or uncertainty focussing around consideration of appropriateness and level of information received, provision of clear direction to sub-groups and a process for managing/monitoring areas for development to ensure the Joint Committee's effectiveness.

The comments from this section noted that there appeared to be a varying degree of scrutiny amongst Members, and although scrutiny is provided it was perceived that this was undertaken by a small number of Members. It was also felt that the Joint Committee was well chaired with clear outcomes.

3.5 **Compliance with the Law and Regulations Governing the NHS**

In this section respondents were asked about the wider elements of the Joint Committee's role, how it integrates with the wider WHSSC governance structure and the assurances it receives from its joint sub-committees.

The responses received within this section highlighted a higher level of uncertainty or disagreement than the previous sections. More than half the respondents felt that there had not been/or were unsure that any formal consideration had been given as to the way in which it integrates within the NHS in Wales. 39% of all respondents were not sure whether/or disagreed that the Joint Committee had a mechanism in place to keep it aware of topical legal and regulatory issues.

It is worth noting that the responses from the Joint Committee in relation to a review of robustness of data behind reports and assurances it receives echoes that of the sub-committee self assessments, in which there was a high level of disagreement/uncertainty around this. As a result the WHSSC team are considering this as a wider piece of work.

3.6 Individual Effectiveness

This section of the assessment sought to identify the individuals' views in regard to their own knowledge and skills relating to identification of issues and ability to challenge executives and management on critical and sensitive matters.

It was interesting to note there was a clear split between responses from Independent Members in relation to opportunities for development. Where Associate Members, Chief Executive Members and WHSSC Officer Members agreed that these opportunities were available, the majority of Independent Members responded 'not sure'.

Overall all Members felt that they had sufficient knowledge and understanding of the organisation to identify issues appropriately and felt confident to challenge colleagues on critical and/or sensitive matters.

3.7 Considerations for Members of the Joint Committee

Overall, responses to the self assessment questions were positive; with 74.5% of all responses agreed with the statements.

Members may wish to discuss and consider:

- The way in which assignments (e.g. delegated tasks including those to Chair's of sub-committees) are distributed to members of the Committee;
- The differing opinion around the Committees effectiveness;
- Independent Members' views in relation to development opportunities to support/improve effectiveness within their role; and
- The way in which members can receive assurance of mechanism in place to keep the Joint Committee aware of topical legal and regulatory issues.

4.0 Recommendations

4.1 Members are asked to:

- **Note** the information presented within the report which is to be presented to the Joint Committee in September 2016.

5.0 Appendices / Annexes

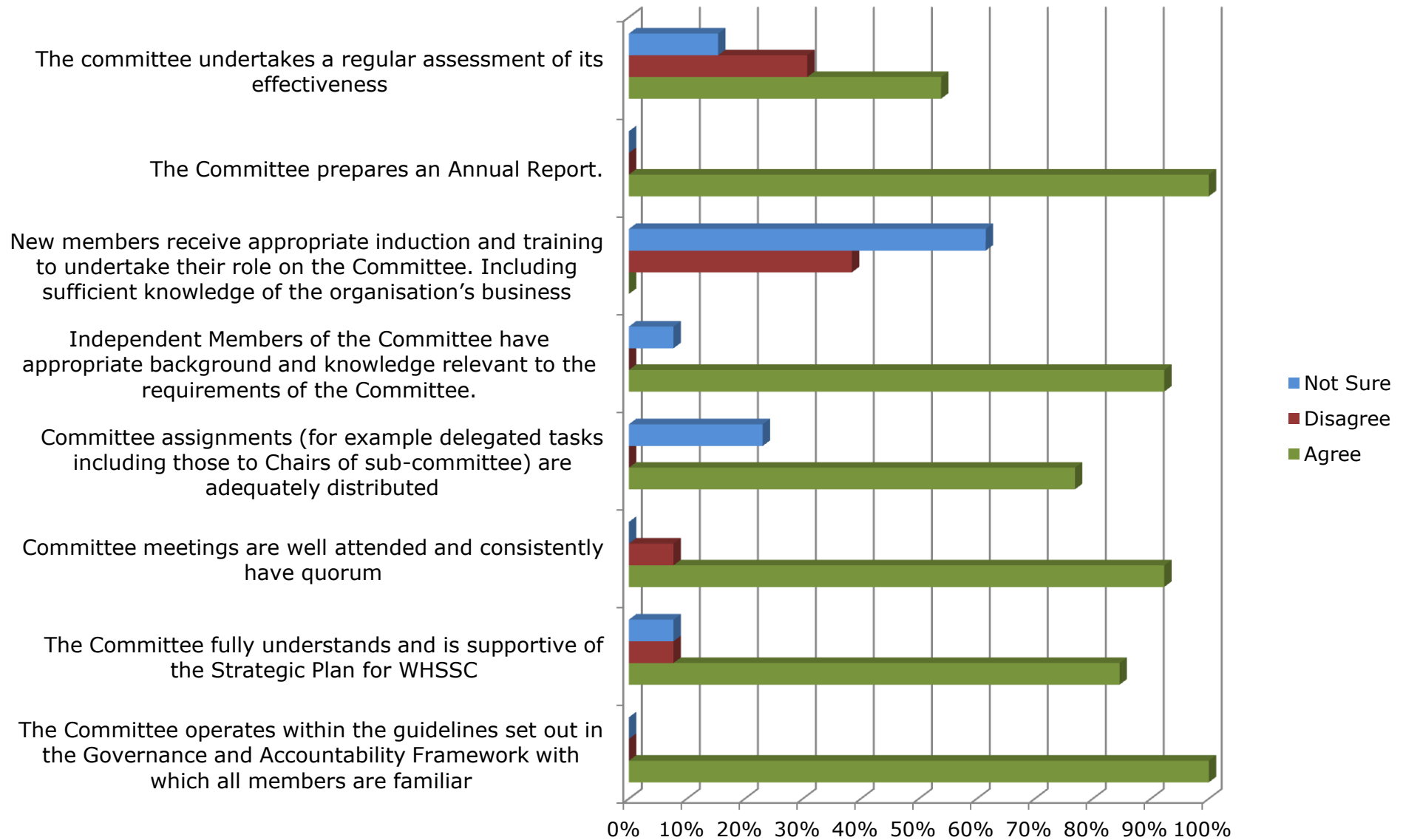
5.1 Appendix A – WHSSC Joint Committee Self-Assessment 2015-16



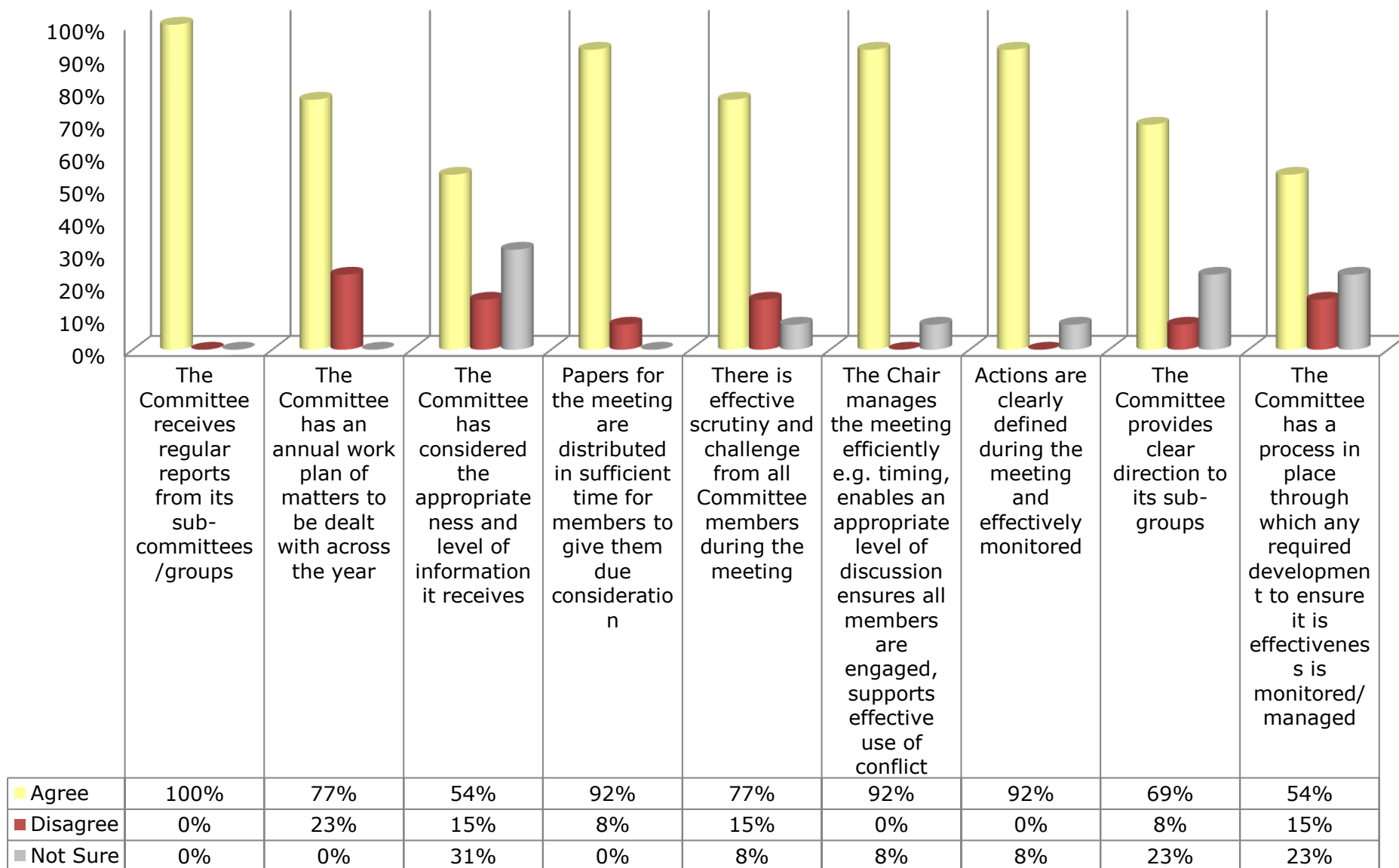
Link to Healthcare Objectives		
Strategic Objective(s)	Governance and Assurance Organisation Development	
Link to Integrated Commissioning Plan	Not applicable	
Health and Care Standards	Governance, Leadership and Accountability	
Principles of Prudent Healthcare	Not applicable	
Institute for HealthCare Improvement Triple Aim	Not applicable	
Organisational Implications		
Quality, Safety & Patient Experience	Strong governance mechanisms will indirectly improve quality of service and patient safety and experience.	
Resources Implications	Not applicable	
Risk and Assurance	In order for the Committee to carry out its duties in relation to scrutiny of potential risks which impact on services provided, it needs to consider its own effectiveness and ability to do this.	
Evidence Base	Appendix A – WHSSC Joint Committee Self –assessment 2015-16	
Equality and Diversity	Not applicable	
Population Health	Not applicable	
Legal Implications	Not applicable	
Report History:		
Presented at:	Date	Brief Summary of Outcome
Not applicable		

WHSSC Joint Committee Annual Self-assessment 2015-16 Results

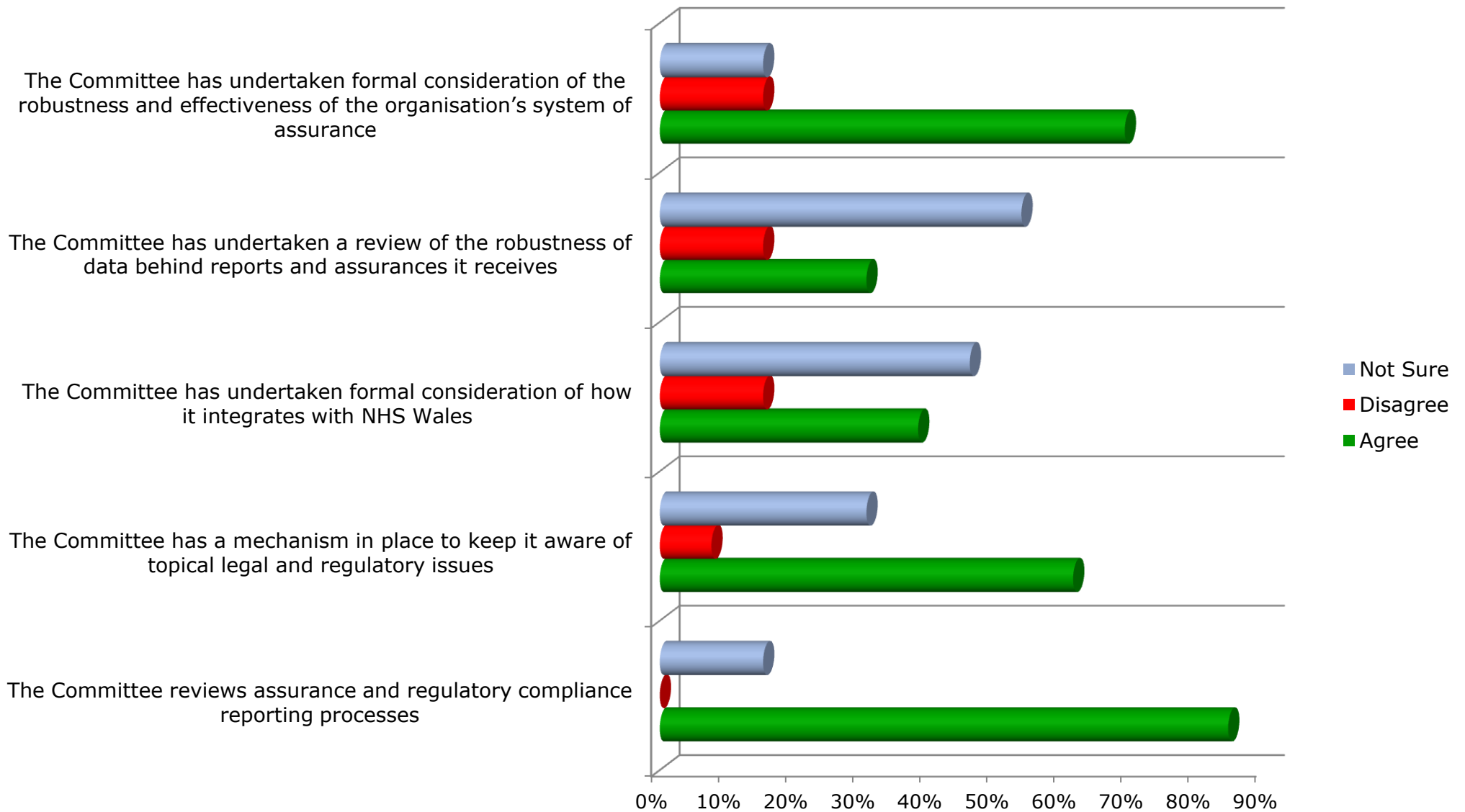
Composition, Establishment and Duties



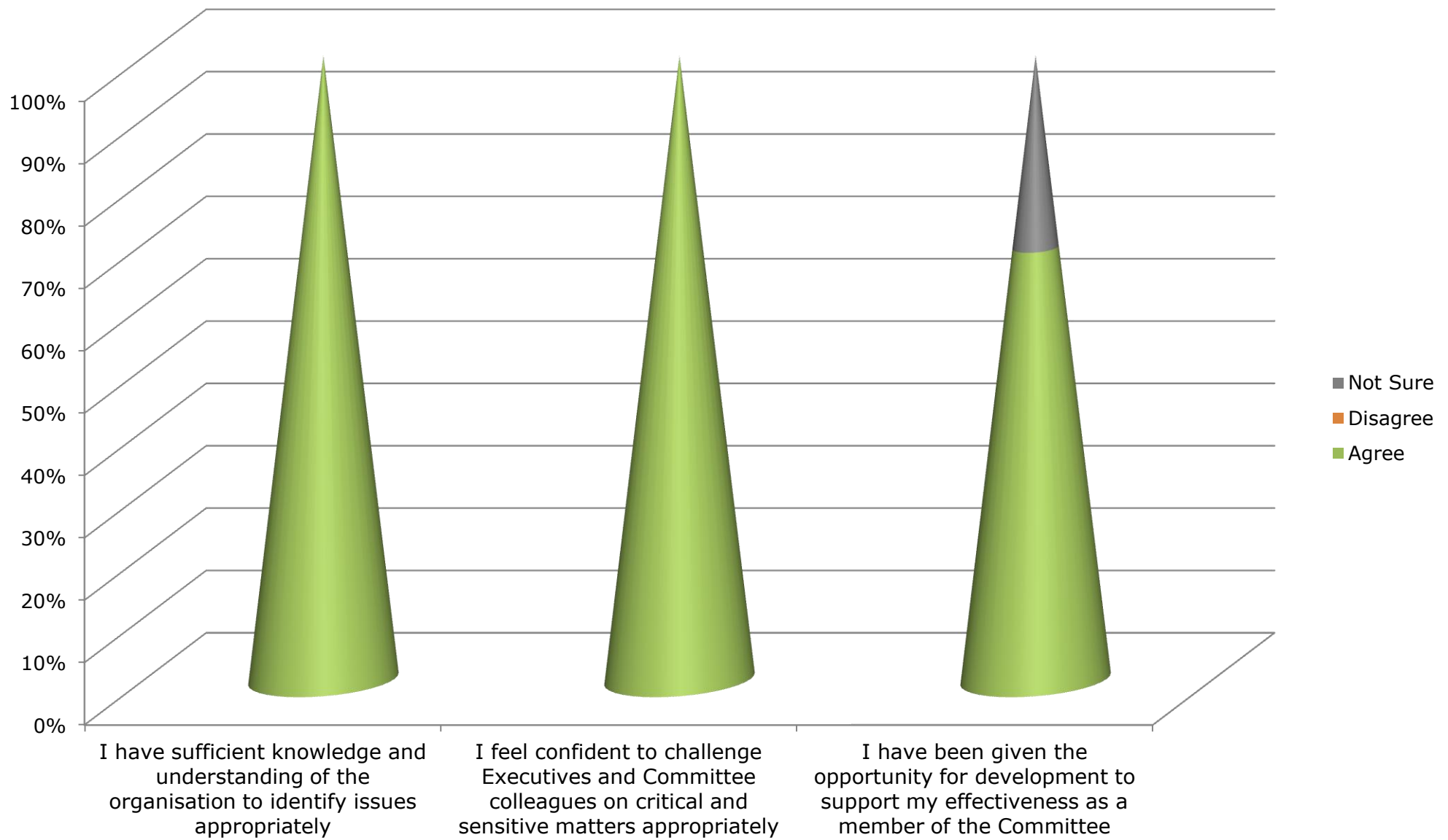
Effectiveness



Compliance with Law and Regulation



Individual Effectiveness



The following additional comments were received:

Composition, Establishment and Duties

The Committee Operates within guidelines but the governance model is not appropriate.

Disagree with the Committee fully understanding the strategic plan for WHSSC due to not currently having one in place.

Independent Members of the Committee have the appropriate background and knowledge but they are about to change.

Answered not sure regarding new members as this is untested.

Not sure if new members receive appropriate induction as have not had anyone new to the committee.

Induction for Independent members would be of benefit

Effectiveness

Scrutiny is variable from amongst Committee members. It gets done but appears to rely on small number of members. Other areas noted "unsure" is because not formally tested

High variability of scrutiny from Committee members

The committee is very well chaired with clear outcomes on all agreed items

Compliance with Law and Regulation

The Officers and Chair may have reviewed these issues but the JC itself has not

Formal governance review has been undertaken but it was not sufficiently comprehensive



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Welsh Health Specialised
Services Committee (WHSSC)

		Agenda Item	14
Meeting Title	Joint Committee	Meeting Date	27/09/2016
Report Title	Delivery of the Integrated Commissioning Plan 2016/17 Progress at the end of July 2016		
Author (Job title)	Assistant Planning Manager		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	Public

Purpose	This paper provides an update on the delivery of the Integrated Commissioning Plan for Specialised Services 2016/17 at the end of July 2016, including the: <ul style="list-style-type: none"> Funding Release Schedule; Progress against the Work Plan; and Risk Management Summary. 			
RATIFY <input type="checkbox"/>	APPROVE <input type="checkbox"/>	SUPPORT <input type="checkbox"/>	ASSURE <input type="checkbox"/>	INFORM <input checked="" type="checkbox"/>

Sub Group /Committee	Management Group Meeting	Meeting Date	25/08/2016
	Corporate Directors Group Board	Meeting Date	15/08/2016
Recommendation(s)	Members are asked to: <ul style="list-style-type: none"> Note the progress made in the delivery of the 2016/17 ICP; Note the funding release proforma schedule; Note the risk management summary. 		

Considerations within the report (tick as appropriate)

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

DELIVERY OF THE INTEGRATED COMMISSIONING PLAN 2016/17

Progress at the end of July 2016

1.0 Situation

- 1.1 The Joint Committee has delegated authority to the Management Group to approve the implementation of the following 'Amber' schemes with the Integrated Commissioning Plan (ICP) for Specialised Services:
- Unavoidable Activity growth / RTT Amber Graded Schemes
 - Economic Benefits to Health Boards Amber Graded Schemes
- 1.2 In addition, whilst the Joint Committee has retained authority to consider and approve risk rated 'Amber' schemes, they have delegated authority to the Management Group to approve the implementation of the Neurosurgery scheme against available recurrent slippage, as this is considered to be a high risk scheme.
- 1.3 The paper provides an update for the delivery and implementation of the work plan 2016/17 (as at the end of July 2016). This includes the following items:
- The progress against the work plan 2016/17
 - The development of the risk management monitoring; and
 - The funding release schedule (Annex i)

2.0 Background

- 2.1 In August 2015 Management Group approved the process to monitor the delivery of the ICP and supported the use of funding release schedules. The table below details which Group has the designated authority to approve the funding release for the different schemes of work listed in the ICP.

Group	Approval Authority
Corporate Directors Group	Black and Red Schemes
Management Group	Amber Schemes <ul style="list-style-type: none"> • Unavoidable Activity growth / RTT Amber Graded Schemes • Economic Benefits to Health Boards Amber Graded Schemes
Joint Committee	Amber Schemes <ul style="list-style-type: none"> • Risk Rated

Details of funding release approvals authorised by the Corporate Directors Group (CDG) will be made available at the following Management Group Meeting. The approvals to date are listed in Annex (i).

Funding release proformas which have been approved are saved on Sharepoint. These can be accessed by clicking the hyperlink - [approved funding releases](#).

In addition, the Management Group approved the risk management plan and the submission of exception reports when required. Both the work plan and risk management plan are reviewed by the Corporate Directors Group on a monthly basis, in order to monitor delivery and performance of the ICP.

Any delivery issues identified through this process will be raised with the relevant Health Boards' and the issue with details of the mitigating action taken will be reported to the Management Group.

3.0 Assessment

3.1 Audit and Outcome Days

A programme of clinical audit and outcome days is undertaken by WHSSC to ensure the quality and patient experience of specialised services commissioned on behalf of Wales. As at the end of July the progress on the delivery of these events is reported below:

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

3.2 Progress Against the Work Plan 2016/17

The work plan has been reviewed by the Programme Teams as at the end of July and progress is reported below.

3.2.1 Completed Schemes of Work

The following schemes of work have already been completed at the time of compiling this report:

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-110	Women and Children	Cystic fibrosis	Use of Ivacaftor for indication	Funding Release Proforma	3 patients identified in South Wales paediatric and adult population.
ICP16-114	Women and Children	Saproterin *	NICE: Not on their proposed list of TAs or HSTs. England: Commissioning Policy in England (The use of Saproterin in Children Reference: E06/P/a, published July 2015) - NHS England will not routinely commission saproterin for children with Phenylketonuria	Funding Release Proforma	Not endorsed at AWMSC in November 2015.
ICP16-125	Women and Children	Elosulfase Alfa *	Background: NICE (HST): Elosulfase alfa, within its marketing authorisation, is recommended for funding for treating mucopolysaccharidosis type IVa (MPS IVa) according to the conditions in the managed access agreement for elosulfase alfa. Published December 2015. Ministerial Announcement - drug available in Wales - 16/3/2016	Funding Release Proforma	Fully implemented.



ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-127	Women and Children	Sebelipase Alfa - LAL *	Background: NICE (HST): After the second evaluation consultation NICE has issued the following advice: Sebelipase alfa is a potentially life-saving treatment for babies with rapidly progressive LAL deficiency, and there is a compelling clinical need. However, the committee was unable to reach a conclusion on the value for money offered by the company's managed access proposal because no associated estimates of costs and benefits were supplied by the company. The committee is therefore minded not to recommend sebelipase alfa for treating lysosomal acid lipase deficiency. The committee recommends that NICE requests further clarification from the company, which should include: · updated budget impact and cost-consequence analyses using the list price to show the impact of the committee's preferred cost-consequence and budget impact modelling assumptions · updated budget impact and cost consequence analyses to show the impact of the managed access proposal including the committee's preferred cost-consequence and budget impact modelling assumptions, and any financial arrangements that would reduce the cost to the NHS · separate budget impact and cost-consequence analyses for each patient group if the managed access proposal has different criteria for different patient groups. Expected publication date October 2016.	Funding Release Proforma	Funding not approved. No Welsh patients identified.
ICP16-050	Women and Children	Fetal cardiology	Service poses a quality and sustainability concern. Currently failing to meet the NHS England CHD standards	Funding Release Proforma	Funding release letter sent out July 2016, awaiting implementation plan from C&V UHB.



ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-053	Women and Children	Paediatric Surgery	Sustainability concerns as there are workforce issues with the middle grades within Paediatric Surgery - Deanery. Increased capacity at the UHB is required to meet backlog, recurrent demand and capacity gap impacting recurrent financial requirements.	Funding Release Proforma	Health Board appointing at risk and backfilling lists from April 16. Funding release approved by MGM in July 2016, implementation to be monitored and waiting list profile to be agreed/monitored.
ICP16-009	Cancer & Blood	PET-CT	To revise the PET Policy on an annual basis to ensure equitable services with England and to contribute towards improving cancer outcomes in Wales	Funding Release Proforma	The PET-CT policy was first published in 2013 and was revised in 2015 to ensure it contained the most up to date evidence-based guidance. The revisions to the policy help to ensure that there is an equitable commissioning position within NHS Wales compared to the rest of the UK, facilitated by the increased number of indications routinely funded.
ICP16-052	Women and Children	Paediatric Cardiology RTT	Increased capacity at the UHB is required to meet backlog, recurrent demand and capacity gap impacting recurrent financial requirements	Funding Release Proforma	Funding release letter sent out July 2016, awaiting implementation plan from C&VUHB.
WHSSC scheme	Cancer & Blood	68-gallium DOTATE scanning for the Management of Neuroendocrine Tumours (NETs)	Specialised Services Policy Review	Policy (New)	Policy and funding release agreed.
WHSSC scheme	Cancer & Blood	Radiolabelled Therapy for the Treatment of Neuroendocrine Tumours (NETs)	Specialised Services Policy Review	Policy (New)	Policy and funding release agreed.
WHSSC scheme	Cancer & Blood	Inherited Bleeding Disorders	Audit Day	Audit Day	Held on 6th July.
WHSSC scheme	Cardiac	Bariatric Surgery	Audit Day	Audit Day	Held in May 2016.
Transfer of Services	Mental Health	CAMHS CITT (Cardiff and CTUHB)	Transfer out of WHSSC	Service Transfer	Funding transfer to LHB.



ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
WHSSC scheme	Neurological and Complex Conditions	Posture and Mobility	Audit Day	Audit Day	Held in June 2016.
WHSSC scheme	Neurological and Complex Conditions	Prosthetics and Rehabilitation	Audit Day	Audit Day	Held in June 2016.
WHSSC scheme	Women and Children	Ivacaftor (Kalydeco) for G551D Cystic Fibrosis	Clinical Access Policy Review	Policy (New)	Completed 21 June by the Medical directorate.
Transfer of Services	Women and Children	Paediatric Scoliosis	Transfer into WHSSC	Service Transfer	A written response has been to the provider stating that this would not be transferred.
Transfer of Services	Women and Children	Paediatric ENT	Transfer into WHSSC	Service Transfer	A written response to the provider to state that this would not be transferred.

A detailed work plan schedule is included in Annex (iii).

3.3 Financial Summary

As reflected in the month 4 financial monitoring, schemes that have been approved for funding release or where there is known slippage to date are set out in the following table:

Category	Scheme	Funding Release Paper to MGMT Group:	2016/17			2017/18		
			2016/17 ICP Requirement	2016/17 Forecast Expenditure	2016/17 Total Slippage	2017/18 ICP Requirement	2017/18 Forecast Expenditure	2017/18 Forecast Slippage
			£m	£m	£m	£m	£m	£m
Black - Pre approved	Prosthetics service sustainability for war veterans	July	0.300	0.121	(0.179)	0.300	0.210	(0.090)
Red - Mandated	Cystic fibrosis - Ivacaftor NONG551D (AWMSG)	June	0.459	0.459	-	0.612	0.612	-
Red - Mandated	Susoctocog - Haemophilia		0.380	-	(0.380)	0.950	-	(0.950)
Red - Mandated	Ataluren NS Duchene Muscular Dystrophy		0.400	0.152	(0.248)	0.750	0.200	(0.550)
Red - Mandated	Asfotase Alfa - HPP ERT		0.450	0.225	(0.225)	0.900	0.900	-
Amber - Unavoidable	Thoracic surgery infrastructure & activity	May	0.800	0.797	(0.003)	2.500	1.670	(0.830)
Amber - Unavoidable	Fetal cardiology	May	0.095	0.095	-	0.189	0.138	(0.051)
Amber - Unavoidable	Paediatric surgery	June	0.500	0.500	-	0.862	0.733	(0.129)
Amber - Unavoidable	PET CT new indications	May	0.062	0.062	-	0.170	0.062	(0.108)
Amber - Unavoidable	Paediatric Cardiology RTT	May	0.187	0.087	(0.100)	0.187	0.173	(0.014)
	Total Funded ICP schemes		3.633	2.498	(1.135)	7.420	4.698	(2.722)

There is in year forecast slippage of £0.853m from the mandated high cost drug schemes, this is due to Susoctocog not being appraised through NICE /AWMSG and no suitable Welsh patients for treatment. Ataluren has had a PAS discount applied and there is currently only one Welsh patient identified commencing treatment in August. Asfotase Alfa NICE guidance is anticipated in October 2016, hence half year slippage is forecast although this is likely to incur further slippage in the lag from approval to treatment.

£2.722m recurrent slippage has been identified against the 2017/18 ICP provision, reducing the full year effect of approved developments.

3.4 Risk Management Summary

Management Group approved the use of exception reports for the management of risk for schemes not included within the ICP in August 2015 ('Green' and 'Purple'). It was agreed that exception reports will be submitted when risks meet the following thresholds:

- Where a scheme has a 'red' rating in one or more of the three domains (Quality and Safety, Patient and Public Sensitivity, and Service Sustainability); and,
- Where a scheme moves from 'green' to 'amber' ratings in one or more of the three domains.

Further work has recently been undertaken to refine the risk management plan (included in Annex ii), and thereafter it will be available on SharePoint as a live document.

As part of the risk management strategy each of the amber risk rated schemes is currently being assessed against each of the protected characteristics, and an EQUIA report will be produced for the September Joint Committee to inform the discussion about the future management of these schemes. This report will also be available for the next meeting of the Management Group.

4.0 Recommendations

Members are asked to:

- **Note** the progress made in the delivery of the 2016/17 ICP.

5.0 Annexes

- Annex i – Funding Release Schedule
- Annex ii - Risk Management Schedule
- Annex iii - Work Plan Monitoring Schedule



Annex i

Funding Release – schedule

Planning Ref	Category	Scheme	Proposed Date of submission to CDG/MGM	Actual / Revised Date of submission to CDG/MG:	Outcome
ICP16-021	Black - Pre approved	Plastics - LVA (For evaluation after 6 months)	TBC	September	
ICP16-030	Black - Pre approved	Bariatrics Stage 2	TBC	August	
ICP16-042	Black - Pre approved	Communication Equipment (WG Allocation in 2016/17)	N/A	N/A	
ICP16-048	Black - Pre approved	Prosthetics service sustainability for war veterans	TBC	July	Approved
ICP16-110	Red - Mandated	Cystic fibrosis - Ivacaftor NONG551D (AWMSG)	TBC	June	Approved
ICP16-114	Red - Mandated	Saproterin - phenylketonuria	TBC	N/A	Removed as not approved by AWMSG
ICP16-120	Red - Mandated	Malignant Melanoma	TBC		
ICP16-124	Red - Mandated	Susoctocog - Haemophilia	TBC	N/A	No suitable patient cohort
ICP16-125	Red - Mandated	Elosulfase Alfa - VIMZIM ERT	TBC		
ICP16-126	Red - Mandated	Ataluren NS Duchene Muscular Dystrophy	TBC	August	
ICP16-127	Red - Mandated	Sebelipase Alfa - LAL ERT	TBC		
ICP16-128	Red - Mandated	Asfotase Alfa - HPP ERT	TBC		
ICP16-131	Red - Cost Neutral	BAHAs and Cochlears - Centralisation	TBC		
ICP16-008	Red - Repatriation	Haemophilia (long lasting blood products)	TBC	Savings	
ICP16-034	Red - Repatriation	ACHD Repatriation	TBC		
ICP16-001	Amber - Unavoidable	Thoracic surgery infrastructure & activity	June	May	Approved (June)
ICP16-003	Amber - Unavoidable	Neuroendocrine Tumours (NETs)	TBC	September	
ICP16-050	Amber - Unavoidable	Fetal cardiology	May	May	Approved
ICP16-053	Amber - Unavoidable	Paediatric surgery	May	June	Approved
ICP16-081	Amber - Unavoidable	BAHA & Cochlears growth North Wales	June	August	
ICP16-064	Amber - Unavoidable	BAHA & Cochlears growth South Wales	TBC	August	
ICP16-047	Amber - Unavoidable	Posture and Mobility - ALAS (Wheelchairs)	June	September	
ICP16-004	Amber - Unavoidable	BMT Phase 3 infrastructure & activity	October	August	
ICP16-105	Amber - Unavoidable	Clinical Immunology non pay growth	July	September	
ICP16-009	Amber - Unavoidable	PET CT new indications	May	May	Approved
ICP16-029	Amber - Unavoidable	Bariatric Surgery Phase 3 (all Wales)	TBC	N/A	Implementation in 2017/18
ICP16-052	Amber - Unavoidable	Paediatric Cardiology RTT	May	May	Approved
ICP16-028	Amber - Unavoidable	Liver ablation	TBC	Aug	



Link to Healthcare Objectives		
Strategic Objective(s)	Governance and Assurance Development of the Plan Implementation of the Plan	
Link to Integrated Commissioning Plan	This paper provides an update on the delivery of the ICP and the ICP risk management plan for schemes as at the end of July 2016.	
Health and Care Standards	Governance, Leadership and Accountability Safe Care Effective Care	
Principles of Prudent Healthcare	Reduce inappropriate variation Only do what is needed Public & professionals are equal partners through co-production	
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Improving Patient Experience (including quality and Satisfaction) Reducing the per capita cost of health care	
Organisational Implications		
Quality, Safety & Patient Experience	The ICP Delivery Report highlights the risks to quality, safety and patient experience resulting in delays/changes to the implementation of schemes and the action being taken to address.	
Resources Implications	Any in year change for individual schemes likely to result in a change in resource requirement will be highlighted in the ICP Delivery Report.	
Risk and Assurance	The ICP Delivery Report will summarise risk assessment and mitigating action for off track ICP schemes.	
Evidence Base	<ul style="list-style-type: none">Funding Release Schedule (Annex (i));Risk Management Plan (included in Annex (ii));Work Plan Monitoring Schedule (Annex (iii))	
Equality and Diversity	There are no equality and diversity implications associated with this report.	
Population Health	There are no additional implications associated for population health in this report.	
Legal Implications	There are no legal implications associated with this report.	
Report History:		
Presented at:	Date	Brief Summary of Outcome
Management Group Meeting	25/08/2016	Noted and supported to Joint Committee
Corporate Directors Group Board	15/08/16	Noted and supported to Management Group

ICP Implementation					Service	Summary	Commissioning Health Boards						Risk Impact Assessment					Original Score			Existing Controls			Risk Impact Assessment					Revised Score		Additional Controls			Date of Review	Planning Lead	Assuring Committee	Included on PT Risk Register	PT Risk Register Ref No.	Review completed by				
ICP Ref Number	Provider 1	Provider 2	Provider 3	Programme Team			BC	Po	HD	ABM	CT	C&V	AB	QPS Impact	QPS Like	PPS Impact	PPSLike	SS Impact	SS Like	QPS Score	PPS Score	SS Score	WHSSC Mitigating Action	HB Mitigating Action - Commissioner	HB Mitigating Action - Provider	QPS Impact	QPS Like	PPS Impact	PPSLike	SS Impact	SS Like	QPS Score	PPS Score							SS Score	WHSSC Mitigating Action	HB Mitigating Action - Commissioner	HB Mitigating Action - Provider
ICP16-115	NHS England	N/A	N/A	Cardiac	VAD - BTR	Ventricular Assist Devices (VADs) as a bridge to myocardial recovery (All Ages) - NHS England service specification A18/S(HSS)/b - commissioned in England	1	1	1	1	1	1	5	1	5	1	1	1	5	5	1	VAD commissioned to NHS England service specification	None identified	None identified	5	1	4	3	4	3	5	12	12	developing policy position	none identified	none identified	Aug-16	KW	CDG	Yes	CT/010	KW	
ICP16-121	NHS England	N/A	N/A	Cardiac	VAD - BTT	Ventricular Assist Devices (VADs) as a bridge to heart transplantation (All Ages) - NHS England service specification A18/S(HSS)/b - commissioned in England	1	1	1	1	1	1	5	1	5	1	1	1	5	5	1	VAD commissioned to NHS England service specification	None identified	None identified	5	1	4	3	4	3	5	12	12	developing policy position	none identified	none identified	Aug-16	KW	CDG	Yes	CT/010	KW	
ICP16-033	CV	ABM	BC	Cardiac	Component waiting times for cardiac services	To commission services to achieve Welsh Government waiting times targets. ***Awaiting outcome from recommendations of WG differential waiting times working group. Provider has asked for the continued HB investment in cardiac services.	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	Welsh Government is undertaking work to pilot measurement of component stages of cardiac pathway. Currently awaiting outcome of pilot and resulting decision from Welsh Government.	Commissioning intentions have been agreed by Management Group which will deliver 36 weeks RTT target and progress towards achieving the component waiting time targets. Plan to shadow monitor component waits for the remainder of 16/17.	None identified	1	1	1	1	1	1	1	1	1	1	None identified	None identified	None identified	Aug-16	KW	MG	No		KW
ICP16-035	CV	N/A	N/A	Cardiac	ACHD Proforma available	2nd stage development for South Wales agreed by Joint Committee on recommendation from cardiac review. Additional requirement, as detailed in the 2015/16 business case, from years 3-5		1	1	1	1	1	4	4	2	2	4	4	16	4	16	Further business case required for phase 2. To be considered for 2017/18 service specific commissioning intentions.	None identified	None identified	4	4	2	2	4	4	16	4	16	None identified	None identified	None identified	Aug-16	KW	MG	No		KW	
ICP16-036	ABM	CV	NHS England	Cardiac	Transcatheter Aortic Valve Implementation (TAVI) Proforma available	To commission TAVI and surgical AVR for patients with severe aortic stenosis, in line with latest evidence and best practice to optimise outcomes for patients. (Discussion with commissioners around the future commissioning of TAVI (policy, volumes) as part of Cardiac Surgical contract schedule with view to increasing activity.)	1	1	1	1	1	1	4	3	2	2	2	2	12	4	4	Contract mechanism in place with marginal rates for over performance. Intention to review commissioning policy in 2016/17.	None identified	ABMUHB developing business case for discussion with WHSSC.	4	3	2	2	2	2	12	4	4	None identified	None identified	None identified	Aug-16	KW	MG	No		KW	
ICP16-078	ABM	N/A	N/A	Cardiac	Left atrial appendage occlusion Proforma available	To develop new service at ABMUHB.			1	1	1	1	2	2	2	2	1	3	4	4	3	Included within evidence appraisal and prioritisation for 2017/18	None identified	Patients continue to be treated by secondary care cardiology.	1	1	2	1	1	3	1	2	3	None identified	None identified	None identified	Aug-16	KW	MG	No		KW	
ICP16-098	NHS England	N/A	N/A	Cardiac	Minimally invasive cardiac surgery	Service currently being offered by LHCH with plans to expand. WHSSC currently gathering information on evidence base and outcomes to inform consideration of	1	1					2	2	2	2	1	1	4	4	1	Identified for evidence appraisal.	None identified	None identified	2	2	2	2	2	2	4	4	4	None identified	None identified	None identified	Aug-16	KW	MG	No		KW	
ICP16-099	ABM	CV	BC	Cardiac	Rates of devices activity. To assess trends to inform ICP 2017/18.	To assess likely trends over the next 3 years following new NICE guidance in 2014 and development of DGH services.	1	1	1	1	1	1	4	4	2	2	2	2	16	4	4	Contract mechanism in place with marginal rates for over performance.	None identified	None identified	4	3	2	2	2	2	12	4	4	Activity rates to be reviewed during 2016/17 and recommendations made for 2017/18 ICP	None identified	None identified	Aug-16	KW	MG	No		KW	
ICP16-123	NHS England	N/A	N/A	Cardiac	VAD - DT	Implantation of a left ventricular assist device for destination therapy in people ineligible for heart transplantation NICE interventional procedure guidance [IPG516] Published date: March 2015	1	1	1	1	1	1	5	1	5	1	1	1	5	5	1	VADs are commissioned to NHS England service specification	None identified	None identified	5	1	5	1	1	1	5	5	1	developing policy position currently commissioning to English guidance	None identified	None identified	Aug-16	KW	MG	Yes	CT/010	KW	
ICP16-037	CT	CV	N/A	Cardiac	Percutaneous Coronary Intervention (PCI) Proforma available	Repatiation of PCI from Cardiff to Cwm Taf - To improve access and treatment times for CTUHB residents.					1		2	2	2	2	2	2	4	4	4	Transfer process is being lead by CTUHB. WHSSC to respond to proposal to be developed by CTHB.	CTUHB required to develop and agree BC for expansion of local service to facilitate repatriation of service from CVUHB	Health Boards working collaboratively, facilitated by the Cardiac Network, to improve pathway for PCI.	3	1	3	1	1	1	3	3	1	None identified	None identified	None identified	Aug-16	KW	MG	No		KW	
ICP16-096	ABM	CV	NHS England	Cardiac	Cardiac Surgery	To sustain achievement of waiting times target in North and South Wales	1	1	1	1	1	1	4	3	4	3	1	5	12	12	5	Implementation of performance management arrangements	None identified	None identified	4	3	4	3	1	1	12	12	1	Maintaining referral pathway from PoW to UHW until Oct. Continue Perf Mgt arrangements.	none identified	none identified	Aug-16	KW	MG	No	CT/030	KW	
ICP16-097	BC	N/A	N/A	Cardiac	Complex devices service	To commission a sustainable service model for North Wales underpinned by service specification	1						3	4	3	2	3	4	12	6	12	To be taken forward as a16/17 workplan issues	None identified	None identified	3	4	2	2	3	4	12	4	12	Developing service specification. Outcomes presented to cardiac audit day.	None identified	BCUHB will be required to undertake self assessment against specification. If a shortfall	Aug-16	KW	MG	No		KW	
ICP16-100	Other	N/A	N/A	Cardiac	Cardiology	Secondary Care Cardiology is awaiting transfer from WHSSC into LHB contracting responsibility and the UHB is supportive of implementing this based on the revised rebased LTA baselines	1	1	1	1	1	1	2	2	2	2	2	2	4	4	4	To be taken forward under transfer of services process	None identified	None identified	2	2	2	2	2	2	4	4	4	To be taken forward as a transfer of service issue.	None identified	None identified	Aug-16	KW	MG	No		KW	
ICP16-101	CV	NHS England	N/A	Cardiac	ACHD	To ensure equity across Wales in access to ACHD service	1	1	1	1	1	1	3	2	3	2	3	3	6	6	9	Identified as a 16/17 workplan issue	None identified	None identified	3	2	3	2	3	3	6	6	9	Review of access rates and current service models required.	None identified	None identified	Aug-16	KW	MG	No		KW	
ICP16-102	Other	N/A	N/A	Cardiac	Cardiac MRI	WHSSC supporting Health Boards through developing commissioning policy and service specification.	1	1	1	1	1	1	3	2	3	2	3	4	6	6	12	Advice provided under collective commissioning agreement	None identified	None identified	3	2	3	2	3	4	6	6	12	WHSSC is providing advice as a collective commissioning issue. Commissioning responsibility and risks reside with HBs	HBs have been recommended to increase CMRI capacity	HBs required to deliver additional CMRI capacity	Aug-16	KW	MG	No		KW	

ICP Reference Number	Financial Table	Provider 1	Provider 2	Provider 3	Programme Team	Service	Commissioning Intention	2016/17	BC	PO	HD	ABM	CT	C&V	AB	Type of proposal	Provider contact details	Business Case Required	Business Case Received?	WHSSC Product	Approving Committee	Date work commenced	Target Date for Completion	Actual Date of Completion	Progress (Completed / In Progress / Not Commenced)	Further Actions e.g. Funding Release Letters, Delivery Plans, etc	Comments	Review completed by	
ICP16-030	9a	ABM	NHS England	N/A	Cardiac	Bariatric Surgery Phase 2 Proforma available	Bariatric surgery is provided for the population of South Wales by ABMUHB. Joint Committee has agreed to the 5 year phased commissioning plan to increase access up to the clinically recommended level. ***Agreed to put back for consideration (2015/16 Green scheme)	1		1	1	1	1	1	1	WHSSC Programme Priority	ABMUHB & Royal Salford		Yes	Funding Release Proforma	CDG	Jul-16	Aug-16		In Progress		Agreed as 2015/16 development. Paper currently being developed to seek commissioner approval for new service model at ABM	LA	
	9a	CV	BC	N/A	Neurological and Complex Conditions	Communication Aids Proforma available	Augmentative and Alternative Communication (AAC) project. WG funding to develop service hub at Rookwood Hospital with staff also located at BCU. AAC project to include recommendations on future funding arrangements to be considered in ICP 2017/18.	1	1	1	1	1	1	1	1	WHSSC Programme Priority	Head of the Electronic Assistive Technology Service, C&V, 029 2031 3852 Jeff.morris2@wales.nhs.uk		Yes	Funding Release Proforma	CDG	Apr-16	Mar-17		In Progress		the WHSSC project will deliver its products to time; Provider service has delayed start and slower than envisaged development.	CN	
	9a	CV	N/A	N/A	Neurological and Complex Conditions	Prosthesis service - prosthetics for war veterans Proforma available	Requirement to sustain performance and the achievement of delivery. *** WHSSC asked to undertake a review of the all Wales position as a matter of urgency.	1	1	1	1	1	1	1	1	Provider Issue	Proposal received from Cardiff and Vale. Chris Bimson, Finance, Andrea Richards, Directorate Manager Neuroscience s.		Yes	Funding Release Proforma	CDG	Jun-16	Jul-16	Jul-16	In Progress	Funding release approved at July CDG, confirming TUPE costs with C&V before sending out release letter.	Awaiting C&V response.	CN	
ICP16-110	9b	CV	NHS England	N/A	Women and Children	Cystic fibrosis	Use of Ivacaftor for indication	1	1	1	1	1	1	1	1	WHSSC Horizon Scanning ('No Surprises')	Duncan Cole, UHW	No	N/A	Funding Release Proforma	CDG	Jun-16	Jun-16	Jun-16	Completed	Fully implemented	3 patients identified in South Wales paediatric and adult population	CC	
ICP16-114	9b	N/A	N/A	N/A	Women and Children	Saproterin *	NICE: Not on their proposed list of TAs or HSTs. England: Commissioning Policy in England (The use of Saproterin in Children Reference:E06/P/a, published July 2015) - NHS England will not routinely commission saproterin for children with Phenylketonuria.	1	1	1	1	1	1	1	1	WHSSC Horizon Scanning ('No Surprises')	NA	No	N/A	Funding Release Proforma	N/A				Completed	NA	Not endorsed at AWMSG in November 2015	CC	
ICP16-120	9b	Vel	N/A	N/A	Cancer & Blood	Malignant Melanoma *	Published NICE TAs: 1. TA357 – published October 2015. Pembrolizumab is recommended as an option for treating advanced (unresectable or metastatic) melanoma in adults only: • after the disease has progressed with ipilimumab and, for BRAF V600 mutation positive disease, a BRAF or MEK inhibitor and • when the company provides pembrolizumab with the discount agreed in the patient access scheme. 2. TA366 – published November 2015 Pembrolizumab is recommended as an option for treating advanced (unresectable or metastatic) melanoma that has not been previously treated with ipilimumab, in adults, only when the company provides pembrolizumab with the discount agreed in the patient access scheme 3. TA384 – published February 2016 Nivolumab as monotherapy is recommended, within its marketing authorisation, as an option for treating advanced (unresectable or metastatic) melanoma in	1		1	1	1	1	1	1	1	WHSSC Horizon Scanning	Velindre NHS Trust	No	N/A	Funding Release Proforma	CDG				In Progress			AC

ICP Reference Number	Financial Table	Provider 1	Provider 2	Provider 3	Programme Team	Service	Commissioning Intention	2016/17	BC	PO	HD	ABM	CT	C&V	AB	Type of proposal	Provider contact details	Business Case Required	Business Case Received?	WHSSC Product	Approving Committee	Date work commenced	Target Date for Completion	Actual Date of Completion	Progress (Completed / In Progress / Not Commenced)	Further Actions e.g. Funding Release Letters, Delivery Plans, etc	Comments	Review completed by	
ICP16-124	9b	N/A	N/A	N/A	Cancer & Blood	Susoctocog *	Background: AWMMSG and NICE: Not referenced on AWMMSG or NICE website. [Was referenced in last years' WHSSC Horizon scanning document as an AWMMSG pending approval]. Baxalta (manufacturer) gained EU marketing authorization in November 2015. WHSSC has also taken advice from Dr Peter Collins, Consultant Haematologist at Cardiff Centre on patient numbers and treatment pathway - which indicated drug is currently going through UK national tender to determine unit price.	1	1	1	1	1	1	1	1	WHSSC Horizon Scanning	N/A	No	N/A	Funding Release Proforma	N/A								AC
ICP16-125	9b	CV	N/A	N/A	Women and Children	Elosulfase Alfa *	Background: NICE (HST): Elosulfase alfa, within its marketing authorisation, is recommended for funding for treating mucopolysaccharidosis type IVa (MPS IVa) according to the conditions in the managed access agreement for elosulfase alfa. Published December 2015. Ministerial Announcement - drug available in Wales - 16/3/2016.	1	1	1	1	1	1	1	1	WHSSC Horizon Scanning ('No Surprises')		No	N/A	Funding Release Proforma	CDG				Completed	NA	Fully implemented	CC/AC	
ICP16-126	9b	CV	N/A	N/A	Neurological and Complex Conditions	Ataluren NS DMD *	Background: NICE (HST): Ataluren, within its marketing authorisation, is recommended for treating Duchenne muscular dystrophy resulting from a nonsense mutation in the dystrophin gene in people aged 5 years and older who can walk, only when: the company provides ataluren with the discount agreed in the patient access scheme the conditions under which ataluren is made available are set out in a managed access agreement between the company and NHS England, which should include the conditions set out in sections 5.12-5.15 of this guidance. Expected publication date July 2016.	1	1	1	1	1	1	1	1	WHSSC Horizon Scanning		No	N/A	Funding Release Proforma	CDG							AC	

ICP Reference Number	Financial Table	Provider 1	Provider 2	Provider 3	Programme Team	Service	Commissioning Intention	2016/17	BC	PO	HD	ABM	CT	C&V	AB	Type of proposal	Provider contact details	Business Case Required	Business Case Received?	WHSSC Product	Approving Committee	Date work commenced	Target Date for Completion	Actual Date of Completion	Progress (Completed / In Progress / Not Commenced)	Further Actions e.g. Funding Release Letters, Delivery Plans, etc	Comments	Review completed by	
ICP16-127	9b	CV	N/A	N/A	Women and Children	Sebelipase Alfa - LAL *	Background: NICE (HST): After the second evaluation consultation NICE has issued the following advice: Sebelipase alfa is a potentially life-saving treatment for babies with rapidly progressive LAL deficiency, and there is a compelling clinical need. However, the committee was unable to reach a conclusion on the value for money offered by the company's managed access proposal because no associated estimates of costs and benefits were supplied by the company. The committee is therefore minded not to recommend sebelipase alfa for treating lysosomal acid lipase deficiency. The committee recommends that NICE requests further clarification from the company, which should include: updated budget impact and cost-consequence analyses using the list price to show the impact of the committee's preferred cost-consequence and budget impact modelling assumptions updated budget impact and cost consequence analyses to	1	1	1	1	1	1	1	1	1	WHSSC Horizon Scanning ('No Surprises')		No	N/A	Funding Release Proforma	CDG				Completed	NA	Funding not approved. No Welsh patients identified.	CC/AC
	9b	CV	N/A	N/A	Women and Children	Asfotase Alfa - HPP *	Background: NICE (HST): After the first evaluation consultation NICE has issued the following advice: Asfotase alfa is not recommended, within its marketing authorisation, for long-term enzyme replacement therapy in paediatric-onset hypophosphatasia to treat the bone manifestations of the disease. Expected publication date TBC.	1	1	1	1	1	1	1	1	1	WHSSC Horizon Scanning ('No Surprises')		No	N/A	Funding Release Proforma	CDG				In Progress	Await NICE guidance October 2016	NICE guidance to be released October 2016	CC/AC
	9b	CV	ABM	N/A	Women and Children	BAHAs and Cochlears Proforma available	Take steps to implement the centralisation of services at the UHB	1		1	1	1	1	1	1	1	Provider Issue Tina Bayliss, C&V UHB; Ceri Gimblett, ABM UHB	No	N/A	Funding Release Proforma	MG		Mar-17		In Progress	Briefing paper, options appraisal, consultation	Met with C&V UHB, they are keen to progress. Meeting with ABMU, they accept the principle of centralisation but question the decision making around Cardiff being the preferred site. Further work required to document intended aims and options appraisal	CC	
	9b	CV	N/A	N/A	Cancer & Blood	Haemophilia	To commission long lasting blood factors when they come to the market via the UK procurement exercise, in September 2016	1	1	1	1	1	1	1	1	1	WHSSC Horizon Scanning ('No Surprises')	CV (Chris Markall)	No	N/A	Other (Please specify in comment section)	CDG	Jul-16	Mar-17		In Progress	Continued monitoring of savings	To monitor savings through improved contract prices and transfer of patients to long lasting products	GJ
	9b	BC	NHS England	N/A	Cardiac	AChD	Repatriation to North Wales service from Trusts in England	1	1	1	1	1	1	1	1	1	WHSSC Programme Priority	BCUHB/Manc hester	No	N/A	Contractual Allocation	MG				Not Commenced		BC to take forward. To be considered within 16/17 if within existing resources	
	9c	CV	ABM	N/A	Cancer & Blood	Thoracic surgery Proforma and demand/capacity data available	To commission sufficient surgery, at full cost, to achieve the 2012 LUCADA upper quartile resection rate for Wales.	1		1	1	1	1	1	1	1	WHSSC Programme Priority	ABMUHB / CVUHB	Yes		Funding Release Proforma	MG	Apr-16	May-16	Jun-16	In Progress	The WHSSC ICP 2016-19 includes the commitment to undertake a review of thoracic surgery in 2016/17.	The WHSSC ICP 2016-19 includes the commitment to undertake a review of thoracic surgery in 2016/17.	GJ

ICP Reference Number	Financial Table	Provider 1	Provider 2	Provider 3	Programme Team	Service	Commissioning Intention	2016/17	BC	PO	HD	ABM	CT	C&V	AB	Type of proposal	Provider contact details	Business Case Required	Business Case Received?	WHSSC Product	Approving Committee	Date work commenced	Target Date for Completion	Actual Date of Completion	Progress (Completed / In Progress / Not Commenced)	Further Actions e.g. Funding Release Letters, Delivery Plans, etc	Comments	Review completed by
ICP16-003	9c	CV	ABM	Vel	Cancer & Blood	Neuroendocrine Tumours (NETs) Proforma available	To commission the service model agreed by the NETs Task and Finish Group.	1	1		1	1	1	1	1	WHSSC Programme Priority	Vicki Myson		Yes	Funding Release Proforma	MG	Apr-16	Sep-16		In Progress	Draft business case received. Director of Nursing leading this work with support from the C&B Programme Team.	Arrangements being made to engage with service users and provider through a user engagement workshop.	GJ
ICP16-050	9c	CV	N/A	N/A	Women and Children	Fetal cardiology Proforma available	Service poses a quality and sustainability concern. Currently failing to meet the NHS England CHD standards.	1		1	1	1	1	1	1	WHSSC Programme Priority	Diane Rogers, C&V UHB		Yes	Funding Release Proforma	MG		Jul-16	Jul-16	Completed		Funding release letter sent out July 2016, awaiting implementation plan from C&V UHB	CC
ICP16-053	9c	CV	N/A	N/A	Women and Children	Paediatric surgery Proforma and demand/capacity data available	Sustainability concerns as there are workforce issues with the middle grades within Paediatric Surgery - Deanery. Increased capacity at the UHB is required to meet backlog, recurrent demand and capacity gap impacting recurrent financial requirements.	1		1	1	1	1	1	1	WHSSC Programme Priority	Rachel Burton, C&V UHB		Yes	Funding Release Proforma	MG		Jul-16	Jul-16	Completed		Health Board appointing at risk and backfilling lists from April 16. Funding release approved by MGM in July 2016, implementation to be monitored and waiting list profile to be agreed/ monitored.	CC
ICP16-081	9c	BC	N/A	N/A	Women and Children	BAHAs and Cochlears	Performance management of growth in the service in North Wales ***Awaiting proforma / risk register / demand and capacity information for further consideration	1	1	1						Provider Issue	Jenny Townsend, BC UHB	No	N/A	Funding Release Proforma	JC		Aug-16	Aug-16	In Progress		Funding release proforma to Management Group August 2016	CC
ICP16-064	9c	CV	ABM	N/A	Women and Children	BAHAs and Cochlears Proforma available	Management of increasing growth in demand	1		1	1	1	1	1	1	Provider Issue	Wendy Rabbaiotti, C&V UHB	No	N/A	Funding Release Proforma	JC		Aug-16	Aug-16	In Progress		Funding release proforma to Management Group August 2016 - note funding does not meet full service requirements	CC
ICP16-047	9c	CV	N/A	N/A	Neurological and Complex Conditions	Posture and Mobility Proforma available	To manage growth in the volume of wheelchair issues and to achieve the current delivery measures. ***Further information required from the provider to RAG-rate the issues (2015/16 Green scheme)	1								Provider Issue	Proposal received from Cardiff and Vale and BCU. Andrea Richards, Directorate Manager, C&V Stephen Jones, Service Manager, BCU		Yes	Funding Release Proforma					Not Commenced			
ICP16-004	9c	CV	ABM	N/A	Cancer & Blood	BMT Phase 3 Proforma available	To commission a sustainable BMT service in South Wales.	1		1	1	1	1	1	1	WHSSC Programme Priority	CVUHB / ABMUHB	Yes	Yes	Funding Release Proforma	MG	Jul-16	Aug-16		In Progress	Funding release proforma requires further work and clarification, in particular the staffing requirements of the new service. Engagement with service to move forward is in progress.	There has been a stream of planning and commissioning work over the last few years which has resulted in a three year phased approach to making the service sustainable and to be able to cope with the increasing demand.	GJ
ICP16-009	9c	CV	BC	NHS England	Cancer & Blood	PET-CT Proforma available	To revise the PET Policy on an annual basis to ensure equitable services with England and to contribute towards improving cancer outcomes in Wales	1	1	1	1	1	1	1	1	WHSSC Programme Priority	PETIC (based at UHW - Dr Chris Marshall) & BCUHB (Dr David Jones, Radiology)	No	N/A	Funding Release Proforma	MG	Apr-16	Jun-16	Jun-16	Completed	No further actions required at present. This policy will be reviewed annually in line with the WHSSC evidence appraisal procedure.	The PET-CT policy was first published in 2013 and was revised in 2015 to ensure it contained the most up to date evidence-based guidance. The revisions to the policy help to ensure that there is an equitable commissioning position within NHS Wales compared to the rest of the UK, facilitated by the increased number of indications routinely funded.	GJ
ICP16-029	9c	ABM	Other	N/A	Cardiac	Bariatric Surgery Phase 3 Proforma available	To implement phase 3 of the bariatric surgery 5 year phased growth plan for all Wales.	1	1	1	1	1	1	1	1	WHSSC Programme Priority	ABMUHB & Royal Salford	No	Received in 2014	Funding Release Proforma	CDG	Jul-16	Aug-16		In Progress		Paper currently being developed to seek commissioner approval for new service model at ABM.	

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ICP16-052	9c	CV	N/A	N/A	Women and Children	Paediatric Cardiology RTT Proforma available	Increased capacity at the UHB is required to meet backlog, recurrent demand and capacity gap impacting recurrent financial requirements.	1		1	1	1	1	1	1	WHSSC Programme Priority	Diane Rogers, C&V UHB	Yes	Yes	Funding Release Proforma	JC		Jul-16	Jul-16	Completed		Funding release letter sent out July 2016, awaiting implementation plan from C&V UHB	CC
ICP16-028	9c	AB	N/A	N/A	Cancer & Blood	Liver ablation Proforma available	US/RF Liver ablation service to include microwave ablations service	1	1	1	1	1	1	1	1	Provider Issue	ABUHB (Philip Meredith - AB Finance)	Yes	Yes	Funding Release Proforma	CDG	Jul-16	Aug-16		In Progress	Funding release proforma complete for CDG with queries to resolve prior to submission to MG.	Change in service provision to reflect new clinical practice.	GJ
ICP16-031	9e	ABM	CV	N/A	Cardiac	Cardiac ablation (AF and VT) - Expansion of EP services Proforma available	To increase access to atrial fibrillation (AF) and ventricular fibrillation (VF) for patients from Mid & West Wales at ABMUHB.	1	1	1	1	1	1	1	1	Provider Issue	ABMUHB	Yes		Spend to Save	MG				Not Commenced			
ICP16-032	9e	ABM	CV	N/A	Cardiac	Cardiac ablation (AF) Proforma available	To increase access to atrial fibrillation (AF) ablation at CVUHB.	1	1	1	1	1	1	1	1	Provider Issue	CVUHB	Yes		Spend to Save	MG				Not Commenced			
ICP16-055	9e	CV	N/A	N/A	Women and Children	Genetics Proforma available	To commission UKGTN tests approved 2015/16 for commissioning in 2016/17	1	1	1	1	1	1	1	1	WHSSC Programme Priority	Rachel Butler, C&V UHB	Yes	Yes	Funding Release Proforma	MG		Sep-16		In Progress		Funding release proforma for September 2016	DG-W
ICP16-056	9e	CV	N/A	N/A	Women and Children	Genetics Proforma available	Stratified medicine tests	1	1	1	1	1	1	1	1	WHSSC Programme Priority	Rachel Butler, C&V UHB		Yes	Funding Release Proforma	MG				In Progress		Two elements of the stratified medicine scheme cannot yet be implemented as waiting for NICE guidance	DG-W
ICP16-021	9e	ABM	N/A	N/A	Cancer & Blood	Plastic Surgery Proforma available	LVA service funded by WG. WG priority	1				1				Horizon scan - ministerial priority	Mel Thomas, National Clinical Lead Lymphoedema Wales Services		Yes	Funding Release Proforma	MG		Sep-16		In Progress			
ICP16-016	9e	CV	N/A	N/A	Cancer & Blood	Endobronchial Valve Replacement (EBVR) Proforma available	To commission sufficient surgery to meet RTT targets	1				1		1		WHSSC Horizon Scanning ('No Surprises')	C&V UHB		Yes	Funding Release Proforma	MG	Apr-16	Dec-16		In Progress	Awaiting business case	EBVR offered to patients via IPFR but is routinely available in North Wales. This scheme aims to build upon WHSSC ICP 15/16 by offering EBVR as a fully commissioned service	GJ
ICP16-130	9e	ABM	N/A	N/A	Cancer & Blood	Plastic Surgery Proforma available	Evaluation and recommendations for future funding of LVA service	1				1				Horizon scan - ministerial priority	Mel Thomas, National Clinical Lead Lymphoedema Wales Services		Yes	Funding Release Proforma	MG		Oct-16		In Progress		Evaluation of first 12 months to include policy review. Indication that one of the criteria in the policy may require amendment (2 episodes of cellulitis in 12 months) to ensure sufficient eligible patients for screening	SK
ICP16-038	9d	CV	N/A	N/A	Neurological and Complex Conditions	Neurovascular Proforma available	To commission a sustainable neurovascular service in South Wales.	1						1		WHSSC Programme Priority	Cardiff and Vale. Hywel Pullen, Finance, Andrea Richards, DM		Yes	Funding Release Proforma	JC				Not Commenced		To be managed through Risk Management Strategy pending decision of Joint Committee	CN
ICP16-040	9d	CV	N/A	N/A	Neurological and Complex Conditions	Neuropathology Proforma available	To commission a sustainable Neuropathology Service.	1		1	1	1	1	1	1	WHSSC Programme Priority	Cardiff and Vale. Hywel Pullen, Finance, Matt Temby, Head of Delivery C,D&T	Yes	No	Funding Release Proforma	JC		Nov-16		Not Commenced		To be managed through Risk Management Strategy pending decision of Joint Committee	CN
ICP16-041	9d	CV	N/A	N/A	Neurological and Complex Conditions	Neurosurgery Proforma and demand/capacity data available	To commission a sustainable Neurosurgery service in South Wales. Deanery changes to medical workforce would leave the service vulnerable with minimal cover overnight and leave the on call unsustainable. Insufficient theatre capacity for higher surgical training could also result in a loss of training numbers.	1		1	1	1	1	1	1	WHSSC Programme Priority	Cardiff and Vale. Hywel Pullen, Finance, Andrea Richards, DM		Yes	Funding Release Proforma	JC	Jun-16	Jul-16	Jul-16	In Progress	Meeting to be arranged between WHSSC, C&V and other HBs to run through the needs of the service as funding release was only part approved.	Joint Committee delegated responsibility to Management Group in June mtg. Submitted for 2nd time to Mgt Group July 16 and part approved.	CN

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ICP16-039	9d	CV	N/A	N/A	Neurological and Complex Conditions	Interventional neuroradiology Proforma available	Phase 2 - To commission a sustainable Interventional Radiology Service	1		1	1	1	1	1	1	WHSSC Programme Priority	Cardiff and Vale, Hywel Pullen, Finance, Matt Temby, Head of Delivery C,D&T		Yes	Funding Release Proforma	JC	Jul-16	Aug-16		In Progress		To be managed through Risk Management Strategy pending decision of Joint Committee	CN	
ICP16-058	9d	CV	N/A	N/A	Women and Children	NICU Proforma available	To increase NICU capacity **Implement the neonatal service model agreed for South and Mid Wales as part of the South Wales Plan (2015/16 Green schemes)	1				1		1		WHSSC Horizon Scanning ('No Surprises')	Cardiff and Vale	Yes	No	Funding Release Proforma	JC				In Progress		To be managed through Risk Management Strategy pending decision of Joint Committee. Current status of scheme to be confirmed with C&V UHB as not currently clear whether additional resource still required.	CC	
ICP16-051	9d	CV	N/A	N/A	Women and Children	Fetal Medicine	Service poses a quality and sustainability concern. Concerns have been raised by the service itself, other Health Boards and Public Health Wales as to how the service is delivered. ***Lack of Fetal Brain MRI provision in South and Mid Wales (2015/16 Green scheme)	1						1		WHSSC Programme Priority	Cardiff and Vale		Yes	Funding Release Proforma	JC				Not Commenced		To be managed through Risk Management Strategy pending decision of Joint Committee. Current status of scheme to be confirmed with C&V UHB as not currently clear whether additional resource still required. C&V UHB currently undertaking service review and as a result BC will also be reviewed.	CC	
ICP16-117	9d	Other	N/A	N/A	Cancer & Blood	Proton Beam Therapy - Child	NHS England's Commissioning Policies are currently used by the UK-wide National Proton Clinical Reference Panel to make recommendations for the clinical suitability of Welsh patients to access Proton Beam Therapy (PBT). WHSSC needs to review its commissioning position for PBT and produce revised, up to date commissioning policies for people in Wales.	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Funding Release Proforma	JC				In Progress		To be managed through Risk Management Strategy pending decision of Joint Committee	IL	
ICP16-118	9d	Other	N/A	N/A	Cancer & Blood	Proton Beam Therapy - TYP	NHS England's Commissioning Policies are currently used by the UK-wide National Proton Clinical Reference Panel to make recommendations for the clinical suitability of Welsh patients to access Proton Beam Therapy (PBT). WHSSC needs to review its commissioning position for PBT and produce revised, up to date commissioning policies for people in Wales.	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Funding Release Proforma	JC				In Progress		To be managed through Risk Management Strategy pending decision of Joint Committee	IL	
ICP16-084	9d	CV	N/A	N/A	Women and Children	Paediatric Cardiology Proforma available	Ensure that the service meets the NHS England CHD standards - as the service is part of a network with Bristol. Also, outpatient component gap for this service and the consultant base is short on sessional time to support activities. This poses a risk to delivery and sustainability.	1							1		WHSSC Programme Priority			Yes	Funding Release Proforma	JC				Not Commenced		To be managed through Risk Management Strategy pending decision of Joint Committee. CHD service specification currently being drafted. Self assessment already circulated by CHD Network and Welsh service providers to return, this will help to identify gaps in services across South Wales.	CC

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ICP16-043	9d	CV	N/A	N/A	Neurological and Complex Conditions	Clinical immunology Proforma available	The service continues to grow and the UHB is keen to discuss the resource implications of this for 2016/17.	1		1	1	1	1	1	1	Provider Issue / expecting business case from provider	Cardiff and Vale. Hywel Pullen/Chris Bimson Finance Anne-Marie Morgan, DM		Yes	Funding Release Proforma	JC	Jun-16	Jul-16		In Progress	Went to July CDG, further discussions with service then return to Aug mtgs.	Clinical Immunology had two schemes - one for infrastructure and the other for non pay, with only the latter scheme having funding agreed in the plan. CDG advised the service to work within the non pay funding for both infrastructure and non pay and return to Aug CDG with this plan.	CN
ICP16-066	9d	ABM	N/A	N/A	Women and Children	Cleft lip and palate service Proforma available	Improve infrastructure within cleft lip and palate service in order to meet national standards ***Further scoping required. ABMU to advise. Possible equity issue for patients in North Wales (2015/16 Green scheme)	1				1				Provider Issue	ABMU		Yes	Funding Release Proforma	JC				Not Commenced		To be managed through Risk Management Strategy pending decision of Joint Committee. SBAR to be submitted to CDG in August.	CC
ICP16-119	9d	Other	N/A	N/A	Cancer & Blood	Proton Beam Therapy - Adult		1	1	1	1	1	1	1	1	WHSSC Programme Priority		No		Funding Release Proforma	JC				Not Commenced		To be managed through Risk Management Strategy pending decision of Joint Committee	IL
ICP16-115	9d	NHS England	N/A	N/A	Cardiac	VAD - BTR	Implantation of a left ventricular assist device for destination therapy in people ineligible for heart transplantation NICE interventional procedure guidance [IPG516] Published date: March 2015	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Funding Release Proforma	JC				In Progress		To be managed through Risk Management Strategy pending decision of Joint Committee	IL
ICP16-121	9d	NHS England	N/A	N/A	Cardiac	VAD - BTT	Ventricular Assist Devices (VADs) as a bridge to heart transplantation or myocardial recovery (All Ages) - NHS England service specification A18/S(HSS)/b - commissioned in England?	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Funding Release Proforma	JC				In Progress		To be managed through Risk Management Strategy pending decision of Joint Committee	IL
ICP16-044	9d	CV	N/A	N/A	Neurological and Complex Conditions	Neuromodulation/pain service Proforma available	Change to the Pain Service model that that could utilise existing baseline and performance funding in a different way with mutual benefit. Spinal Implants - development of an Multidisciplinary Team model.	1		1	1	1	1	1	1	WHSSC Programme Priority	Cardiff and Vale. Hywel Pullen, Finance, Andrea Richards, DM		Yes	Funding Release Proforma	JC		Oct-16		Not Commenced		To be managed through Risk Management Strategy pending decision of Joint Committee	CN
ICP16-111	9d	NHS England	N/A	N/A	Neurological and Complex Conditions	Nerve STIM - occipital nerve	Occipital nerve stimulation (ONS) for intractable chronic migraine. NICE interventional procedure guidance [IPG452] Published date: April 2013. NHS England will commission ONS as a treatment for adult patients with chronic migraine or chronic cluster headaches who have failed to respond to available pharmaceutical treatments, in accordance with the criteria outlined in this document. Reference: NHS England D08/P/c (July 2015).	1	1	1	1	1	1	1	1	WHSSC Horizon Scanning	N/A	No		Funding Release Proforma	JC		Oct-16		Not Commenced		To be managed through Risk Management Strategy pending decision of Joint Committee	CN
ICP16-112	9d	NHS England	N/A	N/A	Neurological and Complex Conditions	Nerve STIM - sphenopalatine ganglion	Implantation of a sphenopalatine ganglion stimulation device for chronic cluster headache. NICE interventional procedure guidance [IPG527] Published date: June 2015. No NHS England commissioning policy.	1							1	WHSSC Horizon Scanning	N/A	No		Funding Release Proforma	JC		Oct-16		Not Commenced		To be managed through Risk Management Strategy pending decision of Joint Committee	CN

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ICP16-057	9d	ABM	N/A	N/A	Women and Children	Genetics Proforma available	Pre-implantation genetic diagnosis (PGD).	1				1				Provider Issue	N/A			Funding Release Proforma					Not Commenced		To be managed through Risk Management Strategy pending decision of Joint Committee	CC
ICP16-113	9d				Women and Children	VAD - CentriMAG (BTR)	NHS England does not commission the implantation of a VAD as a bridge to destination or chronic support (destination therapy - long term device). Whilst there is evidence suggesting that VADs may be effective as long-term treatments for chronic heart failure in patients who are not transplant candidates (destination therapy) this would require further evaluation of the cost effectiveness of the intervention.	1												Funding Release Proforma					Not Commenced		To be managed through Risk Management Strategy pending decision of Joint Committee	CC
ICP16-063	5	NHS England	N/A	N/A	Neurological and Complex Conditions	Ketogenic diet Proforma available	Continue to engage with WHSSC over this cohort of patients and the risks and requirements to support them at C&V.	1		1	1	1	1	1	1	WHSSC Programme Priority		Yes	No	Funding Release Proforma	MG				In Progress		In the Spend to Save/Repatriation category. Currently awaiting business case from C&V.	CN
ICP16-065	3g	CV	BC	N/A	Cancer & Blood	Interstitial Lung Disease (ILD)	The National Respiratory Delivery Plan Implementation Group has indicated a willingness to pump prime the development on confirmation of WHSSC's future commissioning intentions. This should be included in the ICP.	1				1		1		Provider Issue	Cardiff and Vale			Collective Commissioning							Funded by RHIG	IL
ICP16-006	5	BC	N/A	N/A	Cancer & Blood	Haemophilia (BCU) Proforma available	To commission services to complete the implementation of the recommendations of the 2011 Ministerial Task and Finish Group.	1	1							WHSSC Programme Priority	Bryn Jenkins, BCUHB	Yes	No	Service Transfer	MG	Apr-16			In Progress	Awaiting formal submission of proposal from BCUHB	Cost neutral repatriation of aspects of haemophilia service	GJ
ICP16-069	5	ABM	BC	N/A	Mental Health	High Secure Proforma available	Expand gatekeeping role to include clinical case monitoring all patients in independent sector placements.	1	1	1	1	1	1	1	1	WHSSC Programme Priority	ABMU - Mike Sullivan BCU - Sam Watson	Yes	Yes	Funding Release Proforma	MG	Apr-16	Sep-16		In Progress	Funding Release Letters sent to ABM/BC UHBs	In the Spend to Save/Repatriation category	MH Planning Lead
ICP16-070	5	ABM	BC	N/A	Mental Health	Medium Secure - patients with learning disabilities Proforma available	Expand gatekeeping role to include clinical case monitoring all patients in independent sector placements.	1	1	1	1	1	1	1	1	WHSSC Programme Priority	ABMU - Mike Sullivan BCU - Sam Watson	Yes	Yes	Funding Release Proforma	MG	Apr-16	Sep-16		In Progress	Funding Release Letters sent to ABM/BC UHBs	In the Spend to Save/Repatriation category	MH Planning Lead
ICP16-024	3f	CV	N/A	N/A	Cancer & Blood	Hepatology	Scheme AMBER rated in 2015/16 for funding release in 2016/17.	1						1		Provider Issue		No	Yes	Delivery Plan	MG				In Progress	Awaiting BC from provider	2nd phase investment. First phase consultant took up post in Nov 2015.	GJ
ICP16-011	2d	NHS England	N/A	N/A	Cancer & Blood	Liver transplant	To commission a robust outreach service for South Wales in line with the Liver Services Delivery Plan.	1			1	1	1	1	1	WHSSC Horizon Scanning ('No Surprises')	Andrew Yeoman, ABUHB	No	N/A	Delivery Plan	CDG	Aug-16	Mar-17		In Progress	Funding from delivery group	Funded by LDIG.	GJ
ICP16-088	N/A	Other	N/A	N/A	Mental Health	Gender Dysphoria Proforma available	Procurement of Tier 4 services to manage performance (pending clarification from HBs on primary and secondary care and pathways).	1	1	1	1	1	1	1	1	WHSSC Programme Priority	TBC	Yes	No	Collective Commissioning	JC	Apr-16	Dec-16		In Progress	October Workshop to review options appraisal		MH Planning Lead
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Low Dose Brachytherapy in the Treatment of Localised Prostate Cancer	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)		Jul-16			In Progress		Included in first group of policies for review (identified as not requiring significant change)	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Blood and Marrow Transplantation	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)					Not Commenced			
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Treatment of Benign Skin Conditions	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)					Not Commenced		Policy due for renewal July 2016	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Facial Surgery procedures	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)					Not Commenced		Policy due for renewal July 2016	GJ

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WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Body Contouring	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)					Not Commenced		Policy due for renewal July 2016	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Abdominoplasty / Apronectomy following Significant Weight Loss	Policy Position Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A		No						Not Commenced		Policy due for renewal July 2016	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Bevacizumab (Avastin) Use in Patients with Relapsed Glioma	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)					In Progress		Included in first group of policies for review (identified as not requiring significant change)	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	68-gallium DOTATE scanning for the Management of Neuroendocrine Tumours (NETs)	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)					Completed		policy and funding release agreed	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Radiolabelled Therapy for the Treatment of Neuroendocrine Tumours (NETs)	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)					Completed		policy and funding release agreed	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Transarterial Chemoembolisation (TACE) Drug-eluting Doxorubicin (DEBOX) for the Management of Unresectable, Metastatic Liver Disease	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)					In Progress		Included in first group of policies for review (identified as not requiring significant change)	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Breast Surgery Procedures	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)					Not Commenced			GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Hepatobiliary Surgery Service Specification	Service Specification Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority									In Progress		Policy due for renewal Mar 2017	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Enhanced Image Guided Brachytherapy (IGBT) Service for the Treatment of Gynaecological Malignancies	Clinical Access Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)					Not Commenced		Included in first group of policies for review (identified as not requiring significant change)	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Neurological and Complex Conditions	Specialised Immunology	Service Specification Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority									Not Commenced		Currently in Phase 1 of Policy Review but planner recommends waiting until funding is released for related ICP scheme	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Hyperbaric Oxygen Therapy Policy	Specialised Services Policy	1								WHSSC Programme Priority				Policy (New)					Not Commenced		In Phase 4 of Policy Review	
WHSSC scheme	N/A				Cardiac	Pulmonary Hypertension Drug Therapy	Specialised Services Policy	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)					Not Commenced		In Phase 2 of Policy Review	
Transfer of Services	N/A	N/A	N/A	N/A	Cancer & Blood	Haemophilia	Transfer into WHSSC	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Service Transfer					Not Commenced			
Transfer of Services	N/A	N/A	N/A	N/A	Cancer & Blood	Endocrinology	Transfer TBC	1	1	1	1	1	1	1	1	WHSSC Programme Priority									Not Commenced			
Collective Commissioning	N/A	N/A	N/A	N/A	Cancer & Blood	RFA Neurological Diseases inc MND and Huntingdon's disease	Type of Collective Commissioning TBC	1	1	1	1	1	1	1	1	WHSSC Programme Priority												
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	PET-CT	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Audit Day					In Progress		Planned Jan 2017	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Thoracic Surgery in South Wales	Service Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Service Review					In Progress			
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Inherited Bleeding Disorders	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Audit Day					Completed		Held on 6th July	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	BMT	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Audit Day					Not Commenced			GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Thoracic Surgery	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Audit Day					In Progress		Provisional date 11th October 2016	GJ
WHSSC scheme	N/A	N/A	N/A	N/A	Cancer & Blood	Plastic Surgery	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Audit Day					Not Commenced			

ICP Reference Number	Financial Table	Provider 1	Provider 2	Provider 3	Programme Team	Service	Commissioning Intention	2016/17	BC	PO	HD	ABM	CT	C&V	AB	Type of proposal	Provider contact details	Business Case Required	Business Case Received?	WHSSC Product	Approving Committee	Date work commenced	Target Date for Completion	Actual Date of Completion	Progress (Completed / In Progress / Not Commenced)	Further Actions e.g. Funding Release Letters, Delivery Plans, etc	Comments	Review completed by	
WHSSC scheme	N/A				Cardiac	Cardiac Resynchronisation Therapy in the Management of Advanced Heart Failure	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)					Not Commenced		In Phase 2 of Policy Review		
WHSSC scheme	N/A				Cardiac	Bariatric Surgery Services	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Policy (New)					Not Commenced		In Phase 3 of Policy Review		
WHSSC scheme	N/A				Women and Children	Genetic testing for inherited cardiac conditions.	Specialised Services Policy Review	1								WHSSC Programme Priority				Policy (New)					In Progress		Consultation letter sent 20.07.16 for response by 17.08.16	CC	
WHSSC scheme	N/A	NHS England	ABM		Women and Children	Fertility Specialist Services for Welsh Residents	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority		No	N/A	Policy (New)					In Progress		Expert advisory group has met and work is ongoing	DG-W	
Transfer of Services	N/A				Cardiac	Cardiology	Transfer out of WHSSC	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Service Transfer					In Progress				
Collective Commissioning	N/A				Cardiac	Cardiac MRI	Advice and Support	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Collective Commissioning					In Progress				
WHSSC scheme	N/A				Cardiac	Cardiac	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Audit Day					In Progress				
WHSSC scheme	N/A				Cardiac	Bariatric Surgery	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme				Audit Day					Completed		Held in May 2016		
WHSSC scheme	N/A				Mental Health	Child Adolescent Mental Health Services (CAMHS) Commissioning Policy	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Policy (Review)	MG	Oct-16	Mar-17		Not Commenced			MH Planning Lead	
WHSSC scheme	N/A				Mental Health	Eating Disorder Specialised Services Tier 4 Specialised Services Policy	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Policy (Review)	MG	Oct-16	Mar-17		Not Commenced			MH Planning Lead	
WHSSC scheme	N/A				Mental Health	Specialised Adult Gender Identity Services	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Policy (Review)	MG	Apr-16	Dec-16		In Progress			MH Planning Lead	
Transfer of Services	N/A	CV			Mental Health	CAMHS CITT (Cardiff and CTJHB)	Transfer out of WHSSC	1								WHSSC Programme Priority	Rose Whittle/Rob Mahoney	No	N/A	Service Transfer	MG	Apr-16	Apr-16	Apr-16	Completed		Funding transfer to LHB	MH Planning Lead	
WHSSC scheme	N/A	NHS England			Mental Health	Gender Dysphoria services (Tier 4)	Service Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Service Review	JC	Apr-16	Dec-16		In Progress	October Workshop to review options appraisal	Subject to agreement on primary/secondary care pathways	MH Planning Lead	
WHSSC scheme	N/A				Mental Health	Gender Dysphoria services (whole pathway)	Service Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Service Review	JC	Apr-16	Dec-16		In Progress	October Workshop to review options appraisal	Subject to agreement on primary/secondary care pathways	MH Planning Lead	
WHSSC scheme	N/A				Mental Health	Perinatal Services	Service Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Service Review	JC	Oct-16	Mar-17		Not Commenced			MH Planning Lead	
WHSSC scheme	N/A	NHS England			Mental Health	Specialised Adult Eating Disorder Services	Service Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Service Review	JC	Jun-16	Mar-17		In Progress		External support required including funding confirmation	MH Planning Lead	
WHSSC scheme	N/A				Mental Health	CAMHS Best Practice Day	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Audit Day	QPS	Apr-16	Nov-16		In Progress	Audit Day			MH Planning Lead
WHSSC scheme	N/A				Mental Health	Tier 4 Adult Eating Disorders	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No	N/A	Audit Day	QPS	Jun-16	Sep-16		In Progress	Audit Day	Initial meeting held to review 2015/16 data	MH Planning Lead	
WHSSC scheme	N/A				Neurological and Complex Conditions	Deep Brain Stimulation	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	North Bristol NHS Trust	No		Policy (New)	MG				Not Commenced		In Phase 3 of Policy Review		
WHSSC scheme	N/A				Neurological and Complex Conditions	Integrated Specialist Rehabilitation	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority		No		Policy (New)	MG				Not Commenced		Incorporate into Review.		
WHSSC scheme	N/A				Neurological and Complex Conditions	War Veterans - Enhanced Prosthetic Provision	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	C&V Andrea Richards, DM BC Stephen Jones, Service Manager	No		Policy (New)	MG		Jul-16	Jul-16	In Progress		Currently with SD to agree TUPE element of case.		
WHSSC scheme	N/A				Neurological and Complex Conditions	All Wales Posture and Mobility Services	Service Specification Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	C&V Andrea Richards, DM BC Stephen Jones, Service Manager	No		Policy (Review)	MG				Not Commenced				
WHSSC scheme	N/A				Neurological and Complex Conditions	Alternative and Augmentative Communication	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	Head of the Electronic Assistive Technology Service, C&V, 029 2031 3852 Jeff.morris2@wales.nhs.uk	No		Policy (New)	MG				Completed		Completed in Dec 15, with review date put on policy of Mar 16 - need to discuss this with Kamala on her return.		
Transfer of Services	N/A				Neurological and Complex Conditions	Immunology	Transfer into WHSSC	1	1	1	1	1	1	1	1	Provider Issue	N/A	No		Service Transfer					Not Commenced				

ICP Reference Number	Financial Table	Provider 1	Provider 2	Provider 3	Programme Team	Service	Commissioning Intention	2016/17	BC	PO	HD	ABM	CT	C&V	AB	Type of proposal	Provider contact details	Business Case Required	Business Case Received?	WHSSC Product	Approving Committee	Date work commenced	Target Date for Completion	Actual Date of Completion	Progress (Completed / In Progress / Not Commenced)	Further Actions e.g. Funding Release Letters, Delivery Plans, etc	Comments	Review completed by
Transfer of Services	N/A				Neurological and Complex Conditions	Neurology	Transfer out of WHSSC	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Service Transfer					Not Commenced			
Transfer of Services	N/A				Neurological and Complex Conditions	MS	Transfer out of WHSSC	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Service Transfer					Not Commenced			
Collective Commissioning	N/A				Neurological and Complex Conditions	Communication Aids	Full Commissioning	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Contractual Allocation	JC				In Progress			
Collective Commissioning	N/A				Neurological and Complex Conditions	Rare neurological diseases inc MND and Huntington's Disease	Type of Collective Commissioning TBC	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Collective Commissioning					Not Commenced			
Collective Commissioning	N/A				Neurological and Complex Conditions	Specialist Respiratory Disease	Type of Collective Commissioning TBC	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Collective Commissioning					Not Commenced			
Collective Commissioning	N/A				Neurological and Complex Conditions	Major Trauma	Type of Collective Commissioning TBC	1	1	1	1	1	1	1	1	Ministerial Priority	South Wales Alliance for ongoing work on establishing a Trauma Centre	No		Collective Commissioning	N/A				Not Commenced			
WHSSC scheme	N/A				Neurological and Complex Conditions	Specialised Neurosciences: - Neurosurgery - Neurodiagnostics (including Neuropathology and Neuroradiology) - Neurorehabilitation	Service Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Service Review					In Progress			
WHSSC scheme	N/A				Neurological and Complex Conditions	Clinical immunology	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Audit Day	N/A				In Progress		Planned February 2017	
WHSSC scheme	N/A				Neurological and Complex Conditions	Deep Brain Stimulation	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Audit Day	N/A				Not Commenced			
WHSSC scheme	N/A				Neurological and Complex Conditions	Posture and Mobility	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Audit Day	N/A				Completed		Held in June 2016	
WHSSC scheme	N/A				Neurological and Complex Conditions	Prosthetics and Rehabilitation	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Audit Day	N/A				Completed		Held in June 2016	
WHSSC scheme	N/A				Neurological and Complex Conditions	Specialised Rehabilitation: - Neuropsychiatry - Neurorehabilitation - Spinal injuries rehabilitation	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Audit Day	N/A				Not Commenced			
WHSSC scheme	N/A				Neurological and Complex Conditions	Auditory Brain Stem Implants	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority	N/A	No		Policy (New)	N/A				Not Commenced		In Phase 3 of Policy Review	
WHSSC scheme	N/A				Women and Children	Ivacaftor (Kalydeco) for G551D Cystic Fibrosis	Clinical Access Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority		No	N/A	Policy (New)				Jun-16	Completed		Completed 21 June by Medical directorate	CC
WHSSC scheme	N/A				Women and Children	Drug treatment for Lysosomal Storage Disorders	Specialised Services Policy Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority		No	N/A	Policy (New)			Jan-17		In Progress		Need input from audit day in October 2016 before completing	CC
WHSSC scheme	N/A				Women and Children	Drug treatment for Lysosomal Storage Disorders Specialised Services Service Specification	Service Specification Review	1	1	1	1	1	1	1	1	WHSSC Programme Priority		No	N/A	Policy (New)			Jan-17		In Progress		Need input from audit day in October 2016 before completing	CC
WHSSC scheme	N/A				Women and Children	Inhaled Therapy for Patients 6 years and older with Cystic Fibrosis	Clinical Access Policy	1	1	1	1	1	1	1	1	WHSSC Programme Priority		No	N/A	Policy (New)					Not Commenced		In Phase 3 of Policy Review	
Transfer of Services	N/A				Women and Children	NICU/SCBU	Transfer into WHSSC	1	1		1	1	1	1	1	WHSSC Programme Priority		No	N/A	Service Transfer	JC		Sep-16		In Progress		Principles agreed July 16, to be modelled and discussed August 16 and transacted Sept 16	CC

ICP Reference Number	Financial Table	Provider 1	Provider 2	Provider 3	Programme Team	Service	Commissioning Intention	2016/17	BC	PO	HD	ABM	CT	C&V	AB	Type of proposal	Provider contact details	Business Case Required	Business Case Received?	WHSSC Product	Approving Committee	Date work commenced	Target Date for Completion	Actual Date of Completion	Progress (Completed / In Progress / Not Commenced)	Further Actions e.g. Funding Release Letters, Delivery Plans, etc	Comments	Review completed by
Transfer of Services	N/A				Women and Children	Paediatric Scoliosis	Transfer into WHSSC	1	1	1	1	1	1	1	1	WHSSC Programme Priority		No	N/A	Service Transfer					Completed		Bristol were informed in an SLA meeting that WHSSC do not fund these services	CC
Transfer of Services	N/A				Women and Children	Fetal Medicine	Transfer into WHSSC	1	1	1	1	1	1	1	1	WHSSC Programme Priority	Cheryl Evans, C&V UHB	No	N/A	Service Transfer			Mar-17		Not Commenced		Not currently priority area for finance, to look to progress later in year	CC
Transfer of Services	N/A				Women and Children	Paediatric CF	Transfer into WHSSC	1	1	1	1	1	1	1	1	WHSSC Programme Priority		No	N/A	Service Transfer			Mar-17		Not Commenced		Not currently priority area for finance, to look to progress later in year	CC
Transfer of Services	N/A				Women and Children	Paediatric ENT	Transfer into WHSSC	1	1	1	1	1	1	1	1	WHSSC Programme Priority		No	N/A	Service Transfer					Completed		Bristol were informed in an SLA meeting that WHSSC do not fund these services	CC
Collective Commissioning	N/A				Women and Children	Paediatric Radiology	Type of Collective Commissioning TBC	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Service Transfer			Oct-16		In Progress		Scoping exercise to be undertaken to review the resource required to action this for 2017/18	CC
WHSSC scheme	N/A				Women and Children	IVF	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Audit Day			Sep-16		In Progress		Planned September 2016	CC
WHSSC scheme	N/A				Women and Children	Neonatal	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Audit Day			Oct-16		In Progress		Planned October 2016 (Neonatal Network)	CC
WHSSC scheme	N/A				Women and Children	Paediatric Cardiology	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Audit Day			Nov-16		In Progress		To be organised November 2016	CC
WHSSC scheme	N/A				Women and Children	Inherited Metabolic Disease	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Audit Day			Oct-16		In Progress		Planned for Oct 16	CC
WHSSC scheme	N/A				Women and Children	Congenital Heart Disease	Audit Day	1	1	1	1	1	1	1	1	WHSSC Programme Priority				Audit Day			Nov-16		In Progress		To be organised November 2016	CC



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

		Agenda Item	15
Meeting Title	Joint Committee	Meeting Date	27/09/2016
Report Title	Concerns Overview Report		
Author (Job title)	Acting Committee Secretary		
Executive Lead (Job title)	Director of Nursing & Quality	Public / In Committee	Public

Purpose	The purpose of this report is to provide members of the committee with an overview of complaints received by WHSSC and serious incidents reported to WHSSC by provider organisations.			
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RATIFY <input type="checkbox"/>	APPROVE <input type="checkbox"/>	SUPPORT <input type="checkbox"/>	ASSURE <input checked="" type="checkbox"/>	INFORM <input checked="" type="checkbox"/>
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Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	

Recommendation(s)	<p>Members are asked to:</p> <ul style="list-style-type: none"> Note the report; and Receive assurance that there is ongoing review of concerns management processes to continually improve and strengthen processes. 		
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Considerations within the report (tick as appropriate)

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

1.0 Situation

- 1.1 The purpose of this report is to provide members of the committee with an overview of complaints received by WHSSC and serious incidents reported to WHSSC by provider organisations.

2.0 Background

- 2.1 A concern is defined as a complaint, a notification of an incident concerning patient safety or, save in respect of concerns notified in respect of primary care providers or independent providers, a claim for compensation.
- 2.2 As part of the contract arrangements with providers Serious Incidents occurring in specialised services commissioner by WHSSC where the victim is a Welsh patient must be reported to WHSSC within 2 working days of the incident occurring.

3.0 Serious Incidents

- 3.1 The following table provides an overview of the serious incidents reported to WHSSC.
- 3.2 As part of the contract arrangements with providers any Serious Incident occurring in a specialised service commissioned by WHSSC relating to a Welsh patient must be reported to WHSSC within 2 working days of the incident occurring.
- 3.3 2 new serious incidents have been reported since the last report.
- 3.4 Diagram 1 provides an overview of reporting activity and diagram 2 shows the number of incidents open and closed during the financial quarter.

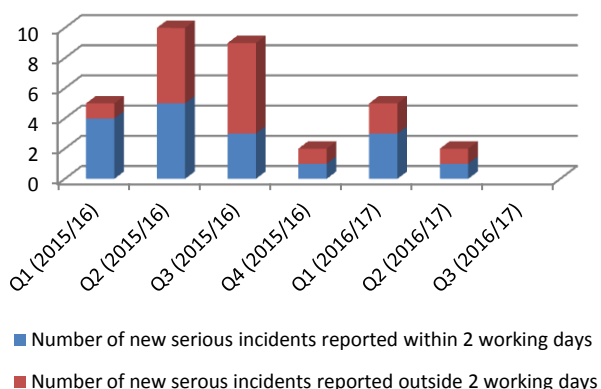


Diagram 1

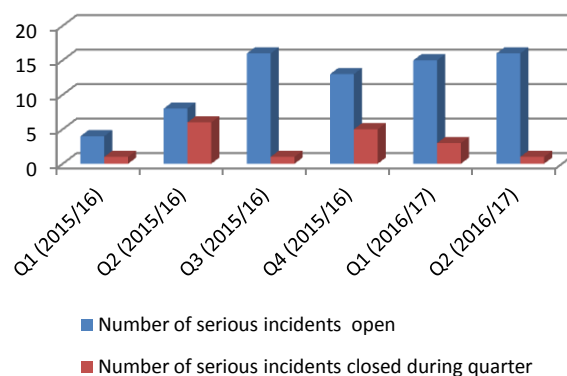


Diagram 2

4.0 Source of complaints

4.1 17 complaints and 18 AM/MP enquiries have been received by WHSSC between 1st May 2016 and 31st August 2016. The figures provided include enquiries received from AM or MPs relating to individual patient enquiries or relating to Individual Patient Funding Requests. Diagram 3 provides a pictorial overview of source.

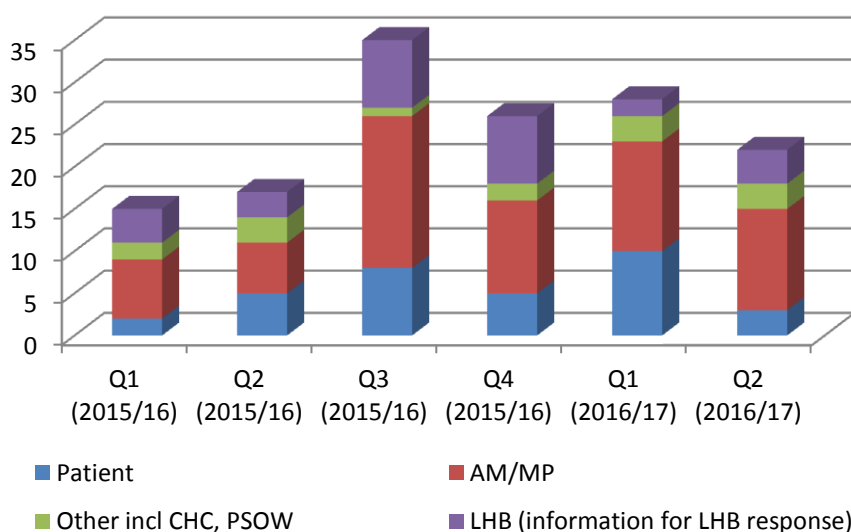


Diagram 3

5.0 Compliance with complaints handling timescales

- 5.1 Under the Putting Things Right Regulations all complaints should be acknowledged within 2 working days and the final response sent within 30 working days (unless due to complexity a different timescale has been agreed with the complainant).
- 5.2 Diagram 4 provides an overview of the timescales for acknowledgment letters being sent.
- 5.3 Diagram 5 provides an overview of compliance for final responses.

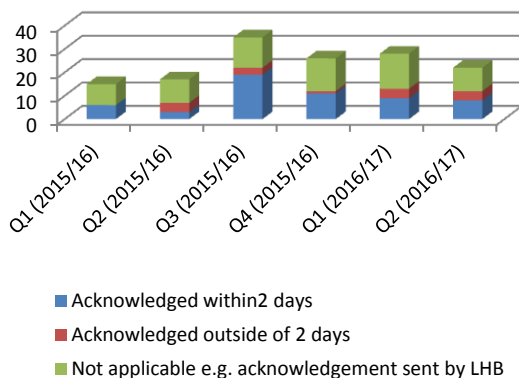


Diagram 4

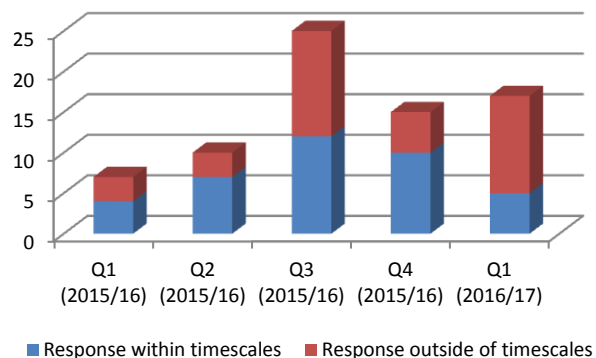


Diagram 5

6.0 Lessons Learnt

6.1 A review of the issues would suggest that further action/discussion is needed in the following areas:

- Timeliness of responses. A review of processes and responsibilities for management of concerns has been undertaken and roles have been clarified. Administration support has been identified to assist with the management of concerns;
- Partnership working with provider to strengthen reporting arrangements;
- Communication with patients. There have been an increase in face to face meetings with complainants which has helped identified the issues to be included in the final response and improved relationships.

7.0 Recommendations

7.1 Members are asked to:

- **Note** the report; and
- **Receive** assurance that there is ongoing review of concerns management processes to continually improve and strengthen processes.

8.0 Appendices / Annex

8.1 There are no appendices or annexes to this report.

Link to Healthcare Objectives		
Strategic Objective(s)	Governance and Assurance	
Link to Integrated Commissioning Plan	Not applicable	
Health and Care Standards	Safe Care Governance, Leadership and Accountability	
Principles of Prudent Healthcare	Not applicable	
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction)	
Organisational Implications		
Quality, Safety & Patient Experience	Some impact on way / manner in which some services are planned in order to meet quality standards and expectation.	
Resources Implications	There are no WHSSC financial implications associated with the contents of this report.	
Risk and Assurance	Aims to provide assurance that WHSSC is monitoring the quality of commissioned services and seeking assurance in relation to Serious Concerns from providers.	
Evidence Base		
Equality and Diversity	No equality issues identified.	
Population Health	To contribute improvements to Specialised Services for the residents for the residents of Wales and to learn lessons from complaints.	
Legal Implications	Compliance with Putting Things Right (PTR) regulations.	
Report History:		
Presented at:	Date	Brief Summary of Outcome
Not applicable		



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

		Agenda Item	16
Meeting Title	Joint Committee	Meeting Date	27/09/2016
Report Title	June 16 Performance Report		
Author (Job title)	Performance Analyst		
Executive Lead (Job title)	Director of Planning	Public / In Committee	Public

Purpose	The attached report provides members with a summary of the key issues arising from the June 2016 Performance Report and details the action being undertaken to address areas of non-compliance.			
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RATIFY <input type="checkbox"/>	APPROVE <input type="checkbox"/>	SUPPORT <input type="checkbox"/>	ASSURE <input type="checkbox"/>	INFORM <input checked="" type="checkbox"/>
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Sub Group /Committee	Corporate Directors Group	Meeting Date	15/08/2016
	Management Group	Meeting Date	25/08/2016

Recommendation(s)	<p>Members are asked to:</p> <ul style="list-style-type: none"> • Note the use of the new interim 2016/17 performance dashboard; • Note current performance and the action being undertaken to address areas of non-compliance. 			
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Considerations within the report (tick as appropriate)

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

JUNE 2016 PERFORMANCE REPORT

1.0 Situation

The attached report provides members with a summary of the key issues arising from the June 2016 Performance Report and details the action being undertaken to address areas of non-compliance.

A copy of the revised performance dashboard is included with an exception report following.

2.0 Background

Development of the Performance Dashboard

The report has been redesigned to provide a clearer and more concise assessment of performance across each of the domains and measures.

The report includes an integrated provider and commissioner dashboard which provides an assessment of the overall progress trend across each of the four domains, and the areas in which there has been either an improvement in performance, sustained performance or a decline in performance.

Further detail (including a three month trend) is included in the subsequent sections on the provider and commissioner dashboards, with key messages relating to provider and commissioner performance over the last month. The dashboard has the following domains:

- Indicator Reference
- Provider – In section 2 aggregate data is used from all providers, in sections 4 onwards, this is broken down by specific providers
- Measure – the performance measure that the organisation is being assessed against
- Target – the performance target that the organisation must achieve
- Tolerance levels – These range from Red to Green, depending on whether the performance is being achieved, and if not the level of variance between the actual and target performance
- Month Trend Data – this includes an indicator light (in line with the tolerance levels) and the numeric level
- Latest Movement – this shows movement from the previous month

The key difference with the previous format is that performance reports are only provided on an exceptional basis, i.e. when the target has not been delivered.

The exception report includes both national and regional dashboards, as well as relevant trend data such as inpatient waiting times. The report sets out

an assessment of current performance, mitigating actions and the timescale for improving performance. The aim is that each of these reports can be used as self-standing documents in their own right by Health Boards to inform their performance improvement processes.

3.0 Assessment

The report provides a clear assessment of the performance of the following areas:

- Cardiac Surgery
- Plastic Surgery
- Paediatric Surgery
- Neurosurgery
- Bariatric Surgery
- Thoracic Surgery
- ALAS
- CAHMS
- Medium Secure

4.0 Recommendations

Members are asked to:

- **Note** the use of the new interim 2016/17 performance dashboard;
- **Note** current performance and the action being undertaken to address areas of non-compliance.



Link to Healthcare Objectives		
Strategic Objective(s)	Governance and Assurance Implementation of the Plan	
Link to Integrated Commissioning Plan	This report monitors the delivery of the key priorities outlined within WHSSCs Integrated Commissioning Plan.	
Health and Care Standards	Governance, Leadership and Accountability	
Principles of Prudent Healthcare	Not Applicable	
Institute for HealthCare Improvement Triple Aim	Not Applicable	
Organisational Implications		
Quality, Safety & Patient Experience	The report will monitor quality, safety and patient experience.	
Resources Implications	There are no resource implications at this point	
Risk and Assurance	There are no known risks associated with the proposed framework There are reputational risks to non-delivery of the RTT standards.	
Evidence Base	N/A	
Equality and Diversity	The proposal will ensure that data is available in order to identify any equality and diversity issues.	
Population Health	The core objective of the report is to improve population heath through the availability of data to monitor the performance of specialised services.	
Legal Implications	There are no legal implications relating to this report.	
Report History:		
Presented at:	Date	Brief Summary of Outcome
Corporate Directors Group Board	15/08/2016	Supported
Management Group	25/08/2016	Supported

WHSSC Performance Report

June 2016

WHSSC



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1. Integrated Provider / Commissioner Dashboard

Domain	Improved Performance	Sustained Performance	Decline in Performance	Trend
Safety	1	0	0	↑
Effectiveness	5	2	5	↓
Staff & Resources	2	0	1	↑
Leadership	3	0	1	↑
Total	11	2	7	↑

2. Provider Dashboard

Indicator Ref.	Provider	Measure		Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movements	Comments	
					Red	Amber	Green							
S01		Quarterly	Number of new Serious Incidents reported to WHSSC by provider within 48hours	100%	<50%	50-99%	100%		83%					Reported Quarterly
E01	All	Monthly	No cardiac surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance		11	8	7			E02 to E04 does not contain English data due to availability of RTT. To be updated in July report
E02	All	Monthly	No plastic surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance		152	145	127			
E03	All	Monthly	No paediatric surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance		146	128	116			
E04	All	Monthly	No neurosurgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance		79	87	95			
E05	All	Monthly	No bariatric surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance		26	28	33			
E06	All	Monthly	No thoracic surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance		4	3	2			
E06D	All	Monthly	Urgent Lung resection within 62 days - All Wales	95% within 62 days	<90% Within 62 days	90-95% within 62 days	=,>95% within 62 days		47%	83%	9%			
E06E	All	Monthly	Non-Urgent Lung resection within 31 days - All Wales	95% within 62 days	<90% Within 31 days	90-95% within 31 days	=,>95% within 31 days		71%	90%	50%			
E07	All	Monthly	Cancer patients to receive a PET scan within 10 days from referral to electronic receipt of image and report by the referring clinician - National	95% within 10 days	<90% Within 10 days	90-95% within 10 days	=,>95% within 10 days		90%	97%	96%			
E08	C&VUHB	Monthly	Delivery of 26 week RTT target for adult posture & mobility service - National	90% within 26 weeks	<85% Within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks		93%	93%	93%			
E09	C&VUHB	Monthly	Delivery of 26 week RTT target for paediatric posture & mobility service - National	90% within 26 weeks	<85% Within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks		98%	98%	98%			
E10	All	Monthly	CAMHS OOA placements	14	>16	>14, <16	=,<14		13	13	11			

*E02 to E04 does not contain English data due to availability of RTT data. To be updated in July report

3. Commissioner Dashboard

Indicator Ref.	Provider	Measure		Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movements	Comments
					Red	Amber	Green						
SR01		Monthly	Sustain financial balance	Within 0.5% of agreed baseline	> +/- 0.5	+/- 0.5%	+/- 0.25%	<div><div></div></div> -0.10%	<div><div></div></div> -0.10%	<div><div></div></div> -0.30%	<div><div></div></div>	<div><div></div></div>	
SR2		Monthly	% WHSSC staff absence due to sickness	<4%	> 5.72%	4.51-5.71%	<4.5%	<div><div></div></div> 2.03%	<div><div></div></div> 2.37%	<div><div></div></div> 0.97%	<div><div></div></div>	<div><div></div></div>	Updated to reflect the December
SR03		Monthly	% of WHSSC staff with an up to date PDR in place	85% by Dec 15, 100% by Mar 16	<75%	75-85%	>85%	<div><div></div></div> 57.1%	<div><div></div></div> 53.2%	<div><div></div></div> 47.7%	<div><div></div></div>	<div><div></div></div>	
L01		Monthly	Ensure all commissioning policies have been reviewed by the agreed review date (inc coding)	50% by 30th Sept 15, 100% by Dec 15	<95%	95-100%	100%	<div><div></div></div> 51%	<div><div></div></div> 51%	<div><div></div></div> 52%	<div><div></div></div>	<div><div></div></div>	50% by 30th Sept 16, 100% by Dec 16
L02		Quarterly	Implementation of internal audit recommendations	100%	<95%	95-99%	100%	<div><div></div></div> 99%			<div><div></div></div>	<div><div></div></div>	Reported Quarterly
L03		Monthly	SLA 16/17 Sign off	75% by 30th Sept 15, 100% 31st Mar 16	<60%	60-74%	>75%	<div><div></div></div> -	<div><div></div></div> -	<div><div></div></div> -			
L04		Quarterly	Number of complaints received acknowledged within 2 working days	100%	<50%	50-99%	100%	<div><div></div></div> 100%			<div><div></div></div>	<div><div></div></div>	Reported Quarterly
L05		Quarterly	Number of responses to complaint sent within agreed timescales	100%	<50%	50-99%	100%	<div><div></div></div> 81%			<div><div></div></div>	<div><div></div></div>	Reported Quarterly

*L03 SLAs have not yet been issued to providers for 2016/17.



Key Messages

3.1 Provider

3.1.1 Safety

Data for the safety measure (number of new serious incidents) is reported on a quarterly basis.

3.1.2 Performance

Cardiac Surgery - At a national level there has been a slight improvement in the number of cardiac surgery patients waiting longer than 36 weeks.

However, at a regional level there continue to be 36 week breaches at ABMU, and following concerns about increased waiting times for cardiac surgery – a summit has been held in South West Wales to discuss and agree the actions to address this.

Whilst there are no breaches in the service at CVU, activity is currently significantly lower than the agreed baseline, and there is ongoing dialogue between WHSSC and the Health Board on this issue as part of the performance management arrangements.

Plastic Surgery – At a regional level there continue to be 36 week breaches at ABMU, with the breast surgery and hand surgery as the sub specialty areas with the longest waiters. Discussions have commenced with ABMUHB to establish two clinical summit meetings to review the current waiting list position, and consider all options to improve RTT performance.

Paediatric Surgery – The total patients waiting in excess of 36 weeks is reducing across Wales, however there remain a significant number in CVU. This includes a number of long waiting patients; however this number has reduced from 88 patients waiting in excess of 52 weeks in December to 46 patients at the end of June.

Following the approval of the business case to expand provision at CVU, a delivery plan has now been submitted and will be circulated for information at the next meeting of the Management Group.

Neurosurgery Surgery – There was a slight deterioration in the waiting list position at C&VUHB with 95 patients waiting in excess of 36 weeks at the end of June. It is anticipated that this position will improve over the next few months, following the appointment of two locum consultants.



Bariatric Surgery – At a regional level in South Wales, there has been a further increase from 28 to 33 patients waiting in excess of 36 weeks at the end of June. The service for North Wales patients continues to deliver in line with the NHS England 26 week RTT. WHSSC officials have met with the ABMU team to discuss the proposals for implementing the new model for bariatric surgery, which will be delivered across Singleton and Morriston hospital. The aim is to create additional internal capacity to improve patient flow, whilst ensuring that the more complex cases can be managed in the most appropriate environment.

Thoracic Surgery – There are 2 patients waiting in excess of 36 weeks in South East Wales. There are no breaches of the target in North or South West Wales. Following the approval of the funding release proformas, both providers have been notified and clear performance monitoring requirements have been confirmed in order to assess the impact of the investment in both centres.

PET Scans – The target has been achieved in June i.e. over 95% of patients have received a PET scan within 10 days from referral to electronic receipt of image and report by the referring clinician. As a result there is no exception report required for this service in the June report.

Posture and Mobility – At a national level, all centres are achieving the 90% waiting times target against 26 weeks for children. The service in North Wales is not currently achieving the 90% target for adults, and at the end of June was reporting a value of 89%. This is related to a number of staffing issues within the service.

CAMHS – The overall number of CAMHS inpatients in the 2 NHS Wales units reduced to 18 in June, compared to 22 in May. The number of patients in out of area placements continues to fall and of the 11 placements at the end of June, only 1 is due to capacity issues within the NHS service.

Medium Secure – The number of patients in Caswell Clinic (ABMU) remains in line with the 95% target (58 beds). There are currently 18 patients on the 20 bedded ward at Ty Llewellyn, the closure of the 5 bed ward for refurbishment has resulted in a temporary increase in out of area admissions.

Lung Cancer – 10 patients on the Urgent Suspected Cancer pathway breached the 62 day target in June, of which 7 were attributed to delays in the diagnostic pathway. However, the data reveals that for a number of these patients, the time between referral to thoracic surgery to definitive treatment exceeds the 31 day target.

3.2 Commissioner

3.2.1 Staff and Resources

The financial balance has been sustained in line with the agreed tolerances over the last three months. Sickness rates have been maintained below 4% since the beginning of the year, and there has been a significant improvement within the last month. Further work is ongoing to improve PDR compliance, and it is expected that this will be reflected in the August and September reports.

3.2.2 Leadership

Work is ongoing on the review of commissioning policies. SLAs for 2016/17 have not been issued at the time of preparing this report.



4. Exception Reports

4.1 Cardiac Surgery

4.1.1 National

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
				Red	Amber	Green					
E01	All	Monthly No cardiac surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	11	8	7	↑	↑

5.1.2 Regional

5.1.2.1 North Wales - Liverpool Heart and Chest Hospital NHS Foundation Trust

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
				Red	Amber	Green					
E01C	LHCH	Monthly No cardiac surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	4	5	4	↓	↑

5.1.2.2 South East Wales - CVUHB

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
				Red	Amber	Green					
E01A	C&VUHB	Monthly No cardiac surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	1	0	0	↑	→

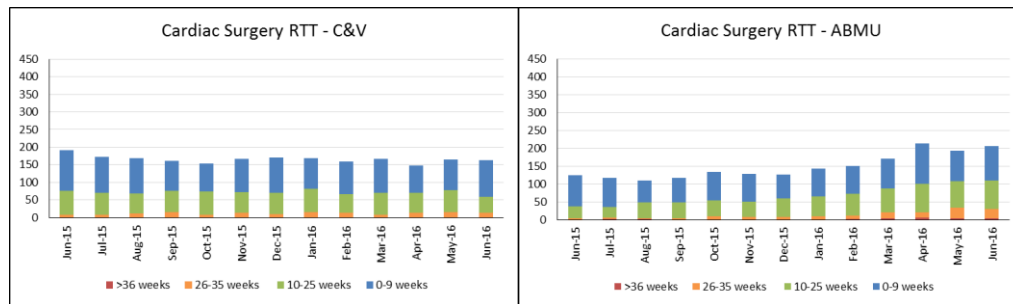
5.1.2.3 South West Wales - ABMUHB

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
				Red	Amber	Green					
E01B	ABMUHB	Monthly No cardiac surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	6	3	3	↑	→

5.1.3 Assessment of Current Performance and Trend

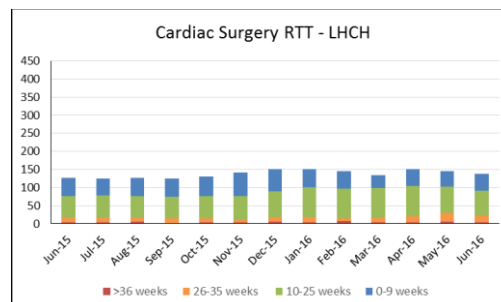
The overall waiting list for cardiac surgery in C&VUHB remains stable; however the overall waiting list for cardiac surgery in AMBU has continued to increase since April 2016. The most recent reported level in June 2016 shows an increase to 206 patients when compared to May 2016 where there were 193 patients. Compared to May 2015 when there were 132 patients.

There recently has been an increase in the number of 36 breaches 3 patients in May 2016, however this has remained the same for June 2016. Potential breaches for June 2016 were identified and consultants made aware.



Due to the building works to increase ITU capacity, there will be a temporary reduction in ITU beds from 8 to 6 beds between mid January and August 2016. ABMUHB advised referrals from PoW to UHW should continue until the end of October, the new CITU facility is expected to be fully operational by the end of September. Over this period, the rate of referral would continue at up to 5 cases per month from ABMUHB to CVUHB to support performance during the period of reduced capacity at Morriston.

Liverpool Heart and Chest Hospital (LHCH) are the main providers of cardiac surgery for North Wales' patients. At the end of June the un-validated data provided by the Trust indicates that there were 138 patients on the total waiting list for cardiac surgery, compared to 146 in May 2016.



Of these 138 patients, 4 were waiting over 36 weeks.

LHCH has acknowledged that the persistent low level breaches of 36 weeks are likely to continue until the current capacity constraints are addressed. The Trust expects to have increased capacity later in quarter 1 of 2016/17. This is expected to improve elective waiting times and to reduce delays for urgent in-hospital referrals.

5.1.4 Mitigating Actions

WHSSC holds monthly performance management meetings with the teams at both centres. WHSSC has requested from C&VUHB and ABMUHB to submit a specific monitoring information data return directly to WHSSC each month as this enables WHSSC to performance monitor the services.

WHSSC concerns over the underperformance have been escalated and Joint Committee was notified in January. CVUHB has also been asked to provide its

capacity and demand analysis for 2016/17. WHSSC has held a summit meeting between ABMUHB and HDUHB to discuss concerns over the current waiting list position and impact on referrals from HDUHB.

5.1.5 Timescale for Improving Performance

The ICP 2016-19 includes schemes to commission an increase in cardiac surgery over the course of the ICP to sustain achievement of waiting times target in North and South Wales .



5.2 Plastic Surgery

5.2.1 National

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
				Red	Amber	Green					
E02	All	Monthly No plastic surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	152	145	127	↑	↑

5.2.2 Regional

5.2.2.1 North Wales

No data submitted from St Helens and Knowsley Hospitals NHS Trust.

5.2.2.2 South Wales - ABMUHB

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
				Red	Amber	Green					
E02A	ABMUHB	Monthly No plastic surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	141	129	127	↑	↑

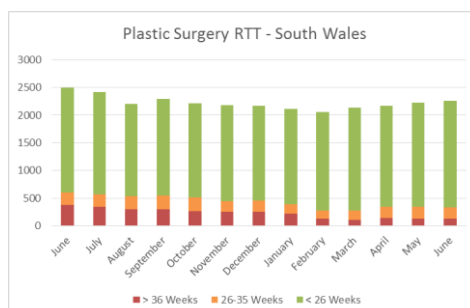
5.2.2.3 Countess of Chester NHS Foundation Trust (BCU SLA)

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
				Red	Amber	Green					
E02D	CoCH	Monthly No plastic surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	13	16		↓	

5.2.3 Assessment of Current Performance and Trend

Plastic Surgery Delivery Plan 2016/17

ABMUHB have submitted a delivery plan for 2016/17. The plan gives detailed profiles for the two sub specialties areas with the longest waiters, breast surgery and hand surgery, and is based on the actual position as at the end of May 2016 it factors in the impact of the unscheduled care cancellations in April and May 2016.



Breast Surgery profile

The plan for breast surgery is to deliver zero patients waiting over 36 weeks by the end of October 2016 and to sustain this position from February onwards. Although the plan makes provision for sick leave and cancellations arising from unscheduled care pressures the time taken to achieve 36 weeks and time of year at which this is forecast to occur increases the risk of non delivery.

Hand Surgery

The extended absence of the two consultant hand surgeons and their phased return to work has led to a significant growth in the backlog. Due to the nature of the absence, neither consultant is in a position to undertake additional activity over and above their core capacity until quarter 2. Based on current capacity and demand modelling, the plan is showing a shortfall in the region of 41 over 36 week breach patients at the end of March 2017. The modelling includes solutions to increase capacity through additional operating by the two hand surgery consultants and MSK support from July with stepped up activity from September.

5.2.4 Mitigating Actions

Discussions have commenced with ABMUHB to establish two clinical summit meetings, one to consider breast surgery and the other hand surgery. The meetings will include representation from WHSSC, ABMUHB and the referring Health Boards. The purpose of the meetings will be to review the waiting list position and consider options to improve RTT performance, for example, closure of the waiting list to new referrals, repatriation of patients to local services and outsourcing inter alia. In preparation for the meeting ABMUHB has been requested to provide a breakdown of the current plastic surgery waiting list, split by sub specialty (procedure level) by Health Board.

5.2.5 Timescale for Improving Performance

The current RTT Delivery Plan will not achieve a maximum 36 week wait for plastic surgery by 31st March 2017. The position will be reviewed following consideration of the full range of options to address long waiting patients at the Clinical Summit meetings. The Summit meetings are planned for September, contingent on the receipt of waiting list information from ABMUHB.








5.3 Paediatric Surgery

5.3.1 National

Indicator Ref.	Provider	Measure		Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
					Red	Amber	Green					
E03	All	Monthly	No paediatric surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	146	128	116	↑	↑

5.3.2 Regional

5.3.2.1 North Wales - Alder Hey Children's NHS Foundation Trust

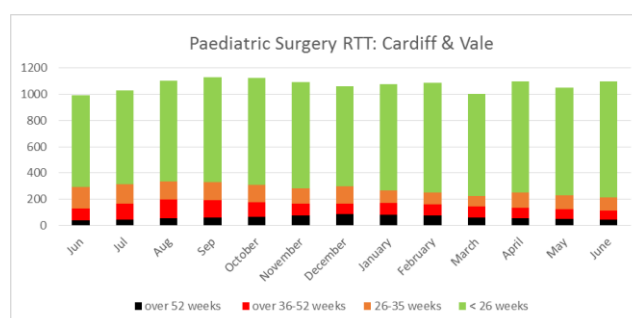
Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
				Red	Amber	Green					
E03B	BCUHB	Monthly No paediatric surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative	 10	 4	 0		

5.3.2.2 South Wales - CVUHB

Indicator Ref.	Provider	Measure		Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
					Red	Amber	Green					
E03A	C&VUHB	Monthly	No paediatric surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	<div><div></div><div>136</div></div>	<div><div></div><div>124</div></div>	<div><div></div><div>116</div></div>	<div><div></div><div>↑</div></div>	<div><div></div><div>↑</div></div>

5.3.3 Assessment of Current Performance and Trend

The total patients waiting >36 weeks is reducing across Wales, however there remain a significant number in C&V UHB. This report therefore focuses on performance there. At the peak in August 2015 there were 196 patients waiting >36 weeks and this has reduced incrementally since that time to 116 at the end of June 2016.



Long waiting patients also remains an issue, with 46 patients waiting >52 weeks at the end of June, however this has also reduced from a peak of 88 in December 2015.

It is anticipated that the total patients waiting in excess of 36 weeks will increase slightly at the end of July 2016. The cause of this is Consultant Surgeon annual leave and does not, therefore, represent a long term issue. In fact, it is anticipated that the 36 week breach position will be significantly reduced by the end of Q2 with plans to continue this through the remainder of 2016/17. A delivery plan will be provided in early August that will demonstrate when a position of 0 36 week breach patients can be delivered in 2016/17.

5.3.4 Mitigating Actions

A fortnightly meeting is held between WHSSC and the service to monitor activity and waiting times. In addition a monthly Executive level meeting is held between WHSSC and C&V UHB.

In order to maximise delivery the service has taken numerous actions including the backfill of all available operating sessions and by implementing theatre efficiency tools to ensure maximum booking and utilisation of lists.

The business case for expansion of paediatric surgery at C&V, including 2 additional operating days, has now been approved and recruitment has already commenced for many of the key staff, including theatre staff and ward nursing staff. As a result, an additional operating day will commence in July 2016 and a 2nd additional operating day will commence in October. As described above, a waiting list model will be provided demonstrating when in 2016/17 it is anticipated that the 36 week RTT target can be delivered.

5.3.5 Timescale for Improving Performance

As described above, it is anticipated that the position will deteriorate slightly in July with significant improvements then anticipated at the end of Q2. A delivery plan will be provided in early August modelling the anticipated timeframe for delivery of the 36 week RTT target in 2016/17.



5.4 Neurosurgery

5.4.1 National

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
				Red	Amber	Green					
E04	All	Monthly No neurosurgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	79	87	95	↓	↓

5.4.2 Regional

5.4.2.1 South Wales - CVUHB

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement	
				Red	Amber	Green						
E04A	C&VUHB	Monthly	No neurosurgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	79	87	95	↓	↓

5.4.2.2 Mid Wales - University Hospital Birmingham NHS Foundation Trust

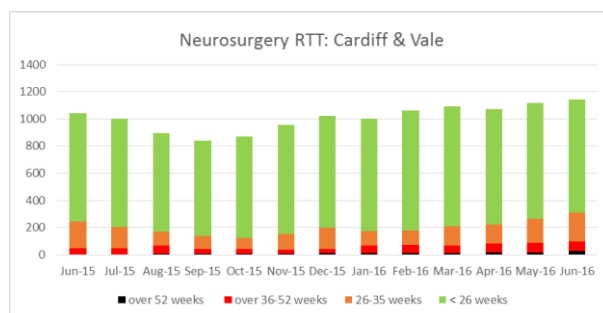
Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement	
				Red	Amber	Green						
E04B	UH Birm	Monthly	No neurosurgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	<div><div></div><div></div><div></div></div> 0	<div><div></div><div></div><div></div></div> 0		<div><div></div><div></div><div></div></div> →	

5.4.2.3 North Wales - The Walton Centre NHS Foundation Trust

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
				Red	Amber	Green					
E04C	The Walton	Monthly	No neurosurgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	0	0		→

5.4.3 Assessment of Current Performance and Trend

The service is currently reporting 95 patients over 36 weeks at month end for June. This is due to a number of factors such as cancellations due to emergency pressures, increase of urgent cases that have taken priority and short term staffing issues.



5.4.4 Mitigating Actions

Enhanced performance management of the service is in place with fortnightly meetings with the service and monthly meetings taking place with the Specialist Services Clinical Board are taking place.






5.4.5 Timescale for Improving Performance

Two locum consultants are due to take up post, the first in July and the second in September, a member of staff on long term sick is due to return in the coming weeks.



5.5 Bariatric Surgery

5.5.1 National

Indicator Ref.	Provider	Measure		Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
					Red	Amber	Green					
E05	All	Monthly	No bariatric surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	 26	 28	 33		

5.5.2 Regional

5.5.2.1 South Wales - ABMUHB

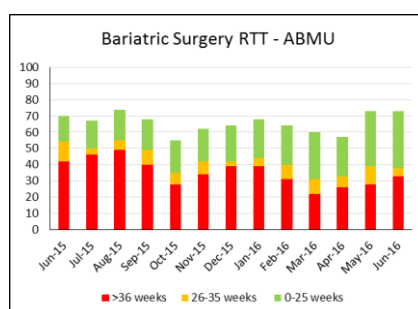
Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement				
				Red	Amber	Green									
E05A	ABMUHB	Monthly	No bariatric surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative		26		28		33		

5.5.2.2 North Wales - Salford Royal NHS Foundation Trust

Indicator Ref.	Provider	Measure		Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement			
					Red	Amber	Green								
E05B	Salford Royal	Monthly	No bariatric surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance		0		0		0		

5.5.3 Assessment of Current Performance and Trend

Underperformance over the last 18 to 24 months in the bariatric surgery service at ABMUHB has led to the accumulation of patients with long waiting times. At the end of May 2016, there were 28 patients waiting in excess of 36 weeks. The figure has increased in June 2016 to 33 patients.



In addition to underperformance, 7 cases undertaken from April 1st 2016 have been for band removal rather than surgery for new patients. This reflects a trend over the last year of an increasing number of patients requiring removal for gastric bands implanted elsewhere.

June has seen the maintenance of zero North Wales patients breaching the 26 week waiting time at Salford Royal.

5.5.4 Mitigating Actions

- WHSSC has requested each of the two providers to submit a specific monitoring information data return directly to WHSSC each month as this enables WHSSC to performance monitor the services.
- New service model in South Wales: ABMUHB has developed a new service model for bariatric surgery that will ensure protected capacity for the service through transferring the majority of activity to Singleton Hospital. Pending the receipt of further information from ABMUHB regarding the model, particularly in relation to governance arrangements for patients that may require post surgical critical care, a paper to recommend commissioner support for the model will be presented to the next available Management Group meeting.
- The WHSSC ICP 2016-19 includes the implementation of phase 2 (black scheme) of the bariatric surgery five year plan to increase access up to the clinically recommended level. The incorporation of this funding into the contract with ABMUHB will be confirmed alongside the approval of the new service model.

5.5.5 Timescale for Improving Performance






Improvement in performance is dependent on implementation of the new service model. ABMUHB has set out plans to commence the new service from September 2016.

ABMUHB is currently in the process of confirming the activity profile and timescales for eliminating breaches of the 36 weeks target for patients listed for bariatric surgery.



5.6 Thoracic Surgery

5.6.1 National

Indicator Ref.	Provider	Measure		Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement	
					Red	Amber	Green						
E06	All	Monthly	No thoracic surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance		4 	3 	2		

5.6.2 Regional

5.6.2.1 North Wales - Liverpool Heart and Chest Hospital NHS Foundation Trust

Indicator Ref.	Provider	Measure		Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement				
					Red	Amber	Green									
E06C	LHCH	Monthly	No thoracic surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative	<div><div></div></div>	0	<div><div></div></div>	0	<div><div></div></div>	0	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>

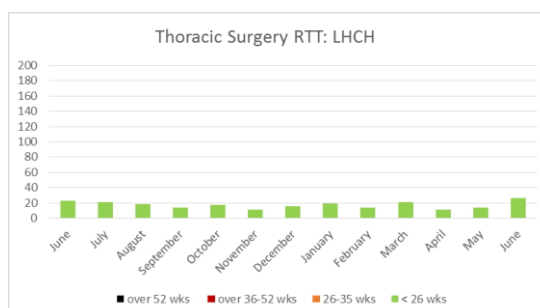
5.6.2.2 South East Wales - CVUHB

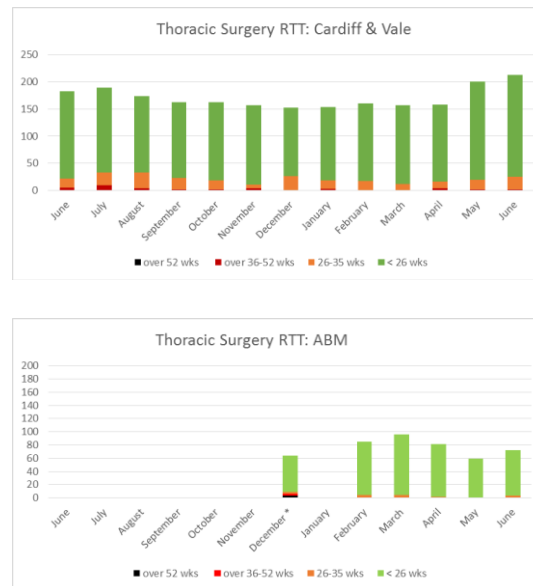
Indicator Ref.	Provider	Measure		Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement			
					Red	Amber	Green								
E06A	C&VUHB	Monthly	No thoracic surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative	<div><div></div></div>	4	<div><div></div></div>	2	<div><div></div></div>	2	<div><div></div></div>	<div><div></div></div>

5.6.2.3 South West Wales - ABMUHB

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement					
				Red	Amber	Green										
E06B	ABMUHB	Monthly	No thoracic surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative	<div><div></div></div>	0	<div><div></div></div>	1	<div><div></div></div>	0	<div><div></div></div>	<div><div></div></div>	<div><div></div></div>

5.6.3 Assessment of Current Performance and Trend





The data shows there are 2 patients nationally who have breached the 36 week waiting time target, both of whom are located in South East Wales. There are no breaches of the target in North Wales or South West Wales. This is an improvement in the national position which is encouraging given the rising number of referrals.

5.6.4 Mitigating Actions

The release of funding for the thoracic surgery ICP schemes to increase capacity was confirmed at Management Group in June. ABMUHB and CVUHB are currently implementing their delivery plans to increase capacity in 2016/17.

WHSSC has requested each of the three main providers to submit a specific thoracic surgery data return directly to WHSSC each month to enable appropriate performance monitoring of the services.

The WHSSC ICP 2016-19 includes the commitment to undertake a review of thoracic surgery in 2016/17.

5.6.5 Timescale for Improving Performance

The ICP 2016-19 includes schemes to commission an increase in thoracic surgery over the course of the ICP to improve access and outcomes for patients, both on urgent cancer pathways and those waiting for elective surgery for other indications. Given the lead-in time required to recruit new staff, the increases in capacity and activity in 2016/17 are not expected until later in quarter 3 and into quarter 4.



5.7 ALAS - Adult

5.7.1 North Wales - BCUHB

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
				Red	Amber	Green					
E08C	BCUHB	Monthly Delivery of 26 week RTT target for adult posture & mobility service in North Wales	90% within 26 weeks	<85% Within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	89%	88%	89%	↓	↑

5.7.2 South East Wales - CVUHB

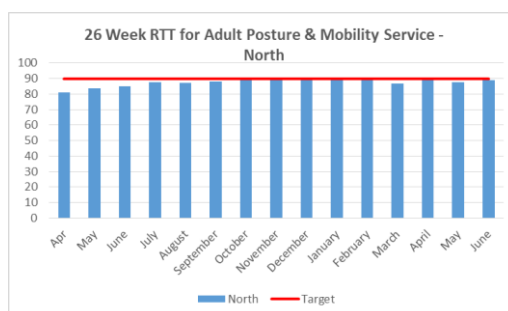
Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
				Red	Amber	Green					
E08A	C&VUHB	Monthly Delivery of 26 week RTT target for adult posture & mobility service in Cardiff	90% within 26 weeks	<85% Within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	91%	92%	90%	↑	↓

5.7.3 South West Wales - ABMUHB

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movement
				Red	Amber	Green					
E08B	ABMUHB	Monthly Delivery of 26 week RTT target for adult posture & mobility service in Swansea	90% within 26 weeks	<85% Within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	100%	100%	100%	→	→

5.7.4 Assessment of Current Performance and Trend

North Wales has seen a marginal increase of 1% in performance between May and June has been recorded. The service have reported a number of staffing issues which is having a direct impact on performance.



South East Wales and South West Wales continue to hit the target; however, performance in South East Wales has decreased to the 90% target.

5.7.5 Mitigating Actions

Increased dialogue is taking place with regular meetings taking place with the service to discuss performance.

5.7.6 Timescale for Improving Performance

Once staffing issues have been resolved an increase in performance should be seen.

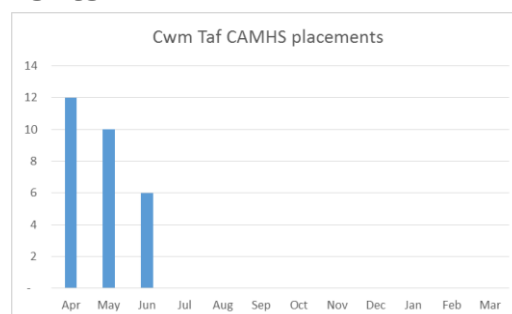
6. Additional Performance Data

This section includes additional performance data for the following specialties:

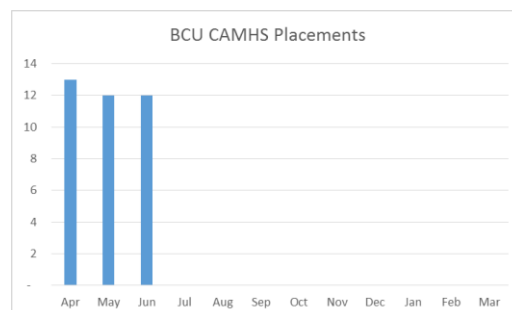
- CAHMS (Placements in NHS)
- Adult Medium Secure (Placements in NHS)
- Lung Cancer

6.1 NHS CAHMS

6.1.1 CTUHB Placements



6.1.2 BCUHB Placements



6.1.3 Assessment of Current Performance and Trend

Overall numbers of CAMHS inpatients in the 2 NHS units reduced to 18 in June compared to 22 at the end of May. The unit in North Wales (Abergele) was operating above capacity in April as the 2nd ward was temporarily used in order to manage complex patient. The unit continued to operate at maximum capacity during June. The number of patients in out of area placements continues to fall and of the 11 placements OoA at the end of June only 1 (North Wales) is due to NHS capacity issues.

6.1.4 Mitigating Actions

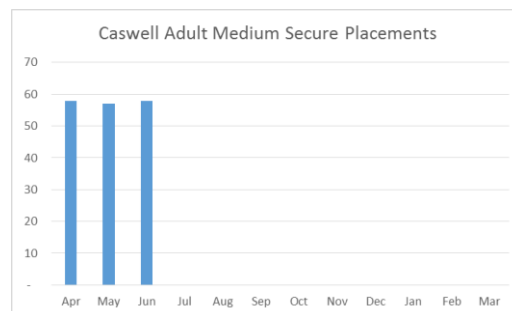
2 patients from BCU were admitted to South Wales (Ty Llidiard) to avoid out of area placements. WHSSC & BCU have commenced a long term strategic review of CAMHS services and are developing a number of options for consideration.

6.1.5 Timescale for Improving Performance

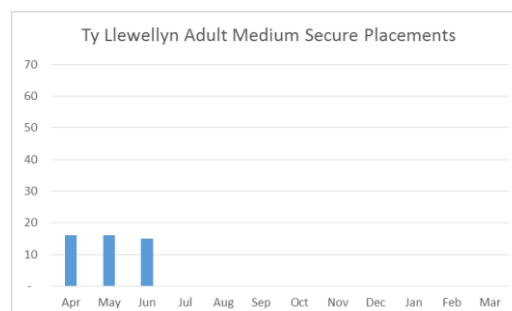
The review of CAMHS services in BCU is expected to be completed by the end of the year and changes introduced by 1st April 2017.

6.2 NHS Adult Medium Secure

6.2.1 Caswell Clinic Placements



6.2.2 Ty Llewellyn Placements



6.2.3 Assessment of Current Performance and Trend

The number of patients in Caswell Clinic is in line with the target of 58 occupied beds (95%).

The 5 bed ward at Ty Llewellyn has been closed since September 2015 due to a complete refurbishment. This work has now been completed and the occupancy levels will increase until September when the unit will be back to its full operating capacity of 25 beds. The closure of this ward has led to a temporary increase in out of area admissions with the loss of seclusion facilities. There are currently 18 patients on the remaining 20 bed ward.

6.2.4 Mitigating Actions

The service has been regularly monitoring the out of area placements and updating a repatriation list. These patients will be returned as soon as possible depending on the clinical priority of any patients on waiting list.

6.2.5 Timescale for Improving Performance

It is expected the service will be back of full operating capacity by September 2016.



6.3 Lung Cancer

6.3.1 Urgent Suspected Cancer

6.3.1.1 National

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movements
				Red	Amber	Green					
E06D	All	Monthly Urgent Lung resection within 62 days - All Wales	95% within 62 days	<90% Within 62 days	90-95% within 62 days	=,>95% within 62 days	47%	83%	9%		

6.3.1.2 Regional

6.3.1.2.1 North Wales

- No resection or breach data has to date been submitted to WHSSC for April or May.
- No resections for North Wales patients were undertaken in June.

6.3.1.2.2 South Wales

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movements
				Red	Amber	Green					
E06Di	South	Monthly Urgent Lung resection within 62 days - South Wales	95% within 31 days	<90% Within 62 days	90-95% within 62 days	=,>95% within 62 days	47%	83%	9%		

6.3.2 Non Urgent Suspected Cancer

6.3.1.3 National

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movements
				Red	Amber	Green					
E06E	All	Monthly Non-Urgent Lung resection within 31 days - All Wales	95% within 62 days	<90% Within 31 days	90-95% within 31 days	=,>95% within 31 days	71%	90%	50%		

6.3.1.4 Regional

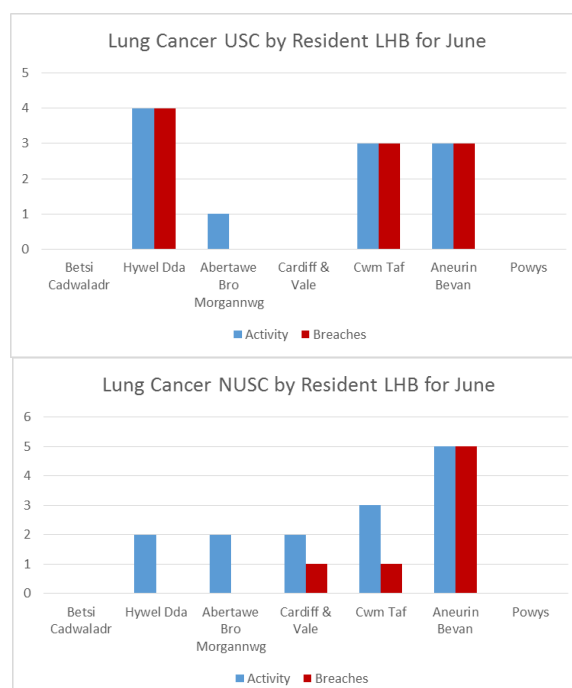
6.3.1.4.1 North Wales

- No resection or breach data has to date been submitted to WHSSC for April or May.
- No resections for North Wales patients were undertaken in June.

6.3.1.4.2 South Wales

Indicator Ref.	Provider	Measure	Target	Tolerance Levels			Apr-16	May-16	Jun-16	Previous Movement	Latest Movements
				Red	Amber	Green					
E06Ei	South	Monthly Non-Urgent Lung resection within 31 days - South Wales	95% within 62 days	<90% Within 31 days	90-95% within 31 days	=,>95% within 31 days	71%	90%	50%		

6.3.2 Assessment of Current Performance and Trend



Patients may breach for a number of reasons that may relate either to delays in the diagnostic pathway or to delays that occur after referral to thoracic surgery. Of the 10 USC patients to breach in June, 3 were attributed to delays in surgery and 7 to delays in the diagnostic pathway.

While the breaches may be attributed to earlier stages of the pathway, data shows that the time from referral to thoracic surgery to treatment is often outside the target of 31 days. This is particularly an issue currently for Hywel Dda UHB patients referred to ABMUHB. However, it should be noted that although waiting times for Hywel Dda patients have increased, this is due to the increased number of referrals, which are in turn increasing the resection rates (which improves patient survival). Hywel Dda UHB currently has one of the highest resection rates in Wales.

6.3.3 Mitigating Actions

- The release of funding for the thoracic surgery ICP schemes to increase capacity was confirmed at Management Group in June. ABMUHB and CVUHB are currently implementing their delivery plans to increase capacity in 2016/17.

- ABMUHB is taking forward specific action to increase out-patient clinic capacity in the short term to reduce waiting times for patients from Hywel Dda UHB.
- WHSSC is working with ABMUHB and HDUHB to monitor waiting times and identify further short term actions to ensure patients are treated within 31 days.
- Monitoring data is submitted monthly to WHSSC from the Cancer Network. In addition a cancer tracker is received from providers to monitor the time from referral to surgery to treatment.
- WHSSC is undertaking a review of thoracic surgery in 2016/17 to inform the long term commissioning plan.

6.3.4 Timescale for Improving Performance

Given the lead-in time required to recruit new staff, the increases in capacity and activity in 2016/17 are not expected until later in quarter 3 and into quarter 4.



GIG
CYMRU
NHS
WALES

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

		Agenda Item	17
Meeting Title	Joint Committee	Meeting Date	27/09/2016
Report Title	Financial Performance Report – Month 5 2016/17		
Author (Job title)	Finance Manager – MH, DRC, IPFR & MMR		
Executive Lead (Job title)	Director of Finance	Public / In Committee	Public

Purpose	<p>The purpose of this report is to set out the estimated financial position for WHSSC for the fifth month of 2016/17. There is no corrective action required at this point.</p> <p>The financial position is reported against the agreed 2016/17 baselines following approval of the 2016/17 IMTP by the Joint Committee in March 2016.</p>			
RATIFY <input type="checkbox"/>	APPROVE <input type="checkbox"/>	SUPPORT <input type="checkbox"/>	ASSURE <input type="checkbox"/>	INFORM <input checked="" type="checkbox"/>

Sub Group /Committee	Corporate Directors Group Board	Meeting Date	12/09/2016
		Meeting Date	
Recommendation(s)	<p>Members are asked to:</p> <ul style="list-style-type: none"> • Note the current financial position and forecast year-end position. • Discuss and agree any specific corrective action to reduce any forecast overspending. 		

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

1.0 Situation

- 1.1 The purpose of this report is to inform various stakeholders of the current financial position of WHSSC.

2.0 Background

- 2.1 The financial position for WHSSC is reported against the agreed 2016/17 baselines following approval of the 2016/17 IMTP by the Joint Committee in March 2016.

3.0 Assessment

- 3.1 The financial position reported at Month 5 for WHSSC is a current underspend to date of £1,522k, with a forecast year-end underspend of £1,569k.

The movement from the previous month is a deterioration of £218k to date and £596k End of Year forecast.

- 3.2 Appendix A contains a full report of the Income and Expenditure values which make up this total, with further detail and explanations.

4.0 Recommendations

- 4.1 Members of the appropriate Group/Committee are requested to:
- **Note** the current financial position and forecast year-end position.
 - **Discuss and agree** any specific corrective action to reduce any forecast overspending.

5.0 Appendices / Annex

Appendix A – full report of the details behind the reported financial position. This includes:

- Annex A – WHSSC Expected Expenditure breakdown across LHB's/budget headings



Link to Healthcare Objectives		
Strategic Objective(s)	Governance and Assurance Development of the Plan	
Link to Integrated Commissioning Plan	This document reports on the ongoing financial performance against the agreed IMTP	
Health and Care Standards	Governance, Leadership and Accountability	
Principles of Prudent Healthcare	Only do what is needed	
Institute for HealthCare Improvement Triple Aim	Reducing the per capita cost of health care	
Organisational Implications		
Quality, Safety & Patient Experience		
Resources Implications	This document reports on the ongoing financial performance against the agreed IMTP	
Risk and Assurance	This document reports on the ongoing financial performance against the agreed IMTP	
Evidence Base		
Equality and Diversity		
Population Health		
Legal Implications		
Report History:		
Presented at:	Date	Brief Summary of Outcome
Corporate Directors Group Board	12/09/2016	Supported to Management Group



Finance Performance Report – Month 5

1. Situation / Purpose of Report

The purpose of this report is to set out the estimated financial position for WHSSC for the 5th month of 2016/17 together with any corrective action required.

This excludes the financial position for EASC, which includes the WAST contracts, the EASC team costs and the QAT team costs, and have a separate Finance Report.

	Annual Budget	Budgeted to Date	Actual to Date	Variance to Date	Movement in Var to date	Current EOYF	Movement in EOYF position
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
WHSSC	536,750	223,646	222,124	(1,522)	218	(1,569)	596
Sub-total WHSSC	536,750	223,646	222,124	(1,522)	218	(1,569)	596
WAST	136,482	56,868	56,868	0	0	0	0
EASC team costs	350	146	164	18	(5)	58	0
QAT team costs (full budget amount tbc)	668	278	232	(46)	(2)	(58)	0
Sub-total WAST / EASC / QAT	137,500	57,292	57,264	(28)	(7)	0	0
Total as per Risk-share tables	674,251	280,938	279,388	(1,550)	211	(1,569)	596

Please note that as LHB's cover any WHSSC variances, any over/under spends are adjusted back out to LHB's. Therefore, although this document reports on the effective position to date, this value is actually reported through the LHB monthly positions, and the WHSSC position as reported to WG is a nil variance.

2. Background / Introduction

The financial position is reported against the agreed 2016/17 baselines following approval of the 2016/17 – 2018/19 IMTP by the Joint Committee in March 2016. The remit of WHSSC is to deliver a plan for Health Boards within an overall financially balanced position. However, the composite individual positions are important and are dealt with in this financial report together with consideration of corrective actions.

The overall financial position at Month 5 is an underspend of £1,522k, with a forecast year-end underspend of £1,569k.

The majority of NHS England is reported in line with the previous month's activity returns. WHSSC continues to commission in line with the contract intentions agreed as part of the IMTP and standard Pbr rules, and declines payment for activity that is not compliant with the business rules related to out of time activity. WHSSC does not pay CQUIN payments for the majority of the English activity.

The inherent increased demand led financial risk exposure from contracting with the English system remains but it is planned that this will have been mitigated to a greater extent in 2016/17 from uplifting financial baselines to more realistic levels based on historic activity.

3. Governance & Contracting

All budgets have been updated to reflect the 2016/17 agreed IMTP, including the full year effects of 2015/16 Developments. CITT team funding and income have been returned to LHB's, and Clinical Immunology has been transferred into WHSSC. Inflation has been allocated to the position, but work on this will be ongoing in future months. The IMTP sets the baseline for all the 2016/17 contract values. This will be translated into the new 2016/17 contract documents shortly and sent to providers.

Distribution of the reported position has been shown using the 2015/16 risk shares based on 2014/15 utilisation. This will be progressed into the 2015/16 utilisation shares as soon as possible over the coming months. The Finance Working Group is working on validating the risk-sharing process, and any update will be shared with Management Group for agreement. Until there is formal agreement from Joint Committee on a change to the risk sharing process the current system will remain in operation but with updated activity shares based in 2015/16 outturn where appropriate.

4. Actual Year To Date and Forecast Over/Underspend (summary)

Financial Summary (see Risk-sharing tables for further details)	Annual Budget	Budgeted to Date	Actual to Date	Variance to Date	Previous month Var to date	Current EOYF Variance	Previous month EOYF Var
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NHS Wales							
Cardiff & Vale University Health Board	187,596	78,165	78,457	292	272	88	417
Abertawe Bro Morgannwg University Health Board	91,473	38,114	37,462	(652)	(706)	(535)	(527)
Cwm Taf University Health Board	5,500	2,292	2,071	(221)	(133)	(531)	(637)
Aneurin Bevan Health Board	2,967	1,236	1,291	55	7	87	21
Hywel Dda Health Board	34	14	14	0	0	0	0
Betsi Cadwaladr University Health Board Provider	36,205	15,086	14,935	(151)	(211)	(166)	(517)
Velindre NHS Trust	35,488	14,787	14,787	0	0	0	0
Sub-total NHS Wales	359,262	149,693	149,015	(677)	(771)	(1,056)	(1,243)
Non Welsh SLAs	109,715	45,714	45,185	(530)	(566)	(66)	104
IPFR	24,346	10,144	10,809	665	315	1,500	1,056
Mental Health & IVF	22,996	9,582	9,590	8	165	(275)	(341)
Renal	4,814	2,006	2,085	80	(56)	148	78
Prior Year developments	3,848	1,508	1,287	(220)	(136)	(309)	(309)
2016/17 Plan Developments	7,875	853	132	(721)	(577)	(1,535)	(1,535)
Direct Running Costs	3,894	1,623	1,496	(127)	(116)	25	25
Phasing adjustment for Developments not yet implemented ** see below	0	2,524	2,524	0	0	0	0
Total Expenditure	536,750	223,646	222,124	(1,522)	(1,740)	(1,569)	(2,165)

The reported position is mainly based on the following bases:

- NHS Wales activity – extrapolation of Month 4 data in most areas; some exceptions if deemed necessary.
- NHS England activity – Month 4 data where received. This excludes the Mental Health High Secure contracts which are already set as block contracts and are now fixed for 2016/17.
- IPFR/IVF – reported based on approved Funding Requests; reporting dates based on usual lead times for the various treatments, with unclaimed funding being released after 36 weeks.
- Mental Health – live patient data as at the end of the month, plus current funding approvals.
- Developments – variety of bases, including agreed phasing of funding. The financial impacts of the approved funding releases are currently accounted for in the forecast. This will be factored into the in month position for next month.

** Please note that Income is collected from LHB's in equal 12ths, therefore there is currently an excess budget in the current position which relates to future months. To keep the Income and Expenditure position equal, the phasing adjustment is shown on a separate line for transparency and is accrued to date to avoid a technical underspend.

5. Financial position detail - Providers

5.1 NHS Wales – Cardiff & Vale contract:

Various over and underspends from the Month 4 data have been extrapolated to a total Month 5 position of £292k overspent. WHSSC is working with the provider to agree baselines this year and would expect this to be completed in the coming weeks. Not all the underlying positions have been extrapolated, with a resulting total year-end forecast overspend of £88k.

- BMT (Cardiff & ABM) – The contract performance would have shown an overspend to date of £76k for M5; as there is funding in Developments, this spend has alternatively been shown in that position to avoid an overinflation of the Cardiff contract. Please note that the funding release is pending, so is an expected adjustment and is highlighted in the Developments tab.
- Cardiology – Activity has remained high for Month 4, leading to a reported overspend of £413k to date. This has been largely kept in line for the year-end forecast of £472k as activity is anticipated to fall over the summer.
- Cardiac Surgery (SW Wales) – the Cardiac Surgery contract is underperforming by £565k to date, mainly relating to casemix. The current indications suggest this may continue. WHSSC is working with the provider to agree a delivery plan and recurrent demand levels.
- Clinical Immunology – the reported overspend of £90k reflects an increase in patients. This is a growing area and has pending Development funding.

- Cystic Fibrosis – The contract performance would have shown an overspend to date of £56k for M5; as there is funding in Developments, this spend has alternatively been shown in that position to avoid an overinflation of the Cardiff contract. Please note that the funding release is pending, so is an expected adjustment and is highlighted in the Developments tab.
- Renal Transplants – The reported underspend of £389k has been projected as £933k by the end of the year. This is line with trend.

5.2 NHS Wales – ABM contract:

WHSSC is currently working with the provider to agree baselines, which should be completed shortly. Various over and underspends from the Month 4 data have been extrapolated to a total Month 4 position of £652k underspent. Not all the underlying underspent have been extrapolated equally, with a resulting total year-end forecast overspend of £535k. The issues include:

- Cardiac Surgery £368k underspent - the indications for the month 4 activity suggest an increase and therefore, WHSSC has assumed an underspend to date, with a catch up to budget by year-end in future months. WHSSC is currently agreeing a delivery plan with the provider.
- Plastic Surgery £102k underspent – this has been extrapolated to a year end forecast underspend of £500k as activity is reducing, but a plan from the provider is awaited.
- Bariatrics £92k underspent – the year-end forecast is £75k underspent as activity is expected to be achieved in future months.

5.3 NHS Wales – BCU contract:

Variances on only Angioplasty, ICD's and Haemophilia have been reported to date. ICD and Haemophilia activities are expected to catch up by year-end. These variances constitute a deterioration of £352k for the year-end position, but is risk-shared back to the LHB itself.

5.4 NHS Wales – Cwm Taf contract:

The CAMHS contract element has a reported underspend to date of £303k. This includes £80k relating to non-South Wales patients; these costs have been reported within the CAMHS Out Of Area budgets to reflect the investment and usage of this contract.

ICD spend has a current overspend of £81k, with a year-end forecast of £195k. This is risk-shared in total to Cwm Taf LHB itself.

5.5 NHS Wales – other contracts:

No material variances to report; however, no contract monitoring has been received from Velindre Trust.

5.6 NHS England contracts:

Total £530k underspend to date, with £66k underspend forecast for year-end. The English position has been reported prudently, with underspends not being fully projected in some cases where activity is expected to catch up by year end. The larger variances include:

- Central Manchester University Hospitals – overspend to date of £171k. This includes one cost PICU patient costing £199k; they have now been discharged hence the year-end forecast has been maintained.
- Imperial College – underspend to date of £198k. This reflects the Month 4 monitoring, with future months assumed to be on plan, as 2015/16 outturn was £220k higher at this point last year.
- Royal Brompton – underspend to date of £238k. This reflects the Month 4 monitoring, with future months assumed to be on plan, as 2015/16 outturn was £60k higher per month at this point last year
- Royal Liverpool & Broadgreen – underspend to date of £330k related to low Blood Product activity and no BMT's reported to date. The year-end forecast has been adjusted to £186k as further months are assumed to be break-even, with a potential risk of high cost Haemophilia patients starting their treatments later in the year based on 2015/16 data.
- Salford – underspend to date of £222k; this relates to underperformance on Bariatric Surgery and Intestinal failure to date.
- University Hospitals Birmingham – overspend to date of £327k. The overspend relates to calculations for 3 long-stay ITU patients yet to be charged through the monitoring totalling £451k, plus a high cost VAD of £193k.
- Walton – underspend to date of £213k. The forecast underspend has been maintained at the same value as activity remains at 2015/16 levels but is expected to increase.
- High Secure block contracts at Ashworth & Rampton – Savings of £500k were entered in the IMPT against High Secure based on an estimated figure for 2016/17, of which £269k has been confirmed as achieved. The remaining undelivered savings of £231k is being considered against the Medium Secure budgets and may be retargeted in a future month.

Detailed explanations of all the English providers are noted on the appropriate tab of the financial Risk-sharing tables sent to all LHB's on the 3rd working day; please see them for any further details.

5.7 IPFR:

Various budgets totalling an overspend to date of £665k, with a projected year-end of £1,500k overspend. These include:

- Eculizimab – due to new funding approvals and the full-year effect of late 15/16 approvals, the year-end forecast is an overspend of £495k. However, a patient on Eculizimab (AHUS) has been confirmed as not yet starting the drug, and this underspend has been reported on that line as an underspend of £174k to date. This has not been extrapolated in 12ths as confirmation is pending whether the patient will eventually start on the drug or not.
- ERT Savings schemes – The Savings target of £1,301k is made up of two schemes. The smaller one of £92k is being achieved, which has been reported and reflected in the year-end forecast. However, the other of £1,209k is not yet being achieved according to the patient detail passed over from Cardiff & Vale. The savings are dependant on drug changes for various patients, and the LHB have been asked to clarify their projections. A full year's non-achievement has been reported for prudence pending further information, and this will be updated in future months.
- A new line has been split out this month to identify Proton Beam Therapy costs; this combines Adult and Paeds approvals. This is a growing area, with 4 new patients receiving treatments in August. Two of these had funding approvals in 2015/16 and the associated financial accruals have been released against the 2016/17 spend, but are noteworthy as it informs the underlying activity in this area. This brings the total activity to 7 to date; 5 within 2016/17 approvals. The extrapolated year-end total has therefore been increased to 12 patients for the year, and is the reason for the £551k cost increase in this area.
Please note that this increased extrapolation creates an average of one patient per month; there is already an expected patient in the system for Month 6, which confirms the basis of this calculation.
- General IPFR, ALAS, HPN, and MS have small underspends to date, and although there have been the usual high-cost patients, the costs have been alleviated by other underspends.. Discussions are ongoing internally regarding splitting the General IPFR line into smaller budgets to help inform of trends and keep extreme high cost patients separate for risk-sharing purposes. Proton Beam Therapies have been split out this month for this reason; VAD's will be split out for the following month.

5.8 Mental Health & IVF:

Various budgets totalling an overspend to date of £12k, with a projected year-end of 284k underspend. These budgets include:

- Adult Mental Health has a projected overspend of £784k based on the patients in OOA placements at this point. This equates roughly to 3 annual patients, and may well be adjusted as activity progresses through the year. Please note that the funding for the Case Management teams has now been agreed, and it is expected that the increased clinical support in this area will reduce patient numbers going forward as staff are recruited.
- CAMHS and FACTS inpatient budgets have continued lower activity than estimated for the Plan. This includes £80k costs for two patients in the Cwm Taf NHS unit, which has been reported in this section due to LHB investment and usage.
- IVF has a small forecast overspend of £9k; this includes a reduction in forecast English NHS activity and an increase in NHS Wales activity.

5.8 Renal:

No material issues to report regarding Renal budgets at this point, except for the costs regarding the ABM transportation contract. Costs for a private sector transport provider may cost more than anticipated due to the short term nature of this contract and an increased cost of £139k is being reported at this point.

5.9 Developments and Savings Reserves:

Phasing for planned Developments as per the IMTP agreement has been reported to exclude £2,524k for future funding as of Month 5. This is shown as a separate line on the risk-sharing, with an equivalent "spend" simply for the purpose of allocating the spend to the Income, which is collected in equal 12ths.

Please note that the costs entered for BMT's and Cystic Fibrosis of £56k and £76k are highlighted as the funding releases have not yet been actioned. The costs have been entered provisionally to avoid over-inflating the Cardiff contract position.

5.10 Direct Running Costs (Staffing and non-pay):

The running cost budget is currently £127k underspent, with a forecast overspend of £25k. This is due to the significant staffing vacancies the organisation is currently running with; most should be appointed to shortly and there is some minimal Agency spend in the meantime. Non-pay overspends include the Cwm Taf hosting fee, Director recruitment costs and equipment (including the Paperless Board equipment)

Please note that the CAMHS/ED and Neonatal networks are due for transfer to Public Health Wales shortly, but do not have a material bearing on the reported position. Pay award funding allocated to Cwm Taf for 2016/17 includes the element for WHSSC staff; the value has yet to be determined and passed over.

6. Financial position detail – by Commissioners

The financial arrangements for WHSSC do not allow WHSSC to either over or underspend, and thus any variance is distributed to LHB's based on a clearly defined risk sharing mechanism. The following table provides details of how the current variance is allocated and how the movements from last month impact on LHB's.

Table 3 – Year to Date position by LHB

	Allocation of Variance							
	Total	Cardiff and Vale	ABM	Cwm Taf	Aneurin Bevan	Hywel Dda	Powys	Betsi Cadwaladr
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Variance M5	(1,522)	(138)	(538)	126	142	(376)	(127)	(612)
Variance M4	(1,740)	(110)	(574)	113	30	(392)	(5)	(802)
Movement	218	(28)	36	13	112	16	(122)	190

Table 4 – End of Year Forecast by LHB

	Allocation of Variance							
	Total	Cardiff and Vale	ABM	Cwm Taf	Aneurin Bevan	Hywel Dda	Powys	Betsi Cadwaladr
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
EOY forecast M5	(1,569)	(281)	(934)	294	216	(423)	8	(449)
EOY forecast M4	(2,165)	(271)	(913)	260	36	(387)	134	(1,025)
EOY movement	596	(10)	(21)	34	180	(36)	(126)	576

Material reporting positions or movements include:

6.1 Betsi Cadwaladr:

Of the forecast deterioration of £576k for BCU, £352k relates to the LHB's own provider contract. The increased projection of Proton Beam Therapy patients has contributed an additional deterioration through the risk-share of £115k, with the remaining £109k being an amalgamation of various budgets.

6.2 Aneurin Bevan:

Of the forecast deterioration of £180k for Aneurin Bevan, £126k relates to the increased projection of Proton Beam Therapy patients.

6.3 ABM:

The forecast position for ABM LHB is an underspend of £934k, which has only marginally moved from Month 4.

This is mainly due to forecast underspends on the Cardiff and ABM provider contracts, the largest of which is the £878k forecast underspend on the Cardiac Surgery Development budget for South West Wales within the Cardiff contract, which is wholly risk-shared to ABM LHB. Other forecast underspends include £222k for Renal Transplants within the Cardiff contract, and £216k for Plastics within the ABM contract.

7. Income / Expenditure Assumptions

7.1 Income from LHB's

The table below shows the level of current year outstanding income from Health Boards in relation to the IMTP and in-year Income adjustments. There are no notified disputes regarding the Income assumptions related to the IMTP. Please note that Income for EASC costs are also included in this table as the Cash for WHSSC/EASC elements is not separated. Secondment recharges are currently netted into the Running Cost expenditure and will be separated out for future months.

Invoices over 13 weeks in age detailed to aid LHB's in clearing them before WG Arbitration date deadlines:

- ABM - £949,000.00 for final 2015/16 Commissioner risk-sharing
- ABM - £390,428.44 for 2015/16 Cardiac Outsourcing funding
- ABM - £217,576.00 for 2015/16 IVF provider underperformance
- Cardiff & Vale - £1,294,000.00 for final 2015/16 Commissioner risk-sharing

Please can these LHB's liaise with the Payments Department at WHSSC to ensure these bills are paid as soon as possible.

Table 5 – 2016/17 Income Expected and Received to Date

	2016/17 Planned Income	Income Expected to Date	Actual Income Received to Date	Accrued Income	Total Income Accounted to Date	EOY Commissioner Position	Other: EASC Medserv e	EOY total expected income
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ABM	112,311	46,796	46,479	317	46,796	(942)	0	111,369
Aneurin Bevan	121,844	50,768	50,185	583	50,769	217	0	122,061
Betsi Cadwaladr	154,819	64,508	64,026	482	64,508	(442)	0	154,377
Cardiff and Vale	116,415	48,506	48,236	271	48,507	(286)	0	116,129
Cwm Taf	61,201	25,500	25,331	170	25,501	294	117	61,611
Hywel Dda	75,586	31,494	31,262	232	31,494	(417)	0	75,169
Powys	32,074	13,364	13,231	133	13,364	8	0	32,082
Total	674,251	280,938	278,751	2,187	280,938	(1,569)	117	672,799



This table includes additional columns to previous years in order to show the total anticipated Income as per the I&E expectations submitted to WG as part of the monthly Monitoring Returns. This should help reconciliation between WHSSC and other organisations' I&E tables, and expedite clarifying any differences, as per WG requests.

Please note the high accrual this month for Income; this relates primarily to the additional £4.5m Income reported in the M4 reports relating to EASC's advised agreements with LHB's regarding WAST funding. This money will be collected over coming months, and work is being completed to split the WHSSC/EASC funding reconciliations to reflect the 2 separate organisations. Please see the EASC narrative report for further detail on the Month 4 additional WAST funding.

Due to the natural delays of reporting, this £4.5m may well show up as differences within the Month 5 Income assumption reconciliations (**WG Action Point 4.1**). For info, this Income is split between LHB's as follows:

	WAST - 16/17 IMTP funding £'000	WAST - 16/17 IMTP funding (adj resulting from ARRP adj) £'000	Total add'l EASC funding £'000
Cardiff and Vale	537	11	548
ABM	629	13	642
Cwm Taf	407	8	416
Aneurin Bevan	749	15	764
Hywel Dda	616	13	628
Powys	335	7	341
Betsi Cadwaladr	1,156	24	1,180
Total	4,429	90	4,519

7.2 Expenditure with LHB's

A full breakdown of the expected expenditure across LHB's and budget headings is included as Annex A. This is an additional table to previous years.

These figures are also reported in the I&E expectations submitted to WG as part of the monthly Monitoring Returns. This Annex should help reconciliation between WHSSC and other organisations' I&E tables, and expedite clarifying any differences, as per WG requests.

The previous month's I&E assumptions have been considered, and reasons for variances include:

ABM – variations on contract projections; the contract performance and projections have been discussed in some detail mid-month and any variations should now be minimal. Please note that the Month 4 variations netted to just

£13k as the reporting of the provider and commissioner positions were both reported on the same basis.

Cardiff & Vale – variations on reporting some budget areas that have funding within Developments. WHSSC will move Development monies over once fully approved.

Velindre – The assumption variations were reduced in Month 4 by the additional funding of £3m into the Welsh Blood Service commissioned for North Wales. The remaining difference includes an uplift included by Velindre related to their contract; discussions are ongoing regarding this.

No LTA contracts have been signed to date.

8. Overview of Key Risks / Opportunities

The key risks remain consistent with those identified in the annual plan process to date.

The additional risk and opportunities highlighted in this report are:

- Phasing of Development funding as projects start; possible slippage in start dates may lead to non-recurrent in-year savings.
- Write back funding related to prudent accruals for performance in 2015/16; this will be assessed once most of the final payments have been agreed.
- Growth in all activity above that projected in the IMTP.
- Please note that at this early stage none of these are felt to be significant; the IMTP was agreed in March and assumptions remain the same.
- Dealing with in year service risks associated with amber rated schemes which are yet to be funded.

9. Public Sector Payment Compliance

The WHSSC payment compliance target is consolidated and reported through the Cwm Taf monitoring process.

10. Responses to Action Notes from WG MMR responses

Action Point 4.1 – Detail have been provided in the main monthly report for LHB's reconciling which areas we are expecting spend and the values – please see Appendix A. Please see sections 7.1 and 7.2 for specific differences that are being discussed/resolved.

Action Point 4.2 – No LTA contracts have been signed to date.

11. Confirmation of position report by the MD and DOF:

Stuart Davies, Director of Finance, WHSSC

Daniel Phillips, Acting Managing Director, WHSSC



Annex A – 2016/17 Expected Expenditure

	2016/17 Baseline contract	2016/17 Contract EOYF variance	IPFR	MH & IVF	Renal	Develop- ments	WHSSC/ EASC/QAT Running Costs	2016/17 Sub- Total Other Spend	2016/17 Total expected spend
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ABM	91,473	(535)	37	2,922	590		47	3,061	94,534
Aneurin Bevan	2,967	87	1		139		(83)	143	3,110
Betsi Cadwaladr	36,205	(166)	1,079	125	844		70	1,952	38,158
Cardiff and Vale	187,596	88	7,280		706	1,522	177	9,773	197,369
Cwm Taf	5,500	(531)	220	82	0		589	360	5,861
Hywel Dda	34	0	48		470		74	591	625
Powys			0		0		0	0	0
Public Health			48		0		0	48	48
Velindre	35,488	0	0		104		(23)	80	35,568
WAST (managed by EASC)	136,482	0	0		106		(5)	101	136,583
Total	495,744	(1,056)	8,713	3,130	2,957	1,522	845	16,110	511,855

Reporting Committee	Integrated Governance Committee
Chaired by	Ann Lloyd
Lead Executive Director	Acting Committee Secretary
Date of last meeting	20 July 2016 and 8 June 2016
Summary of key matters considered by the Committee and any related decisions made on 20 July 2016	
<p>1. Minutes of the Previous Meeting and Matters Arising The Integrated Governance Committee (the Members) agreed the minute of the meeting held on 8 June 2016 to be a true and accurate record.</p> <p>Members received an update on Gender Dysphoria Partnership Board, transfer of networks, governance action plan.</p> <p>2. WHSSC Annual Report Members received the draft Annual Report 2015-16 and noted that the final report was to be presented to the Joint Committee in September 2016 for information.</p> <p>Comments were invited from members and suggestions were made.</p> <p>Members resolved to:</p> <ul style="list-style-type: none"> • Review the content of the draft report; • Provide comments and suggestions of the current content; • Recommend further areas of information required for the report; and • Support the final annual report being taken to the Joint Committee. <p>3. Review of Sub-Committee and Advisory Group Terms of Reference Template Members received a brief summary of the background to this report, picking up on comments received at Joint Committee in June 2016. Members were asked to provide feedback on each of the terms of reference and annual reports and approve the template.</p> <p>It was agreed that clarity should be provided within all terms of reference around the individual committee/group's authority and decision making and escalation process.</p> <p>Members resolved to:</p> <ul style="list-style-type: none"> • Note the content of the report; • Note the terms of reference of the sub-committees and advisory groups as presented and provide feedback; • Approve the template; • Agree for the template to be circulated to all sub-committees and Advisory Groups to update their terms of reference accordingly; and • Support their presentation to the Joint Committee for Ratification in 	

September 2016.

4. Implications of the Report of the Specialised Services Commission for NHS Wales

Members **received** the paper which set out the key messages and recommendations of the report of the Specialised Services Commission; its relevance and implications for NHS Wales; and to recommend actions to address relevant issues.

Members **resolved** to:

- **Note** the key messages and recommendations of the Report of the Specialised Services Commission;
- **Note** the relevance and implications for NHS Wales;
- **Support** the content informing the development of the new strategy for specialised services for Wales; and
- **Approve** the actions to address issues relevant to NHS Wales.

5. Corporate Risk and Assurance Framework

Members **received** a copy of the Corporate Risk and Assurance Framework noting that an updated version had been reviewed by the Corporate Directors Group on 18 July 2016.

Members **noted** the work undertaken to strengthen the main report and acknowledged that further work was still required regarding the wording of the risks to be more patient focuses and work to review the risk score.

Members **resolved** to:

- **Note** the update provided within the report; and
- **Discuss** whether there are any other risks, for which the Corporate Risk Committee should be the assuring committee, which should be included on the Framework.

6. Governance Action Plan

Members **received** the paper which provided an update against the actions.

Members **resolved** to:

- **Note** the contents of this report; and
- **Receive assurance** that work is progressing to complete actions within agreed timescales.

7. Joint Committee Annual Self-Assessment

Members **noted** the interim results of the Joint Committee Assessment and raised concern regarding the low response rate so far.

Members **agreed** that the survey should be resent with all Members of the Joint Committee to repeat the exercise. It was **agreed** that an additional element would be added to the survey to identify the type of member to enable a greater understanding of view within each of their roles on the Joint Committee.

Summary of key matters considered by the Committee and any related decisions made on 8 June 2016

1. Matters Arising and Matters Arising

The Integrated Governance Committee (the Members) **agreed** the minute of the meeting held on 5 May 2016 to be a true and accurate record.

Members **received** an update on the Gender Dysphoria Partnership Board.

2. Transfer of Networks

Members received an overview of the report which had been produced to provide confirmation of the governance arrangements for the CAMHS and Neonatal networks which were to be hosted by Public Health Wales from 1 July 2016. Members noted that although operational responsibility would be with Public Health Wales there would still be a line of accountability into WHSSC.

Members **resolved** to:

- **Note** the contents of the report; and
- **Support** the continuation of the governance and reporting arrangements for the Neonatal and CAMHS/ED Networks.

3. Annual Business Reporting

Members noted that at the next meeting, to be held 20 July 2016, they would receive the annual reports and terms of reference from each of the sub-committees, including that for Integrated Governance Committee.

Members **resolved** to:

- **Note** the update.

4. Integrated Governance Committee Annual Self Assessment

Members received an overview of the report noting areas of improvement around member's knowledge and level of detail covered during the meeting.

Members **resolved** to:

- **Note** the contents of the report;
- **Support** the **agreed** actions for inclusion in the Committee's Annual Report to Joint Committee.

5. Corporate Risk and Assurance Framework

Members received overview and work being undertaken to further develop the Corporate Risk and Assurance Framework (CRAF).

Members reviewed and made comment on a number of risks as identified within the report.

Members **resolved** to:

- **Note** the update provided within the report

6. Governance Action Plan

Members noted the report presented and requested that an exception report be produced for future meetings, which made clear areas of progression and of risk.

Members **resolved** to:

- **Note** the contents of this report; and
- **Receive assurance** that work is progressing to complete actions within agreed timescales.

7. Reports from joint Sub Committees and Advisory Groups

Members **received** oral reports from the chairs of the joint sub committees and advisory groups.

Confirmed minutes for the meeting held 8 June 2016 are available to members on request.

Date of next meeting	Wednesday 19 October 2016
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Agenda Item 18.2
WHSSC Joint Committee
27 September 2016

Reporting Committee	Quality Patient Safety Committee
Chaired by	Chris Koehli
Lead Executive Director	Director of Nursing & Quality
Date of last meeting	30 August 2016
Summary of key matters considered by the Committee and any related decisions made.	
<ul style="list-style-type: none"> Development Day for the Committee members arranged for 3rd November 2016. It was agreed that an invitation would be sent to the chairs of each of the Health Board Quality Patient Safety Committees to attend a development day. This will give the committee members' an opportunity to examine roles and responsibilities and also how information is shared across organisations. Update regarding progress against the implementation of the Quality Assurance Framework received The quality assurance report against the four quality domains for the months March – June 2016 was approved The Annual Quality Statement will be integrated into the Annual Report. Work has been ongoing with the Quality Leads from each of the Welsh Health Boards and a section on the commissioning of specialised services has been incorporated into each of their submissions. A draft Patient Engagement Framework was presented to the Quality & Patient Safety Committee on August 30th to compliment the patient experience domain of the framework. This work will be shared with the CHC and stakeholder groups to ensure that the framework is both fit for purpose and meets the needs of users and the organisation. Terms of reference and Annual report agreed Policy Review group reporting arrangements agreed. Update paper to be brought to next committee meeting 	
Key risks and issues/matters of concern and any mitigating actions	
<ul style="list-style-type: none"> A business case setting out the resources for the Quality Team as part of Quality Framework Implementation was to be presented to the Quality & Patient Safety Committee. Whilst there was support for the need for a dedicated team the committee suggested that further work needed to be undertaken to strengthen the added value of the team especially from an All Wales basis. Further work required on the risk assurance framework 	
Matters requiring Committee level consideration and/or approval	
<ul style="list-style-type: none"> None 	

Matters referred to other Committees	
<ul style="list-style-type: none"> • None 	
Confirmed Minutes for the meeting held 2 June 2016 are available to members on request.	
Date of next meeting	28 November 2016

Reporting Committee	All Wales Individual Patient Funding Request (IPFR) Panel
Chaired by	Professor Vivienne Harpwood
Lead Executive Director	Director of Nursing & Quality Assurance
Date of last meeting	31 August 2016
Summary of key matters considered by the Committee and any related decisions made on 31 August 2016.	
<p>The action log of the All Wales IPFR Panel was reviewed and updates provided.</p> <p>The Panel considered 14 Requests.</p> <p>Updates were provided where clinical reports had been received on patients previously agreed funding by the Panel.</p> <p>Panel were updated on urgent Panel decisions made via a virtual panel.</p> <p>The Panel nominated Brian Hawkins, Chief Pharmacist as Vice Panel Chair.</p> <p>The Panel was not quorate (3 Health Boards unable to provide representation). Panel recommendations were circulated to non-attendee and ratified</p>	
Key risks and issues/matters of concern and any mitigating actions	
<p>Revised All Wales Individual Patient Funding Request Policy</p> <p>IPFR decisions are at risk of judicial review if not made in line with All Wales policy and procedure. Therefore, decisions made by the All Wales Panel must be open, transparent and equitable. The Panel is actively working towards full compliance with the All Wales policy by:</p> <ul style="list-style-type: none"> • Improving clinical representation on the Panel; • Improving quoracy. From September Powys are now able to provide representation; • One Lay representative has been appointed and there are plans to recruit a second. 	
Matters requiring Committee level consideration and/or approval	
<ul style="list-style-type: none"> • None 	

Matters referred to other Committees	
<ul style="list-style-type: none"> Internal Performance Group – Commissioning, Service and Policy development <p>There are issues around the Panel being asked to consider commissioning issues and areas where policy either needs to be developed or revised. WHSSC has undertaken a full review of existing commissioning policies and are developing policy where gaps have been identified.</p>	
The Annual Report of the All Wales Individual Patient Funding Request (IPFR) Panel for 2015/16 is attached as annex (i) for information.	
Date of next meeting	28 September 2016

The All Wales Individual Patient Funding Request (IPFR) Panel

ANNUAL REPORT 2015-16

1. BACKGROUND

The All Wales Individual Patient Funding Request (IPFR) Panel is a Sub Committee of the Welsh Health Specialised Services Committee and holds delegated Joint Committee authority to consider and make decisions on individual patient requests to fund NHS healthcare for patients who fall outside the range of services and treatments that routinely provided.

The All Wales IPFR Panel act at all times in accordance with the all Wales IPFR Policy and extant WHSSC commissioning policies.

The decisions of the Panel are made on the basis of the information within the application form and any supplementary clinical evidence provided in support of the application.

The Panel take into account all of the following factors when considering funding:

- Cost effectiveness
- Clinical effectiveness
- Ethical and equity
- Clinical exceptionality

2. MEMBERSHIP

The membership of the Panel has been agreed as part of the all Wales IPFR Policy to include an appropriate balance of professional disciplines and to enable a secure and informed multi-disciplinary decision.

Membership is as follows:

- Independent Chair
- A named representative from each of the seven Health Boards at Director/ Assistant Director level , or a named deputy with appropriate seniority and experience who can operate in the capacity of the primary representative.
- 2 Lay members (The Panel currently has 1 and is actively looking to

- recruit a second)
- A further two Panel members may be appointed at the discretion of the Chair. The current Panel includes a Senior Pharmacist.
- In attendance from WHSSC
 - Medical Director or Deputy
 - Director of Nursing or Deputy
 - IPFR Co-ordinator
 - Finance Advisor (if required)
 - Other WHSSC staff as and when required

The Panel may also, at its discretion, request the attendance in person, via VC or telephone conference of any clinician to provide clarification on any issue or request independent expert clinical advice to support consideration of an individual request.

3. MEETINGS

The Chair or Vice-Chair and representation from five of the seven Health Boards, three of which must be clinical representatives need to be represented for the Panel to be quorate.

The IPFR Panel meet monthly in person. However, virtual Panels can be arranged via email if a decision required within days or if urgent i.e. required in 24 hours, the Chair/Vice Chair together with the WHSSC Managing Director and Medical Director or Director of Nursing are authorised to make outside of a full Panel meeting.

Decisions made outside of a full meeting are reported at the next meeting.

In 2015/16, 21 Panels in total were held of which:

- 9 virtual
- 6 where not quorate of which 2 where not quorate because there was not enough clinical representation

4. MAIN AREAS OF COMMITTEE ACTIVITY

The agenda for each meeting follows a standard format which is broken down into:

Preliminary matters

This section of the meeting covers off standard issues such as apologies, welcome, declarations of interest, minutes of the last meeting, reports on clinical outcomes received , reports on virtual Panels held in previous month, action log updates and matters arising.

Items for discussion and consideration

This section covers IPFR Requests (Cases) for discussion.

The requests are anonymised. The Panel consider on average 8 requests per meeting.

The IPFR Panel cannot make policy decisions. Any policy proposals arising from their considerations and decisions are reported to the WHSSC programme teams.

The Panel have financial authorisation to agree funding up to a set limit of £300,000 for one-off packages and £1million for lifetime packages

Authorisation for any decisions resulting in a financial cost in excess of this limit must be obtained from the relevant Health Board and reported to the Managing Director of Specialised and Tertiary Services.

Any Other Business

5. LINKS WITH OTHER COMMITTEES

The WHSSC Director of Nursing and Quality Assurance and Medical Director provide a connection with other committees such as the Quality and Patient Safety Committee and Clinical Networks.

6. WORK PROGRAMME

In order to monitor progress and any necessary follow up action, the Panel has developed an Action Log that captures all agreed actions and is updated on a monthly basis.

7. ASSESSMENT OF GOVERNANCE AND RISK ISSUES

As IPFR decisions are at risk of judicial review if not made in line with All Wales policy and procedure. Therefore, decisions made by the All Wales Panel must be open, transparent and equitable.

8. ASSURANCE TO THE JOINT COMMITTEE

In line with the Welsh Government review of IPFR Process recommendation Nov 2014, the All Wales Policy has been reviewed and updated.

It is anticipated that the changes to the All Wales IPFR policy will improve transparency and confidence in decision-making across NHS Wales and provide an improved system of monitoring and analysing the outcomes of IPFR decisions.

The policy was published in May 2016 and is currently being approved via respective Health Board governance processes.

The Panel have undertaken a self assessment and the outcomes will be picked up as part of the action log for 2016/17.

9. CONCLUSION AND LOOK FORWARD

The Panel is actively working towards full compliance with the All Wales policy and intends to seek further assurance in 2016/17 in the following areas:

- Nomination of Vice Chair
- Improve clinical representation
- Improve Health Board attendance
- Outcomes of self assessment to be actioned
- Recruit a second lay member

Agenda Item 18.4
WHSSC Joint Committee
27 September 2016

Reporting Committee	Welsh Renal Clinical Network
Chaired by	Chair, Welsh Renal Clinical Network
Lead Executive Director	Director of Finance
Date of last meeting	12 July 2016
Summary of key matters considered by the Committee and any related decisions made.	
<ul style="list-style-type: none"> • Draft Terms of Reference for the WRCN Board were APPROVED by the Board subject to confirmation from WHSSC regarding relationship with WHSSC Management Group • Policies APPROVED by the Board: Routine Visitor to Haemodialysis Units and Haemodialysis Away from Base. • The Financial position remains positive for 2016/17 but forward look indicates a shortfall in 2017/18 onwards. The WRCN will be seeking to submit priorities to the WHSSC ICP process • Board INFORMED of changes to the commissioning arrangements for organ donation (transferring from Welsh Government to WHSSC). 	
Key risks and issues/matters of concern and any mitigating actions	
<ul style="list-style-type: none"> • Paediatric Nephrology Services – The WRCN has been tasked with including paediatrics into the next iteration of the Renal Delivery Plan. Initial discussions around these services identified some areas of concern regarding service provision and sustainability. 	
Matters requiring Committee level consideration and/or approval	
<ul style="list-style-type: none"> • WRCN Terms of Reference needs to be confirmed by the Joint Committee 	
Matters referred to other Committees	
<ul style="list-style-type: none"> • Paediatric Nephrology issues and papers have been referred to WHSSC Corporate Directors Group for consideration as this is not part of the WRCN's function (Adults only). 	
Annexes: <ul style="list-style-type: none"> • Annex (i) Welsh Renal Clinical Network for 2015/16 • Annex (ii) Welsh Renal Clinical Network Terms of Reference 	
Date of next meeting	5 October 2016



Rhwydwaith Clinigol Arennol Cymru
Welsh Renal Clinical Network

Annual Report

2015-2016

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Summary

The WRCN continued to develop its commissioning role for adult renal services during 2015/16 with the production of a range of services specifications and a Renal Delivery Plan, which collectively replace the National Service Framework "Designed to tackle Renal Disease".

The specifications will be fundamental to identifying the breadth and depth of service delivery as well as mechanism for matching outcomes, experiences together with resource utilisation.

It has been a busy year of engagement with stakeholders to develop the specifications in a meaningful manner rather than a simple tick box exercise.

Overall, Welsh adult renal services have much to proud of; Collaboration has never been closer and this common vested interest is enabling service change at a national level. Performance against the other home nations puts Wales in favourable position. Extract of data form the latest UK Renal Registry Report (2014) shows the following key data.

Incidence / Prevalence of Home Nations for Renal Replacement Therapy

	Wales	England	Scotland	Northern Ireland
Incidence (pmp)	117	111	94	98
Dialysis prevalence (pmp)	901	892	857	845
UHD (%)	79.3	82.3	86.6	84.7
HHD (%)	6.3	4.1	2.6	4.2
PD (%)	13.9	13.5	10.8	10.7
Tx (pmp)	492	460	465	445

pmp = per million population

Wales, therefore, offers treatment for End Stage Renal Failure (ESRF) to more of its population each year and has more patients being treated by dialysis or transplantation. In addition Wales has a higher proportion of patients with functioning transplants and on home therapies, both of which in general are seen to offer the best 'value for money' as well as a number of social and clinical advantages.

The WRCN is increasing using the functionality of its national renal IT system to prospectively collect, collate and then analyse the data. This will enhance an already well developed national audit programme which is critical to identifying opportunities for improvement.

The Welsh Renal Clinical Network holds a national audit event annually in September. This runs over two days with the first day open to patients, patient groups and other stakeholders.

For 2015 /16 the event included a number of national and local audits including:

- **Prevention of blood born virus infection in dialysis units in Wales**
- **Renal Transplantation in CKD Patients with High BMI**
- **All Wales Dialysis Access Audit**

Details of the audit event are available from the following website:

<http://www.wales.nhs.uk/sites3/home.cfm?orgid=773>

At a previous audit event, the Swansea team announced it was to develop a nocturnal home haemodialysis service which was novel for Wales and only one or two other centres in the UK were trialing.

With the support of the WRCN, the unit received capital funding from Welsh Government to refurbish a self care area at the Morriston main unit and the WRCN commissioned additional staffing to provide the training and support.

Since 2011, the programme has gone from strength to strength with over 40 patients trained. There are currently over 20 undertaking nocturnal home haemodialysis with a further similar number due to start training throughout the coming months. Patient experience and their feedback has been overwhelming and the option for this is to be rolled out at the other units in Wales (Bangor has also now a well established nocturnal programme).

"I have been on Nocturnal dialysis for 2 ½ years, previously I dialysed three times a week at Morriston Hospital. Nocturnal dialysis is the best treatment, I feel more comfortable in my own home, once connected I don't even know that I'm on the machine because I'm asleep. The machine is my alarm clock, it wakes me up in the morning, this is a wonderful feeling as my days are free. I can eat and drink what I like, I feel better, I have more energy and my tablets have been reduced. I never want to go back to unit dialysis because I don't want my life restricted again."

David Boyes, Swansea haemodialysis patient

Ultimately our purpose is to make improvements to patients that affect their well-being and quality of life alongside an extension of life. Patients, carers and their representatives are central to the

WRCN's functions. We work collectively to review needs and requirements with stakeholders sighted on the information necessary to make sound decisions. Since its inception, the WRCN has promoted a transparent relationship with our representatives and this whilst at times challenging, has brought many rewards. The WRCN Management Team extends its thanks to all those who have helped guide and challenge us, in particular the Welsh Kidney Patients Association, the British Kidney Patients Association and Kidney Wales Foundation.

Unit Haemodialysis

The key work during this year has been the undertaking of a competitive procurement exercise for the replacement of the service contracts in South East Wales.

Following evaluation, the ten year contract has been awarded to B Braun Avitum. The evaluation process included a novel approach of using a patient board to also review the bidder as well as a usual group of professionals and Health Board officers. Overall the process worked well and with refinement provides a model for future procurement activities.

This was the largest of these schemes to date, encompassing two existing units (Llantrisant and Pentwyn), two replacement units (South Cardiff and Newport) and a brand new unit in North Gwent.

Benefits for patients include:

- Larger capacity with future proofing for the next ten years;
- Increased number of cubicles and spaces for beds;
- Additional rooms to facilitate local provision of renal services such as psychology, dietetics and home therapy training.
- The units will have additional staff per shift and greater manual handling capability. This is in response to the change in patient demographics i.e. older and frailer with multiple co-morbidities.

The new units are to open in the coming months:

- South Cardiff (replacing the West Wing) in September 2016;
- Cleppa Park (replacing St.Woolos) in December 2016; and
- Mamhalid in March 2017

The development of the subsidiary units is part of the regional plan to enhance renal services. With the increase of peripheral capability and capacity, the next step will be to refurbish the main unit at University Hospital of Wales so that it provides a specific high dependency dialysis service consistent with the desired clinical model.

This project has been delivered with a marginal increase against the original baseline of resources and within an agreed allocation.

Home Dialysis

Covering both home haemodialysis and peritoneal dialysis, this remains a key area of activity for the WRCN. This period has seen the renal community in Wales implementing a new national

framework for these treatments. Whilst there have been some teething difficulties, this approach will see increase in opportunity for patients to benefit. With the planned refinement, the framework will enable the expansion of the following across Wales, providing equitable access:

- Nocturnal home haemodialysis
 - (the largest UK programme is already in place in Swansea)
- Assisted Automated Peritoneal dialysis
 - This recent development is now in use across Wales
- Increased frequency of home haemodialysis
 - All units in Wales offer increased frequency above the typical thrice weekly regime.

All of these are linked to improved patient empowerment, outcomes and experience.

These enhancements have been secured nationally within the previous baseline of resources.

Vascular Access

The WRCN has an established All Wales Vascular Access Group to oversee the services that provide vascular and peritoneal access for dialysis.

Wales has steadily improved its achievement against the UK Renal Association standards. For example, for prevalent patients, the target is 85% should have permanent access (Fistula or Graft) and the performance against the national audit (presented in September 2015):

- Bangor 84%
- Cardiff 73%
- Glan Clwyd 75%
- Swansea 84%
- Wrexham 72%

Further details from the audit are available via the WRCN website:

<http://www.wales.nhs.uk/sites3/page.cfm?orgid=773&pid=84024>

To share learning and development, the AWWAG has established a Peer Review process. This involves an MDT representative visit to each of the providers who meet with the staff and review processes, successes and challenges. Findings are shared across the WRCN and the host Health Board. These visits are repeated annually.

These reviews have led to changes in protocols, investment in staffing resource and development of plans for service sustainability and improved outcomes.

Further details are contained in the report presented at the October 2015 WRCN Board.

Renal Transplantation

December 2015 saw the introduction of the Soft Opt out policy for the donation of organs in Wales.

Further details on the Act can be found via following the link:

<http://gov.wales/topics/health/nhswales/organ/human-transplantation-act/?lang=en>

Early indications suggest that the Act has made it easier for families and professionals to discuss the wishes of a loved one and this has led to an increase in the number of organs donated.

Renal transplantation for Welsh residents is largely provided by the Cardiff Transplant Unit which serves South Wales. Typically this undertakes around 120 transplants per annum. The unit performs well against the national indicators for survival and outcomes. A detailed report on the performance of the Cardiff Transplant Unit was presented to the WRCN Board in December 2015 and a copy of this can be found via the WRCN website.

The key trends for patients are shorter waiting times for a transplant, far fewer patients dying waiting for a transplant, and graft and patient survival comparable or better than the national average. The waiting list has fallen steadily and as a result the unit is receiving fewer organ offers than in previous years, but has a good record of accepting those offers that are of good quality. The prevalent transplant population has grown steadily and as a result many more patients are enjoying a better quality of life and increased life expectancy (and the NHS is saving huge sums of money every year). The additional prevalent patients and the fall in transplant offers means the work load for the transplant specialists has changed, with much more time spent managing prevalent patients than has historically been the case. The unit is adapting to this and will continue to monitor the outcomes in a pro-active way.

For North Wales, the number of transplants continues to rise with over 20 per annum. These are predominantly undertaken in Liverpool with Pancreas transplants performed at Manchester. Performance in both these units also continues to be good when viewing mortality and graft survival.

Unit Haemodialysis Transport

The WRCN has for many years raised awareness of the shortcomings in the provision of transport to and from unit haemodialysis. Throughout 2015/16 the WRCN participated in the development of a business case to transform Non Emergency Patient Transport services. Demonstrating the clinical impact of untimely transport on patient outcomes, the Welsh Renal Clinical Network secured national agreement to include the 303030 standards for transport to and from unit haemodialysis:

- Standard 1 – Patients are to have a journey time of 30 minutes or less to and from unit haemodialysis
- Standard 2 - Patients are to arrive at the renal unit within 30 minutes of their appointment time but not late
- Standard 3 - Patients should be picked up within 30 minutes of their ready time following dialysis

As agreed by the Minister for Health, these are to be implemented by September 2016 and this work is being overseen by the Enhanced Services Reference Group (of which the WRCN is a member).

Medicine Management

This is a cornerstone of the WRCN activities and has been supported with investment and development. In 2105, the WRCN supported the case for Consultant Renal Pharmacists and we now have two; one based in Cardiff and Swansea. Plans for a post in North Wales are to follow.

Initially much work has been directed at procurement and the transferring of prescribing responsibility. This activity has improved patient safety, maintained or improved performance against clinical indicators and saved NHS Wales many millions of pounds. Whilst this work will continue, a greater focus is being brought to renal polypharmacy, development of national protocols and policies and their implementation.

During 2015/16 the renal pharmacy teams completed the repatriation of all post transplant immunosuppression prescribing and where agreed, switching patients to cheaper equivalents.

Service Specifications

These set out the minimum requirements of a service, measures of good practice and the national audit requirements and are central to delivering renal services in Wales.

Produced in collaboration with service users and clinicians, the Welsh Renal Clinical Network led the development of a range of service specifications covering the care pathway across Chronic Kidney Disease, from pre-dialysis care through to end of life care.

	Service
	Common Themes
1	Chronic Kidney Disease (CKD)
2	Vascular Access
3	Peritoneal Dialysis
4	Home Haemodialysis
5	Unit Haemodialysis
6	Conservative Management & End of Life
7	Transplantation
8	AKI (Acute Kidney Injury)
9	Unit Haemodialysis Transport

The service specifications were published in April 2016 and are available via the WRCN website.

Financial Management

The WRCN manages a commissioning budget of circa £70m on behalf of WHSSC. As in previous years, the WRCN has returned a surplus albeit of a smaller amount (c£300,000) due to the commitment of allocated schemes.

It should be noted that the WRCN has managed to grow and consume its costs since 2009/10 either through prudent

commissioning or income releasing / saving schemes such as medicine and service procurement.

Since it started in 2010, the WRCN has increased the capacity and capability of adult renal services in Wales and this places it on a good footing going forward. Whilst the WRCN will need to seek net funding from the Joint Committee for 2017 onwards, the requirements will be a lot lower than would have otherwise been. Added to this, the WRCN has its own process for scrutiny and all business cases and service developments are subject to a national prioritisation process before they go forward WHSSC and Health Boards.

Board and Governance

The WRCN aligns its meetings such that sub groups feed into its Board and this to the Joint Committee. This ensures a consistent approach to governance.

The Board met five times in 2015/16 and agendas and papers are available on the WRCN website.

The WRCN Board has two sub-committees:

- WRCN Management Group which includes the Directorate Management teams from North, South West and South East Renal services; and
- WRCN Quality & Patient Safety Sub-committee which provides oversight on clinical governance and development of national policies. This also reports to the WHSSC QPS committee.

The Board participated in a Good Governance survey and whilst responses were limited (the survey is to be repeated later in 2016), it did highlight the need for further development included:

- Induction packs for all board members;
- Refresh of the board membership to ensure consistent participation;
- Improved agenda planning to aid communication and engagement.

Key activities for 2016/17

These include:

- Publication of the Renal Delivery Plan and the routine use of the Service Specifications;

- Completion of a Self Assessment against the Service Specifications
- Completion of a workforce assessment in collaboration with the UK Renal Registry
- Appointment of a National Lead Pharmacist
- Completion of the South East Wales Unit Haemodialysis contract implementation



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Services Committee (WHSSC)



Rhwydwaith Clinigol Arennol Cymru
Welsh Renal Clinical Network

Welsh Renal Clinical Network

Terms of Reference

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Approved by:	
Issue Date:	
Review Date:	

1.0 Constitution and Purpose

In accordance with WHSSC Standing Order 3, the Joint Committee may and, where directed by the LHBs jointly or the Welsh Government must, appoint joint sub-committees of the Joint Committee either to undertake specific functions on the Joint Committee's behalf or to provide advice and assurance to others (whether directly to the Joint Committee, or on behalf of the Joint Committee to each LHB Board and/or its other committees).

These may consist wholly or partly of Joint Committee members or LHB Board members or of persons who are not LHB Board members or Board members of other health service bodies.

The Joint Committee shall establish a joint sub-committee structure that meets its own advisory and assurance needs and in doing so the needs of the LHBs jointly.

On 13th August 2009 the Minister for Health and Social Services formally agreed the establishment of a single Welsh Renal Clinical Network to be managed by the WHSSC and to be hosted by Cwm Taf LHB and the Joint Committee shall nominate annually a committee to be known as the Welsh Renal Clinical Network.

The Welsh Renal Clinical Network is not a legally constituted body, but has been set up under general powers conferred on the Welsh Ministers under the National Health Service (Wales) Act 2006 (the 2006 Act). Section 1 of the of the National Health Service (Wales) Act 2006 requires the Welsh Ministers to continue the promotion of a comprehensive health service for the people of Wales. In turn, section 3 requires the Welsh Ministers to provide, to such extent as they consider necessary, "medical...and ambulance services" and such other services or facilities or facilities as are required for the diagnosis and treatment of illness. In turn, section 2 of that Act confers on the Welsh Ministers the power to do anything which is calculated to facilitate, or is conducive or incidental to their duties under the Act. In addition, under section 16 of that Act each LHB is required to make arrangements with a view to securing they receive appropriate professional advice from health experts in order to enable them to exercise their functions effectively.

The detailed terms of reference and operating arrangements set by the Joint Committee in respect of this committee are set out below.

1.1. Purpose

The Welsh Assembly Government published in April 2007, a National Service Framework and Policy Statement "Designed to Tackle Renal Disease in Wales". Improving the quality of the care of those people with or at risk from renal disease is the cornerstone of that policy statement and National Service Framework (NSF) which defines evidence based standards for the planning, organisation and delivery of care for those with or at risk from renal disease. Whilst the principle requirements of the NSF remain, it has

been superseded by the Renal Delivery Plan and its service specifications (2016).

The Welsh Renal Clinical Network is the vehicle through which specialised renal services can be planned and commissioned on an all Wales basis in an efficient, economical and integrated manner and will provide a single decision-making framework with clear remit, responsibility and accountability. National prioritisation and implementation will generate economies of scale and increased synergy between the network and its stakeholders.

Role of the Welsh Renal Clinical Network:

- Lead the development and implementation of renal service strategy;
- Provide evidence based and timely advice to the Welsh Government and Joint Committee to assist the LHBs in discharging their functions and meeting their responsibilities with regard to the delivery of renal policy and services across Wales;
- Undertake planning for the development and delivery of an integrated renal service on an all Wales basis on behalf of, and with the agreement of the WHSSC;
- Determine in conjunction with the WHSSC the renal services that should be procured in Wales;
- In conjunction with WHSSC, manage the centrally held, ring-fenced, renal budgets required for delivery of services;
- Performance manage, on behalf of WHSSC, the delivery units against national standards and agreed service level agreements for delivery of renal services;
- Provide timely delivery and performance reports to WHSSC and Welsh Government;
- Advise and monitor clinical governance in relation to renal services within the agreed WHSSC Quality and Safety framework;
- Lead and assist in the creation, implementation and monitoring of service specifications / care pathways / care bundles for renal services;
- Fulfil a national remit, with a sub-structure that (i) is fit for purpose and (ii) enables local interface;
- Ensure a full-time, central support function so that it can successfully undertake its delegated responsibilities;
- Lead on the strategic development and implementation of renal related IT systems, ensuring accurate and timely returns to the UK Renal Registry;
- Engage with public and patients on current and future renal service and policy developments.

1.2. Relationships and accountabilities

Although the Joint Committee WHSSC has delegated authority to the Welsh Renal Clinical Network for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens.

The Welsh Renal Clinical Network, through its Chair and members, shall work closely with the Joint Committee's other sub-committees and groups to provide advice and assurance to the Joint Committee through the:

- joint planning and co-ordination of the Joint Committee and Welsh Renal Clinical Network business; and
- sharing of information

In doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Joint Committee's overall risk and assurance framework.

The Welsh Renal Clinical Network shall embed the WHSSC / LHB corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

WHSSC Management Group

The WHSSC Management Group has a number of functions delegated to it by the Joint Committee including the development of the Integrated Commissioning Plan and its interface with Health Board Integrated Medium Term Plans.

The WRCN is required to contribute to these plans as part of its commissioning and / or advisory role.

Whilst the majority of the WRCN's activities will report directly through to the Joint Committee, there will be times that this will need to go through the WHSSC Management Group first to ensure relevant and appropriate debate and contribution. This will be on an exceptional basis and will be determined in collaboration between the WRCN Management Group and WHSSC Directors.

Examples of this would include:

- Contribution to the development of the ICP / IMTPs where resources for specialist renal services are required;
- Where there is collaborative commissioning responsibility for a part of the care pathway between the WRCN and Health Boards
- Where the WRCN is providing specialist advice to Health Boards on

general nephrology activities that are outside of its commissioning responsibilities e.g. non-specialist medicine prescribing

- Where there is potential for a resource transfer between the WRCN and Health Boards akin to the previous ESA and Immunosuppression projects.

The WRCN will be represented at the WHSSC Management Group by the Network Lead Clinician and Manager (or their deputies) where such items are on the WHSSC Management Group agenda.

2.0 Delegated Powers and Authority

The Welsh Renal Clinical Network is a non-statutory body and therefore obtains its authority and responsibility as delegated by the new Local Health Boards (LHBs) through the Joint Committee.

This delegation will provide the autonomy within an agreed framework for the officers of the Welsh Renal Clinical Network to carry out the duties required of them to manage and lead the planning and performance management of the renal service contracts. These roles are to be based on professional standards set by the Welsh Government (including the Renal Delivery Plan and Service Specifications) and the renal professional groups such as the Renal Association, and will ensure a consistent and equitable approach across Wales.

The Welsh Renal Clinical Network is authorised by the Joint Committee to undertake all roles and activities within its terms of reference. In doing so, the Welsh Renal Clinical Network shall have the right to request information relevant to renal services of the relevant LHBs. It may seek any relevant information from any employee and all employees are directed to cooperate with any reasonable request made by the Welsh Renal Clinical Network.

The Welsh Renal Clinical Network is authorised by the Joint Committee to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Joint Committee's procurement, budgetary and other requirements.

Fundamentally the Welsh Renal Clinical Network will be able to recommend the use of ring-fenced resources that have been identified as part of the phased resource-mapping process for renal services and the wider national exercise. Initially this included transplantation, dialysis, vascular access, Erythropoietin Stimulating Agents (ESAs) and dialysis transport. Immunosuppressants for Renal Transplantation have since been added. With its central management team, the Welsh Renal Clinical Network will manage the utilisation of ring-fenced funds on behalf of the WHSSC and in collaboration with the service providers.

The Welsh Renal Clinical Network will also have the responsibility on behalf of the Welsh Government for overseeing the implementation of the renal standards (principally by reference to the Service Specifications) by the LHBs for their populations. Included within this work will be to support LHBs, Clusters and practices in managing patients who may not require referral to a Nephrologist. WRCN will need to engage with other Cardiovascular Disease clinicians and clinical networks to fulfil this role.

The requirements for the conduct of business as set out in the WHSSC / Standing Orders are equally applicable to the operation of the Welsh Renal Clinical Network

3.0 Sub-groups

As a minimum, the Welsh Renal Clinical Network will utilise two tiers of forum:

- National Board
- Two sub-committees:
 - WRCN Management Group
 - WRCN Quality & Patient Safety Sub-committee

WRCN 'Management Group'

A sub-committee of the Welsh Renal Clinical Network Board, the Management Group will provide a forum to enable meaningful interface with the providers of renal services within Wales.

The Management Group will meet more frequently than the Network Board. A full 'terms of reference' and membership of the Management Group will be agreed by the Network Board once established.

Membership of the Management Group:

- Network Lead Clinician / deputy (Chair)
- Network Lead Nurse
- Network Manager / deputy
- Network Finance Manager
- Network Clinical Lead for Quality & Patient Safety
- Network Clinical Information Lead
- Network Lead Pharmacist
- Nominated Director of Welsh Health Specialised Services Team
- Provider Health Boards (Abertawe Bro Morgannwg, Betsi Cadwaladr and Cardiff & Vale):
 - Nephrology Clinical Directors
 - Nephrology Directorate Managers
 - Nephrology Lead Nurses

- Nephrology Finance Managers
- National Renal Pharmacy Advisor
- National Lead for Renal Transplantation

WRCN Quality & Patient Safety Sub-committee

This will be a forum to review and analyse matters relating to Quality and Patient Safety for renal services. Focus will be commissioning aspect but with alignment to operational aspects so as to help ensure appropriate governance.

Membership includes:

- Network Clinical Lead for Quality & Patient Safety (Chair)
- Network Lead Nurse
- Network Manager
- Network Clinical Information Lead
- Network Lead Pharmacist
- Network Audit and Information Analyst
- Consultant Nephrologists (the QPS leads) from each of the five units
- Regional Directorate Managers
- Regional Lead Nurses
- Patient advocates from the WRCN Board

The Chair will report to the WRCN Board and the WHSSC Quality & Patient Safety Sub-committee.

Programme Management

The Welsh Renal Clinical Network may establish sub groups or task and finish groups to carry out on its behalf specific aspects of Welsh Renal Clinical Network business.

A number of specific standing “All Wales” project groups will be established to oversee activities linked to core renal services including:

- Quality & Patient Safety
- Vascular (Dialysis) Access
- Unit Haemodialysis
- Transplantation
- Medicine Management
- Home Therapies
- Clinical Information & IT

The full range of sub groups to be established and their terms of reference will be proposed and agreed by the Network Board

4.0 Membership

How will members be appointed to the Committee/Group?

Provide clear guidance on who will Chair the Committee/Group (including who will Chair or how a Chair will be chosen in the Chair's absence) and members.

Also include any invited attendees (In Attendance) who may be invited to attend meetings but do not have authority to make decision.

You may wish to consider noting that the committee may request attendance at meetings by individuals to support the work of specific pieces of work.

Provide clear guidance on members' authority to make a decision and whether the authority can or cannot be transferred to deputies.

The Chair of the Welsh Renal Clinical Network will be appointed by the Chair of WHSSC.

Member Appointments

The membership of the Renal Network Board shall be determined by Joint Committee Chair, based on the recommendation of the Chair of the Renal Network Board - taking account of the balance of skills and expertise necessary to deliver the Sub-Committee's remit and subject to any specific requirements or directions made by the Welsh Government. The need to ensure appropriate geographical representation across Wales will also be required.

Appointed members shall hold office for a period of three years, during which time a member may resign or be removed by the Welsh Renal Clinical Network. An appointed member may be asked to continue their role on the Welsh Renal Clinical Network following an annual review and by the agreement of the Joint Committee Chair.

Membership of the Welsh Renal Clinical Network

Core (voting) members:

- Network Lead Clinician
- Network Lead Nurse
- Network Clinical Lead for Quality and Patient Safety

- Regional (North, South West and South East Wales) Renal Services Clinical Directors
- WHSSC Management Group representatives (from different health boards for planning and finance);
- Non-officer member LHB representative
- Patient group representative*
- Community Health Council Representative

*Patient Groups will include:

- Kidney Wales Foundation
- National Kidney Federation
- Welsh Kidney Patients Association

In attendance:

- Nominated Director of Welsh Health Specialised Services Team;
- Network Manager
- Network Finance Manager
- Deputy Network Manager
- Welsh Government – Policy Lead for Renal Services;
- Individual patient representatives from renal services and dialysis units as agreed advocates.

The following only where an agenda item requires their presence:

- Network Dialysis Transport Manager
- Network Audit and Information Analyst
- National Lead for Renal Transplantation
- National Renal Pharmacy Advisor
- Welsh Renal Research Unit representative
- WHSST Medical Director
- Welsh Government – Chief Medical Officer
- Welsh Government – Chief Nursing Officer
- Welsh Association of Renal Physicians & Surgeons representative
- Members of Welsh Renal Clinical Network Project Boards

The Welsh Renal Clinical Network may also co-opt additional independent external members from outside of the organisation to provide specialist knowledge and skills.

Conduct of Meetings

The Chair, will preside at any meeting of the Welsh Renal Clinical Network Board.

The Welsh Renal Clinical Network may invite individuals or groups to address its meetings

All Board meetings will normally be held in Cardiff; however they may alternate with other suitable venues across Wales.

Values and Standards

The Welsh Renal Clinical Network will conduct all its activities in accordance with NHS Values and the Standards of Behaviour Framework set for public services in Wales. Individual members will operate within their defined standards of behaviour framework which incorporates the Seven Principles of Public Life (the Nolan Principles).

4.1. Quorum

At least five (voting) members must be present to ensure the quorum of the Renal Network Board one of whom should be the Committee Chair or Vice Chair. The Chair will agree with the Network Board the arrangements for the role of Vice Chair once it is established.

4.2. Frequency and Attendance

Board meetings shall be held at a frequency to allow synchronisation with the meeting of the Joint Committee (and at least three times per annum) and otherwise as the Chair of the Committee deems necessary.

4.3. Dealing with Members' interest during meetings

The Chair, advised by the Committee Secretary, must ensure that the Network Board's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual board members must demonstrate, through their actions, that their contribution to the Network Board's decision making is based upon the best interests of the NHS in Wales.

Where individual members identify an interest in relation to any aspect of Network Board business set out in the Network Board's meeting agenda, that member must declare an interest at the start of the Network Board meeting. Members should seek advice from the Chair, through the Committee Secretary before the start of the meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the Network Board minutes.

Withdrawal of individuals in attendance

The Network Board may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

4.4. Decision Process

Decisions will normally be achieved through consensus.

In exceptional circumstances the decision may proceed to a vote. In these circumstances the each core member will have one vote. The vote will be a simple majority. The detail of any vote will be recorded in the minutes of the meeting and as part of any recommendation made to the Joint Committee.

5.0 Administrative Support

Support to Welsh Renal Clinical Network Members

The Welsh Renal Clinical Network Secretariat, on behalf of the Chair, shall:

- Arrange the provision of advice and support to members on any aspect related to the conduct of their role; and
- Co-ordinate the provision of a programme of organisational development for members.

The WRCN Board will be supported by the Renal Network Co-ordinator, whose duties and responsibilities include:

- Agreement of agendas with Chair and attendees and preparation, collation and circulation of papers
- Ensuring that those invited to each meeting attend
- Taking the minutes/action notes (delete as applicable see admin process for clarification)
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Committee/Group
- Maintaining records of members' appointments and renewal dates
- Ensuring that there is a register of actions agreed at meetings and seeking timely updates from members with regards to their specific action points
- Maintaining the register of interests for the committee/group

5.1. Circulation of papers

The Welsh Renal Clinical Network Chair will determine the agenda for each meeting, taking into account any suggestions or requests from individual members.

Members will be provided with the Agenda and supporting papers for each meeting at least five working days in advance of each meeting.

A schedule of dates for the meetings will be published for the year ahead.

Welsh Renal Clinical Network meetings will be carried out openly and transparently in a manner that encourages the active engagement of stakeholders. This will be facilitated in a number of ways including:

- active communication of forthcoming Welsh Renal Clinical Network business and activities;
- agenda published at least 5 working days in advance of each meeting; and
- the selection of accessible, appropriate meeting venues,
- An agreed record of each meeting will be published within 10 working days of the meeting;
- The Board agenda and papers /record will be published on the Welsh Renal Clinical Network website.

6.0 Training, Development and Performance

Indicate how training, development and performance of the group will be managed/monitored – will it be through lead director, committee secretary, self-assessment – induction process for new members?

7.0 Reporting and Assurance Arrangements

The Welsh Renal Clinical Network Chair shall:

- report formally, regularly and on a timely basis to the Joint Committee on the activities of the Welsh Renal Clinical Network. This includes verbal updates on activity, the submission of Network Board minutes and written reports, as well as the presentation of an annual report;
- bring to the Joint Committee specific attention any significant matters under consideration by the Welsh Renal Clinical Network;
- ensure appropriate escalation arrangements are in place to alert the Joint Committee Chair, WHSSC Director or Chairs of other relevant

WHSSC committees of any urgent/critical matters that may affect the operation and/or reputation of the WHSSC.

The Joint Committee may also require the Welsh Renal Clinical Network Chair to report upon the committee's activities at public meetings or to partners and other stakeholders including NHS Wales Health Boards where this is considered appropriate.

The WHSSC Committee Secretary, on behalf of the Joint Committee, shall oversee a process of regular and rigorous self assessment and evaluation of the Welsh Renal Clinical Network's performance and operation including that of any sub-groups established. In doing so, account will be taken of the requirements set out in the NHS Wales Quality and Safety Committee Handbook.

The Head of Internal Audit of the host LHB shall have unrestricted and confidential access to the Chair of the Welsh Renal Clinical Network.

The Welsh Renal Clinical Network will meet with Internal Audit (and as appropriate, nominated representatives of Healthcare Inspectorate Wales) without the presence of officials on at least one occasion each year.

The Chair of the Welsh Renal Clinical Network shall have reasonable access to the Directors and other relevant senior staff within the Welsh Health Specialised Services Team.

- The Welsh Renal Clinical Network Chair will be directly accountable to the Chair of the Joint Committee. The Welsh Renal Clinical Network Lead Clinician will be directly accountable to the Chair of the Joint Committee but will also provide advice to Welsh Government through the NHS Medical Director and Chief Medical Officer as required.
- The Renal Network Manager will be managerially responsible to the nominated Director of WHSST but accountable to the Network Chair / Lead Clinician for the development and delivery of the Network objectives and work plan as appropriate to this role.
- The Network Lead Nurse will be accountable to the WHSSC Director of Nursing, and managerially responsible to the Network Manager.

8.0 Review

These Terms of Reference shall be reviewed annually by the Welsh Renal Clinical Network with reference to the Joint Committee.

Network Staffing Structure

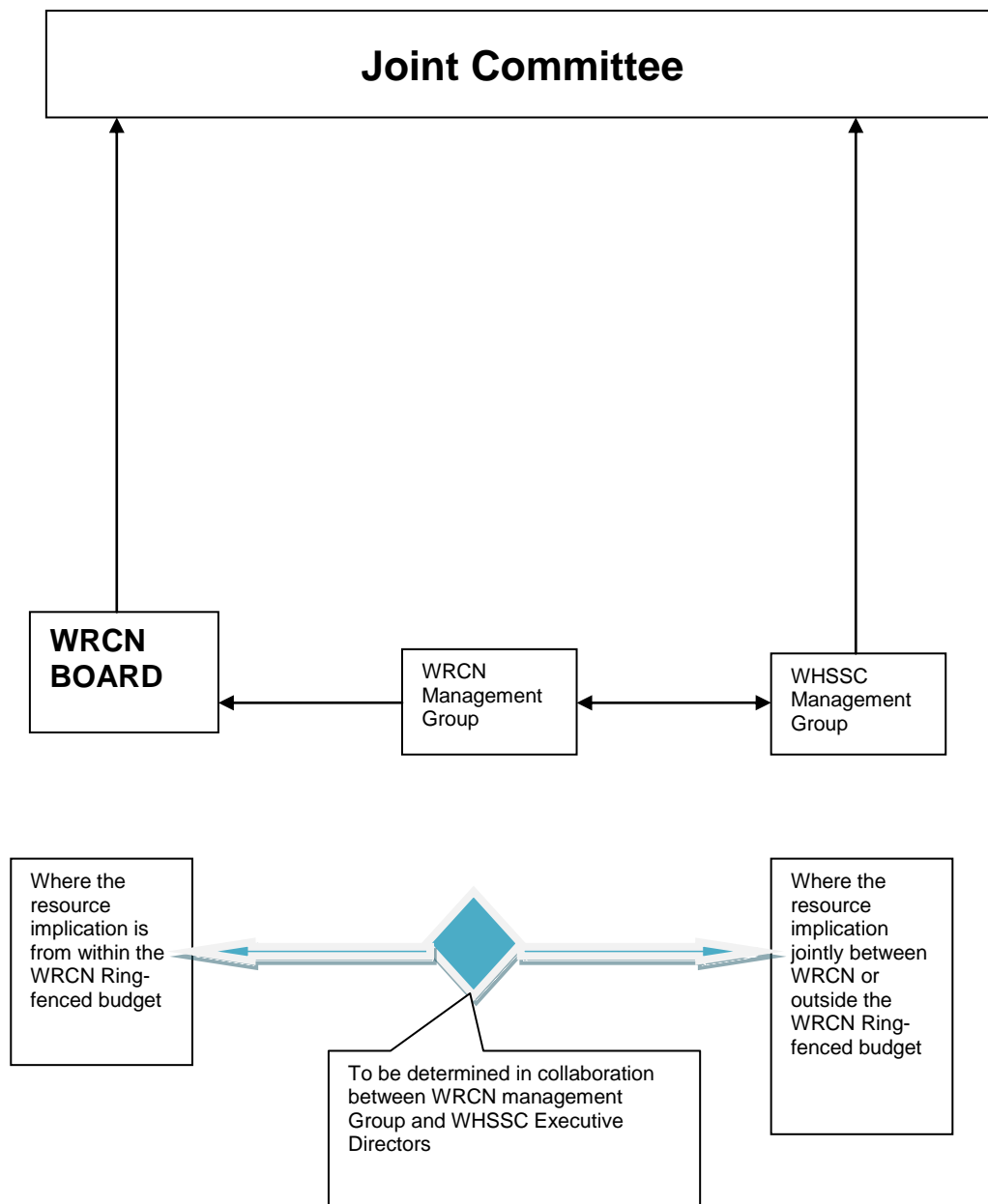
The following posts will be included within the Welsh Renal Clinical Network:

- Independent Chair
Appointed on a sessional basis; half a day a week.
Period of three years
Appointed by Chair of WHSSC
- Lead Clinician
Appointed on a sessional basis; 1 day per week.
Period of three years
- Deputy Lead Clinician
Appointed on a sessional basis; 1 day per week.
Period of three years
- Clinical Lead for Quality & Patient Safety
Appointed on a sessional basis; half a day a week.
Period of three years
- Clinical Information Lead
Appointed on a sessional basis; half a day a week.
Period of three years
- Lead Nurse
Permanent full time appointment into WHSSC.
- Network Manager
Permanent full time appointment into WHSSC
- Deputy Network Manager
Permanent full time appointment into WHSSC
- Deputy Network Manager (Transport / Projects)
Permanent full time appointment into WHSSC
- Network Finance Manager
Permanent full time appointment into WHSSC
- Network Audit and Information Analyst
Permanent full time appointment into WHSSC
- Network Coordinator
Permanent full time appointment into WHSSC

Welsh Renal Clinical Network members' terms and conditions of appointment, (including any remuneration and reimbursement) are the basis of advice from the

LHB Remuneration and Terms of Service Committee. Patient and carer representatives will have reasonable travel expenses for attending Board meetings reimbursed according to LHB policy.

Appendix 1 – Diagram of reporting of WRCN activities to the Joint Committee



Reporting Committee	Management Group
Chaired by	Daniel Phillips
Lead Executive Director	Acting Managing Director of Specialised and Tertiary Services Commissioning
Date of last meeting	25 August 2016, 28 July 2016 and 30 June 2016

Summary of key matters considered by the Committee and any related decisions made on 25 August 2016

1. Minutes of the Previous Meeting, Action Log and Matters Arising

The Management Group (the Members) **agreed** the minute of the previous. Members received clarification regarding the discussion on thoracic surgery.

Members **received** an update, as part of the action log, on MG004 68Gallium DOTA Scanning Policy; MG016 Savings Plan; MG036 Cardiac Surgery: Update on Service Performance; MG037 and MG038 Thoracic Surgery; and MG040 Performance Report.

2. Report from the Acting Managing Director

Members **received** the regular report from the Acting Managing Director. The report included updates on All Wales Lymphoma Panel, Cardiac Surgery, Equality Impact of Amber Funding Schemes, Paediatric Surgery, Bariatric Surgery, Blood and Marrow Transplant, and Cleft, Lip and Palate service.

The Acting Chair provided further information on the following:

- All Wales Lymphoma Panel; and
- Cardiac Surgery.

Members **resolved** to:

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

3. Cardiac Surgery Commissioning

Members **received** a paper making recommendations on the commissioning plan for cardiac surgery for South Wales in 2016/17.

It was **agreed** that future updates would include the figures for recurrent demand and non-recurrent demand and that information would be provided, when available, on LHB demand patterns. It was also **agreed** that the revised financial position would be reflected in the next finance report.

Members **resolved** to:

- **Note** the previous agreement to commission an additional 100 major cases at CVUHB in 2015/16 and 2016/17 (80 cases for Mid & West Wales, 20 cases for SEW);
- **Support** the proposed commissioning intentions and specific commissioning objectives for 2016/17;
- **Note** capacity at CVUHB for 100 additional major cases (80 cases for Mid &

West Wales, 20 cases for South East Wales), and the associated ICP allocation of £1.7m, is not required in 2016/17;

- **Support** the commissioning proposal outlined in 3.1.5; and
- **Support** the proposed actions to inform the ICP 2017/18, including tariff based contractual arrangements, assessment of recurrent demand, implementing the outcome of the collaborative work on sub-specialisation, developing proposals for achieving 10 week component wait.

4. Clinical Commissioning Policy: Ataluren for treating Duchenne Muscular Dystrophy with a nonsense mutation in the dystrophin gene

Members **received** a paper providing the draft policy which outlined the circumstances for the use of Ataluren for the treatment of Duchenne Muscular Dystrophy (DMD) for patients in Wales. The policy has been based on the Managed Access Agreement drawn up by NHS England, PTC Therapeutics International (the "Market Authorisation Holder" or "MAH"), patient community experts and clinicians. It was **noted** that NICE requires that there is compliance with the recommendations of their evaluation within three months of its date of publication, which for this treatment was the 20th July 2016.

Members **resolved** to:

- **Approve** the clinical commissioning policy.

5. BAHA and Cochlear Funding Release: South Wales

Members **received** a paper requesting funding release approval to implement the Amber rated ICP scheme for BAHA & Cochlear grown in South Wales (ICP16-064).

The Acting Chair noted that the recommendations being made differed to the paper. Further information was provided. Members discussed the paper further.

Members **resolved** to:

- **Note** the funding release for BAHA and Cochlear growth in South Wales;
- **Support** that there is a need to invest in the service;
- **Support** the WHSSC working with the provider and others to gather further information including value for money and benchmarking information;
- **Support** Chair's action to approve the funding release to resolve the surgical waiting list issues if the assurance data is received;
- **Receive** a further report at a future meeting requesting full funding release.

6. BAHA and Cochlear Funding Release: North Wales

Members **received** a paper requesting funding release approval to implement the Amber rated ICP scheme for BAHA & Cochlear grown in North Wales (ICP16-081).

Members **resolved** to:

- **Approve** the funding release for BAHA and Cochlear growth in North Wales (ICP16-081).

7. Neurovascular Service

Members **received** a paper notifying members of the current quality and sustainability issues around Neurovascular services and the need for a dedicated MDT team and a specialist vascular neurosurgeon.

Members discussed the service further including assessing the sustainability of the service, the need for a strategic review of neurosciences, the resources committed within LHB plans and risk management. Members agreed that a piece of work was to be undertaken to further understand the issues and broader strategic issues within the service.

Members resolved to:

- **Note** the sustainability of the neurovascular service in Cardiff is at risk due to the lack of a Specialised Vascular neurosurgeon and a Multi Disciplinary Team;
- **Note** the further information that is being sought from Cardiff to address the gaps in this case; and
- **Support** further work to be undertaken to address queries raised during the discussion.

8. Development of the Integrated Commissioning Plan 2017-20: including 2017-20 Commissioning Intentions

Members **received** a paper which included a series of proposals for ensuring closer integration between NHS Wales provider and commissioner organisations in the development of the *Integrated Commissioning Plan for Specialised Services 2017-20*, and setting out the draft commissioning intentions to guide the development of the plan.

Members discussed the need to consider equitable access, patient voice, clinical engagement, and elective services. Members noted that there were a number of workshops planned which will allow the opportunity to explore the elements further. It was recognised that historically timelines for the development of the ICP did not align with that of the Health Boards and that consideration had been given to how this might be managed for the development of the 2017-20 ICP.

Members resolved to:

- **Approve** the proposed process and draft timeline for the development of the integrated commissioning plan for specialised services for 2017-20; and,
- **Approve** the draft Strategic Commissioning Intentions for Specialised Services 2017/18.

9. AAC Report and Recommendations

Members **received** a paper which provided an update on the implementation and evaluation of the consequent project and recommendations regarding future funding and evaluation.

Members **resolved** to:

- **Note** the contents of this report;
- **Support** the extension of the evaluation period for the specialist AAC service;

and

- **Support** the carry forward of a forecast underspend of non-recurrent budget.

10. Funding Release Process – Value for Money Assessment and Contracting Framework

Members **received** a paper setting out an approach to testing value for money for ICP developments and the principles for ensuring appropriate contracting arrangements are put in place for implementation and monitoring schemes in line with commissioning intentions.

Members **resolved** to:

- **Note** the contents of this report

11. Quality Assurance Framework: Update

Members **received** an update report providing an overview of the progress made against the implementation of the quality framework.

Members **resolved** to:

- **Note** the contents of this report

12. Annual Business Process

Members **received** a paper presenting Members with the revised draft Terms of Reference and draft Group Annual Report

It was **agreed** that further consideration on elements of the terms of reference was required including consensus and circulation of papers

Members **resolved** to

- **Note** the contents of the report;
- **Support** the revised draft Terms of Reference for approval at the Joint Committee Meeting in September 2016.

13. Delivery of the Integrated Commissioning Plan 2016-17 progress: mid July 2016

Members **received** for assurance.

14. Finance Report: Month 3 2016-17

Members **received** for assurance.

15. Performance Report: May 2016

Members **received** for assurance.

Summary of key matters considered by the Committee and any related decisions made on 28 July 2016

1. Matters Arising and Action Log

The Management Group (the Members) agreed the minute of the previous meeting and received an update on the actions of agreed at the meeting.

2. Proton Beam Therapy: Current Position and Future Work

Members **received** a paper requesting **support** for the development of a package of commissioning policies and a service specification for people in Wales and the mechanism through which this would be achieved.

Members **resolved** to:

- **Note** the contents of the report and current position for NHS England and NHS Wales;
- **Support** the proposal and process to develop a package of commissioning policies and service specification for the delivery of PBT to people in Wales to inform the ICP; and
- **Support** the proposal that this work should be the responsibility of the all Wales PBT Task and Finish group with accountability to WHSSC and reporting via the Clinical Oncology Sub-Committee (COSC) to the Welsh Scientific Advisory Committee (WSAC).

3. Funding Opportunities for Higher Risk Amber Schemes: Core Neurosurgery

Members **received** a paper informing them of the outcome of the Joint Committee discussions regarding opportunities for funding high risk 'amber' scheme and were asked to approve the core neurosurgery scheme.

Following discussion members **agreed**, through consensus, to approve the provision of an additional three medical staff subject to the following conditions:

- Information regarding the current service arrangements were provided;
- Information regarding the expected outcomes of implementation are provided;
- Provider is advised that the funding was conditional and would be reviewed following the outcome of the commissioning strategy work. It was agreed that it should be made explicit to the provider that there was a possibility of funding being removed following the commissioning strategy, depending on its outcome in relation to service modelling; and
- Funding will only be provided for actual costs of staff if less than the business case. The WHSSC Team will explore, with the provider, the funding of additional staff in view of confirmation that the provider had advertised only two posts to date.

Members **agreed** to receive a formal letter from WHSSC outlining the decision made at the meeting.

Members **resolved** to (in relation to the Funding Opportunities for Higher Risk Amber Schemes report):

- **Note** the recommendations from Joint Committee;
- **Note** the current slippage position within the Amber Higher Risk Schemes;
- **Approve** the utilisation of slippage from new developments to fund the core Neurosurgery scheme; and

- **Note** that recommendations on the remaining schemes will be made to the Joint Committee scheduled for September.

Members **resolved** to (in relation to Core Neurosurgery):

- **Note** the current position and immediate medical concerns of core Neurosurgery at Cardiff and Vale UHB;
- **Note** that without additional investment there is a significant risk that the neurosurgery service will no longer be sustainable in Cardiff;
- **Note** the immediate risks to the sustainability and deliverability of the service and the implications for the care of individual patients and viability of other associated specialist neurosciences services for the population of South Wales; and
- **Approve** the provision of an additional three medical staff subject noted conditions.
- **Not to approve** the provision of additional Nurse Practitioners pending the completion of the commissioning strategy work.

4. **Cardiac Surgery: Update on Service Performance**

Members received an overview of the report which provided a summary of cardiac surgery performance over the last year and to highlight current potential risks to the sustained delivery of RTT and activity performance.

Members **resolved** to:

- **Note** the summary of activity and waiting times performance in 2015/16;
- **Note** the performance position in the first quarter 2016/17; and
- **Note** the potential risks identified and action being taken.

5. **Thoracic Surgery**

Members were informed that concerns had been raised by a single Health Board in relation to the delivery and waiting times for Thoracic Surgery and had proposed an option for outsourcing.

It was **agreed** that, further work was required to gain a greater understanding of the issues and proposed benefits for transferring patients and criteria for doing so. However, in principle it was agreed that this option could be explored, if required, being mindful to ensure application of lessons learnt from the Cardiac Surgery work. It was noted that if progressed would need consideration and approval by the Joint Committee.

Members **resolved** to

- **Receive** the update; and
- **Agreed** actions to be taken

6. **Report from the Acting Managing Director**

Members **received** the regular report from the Acting Managing Director. The report included updates on: Efficiency and Savings Plans, Funding Release schemes approved by Corporate Directors Group Board and the Specialised Services Policy:

Selective Dorsal Rhizotomy (SDR).

Members **noted** that there was now a pause on any new patient referrals to the SDR service as this was now in the evaluation phased of the process. However, those currently on the pathway will receive treatment.

Members **resolved** to:

- **Note** the content of the report.

7. Delivery of the Integrated Commissioning Plan 2016-17 progress: mid July 2016

Members **noted** the update on the delivery of the Integrated Commissioning Plan for Specialised Services 2016/17 at the mid July 2016 position, including the:

- Funding Release Schedule;
- Progress against the Work Plan; and
- Risk Management Summary.

Members discussed sharing information regarding capacity for slippage on red schemes, Member engagement at audit days and the risk management plan.

Members **agreed** to consider most effective way for their respective engagement with service audit days.

Members **resolved** to:

- **Note** the progress made in the delivery of the 2016/17 ICP

8. Performance Report

Members **received** the performance report noting the change in format and **supported** the progress in developing the commissioning teams and quality framework to further input into the dashboard.

9. Finance Report

Members **received** and **noted** the finance report.

Summary of key matters considered by the Committee and any related decisions made on 30 June 2016

1. Minutes of the Previous Meeting, Action Log and Matters Arising

The Management Group (the Members) agreed the minute of the previous meeting and received an update on the actions of agreed at the meeting.

Members **noted** the intention to review the terms of reference and **agreed** that the revised terms of reference would be circulated outside of the meeting for comment and amendments. The final terms of reference will be presented to the August Management Group for support prior to presenting to Joint Committee for approval.

Update on Implementation of Plan

As part of matters arising, Members **received** a paper, presented to the Joint Committee, describing opportunities for funding higher risk 'amber' schemes and to

providing the timeline for considering economic benefit amber schemes.

2. Horizon Scanning and Prioritisation of New Interventions by WHSSC for Funding in 2017/18

Members **received** a paper inviting them to review a new horizon scanning and prioritisation process for WHSSC and to request feedback on the draft document.

Members **resolved** to:

- **Support** consultation with stakeholders and clinicians;
- **Support** the recommendation that this approach offers a clear and transparent process of prioritisation when comparing competing proposals for new investment; and
- **Support** consideration of evidence appraisals whilst consultation is underway.

3. Integrated Commissioning Plan 2015/2016 Closure Report

Members **received** a report summarising the progress and outcomes of the schemes for delivery in 2015-16.

Members **resolved** to:

- **Note** the work completed in the WHSSC 2015-16 ICP;
- **Note** the Lessons Learned; and
- **Approve** the recommendation that a single point of contact be identified by provider for each scheme to ensure consistent engagement on its development, assessment, implementation and evaluation.
- **Approve** the closure of the WHSSC Integrated Commissioning Plan (ICP) 2015-16.

4. WHSSC Specialised Services Policy CP67: Peptide Receptor Radionuclide Therapy (PRRT) for the Treatment of Neuroendocrine Tumours (NETs)

Members **received** a paper recommending approval of the Specialised Services Policy CP67: Peptide Receptor Radionuclide Therapy (PRRT) for the Treatment of Neuroendocrine Tumours (NETs). Members **noted** that the policy had been revised as a result of recommendation 2 of the NETs Task and Finish Group recommendations.

Members **resolved** to

- **Approve** the Specialised Services Policy; CP67: Radio labelled Therapy for the Treatment of Neuroendocrine Tumours (NETs).

5. Paediatric Surgery Funding Release

Members **received** a report requesting funding release approval to implement the Amber rated ICP scheme for Paediatric Surgery (ICP16-053).

Members **resolved** to:

- **Approve** the funding release for Paediatric Surgery (ICP16-053).

6. Secure Gatekeepers and Clinical Case Monitoring

Members **received** a paper requesting approval of funding for the enhancement of the medium secure gatekeeper function and the roll out of the Clinical Case monitoring pilots in ABMUHB & BCUHB for secure patients.

Members **resolved** to:

- **Approve** the funding release identified as invest to save schemes in the 2016/17 Annual Plan.

7. Annual Business Process

Members **received** a paper providing members with the outcome of the self-assessment and highlighting areas for further consideration.

Members **resolved** to

- **Support** any **agreed** actions for inclusion in the Committee's Annual Report to Joint Committee;
- **Support** the draft Annual Report, subject to agreed amendments, for onward review by the Integrated Governance Committee (20 July 2016); and
- **Support** the proposed process for the development of the Terms of Reference.

8. NHS Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR) – Policy Revisions 2016

Members **received** a paper providing members with a summary of the key revisions to the *All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR)*.

Members **resolved** to:

- **Approve** the revised All Wales policy; and
- **Support** the implementation of the All Wales policy

9. Report from the Acting Managing Director

Members **received** the regular report from the Acting Managing Director. The report included updates on NAO Report: The Commissioning of Specialised Services in NHS England, Specialised Services Commission, Strategy for Specialised Services, Impact of the Deanery Decision on Specialist Service Provision, Quality Implementation Plan and Quality Assurance Report, Neonatal Service and Staffing Model Reconfiguration, Gender Variance Clinical Pathway Task and Finish Group, Neuro Endocrine Tumour Service (NETs) and Bariatric Services.

Further information was provided relating to the Independent Review of Children's Cardiac Services in Bristol and the recommendations within the report.

Further detail was also provided on Thoracic Surgery.

Members **noted** that Chair's Action had been taken to approve the Specialised Services Policy: CP46 Ivacaftor (Kalydeco) for Cystic Fibrosis (G551D and Specific Other Non G551D Mutations).

Members **resolved** to:

- **Ratify** the urgent action taken in relation to the Specialised Services Policy: CP46 Ivacaftor (Kalydeco) for Cystic Fibrosis (G551D and Specific Other Non G551D Mutations)

10. Performance Report

Members **received** for assurance the performance report.

11. Finance Report

Members **received** for assurance the finance report.

Confirmed Minutes for the meeting held 30 June 2016 and August 2016 are available to members on request.

Date of next meeting	Thursday 22 September 2016
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Agenda Item 18.6
WHSSC Joint Committee
27 September 2016

Reporting Committee	Wales Neonatal Network
Chaired by	Director of Planning, Cwm Taf University Health Board
Lead Executive Director	Director of Planning, WHSSC
Date of last meeting	7th September 2016
Summary of key matters considered by the Committee and any related decisions made.	
<p>Members:</p> <ul style="list-style-type: none"> Received a verbal update from the South Central Alliance with regards neonatal service reconfiguration Received a report on Neonatal Intensive Care Services in South Wales, highlighting the progress made by the WHSSC Programme Board Received a report on the Neonatal Network Dashboard providing an overview of performance against the key service indicators for neonatal services in Wales for the period January – June 2016. Also included more detailed activity, for the period April – June 2016. Received an update Health Board compliance against the All Wales Neonatal Standards as at June 2016 Received a presentation on the Bliss baby report 2016: time for change Wales Received update reports from neonatal units on a health communities basis Received an update report from Bliss (charity for parents and families of babies who have been in neonatal care) Received an update from the Steering Group sub groups <ul style="list-style-type: none"> Transport Nursing & Therapies 	
Key risks and issues/matters of concern and any mitigating actions	
<ul style="list-style-type: none"> Challenges identified in the Bliss baby report relating to staffing, occupancy, transfers and support for families Deficits in meeting staffing Standards Implications of the reduction in trainees on the provision of neonatal intensive care <p>Lack of a 24 hour neonatal transfer service</p>	
Matters requiring Committee level consideration and/or approval	
<ul style="list-style-type: none"> None 	
Matters referred to other Committees	

<ul style="list-style-type: none"> • None 	
The confirmed minutes of the meeting held on 26 th April 2016 are available to members on request.	
Date of next meeting	4 February 2016

Agenda Item 18.7
WHSSC Joint Committee
27 September 2016

Reporting Committee	Gender Partnership Board
Chaired by	Carole Bell Director of Nursing & Quality
Lead Executive Director	Director OF Nursing & Quality
Date of last meeting	27/9/2016
Summary of key matters considered by the Committee and any related decisions made.	
<ul style="list-style-type: none"> As from September 2016 Tracey Myhill has accepted the role of the Chair of the Partnership Board and will also take over the lead CEO from Paul Roberts. Changes to the Terms of Reference for the Board have been suggested to ensure adequate representation and strengthen the mechanism of feedback into each of the Health Boards. The Annual Report and the key areas of work for 2016-17 have been finalised by the group. Confirmation and release of 50K funding has been received from Welsh Government to support the gender collaborative commissioning project. A draft options appraisal has been prepared by the Task & Finish group and this will be presented at a joint stakeholder public event on Tuesday 18th October at City Hall, Cardiff. Representation for Primary Care remains poor, further invitations have been sent. 	
Key risks and issues/matters of concern and any mitigating actions	
<ul style="list-style-type: none"> On the 25th August the West London Mental Health Trust (WLMHT) announced that the Board have made a decision in line with their medium-term strategic focus patients requiring gender identity services would be better served in the longer term by another provider. They have therefore served notice and NHS England as the commissioner for gender identity services are in the process of finding a suitable alternative provider as quickly as possible. WHSSC have issued a statement to reassure the Welsh patients that they are working with the Trust to ensure a seamless handover of services to another provider. The Gender Identity Clinic at West London Mental Health NHS Trust had a CQC inspection on the 19/20th January and a report issued on the 9th May and a requirement notice was served under Regulation 17 HSCA. WHSSC officials have met with a senior team from the Trust on the 3rd August to go through the actions taken in relation to the inspection. The action plan and minutes from the steering group reported through the Quality Patient Safety Committee. A number of problems have been identified in GP's reluctance to prescribe hormone therapy for transgender individuals following referral to the GIC. These have been forwarded to the Medical Directors within the respective Health Boards and Welsh Government are in the process of issuing a letter to GP's reminding them of the GMC guidance and advice for doctors treating 	

transgender patients.	
Matters requiring Committee level consideration and/or approval	
<ul style="list-style-type: none"> • Annual Report for approval 	
Matters referred to other Committees	
<ul style="list-style-type: none"> • CQC report for West London Mental Health Trust being monitored by QPS 	
Confirmed Minutes for the meeting held 8 June 2016 are available to members on request	
The Annual Report of the Gender Partnership Board for 2015/16 is attached as annex (i) for information.	
Date of next meeting	03 November 2016

All Wales Gender Dysphoria Partnership Board

Annual Report 2015-16

1. BACKGROUND / INTRODUCTION

The All Wales Gender Dysphoria Partnership Board, is accountable to WHSSC and advises the Joint Committee on issues regarding the development of a NHS Wales strategy for Gender Dysphoria services.

The purpose of the Partnership Board is to support the development of a future NHS Wales Strategy for Gender Dysphoria services within current NHS Wales funding parameters and to review the audit of assessment and surgical services against the quality indicators and key performance indicators.

The Terms of Reference of the Partnership Board are as follows:

- To identify and address gaps in provision of locally delivered services, for example, endocrinology;
- To develop proposals for providing regional specialised assessment services within existing resources;
- To monitor the quality of care and patient experience;
- To improve and expand meaningful engagement with service users and providers and
- To involve others, GP's, Groups, advocates etc.

2. MEMBERSHIP

The Chair of the Partnership Board will be a Chief Executive Officer or Independent Member from within NHS Wales.

The membership of the Partnership Board will include:

- Chair
- Specialised Planner, WHSSC
- Director of Nursing and Quality, WHSSC
- Representative from NHS Wales Centre for Equality and Human Rights (NHS CEHR)
- Representative from Welsh Government
- Nominated champion from each of the Local Health Boards

- Representative from Public Health Wales Observatory
- Service user representative/stakeholders from across the trans community
- Representative from CAMHS
- Representative from NHS Wales Mental Health

Where the Chair considers that it would facilitate the business of the group, they may invite non-members to attend for either part or the whole of any meeting to contribute.

3. MEETINGS

During 2015-16 the All Wales Gender Dysphoria Partnership Board scheduled five meetings, however only three took place. All meetings held had quorum membership.

4. MAIN AREAS OF COMMITTEE ACTIVITY

The agenda for each meeting follows a standard format, broken down into two main parts:

Preliminary Matters

This section of the meeting covers off standard issues such as apologies, welcome, minutes of the last meeting and matters arising.

NHS Gender Services

This section of the meeting has a specific focus on updates from key stakeholders, developments within guidance and progress updates for individual work streams.

5. LINKS WITH OTHER COMMITTEES

The Partnership Board reports progress at each meeting and also provides a report to the Joint Committee on its activities including submission of minutes from each meeting. Any patient specific risks are directed to the Quality and Patient Safety Committee and the link for this is the Director of Nursing & Quality.

6. ADVICE TO THE JOINT COMMITTEE

The Partnership Board wishes to highlight the importance of progressing the clinical pathway review and development of proposed models. As this work is primarily outside of the remit of WHSCC it is critical that there is appropriate level input from each the LHB's in the work.

7. CONCLUSION AND LOOK FORWARD

The Partnership Board is committed to continuing to develop its function and effectiveness and intends seeking further assurance in 2016/17.

Key areas of work for 2016-17 are as follows:

- Progressing the development of a clinical model for gender variance. Present a final report from the task & finish group to Joint Committee.
- Identifying training requirements and opportunities for all health care professionals.
- Ensure that the action plan following the CQC West London Mental Health NHS Trust CQC inspection is reported and monitored by the Quality Patient Safety Committee. Along with the contracting arrangements between this provider and NHS England an opportunity will arise for the contracting arrangements to be considered as part of the pathway work.
- Work with the older and children's commissioner to consider gender variance and implications for these groups such as transition and dementia.
- Strengthen the links with Welsh Government to ensure progress made against the health element of the Trans gender action plan

Agenda Item 18.8
WHSSC Joint Committee
27 September 2016

Reporting Committee	Mental Health & Learning Disability Collaborative Commissioning Group
Chaired by	Chief Executive, Powys Teaching Health Board
Lead Executive Director	Director of Planning, WHSSC
Date of last meeting	8th July 2016
Summary of key matters considered by the Committee and any related decisions made.	
<p>Members:</p> <ul style="list-style-type: none"> Reviewed groups terms of reference and membership Discussed demand and capacity and agreed to share relevant extracts from HB IMTPs and complete templates showing current and planned beds for next 3 years. This would help the group consider strategic planning of services across the pathway on all Wales basis. Discussed the potential for widening the scope of any future developments across HBs Received the draft Annual Report on the National Frameworks from the Quality Assurance & Improvement Team (QAiT) Were given an oral overview of the interim key findings from the review of secure LD patients that had been commissioned by Welsh Government and it is expected recommendations will follow to HBs Commented on the level of complexity and frequent co-morbidity of LD patients and support closer links and greater collaboration with MH services Received confirmation that Management Group had approved the funding release for the expansion of the gatekeeping & case management functions delivered by ABMU/BCU HBs on behalf of WHSSC Discussed the clinical oversight arrangements for patients and reminded of the legal requirements of the Mental Health (Wales) Measure 	
Key risks and issues/matters of concern and any mitigating actions	
<ul style="list-style-type: none"> There are no NHS secure services for people with learning disabilities in Wales and there is a UK wide lack of capacity of secure learning disability beds. This represents an important planning and commissioning issue to be taken forward as a priority. Welsh Government asked the QAiT to review of all current secure LD placements and the findings have been submitted. Full discussion of the final findings and recommendations has yet to be considered formally by the Group in order to advise the Joint Committee Members. 	

An assurance discussion has been held due to the above a small number of Welsh patients currently placed in sub-optimal environments and additional safeguards have been put in place where required	
Matters requiring Committee level consideration and/or approval	
None	
Matters referred to other Committees	
None	
Confirmed Minutes for the meeting held 8 July 2016 are available to members on request	
Date of next meeting	16 September 2016

Reporting Committee	All Wales Posture and Mobility Partnership Board
Chaired by	Ian Langfield, Acting Director of Planning
Lead Executive Director	Ian Langfield, Acting Director of Planning
Date of last meeting	7 March 2016

Summary of key matters considered by the Committee and any related decisions made.

Changes to the Commissioning Team responsible for ALAS

- Due to staffing changes within the Planning Team at WHSSC, the Chair confirmed the planning lead now responsible for this area of work (Luke Archard and Rhian Meredith-Spurr.)
- This responsibility has further changed and is now within the Neurosciences and long term conditions portfolio (Claire Nelson and Kimberley Meringolo are now responsible for this area of work).

Service User Feedback

- The Board meeting provides service user representatives in attendance the opportunity to present any feedback received from service users within their Constituency.
- It was suggested that a representative from WHIZZ kids be invited to the next meeting. An invitation has been extended for the meeting that is due to take place in October.

Partnership Board Membership

- The Board were notified of the appointment of three new Stakeholder Group representatives that have been recruited.

Stakeholder Reference Working Group

- The Chair notified the Group that an interim Chair was in place for the Stakeholder Reference Group. The appointment of a new chair would take place and would be reported back to the Partnership Board in October.
- All members of the Partnership Board and the two sub-committees (Stakeholder Reference Group and Technical Working Group) were invited to attend Disability and Equality Training and it took place on the 25th of May 2016.

<u>Posture and Mobility Service – Revised Service Specification</u> <ul style="list-style-type: none"> An update was provided on the revised Service Specification for consideration. Changes were suggested before presentation to Joint Committee for approval. This work is still ongoing. 	
<u>Posture and Mobility Service Performance</u> <ul style="list-style-type: none"> The Board discussed the Key Performance Indicators in place, Quality Indicators and performance against these. The three sites reported staffing issues as an area of concern. It was agreed that the Technical Working Group would be tasked with reviewing and refreshing the KPI's and QI's in time for the next meeting. 	
Key risks and issues/matters of concern and any mitigating actions	
<ul style="list-style-type: none"> None 	
Matters requiring Committee level consideration and/or approval	
<ul style="list-style-type: none"> The All Wales Posture and Mobility Partnership Board, Annual Report 2015-16 is provided at annex (i) for information. 	
Matters referred to other Committees	
<ul style="list-style-type: none"> None 	
<p>The minutes of the meeting held on 7 March 2016 are yet to be confirmed by members of the Board and will be available once formally agreed.</p>	
Date of next meeting	19 October 2016

ALL WALES POSTURE AND MOBILITY PARTNERSHIP BOARD

ANNUAL REPORT 2015-16

1. BACKGROUND / INTRODUCTION

The Posture and Mobility Service is planned and funded by the Local Health Boards through the Welsh Health Specialised Services Committee (Joint Committee).

The establishment of the Partnership Board was a specific recommendation of the Welsh Assembly Government review of wheelchair services (All Wales Posture and Mobility Service Review, October 2010).

The purpose of the Partnership Board is:

- to monitor the service's delivery against the key performance and quality indicators, in order to provide assurance to the Joint Committee that the service is delivering in line with the All Wales Service Specification.
- to review and refresh the indicators on an annual basis
- to advise the Joint Committee on the commissioning strategy for Posture and Mobility services, including identification of, and supporting opportunities for embedding coproduction as a core principle of the commissioning strategy

2. MEMBERSHIP

The Partnership Board is chaired by the Director of Planning. In the event that the Chair is not available to chair a meeting of the Partnership Board they may temporarily appoint another member of the board to undertake this role on their behalf for the duration of that meeting.

Membership will be drawn from across the wide range of stakeholders of the Posture and Mobility Service (service leads, Service Users, Carers, Third Sector groups, Social Services, Education Authorities, and Local Health Boards).

Service user/carers representatives are required to demonstrate the ability to represent a constituency of users. This may be through, for example:

- Membership and active involvement in relevant voluntary sector organisations
- Demonstrating informal links and networks with service users

Where the Chair considers that it would facilitate the business of the group, the Partnership Board has the authority to co-opt non-members to attend for either part or the whole of any meeting.

Title	Role	Organisation
WHSSC / LHB Non Executive Director	Chair	WHSSC
Planning lead for Neurosciences & Complex Conditions	Secretary	WHSSC
Directorate Manager – Cardiff Posture and Mobility Service	Service Lead	Cardiff and Vale UHB
Clinical Director – North Wales Posture and Mobility Service	Service Lead	Betsi Cadwaladr UHB
Head of Rehabilitation Engineering	Service Lead	Abertawe Bro Morgannwg UHB
Clinical Director of Medical Physics	Service Lead	Betsi Cadwaladr UHB
Director of Therapies and Health Science	Representative of the Director of Therapies and Health Science	Health Board
Service User / Carer x 5	Service Users/Carers' Representative	N/A
(Title of Post)	Third Sector Representative	Wales Neurological Alliance
(Title of Post)	Third Sector Representative	Children in Wales
(Title of Post)	Third Sector Representative	Spinal Injuries Association
Director of Education	Representative of the Directors of Education	Local Authority
Director of Social Services	Representative of the Directors of Social Services	Local Authority
Director of Housing	Representative of the Directors of Housing	Local Authority
Senior Equality Manager	Equality and Human Rights Representative	NHS Centre for Equality and Human Rights
Administration Officer	Meeting administration	WHSSC
In attendance		
Policy Lead	Welsh Government Policy Lead	Welsh Government

3. MEETINGS

The All Wales Posture and Mobility Partnership Board met on three occasions during 2015/16 and was quorate at each meeting.

4. MAIN AREAS OF ADVISORY GROUP ACTIVITY

The agenda for each meeting varies however there are four standing items:-

Service user feedback

This section provides service user representatives in attendance the opportunity to present any feedback received from service users within their constituency.

Stakeholder Reference Working Group

This section of the meeting provides feedback from the stakeholder reference group which is a sub-group of the Board. The Reference Working Group's purpose is to:

- ***Make recommendations*** on how channels of communication can be improved with service users, to maximise opportunities to engage; including links with social media and other methods of communication.
- ***Provide advice and feedback*** in relation to the governance and secretariat of the All Wales Posture and Mobility Service Partnership Board on behalf of service users.
- ***Identify opportunities*** for coproduction with service users
- ***Act as a sounding board*** for emerging policies, and proposals and will be the forum for structured discussions amongst stakeholders.
- ***Assist in the development and revision*** of policies and proposals.

Technical Working Group

This section provides the Technical Group (a sub-group of the Board) to feedback issues and update on Key Performance Indicators, Quality Indicators from within the service and Audit Days.

Posture and mobility performance

The service leads of the Wheelchair Service prepare information which presents the latest waiting time data for the wheelchair service.

5. LINKS WITH OTHER COMMITTEES

The Partnership Board may establish sub-groups or task and finish groups to carry out on its behalf specific work. Where appropriate such groups will include stakeholder representation.

6. ASSESSMENT OF GOVERNANCE AND RISK ISSUES

The All Wales Posture and Mobility Partnership Board provides an essential element of the overall governance framework for the organisation and has operated within its Terms of Reference and in accordance with the Governance and Accountability Framework.

7. WORK PLAN

The Board provided advice and feedback on the new Service Specification which is due to be presented to Corporate Directors Group for approval. The Board also considered and provided advice on the ALAS website which is now live and available to service users.

8. ASSURANCE TO THE JOINT COMMITTEE

The Chair:

- Reports formally to the Joint Committee on the Partnership Board's activities. This includes updates on activity, the submission of Partnership Board minutes and written reports as well as the presentation of an annual report.
- Brings to Joint Committee's attention any significant matters under consideration by the Partnership Board.
- Ensures appropriate escalation arrangements are in place to alert the Director of any urgent or critical matters that may compromise patient care and affect the operation or reputation of the Joint Committee.

Reporting Committee	CAMHS and ED Steering Group
Chaired by	Carol Shillabeer, CEO Powys Teaching HB
Lead Executive Director	Daniel Phillips, Acting Managing Director of Specialised and Tertiary Services Commissioning
Date of last meeting	6 September 2016

Summary of key matters considered by the Committee and any related decisions made.

- Eating Disorder Sub Group

This group continues to meet one month in advance of the main steering group and report to the CAMHS and ED Steering Group as a standing agenda item.

Transition of young people with eating disorders remains challenging. There is variability across Health Boards, with some paediatric services not accepting young people after their sixteenth birthday. The Eating Disorder Sub Group has agreed to coordinate a position statement on current practice across Wales.

- Perinatal Services

- All health boards have started developing local models
- The focus is on early identification and detection of those most at risk
- Tier 4 specialised pathway group has been re-convened, Chaired by Carole Bell
- Lived experiences from service users are being collated
- A visit to Scotland to benchmark best practice has taken place

- Effective Planning and Commissioning

The CAMHS and ED Steering Group continue to work alongside the Health Boards and Welsh Government to operationalise the agreed proposals for the 7.6 Million investment for CAMHS services.

Professor Dame Sue Bailey, continues to support the Welsh Government and CAMHS and ED Steering Group in the following:

1. The development of a quality and delivery framework
2. Care Standards
3. Activity Outcomes
4. Performance Management Outcomes and Measures
5. Evaluation by an Academic organisation

Annual Report 2015 – 2016

The annual report for 2015-2016 was presented and approved, subject to minor

<p>amendments.</p> <ul style="list-style-type: none"> • <u>Development Day</u> A development day took place on the 6th September 2016, to review the role of the CAMHS/ED Steering Group, evaluate progress to date and establish key priorities for the future. 	
Key risks and issues/matters of concern and any mitigating actions	
<ul style="list-style-type: none"> • None 	
Matters requiring Committee level consideration and/or approval	
<ul style="list-style-type: none"> • CAMHS/ED Annual Report 2015 -2016 provided for information (Annex (i)). • <i>18 Month Refresh of Collaborative National Framework for Child and Adolescent Mental Health Services (CAMHS) – Low Secure and Acute Non-NHS Wales Hospital Services</i> requires approval (Annex (ii)). 	
Matters referred to other Committees	
<ul style="list-style-type: none"> • None 	
Confirmed Minutes for the meeting held 6 September 2016 are available to members on request.	
Date of next meeting	20 December 2016

Child and Adolescent Mental Health Services and Eating Disorders Network Steering Group

Annual Report 2015 – 2016

(Report on achievements, service developments and outcomes)

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FOREWORD

I am pleased to present the second Annual Report of the Wales Child and Adolescent Mental Health Services and Eating Disorder Services Network Steering Group (CAMHS/ED Network Steering Group).

The outcome of the review of clinical networks in Wales has concluded that Public Health Wales will 'host' all clinical networks including the CAMHS/ED network from 1st October 2016.

I was appointed as the chair of the first single all Wales CAMHS network in February 2014. I am also the Chief Executive of Powys (Teaching) Health Board and continue with commitment to progress the work of the CAMHS/ED network and all associated work in order to achieve improved outcomes in the emotional health and well being of children and young people in Wales.

This second annual report tracks progress in CAMHS development and its alignment to other National Children's service developments and plans for the year of 2015 – 2016 building on the success of the previous year's achievements.

This has been achieved against a background of escalating pressures on NHS services. During 2015/16 NHS CAMHS services continued to experience a rise in demand for services. Over the past 5 years total referrals into NHS Wales CAMHS have almost doubled. A particular challenge has been the even greater rise in children presenting with urgent mental health concerns especially those self harming. This patient group has increased by up to fourfold over the past 5 years. This phenomenon is an issue across the United Kingdom and seen in most Western countries. Specialist services saw more cases than ever but the increasing demand outstripped the increased activity in many areas leading to increased waiting lists, particularly for those requiring routine care. The network continues to meet quarterly to take forward the work to address the key issues and has in this second year reviewed its membership to ensure all key players in the field of emotional health and well being are 'on board' to drive forward the work required to achieve improved outcomes for children and young people in.

This second annual report of the Wales CAMHS/ED Network steering group provides a summary of work taken forward in its second year 2015 – 2016 and the work at the interface of parallel strategies such as the Together for Children and Young People Welsh Government Strategy.

EXECUTIVE SUMMARY

Notable achievements in this second year of the CAMHS/ED network steering group include the following;

- Clarity on the process of inappropriate admissions
- Performance against waiting times targets
- Set up, facilitate and maintain Eating Disorders sub group inclusive of the full age range
- Set up, facilitate and maintain an ED specific full age range 'Transition' group
- Assisted with the follow up stakeholder events for T4CYP in 2015 – 2016
- Announcement by the Minister of £7.5 million towards service improvement ; network managers have assisted in the scrutiny of bids submitted to Welsh Government for additional neurodevelopmental services
- Additional on going input in CITT provision in areas where previously such services did not exist
- Clarity of funding of CAMHS/Learning disability service provision and associated posts previously funded by the 3 former regional networks
- Clarity of implementation of the Welsh Government guidance on Did Not Attend (DNA) policy
- Production of the second annual report for 2015 – 2016
- Production of the second annual work plan 2015 - 2016
- Assisted with the proposal for the service model for the enhancement of mental health services for young people in Wales in the Youth Justice system
- Setting up of a perinatal sub group that assures robust governance arrangements for developing services are in place
- Assisted in securing key speakers, information resources and displays for the first all Wales Community of Perinatal Practice to be held in March 2016 then annually
- Undertook a scope of data to be included in a future CAMHS audit day and subsequent yearly audit cycle and event
- Assisted with a variety of work streams from the Together for Children and Young People (T4CYP) programme

Carol Shillabeer

Chair, Wales Child and Adolescent Mental Health Network Steering Group

Chief Executive Powys (Teaching) Health Board.

ROLE OF THE CHILD AND ADOLESCENT MENTAL HEALTH SERVICES AND EATING DISORDERS NETWORK STEERING GROUP

The All Wales CAMHS/ED Network Steering Group was established in April 2014 and brings together NHS Wales professionals and key multiagency partners to jointly design and plan services in order to improve access, effectiveness and the quality of services from a patient perspective in Child and Adolescent mental health services, emotional health and well-being.

A review of clinical networks has concluded that the CAMHS/ED network steering group is to be hosted by Public Health Wales Collaborative from 1st October 2016. The NHS Wales Health Collaborative works to support NHS Wales Chief Executives to help shape, plan and make recommendations on the future of NHS services across Wales.

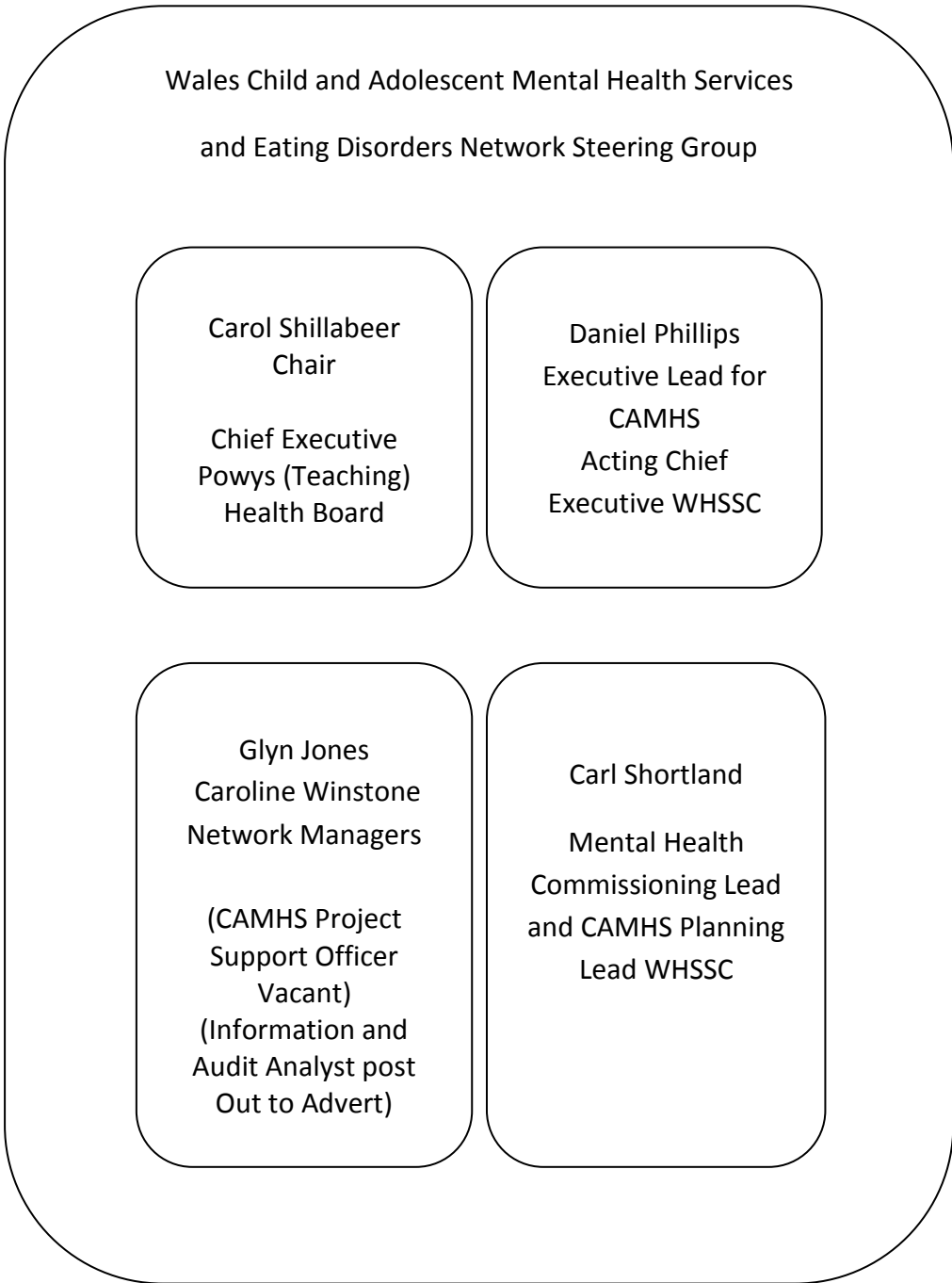
The CAMHS/ED Network recognises the importance of involving appropriate clinical advice and leadership in developing their plans and from each health board in Wales to ensure full geographical service representation.

Some of the on going and key responsibilities of the CAMHS/ED Network Steering Group are:

- Produce the plans for ongoing delivery of services in response to national policy and strategy;
- Develop a national vision and a service delivery model for CAMHS/ED services that addresses interconnectivities across the services and is based upon a philosophy of early intervention, prevention and recovery;
- Builds on local interagency planning mechanisms and ensures best practise is shared nationally;
- Develops plans to ensure equitable access to high quality sustainable services within financial resource limits;
- Co-ordinates the national planning and submission of funding proposals to funding bodies as appropriate;
- Develops and uses a common performance monitoring framework to monitor service delivery against the agreed plans;
- Acts as a source of expertise, to influence policy and strategic service development;
- Acts as a resource to promote communication across local planning structures, providers of service and WG policy leads.

The All Wales CAMHS/ED Network Steering Group meets quarterly and is accountable to the Joint Committee, Welsh Health Specialised Services Committee (WHSSC) and via its reporting process to the Joint Committee the CAMHS/ED Network Steering group advises Health Boards on issues regarding the development of Child and Adolescent mental health services in Wales.

ROLES WITHIN THE CAMHS/ED NETWORK STEERING GROUP STRUCTURE



RELATIONSHIP OF THE CAMHS/ED NETWORK STEERING GROUP WITH T4CYP SERVICE IMPROVEMENT PROGRAMME

Improving emotional and mental health for children and young people in Wales is a priority for Welsh Government. It is one that requires new ways of working across all agencies and sectors. Professor Mark Drakeford, AM, Minister for Health and Social Services asked Professor Dame Sue Bailey OBE DBE Chair, Academy of Medical Royal Colleges and Member of the Children and Young People's Mental Health Task Force as Senior Clinical Advisor for Mental Health Education England to offer advice and to support service development and change in line with the prudent healthcare agenda. This will ensure that we can all work together to improve the emotional, mental health and well being needs of children and young people in Wales.

The Minister formally launched the *Together for Children and Young People* programme at a national conference event on 26 February 2015. Professor Dame Sue Bailey facilitated the discussions with senior representatives from all relevant agencies at the launch event to agree the priority areas for high impact change. The engagement and involvement of young people across Wales has been secured through linking in with existing mechanisms including those of the Children's Commissioner and Children in Wales. The CAMHS/ED network managers have been providing input and support to several of the work streams to take forward the Programme's priorities.

Carol Shillabeer is the chair of both the CAMHS/ED Network Steering Group and the Chair of the T4CYP programme board. WHSSC is a key partner organisation in the delivery of additional cross linkage and work streams achieved through Sian Richards the programme director for T4CYP who sits on the CAMHS/ED network steering group and Carol Shillabeer who sits on the T4CYP project team. Governance arrangements for the T4CYP programme are through Carol Shillabeer directly to the Chief Executives of Health Boards in Wales.

The T4CYP programme consists of several work streams;

- Universal Resilience and Well Being
- Early Intervention and Enhanced Support for Vulnerable Groups
- Neurodevelopmental issues
- Specialist CAMHS

And includes cross cutting workstreams for;

- Care transitions
- Workforce, Education and Training

This work is led by the National Programme Director Sian Richards at Welsh Government.

BASELINE VARIATION AND OPPORTUNITIES AUDIT

Part of the SCAMHS workstream of the T4CYP programme was the undertaking of a Baseline Variations and Opportunities Audit to take forward the initial priorities of the programme and towards the development of a Framework for Improvement using the Caremore commissioning method. The CAREMORE baseline audit of variations and

opportunities (BAVO) was undertaken to inform the Programme and secured a vast amount of data from all Health Boards in Wales. The audit for Wales was led by the T4CYP programme and was assisted by the CAMHS network managers. An initial report on an all Wales basis has been received and it is anticipated that the individual Health Board reports will be available early in 2016.

A CAMHS needs assessment was undertaken by Public Health Wales with network managers assisting to establish the extent of the scope and content of the needs assessment.

Network managers continued to provide input in several ways. This included providing scrutiny of the Neurodevelopmental bids submitted to Welsh Government by Health Boards in Wales, providing key input to the work required on the 'Caremore' data set, to the design and development of the CITT standardised data set and also to providing key input to the workforce work stream and the early years and resilience work stream.

PARRALEL SERVICE DEVELOPMENTS ; ADDITIONAL FUNDING FROM WELSH GOVERNMENT

Additionally to the work of the T4CYP workstreams, funding was made available from Welsh Government to the amount of £7.65 million at the end of 2015 and WG requested that each Health Board submit bids against the following areas:

1. Neurodevelopmental Services
2. Local Primary Mental Health Support Services
3. Psychological Therapies
4. Early Intervention in Psychosis
5. Crisis Intervention
6. Youth Justice Board / Youth Offending Treatment Funding

The funding element of the bids were developed successfully in a very short timescale across the seven Health Boards. All of the bids have been approved by Welsh Government and are now being taken forward by the respective Health Boards. Network managers provided detailed scrutiny of the bids.

PROGRESS BY CAMHS/ED NETWORK STEERING GROUP

Membership of the group was reviewed in this second year to ensure that it is 'fit for purpose'. It includes both clinical leadership and expertise from Health Boards along with the range of multi agency partners deemed essential in the work required towards the provision of the full range of services. This ensures coverage of all of the levels of need required to address the mental, emotional health and well being needs of children and young people in Wales. Organisational change in the NHS in Wales has been

reflected within the membership of the CAMHS/ED network steering group and this will remain a priority.

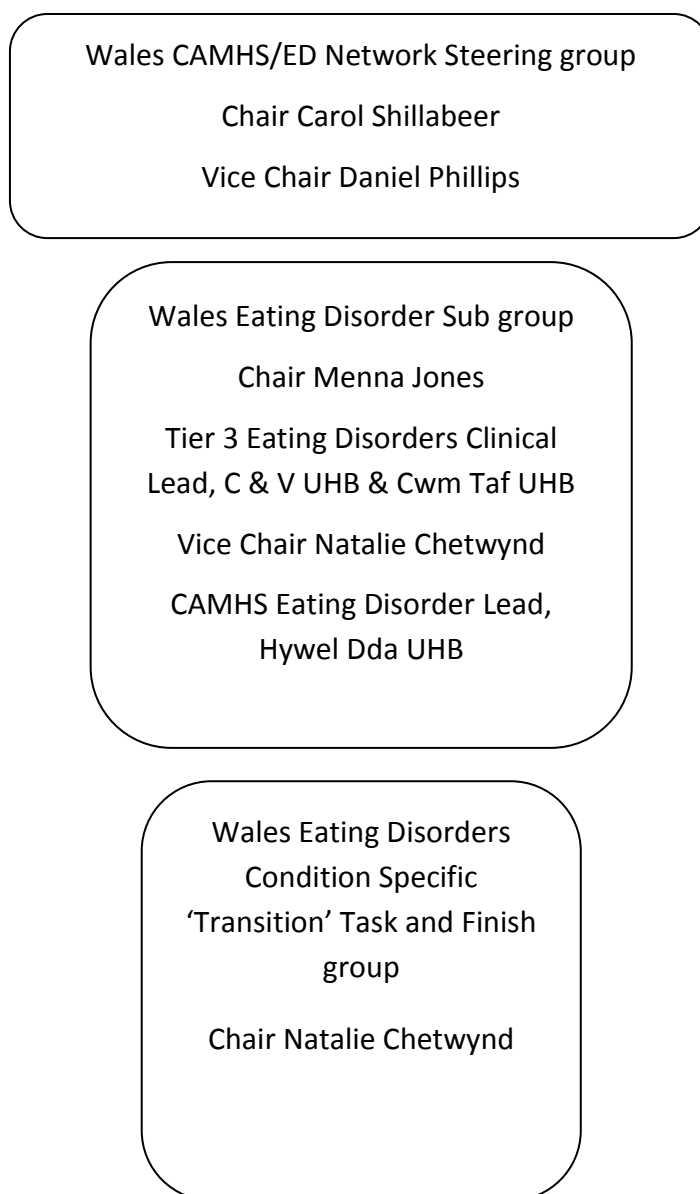
Outstanding work from the follow up report on safety issues from HIW/WAO on CAMHS was progressed and reviewed by the network via network managers last year.

This second year has seen the development of network sub groups to progress individual work streams and to achieve specific products from each of the sub groups. Membership is detailed in appendices 1 and 2. The Eating Disorders sub group was set up at the end of the first year and is facilitated by the network managers. It continues to work at a pace across the whole age range and has a work plan in place to monitor progress.

In February 2016 an Eating Disorder condition specific 'Transition' Task and Finish Group was set up. This addressed issues of 'Transition' between CAMHS and Adult services across the full Eating Disorder pathway and across the complete age range.

Finally this year, work progresses in the setting up of a perinatal sub group and co-ordination of all associated perinatal work streams. The CAMHS/ED network steering group managers continued with the completion of outstanding work from the existing WHSSC hosted Perinatal Psychiatry Steering Group and advisory groups. These included the Welsh Government National Expert Advisory Group (WGNERG) and the National Partnership Board.

CAMHS/ED NETWORK STEERING GROUP AND EATING DISORDERS SUB GROUP STRUCTURE



PROGRESS BY THE EATING DISORDERS SUB GROUP

This year the Eating Disorder sub group has;

- Established Membership.
- Set and ratified Terms of Reference.
- Ensured service user and carer representation from both CAMHS and AMHS.
- Refined the work programme with allocated timescales for each work stream.
- Agreed the development of a set of clinical outcome measures in CAMHS for use in Eating Disorder services across Wales working in collaboration with Public Health Wales.

- Collaborated with 'Gofal' to develop Eating Disorder actions in the Mental Health strategy delivery plan 2016-2019.
- Ensured that the 4 clinical leads of the Tier 3 Adult community based teams continued with the retrospective audit of those placed outside of Wales in Specialist Eating Disorders 'In Patient Units'. This has resulted in a comprehensive review of the existing contractual arrangements in place to achieve improved outcomes for patients.
- The group has set up an Eating Disorders condition specific 'Transition' Task and Finish group to deliver a protocol/guideline on pathway development from CAMHS to AMHS.
- Facilitated the work associated with the Re-fresh document of the Eating Disorder Framework for Wales. Networks managers attended the consultation events.

DEVELOPMENTS, GOOD PRACTICE AND PROGRESS IN CAMHS/ED SERVICES FROM HEALTH BOARDS ACROSS WALES

- Development of T4CYP Boards.

Some Health Boards have set up groups to progress the development of T4CYP in their region and these groups are playing a vital role in the development across the spectrum of Child and Adolescent Mental Health Services. They are at different stages of development however they each have multiagency representation and engagement.

- Contribution to National Development for Children and Young People's planning.

Senior Management Teams in some Health Boards for CAMHS have seats on some of the National Boards and are at the forefront of all of the discussions taking place on CAMHS across Wales.

- Development of Service Specifications.

Health Boards are developing comprehensive Service Specifications in their areas for CAMHS with 'sign off' anticipated in spring 2016.

- All Wales Clinical Directors.

A Group has been set up. This forum is recognized by the Welsh Government and meets on a regular basis and CAMHS is firmly on the agenda.

- Locality models.

Some Health Boards have opted for a locality model in CAMHS. Most are fully rolled out and functioning in each area. Each team consists of a Clinical Lead, Senior Nurse and Locality Manager. These are leading the service change in each of their locality areas.

- Tier 4 new model (South Wales).

A new cost and volume contract was rolled out in Tier 4 Unit at Ty Lydiard from the 1st April 2015 with the number of beds now available to South Wales increasing to 15. This remodeling work has continued in 2016. The 'Seren' Ward was officially opened by Mark Drakeford in November 2015. Due to the increased and additional provision in CITT/CATT/COTT teams across the region, and the resulting change in the type of referral made to the unit, this has enabled more young people to be treated. Following this change the unit is now providing care and treatment to more challenging young people. A comprehensive Psychological Assessment model has been developed and introduced that is more appropriate to the needs of these client groups. This model provides all young people referred to the service with a nursing, medical and full psychological therapies assessment.

- Eating Disorder Outreach Service.

New CITT provision in Health Boards across Wales has linked to Tier 4 services to provide increased outreach services in those areas where additional new investment has been awarded and builds firmly on the previous years CITT set up.

- Neurodevelopmental Disorder Service Development.

There has been a great deal of progress in the provision of Neurodevelopmental in Health Boards in Wales. It varies in each Health Board subject to existing local provision and the new services are fully operational. The aim is to reduce waiting times for assessments and with a phased transfer of existing patients to the new services. These new services have been funded from the new Welsh Government announced funding in 2015. Clear pathway development is at the heart of the new services.

- Service Specification for the Child and Adolescent Intellectual Disability Service (CAIDS).

A new CAIDS specification has been developed in some health boards in Wales for this client group.

- Out of Hours provision.

Some Health Boards have implemented new 'Manager On Call' arrangements. These will be monitored and reviewed to improve provision.

- Out of hours rotas.

Some Health Boards have increased the number of consultants on their CAMHS out of hour rotas to increase and improve accessibility and provision.

- E-prescribing.

Some Health Boards such as Cwm Taf CAMHS and the Pharmacy Department have been working together to bring to life the first computerised Out-patient Prescription Printing System 'COPPS'. This is otherwise known as an e-Prescribing system and in a Specialist Hospital setting in Wales. This earlier pilot is now fully operational and both clinicians and service users are benefiting from this. The system has brought quality and efficiency in how this aspect of the service is delivered. Further data is being gathered to audit the quality of the service.

- Waiting List Initiatives.

All Health Boards have implemented waiting list reduction initiatives. This will bring waiting times down and improve service provision and facilitate quicker access to Neurodevelopmental Disorder assessments. This will achieve compliance with Part 1 of the Mental Health (Wales) Measure.

- Tier 3 Forensic Services.

The model has been reviewed and agreed. Teams have gone through the organisational change policy and are now successfully remodeled.

- New Clinical Leadership Model.

Roles of Clinical Directors in some Health Boards have been remodeled. These changes are firmly embedded in Job plans therefore providing 'protected' input.

THE ROLE OF THE CAMHS/ED NETWORK MANAGERS

Network managers have been involved in the following actions:

- Participated in the consultation of the review of clinical networks which has concluded that all will be hosted by Public Health Wales from 1st October 2016.
- Assisted in the retrospective audit of Tier 4 adult eating disorder in patient units, in England, for improved contractual arrangements and outcomes for patients.
- Continued to facilitate the training of CAMHS staff across Wales delivered by the South London and Maudsley NHS Foundation Trust in evidence based therapies for eating disorders.
- Commenced work on the development of a performance and outcome measures framework.
- Assisted with the recruitment of an Information and audit analyst for the network. This involved the creation of a person specification and job description. This role will support the development of robust data collection across all SCAMHS teams in Wales and develop templates and systems for recording waiting times.

- Designed a proposal for a CAMHS audit and best practice day to be held in January 2017.
- Progressed the work required to establish an annual audit cycle.
- Collaboratively assisted the T4CYP project group in several workstreams e.g. development of the Caremore Data set; facilitated several of the consultation events; commissioned the needs assessment from Public Health Wales on SCAMHS; provided scrutiny of the neurodevelopmental bids submitted to Welsh Government from Health Boards in Wales; developed the CITT data set; provided input to the workforce work stream; provided input to the early years and resilience work stream; attended the Transition work stream consultation events assisting at the North Wales event on 5th May 2016.
- Historically the former 3 CAMHS regional networks worked closely with the Office of the Childrens Commissioner. The Commissioner has acknowledged the purpose of the single all Wales CAMHS network as a key driver for change in the planning of the delivery of CAMHS in Wales. 'Beth Nesa / What's Next' consultation report in Autumn 2015 highlighted many key findings including a perceived shortage of mental health service provision. The topic of mental health in general terms emerged as a particularly prominent theme. Therefore the Office of the Childrens Commissioner is directly linked to the work of the CAMHS/ED network.

NEW DEVELOPMENT OF COMMUNITY INTENSIVE THERAPY TEAMS (CITT) / ASSERTIVE OUTREACH TEAMS ACROSS WALES

WHSSC has continued to monitor the redesign of Tier 3/4 CAMHS services in areas where there was previously no CITT provision. This has resulted in the implementation of new models across Wales to include the following:

- Hywel Dda University Health Board - New CATT (Crisis Assessment and Treatment Team) in April 2015 and provides 7 day service with operating hours of 9-9pm Mon to Fri and weekend working 11-7pm.
- Aneurin Bevan University Health Board - Crisis Outreach Team (COT) will be extending their hours from 8am until 8pm weekdays and will also be providing a shorter day service over the weekends from 9am until 5pm.
- Powys (Teaching) Health Board - Powys Co-ordinated Intervention and Treatment Team (CITT) has been fully operational since September 2015 and operates everyday throughout the year.
- Betsi Cadwaladr University Health Board - 'Kite' Intensive Community Support Team; was fully functional from October 2014 and extended its out of hours provision and is aiming to provide a 9am – 9pm service including weekends and bank holidays.

ALL WALES FORENSIC ADOLESCENT AND CONSULTATION TREATMENT TEAMS (FACTS)

The All Wales Forensic Teams in Wales or (FACTS) provides for young people of 15, 16 or 17 years of age who are either detained, on remand or sentenced within the Youth Justice System. These young people who have committed offences and those exhibiting high risk behaviours likely to bring them to the notice of Youth Justice Services should have the same access to Mental Health Services as other young people. A proposal for a revised service which enhances current provision across Wales in every Health Board was supported by the CAMHS/ED network. It is funded by Welsh Government and will provide a more robust core FACT service to these high risk young people. The remodelled service will also provide further support to existing Youth Offending Teams and tier 3 Forensic CAMHS primarily through training and consultation. This will build incrementally in response to the developing evidence base with a view to ensuring that the most complex and high risk young people can access CAMHS through the most appropriate route.

PROGRESS AND DEVELOPMENTS IN ADULT TIER 3 COMMUNITY BASED EATING DISORDER SERVICES

There are 4 regional Tier 3 adult Eating Disorder community based teams in Wales. They have developed at varied levels. They have focussed on the following aspects of service development and enhanced service provision; training and supervision including clinical supervision, research and audit, service user involvement and information governance.

REGIONAL UPDATES FROM THE 4 ADULT EATING DISORDER TIER 3 COMMUNITY BASED TEAMS

Aneurin Bevan UHB & South Powys Teaching HB

- Research and audit.

They will continue to run an audit cycle of the Intelligent Targets across Tier 2 and 3. Compliance with Driver 2 and 3 Bundle 85% across the health board area.

- Funding.

This has been agreed by ABUHB for a project that will investigate self-harm and suicide rates for people with an eating disorder across Wales. This project will link to the current investigation of the 'SAIL' database. With the new monies, CAMHS have employed an ED Clinical Nurse Specialist within the tier 3 service to develop the intensive treatment of young people with an Eating Disorder.

- Information governance.

An audit of the interface between Primary and Secondary Care to improve assessment and referral across the Tiers. We have completed an audit on our joint protocol between CAMHS and Paediatrics.

- Exploring the use of new technologies to deliver training, supervision and treatment across South Powys and ABUHB.
- Explore ways of improving service user and carer engagement.

Cardiff and Vale UHB & Cwm Taf UHB

- Development of new information material for new clients of the service regarding the team's assessment process and staff members, following service user feedback.
- To access electronic completion of annual clients' satisfaction survey.
- To establish access for team members to Merthyr 'SWIFT' patient records system in Cwm Taf UHB.
- Review format and content of support provided to family members of team service users to improve effectiveness and accessibility.

Betsi Cadwaladr and North Powys

- To have an agreed and signed off MARSIPAN protocol for North Wales.
- To continue the training, supervision and consultation offered at tiers 1 & 2 and to formalise the "links" role in each CMHT and develop a structure that encourages managers to commit to allowing time for attendance. To improve the understanding of eating disorders at in Tiers 1 & 2, and dispel the belief that it is not the work of those tiers and should only reside at tier 3.
- To have some funding in place for CAEDS staff to receive training.
- To work with the clinical leads of the other tier 3 services to find a solution to the unavailability of tier 4 beds.
- To amend outcome measures used to reflect more consistency across tier 3 services and to develop formal structures to ensure that agreed outcome measures are administered and collected.
- To promote CAEDS as a placement opportunity for clinical psychology trainees and other mental health professionals.
- Continued service user involvement.

Hywel Dda and ABMU

- Whole team training in compassion focussed therapy, particularly looking at the work of 'Ken Goss' around delivering a group programme for those patients with severe and enduring Eating Disorder.
- Possible integration of the two teams (Carmarthen based and Swansea based) to create a critical mass of staff and enable the cross fertilisation of skills/resources.
- Possible development of short intensive home treatment programme to bridge the gap between hospital and out patient treatment.

Clinical Audit of Adult Specialist Inpatient Eating Disorder Units in England

Each of the 4 Tier 3 Adult Eating Disorder community based teams in Wales continue to undertake a retrospective audit of case notes of those Welsh patients placed at the current specialist eating disorder preferred provider in patient units outside of Wales. The on-going aim of the annual audit (1st April to 31st March) is to continue a programme of the review of the standards of eating disorder services at in-patient units against the Royal College of Psychiatry Quality In Patient Eating Disorder Standards. This will enable a review of the care and treatment of Welsh patients placed in such units. Reflecting the prudent healthcare agenda, this will further assist in the review of existing contractual arrangements.

Re- fresh of the Eating Disorders Framework for Wales

The Eating Disorders Sub Group linked to the work of the Re-fresh of the Eating Disorders Framework for Wales with network managers supporting the 2 consultation events held in North and South Wales in November 2015. The final results and recommendations of the consultation process are due in 2016. The recommendations and guidance from the refresh document will be embedded in the work of the Eating Disorders sub group.

Appendix 1

Membership CAMHS/ED Network Steering Group

Role	Name and Job title	Organisation/ Health Board
Carol Shillabeer (CHAIR)	Chief Executive Powys Teaching Health Board	Powys tHB
Daniel Phillips	Acting Chief Executive of WHSSC	WHSSC
Dr Dave Williams	Divisional Director of Family and Therapies Aneurin Bevan Health Board and Professional Adviser CAMH to CMO and Welsh Government	Aneurin Bevan UHB and Welsh Government
Angela Lodwick	Head of Specialist CAMHS and Psychological Therapies services	Hywel Dda UHB
Carl Shortland	CAMHS Planning Lead	WHSSC
Caroline Winstone	CAMHS Network Manager	BCUHB
Claire Ball	Clinical Director Tier 4	Cwm Taf UHB
Claire Lines	Assistant Director	Powys HB
Dr Samantha Sharpe	Clinical Lead, Specialist Eating Disorder Services (Adult) Tier 3	BCUHB
Paul Davies	Assistant Director of Operations (Mental Health)	Cwm Taf UHB
Darren Griffiths	Acting Director of Planning	Cwm Taf UHB
Dr Peter Gore-Rees	Consultant Child Psychiatrist	BCUHB
Dr Mark Griffiths	Consultant Child Psychiatrist	Aneurin Bevan UHB
Dr Robin Glaze	Clinical Director	BCUHB
Gerrard McCullagh	Clinical Lead, Specialist Eating Disorder Services (Adult) Tier 3	Aneurin Bevan HB and Powys HB
Glyn Jones	Manager Specialist CAMHS Network	Hywel Dda UHB
Helen Hayes	Consultant in Child and Adolescent Psychiatry	Powys HB

Helen Matthews	Consultant Psychiatrist	Hywel Dda UHB
Jayne Lawrence	Head of Primary Care	Cwm Taf UHB
Jason Pollard	Policy Lead	Welsh Government
Jenni Richards	CAMHS Case Manager	WHSSC
Joanne Davis	Chief Executives Department	ABMU
Joanna Williams	Directorate Manager	Cwm Taf UHB
Julie Withecombe	All Wales Forensic Adolescent and Consultation Treatment Services	Cwm Taf UHB
Lindsay Lowe	Paediatrics	Cardiff and Vale UHB
Menna Jones	Clinical Lead , Specialist Eating Disorder Services (Adult) Tier 3	Cardiff and Vale UHB and Cwm Taff UHB
Neil Bradshaw	Director of Planning	BCUHB
Rose Whittle	Head of Operations and Delivery Community Child Health Directorate	C&V UHB
Sally Baxter	Assistant Director Strategy & Engagement (Planning)	BCUHB
Shane Mills	NHS Wales Quality Assurance Team	WHSSC
Sian Harrop-Griffiths	Director of Strategy	ABMU
Sian Richards	Programme Director T4CYP	Welsh Government
Warren Lloyd	Consultant Child Psychiatrist, Clinical Lead S-CAMHS, Associate Medical Director; Mental Health & Learning Disabilities	Hywel Dda UHB
Wendy Bell	Clinical Lead Specialist Eating Disorders Services (Adult) Tier 3	Hywel Dda & ABMU HB
Wendy Clarke	Senior Nurse & Specialist Lead for Eating Disorders CAMHS	Aneurin Bevan UHB
Leslie Rudd	Head of Wales Centre for Mental Health	Public Health Wales

Appendix 2

Membership Eating Disorder Services Sub Group

Name	Position	Organisation
Service User Representatives		
Manon Lewis	Service User Representative	n/a
Rhiannon Jones	Service User Representative	n/a
Family Representatives		
Mr & Mrs Beach	Family Representative	n/a
Helen Missen	Family Representative	n/a
CAMHS		
Gillian Davies	CAMHS Clinical Lead	Cwm Taf UHB
Natalie Chetwynd	CAMHS Eating Disorder Lead / Vice Chair	Hywel Dda UHB
Robin Glaze	Clinical Lead Tier 4 NWAS and Consultant in Adolescent Psychiatry	Betsi Cadwaldr UHB
Helen Hayes	Consultant Child and Adolescent Psychiatrist	Powys THB
Mark Griffiths	Consultant Child and Adolescent Psychiatrist	Aneurin Bevan UHB
Wendy Clarke	Senior Nurse & Specialist Lead for ED	Aneurin Bevan UHB
Kim Palmer	Senior Nurse	Cwm Taf UHB
Daune Green	Occupational Therapist	Aneurin Bevan UHB
Sian Taylor	Dietician	Aneurin Bevan UHB
Ruth Sandeman	Senior Nurse	Powys THB
Adult Tier 1		
Jane Burgoyne	Primary Care Counsellor	Cardiff and Vale UHB

Teresa Delaney	PMHSS Team Leader	Cardiff and Vale UHB
Adult Tier 2		
Carolyn Sansom	Tier 2 ED Lead Clinician	Cwm Taf UHB
Debbie Woodward	Tier 2 ED Lead Clinician	Cardiff and Vale UHB
Toni Hoefkens	Tier 2 ED Lead Clinician	Cardiff and Vale UHB
Annette Dunne	Dietician	Cardiff and Vale UHB
Catherine Arnold	Tier 2 ED Lead Clinician	Powys THB
Adult Tier 3		
Menna Jones	Clinical Lead Specialist Eating Disorder Services (Adult) Tier 3 / Chair	Cardiff and Vale UHB & Cwm Taf UHB
Gerrard McCullagh	Clinical Lead Specialist Eating Disorder Services (Adult) Tier 3	Aneurin Bevan UHB & South Powys THB
Samantha Sharpe	Clinical Lead Specialist Eating Disorder Services (Adult) Tier 3	Betsi Cadwaldr UHB & North Powys THB
Wendy Bell	Clinical Lead Specialist Eating Disorder Services (Adult) Tier 3	ABM UHB & Hywel Dda UHB
Clare O'Reilly	Occupational Therapist	Cardiff and Vale UHB & Cwm Taf UHB
Older Adults		
Therapies		
Paediatrics		
Nicola Morgan	Consultant Paediatrician	Aneurin Bevan UHB
Medicine		
Dev Datta	Consultant in Biochemistry & Metabolic Medicine	Cardiff and Vale
Universities		
Vicky Groves	University Counsellor	Cardiff University
WHSSC		
Carl Shortland	Planning Lead	WHSSC
Jenni Richards	CAMHS Case Manager	WHSSC
Caroline Winstone	CAMHS Network Manager	WHSSC
Strategics		
Paul Davies	Assistant Director of Operations	Cwm Taf

	(Mental Health)	University Health Board
	PWH	
	CHC	
3rd Sector Organisation		
Ewan Hilton	Senior management team	Gofal

GLOSSARY OF TERMS

CAMHS

Child and adolescent mental health services

SCAMHS

Specialist CAMHS

LD

Learning disability

ED

Eating disorders

SEDU

Specialist eating disorder in patient unit

SEDS

Specialist eating disorder services

AMHS

Adult mental health services

T4CYP

Together for Children and Young People

WHSSC

Welsh Health Specialist Services Committee

HB

Health Boards

WG

Welsh Government

CAPA

Choice and Partnership model

CITT

Community Intensive Treatment Team

CATT

Crisis Assessment and Treatment Team

FACTS

Forensic Adolescent Consultation and Treatment Services

**AGENDA ITEM 6.1****6TH SEPTEMBER 2016****CAMHS NATIONAL FRAMEWORK REFRESH – OCTOBER 16**

Report of	CAMHS/ED Network
Paper prepared by	WHSSC CAMHS Planning Lead
Action/Decision required	To consider the refresh evaluation report from NHS Wales Shared Services Partnership (NWSSP) and support its recommendations to Joint Committee. This ratification will enable NWSSP to formally action the refresh contractually with effect from 1 st October 2016.
Link to Board Committee (s)	Joint Committee
Link to Standards for Health Services in Wales	This paper supports Standards for:- Safe & Effective Care Staff & Resourcing Governance, Leadership & Accountability

INTRODUCTION

The purpose of this report is to present the Network Board with the evaluation report (see annex 1) from NWSSP following the refresh of the CAMHS National Framework.

BACKGROUND

The CAMHS National Framework was approved by the Minister and commenced on 1st April 2015. The initial Framework was for a period of 3 years and contained a refresh point at 18 months (1st October 2016). The refresh was designed to allow new providers' access to the Framework and give existing providers the option to change services and prices.

The Framework is split into 4 lots with providers offering beds for Male or Female patients in Low Secure or Acute/General wards.

Patients are placed onto the Framework using a CAARE process which takes account of the exact needs of patient along with the quality and cost of providers with available beds. The entrance into the market of a independent sector CAMHS provider in Wales has significantly influenced patient placement decisions and numbers of placements have continued to decline.

This raises a couple of major issues for the future arrangements of the Framework as follows:-

- 1) Patients placed closer to home in Wales are generally costing significantly more than other framework providers. As providers further reduce prices to attract new business they expect placements to flow. If this doesn't happen in practice they are likely to withdraw from future Frameworks.
- 2) As the numbers have significantly reduced the benefits of a competitive cost per case Framework decrease especially if current placement patterns continue. Alternatives to the current Framework (eg cost and volume with limited providers) need further consideration before the decision to extend or repeat procurement process is made in 2017.

CONCLUSION

The refresh will increase the number of providers on the Framework Agreement and include some sub specialist services for the 1st time (eg Deaf).

Based on the census date of 1st May 2016 the change in the cost of the current patient placements is negligible but considerable further savings could be achieved by using lower cost providers.

RECOMMENDATION

The CAMHS/ED Network Board is asked to:

- **CONSIDER** the evaluation report
- **AGREE** to support recommendations to Joint Committee.

Commercial and in Confidence

**Evaluation and Selection Report
August 2015**

**18 Month Refresh of Collaborative National Framework for Child and
Adolescent Mental Health Services (CAMHS) - Low Secure & Acute Non-
NHS Wales Hospital Services**

Evaluation and Selection Report

18 Month Refresh of Collaborative National Framework for Child and Adolescent Mental Health Services (CAMHS) - Low Secure & Acute Non-NHS Wales Hospital Services

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The following documents are not included in the evaluation report presented as they are not considered essential for the agreement of the recommendations. However, they are retained for audit and/or scrutiny purposes by NHS Wales Shared Services Partnership - Procurement Services:-

- i. Refresh/Variation Notice to Current Service Providers
- ii. Pre-Qualification (PQQ) and Invitation To Tender for New Providers (ITT)
- iii. Tender Evaluation – Verification & Audit Supporting Information

Version	Comment	Date
1.0	Presented to the 6th September 2016 CAMHS Network Board Meeting	30/08/2016

Executive Summary

Purpose

To seek approval from the Welsh Health Specialised Services Joint Committee (WHSSC) of the outcome from a refresh exercise on the framework for Child and Adolescent Mental Health Services (CAMHS) at Low Secure & Acute Non-NHS Wales Hospitals.

Governance

When the Framework was established it was agreed that the formal governance of the Framework Agreement would continue through WHSSC. Carl Shortland, CAMHS Planning Lead, has requested this report should go forward for support to the CAMHS Network Board meeting on the 6th September 2016. It is then understood that, in view of the urgency for putting variation letters/Frameworks in place for existing providers and new Frameworks in place for new providers by the 1st October 2016, the Governance and Accountability Framework (2015-2017) for WHSCC will apply and Chair's action will be needed to approve the outcome of the refresh, with any actions then being ratified at the next WHSSC Committee meeting on the 27th September 2016. Welsh Government Cabinet Secretary sign-off is not required as this is a refresh of the Framework.

Background

NHS Wales achieved both clinical and financial benefits from a Framework Agreement for low secure and acute child and adolescent mental health services (CAMHS) which commenced on the 1st April 2015, namely.

- An approved list of suitably qualified, financially viable providers to meet NHS Wales quality, service and cost criteria;
- The establishment of bespoke NHS Wales care standards, standard contract terms/conditions and a transparent pricing framework;
- Access to management information and the provision of clear and consistent patient level data to underpin a performance management framework; and
- Consistent and sustainable high quality service provision and improved patient outcomes.

There have been 44 CAMHS admissions across the 4 lots within the scope of the Framework since April 2015. At the last Census Day (1st May 2016) there were 11 CAMHS patients placed in hospitals on the framework.

The framework included refresh points at 9 month and 18 month intervals to be subsequently repeated during the remainder of the agreement. The 18 month refresh is more substantive than simply a price refresh and includes an opportunity for current providers to refresh their prices upwards or downwards; to apply to add new sites or units or to remove sites/units and for new providers to gain entry onto the framework.

A more detailed analysis of this, the 18 month refresh exercise follows on from this Executive Summary.

Evaluation Methodology and Results

A summary of the phases and results of the refresh is as follows:

PHASE	OUTCOMES
Initial Due Diligence test on financial standing of current providers	After the financial due diligence 1 (The Huntercombe Group) of the 11 current providers failed one or more of the tests and has agreed to provide a Company Guarantee. Two other current providers (Regis & Cambian) also failed one or more of the financial due diligence tests and will be required to maintain their current Parent Company Guarantees.
Initial screening of New bidders in respect of their regulatory requirements (PQQ)	2 potential new providers (Greater Manchester West Mental Health NHS Foundation Trust and South West London & St George's Mental Health NHS Trust) submitted PQQs and met the qualification criteria for entry onto the framework.
Current Providers revision of Units	All 11 current providers responded. There were: <ul style="list-style-type: none"> • 3 new units proposed (2 by Cygnet Health Care Limited and 1 by St Andrew's Healthcare). • 1 unit was withdrawn from the Framework (Regis Healthcare acute Unit). • 2 new units (both Cygnet Healthcare) have passed their audits and can be added to the Framework. • 1 unit (St Andrews Healthcare) is subject to a RAP which is scheduled to be reviewed on the 6th September 2016 and an update will be issued.
New Providers Bid to enter Framework	The 2 potential new providers who met the requirements of initial screening responded as follows: <ul style="list-style-type: none"> • 4 new Units proposed (1 by Greater Manchester West Mental Health NHS Foundation Trust and 3 by South West London & St Georges Mental Health NHS Trust) • Following audits all 4 new units proposed are subject to RAPs which are scheduled to be reviewed on the 6th September 2016 and an update will be issued.
Review of Initial Pricing Proformas	An evaluation of initial costs was prepared and an analysis made available to the Project Team. These were then subjected to a further Stage 2 pricing submission.

PHASE	OUTCOMES
Unit visits to verify potential new provider's ability to meet the current twenty-five essential requirements and Stage 1 price clarifications. Units were visited to verify the details and information provided in the bidders' responses.	<p>The Quality Assurance and Improvement Team (QAIT) undertook audits of 5 units across 2 hospital sites of 2 current providers and 8 units across 2 hospital sites of 2 potential new providers. The audits measured each Unit's performance against the 162 care standards currently used within the Framework Agreement.</p> <p><u>Current service providers:</u></p> <p>The QAIT undertook audits of 3 units of 2 current providers that wished to add further units to their portfolio. Of these audits:</p> <ul style="list-style-type: none"> • 2 units (both Cygnet Healthcare) passed the audit at the first attempt. • A Remedial Action Plan (RAP) was issued for one unit (St Andrews Healthcare) where issues were found and the provider has 10 working days to ensure that all identified issues are rectified. The RAP is scheduled to be reviewed on the 6th September 2016. If the unit passes the RAP it will be added to the framework and an update will be issued. <p><u>New providers:</u></p> <p>The QAIT undertook audits of 4 units across 2 sites of 2 potential new providers. Of these audits:</p> <ul style="list-style-type: none"> • All 4 units have been issued with RAP's • The RAP is scheduled to be reviewed on the 6th September 2016. If the units pass their RAPs they will be added to the framework and an update will be issued.
Stage 2 Pricing Submission	Both current providers and potential new providers were given their initial ranking and points for clarification and afforded the opportunity to resubmit revised prices. 3 providers submitted revised prices.

Benefits Realisation

Qualitative Benefits:

- WHSSC and Health Boards will continue to receive assurance that providers are maintaining the required clinical standards, good clinical practice and evidence based care, whilst reducing risk and dependency and promoting hope, recovery and rehabilitation.
- Where providers are found not to be providing the required standards remedial action or suspension/termination will be implemented. This can be evidenced by the issuing of 6 Performance Improvement Notices with a total of 163 corrective actions and 5 Performance Improvement plans with a total of 99 corrective actions since the Framework commenced on the 1st April 2015.
- All potential new providers have been audited to ensure that they provide care in safe and high quality which use treatments that are evidence-based and effective, whilst ensuring public protection and value for money.

- South West London & St Georges Mental Health NHS Trust has applied to add a unit for deaf patients. Subject to this unit passing its quality audit this would provide wider service provision on the Framework albeit there are currently no deaf patients in Tier 4 CAMHS beds.

Financial Evaluation Summary:

The new prices show a mixed picture in terms of price movements:

- 6 of the current providers have not changed their pricing, namely:
 - a) Priory Healthcare Limited
 - b) Newbridge Care Systems Limited
 - c) Regis Healthcare Limited (Lots A and B, services withdrawn for Lots C and D)
 - d) Cambian Healthcare Limited
 - e) Huntercombe
 - f) Birmingham & Solihull Mental Health NHS Foundation Trust
- 3 of the current providers have increased their prices, namely:
 - a) Cheshire & Wirral Partnership NHS Foundation Trust (+2.4%)
 - b) South London & Maudsley NHS Foundation Trust (+1.0%)
 - c) Tees, Esk & Wear Valley NHS Foundation Trust (+1.1%)
- 2 of the current providers have reduced their prices, namely:
 - a) Cygnet Health Care Limited (-4.0%)
 - b) St Andrews Healthcare (c. -20.0%)
- Based on placements on Census Day (1st May 2016) being maintained the reduction in pricing by St Andrews Healthcare would lead to a saving of £130.00/patient/day (equivalent to £47,450 if the placement is in place for a full year) with that provider. However the particular patient placed with St Andrews on Census Day would have left the service before the 1st October 2016 when the price changes come into effect because they will have passed their 18th birthday.

These price movements should be viewed within the following context:

- There is a price differential of £251.00/day between Regis Healthcare in Wales, where the majority of patients are currently placed, and St Andrews Healthcare.
- There will be an opportunity in 9 months time (1st July 2017) for providers to review their prices downward only should they wish to.
- Cost increases associated with the introduction of the National Living Wage can be anticipated at the point of the next full refresh of the Framework on the 1st April 2018.

Any potential increase in overall costs of Framework placements could be mitigated by:

- Acceleration of repatriation plans of patients from Independent sector/NHS England to NHS Wales facilities
- Acceleration of discharge plans for patients to community/independent living placements
- The movement of patients, where clinically appropriate, to higher ranked, lower priced providers.
- The minimising, where clinically appropriate, of the use of higher priced, lower ranked providers.

Recommendations & Next Steps

The CAMHS Network Board on behalf of the WHSSC Joint Committee approves the revised units (current and new providers) per lot to be placed onto the National Framework Agreement and supports the next steps below:

1. Executing variation letters and Framework Agreements with all appointed providers.
2. If necessary executing individual Patient Placement Agreements for existing patient placements.
3. The Quality Assurance and Improvement Team continuing to enhance its quality assurance role across all services.
4. Publicising the new arrangements and outcome of the refresh exercise within NHS Wales.

Detailed Report

Evaluation and Selection Report re: 18 month Refresh of Collaborative National Framework for Child and Adolescent Mental Health Services (CAMHS) - Low Secure & Acute Non-NHS Wales Hospital Services

1. Purpose

To seek approval from the Welsh Health Specialised Services Joint Committee (WHSSC) of the outcome from a refresh exercise on the framework for Child and Adolescent Mental Health Services (CAMHS) at Low Secure & Acute Non-NHS Wales Hospitals.

2. Background

NHS Wales achieved both clinical and financial benefits from a Framework Agreement for low secure and acute child and adolescent mental health services (CAMHS) which commenced on the 1st April 2015, namely.

- An approved list of suitably qualified, financially viable providers to meet NHS Wales quality, service and cost criteria;
- The establishment of bespoke NHS Wales care standards, standard contract terms/conditions and a transparent pricing framework;
- Access to management information and the provision of clear and consistent patient level data to underpin a performance management framework; and
- Consistent and sustainable high quality service provision and improved patient outcomes.

The 4 lots included within the framework are:

Lot No.	Category
A	Low Secure - Male
B	Low Secure - Female
C	Acute - Male
D	Acute – Female

There have been 44 CAMHS admissions across the 4 lots within the scope of the Framework since April 2015. At the last Census Day (1st May 2016) there were 11 CAMHS patients placed in hospitals on the framework.

There are currently 11 providers included on the CAMHS framework, namely:

- Birmingham & Solihull Mental Health NHS Foundation Trust
- Cambian Healthcare Ltd
- Cheshire & Wirral Partnership NHS Foundation Trust
- Cygnet Health Care Limited
- Newbridge Care Systems Limited
- Regis Healthcare Limited

- South London & Maudsley NHS Foundation Trust
- St Andrew's Healthcare
- Tees, Esk & Wear Valley NHS Foundation Trust
- The Huntercombe Group
- Priory Healthcare Limited

A further two new providers have now applied to join the Framework, namely:

- Greater Manchester West Mental Health NHS Foundation Trust
- South West London & St George's Mental Health NHS Trust

The framework included refresh points at 9 month and 18 month intervals to be subsequently repeated during the remainder of the agreement.

The refresh exercise at the 6 month (1st January 2016) interval provided an opportunity for current providers to review their prices downwards only. One provider, St Andrews Healthcare, reduced prices at the January 2016 refresh and this could have realised modest savings of up to £19,958 based on a full year placement.

The 18 month refresh is more substantive than simply a price refresh and in line with the original Invitation to Tender the documentation issued to Service Providers in respect of the Framework Agreement contained a refresh/variation of the original Framework Agreement encompassing the: (i) commercial arrangements, (ii) service specification, and (iii) contract management arrangements.

3. Project Objectives & Procurement Aims

The 18 month refresh point also includes an opportunity for current providers to refresh their prices upwards or downwards (subject to a sustainable financial appraisal), to apply to add new sites or units or to remove sites/units and for new providers to gain entry onto the framework (subject to satisfying the contracting authority's applicable minimum selection criteria).

The procurement exercise took a parallel approach separating out current providers and potential new providers.

4. Project Team

A multi-professional Project Team was set up for the refresh, with the same external support as previously from legal advisors, Blake Morgan Solicitors.

5. Governance

Effective governance arrangements are as follows

- Any sign off/approvals or issues of substance around the Framework Agreement formally need to be via the WHSSC Joint Committee, as the original project sub group no longer meets. If there is a requirement for an urgent decision outside of the Committee meetings, the governance

framework for WHSSC will be applied and Chair's action taken. This will then be ratified at the next Joint Committee meeting.

- Equality Impact Assessment (EqIA) - A review of the EqIA, undertaken by the QAIT with the support and advice of the NHS Centre for Equality and Human Rights when the Framework was established, is due to be carried out in October 2016.

6. Procurement Process

As detailed above, the exercise took a parallel approach separating out current providers and potential new providers.

Current Providers were given the opportunity to request addition to, revision of or removal of units from the framework, during early July 2016, to enable the Quality Assurance & Improvement Team to programme their audits. This exercise ran parallel to the advertising of the refresh exercise in the Official Journal of the European Union (OJEU) and evaluation of Prequalification Questionnaires (PQQ) for new suppliers. A due diligence test on the financial standing of these suppliers has also been undertaken as an assurance that they are still financially viable.

As part of the refresh/variation of the Framework Agreement, there will be a variation by the Trust of the following aspects of the Framework Agreement:

- a. the Service standards;
- b. the Quality Assurance & Improvement System; and
- c. certain of the terms governing the provision of the Services

The Variations will be effective from 1st October 2016. As part of the initial submission, providers were requested to confirm compliance with the service standards.

During late July/early August 2016, current providers were given the opportunity to revise their prices and submit prices for new and revised units which ran alongside the tender stage for new providers. Clinical audits were undertaken of new units in mid August 2016 and providers were informed of their price ranking within the allocated lots and given another opportunity to review pricing.

New Providers have been given an opportunity to join the framework. To ensure this process is open, fair and transparent, an advert was issued in the Official Journal of The European Union (OJEU) in early July 2016, supported by a PQQ. Providers who met the minimum requirements outlined in the PQQ were given the opportunity to submit tenders by the 25th July 2016. Two potential new providers submitted PQQs and both were shortlisted to proceed. Clinical audits were undertaken of the new units in mid August 2016 and providers were informed of their price ranking within the allocated lots and given another opportunity to review pricing.

Evaluation then continued during the remainder of August 2016.

7. Evaluation Methodology & Results

A summary of the phases and results of the refresh is as follows:

PHASE	OUTCOMES
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PHASE	OUTCOMES
Initial Due Diligence test on financial standing of current providers	After the financial due diligence 1 (The Huntercombe Group) of the 11 current providers failed one or more of the tests and has agreed to provide a Company Guarantee. Two other current providers (Regis & Cambian) also failed one or more of the financial due diligence tests and will be required to maintain their current Parent Company Guarantees.
Initial screening of New bidders in respect of their regulatory requirements (PQQ)	2 potential new providers (Greater Manchester West Mental Health NHS Foundation Trust and South West London & St George's Mental Health NHS Trust) submitted PQQs and met the qualification criteria for entry onto the framework.
Current Providers revision of Units	All 11 current providers responded. There were: <ul style="list-style-type: none"> • 3 new units proposed (2 by Cygnet Health Care Limited and 1 by St Andrew's Healthcare). • 1 unit was withdrawn from the Framework (Regis Healthcare acute Unit). • 2 new units (both Cygnet Healthcare) have passed their audits and can be added to the Framework. • 1 unit (St Andrews Healthcare) is subject to a RAP which is scheduled to be reviewed on the 6th September 2016 and an update will be issued.
New Providers Bid to enter Framework	The 2 potential new providers who met the requirements of initial screening responded as follows: <ul style="list-style-type: none"> • 4 new Units proposed (1 by Greater Manchester West Mental Health NHS Foundation Trust and 3 by South West London & St Georges Mental Health NHS Trust) • Following audits all 4 new units proposed are subject to RAPs which are scheduled to be reviewed on the 6th September 2016 and an update will be issued.
Review of Initial Pricing Proformas	An evaluation of initial costs was prepared and an analysis made available to the Project Team. These were then subjected to a further Stage 2 pricing submission.

PHASE	OUTCOMES
Unit visits to verify potential new provider's ability to meet the current twenty-five essential requirements and Stage 1 price clarifications. Units were visited to verify the details and information provided in the bidders' responses.	<p>The Quality Assurance and Improvement Team (QAIT) undertook audits of 5 units across 2 hospital sites of 2 current providers and 8 units across 2 hospital sites of 2 potential new providers.</p> <p>The audits measured each Unit's performance against the 162 care standards currently used within the Framework Agreement.</p> <p><u>Current service providers:</u></p> <p>The QAIT undertook audits of 3 units of 2 current providers that wished to add further units to their portfolio. Of these audits:</p> <ul style="list-style-type: none"> • 2 units (both Cygnet Healthcare) passed the audit at the first attempt. • A Remedial Action Plan (RAP) was issued for one unit (St Andrews Healthcare) where issues were found and the provider has 10 working days to ensure that all identified issues are rectified. The RAP is scheduled to be reviewed on the 6th September 2016. If the unit passes the RAP it will be added to the framework and an update will be issued. <p><u>New providers:</u></p> <p>The QAIT undertook audits of 4 units across 2 sites of 2 potential new providers. Of these audits:</p> <ul style="list-style-type: none"> • All 4 units have been issued with RAP's • The RAP is scheduled to be reviewed on the 6th September 2016. If the units pass their RAPs they will be added to the framework and an update will be issued.
Stage 2 Pricing Submission	Both current providers and potential new providers were given their initial ranking and points for clarification and afforded the opportunity to resubmit revised prices. 3 providers submitted revised prices.

8. Benefits Realisation

Qualitative Benefits:

- WHSSC and Health Boards will continue to receive assurance that providers are maintaining the required clinical standards, good clinical practice and evidence based care, whilst reducing risk and dependency and promoting hope, recovery and rehabilitation.
- Where providers are found not to be providing the required standards remedial action or suspension/termination will be implemented. This can be evidenced by the issuing of 6 Performance Improvement Notices with a total of 163 corrective actions and 5 Performance Improvement plans with a total of 99 corrective actions since the Framework commenced on the 1st April 2015.
- All potential new providers have been audited to ensure that they provide care in safe and high quality which use treatments that are evidence-based and effective, whilst ensuring public protection and value for money.
- South West London & St Georges Mental Health NHS Trust has applied to add a unit for deaf patients. Subject to this unit passing its quality audit this would provide wider service provision on the Framework albeit there are currently no deaf patients in Tier 4 CAMHS beds.

Financial Evaluation Summary:

The new prices show a mixed picture in terms of price movements:

- 6 of the current providers have not changed their pricing, namely:
 - g) Priory Healthcare Limited
 - h) Newbridge Care Systems Limited
 - i) Regis Healthcare Limited (Lots A and B, services withdrawn for Lots C and D)
 - j) Cambian Healthcare Limited
 - k) Huntercombe
 - l) Birmingham & Solihull Mental Health NHS Foundation Trust
- 3 of the current providers have increased their prices, namely:
 - d) Cheshire & Wirral Partnership NHS Foundation Trust (+2.4%)
 - e) South London & Maudsley NHS Foundation Trust (+1.0%)
 - f) Tees, Esk & Wear Valley NHS Foundation Trust (+1.1%)
- 2 of the current providers have reduced their prices, namely:
 - c) Cygnet Health Care Limited (-4.0%)
 - d) St Andrews Healthcare (c. -20.0%)
- Based on placements on Census Day (1st May 2016) being maintained the reduction in pricing by St Andrews Healthcare would lead to a saving of £130.00/patient/day (equivalent to £47,450 if the placement is in place for a full year) with that provider. However the particular patient placed with St Andrews on Census Day would have left the service before the 1st October 2016 when the price changes come into effect because they will have passed their 18th birthday.

These price movements should be viewed within the following context:

- There is a price differential of £251.00/day between Regis Healthcare in Wales, where the majority of patients are currently placed, and St Andrews Healthcare.
- There will be an opportunity in 9 months time (1st July 2017) for providers to review their prices downward only should they wish to.
- Cost increases associated with the introduction of the National Living Wage can be anticipated at the point of the next full refresh of the Framework on the 1st April 2018.

Any potential increase in overall costs of Framework placements could be mitigated by:

- Acceleration of repatriation plans of patients from Independent sector/NHS England to NHS Wales facilities
- Acceleration of discharge plans for patients to community/independent living placements
- The movement of patients, where clinically appropriate, to higher ranked, lower priced providers.
- The minimising, where clinically appropriate, of the use of higher priced, lower ranked providers.

9. Recommendations & Next Steps

The CAMHS Network Board on behalf of the WHSSC Joint Committee approves the revised units (current and new providers) per lot to be placed onto the National Framework Agreement and supports the next steps below:

1. Executing variation letters and Framework Agreements with all appointed providers.
2. If necessary executing individual Patient Placement Agreements for existing patient placements.
3. The Quality Assurance and Improvement Team continuing to enhance its quality assurance role across all services.

4. Publicising the new arrangements and outcome of the refresh exercise within NHS Wales.

CAMHS/ED Network Steering Group Meeting

Monday 27th June 2016 10:00am – 12:30pm
Training rooms 1 and 2 Bowel Screening Wales Unit,
Unit 6, Green Meadow, Llantrisant, CF72 8XT

MINUTES

Present:

Carol Shillabeer (CS) (Chair)	Chief Executive Powys Teaching Health Board
Glyn Jones (GJ)	CAMHS Network Manager
Carl Shortland (CSh)	CAMHS Planning Lead, WHSSC
Caroline Winstone (CW)	CAMHS Network Manager
Menna Jones (MJ)	T3 Specialist Eating Disorders Services Clinical Lead, C&V UHB Cwm Taf
Gerrard McCullagh (GMc)	T3 Specialist Eating Disorders Services Clinical Lead, Aneurin Bevan & South Powys HB
Robin Glaze (RG)	Consultant in Child and Adolescent Psychiatry, Clinical lead Tier4 BCU HB
Dave Williams (DW)	Divisional Director, AB UHB, Advisor to the Minister Welsh Government
Angela Lodwick (AL)	Head of CAMHS/Strategic & Commission HD UHB
Rose Whittle (RW)	Head of Operations & Delivery, Community Child Health Directorate C&V UHB C&V UHB
Mark Griffiths (MG)	Consultant in Child and Adolescent Psychiatry, Aneurin Bevan UHB
Sian Richards (SR)	National Programme Director, T4CYP
Peter Gore-Rees (PG)	Consultant in Child and Adolescent Psychiatry, Clinical Director for CAMHS North Wales
Gillian Davies (GD)	Child Psychiatrist, Outreach Service CAMHS EDDS, Clinical Lead, Cwm Taf UHB
Kim Palmer (KP)	Senior Nurse, Tier 4 ED, Cwm Taf UHB
Joanne Davies (JD)	Assistant Director of Strategy and Partnerships, ABMU
Wendy Clarke (WC)	Senior Nurse & Specialist Lead for ED, Aneurin Bevan UHB
Sharon Evans (SE)	Project Administrator, CAMHS, WHSSC
Leslie Rudd (LR)	Mental Health Development Lead, Public Health Wales 1000 Lives

CEDN/16 13	<p>Welcome and apologies for absence Chair welcomed members to the meeting & introductions were made.</p> <p>Apologies for absence received from: Daniel Phillips, Acting Managing Director WHSSC Jenni Richards, CAMHS Case Manager, WHSSC Warren Lloyd, Consultant Psychiatrist CAMHS, Hywel Dda UHB Julie Withecomb, Consultant in Child & Adolescent Psychiatry, FACTS lead Wales, Cwm Taf UHB Jason Pollard, Policy Advisor Welsh Government Tracy Gardiner, Child Psychotherapist, Clinical lead Ty Lyddiard Chris Moss, Specialist Services Manager, ABMU HB</p>	
CEDN/16 14	<p>Minutes of the Network Steering Group meeting held on 1st March 2016 Amendments: (Page 5) <i>Update of ongoing work from project group Together for Children and Young People & Next Steps</i> – Page 5 2nd paragraph amend to read; 're-enforce the key role of local mental health partnerships boards as the multi agency partnership groups to deliver T4CYP and that we have formally asked all the local partnership boards to re-look at their constitution and also agenda setting to ensure they are fit for purpose for that role.'</p> <p>Page 4 of 14/15 Annual work plan – amend to read clear in the action log and clear in the agenda, today it is 'sign off' of 14/15 annual report. The 15/16 annual report is to be discussed and 16 – 17 workplan. Any further comments to be sent to CW.</p> <p>GM - correction on 7 draft on coordination, part 23.2 error amend to reflect; Outcome measures in adult services.</p>	CW/SE
CEDN/16 15	<p>Matters arising from the Network Steering Group meeting held on 1st March 2016</p> <p>Action Log Action log – several on Page 1 are completed. The annual report 14/15 should read 15/16 annual report. 16/17 annual work plan is correct and on agenda.</p> <p>Page 2 07 should read part 2 not 23</p> <p>Update in outcome measures referred to 'adult' services by GMc</p>	CW/SE
CEDN/16 16	<p>Chairs Report Chair noted her reflections at the end of year 2 of the network;</p> <ul style="list-style-type: none"> • Now a quarter of the way in to year 3, usually takes approximately 2 years to establish a network, time now to firm up the work plan and programme for the future incorporating past deliverables and future for the next 18 months work. • Recent T4CYP conference highlighted a number of factors that will shape what the critical issues are in moving forward, the T4CYP team and all workstream leads are to be thanked for their input a in facilitating the event of some 200 delegates. • The Social Services and Well Being act is now invoked and 	

	<p>makes clear reference to working holistically with CAMHS in an integrated way.</p> <ul style="list-style-type: none"> • New government now in place and CAMHS remains a priority on the agenda with a high level of commitment. • The critical issues that we as a network will be judged on will be access times, though not required to performance monitor health boards with the key drivers being the T4C&YP programme, CAMHS/ED network work programme and Welsh Government. We will continue to be held to account by the National Assembly for Wales Education committee. • The forthcoming September meeting; Chair proposed a 'Development Day' to clarify priorities and members noted that a robust communication strategy would assist to disseminate actions and progress on going. This would need to provide clarity over the respective roles of T4C&Y and that of the CAMHS/ED network to avoid potential overlap. <p>One of the general observations from the conference and listening to the voice of service users is that there still appears to be a trend to refer any young person with an emotional health and well being problem, mild to moderate and those with ASD, in to the NHS when in some cases this is inappropriate. Access to mental health services is often not the need but rapid access and treatment at the required point usually in crisis. Social services and education have a major part to play in assessment but often too late in the day and it is a rapid access to CAMHS that both services then wish to activate. Chair referred to the 'windscreen model' across the full range from mild to moderate and across to complex need. Recently at a workshop with colleagues in Eating Disorders with over 150 GPs in Gwent it was apparent that the audience did not understand what specialist CAMHS consists of. A communication strategy developed and rolled out might provide clarity of what <i>is</i> and what <i>is not</i> in specialist CAMHS.</p> <p>CAMHS professionals do need to be visible, out there consulting and doing more of the indirect work required but Part 1 of the mental health measure has diminished that aspect of indirect work and has resulted in the loss of training, supervision and the valuable indirect element of work. 'Consultation' is key and appears to have been diminished.</p> <p>Chair majored on the need for a whole systems approach in CAMHS and referred to budgetary pressures faced by social services and similar services that previously interfaced well with Specialist CAMHS but they are in some areas disappearing. Specialist CAMHS then is seen as the 'only option' for referral. It is hoped that the arrival of the Social Services and Well-being (Wales) act might assist to improve the required whole systems approach.</p> <p>Consultation sessions with social services and with colleagues in secondary and primary schools previously extended across large geographical areas but now can no longer be delivered due to the requirements to undertake assessments in line with part 1 of the measure. There is no consistency about what is delivered under part 1 of the Measure and such services across Wales are different.</p>	
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	<p>Perhaps a scope of current practise in terms of what is being delivered could be done, looking back to historical provision and a mapping out how many primary mental health workers, previously allocated on a population of each health board basis to identify gaps in consultation, advice and training as required in previously set AQF targets should be revisited.</p> <p>GJ stated that based on feedback received at the T4C&YP conference workshop that we need to look at eligibility criteria. A third sector group argued that we needed a special service for vulnerable individuals but it should be equal access for everyone based on clinical need . Some services are quick to say unfairly that they cannot access Specialist CAMHS.</p> <p>Concerns were raised at the conference that this would result in some young people having no service at all. Specialist CAMHS need to ensure adequate consultation and advice can be sought as a priority as opposed to needing to see a young person face to face</p> <p>Services in Cwm Taff HB have seen the withdrawal of input from Social Services over the past years and hence Specialist CAMHS services have been expected to pick up a lot of the behavioural issues. April 2016 saw a further withdrawal of the last social workers from Cwm Taf Specialist CAMHS with no alternative replacement, provision or plans particularly for those young people who fall between services. Specialist CAMHS are then expected to pick them up, inevitably in crisis and for those in danger of 'placement break down'. An alternative for this cohort of vulnerable young people needs to be prioritised because unless they present with a specialist mental health need, they are not a priority for specialist CAMHS. Service re-design within existing provision to meet the needs of these young people is essential, no joint discussions on such withdrawal was carried out with the service simply ceasing. JW felt the T4CYP programme needs to bring social services to the table more effectively to highlight this issue and to flag up these jointly owned concerns for effective service planning albeit in another form.</p> <p>Clarity around whole system provision was essential; the developmental day planned for September might assist to achieve this. SR noted that there is to be a CAMHS clinical director's developmental 'away day' in July and that this would look at the actions required as a result of the Frame work for Improvement. This sets out clear definitions of the role of sCAMHS.</p> <p>RW noted that whilst accepting all previous comments and discussion here today there remains a group of young people with significant issues that we are not able to offer a service for. Consultation is really helpful, but actually what young people who have gone through trauma need is some form of intervention and that may not be down to Specialist CAMHS and it might also meet specialist CAMHS criteria. Resting the blame on e.g. Social Services due to the complexity of the young persons need, who has often gone through multiple family breakdown and reacting to situation that they are in is not acceptable. Those families are often informed that they do not meet the criteria for access at the point they seek</p>	
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help. Social services in Cardiff are working very hard with CAMHS with psychological approaches, working with the parents and families jointly to try to manage behaviour. Therefore we need to have some criteria in place for this complex group of young people and their families or it presents a constant revolving door to services.

Chair listened to the young people at the conference and their message was clear with several key points;

- They *did* want clear referral criteria; they think that would be very helpful, it is about system not silo working
- How do we make the most of the Social Services Act to enable us collectively to find solutions of the life and world of today's social work service as their role is very different from many years ago to what is required of them today as they previously provided an intervention rather than sign posting.
- Clearly, consultation, training and liaison are required but do we have enough staff supporting and delivering this function, social services owning their part to play?
- It might mean social services delivering previously core CAMHS business but importantly it will be about finding solutions for children

Chair also made comment of the opportunity at the forthcoming social services conference to raise all these points brought to our attention by the young people at the recent T4C&YP workshop and here at the network steering group meeting today.

The Director of Social Services on the T4CYP board had recently highlighted how the Social Services and Well-being (Wales) Act could herald a positive environment for joint working across agencies.

It was made very clear by the young people who spoke at the event that the first line of delivery for them is often to simply speak with friends and family.

DW noted that referral guidelines can still be manipulated. A professional sitting face to face with a young person is as important as any therapeutic intervention delivered. The opportunity to have a discussion is the key starting point for the young person seeking help in CAMHS. Often the referral guidelines provide too medical a model and mean a young person cannot access the service unless there is a clear diagnosis. This could be covered at the September development day.

The importance of youth workers working in with voluntary sectors and other services as in England CCGS was noted as being a good way to engage with young people in Specialist CAMHS and provide the links required to the voluntary sector. Youth workers come from a variety of backgrounds and offer a different perspective in engaging young people in the design of young person centred services.

Chair referred to Powys local mental health partnership board which has youth workers as part of that sub group and can reach out and access to all sorts of existing groups e.g. school counsels, the youth groups, or young farmers. About 18 months ago a major piece of

	<p>work was undertaken with all of the youth community and mental health came out as one of the biggest issues. They came also and presented to the local service board their findings. ;</p> <ul style="list-style-type: none"> • They are very concerned that they wanted to support their friends, but they didn't know how to deal with difficult conversations. • Mental health was seen as a big issue for young people and the mental health partnerships should really be mechanism by which this engagement can happen at a local and meaningful level <p>It was thought by all to be very positive to place a youth worker in each health board area, as part of Specialist CAMHS for meaningful engagement to tangibly hear the young person's voice rather than tokenism. Wrexham has recently lost its youth workers posts when we need to increase their input. Hywel Dda also have service users' forums; their young people sit on and are fully included in all policies and consultations.</p>	
CEDN/16 17	<p>Final Annual Report 2014 – 2015</p> <p>Content perspective needs agreement. SR – there are a couple of inaccuracies in terms of the terminology about the T4CYP programme and the network and the linkages between the programme board and that of the network. SR will provide amendments on hard copy to network manager at the end of the meeting. Same for 2nd report for 15 - 16.</p> <p>It was agreed to:</p> <ul style="list-style-type: none"> • Approve subject to minor amendments and approve but we can 'sign off' 14 – 15 annual report 	CW/SE
CEDN/16 18	<p>Draft Annual Report for comment 2015 – 2016</p> <p>CS commented this is a draft and welcomed comments</p> <p>It was agreed that:</p> <ul style="list-style-type: none"> • Forward comments to CW • Update following receipt of comments & re-circulate. Send to CSh then send out for comment by email. Seek to approve by 1st September 2016 then submit to WHSSC joint committee. 	ALL CW
CEDN/16 19	<p>Draft Annual Work Plan 2016/2017</p> <p>Chair advised this is draft from. Chair requested we use this as the working document for September development day as our planning meeting/workshop/development session. Noted as a roll over programme in draft version until we meet in September.</p> <p>Chair proposed we use this until the meeting in September where we will aim to have a new work programme that will take us through the 18 months from September October right through the end December of 17/18 – 18 months worth of work programming.</p>	CW
CEDN/16 20	<p>Clinical Networks Update of transfer of clinical networks including CAMHS/ED Network, to PHW & dates</p> <p>There has been a temporary 'pause' in the transfer until further notice. Chair re-assured all members that it was business as usual.</p> <p>Chair explained the background to the temporary 'pause' due to discussions held at the recent chief executives meeting. There are several designated networks ready to transfer to the NHS Wales collaborative. Network Chairs collectively are clear that they see the</p>	

	<p>network working in a way that fits with the original ambitions roles and responsibilities of networks as approved in the formal network review, so they are still extant. The Chair of the network is the accountable person for the network so no change but that it is primarily around the hosting. Chair made it clear that leading and managing the network as it stands remains same except for hosting element. We are aware that there remains a need to recruit to a data analyst post to secure robust data. Cross fertilisation of and with other networks will happen but the delay should not be perceived as a problem it will be 'business as usual' for the CAMHS/ED network.</p> <p>The delay in the transfer presented problems with the recruitment process to the vacant data analyst post but this has been progressed via discussion between Daniel Phillips, CSh and Mark Dickinson to progress this and get the post out to advert quickly.</p> <p>Welsh Government has done some work on data performance but much remains outstanding. Data on waiting times and outcome measures need to be captured but this specialised piece of work requires someone appropriately qualified to undertake it. Chair reassured members that all financial resources from previous networks configurations have been firmly accounted for by finance colleagues in PHW in advance of the official transfer.</p>	
CEDN/16 21	<p>Update of on going work from project group <i>Together for Children and Young People and Next Steps</i> Positive discussion was noted earlier in the meeting by chair and members. SR confirmed that the key purpose of the conference had been to share the work done to date and to get ownership from people to what the high impact changes for the next 12 months would be and earlier discussions here will also fall into that category. Next actions would include:</p> <ul style="list-style-type: none"> • a pathway for the local primary care schemes given different models across Wales • information for GPs and for families and carers based on the Framework for Improvement. This would need to be supplemented by locally developed electronic directories to 'signpost' to other services that sit around the CAMHS in each health board area to include 3rd sector provision • Carol Shillabeer and of T4C&YP programme director are raising the profile at as many events / forums as possible this includes the forthcoming national conference of the Directors of Social Services and the All Wales Directors of Education Group (ADEW) <p>CS noted that a conference report in the form of an expanded newsletter will be out in August.</p> <p>It was agreed that:</p> <ul style="list-style-type: none"> • SE to distribute newsletter to members of this group. • CS informed all network steering group members that all presentations at the T4C&YP will be placed on the website also. 	SE SE

CEDN/16 22	<p>CS referred members to the website to view the work of Dr Ann Jones and directed them to the focus on prescribing within the document which was considered at the last T4C&YP event. SR confirmed that it had been widely circulated and subsequently at the recent T4C&YP event delegates were asked to identify 2 issues from the needs assessment for priority. The report is a publicly available document on the T4C&YP and the Swansea University websites. Key messages from that work have been integrated into the final version of the needs assessment. Anxiety is highlighted as a major issue emerging from her work.</p> <p>DW noted that anxiolytic prescribing was not related to social demographics in comparison with all other medication studied by Prof John. He also highlighted that it is the implementation of a regular audit cycle that enables health boards to review practice on a regular basis and that perhaps prescribing practices should be something the network audits on a regular basis.</p> <p>It was agreed that: SE to send hyperlink to report to network members and for all to read prior to September meeting / development day.</p>	SE
CEDN/16 23	<p>Development of future training for the specialist CAMHS workforce</p> <p>GJ was asked to look at training needs based on original bid submissions to WG, the training required in these bids highlighted 3 the common themes, CBT, EMDR and Independent Prescribing. GJ looked at</p> <ul style="list-style-type: none"> • Which trainers are available • Who will actually come to Wales and deliver it in house • What is the quality of the training • Accreditation <p>Discussion with WG clarified there is no further funding available except that created by the slippage on spend against the original additional £7.65m funding. WG are willing to consider Health boards using their share of this to support the training in the form of a "Once for Wales" bid.</p> <p>CSh stated that the key issue here is the benefit of a "Once for Wales" mechanism. CBT and EMDR remain a priority although family therapy is one of the key therapies that have been encouraged across services in Wales. A steer from the chair was sought? SR reminded the group of the 'Once for Wales' approach</p> <ul style="list-style-type: none"> • people across health boards would be training together • keeping travel and time away from clinical duties to a minimum through provision in Wales • staff learning together, thinking together and adopting and developing a common standardised approach across Wales • potential cost benefits of this approach WHSSC as a commissioning organisation can in terms of process and governance ' could potentially lead the contracting process for a Once for Wales package • health boards who wanted to take up this training option would clearly need to fund the appropriate component of the training from their additional allocation 	

	<p>Some members felt as family therapy is a core therapies that we are looking to develop across our services in Wales it should be included and if we are considering the evidence based going forward then both CBT and family therapy need to be core to the CBT, EMDR and Independent prescribing. A "Once for Wales" bid would enable quality accredited trainers to deliver and to support ongoing supervision. A position of who is in, who is out needs to be firmed up, GJ will progress this via email.</p> <p>AL flagged up the psychological matrix for Wales in the development of the CAMHS workforce development. It was also noted that some of the health boards have already committed to their training needs. Chair asked that an email is sent by GJ to those leads of training in health boards to establish numbers ASAP.</p>	<p>GJ</p> <p>GJ</p>
<p>CEDN/16 24</p>	<p>ED Services Report/Update from ED Sub-group & work programme</p> <p>Menna Jones as chair provided an on progress of the work undertaken to date. A lot of work and activity is underway;</p> <ul style="list-style-type: none"> • A GP has contacted the chair and wishes to be a member of the sub group • Eating disorders refresh document has been submitted to WG and is awaited <p>Chair has requested that the CAMHS/ED network and sub groups can pass comments on final draft. GMc will report later on the work of the transition group. However, MJ asked that a particular issue that has been brought to her attention from the Transition groups work is about the variability and provision of paediatric inpatient services for 16-18 year olds. Transitions issues are noted as being both disruptive and challenging in the management of young people across different health boards especially with paediatric services that do or do not accept children within the 16 to 18 year old age group and similarly the agreed processes in adult mental health ward admissions. There is no consistency of practise and little in the way of set protocols and guidelines except those generic service provision guidelines.</p> <p>The policy in each health board is different even within the same health board but at different DGH's. PGR noted the work in BCU of securing input from Paediatrics and that it would be helpful for the Royal College of Paediatrics to provide a national steer on this. Self harming is noted as presenting a much bigger issue.</p> <p>It was agreed to</p> <ul style="list-style-type: none"> • To coordinate a position statement on current practise across health boards in Wales. <p>An audit of Tier 4 specialist inpatient eating disorder units has gathered data over 2 years within adult services. This will enable us to assess capacity and demand and outcomes and will meet shortly with CS to assess progress in understanding the data better. CS explained this data will be useful to flag up for inclusion in Health boards IMTPs for 17 – 18.</p>	<p>ALL</p> <p>MJ</p>
<p>CEDN/16 25</p>	<p>Report on outcome measures</p> <p>GMc presented his report on outcome data collated for adult eating</p>	

	<p>disorders since 2011;</p> <ul style="list-style-type: none"> • A number of measures specific for eating disorders are comparable with those that other services use therefore we can compare like for like services with outcomes. • The Tier 3 adult network meeting was held to present the audit data gained from the Intelligent targets which would map what happens at Tier 2 and Tier 3 in terms of assessment and treatment. These standards came from the framework however CAMHS were also required in the framework to collect and collate the same sort of sets of data as in AMHS. CAMHS outcome measures sub group continues to meet in parallel and what would be most useful in a data collection would be the linkages between CAMHS and AMHS on joint outcome measures. <p>All agreed that there is a danger of having too many measures and the need to minimise it to what is most useful.</p> <p>DW asked that ideally we pick a tool which is valid across the full age range, although age will modify what measure is to be used for the child, young person, young adult and the professional.</p> <p>AL leads on the national transition work stream although it is generic, she chairs this WG T4C&YP workstream and is keen to avoid duplication of effort between the two groups and has asked this is fed back to NC and the transition group.</p> <p>It was agreed to</p> <ul style="list-style-type: none"> • Obtain the draft refresh document on eating disorders • Develop joint measures and data collection between CAMHS and AMHS data collection and outcome reporting but this led by the two existing groups. • Establish a national audit with goal based outcomes in CAMHS and AMHS in ED and a proposal for a goal based outcomes • Establish clarity of future audit processes. 	<p>CW</p> <p>SR</p>
CEDN/16 26	<p>Report/update from Eating disorders 'Transition' task and finish group</p> <p>Discussed previously under item CEDN16/24</p>	
CEDN/16 27	<p>Report/update on Perinatal service</p> <p>Chair invited Les Rudd to open discussion on this paper and informed all that Lisa Kinsella is leading it. Les Rudd wanted to thank AL for releasing Lisa to PHW to avoid the loss of momentum around the workstreams and the project.</p> <p>Progress to date was noted following Welsh Government additional new recurrent funding to health boards from Welsh Government for development for community based perinatal services;</p> <ul style="list-style-type: none"> • All health boards have started developing local models • New services focus on early identification and detection of those most at risk • Perinatal community of practice (PCOP) has set (PHW) • Tier 4 specialised pathway group has been re-convened chaired by Carole Bell • Lived experiences from service users is being collated • A visit is planned in line with recommendations in the MBRRACE report on models of best practice in Scotland. 	

	<p>Guidance is sought from the CAMHS/ED network steering group that a quarterly update is placed on the agenda to provide a 'home' and governance for this work. All supported this recommendation and chair advised consolidation of the workstreams.</p> <p>In perinatal terms, on talking of children and adults colleagues talk of the mental health of the mother and impact on the child and not the mental health of the child and so this is about the mental health of the mother which must of course be addressed but it has an impact on but is different to that of the child.</p> <p>The 1000 days programme work must link in to the CAMHS/ED network business but we need to be satisfied that the work on going at the T4C&YP workstream around early years and resilience is linked fully to the network work programme. This can form a strand of work at the September development day.</p> <p>SR explained that Julie Bishop from PHW was providing the link between the T4CYP programme board and the 1000 days programme board.</p> <p>The former Tier 4 pathway group is now re-established under Carole Bell as Chair. Robust data needs to be secured to support any service development proposals, the service is small but it is difficult to obtain any evidence and outcomes for patients. It is not a service in Wales, it is commissioned by WHSSC outside of Wales but we also need to see what the alternatives currently are in Wales e.g. in adult mental health as well as those mother and baby specialist in patient unit admissions, outside of Wales and those in local community mental health services.</p> <p>It was noted that a there is a requirement for a single lead for this Perinatal workstream to be in place and for a single forum to co-ordinate all of the associated work.</p> <p>The CAMHS/ED network has been formally asked by Welsh Government to provide a leadership home for Perinatal service development.</p> <p>It was agreed to: Discuss with the key people outside of meeting to identify a lead and how to provide overall co-ordination.</p>	Chair
CEDN/16 28	<p>Tier 4 Gate keeping responsibilities This referred to gatekeeping of potential inpatient admissions at tier 4 units.</p> <p>Tier 4 planning meeting will enable finalisation of this.</p>	CSH
CEDN/16 29	<p>Report/update of Progress to date on the Proposal for Enhancement of Mental Health Services for Young People in the Youth Justice System in Wales</p> <ul style="list-style-type: none"> • Update from Julie Withecombe stated that the proposal has enabled the setting up of a multi agency group at WG. • Preferred provider identified for attachment training for YJ workers. 	

	<ul style="list-style-type: none"> JD's being prepared for associated new posts. 	
CEDN/16 30	<p>Progress on CAMHS waiting times from stats Wales</p> <p>There is a need to establish an idea on current waiting times. A late paper was received.</p> <p>It was agreed to</p> <ul style="list-style-type: none"> To re circulate to all members but requires further in depth. Chair asked SR to include this on as a 'slot' at the forthcoming clinical leads meeting and included in September development meeting for discussion, overall brief verbal summary across health boards is as follows: <p>BCU ; numbers are dropping quite significantly Hywel Dda ; hardly any waits Powys ; hardly any waits ABM ; fairly static ABHB ;dropping Cwm Taff ; increasing</p> <p>SR – the data that goes on to stats Wales is what health boards self submit and it is what will go into the ministerial briefings. Stats Wales provide a 'combined' report to include neurodevelopmental and ASD assessments.</p> <p>Data quality and validation of data needs to be progressed at a health board level.</p>	SE SR
CEDN/16 31	<p>Update on progress re the development of a performance and outcome measure framework for CAMHS/ED Network and 'CAREMORE' performance indicators</p> <p>GJ tabled a paper that highlighted the current CAREMORE data requirements. Currently three different organisations looking at data collection of CAMHS. The new data analyst post will support this work. The post will examine data quality and validation of data. It is the responsibility of health boards to secure and upload their own CAMHS data. It was noted that in terms of framework, duplication of data is to be avoided. It will also link in to the NHS Benchmark exercise across the UK.</p>	
CEDN/16 32	<p>To consider key performance issues relating to service quality and outcomes in:</p> <p>Eating disorder services and Tier 4 to be considered and using the CAREMORE formula to describe pathways and models makes it clear what young people can expect from CAMHS.</p>	
CEDN/16 33	<p>Proposal for an All Wales CAMHS audit day</p> <p>CW presented the proposal for an annual audit day and cycle in CAMHS working with DW. His suggestion is to audit several fields of data including implementation of the CAPPA model across Wales and to set a date for January All agreed that the day is one of sharing of best practice and innovation in services.</p> <p>It was agreed to:</p> <ul style="list-style-type: none"> Identify a date in January Utilise the September date for the purpose of the developmental day. 	SE/CW
CEDN/16 34	<p>Actions:</p> <p>See Action Log</p>	

	DATE OF NEXT MEETING: The next meeting of the CAMHS/ED Network Steering Group will take place on 6 th September, 13:30-16.30, Bowel Screening Wales	
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COLLABORATIVE NATIONAL FRAMEWORK FOR CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) - LOW SECURE & ACUTE NON-NHS WALES HOSPITAL SERVICES

Update to 30th August 2016 Evaluation and Selection Report on 18 Month Refresh (w.e.f. 1st October 2016)

1. Outcomes of Remedial Action Plans (RAPs)

As detailed in the 30th August Evaluation and Selection Report presented to the 6th September 2016 CAMHS Network Board after initial quality audits the following Units proposed to be added to the Framework were subject to Remedial Action Plans (RAPs):

- St Andrews Healthcare – 1 new Unit
- Greater Manchester West Mental Health NHS Foundation Trust – 1 Unit
- South West London & St George's Mental Health NHS Trust – 3 Units

Providers were given 10 days to rectify the issues detailed in the RAPs and following telephone conference calls between the Providers and representatives of the NHS Wales Quality Assurance & Improvement Team (QAIT) all Units passed their RAPs and can be added to the Framework.

2. Recommendations & Next Steps

In light of the 30th August 2016 Evaluation and Selection Report and above update the WHSSC Joint Committee is invited to note the CAMHS Network Board's approval of the outcome of the 18 month Refresh and support the next steps below:

1. Executing variation letters and Framework Agreements with all appointed providers.
2. If necessary executing individual Patient Placement Agreements for existing patient placements.
3. The Quality Assurance and Improvement Team continuing to enhance its quality assurance role across all services.
4. Publicising the new arrangements and outcome of the refresh exercise within NHS Wales.

Version	Comment	Date
1.0	Presented to the 27 th September 2016 WHSSC Joint Committee Meeting	21/09/2016