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

WHSSC Joint Committee Meeting held in public
Tuesday 28 March 2017 at 9.30am

Board Room 1, Welsh NHS Confederation, Ty Phoenix, 8 Cathedral Road, Cardiff, CF11 9LJ

Video Conferencing: 51 2121

Agenda

Item	Lead	Paper/ Oral
Preliminary Matters		
1. Welcome, Introductions and Apologies - To open the meeting with any new introductions and record any apologies for the meeting	Chair	Oral
2. Declarations of Interest - Members must declare if they have any personal or business pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for the meeting	Chair	Oral
3. Patient Story - To hear a patient story.	Director of Nursing and Quality Assurance	Pres.
4. Accuracy of Minutes of the Meeting held 17 January 2017 - To **agree** and **ratify** the minutes.	Chair	Att.
5. Action Log and Matters Arising - To **review** the actions for members and consider any matters arising.	Chair	Att.
6. Report from the Chair of the WHSSC Joint Committee - To **receive** the report and consider any issues raised.	Chair	Att.
7. Report from the Acting Managing Director - To **receive** the report and consider any issues raised.	Acting Managing Director, WHSSC	Att.

Item	Lead	Paper/ Oral
Items for Decision and Consideration		
8. WHSSC Integrated Commissioning Plan 2017-20 - To **discuss** **Contact:** - Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Oral
9. Neonatal Intensive Care Unit Medical Workforce Employment Models To **note** the task and finish group recommendation and **approve** that the functions of the alliance model be taken forward **Contact:** - Acting Medical Director – sian.lewis100@wales.nhs.uk	Acting Medical Director, WHSSC	Att.
10. Wales Neonatal Network – Standards 3rd Edition To **note** the revised standards, **support** recommendations **Contact:** - Acting Medical Director – Ian.Langfield@wales.nhs.uk	Acting Director of Planning	Att.
11. Thoracic Surgery - To **receive** the report, **note** the content and **approve** the proposed process for completing the review **Contact:** - Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
12. Neurosciences Strategy - To **note** the overview and **support** the Programme Team initially focusing on the three outlined areas. **Contact:** - Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.

Routine Reports and Items for Information

13. Delivery of the Integrated Commissioning Plan 2016/17 - To **note** **Contact:** Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.
14. Performance Report - To **note** current performance and the action being undertaken to address areas of non-compliance. **Contact:** Acting Director of Planning – Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.

Item	Lead	Paper/ Oral
15. Financial Performance Report - To **receive** the report and consider any specific corrective action to reduce any forecast overspending. **Contact:** Director of Finance – stuart.davies5@wales.nhs.uk	Director of Finance, WHSSC	Att.
16. WHSSC Joint Committee Annual Business Cycle - To **note** **Contact:** Committee Secretary– Kevin.Smith3@wales.nhs.uk	Committee Secretary, WHSSC	Att.
17. Reports from the Joint Sub-committees and Advisory Group Chairs' - To **receive** the report and consider any issues raised. **Sub Committees** **17.1** WHSSC Quality and Patient Safety Committee **17.2** All Wales Individual Patient Funding Request Panel **17.3** Welsh Renal Clinical Network **17.4** WHSSC Management Group **Advisory Groups** **17.5** Wales Neonatal Network Steering Group **17.6** All Wales Posture and Mobility Service Partnership Board	Joint Sub Committee and advisory group Chairs	Att.
Concluding Business		
18. Date of next meeting - 30 May 2017, 09.30am - Health and Care Research Wales, Castlebridge 4, 15 - 19 Cowbridge Road East, Cardiff, CF11 9AB	Chair	Oral

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

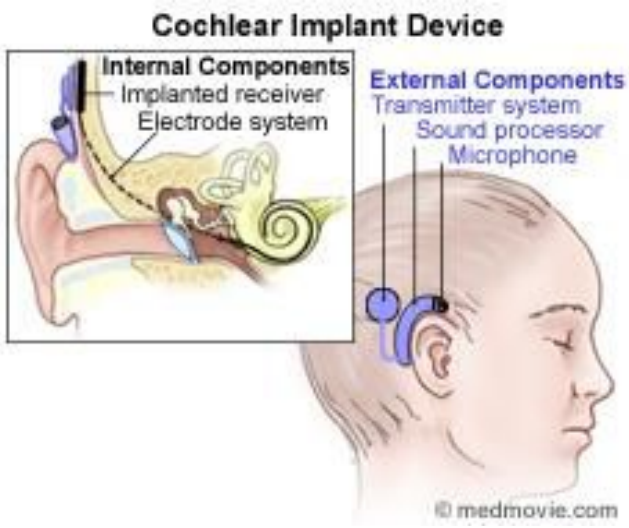
GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

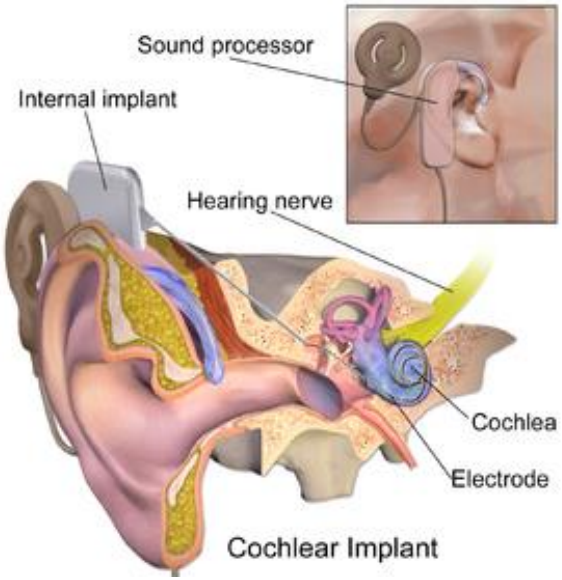
Cochlear Implants

Patient Stories

Joint Committee March 2017

A cochlear implant is an electronic medical device that replaces the function of the damaged inner ear. Unlike hearing aids, which make sounds louder, cochlear implants do the work of damaged parts of the inner ear (cochlea) to provide sound signals to the brain.





Current commissioning

- Services in South Wales - delivered from UHW (Cardiff) and POW (Bridgend)
- Services in North Wales – adult services delivered from Glan Clwyd and paeds from Central Manchester
- Waiting time standard currently 26 weeks for paeds, 52 weeks for adults – additional investment in North and South Wales in 2016/17 to meet this
- Proposal to reduce the waiting time standard to 26 weeks for adults – scored as high clinical risk by CIAG

Jackie’s Story

Elizabeth's Story

Any Questions ?

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

Minutes of the Welsh Health Specialised Services Committee
Meeting of the Joint Committee
held on 17 January 2017, 1.15pm

Conference Room 1 and 2 St Cadoc's Hospital, Lodge Road, Caerleon, Newport NP18 3XQ

4

Members Present

Ann Lloyd	(AL)	Chair
Lyn Meadows	(LM)	Vice Chair
Marcus Longley	(ML)	Independent Member
Chris Turner	(CT)	Independent Member/ Audit Lead
Gary Doherty	(GD)	Chief Executive for Betsi Cadwaladr UHB (via videoconference)
Sharon Hopkins	(SH)	Interim Chief Executive, Cardiff and Vale UHB
Steve Moore	(SM)	Chief Executive, Hywel Dda UHB
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB (item 3 only)
Carol Shillabeer	(CS)	Chief Executive, Powys THB
Allison Williams	(AW)	Chief Executive, Cwm Taf UHB
Stuart Davies	(SD)	Acting Managing Director of Specialised and Tertiary Services Commissioning, WHSSC
Carole Bell	(CB)	Director of Nursing and Quality, WHSSC
Sian Lewis	(SL)	Acting Medical Director, WHSSC

Associate Members

Chris Koehli	(CK)	Interim Chair of Quality and Patient Safety Committee
John Williams	(JW)	Chair of Welsh Renal Clinical Network

Apologies:

Tracey Cooper	(TC)	Tracey Cooper, Chief Executive, Public Health Wales
Steve Ham	(SH)	Chief Executive, Velindre NHS Trust
Paul Roberts	(PR)	Chief Executive, Abertawe Bro Morgannwg UHB

In Attendance

Paul Buss	(PB)	Medical Director, Aneurin Bevan UHB
Sian Harrop-Griffiths	(SHG)	Director of Strategy, Abertawe Bro Morgannwg UHB
Phil Jones	(PJ)	Consultant Physician and Hospital Director of Bronglais Hospital
Ian Langfield	(IL)	Acting Director of Planning, WHSSC
Kevin Smith	(KS)	Committee Secretary and Head of Corporate Services, WHSSC

Minutes:

Juliana Field	(JF)	Corporate Governance Officer, WHSSC

The Meeting opened at **1.20pm**

JC059 **Welcome, Introductions and Apologies**

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

Apologies were received from Paul Roberts and it was noted that Sian Harrop-Griffiths, Director of Strategy, ABMUHB, attended the meeting on his behalf.

JC060 **WHSSC Integrated Commissioning Plan (ICP) 2017-20**

Members received the pre-circulated paper which described the process used to develop the WHSSC 2017-20 ICP, presented recommendations regarding the finalisation of the Plan, submission to Welsh Government by 27 January, and detailed the further work required to submit a final version to the Joint Committee in March 2017 for final approval.

Members received a presentation providing a high-level overview of the key themes from the Plan. A financial reconciliation of the 2017- 20 ICP to the 2016-19 ICP year two assumptions was included, showing that £5.3m of red schemes were catered for within the £23m provision indicated in the 2016-17 ICP base plan. Members were also briefed on the further actions required to ensure approval of the ICP within the required timeline.

The Chair provided an update on recent communications with Welsh Government regarding the constraints presented by the revised timeline for approval of the ICP and LHB Integrated Medium Term Plans (IMTPs). Members were advised that a positive response was received from the Welsh Government, which acknowledged the concerns raised and encouraged best efforts in finalising the ICP in conjunction with development of the IMTPs. The Chair invited members to share their views on the development process and offer suggestions on a more effective co-produced approach of the ICP and IMTPs for future years.

Members discussed the challenges of aligning available funds to the financial assumptions included within the ICP and the anticipated future cost pressures across the healthcare system in Wales. In relation to growth within the ICP it was noted that the majority of this related to existing services and that any innovation was already subjected to a high level of scrutiny. The full year impact of schemes approved during 2016-17 accounted for a relatively small proportion of overall spending.

Regarding the progress on development of a strategy for specialised services and sustainability of services, it was noted that the ICP provided some detail regarding the strategy for specialised services over the next year and that a number of the recent service reviews had been focussed in areas where sustainability had been noted as an issue.

Members also discussed sustainability and risk in the context of the importance of effective horizon scanning.

In response to observations from members, the Chair confirmed the intention to increase the rigor applied to commissioning value for money, focus on sustainability of services and introduce enhanced clinical review.

It was suggested that consideration of whole pathways was desirable to support realisation of benefits across the entire pathway, rather than focusing on specific specialist elements in isolation. The Chair invited LHB members to consider this and suggest suitable pathways for review.

A discussion was held around the role of the proposed Clinical Prioritisation Advisory Group which would review red and amber schemes to provide clinical guidance in relation to mitigation of clinical risk and prioritisation areas for investment.

It was noted that the WHSSC team would be working with LHB Directors of Finance to ensure that the financial assumptions in the 2017-20 ICP were reflected in LHB IMTPs.

Members extended their thanks to the WHSSC Team and the Management Group for their work and commitment in developing the ICP to date.

Members **resolved** to:

- **Receive** assurance regarding the development process which underpinned the 2017-20 ICP;
- **Support** the development of a proposal to increase the staffing within the Quality and Planning Directorates;
- **Support** the further work required to complete a final version of the plan for Joint Committee approval and submission to Welsh Government in March 2017
  - Review timescale for developing and agreeing WHSSC ICP;
  - Establish a Clinical Prioritisation Advisory Group to review Red and Amber schemes;
  - Explore opportunities for aligning existing Health Board Co-production work with ICP;
  - Undertake stakeholder engagement;
  - Discussion with Welsh Government regarding retained funding, WG priorities, and critical tariff assumptions; and
- **Note** the constraints which have prevented completion of the ICP in line with Welsh Government timescale.

JC061 **Clinician's Story**

The Chair welcomed Dr Phil Jones, Consultant Physician and Hospital Director of Bronglais Hospital, to the meeting. PJ presented an overview of the spinal and Neuro-rehabilitation services offering a clinician's perspective on both the service and patient experience.

PJ presented cases from both the past (1987) and present day (2014)

noting the ways in which the services had developed positively over the years. In the more recent example, the initial care given to the patient was exemplary. However, the issues arose during the follow up phase and specifically within the neuro-rehablitation service where there were significant delays in trying to arrange a preliminary assessment for the patient. In this specific case there was third party funding availability and it was this which enabled an assessment to be undertaken in a more timely fashion. PJ provided a detailed overview of the process outlining the difficulties including (1) the family having to travel across Wales from the west to Cardiff and Bristol, and (2) repatriating the patient to a local service due to the lack of facilities and qualified professionals

It was noted that despite the progress made within neuro-services, there appeared to have been a focus on the 'front-end' of the service. It was important to ensure that there was integration between acute services, specialist rehabilitation, step down rehabilitation, specialist support and support for the family.

PJ noted that he felt that there was a need to look at a quality of life perspective and to view the pathway as a whole rather than just the initial phase of treatment.

Members acknowledged the difficulties recognising elements which underpinned the rationale for undertaking a review of the neurosciences services in Wales.

A discussion was held regarding the clinical benefits and outcomes, how to measure value for patients, prioritisation of services from limited finances, limited opportunity for generating evidence of the longer term outcomes for patients and understanding patient and relatives' expectations.

Members extended their thanks to PJ for his interesting and insightful presentation.

JC062 **Declarations of Interest**
There were no declarations to note.

JC063 **Accuracy of Minutes of the meetings held 22 November 2016**
Members approved the minutes of the meeting held on 22 November 2016 as a true and accurate record.

JC064 **Action Log and Matters Arising**

Action Log
Members reviewed the action log and noted the updates provided.

JC018- KS explained that this matter had been dealt with and was now closed.

Matters Arising
There were no matters arising.

JC065 **Report from the Chair of WHSSC**
Members received the report which provided an update of the issues considered by the Chair since the last report to Joint Committee.

Members noted that the Chair was due to meet with the Cabinet Secretary and would be discussing a number of key issues including PET scans, Neuroendocrine Tumours (NET) services, Transgender services, Thoracic surgery services, Neonatal services, sickle cell anaemia, review of high risk services, governance arrangements for WHSSC, WHSSC resources and the Integrated Commissioning Plan 2017-20.

The Chair extended her thanks to Maria Battle, Chair of Cardiff and Vale University Health Board and Carole Bell for their support in achieving a positive outcome in regard to the work relating to the NET service.

JC066 **Report from the Acting Managing Director of WHSSC**
Members received the report which provided an update on key issues that have arisen since the last meeting. The following areas were highlighted to note.

Medical Directorate Structure
Members noted that a review of the WHSSC Medical Directorate Structure had been undertaken with the objective of enhancing the clinical leadership within the organisation. A detailed report was included in the meeting papers for information.

Left Ventricular Assist Devices (LVADs)
Members noted that the Management Group approved the English Commissioning Policy and Service Specification for LVADs as an interim position.

Neuroendocrine Tumours (NET)
An update was received on the action taken since funding had been approved to implement the initial development of a NET service for south Wales. Members offered their support to the group which had been established to monitor the first phase of the service, and to the WHSSC team, recognising the sensitivities around this service.

JC067 **Neonatal Intensive Care Unit (NICU) - Medical Workforce Update**
Members received an update on the NICU medical workforce position, which included progress on the BAPIO supported recruitment process, the current risk log, a description of the employment models that had been considered by the Workforce Task and Finish Group, and draft contingency and escalation plans for south Wales.

Members noted that the current vacancy position across all three NICUs was positive and provided a good position as work moved forward.

Members were provided with an overview of the employment model as detailed in section 3.4 of the report and noted that detail regarding the preferred alliance model would be presented at the WHSSC Joint Committee meeting in March 2017.

Members were asked to support a proposal to maintain the neonatal network leadership of the task and finish group through a temporary governance arrangement between the WHSSC and the NHS Wales Collaborative. AW suggested that SL might want to consider putting into place a memorandum of understanding between WHSSC and the Collaborative to record the temporary governance structure.

A question was raised regarding availability of the higher level qualification for MTIs within Wales. It was noted that whilst a qualification was already available, there was currently no curriculum specific to Wales; however it was believed that there was an appetite for this happen.

Members **resolved** to:

- **Receive assurance** that the predicted workforce for March 2017 will deliver a sustainable model across the three Neonatal Intensive Care units in South Wales;
- **Support** maintaining the neonatal network leadership of the task and finish group through a temporary governance arrangement between the Welsh Health Specialised Services Committee and the NHS Wales Collaborative;
- **Note** that a comprehensive workforce model with supporting governance arrangements will be presented to the March Joint Committee meeting; and
- **Note** the draft escalation and continuity plan for completion by the March 2017 Joint Committee.

JC068 **Neurosciences Commissioning Plan**

Members received a paper which outlined the proposed process for developing the neuro-radiology element of the Neurosciences Commissioning Plan and provided an update on the development of the five year commissioning plan for Neurosciences.

Members were provided with an overview of the key issues relating to each service area detailed within the report. A discussion was held around the development of a model of care for the whole system neurosciences plan and that concerns had previously been noted regarding the risk of further requirements for piecemeal investment and a preference was voiced that, if required, additional funding should be used to support the team to complete the review and revise the system accordingly, rather than investing on an

ad hoc basis until the review process was complete. It was noted that the review remained on schedule; however the review element of the process may run beyond March 2017.

Members suggested sources other than a Royal College of Radiologists Invited Review that might be considered to provide expert external advice and support to the Neuro-radiology element of the Plan.

Clarity was sought in relation to the paragraph provided at the bottom of page two which suggested that despite being recorded as complete, some of the recommendations from the previous strategic review of neurosciences had not been completed. It was suggested that it may have been the case that following the review, the recommendations were implemented then later reversed as services moved forward. Members agreed that this should be further explored by the WHSSC team and clarity provided.

[**Secretary's Note regarding previous paragraph:** The main recommendation that had been deemed as successfully implemented in update reports since the Axford Review, that of "urgently establishing a single neuro-surgical service, with all emergency and intra-cranial activity being undertaken at the University Hospital…" was accepted to have not been fully implemented as, whilst a transfer of services took place, two of the neurosurgeons had not transferred to UHW, and now undertook spinal surgery as part of the Health Board's spinal surgery service at Morriston Hospital. Further work is required to clarify the pathways for patients from ABMUHB and HDUHB requiring non elective spinal surgery. *(Note the information in this paragraph was provided within the report but not explicitly discussed at the meeting and is provided for clarification)*]

Members noted their disappointment that Public Health Wales (PHW) was unable to support WHSSC by the provision of Healthcare Needs Assessments. Members agreed this was unacceptable and noted that the Chair had formally raised this with the Acting Chair at PHW and that WHSSC had since terminated its Service Level Agreement (SLA) with PHW and was looking toward other means of replacing the relevant support.

Members **resolved** to:

- **Support** the proposal to commission expert external advice and support to the Neuro-radiology element of the Plan via the Royal College of Radiology's service review process or an alternative source; and
- **Note** the update on the five year Commissioning Plan for Specialised Neurosciences.

JC069 **Risk Sharing Review Update**

Members received a report providing an update on progress of the Risk Sharing Review and the validation previously requested.

SD provided a high level overview of the technical elements of the process and assurance was received that all of the concerns of Health Boards had been taken through the Finance Working Group and were fully reflected in the paper.

Members acknowledged previous discussions on the points of principle agreed and delegation of work to the Finance Working Group which reported directly into the All Wales NHS Directors of Finance Group.

A discussion was held which provided clarity regarding the available options and the need to ensure that there was a flexible rather than rigid process in place. It was recommended for the purposes of financial planning that (1) 2011-12 was to be used as the base year, and (2) LHBs consider providing for a third of the pooling adjustment (as previously advised), as whilst there were some areas outstanding for validation, this was coherent with the direction of travel that LHBs were experiencing.

It was agreed that the WHSSC team would resolve the remaining technical details and implementation options with the Finance Working Group for implementation by Health Board Directors of Finance, to evaluate the task to be concluded.

Members **resolved** to:

- **Support** the following recommendations for approval by the Joint Committee;
- **Receive assurance** that there are robust processes in place to ensure delivery of the Risk Sharing Review; and
- **Note** the information presented within the report.

JC070 **Delivery of the Integrated Commissioning Plan 2016-17**

Members received a paper which provided an update on the delivery of the Integrated Commissioning Plan for Specialised Services 2016-17 at the end of November 2016, including the Funding Release Schedule, Progress against the Work Plan, and Risk Management Summary.

Members **resolved** to:

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

JC071 **Performance Dashboard**

Members received an overview of the performance dashboard for October 2016.

Members noted that there had been an overall deterioration in performance, with winter pressures impacting on the delivery of services from tertiary providers.

The content of the report was reviewed and it was suggested that a greater level of information around patient outcome and quality assurance should be included; it was anticipated that this would be possible following the establishment of a Quality Assurance team within WHSSC.

Members discussed the referral to treatment performance; assurance was provided that accountability sat with providers for performance and financial issues.

Members **resolved** to:

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

JC072 **Financial Performance Report**

Members received an overview of the Financial Performance Report which set out the estimated financial position for WHSSC for the eighth month of 2016/17.

Members noted that the movement from the previous month was a deterioration of £450k to date and a forecast deterioration of £948k for year-end. The movement was due to various adverse provisions against the CVUHB and ABMUHB and NHS England contracts, versus a favourable release of Development budget.

Members noted that the month 9 position was positive and showed improvement with an anticipated £3.7m year-end underspend.

Members **resolved** to:

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

JC073 **Medical Leadership Proposals**

Members received the report which presented the planned model of medical leadership in WHSSC which was designed to address the recommendations of the Good Governance Institute and Healthcare Inspectorate Wales Reviews.

Members noted that there was a focus on increasing clinical drive within WHSSC. A discussion was held around the way in which the LHBs could encourage clinical staff to apply for the roles and support them in undertaking the roles.

Members **resolved** to:

- **Note** the planned model of medical leadership within WHSSC.

JC074 **Reports from the Joint Sub-committees and Advisory Group Chairs'**

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

Sub Committees
WHSSC Quality and Patient Safety Committee
Members noted the update from the meeting held 28 November 2016

All Wales Individual Patient Funding Request Panel
Members noted the update from the meeting held 14 December 2016

Welsh Renal Clinical Network
Members noted the update from the meeting held 2 December 2016

It was noted that Health Boards had an open invitation to the Network Board Meeting and at present there was limited Health Board representation at the meetings; members were asked to encourage appropriate staff to attend.

Members noted the Chronic Kidney Disease (CKD) WRCN view and approach which had been provided along with the report.

WHSSC Management Group
Members noted the update from the meetings held 24 November 2016 and 15 December 2016.

Members noted that the terms of reference for the Management Group would be reviewed as part of the wider culture review of WHSSC.

It was noted that concerns had been raised around performance within Bariatric services and that over the next quarter work would be carried out to review provider arrangements for the service to ensure the service was protected.

Advisory Groups
Wales Neonatal Network Steering Group
Members noted the update from the meeting held 8 November 2016

All Wales Gender Dysphoria Partnership Board
Members noted the update from the meeting held 3 January 2017.

Members noted that the revised terms of reference would be brought to the Joint Committee for approval.

Members were asked to and supported the recommendation that the name of the Gender Dysphoria Partnership Board be changed, with immediate effect, to NHS Wales Gender Identity Partnership Group.

JC075 **Date and Time of Next Meeting**
It was confirmed that the next meeting of the Joint Committee would be held on 28 March 2017.

The public meeting concluded at approximately 15.20pm

Chair's Signature: ……

Date: ……

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

2016/17 Action Log
Joint Committee Meeting

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
22.03.16	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 – there continues to be difficulty progressing this work due to staffing constraints. Efforts are being made to identify an additional resource to support this work. 22.11.2016 - Noted process for early stakeholder engagement and further discussions held regarding capacity and process. **17.01.2017** - Update provided in Acting Managing Directors Report - Action Completed	CLOSED

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
22.03.16	JC002	**WHSSC15/82 – Risk Sharing Review** SD agreed to lead the work with the Directors of Finance to work through the consequences of the proposal from BCUHB to consider how in year risks are shared.	Director of Finance	April 2016	Action Completed	CLOSED
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 – Paper to Be presented at November 2016 Joint Committee **22.11.2016 – Agenda Item 12** – Action Completed	CLOSED

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 – Paper to Be presented at November 2016 Joint Committee **22.11.2016 – Agenda Item 12** – Action Completed	CLOSED
22.03.16	JC005	**WHSSC15/33 – Integrated Commissioning Plan 2016-19** To discuss the high risk amber schemes with Welsh Government in terms of additional sources of funding;	Acting Managing Director	April 2016	Completed	CLOSED
22.03.16	JC006	**WHSSC15/33 – Integrated Commissioning Plan 2016-19** Write to the Management Group for their work in the development of the ICP	Chair	April 2016	Letter sent to Members.	CLOSED
22.03.16	JC007	**WHSSC15/87 – Emergency Medical Retrieval Service** To write to the Chief Ambulance Commissioner confirming the agreed commissioning responsibility from April 2016.	Acting Director of Planning	April 2016	Letter sent to Chief Ambulance Commissioner confirming the transfer.	CLOSED

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
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	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
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

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
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. 22.11.2016 – Queries were raised in England around legalities of transferring responsibility. These being reviewed for Wales. WHSSC have liaised with the WG and have standard ToR and contract and agreed with WG MOU setting out responsibilities. Action Completed	CLOSED
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	Completed	CLOSED
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

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
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
27.09.16	JC015	**JC026 - Action Log and Matters Arising** Risk Sharing Review: Chair to speak with Welsh Government regarding an escalation process for Risk Sharing.	Chair	Nov 2016	**22.11.2016 – Agenda Item 12** – Action Completed	

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
27.09.16	JC016	**JC031 - Development of the ICP 2017/20 including Commissioning Intentions** WHSSC to provide members with an update following the work being carried out with Aneurin Bevan University Health Board around identifying specialised elements within care pathways.	Acting Director of Planning	Nov 2016	22.11.2016 – Work is progressing through the ICP and a list of candidate schemes had been circulated. Action Completed	CLOSED
27.09.16	JC017	**JC032 Thoracic Surgery Review** WHSSC to provide a briefing for Joint Committee Members once confirmation of a resolution had been received from CVUHB and ABMUHB in relation to on-call arrangements for Thoracic Surgery.	Acting Medical Director	Nov 2016	Verbal update to be provided at November 2016 Meeting. 22.11.206 – Members noted the update and received a confidential report at the 'In Committee' session. Action Completed	CLOSED

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
22.11.2016	JC018	**JC048 Non- Financial Outcome for Gender Identity Services Care Pathway in Wales Neonatal Workforce Group Update** WHSSC Chair to write to Cluster Chairs to present feedback received from the gender stakeholder event in relation to the use of inappropriate language.	Chair	Dec 2016	17.01.2017 – KS informed members that this matter had now been dealt with and could be closed. Action Completed	CLOSED
22.11.2016	JC019	**JC049 - Neonatal Workforce** Details of the Neonatal Workforce analysis to be circulated to members.	Acting Medical Director	Dec 2016	Information circulated to members 19 December 2016	CLOSED
22.11.2016	JC020	**JC055 - Financial Performance Report** Next iteration of the finance performance report to provide additional detail regarding 'other sundry income' and the recurrent and non-recurrent position.	Director of Finance	Jan 2017	Update report received	CLOSED

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

		Agenda Item	6
Meeting Title	**Joint Committee**	Meeting Date	28/03/2017
Report Title	Report from the Chair of the WHSSC Joint Committee		
Author (Job title)	Committee Secretary		
Executive Lead (Job title)	Chair	Public / In Committee	Public

6

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

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☒	☐	☐	☐	☒

Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the contents of the report; and • **Ratify** the Chair's action referred to in the report.		

Considerations within the report (tick as appropriate)

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

1.0 Situation

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

2.0 Background

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

3.0 Assessment

3.1 **Meeting with Cabinet Secretary**
I met with the Cabinet Secretary on 19 January. Amongst other things we discussed performance issues on Bariatric and Plastic Surgery, PET scans and the Thoracic Surgery Review.

3.2 **Welsh NHS Confederation Annual Conference**
I attended the NHS Confederation Annual Conference on 1 February, at which a variety of interesting presentations were delivered.

3.3 **Chairs' Meeting with Cabinet Secretary – IMTP follow up**
I attended a further meeting with the Cabinet Secretary, together with the Health Board Chairs and/or Vice Chairs, on 15 February. The importance of LHBs submitting balanced IMTPs on a timely basis and including the cost of specialised services from the WHSSC Integrated Commissioning Plan was stressed.

3.4 **Attendance at Health Board Meetings**
Stuart Davies and I attended AMBUHB's Board Meeting on 16 February, the first of this year's cycle of Health Board meetings that we will be attending. We are due to visit ABUHB on 22 March and CVUHB on 30 March.

3.5 **All Wales Chairs Meeting**
I attended the All Wales Chairs Meeting on 21 February and 20 March 2017.

3.5 **Expert Seminar – Governance in Public Service 'Doing it right, doing it better'**
I attended the Academi Wales and Welsh NHS Confederation seminar on 13 March, which brought together senior colleagues from both NHS Wales and the wider public sector with a common interest in the governance of health and social services in Wales.

3.6 **Integrated Commissioning Plan & IMTPs**
The latest iteration of the WHSSC Integrated Commissioning Plan is an agenda item for this meeting. Members will be well aware of the pressure that Health Boards are under to complete and approve the WHSSC ICP and their own IMTPs.

3.7 **Chair's Action**

I wrote to the Joint Committee on 3 March (letter appended) regarding the universal screening of blood products for Hepatitis E Virus (HEV) and, in accordance with the WHSSC Standing Orders, urgent action was taken on 10 March 2017, in consultation with Stuart Davies, Acting Managing Director, and Lyn Meadows, Vice Chair.

You are asked to ratify this Chair's action.

4.0 **Recommendations**

Members are asked to:

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

5.0 **Appendices/ Annex**

The letter dated 3 March 2017 outlining the Chair's action is appended to this report.

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

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

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

		Agenda Item	7
Meeting Title	**Joint Committee**	Meeting Date	28/03/2017
Report Title	Report from the Acting Managing Director		
Author (Job title)	Acting Managing Director, Specialised And Tertiary Services Commissioning, NHS Wales		
Executive Lead (Job title)	Acting Managing Director, Specialised And Tertiary Services Commissioning	Public / In Committee	Public

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

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

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

Considerations within the report (tick as appropriate)

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

1.0 Situation

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

2.0 Updates

2.1 **Medical Directorate Structure**
A number of good quality candidates have applied for the advertised AMD roles. The recruitment process continues with some interviews scheduled for later this month.

2.2 **Collective Commissioning – (1) Inherited Bleeding Disorders (IBD), (2) Endoscopic Mucosal Resection (EMR) and Radio Frequency Ablation (RFA) for Oesophageal Cancer**
At its January meeting, Management Group received three papers that set out to highlight the quality, equity and sustainability issues affecting the IBD service and EMR/ RFA treatment for oesophageal cancer that require a collective commissioning approach; and a proposal that funding for the additional member of staff required for this work is provided from some of the savings that are expected from improved prices for blood products.

After lengthy discussion (1) the decision to support the implementation of the Management Group decision in 2015 to transfer resources to WHSSC to bring the IBD service under a single commissioner, within the WHSSC workplan for 2017-18, was unanimously deferred; (2) the decision regarding the proposal that WHSSC takes on full commissioning responsibility to scope and develop a commissioning strategy for EMR/ RFA for oesophageal cancer failed to receive sufficient support to proceed; and (3) the proposal to fund an additional member of staff from anticipated cost savings, for a fixed period, required for these two schemes failed to receive support.

I subsequently wrote to LHB Chief Executives to advise them that responsibility for these services lies with UHBs as a result of these decisions.

2.3 **Funding Release: Bone Anchored Hearing Aids (BAHA) and Cochlear growth South Wales**
Management Group received a paper requesting approval for a funding release of £500k for 2016-17 to meet existing waiting time standards and maintenance requirements for cochlear implants and BAHA in South Wales. The Group approved the funding release by majority decision.

2.4 **NHS England consultation – Congenital Heart Disease (CHD)**
Management Group received a paper summarising the consultation that had commenced in England regarding the implementation of standards for CHD services for children and adults in England and the potential impact for patients from Wales accessing those services. Minimal impact was

anticipated for patients from Wales but interventional cardiology and surgery services currently sourced for adults from Central Manchester University Hospital were proposed to transfer to Liverpool Heart and Chest Hospital.

2.5 **Individual Patient Funding Requests: Independent Review**
The report arising from the Independent Review requested by the Cabinet Secretary was published in January. We are awaiting the Cabinet Secretary's response but an All Wales workshop has been arranged for 22 March to consider the recommendations.

2.6 **Risk Sharing Arrangements**
Since the last Joint Committee meeting, the Finance Working Group has met to progress matters and Directors of Finance (or their nominees) have considered the outstanding issues further. A summary of these issues and a plan to resolve them is being prepared and will be shared with Directors of Finance and Joint Committee.

2.7 **Neurosciences**
A further update on the Neurosciences review is included in the meeting papers.

2.8 **Thoracic Surgery**
An update on the Thoracic Surgery Review is included in the meeting papers, which incorporates the RCS report and the service specification.

2.9 **Integrated Commissioning Plan 2017-20 (ICP)**
Work has continued on the ICP since January, including a clinical prioritisation review and further Management Group workshops.

The latest version of the ICP is included within the meeting pack.

3.0 Recommendations

3.1 Members are asked to:

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

4.0 Annexes and Appendices

4.1 There are no annexes or appendices to this report

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

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

7

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

		Agenda Item	9
Meeting Title	**Joint Committee**	Meeting Date	28/03/2017
Report Title	Neonatal Intensive Care Unit Medical Workforce Employment Models		
Author (Job title)	Acting Medical Director WHSSC Neonatal Network Manager		
Executive Lead (Job title)	Acting Medical Director	Public / In Committee	Public

Purpose	The purpose of this paper is to provide the Joint Committee with an option appraisal of the potential employment models to support a sustainable neonatal medical workforce across South Wales and to describe the governance arrangements required for such models.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☒	☐	☐	☐

Sub Group /Committee		Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the Task and Finish Group reaffirming their recommendation that an Alliance workforce model is best suited to managing Neonatal workforce issues • **Approve** that the functions of the Alliance model be taken forward by the South Central Alliance Neonatal Task and Finish Group, with revised terms of reference and membership		

Considerations within the report (tick as appropriate)

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

9

1.0 Situation

1.1 In September 2016 the Joint Committee supported the recommendation that Wales Deanery trainees be located in the Singleton and University Hospital of Wales Neonatal Intensive Care Units (NICUs) from March 2017, leaving the Royal Gwent NICU without post graduate trainees.

1.2 This was with the expectation that the three units worked together as a unified team to deliver a sustainable workforce model and that work continued to identify how this is best achieved.

1.3 In November 2016 the Neonatal Task and Finish Group made a recommendation to the Committee that the most effective employment model to support a sustainable neonatal workforce was an Alliance Employment model. The Committee requested more detail on the employment model, specifically the rationale behind the decision making and the governance framework.

1.4 In January 2017 a further paper was taken to Committee to provide them with reassurance that the March 2017 workforce position was sustainable across the three sites. This included an updated risk assessment.

1.5 The Committee also requested a comprehensive workforce model be provided at the March 2017 meeting that includes supporting governance arrangements.

2.0 Background

2.1 The expectation that all three units in South Wales work together to ensure sustainable high quality services are maintained in South Wales was the driver for changing the existing workforce employment model.

2.2 Through the workforce planning process the Neonatal Task and Finish group identified a number of key enablers to deliver both the short term solutions required and the longer term strategic workforce plan. They were as follows:

- A commitment to collaborative working
- Joint and coordinated recruitment planning
- Dedicated HR resource
- Exploring a more integrated approach for future workforce planning to increase resilience in the service
- An equitable approach to managing risk across South Wales.

2.3 The group subsequently recommended the adoption of an Alliance Employment model. This recommendation was made following an evaluation of the following three options:

- Status Quo
- A Lead Employer model
- An Alliance Employer model.

2.4 Following on from the recommendation made to the Committee in November 2017, the Task and Finish Group revisited their recommendation to ensure that a full and thorough assessment had been undertaken of all options and discussed how the recommended model would be implemented. This paper will seek to provide the Committee with a descriptor of each model, identify the benefits and disadvantages, and outline how each of these options performed against key acceptance criteria and also provides an implementation framework for the recommended model.

3.0 Assessment

3.1 Option 1 - Current model

The current service employment model in place for the three NICUs is one where both management and professional accountability is held within each provider organisation. Health Boards are primarily the employer, with the exception of Wales Deanery trainees. They are responsible for contracts of employment and managing terms and conditions for their employees.

There is limited inter-organisational mobility in neonatology, aside from Deanery rotations.

Each individual Health Board develops its own workforce plans and oversees its implementation in isolation, with locally managed recruitment. Some collaboration takes place if for example, should surplus candidates be interviewed for a post; they can be signposted to another organisation.

Within the current model, Health Boards are responsible for service delivery, compliance with standards, identifying temporary staff and commissioning Special Care services on behalf of their local population.

3.2 Benefits / disadvantages

There are many benefits with the current Health Board centred workforce model. There is a local focus on services, solutions are understood, relationships are built and contractual arrangements are clear. This model provides a local solution for a local problem.

However, neonatal services, and specifically the intensive care element of the service is no longer viewed as a local service. The sustainability of the three NICUs has been agreed by Welsh Government, through the South Wales Programme and the Chief Executives at the start of this programme of work.

The model of single Health Board planning has not been successful in developing the suitably skilled robust workforce required for high quality care. High levels of vacancies were documented in the BLISS Baby Report 2016: Time for Change. There is little shared understanding of risk and a competitive workforce market has led to inconsistent pay rates and different

contractual obligations. Governance arrangements to support collaborative working are not evident.

3.3 Based on this information the option of maintaining the current model was immediately discounted.

3.4 **Option 2 - Lead Employer Model**
A lead employer model is described as a model where the whole Neonatal Intensive Care service is managed by one Health Board or Shared Service with stakeholder representation from Health Boards. This therefore represents a fundamental change of current employee's terms and conditions of employment.

3.5 **Governance and accountability**
As a single provider the host organisation would need to be accountable to a specialist commissioner. The commissioner would manage financial and operational performance against a pre-agreed service specification / contract. Clinical accountability would be two-fold as follows:

- Nominated on site named clinician would hold clinical responsibility for service delivery
- Wider clinical accountability may need to be delivered through an enhanced network.

3.6 This model would require a management team to be responsible for operational management of the service on behalf of the host.

3.7 **Responsibilities**
The Lead employer would be responsible for:

- The employment including recruitment, management and training of all staff dedicated to the service Developing the Integrated Medium Term Plans (IMTP) along with the operational work plans
- Delivering the agreed financial plan
- Instigate service change, improvement and reconfiguration
- Meeting the All Wales Neonatal Standards

3.8 The individual Health Board would retain responsibility for:

- Commissioning special care services on behalf of the local population
- Performance managing pre-defined service specifications / standards.

3.9 **Benefits and disadvantages**
The benefits of implementing a lead employer model in NICU services are identified as:

- Comparable workforce terms and conditions for identified staff groups
- Development of 'own brand' in the longer term
- Increased staff flexibility where geography permits
- Enhanced training opportunities across more than one unit
- Removal of barriers that prevent full potential of Health Board collaboration
- Single HR input and reduced inconsistencies.

The disadvantages are identified as:

- Highly complex contractual arrangements would be required for a single lead employer to provide services in multiple UHBs. There is limited legal precedent for lead provider models in Wales where the organisation is required to cost services in multiple other locations.
- There would also be associated overheads that would need to be agreed to cover the other providers embedded costs.
- Recruitment and retention of staff because of uncertainty regarding work location.
- Lack of flexibility within Health Boards to utilise staff between services e.g. paediatrics and neonatology.
- Excessive timescales for transfer to a lead employer. Staff consultation required. This could be a potential issue in light of the progression of the South Wales Programme, causing confusion.
- Difficulty in disaggregating local and tertiary commissioned staff resource.
- Potential to drive professional rather than organisational allegiance, this could lead to a loss of departmental loyalty and flexibility to cover unpredictable workforce shortfalls across multiple sites.
- Would still require the development of network relationships between a single employer and Health Boards.
- Potential to reduce multi-disciplinary team working without re-establishing good networks.
- There will be a considerable financial commitment required to facilitate the consultation process and structural changes required.

In addition to these risks identified by the Workforce Task and Finish Group as a whole, there were specific concerns expressed by clinical colleagues on the group. They were summarised as:

- Recruitment needs to be flexible and responsive enough to meet local need.
- Could have a negative impact on recruitment and retention of staff. Medical staff like to have a single base. Structured rotation could work well through formal collaboration without the need to change the employment model. Logistical difficulties will be an issue, particularly for overseas recruitment. Health Boards need the freedom to use different models of delivering compliant rotas. A lead employer model would be unable to undertake the same level of innovative working, as it will need to balance the views of many Health Boards.
- A lead employer would not be able to accommodate the level of variance needed to provide a bespoke service model. Individual units need the flexibility to design its rota in line with local need. This flexibility would potentially be lost with a lead employer.

3.10 **Option 3 - Alliance employment model**

An alliance employment model allows formal employment arrangements to remain with the current Health Boards. This model facilitates collaboration between Health Boards on specific areas pertinent to service sustainability,

for example, workforce planning, joint recruitment, training and development and potential joint temporary staffing arrangements. This will provide greater flexibility in respect of resource utilisation but would require a formal agreement on how arrangements would work across the three Health Boards that deliver neonatal intensive care services.

Contractual mechanisms to enable workforce mobility through mutual consent i.e. honorary contracts, facilitated by developing a single work plan that facilitates shared recruitment and planning for targeted high risk staff groups.

3.11 **Governance and accountability**

Organisations would continue to adhere to local governance and accountability arrangements, with the exception of the workforce and service planning which would be the responsibility of an Alliance Management Group.

This group would require membership from Health Boards and professional leads and hold a central co-ordination function with a mandate to undertake the required functions of an Alliance.

3.12 **Responsibilities**

The Alliance Management Group would have the responsibility to:

- Manage escalation of HR across South Wales, including managing contingencies.
- Coordinate an overarching response to workforce issues across the three NICUs on behalf of the Health Boards.
- Facilitate joint recruitment events for medical and nursing staff in collaboration with Health Boards.
- Facilitate joint delivery of training and development plans to comply with professional standards.
- Ensure that IMTPs, workforce plans, educational commissioning numbers, operational work plans are coordinated and reflect the All Wales Neonatal Standards.
- Ensure the plans reflect the opinions gained from patients, clinical guidelines, government initiatives and directives.
- Coordinate relevant staff groups to discuss developments in the service, ensuring benefits are realised.
- Developing a workforce strategy to deliver a coordinate temporary staffing function across the network in collaboration with the All Wales Temporary Staffing Group.
-

Individual Health Boards will remain responsible for:

- Service delivery and compliance with the All Wales Neonatal Standards.
- Employment of staff (except trainees).
- Participating in the joint recruitment of staff.

- Delivery of training and development plans to comply with professional standards.
- Developing local IMTP, workforce plans.
- Collaborating with other Health Boards on workforce planning through formal arrangements.
- Delivering agreed financial plan.

3.13 **Benefits and disadvantages**

The benefits of an alliance model were identified as:

- Improved formal mechanisms of operational management and escalation of HR / workforce issues across South Wales.
- Coordinated workforce planning, understanding as a collaborative the workforce requirements to deliver a sustainable service in all three NICUs, as demonstrated by the work of the Workforce Task and Finish Group.
- Identify and manage risk as a collaborative.
- Equity of service provision and compliance with the workforce requirements identified in the All Wales Neonatal Standards.
- Voluntary and contracted arrangements improving staff flexibility.
- Coordination of education programmes, for example developing a curriculum for MTI training, ensuring that Wales stands out as providing excellent training opportunities.
- Clinical view was that this model would be most acceptable to staff currently in post.
- Joint recruitment and collaborative working can be successful without the need for a lead employer.
  There should be a mandate to formally manage collaboration whilst allowing Health Boards the freedom to try different ways of working.

The disadvantages were identified as:

- Multiple HR systems input with potential for inconsistency.
- No current system in place to manage such an alliance. Development of skills and capacity would be required.

3.14 **Option Appraisal**

The Task and Finish Group discussed the three options identified and appraised them against key acceptance criteria. These criteria are:

- Strategic fit
- Workforce flexibility
- Quality and regional oversight
- Sustainability
- Degree of collaboration
- Ease of implementation.

The Group is made up of both clinical and managerial and HR Health Board staff, the Neonatal Network and representatives from Welsh Health Specialised Service Committee, and had the remit to act on behalf of their Health Boards.

A stated previously the preferred option recommended to the Joint Committee is to adopt an Alliance Employment model.

This is recommendation is made predominantly based on the following advantages:

- This model maximises the opportunity for collaboration, whilst maintaining local clinical governance and professional accountability
- Builds on the work already underway to establish new innovative workforce models.
- Will minimise cost and time to implement improved, more sustainable workforce and wider service models, and will be a natural progression from the work of the Task and Finish Group.

In making this recommendation the Task and Finish Group has recognised that maintaining the status quo is not a sustainable option, due to the recognised workforce challenges. The rising demands of the service and the competitive workforce market required Wales to be planning from a position of collaborative strength.

Option 2 of a Single Employer Model was excluded based on the following:

- Prohibitive timescales and complexity to implement the transition to a single employer and service delivery host.
- Identified challenges regarding the management of infrastructure costs and contractual / commissioning models.
- Perceived risk of potential to disproportionately allocate resource to the host site.
- Clinically not favoured as the best option as concerns around recruitment of new staff and retention of existing staff outweigh any benefits.

The table shown (appendix 1) summarises the qualitative assessment of each of the models described according to the objectives specified, and reaffirms the recommendation made to the Committee in November 2016. The scoring of each model against the acceptance criteria was:

- Status quo - 13
- Lead employer - 19
- Alliance model – 26

3.15 **Implementation of Alliance model**

The Workforce Task and Finish Group next considered how the Alliance model would be implemented across South Wales, along with timescales for implementation.

There were two options considered; the first would be to establish a new Alliance Board and the second option would be to use an existing group/ organisation, this would require amendment to its terms of reference and membership. Both options would require clinical, HR and planning representation from each provider Health Board.

This Board would need the remit to delivery 2 primary functions; the development and delivery of regional workforce planning and contingency management and would need to respond to the wider strategic workforce issues as well as current operation contingency planning.

Essentially, as this is a continuation of the work of the Workforce Task and Finish Group with added responsibility and accountability, the group felt that the most natural fit would be for the South Central Alliance Neonatal Task and Finish Group to combine the Alliance workforce model role within its function.

For clarity, for the next twelve months (until implementation of the South Wales Programme service model) it will take on the implementation role for the planned workforce changes in addition to their current role. After this time the group will continue with the Alliance workforce model functions outlined within this paper.

This recommended governance model identifies that the Alliance reporting mechanisms would be into the South Wales Workforce Group, led by the Workforce Directors and attended by a broad range of clinical, workforce and staff side representatives. The Workforce Group is aligned with the identified Alliance objectives in the following key areas:

- Management of regional workforce risks and any corresponding targeted interventions
- Development and delivery of changes to regional workforce issues

Initially the schedule of meetings will be on a monthly basis and will require a formal commitment from the Health Boards to engage in this dedicated Board.

4.0 Recommendations

4.1 Members are asked to:

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

5.0 Appendices / Annexes

5.1 Appendix 1 - Qualitative Assessment of Employment Models

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Organisation Development
Link to Integrated Commissioning Plan	Not applicable
Health and Care Standards	Safe Care Effective Care Staff and Resourcing
Principles of Prudent Healthcare	Only do what is needed Public & professionals are equal partners through co-production Reduce inappropriate variation
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Improving Health of Populations
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 WHSSC finance working group. As employment responsibilities remain within the Health Boards the cost of this employment model is minimal
Risk and Assurance	A workforce risk assessment has been undertaken
Evidence Base	BAPM standards 2014 All Wales Neonatal Standards 2012
Equality and Diversity	There is no planned service change
Population Health	n/a
Legal Implications	n/a

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**

Qualitative Assessment of Employment Models

Appendix 1

	Strategic fit	Flexible workforce	Quality and regional oversight	sustainability	Degree of collaboration	Ease of implementation Cost Complexity Time to implement	score	comments
Current	Not aligned with principles agreed for regional collaboration ✔ ✔	Little or no flexibility to jointly appoint to posts or rotate between providers ✔ ✔	Limited facility for shared training and central capacity management ✔	Not sustainable ✔	Limited ✔ ✔	Status quo ✔ ✔ ✔ ✔ ✔	13	Least preferred option. Does not address any service challenges with only associated benefit drawn from not causing disruption through change
Alliance	Fully aligned with regional collaboration ✔ ✔ ✔ ✔	Flexible opportunities for joint appointments where desirable ✔ ✔ ✔ ✔ ✔	Provides enhanced blend of local clinical governance and regional oversight ✔ ✔ ✔ ✔	Optimally sustainable through formal contractual mechanisms ✔ ✔ ✔ ✔	Highly collaborative delivery ✔ ✔ ✔ ✔	Some complexity regarding establishment of new governance model ✔ ✔ ✔ ✔ ✔	26	Preferred recommended short and medium term option
Lead	Could be aligned with regional strategic direction ✔ ✔ ✔	Maximises deployment flexibility but only following employee consultation regarding changes to terms and conditions ✔ ✔ ✔ ✔ ✔	Challenges relating to visibility of remote managed sites and technical obstacles regarding indemnity and clinical accountability ✔ ✔	Sufficient stability in the longer term providing alliance principles are agreed and adhered to consistently ✔ ✔ ✔	Collaborative commissioning ✔ ✔ ✔ ✔	Highly complex longer term development with significant implementation costs ✔ ✔	19	Some scope to further explore this option at a later date but highly complex to implement with no benefits over Alliance model

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

		Agenda Item	10
Meeting Title	**Joint Committee**	Meeting Date	28/03/2017
Report Title	Wales Neonatal Network – Standards 3rd Edition		
Author (Job title)	Director of Planning		
Executive Lead (Job title)	Director of Planning	Public / In Committee	Public

Purpose	The purpose of this paper is to present the Joint Committee with the final draft of the revised All Wales Neonatal Standards – 3rd Edition 2017 (*the standards*) for approval prior to their implementation. The paper will also discuss the process of peer review in assessing the units against these revised standards, and recommend that the standards and baseline assessment are submitted to Welsh Government for approval.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☐

Sub Group /Committee	Corporate Directors Group Board	Meeting Date	20/03/2017
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the revised Wales Neonatal Standards - 3rd Edition March 2017 • **Support** in principle the revised standards and the planned baseline assessment against the standards of each neonatal unit in Wales • **Support** the suggested process for referring the standards to Welsh Government for approval		

10

Considerations within the report (tick as appropriate)

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

1.0 Situation

1.1 Neonatal services in Wales are currently delivered in 11 units by 6 Health Boards. These units specialise in the care of babies born early, with low birth weight or who have a condition that requires specialist treatment. Around 10% of all births in Wales will require care in a neonatal unit. This will range from days, to many weeks or even months.

1.2 The care provided within these units is categorised in to the following 3 levels:

- Level 1 – special care
- Level 2 – high dependency care
- Level 3 – Intensive care.

1.3 In order to deliver high quality, equitable, evidence based care it is essential that units work to agreed standards and are measured and monitored against these standards. It is the role of the Neonatal Network to ensure compliance with the standards or structured service improvement towards compliance is evidenced.

2.0 Background

2.1 The All Wales Neonatal Standards were first published in 2008 as part of a series of standards for specialised services for children and young people in Wales.

2.2 These standards were based on recommendations from a number of reviews and on best practice principles published by the British Association of Perinatal Medicine (BAPM).

2.3 The standards were updated in 2013, using these same principles. In this third edition the Network aims to continue to build on previous standards to improve services for babies and their families across Wales, incorporating the increasingly important role of the Neonatal Network and the Units working collaboratively in order to share the knowledge and skills required, to promote continuous service improvement.

3.0 Assessment

3.1 The key actions included in the 3rd Edition of the Standards (annex 1) have been developed to provide a basis for delivery of high quality, equitable, neonatal services across Wales, and will be used to benchmark current services and inform the development of future service improvement.

3.2 The main changes within these standards include the strengthening of collaborative working across the network and improving professional development for all relevant staff within neonatal services.

3.3 The process of revising the Standards has used the knowledge and clinical expertise of the multi-disciplinary workforce across the service. Many of the new standards are influenced by neonatal developments across the UK, using recommendations from prestigious authorities, such as the British Association of Perinatal Medicine (BAPM), National Neonatal Audit Programme (NNAP), Royal College of Paediatric and Child Health (RCPCH) and Bliss. It also draws of best practice evidence in the English and Scottish Standards.

3.4 The standards are based on the premise that the people we care for should be at the heart of everything we do and follow the six domains of quality healthcare identified within the Quality Improvement Guide: Improving Quality Together (2014). These domains are:

- Patient centred
- Safety
- Effective
- Timely
- Efficient
- Equitable.

3.5 The six domains identified will form the basis of the delivery framework to identify key priorities for 2017 / 18 and any assessment against the standards will follow the same format.

3.6 Monitoring Against Standards

The monitoring of these standards will be coordinated by the Neonatal Network using a combination of self assessment by the Health Boards and a peer review process.

3.7 Peer review is a process designed to drive quality improvement involving self assessment, enquiry and learning between teams of equivalent specialisation and knowledge. This process focuses on the quality of a service and the outcomes and experience it delivers for patients / service users by looking at compliance with standards and benchmarking with others.

3.8 The review of clinical networks conducted in 2015 recommended that one of the roles of the networks should be to review compliance with standards, including peer review where appropriate. Determining a peer review process that is effective, equitable and delivered to a consistent standard is a challenge to the Network. The process of establishing, coordinating and delivering peer review will require a resource currently not available within the network team. The All Wales Peer Review Steering Group identify that some of the costs of supporting the peer review process can be drawn from the budgets allocated to the Delivery Plan Implementation Groups.

3.9 The Neonatal Network does not have this allocated budget and has raised this as an issue with the NHS Wales Health Collaborative

3.10 The NHS Wales Health Collaborative is exploring the development of a central administrative resource to facilitate the peer review process for all networks.

3.11 The Network will maintain the current self assessment process for each unit and report through to steering group. Pending approval of the revised standards it is anticipated that Health Boards will be asked to self assess in April 2017.

4.0 Recommendations

4.1 The Neonatal Network was, prior to October 2016 managed by WHSSC with the Steering Group an advisory group to the Joint Committee. From October 2016 the management has transferred to the NHS Wales Collaborative, with the governance framework still through WHSSC. This arrangement is currently under discussion.

4.2 Whilst previous Neonatal Standards have been approved via the Joint Committee the change in Network management and pending changes in the governance framework has resulted in discussion on the approval process for these revised standards.

4.3 In line with other Network standards / delivery plans it is felt that the final approval process sits with Welsh Government. Therefore, it is the recommendation that following a baseline assessment of each neonatal unit the standards are sent to Welsh Government for approval.

4.4 Members are asked to:

- **Note** the revised Wales Neonatal Standards - 3rd Edition March 2017
- **Support** in principle the revised Standards and the planned baseline assessment against the Standards of each neonatal unit in Wales
- **Support** the suggested process for referring the Standards to Welsh Government for approval

5.0 Appendices / Annexes

Annex (i) All Wales Neonatal Standards – 3rd Edition (draft)

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Organisation Development
Link to Integrated Commissioning Plan	Not applicable
Health and Care Standards	Safe Care Effective Care Governance, Leadership and Accountability
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
Organisational Implications	
Quality, Safety & Patient Experience	Delivery of high quality, safe and effective care is fundamental to neonatal services
Resources Implications	The initial baseline self assessment by units will identify any resource implications for Health Boards
Risk and Assurance	
Evidence Base	The standards are based on current evidence and best practice
Equality and Diversity	The standards consider all aspects of equality and diversity
Population Health	Taken into consideration
Legal Implications	None known

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	28/03/2017	Supported subject to minor amendments

10

All Wales Neonatal Standards 3rd Edition

All Wales Neonatal Standards – 3rd Edition
Approved: Neonatal Network Steering Group 28th February 2017

Acting on behalf of Local Health Boards in Wales in the Planning and Securing of Specialised Services

All Wales Neonatal Standards – 3rd Edition
Approved: Neonatal Network Steering Group 28th February 2017

CONTENTS

Forward

The All Wales Neonatal Standards are designed to ensure high quality neonatal care is available for the people of Wales. The first edition published in 2008 was part of a series of standards for specialised services for children and young people in Wales. These standards were updated in 2013.

In this third edition, we aim to build on the previous standards using the latest evidence and best practice guidelines. Many of the new standards are influenced by neonatal developments across the UK, using recommendations from prestigious authorities such as the British Association of Perinatal Medicine (BAPM), Neonatal Audit Programme (NNAP), Royal College of Paediatric and Child Health (RCPCH), Bliss or based upon standards in England and Scotland.

The standards incorporate the increasingly important role of the Neonatal Network and Units, working together to share learning, maintain expert skills and continually improve services.

Introduction

The All Wales Neonatal Standards outline the requirements for delivery of high quality, person centred, safe and effective care. They are designed to provide a framework for units to assess quality service provision at local level and also to benchmark across other units in Wales.

The Standards are intended to be applied at unit level, however it is recognised that on occasions, units may need to look to neighbouring units for support.

The Neonatal Network, through its advisory and monitoring responsibility, will undertake assessments of each neonatal unit using a variety of means:

- Self assessment at unit level
- Evaluation of national audit data
- Peer review (when resourced and established)

Within Wales there are three different types of unit, as follows:

Special Care Units (SCU) These provide special care for their own local population. Depending on arrangements, they may provide some high dependency care.

Local Neonatal Units (LNU) these units provide special care and some high dependency care with a locally agreed small volume of initial intensive care. Babies who require complex or longer term intensive care will be transferred to a Neonatal Intensive Care Unit.

Neonatal Intensive Care Units (NICU) these are larger units that provide the whole range of medical and sometimes surgical neonatal care for their local population, along with additional care for babies and their families referred from the Health Community in which they are based. NICUs are specialist centres of expertise and experience for the sickest infants. NICUs will work closely with the LNUs, SCUs paediatric and obstetric services.

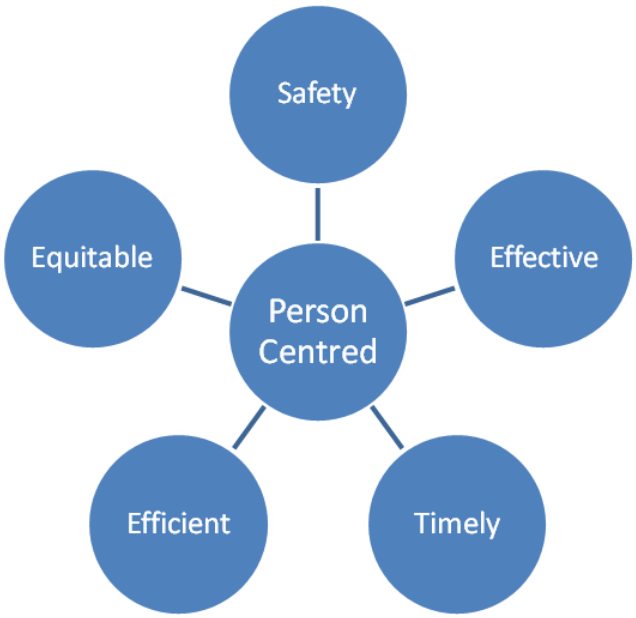
The role of transitional care is increasingly recognised as important to provide high quality and safe care whilst keeping mothers and babies together and reducing unintended harm caused by unnecessary separation.

The Standards are based on the premise that the babies and families we care for should be at the heart of everything we do. The Quality Improvement Guide: Improving Quality Together (2014) identifies that patient centred care can lead to improved quality,

reduced waste, better experiences and better use of resources. The All Wales Neonatal Standards follow the six domains of quality healthcare as follows:

- Patient Centred
- Safety
- Effective
- Timely
- Efficient
- Equitable

PATIENT CENTRED CARE



Domain 1: Patient Centeredness and care of baby and family[7-11]

Rationale: The baby and the family will receive family centred, high quality care as close to home as possible, with ease of access to specialist centres when this care is required. Family centred care is an approach which places parents at the centre of their baby's care and is hugely beneficial to babies and parents. It can lower a baby's stress levels, promote better health, shorten hospital stays and reduce hospital readmissions. It helps parents to bond with their baby and improves confidence as a parent. It helps families whose baby is in a neonatal unit cope with the stress, anxiety and altered parenting roles that accompany the baby's condition. It puts the physical, psychological and social needs of the baby and family at the heart of all care given.

The care pathway will be seamless across the various professions who are involved in the care. Excellent communication between groups of professionals who care for the baby and parents is essential. Parents will be supported to be fully involved in caring for their baby, and fully informed on their baby's condition so they can make appropriate, informed decisions about their ongoing care.

Domain 1a - Communications and seamless care

Parent information leaflets will be available at all antenatal facilities regarding post natal and neonatal service provision.

Neonatal medical staff will discuss options and care pathways with parents who are expecting a baby requiring neonatal care. These discussions are to be documented in the mother's notes.

Where time allows prior to birth, parents will be offered an opportunity to visit the neonatal unit to which their baby is likely to be admitted.[2]

All parents will be fully inducted on entry to the Neonatal Unit, so they can orient themselves with routines and are aware of the different equipment, monitoring and alarms within the Unit.[2]

Written information will be provided to parents upon their baby's admission in languages and formats appropriate to their needs. This will cover as a minimum:

- Admission to hospital, including travel, parking and information on local amenities
- Transfer service and repatriation
- Discharge service and arrangements for going home
- National and local support groups available
- Who to contact in the hospital with queries or for advice
- Where to go for further information and support, including sources of financial support and useful websites[12]
- How to access financial support (regardless of length of stay)[12]
- Services to which a baby is being transferred, including a named contact and telephone number
- Condition/diagnosis
- Treatment options available
- Likely outcomes/benefits of treatment
- Possible complications/risks
- Circumstances requiring consent.

Parents will be offered access to appropriate communication/ translation and advocacy services to support them, while their babies are receiving neonatal care, in their participation in ward round discussions, clinical care decision making, palliative care planning and end of life care if required.[2,8]

Domain 1b -Duty of candour

All staff will be reminded of duty of candour during the staff induction programme for each unit/health board.[14]

Domain 1c - Parents' participation in decision making and the care of their baby[5,7-11]

Every effort will be made to keep the mother and her baby/babies in the same hospital. [5]

Parents will be offered the opportunity to be present when care and other medical interventions are delivered if clinically appropriate.[5,7]

Every baby will be treated as an individual with dignity and respect:

- Clinical interventions will be managed to minimise stress, avoid pain and conserve energy
- Noise and light levels will be managed to minimise stress
- Appropriate clothing is used at all times, taking into account parents' choice
- Privacy will be respected and promoted as appropriate to the baby's condition.[2,5,8]

Every parent will have unrestricted access to their baby, unless there are safeguarding restrictions imposed.[2,5,8,36]

Parents will be encouraged to be present on, and be an active part of, every ward round.

Parents who are unable to visit their baby will be able to access an electronic means of maintaining audiovisual contact with the baby, in line with Health Board Information Governance Policies.

Every unit will have free WIFI available to parents to enable access to digital information.

Parents will be offered opportunities to discuss their baby's diagnosis and care with a senior clinician within 24 hrs of admission, or following a significant change in condition.[2,5,8,36]

Parents will be actively encouraged, and provided with the necessary teaching and supervision to participate in all aspects of the daily care of their babies.

Up to date, documented care plans will be used to direct care and are formulated in discussion with, and input from, parents where appropriate.[2,8]

Whenever possible transfers of babies should be planned in collaboration with the parents.

Staff will provide assistance to parents in making travel and accommodation arrangements.

Parents will be given information on how to contact national and local support groups and where to get further information, including advice on financial support and useful websites.

If required, palliative care planning and end of life decisions will be made in partnership with parents and professionals, in a suitable environment. All available, clinically appropriate options will be explored.[2,8,15,34]

Parent will be offered the opportunity to feedback their experiences of the service during their stay via Parent Satisfaction Surveys, parent stories or follow up phone calls.[8,14,51]

Domain 1d - Professional support

It is vital that timely access to psychological support is available to prevent any impact on a parent's mental health, which in turn can have an impact on the whole of the family[7,8,13,53]

Each unit will ensure there are enough psychologists, counsellors and other mental health workers available so that parents, siblings and staff have access to psychological support.[8,9,53]
In addition access to the following support services is also required:

- Social worker

- Spiritual advisor
- Bereavement counsellor
- Breast feeding support staff
- Occupational Therapist (providing psycho-social intervention)
- Multi-ethnic health advocates and translators.[2,4,5]

Domain 1e - Facilities for parents

All future designs for new Neonatal Units will comply with the Welsh Health Building Note 09-03: Neonatal units (2016) and with the Disability and Equality act (2010).

Transitional care[44] will be recognised as part of the full spectrum of neonatal care. Units will plan to develop transitional care facilities in order to reduce the need to separate (near term and term) babies from their mothers.

Dedicated facilities will be available for parents and families of babies receiving neonatal care. As a minimum there is:

- One room per intensive care cot located within 10 – 15 minutes' walking distance of the unit in a NICU
- At least two rooms for 'rooming in' prior to discharge will be available within or adjacent to the Unit (with gas and air supply points to be available). All rooms should be free of charge and with bathroom facilities
- Arrangements for secure and readily accessible storage of parents' personal items
- Non–secure storage for baby's personal items (e.g. baby clothes) at the cot-side
- A parents sitting room
- Access to hot drinks and food outside normal hours
- A toilet and washing area
- A changing area for other young children
- A play area for siblings of babies receiving care
- Access to a telephone and internet connection within the hospital
- A room set aside and furnished appropriately for counselling where dignity, privacy and respect is maintained
- Where car parking is not free, parents will be informed of the cost and any local arrangements for reimbursement.[5,7,8,9,11]

Local and special care units will ensure that there are parent rooms available to accommodate any parent who wishes to stay close to their baby.[53]

Parents will have access to Family Friendly outpatient facilities including:

- An appropriate area to feed baby
- Changing area
- Access for prams
- Consulting room large enough for baby, parents and siblings

- Play area
- Appropriate toys available.[5,7]

Units will actively participate with the Bliss Baby Charter audit tool to assess the quality of family-centred care they provide and identify areas for improvement.[7]

Domain 1f – Breast feeding

All units will have an Enteral Feeding Guideline; either the All Wales Enteral Feeding Guideline for Preterm Infants (2015) or local feeding policy.

Health Boards and neonatal units will be able to evidence that they are actively working towards improving breast feeding rates. Breast feeding promotes health benefits for the mother and baby throughout their lives.

Maternity and neonatal services will encourage breastfeeding and the expression of milk through the provision of information and dedicated support, including:

- All units will have a breast feeding policy in place that promotes skin to skin, bonding, breast feeding or expressing
- All units will have a medical and nursing lead, with dedicated time, who works to improve breast feeding rates and educate staff and parents
- Support to initiate breastfeeding as soon as possible after birth
- When necessary, support to start expressing within 1 hour if mother's condition allows or if not, as soon as possible after that, to maximise the benefit of colostrum and optimise milk production
- There will be enough breast pumps and associated equipment for every mother who requires them
- Mothers will be shown how to make the best use of techniques such as double pumping and skin to skin
- Mothers will be requested to keep a record of volumes expressed so that problems with expression may be identified and addressed early
- Availability of a comfortable, dedicated and discreet area for feeding or expressing. This could be at the cot-side
- Mothers will be actively encouraged and supported to breast feed throughout the stay by neonatal staff (medical and nursing) and breast feeding supporters/advisors. All staff involved in this aspect of care will receive training on the benefits of breastfeeding on the health of both the mother and baby throughout their life spans
- Supporting breastfeeding as part of the discharge process
- Promotion of safe and hygienic handling, labelling, storage and

administration of breast milk in line with national and local guidelines [47]
- Access to donor breast milk, as clinically indicated [18]
- Parents will be given information on donor milk (admission packs/notice board) and there will be a process for consent [18,47]

Written information on breast feeding is to be provided at key stages. Where possible this should be in different languages. This includes:
- Pregnancy
- Antenatal consultation with the neonatal team
- Initiation and maintenance to around 34 weeks
- Transitioning to feeding at the breast
- Maintenance of breast feeding at home

Units and postnatal wards should display information showing their own breast feeding rates. [5,7,17,19-26]

Parents will have access to information and support on alternative feeding practices e.g. bottle feeding. Both mothers and fathers will be supported and shown how to make feeds and sterilise bottles and teats.[7]

Standard 1g - Developmental care

Effective developmental care results in less stress for babies, shorter hospital stays and better long terms outcomes. Parents feel more involved in the care of their babies and relationships between hospital staff and parents are strengthened.[1,2,5,7]

- A multi-disciplinary developmental care group is established on each unit
- There will be unit guidelines for delivery of developmental care, supported by education and training of staff
- Each unit will have a guideline and scoring system to aid recognition and treatment of pain in the neonate
- Parents will be encouraged and supported to participate in their baby's care at the earliest opportunity, including:
  - Regular skin-to-skin
  - Providing comforting touch and comfort holding, particularly during painful procedures
  - Feeding
  - Day-to-day care, such as nappy changing
  - Handling and positioning of their baby
- Parents will be educated in family centred developmental care (in admission packs, information in the unit and discussion with staff).

Domain 1h -Equipment on neonatal units

Appropriate, safe equipment will be available on all neonatal units. [1,2]

Resources will be available to purchase and maintain equipment for the level of neonatal care being delivered.

Joint working arrangements will be in place with the local Medical Technical Department responsible for equipment safety and maintenance.

The blood gas analyser will be maintained in line with point of care testing protocols and IPC standards.

24-hour laboratory services will be available which are orientated to neonatal needs.[1]

Each Neonatal Unit will have access to the following equipment:

- Resuscitaire and difficult airway box
- Blood gas analysis with facilities for measuring lactate and Haemoglobin
- Syringe/infusion pumps
- Phototherapy units
- Transillumination by cold light
- Portable x-ray machine
- Ultrasound scanner to be available 24/7
- Internal hospital transport equipment (including mechanical ventilation)
- Cerebral function monitor
- Non-invasive blood pressure measurement
- Instant photographs
- Specialist equipment to support discharge home. [1,2]

Each intensive care cot (including stabilisation cot) will be equipped with the following equipment:

- Ventilator
- Incubator
- CPAP and or high flow machine
- Cardio- respiratory monitor with facilities to measure ECG, respiration, temp x2, Saturation X2, invasive and non invasive blood pressure
- A pressure limited resuscitation device with air oxygen blender e.g. a neopuff
- Data point
- A breast milk pump
- A suitable light source for clinical procedures e.g. insertion of lines. [1,2]

Each intensive care cot will have facilities to provide:

- Inhaled Nitric Oxide
- Whole body cooling

- High Frequency Oscillation. [1,2]

Domain 1i –Research Consent

Clinical research activity on neonatal units is extremely important in order to advance knowledge and improve care. Counselling and Randomisation will be undertaken only by clinicians who have completed the course and use the principles of 'Good Clinical Practice' guidelines.[43]

All efforts will be made to include families and their baby in appropriate clinical research activity:

- Families and carers are informed about all research that their baby is eligible to participate in by using appropriate leaflets, inserts in maternity notes and inserts in Unit induction packs
- When a baby becomes eligible for a research study during their admission parents and carers are informed of this, and provided with regular, appropriate updates
- Each Unit supports families and carers during the research process by providing regular updates after a baby has been recruited to a study
- Families and carers are informed that they can withdraw from research trials at any time without compromising the care of their baby.

Domain 2: Safe Care

Rationale: Assurance regarding quality and safety of care will be supported by a robust clinical governance framework. Each unit will monitor and act upon data and information gathered from quality outcome measures, clinical outcomes and other methodologies and demonstrates a culture of continuous improvement. Care will be where possible, evidence based and provided in line with approved patient pathways by appropriately skilled staff, treating babies in units with appropriate facilities. Staff should undertake regular audit of practice and receive the required training and updating of their skills.

Domain 2a - Designation of units and appropriate activity

Neonatal care will be commissioned to meet the local and national population needs of Wales based on up to date and accurate data. [1,2,5,6]

Each neonatal unit in Wales will be designated according to the BAPM criteria (Intensive Care unit, Local neonatal unit or special care unit) for intensity, facilities and workforce.[1,2,5,6]

It is recognised that there will be a Sub Regional Neonatal Intensive Care Centre in North Wales.

A baby thought likely to require specialist care or intensive care after birth, (including babies with prenatally diagnosed conditions) should, wherever possible, be delivered in a unit with the associated specialist service or intensive care service, to avoid unnecessary postnatal transfer.[1,2,29]

Each unit will manage babies in line with the agreed service specifications.

Domain 2b – Midwifery led care

Midwifery led units (including free standing) should have in place the following clear clinical governance arrangements to ensure safe pathways for neonatal care.[50]

- A program of regular neonatal training for midwifery staff which includes resuscitation, newborn examination, and common neonatal problems
- Clear pathways for both emergency neonatal care and common neonatal problems eg jaundice, jitteriness, hypothermia, respiratory distress.
- Audit and data collection
- Case reviews which involve neonatal clinicians of any adverse outcomes, incidents or near misses
- Records of all of the above which can be reviewed.

Domain 2c - Working relationships between neonatal units

Each special care or local neonatal unit will be aligned to a NICU. Agreement on frequency and nature of ward rounds will be determined and documented in the unit's service specification. This will encourage:

- Ward rounds from NICU consultants at LNUs and SCUs
- Regular participation on NICU ward rounds of all consultants from non NICUs who contribute to their neonatal unit on call rota in order that their knowledge is current and to maintain their skills.

For each NICU / SURNICC there will be at least 2 consultant led ward rounds per day. For each local neonatal unit or special care unit in Wales there will be at least one consultant ward round per day.

Each unit will have in place robust procedures for clinical handover for both medical and nursing staff to maintain patient safety in line with Health Board policy.

Across the network there will be agreed pathways of care for repatriation of babies.

There will be a process in place whereby a consultant working on a special care unit or LNU will access advice from their associated NICU 24/7.

All units outside of a NICU / SURNNIC will be required to have 24/7 Consultant to Consultant discussion on babies who fit the following criteria:

- Newborn <1500g
- Newborn <32/40 or 34/40 for multiple pregnancy
- Any ventilated baby
- Non-invasive ventilation (CPAP / High Flow) requiring FiO2 > 0.4, or rising FiO2 requirement

- A baby with a pneumothorax requiring intervention
- Any baby with an abnormality diagnosed in the antenatal period and a plan to deliver in a tertiary centre
- Seizures
- Abdominal distension and feed intolerance
- Suspected NEC
- Refractory or unanticipated symptomatic hypoglycaemia
- Persistent metabolic acidosis
- Any baby requiring therapeutic cooling
- Any other baby who is causing concern.

All units providing care for babies outside of their agreed gestational age for delivery will exception report to the Neonatal Network.

Domain 2d- Resuscitation

The Standards for neonatal resuscitation are set out in the Neonatal Life Support Manual (4th Ed 2016) which is issued under the auspices of the Resuscitation Council (UK) and reflect current opinion published by the International Liaison Committee on Resuscitation (ILCOR).

Personnel

Each unit will ensure that all doctors and nurses caring for critically ill neonates receive Newborn Life Support (NLS) training and maintain NLS certification.[27]

Health Boards and Welsh Ambulance Services Trust will ensure that staff attending deliveries in midwifery led units and home births, including paramedics, are suitably trained in Newborn resuscitation and stabilisation and maintain their certification.[1,2]

All obstetric delivery units involved in the care of babies will have associated neonatal staffing arrangements for the prompt, safe and effective resuscitation and stabilisation of babies. Ongoing stabilisation may be necessary until retrieval to a unit able to provide ongoing care at the appropriate level.

Equipment

Resuscitation equipment will comply with the latest Resuscitation Council Guidelines and be available in any area where neonates receive care, including Midwifery led Units.[27,28]

Clinical Management

Every Neonatal Unit will have an agreed protocol for the resuscitation and/or management of the extremely preterm infant. [3,4]

When delivery of a baby at <32 weeks gestational age is

anticipated, a consultant or career grade/training grade doctor or ANNP with middle grade equivalent neonatal training and experience will also be present.[1,2]

If the decision after resuscitation is that the baby should remain with the mother, a clear management plan will be documented including the frequency of required observations and specified time for review.

Domain 2e - Infection prevention and control (IPC)

All neonatal units will have a detailed written guideline regarding infection prevention and control (IPC) practices, based on their own Health Board and Public Health Wales IPC policies. The guideline will be updated in line with best practice.[49,58] Staff will need to be familiar with the guidelines and follow the recommendations.
There will include details of:

- Standard infection control precautions
- Prevention of infection
- Admission screening
- Hand Hygiene
- Enhanced precautions
- Control of the environment
- Cleaning schedule
- Management of blood and body fluid spillages
- Safe disposable of waste
- Safe disposable/cleaning of linen and laundry
- Sink and water policy
- Management of care equipment
- Avoidance of contamination and decontamination
- Isolation Precautions
- Personal Protective Equipment (PPE)
- Management of outbreaks or suspected outbreaks including liaison with the network.

All staff will receive IPC training during their induction programs with mandatory annual updates.

Infection prevention control practices are audited in line with local policy, with feedback provided to staff and service users

Domain 2f - Fire Safety

All units will have a written policy on fire prevention and actions to be taken if a fire should develop on the unit. An area for continuation of care, if evacuation is necessary, will be identified.

All staff will have undertaken Fire Safety as part of their induction and maintain updates.

All staff will be aware of the policy and there will be regular fire

drills and scenarios acting out evacuation plans.

Domain 2g - Safe guarding

All units will have systems, policies and procedures in place to support their staff in safeguarding babies effectively. These will reflect local (Health Board, Regional safeguarding Children Board) professional (RCN, GMC) and national guidance (AWCPP 2008). [32,33,39-42]

Each unit will identify a lead professional for safeguarding to provide other staff with support and advice on safeguarding issues, updates on safeguarding developments and information on training.

All neonatal staff will undertake training on safeguarding appropriate to their role and in line with Health Board policy. Neonatologists and neonatal nurses are expected to be at Level 3 training. [32,33,39,40,41]

All staff will take action if a baby is identified as being at risk in line with the safeguarding policy.

Where safeguarding concerns are identified, staff will ensure that details of interactions with the parents are comprehensively documented in the baby's records.

Staff will work with families using a multiagency and multidisciplinary approach. Information will be shared appropriately amongst multi professional agencies and there will be active engagement with the primary care team of GP, midwife, Health visitor and social care worker where appropriate.

Each unit will have agreed pathways of care in place for the management of a baby where the parent has a known history of substance misuse or other safeguarding concerns have been identified.

Domain 2h - Case reviews

Each unit will have in place a protocol for post mortem consent supported by appropriate staff training. The findings at post mortem must be shared at a later date with the parents.

Each Health Board will undertake a detailed case review following the death of every baby using a specified tool, by a consultant least involved in the case. There will also be a detailed review of every baby who requires cooling. [59]

Each unit will have in place a process whereby the outcome of this review is presented at a unit meeting. In addition an external peer review clinician will be invited to participate in the case

presentation to give independent advice. Lessons learnt should be fed back to all relevant staff at unit level.[59]

The neonatal network will set up network mortality review meetings at which individual deaths can be reviewed and a more detailed review undertaken when necessary. If a more detailed review is required this should be done by a multidisciplinary team involving midwifery, obstetrics, neonatal medical and neonatal nursing colleagues with appropriate input from any other involved specialists[59]. All units must participate in this process, so that when a baby is born in one unit and transferred to another, the care can be discussed openly across the baby's pathway.

Lessons learned will be shared with all units in Wales.

Domain 2i - Incident reporting

All units will have in place effective mechanisms for reporting and investigation to WAG serious untoward incidents (based on the "never events" list). [60]

There will be at unit level effective mechanisms for reporting and investigating untoward incidents with any identified lessons communicated effectively to staff. Lessons learnt will be shared at network level. If a baby is involved parents need to be fully informed and involved.

If a member of staff is involved in, or witnesses an untoward incident, whether as a staff member or as the transport team, they will report this to their line manager, in accordance with the Health Board reporting and investigation process. The parents will also be informed.

If a transport team member is involved in an untoward incident, they will report the incident and discuss with their line manager. They will also inform the consultant who is caring for the baby, and parents will be informed. If this is not possible at the time (because of the nature of the transport service) arrangements will be made to meet the parents at a later time or delegate the responsibility to the receiving consultant. This will be documented.

The neonatal network will be informed if a baby requiring NICU care is unable to be transferred due to capacity reasons. An incident report will also be generated.

Domain 3: Effective Care

Rationale: A high quality service with an effective governance structure will demonstrate the use of quality indicators to monitor and improve outcomes and will produce an annual report evidencing the planning and delivery of continuous improvement in the service. This will be supported by active engagement with staff at all levels.

Domain 3a – Leadership and Management

The Neonatal Network will have in place clinical leadership with time dedicated to the role.[1,2]

All neonatal units will have a leadership team which consists of a medical lead, a nurse lead and a Directorate manager.

The neonatal unit medical lead will have 2 sessions per week in their job plan devoted to the management role. This is in addition to the sessions in their job plan devoted to clinical care and CPD.

All units will have an office/ward manager who can work clinically when required.[1,2]

All units will have a nursing co-ordinator/team leader on every shift; who can work clinically when required.[5]

The Neonatal unit providing surgical services will have a nurse with neonatal surgical experience who has clinical leadership responsibility for nursing care of babies needing surgery.[5]

Domain 3b - Data reporting and benchmarking

All units will participate in data collection through the following agreed systems

- Badgernet
- Vermont Oxford Network
- MBRRACE
- National Neonatal Audit Project NNAP
- CARIS.[36,57,59]

In order to maintain data quality, completeness and troubleshooting, all units will have allocated senior staff responsible for each of the data bases.

Units will have training and monitoring plans to ensure accurate data entry in both a local and national context.

All units will generate an Annual Report including key performance indicators and benchmarking.

The Neonatal Network will generate an All Wales Annual Report.

All units will provide effective staff feedback on outcomes, including published reports and any remedial steps required

Domain 3c – Evidence based guidelines

Units will use evidence based guidelines such as those published by the Clinical Guideline Group (CGG).

Domain 3d - Cooling

Infants fulfilling criteria for therapeutic hypothermia (TH) will be looked after in a NICU or SURNICC in line with the All Wales Cooling Guideline. [54-56]

If born in a LNU or a SCBU, contact will be made with the CHANTS team and NICU in line with the All Wales Cooling Guideline.

All surviving infants undergoing therapeutic hypothermia will have an MRI brain scan between postnatal days 5 to 14.

Domain 3e- The newborn Examination

The newborn examination will only be undertaken by clinicians who have been trained in the technique and who maintain their practice[46]. Clinicians will perform at least 30 examinations per year to maintain their skills. Refresher training will be provided with an experienced neonatal clinician and this training will include at least three satisfactory supervised newborn examinations. The newborn examination includes:

- Cardiovascular system examination (including assessment of oxygen saturation)
- Eye examination
- Hip examination
- In male infants examination for the presence of testes in the scrotal sac
- Examination of the soft palate using a tongue depressor and torch.

Pathways will be put in place to ensure prompt referral and treatment when abnormalities are detected [46]. These pathways include:

- Hip USS scan should by 6 weeks:
  - if there is a family history (first degree relative) of hip problems requiring treatment with a splint, harness or operation in infancy
  - if there was a history of breech presentation at or after 36 weeks gestation. In the case of multiple births, if any of the babies is breech after 36 weeks gestation, all babies should receive an USS
- If the clinical examination of the hips is abnormal, USS scan will be done within 2 weeks

- If a cataract is suspected on examination of the eyes, the baby will be seen by a specialist ophthalmologist within two weeks of age
- For babies with bilateral undescended testes the baby will be seen by a consultant neonatologist +/- specialist endocrinologist within 24 hours after birth to rule out life threatening endocrine disease.

Domain 3f - Screening pathways

There will be agreed screening pathways for

- ROP screening of high risk infants [64]
- Hearing screening [65]
- Newborn blood spot [66]

Protocols will be in place for management of

- Those infants requiring BCG
- Those infants requiring hepatitis b vaccination
- Infants born to mothers with HIV infection.

Domain 3g – Vaccinations

Babies will receive their childhood immunisations according to the latest JCVI Green Book recommendations.

Palivizumab to be offered to a select group of neonates as recommended in the latest JCVI Green Book and in line with local policy.

Vaccinations to be given by a clinician trained to immunise. Immunisation administrators to undertake a yearly update in line with local policy.

Domain 3h- Neuro-developmental follow up

All Health Boards should ensure that they take responsibility for their babies' neurodevelopmental follow-up pathways. As a minimum, babies in the following categories will receive an appropriate neurodevelopmental assessment at 2 years of age with data entry into Badgernet:

- Less than 32 weeks (corrected)
- Less than 1500g
- All babies who received therapeutic hypothermia.[61,67]

Domain 4: Equity

Rationale: The service will be of a uniform high standard wherever the patient lives within Wales. Every effort will be made to secure timely access to the most appropriate care. Units will have sufficient capacity to ensure that where appropriate, all babies receive the care they need as close to home as possible, depending on the condition of the baby.[6]

Domain 4a – Access and capacity

Neonatal care is commissioned to meet the local and national population need based on an adequate assessment of need undertaken at least once every year. [1,2,5,57]

Agreed out of network activity e.g. cardiac surgery, ECMO, specialist surgery and agreed cross border flow will be maintained in line with agreed commissioning.

Average cot occupancy will not exceed 70% for critical care and 80% for special care.[1,2,3]

There will be sufficient surgical capacity in the neonatal surgical centre to accommodate those babies who require access for surgical care.

Domain 4b – System of network review

The All Wales Neonatal Network will have in place a clinical lead who has sessions dedicated to the role and enable support to be provided equally to North and South Wales as required. [1,2]

Within the Network leadership arrangements will be in place for:

- Workforce
- Education and Training
- Quality & Safety
- Guideline development
- Audit
- Family Centred Care/Developmental Care
- Transport.

Domain 4c – Staffing

Medical workforce

Neonatal intensive care units

At **Tier 3**, all consultants will be full time neonatal specialists. There will be a neonatal consultant 24/7 on-call rota, separate

from general paediatric cover with a minimum of 7 Staff. All consultants will have CCT in Paediatrics, Neonatal Medicine or equivalent training.

Neonatal consultant staff will be available on site in all NICUs for at least 12 hours a day and for units undertaking more than 4000 intensive care days per annum consideration will be given to 24 hour consultant presence. [16]

NICUs undertaking more than 2500 Intensive care (IC) days per annum will provide at least two consultant led teams during normal hours.[16]

At **Tier 2** there will be a separate neonatal rota 24/7 with a minimum of 8 staff, made up from the following:

- Paediatric ST4-8
- Specialty doctors
- Other non training grade doctors
- ANNPs (with appropriate additional skills and training)
- Resident neonatal consultants.

NICUs undertaking more than 2500 Intensive care (IC) days per annum will augment their tier 2 medical cover by providing a second trained doctor or suitably trained ANNP or resident consultant.[16]

At **Tier 1** there will be a separate neonatal rota with a minimum of 8 staff, made up from the following:

- Paediatrics ST1-3
- ENNPs
- ANNPs
- Specialty doctors.

Units with more than 7000 deliveries will augment their tier 1 medical support by providing extended nurse practice or a second junior doctor/ ANNP. [16]

Neonatal surgical services – University Hospital of Wales

Neonatal surgery is performed by specialist paediatric and neonatal surgeons, or surgeons with a specialist interest and complimented by specialist paediatric and neonatal anaesthetic support. [35]

A specialist paediatric surgeon is on call 24/7 for the neonatal surgical service and to provide advice to referring centres. [35]

The surgical service requires 24/7 paediatric radiology support either locally delivered or within a network. In the absence of a 24/7 service the local provider will ensure that efficient and clear processes are in place to mitigate any risks and to offer the best possible care to the baby. [35]

Local Neonatal Units [1,2,3]

At **Tier 3** the LNU has a minimum of 7 consultants on the on-call rota. There should be one consultant who has a designated leadership role in neonatology and is responsible for the direction and management of the Unit, with a minimum of 2 sessions identified in the job plan for this role. This is in addition to the recommended sessions for CPD and clinical work.

There will be 24-hour 7 day availability of a paediatric/ neonatal consultant who can demonstrate expertise in neonatal care (based on training, experience, CPD and ongoing appraisal).[3]

At **Tier 2** the LNU may have a shared rota with paediatrics, with the minimum staff needed to meet BAPM and Wales Deanery requirements.* Staff will have the training and experience to resuscitate and stabilise babies unexpectedly requiring short term Intensive care. Staffing will be made up from the following:

- Paediatric ST3-8
- Specialty doctors
- Other non training grade doctors
- ANNPs
- Resident paediatric/neonatal consultants.[3]

* Where LNUs regularly provide intensive care and/or have a very busy paediatric service and/or have a neonatal and paediatric services that are a significant distance apart the above staffing should be enhanced. Such enhanced measures would include separate Tier 2 rotas 0900 until 2400 each day or, depending on an assessment of patient safety, throughout the 24 hours.

At **Tier 1** the LNU will have a separate neonatal rota with the minimum staff needed to meet BAPM and Wales Deanery requirements who do not cover general paediatrics in addition at any time of day or night, made up from the following:

- ANNP's,
- tier 1 trainees,
- non training grade doctors,
- specialty doctors.

Special Care Units [1,2]

At **Tier 3** there will be a minimum of 7 consultants on the on-call rota with a minimum of one consultant with a designated lead interest in neonatology and responsible for the direction and management of the unit.

At **Tier 2** there will be a shared rota with paediatrics with the minimum staff needed to meet BAPM and Wales Deanery requirements.

At **Tier 1** the rotas will be EWTD compliant with the minimum staff needed to meet BAPM and Wales Deanery requirements who may cover paediatrics in addition, made up from the following:

- Paediatric ST1-2
- GPST1 or FY2
- Specialty doctors
- ANNPs
- Non training grade doctors.

In some settings Tier 1 and 2 may be able to merge where appropriate skilled nursing support exists.

Nursing Workforce [30,31]

A nursing ratio of 1:1 is provided for babies requiring Neonatal Intensive care. The named nurse is Qualified in Speciality (QIS) and will have no other managerial responsibilities during the clinical shift. The nurse may be involved in the support of a less experienced nurse working alongside in caring for the same baby.[3]

A nursing ratio of 1:2 is provided for babies requiring High Dependency care. The named nurse is Qualified in Speciality (QIS). More stable and less dependent babies may be cared for by registered nurse not QIS, but who are under the direct supervision and responsibility of a neonatal nurse.[3]

A nursing ratio of 1:4 is provided for babies requiring Special Care. Registered nurses and non-registered clinical staff will be under the direct supervision and responsibility of a neonatal nurse QIS.[3]

NICUs will have a minimum of 70% and local and special care units a minimum of 80% of the workforce establishment holding a current Nursing and Midwifery Council (NMC) (registration).[5]

The nursing establishment for direct nursing care will be calculated to include an uplift of 27% to accommodate expected leave.[63]

Staffing records will evidence that units have a minimum of two registered nurses on duty at all times, of which at least one is qualified in speciality (QIS).[5]

All units will have nurses within the workforce with added non-clinical responsibilities. Identified nurses, acting as Champions for the quality of practice within each unit will have dedicated time to support[5]:

- Transport
- Bereavement support and palliative care
- Discharge Planning
- Health, safety & risk management
- Infection control
- Equipment.

All units will have a dedicated supernumerary neonatal outreach team additional to the nursing staff providing direct acute care. The size of the team will depend on local criteria and geographical

area.

Support staff

All units will ensure that adequate clerical and support staff are in post.

Allied Health Professionals

All Neonatal units will have appropriately funded

- Dietetic care provided by a highly specialist paediatric dietician with specialist knowledge, training and experience of complex neonatal and surgical dietetics
- Physiotherapy care provided by highly specialist physiotherapists with knowledge, training and experience to provide neurological and neurodevelopmental assessment and intervention
- Occupational therapy provided by highly specialist Occupational therapists with knowledge, training and experience to provide neurodevelopmental, behavioural and psychosocial assessment, intervention and anticipatory guidance to the infant and their family/care giver, to support the development of parenting co-occupations and baby occupations
- Speech & Language Therapy (SLT) care by a highly specialist SLT with knowledge, training and experience of the feeding and developmental care needs of complex neonates. [3,4,5]

Additional staffing will be needed to support follow up care including assessment, intervention and anticipatory guidance in the community.

All NICUs & LNUs will provide:

- A minimum of 0.05 – 0.1 WTE highly specialist paediatric dietician, Physio, Occupational and Speech and Language Therapist per intensive care cots
- a minimum of 0.025-0.05 WTE highly specialist paediatric dietician, Physio, Occupational and Speech and Language Therapist for high dependency cots
- a minimum of 0.025-0.05 WTE highly specialist paediatric dietician, Physio, Occupational and Speech and Language Therapist WTE for special care cots. [3,4,5,68,69]

For highly specialist paediatric dieticians providing advice to neighbouring LNUs and SCUs additional capacity will be required in the job plans to provide this advice and support to the Network.

All neonatal units will have appropriate access to paediatric/neonatal pharmacists with the appropriate skills,

knowledge and experience in neonatal intensive care.

Domain 4d – Training of Staff

Medical Staff

Medical staff are expected to possess skills and knowledge appropriate to their role.

Neonatal consultants working at tier two or tier three are identified neonatal specialists. Their skills, knowledge and clinical CPD must be assessed at annual appraisal. Any deficiencies need to be rectified as soon as possible with agreement from their clinical lead or appraiser.

General paediatricians and others such as associate specialists, specialty doctors or other non-training grades who provide cover to neonatal units also need to maintain appropriate skills and knowledge.

In general terms, the time spent in neonatal CPD should be proportional to their neonatal work.

The neonatal element of the CPD would be assessed at annual appraisal with remedial action taken promptly in agreement with the clinical lead, or appraiser if concerns were apparent.

Those working on LNU's or SCU's are encouraged to spend time on a NICU either as a secondment or as fixed sessions in order to further develop their skills and learning.

All staff should possess the appropriate skills required to resuscitate and stabilise sick infants pending arrival of the transport team

Registered and non registered nursing staff

Each unit to have a continual professional development nurse/team (minimum 1 WTE) with protected time dedicated to providing teaching and education at the cot-side.

All nurses involved in direct clinical care will have undertaken a newborn life support course, appropriate to their role, as recommended by the Resuscitation Council UK.[27]

Registered staff will achieve the competencies identified within the All Wales Education Pathway for Neonatal Nurses (2015) within recognised timescale.

All staff will be supported to participate in continuing professional development of relevance to their role on the unit or in the community.[5,34]

All staff will be formally reviewed on an annual basis through appraisal and e-KSF or other appropriate performance management process.[5,34]

Robust training records will be maintained for all levels of staff within the neonatal unit.[5,34]

Nurse post registration neonatal education is readily available based on the Matching knowledge and skills for Qualified in Speciality (QIS) Neonatal Nurses competency framework.[30]

A minimum of 70% of the registered nursing workforce establishment hold an accredited post registration qualification in specialised neonatal care (qualified in speciality (QIS).[5]

Non registered clinical staff (including nursery nurses) will complete the child specific Credit Qualification Framework Wales (CQFW) level 3 training within 1–5 years of appointment.[3,4,30]

For nurses QIS working in roles with enhanced practice skills (ENNP), a defined level of competency for the theoretical and practical assessment of new skills needs to be agreed with local higher education institutions (HEI). [3,4]

Clear tiers of responsibility and accountability will be put in place for staff working in Advanced Neonatal Nurse Practitioners (ANNPs) roles based on the 4 pillars of Advanced Practice.[4]

Allied Health Professionals

All Therapists involved in neonatal care will be suitably trained and experienced and as a minimum:

- Dietitians/specialist neonatal Dietitian – will have completed the British Dietetic Association Paediatric masters module two/five or equivalent levels of knowledge and skills and achieved competencies
- Speech & Language Therapists – will demonstrate competences at least to level C with support from a SLT working at level D
- Pharmacists – will have successfully completed the Centre of Postgraduate Pharmacy Education paediatric learning pack or have equivalent levels of skills and knowledge.
- Occupational therapists - will have competency and postgraduate training in neuro developmental, behavioural and psychosocial assessment, intervention and anticipatory guidance to the infant and their family/care giver, to support the development of parenting co- occupations and baby occupations
- Physiotherapists - will demonstrate competencies in line with the requirements of the Association of Paediatric Chartered

Physiotherapists neonatal competence framework. [68,69]

Therapists involved in neonatal care will have access to post graduate training appropriate to their service and should be supported to participate in continual professional development specific to their role.

Therapists involved in neonatal care will have their performance reviewed annually according to their HB requirements for appraisal based within their professional department and in line with the requirements of their professional bodies.

Domain 4e - Cross site working

Local arrangements will be in place to ensure staff working across sites and Health Boards have the appropriate contractual arrangements.

Contractual arrangements need to be in place to support the rotation of nursing staff between in order to maintain their Qualified in Speciality (QIS) intensive care skills and competencies.

Domain 5: Timeliness

Rationale: Neonates will be cared for in the right place, at the right time and by the right people with the right skills. A high quality neonatal service will demonstrate timely provision of clinical care, minimise delays in emergency transfer and access to care; effective deployment of teams for planned transfers; a sustainable transport infrastructure to support the service and timely communication with obstetric staff.

Domain 5a - Preterm labour

A preterm labour pathway will be in place to support:

- A single course of antenatal steroids when the baby is expected to deliver between 23 weeks and 37 weeks gestation[37]
- Mothers who deliver babies < 30 weeks gestation will where time allows be given Magnesium sulphate for neuro protection of their infant in the 24 hours prior to the delivery.[38]

Domain 5b – Transport

Transport services are planned and commissioned on an All Wales basis with working arrangements in place for each Network and across the border with England.[5,52,53]

There is a robust clinical governance framework including an ongoing risk assessment and reporting of clinical incidents and near misses with feedback of any lessons learned to all members of the team.

All units accepting or receiving neonates have 24 hours access to timely and appropriately staffed and equipped neonatal transport services 365 days a year. [5,52,53]

The Network is responsible for monitoring neonatal transfers in line with UK Neonatal Transport Group. The transport service will contribute data to the National minimum data set and produce an annual report. To enable this, transport teams will enter every transport episode into the Badgernet system within 3 weeks of the transfer event.

Staff working within the transport teams are in addition to those

of the clinical inpatient team.[1,2,5,52,53]

The neonatal transport team will have facilities for conference calls to enable a 3 way discussion between referring unit, transport team and receiving unit to optimise the care of the baby and initiate a timely transfer.

A dedicated vehicle specifically designed to support the transfer of babies between units will be available. The specification and suitability of this vehicle will be reviewed annually.[1,2,5,52,53]

Each Neonatal Unit will keep a detailed log of all neonatal transfers including unmet requests with the reasons. This information will be included as part of Unit and Network Annual Reports.

Neonatal units will ensure parents are involved in the possible transfer of their baby, including:

- Involving them in discussion on transfers
- Giving them comprehensive information on transfers
- Encouraging them to visit a new unit in advance of the transfer where possible
- Making sure parent know who to talk to at the new unit, for example, the nurse in charge
- Supporting the family to make alternative travel arrangements for the family if they are unable to travel with their baby.

Parents will be offered the opportunity, where appropriate, to travel in the ambulance with their baby if this has been agreed with the transport team.

Arrangements will be in place between maternity and neonatal Units for the timely transfer of the mother (in-utero transfer) when a high-risk situation is anticipated in line with the All Wales In–Utero Transfer Guideline and of the mother post delivery as soon as her condition allows.

Each Maternity Unit will keep a detailed log of all in-utero transfers of mothers whose babies are likely to need neonatal care, and all those where requests are refused with reasons.[1,2]

The transport service may request the assistance of EMRTS to enable safe and timely transport in the following situations:

- Responding to a time critical referral where arrival by road transport will not provide a timely response
- Long distance transfers of a baby where a road travel is anticipated to be in excess of 2.5 hrs (baby journey).

Babies born at home or at an MLU who require transfer to hospital will be transferred [70] safely with appropriate monitoring (including saturations and temperature), observations recorded, airway

control, ventilation or oxygen administration as required, and safely secured on a trolley in the supine position with appropriate arrangements to keep the baby's temperature at 37◦C.

Domain 5c – Discharge Planning

The discharge planning process will be commenced at the point of admission to facilitate safe and effective discharge.[1,2,8] This will include:

- Parents will be involved in the multi-disciplinary discharge planning from the point of admission. Health and social care plans will be continually reviewed
- A named member of staff will be responsible for co-ordinating a multi-agency discharge process.
- High risk neonates and those with complex on-going needs will have a multi-disciplinary Discharge Planning Meeting
- Parents will have access to rooming-in so they can stay with their baby and develop confidence in day-to day care prior *t*o discharge
- Families will have appropriate education, information and training (e.g. home oxygen, NGT feeding) prior to discharge
- Families will have resuscitation training (including information on SIDs) offered before discharge home
- Parents will have the opportunity to meet the neonatal outreach team prior to discharge if they are to be involved in their baby's future care
- Parents will be given copies of correspondence such as antenatal care plans and baby's discharge summary on or before the day of discharge. This may be accompanied by an explanation from a clinician.

All units are to have a local neonatal outreach team[1-5] who co-ordinate the multi-agency care of the neonate post discharge.

- As a minimum all 'high risk' neonates (<32wks, <1.5kg, HIE) will be followed up by the neonatal outreach team.
- Where there is a need for continuing care or palliative care, the responsibility for meeting those additional needs will rest with a workforce skilled in delivering neonatal care in the community[4,6,15]
- Bereavement support will be offered to families whose baby has passed away in the neonatal unit[1,2,15]
- Plans will include support and monitoring for vulnerable families to safeguard and promote the welfare of the baby[39-42]
- For those babies who need long term community care and support, the neonatal team will arrange appropriate and timely transfer of care to children's services
- Where there is no requirement for neonatal outreach, the responsibility for ongoing health monitoring will be transferred

to the primary care team.

The baby and family will have their ongoing needs at home co-ordinated and met by health professionals appropriately skilled in delivering neonatal care and support in the community.

Neonatal follow-up will be provided as close to the family home as possible.

- Local follow-up will be arranged and communicated to parents prior to discharge
- High risk neonates will have a 6 month and 2 year corrected neurological and developmental assessment.

Domain 6: Efficiency

Rationale: The services will provide value for money. Staff will be appropriately trained and skilled to undertake the tasks required in an efficient manner to reduce any wastage. The network will aim to achieve units working together efficiently to avoid any unnecessary duplication of services and using most efficient practices.

Domain 6a – Reducing unnecessary term admissions [44]

Where a baby > 37 weeks gestation (excluding those admitted because of congenital surgical problems) is admitted to the neonatal unit, a case review will be conducted involving obstetricians and neonatologists of the whole care pathway including the antenatal management to see if the admission could have been prevented.

Postnatal wards and transitional care units will have arrangements in place for regular clinical observations. This will include the use of a trigger tool to identify an appropriate review by a clinician when there are concerns (BAPM or similar). [48]

There should be pathways in place for the management of babies with the following conditions:
Jaundice
Risk of hypoglycaemia[45]
Respiratory concerns

Domain 6b – Avoidance of unwanted variation in practice

The network and neonatal units will work together to reduce unwanted variation in practice in order to ensure prudent and effective care through the development of pathways of care.

Domain 6c – Length of stay

Length of stay at various gestations will be benchmarked against those of similar units and information will be reported to units and health boards by the Network.

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38	Magnesium sulphate for women at risk of preterm birth for neuroprotection of the fetus. Cochrane database Syst Rev 2009 :CD004611 Doyle LW et al
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40	Safeguarding children and young people – every nurse's responsibility RCN guidance for nursing staff
41	Protecting children and young people. The responsibility of all doctors. GENERAL MEDICAL COUNCIL
42	The role of supervision in safeguarding children, young people and vulnerable adults
43	Good clinical Practice (GCP) – Health and Care research Wales. https://www.healthandcareresearch.gov.wales
44	Avoiding term admissions into neonatal units (ATAIN). Changing practice to keep mother and baby together. NHS England
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46	Newborn and Infant physical examination: standards 2016 to 2017-Gov.uk Newborn and Infant physical examination :clinical guidance GOV.UK
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49	Managing and preventing outbreaks of gram negative infections in UK neonatal units M Antony et al Arch Dis Child Fetal and Neonatal Edition 2013 Nov 98(6);F549-553
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58	Independent review of Incidents of Pseudomonas aeruginosa Infection in neonatal units in Northern Ireland 31/5.2012 The regulation and quality improvement authority
59	MBRRACE Mothers and babies reducing risk through audit and confidential enquiry Perinatal Mortality Surveillance reports 2013 and 2014
60	Welsh Assembly government PUTTING THINGS RIGHT- dealing with concerns. Guidance on the reporting and handling of serious incidents

	and other patient related concerns / no surprises

61	Developmental follow up of children and young people born preterm NICE guidance (Draft) Expected publication August 2017
62	Safety and governance issues for neonatal transport services Early Human Development 2009;85(8);483-6 Ratnavel N.
63	All Wales Nursing staffing principles
64	BAPM guideline for the screening and treatment of retinopathy of prematurity May 2008
65	Newborn hearing screening Wales website
66	Newborn Bloodspot screening Wales Website
67	National Neonatal Audit Project (NNAP) annual reports. RCPCH website
68	Dietician staffing on neonatal units – NDIG recommendations for commissioning 2014
69	Competence framework and evidence based practice guideline for the physiotherapist working in NICU and SCU in the UK (updated Nov 2015) The Association of Paediatric Chartered Physiotherapists
70	UK Ambulance services Clinical practice guidelines 2016

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

		Agenda Item	11
Meeting Title	**Joint Committee**	Meeting Date	28/03/2017
Report Title	Thoracic Surgery		
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: <u>Thoracic Surgery Review</u> • To notify Joint Committee that the RCS report is now available and has been shared with the Project Board; • To approve the service specification for thoracic surgery; • To request that Joint Committee approve the revised process for completing the thoracic surgery review. <u>Additional Interim Capacity to Achieve Cancer Waiting Times Targets</u> • To update Joint Committee on the implementation of the Additional Capacity Project.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☒

Sub Group /Committee		Meeting Date	
Recommendation(s)	Members are asked to: <u>Thoracic Surgery Review</u> • **Receive** the RCS report; • **Approve** the thoracic surgery service specification; • **Approve** the proposed process for completing the review, in particular, the approach to stakeholder engagement and the role of the independent panel. <u>Additional Interim Capacity</u> • **Note** the progress implementing the Additional Capacity Project.		

11

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

The purpose of this paper is to:

Thoracic Surgery Review

- To notify Joint Committee that the RCS report is now available and has been shared with the Project Board;
- To update the Joint Committee on progress developing the service specification for thoracic surgery;
- To request that Joint Committee approve the revised process for completing the thoracic surgery review.

Additional Interim Capacity to Achieve Cancer Waiting Times Targets

- To update Joint Committee on the implementation of the Additional Capacity Project.

2.0 Background

WHSSC is currently undertaking a project to review thoracic surgery provision in Wales in order to inform the development of a commissioning plan for the future of the service over the next 10 years. The Royal College of Surgeons (RCS) was commissioned, through the Invited Review Mechanism, to provide advice to this project. The RCS draft report was received in January 2017.

In addition to this strategic work, WHSSC is also implementing the Thoracic Surgery Additional Interim Capacity Project to commission additional short term capacity to achieve cancer waiting times targets for lung cancer patients referred to thoracic surgery for resection.

3.0 Assessment

3.1 Thoracic Surgery Review

3.1.1 RCS Invited Review Report

WHSSC received the report from the RCS Invited Review on 9 January 2017. In addition to strategic service issues, the report also included information gathered, conclusions and a recommendation that related to a single potential patient safety matter. This material has been removed from the version of the report ('the short form report') that was shared with the Project Board because the subject matter is based on personal identifiable information that cannot be made generally available and is not related to strategic service issues; however, it will be shared with the Joint Committee in private session to enable the Joint Committee to understand the issue and receive appropriate assurance on its handling.

This short form report (attached) was shared with the Thoracic Surgery Review Project Board on 9 March. It should be noted that the report does contain certain unverified personal views and observations but this is part of the RCS Invited Review Mechanism methodology.

The report has informed the development of the thoracic surgery service specification. It will form key evidence for the next phase of the work as the project moves forward to consider the stakeholder engagement process and assessment of options in order to make a recommendation on the future service model and commissioning plan.

3.1.2 Service Specification

The service specification is a key product of the review. In January, the Project Board agreed the draft specification to go forward for wider consultation. In February, the specification was issued to wider stakeholders for consultation, including Community Health Councils, patient groups, Health Boards, professional clinical groups, English providers and the wider public. The responses have been considered by the Project Board in March (scheduled meeting of the Board on 9th March and an additional meeting via conference call on 15th March) and further amendments agreed (a copy of the specification is contained in appendix 2; the responses to the consultation are set out in appendix 3).

While it was able to consider the responses to the consultation, the Project Board was not quorate in either the scheduled or additional meeting in March and so was not able to approve the specification. Approval has been sought from Project Board on the service specification via written resolution, in order to ensure that the document can be considered for approval at the March meeting of the Joint Committee. An oral update on the outcome of this exercise will be provided at the Joint Committee meeting.

3.1.3 Review of Process for Engagement and Assessment of Options

WHSSC has re-assessed the approach to the next phase of the Review, namely how stakeholder engagement will be conducted and how the assessment of options will be undertaken. This has included legal advice in relation to obligations for engagement and public consultation, and a meeting with the Acting Chief Executive of the Board of Community Health Councils to seek their view and build a collaborative approach to engagement.

The current PID sets out a traditional approach in which engagement occurs after options have been evaluated and a preferred option identified. While this may be legally acceptable, the advice we have received is that this would not meet best practice standards for stakeholder engagement. Engagement is an on-going process that should be in place throughout the project; formal consultation is an instance of engagement and part of the overall engagement process. Recent experience with other strategic service reviews in Wales with potential for service reconfiguration, suggests that a collaborative approach to engagement is required to maximise the likelihood of achieving stakeholder support for recommendations.

We were also advised that a formal public consultation on a preferred option would not be a legal requirement in this case.

Revised Process

It is proposed to separate the decision process into 2 stages.

The first stage decision will be over whether there should be one or two thoracic surgery centres. This will be addressed by the Project Board. Since this is a technical question, no specific engagement is proposed in relation to this decision.

If the first decision is in favour of a single centre, the second stage decision will concern where to locate the centre. The process for this decision will include 2 main elements:

i) Extensive stakeholder engagement in relation to the criteria on the basis of which the preferred location will be determined;
ii) The use of an independent panel to apply the criteria to undertake an appraisal and select a preferred option.

The independent panel approach has been successfully used previously by WHSSC in relation to neonatal services. A similar approach would be taken for thoracic surgery to reach a recommendation on where to locate the thoracic surgery centre.

The proposed process and timelines are set out in table 1.

Table 1: Proposed process and timescale to complete the thoracic surgery review

Phase	Timescale	Project Board	Joint Committee
Specification	March	March	March
Agree process for engagement and OA	March	March	March
Decision 1: one or two centres	March - May	April / May	May
Engagement process	June - August		
Independent panel	September	September	
Recommendation to Joint Committee		November	November

This proposal has been discussed with the CHC. It was positively received. While they were supportive of the approach, they needed to engage the support of their members through the Board. WHSSC is currently awaiting the outcome of

this meeting. Subject to the approval of this revised process by the Joint Committee, the PID will be amended to include the new timeline and process.

3.2 Additional Interim Capacity Project

While the providers have been delivering the contracted levels of activity, and resection rates continue to improve, it was recognised that many patients have experienced delays and have breached the cancer targets. In November, the Joint Committee supported the proposal that WHSSC assess the feasibility of commissioning additional capacity to treat the current backlog of patients. The Thoracic Surgery Additional Capacity Project was established to take this forward, with clinical and commissioning stakeholder input. In January 2017, Joint Committee agreed to provide the additional funding required.

The Additional Capacity Project has achieved the following to date:

- For patients in South East Wales:
  - Additional activity through a weekend working initiative at Cardiff & Vale commenced on 11 February 2017. This plan aims to treat the backlog over a 2 month period.
- For patients from South West Wales:
  - Referral pathway developed
  - Potential providers assessed and preferred providers identified
  - Patient information developed
  - Detailed pathway discussions with the potential provider will take place on 15 March.

4.0 Recommendations

Members are asked to:

Thoracic Surgery Review

- **Receive** the RCS report;
- **Approve** the thoracic surgery service specification
- **Approve** the proposed process for completing the review, in particular, the approach to stakeholder engagement and the role of the independent panel.

Additional Interim Capacity

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

5.0 Appendices / Annexes

A1: RCS Invited Review Report.
A2: Draft thoracic surgery service specification.
A3: Responses to the consultation on the thoracic surgery service specification.

Link to Healthcare Objectives	
Strategic Objective(s)	Implementation of the Plan
Link to Integrated Commissioning Plan	The Thoracic Surgery Review is included within the WHSSC ICP 2016/17.
Health and Care Standards	Effective Care Safe Care
Principles of Prudent Healthcare	Reduce inappropriate variation
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Improving Patient Experience (including quality and Satisfaction)
Organisational Implications	
Quality, Safety & Patient Experience	This paper provides a brief update on the progress of the Thoracic Surgery review. The aim of the Review is to develop a commissioning plan for thoracic surgery in Wales. The paper also describes the project to commission additional capacity to address waiting times targets.
Resources Implications	With regard to the Review, resource implications will be incorporated within the implementation plan for the Review's recommendations.
Risk and Assurance	Risk and assurance issues are being addressed by the review.
Evidence Base	The evidence base for sustainable, high quality, safe and effective thoracic surgery services, is being considered as part of the review.
Equality and Diversity	Equity in access across Wales is part of the review terms of reference.
Population Health	The commissioning plan will improve population health through ensuring access to effective and sustainable services.
Legal Implications	None identified.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**

Abridged Report of the Royal College of Surgeons of England in relation to an Invited Review of Thoracic Surgery Services in Wales

The following 46 pages comprise an abridged version of a Report of the Royal College of Surgeons of England ('RCS') in relation to an Invited Review of Thoracic Surgery Services in Wales that was commissioned by the Welsh Health Specialised Services Committee ('WHSSC') in 2016 to consider strategic service issues. The full Report was delivered to WHSSC in January 2017. The abridged version of the Report was prepared by WHSSC.

In addition to strategic service issues, the Report included information gathered, conclusions and a recommendation that related to potential patient safety issues. This material has been removed from the following abridged version of the Report because the subject matter is based on personal identifiable information. WHSSC has addressed the related potential patient safety issues, as a priority, with the service provider.

The sections of the full Report that have been revised to generate the abridged version of the Report follow:

Section	Revision	Section	Revision
3.4, 3.5, 3.7 and 3.8	Names removed	6.2.29	Three sentences and part of two other sentences removed
6.1.8	Final sentence removed	6.2.30 – 6.2.34	Removed
6.2.6	Three sentences removed	6.3.27	Part of first sentence removed
6.2.7	Four sentences removed	7.2.12	Two sentences removed
6.2.9	Part of final sentence removed	7.3.3 - 7.3.5	Removed
6.2.11	Removed	Recommendation 4	Removed
6.2.22	Part of one sentence removed		

Welsh Health Specialised Services Committee
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Caerphilly
CF83 3ED

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
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Chair/Cadeirydd: *Mrs Ann Lloyd, CBE*
Acting Managing Director of Specialised and Tertiary Services Commissioning/Rheolwr Gyfarwyddwr Dros Dro Comisiynu Gwasanaethau Arbenigol a Thrydyddol: *Mr Stuart Davies*

WHSSC abridged report

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND

INVITED REVIEW MECHANISM

A Service Review on behalf of:

The Royal College of Surgeons of England
35 – 43 Lincoln's Inn Fields, London WC2A 3PE

Society for Cardiothoracic Surgery
35 – 43 Lincoln's Inn Fields, London WC2A 3PE

Report on the thoracic surgical service in Wales

Welsh Health Specialised Services Committee

12 – 14 September 2016

REVIEWERS:
Mr Alan Wood FRCS,
The Royal College of Surgeons of England

Mr John Duffy MBBS; BSc; FRCS; MS; FRCS (CTh),
Society for Cardiothoracic Surgery

Mr Sion Barnard FRCS,
Society for Cardiothoracic Surgery

Ms Jane Corfield, Lay Reviewer

11

Royal College of Surgeons

WHSSC abridged report

Contents

Royal College of Surgeons

WHSSC abridged report

1. Background to the review

1.1 On 23 June 2106, Mr Daniel Phillips, Acting Managing Director of Specialised and Tertiary Services Commissioning at Welsh Health Specialised Services wrote to the Chair of the Invited Review Mechanism (IRM) to request an invited service review of the provision of thoracic surgery services in South Wales, specifically in relation to Morriston Hospital and Cardiff University Hospital. This request was considered by the Chair of the RCS IRM and representatives of the Society for Cardiothoracic Surgeons, and it was agreed that an invited service review would take place. A review team was appointed and an invited review visit was held on 12 – 14 September 2016.

2. Terms of reference for the review

The following terms of reference for this review were agreed prior to the RCS review visit between the RCS and WHSSC.

a) To assess the current provision of thoracic surgery services in Wales, with particular focus on Morriston Hospital and the University Hospital of Wales, with reference to:
   - the current model performs against published best practice
   - current patient outcomes and experience
   - which sub-specialty areas of surgery are currently being delivered
   - the services interact with other regional services
   - and how sustainable the current model is

b) To consider what a suitable future model for the provision of Thoracic Surgery Services in Wales would be, with reference to:
   - the delivery of high quality and timely patient care
   - accessibility and equitability
   - patient experience
   - sustainability (including training)
   - cost-effectiveness
   - effective co-operation with other services
   - an effective staffing model (including the wider MDT)

c) To comment on any additional issues that may arise during the review, including issues that bear relevance to Mid and North Wales Thoracic Surgery Services.

d) To make recommendations for the consideration of The Welsh Health Specialised Services Committee on the development of a commissioning plan for Thoracic Surgery in Wales.

3. Details of surgical service being reviewed

3.1 The Welsh Health Specialised Services Committee (WHSSC) is responsible for the joint planning of Specialised and Tertiary Services on behalf of Local Health Boards. WHSSC was established in 2010 by the seven Local Health Boards in Wales to ensure that the population of Wales has fair and equitable access to the full range of specialised services.

3.2 Thoracic Surgery in South Wales was provided at two different hospital sites, in Swansea and Cardiff.

3.3 Morriston Hospital, in Swansea, was responsible for delivering thoracic surgery services to Abertawe Bro Morgannwg University Health Board (ABM) and Hywel Dda University Health Board (Hywel Dda). ABM encapsulated patients from Morriston, Singleton, Neath, Port Talbot and Bridgend hospitals, equating to a population of approximately 500,000. Hywel Dda included patients from hospitals situated in Llanelli, Carmarthen, Aberystwyth and Haverfordwest, which covers a population of around 372,320 patients.

3.4 The thoracic surgery services formed part of the larger cardiothoracic department, for which Mr Pankaj Kumar was Interim Clinical Director. The department was made up of five Cardiothoracic Surgeons and two Thoracic Surgeons.

3.5 One Consultant Thoracic Surgeon was responsible for providing surgical care to patients in the Hywel Dda and Princess of Wales Hospitals, whilst the other treated patients from the ABM region. Each consultant covered a population of approximately 500,000 people.

3.6 Cardiff University Hospital provided thoracic surgery to patients served by the Cwm Taf, Aneurin Bevan and Cardiff Vale University Health Boards. This covered patients being referred from the University Hospital of Llandough, Royal Gwent, Nevill Hall, Royal Glamorgan and Prince Charles Hospitals. In total Cardiff University Hospital provided thoracic surgery services to a population of around 1.35 million people.

3.7 Similarly to the Morriston Hospital, the thoracic surgery team in Cardiff was part of the wider cardiothoracic surgery service, which was led by Miss Indu Deglurkar. The team consisted of four Consultant Cardiac Surgeons, with one role vacant at the time of the review. There were two Consultant Thoracic Surgeons.

3.8 One Consultant Thoracic Surgeon was primarily responsible for treating patients covered by University of Llandough, Prince Charles and Royal Glamorgan Hospitals, whilst the other covered Royal Gwent and Neville Hall Hospitals.

4. Royal College review team

Lead reviewer	Mr Alan Wood FRCS, The Royal College of Surgeons of England Mr Wood has been a consultant cardiothoracic surgeon in London for over 25 years with a particular interest in video assisted thoracic surgery. He has served on GMC fitness to practice and interim orders committees for many years and with the RCS invited review mechanism since its inception as the Rapid Response programme.
Clinical reviewer	Mr John Duffy MBBS; BSc; FRCS; MS; FRCS (CTh), The Society for Cardiothoracic Surgeons Mr Duffy has been a consultant General Thoracic surgeon in Nottingham since 1997. He has led the Thoracic surgical service at Nottingham for more than 15 years and has been an active member of the Society for Cardiothoracic Surgeons.
Clinical reviewer	Mr Sion Barnard FRCS, The Society for Cardiothoracic Surgeons Mr Barnard has been a Consultant Thoracic Surgeon for 17 years in Freeman Hospital Newcastle. He has been a member of the National Cancer Intelligence Network, and has a strong interest in Cardiothoracic training, being SAC Chairman from 2013-2016. He has taken part in the Keogh Reviews in the past.
Lay reviewer	Ms Jane Corfield Ms Corfield has over 25 years' experience in the fields of Communications, Public Relations and Management. She is a founder member of the Royal College of Surgeons Patient Liaison Group and of the Rapid Response programme. She has served as a lay reviewer for the Invited Review Mechanism since its inception.

5. Interviews held

Mr Daniel Phillips	Acting Managing Director WHSSC
Ms Sian Lewis	Acting Medical Director
Mr Ian Langfield	Acting Director of Planning
Dr Ian Williamson	Respiratory Physician ABUHB
Ms Clare Lines	Assistant Director for Commissioning, Powys Health Board
Mr Peter Richards	Planning and Performance, Powys Health Board
Mr Neil Miles	Planning and Performance, Powys Health Board
Mr Gareth Collier	Respiratory Physician, Hywel Dda UHB
Dr Diane Parry	President of Welsh Thoracic Society
Dr Ben Hope-Gill	Respiratory Physician
Dr Gareth Collier	Chest Physician
Mr Keith Jones	Lead Cancer Senior Manager
Ms Clare Jenkins	Acting CEO, Board of Community Health Councils
Mr Michael Shackcloth	Clinical Lead of Thoracic Surgery
Mr Tony Wilding	Chief Operating Officer
Dr Caroline Williams	Respiratory Medicine, Ysbyty Glan Clwyd
Dr Sakkarai Ambalavanan	Respiratory Medicine, Ysbyty Glan Clwyd
Dr Anna Mullard	Consultant Medical Oncologist, Ysbyty Gwynedd
Dr Neil McAndrew	Consultant Chest Physician, Ysbyty Gwynedd
Dr Robin Poyner	Consultant Chest Physician, Wrexham Hospital
Ms Tersa Humphreys	General Manager, ABMUHB
Mr Pankaj Kumar	Interim Clinical Director for Cardiothoracics
Ms Helen Davies	Directorate Nurse Manager, ABMUHB
Dr Martin Rolles	Consultant Clinical Oncologist and Health Board lead Clinician, ABMUHB
Ms Nicola Dickens	Theatre Scrub Sister, ABMUHB
Mr Jason Hoskins	Operational Manager Anaesthetics
Dr Rachel Barlow	National Programme Lead for Lung Cancer
Mr Francois Lhote	Consultant Thoracic Surgeon
Mr Ira Goldsmith	Consultant Thoracic Surgeon
Dr Umiar Aslam	Cardiac Registrar
Dr Ahmed Ajzan	Thoracic Surgeon
Mrs Joanne Mahon	Physiotherapy Manager – Swansea Locality
Dr Mike Gilbert	Consultant Anaesthetist
Dr Ahmed Ajzan	Specialist Registrar
Dr Umair Aslam	Specialist Registrar
Dr Rhian Finn	Lung Cancer Lead (West)
Dr Madhu Shetty	Lung Cancer Lead (West)
Dr Martin Sevenoaks	Lung Cancer Lead (East)
Dr Graham Shortland	Medical Director, CUH
Mr Nick Gidman	Directorate Manager
Ms Sian Williams	Senior Nurse, Cardiac Services
Mr Jonathan Kell	Clinical Board Director

Ms Zoe Morgan	Physio Lead
Ms Cath Von Oppell	Case Manager
Ms Emma King	Case Manager
Mr Adam Cairns	Chief Executive Officer
Dr Peter O'Callaghan	Clinical Director
Mr Kevin Nicholls	Service Manager
Miss Malgorzata Kornaszewska	Consultant Thoracic Surgeon
Mr Ainis Pirtnieks	Consultant Thoracic Surgeon
Ms Jessica Castle	Head of Operations and Delivery
Miss Indu Deglurkar	Consultant Cardiothoracic Surgeon and Clinical Lead
Dr Joseph George	Specialty Trainee Year 3 – Cardiothoracic Surgery
Dr Hatam Nasse	Clinical Fellow – Cardiothoracic Surgery
Dr Rob Abel	Consultant Anaesthetist
Dr Tom Crosby	Clinical Director, Wales Cancer Network
Ms Sian Crowley	Directorate Manager Theatres
Ms Alison Jenkins	Recovery Nurse
Ms Leanne Cross	Anaesthetic Practitioner
Ms Karen Sergeant	Staff Nurse Scrub
Ms Lorraine Kruger	Clinical Lead Cardiac Thoracic Theatre

6. Information gathered by the review team

The following information represents a summary of the information gathered by the reviewers during the interviews held during the review visit and from the documentation submitted. It is organised under the headings of the themes that emerged. The information presented will sometimes reflect the viewpoints of those individual staff members being interviewed; it will not necessarily always reflect the views of the RCS or its reviewers on these circumstances.

6.1 The background to the thoracic surgery service review in South Wales

Background to the review

6.1.1 Healthcare in South Wales was commissioned by WHSSC, which has the jurisdiction to decide where services should be based and how resources should be allocated. The reviewers were advised that healthcare in Wales was high on the political agenda with the Welsh Government closely involved in healthcare strategy across the country.

6.1.2 There had been some movement to centralise different services at one site within South Wales. The review team heard how neurosurgery was being performed solely at Cardiff University Hospital, whilst plastic and reconstructive surgery had been centralised at the Morriston Hospital. The rationale behind this was said to be that the quality and delivery of care provided to patients was improved when services and resources were centralised in one site as opposed to being spread across several sites.

6.1.3 There had been some discussion regarding the reconfiguration of thoracic surgery services for some time. The basis of this was that both thoracic surgery services had been underperforming in comparison to national and European standards. There had been previous attempts to review thoracic surgery for South Wales however there was no action borne out of the findings of the previous reports. The review team did not have sight of all these reports.

Resection rates in South Wales

6.1.4 The review team heard that lung cancer outcomes in Wales were amongst the poorest in Europe. Interviewees were specifically concerned that the resection rates for Wales were lower than the rest of Europe, which they felt may adversely affect survival rates for lung cancer. The WHSSC had set the aim for the lung cancer resection rate to be among the upper quartile for the UK within the coming years. The resection rate for South Wales for 2015/16 was 14%, up from 11% in 2012/2013. Cardiff University Hospital reported a resection rate of around 16%, whilst Morriston Hospital reported a resection rate of around 15%. The aim of a 17% resection rate

was set for 2016/17 and a 'task and finish' group had been put together by WHSSC to help address resection rates.

6.1.5 There was some level of uncertainty regarding the cause of the low resection rates in South Wales. One suggested cause was that it was due to patients presenting late, having co-morbidities and generally being a population of patients unsuited to undergoing surgery. This meant that some patients considered at MDT meetings had cancers that were too advanced to be surgically treated. There had been some attempt to address this with public awareness campaigns being developed to encourage the public to come forward if they were exhibiting symptoms of lung cancer.

6.1.6 Some interviewees considered that the ethos of MDT meetings could have previously had a bearing on the resection rates. In particular, participants at previous meetings were said to have had a tendency to analyse which patients could have resections whereas there was more recently a view adopted that resections should be offered to everyone unless there was a significant reason not to. Consequently there were more patients with poor performance status and more radical cases undergoing resections. There was some difference in opinion about this change, with some believing that this has improved resection rates whilst others asserting that risky patients can sometimes be re-staged by the time of the operation and turned down for surgery at that stage.

6.1.7 Capacity problems were considered instrumental in causing the poor resection rate, with the average wait time from accepting the patient in clinic to surgery being 5 –6 weeks. It was alleged by some interviewees that patients were consistently breaching the 31 and 62 day limit for referral, which was somewhat supported by the breach data for the respective hospitals. Interviewees at the Swansea site were in agreement that referring patients to hospital from West Wales could be particularly challenging. However, this was something that was rejected by Cardiff University Hospital, who felt that their referral to treatment rates were adequate. The effect of this delay was that patients had to be re-staged because their cancer had deteriorated by the time they were ready for surgery. Subsequently these patients would have to be referred to an additional MDT to agree a new treatment plan, as the previous plan was no longer viable. The two departments maintained that they were attempting to identify cancer patients earlier so that they can be moved along the patient pathway as quickly as possible but that a lack of resources and capacity did undermine the success of this.

6.1.8 In Swansea there was some suggestion that there was a disparity between the resection rates of the two consultant thoracic surgeons who attended the MDT meetings. It was contended that in 2009/2010 the resection rate was 20%; which was achieved by merging the West Wales MDT meetings. This rate apparently decreased to 15% following changes in the consultant thoracic surgeons servicing the MDT. There was also a large disparity in resection rates for the local MDTs, for example there was a resection rate of 24% at Prince Charles Hospital compared to

6% for patients presenting at Morriston Hospital. This was considered to be unusual, as resection rates for central hospitals tended to be higher than at peripheral sites.

6.1.9 There was some concern regarding the accuracy of the resection rate data, with suggestion that this may not have been recorded correctly, thus giving the illusion that resection rates were worse than was actually the case. However a number of other interviewees rejected this idea, submitting that data collection was generally good with no issues being flagged. Furthermore it was considered that the MDT leads for Swansea were fastidious at looking into data and therefore it was likely that the collected data sets were correct.

Population

6.1.10 The review team were provided with information regarding the population making up South Wales. The Swansea site covered a largely rural population with some more concentrated areas like Port Talbot. Cardiff University Hospital covered the more built up areas of Cardiff and Newport as well as more rural surrounding areas. Historically there was said to have been poor patient health and co-morbidities within South Wales. It was also suggested that the socio-economic factors contributed towards poor health, with patients from the deprived areas of South Wales typically having less access to facilities such as chemotherapy. Interviewees did, however, confirm that that the Welsh Government had invested funding to tackle cancer, particularly to improve resection rates and to reduce death rates.

Financial Investment

6.1.11 The review team were provided with a copy of the details of the funding allocated from WHSSC to thoracic surgery services in South Wales. It was evident that the Cardiff site received a significantly higher investment from WHSSC, which was considered to be in part because of the larger size of the catchment population being treated by Cardiff. The budget for Cardiff for 2016/2017 was £3.28 million whilst Morriston Hospital received £2.12 million, which was significantly higher than funding received in previous years for the services. Interviewees informed the review team that money was given to each service so that they could meet the targets that were set by WHSSC.

6.1.12 Interviewees at both Morriston and Cardiff University Hospital sites stated that they were over-performing in relation to what was expected of them by WHSSC; however they were not receiving the full rate remuneration for over-performance. The review team heard that services were at the limit of what they could achieve based on the funding provided to them, despite pushing for additional monies. It was commented that additional operating hours for surgeons, beds and 'pre-habilitation' could be provided if additional funding was provided by WHSSC.

6.2 The current provision of thoracic surgery services in South Wales

Swansea Thoracic Surgery Service

Patient capacity

6.2.1 Interviewees in Swansea highlighted that staff would often be left searching for beds and that HDU beds in particular were in short supply. It was reported that operations had been cancelled as there were not the facilities available to keep the patients in overnight. This had also led to some patients being transferred to Cardiff to undergo surgery. Interviewees commented that within the hospital's existing wards there was not enough space to accommodate beds that were required and that a dedicated ward was highly desirable. Furthermore, some interviewees also reported that the service required better access to high dependency beds as well as a higher nursing compliment. The review team were made aware that there had been a push to have same day admission for patients in order to free up some beds.

6.2.2 Interviewees reported that the length of stay of patients on the ward was longer than it should be. This was said to be partly because patients typically had to be admitted the day before surgery as they had to travel some distance for treatment. Similarly patients' length of stay was extended following surgery also as a result of the distance patients had to travel. This consequently meant that fewer beds were available for use and patient throughput was reduced, leading to increased patient waiting times for treatment and the organisation missing SaFF targets[1]. The review team learnt that at the time of the review visit there were no plans to increase the amount of beds available.

Theatre Access

6.2.3 The thoracic surgeons had access to one theatre and each operated once a week. One session took place on a Tuesday from 08:00 – 20:00, whilst the other session was on Thursday from 08:30 – 18:30. The second operating day was said to be shorter as budget constraints prevented the day from being extended. Typically the surgeons would perform numerous operations including resections, biopsies and lobectomies during these sessions.

6.2.4 When questioned, interviewees confirmed that most of the lists started on time. It was said by some that, typically, there would be a team brief taking place at approximately 07:50. Operating would reportedly commence, at around 09:30 – 10:00 depending on the time required for the anaesthetist to prepare the patient. Some interviewees reported that operating could at times start late. This was said to be due to resourcing problems as opposed to any issues at consultant level.

[1] Service and Financial Framework targets

6.2.5 Interviewees also commented that they were lacking resources for surgery and that on the day of surgery equipment was sometimes missing. For instance, one interviewee explained that there were a number of major, non-thoracic cases performed on Mondays, which meant that there was pressure on staff to ensure that equipment was replenished and ready for the next day. Similarly if any operating lists took place on additional days, it could be difficult to obtain the correct equipment in time. Interviewees also expressed dissatisfaction at the lack of portering services available; reporting that for some cases there was nobody available to collect the patient, meaning that this fell to the nurses or clinicians to do. When questioned further, interviewees confirmed that patients would not walk to theatre as there was resistance from management for this to be implemented. Interviewees articulated that the lack of porters could detrimentally affect surgery as it could delay start times.

6.2.6 Interviewees reported that the organisation of lists and theatre differed between the two surgeons.

6.2.7 Interviewees further noted that there were differences in operating style between the two consultants.

6.2.8 The staff at Swansea reported issues with scheduling of the theatre lists, particularly in respect of the Thursday theatre session. Interviewees reported that many of the patients treated during the Tuesday theatre sessions have epidurals as part of their treatment. The review team was advised that it was policy for epidural patients to spend two days on the HDU following the procedure; although it was the view of some that patients did not always require transfer to the HDU. This meant that patients due to be operated on during the Thursday theatre list occasionally had their sessions cancelled as there was insufficient access to HDU beds. It was considered that this policy hindered throughput and contributed towards the patient backlog. Interviewees also submitted that attempts made to extend operating hours had been rejected.

6.2.9 It appeared that there had been some discussion centred on moving surgery days to from Tuesday to Monday to improve patient care and accessibility to services. Some interviewees felt this was not viable because there were already nine theatres working on this day, many of which were involving major surgical cases. Further suggestions were put forward such as alternating days in theatre for surgeons, this was said to have been rejected on the basis that it would conflict with one of the surgeon's arrangements.

6.2.10 A number of interviewees highlighted that some patients had had their operation delayed or cancelled as a result of lack of resources or from overbooking. To attempt to maximise the number of patients treated, operating days were often extended, however it was noted that this was not sustainable because staff fatigue may be a risk to patient safety. Both consultants have also tried to look for extra operating where possible and have taken up additional lists for which they are not

remunerated. The review team learnt that one consultant had not been taking annual leave so that patients did not have to lose their operation slots. Patients cancelled on their scheduled operating day remained in hospital until the consultant's next operating list, which was usually the week after. Despite these cancellations, interviewees affirmed that patient complaints were rare because they had had their expectations managed prior to surgery.

6.2.11

6.2.12 Interviewees stated that the current model was not sustainable for the surgeons and was not in the best interests of patients because it often caused their operations to be delayed for longer than was necessary. For instance, it could mean that a patient was treated a full week later as opposed to just a few days later. It also meant that if a consultant was away, whole theatre lists would not be performed. Interviewees asserted that a third surgeon was required to help alleviate this issue as opposed to recommending pooled lists.

Surgical techniques

6.2.13 It was reported that there was a tendency to use epidurals for patients on the Tuesday list. While this was considered a reasonable approach to employ, it did require patients to stay in the HDU unit for two days following their procedure, which could pose problems in terms of bed availability for patients due to be operated upon on during the Thursday session.

6.2.14 The two consultant thoracic surgeons used different techniques, with one preferring to do hybrid thoracotomies using video-assisted thorascopic surgery (VATS), on the basis that he believed this to be quicker and safer, while the other preferred the more standard VATS lobectomy. It was asserted by interviewees that there had been a drive to use new techniques and to increase the amount of VATS lobectomies but that not all staff had bought into this.

MDT process

6.2.15 There were three MDTs linked with Morriston Hospital, these were as follows:

- ABM Swansea consisting of Morriston, Singleton and Neath Port Talbot Hospital
- ABM Princess of Wales, which was for patients from Bridgend
- West Wales, which included patients from Llanelli-Carmarthen, Aberystwyth and Haverfordwest

6.2.16 The MDT meetings were split between the two consultants with one consultant attending the ABM Swansea MDT every Monday, whilst the other consultant attended the other MDTs every Thursday.

6.2.17 MDT meetings were predominantly conducted via video conferencing. This was

thought to be necessary due to the large geographical area being covered, making it impractical for the consultant to travel to each referring hospital. For instance, it would have taken physicians approximately an hour and a half to travel to areas like Aberystwyth. The view widely held amongst interviewees was that video conferencing generally worked well although, were it viable, having everyone in the same room would have been preferable. There were said to be some minor issues during videoconferencing calls, like transmission of images being delayed, meaning that the radiologist could potentially be reviewing images for the wrong case, albeit it was implied that these errors were always noticed and rectified.

6.2.18 There were said to have been some previous efforts to reduce the amount of MDT meetings with Neath and Port Talbot being merged into one MDT and it was further suggested that the two ABM MDTs could be merged into one MDT. These changes were said to reduce the demand on consultant surgeons to attend meetings, so that they could continue to deal with patient care.

6.2.19 The rate of consultant surgical attendance for these MDT meetings was usually high with the lowest recorded at 88%. The review team heard that one consultant surgeon avoided taking leave so that he did not miss MDT meetings. There was some discussion as to whether the presence of a nurse specialist at the MDT would help facilitate decision making when surgeons were not present and provide general support. This appeared to be an area of some disagreement with a number of staff maintaining that any nurse specialist recruited should be focussed on aftercare instead.

On-call

6.2.20 The consultant cardiac surgeons were responsible for providing the majority of on-call cover for patients. The two consultant thoracic surgeons provided on-call cover on their operating days only. It was widely considered that there was not the capacity to provide an on-call rota staffed solely by the consultant thoracic surgeons.

6.2.21 It was commented that, traditionally, the more recently appointed cardiac surgeons would provide on call cover for both cardiac and thoracic surgery. Interviewees noted that there were perhaps some differences in care provided by the various on-call surgeons, and it was intimated that alternative management may have been employed had the consultant thoracic surgeons provided the on-call care. Despite this there was said to have been no indication that those providing on-call care to date had put patient safety at risk.

6.2.22 There were some inconsistencies between emergency care provided by the two thoracic consultant surgeons. Both thoracic surgeons were said to have been willing to attend emergency on-calls and there was one example where a surgeon was contacted following the admission of a stab wound victim and he attended the patient at A&E and subsequently operated that evening. It was of concern that there may be times when a consultant surgeon may not be in close enough proximity to

provide emergency care to their own patients.

6.2.23 It was proposed by some that a joint on-call could be established, where thoracic surgeons would undertake on-call duties at Morriston and Cardiff University Hospital on a one in four basis. This was rejected by a number of interviewees who suggested that it would be too far for the surgeons to travel and that organising after-care would be problematic.

Governance

6.2.24 Interviewees suggested that there was a good level of governance within the department. There were ten audit meetings per year as well as monthly M&M meetings. These M&M meetings were held with the cardiac team, with the lead being rotated monthly. The meetings were described as fair, with issues being widely discussed.

Patient satisfaction

6.2.25 Staff in Swansea reported that patients rarely complained about their treatment and they consistently received positive feedback regarding the quality of the service provided, although there had been no patient experience initiatives conducted by the department. One interviewee did report that there were a couple of occasions where patients had asked to be transferred to Cardiff University Hospital for treatment. The complaints seen by the review team mainly related to the cancellation of operations or waiting times for treatment. Staff were said to have attempted to manage expectations by informing patients of the possibilities of delays to treatment.

Staffing

6.2.26 One of the main challenges raised by interviewees was the lack of staffing, particularly at consultant surgeon and nursing levels. There was said to have been some conversations held around reducing the demand placed on consultants and the department was said to have utilised other staff to assist in this regard. Examples were given of respiratory physicians assisting with stenting and personal assistants recording patient-related data.

6.2.27 It was confirmed that WHSSC had authorised funding for a third consultant thoracic surgeon in Swansea, but this was seen to pose some difficulties, primarily in establishing a theatre list which were said to be difficult to come by. There were also concerns raised by one interviewee that a three consultant model may undermine the consistency of consultant oversight of patients, although it was hoped that there would be a move toward a more fluid and team based approach.

6.2.28 It was highlighted that there was a lack of nurses within the department with several vacancies at the time of the review visit. There was said to have been some specific difficulty advertising for a nurse specialist role within the department as there had

been a dispute regarding the job plan for the position. It was advised that there was an appetite for progression amongst the nursing contingent; therefore it was possible that these nurses may apply for the nurse specialist roles when the job plan had been agreed and the post advertised.

Team working

6.2.29 The working relations between the two consultant thoracic surgeons at Morriston Hospital were said to be strained. It was made clear to the review team that the working styles of each consultant were very different.

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Relationship with cardiac surgeons

6.2.35 The review team heard that whilst the working dynamics between cardiac and thoracic surgeons were generally positive there was perceived to be a tendency for management to prioritise cardiac patients over thoracic patients. Interviewees asserted that where patient beds were concerned, cardiac had a priority list and if there was only one bed remaining this would invariably be given to a cardiac patient. It was also reported that, historically, cardiac patients would sometimes stay on the ward for longer than therapeutically necessary, meaning beds were not free for thoracic patients to use. This was said to have improved since the thoracic review in 2013, when the ward expanded and facilities improved. It was also said that if theatre cancellations were needed it was more likely that thoracic patients would be cancelled than cardiac patients.

Facilities

6.2.36 The review team was informed that there were not enough facilities to meet patient demand. There was said to have been no substantive increase in operating sessions, funding or services and that as a result the thoracic service was being 'flooded'. It was said that patient waiting times to be seen in a clinic were now approximately one month and operative cases were often cancelled. In an effort to maximise operating time, staff were said to have resorted to using the emergency CEPOD theatre in the main suite. Some staff were reluctant to utilise this facility as they were not familiar with the theatre.

6.2.37 The lack of funding for facilities was also said to mean that it was difficult to replace important equipment. In addition, staff were said to feel they missed out on the

training and development opportunities that would be beneficial to patients, and them professionally. One example highlighted was the opportunity to expand their practice to undertake pectus repairs; however this was not approved by WHSSC.

6.2.38 Recently, there was said to have been some breakthrough in terms of the facilities being authorised by WHSSC. Specifically the review team was informed that after a number of years of requests, the use of endobronchial ultrasound (EBUS) facilities and thoracoscopy had been approved for South Wales. The waiting time for patients to access this service was one week, which was considered to be reasonable. It was reportedly believed that this would help improve the hospital's resection rate. There was, however, no data available at the time of the review to check the effectiveness of this aspect of the service.

Pre-admission facilities

6.2.39 The thoracic department in Swansea had been given funding for 'pre-habilitation' by WHSSC, although historically this funding was said to have been *ad-hoc*. The review team heard that the intention of the thoracic surgery service in Swansea was to develop a system similar to that in Cardiff, where initial contact through primary care was instigated to get patients physically fit for surgery. It was said that the intention was for these services to be available at sites across South Wales to ensure that patients could be worked up for surgery near their homes. The review team was informed that the thoracic surgery service in Swansea was looking to secure enough funding to recruit an individual member of staff who would be responsible for the delivery of 'pre-habilitation'. Until such a point the Swansea service would be reliant upon cardio-pulmonary exercise testing (CPEX), to assess if patients were fit enough to undergo surgery.

Training

6.2.40 Swansea has a medical school centred in the city and many of the students had undertaken placements at Morriston Hospital. Historically the hospital was said to have sometimes had a challenging relationship with trainees, with the removal of junior doctors by the Deanery reportedly leading to the collapse of the neurosurgery service in Swansea. In contrast the quality of training for trainees within the thoracic surgery service was considered to be highly positive. The consultant surgeons were deemed strong leads for teaching and it was felt that they were both approachable and willing to discuss queries. In terms of operating opportunities, it was suggested that trainees had a great deal of exposure to cases, and some of the trainees were in a position where they could operate independently. Typically these cases included VATS lobectomies, non-cancer cases and resections.

Development

6.2.41 The reviewers were informed that Morriston Hospital had intended to reconfigure its thoracic surgery service and were in the process of re-organising at the time of the review to establish a final structure. The Health Board's management had commissioned an independent report to review the resection rates within the service so that they could address this issue. Furthermore funding had also been

secured to expand the service so that an extra day of operating could be undertaken by a third consultant.

Non-cancer patients

6.2.42 The review team heard that there was a significant disparity between the way patients with cancer and those with other thoracic conditions, such as emphysemas and secondary pneumothoraces, were being managed. According to a number of staff, the WHSSC had developed waiting time initiatives in respect of cancer patients with the intention to improve care for them. This, in combination with limited capacity to admit patients, meant that cancer patients were being prioritised ahead of patients with non-cancer related condition.

6.2.43 Some interviewees maintained that access to surgery for non-cancer patients was difficult with surgical capacity being a problem. It was felt that this affected decision making in respect of these cases and it took longer to refer the cases to the service. Many of the non-cancer patients allegedly had to wait many months before they were referred into the service for routine treatment such as a lung biopsy. It was said that, once surgery was scheduled, patients often had their operations cancelled because beds were not available or cancer patients had been moved up the lists. It was commented that by the time some of these patients were treated the delay had been such that their conditions had worsened and they were typically very unwell at admission.

6.2.44 There were some concerns with non-cancer cases may have been going '*missing*' and '*dropping off lists'*. Interviewees maintained that they did not know what happened to these patients and the review team was not able to fully establish the reasoning for this. Some interviewees were concerned that patients may have been removed from waiting lists and subsequently not re-added, meaning that they may not have received the treatment they required. Some interviewees suggested that these patients had been managed by physicians at local hospital sites with medical and conservative treatments, which it was said may result in a significant period of discomfort and a potentially prolonged hospital stay.

6.2.45 There did not appear to be any formal initiatives in place within the department to address the backlog of non-cancer patients. Interviewees reported that one consultant typically undertook a significant amount of the non-cancer work and would attempt to obtain extra theatre time where possible to treat non-cancer patients.

Accessibility

6.2.46 Accessibility for patients was considered one of the major issues affecting patients in South Wales. Morriston Hospital in Swansea provided services to patients who were as far away as Aberystwyth and Machynlleth, which potentially equated to over two hours travel each way to access care. A few interviewees reported that patients had to make multiple trips for treatment because there was no access to pre-admission care at their local district general hospital or alternatively they would utilise other Health Boards' facilities in North Wales.

6.2.47 There was some concern raised about the access to timely care for emergency patients as ambulance services were reportedly slow on occasions. The review team was advised that there was an on-site helicopter, which could be used if necessary.

6.2.48 There was some degree of consensus that patients were willing to travel to obtain medical services, particularly if the quality of care provided was high and timely. Interviewees comment that patients travelled to Cardiff University Hospital for PET scans. This was a view that was supported by the Board of Community Councils who represents patient interests across Wales. Other interviewees stated that they felt that more services needed to be developed in order to help facilitate patients and their families, for example patient hotels or clinics for pre-admission and follow up care.

6.3 Cardiff Thoracic Surgery Service

Patient capacity

6.3.1 Interviewees in Cardiff reported that a lack of beds had a negative impact on the flow of patients through the department, with the process being less fluid than the previous system. Interviewees believed that thoracic patients would benefit from a designated ward and better access to high dependency beds and designated nursing staff to look after them.

6.3.2 It was reported that the specialist thoracic beds the unit had were utilised by patients who did not require thoracic treatment. It was stated that patients with rib fractures were being put into thoracic beds. The amount of 'outlying' patients in these beds was said to vary, however, it was reported that there had been up to a dozen patients at one time. Access to patient beds was said to be further obstructed by the length of stay of patients who were admitted the day prior to surgery. It was reported that there had previously been some attempts to admit patients on the day of surgery but this was not sustained by the service. Interviewees did not report that they were aware of there being an intention to increase the amount of beds available to thoracic patient despite the on-going throughput issues.

Theatre Access

6.3.3 The two consultant thoracic surgeons operated twice a week each, with thoracic surgery lasting from 08:00 to 18:00. Typically the surgeons treated a high proportion of cancer patients and undertook VATS lobectomies, metatstectomies and pleural biopsies amongst other surgical procedures, as well as a monthly pectus deformity list. It was commented that a minimally invasive approach to thoracic surgery was adopted where possible. The use of paravertebral analgesia was said to have reduced the need for HDU beds as well as postoperative stays.

6.3.4 The main issue with operating was said to be gaining enough access to theatres to accommodate the number of patients accessing the service. The review team were advised that an estimated 600 patients had to be treated by the consultants each year. Interviewees felt that there was limited capacity in the main theatre and all

theatre templates were full, making it difficult to put on additional theatre lists. It was said that it was the unit's priority was to gain another theatre list so that waiting times could be improved.

6.3.5 There was perceived to be some movement towards this objective as it was reported that management was looking to build two more theatres, however there was no definitive timeline provided for this. Other mechanisms for this had been considered and it was suggested that, where possible, Saturday theatre time could be allocated to address waiting lists. In addition the possibility of extending the operating day or overlapping patients has been discussed although no definitive action had been taken.

6.3.6 Consideration was said to have been given to the recruitment of a third consultant thoracic surgeon, and this had been approved by WHSSC. However there was concern regarding the access to operating that this surgeon may have, as there was not currently the theatre capacity for a third surgeon to perform theatre lists.

6.3.7 The review team heard that patients were seen by 'case managers' before being admitted for surgery. These case managers provided the pre-assessment for surgery and assisted to develop the lists and theatre schedules. It was considered that the flow of patients into surgery worked well and was well established. As a result it was submitted that the potential for cancellations was lower. However, it was confirmed that consultants would cancel or re-schedule patients where there was an urgent need for another patient to be treated instead. Staff estimated that the frequency of this varied from once a fortnight to as many as six in one week.

6.3.8 It was reported that the unit had previously tried admitting patient on the day of surgery. This was not adopted permanently as there could be last minute issues prior to surgery and delays to the anaesthetic assessment of patients, which consequently delayed surgery start times. The admission of patients the day before surgery was said to be favoured because this ensured that operations started on time with prompt list starts said to be helpful in avoiding 'queues'.

6.3.9 One of the biggest challenges facing the service, according to interviewees, was the issue of early theatre finishes. The review team heard that there was a pressure to have all surgical procedures finished by 18:00 as there were no members of theatre staff scheduled to be available after this time. In reality, it was said that surgery often finished around 16:00 because no new cases were able to be started after this time as they would be unlikely to finish before the 18:00 deadline. It was reported that as a result the surgeons were only operating on two or three patients per session and lists could not always be completed leading to the cancellation of patient operations. Some interviewees felt that this issue undermined the success of the unit and it was suggested that more staff were required so that surgery could be more flexible, particularly as other specialties like cardiac surgery were able to continue later in to the day.

6.3.10 It was reported that, following surgery, the anaesthetist went with the patient to

recovery and the next operation did not begin until the anaesthetist arrived back to the operating theatre. Interviewees stated that there could intermissions of around 45 minutes while the handover of care from the anaesthetist to the recovery staff took place. It was said by some that, whilst the number of theatres had grown, there were still few recovery staff, which undermined the effectiveness of this additional theatre space. Some interviewees did counter this by saying that that there was a system which recorded timings in theatre with a notification sent if a patient was not admitted to theatre within ten minutes.

6.3.11 There were said to have been good cross-cover between surgeons, with any cancellations being re-listed where possible on the next operating list regardless of the surgeon scheduled to perform that surgery. For complex cases the surgeons reportedly occasionally operated together. All changes to the operating lists were said to be discussed with the patients to ensure that they remained fully informed. Furthermore, it was reported that the consultant surgeons when conducting a ward round would see all patients, including their colleagues' and also cover each other's patients during periods of leave.

Surgical techniques

6.3.12 It was reported that the consultant thoracic surgeons in Cardiff preferred to use paravertebral blocks for post-operative pain relief. This method was considered to be preferable because it enabled patients to be transferred back to the main ward shortly after surgery, therefore freeing up HDU beds for future patients.

6.3.13 The review team heard that one of the consultant thoracic surgeons in Cardiff had been instrumental in implementing new procedures and more radical treatment within the department. This surgeon was said to have been involved in the introduction of progressive procedures such as VATS and other minimally invasive procedures. This reportedly meant that the department could maximise the amount of patients being treated as these sorts of procedures reduced recovery time of patients.

MDT processes

6.3.14 Cardiff University Hospitals contributed to five thoracic MDT meetings per week, which were at:

- Royal Glamorgan
- University Hospital Llandough
- Royal Gwent Hospital
- Nevill Hall Hospital
- Prince Charles Hospital

6.3.15 The MDT meetings were split between the two consultant thoracic surgeons, with one consultant responsible for the Prince Charles, Royal Glamorgan and Llandough

Hospitals' MDT meetings and the other for the Nevill Hall and Royal Gwent Hospitals.

6.3.16 Interviewees agreed that the MDTs could be consolidated from five into three for Cwm Taf, Aneurin Bevan and Cardiff. In particular it was considered that the Cwm Taf MDT did not need to have as many meetings. It was hoped that merging MDTs could free time for consultants to devote to addressing any patient backlogs and that this would also reduce the amount of cover required for MDT meetings when consultants were away. There was, however, also some apprehension expressed as some of the MDT meetings were considered to already be busy and continuing to grow in size, meaning that it was challenging to discuss all the cases within the allotted time.

6.3.17 There was a relatively low attendance at these MDT meetings, with rates being as low as 55%. This was said to be due to a number of reasons; firstly competing work demands sometimes meant that the surgeon was not able to attend the MDT via video link. Furthermore interviewees explained that there was not the capacity for staff to cross cover MDT meetings therefore when the consultant surgeon was away the MDT would proceed without the presence of any consultant thoracic surgeon. This issue was considered by some as a contributing factor to Cardiff's low resection rates, as there was no consultant to provide expert advice on whether a resection should be offered.

On-call

6.3.18 Consultant thoracic surgical on call cover was provided by the two consultant thoracic surgeons each working a 1 in 6 on-call with the rest of on call commitment provided by consultant cardiac surgeons.

6.3.19 There was concern that there was not adequate cover available for emergency out of hours patients. There was only one consultant cardiac surgeon who was considered to be confident enough to undertake full thoracic surgery on-call. Interviewees emphasised that many of the cardiac surgeons had had little exposure to thoracic work and felt uncomfortable providing care for fear that they did not have the requisite skills. As a result there had allegedly been occasions when the cardiac surgeons had required assistance from the thoracic surgeons as they were not able to deal with the matter themselves. It was, however, noted that often when the on-call surgeon did see thoracic patients they were not required to perform thoracic specific procedures.

6.3.20 One interviewee described the emergency on-call arrangement as a 'nightmare'. This individual stated that the cardiac surgeons would sometimes refuse to undertake a case, which meant that they would need to call one of the consultant thoracic surgeons instead. An example was cited, in which a patient presented with an obstructed airway and there were no thoracic surgeons available at either of the South Wales sites meaning that the patient had to be transferred across the border

to Bristol. Interviewees went on to confirm that referral to Bristol, whilst not frequent, was not wholly uncommon either and that staff were aware of who they could contact should they require assistance.

6.3.21 Like interviewees in Swansea, respondents in Cardiff also provided conflicting views regarding the possibility of an on-call system shared between both sites with some feeling that this was important to ensure patient safety and others who felt that this was not viable.

Governance

6.3.22 There was reported to have been a reasonable standard of clinical governance within the department. There were 10 audits meetings held each year, which were said to be widely attended. In addition to this there were weekly consultant and directorate management meetings. There was, however, an acknowledgement that M&M meetings were not held regularly due to there being no dedicated time for this.

Patient Satisfaction

6.3.23 Interviewees reported that patient satisfaction rates were high with patients typically providing good feedback following in-patient care. There had been some attempt at trying to gather formal feedback from patients and a group of staff had recently conducted a patient satisfaction audit following treatment at the pre-admission clinic. The team wrote to 50 patients and received 28 replies. It was reported that every respondent supplied positive feedback to the hospital with no negative comments being received.

Staffing

6.3.24 It was reported that Cardiff experienced similar problems to Swansea with regard to a lack of consultant thoracic surgeons to cope with patient demand. Initially it was suggested that an additional consultant thoracic surgeon could be hired and then contracted out to Morriston Hospital, therefore providing extra resources for both sites. However, there were concerns as to whether this was viable because it would mean a lot of travel for the consultant surgeon employed.

6.3.25 WHSSC had agreed funding for a third consultant to be employed in Cardiff. At the time of the review attempts to hire a third consultant on a locum basis had been unsuccessful. It was hoped that a further recruitment drive would mean that a surgeon was in post on a locum basis by December 2016. Staff did express some concerns that it may be difficult to establish operating sessions for a third surgeon given that there was only currently access to one theatre with consultants operating on four days already.

6.3.26 The review team heard that there was a shortage of theatre staff, with there being

42 theatre staffing vacancies across the whole of the organisation at the time of the review visit. Although it was noted that an anaesthetist had recently been employed within the department which had helped alleviate some of the burden.

Team working

6.3.27 There appeared to be strong working relationships between the consultants in Cardiff. Interviewees agreed that the consultants worked together in the interests of patient care, for example jointly preparing cases and putting urgent matters to the board. The review team were further informed that there was a highly supportive atmosphere. Even on occasions where there were disagreements about patient care it was said that the consultants would discuss this in a non-aggressive manner and resolve any differences swiftly.

Relationship with cardiac surgery

6.3.28 There was said to be good collegiate working with cardiac surgery with the two teams working closely together. The review team heard that both teams' interests were treated fairly, that there were rarely issues with beds and, in instances that this did occur, thoracic patients often took precedence. Despite this positive interaction between teams, some interviewees felt that cardiac surgical service generally received preferential treatment. An example provided was dedicated specialist registrars allocated to the cardiac surgery service, but no such resources provided to the thoracic service.

Facilities

6.3.29 Like Swansea, Cardiff was also said to have experienced a lack of facilities which had made it hard to keep up with demand. Staff reported that they were unable to reconcile throughput issues with their current resources and that they felt further investment from WHSSC was required to ensure that patients could receive timely care.

6.3.30 It was commented that generally the facilities in Cardiff were better than those at Morriston Hospital. For example they housed the only PET scanning facility, which all patients across South Wales had to travel to use. Furthermore funding had been provided to build an improved diagnostic site by the other thoracic facilities, so that eventually a one-stop service could be established. Additional funding for EBUS facilities had also been granted.

Pre-admission facilities

6.3.31 There was said to have been a drive to improve referral pathways into hospital by utilising 'pre-habilitation' schemes. It was reported that all routine check-ups and assessments were done via pre-assessment. Interviewees reported that prior to admittance to hospital the patients were fully informed of their role and

responsibilities as well as what to expect from the service. Patients were required to undertake a six minute walk test to identify risks and to ensure they were fit and well enough to undergo treatment. It was further reported that efforts had been made to minimise the risk of patients being refused for surgery by engaging with GPs and dieticians to ensure that they were making positive steps to improve the patients' fitness before referral for surgery. Furthermore patients were taught how to use a respiratory muscle trainer which assisted in ensuring the patient's fitness for their operation and to improve post-operative recovery. It was said that, in the future, Cardiff proposed to deliver a programme of 'pre-habilitation' intervention over a six week period prior to surgery. It was proposed that each programme would be tailored to each individual patient and delivered locally with a weekly clinic within the Health Board in which the patient was situated.

Training

6.3.32 There is a large medical school situated in Cardiff with whom Cardiff University Hospital had a strong affiliation. It was reported that trainees were very happy with the quality of training received and had good opportunities to develop their skill base. The review team were told that one consultant thoracic surgeon was particularly instrumental in ensuring that there were good training facilities and learning opportunities for junior doctors.

Development

6.3.33 The review team learnt that there was a clear intention to extend the thoracic surgery service with requests put in to increase funding. Whilst attempts to approve a fourth consultant surgeon had been rejected, there had been investment in other areas of the service. It was reported that money had been invested in re-developing the out-patient area, moving it to an area that was closer to the thoracic ward and making it larger so that there was more privacy for patients.

Non-cancer patients

6.3.34 The thoracic surgery service at Cardiff University Hospital was also said to have experienced difficulties in ensuring that both patients with cancer and those with non-cancerous conditions received appropriate access to treatment. Interviewees did, however, highlight that mechanisms had been put in place to ensure that non-cancer patients were not missed. There were specific lists for pectus patients as well as weekly meetings to discuss referral to treatment waiting lists to ensure that non-cancer cases were discussed. Interviewees did, though, suggest that the service lacked the facilities to adequately treat non-cancer patients and that access to an extra theatre would assist with this.

Accessibility

6.3.35 It was largely agreed amongst respondents that accessibility to services could be challenging, specifically for those patients living outside the city in the more rural areas and in the Valleys. Like Swansea, there were clinics available within local Health Boards to provide pre-admission and follow up care to patients.

6.3.36 Some interviewees felt that it was a matter of concern that emergency care was not easy to access for some patients. Patients near the English border were on occasion referred to Bristol although it was noted that that was avoided as much as possible as funding needed to be approved via IFAR and it posed problems in terms of post-operative care. There was access to helicopter facilities although it was noted that it could be difficult to use these facilities at night as there were a number of tall buildings around the landing pad.

6.4 Mid and North Wales Thoracic Surgery Services

6.4.1 Patients in Mid or North Wales who required thoracic surgery were said to be referred to England. Mid Wales is mostly rural with a relatively low density population, spread across a large geographical area. There was a complex network for thoracic surgery with some patients being referred into hospitals in the Midlands such as Birmingham and Stoke, others into the Hereford and Worcester region and a minority of patients into the Swansea service. There was no district hospital and therefore patients also had to travel to access out-patient services. In North Wales all patients were referred to Liverpool Heart and Chest Hospital for surgery, with three district hospitals within North Wales providing a significant proportion of pre-admission and follow up services.

6.4.2 The review team heard that accessibility for patients had been challenging, however both sites had managed to work around such issues. It was said that the current arrangements for Mid Wales highlighted the need to utilise GPs to build good connections between primary care and secondary care providers. There was no indication that there had been any issues in establishing good working relationships between primary and secondary care.

6.4.3 In North Wales mechanisms had been put in place to ensure patient accessibility to services. Some services were provided by local hospitals in Glan Clywd, Wrexham and Bangor, for example patients would travel to Wrexham for PET scans, as well as out-patient clinics. Furthermore initiatives were put in place to make hospital access prior to surgery easier. Patients were admitted the day before surgery with ambulance services being utilised to transport patients to hospital, although this service was unavailable on a Sunday. There were also patient hotels near Liverpool Heart and Chest Hospital for patients and their families to use as necessary. In terms of emergency care, there was a trauma centre in Aintree where patients with polytrauma could be referred for treatment. Minor cases were referred to Glan Clwyd or Wrexham, which was said to have been no more than 45 minutes travelling time for patients in North Wales.

6.4.4 In the view of interviewees from North Wales, there was a good quality of care provided by Liverpool Heart and Chest Hospital. It was reported that there was good engagement with the hospitals in Wales, with physicians being able to call their colleagues at Liverpool for advice as necessary. The average referral time to treatment was reported to be two to three weeks. It was asserted that the 31 and 62 targets for cancer treatment were rarely breached and patients were managed efficiently. When questioned about non-cancer patients, it was reported that their quality of care was also high. Interviewees stated that there was no particular capacity issue with these patients. It was, however, noted that there may occasionally be delays in seeing a consultant thoracic surgeon, which sometimes meant that it was approximately four weeks before treatment could be provided.

6.4.5 It was recognised that resection rates for North Wales were not as high as they ought to be, according to national standards, with rates being under 10% in the last NLCA data set. It was suggested that this may, in part, be due to a general lack of attendance at the MDT. There were three MDT meetings, one at each of the three hospital sites in North Wales. Each MDT lasted approximately an hour and a half and involved the discussion of around 10 – 15 patients, including both existing and new cases. It was commented that the attendance at MDT meetings was approximately 50% with rates reaching as low as 35% when the Consultant Surgeon was on annual leave. There did not appear to be any cross cover by other surgeons. There was said to have been some conversations about the possibility of merging the MDTs, which some interviewees felt would be beneficial as there would always be a consultant presence at the MDT. Other interviewees suggested, however, that logistically it would not be possible to construct a merged MDT.

6.5 Potential future models for thoracic surgery in South Wales

Cross site working

6.5.1 It was acknowledged that typically there was a level of rivalry between Morriston and Cardiff University Hospitals; however this trend was said not to be prevalent in thoracic surgery. Whilst interviewees at both sites admitted that there was little cross working between the two departments, there was said to be a good level of professional communication between the two sites. For example, interviewees agreed that they could contact colleagues at the other site to seek a second opinion or discuss patients. One interviewee did intimate that there may have been a propensity for physicians at Cardiff University to 'poach' Morriston patients based in Bridgend and, whilst this was denied, it was acknowledged that occasionally patients from Morriston were referred to Cardiff University Hospital.

Future of thoracic surgery

6.5.2 Interviewees acknowledged that the separation of cardiaothoracic surgery into cardiac and thoracic surgery was something that had affected services and would be a significant issue going forward. Some respondents reported that there were a

limited number of cardiac surgeons that were able to offer thoracic on-call emergency support. This was said to be because some cardiac surgeons had not had the opportunity to maintain their thoracic skills and therefore it would not be appropriate for them to treat thoracic patients.

6.5.3 A number of interviewees suggested that both of the cardiothoracic departments should be deconstructed, and replaced with individual cardiac and thoracic departments. The review team heard that if the departments were to split into separate entities then the thoracic surgery services would require more resources to ensure that they could function effectively and in accordance with national guidelines. The requirement of additional thoracic surgeons was highlighted by a number of interviewees, who maintained that this would be necessary to provide safe emergency on-call and effective patient through-put.

Number of sites

6.5.4 The general consensus of interviewees was that a model of a single thoracic service on one site would be preferable to that of two separate services or a single serviced based across two sites. It was submitted that a two site model would not be sustainable and was unlikely to work effectively. This suggestion was made for a number of reasons. A number of interviewees felt that the changing landscape of cardiothoracic surgery, specifically the lack of cross-working, would have implications on maintaining a two site model. In the view of some, it would difficult to obtain the staff required or develop an adequate on-call rota to sustain a two site model. It said that it would not be possible therefore to develop a 24/7 unit delivering services over two sites.

6.5.5 Some interviewees pointed out that the current two site model was not working efficiently in its current state, describing services as ‘dysfunctional’ and ‘non-effective’. As such, it was thought that investing in developing a one site model may be a way to revitalise the delivery of thoracic surgery. Interviewees reported that a one site model would address some of the problems of the current service, such as having sufficient staffing to develop on-call rotas and cross cover schedules.

6.5.6 There were some comments that a one site service would also be beneficial because it would allow for a state of the art centre of thoracic surgery to be developed. It was suggested that this would attract funding, staff and innovation which would have a beneficial impact on patient care.

6.5.7 When questioned regarding whether staff would accept the merger of the current thoracic services into one, it was largely agreed that staff would be open to this. This was validated by staff actively agreeing that they would be willing to work at a different site if necessary. It was implied that provided there was good infrastructure in place staff would be more supportive of a single site service rather than a multiple site service.

6.5.8 The issue of accessibility was discussed extensively by interviewees, some of whom believed merging into one service would be disastrous for patient care because some patients would have significant difficulties accessing care. These interviewees contended that it would stressful for patients to have to travel such long distances. It was further asserted that there would potentially be a backlash from the populations who felt they were losing out on local resources. However, this was countered by the view expressed by others that patients were willing to travel for high quality care. It was asserted by interviewees that mechanisms could be put in place to reduce the stress on patients travelling long distances, for example developing patient hotels. Interviewees gave further examples of similar services that had worked successfully, citing NHS Highlands as looking after patients who have to travel from remote areas.

6.5.9 There was some trepidation around whether patients would be willing to present to a large single unit, with some feeling that patients may feel too intimidated to attend the service. Instead it was suggested that money should be invested in the current structures to improve the facilities for patients, for instance supplying more beds and creating a dedicated HDU unit for thoracic patients. Similarly other interviewees suggested two sites with a smaller and larger unit would best accommodate patients.

Location

6.5.10 It was considered by some interviewees that Swansea may be a preferable site to base a single thoracic surgery service because it would provide a more central location for patients in comparison to Cardiff. Whilst it was acknowledged that patients in West Wales would still have a significant distance to travel, this would be less than having to travel to Cardiff. Furthermore, whilst patients from East Wales would have to travel further, it was not considered that this would not be an unreasonably long distance to travel in comparison to West Wales residents. It was considered that the distance of travel may impact patients' willingness to present for treatment and the treatment options they make. Ultimately it was said that most patients were willing to travel for care, provided that this care is high quality.

6.5.11 In terms of space, it was commented that Morriston Hospital in Swansea had undergone a period of restructuring and was continuing to develop and grow as a hospital. It was noted that there was space around the site to expand, meaning that there was potentially the opportunity to build new facilities or a dedicated thoracic ward. Management staff at Morriston Hospital were said to have put forward business plans to establish a dedicated level 1 area in the existing bed pool, the intention of this was to help facilitate discharge of patients.

6.5.12 A number of other interviewees advocated Cardiff University Hospital as the preferable site for a single thoracic surgery service. One of the main factors used to support this was the positive working relations and leadership amongst the staff in the department. Respondents highlighted that there was one Consultant Surgeon who was particularly proactive and instrumental in developing and advancing the

department. It was felt that this individual could potentially lead the development of a single site service. Interviewees felt that this was the right environment to establish the thoracic surgery service as staff would work together to create a new system that was in the best interests of patients.

6.5.13 A number of interviewees highlighted that Cardiff was the fastest growing city in the United Kingdom and that this influx of people would mean a larger pool of people to recruit from and therefore would arguably allow for recruitment of better quality staff. Moreover, it was felt that there was scope for investment from science and research projects, which would benefit the public in terms of providing more funding. One interviewee noted that, if the service were not located in Cardiff, patients would miss out on benefits from innovation and research.

6.5.14 Cardiff University Hospitals had emphasised their intention of establishing themselves as a major trauma centre. At the time of the review this had not been put forward to or approved by WHSSC. The review team had heard that both Cardiff University Hospital and Morriston Hospital had been mapped against the specification for trauma centres in England. It was asserted that Morriston Hospital did not currently have the resources to establish this but that Cardiff University Hospital did. Respondents highlighted that a trauma site would almost certainly include neurosurgery which only took place at Cardiff, therefore it was felt that the hospital would be the natural location for a trauma centre. It was further argued that a good trauma centre should include thoracic surgery services meaning that thoracic surgery, in their view, should be based in Cardiff.

6.5.15 In terms of accommodating a larger thoracic service in Cardiff interviewees advised that there were already plans to expand the hospital in the next five years and the intention of moving some other departments to Swansea, for example the dental hospital or ophthalmology. It was said that this would allow space for the department to expand so that there was enough ward and theatre capacity for thoracic patients.

6.5.16 Some interviewees had raised the possibility of Llandough Hospital forming the central site for thoracic surgery services. At the time of the review respiratory medicine was based at Llandough Hospital and many patients attended the hospital for specialised services prior to admission. The reviewers learnt that there were theatres that could be utilised at Llandough Hospital, although it was said that it the intention was to utilise these for day case surgery in the future. Some interviewees considered that it would not be viable to develop thoracic surgery at the site as there were no longer any thoracic beds available and any plan to build a service at this site would be highly expensive.

7. Conclusions

The following conclusions are reached on the basis of the documentation reviewed as set out in section 6 above and the interviews held with staff as described in section 5 above.

7.1 Future model of thoracic surgery services

7.1.1 It was clear to the reviewers that the current two site model of thoracic surgery was not working effectively and was not sustainable. It was of significant concern that patient care was undermined due to the lack of on-call rota, delays in treatment and under-funding.

7.1.2 In the opinion of the reviewers South Wales should be serviced by a one-site surgery service model for thoracic surgery, with potential for regional sites within each health board for pre-admission and out-patient clinics.

7.1.3 When considering where a single-site should be it is important to consider the important interdependencies that exist between services. It is the view of the team that it makes sense to locate thoracic surgery on the same site as cardiac, trauma and respiratory services. It would be appropriate for any site performing thoracic surgery to have appropriate access to equipment such as a PET scanner and EBUS.

7.1.4 It is the view of the review team that although there are stand-alone Thoracic units in the UK there are real advantages to having both cardiac and thoracic surgery on one site. This would favour location of a future Thoracic surgical service at either of the existing cardiothoracic units.

7.1.5 The thoracic surgery service could be delivered at either Morriston Hospital in Swansea or Cardiff University Hospital effectively, given the right level of investment. At the time of the review visit Cardiff University Hospitals was considered the site where less work would be required to establish a single site service, with Morriston Hospital requiring more investment from WHSSC. However, the review team was clear that a decision on where to establish a single thoracic surgery should not be based solely on this factor and should consider all relevant issues including geographic location.

7.1.6 In line with units of a similar size it was considered that five consultant thoracic surgeons were required to service a population of 2.4 million people safely. This would provide adequate emergency on-call cover as well as other services to ensure adequate patient throughput.

7.2 Delivery of high quality and timely patient care

7.2.1 The review team found that neither site had a dedicated unit to provide care for thoracic surgery patients and had to share space with the cardiac team. Whilst unavoidable within the current two site model, this would not be appropriate within a one site model. Going forward, a dedicated thoracic surgery unit should be established if a one site model is to be adopted.

7.2.2 There were not enough beds available to accommodate patients, with few beds being ring-fenced for thoracic patients. The review team identified that HDU beds were particularly in low supply. The beds that were available to thoracic patients were often not utilised effectively and not allocated to patients in higher need of treatment. This hindered the fluid movement of patients through the service and prevented some very unwell patients from receiving prompt treatment.

7.2.3 The review team found that at both sites the length of stay in hospital for patients could be shorter. It was concluded that this at least in part due to the distance patients had to travel for care, meaning same day admission was not practical at the time of the review. This is a key issue, which would need to be addressed if a single site model is to be adopted as this will require some patients to travel further.

7.2.4 The current theatre capacity for thoracic surgery at each site was inadequate. It was clear that the surgeons were not afforded enough operating time in which to treat all of the patients waiting for surgery. This meant that patient operations were, on numerous occasions, cancelled. Patients were kept as in-patients until they could be operated upon, which meant beds were blocked, delaying patient through-put and contributing towards waiting list breaches.

7.2.5 Both departments would have benefitted from additional operating days to address patient backlogs. In the short term, Morriston Hospital in particular may gain from looking at ways to ensure that both consultant thoracic surgeons have equitable access to theatre time and post-operative beds.

7.2.6 The review team found that the two services were lacking resources, in terms of equipment and staffing, during operating days. It was of specific concern that at Cardiff University Hospital operating lists were consistently ending up to two hours early for fear of a list then overrunning.

7.2.7 The introduction of funding for EBUS and ‘pre-habilitation’ services was positive, however, the review team found that neither site had the funding required to adequately resource these initiatives fully. This lack of funding also contributed to both services being unable to keep up with patient demand.

7.2.8 The review team concluded that there were too many separate MDT meetings per week and considered that it would be appropriate to merge meetings. This would place fewer burdens on consultant surgeons attending multiple MDT meetings, and

may help address the low attendance rates at MDT meetings.

7.2.9 Whilst video-conferencing was not considered the ideal means of conducting MDT meetings, it was accepted that this was the only viable method of running the MDT given geographical constraints. It was noted that attendees should be vigilant in ensuring that the correct patient data is presented at the MDT.

7.2.10 The review team found that the underlying causes for the low resection rates in South Wales was not altogether clear. The variation in resection rates both geographically and temporally was high. They acknowledged that variation in resection rates between MDTs reflected more on the MDT itself than the individual surgeon attending it. There are multiple factors that could relate to variation in resection rates, including how the MDT is run, the aggressiveness of investigation and its timeliness, the skills of the thoracic surgeon, the capacity in the surgical centre and patient centred factors such as fitness and preference.

7.2.11 It was considered that both sites needed to conduct further investigations into their resection rates and the causes for this. This would then allow both sites to work out a strategy for improving resection rates.

7.2.12 The review team was concerned about the disparity of treatment between cancer and non-cancer patients, with patients with non-cancerous conditions often facing treatment delays and cancellations. It was concluded that the failure to treat non-cancer patients within a reasonable timescale was a patient safety issue, particularly given that many non-cancer patients' conditions had significantly deteriorated by the time of treatment. It was also worrying that a number of non-cancer patients appeared to have 'dropped off' patient waiting lists, and both hospitals will need to follow up such patients to ensure they have been provided adequate care.

7.2.13 The reviewers observed that the surgical techniques employed at each site were appropriate. They were encouraged to see the use of a number of innovative techniques, in particular the use of minimally invasive procedures, which had helped reduce patient length of stay and improve patient experience through the surgical pathway.

7.3 Staffing model

7.3.1 The review team found that the current on-call arrangements for thoracic patients were unacceptable and posed a direct risk to patient safety. Specifically there appeared to be a lack of on-call cover over weekends as well as cover being provided by some cardiac surgeons who did not have the requisite skills to deliver treatment if this were to be required. It is crucial that an on-call rota incorporating all surgeons with thoracic skills is developed as a matter of urgency to ensure that patients have access to emergency care if required.

7.3.2 The review team considered plans to recruit additional consultant thoracic surgeons

at both Swansea and Cardiff sites to be less preferable than full reconfiguration of the thoracic surgery services for South Wales. As such it was strongly recommended that WHHSC did not proceed with recruitment until a strategy has been developed for the continuation of thoracic surgery. The review team did acknowledge that both departments were understaffed, and did not have the number of surgeons or nurses to deliver optimum patient care. It was considered that for a single site service to be established there would be a requirement for five consultant thoracic surgeons as well as increased support staff.

7.3.3

7.3.4

7.3.5

7.3.6 A single service model would require a Clinical Lead who is an established and well respected consultant thoracic surgeon to gain the respect of their peers. This individual should be able to bring innovation to the department and support staff within the unit.

7.3.7 The review team found that both departments were supported by high quality support staff who worked well to deliver patient care. The reviewers were particularly impressed by the case managers employed at Cardiff University Hospital who worked hard to improve the patient pathways and make pre-admission for patients more accessible.

7.4 Accessibility and equitability

7.4.1 Many patients had experienced difficulty accessing the thoracic surgical services. This was due to the fact that the current thoracic services cover a large geographical area. Morriston Hospital in particular had a lot of patients attending the service who were from rural regions that were hard to reach.

7.4.2 It was recognised that the creation of a one site thoracic surgery service would mean that some patients would have to travel even further to access treatment. However, the review team understood that patients were willing to travel for treatment provided that the quality of care was high; therefore the benefits of a one site service outweighed that of the travel difficulties.

7.4.3 There are steps that can be taken, such as the creation of good, local follow up clinics in all regional hospitals, to minimise the amount of travelling for patients. Other means of support, such as transport schemes and accommodation will also be crucial in ensuring that a single site service model works for patients.

7.5 Patient experience

7.5.1 The review team found that many of the patients presenting for treatment had significant co-morbidity and were generally unfit for surgery. Reasonable efforts had been made to encourage patients to come forward for treatment at an early stage. Efforts had also begun in terms of the 'pre-habilitation' of patients to ensure they could receive the surgical treatment they required.

7.5.2 Patients were largely happy with the quality of treatment provided to them at both sites, and there did not appear to be any specific concerns regarding the quality of surgical treatment provided to patients. However, patient experience was significantly undermined by the delays in referring patients for treatment. Both departments had consistently breached 31 and 62 day targets for cancer waiting times. These waiting times were not satisfactory and it is important that steps are taken to address this issue as a matter of priority.

7.6 Effective co-operation of services

7.6.1 Whilst NHS guidance on trauma services does not stipulate that thoracic surgery must be included within a trauma service, the review team felt that the thoracic surgery service would be best placed at the same site as a major trauma centre.

7.6.2 Co-location with the oesophago-gastric cancer surgical team would be appropriate, since complications of such surgery often require the input of the thoracic surgical team.

7.6.3 The recent agreement to fund 'pre-habilitation' services was welcomed, helping to improve the health of patients prior to surgery and reduce the length of stay.

7.7 Sustainability

7.7.1 It is likely that the future will see further divergence between cardiac and thoracic surgery services, with surgeons being required to train in either thoracic or cardiac surgery, leading to the reduction in capacity to provide cross-over. It is not sustainable, in the long term, for the services in South Wales to rely on consultant cardiac surgeons to staff thoracic surgery on call rota.[2] The review team was clear that, in the immediate future, on-call work should only be completed by consultant cardiac surgeons who are both competent and confident at undertaking thoracic work.

7.7.2 Trainees appear to have received good quality training with exposure to adequate

[2] NHS Commissioning guidance states '*Based on likely retirements over the next 5 years, the need to produce sufficient numbers of thoracic trainees to become available to fill the consultant posts for the service and the time needed for Units to make the appropriate adaptations to their staffing arrangements based on the requirements of the service specification already alluded to, it will not be necessary for Units to employ surgeons who have a mixed cardiothoracic practice beyond the year 2020 at the latest.*'

operating time at both sites. As both Swansea and Cardiff have Universities with medical schools, the review team were assured that both locations had the propensity to attract good quality employees in the future.

7.7.3 The current level of funding for the two thoracic surgery services is not sustainable and it seems likely that the backlog of patients waiting to be treated would continue to increase without additional resources being provided or a significant reconfiguration of services. The review team was concerned that without intervention the future standard of patient outcomes and care would be at risk.

7.7.4 Staff had taken positive steps to introduce innovative surgical techniques within their practice, such as minimally invasive surgery. It was encouraging that one consultant surgeon had actively sought out opportunities to train staff on new surgical practices, particularly given that thoracic surgery in the UK is using more complex techniques such as robotically assisted surgery. These actions were considered necessary so that consultant surgeons would have the requisite skills to provide high quality care to patients.

7.8 Cost effectiveness

7.8.1 The review team was unable to comment on the most cost effective option for WHSSC with regards to a future model for thoracic services. Instead it was considered that WHSSC should utilise the services of a health economist to provide this advice.

7.8.2 It was however clear that the development of any thoracic surgery model would require significant investment from WHSSC to ensure that a good standard of service is provided to patients.

7.9 Mid and North Wales

7.9.1 It appeared that the provision of thoracic surgery to patients in Mid and North Wales generally worked well, given the access constraints to surgical services. It was clear that, particularly in North Wales, efforts had been made to facilitate easier accessibility for patients. There were no concerns regarding the quality of care provided to patients, which seemed consistent with the care provided to English patients. It was, however, clear that the resection rates achieved required improvement and it may be helpful to have an independent source to review whether the MDT is effective in its current state, or if it requires restructuring.

8. Recommendations

The following recommendations are for WHSSC to consider.

Recommendations to address immediate patient safety risks

1. The current structure of the emergency on-call rotas in both Swansea and Cardiff are not appropriate and should be reviewed immediately to ensure that the consultants involved are able to deliver emergency thoracic surgical care when required. In order to achieve this, the following should be considered:
    - A joint on-call rota incorporating surgeons with thoracic surgery competencies from both Swansea and Cardiff should be developed, providing emergency care to both sites 24 hours a day, seven days a week. The on-call rota should remain in place until such a time that a new model for thoracic surgery services has been agreed and implemented by WHHSC.

Recommendations to address potential patient safety risks

2. Morriston Hospital and Cardiff University Hospital should review the care provided to non-cancer patients, to address the concerns highlighted in this report about delays in providing treatment to these patients. Both sites should produce protocols regarding the care of patients with non-cancerous thoracic conditions and review the level of access to operative care these patients receive.

3. Both hospitals should conduct an audit of previous non-cancer patients to ensure that none have been lost from waiting lists for the treatment that they require.

4.

Recommendations for current service improvement

The following recommendations are made to help improve the quality of the care provided by the two current thoracic surgical services.

5. WHSSC should reconsider plans for the substantive recruitment of additional consultant thoracic surgeons at both sites until a future model of thoracic surgery services has been agreed. An additional, consultant surgeon should then be employed at the permanent site of thoracic surgery whilst the new model is being implemented.

6. Both services should review and seek to address the issues affecting cancer resection rates described in this report. As part of this it may be helpful to give consideration to how MDT meetings are operated.

7. Both services should undertake a review of their current level of theatre access. In

order to address any short-comings. As part of this the services may want to consider:

- Proceeding with plans to change the operating days of one of the Consultants so that there is a longer gap between operating days at Morriston Hospital
- Providing sufficient staffing resources to ensure that theatre days are not unduly cut short
- Allocating more operating time to consultants

8. WHSSC should continue to fund and implement preadmission initiatives such as 'pre-habilitation' and EBUS to help improve the rate of patient through-put to surgery.

9. Both sites should review their MDT arrangements to assess whether it is possible to merge some MDT meetings in an effort to streamline the process and to better consultant thoracic surgeon attendance.

Recommendations for future service development

10. It is the review team's recommendation that WHSSC adopts a single site thoracic surgery service model for South Wales. The review team considered that this reconfiguration was in the best interests of patient care and was the most sustainable option for thoracic surgery going forward. It was considered that changes to cardiac and thoracic surgery would mean there would not be a staffing resource that could adequately sustain a two site model in the future. Furthermore, splitting finances between two sites meant that neither site had the resources to provide the resources necessary to provide high quality and timely care to all patients.

11. The review team was not able to make a recommendation on the location of the new thoracic surgery site and ultimately considered that it would be viable to locate the thoracic surgery service at either Morriston Hospital or Cardiff University Hospital, if given the requisite level of investment. At the time of the review, Cardiff University Hospital was considered the site that would require the least work to establish the service, with Morriston requiring further investment from WHSSC. In making this decision WHSSC should take into account the level of investment required by either site, the geographic location of the two hospitals, the other specialist services that are currently based at each site as well other future development plans in place.

Recommendations should a single site model be adopted

12. WHSSC should begin development of plans for the allocation and implementation of a single site model immediately, keeping the teams in Swansea and Cardiff as well as other relevant parties fully informed of any developments. It may be helpful for WHSSC to refer to NHS England '*Thoracic Surgery Specification*', when published, for

guidance on how to develop the service.

13. WHSSC should seek independent advice from a health economist to help them undertake a cost analysis in respect of any service changes to thoracic surgery.

14. Five consultant thoracic surgeons should be employed to meet service demands. WHSSC should review each of the consultants job plans to ensure that each specification includes:
    - A one in five on-call duty which includes weekend cover
    - At least one specified operating day
    - Fair distribution of MDTs with adequate cross-over cover
    - Attendance at out-patient clinic

15. WHSSC should consider allocating or funding the construction of a separate unit for thoracic surgery, with designated access to the following resources:
    - Ward, HDU and ITU beds
    - A dedicated theatre for elective procedures and carefully planned access to emergency theatres
    - Appropriate levels of support staff to accommodate the ward and all theatre lists.

16. Steps will need to be taken to ensure that an appropriate level of junior medical and surgical registrar staffing is in place to support the service.

17. WHSSC should liaise closely with relevant stakeholder organisations, such as the Community Health Councils, primary care services, and the ambulance service to ensure that interests of the patients are maintained during the development of a new thoracic surgery service.

18. WHSCC should draw up guidance for staff and patients (both non-cancer and cancer) mapping out the patient journey from pre-admission to follow up. This should set out what patients should expect from the service as well as provide staff with a clear guide on how the pathway should operate.

19. WHSSC should consider what measures need to be put in place to maintain patient experience in outlying areas, that may need to travel further to access a centrally located service. WHSSC may want to consider the following:
    - Establishing outreach clinics for pre-admission and follow up care in each of the regional hospitals that would be referring in to a central service
    - The provision of accommodation for patients and their families within or nearby the hospital where the service would be located
    - Transport services for patients in remote locations

20. WHSSC should ensure that the new, single site based service has robust MDT

arrangements. As part of this the following should be taken into account:

- Reducing the amount of weekly MDTs
- Evenly spread MDT sessions amongst consultant thoracic surgeons
- Maximising the input of the consultant thoracic surgeons
- Providing consultant cover when staff are on leave
- Producing new protocols which prioritise patient through-put
- Having specialist nurse and surgical registrar attendance at MDT meetings
- Involvement of staff from the various regional hospitals in the MDT

Responsibilities of WHSSC in relation to these recommendations

This report has been prepared by The Royal College of Surgeons of England and the Society for Cardiothoracic Surgery under the IRM for submission to Welsh Health Specialised Services Committee. It is an advisory document and it is for WHSSC to consider any conclusions and recommendations reached and to determine subsequent action.

It is also the responsibility of WHSSC to review the content of this report and in the light of these contents take any action that is considers appropriate to protect patient safety and ensure that patients have received communication in line with the responsibilities set out in the Health and Social Care Act 2008 (Regulated activities) Regulations 2014, Regulation 20.[3]

Further contact from the Royal College of Surgeons

Where recommendations are made that relate to patient safety issues, the Royal College of Surgeons will follow up this report with WHSSC to ask them to confirm that these recommendations have been addressed. The College's Lead Reviewer may be available to support this process.

[3] The Health and Social Care Act 2008 (Regulated Activities) Regulations, 2014: http://www.legislation.gov.uk/uksi/2014/2936/contents/made

Royal College of Surgeons

11. Appendices to the report

11.1. Documents received as part of the Invited Review visit

The review team asks that the Trust keeps a copy of all the documentation listed below for their records and in order to be in a position to make it available on request to those reading a copy of this report. Once the report has been provided to the Trust the RCS will not keep a "master copy" of this information – it is for the Trust to do this should this be required for reference purposes.

- MDT meeting attendance rates
- MDT attendance rates (2015/2016)
- Resection rates
- Breach of cancer waiting times (June 2016)
- Activity data (2013 - 2016)
- Case mix data (2009 – 2013)
- Surgical management of chest wall sarcoma: An audit of practice (2014)
- Outcome of pulmonary metastasectomy in patients with previous colorectal malignancy
- G Chesterfield-Thomas & I Goldsmith, Impact of preoperative pulmonary rehabilitation on the thoracoscore of patients undergoing lung resection, Interactive Cardiovascular and thoracic surgery (17 July 2016)
- I Goldsmith & G Thomas, Swansea Pre-hab leads the way in addressing frailty in patients undergoing thoracic surgery
- I Goldsmith & G Thomas, Preoperative pulmonary rehabilitation helps to improve the frailty index and vulnerability of patients undergoing thoracic surgery
- Testimonials for Mr Goldsmith
- Schedule and feedback for Welsh Cardiothoracic Society inaugural meeting on 7 November 2015
- SWOT analysis for thoracic surgery at ABMUHB
- WHSSC's committee paper on thoracic surgery (21 January 2016)
- Minutes from Abertawe Bro Morgannwg University Health Board (ABMUHB) directorate meeting on 19 October 2015
- Minutes from ABMUHB directorate board meeting on 29 February 2016
- Lung cancer table assessment I and II
- South Wales Cancer Network directory of cancer services
- NICE lung cancer in adults (26 March 2016)
- F Detterback et al, diagnosis and management of lung cancer, American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (3rd edition)
- P Mazzone, components necessary for high-quality lung cancer screening, American College of Chest Physicians and American Thoracic Society Policy Statement
- Policy on image guided lung biopsies: procedure for booking CT guided lung biopsies

- Morriston Hospital lung biopsy checklist
- ABMUHB lung biopsy leaflet
- The Royal College of Radiologists, Recommendations for cross-sectional imaging in cancer management (2nd edition)
- The Royal College Radiologists, Cancer multidisciplinary team meetings – standards for clinical radiologists (2nd edition)
- Operational protocols for Princess of Wales Hospital
- Princess of Wales Hospital, Bridgend lung cancer MDT, ongoing care: non-small cell lung cancer
- Survival data across South Wales sites
- D Martin & D Roberts, New guidelines for pulmonary nodules
- Pathways for nodules
- Guidance on radiofrequency ablation for NSCLC
- SABR UK Consortium, Stereotactic ablative body radiation therapy: A resource
- SABR UK consortium guidelines
- Pleural effusion: Guidelines on diagnosis and initial management, Morriston Hospital Respiratory Unit
- D Martin & D Roberts, staging audit
- Performance status at diagnosis
- Number of Morriston's NSCLC patients in stages I – IV
- Percentage of lung cancer patients presenting with stage IV disease at Moriston MDT
- Ebus audits (2014 – 2015)
- Small cell lung cancer : An email alert system to reduce time to first treatment
- USC vs NUSC data
- Royal College of Physicians, National lung cancer audit report (2015)
- Public Health Wales, Lung cancer in Wales: Lung cancer survival and survival by stage
- Number of Morriston NSCLC patients in stages I – IV (2013 – 2014)
- Patients treated at ABMUHB (2015)
- Minutes of M&M meeting held on 23 June 2016 at Morriston Hospital
- Minutes of M&M meeting held on 18 May 2016 at Morriston Hospital
- Minutes from Hywel Dda MDM meeting dated 21 July 2016
- Minutes from Hywel Dda MDM meeting dated 14 July 2016
- Minutes from Morriston MDM meeting dated 18 July 2016
- Minutes from Morriston MDM meeting dated 11 July 2016
- Minutes from Princess of Wales MDM meeting dated 21 July 2016
- Minutes from Princess of Wales MDM meeting dated 14 July 2016
- Attendance list at cardiac governance meetings May 2015 and June 2016
- Attendance list at MDT meeting 11 July 2016
- Attendance list for MDT meeting at Bridgend (July 2016)
- Operating lists (September 2016)
- Thoracic returns data (2014 – 2015)
- Activity and outcome data for Mr Goldsmith
- CV of Mr FL and IG
- Timetable for Consultant Thoracic Surgeons

- Job plan for Consultant Surgeons at Morriston Hospital
- Job description for Consultant post at Morriston Hospital
- Structure of Morriston Hospital delivery unit
- Mr AP appraisal documents
- P Brahmabhatt, An audit of the effectiveness of the recovery room chest x-ray
- Cardiothoracic surgery consultant rota (September 2016)
- Copy of tumour site compliance (2014- 2015)
- Copy of tumour site compliance (2016 – 2017)
- Complaints data for Cardiff University Hospital
- CV for Mr AP and Miss MK
- Job plan for Miss MK
- Job description template
- Service overview for Cardiff University Hospital
- Executive structure for Cardiff and Vale University Health Board
- MDT attendance list for Prince Charles Hospital
- MDT minutes University Hospital Cardiff
- Sample of MDT minutes for University Hospital Cardiff
- Sample of Cardiff University Hospital minutes from cardiothoracics consultants meeting
- Specialist services clinical board management structure
- Sample of theatre lists from University Hospital Cardiff
- Activity data for University Hospital Cardiff (2014 – 2015)
- Thoracic surgery in-patient template record
- Thoracic breach data for Cardiff University Hospital
- Cardiff and Vale University Health Board, Thoracic surgery: A guide to your journey for you and your relatives/carers
- Funding for the NHS data
- Email dated 4 January 2016 from Mr Goldsmith to Cwm Taf Local Health Board
- Resection rates for histological NSCLC
- Health board overview presentation
- Thoracic surgery expansion and sustainability: Service and funding proposal 2016/17 (March 2016)
- WHHSC funding to thoracic surgery in South Wales (2011 – 2016)
- Patient satisfaction surveys for CUH
- Letter dated 10 September 2016 from Mr Lhote

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

Specialised Services Service Specification:

Thoracic Surgery

Issue Date:	
Review Date:	
Document No:	

Document History

Revision History			
Version No.	Revision date	Summary of Changes	Updated to version no.:
0.1	Thoracic Surgery Review Project Board on 09/11/16.	Alignment of the draft NHS Wales service specification with the standards set out in the draft NHS England service specification.	0.2
0.2	Thoracic Surgery Review Project Board on 18/01/17	Alignment of the draft NHS Wales service specification with Royal College of Surgeons Invited Review report.	0.3
0.3	03/02/17	Update following further comment from Thoracic Surgery Review Project Board before issue for consultation.	0.4
Date of next revision			

Consultation		
Name	Date of Issue	Version Number
Stakeholder consultation (distributed to patient representatives, Health Boards, the thoracic surgery service providers for Wales, Wales Cancer Network, professional bodies)	06/02/2017	0.4

Approvals		
Name	Date of Issue	Version No.
Thoracic Surgery Review Project Board		
WHSSC Joint Committee		

Distribution – *this document has been distributed to*			
Name	By	Date of Issue	Version No.

Table of Contents

1. Aim

1.1 Introduction

The purpose of this document is to define the service specification for the provision of thoracic surgery for adult patients resident in Wales.

The objectives of this service specification are to:

- Describe the service model and pathway required to ensure the highest quality, safe, sustainable and equitable thoracic surgery service is provided for the population of Wales;
- Set out the level of service that patients and their families can expect to receive;
- Specify the quality standards and indicators that must be achieved;
- Ensure that the needs and experience of patients, families and carers are integral to the delivery of the thoracic surgery service for Wales.

1.2 Background

South Wales has a legacy of heavy industry and coal mining; both of which contribute significantly to lung disease. Primary lung cancer, related to tobacco is the commonest cause of cancer death in Wales. However, the population in Wales has a poor survival rate for lung cancer compared to the UK, the rest of Europe and the USA. Surgery is known to provide the best chance of survival. However, patients often present with advanced disease making surgery less likely to be suitable or successful. It is therefore essential that cases are detected early in order to provide the best prognosis.

In Wales, lung cancer incidence rates vary across the seven Health Boards. The highest overall incidence rate is in Cwm Taf UHB which is two-thirds higher than the lowest in Powys. Geographical differences in lung cancer across Wales are primarily due to historic trends in smoking and exposure to tobacco smoke, especially in areas of deprivation (WCISU, Public Health Wales 2015)

There are two types of lung cancer: Non Small Cell Lung Cancer (NSCLC), which accounts for 90% of lung cancers, and Small Cell Lung Cancer (SCLC). There are three common sub-types of NSCLC: squamous cell carcinoma, large cell carcinoma and adenocarcinoma.

The lung cancer resection rate in Wales is lower than in many other parts of the UK. The National Lung Cancer Audit has demonstrated that there is wide variation in surgical resection rates across the UK. Patients are ~~50%~~ more likely to have surgery for lung cancer if they present to a hospital that provides thoracic surgery on site as this is thought to represent easier access to specialist thoracic surgeons.

In addition to the treatment of lung cancer, there are many other conditions which require thoracic surgery. These include other types of thoracic malignancies, pneumothorax, various forms of thoracic sepsis and a large group of miscellaneous conditions which fall outside the remit of other surgical specialties

1.3 Relationship with other Policy and Service Specifications

This document should be read in conjunction with the following documents:

- Commissioning policy for PET-CT
- Commissioning Policy for Stereotactic Ablative Body Radiotherapy for the Management of Surgically Inoperable Non-Small Cell Lung Cancer in Adults.

2. Service Delivery

2.1 Definition of Thoracic Surgery

Thoracic Surgery is concerned with the diagnosis and surgical treatment of a range of diseases and conditions of the chest. These structures include:

- the airway
- lungs
- pleura
- mediastinum
- chest wall
- diaphragm

Thoracic Surgery excludes surgery on the heart and great blood vessels, which is undertaken by Cardiac Surgeons, and surgery of the oesophagus, which is undertaken by Upper Gastrointestinal Surgeons.

A general thoracic surgeon will operate to treat the following indications:

Cancer

- Lung cancer
- Mesothelioma
- Mediastinal malignancy
- Lung metastasis from non lung cancer primaries

Non Cancer

- Severe emphysema
- Empyema
- Chest wall deformity
- Primary and secondary pneumothoraces
- Diagnostic lung biopsies
- Air leak
- Chest trauma

This specification excludes lung transplantation which is undertaken in designated units in England under standards set by NHS England.

2.2 Aims of Thoracic Surgery

The Thoracic Surgery service set out in this specification aims to:

- Where possible, provide curative treatment for patients with lung cancer;
- Increase survival for patients with lung cancer;
- Where possible, provide curative treatment for non cancer conditions;
- Maximise patients' functional capability and quality of life;
- Provide patient centred care and optimise the quality of patient and family experience;
- Provide access to the highest quality surgical practice, including new surgical techniques, based on robust evidence and best practice guidance;
- Provide a service that is equitable;
- Provide a service that is sustainable;
- Provide timely access to treatment and achieve mandated waiting time targets;
- Provide a service seamlessly integrated into referral pathways with secondary care and inter-dependent services.

2.3 Service Provision

The thoracic surgery service will include the following infrastructure and service components:

- Thoracic surgery unit
    - The thoracic surgery service will have designated resources:
        - Dedicated thoracic surgery ward beds
        - Dedicated thoracic surgery theatre/s

        - Dedicated thoracic surgery HDU (level 2) and access to ITU (level 3)
    - ~~Appropriate levels of staff for the required level of ward, theatre and HDU/ITU capacity.~~

- Out-patient clinics
    - Patients will be assessed for their suitability for thoracic surgery, receive pre-operative/pre-admission assessment and post operative follow up, in dedicated thoracic surgery clinics.
    - Thoracic surgery outreach clinics will be established in each Health Board for assessment of suitability for surgery, pre-operative/pre-admission assessment and post operative follow up, for the convenience of patients and families to maximise accessibility.

- Inter-dependent services
  The thoracic surgery service must have access to the following services. It is anticipated these services will usually be co-located with the thoracic surgery service.

    - Respiratory medicine
    - Haematological biochemical and microbiological laboratories
    - Respiratory pathology laboratory
    - Endoscopic examinations by bronchoscopy and oesophagoscopy (including endobronchial ultrasound and endoscopic ultrasound)
    - Radiological investigation by plain X-ray, contrast studies, ultrasound needle biopsy, vascular imaging and computed tomography (including PET CT)
    - Cytology, histopathology and frozen section analysis of intra-operative specimen, the results of which should be communicated with the operating surgeon within 1 hour of the sample being taken.
    - Support from all other hospital services especially interventional radiology and pulmonary rehabilitation.

- Other co-located services

- The thoracic surgery service will benefit from co-location with cardiac surgery:
  - To share cardiothoracic trainees
  - Operational efficiencies from pool of support staff skilled in both thoracic and cardiac surgery.

- Thoracic emergencies and out of hours service

  - The service will provide 24/7 emergency cover by general thoracic surgical consultants (with or without mixed-practice cardiothoracic surgical colleagues).
  - The surgeons on the rota should be able to deal with the full range of thoracic surgical emergencies.
  - Cross cover of rotas from consultants with a purely cardiac practice or from consultants from other specialities is unacceptable.
  - The service will ensure that there is 24/7 cover of thoracic surgical inpatients. This may be delivered with support from surgical trainees, speciality doctors and appropriate trained advanced care practitioners.

- Lung Cancer Multi-Disciplinary Team Meetings

  - Thoracic surgeons are core members of the Lung Cancer MDT. All patients referred to thoracic surgery for further assessment of suitability for surgical resection of lung cancer must be referred through the Lung Cancer MDT.

  - The thoracic surgery service will ensure that thoracic surgeons' job plans include sufficient allocation for Lung Cancer MDT meetings, including cross cover for annual leave, study leave or sickness. While surgeon attendance at the MDT in person is desirable, video conference linkage from the surgeon's base hospital is an acceptable alternative.

  - MDTs should have in place access to the full range of radiology facilities and the technology to facilitate the electronic transfer of images between the referring hospital and the thoracic surgery centre.

3. Quality and Patient Safety

3.1 Quality and Patient Safety

- Providers are expected to immediately (within 24 hrs) provide information to WHSSC on the following:
  - Serious Untoward Incidents
  - Serious complaints
  - Issues which may gather media or political interest.

- The providers must work to the quality standards as stated in 3.2 of this document.

- The thoracic surgery service is underpinned by the quality standards as outlined in the NICE Quality Standard for Lung Cancer and the Thoracic Society for Cardiothoracic Surgery in the UK Guidelines for radical management of patients with Lung Cancer.

- The providers are expected to participate in relevant national audits, including the National Lung Cancer Audit.

- The providers are expected tol participate in peer review of lung cancer services.

3.2 Quality Indicators (Standards)

The Provider must work to the following quality standards:

3.2.1 Thoracic Surgery Unit

- Thoracic surgery must be performed by qualified surgeons who have full GMC Registration with a licence to practice, and

specialised in general thoracic surgery in accordance with National and European regulations.

- A surgeon practising in thoracic surgery must have extensive and updated knowledge of all aspects of pathophysiology, epidemiology, diagnosis, perioperative, intraoperative and postoperative care of patients with surgical disease of the chest.

Minimum volumes

- The thoracic surgery unit should undertake a minimum of 150 primary lung resections per year.
- The thoracic surgery unit should have a minimum of 3 full time general thoracic surgeons.
- Thoracic surgery units should have access to dedicated high dependency beds ~~(ideally 1 HDU bed per 75 major thoracic procedures)~~. There should be access to the Intensive Care Unit (ITU) when necessary.

Organisation

- Thoracic Surgery should be identified as a separate service line within the hospital's directorate management structure.

Outpatient Facilities

- Thoracic Surgery Units should have sufficient facilities for outpatient visits including facilities for pre-op assessment and preadmission.
- The unit should have the capability of allowing same day access to radiology, pulmonary function tests, endoscopy and cardiological testing if needed.
- Patients are seen for opinions as to their suitability for thoracic surgery and pre-operative assessment in dedicated thoracic clinics.
- Where possible this should be arranged in outreach clinics in the hospitals served by the regional thoracic unit for the convenience

of patients and to ensure full access to the thoracic surgical service

Outreach Services

- For those hospitals without on-site thoracic surgery it is essential that the populations served are not disadvantaged in any way. These hospitals should have close links with nominated surgeons working in the regional centre, such that thoracic surgical expertise can be accessed throughout the working week.
- It is essential that these hospitals ensure that all relevant patient information especially documentation and imaging via PACS (e.g. CT and PET-CT scans) is readily available to the regional centre.
- Services in outreach clinics should be of the same high standard as at the tertiary centre, including provision of information and support.

Second Opinion Process

The service will put arrangements in place to provide a second opinion:

- Any patient with borderline resectability and acceptable fitness for surgery, and not initially accepted for surgery, should be offered a second opinion through an alternative MDT.
- In accordance with NICE guidelines for patients with lung cancer, any patients with a resectable lung cancer who are of borderline fitness and not initially accepted for surgery, should be offered the choice of a second surgical opinion and a multidisciplinary team opinion on non surgical treatment with curative intent.
- ~~Patients with a resectable lung cancer who are of borderline fitness for surgery should be offered the opportunity to engage in a pre-habilitation programme.~~

Pre-habilitation and Enhanced Recovery

- ~~Providers should ensure that patients are offered pre-habilitation prior to thoracic surgery.~~

- Pre-habilitation is a service which aims to ensure patients are in a fit state prior to surgery.
- Patients with a resectable lung cancer who are of borderline fitness for surgery should be offered the opportunity to engage in a pre-habilitation programme prior to referral to thoracic surgery.
- ~~Pre-habilitation is a service which aims to ensure patients are in a fit state prior to surgery. Many pre-habilitation programmes can include physiotherapy combined with gentle exercises to improve lung function.~~
- There should be clear pathways established in the thoracic surgery units to provide an enhanced recovery programme. Enhanced recovery programmes are usually supported by physiotherapy, dietetics and nursing staff.
- Enhanced recovery pathways enable patients to recover at a faster pace from major surgery and should be adopted by the thoracic surgery centre.

The Care Team

- Consultant-led care by general thoracic surgeons, with or without surgeons with a mixed cardiothoracic practice[1]
- Surgical trainees
- Specialty doctors and advanced care practitioners
- Consultant anaesthetists with specialist thoracic expertise
- Theatre staff with thoracic expertise
- Specialist ward and HDU nurses with thoracic expertise
- Thoracic nurse specialist support in all areas
- Lung cancer nurse specialist support in thoracic surgical clinics and wards
- Specialised thoracic physiotherapy (including out of hours and at weekends)
- Specialist support in post operative pain control
- Access to specialist palliative care
- A designated pathologist
- Designated administrative staff to ensure all clinical staff are supported in the timely delivery and monitoring of the service
- Case managers

[1] It is recognised that dual cardiothoracic practice is in the process of being phased out in England. Within the next few years, it is anticipated that thoracic surgery will be delivered by full time general thoracic surgeons only.

Follow up

- Patients should be offered a specialist follow up appointment within 6 weeks of surgery (3 weeks for oncological patients) and regular specialist follow up thereafter, which may be delivered within a local setting and include a protocol led clinical nurse specialist follow up.
- A system of follow up appointments at outpatient and peripheral clinics should be in place.
- There should be rapid and comprehensive feedback to referral teams including the patients GP to ensure that as much follow up care as possible can be provided locally.
- There should be an agreed referral process back to the centre for patients requiring specialist advice or support. Urgent cases should be on an immediate basis. Failure to attend an appointment without explanation should be followed up.

Emergency cover and on-call arrangements

- Providers are required to have 24/7 emergency cover by general thoracic surgical consultants with or without mixed-practice cardiothoracic surgical colleagues.
- The surgeons on the rota should be able to deal with the full range of thoracic surgical emergencies. Cross cover of rotas from consultants with a purely cardiac practice or from consultants from other specialities is unacceptable.
- A sustainable on call rota should not be more frequent that 1 in 4.

Holistic Needs Assessment

- As recommended by NICE guidelines, patients with lung cancer should be offered a holistic needs assessment at each key stage of care that informs their care plan and the need for referral to specialist services. The holistic needs assessment is usually carried out by the clinical nurse specialist.

Palliative Care

- All services caring for patients with progressive life threatening disease have a responsibility to provide care with a palliative approach.
- All patients should have access to specialist palliative care services as described in the CSCG Minimum Standards for Specialist Palliative Care (NHS Wales 2005).

Patient experience

- All patients must be given details of their Key Worker and how to contact their key worker at all stages of their treatment. Support and counselling should be available, either personally or be telephone.
- Feedback from patients regarding their experience must be gained in a structured manner at least annually and reported to WHSSC. This feedback may also be used to make service change where required.
- The centre must enable the patient's, carer's and advocate's informed participation and to be able to demonstrate this. Provision should be made for patients with communication difficulties.

Clinical Trials

- Patents should be given the opportunity to enter approved clinical trials for which they fulfil the entry criteria.

Education, training and research

- Providers of thoracic surgery should be linked to a University.

- There must be programmes for ongoing education and development for all professionals involved in the service.

- Providers are expected to offer programmes for ongoing education and development for all professionals involved in the

service. There should be an ongoing programme for research activity in line with research governance requirements.

Referral Links for patient support

- There should be close links with support services such as social workers, psychiatrists, chaplain, bereavement support and the primary health care team.

3.2.2 Timely access to treatment

The following targets should be achieved:

- Cancer waiting time targets
  - Urgent Suspected Cancer: treatment within 62 days of referral from Primary Care.
  - Non Urgent Suspected Cancer: treatment within 31 days of the decision to treat.

- The results of cytology, histopathology and frozen section analysis of intra-operative specimens, should be communicated to the operating surgeon within 1 hour of the sample being taken.

- Urgent (non cancer) in-patient treatment:

Indications for urgent treatment (such as empyema or pneumothorax) often requiring in-patient transfer from General Hospitals to the thoracic surgery unit:

  - Transfer to the thoracic surgery unit and treatment within 48 hours of referral.

- Patients with non malignant conditions on elective referral pathways should be treated within the referral to treatment targets for Wales:
  - 95% within 26 weeks from GP referral to treatment
  - No patient should wait in excess of 36 weeks from referral to treatment.

- Where there is a clinical suspicion of malignancy, patients referred for a diagnostic biopsy of lung or mediastinal lymph node should have this performed within a clinically appropriate timeframe. The time from referral for diagnostic biopsy to performing the biopsy will form part of the performance monitoring of the service. **(Added following conference call on 15.03.17)**

3.2.3 Responsibilities of referring Health Boards

It is important to recognise the key role of referrers in enabling the thoracic surgery service to achieve the quality standards in this specification. This includes the timely assessment and referral of patients, the provision of full diagnostic information and repatriation of patients back to secondary care once the tertiary service is no longer clinically required.

4. Putting Things Right: Raising a Concern

Whilst every effort has been made to ensure that decisions made under this policy are robust and appropriate for the patient group, it is acknowledged that there may be occasions when the patient or their representative are not happy with decisions made or the treatment provided. The patient or their representative should be guided by the clinician, or the member of NHS staff with whom the concern is raised, to the appropriate arrangements for management of their concern:

- When a patient or their representative is unhappy with the decision that the patient does not meet the criteria for treatment further information can be provided demonstrating exceptionality. The request will then be considered by the All Wales IPFR Panel.
- If the patient or their representative is not happy with the decision of the All Wales IPFR Panel the patient and/or their representative has a right to ask for this decision to be reviewed. The grounds for the review, which are detailed in the All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR), must be clearly stated. The review should be undertaken, by the patient's Local Health Board;
- When a patient or their representative is unhappy with the care provided during the treatment or the clinical decision to withdraw treatment provided under this policy, the patient and/or their representative should be guided to the LHB for NHS Putting Things Right. For services provided outside NHS Wales the patient or their representative should be guided to the NHS Trust Concerns Procedure with a copy of the concern being sent to WHSSC.

5. Performance Monitoring and Information Requirements

5.1 Performance Monitoring

WHSSC will be responsible for commissioning services in line with this specification. This will include agreeing appropriate information and procedures to monitor the performance of organisations.

- **Service providers to evidence quality and performance controls and procedures.**
- **Service providers to evidence compliance with standards of care.**

WHSSC will conduct performance and quality reviews on an annual basis.

5.2 Key Performance Indicators

The providers will be expected to monitor against the following target outcomes:

- Cancer Waiting Times
- Referral to Treatment waiting times
- Thoracic surgery component waiting times for patients on cancer and elective pathways.
- Urgent treatment/transfer times (non cancer indications)
- Resection rates by MDT
- Thoracic surgeon attendance at Lung Cancer MDT
- Intra-operative pathology results
- Length of stay for patients having lung surgery – cancer and non cancer

- Outcomes specified by the Society for Cardiothoracic Surgeons for submission to the SCTS Thoracic Surgical Database:
  - Post operative mortality
  - Post operative complications
  - Air leak after lung resection for primary cancer
  - Return to theatre
  - ITU readmission

- Need for ventilation

Cancer Waiting Times
Providers are expected to comply with the cancer waiting times in Wales, these are:

a) Newly diagnosed cancer patients that have been referred as Urgent Suspected Cancer (USC) should start definitive treatment within 2 months (62 days) from receipt of referral at the hospital.

b) Newly diagnosed cancer patients not included as USC referrals to start definitive treatment within 1 month (31 days) of a decision to treat.

Referral to Treatment Waiting Times
Referral to Treatment Time (RTT) is the period of time from referral by a GP or other medical practitioner to the start of definitive treatment.

The RTT waiting times for patients in Wales are:

- 95% of patients waiting less than 26 weeks from referral to treatment; and
- 100% of patients treated within a maximum of 36 weeks.

Urgent treatment (non cancer indications)

- Indications for urgent treatment (such as empyema or pneumothorax) often requiring in-patient transfer from General Hospitals to the thoracic surgery unit:
    - Transfer to the thoracic surgery unit and treatment within 48 hours of referral.

Intra-operative results

- The results of cytology, histopathology and frozen section analysis of intra-operative specimens, should be communicated to the operating surgeon within 1 hour of the sample being taken.

Length of stay

- Average length of stay for patients admitted for primary lung cancer resection and average length of stay for patients admitted for non cancer thoracic surgery.

Resection rates by MDT

- Reported annually through the National Lung Cancer Audit.
- Providers should ensure that all data items required for cancer registration are correctly recorded in the patient record and coded in accordance with national coding standards. This dataset should be transmitted to the Welsh Cancer Intelligence and Surveillance Unit (WCISU) within an agreed time frame.

Thoracic surgeon attendance at Lung Cancer MDT

- The number and proportion of Lung Cancer MDT meeting attended by a consultant thoracic surgeon (either in person or via VC), by MDT in Wales.

SCTS outcomes

- Units should report all cases to the UK Registry for thoracic surgery (SCTS) as specified by the Registry. Information from the registry should be analysed and given to every surgeon who undertakes work for the unit.

6. Monthly Performance Data Submission

Every month providers should send to WHSSC by email Cancer Waiting Times, RTT waiting times and activity (number of operations by casemix) performance. It is the provider's responsibility to notify WHSSC as the commissioner should there be any breaches of the waiting times targets.

6.1 Cancer Waiting Times

Performance against cancer waiting times targets should be submitted to WHSSC on the first working day of each month. For all patients who receive a primary lung cancer resection:

- LHB of residence, Referring MDT, date of referral for surgery, date of out-patient appointment, date of surgery
- Where cancer waiting times targets are not achieved, a breach report will be submitted (inc. the reason for breach and action taken).

6.2 RTT Waiting Times

These should be submitted to WHSSC via the NWIS monthly submission route on the 10th working day of the month.

Profile of the number of patients on an RTT pathway:

- < 26 weeks for surgery
- Between 26-35 weeks for surgery
- >36

The provider should also monitor the appropriateness of referrals into the service and provide regular feedback to referrers on inappropriate referrals, identifying any trends or potential educational needs.

6.3 Activity

Surgical activity, out-patient and in-patient, by indication for surgery, will be reported to WHSSC on a monthly basis.

7. Equality Impact and Assessment

The Equality Impact Assessment (EQIA) process has been developed to help promote fair and equal treatment in the delivery of health services. It aims to enable Welsh Health Specialised Services Committee to identify and eliminate detrimental treatment caused by the adverse impact of health service policies upon groups and individuals for reasons of race, gender re-assignment, disability, sex, sexual orientation, age, religion and belief, marriage and civil partnership, pregnancy and maternity and language (welsh).

Respondent	Comment Number	Comments Received from Stakeholders	Proposed Response to comment	Change to Spec: Y/N	Section	Proposed Amendment to Specification
Respiratory Physician, AB UHB	6	**Background** Should have some comments here about benign conditions that require thoracic surgical support.	Agree to include.	Yes	1.2 (p5)	In addition to the treatment of lung cancer, there are many other conditions which require thoracic surgery. These include other types of thoracic malignancies, pneumothorax, various forms of thoracic sepsis and a large group of miscellaneous conditions which fall outside the remit of other surgical specialties.
Respiratory Physician, AB UHB	7	**Definition of Thoracic Surgery** Non-cancer conditions listed here should also include – • Primary and secondary pneumothoraces • Diagnostic lung biopsies	Agree to include.	Yes	2.1 (p6)	Addition of : - Primary and secondary pneumothoraces; - Diagnostic lung biopsies
Respiratory Physician, AB UHB	10	**Timely Access to Treatment** Diagnostic biopsies in patients with suspicion of cancer should be performed within 2 weeks once agreed by the surgeon.	Specific target for further discussion with Project Board. Agreed to include requirement to measure and report thoracic surgical component waits. Agreed to include statement of responsibilities of referrers.	Yes	5.2 (p19) 3.2.3 (p17) 3.2.2 (p17)	5.2 KPI: Thoracic surgery component waiting times for patients referred on cancer and elective pathways. 3.2.3 It is important to recognise the key role of referrers in enabling the thoracic surgery service to achieve the quality standards in this specification. This includes the timely assessment and referral of patients, the provision of full diagnostic information and repatriation of patients back to secondary care once the tertiary service is no longer clinically required. ***3.2.2 Teleconference 15.03.17:*** *Where there is a clinical suspicion of malignancy, patients referred for a diagnostic biopsy of lung or mediastinal lymph node should have this performed within a clinically appropriate timeframe. The time from referral for diagnostic biopsy to performing the biopsy will form part of the performance monitoring of the*
Respiratory Physician, AB UHB	12	**Key Performance Indicators** Need a reference here to continued participation in the National Lung Cancer Audit.	Reference to NCLA already made in section 5.2 KPIs. However, agree include further statement.	Yes	3.1 (p10)	Addition of: The providers are expected tol participate in relevant national audits, including the National Lung Cancer Audit.

Respondent	Comment Number	Comments Received from Stakeholders	Proposed Response to comment	Change to Spec: Y/N	Section	Proposed Amendment to Specification
Respiratory Physician, AB UHB	13	**Key Performance Indicators** Also a need to engage with Peer review of Lung Cancer services and address concerns raised within the resultant action plans	Agree to include.	Yes	3.1 (p10)	Addition of: The providers are expected to participate in peer review of lung cancer services.
CVUHB, Specialist Services Clinical Board	24	**Section 1.2 Background** p.5 - text notes that patients are 50% more likely to have surgery for lung cancer if they present to a hospital that provides throracic surgery on site. Is this comment evidence based? If not, it should be removed.	The statement that patients are 50% more likely to have surgery was included in the previous WHSSC draft specification. Propose to remove if the reference	Yes	1.2 (p5)	Reference to 50% deleted.
CVUHB, Specialist Services Clinical Board	25	**Section 2.1 Definition of Thoracic Surgery** p.6 - Non-cancer indications for surgery – could include air leak, chest trauma/rib fractures etc	Agree to include.	Yes	2.1 (p6)	Addition of: air leak, chest trauma/rib fractures
CVUHB, Specialist Services Clinical Board	28	p.7 - Appropriate levels of staff – should this be defined, what standards are being used.	No specific standards cited in source documents.	Yes	2.3 (p8)	Statement removed.
CVUHB, Specialist Services Clinical Board	31	p.11 - Thoracic surgery HDU beds (1 per 75 major thoracic procedures) – we would need circa 6 beds commissioned on that basis so significant resource implications with this.	This standard was taken from the previous WHSSC service specification. Reference not found.	Yes	3.2.1 (p11)	Reference removed.
CVUHB, Specialist Services Clinical Board	33	p.12 - Pre-habilitation and Enhanced Recovery – should be separated out as they are two different things. We would consider pre-habilitation to be a primary/secondary care part of the pathway and should therefore be Health Board commissioned and funded.	Agree they are separate phases.	Yes	3.2.1 (p13)	Amended to: Patients with a resectable lung cancer who are of borderline fitness for surgery should be offered the opportunity to engage in a pre-habilitation programme prior to referral to thoracic surgery.
CVUHB, Specialist Services Clinical Board	37	p.16 - Transfer to the thoracic surgery unit and treatment within 48 hours of referral – we should also include something here regarding repatriation protocols and timely transfer of patients back under the care of respiratory physicians once the tertiary episode of care is complete.	Implementation issue. However, statement proposed on responsibilities of the referrer to support achievement of this specification.	Yes	3.2.3 (p17)	It is important to recognise the key role of referrers in enabling the thoracic surgery service to achieve the quality standards in this specification. This includes the timely assessment and referral of patients, the provision of full diagnostic information and
ABM UHB	41	Where there is references in the specification to specific infrastructure requirements could the evidence base for these be included in the document: o minimum 150 resections per annum and the 3 thoracic surgeons per unit; o 1 HDU bed per 75 cases; o Need for PET scanner on the same site.	150 resections: evidence assessment undertaken by NHS England to inform their specification. PET: specification does not require co-location but states "usually co-located". HDU beds: previous WHSSC specification/no supporting reference found.	Yes	3.2.1 (p11)	Reference to 1 HDU bed per 75 cases deleted.

Respondent	Comment Number	Comments Received from Stakeholders	Proposed Response to comment	Change to Spec: Y/N	Section	Proposed Amendment to Specification
ABM UHB	46	**Secondary and primary care commissioning requirements** - should the service specification be more explicit about the services that need to be in place in primary care and secondary care to ensure a patient achieves seamless and timely access to thoracic surgery treatment.	General statement proposed on responsibilities of referrers to enable this specification to be achieved.	Yes	3.2.3 (p17)	It is important to recognise the key role of referrers in enabling the thoracic surgery service to achieve the quality standards in this specification. This includes the timely assessment and referral of patients, the provision of full diagnostic information and repatriation of patients back to secondary care once the tertiary service is no longer clinically required.
RAW/WTS	52	There is little reference to non-cancer thoracic surgery. In relation to this we would like to highlight the following specific considerations: 1) The introduction refers only to challenges faced by thoracic surgery associated with lung cancer including low cancer resection rates in Wales.	Agree to include background reference to non cancer surgery.	Yes	1.2 (p5)	In addition to the treatment of lung cancer, there are many other conditions which require thoracic surgery. These include other types of thoracic malignancies, pneumothorax, various forms of thoracic sepsis and a large group of miscellaneous conditions which fall outside the remit of other surgical specialties.
Respiratory Physician, ABMU	1	On Page 11 it is stated that the thoracic surgery unit (singular) should have 3 thoracic surgeons. Should this therefore be changed to recommend that the minimum number of thoracic surgeons for a given thoracic surgery unit should be 3. If thoracic surgery is centralised to one unit for South Wales then you would require more than 3. Is there a national standard for the number of thoracic surgeons required per population size/projected resection rate etc?	This is consistent with the current draft which states a minimum of 3 full time thoracic surgeons. The NHS England specification suggests a ratio of 1 surgeon per 500,000 population. Issue for implementation.	No	n/a	n/a
Respiratory Physician, ABMU	2	Re: my second point, will the standard be changed to recommend that we have 2 thoracic surgeons present for each MDT?	The sources that have informed the draft specification do not include this as a standard. This would probably only be deliverable if the number of MDTs are significantly reduced. It may be a future consideration, however.	No	n/a	n/a

Respondent	Comment Number	Comments Received from Stakeholders	Proposed Response to comment	Change to Spec: Y/N	Section	Proposed Amendment to Specification
Clinical Lead, Thoracic Surgery, LHCH	3	Many thanks for sending the draft service spec for comment. I have no concerns about what has been written, but no doubt my colleagues who provide the outreach service to N Wales from LHCH will have their views. I do have a concern that given the number of autonomous lung cancer MDTs and independent secondary lung cancer services throughout Wales that it will never be possible to provide adequate cover from the pool of available thoracic surgeons, especially when the core members of the MDTs are on leave. I would suspect the same concern applies to medical and clinical oncology. I believe that the amalgamation of the three N Wales services into one would make the overall service a lot better in many ways, and would allow us to manage the patients properly, with 2 thoracic surgeons present at every MDT, flexible input to the outreach clinic(s) and to provide cover throughout the year for leave. I suspect the same changes could be made in S Wales with a similar improvement. It is recognised that the absence of thoracic surgeons at lung cancer MDTs can lead to patients not having access to surgery and a lower overall cure rate for their disease. I would welcome the opportunity to discuss these issues further with you.	The number of MDTs is outside the scope of the specification. However, the Project Board should consider whether recommendations should be made with regard to further work to explore the feasibility, advantages and disadvantages, of further reducing the number of lung cancer MDTs.	No	n/a	n/a
Respiratory physician, Hywel Dda UHB	4	At this stage I think it crucial that we agree a service specification, one of the problems we have encountered in Hywel Dda is that when we have approached our provider to challenge them on time to surgery and access to investigative procedures such as mediastinoscopy the reply has been that they are doing more than they were paid for already. **Which is true but this is why we need to build into the specification quality standards and maximum times to resection and investigative procedures.** I'm stressing this because I have been heavily criticised by the ombudsman for a patient who had to wait 6 weeks for mediastinoscopy. This is considered my fault as the referring clinician rather than organisation that delivers the service. Therefore 2 weeks from referral to procedure should be a maximum. I also would consider it vital that in deciding the specifications and then the solution we are able to consider the 2 reviews that took place before Christmas, there seems to be some delay in this.	Existing waiting times targets (cancer and RTT) apply to resection. It is unclear whether there are recognised quality standards for time to investigative procedures.	No	n/a	n/a
Respiratory Physician, AB UHB	5	**Introduction** How does this service specification relate to the service provided by centres in England? This will be relevant particularly for North Wales and ensure an equitable service to all residents across Wales	This specification is consistent with the NHS England specification.	No	n/a	n/a

Respondent	Comment Number	Comments Received from Stakeholders	Proposed Response to comment	Change to Spec: Y/N	Section	Proposed Amendment to Specification
Respiratory Physician, AB UHB	8	**Timely Access to Treatment** Statement required here about the proposed single cancer pathway	This pathway is not yet in place. If adopted by Welsh Government, this would trigger review of WHSSC specifications relating to	No	n/a	n/a
Respiratory Physician, AB UHB	9	**Timely Access to Treatment** I would stipulate that surgery for cancer patients should be within 3 weeks of DTT	Cancer targets are stipulated nationally.	No	n/a	n/a
Respiratory Physician, AB UHB	11	**Timely Access to Treatment** In-patient transfers should occur within 48 hours once agreed by the surgeon.	This is already stated as a KPI.	No	n/a	n/a
Directors of Therapies	14	The Directors of Therapies and Health Science have general concerns regarding the commissioning of diagnostic, therapy, therapeutic, intraoperative, medical equipment and decontamination support associated with this specialist service. We trust this will be appropriately considered and additional capacity for these clinical services accurately costed in the business case. Consideration should be given in the service specification and commissioning framework to the following clinical services and functions and the impact of increased demand: **Radiology** Availability of resilient radiology expertise which can be scaled up through commissioning. Radiographer capacity. Routine imaging gantry capacity. Access to specialist imaging and interventional modalities and facilities including PET /CT. Additional demand for nuclear machine and associated radio-pharmaceuticals.	These are issues to consider for implementation rather than for inclusion in the specification.	No	n/a	n/a
Directors of Therapies	15	**Pathology** Availability of resilient Histopathologists expertise which can be scaled up through commissioning. Healthcare scientist capacity to dissect and process lung resections including equipment capacity. List of co-located services must include transfusion. Also POCT should be considered as an option including costs associated with additional devices.	These are issues to consider for implementation rather than for inclusion in the specification.	No	n/a	n/a
Directors of Therapies	16	**MDT – this should have a comparable commissioning specification for all core membership not just surgeons**	While important, this is outside the scope of the surgical specification.	No	n/a	n/a
Directors of Therapies	17	**Emergency OOH service** Predictable access to imaging resources and capacity Predictable turnaround times of 1 hour for urgent frozen sections may be challenging and not all Histopathology departments offer an OOH service	These are issues to consider for options appraisal and implementation rather than for inclusion in the specification.	No	n/a	n/a

Respondent	Comment Number	Comments Received from Stakeholders	Proposed Response to comment	Change to Spec: Y/N	Section	Proposed Amendment to Specification
Directors of Therapies	18	**Therapies** Pulmonary prehabilitation and rehabilitation capacity and availability of specialised respiratory physiotherapy expertise	Already included.	No	n/a	n/a
Directors of Therapies	19	**Clinical Physiological testing** Respiratory Clinical Physiology expertise and capacity (scarce resource)	Not currently included. Not listed in source documents.	No	n/a	n/a
Directors of Therapies	20	**Operating Department Practitioner capacity (scarce resource)**	These are issues to consider for options appraisal and implementation rather than for inclusion in the specification.	No	n/a	n/a
Directors of Therapies	21	**Endoscopy equipment** Capacity and age of existing stock of endoscopes and stacks. Access to expensive ultrasound endoscope technologies	Potential considerations for options appraisal / implementation issues.	No	n/a	n/a
Directors of Therapies	22	**Decontamination** Consideration should be given to the impact of additional surgical tray sets and sterile services staffing requirements. Decontamination capacity for endoscopes including	These are issues to consider for implementation rather than for inclusion in the specification.	No	n/a	n/a
Directors of Therapies	23	**Workforce planning & training n deduction commissioning** For expert and specialist scientific, AHP and medical roles We look forward to seeing how this service specification	These are issues to consider for implementation rather than for inclusion in the specification.	No	n/a	n/a
CVUHB, Specialist Services Clinical Board	26	**Section 2.3 Service Provision** p.7 - Dedicated thoracic surgery ward beds – we do not currently meet this, our ward is mixed cardiothoracic surgery beds, with 10 notionally allocated to thoracic surgery.	Issue for options appraisal.	No	n/a	n/a
CVUHB, Specialist Services Clinical Board	27	p.7 - Dedicated thoracic surgery HDU beds – we do not currently meet this, we have the use of the PACU. Would question whether all English units have access to dedicated beds and what the evidence base is around this	Issue for options appraisal. Dedicated unit recommended by RCS report.	No	n/a	n/a
CVUHB, Specialist Services Clinical Board	29	p.8 - Outpatient clinics – requirement for thoracic surgery outreach clinics to be established in each Health Board. There will clearly be a resource implication for this as additional to MDT. Would question whether this is required or whether we would operate a model similar to	Outreach out-patient clinics are integral to both the RCS report and NHS England specification to enhance patient access	No	n/a	n/a
CVUHB, Specialist Services Clinical Board	30	**Section 3.2 Quality Indicators** p.11 - Minimum volumes of 150 primary lung resections per year – assume there is an evidence base that supports this?	Yes. This is based on the evidence assessment undertaken to inform the NHS England specification.	No	n/a	n/a
CVUHB, Specialist Services Clinical Board	32	p.11 - Thoracic surgery should be identified as a separate service line – would be helpful to clarify what is meant by this. Our understanding is that in England, this relates to service line reporting of activity.	This is intended to refer to management structure as per the NHS England specification.	No	n/a	n/a

Respondent	Comment Number	Comments Received from Stakeholders	Proposed Response to comment	Change to Spec: Y/N	Section	Proposed Amendment to Specification
CVUHB, Specialist Services Clinical Board	34	p.13 - Thoracic nurse specialist support – this is available in Medicine as part of secondary care but this is currently not in place within the tertiary surgical service.	Issue for options appraisal.	No	n/a	n/a
CVUHB, Specialist Services Clinical Board	35	p.13 - Specialised thoracic physio – not currently available out of hours and at weekends.	Issue for options appraisal.	No	n/a	n/a
CVUHB, Specialist Services Clinical Board	36	p.15 - provision should be made for patients with communication difficulties – should also include patients with learning disabilities, cognitive impairment, dementia etc.	These the causes of communication difficulties.	No	n/a	n/a
CVUHB, Specialist Services Clinical Board	38	**Section 4 Putting Things Right** p.17 - consideration of requests under IPFR – timescales should be made clear, particularly as many of the patients are likely to require timely surgical intervention.	Generic statement on all WHSSC specifications.	No	n/a	n/a
CVUHB, Specialist Services Clinical Board	39	**Section 6.3 Activity** p.22 - Data set to include indication for surgery – not sure that this is routinely collected within our information systems so may not be able to provide this.	Issue for options appraisal.	No	n/a	n/a
ABM UHB	40	Thank you for giving us the opportunity to provide our comments on the draft Thoracic Surgery Service Specification. We have shared the document widely within our Health Board to ensure that we have a good cross section of comments and feedback. The groups covered in the circulation were:	The RCS report will be shared with the Project Board.	No	n/a	n/a
ABM UHB	42	**Access to second MDT opinion** - will be commissioned through WHSSC at one of the expert centres in England?	Implementation issue.	No	n/a	n/a
ABM UHB	43	**Access to clinical trials** - does this include trials outside Wales and will this be funded via WHSSC?	WHSSC funds service costs; trial costs covered by trial funding. Expected that local commissioned centre would be participating.	No	n/a	n/a
ABM UHB	44	**Clinical Psychology** - the specification should reference the importance of clinical psychology in the provision of a holistic service and for achieving better outcomes for patients	Not currently included. Not listed in source documents.	No	n/a	n/a

Respondent	Comment Number	Comments Received from Stakeholders	Proposed Response to comment	Change to Spec: Y/N	Section	Proposed Amendment to Specification
ABM UHB	45	**Electronic communication** – specification should highlight the importance of electronic communication on discharge for patients being managed in primary care following surgery.	Outside scope of specification. Dependent on wider communication systems.	No	n/a	n/a
ABM UHB	47	**Wales Cancer Network** – should the specification reflect the focus by the Wales Cancer Network on earlier diagnosis of cancer? This will give the specification a welsh identity. It is also important to point out the effect that work to improve earlier diagnosis of cancer across Wales may have an impact on the numbers requiring thoracic surgery in future. Both ABMU and Cwm Taf have recently received funding from the WCN to undertake significant pilot projects in to identifying cancer earlier in a patient's pathway and therefore increasing the chance of curative treatment.	Outside scope of specification.	No	n/a	n/a
ABM UHB	48	**CT reconstructive surgery** - Should the requirements for CT reconstructive surgery as part of sarcoma pathways be included in the specification. If not where does the commissioning for this sit?	This specification is for the core thoracic surgery service.	No	n/a	n/a
ABM UHB	49	**Unscheduled care** – Specification is extremely light on what things should be referred in to such a service. Two references in passing to the surgeons being able to deal with the whole spectrum of thoracic surgical emergencies, but concern that this is too vague and needs to be more detailed. The initial list of things that thoracic surgeons operate on does not include any emergencies and seems to miss some elective things (surgery for recurrent pneumothorax and thymoma for	Description was taken from NHS England specification and RCS report.	No	n/a	n/a
ABM UHB	50	Building on an earlier point, we understand that WHSSC is having ongoing discussions with the RCS about the finalisation of the externally commissioned review. We believe that the service specification should not be finalised until the outcomes of this review have been shared and clearly reflected in the draft specification.	RCS report shared with Project Board.	No	n/a	n/a

Respondent	Comment Number	Comments Received from Stakeholders	Proposed Response to comment	Change to Spec: Y/N	Section	Proposed Amendment to Specification
RAW/WTS	51	I have been in discussion with colleagues in Respiratory Alliance Wales and Welsh Thoracic Society. Please see below a distillation of the comments received therefore and I hope this is useful. RAW welcomes the review of Thoracic surgery in Wales and the resulting service specification. We would like to make the following comments: The service specification refers in the main to lung cancer. On this issue there is no specific indication of how 2nd opinions for Surgical cases will be facilitated via MDT discussion and so clarification of how the logistics of this process will work should be considered as this would have an impact on the number of Consultants required and the number of MDTs that should be configured.	Precise detail of 2nd opinion is an implementation issue.	No	n/a	n/a
RAW/WTS	53	2) The introduction makes no mention of the challenge of long waiting lists for non-cancer surgery including lung biopsy.	Agree to include background reference to non cancer surgery. Outside scope and function of specification to	No	n/a	n/a
RAW/WTS	54	3) The introduction does not mention bronchoscopic lung volume reduction procedures and the limited access to these services in Wales as compared to the rest of the UK	Agree to include background reference to non cancer surgery. Outside scope and function of specification to	No	n/a	n/a
RAW/WTS	55	4) No mention is made in the definition of Thoracic surgery of lung biopsy and of bronchoscopic lung volume reduction procedures both of which are currently provided by thoracic surgery	Agree to include background reference to non cancer surgery. Outside scope and function of specification to detail all current service issues.	No	n/a	n/a
RAW/WTS	56	5) The professionals listed in the Thoracic surgery Care team does not include non-cancer physicians for example Interstitial lung disease or COPD respiratory medicine specialists	Respiratory medicine is included.	No	n/a	n/a
RAW/WTS	57	6) The document does not mention Thoracic surgery liaison with the Interstitial lung disease MDT to plan lung biopsy site or with respiratory physicians in general for the discussion of non-cancer thoracic surgery.	The specification includes respiratory medicine as the first interdependent service.	No	n/a	n/a
RAW/WTS	58	7) The document commits only to RTT targets of 95% compliant 26 weeks and 100% 36 weeks for non-cancer surgery. This is inadequate for lung biopsy where, by definition, those referred have a progressive, life threatening but potentially reversible condition where diagnostic delay will adversely affect the patient outcome.	As comment 20. Specific target for further discussion with Project Board. Agreed to include requirement to measure and report thoracic surgical component waits. Agreed to include statement of responsibilities of	No	5.2 (p19) 3.2.3 (p17)	5.2 KPI: Thoracic surgery component waiting times for patients referred on cancer and elective pathways. 3.2.3 It is important to recognise the key role of referrers in enabling the thoracic surgery service to achieve the quality standards in this specification. This includes the timely assessment and referral of patients, the

Respondent	Comment Number	Comments Received from Stakeholders	Proposed Response to comment	Change to Spec: Y/N	Section	Proposed Amendment to Specification
RAW/WTS	59	8) The document does not refer to the additional resources needed to reduce waiting times to lung biopsy and other non-cancer lung surgery	Outside the scope and function of a specification.	No	n/a	n/a
RAW/WTS	60	9) The IPFR (Individual Patient Funding Request) has just undergone an independent review and is awaiting final sign off from the Cabinet Minister re. Recommendations. Therefore it is suggested that the content of the document needs to reflect any revised process from this review.	All WHSSC specifications will be appropriately revised to reflect IPFR process changes.	No	n/a	n/a

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

		Agenda Item	12
Meeting Title	**Joint Committee**	Meeting Date	28/03/2017
Report Title	Neurosciences five year Commissioning Strategy update		
Author (Job title)	Specialised Planner, Neurosciences		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	**Public**

Purpose	This paper provides an overview of the five year Commissioning Plan for Specialised Neurosciences.			
RATIFY ☐	APPROVE ☐	SUPPORT ☒	ASSURE ☐	INFORM ☒

Sub Group /Committee	Not Applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the overview of the five year Commissioning Strategy for Specialised Neurosciences. • **Support** the Neurosciences and Complex Conditions Programme Team initially focusing on the three outlined areas.		

Considerations within the report (tick as appropriate)

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

12

1.0 Purpose

The purpose of this report is to provide Joint Committee with an overview of the five year Commissioning Strategy for Specialised Neurosciences.

2.0 Background

WHSSC were asked by Joint Committee to develop a clear strategy for specialised Neurosciences services for patients from NHS Wales, in order to set the direction for specialised and non-specialised services in this area. This was in response to:

- The emergence of a number of Neurosciences service issues that required financial support outside of Integrated Commissioning Plans;
- Three Service Reviews: Steers (2008), Axford (2009) and Price-Morris (2009) which highlighted areas within Neurosciences that required development;
- The number of Neurosciences schemes proposed for inclusion in the WHSSC Integrated Commissioning Plans;
- Continued inability of the inpatient Neurosurgery service in Cardiff to deliver the 26 week referral to treatment (RTT) target – the service has not even been able to achieve a 36 week referral to treatment (RTT) target.
- Key developments on the horizon within Neurosciences, most notably with the introduction of Medical Thrombectomy (clot retrieval) for the treatment of strokes.

The five year Commissioning Strategy for Specialised Neurosciences will set out how services are currently delivered and commissioned across Wales, and will make recommendations on the future delivery and commissioning of these services. The aim is to provide Health Boards with assurance that WHSSC are commissioning safe and effective services, which meet the requirements of the population of Wales.

In June 2016 Joint Committee members approved the Project Initiation Document (PID) which described the development of a Commissioning Plan for Specialised Neurosciences. It was acknowledged that the plan only took into consideration those services commissioned directly by WHSSC and clarification was sought as to what these services were. The services were broadly outlined as:

- Neurosurgery
- Interventional Radiology
- Neuro-rehabilitation
- Spinal Rehabilitation
- Paediatric Neurosciences including Paediatric Neurosurgery, Paediatric Neurology and Paediatric Neuro-Rehab

Members noted the establishment of the Working Groups and the intentions to seek nominations from Health Boards for membership.

In order to inform the development of the Commissioning Strategy, a needs assessment for Specialised Neurosciences was requested from Public Health Wales. Unfortunately the data to inform this was not readily available, and Public Health advised that they do not have the staff to undertake a needs assessment. This is considered to be an integral part of a Commissioning Strategy and the intention is to try and source this data by other means including from national databases such as UK Rehabilitation Outcomes Collaborative (UKROC). Until this data is available, we have made reference to the Public Health Wales Needs Assessment published in December 2015 which provides an overview of the burden of neurological conditions across Wales and description of the service provision and utilisation.

3.0 Assessment

3.1 Progress

Since the approval of the PID, the Neurosciences and Complex Conditions programme team engaged with stakeholders from across all Health Boards and relevant NHS Trusts in England in order to:

- Gain an understanding of the progress made since the three reviews;
- Recognise the best practice and share this where relevant across services;
- Understand the priorities for services over the next five years.

The increased engagement particularly with English providers has led to changes to contracts, notably with Robert Jones Agnes Hunt there has been a reduction in the bed day rates due to managing patients differently. We are working with the Walton to introduce a bed day rate within Neuro-rehabilitation which will again reduce spend.

There have been improvements made to the Gate-keeping arrangements so that Lead Consultants for their specialities are being made aware of referrals outside of their service. This has led to improved retention of patients locally which has consequently avoided increased costs of sending patients to NHS England.

There have also been changes to the Neurosurgery contract within Cardiff, moving from a block contract of emergency and electives to a more reflective case-mix contract. The details of this are detailed in Appendix 1 and will be described in more detail on the Financial paper that is due to be presented at Management Group in April and included in the overall Strategy presented to Joint Committee in May. Increased engagement with relevant Consultants on this work has led to improved coding of cases ensuring that the contract is truly reflective of the work undertaken.

3.2 Schedule of schemes

The engagement through individual discussions and the meetings of the three work-streams set up specifically for Neurosurgery, Neuro-diagnostics and Neuro-Rehabilitation, has led to the development of a schedule of schemes for the five

year duration of the plan which is outlined in Appendix 2. The 54 schemes can be categorised into 42 work-plan and 12 requiring financial input, although it is likely that as the work-plan is undertaken, that more schemes will need to be quantified financially.

The schemes include recommendations from the Steers, Axford and Price-Morris reviews, which following assessment, are still felt to be outstanding and requiring implementation.

It is anticipated that the schedule will continually evolve and although we have undertaken horizon scanning, within the five years there are likely to policy developments and other external influences which will need to be considered for inclusion.

3.2 Priorities established

The Commissioning Strategy has identified that there are a number of issues which impact on wider pathways across Wales and span across both WHSSC and Health Board Commissioning.

By initially focusing on a number of key pathways, which in the initial stages require limited financial input, it is possible to improve processes which will contribute to increasing the sustainability and capacity of services. This work can then be rolled out to other areas which have been highlighted through the discussions with Stakeholders and working group meetings.

The ongoing consultation has identified three immediate areas of focus which represent a cross section of the Specialised Neurosciences programme. Focussing on these three areas in 2017/18 will help to stabilise not only these services directly, but also other specialised Neurosciences services commissioned by WHSSC and individual Health Boards. The following three schemes have been selected from the 54 schemes that have been discussed to date, which when worked through over the next five years, will help in sustaining Specialised Neurosciences for NHS Wales:

1. Provision and utilisation of Specialised Rehabilitation Services
2. Provision of Paediatric Neurology
3. The delivery of Neuro-Radiology.

3.2.1 Specialised Rehabilitation Services

Scoping work and assessments of specialised rehabilitation services provided to patients from NHS Wales, including benchmarking against the British Society of Rehabilitative Medicine standards, present a picture of overwhelmed services, which are unable to meet demand and provide timely rehabilitation. The principle reason for this is inability to discharge patients back to Health Boards following the completion of specialised rehabilitation. For patients from North Wales, access to level 2 rehabilitation is limited to what is commissioned from NHS England, as the

Price-Morris review recommendation for an inpatient rehabilitation centre to be established in North Wales has yet to be implemented.

In terms of the English contracts, this results in higher spend and a threat of limiting the number of Welsh patients who can be accommodated by a provider at any one time. There are also delays for patients from Powys and BCU UHB in determining if the rehabilitation placements will be funded by Health Boards or WHSSC. For the South Wales services, such bottlenecks also have an effect earlier in a patient's pathway, with cancellations of elective admissions and patients waiting in excess of the referral to treatment targets for Neurosurgery.

Measures have already been taken through the revision of the Specialised Rehabilitation policy to re-affirm WHSSC's commissioning intentions and introduce a system which will highlight patients who have completed their specialised rehabilitation but due to delayed discharges remain in a specialised unit. However, the amendment of the policy only goes part way to produce whole system change.

There are opportunities of improving patient flow throughout the whole Neurosciences system by reducing the time to discharge once a patient's rehabilitation is complete. Improved flow would allow patients to receive rehabilitation earlier in their pathway which is proven to be more effective and consequently reduces the burden of disease on both health and social care. Further investigation in the current flow for Rehabilitation of North Wales patients is required with a view to redesigning the delivery model of Rehabilitation following this work.

The Neurosurgery service in Cardiff would also benefit from improved flow to the Rehabilitation wards with the service regularly having to cancel surgery due to unavailability of beds.

A scheme to reduce the long waits within Neurosurgery through increased theatre capacity was proposed for inclusion in the 2017/18 ICP. However as one of the main reasons for not being able to meet the targets is unavailability of beds and this scheme does not address this specific issue, the decision has been taken to remove the scheme from the ICP until the wider capacity issues begin to be addressed.

3.2.2 Provision of Paediatric Neurology

Specialised Paediatric Neurology is commissioned from the Children's Hospital of Wales, Cardiff and Alderhey Children's Hospital. An additional Paediatric Neurologist funded by ABM UHB undertakes specialist clinics in both ABM UHB and Hywel Dda UHB which avoids the need for a number of patients to access the Cardiff service. However, this post-holder is shortly to retire and return to work part-time which will increase the demand on an already under-resourced Specialist Centre.

In North Wales, Paediatric Neurology support is provided by Alderhey in terms of both inpatient care and outreach clinics and ongoing locally by Consultant Community Paediatricians. The Lead Paediatrician with a special interest in Neurology due to retire completely from the service in April 2017, but has been replaced with another Paediatrician with an interest in Neurology. There have been discussions around a joint Consultant Paediatric Neurologist post between BCU and Alderhey which would reduce admissions to Alderhey and patients overall length of stay, with specialist support provided within North Wales.

The provision of specialised Paediatric Neurology in South Wales is vulnerable with 50% of the Consultant body due to retire within the next five years and the services being commissioned by both WHSSC and a Health Board, which restricts a pan South Wales approach to recruitment and retention. Elements of Paediatric Neurology and interdependent Paediatric Neurosurgery service are provided in England in a piecemeal fashion and repatriation of these services with limited financial requirements would go towards stabilising the workforce and provide the added benefit of more local services to patients.

3.2.3 The delivery of Neuro-Radiology services

Specialised Neuro-Radiology services are provided in both ABM UHB and C&V UHB although at a reduced level from when Neurosurgery was provided on both sites. The need to react to services being under-resourced and having to be provided temporarily in England, along with the introduction of pioneering treatments such as mechanical thrombectomy without any increase in staff has led to piecemeal commissioning of Radiology services from WHSSC and Health Boards. WHSSC is responsible for commissioning Neuro-Radiology only as part of a Neurosurgery episode with the remaining and majority of work undertaken in C&VUHB commissioned by Health Boards. All the activity undertaken within ABMUHB is Health Board commissioned. Cardiff as the provider of many specialised services has the oldest and the least number of scanners in Wales based on population served and yet it is estimated that it undertakes 66% of all Neuro MRIs within Wales.

The Radiology service in Cardiff in its entirety has undergone a number of reviews in recent years, with the highest profiled Service Review conducted by NHS England concluding that whilst the service has the potential to be leaders in health provision with an excellent calibre of clinical staff, sub-specialisation has achieved clinical excellence at a cost of providing a DGH service to the local population. Whilst mindful not to repeat this work, there are benefits in the Royal College of Radiology providing an over-arching review of the two Specialised Neuro-Radiology services to understand the priorities for the service.

3.3 Finance

As noted previously, the schedule of schemes has identified 12 Finance and contracting issues to be addressed over the next five years. These can be categorised into three key areas:

- Contracting and reporting
- Repatriation and referral management
- Classification/definition

A specific paper outlining the current WHSSC contracting arrangements for Neurosciences will be presented at the April Management Group. It is intended that following this data being shared with Health Boards, that appropriate Task and Finish groups will be convened to ensure that all funding mechanisms align with commissioning responsibilities and reflect the five year Commissioning Strategy.
The paper will also outline the investments that have been made in Specialised Neurosciences since the Steers Review and subsequent transfer of Neurosurgery from Swansea to Cardiff.

A specific five year financial plan will be included in the final presentation of the Commissioning Strategy to Joint Committee in May 2017.

3.4 Final presentation of the Five year Plan

The final version of the five year Commissioning Strategy for Neurosciences will be presented to Joint Committee in May and include:

- Background for the Commissioning Strategy;
- Assessment of the implementation of recommendations from the three service reviews;
- Details of the Stakeholders consulted with;
- Details of the three work-streams established including membership, terms of reference and outputs;
- Information gathered in the development of the Strategy;
- A map of the current provision of Specialised Neurosciences along with activity and financial costs;
- The requirement of Specialised Neurosciences services in Wales;
- The schedule of schemes prioritised over five years.

4.0 Recommendations

4.1 Members are asked to:

- **Note** the overview of the five year Commissioning Strategy for Neurosciences.

- **Support** the Neurosciences and Complex Conditions Programme Team initially focusing on the three outlined areas.

Link to Healthcare Objectives	
Strategic Objective(s)	Development of the Plan Organisation Development Governance and Assurance
Link to Integrated Commissioning Plan	The Neurosciences Commissioning Strategy is to inform future Integrated Commissioning Plans.
Health and Care Standards	Staff and Resourcing Effective Care Choose an item.
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Reduce inappropriate variation Only do what is needed
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Improving Patient Experience (including quality and Satisfaction) Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	The Commissioning Strategy has been written with the Quality, Safety and Patient Experience at the forefront.
Resources Implications	There will be resource implications as it is evident that Neurosciences in South Wales is under-resourced compared to the service in the Walton Centre that serves North Wales and a number of developments have been delayed awaiting the outcome of this commissioning plan.
Risk and Assurance	There is risk to patient safety as a number of services within Neurosciences for patients across Wales are not sustainable.
Evidence Base	A gap analysis was undertaken on the South Wales service compared to the English service specification which highlighted deficits in the provision of Neurosurgery compared to English counterparts such as the Walton Centre.
Equality and Diversity	Investment in this service would reduce the inequities with the service received by patients in North Wales in the Walton Centre and reduce inequities between West and East Wales in accessing other services such as acute neuro-rehabilitation.
Population Health	None
Legal Implications	None

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

12

Appendix 1: Case-mix contract for Neurosurgery undertaken in Cardiff and Vale UHB

The proposed case mix categories have been incorporated into a cost & volume model. Baselines agree to the current LTA contract and the core currency remains on a FCE basis.

Case Mix Category	Financial Baseline			Activity Baseline				Marginal Price
	DC/IPEL	IPNEL	Total	DC	IPEL	IPNEL	Total	£
Admitted Patient Care (APC) [FCEs]:								
Brain tumours or cerebral cysts - cat 2 and below				1	16	56	72	1,374
Brain tumours or cerebral cysts - cat 3 and 4				-	139	145	284	1,772
Cerebral degenerations or miscellaneous disorders of nervous system				-	56	77	133	1,440
Diagnostic vascular radiology				26	15	48	88	465
Extradural spinal conditions / procedures				-	184	72	256	1,568
Functional neurosurgery				2	7	-	9	1,040
Haemorrhagic cerebrovascular disorders				1	-	53	53	1,180
Haemorrhagic cerebrovascular disorders with intracranial procedures				-	11	36	47	2,330
Interventional neuroradiology				12	61	74	148	904
Intracranial procedures for trauma				-	-	120	120	1,833
Intradural spinal conditions /				4	31	37	72	1,705

Case Mix Category	Financial Baseline			Activity Baseline				Marginal Price
	DC/IPEL	IPNEL	Total	DC	IPEL	IPNEL	Total	£
procedures								
Multiple trauma				-	-	32	32	1,927
Muscular, balance, cranial or peripheral nerve disorders or epilepsy				1	27	60	88	1,303
Non-transient stroke or cerebrovascular accident, nervous system infections or encephalopathy				-	-	25	25	2,317
Other Diagnoses with intracranial procedures				2	64	48	114	1,926
Other Diagnosis				-	4	12	16	466
Other neurosurgery episodes				31	16	53	100	877
Other spinal conditions / procedures				-	3	21	24	730
Other vascular				-	16	5	21	1,486
Paediatric Neurosurgery Episodes				8	47	110	165	1,029
Planned procedures not carried out				8	69	6	84	230
Uncoded				4	23	62	88	1,987
TOTAL	**5,010**	**9,800**	**14,809**	**102**	**788**	**1,152**	**2,040**	

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan
Year 1 (2017/18)				
Neurosurgery RTT	Neurosurgery	Funding to support achievement of RTT which has not been achieved for a number of years. In an interim pl an for extended lists in theatres and Radiology.	Further work will be required scoping demand and capacity requirements for beds and theatre lists.	RTT
Neuro-oncology	Neurosurgery	Outcomes of Peer Review between Cardiff and the Walton service has highlighted the need for additional formal support for the MDT, nurse specialist within the South West area and AHP's as a priority.	The outcomes of the peer review were very stark and highlighted the significant inequities between the services for patients in South Wales and North Wales.	Standards
Neuro-modulation (pain management)	Neurosurgery	Implementation of formal MDT for delivering Neuromodulation pain service and consistent management of Neuro-stimulators.	The cost of the scheme needs further consideration.	RTT
Bladder and Bowel nurse led clinic (for neuro-rehabilitation patients)	Neuro-rehabilitation	Improve bowel and bladder care for patients with spinal cord injuries.	Continuation of successful trial which resulted in an NHS Wales award.	
Spinal Rehabilitation MDT (phase 1)	Neuro-rehabilitation	Spinal Rehabilitation service sustainability and the achievement of standards.	Service is extremely fragile with only one spinal rehabilitation consultant in Rookwood and inadequate levels of MDT support.	Standards
Neuro-rehabilitation MDT (phase 1)	Neuro-rehabilitation	Neuro Rehabilitation Service – sustainability and standards.	Service is extremely fragile with only one WTE neuro-rehabilitation consultant in Rookwood and inadequate levels of MDT support.	Standards
Clot retrieval/Mechanical Embolisation	Neuro-diagnostic	Following scoping work commissioning of a safe and sustainable service.	Currently being undertaken for patients across 6 Health Boards in Cardiff on an individual patient basis. Pts from North Wales being treated in the Walton are being picked up through the contract.	National Body
Gatekeeping arrangements	All	Need to consider the current gatekeeping arrangements and potential changes that are needed following new appointments in specific areas such as Neurovascular.		Contracting
Establish Neurosciences Network for South Wales	All	Assess if elements of good practice in the North Wales Neurosciences Board that could be replicated for South Wales.		
Neurosurgery	Neurosurgery	Service specification setting out the pathway, repatriation and Delayed Transfer of Care (DTOC).	Currently there is no service specification in place outlining the commissioning intentions for this service.	
Coding issues	Neurosurgery	Work to ensure coding is accurate for Neurosurgical procedures carried out in Cardiff and Vale. This will ensure correct allocation of funding in line with the new case mix contract and make comparison with funding provided to England services more transparent.	Mr Nannapaneni has agreed to be the Clinical Lead for this work, the Neurosciences Directorate currently pulling notes of uncoded procedures.	Contracting

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan
Paediatric Epilepsy	Neurosurgery	Write a service specification that covers paediatric services not only at Great Ormond Street Hospital where we historically commission but the other centres commissioned in the NHS England model. in line with NHS England guidance. Currently only have service specification available for adult epilepsy.	This was identified following different referring practices being carried out in Wales.	NHS England
Paediatric Epilepsy	Neurosurgery	Historically have commissioned from GOSH, but NHS England have designated Bristol as a specialist centre as well. Cardiff also working on developing a service for over 3s which helps to sustain Cardiff Paediatric Neurosurgery.	No theatre capacity currently to repatriate. Have written to Women and Childrens Board to query the empty theatre that was due to be dedicated to Neurosurgery and emergencies, awaiting a response. Removing the paediatric cases from the adult theatres will free up valuable theatre capacity.	RTT
Pipeline Embolisation Devices	Neurosurgery/Neuro-diganostic	Amend the Pipeline Embolisation Device Policy to reduce the need for prior approval for the less complex and costly devices.	This is a terminology issue there are no cost implications.	Contracting
Formalise DBS contracting arrangements with North Bristol	Neurosurgery	Currently pay on a case by case basis, formalise arrangements with North Bristol for improved reporting and exploring the potential additional work that could be carried out in Wales (pre-operative and post-operative care).		Contracting
Selective Dorsal Rhizotomy	Neurosurgery	Consider the findings of the NHS England commissioning through evaluation that is due to report in 2018. Will require a service specification dependant on the outcome.		NHS England
Specialised Rehabilitation	Neuro-rehabilitation	Policy was due for review in Autumn 2016.	Consultation underway, due to end iin February 2017.	Standards
Paediatric Neuro-rehabilitation	Neuro-rehabilitation	Service specification currently being developed by the South Wales service, but will encompass the Alderhey service.		Standards
Neuro-psychiatry provision in North Wales	Neuro-rehabilitation	No contracting arrangements in place or clear pathways for patients from North Wales.	Dependant on the outcome of the specialised rehabilitation policy review in 2017.	Standards
Major Trauma	All	Need to consider the outcome of the major trauma review and the potential implications on the service.	Commissioning model for Major Trauma Network has not yet been decided.	
Year 2 - 5				
Retirement of Consultant staff.	All	Retirement of key members of staff during the duration of the five year plan. Need to ensure succession planning is in place so service are not destabilised.	Staff from Neurosurgery, Radiology Paediatric/Adult Neurology and Neurophysiology.	RTT

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan
Theatre Capacity	Neurosurgery	Demand and Capacity work is needed in order to clearly understand theatre requirements. Deficits in capacity were highlighted by the SBNS as an area of concern during National meeting held in Wales, in the summer of 2016.	This was included within the original 2016/17 Core Neurosurgery business case as phase 2.	RTT
Spinal Surgery	Neurosurgery	Clarify pathways for out of hours emergency and non-emergency work. This is an outstanding recommendation from the Axford review.	Work has been undertaken by the Spinal Surgery Network, with plans to share recommendations with WHSSC shortly.	Standards
Neurosurgery consultant numbers	Neurosurgery	Currently Cardiff do not have the numbers of neurosurgeons for the size of the population, raised by the Society of British Neurosurgeons as a concern.	Need to address additional theatre capacity and scanning facilities before additional posts can be considered.	Standards
Neuro-oncology, nurse specialist support in South Wales service.	Neurosurgery	Overwhelmed with intrinsic tumours, do not have skull based support.	This was noted within the outcomes of the Peer review	Standards
Neuro -oncology (North Wales) post-operative treatment.	Neurosurgery	Currently no service in Wales for post-operative treatment. Patients receive surgery in the Walton and post operative cancer treatment in Clatterbridge but no formal oncology service from BCU.	Features in the outcomes for the peer review.	Standards
Neuro-oncology dedicated consultant neurosurgeons	Neurosurgery	Identified in peer review that in other services of a similar size there are dedicated neuro-oncology consultants. Currently Cardiff and Vale feature all consultants on MDT list as it is done rotationally with two neurosurgeons with an interest.	Other Centres in the UK with a similar population have dedicated neuro-oncology consultants. Need to explore services in other centres.	Standards
Post operative MRI scan within 72 hours.	Neurosurgery/neuro-diganostic	Scheme is dependant on a number of factors in particular increase in MRI capacity at UHW.	Undertake benchmarking as initial findings show that Cardiff carry out a third less post-operative scans than Southampton which is similar in size.	Standards
Selective Dorsal Rhizotomy	Neurosurgery	Potentially fund surgeries - dependant on the outcomes of NHS England's Commissioning through Evaluation.	This is linked with the service specification included in year 1.	NHS England
Intra-operative monitoring	Neurosurgery	Not currently available in Cardiff, have equipment but no staff.		Standards
Neuro-physiology presence at open craniotomy, skull based and spinal tumour surgeries.	Neurosurgery	Insufficient numbers of Neuro-physiologists to attend theatre in order to monitor the cranio-nerve during surgery.		Standards
Adult Telemetry	Neurosurgery	Currently have the space, and equipment to carry out the service but insufficient staffing capacity to carry out clinics.	Need to understand the requirements and demand for this service.	Standards

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan
Paediatric Telemetry	Neurosurgery	There is space available in the Children's Hospital for Wales and charity funding has purchased equipment however there is no technician within the current workforce.	Currently this service is provided in Bristol, the repatriation costs are insufficient for a technician. Need to establish a better understanding of current demand.	Standards
Neuro-physiology	Neuro-diagnostic	WHSSC to Strengthen fragile service. Explore whether WHSSC can support the work undertaken by the Assistant Director of Therapies on behalf of Directors of Therapies to strengthen service.	Need to understand current service and numbers, previously commissioned by WHSSC.	Standards
Commissioning arrangements for Specialised neuro-radiology including both diagnostic and interventional elements	Neuro-diagnostic	Confirm resources currently utilised for specialised neurosciences and what is actually commissioned.	Will need to understand from Health Baords if they wish to commission centrally or maintain current commissioning mechanisms.	Contracting
Paediatric MRI	Neuro-diagnostic	Additional sessions in the Childrens Hospital for Wales as MRI sessions available but require funding for staffing.	Outline current waits.	Standards
Neuro-pathology	Neuro-diagnostic	Two phase business case, additional support staff to make Consultant post more attractive and a post without sub-speciality requirement which will be a training opportunity.	Current service very fragile with only one neuro-pathologist in Wales, arrangements have been put in place by Cardiff and Vale for Bristol to provide in and out reach support.	Standards
Spinal Rehabilitation MDT (phase 2)	Neuro-rehabilitation	Following implementation of phase one further work will be required to strengthen the in-reach and potential out-reach elements of the service.		Standards
Neuro Rehabilitation MDT (phase 2)	Neuro-rehabilitation	Following implementation of phase one further work will be required to strengthen the in-reach and potential out-reach elements of the service.		Standards
Prolonged Disorder of Consciousness	Neuro-rehabilitation	Understand requirements to increase in capacity to have in-reach and out-reach service.	Currently commission four beds however due to level of care required by patients and that the majority of patients having a tracheostomy, there is insufficent capacity at Rookwood. Increases in staff capacity would allow for potential in-reach and out-reach service.	Standards
Paediatric Neuro-rehabilitation	Neuro-rehabilitation	Prepare for Neurological Conditions Implementation Group evaluation (after 3 years) to determine the continuation of funding.		Contracting
Information Technology/Virtual communication	All	Explore with each health board what capacity there is available to strengthen communication and the sharing of information.		Standards

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan
PROMS/PREMS	All	Assess how this form of outcome data can inform Audit and outcomes day and commissioning of services.		Standards
Attendance the Mid Wales Healthcare Collaborative	All	WHSSC to attend the quarterly meeting of the collaborative to feed in and to hear of emerging developments. This is similar to attendance to the North Wales Neurosciences Board		National Body
Patient Pathways for Powys and Betsi Cadwaladr patients	All	Work with Powys to track where their patients are being treated and whether WHSSC or Health Board contracts are funding them.	There is a crossover of specialised constracts for both Powys and Betsi Cadwaladr with WHSSC and HBs. Need to identify the most effective model	Contracting
Paediatric Spasticity/Intrathecal Baclofen pumps	Neurosurgery	These procedures are currently carried out in Bristol and can potentially be repatriated.	Due to capacity constraints can only be achieved once additional theatre for Neurosurgery has been approved or the agreed use of the the theatre within the Children's Hospital for Wales.	Contracting
Deep Brain Stimulation	Neurosurgery	Repatriation of service from England back to Wales.	Dependant on theatre capacity before full repatriation can take place, likely that pre-operative and post-operative treatment can be carried out in Wales which will be explored at the DBS Audit Day.	Contracting
Paediatric Cranio-facial procedures	Neurosurgery	The less complex procedures could be repatriated back to Wales from Birmingham.	As above, need additional theatre in place for this work to be repatriated.	Contracting
Arteriovenous Malformation Surgery	Neurosurgery/neuro-diganostic	Currently send 15-20 cases per year to Sheffield, have begun undertaking trials in Cardiff. Equipment already in place and would be carried out by Vascular Neuro-surgeon.	Currently Radiology not commissioned to do this therefore scheme would need to consider both neurosurgery elements and neuro-diagnostic if looking to repatriate.	Contracting
MRI Scanners	Neuro-diagnostic	Requires capital investment from National Imaging Board/WG. Cardiff and Vale has oldest MRI in Wales.	Write letter to National Imaging Board/WG setting out concerns.	Standards
Utilisation of CUBRIC	Neuro-diagnostic	Use of the Cardiff University facilities to carry out clinical diagnostic work. Could use 3T scanners for functional imaging.	Look at feasibility cost of outsourcing.	Contracting
Palliative Care	Neuro-rehabilitation	Gain a better understanding the timing and nature of palliative and supportive care interventions for patients with brain and spinal cord tumours.	Strengthen supportive and palliative care for people with neurological conditions to be delivered by multi-disciplinary teams with a specialist interest in neurological conditions was originally included within the Axford report, however this has not been fully implemented.	
Rookwood move	Neuro-rehabilitation	Current plans in place for services at Rookwood to transfer to Llandough due to condition of facilities. No plans in place for expansion.	The Capital investment requirements for this move would be the responsibility of the HB/WG however there are potential staffing issues as a consequence of the move which would have revenue implications.	Standards

Service	Sub-Group	Description	Comments	Identification of scheme/Workplan
Rehabilitation for Tracheostomy patients	Neuro-rehabilitation	Explore the demand for tracheostomy rehabilitation beds.	Currently Neath Port Talbot are not able to take rehabilitation patients with a tracheostomy and Rookwood can only take a maximum of 4.	
Network rehabilitation units in South Wales	Neuro-rehabilitation	Establish a South Wales rehabilitation network in order to ensure service meets standards and provides optimal patient care.	Recommendation from the Steers review.	Standards

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

		Agenda Item	13
Meeting Title	**Joint Committee**	Meeting Date	28/03/2017
Report Title	Delivery of the Integrated Commissioning Plan 2016/17 Progress at the end of January 2017		
Author (Job title)	Assistant Planning Manager/Acting Assistant Director of Planning		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	Public

Purpose	This paper provides an update on the delivery of the Integrated Commissioning Plan for Specialised Services 2016/17 at the end of January 2017, including the: • Funding Release Schedule; • Progress against the Work Plan; and • Risk Management Summary.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Not Applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the progress made in the delivery of the 2016/17 ICP; • **Note** the funding release proforma schedule; • **Note** the risk management summary.		

Considerations within the report (tick as appropriate)

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

13

DELIVERY OF THE INTEGRATED COMMISSIONING PLAN 2016/17
Progress at the end of January 2017

1.0 Situation

1.1 The Joint Committee has delegated authority to the Management Group to approve the implementation of the following 'Amber' schemes with the Integrated Commissioning Plan (ICP) for Specialised Services:

- Unavoidable Activity growth / RTT Amber Graded Schemes
- Economic Benefits to Health Boards Amber Graded Schemes

1.2 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 January 2017) to enable the Group to undertake this role. This includes the following items:

- The progress against the work plan 2016/17
- The development of the risk management monitoring; and
- The funding release schedule (Annex i)

2.0 Background

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

Group	Approval Authority
Corporate Directors Group	Black and Red Schemes
Management Group	Amber Schemes • Unavoidable Activity growth / RTT Amber Graded Schemes • Economic Benefits to Health Boards Amber Graded Schemes
Joint Committee	Amber Schemes • Risk Rated

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

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

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

3.0 Assessment

3.1 Audit and Outcome Days

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

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

3.2 Progress Against the Work Plan 2016/17

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

3.2.1 Completed Schemes of Work

The following is a full list of schemes of work which have been completed:

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-048	Neurological and Complex Conditions	Prosthesis service - prosthetics for war veterans	Requirement to sustain performance and the achievement of delivery. *** WHSSC asked to undertake a review of the all Wales position as a matter of urgency.	Funding Release Proforma	Funding release letter has been sent to Cardiff.
ICP16-110	Women and Children	Cystic fibrosis	Use of Ivacaftor for indication	Funding Release Proforma	3 patients identified in South Wales paediatric and adult population
ICP16-114	Women and Children	Sapropterin *	NICE: Not on their proposed list of TAs or HSTs. England: Commissioning Policy in England (The use of Sapropterin in Children Reference:E06/P/a, published July 2015) - NHS England will not routinely commission sapropterin for children with Phenylketonuria.	Funding Release Proforma	Not endorsed at AWMSG in November 2015
ICP16-120	Cancer & Blood	Malignant Melanoma *	NICE Mandated	Contractual Allocation	NICE Mandated

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-124	Cancer & Blood	Susoctocog *	Background: AWMSG and NICE: Not referenced on AWMSG or NICE website. [Was referenced in last years' WHSSC Horizon scanning document as an AWMSG pending approval]. Baxalta (manufacturer) gained EU marketing authorization in November 2015. WHSSC has also taken advice from Dr Peter Collins, Consultant Haematologist at Cardiff Centre on patient numbers and treatment pathway - which indicated drug is currently going through UK national tender to determine unit price.	Contractual Allocation	Advice from Medical Directorate that this drug has not been evaluated by NICE or AWMSG. Currently, the drug is not scheduled for evaluation by NICE or AWMSG.
ICP16-125	Women and Children	Elosulfase Alfa *	Background: NICE (HST): Elosulfase alfa, within its marketing authorisation, is recommended for funding for treating mucopolysaccharidosis type IVa (MPS IVa) according to the conditions in the managed access agreement for elosulfase alfa. Published December 2015. Ministerial Announcement - drug available in Wales - 16/3/2016.	Funding Release Proforma	Fully implemented

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-126	Neurological and Complex Conditions	Ataluren NS DMD *	Background: NICE (HST): Ataluren, within its marketing authorisation, is recommended for treating Duchenne muscular dystrophy resulting from a nonsense mutation in the dystrophin gene in people aged 5 years and older who can walk, only when: · the company provides ataluren with the discount agreed in the patient access scheme · the conditions under which ataluren is made available are set out in a managed access agreement between the company and NHS England, which should include the conditions set out in sections 5.12–5.15 of this guidance. Expected publication date July 2016.	Funding Release Proforma	The policy has been approved by Management Group and is published on the WHSSC website
ICP16-001	Cancer & Blood	Thoracic surgery	To commission sufficient surgery, at full cost, to achieve the 2012 LUCADA upper quartile resection rate for Wales.	Funding Release Proforma	Implementation plans have been received in November 2016 from both ABMUHB and CVUHB.

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-003	Cancer & Blood	Neuroendocrine Tumours (NETs)	To commission the service model agreed by the NETs Task and Finish Group.	Funding Release Proforma	The funding release for Phase 1 investment was considered by MG in October 2016 and approved. Further work will need to be undertaken to develop the second phase of the business case to support the advancement of the service. An implementation and evaluation group will be created to oversee this work as well as monitoring progress and examining the outcomes of the first phase. The group will also ensure that the recommendations from the task & finish group have been met and this will include the agreement of an All Wales policy for Somatostatin Analogue which remains outstanding. Funding release letters have been sent.
ICP16-050	Women and Children	Fetal cardiology	Service poses a quality and sustainability concern. Currently failing to meet the NHS England CHD standards.	Funding Release Proforma	Funding release letter sent out July 2016, implementation plan received from C&V UHB for full implementation by end December 2016.

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-053	Women and Children	Paediatric surgery	Sustainability concerns as there are workforce issues with the middle grades within Paediatric Surgery - Deanery. Increased capacity at the UHB is required to meet backlog, recurrent demand and capacity gap impacting recurrent financial requirements.	Funding Release Proforma	Health Board appointing at risk and backfilling lists from April 16. Funding release approved by MGM in July 2016, implementation now being monitored against agreed waiting list profile.
ICP16-064	Women and Children	BAHAs and Cochlears	Management of increasing growth in demand.	Funding Release Proforma	Agreement reached with C&V UHB to reviewed contract model. Funding release approved non-recurrently by MGM in January 2017. Letter to be drafted and further work required on value for money assessment for recurrent approval.
ICP16-081	Women and Children	BAHAs and Cochlears	Performance management of growth in the service in North Wales ***Awaiting proforma / risk register / demand and capacity information for further consideration	Funding Release Proforma	Funding release approved at August MG

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-004	Cancer & Blood	BMT Phase 3	To commission a sustainable BMT service in South Wales.	Funding Release Proforma	There has been a stream of planning and commissioning work over the last few years which has resulted in a three year phased approach to making the service sustainable and to be able to cope with the increasing demand. The funding release for Phase 3 was considered by MG in Nov 2016 and approved. Funding release letter has been sent to CV UHB.
ICP16-009	Cancer & Blood	PET-CT	To revise the PET Policy on an annual basis to ensure equitable services with England and to contribute towards improving cancer outcomes in Wales	Funding Release Proforma	The PET-CT policy was first published in 2013 and was revised in 2015 to ensure it contained the most up to date evidence-based guidance. The revisions to the policy help to ensure that there is an equitable commissioning position within NHS Wales compared to the rest of the UK, facilitated by the increased number of indications routinely funded.
ICP16-052	Women and Children	Paediatric Cardiology RTT	Increased capacity at the UHB is required to meet backlog, recurrent demand and capacity gap impacting recurrent financial requirements.	Funding Release Proforma	Funding release letter sent out July 2016, implementation plan received from C&V UHB.

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-028	Cancer & Blood	Liver ablation	US/RF Liver ablation service to include microwave ablations service	Funding Release Proforma	Funding release proforma approved in December 2016. Funding release letter to be finalised.
ICP16-055	Women and Children	Genetics	To commission UKGTN tests approved 2015/16 for commissioning in 2016/17	Funding Release Proforma	Funding release proforma approved October 2016, funding release letter sent.
ICP16-056	Women and Children	Genetics	Stratified medicine tests	Funding Release Proforma	Funding release proforma approved October 2016, funding release letter sent
ICP16-021	Cancer & Blood	Plastic Surgery Proforma available	LVA service funded by WG. WG priority	Funding Release Proforma	The paper was considered by Management Group and they supported extension of the trial period, but did not approve changes to commissioning policy.
ICP16-038	Neurological and Complex Conditions	Neurovascular	To commission a sustainable neurovascular service in South Wales.	Funding Release Proforma	Funding release was approved in December 2016. Funding release letter to be sent.
ICP16-039	Neurological and Complex Conditions	Interventional neuroradiology	Phase 2 - To commission a sustainable Interventional Radiology Service	Funding Release Proforma	Funding release was approved in December 2016. Funding release letter to be sent.
ICP16-041	Neurological and Complex Conditions	Neurosurgery	To commission a sustainable Neurosurgery service in South Wales. Deanery changes to medical workforce would leave the service vulnerable with minimal cover overnight and leave the on call unsustainable. Insufficient theatre capacity for higher surgical training could also result in a loss of training numbers.	Funding Release Proforma	Funding release was approved in December 2016. Funding release letter to be sent.

ICP Reference Number	Programme Team	Service	Commissioning Intention	WHSSC Product	Comments
ICP16-043	Neurological and Complex Conditions	Clinical Immunology	The service continues to grow and the UHB is keen to discuss the resource implications of this for 2016/17.	Funding Release Proforma	Funding release was approved in December 2016. Funding release letter has been sent to service.
ICP16-047	Neurological and Complex Conditions	Posture and Mobility (Wheelchairs)	To manage growth in the volume of wheelchair issues and to achieve the current delivery measures.	Funding Release Proforma	Funding release was approved in December 2016. Funding release letter has been sent to service.
ICP16-058	Women and Children	NICU	To increase NICU capacity ***Implement the neonatal service model agreed for South and Mid Wales as part of the South Wales Plan (2015/16 Green schemes)	Funding Release Proforma	To be managed through Risk Management Strategy pending decision of Joint Committee. Confirmed with C&V that this scheme is no longer required.
ICP16-066	Women and Children	Cleft lip and palate service	Improve infrastructure within cleft lip and palate service in order to meet national standards ***Further scoping required. ABMU to advise. Possible equity issue for patients in North Wales (2015/16 Green scheme)	Funding Release Proforma	To be managed through Risk Management Strategy pending decision of Joint Committee. SBAR provided by service but currently awaiting Exec approval from within ABMU. Funding release taken to Management Group in November but not approved, to be considered again through 2017/18 ICP.
ICP16-069	Mental Health	High Secure	Expand gatekeeping role to include clinical case monitoring all patients in independent sector placements.	Funding Release Proforma	Funding Release Letters sent to ABM/BC UHBs
ICP16-070	Mental Health	Medium Secure - patients with learning disabilities	Expand gatekeeping role to include clinical case monitoring all patients in independent sector placements.	Funding Release Proforma	Funding Release Letters sent to ABM/BC UHBs

3.2.2 Schemes not yet completed

The table below summarises the position for each of the schemes for which funding has not yet been released:

ICP Reference Number	Financial Table	Programme Team	Service	Commissioning Intention	Comments
ICP16-030	9a	Cancer & Blood	Bariatric Surgery Phase 2	Bariatric surgery is provided for the population of South Wales by ABMUHB. Joint Committee has agreed to the 5 year phased commissioning plan to increase access up to the clinically recommended level.	Agreed as 2015/16 development. Capacity is not available to implement in 2016-17. This scheme will not be achieved. In addition, commissioner concerns re the proposed service model, in particular the management of high risk patients, are addressed.
ICP16-042	9a	Neurological and Complex Conditions	Communication Aids	Augmentative and Alternative Communication (AAC) project. WG funding to develop service hub at Rookwood Hospital with staff also located at BCU. AAC project to include recommendations on future funding arrangements to be considered in ICP 2017/18.	An extension to the evaluation period was supported by Joint Committee in September 2016. Stakeholder event being planned for Feb 17. Additional funding requirements to be discussed in Board meeting 29 Nov 16. Board meeting took place on 29th Nov, agreed discussions need to take place with WG around future funding. Agreed future funding and evaluation would be discussed at JC in September.
ICP16-127	9b	Women and Children	Sebelipase Alfa - LAL *	Sebelipase alfa is a potentially life-saving treatment for babies with rapidly progressive LAL deficiency, and there is a compelling clinical need.	Final Appraisal Determination (FAD) not yet published nor date provided
ICP16-128	9b	Women and Children	Asfotase Alfa - HPP *	Background: NICE (HST): After the first evaluation consultation NICE has issued the following advice: Asfotase alfa is not recommended, within its marketing authorisation, for long-term enzyme replacement therapy in paediatric-onset hypophosphatasia to treat the bone manifestations of the disease. Expected publication date TBC.	Final Appraisal Determination (FAD) not yet published nor date provided

ICP Reference Number	Financial Table	Programme Team	Service	Commissioning Intention	Comments
ICP16-131	9b	Women and Children	BAHAs and Cochlears	Take steps to implement the centralisation of services at the UHB	Met with C&V UHB, they are keen to progress. Meeting with ABMU, they accept the principle of centralisation but question the decision making around Cardiff being the preferred site. Each centre has provided a summary of position against BCIG standards. Process to progress to be agreed. Now deferred until 2017/18.
ICP16-029	9c	Cancer & Blood	Bariatric Surgery Phase 3	To implement phase 3 of the bariatric surgery 5 year phased growth plan for all Wales.	Phase 3 will not be implemented in 2016-17 due to provider capacity constraints.
ICP16-040	9d	Neurological and Complex Conditions	Neuropathology	To commission a sustainable Neuropathology Service.	C&VUHB have indicated that this issue could be managed through improved links with either Bristol or Oxford and have requested our input in contract discussions.
ICP16-051	9d	Women and Children	Fetal Medicine	Service poses a quality and sustainability concern. Concerns have been raised by the service itself, other Health Boards and Public Health Wales as to how the service is delivered. ***Lack of Fetal Brain MRI provision in South and Mid Wales (2015/16 Green scheme)	Agreed with C&V that not a priority for 2016/17, to be taken forward as part of 2017/18 planning.
ICP16-117	9d	Cancer & Blood	Proton Beam Therapy - Child	NHS England's Commissioning Policies are currently used by the UK-wide National Proton Clinical Reference Panel to make recommendations for the clinical suitability of Welsh patients to access Proton Beam Therapy (PBT). WHSSC needs to review its commissioning position for PBT and produce revised, up to date commissioning policies for people in Wales.	Assessed in 2017/18 Prioritisation Panel

ICP Reference Number	Financial Table	Programme Team	Service	Commissioning Intention	Comments
ICP16-118	9d	Cancer & Blood	Proton Beam Therapy - TYP	NHS England's Commissioning Policies are currently used by the UK-wide National Proton Clinical Reference Panel to make recommendations for the clinical suitability of Welsh patients to access Proton Beam Therapy (PBT). WHSSC needs to review its commissioning position for PBT and produce revised, up to date commissioning policies for people in Wales.	Assessed in 2017/18 Prioritisation Panel
ICP16-084	9d	Women and Children	Paediatric Cardiology	Ensure that the service meets the NHS England CHD standards - as the service is part of a network with Bristol. Also, outpatient component gap for this service and the consultant base is short on sessional time to support activities. This poses a risk to delivery and sustainability.	To be managed through Risk Management Strategy pending decision of Joint Committee. CHD service specification currently being drafted. Self assessment already circulated by CHD Network and Welsh service providers to return, this will help to identify gaps in services across South Wales.
ICP16-119	9d	Cancer & Blood	Proton Beam Therapy - Adult		Assessed in 2017/18 Prioritisation Panel
ICP16-115	9d	Cardiac	VAD - BTR	Implantation of a left ventricular assist device for destination therapy in people ineligible for heart transplantation NICE interventional procedure guidance [IPG516] Published date: March 2015	Recommendation from JC that English policy and service specification should be adopted as an interim position. Recommendation agreed at November Management Group, permanent policy to be developed as appropriate. Assessed in 2017/18 Prioritisation Panel
ICP16-121	9d	Cardiac	VAD - BTT	Ventricular Assist Devices (VADs) as a bridge to heart transplantation or myocardial recovery (All Ages) - NHS England service specification A18/S(HSS)/b - commissioned in England?	Recommendation from JC that English policy and service specification should be adopted as an interim position. Recommendation agreed at November Management Group, permanent policy to be developed as appropriate. Assessed in 2017/18 Prioritisation Panel

ICP Reference Number	Financial Table	Programme Team	Service	Commissioning Intention	Comments
ICP16-044	9d	Neurological and Complex Conditions	Neuromodulation/ pain service	Change to the Pain Service model that that could utilise existing baseline and performance funding in a different way with mutual benefit. Spinal Implants - development of an Multidisciplinary Team model.	Given priority to other Neurosciences schemes, this has rolled forward to 17/18
ICP16-016	9e	Cancer & Blood	Endobronchial Valve Replacement (EBVR)	To commission sufficient surgery to meet RTT targets	Will be taken forward as a 17/18 ICP scheme.
ICP16-130	9e	Cancer & Blood	Plastic Surgery	Evaluation and recommendations for future funding of LVA service	Evaluation of first 12 months to include policy review. Indication that one of the criteria in the policy may require amendment (2 episodes of cellulitis in 12 months) to ensure sufficient eligible patients for screening. The paper was considered by Management Group and they supported extension of the trial period, but did not approve changes to commissioning policy.

3.3 Financial Summary

As reported in the month 10 financial monitoring, 2016/17 developments are forecast to underspend by £3.053m, this includes £0.540m of expenditure for the high risk amber schemes approved which were unfunded in the 2016-19 ICP:

				2016/17			2017/18		
Planning Ref	Category	Scheme	Funding Release Paper to MGMT Group:	2016/17 ICP £m	2016/17 Forecast Expenditure £m	2016/17 Total Slippage £m	2017/18 ICP £m	2017/18 Forecast Expenditure £m	2017/18 Forecast Slippage £m
ICP16-030	Black - Pre approved	Bariatrics Stage 2	N/A	0.084	-	(0.084)			
ICP16-048	Black - Pre approved	Prosthetics service sustainability for war veterans	July	0.300	0.121	(0.179)	0.300	0.210	(0.090)
ICP16-110	Red - Mandated	Cystic fibrosis - Ivacaftor NONG551D (AWMSG)	June	0.459	0.214	(0.245)	0.612	0.612	-
ICP16-120	Red - Mandated	Malignant Melanoma Pathway Drugs	N/A	1.500	0.929	(0.571)	1.750	2.400	0.650
ICP16-124	Red - Mandated	Susoctocog - Haemophilia	N/A	0.380	-	(0.380)	0.950	-	(0.950)
ICP16-125	Red - Mandated	Elosulfase Alfa - VIMZIM ERT	N/A	0.660	0.150	(0.510)	0.880	0.880	-
ICP16-126	Red - Mandated	Ataluren NS Duchene Muscular Dystrophy	July	0.400	0.100	(0.300)	0.750	0.200	(0.550)
ICP16-128	Red - Mandated	Asfotase Alfa - HPP ERT	N/A	0.450	0.112	(0.338)	0.900	0.900	-
ICP16-001	Amber - Unavoidable	Thoracic surgery infrastructure & activity	May	0.800	0.797	(0.003)	2.500	2.100	(0.400)
ICP16-003	Amber - Unavoidable	Neuroendocrine Tumours (NETs)	October	0.187	0.156	(0.031)	0.375	0.375	-
ICP16-050	Amber - Unavoidable	Fetal cardiology	May	0.095	0.095	-	0.189	0.138	(0.051)
ICP16-053	Amber - Unavoidable	Paediatric surgery	June	0.500	0.500	-	0.862	0.862	-
ICP16-081	Amber - Unavoidable	BAHA & Cochlears growth North Wales	August	0.290	0.240	(0.050)	0.500	0.500	-
ICP16-064	Amber - Unavoidable	BAHA & Cochlears growth South Wales	January	-			0.750	0.737	(0.013)
ICP16-047	Amber - Unavoidable	Posture and Mobility - ALAS (Wheelchairs)	December	0.500	0.373	(0.127)	0.500	0.500	-
ICP16-004	Amber - Unavoidable	BMT Phase 3 infrastructure & activity	October	1.150	0.550	(0.600)	2.400	2.400	-
ICP16-105	Amber - Unavoidable	Clinical Immunology non pay growth	September	0.400	0.400	-	0.800	0.800	-
ICP16-009	Amber - Unavoidable	PET CT new indications	May	0.062	0.062	-	0.170	0.062	(0.108)
ICP16-052	Amber - Unavoidable	Paediatric Cardiology RTT	May	0.187	0.087	(0.100)	0.187	0.173	(0.014)
ICP16-028	Amber - Unavoidable	Liver ablation	December	0.105	0.030	(0.075)	0.105	0.105	-
		Total Funded ICP schemes		**8.509**	**4.916**	**(3.593)**	**15.480**	**13.954**	**(1.526)**
ICP16-055	Amber - Economic Benefits	Genetics - UKGTN	October		0.020	0.020		0.030	0.030
ICP16-056	Amber - Economic Benefits	Genetics - Stratified Medicine	October		0.136	0.136		0.218	0.150
ICP16-038	Amber - Sustainability	Neurovascular	November		0.100	0.100		0.280	0.280
ICP16-041	Amber - Sustainability	Neurosurgery	November		0.200	0.200		0.400	0.400
ICP16-039	Amber - Sustainability	Interventional neuroradiology	November		0.017	0.017		0.207	0.207
ICP16-043	Amber - Sustainability	Clinical Immunology (infrastructure)	November		0.067	0.067		0.400	0.400
		Additional Funding Required for High Risk & Economic Schemes		**-**	**0.540**	**0.540**	**-**	**1.535**	**1.467**
		Total Reported 16-17 Developments		**8.509**	**5.456**	**(3.053)**	**15.480**	**15.489**	**(0.059)**

£2.344m of slippage is against mandated drug schemes and is reported based on actual IPFR approvals for the drugs and Velindre monitoring for the Melanoma drugs.

South Wales BAHA and Cochlear growth was approved non recurrently in January and will be funded on an actual activity basis within the £0.500m provision.

The revised full year effect of 2016/17 developments is within £0.059m of the 2016-19 ICP provision. This assumes that the genetics, high risk neurosciences schemes and clinical immunology infrastructure will be funded recurrently from resources arising from re-evaluating the full year cost of 16/17 schemes.

3.4 Risk Management Summary

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

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

Further work has recently been undertaken to refine the risk management plan and is available on SharePoint as a live document.

4.0 Recommendations

Members are asked to:

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

5.0 Annexes

- Annex i – Funding Release Schedule

Annex i

Funding Release Schedule

Planning Ref	Category	Scheme	Proposed Date of submission to CDG/MGM	Actual/ Revised Date of submission to CDG/MG:	Outcome
ICP16-021	Black - Pre approved	Plastics - LVA (For evaluation after 6 months)	TBC		
ICP16-030	Black - Pre approved	Bariatric Surgery Phase 2	TBC		
ICP16-042	Black - Pre approved	Communication Equipment (WG Allocation in 2016/17)	N/A	N/A	
ICP16-048	Black - Pre approved	Prosthetics service sustainability for war veterans	TBC	July	Approved
ICP16-110	Red - Mandated	Cystic fibrosis - Ivacaftor NONG551D (AWMSG)	TBC	June	Approved
ICP16-114	Red - Mandated	Saproterin - phenylketonuria	TBC	N/A	Removed as not approved by AWMSG
ICP16-120	Red - Mandated	Malignant Melanoma	Contractual Allocation made		
ICP16-124	Red - Mandated	Susoctocog – Haemophilia	TBC	N/A	Currently the drug is not scheduled for evaluation by NICE or AWMSG.
ICP16-125	Red - Mandated	Elosulfase Alfa - VIMZIM ERT	TBC		Approved
ICP16-126	Red - Mandated	Ataluren NS Duchenne Muscular Dystrophy	TBC	August	Approved
ICP16-127	Red - Mandated	Sebelipase Alfa - LAL ERT	TBC		
ICP16-128	Red - Mandated	Asfotase Alfa - HPP ERT	TBC		
ICP16-131	Red - Cost Neutral	BAHAs and Cochlears – Centralisation	Deferred to 2017/18		
ICP16-008	Red - Repatriation	Haemophilia (long lasting blood products)	January		
ICP16-001	Amber - Unavoidable	Thoracic surgery infrastructure & activity	June	May	Approved (June)
ICP16-003	Amber - Unavoidable	Neuroendocrine Tumours (NETs)	October	October	Approved
ICP16-050	Amber - Unavoidable	Fetal cardiology	May	May	Approved
ICP16-053	Amber - Unavoidable	Paediatric surgery	May	June	Approved
ICP16-081	Amber - Unavoidable	BAHA & Cochlears growth North Wales	June	August	Approved
ICP16-064	Amber - Unavoidable	BAHA & Cochlears growth South Wales	October	January	Approved
ICP16-047	Amber - Unavoidable	Posture and Mobility - ALAS (Wheelchairs)	October	December	Approved
ICP16-004	Amber - Unavoidable	BMT Phase 3 infrastructure & activity	October	October	Approved
ICP16-105	Amber - Unavoidable	Clinical Immunology non pay growth	July	October	Approved
ICP16-043	Amber – Risk Rated	Clinical Immunology (infrastructure)	September	October	Approved (November)
ICP16-009	Amber - Unavoidable	PET CT new indications	May	May	Approved
ICP16-029	Amber - Unavoidable	Bariatric Surgery Phase 3 (all Wales)	N/A	N/A	Implementation in 2017/18
ICP16-052	Amber - Unavoidable	Paediatric Cardiology RTT	May	May	Approved
ICP16-028	Amber - Unavoidable	Liver ablation	October	December	Approved

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Development of the Plan Implementation of the Plan
Link to Integrated Commissioning Plan	This paper provides an update on the delivery of the ICP and the ICP risk management plan for schemes as at the end of January 2017.
Health and Care Standards	Governance, Leadership and Accountability Safe Care Effective Care
Principles of Prudent Healthcare	Reduce inappropriate variation Only do what is needed Public & professionals are equal partners through co-production
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Improving Patient Experience (including quality and Satisfaction) Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	The ICP Delivery Report highlights the risks to quality, safety and patient experience resulting in delays/changes to the implementation of schemes and the action being taken to address.
Resources Implications	Any in year change for individual schemes likely to result in a change in resource requirement will be highlighted in the ICP Delivery Report.
Risk and Assurance	The ICP Delivery Report will summarise risk assessment and mitigating action for off track ICP schemes.
Evidence Base	• Funding Release Schedule (Annex (i)); • Risk Management Plan (available on Sharepoint) • Work Plan Monitoring Schedule (available on Sharepoint)
Equality and Diversity	There are no equality and diversity implications associated with this report.
Population Health	There are no additional implications associated for population health in this report.
Legal Implications	There are no legal implications associated with this report.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**

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

		Agenda Item	14
Meeting Title	**Joint Committee**	Meeting Date	28/03/2017
Report Title	December 16 Performance Report		
Author (Job title)	Performance Analyst		
Executive Lead (Job title)	Director of Planning	Public / In Committee	In Committee

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

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☐

Sub Group /Committee	Not Applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** current performance and the action being undertaken to address areas of non-compliance		

Considerations within the report (tick as appropriate)

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

14

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

DECEMBER 2016 PERFORMANCE REPORT

1.0 Situation

The attached report provides members with a summary of the key issues arising from the December 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.
- 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.

14

3.0 Assessment

The report provides a summary of the performance of the following areas:

- Cardiac Surgery
- Plastic Surgery
- Paediatric Surgery
- Neurosurgery
- Bariatric Surgery
- Thoracic Surgery
- Lung Resection
- PET
- CAHMS
- Medium Secure

4.0 Recommendations

Members are asked to:

- **Note** the use of the new interim 2016/17 performance dashboard;
- **Support** the progress in developing the commissioning teams and quality framework to further input into the dashboard; and
- **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	Not applicable
Equality and Diversity	The proposal will ensure that data is available in order to identify any equality and diversity issues.
Population Health	The core objective of the report is to improve population heath through the availability of data to monitor the performance of specialised services.
Legal Implications	There are no legal implications relating to this report.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**

14

WHSSC Performance Report

December 2016

WHSSC

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

Contents

14

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

1. Integrated Provider / Commissioner Dashboard

Domain	Improved Performance	Sustained Performance	Decline in Performance	Trend
Safety	0	0	1	↓
Effectiveness	6	0	9	↑
Staff & Resources	0	1	2	→
Leadership	4	1	0	↑
Total	**10**	**2**	**12**	↑

2. Provider Dashboard

Indicator Ref.	Provider	Measure		Target	Tolerance Levels: Red	Amber	Green	Oct-16	Nov-16	Dec-16	Previous Movement	Latest Movements	Comments
S01		Quarterly	Number of new Serious Incidents reported to WHSSC by provider within 48hours	100%	<50%	50-99%	100%		21%		↑	↓	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	11	14	→	↓	E02 to E04 does not contain English data due to availability of RTT. To be updated in January 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	81	91	97	↓	↓	
E03	*All*	Monthly	No paediatric surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	93	85	88	↑	↓	
E04	*All*	Monthly	No neurosurgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	107	123	122	↓	↑	
E05	*All*	Monthly	No bariatric surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	29	26	30	↑	↓	
E06	*All*	Monthly	No thoracic surgery patients to be waiting > 36 weeks	100% within 36 weeks	Positive variance	N/A	Zero or negative variance	98%	99%	99%	↑	→	
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	58%	25%	43%	↓	↑	
E06E	*All*	Monthly	Non-Urgent Lung resection within 31 days - All Wales	95% within 31 days	<90% Within 31 days	90-95% within 31 days	=,>95% within 31 days	80%	71%	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	96%	100%	99%	↑	↓	
E08	*All*	Monthly	Delivery of 26 week RTT target for adult posture & mobility service - National	90% within 26 weeks	<85% Within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	91%	90%	87%	↓	↓	
E09	*All*	Monthly	Delivery of 26 week RTT target for paediatric posture & mobility service - National	90% within 26 weeks	<85% Within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	95%	97%	96%	↑	↓	
E10	*All*	Monthly	CAMHS OOA placements	14	>16	>14, <16	=,<14	10	12	11	↓	↑	
E11	*All*	Monthly	CAMHS NHS Beddays - National	95% with +/-5% tolerance	<85%,>105%	< 90%, >100%	90% - 100%	72%	66%	93%	↓	↑	
E11i	*All*	Monthly	CAMHS NHS Home Leave - National	25% - 35 % of Beddays	<20%, >40%	<25%, >35%	25%-35%	21%	23%	43%	↑	↓	
E12	*All*	Monthly	Adult Medium Secure NHS Beddays - National	100% with +/-5% tolerance	<90%, >110%	< 95%, >105%	95% - 105%	95%	93%	96%	↓	↑	

**E02 to E04 does not contain English data due to availability of English RTT data. Due to the process of RTT data submission from England, there is a month delay in publication. To be updated in January report*
E11i an increase in Home Leave during December is normal as patients are allowed home over Christmas period whenever clinically appropriate

14

3. Key Messages

3.1 Provider

3.1.1 Safety

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

3.1.2 Performance

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

At the end of December, 1% of patients waiting at CVUHB, and 2% at ABMUHB, breached 36 weeks. Activity at CVUHB remains significantly lower than the agreed baseline, and there is ongoing dialogue between WHSSC and the Health Board regarding this issue as part of the performance management arrangements.

Despite advice from LHCH that investment in cardiac surgery capacity planned for quarter 1 would result in improvements in RTT, 6% of patients waiting breached 36 weeks. At the recent SLA review meeting on the 22nd December, LHCH advised that a further surgeon was undergoing the training required to undertake this procedure and as a consequence waiting times should reduce. WHSSC are going to review whether patient choice i.e. electing to have mini mitral valve surgery in the knowledge that waiting times are in excess of 36 week target has any effect on recording these cases as breaches.

Plastic Surgery – At a regional level there continues to be 36 week breaches at ABMUHB, with the breast surgery and hand surgery as the sub specialty areas with the longest waiters. The Health Board's plastic surgery delivery plan for 2016/17 set a target to reduce the number of 36 week breaches to 40 by year end. This target is now not expected to be achieved as ABMUHB are reporting lost capacity due to unscheduled care pressures as the main reason for the position.

ABMUHB is currently exploring with staff the potential for utilising additional capacity through the independent sector. WHSSC is escalating the performance management arrangements for plastic surgery through establishing monthly executive level performance meeting.

Paediatric Surgery – The total number of 36 week breach patients has reduced to a position of 88 patients waiting over 36 weeks in December.

However, this was an increase of 3 breach patients compared to November. The number of patients waiting over 52 weeks has reduced consistently, since a peak of 88 breach patients in December 2015 to 30 patients waiting longer than 52 weeks in December 2016.

The position is behind the CVUHB modelling that demonstrates delivery of zero 36 week breach patients by February 2017 and discussions are ongoing regarding when this will be delivered. Furthermore, a plan has been developed for each patient waiting over 52 weeks.

Following approval of the business case for additional funding at Management Group in June 2016, implementation of the expanded service is underway with 1.5 additional operating lists implemented from October 2016 and additional ward staff appointed.

Neurosurgery – The waiting list position has improved slightly at CVUHB with 122 patients waiting over 36 weeks at the end of December. Frequent dialogue is taking place between WHSSC and CVUHB to identify and address the difficulties within the service. The service is facing increasing numbers of emergency patients who have longer length of stay than elective patients which in turn is increasing the number of bed related cancellations. WHSSC's concerns have been escalated to Steve Curry, Acting Chief Operating Officer at CVUHB.

Bariatric Surgery – At a regional level in South Wales, there were 30 patients waiting over 36 weeks at the end of December. For North Wales, there were 0 breaches of the 36 weeks maximum target (service provided by Salford Royal NHST).

In order to address the clinical risks associated with long waiting times for patients listed for bariatric surgery at Morriston Hospital, it was agreed that ABMUHB would implement a plan to ensure more timely access to treatment for these patients, including through outsourcing for additional capacity. An update on the current status of this plan is currently outstanding (this has been escalated to the Acting Chief Executive, ABMUHB).

WHSSC has also written to ABMUHB to confirm the intention to take forward a tender for future service provision for South Wales.

Thoracic Surgery – 1% of patients waiting nationally breached 36 weeks in December, all of which were located in South East Wales.

PET Scans – The target that 90% of scans are received within 10 days from referral to receipt of image was achieved in December for both North and South Wales.

Posture and Mobility – The paediatric service is achieving the 90% target nationally, however for the adult service both BCUHB and CVUHB have seen deterioration in performance resulting in underperformance nationally. WHSSC are aware that this position has deteriorated in January due to staff vacancies across two of the three sites and is not likely to recover and achieve the national target until at least April 2017.

Lung Cancer – In December, 8 patients on an Urgent Suspected Cancer (USC) pathway breached the 62 day target. For patients on a Non Urgent Suspected Cancer (NUSC) pathway, there were also 5 breaches.

The Thoracic Surgery Additional Capacity Project has been established to develop plans to reduce the waiting times for lung resection in South Wales. It has been agreed that CVUHB will provide additional capacity over an 8 week period commencing on 11th February to address the current backlog of patients in South East Wales. The Additional Capacity Project is also taking forward work to establish referral pathways for patients in South West Wales to NHS Trusts in England to increase access and reduce waiting times.

CAMHS – The overall number of CAMHS inpatients in the 2 NHS Wales units increased to 26 in December, compared to 19 in November. The number of patients in out of area placements decreased to 11 placements in December.

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

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

		Agenda Item	15
Meeting Title	**Joint Committee**	Meeting Date	23/02/2017
Report Title	Financial Performance Report – Month 10 2016/17		
Author (Job title)	Finance Manager – MH, DRC, IPFR & MM		
Executive Lead (Job title)	Director of Finance	Public / In Committee	Public

Purpose	The purpose of this report is to set out the estimated financial position for WHSSC for the 10th month of 2016/17. There is no corrective action required at this point. 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.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Not applicable	Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the current financial position and forecast year-end position.		

Considerations within the report (tick as appropriate)

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

15

1.0 Situation

1.1 The purpose of this report is to provide the current financial position of WHSSC together with outturn forecasts for the financial year.

2.0 Background

The financial position 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 10 for WHSSC is an underspend to date of £6,110k, with a forecast year-end underspend of £5,165k.

The movement from the previous month is an improvement of £1,424k to date and £1,271k End of Year forecast. The movements are across various budget headings, including slippage on Development funding and the final release of 15/16 Balance Sheet accruals.

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

4.0 Recommendations

4.1 Members of the appropriate Group/Committee are requested to:

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

5.0 Appendices / Annex

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

- WHSSC Expected Expenditure breakdown across LHB's/budget headings. This reconciles to the total reported to WG.

15

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Development of the Plan
Link to Integrated Commissioning Plan	This document reports on the ongoing financial performance against the agreed IMTP
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	Only do what is needed
Institute for HealthCare Improvement Triple Aim	Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	Not applicable
Resources Implications	This document reports on the ongoing financial performance against the agreed IMTP
Risk and Assurance	This document reports on the ongoing financial performance against the agreed IMTP
Evidence Base	Not applicable
Equality and Diversity	Not applicable
Population Health	Not applicable
Legal Implications	Not applicable

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**

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

Finance Performance Report – Month 10

1. Situation / Purpose of Report

The purpose of this report is to set out the estimated financial position for WHSSC for the 10th month of 2016/17 together with any corrective action required.

The narrative of this report excludes the financial position for EASC, which includes the WAST contracts, the EASC team costs and the QAT team costs, and have a separate Finance Report. For information purposes, the consolidated position is summarised in the table below.

Table 1.

	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	538,577	448,815	442,705	(6,110)	(1,424)	(5,165)	(1,271)
Sub-total WHSSC	**538,577**	**448,815**	**442,705**	**(6,110)**	**(1,424)**	**(5,165)**	**(1,271)**
WAST	136,482	113,735	113,735	0	0	0	0
EASC team costs	350	292	366	74	46	90	40
QAT team costs	672	560	500	(60)	(3)	(55)	7
Sub-total WAST / EASC / QAT	137,504	114,587	114,601	14	43	35	47
Total as per Risk-share tables	676,082	563,401	557,306	(6,095)	(1,382)	(5,130)	(1,224)

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 as the need arises.

The overall financial position at Month 10 is an underspend of £6,110k with a forecast year-end underspend of £5,165k.

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 as financial baselines have been uplifted to more realistic levels based on historic activity. Reported variances are currently in line with this intention.

3. Governance & Contracting

All budgets have been updated to reflect the 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 has been translated into the new 2016/17 contract documents sent to providers for agreement.

Both the Neonatal and CAMHS/ED Networks transferred to Public Health Wales in October 2016, with 50% of the funding returned to LHB's in M7 in respect of their now needing to fund Public Health Wales with those values. Please see the Income tab of the risk-sharing tables for the breakdowns by LHB.

Distribution of the reported position has been shown pre-dominantly using the 2016/17 risk shares based on 2015/16 outturn utilisation. There remain a number of utilisation shares that are yet to be updated and these will be progressed as soon as possible. The impact of any outstanding changes is not expected to be material. The Finance Working Group is working on validating prospective changes to the risk-sharing process, and any update will be shared with Management Group for agreement. Until there is formal agreement from Joint Committee on a change to the risk sharing process the current system will remain in operation but with updated activity shares based in 2015/16 outturn where appropriate.

Funding for non specialist cardiology has transferred back to Health Boards with effect from January 2017 and has therefore been reflected in the Month 10 financial tables. In addition, the South Wales contracting mechanism for SCBU, NHDU and NICU have been finalised and funding realigned, also with effect from January. Updated contracting schedules were shared with Health Boards for a "go-live" position in Month 10.

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

Table 2.

Financial Summary (see Risk-sharing tables for further details)	Annual Budget £'000	Budgeted to Date £'000	Actual to Date £'000	Variance to Date £'000	Previous month Var to date £'000	Current EOYF Variance £'000	Previous month EOYF Var £'000
NHS Wales							
Cardiff & Vale University Health Board	178,946	149,122	150,800	1,678	1,627	2,045	2,434
Abertawe Bro Morgannwg University Health Board	94,192	78,493	78,930	437	287	696	517

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
Cwm Taf University Health Board	7,307	6,089	5,547	(543)	(560)	(651)	(747)
Aneurin Bevan Health Board	8,674	7,228	7,009	(219)	(93)	(263)	(125)
Hywel Dda Health Board	1,457	1,214	1,406	192	0	231	0
Betsi Cadwaladr University Health Board Provider	36,693	30,578	30,261	(317)	(171)	(305)	(229)
Velindre NHS Trust	35,488	29,573	29,585	12	21	14	28
Sub-total NHS Wales	**362,757**	**302,298**	**303,537**	**1,240**	**1,109**	**1,767**	**1,879**
Non Welsh SLAs	109,715	91,429	91,264	(165)	299	638	1,066
IPFR	24,796	20,664	21,816	1,152	884	1,383	1,179
Mental Health & IVF	22,996	19,164	18,788	(376)	(434)	(200)	(368)
Renal	4,449	3,708	3,844	136	132	225	219
Prior Year developments	3,848	3,207	2,378	(829)	(726)	(665)	(803)
2016/17 Plan Developments	6,228	4,773	1,900	(2,873)	(2,689)	(3,103)	(2,798)
Direct Running Costs	3,787	3,156	2,971	(185)	(138)	(158)	(103)
2015/16 Reserves	0	0	(4,210)	(4,210)	(3,124)	(5,052)	(4,165)
Phasing adjustment for Developments not yet implemented ** see below	0	417	417	0	0	0	0
Total Expenditure	**538,577**	**448,815**	**442,705**	**(6,110)**	**(4,685)**	**(5,165)**	**(3,894)**

The reported position is based on the following:

- NHS Wales activity – extrapolation of Month 9 data in most areas; some exceptions if deemed necessary.
- NHS England activity – Month 9 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. Financial impacts of approved funding releases are currently accounted for in the forecasts.
  ** Please note that Income is collected from LHB's in equal 12ths, therefore there is currently an excess budget in the current position which relates to Developments funding in future months. To keep the Income and Expenditure position equal, the phasing adjustment is shown on a separate line for transparency and is accrued to date to avoid a technical underspend.

5. Financial position detail - Providers

5.1 NHS Wales – Cardiff & Vale contract:

Various over and underspends from the Month 9 data have been extrapolated to a total Month 10 position of £1,678k overspent. WHSSC has worked with the provider to agree baselines this year and the contract has been signed off. Not all the underlying positions have been extrapolated; with a resulting total year-end forecast overspend of £2,045k. This is a year-end improvement of £388k, including the following areas:

- Cardiology – Activity has remained high for Month 9, and indications are that this will continue, so the forecast year-end overspend is straight lined at £1,318k. WHSSC is working with the programme team and the network to assess this area.

- Cardiac Surgery – underperformance remains on track with previous months. The current indications suggest this will continue. WHSSC is working with the provider to agree a delivery plan and recurrent demand levels.

- ALAS – the income and expenditure postion has now been reflected in the forecast and is being offset by the release of funding in the development. This has reduced the overspend reported as £248k in Month 9 to a breakeven position.

- Renal budgets – The reported underspend of £813k on Transplant spend has been projected as £976k by the end of the year, in line with trend. However, Hospital Dialysis is in an opposite position and is currently £446k overspent, with a year-end forecast of £535k overspent.

- Haemophilia – The year-end forecast has improved by £48k. However, this element of the contract has been volatile and further information has been requested to help inform the year end forecast.

- Paediatric Oncology – the reported overspend of £472k to date has been extrapolated to a year-end overspend of £566k as activity is expected to remain at this level.

- Neonatal Care – A revised neonatal model has been reported, leading to a year-end forecast improvement of £215k based on April-December Badgernet data.

- AICU – Whilst approximately break-even, the position continues to deteriorate slightly. Conversations with the provider have suggested that this service continues to be under pressure and therefore over performance is expected to year end.

- Cystic Fibrosis – continues on trend as per the reported position in previous months, and currently has a year-end overspend forecast of £422k

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 9 data have been extrapolated to a total Month 10 position of £437k overspent. Not all the underlying underspends have been extrapolated equally; with a resulting total year-end forecast overspend of £696k. The issues include:

- Cardiac Surgery - £150k underspent to date. However, the year-end end forecast is a reported £229k overspent, an improvement of £133k. Please note the forecast is against the projected 681 surgical cases, with 70 TAVI's. Casemix complexity can make this area more volatile.

- Cardiology – £457k overspent to date. Activity is on an upward trend, so the year end forecast is £548k overspent, expected at a similar position as 15/16.

- Thoracic - £353k overspent to date, and £424k overspend year-end forecast, deteriorations of £184k and £198k respectively. This is due to a coding "catch-up".

- Plastic Surgery - £66k overspent – with a reported year end forecast underspend of £273k as activity is reducing, an improvement from last month of £105k. A plan from the provider is awaited, hence there remains residual uncertainty regarding the level of forecast underspend.

- Sarcoma has remained on line with previous months with a reported overspend of £203k to date and £244k to year end.

5.3 NHS Wales – BCU contract:
Variances on only Angioplasty, ICD's and Haemophilia have been reported to date. Haemophilia activities are expected to catch up by year-end, leaving a net underspend forecast for year-end of £305k. This is risk-shared wholly to BCU.

5.4 NHS Wales – Cwm Taf contract:
The CAMHS contract element has a reported underspend to date of £588k, with a year-end forecast underspend of £705k, based on the M9 returns from the LHB. This includes £82k 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.

Discussions are ongoing with the LHB about whether the lower activity levels being experienced in this contract are likely to be sustained, in the context of the development of new LHB CITT teams elsewhere in the pathway.

5.5 NHS Wales – Aneurin Bevan contract:
There are small variances totalling underspends of £219k to date and £263k year-end forecast; theses are mostly risk-shared to AB.

5.6 NHS Wales – Hywel Dda contract:

No variances except the new Neonatal budget, which has a year-end overspend forecast of £231k.

5.7 NHS Wales – Velindre contract:
The main Velindre contract has been reported as an overspend of £12k to date, and extrapolated to £14k for year-end. The reported position includes provision for a net 1% inflation offer from commissioners consistent with the position of the commissioning collaborative led by CVUHB. The reduction in the forecast from last month relates to the reduction in the providers forecast for melanoma drugs.

5.8 NHS England contracts:
Total £165k underspend to date, with £638k overspend forecast for year-end. This is a year-end improvement of £428k. 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 – has continued along the same trend as previous months and is currently forecast as £460k overspent. The contract provides some respiratory service and is therefore subject to adverse movements in the winter period.

- Chisties – overspend to date of £379k; this includes BMT costs in Months 5 and 6 and generally high BMT activity that are no longer presenting in other North West contracts.

- Imperial College – underspend to date of £263k.
  This reflects the Month 9 monitoring, with future months assumed to be on plan, as 2015/16 outturn was higher at this point last year.

- Royal Brompton – underspend to date of £228k.
  This reflects the Month 9 monitoring, with future months assumed to be on plan; the underspend has been maintained as the activity to date is lower than in 15/16 for Critical Care and Transplant Surgery. This may be subject to movements in future months.

- Salford – underspend to date of £268k; this relates to underperformance on Bariatric Surgery and Intestinal failure to date.

- University Hospitals Birmingham – overspend to date of £430k.
  The overspend relates primarily to low volume/high cost activity (Heart transplants, VADs etc) and associated ITU and drug costs.

- 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 £204k has been confirmed as achieved. The remaining £296k savings target is therefore undelivered. The Rampton contract has been finalised for 2016/17, but Rampton have given notice that 2017/18

onwards will be charged as in-year actuals. This will give an element of risk, but there are currently only 4 patients with that provider.

Detailed explanations and trends on all the English providers are noted on the appropriate tab of the financial Risk-sharing tables sent to all LHB's on the 3rd working day; please see them for any further details. Triangulation of alternative methods of forecasting informs the degree of risk at any time and are reviewed each month. The current reported forecast outturn position is prudent compared with straight line forecasting.

5.9 IPFR:
Various budgets totalling an overspend to date of £1,152k, with a projected year-end of £1,383k overspend. These include:

- 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 prudency pending further information, and this will be updated in future months.

- A new line was split out in Month 5 to identify Proton Beam Therapy costs, as this is a growing area and contains material costs per patient; this combines Adult and Paeds approvals. The movement in the position is in line with the trend experience in previous months of one new patient/month.

- General IPFR, ALAS, HPN, PHT and MS have various performance 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.

5.10 Mental Health & IVF:
Various budgets totalling an underspend to date of £376k; with a projected year-end of 200k underspend. These budgets include:

- Adult Mental Health has a projected overspend of £1,237k based on the patients in OOA placements at this point. As per last month, this equates roughly to 4 annual patients, and may well be adjusted as activity progresses through the year. There was an unusually high cost patient admission within Month 9; this patient is to be reassessed shortly and repatriation will be actioned as soon as possible.

  Please note that the new Case Management teams are now progressing to recruitment, and it is expected that the increased clinical support in this area

will reduce patient numbers going forward as staff come into post. The delay in recruiting may well give an underspend back into the position, and 16/17 staffing forecast costs are awaited from ABM and BCU.

- South Wales CAMHS and All-Wales FACTS inpatient budgets have continued lower activity than estimated for the Plan and currently have a combined forecast underspend of £474k.

- BCU CAMHS inpatient budgets have continued underspent due to the lower activity this year, and currently has a forecast underspend of £509k.

- IVF has a small forecast underspend of £62k; this includes extra NHS Wales activity offset by lower NHS England activity

5.11 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 £100k is being reported at this point, with a potential year-end cost of £239k.

5.12 Developments and Savings Reserves:
Phasing for planned Developments as per the IMTP agreement has been reported to exclude £417k for future funding as of Month 10. 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.

Reserves released from 2015/16 provisions are shown on a separate tab in the risk-sharing tables at this point so that LHB's can identify this specific issue. The forecast £5,052 release of funds has been phased in equal 12ths, leading to the £4,210k funds to Month 10. Please note that the further release of £887k represents the final clearance of ALL accruals, and any commitments which now appear would be an additional spend from the current position.

5.13 Direct Running Costs (Staffing and non-pay):
The running cost budget is currently £185k underspent, with a forecast underspend of £158k. This is due to the significant staffing vacancies the organisation is currently running with; some should be appointed to shortly and there is some minimal Agency spend in the meantime. 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 transferred to Public Health Wales in Month 7, but do not have a material bearing on the reported position. Pay award funding allocated to Cwm Taf for 2016/17 included the element for WHSSC staff; £25k was transferred in Month 7, including £4k for the EASC/QAT team and £1k relating to the Neonatal Network, which has been included in the network transfer calculations.

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 M10	(6,110)	(386)	(487)	69	(814)	(243)	(667)	(3,582)
Variance M9	(4,685)	(251)	(622)	16	(284)	(338)	(644)	(2,563)
Movement	(1,425)	(136)	135	53	(530)	95	(23)	(1,019)

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 M10	(5,165)	(111)	(206)	117	(800)	18	(609)	(3,575)
EOY forecast M9	(3,894)	101	(501)	23	(139)	(69)	(648)	(2,661)
EOY movement	(1,271)	(212)	295	95	(661)	87	39	(914)

Material reporting positions or movements include:

6.1 Cardiff & Vale LHB:

- Cardiff & Vale contract – underspend of £55k to date and £73k year-end regarding ALAS, and £79k to date and £90k year-end regarding Paediatric Neurology.
- The year-end effect of the additional and final 15/16 Reserves release is £96k

6.2 ABM LHB:

- ABM contract – various areas totalling deteriorations of £229k to date and £270k year-end. This includes underspends of £68k year-end on Cardiac Surgery, and £82k to date on Plastics. Overspends include £113k to date and £133k year-end on Renal, £124k to date and £133k year-end on Thoracic, and £87k to date and £109k year-end on the revised Neonatal line.
- Cardiff & Vale contract – underspend of £120k to date and £73k year-end on Cardiac Surgery (SW Wales). This was negated within the total of the contract by various small overspends.
- Mental Health – year-end deteriorations of £72k relating to a CAMHS patient being reclassified as FACTS, and £76k relating to new Perinatal admissions.

Please note that since reporting, one of the Perinatal admissions has been discharged, and this will be reflected in the M11 reports.
- The year-end effect of the additional and final 15/16 Reserves release is £109k

6.3 Cwm Taf LHB:
- Aneurin Bevan contract – overspends of £58k to date and £70k year-end on the new Neonatal line.
- Cardiff contract – underspends of £82k to date and £96k year-end on the new Neonatal line.
- Cwm Taf contract – ICD spend (100% risk-shared to CT) – £29k adverse movement to date; £26k year-end effect.
  Underspends of £62k to date and £74k year-end on the new Neonatal line.
  Please note that the CAMHS underspend is still at a high level in line with last month.
- Mental Health – one patient has been reclassified by the clinical team from CAMHS to FACTS; this has led to increased costs to Cwm Taf of £86k to date and £155k year-end due to the different risk-sharing on these 2 lines. Please note that this patient had already been reclassified previously, and was FACTS in early months, so the movement has not changed the underlying classification at the start of the year.
- NHS England – Various small movements; the largest of which is £61k year-end deterioration for Royal Liverpool & Broadgreen (Occular Oncology).
- The year-end effect of the additional and final 15/16 Reserves release is £50k

6.4 Aneurin Bevan LHB:
- Aneurin Bevan contract – underspends of £107k to date and £128k year-end on the new Neonatal line.
- Cardiff & Vale contract – underspends of £204k to date and £241k year-end on the new Neonatal line.
- Development budget - further underspends of £23k to date and £98k year-end, on various areas primarily including BMT Phase 3.
- Various small movements; the largest of which is £64k year-end deterioration for Royal Liverpool & Broadgreen (Occular Oncology).
- The year-end effect of the additional and final 15/16 Reserves release is £73k

6.5 Hywel Dda LHB:
- ABM contract – various underspends including Cardiac Surgery, Thoracic - £20k to date and £56k year-end movements in total.
- Hywel Dda contract – overspends of £215k to date and £259k year-end on the new Neonatal line.
- Mental Health – one patient has been reclassified by the clinical team from CAMHS to FACTS; this has led to decreased costs to Hywel Dda of £59k to date and £92k year-end due to the different risk-sharing on these 2 lines.
- The year-end effect of the additional and final 15/16 Reserves release is £43k

6.6 Powys LHB:

- Non-Welsh SLAs – Further adverse movements of £69k to date and £109k year-end, primarily on the University Hospitals of North Staffordshire NHS Trust.
- The year-end effect of the additional and final 15/16 Reserves release is £67k

6.7 BCU LHB:

- BCU contract – underspend movement on Angioplasty of £74k to date and £49k year-end.
- NHS England contracts – various contract movements of both under and overspends, which have been discussed with BCU LHB prior to reporting. The biggest values of the £337k underspend movement to date and £527k year-end include:
  Alderhey – underspends of £57k to date and £57k year-end
  Liverpool Heart & Chest – underspends of £271k to date and £271k year-end
  Royal Liverpool & Broadgreen – underspend of £195k year-end
- The year-end effect of the additional and final 15/16 Reserves release is £448k

7. Income / Expenditure Assumptions

7.1 Income from LHB's

The table below shows the level of current year outstanding income from Health Boards in relation to the IMTP and in-year Income adjustments. There are no notified disputes regarding the Income assumptions related to the WHSSC IMTP.

Please note that Income for WHSSC/EASC elements has been separated, although both organisations share one Bank Account. The below table uses the total Income to allow reconciliation to the MMR returns; please refer to the Income tab on the monthly risk-sharing file to see all the details relating to the Commissioner Income if necessary.

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

	2016/17 Planned Commissioner Income £'000	Income Expected to Date £'000	Actual Income Received to Date £'000	Accrued Income - WHSSC £'000	Accrued Income - EASC £'000	Total Income Accounted to Date £'000	EOY Commissioner Position £'000	Other sundry Income (invoiced) £'000	EOY total expected income £'000
ABM	114,147	95,122	93,389	1,733	0	95,122	(208)	0	113,939
Aneurin Bevan	125,721	104,767	101,511	3,257	0	104,768	(793)	51	124,979
Betsi Cadwaladr	154,778	128,982	128,982	0	0	128,982	(3,559)	0	151,219
Cardiff and Vale	110,220	91,850	90,720	1,130	0	91,850	(112)	105	110,213

	2016/17 Planned Commissioner Income	Income Expected to Date	Actual Income Received to Date	Accrued Income - WHSSC	Accrued Income - EASC	Total Income Accounted to Date	EOY Commissioner Position	Other sundry Income (invoiced)	EOY total expected income
Cwm Taf	61,807	51,506	51,000	166	339	51,505	119	117	62,043
Hywel Dda	77,288	64,406	62,971	1,435	0	64,406	29	0	77,316
Powys	32,122	26,768	26,691	77	0	26,768	(606)	0	31,516
Total	**676,082**	**563,401**	**555,264**	**7,798**	**339**	**563,402**	**(5,130)**	**273**	**671,225**

An additional column relating to Other Sundry Income is shown to reconcile the total anticipated Income as per the I&E expectations submitted to WG as part of the monthly Monitoring Returns Ie. Both risk-shared Commissioner Income plus sundry non-recurring income through invoices. This should help reconciliation between WHSSC and other organisations' I&E tables, and expedite clarifying any differences, as per WG requests.

The Other Sundry Income relates to :
£117k –Medserve Allocation funding from WG from Cwm Taf LHB
£105k - DTOC recharge income from Cardiff & Vale LHB
£51k – DTOC recharge income from Aneurin Bevan LHB

Secondment recharges are currently netted into the Running Cost expenditure and are not shown as Income in the table above.

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

Cwm Taf – Invoice 3316 dated 6/9/16 - £58,667.00 (Installment no. 2 of EASC/Medserve allocation from WG passed over June 2016)

Please note the accruals for EASC 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. There is further detail in the separate EASC narrative report.

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.

Confirmation has been received from all Health Boards that the LTA contracts have been agreed and are/will be signed; the paperwork from Cardiff and ABM have been received. (WG MMR Action Point 8.2)

8. Overview of Key Risks / Opportunities

The key risks remain consistent with those identified in the annual plan process to date.

The additional risk and opportunities highlighted in this report are:

- Phasing of Development funding as projects start; possible slippage in start dates may lead to non-recurrent in-year savings.
- Growth in all activity above that projected in the IMTP.
- Dealing with in year service risks associated with amber rated schemes which are yet to be funded. Please note the forecast outturn now includes provisions of £188k for amber schemes.
- The risk of inflation funding expectation gaps with Velindre Trust.
- The risk of Velindre Trust performance variation, which is unknown owing to the lack of financial returns from the Trust.

9. Public Sector Payment Compliance

The WHSSC payment compliance target is consolidated and reported through the Cwm Taf monitoring process.

10. Responses to Action Notes from WG MMR responses

Action Point 7.1 – Please see section 7.2 regarding expenditure with LHB's for details

11. Confirmation of position report by the MD and DOF:

Stuart Davies,
Acting Managing Director, WHSSC

Stacey Taylor,
Deputy Director of Finance, WHSSC

Annex A – 2016/17 Expected Expenditure

	2016/17 Baseline contract £'000	2016/17 Contract EOYF variance £'000	IPFR £'000	MH & IVF £'000	Renal £'000	Develo-pments & Reserves £'000	WHSSC/ EASC/QAT Running Costs £'000	2016/17 Sub-Total Other Spend £'000	2016/17 Total expected spend £'000
ABM	94,192	696	86	2,836	367		42	4,027	98,219
Aneurin Bevan	8,674	(263)	8	180	139		(122)	(59)	8,615
Betsi Cadwaladr	36,693	(305)	1,363	125	585	119	61	1,948	38,642
Cardiff and Vale	178,946	2,045	6,779		733	1,439	149	11,146	190,092
Cwm Taf	7,307	(651)	43	82	0		605	79	7,386
Hywel Dda	1,457	231	36		483		38	788	2,245
Powys			0	7	0		0	7	7
Public Health			48		0		(30)	18	18
Velindre	35,488	14	0		112	123	(32)	217	35,705
WAST (managed by EASC)	136,482	0	0		77		8	85	136,567
Total	**499,239**	**1,767**	**8,363**	**3,230**	**2,496**	**1,680**	**720**	**18,257**	**517,496**

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

		Agenda Item	16
Meeting Title	**Joint Committee**	Meeting Date	21/03/2017
Report Title	WHSSC Joint Committee Annual Business Cycle 2017-18		
Author (Job title)	Corporate Governance Officer		
Executive Lead (Job title)	Committee Secretary & Head of Corporate Services	Public / In Committee	Public

Purpose	The purpose of the paper is to provide Members with the Annual Business Cycle for the Joint Committee.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Corporate Directors Group Board	Meeting Date	03/01/2017
	Integrated Governance Committee	Meeting Date	18/01/2017
Recommendation(s)	Members are asked to: • **Note** the content of the report, including the schedule of meetings for 2017-18		

Considerations within the report (tick as appropriate)

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

1.0 Situation

1.1 The purpose of this report is to present the Business Cycle for the Joint Committee covering the period 2017-18.

2.0 Background

2.1 Good governance practice dictates that Boards and Committees should be supported by an annual cycle of business that sets out a coherent overall programme for meetings. The forward plan is a key mechanism by which appropriately timed governance oversight, scrutiny and transparency can be maintained in a way that doesn't place an onerous burden on those in executive roles or create unnecessary or bureaucratic governance processes.

2.2 It is recognised that the business cycle does not contain all items that will be considered by the Joint Committee. It is intended to provide a broad framework to support the agenda planning process. The document will be reviewed and modified as new issues develop.

3.0 Assessment

3.1 In summary, the Joint Committee has three key functions;

- To set strategy;
- To ensure accountability by:
  - holding the organisation to account for the delivery of the strategy;
  - being accountable for ensuring the organisation operates effectively and with openness, transparency and candour; and
  - Seeking assurance that the systems of control are robust and reliable; and
- To shape culture.

3.2 The Financial Reporting Council Guidance on Board Effectiveness outlines the following useful advice when considering the arrangements in place to inform Board decision making.

- Well informed and high quality decision making is a critical requirement for a board to be effective and does not happen by accident. Flawed decisions can be made with the best of intentions, with competent individuals believing passionately that they are making a sound judgment, when they are not. Many of the factors which lead to poor decision making are predictable and preventable.

- Boards can minimise the risk of poor decisions by investing time in the design of their decision making policies and processes, including the contribution of committees.

3.3 **Meeting Schedule**

The meeting schedule for the Joint Committee has been arranged to ensure there are no clashes with Local Health Board Meetings. The Management Group will meet on a monthly basis.

As previously agreed, the Joint Committee for Welsh Health Specialised Services (WHSSC) and Emergency Ambulance Services Committee (EASC) will be held on the same day.

The schedule of meeting dates for 2017/18 is as follows:-

Date	Time
30 May 2017	9.30am
27 June 2017	1.30pm
25 July 2017	9.30am
26 September 2017	9.30am
28 November 2017	1.30pm
30 January 2018	9.30am
27 March 2018	1.30pm

Additional meetings have been arranged in May and June 2017 to better align with the approval process for the Integrated Commissioning Plan

The forward work plan will be subject to change throughout the year, but will steer agenda planning going forward.

In addition to the specific papers detailed within the forward work plan, the Joint Committee will also:

- Routinely consider members' registered interests at the start of each meeting.
- Receive minutes from the previous meeting and an update against an on-going log of agreed actions.
- Receive summary reports from each of its Committees in order to demonstrate that delegated responsibilities are being effectively discharged.

A schedule of meetings has been produced (annex (i)) which includes dates for the following key meetings:

- Corporate Directors Group Board Meeting
- Management Group Meetings (and workshops)
- Joint Committee
- Quality and Patient Safety Committee
- Integrated Governance Committee
- Audit Committee (Cwm Taf)

The schedule has been developed so that the Management Group that takes place the month before the Joint Committee will support items to the Joint Committee.

3.4 **Joint Committee Workplan**

The Joint Committee Workplan (annex (ii)) provides an overview of the scheduled items for the period 2017/18. It is anticipated that there will be minor amendments following the approval of the Integrated Commissioning Plan 2017/20.

4.0 Recommendations

4.1 Members are asked to:

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

5.0 Appendices / Annexes

5.1 Annex (i) – Schedule of WHSSC Meetings
5.2 Annex (ii) – Joint Committee Workplan 2017/18

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Development of the Plan Implementation of the Plan
Link to Integrated Commissioning Plan	An annual plan of work provides each committee/group with an indication of the planned work for the year. This will also enable WHSSC to operate a more efficient way and support delivery of the Integrated Commissioning Plan.
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	Only do what is needed
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	There is a requirement to ensure that committees/groups are have a clear understanding of their expected annual work plan to ensure that the correct governance process can be followed and appropriate, well informed and timely decisions can be made.
Evidence Base	Financial Reporting Council: Guidance on Board Effectiveness March 2011
Equality and Diversity	Not applicable
Population Health	Not applicable
Legal Implications	Not applicable

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	03/01/2016	Supported subject to minor amendments.
Integrated Governance Committee	18/01/2017	Supported

Annex (i)

WHSSC 2017/18
High Level Meeting Planner

	Audit Committee (Cwm Taf)	Corporate Directors Group Board	Quality and Patient Safety Committee	Integrated Governance Committee	Management Group Workshop	Management Group	Joint Committee
Apr-17	5	18			27	27	
May-17	15	8	10	10	25	25	30
Jun-17	31 May/1June	19			29	29	27
Jul-17		17			27	27	25
Aug-17		21	15	15	31	31	
Sep-17	11	4			7	21	26
Oct-17		16	17	17	12	26	
Nov-17	13	6			9	23	28
Dec-17		4			7	14	
Jan-18		8	9	9	4	25	30
Feb-18	12	5			8	22	
Mar-18		12	6	6	7	22	27

Annex (ii)

Item	March	May	June	July	Sept	Nov	Jan	Mar
Strategy and Planning								
Strategy for Specialised Services			✓					
Collective Commissioning			✓		✓	✓	✓	✓
2017-20 Integrated Commissioning Plan - Delivery updates			✓		✓	✓	✓	✓
2018-21 Integrated Commission Plan - Development			✓		✓	✓	✓	✓
Rare Diseases Plan			✓			✓		
Commissioning Strategies								
Thoracic Surgery Commissioning Plan - Implementation	✓	✓	✓	✓	✓	✓	✓	
Neurosciences Commissioning Plan - Implementation	✓	✓	✓	✓	✓	✓	✓	
Heaptobiliary Services Commissioning Plan - Development		✓						
Haematology Services Commissioning Plan - Development		✓						
Cardiac Services								
Paediatric Services								
Finance								
Risk Sharing and Contracting Framework								
Governance								
Corporate Risk and Assurance Framework			✓			✓		
Governance and Accountability Framework (Refresh)						✓		
Review of the Management Group Responsibilities: Outcome			✓					
WHSSC Annual Report			✓					
WHSSC Joint Committee Annual Cycle of Business							✓	
Annual Self-assessment					✓			
Annual Reports from the Chairs of the joint sub-committees and advisory Groups					✓			

Annex (ii)

Item	March	May	June	July	Sept	Nov	Jan	Mar
Standing Items/Routine Reports								
Report from the Chair of WHSSC	✓	✓	✓	✓	✓	✓	✓	✓
Report from the Managing Director of WHSSC	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of the last meeting held	✓	✓	✓	✓	✓	✓	✓	✓
Action log	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest	✓	✓	✓	✓	✓	✓	✓	✓
Patient Story	✓	✓	✓	✓	✓	✓	✓	✓
Performance Dashboard (inc Quality performance)	✓	✓	✓	✓	✓	✓	✓	✓
Financial Performance Report	✓	✓	✓	✓	✓	✓	✓	✓
Concerns Overview Report	✓	✓	✓	✓	✓	✓	✓	✓
Concerns Report (Confidential)	✓	✓	✓	✓	✓	✓	✓	✓
Reports from the Joint Sub-committee Chairs'								
Integrated Governance Committee		✓			✓	✓	✓	✓
Quality and Patient Safety Committee		✓			✓	✓	✓	✓
All Wales Individual Patient Funding Request Panel								
Welsh Renal Clinical Network								
Management Group	✓	✓	✓	✓	✓	✓	✓	✓
Audit Committee		✓			✓	✓		
Reports from the Joint Advisory Group Chairs'								
All Wales Gender Dysphoria Partnership Board								
All Wales Mental Health and Learning Disabilities Collaborative								
All Wales Posture Mobility Partnership Board								
Children and Adolescent Mental Health Service & Eating Disorders								
Neonatal Network								

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

Agenda Item 17.1
WHSSC Joint Committee Meeting
28 March 2017

Reporting Committee	**Quality Patient Safety Committee**
Chaired by	**Chris Koehli**
Lead Executive Director	**Director of Nursing & Quality**
Date of Meeting	**28 February 2017**

Summary of key matters considered by the Committee and any related decisions made

Patient Story

Members received a patient story detailing the difficulties and limitations faced by patients when trying to book dialysis before going on holidays. Members noted that work is ongoing to address, where possible, the difficulties and put adequate processes in place. The Committee was concerned in particular about the equity of the current arrangements. It was agreed that further feedback would be received from the Welsh Renal Clinical Network at a future meeting.

Serious concerns

Members received updates on:

- Heater Cooler Units: Members received assurance that appropriate actions were being taken to address the concern;
- Peer review of the Renal and Pancreas Transplant Service: Members requested that the Welsh Renal Clinical Network provide an update. Members also requested that an updated action plan be obtained from the provider in advance of the next Quality and Safety Committee;
- Wales Fertility Institute: Members received a copy of the providers report and action plan. It was agreed that the Director of Nursing and Quality would write to the provider's Medical Director and that the Committee Chair would write to the Chair of the provider's Quality and Patient Safety Committee;
- Peer Review of the Burns Service: Members received an update on the actions taken following the external review of the Regional Burns Service and the actions taken to date following the latest outbreak. It was agreed that the Director of Nursing and Quality would meet with the IP&C lead and the Provider's Director of Nursing and would report back at next committee meeting;
- Blood & Marrow Transplantation: A paper was presented to the committee detailing the long standing issues and failure of a provider to achieve JACIE accredited status. Members were concerned that that unit still did not have JACIE accredited, despite assurances and extension of time to achieve accreditation, and questioned whether activity levels were sufficient to deliver a sustainable and high quality service to patients. Members recommended that this issue be brought to the attention of the Joint Committee;

- Sarcoma Surgery: Members received an update regarding the suspension of the sarcoma service within one provider. Members were assured that that arrangements are being made for patients to be seen at an alternative neighbouring provider;
- Inquest to be held by HM Coroner: Members received an oral update regarding a request by HM Coroner for information relating to a funding decision.

Serious Concerns Report
Members received the serious concerns report with 4 new serious concerns, 5 no surprise notifications and 2 significant concerns recorded within WHSSC. 3 closure forms have been received.

Members discussed the reporting of serious concerns, the timescales and the adequacy of monitoring whilst investigations are being carried out. It was agreed that work would be undertaken to strength processes.

Quality Assurance Report
Members received an update on the work to amalgamate the performance, quality and concerns report.

Members reiterated their support in resourcing the quality team to support the implementation. It was reported that the lack of a quality team had been risk assessed and added to the risk register.

Corporate Risk and Assurance Framework
Members received the Corporate Risk Assurance Framework. The Chair recognised that progress was being made; however concern was raised that despite actions being taken, risks were not reducing. It was agreed that this issue would be escalated to the Integrated Governance Committee.

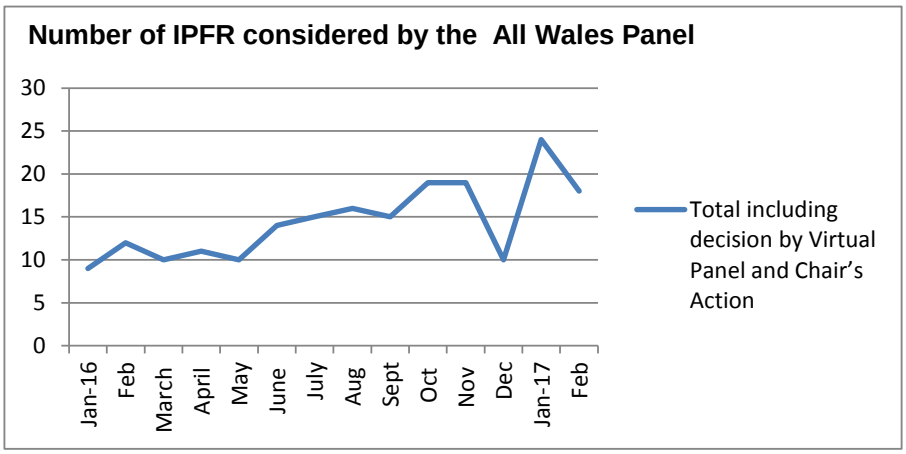
Key risks and issues/matters of concern and any mitigating actions	
Matters requiring Committee level consideration and/or approval	
Bone and Marrow Transplantation	
Matters referred to other Committees	
Corporate Risk Assurance Framework and mitigating actions to reduce risk will be raised at the Integrated Governance Committee.	
Confirmed Minutes for the meeting held 28 November 2016 are available from http://www.whssc.wales.nhs.uk/quality-and-patient-safety-committee-con	
Date of next meeting	10 May 2017

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

Agenda Item 17.2
WHSSC Joint Committee Meeting
28 March 2017

Reporting Committee	**All Wales Individual Patient Funding Request (IPFR) Panel**
Chaired by	Brian Hawkins, Vice Chair
Lead Executive Director	Director of Nursing & Quality Assurance
Date of last meeting	25 February 2017

Summary of key matters



All Wales Panel Decisions – 6 months

Month	Total
Sep-16	16
Oct-16	19
Nov-16	19
Dec-16	10
Jan -17	24
Feb-17	18

Funding requests received by WHSSC – 6 months

Month	New requests	Prior approval/ routine	Panel (IPFR)
Sep -16	152	136	16
Oct-16	167	148	19
Nov-16	130	111	19
Dec-16	130	120	10
Jan-17	186	162	24
Feb-17	169	151	18
Total	934	828	106*

*** represents 11% of all requests received**

Key risks and issues/matters of concern and any mitigating actions	
Individual Patient Funding Request Review 2016 The Independent review of the Individual Patient Funding Request Process in Wales was published in January 2017. The All Wales Panel response to the report's 27 Recommendations has been submitted. The AWTTC /IPFR event on 22 March will re-cap on the progress made against the 2014 IPFR Review recommendations and introduce the 2016 recommendations including the legal and ethical implications of changing the IPFR policy. Panel members, clinicians and Lay representatives from across NHS Wales are attending.	
Matters requiring Committee level consideration and/or approval	
• None	
Matters referred to other Committees	
• Internal Performance and Risk Group – Commissioning, Service and Policy development gaps are reported monthly.	
Date of next meeting	29 March 2017

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

Agenda Item 17.3
WHSSC Joint Committee Meeting
28 March 2017

Reporting Committee	**Welsh Renal Clinical Network**
Chaired by	**Chair, Welsh Renal Clinical Network**
Lead Executive Director	**Director of Finance**
Date of last meeting	**2 February 2017**

Summary of key matters considered by the Committee and any related decisions made.

The WRCN is in the process of reviewing the Net Investment Plan with letters going out to LHB's and to WAST to ask for confirmation of how each resource invested is currently being utilised. The intention is to review the investments across Wales and provide assurance to the board that resources are being are still relevant, utilised appropriately and review the need for investments to change as required to provide equity of service across Wales

A meeting with the Cabinet Secretary for Health took place on afternoon of 2nd Feb. The WRCN presented to the Cabinet secretary the achievements to date and challenges ahead for WRCN. The cabinet secretary commended the network on their prudent use of the budget and confirmed that WG were content with the continuation of the ring fenced funding. He also endorsed the principle of the movement of resource within the Network so long as it involved transparent discussions with the health boards and patients.

Appointments have now been made to the positions of Deputy Network Manager and WRCN Lead Nurse who will take up their posts in April 2017

Key risks and issues/matters of concern and any mitigating actions

The Financial position remains positive for 2016/17 but forward look indicates a shortfall in 2017/18 onwards. The WRCN has submitted priorities to the WHSSC ICP process. These include growth in patients requiring renal replacement therapies.

Matters requiring Committee level consideration and/or approval

None

Matters referred to other Committees

These priorities based on growth of RRT

Date of next meeting	

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

Agenda Item 17.4
WHSSC Joint Committee Meeting
28 March 2017

Reporting Committee	**Management Group**
Chaired by	Acting Managing Director of Specialised and Tertiary Services Commissioning
Lead Executive Director	Acting Managing Director of Specialised and Tertiary Services Commissioning
Date of last meeting	26 January 2017 and 23 February 2017

Summary of key matters considered by the Committee and any related decisions made 26 January 2017.

1. Minutes of the Previous Meeting, Action Log and Matters Arising
The minutes of the meeting held on 15 December 2016 were approved.

The group noted the updates to the action log. MG049 Briefing on Proton Beam Therapy, MG059 Update on CAMHS out of area placements, MG061 Additional information regarding I&E and VfM for ALAS were all now completed and closed. MG060 Overview of ablation services was to be covered during the meeting and was therefore closed.

2. Report from the Acting Managing Director
The group received the report from the Acting MD which had previously been considered by the Joint Committee at its 17 January 2017 meeting.

The draft 2017-20 Integrated Commissioning Plan had been well received by Joint Committee and the pressures around affordability had been noted. A clinical impact assessment of the red and amber schemes would be undertaken before the final version of the Plan was submitted to the March 2017 Joint Committee meeting.

Work on progressing interim support for Thoracic Surgery was proceeding with emerging data providing greater clarity on demand and capacity.

An update was given on the timeline for NHS England Proton Beam Therapy centres coming on line. In the meantime WHSSC had started to look at a service specification for Wales.

Members received an oral update on the Specialised Services Policy: Specialist Fertility Services. When the policy had been received by Management Group for approval in November 2016 cryopreservation had been removed as there had been an intention to develop a separate policy for this area. However, given the complexities, members were asked to approve reinsertion of the original wording relating to cryopreservation into the Specialised Services Policy: Specialist

Fertility Services until such time that a separate policy could be produced. Members approved the temporary re-insertion of the previous cryopreservation section into the Specialist Fertility Services Policy.

3. Collective Commissioning – (1) Inherited Bleeding Disorders (IBD), (2) Endoscopic Mucosal Resection (EMR) and Radio Frequency Ablation (RFA) for Oesophageal Cancer

The group received three papers that set out to highlight the quality, equity and sustainability issues affecting the IBD service and EMR/ RFA treatment for oesophageal cancer that require a collective commissioning approach; and a proposal that funding for the additional member of staff required for this work is provided from some of the savings that are expected from improved prices for blood products.

After lengthy discussion (1) the decision to support the implementation of the Management Group decision in 2015 to transfer resources to WHSSC to bring the IBD service under a single commissioner, within the WHSSC workplan for 2017-18, was unanimously deferred; (2) the decision regarding the proposal that WHSSC takes on full commissioning responsibility to scope and develop a commissioning strategy for EMR/ RFA for oesophageal cancer failed to receive sufficient support to proceed; and (3) the proposal to fund an additional member of staff from anticipated cost savings, for a fixed period, required for these two schemes failed to receive support.

4. Funding Release: Bone Anchored Hearing Aids (BAHA) and Cochlear growth South Wales

The group received a paper requesting approval for a funding release of £500k for 2016-17 to meet existing waiting time standards and maintenance requirements for cochlear implants and BAHA in South Wales. The contract will be subject to a review and VfM assessment but this will not be completed before the end of 2016-17.

Members approved the funding release for BAHA and Cochlear growth in South Wales by majority decision.

5. AWMSG recommendation for Nebulised Levofloxacin (Quinsair) for Cystic Fibrosis

The group received a paper seeking approval to implement the proposed changes to the WHSSC Clinical Access Policy CP74: Inhaled Therapy for Patients 6 years and older with Cystic Fibrosis, following AWMSG approval of Levofloxacin (Quinsair) as a 3rd line treatment and were advised that the change only applied to adults therefore, subject to approval, the policy would be written up accordingly.

Members resolved to approve the amendments to the Clinical Access Policy (CP74): Inhaled Therapy for Patients 6 years and older with Cystic Fibrosis) and the introduction of Levofloxacin as a 3rd line treatment for adults.

6. Delivery of Integrated Commissioning Plan 2016-19 – December 2016
The group received the December 2016 Progress Report.

The Acting Deputy Director of Planning gave a high level summary of the schemes for which funding had not yet been released (pages 12-14).

Regarding Bariatric Surgery it was reported that no further attempts would be allowed for the provider to achieve agreed activity. The unit has been unable to get activity flowing and plan for high risk patients. A letter has been sent escalating the issue.

7. Financial Performance Report – Month 9 2016-17
The group received the month 9 Financial Report. There was an under spend of £4,685k year to date and forecast under spend of £3,894k at year end.

8. Performance Report – November 2016
The group received the November 2016 Performance Report.

Cardiac Surgery, Neurosurgery and Thoracic Surgery waiting time performance at CVUHB had deteriorated, as had Plastic Surgery performance at ABMUHB. Eight patients waiting in excess of 36 weeks for treatment in Liverpool were mini mitral-valve cases, where only one surgeon was currently able to deliver the procedure; the patients had elected for this treatment and understood the situation. Bariatric Surgery waiting time performance at ABMUHB had improved, as had Paediatric Surgery performance at CVUHB and BCUHB.

An increase in out of area CAMHS placements was noted but it was unclear whether all of these were clinically appropriate.

9. Neurosciences Commissioning Update
The group received a paper that had been considered by Joint Committee at its 17 January 2017 meeting. The Joint Committee had supported the recommendation to commission expert external advice and support to the Neuro-radiology element of the Commissioning Plan via the Royal College of Radiology's service review process or alternative sources.

The group noted the progress made to date in developing a five year Commissioning Plan for specialised Neurosciences.

The Commissioning Plan would be shared with members outside of a Management Group meeting.

Summary of key matters considered by the Committee and any related decisions made 23 February 2017.

10. Minutes of the Previous Meeting, Action Log and Matters Arising
The minutes of the meeting held on 26 January 2017 were approved, subject to

clarification by e-mail outside of the meeting of proposed revisions.

The group noted the updates to the action log. MG064 the Committee Secretary had written to members earlier in the day setting out the governance position related to the group's authority regarding decisions on the transfer of services and taking decisions by majority vote – members were invited to respond to the Committee Secretary by e-mail as appropriate.

11. Report from the Acting Managing Director

The group received the report from the Acting MD.

Attention was drawn to the Thoracic Surgery Additional Capacity Project; a waiting list initiative had been agreed with weekend working to clear the current backlog for south east Wales patients and a referral pathway utilising potential English providers was being pursued for south west Wales patients.

The draft service specification was out for consultation in relation to the Thoracic Surgery Review and advice was being taken on the approach to engagement regarding potential service change. The final RCS Review report wasn't available yet.

12. NHS England consultation – Congenital Heart Disease (CHD)

The group received a paper summarising the consultation that had commenced in England regarding the implementation of standards for CHD services for children and adults in England and the potential impact for patients from Wales accessing those services. Minimal impact was anticipated for patients from Wales but interventional cardiology and surgery services currently sourced for adults from Central Manchester University Hospital were proposed to transfer to Liverpool Heart and Chest Hospital.

Members supported (1) the proposals put forward by the NHS England consultation (with feedback to be provided to the consultation regarding the specific concerns as described within the paper), and (2) the proposal to develop equivalent standards for NHS Wales once the consultation was complete and a decision was known regarding the implementation of the standards and impact on services; received assurance that WHSSC would work closely with NHS England and service providers to ensure that patients from Wales were not negatively impacted by the changes, and noted the information presented within the report.

13. Delivery of the Integrated Commissioning Plan 2016-17

The group received the January 2017 Progress Report.

It was noted that two major reviews had begun during the year, Neurosciences and Thoracic Surgery, and that the outcome of these would be reported in the coming months. Feedback would be required on volume delivery and investments in staff and infrastructure at providers.

14. Integrated Commissioning Plan 2017-18 - Update

The group received an oral update. The clinical impact advisory group would be meeting on 6 March to assess the level of clinical impact for all non-mandatory red and high risk yellow schemes. At the March workshop the group would consider the output from the clinical impact advisory group, together with decommissioning and cost avoidance actions. A robust process would be required to control activity levels and costs for 2017-18, which might cause an increase in IPFR requests.

15. Financial Performance Report – Month 10 2016-17

The group received the month 10 Financial Report. There was an under spend of £6,110k year to date and forecast under spend of £5,165k at year end.

16. Performance Report – December 2016

The group received the December 2016 Performance Report.

The WHSSC Team were holding performance management meetings with providers in relation to Paediatric Surgery, Cardiac Surgery, Plastic Surgery and Bariatric Surgery and would report on these to the next meeting. A full year look back would also be brought to the next meeting.

Confirmed Minutes for the meeting held 26 January 2017 are available on request.	
Date of next meeting	Thursday 30 March 2017

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

Agenda Item 17.5
WHSSC Joint Committee Meeting
28 March 2017

Reporting Committee	**Wales Neonatal Network**
Chaired by	Director of Planning, Aneurin Bevan University Health Board
Lead Executive Director	Director of Planning, WHSSC
Date of last meeting	28 February 2017

Summary of key matters considered by the Committee and any related decisions made.

Members:

- Received a presentation from a parent who's baby received neonatal care at Royal Gwent Hospital
- Received a report on the establishment of a Neonatal Mortality Review Group
- Received a report on progress of the 3rd Edition All Wales Neonatal Standards
- Received a report on the Neonatal Network's Delivery Framework 2017/18 which included changes to the Network structure and establishment of a delivery group to identify the priorities for 2017/18 and facilitate service improvement on an all Wales basis
- Received a Neonatal Network report providing and update on
    - Newborn Infant Physical Examination
    - 2016 Key priorities
    - Health Board End of Year Reports
    - Neonatal Intensive Care Services in South Wales
    - South Central Alliance Programme
- 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 October - December 2016
- Received update reports from neonatal units on a health communities basis
- Received an update report from British Association of Perinatal Medicine (BAPM)
- 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
    - Transport
    - Nursing & Therapies (verbal)

Attached at Annex (i) is a copy of the confirmed minutes of the meeting held on 8th November 2016.

Key risks and issues/matters of concern and any mitigating actions

- Lack of a 24 hour neonatal transfer service

Matters requiring Committee level consideration and/or approval

• All Wales Neonatal Standards – 3rd Edition	
Matters referred to other Committees	
• None	
Confirmed Minutes for the meeting held 8th November 2016 are available on request.	
Date of next meeting	6th June 2017

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

Agenda Item 17.6
WHSSC Joint Committee Meeting
28 March 2017

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	06 March 2017

Summary of key matters considered by the Committee and any related decisions made.

Posture and Mobility Service Performance

- The Board discussed the Key Performance Indicators in place, Quality Indicators and performance against these. Performance against targets was beginning to drop minimally in two out of the three sites, all three sites reported continued staffing issues as an area of concern.

Service User Feedback

- No service users were present to feedback any issues.

Stakeholder Reference Working Group

- The Chair of the Stakeholder Reference Group raised three issues on behalf of members.
- The Stakeholder Reference Group is going to explore different ways service users could engage with the Stakeholder Reference Group and the wider service. Options such as establishing contacts who may wish to contribute through commenting on documents only or that may wish to be formal members of the Stakeholder Group, or that may wish to only be kept updated with developments. The Group are due to consider this at the next meeting scheduled for April 2017.
- Information was provided on the development of Stakeholder Group work plan. The Board would be updated with progress at the next meeting.
- Mixed feedback was received from the Stakeholder Reference Group in response to the Disability Awareness Training provided to all members. It was agreed that additional training would be provided however in advance of arranging this event clear objectives from the Stakeholder Reference Group and Technical Working Group would be sought to ensure the appropriateness of the training provided.

Audit Day

- The Board were informed that All Wales Posture and Mobility service Audit

Day would take place on the 6th of June. The Audit Day would include presentations and performance information from the Prosthetics Service, the Wheelchair Service and the Alternative and Augmentative Communication Service.	
Key risks and issues/matters of concern and any mitigating actions	
• None	
Matters requiring Committee level consideration and/or approval	
• None	
Matters referred to other Committees	
• None	
The notes of the meeting held on 19th of October are attached following confirmation by member and the minutes of the meeting held on the 6th of March 2017 are yet to be confirmed. These will however be available once formally accepted by the Board.	
Date of next meeting	**18 September 2017**

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

Action Points
All Wales Posture & Mobility Partnership Board
Wednesday, 19th October 2016
The Cut, Shrewsbury

In Attendance

Name	
Ian Langfield (Chair)	Acting Director of Planning, WHSSC
Claire Nelson	Specialised Planner, WHSSC
Kimberley Meringolo	Assistant Planner, WHSSC
Andrea Richards	Directorate Manager, C&VUHB
Clive Morgan	Assistant Director of Therapies, C&VUHB
Urtha Felda	Chair of the All Wales Posture and Mobility Stakeholder Group
Alison Strode	Chief Therapy Advisor, WG
Catherine Lewis	Children in Wales representative
Catherine Chin	Physiotherapist, Health Disability Sports Officer
Tony Stephenson	Spinal Injuries Association representative
Apologies	
Stephen Jones	Operations Manager, BCUHB
Lorna Tasker	Head of Rehabilitation Engineering, ABMUHB
Vin West	Stakeholder Group representative
Bryan Harrison	Stakeholder Group representative

Item	Note	Action
1	**Welcome and Introductions**	
	IL welcomed all attendees to the meeting and all apologies were noted.	
2	**Minutes of the meeting held on the 7th of March 2016**	
	The minutes from the meeting held on the 7th of March 2016 were reviewed for accuracy, and the following points were highlighted: Members suggested amendment on page 4, section 3 Partnership Board membership. Once the changes have been made the minutes will be circulated to all members for approval before ratification. Action points from last meeting: Page 3 - Information on retired wheelchairs has been made available on the Posture Mobility Service (PMS) website. Page 3 - Whizzkidz nomination was invited to join this meeting. We were advised that Louise Davies would attend this meeting and Jo Fashan would attend the meetings thereafter. Page 3 - WHSSC circulated a meeting schedule for the next twelve months. Page 3 - Contact was made with Media Resource Centre, Llandrindod Wells and it was confirmed that there was no video conferencing facilities planned in the near future. Page 4 - The Stakeholder Reference Group appointed a new Chair, Urtha Felda. The process of appointment was agreed by the Stakeholder Group and the Terms of Reference have been updated to reflect this process. Page 4 - All newly recruited and existing members of all the Posture and Mobility groups were invited to the Disability Equality Training in May 2016. Following the recruitment of further members to the Stakeholder Group, it was agreed that this training would run again. **Action: KM to liaise with members that have not previously attended and organise future training**	

	dates. Page 4 - An e-mail address has been set up for the Stakeholder Group. Concerns were raised as to the user friendliness of the underscore within the e-mail address and it was agreed that an alternative address would be explored further by WHSSC and Cardiff in a hosting perspective. **Action: KM and CM to work with C&VUHB to resolve the email address concerns and make it more user friendly.** Page 5 - The actions relating to the service specification have been completed. The amended version is due to be presented for ratification at Management Group on Thursday 27th October. Page 5 - Seeking Local Authority membership is an ongoing action. AS will provide the contact detail for the Chair of the ADSS Group. WHSSC will draft a letter to the Chair of the ADSS Group, copying in Albert Heaney, Director of Social Services, seeking nominations for the Partnership Board. It was suggested that there is representative from Social Services, Education and Housing. **Action: KM and CM to seek local authority membership.** Page 5 - A self-referral questionnaire is being piloted in BCUHB. Once an assessment of its effectiveness has been completed, this will be shared with the other Posture and Mobility services. Page 5 - The Technical Group considered the KPIs and Quality Indicators in their meeting in August and these have subsequently been added to the previously discussed service specification. Page 6 - Catherine Chinn will present under agenda item 8. Page 6 - This Partnership Board meeting was re-scheduled from September to today.	
3	**Service User Feedback**	
	No service users were present to feedback on any issues.	
4	**Stakeholder Reference Working Group**	
	UF noted that there were a number of new Stakeholder Group members – • Phil Dodd, representing MS in North Wales • Roger Sowersby representing Motor Neurone Disease in North Wales	

	• Bryn Roberts representing Spina Bifida in North Wales • Carol McCudden representing Ataxia UK in North Wales • Carol Ross who is involved with the Welsh Neurological Alliance in South Wales • Bryan Harrison, involved with the Welsh Neurological Alliance in North Wales. **Action: KM to re-circulate the terms of reference which includes the above new members.** UF raised three issues on behalf of the Group. 1. <u>Stakeholder representation</u> Two new nominated members had been put forward from the Stakeholder Reference Group as representatives for the Partnership Board. Following their appointment, they have been unable to attend two Stakeholder meetings and today's Partnership Board. Concerns had been raised that in order for meaningful feedback from the Stakeholder Group, attendance at both meetings was required. Board members agreed that the Stakeholder Group should agree on a substitute in these instances. UF would also explore the potential reasonable adjustments that could be made in order for the nominated representatives to partake. **Action: UF to discuss this solution at the next Stakeholder meeting and feedback at the next Partnership Board.** 2. <u>Equality Impact Assessment (EQIA) of Policies</u> Members of the Stakeholders requested further information on WHSSC's process for undertaking EQIAs when reviewing policies. IL provided assurance that WHSSC have worked rigorously with the NHS Centre for Equality and Human Rights (CEHR) for the last five years on WHSSC policies and specifications. **Action: KM to feedback to the Stakeholder Group on the timings and details of the most recent EQIA for the Posture and Mobility service specification.** 3. <u>Analysis of over 52 week waiters</u> The Stakeholder Group had previously requested a breakdown of the reasons for any service users waiting over 52 weeks. To date, this information had not been provided to the group. AR confirmed that Cardiff has since provided this information for the South East Wales service and we were awaiting the equivalent from the North	

	Wales service. The ABM service has not reported any recent patients breaching 52 weeks. **Action: KM to collate this information for the next Stakeholder Group.**	
5	**Group Membership**	
	CN confirmed that the All Wales Posture and Mobility portfolio of work was now in the remit of herself and KM. CN requested clarity on the representation on the Technical Working Group as the Stakeholder Group recalled from the last Partnership Board that two representatives from the Stakeholder Group would attend the Technical Group. This was not however reflected in the minutes of the March Partnership Board. Nominees for attending was subsequently discussed and agreed in the June Stakeholder Group meeting – Tony Stephenson and Carol McCudden. As the remit of the Technical Group is to look at the operational issues and performance of the service and only recently considered issues such as the website, it was agreed that this position would be reviewed in twelve months from this meeting. **Action: The minutes of the March Partnership Board need to be updated to accurately reflect this position. UF to provide a summary of the discussions that took place for inclusion.**	
6	**Posture and Mobility Service Performance**	
	CN presented the data on the Rehabilitation Engineering Unit in ABMU in the absence of Lorna Tasker. <u>Key Performance Indicators</u> Meeting the RTT for both adult complex and paediatric complex chair. A few instances over the year when 100% has not been met and this is due to: • The complexity of the equipment; and • Delays associated with trialling specialist mobility equipment that requires company representatives at assessment. It was noted that there was a slight deterioration in performance from September and expected until December 2016 due to, 2 vacancies, long term sickness (1 member of staff), and Clinical staff level in Seating team is currently at 2 wte (full capacity is 4.2wte).	

	AR presented the data for the South East Wales service. Key Performance Indicators Meeting the RTT target for standard Wheelchairs since Autumn 2015. There were still some KPI's that were not being met however improvements in these areas were the main focus for the service now that the RTT target was being maintained. There are still significant staffing issues with 7 out of 15 OTs currently on maternity leave. As a solution to this issue the service has set up honorary contracts with *Invacare* and *Sunrise* to carry out some duties in order to maintain RTT levels. Acknowledgement of referral was less that 50% which is below target, however resource issues are the main factor and are being addressed. This was also linked to the underperformance for referral letters and the service is exploring a new system where the two are linked to current systems and potentially automatically generated. SJ had sent apologies therefore the North Wales service performance would be circulated to members. AS noted the significant improvements in the service in recent times and thanked staff for their hard work. It was agreed that the Board would write to each service thanking them for the improvement and also notifying the Minister of said improvements. **Action: KM to circulate the North Wales service presentation and draft letters to each service and the Minister.**	
7	**War Veterans – Enhanced Prosthetic Provision Policy (reference CP49)**	
	CN advised that the War Veterans Policy was due for review in October 2016 and would be circulated for consultation. The notable change since the policy was last reviewed in October 2013 was the change in stump management in Headley Court. **Action: KM to circulate an electronic version of the policy to all members.**	
8	**Any other business**	
	WHSSC 5 year commissioning plan for Neurosciences CN provided an update on the 5 year commissioning plan that WHSSC were in the process of carrying out for Neurosciences. It was the first of its kind for WHSSC and if successful would be rolled out to other commissioned services. The need for a commissioning plan came about following a number of issues within the specialised	

	Neuroscience services emerging, as examples: the Neurosurgery in-patient waiting times, with a number of patients waiting longer than 36 weeks for treatment; and the Neuro-radiology department being left with only one Consultant in 2015 and as a consequence the need to out-source services to Bristol. The first phase of the project is underway, a number of meetings have already taken place with the services, HBs and third sector to discuss the current services and any emerging issues. As part of the project there will be three sub-specialty working groups looking at previous reviews of Neurosciences and looking at the priorities for the future. The three working Groups are Neurosurgery, Neuro-diagnostic and Neuro-rehabilitation. Each HB and the WNA have been invited to nominate individuals to sit on each of the groups. The first meetings are scheduled to take place in early November. <u>Venue</u> Members were invited to provide feedback on the change of venue to Shrewsbury. It was suggested that those that had sent apologies were contact to see if the location was the reason for their absence. Those in attendance were happy with the venue and the transport links however in future it would be beneficial to provide a more detailed map and direction. The location for the meeting in March was yet to be confirmed, members would be notified once confirmed. **Action: KM to notify all members of the location for the next meeting.**	
9	**Date of next meeting**	
	The date of the next meeting was confirmed as 6th March 2017.	