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

WHSSC Joint Committee Meeting held in public
Tuesday 27 March 2017 at 1.30pm

Health and Care Research Wales - Castlebridge 4,
19-15 Cowbridge Rd East, Cardiff CF11 9AB

Agenda

Item	Lead	Paper / Oral	Time
Preliminary Matters			
1. Welcome, Introductions and Apologies - To open the meeting with any new introductions and record any apologies for the meeting	Chair	Oral	1.30 - 1.40
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. Accuracy of Minutes of the Meetings held 29 January 2018 - To **agree** and **ratify** the minutes.	Chair	Att.	
4. Action Log and Matters Arising - To **review** the actions for members and consider any matters arising.	Chair	Att.	
5. Report from the Chair - To **receive** the report and consider any issues raised.	Chair	Oral	1.40 - 1.45
6. Report from the Managing Director - To **receive** the report and consider any issues raised.	Managing Director, WHSSC	Att.	1.45 - 1.50
Items for Decision and Consideration			
7. Five-year Specialised Neurosciences Strategy - To **support** **Contact:** Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.	1.50 - 2.05

Item	Lead	Paper / Oral	Time
8. Neonatal Workforce Model: Progress update - To **note** and **support** **Contact:** Sian.Lewis100@wales.nhs.uk	Managing Director, WHSSC	Att.	2.05 - 2.15
9. High Cost Drugs - To **note** **Contact:** Sian.Lewis100@wales.nhs.uk	Managing Director, WHSSC	Att.	2.15 - 2.25
10. Thoracic Surgery: Implementation Plan Update - To **note** **Contact:** Sian.Lewis100@wales.nhs.uk	Managing Director, WHSSC	Att.	2.25 - 2.35
11. Development of a Specialised Services Commissioning Strategy - To **support** **Contact:** Sian.Lewis100@wales.nhs.uk	Managing Director, WHSSC	Att.	2.35 - 2.45

Routine Reports and Items for Information

12. Integrated Performance Report - To **note** **Contact:** Ian.Langfield@wales.nhs.uk	Acting Director of Planning, WHSSC	Att.	2.45 - 2.50
13. Financial Performance Report - To **note** **Contact:** Stuart.Davies5@wales.nhs.uk	Director of Finance, WHSSC	Att.	2.50 - 2.55
14. Reports from the Joint Sub-committees - To **receive** the report and consider any issues raised. **Sub Committees** • All Wales Individual Patient Funding Request Panel • Welsh Renal Clinical Network	Joint Sub Committee and advisory group Chairs	Att.	2.55 - 3.00
Concluding Business			
15. Date of next meeting - 15 May 2018, 9.30am - Health and Care Research Wales, Cardiff	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)".

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Welsh Health Specialised Services Committee (WHSSC)

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Minutes of the Meeting of the Welsh Health Specialised Services Committee

held on 29 January 2018
at Health and Care Research, Castlebridge 4,
Cowbridge Road East, Cardiff

Members Present

Vivienne Harpwood	(VH)	Chair
Carole Bell	(CB)	Director of Nursing and Quality, WHSSC
Stuart Davies	(SD)	Director of Finance, WHSSC
Gary Doherty	(GD)	Chief Executive, Betsi Cadwaladr UHB
Sian Lewis	(SL)	Managing Director, WHSSC
Lyn Meadows	(LM)	Vice Chair (via VC)
Steve Moore	(SM)	Chief Executive, Hywel Dda UHB (part meeting)
Carol Shillabeer	(CS)	Chief Executive, Powys THB
Chris Turner	(CT)	Independent Member/ Audit Lead
Allison Williams	(AW)	Chief Executive, Cwm Taf UHB

Apologies

Tracey Cooper	(TC)	Chief Executive, Public Health Wales
Alexandra Howells	(AH)	Acting Chief Executive, Abertawe Bro Morgannwg UHB
Len Richardson	(LR)	Chief Executive, Cardiff and Vale UHB
Steve Ham	(SH)	Chief Executive, Velindre NHS Trust
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB

In Attendance

Sian Harrop-Griffiths	(SHG)	Director of Strategy, ABMUHB (part meeting)
Sharon Hopkins	(SH)	Deputy Chief Executive, CVUHB
Glyn Jones	(GJ)	Director of Finance, ABUHB
Claire Nelson	(IL)	Acting Assistant Director of Planning, WHSSC
Kevin Smith	(KS)	Committee Secretary & Head of Corporate Services, WHSSC
John Williams	(JW)	Chair of Welsh Renal Clinical Network

Minutes:

Juliana Field	(JF)	Corporate Governance Officer, WHSSC

The Meeting opened at **9.30am.**

JC17/078 **Welcome, Introductions and Apologies**
The Chair opened the meeting and welcomed members. Apologies were noted as above.

JC17/079 **Declarations of Interest**
Dr Chris Turner declared an interest in relation to item 9, Alternative Augmentative Communication (AAC) Service Evaluation, as a Governor of Cardiff Metropolitan University, as it was Dr Squire of the University who had been commissioned to undertake the evaluation of the AAC service.

The interest was noted; no action was required.

JC17/080 **Accuracy of Minutes of the meetings held 28 November 2017 and 19 December 2017**

Members reviewed and approved the minutes of the meetings held on 28 November 2017 and 19 December 2017 as a true and accurate record.

JC17/081 **Action Log**
Members reviewed the action log and noted the updates.

Matters Arising
There were no matters arising. A presentation on the Integrated Commissioning Plan 2018-21 was to be considered in private session.

JC17/082 **Chair's Report**
Members received and noted the report which provided an update of the key issues considered by the Chair since the last report to the Joint Committee.

It was noted that, following the end of his four year term as an Independent Member at ABUHB, Chris Koehli had stepped down as acting Chair of the WHSSC Quality and Patient Safety (QPS) Committee. Members were asked to approve the appointment of Charles (Jan) Janczewski as the new Chair of the QPS Committee, with affect from 1 February 2018.

Members expressed their gratitude and thanks to Chris for his service to WHSSC.

It was noted that following his appointment as Chair of Cwm Taf University Health Board, Marcus Longley tendered his resignation as an Independent Member of the Joint Committee. Therefore it was recommended that Charles Janczewski also be appointed as an Independent Member of the Joint Committee for an initial term of two years.

Members resolved to:

- **Note** the contents of the report; and

- **Approve** the appointment of Charles Janczewski as an Independent Member of the Joint Committee and Chair of the WHSSC QPS Committee.

JC17/083 **Report from the Managing Director**

Members received a report from the Managing Director; the following areas were highlighted:

- An update on the Inherited Bleeding Disorders project.
- Appointment of an Information Manager to the WHSS Team.
- Cardiac Inter Hospital Transfers in south Wales

Members noted that concerns had been raised around the increase in the numbers of inter hospital transfers which was impacting on the waiting times for elective patients. It was unclear as to the extent of the impact and whether there were opportunities to reduce the number of transfers. Therefore, the WHSS Team had approached the society of Cardio-Thoracic Surgeons to seek their support in identifying appropriate clinicians to undertake a review; it was anticipated this would include a review of the data from centres, interviews with clinicians and managers, and a case note review.

Members enquired as to whether there was a particular concern. It was noted that the source of the issue was unclear and that it appeared to have risen over time impacting on the flow of the whole unit. Therefore, it was important to undertake a root cause review.

Members resolved to:

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

JC17/084 **Alternative Augmentative Communication (AAC) Evaluation**

Members received a paper sharing the Evaluation report of the Alternative Augmentative Communication Service that had been undertaken by Dr Amanda Squire of Cardiff Metropolitan University.

Members received an overview of the report and recommendations, in particular recommendations were made for the service to be fully funded for a further two years followed by a service review in 2020 based on ongoing data collection and service user evaluation; with the strengthening of management and assessors to address current underperformance against key performance indicators. It was noted that Welsh Government had been approached regarding funding but had indicated that any funding would come from specialised services budgets.

It was noted that the original funding provision did not include infrastructure costs. Members noted that AAC consumable costs were considered as part of the ICP prioritisation process.

Whilst members acknowledged the value of the service, they considered there to be significant benefit for both social services and education and believed that tripartite funding would be more appropriate, acknowledging that this may come from the Integrated Care Fund.

SM joined the meeting at approximately 10am

Members agreed to receive a paper in March 2018 which would provide greater level of detail, bringing together the various areas of concern and potential funding options. It was suggested that consideration was also required as to who would undertake a second evaluation in 2020, should funding be approved to continue the service in the interim.

Action: Paper to be prepared for the March 2018 Joint Committee Meeting bringing together the various areas of concern and potential funding options for decision.

Members resolved to:

- **Note** the Evaluation Report of the Alternative Augmentative Communication Service.

JC17/085 **Thoracic Surgery Recommendation**

Members received a paper that (1) made a recommendation regarding the optimal number of thoracic surgery centres in south Wales; (2) made a recommendation on the location of a single centre based on non-financial criteria; (3) provided an update on the ongoing need for a value for money assessment of the recommendation on the location of a single centre; (4) sought approval for the recommendations on the number and location of thoracic surgery centres in south Wales; and (5) sought approval of the next steps in taking forward the recommendations.

Members were presented with an overview, the key issues encountered and the methodology followed to arrive at the recommendations. Members noted that there were difficulties in assessing value for money due to lack of information submitted by both provider health boards; also that there was some criticism from the Independent Panel of the overall quality of information provided by both health boards. However, members received assurances that the Project Board and Independent Panel felt that that they received sufficient information to make their recommendations. Specifically, reassurance was given that although the criterion regarding the infrastructure was weighted most heavily and there was criticism of the quality of the evidence to assess this criterion the panel recommendation remained unchanged when unweighted criteria were considered.

The recommendations were that services should be provided from a single site rather the current two sites in Cardiff and Swansea, and that the new single unit should be based in Morriston Hospital, Swansea.

Members commended the WHSS Team and those involved in the process and acknowledged that the case for change was compelling and founded on non-financial information that was evidence based, quality related and patient centred. A discussion followed around the importance of ensuring that it was clear that this was effectively the creation of a new surgical service to support and develop the existing network across south Wales with care provided locally, wherever possible, for non-surgical parts of the patient pathway, enhancing patient care.

Members recognised the need to ensure that both staff and public perception was considered, and consistent and clear language was used around the recommendations being to accommodate a more sustainable service, focussed on quality and best use of resource.

A question was raised around whether or not there had been any indication of a requirement for full public consultation. Members voiced concerns around the potential of such a requirement given that an extensive engagement process had been carried out which supported the work leading to the recommendations. It was agreed that WHSS Team would liaise with the Board of the CHCs to share the Joint Committee's concerns around the impact of going to full public consultation and, should this be the CHCs' preference, gain an understanding of the reasoning.

Action: WHSS Team to approach the Board of the CHCs to determine whether there is a requirement for full public consultation and, if so, to explain JC's concerns and gain understanding of reasoning.

It was noted that the difficulty in obtaining information to be able to assess value for money was problematic and that it was now vital that this be addressed by the implementation plan.

Members discussed the requirements for implementation and it was suggested that a clinical implementation lead be identified through a competitive process and that both ABMUHB and CVUHB undertake a collaborative implementation process; this was supported by the members present from each health board.

It was agreed that the implementation plan would need to demonstrate value for money with the expectation being that of reasonable affordability, identifying both capital and revenue expenditure requirements, recognising the potential need to incur transitional costs but with ongoing revenue neutrality or better. It was further noted that in addition to finance considerations there needed to be a clear and positive quality impact assessment.

Members asked that consideration be given as to how learning could be drawn from the processes followed during this work and how this might be applied to future service change, redesign or development.

Members resolved to:

- **Support** the recommendation regarding the configuration of thoracic surgery services at a single centre;
- **Support** the recommendation of the location of that single centre at Morriston Hospital, Swansea; and
- **Approve** the recommendations subject to:
  - The appointment of a clinical implementation lead to drive the process forward;
  - A collaborative implementation process being taken forward jointly by ABMUHB and CVUHB;
  - The submission by ABMUHB and CVUHB of a comprehensive Implementation Plan for consideration at the 15 May 2018 Joint Committee meeting; and
  - The submission of information to the WHSS Team to enable it to present a value for money assessment to the 15 May 2018 Joint Committee meeting.

JC17/086 **Perinatal Mental Health Options Appraisal**

Members received a paper which provided an update and presented the clinical view of the Tier 4 Perinatal Mental Health task and finish group.

Members were presented with an overview of the paper and current position. It was noted that a number of clinical workshops had been held to review the service model on an all Wales approach, considering the role of the mental health team with close working relationships with home treatment and crisis teams. Members noted that there were a small number of Welsh patients within Tier 4 inpatient facilities with increased complexity. It was further noted from the paper that there was evidence to support development of an inpatient mother and baby unit facility (MBU) in south Wales as part of an integrated whole system model of care; the predicted demand for inpatient facilities in north Wales meant that a single approach was not yet clear and that further work was required to consider the options; there was political and stakeholder support for a MBU in south Wales with ongoing work to clarify costs and identify funding; and there was a need to move swiftly in developing provision in Wales and an interim solution was suggested.

It was reported that NHS England was exploring service specifications and considering the impacts of co-location of services, which may assist with the work being taken forward by NHS Wales around service provision.

A discussion was held around the importance of understanding the rationale of the decision previously taken to disinvest in the Cardiff

service. It was suggested that significant factors included lack of demand because of a limited catchment area and lack of skills and knowledge in community care at that time to recognise appropriate cases for the unit. Members acknowledged the importance to learn from previous experiences around investment and sustainability of services.

Members noted that further discussions were required with Welsh Government to understand availability of funding and gain assurances around the levels of activity and longer term arrangements.

It was noted that the Welsh Assembly was to debate the Children, Young People and Education Committee's report on Perinatal Mental Health on 31 January 2018. It was suggested that the Joint Committee await the outcome of the debate before taking a final decision. It was also acknowledged that no provision had been made within the 2018-21 ICP for perinatal mental health and therefore new funding would be required to deliver such a service. It was suggested that a task and finish group be established, comprising representatives from each health board to understand availability of resources/ facilities to potentially support a service.

Members resolved to:

- **Note** the information presented within the report;
- **Support** the recommendation of an interim model for inpatient care in south Wales, subject to the learning from the Cardiff MBU closure;
- **Support** the recommendation that WHSSC continue to work with BCU and NHS England in developing the feasibility of a Mother and Baby Unit in north east Wales; and
  Agree that interim options for provision are worked up in detail, with an update brought forward in March 2018, which would include discussions with Welsh Government officials regarding investment options and establishment of task and finish group with representatives from all health boards to identify available resource/facilities to support a service.

JC17/087 **Interventional Neuroradiology (INR) and Thrombectomy**

Members received an oral update on the work being done to ensure a sustainable INR service and to explore the prospects for the phased introduction of a thrombectomy service for south Wales, both in conjunction with North Bristol NHS Trust. The WHSS Team had also been exploring the introduction of a thrombectomy service for north Wales and north Powys with North Midlands NHS Trust.
The WHSS team had held a meeting with CVUHB on 26 January 2018, to agree a way forward and it was anticipated a report will be provided to the next Management Group meeting.

Members noted the work taken forward by the project group and discussed the requirement to ensure there would be a sustainable system

and pathway which ensured timely access to care, which for thrombectomy patients was time critical. Members also noted that considerations were needed around the implications for the Welsh Ambulance Service NHS Trust and that the plan for thrombectomy would be a phased introduction over the next five years, which was aligned to the NHS England position.

Members resolved to:

- **Note** the update.

JC17/088 **Risk Sharing**

Members received a report which set out a proposed new risk sharing framework consistent with the presentation received in November 2017.

Members were provided with an overview of the report which outlined previous proposals presented to Joint Committee members and reiterated the underlying need for a new process.

The latest proposal was based on establishing a neutral baseline based on the latest known two financial years' averages followed by IMTPs based on two year averages. The IMTP impact would be neutral in 2018-19 followed by partial impact in 2019-20 with the full impact biting from 2020-21. Members of the Finance Sub-group were supportive, noting the residual concern of one health board regarding the current year. The paper had been circulated in advance to CEOs and DOFs to enable them to provide feedback ahead of the meeting.

It was confirmed that the proposed model presented three pools 1) utilisation, pay for services received; 2) risk, for high cost low volume services, such as Individual Patient Funding Requests; and 3) opt out, for significant planned changes in provision, for example repatriated services back to locality.

Members were informed that the Finance Sub-group had thoroughly reviewed the proposed new framework and were supportive as was the Management Group.

Members acknowledged the requirement for all health boards to sign up and commit to the principles set out in the paper, recognising that there is volatility within the system that would need to be managed.

Members held a discussion around there being no requirement for an impact assessment, if the principles were agreed due to there being no initial loss or gain by health boards within the proposal set out.

Members of the Joint Committee thanked the Directors of Finance and Finance Sub-group for their efforts in developing the new framework.

Members resolved to:

- **Approve** the proposed risk sharing system detailed within the report.

SHG left the meeting at approx. 11.30am

JC17/089 **WHSSC Governance and Assurance Framework Review**
Members received a paper which provided an overview of the proposed amendments to the Governance and Accountability Framework (GAF) for the Welsh Health Specialised Services Committee.

Members noted that the GAF was due to be reviewed in November 2017, however due to capacity constraints within the Corporate Governance Team, this had not been possible. Therefore, a high level review had been undertaken taking into account key areas of change, relating mainly to the transfer of two clinical advisory groups, the Child and Adolescent Mental Health Service and Eating Disorders Network and the Neonatal Network, to Public Health Wales in October and the subsequent transfer of their Governance arrangements to the NHS Health Collaborative as at 1 January 2018.

Members were informed that a more robust 'deep dive' review would be undertaken over the next few months which would be presented to the Joint Committee in September 2018.

Members resolved to:
- **Note** the content of the report;
- **Note** the proposed amendments to the Governance and Accountability Framework; and
- **Support** the proposed amendments and the proposed action to undertake a full 'deep dive' review of the Governance and Accountability Framework by 30 September 2018.

JC17/090 **WHSSC Joint Committee Annual Business Cycle 2018-19**
Members received a paper detailing the draft business cycle for 2018-19.

Members noted that this was an annual exercise to support the decision making processes of the Joint Committee. It further noted that the work plan presented was a dynamic document and would change throughout the year as new areas of work arose.

Members resolve to:
- **Note** the content of the report, including the schedule of meetings for 2018-19.

JC17/091 **Corporate Risk and Assurance Framework**
Members received a paper which provided an update on progress made in developing the WHSSC Corporate risk management framework.

Members noted the recent changes following feedback received from various assurance committees, and the actions taken forward by the WHSSC internal risk management group. It was noted that all risks on the register were owned by the Director of Planning, as lead Executive, and the WHSSC Quality and Patient Safety Committee, as the assuring committee.

A discussion was held around the Joint Committee's risk appetite, the way in which risk was presented to the Joint Committee and clarity was requested around how the Joint Committee could receive assurance around how risks were scrutinised by the different joint sub-committees. Members noted that the report was presented to all assurance committees in a similar format to that presented to the Joint Committee, and that the Internal Risk Management Group and the Corporate Directors Group Board scrutinised all risks identified for the organisation. Each of these sub-committees and groups were represented on the Joint Committee and the work of the sub-committees was expressly reported to the Joint Committee.

It was noted that the role of the WHSSC Audit Committee was to ensure that there was a risk management system in place and that it was operating effectively. The Audit Committee had not been assured to date that the process was working as well as it might because of the lack of visibility of a risk register or 'risk on a page' reports, however it had recognised that positive steps had been made by the WHSS Team in developing the Corporate Risk and Assurance Framework (CRAF).

A question was raised around the apparent lack of risks relating to the long term strategy or around ongoing development of skills. It was noted that currently all corporate risks were below the reporting threshold (score of 15 or above) and therefore sat on Directorate or Programme risk registers and were considered by the WHSS Team but did not require escalation to the CRAF for consideration by the Joint Committee.

A question was raised as to the level of communication between the WHSS Team and health boards to share risks. It was noted that there was a Risk Management Framework relating to risks associated with schemes within the ICP and that these were discussed with individual service areas. It was further noted that there was a triangulation across the Quality and Patient Safety Committees in relation to WHSSC risks on the CRAF.

Assurances were sought in relation to the actions being taken and regular monitoring for risk CH/020 (Lung Cancer RTT) as there was a question around sustainability of the current position. It was noted that the WHSS Team was in regular contact with the provider and that the current issues related to unexpected leave within the service team.

Members resolved to:

- **Note** the update provided within the report and received assurance that risks were being appropriately assessed and managed.

JC17/092 **Integrated Performance Report**

Members received the report for November 2017, which provided a summary of the key issues arising and detailed the actions being undertaken to address areas of non-compliance.

The services currently in the WHSSC escalation process were noted. Paediatric Intensive Care had been escalated to level 2; there had been no PICU beds available in Cardiff or Bristol for a 24 hour period. Paediatric surgery at CVUHB remained at level 3; a commissioning quality visit had taken place on 26 January. A performance meeting had been held in December in respect of the lymphoma panel, which was at level 2. The tender process had been paused for the Bariatric service pending further assessment against the specification.

Members resolved to:

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

JC17/093 **Financial Performance Report**

Members received the report setting out the estimated financial position for Month 9 2017-18 noting a year to date overspend of £839k with a forecast overspend to year-end of £19k for WHSSC.

It was noted that the position remained relatively stable although material uncertainty remained around the risk of HRG4+ price increases proposed by English NHS providers.

Members noted that the WHSS team were working with Welsh Government, NHS England, NHS Improvement and the Department of Health to resolve the issues. It was felt that there had been positive movement and it was anticipated that a resolution would be achieved by the end of the financial year. Members held a discussion around HRG4+ and noted that there would be no additional write backs beyond what had already been made to date.

Members resolved to:

- **Note** the current financial position and forecast year-end position.
- **Note** the residual risks for the year including the HRG4+ risk.

JC17/094 **Reports from the Joint Sub-committees and Advisory Group Chairs**

Members received the following report from the Joint Sub-committees and Advisory Group chairs:

Sub Committees

Integrated Governance Committee

Members received and noted the report of the meeting held 9 January 2018.

All Wales Individual Patient Funding Request Panel
Members received and noted the report of the meeting held 13 December 2017. Members were informed that an All Wales workshop was scheduled for May 2018 in relation to the new laws relating to consent to treatment and an information leaflet was to be produced for patients and the public.

Welsh Renal Clinical Network
Members received and noted the report of the meeting held 4 December 2017. Members noted that the Renal Procurement team had won a national award for the best process/procurement initiative in relation to their work on south east dialysis expansion.

Audit Committee
Members received and noted the report of the meeting held 15 January 2018. It was noted that WHSSC had received substantial assurance on the Internal Audit Report against Core Financial Systems, for which the WHSS Team should be commended.

Advisory Groups

NHS Wales Gender Identity Partnership Group
Members received and noted the report of the meeting held 18 December 2018. Appended to the report was the work plan for the work being taken forward, by the recently appointed project lead, in developing an interim gender pathway. Members noted that there had been ongoing discussions with Welsh Government around funding provision and it was anticipated that a finalised business case for the service, for consideration by Welsh Government, would be available shortly.

Members resolved to

- **Note** the updates.

JC17/095 **Date and Time of Next Meeting**
It was confirmed that the next Meeting of the Joint Committee would be held on 27 March 2018, Health and Care Research Wales - Castlebridge 4, 15-19 Cowbridge Rd East, Cardiff, CF11 9AB

The public meeting concluded at approximately **12.00noon**

Chair's Signature: .....

Date: .....

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

2017/18 Action Log
Joint Committee Meeting

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
30/05/2017	JC011	**JC17/009 - Provision of Specialised Neurosciences in NHS Wales** Details regarding patient and public engagement to be included in the final neurosciences strategy paper when presented to the Joint Committee	Acting Director of Planning	Mar 2018	26.09.2017 - Members noted that work was progressing on development of the strategy, that these actions would be rolled into the output on the Neurosciences Strategy and it was anticipated that the paper would be presented in March 2018. **March 2018 –** Presented at meeting Agenda Item 7	CLOSED
30/05/2017	JC012	**JC17/009 - Provision of Specialised Neurosciences in NHS Wales** IL to ensure that that the Strategy paper clearly differentiates the commissioning responsibilities of WHSSC and those of the Health Boards	Acting Director of Planning			
27.06.2017	JC013	**JC17/019 – Neurosciences Strategy Group timescales** Timescales for work agreed by the Neurosciences Strategy group to be circulated to member of the Joint Committee for information	Acting Director of Planning			

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
26.09.2017	JC032	**JC17/064 WHSSC Joint Committee Annual Self-Assessment** Chair and Committee Secretary to review options for a development day for the Joint Committee and induction programme for members.	Committee Secretary	May 2018	**Nov 2017 –** Principles discussed. Scoping work has begun. Development session likely to be scheduled for May-July 2018	OPEN
29.01.2018	JC035	**JC17/084 AAC Evaluation** Paper to be prepared for the March 2018 Joint Committee Meeting bringing together the various areas of concern and potential funding options for decision.	Director of Planning	~~Mar~~ May 2018	**March 2018** – Discussions ongoing. Further update to be provided in May 2018.	OPEN
29.01.2018	JC036	**JC17/085 - Thoracic Surgery Recommendation** WHSS Team to approach the Board of the CHCs to determine whether there is a requirement for full public consultation and, if so, to explain JC's concerns and gain understanding of reasoning.	Director of Planning	Mar 2018	**March 2018** - Contact initiated with Joint Chief Executives of the Board of CHCs. SL invited to attend CHC meeting held on 14 March 2018. Update provided within the Managing Director's Report – Agenda Item 6	CLOSED

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Welsh Health Specialised Services Committee (WHSSC)

		Agenda Item	6
Meeting Title	**Joint Committee**	Meeting Date	27/03/2018
Report Title	Report from the Managing Director		
Author (Job title)	Managing Director, Specialised And Tertiary Services Commissioning, NHS Wales		
Executive Lead (Job title)	Managing Director, Specialised And Tertiary Services Commissioning	Public / In Committee	Public

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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 Specialised Service Strategy

- Strategy Development: An outline plan is included within the meeting papers; this includes reference to the output from the Parliamentary Review and acknowledges the interdependencies which are likely to arise.
- WHSSC 'Values' Development: In addition piece of work is underway to define the 'Values' of WHSSC and to ensure that these are incorporated into the organisation's day to day business. It is planned that the product of this work will be launched on the 5th July 2018 (the 70th Anniversary of the NHS). It is recognised that there is overlap between this work and strategy development. A range of stakeholder groups, including colleagues from the WHSS Team, will be asked to engage in a 35 minutes structured feedback process which will feed into both pieces of work. Members of the Joint Committee will be asked to participate at the May 2018 meeting.

2.2 Proton Beam Procurement

- NHS England (NHSE) has commissioned the development of two PBT centres. The first of these, based at Christie NHS Foundation Trust, Manchester, is due to open in Sept 2018; the second based at University College London Hospitals Foundation Trust, is due to open in summer 2020.
- In 2017 NHSE procured another PBT provider in Essen, to ensure sufficient access to PBT during the transition to an NHS service.
- The cost of treating patients in Essen (and the UK) will be approximately half of the current cost for Jacksonville in the US
- The referral process for patients from Wales will continue to be via the UK Proton Clinical Reference Panel. The Panel will also give a recommendation as to where the patient should be treated.
- As WHSSC does not need to go through a formal procurement process for commissioning from NHS providers, patients from Wales will have access to the NHSE PBT service in Manchester from Sept 2017. Some patients, however, will still need to be referred overseas (for example, patients requiring more complex treatment) while the Christie service increases in capacity and expertise
- WHSSC may consider alternative providers where they are able to demonstrate compliance with the required standards of quality and patient safety.
- A briefing document from WHSSC on all the above was released to the service on the 5 March 2018 (Appendix A).

2.3 Thoracic Surgery Update: Consultation

On the 14th March I attended a meeting with the Chairs and Chief Officers of the six CHCs in south Wales. They informally confirmed that each of the affected CHCs had agreed that a formal public consultation was appropriate. They explained that this was not because they felt there were weaknesses in the process of engagement, and indeed they complimented us on the work that had been done, but they were recommending formal consultation because, in their view, the proposed change represented major service change. They emphasised that this would be an extension of the co-operative working between the CHCs and the NHS. They were keen to engage with the WHSS Team and the LHB engagement leads in developing the timescales and details of the consultation process and invited us to write to them setting out our response, on which we are working.

I will provide an oral update on progress to the 'In Committee' session at the Joint Committee meeting.

2.4 Commissioning Quality Visit: Paediatric Surgery

This meeting was held on the 26th of January. The meeting was extremely productive and a joint action plan has been agreed. In the absence of an Escalation Process Scrutiny Group at present this was considered by the Corporate Directors Board within the WHSS Team and it has been decided the service will remain on Escalation Stage 3 with monitoring of the action plan.

2.5 Autologous chondrocyte implantation using Chrondrosphere (registered trademark) for treating symptomatic articular cartilage defects of the knee.

On 7th March NICE published Technology Appraisal Guidance TA508. This states Chrondrosphere is recommended as an option for treating symptomatic articular cartilage defects of the femoral condyle and patella of the knee (International Cartilage Repair Society grade III or IV) in adults, only if:

- the person has not had previous surgery to repair articular cartilage defects;
- there is minimal osteoarthritic damage to the knee (as assessed by clinicians experienced in investigating knee cartilage damage using a validated measure for knee osteoarthritis); and
- the defect is over 2 cm^2.

The technique involves harvesting cartilage cells from patients, transporting them to the company in Germany for culture then re-implantation in the UK. NICE estimate a cost of £10,000 per culture per patient, including cell costs and transportation although they note costs may vary in different settings because of negotiated procurement discounts. It is estimated there will be approximately 500 eligible patients per year in the UK.

WHSST became aware of this when it was brought up at the AWMSG Steering Committee by one of the HB pharmacists asking for advice regarding HB procurement. This is now being brought to the Joint Committee's attention for two reasons:

1. Currently there are individual HB negotiations going ahead and consideration should be given to all Wales procurement;
2. This is likely to be the first of many cell and gene therapies which fall outside services designated to WHSSC and raises the question of whether there should be delegation of cell and gene therapies as a technique to WHSSC in the short term.

We would suggest that further investigation of the issue is undertaken by WHSST and a formal paper brought to the Joint Committee in May.

2.6 WHSSC Escalation Process

We have agreed that the scrutiny and assurance function for the WHSSC Escalation Process will be taken forward in collaboration with the Chief Operating Officer Peer Group, given that the COOs are best placed to understand and deal with the type of issues that are being referred into the Process.

3.0 Recommendations

3.1 Members are asked to:

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

4.0 Annexes and Appendices

4.1 Appendix A: PBT Stakeholder Briefing Paper

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		

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

		Agenda Item	7
Meeting Title	**Joint Committee**	Meeting Date	27/03/2018
Report Title	Five year Specialised Neurosciences Strategy		
Author (Job title)	Acting Assistant Director of Planning		
Executive Lead (Job title)	Director of Planning	Public / In Committee	Public

Purpose	To provide the committee with a commissioning strategy for Specialised Neurosciences which, over the next 5 years, will deliver a service of the highest quality for the population of Wales.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☒

7

Sub Group /Committee		Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note:** the Five year Strategy for Specialised Neurosciences		

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

In May 2015 the Joint Committee of WHSSC asked for the development of a neuroscience strategy for south Wales. 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 further 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 been able to achieve a 36 week referral to treatment (RTT) target within the last five years.
- Key developments on the horizon within Neurosciences, most notably with the introduction of Medical Thrombectomy (clot retrieval) for the treatment of strokes.

In May 2017 a document describing the current service provision of Specialised Neurosciences in NHS Wales and the key service issues was brought to the Joint Committee and this document now builds on that analysis. This took note of the recommendations from the previous Axford, Steers and Price-Morris reviews, many of which remained outstanding.

2.0 Background

In June 2016 Joint Committee members approved the Project Initiation Document (PID) which described the development of a Specialised Neurosciences Strategy. It stated that the Strategy would focus on those services commissioned directly by WHSSC which were broadly outlined as:

- Neurosurgery
- Interventional Radiology
- Neuro-rehabilitation
- Spinal Rehabilitation
- Paediatric Neurosciences including Paediatric Neurosurgery, Paediatric Neurology and Paediatric Neuro-Rehabilitation.

Due to restricted additional funding for new investments in the WHSSC 2017-20 Integrated Commissioning Plan, year one of the Five year Strategy was taken to be 2018/19.

3.0 Assessment

The following four key strategic questions were identified:

1. Which elements of a Specialised Neuroscience service should continue to be commissioned from providers within Wales and which elements should no longer be commissioned because of a lack of significant service interdependency and:
   - insufficient case load related to population size?
   - new evidence for the benefits of super-specialisation?

2. Which elements of a Specialised Neuroscience service should be commissioned from providers in Wales but may require strengthening through the development of a commissioned network?

3. Of those services that are currently delivered in Wales, or which will need to be delivered in the future, how do we ensure that we commission a service that is designed around the patient and delivers the quadruple aims. This will include service redesign, recommissioning interventions, incentivisation and investment.

4. Are there other neuroscience services which would benefit from national commissioning or nationally commissioned services from inside or outside Wales which should be devolved to HBs an example would be Neurology services in north Wales?

Issues related to question 4 are covered under section 3.8.

3.1 Neurosurgery

It is recognised that the location of the Neurosurgical Centre at Cardiff & Vale University Health Board (C&VUHB) was widely consulted upon within the Steers Review and supported.

3.1.1 Population

Serving the Mid and South Wales population of approximately two million, the C&VUHB tertiary service has more than sufficient numbers in line with national specifications to sustain it at as a core NHS Wales service. This was acknowledged during the Steers Review and since then demand on the service has continued to increase.

3.1.2 Lack of capacity within alternative providers to deliver neurosurgery for the population of south Wales

Whilst north Bristol has previously provided C&VUHB with support on a sub specialty level following the retirement of a Consultant Neurosurgeon, we are

aware from discussions around providing support to the Interventional Neuro Radiology service, that North Bristol, the nearest geographical Neurosciences Centre to South Wales, do not have capacity to take on Welsh patients. Birmingham also advised that they are running at full capacity.

3.1.3 Delivering a Major Trauma Network for South Wales

The World Health Organisation's (WHO) 'Guidelines for essential trauma care' published in 2004 stated that 'Head Injury is one of the major causes of trauma related death and disability worldwide'. The WHO guidance also advised that spinal injuries should arrive at tertiary care centres within two hours of injury and that management of complicated spinal cord injuries through surgery should be essential at tertiary care facilities. The NHS England Neurosurgery service specification notes Traumatology as one of the major areas of neurosurgical activity. We recognise that one of the major considerations behind the recommendation of C&VUHB as being the location of the Major Trauma Centre was the location of Neurosurgery.

3.1.4 Sub-Specialty interdependence

Both the WHO and NHS England guidance highlight the need for Neurosurgery inter-specialty working. The Centre's current location on the Heath Park site, allows the Centre to work closely with a range of specialties including: neurology, neurophysiology, neuro-radiology, paediatrics, ENT and maxillo-facial surgery.

3.1.5 Performance of the C&V Neurosurgical Centre against National Standards

The C&VUHB Neurosurgery Centre is achieving a number, but not all, of the minimum requirements for a Neurosurgical Centre as set out in NHS England's Neurosurgery Service Specification published in 2013. The table below sets out the minimum requirements and how the Neurosurgical Centre in Cardiff performs against these, based on them serving a tertiary population of approximately two million.

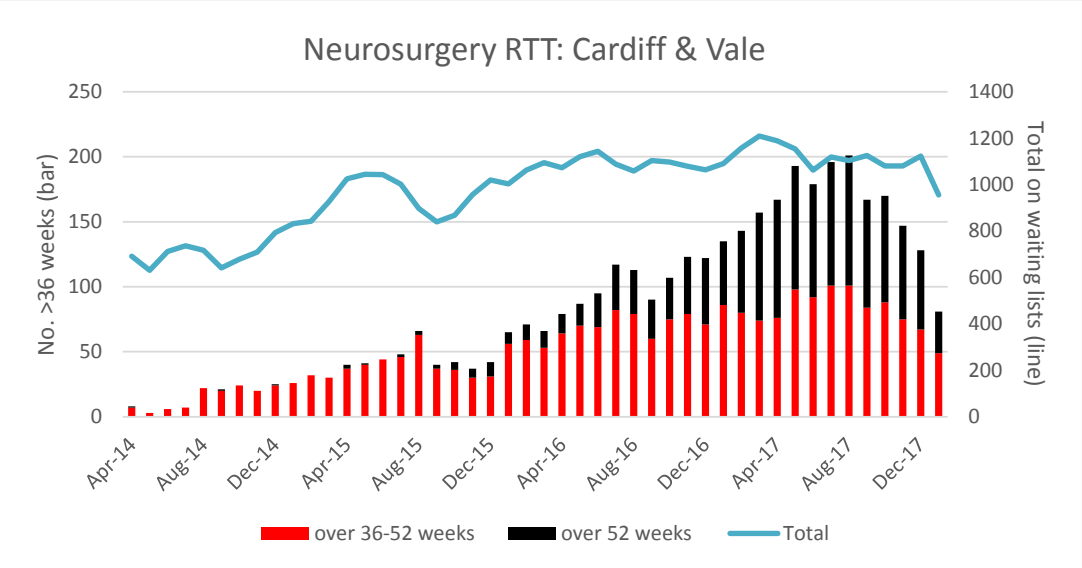
Table 1: NHS England's minimum recommendations for a Neurosurgical Centre and C&VUHB's performance against these

Minimum requirement	C&V's achievement of minimum target
1 whole time equivalent (wte) Neurosurgeon for full 24hr Consultant led service per 200,000 population (equivalent to 10 Neurosurgeons for C&V's tertiary population)	✓
30 Neurosurgical level 1 and 2 beds per million population to ensure timely and equitable access to inpatient care and to maintain a safe service	✓
Four level 3 Neurosurgical Intensive Care Unit beds per million population (equivalent to eight ICU beds for C&V's tertiary population)	✓
Two fully resourced operating theatres and immediate access to an emergency NCEPOD theatre	✓
Units serving a population of more than 2 million to have a minimum of four theatres	X
24hr access to a specialist Neuro-radiological opinion	✓
24hr access to CT and CT angiography	✓
24hr access to MRI scanning including under General Anaesthetic for selected patients	X
Elective functional MRI scanning, intraoperative CT and MRI image guidance	✓
Comprehensive Neurophysiology service including spinal cord monitoring, 24hr EEG and Nerve Conduction	X
Neuro-Vascular services must have an MDT including Neurosurgeons and Interventional Neuro-Radiologists	✓
Neuro-oncology services should be delivered in accordance with NICE and therefore fully supported by Neuro-oncologists, Neuro-Radiologists, Neuropathologists and Clinical Nurse Specialists	X

3.1.6 Referral to treatment times

The Neurosurgery RTT is a Welsh Government priority 1 target but it has not been met by the Centre for at least the last five years. Detailed performance measures show that over the last few years, the number of patients awaiting Neurosurgery has increased exponentially. In April 2014 there was a total of 691 patients waiting for treatment. This had increased by 38% to 1123 in December 2017. Over the same time period, the number of patients waiting over 36 weeks as a percentage of the total numbers waiting, was 1% in April 2014 compared to 11% in December 2017. It reached its highest level at 18% in July 2017.

The graph below shows the number of patients waiting over 36 and 52 weeks for a Neurosurgical procedure along with the total number of patients on the waiting list.



In contrast, on average 98% of patients from North and Mid Wales who undergo their neurosurgical treatment in NHS England receive treatment within the 26 week RTT target.

Regular Commissioner/Provider performance management meetings with C&VUHB which began in May 2016 have identified the following factors as adversely affecting performance:

- Delayed transfers of care;
- Cancellation of patients due to lack of beds;
- Emergency/ Elective split and the impact of the increase in emergencies on the service;
- Lack of physical theatre capacity;
- Work that could be undertaken by Orthopaedic Surgeons undertaken by the Neurosurgeons.

3.1.7 Quality Outcomes

The all Wales Cancer Network undertook a peer review of Neuro-oncology in November 2016 between C&VUHB as provider of the only Neuro-oncological service in Wales and the Walton Centre which serves the North Wales population. The review highlighted a number of serious concerns with the south and mid Wales service including:

- Lack of dedicated Radiology time to both attend and prepare for the MDT meetings;
- Lack of access to a Neuro-oncology Clinical Nurse Specialist in West Wales. This issue was also raised in a patient survey undertaken by the Brain Tumour Charity; and
- Limited allied health professional input – no cover for neuro-psychologist, no speech therapy support in Theatres which is best practice. Lack of dedicated preparation time in job plan of one of the attending Radiologists.

3.1.8 Conclusion

Neurosurgery is a core Neuroscience service which should continue to be delivered in south Wales. There is sufficient service resilience for adult services to be maintained as a stand-alone model. Delivering a high quality service will however require service improvement initiatives. In addition there at least two sub speciality services that have been repatriated to Wales but have failed to deliver the levels of anticipated activity and have not significantly reduced the flow to English centres; these will require examination.

3.2 Neuro Rehabilitation

3.2.1 Population

Currently WHSSC commissions two tertiary rehabilitation units for mid and south Wales. The Neath Port Talbot service based within ABMUHB predominantly serves the populations of Hywel Dda UHB and ABMUHB which combined is approximately 910,000. The Rookwood service in C&VUHB predominantly serving the populations of Aneurin Bevan UHB (ABUHB), C&VUHB and Cwm Taf UHB (CTUHB) which combined is approximately 1,500,000. The British Society of Rehabilitation Medicine states that tertiary specialised services which are categorised as level 1 Rehabilitation, are high cost/low volume services which provide for a regional population of between 1-5 million.

Patients in North and Mid Wales receive level 1 rehabilitation from centres in NHS England – predominantly the Walton Centre as part of the Cheshire and Merseyside Rehabilitation Network and also the Heywood Centre, Stoke.

3.2.2 Alternative providers

The relocation of the Neuro-Rehabilitation Unit from Rookwood to University Hospital Llandough to address the physical infrastructure concerns with the current site has been discussed over a number of years. This move, although not yet timetabled, could provide an opportunity to restructure the delivery of Neuro-Rehabilitation in south Wales. In particular there is the ongoing issue of the Neath Port Talbot Rehabilitation Unit having below the BSRM's recommended minimum number of beds.

There is also a potential new private/public provider coming on-line. WHSSC has been approached by the Llanelli Well Being Village a private public partnership although this project is very much in a development stage.

3.2.3 Interdependencies

Aside from the interdependencies between Neuro Rehabilitation and Neurosurgery which sees the Neuro Rehabilitation Consultants 'in-reaching' to patients through ward rounds on the surgical wards, there are interdependencies with other specialities for care during rehabilitation phase including ENT and Critical Care for tracheostomy and ventilation support and Urology for bladder function. Whilst these services do not require co-location, their close proximity allows the services to be delivered in a more clinically and cost effective way.

Welsh Government's continued focus on aligning Healthcare and Social Services through the Social Services and Wellbeing (Wales) Act 2014 and the Well Being and Future Generations (Wales) Act 2015 positively supports neuro-rehabilitation pathways in improving patient flow from specialised to continued, more local care.

3.2.4 Standards

Work needs to be undertaken to confirm whether both Rehabilitation Units are providing level 1 rehabilitative care and conforming to the same pathways and standards.

The British Society of Rehabilitation Medicine's definition for a 'tertiary specialised' rehabilitation service is based on five main criteria. C&VUHB's and ABMUHB's Neuro-Rehabilitation Centres performance against these criteria is outlined below:

Table 2: BSRM's criteria for a specialised rehabilitation service and the performance of C&VUHB's and ABMUHB's Neurorehabilitation Units against these

Definition	C&VUHB	ABMUHB
Led by a Consultant trained and accredited in Rehabilitative Medicine	X	✓
Covers a population of >1million	✓	✓

Definition	C&VUHB	ABMUHB
Caters for a high proportion of patients with very complex rehabilitation needs	✓	✓
Provides a higher level of service in terms of specialist expertise, facilities and programme intensity to meet those needs	In part	In part
Plays a recognised Networking role to: - Support local specialist and general teams in the management of complex cases	In part	In part
- Act as a resource for research and development, as well as education and training	In part	In part

The table below sets out the BSRM standards for whole time equivalent staff against the staffing levels of the current service in C&VUHB. In contrast to the performance of the Neurosurgical Centre against national standards, there is only one staff group – medical staff junior doctors which is meeting the national standards.

Table 3: BSRM staffing levels against the current staffing levels of the C&VUHB Neurorehabilitation Unit

	BSRM standards 2015	Current Establishment	Difference
	WTE	WTE	WTE
Medical consultant	3.60	1.00	2.60
Medical staff – junior doctors	3.00	3.00	0.00
Nurses – qualified	36.00	20.44	15.56
Health Care Support Workers	24.00	21.87	2.13
Physiotherapists	8.40	4.84	3.56
Occupational Therapists	8.40	4.21	4.19
Speech and Language Therapists	4.20	1.40	2.80
Psychologists	3.60	1.10	2.50
Discharge Co-ordinator / Social worker	2.40	0.00	2.40
Dieticians	1.20	0.60	0.60
Clerical staff	3.60	1.55	2.05
TOTAL	**98.40**	**60.01**	**38.39**

In NHS England, rehabilitation units were funded to BSRM staffing levels in order to be designated as providers for specialised rehabilitation. Therefore patients from North Wales who receive all their level 1 neuro-rehabilitation from NHS

England are receiving a far higher level of specialised rehabilitation than patients in South and Mid Wales.

Level 2 and 3 rehabilitation is currently outside the remit of WHSSC commissioning, although the impact that the deficit of level 2 and 3 rehabilitation beds is having on patient flow through level 1 facilities requires its attention.

A scheme to scope out the requirements of neuro rehabilitation facilities in North Wales has received financial support from the Welsh Government Neurological Conditions Delivery Group. However, the scheme has failed to deliver any outputs since it received funding in 2015/16.

3.2.5 Performance measures

Currently Rehabilitation services in Wales are unable to meet demand and provide timely rehabilitation. The principle reasons for this are inadequate staffing levels as previously described and an inability to discharge patients back to Health Boards following the completion of specialised rehabilitation.

The reasons behind the inability unable to discharge patients back to Health Boards range from a no provision of District General Hospital beds within C&VUHB and BCUHB, to Health Boards unwillingness to accept patients citing that they do not have the appropriate staff and skill set to manage the patients. This does not appear to be the case in Powys, where the Consultant Therapist led model does appear to have the repatriation of patients to as close to home as possible as a prime motive and have developed skills in tracheostomy care for example, in order to achieve this.

3.2.6 Quality/Outcome measures

The BSRM advises that despite their longer length of stay, the cost of providing early specialised rehabilitation for patients with complex needs is rapidly offset by longer term savings in the cost of community care, making this a highly cost-efficient intervention. This focus on the need to provide effective level 1 care, supports WHSSC prioritisation of strengthening the Neuro-Rehabilitation services in South Wales.

3.2.7 Conclusion

There is sufficient population demand for adult rehabilitation services to be delivered in south Wales. Delivering a high quality service will however require significant service improvement initiatives including looking at alternative service models.

3.3 Neuroradiology and Interventional Neuro-radiology:

3.3.1 Population

There are no published population requirements specifically for neuroradiology services.

The current service model in Wales is as follows:
Specialised Neuro-Radiology services are provided in both ABMUHB and C&VUHB although at a reduced level following the relocation of Neurosurgery to a single site. The activity undertaken within ABMUHB is diagnostic only and Health Board commissioned. WHSSC does not currently commission any Neuro-diagnostics specifically from C&VUHB (although it is funded as part of the Walton activity and other Neurological activity commissioned from England), but as this is an essential element of the Neuro-Interventional Radiologist job plan (for which WHSSC funds 1wte) and it is categorised as specialised work, formal commissioning of the work does need to be considered.

For patients in north Wales, Neuro-Radiology is accessed through the Walton Centre although scans are undertaken in North Wales where possible with results accessed by the relevant staff in the Walton.

3.3.2 Alternative providers

The most recent and second collapse of the Interventional Neuro Radiology (INR) service at C&V UHB made it necessary to establish an outsourcing arrangement with an alternative provider for between 1 and 2 patients per week. This process involved discussion with a number of NHS England Trusts located near the Welsh border and has revealed a widespread lack of capacity to even take on the relatively small number of patient related to this services.

North Bristol NHS Trust has however supported this service over the last 10 months but we are aware this has caused capacity issues related to both their elective and emergency work-streams. This is primarily due to lack of Critical Care capacity related to their recent status as a Major Trauma Centre for South West England.

3.3.3 Interdependencies

A Neurosurgical Centre cannot function without Interventional Neuro-Radiological input and it is also a main requirement within a Trauma Centre.

3.3.4 Standards

It is well documented that the Neuro-Radiology department is not currently staffed to full establishment. However, it is managing to deliver a 24hr diagnostic radiology rota despite not having the optimum number of six Consultants to run it albeit with support from an external Radiology reporting company. We will explore

the feasibility of a networked rota with the Neuro Radiologists based at ABMUHB to enhance Neuro-diagnostic support. This was a recommendation within the Axford report.

3.3.5 Conclusion

Neuro-Radiology services both diagnostic and interventional are core Neuroscience services which should continue to be delivered in south Wales. However, there is insufficient service resilience to deliver a high quality service and will require significant service improvement initiatives including looking at networked services with NHSE providers.

3.4 Paediatric Neuroscience Services

Paediatric Neuroscience Services include:

- Paediatric Neurology commissioned from C&VUHB and Alderhey Children's Hospital
- Paediatric Neurosurgery, the majority of which is undertaken in C&VUHB and Alderhey Children's Hospital
- Paediatric Epilepsy commissioned from NHS England
- Paediatric Neuro-Rehabilitation which is delivered from C&VUHB and Alderhey Children's Hospital

3.4.1 Population

There are no published population requirements specifically for Paediatric Neuroscience services.

The current service model is as follows:

The NHS England Specification for Paediatric Neurology recognises that the majority of Paediatric Neurology services are specialised and are consequently based alongside Neuroscience Centres which have the necessary infrastructure in terms of diagnostic services and co-location with other specialties. It outlines the model of providing out-reach outpatient services in order to provide specialist care as near to patients as reasonably possible.

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 has recently retired and returned to work part-time which is likely to increase the demand on an already under-resourced Specialist Centre. All Paediatric Neurologists undertake outreach clinics in surrounding Health Boards.

3.4.2 Alternative providers

Although there are no hard standards on the population requirements for Paediatric Neurology services, there is a strong focus on the services being provided as close to patients' homes as possible. It is clear that where elements of Paediatric Neurology services are accessed from England, that access rates are not as high as those services delivered in Wales. This has been attributed to a number of paediatric neurological conditions being more prevalent in deprived communities which provides further obstacles to travelling for treatment.

The provision of specialised Paediatric Neurology in South Wales is however 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. It is proposed that a collective commissioning approach be taken to Specialised Paediatric Neurology in South Wales between ABMUHB and C&VUHB and in North Wales between BCUHB and Alderhey Children's Hospital.

Elements of Paediatric Neurology and interdependent Paediatric Neurosurgery service are provided to NHS Wales from 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.

3.4.3 Interdependencies

Paediatric Neurology is a fundamental element of Paediatric Neurosciences and Paediatrics as a whole and any shortfalls within it, will have a profound effect on the whole Paediatric Neurosciences system and the ability to deliver it within Wales.

The Department of Health's 'Commissioning Safe and Sustainable Specialised Paediatric Services: A framework of Critical Inter-Dependencies' outlined Paediatric Neurology's inter-dependencies with a great number of services including: Paediatric Intensive Care, Fetal Medicine and Genetics.

There are clear interdependencies with Adult Neurology and Adult Rehabilitation services with specific standards on managing the 16-18 year old age group of patients who fall between the Paediatric and Adults services, leading to problematic commissioning arrangements. The Children's National Services Framework states that special consideration needs to be given to transition management into adult services beyond the 18th birthday for those requiring support services. This would reduce the risk of disengagement with healthcare service and unnecessary delays in their care.

3.4.4 Standards

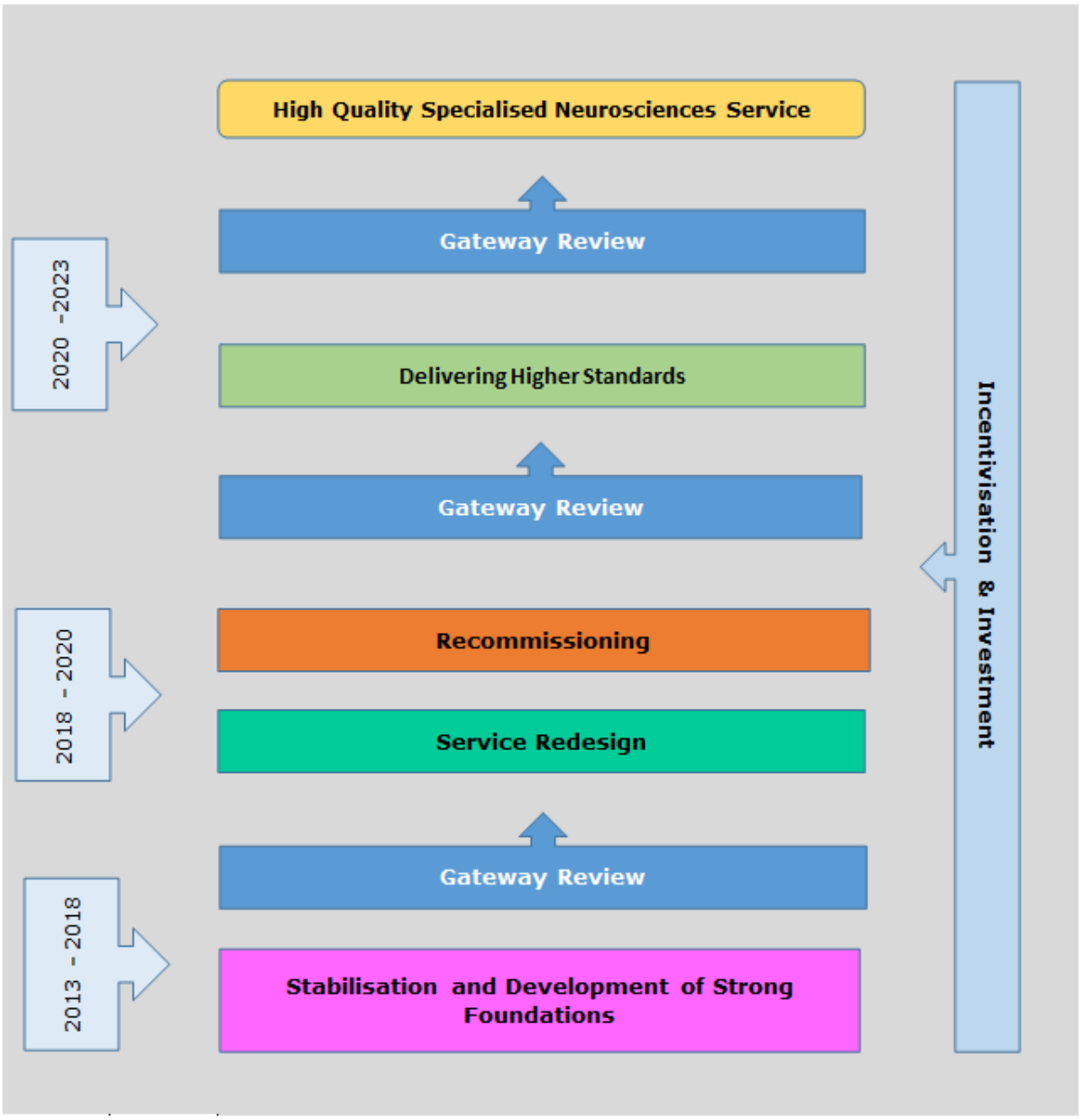
The All Wales Neurosciences Standards for Children and Young People's Specialised Healthcare Services were published by Welsh Government in 2009 along with 65 actions to be taken to ensure equity and sustainability of the services across Wales. It was recognised within the publication that due to workforce and financial constraints, a number of the actions would take up to ten years for delivery. Almost ten years on from when the standards were published many of the actions have not been implemented due to the constraints noted previously. Specific concern is that the support services for Paediatric Neurosciences are still under-resourced and there is not adequate Neuro-imaging, Neuro psychology support or comprehensive access to Neurophysiology testing. C&VUHB is the only known specialist centre without access to video telemetry, resulting in patients having to go to Oxford to receive this five day diagnostic (Bristol Children's Hospital have advised that they do not have capacity to accept Welsh patients for this).

Some notable achievements of the standards have been made. Since funding provision was identified allowing for a Paediatric Neuro-Rehabilitation Service for Mid and South Wales to be established, C&VUHB is almost fully compliant with the standards relating to Acquired Brain Injury Rehabilitation. Similarly, all children and young people requiring wheelchairs are seen by a multi-professional specialist team with ongoing assessment in a timely manner.

3.4.5 Conclusion

Paediatric Neurology is a core Neuroscience service which should continue to be delivered in south Wales. Delivering a high quality service will however require significant service improvement initiatives including introduction of different staff to deliver key services and repatriating activity from England to assist in making the Cardiff service attractive to future Consultants.

3.6 Key strategic priorities



Immediate stabilisation is required for:

- Neuro-rehabilitation because of its increased effectiveness early on post injury/treatment and key importance in patient flow
- Paediatric Neurology because of the current workforce shortfalls
- Interventional Neuro-Radiology because of its sustainability issues.

This stabilisation will involve service redesign, incentivisation, investment and re-commissioning.

Longer term planning requiring capital planning support needs to be instigated within:

- Neurosurgery in relation to increasing theatre capacity
- Neuro-rehabilitation in terms of relocation of Rookwood services
- Interventional Neuro Radiology in order to deliver Mechanical Thrombectomy.

NB: Re-commissioning is a term used within the WHSSC Integrated Commissioning Plan to describe the approach being taken to ensure that the organisation is making best use of resources by reviewing existing patient care pathways into and across specialised services, to identify the point at which greatest benefit for the patient can be achieved. This will require collaborative working across local, regional and national commissioning elements of the care pathway and in some cases, this will require a redesign of the existing commissioning arrangements for a specific condition, pathway or service

3.6.1 Neuro-Rehabilitation service improvement

3.6.1.1 Incentivisation

The Parliamentary Review's recommendations to create a more creative set of financial incentives has already been considered with the re-focussing of the commissioning policies for both Adult and Paediatric Neuro-rehabilitation services, Spinal Injuries Rehabilitation and Neuropsychiatry. Introduced within the policies is the incentive to move patients who no longer require specialist rehabilitation to more appropriate settings in secondary or primary care through implementation of a financial penalty to the responsible Health Board if they delay the patient's transfer of care. It is hoped that this will reduce delayed transfers of care within the tertiary rehabilitation centres, allowing for a more effective flow of patients at the period of time when rehabilitation is most effective. It is also envisaged that this will provide a strong financial case for the presence of different levels of rehabilitative care within Health Boards, particularly in areas such as North Wales where there is no Neuro Rehabilitation Unit despite this being one of the recommendations from the Price-Morris Review. This is being introduced from April 2018 and will provide a key tool for immediate stabilisation.

Another area within Rehabilitation where incentivisation would benefit both providers and Commissioners is with pump priming of administrative support, a relatively low investment, to enter their details into UK Rehabilitation Outcomes Collaborative (UKROC). This would allow WHSSC to benchmark the Welsh rehabilitation services with rehabilitation services form across the UK and have an accurate picture of how they are performing and for the service, demonstrate shortfalls in comparisons with other services that need to be addressed.

3.6.1.2 Service redesign

The Steers Review and working groups that followed it, highlighted the importance of establishing network arrangements within Neuro Rehabilitation. This is a

recommendation supported by the National Services Framework for long term neurological conditions which emphasises the need for rehabilitation provision at all levels, planned and delivered through co-ordinated networks.

The Paediatric Neurorehabilitation service in C&VUHB are already in the process of developing networking links with Bristol, AlderHey and the Children's Trust and have been invited to join the South West ABI Neurorehabilitation Network for Children (SWANN).

Longer term service redesign has been discussed for a number of years with the mooted transfer of Neuro and Spinal Injuries Rehabilitation from Rookwood to Llandough Hospital in order to mitigate the problems associated with an antiquated infrastructure. It is however a number of years since the consultation on this relocation was undertaken and it is unclear whether issues raised at the time by the Spinal Injuries Association and Headway around access to the Llandough site, have been addressed.

3.6.2 Paediatric Neurology service improvement

3.6.2.1 Service redesign

In the previous update on a Neurosciences Strategy, the importance of establishing a Paediatric Neurology network in south Wales between ABMUHB and C&VUHB to strengthen Paediatric Neurology support in south west Wales and strengthening the Paediatric Neurological links between Alderhey NHS Trusts and Paediatrician colleagues based in BCUHB was emphasised.

The need for undertaking further redesign in south Wales has escalated in the last few months following the departure of one of the four Paediatric Neurologists in C&VUHB and an inability to recruit to this vacancy due to a limited number of trainees qualifying in this speciality and the semi-retirement of the sole Paediatric Neurologist in ABMUHB. Different models of delivering the service need to be explored including use of a staff grade and supporting the service with nurse practitioners who have similarly been funded recently to address the junior doctor shortfall within Adult Neurosurgery.

Changes in the commissioning of Paediatric Epilepsy in NHS England with the establishment of four designated centres, with Bristol being geographically closest to the South and Mid Wales population, suggests a rethink in the historical pathway of referring Welsh patients for surgery to Great Ormond Street Hospital, London. The establishment of network arrangements with Bristol aside from the benefits it will bring to patients in NHS Wales, could bring the benefit of access to CUBRIC to the Bristol service, benefiting patients in NHS England who require highly specialised diagnostics. This represents a longer term service improvement approach.

3.6.3 Neuro Radiology

3.6.3.1 Service redesign

A commissioned Network internal and external to Wales is needed in order to manage the current Interventional Neuro Radiology situation and advent of Thrombectomy. WHSST is currently in discussion with a number of English providers and Commissioners about this. This will be covered in detail in a separate suite of documents.

3.6.3.2 Investment

A key issue raised in the Neuro-oncology peer review was the absence of funded Neuro-Radiological support for MDT preparation and attendance at MDT (also allowing for covering absence). These issues have been included in an overarching Neuro-oncology scheme for consideration in the WHSSC Integrated Commissioning Plans 2017-20 and 2018-21 but have not been prioritised highly enough to receive funding.

3.6.4 Neurosurgery

3.6.4.1 Investment

Given the capacity shortfalls in Theatres in C&VUHB against the national standards and the need of a capital build to increase the theatre capacity for Neurosurgery, it is imperative that the planning for this resource commences. Although efficiencies are looking to be made within existing resource such as running three session days, this is not sustainable long term. The impact of introducing a third session day in other specialties has shown that it does not create the equivalent throughput of a session in the morning or afternoon as a number of lists already over-run into this period and also there are case-mix limitations to avoid over-runs into the night.

Capital plans for a third dedicated Neurosurgery theatre is currently being worked up by the C&VUHB Planning team. Recognising the need for capital funding for this and a likely timeframe of three years for this to reach fruition, the service is currently working up plans for a three year programme of increased theatre capacity which are likely to have revenue requirements for WHSSC.

Currently there is deteriorating performance against the maximum target of 36 week Referral to Treatment (RTT). When Welsh Government funding to address RTT was released in 2017/18 Neurosurgery was prioritised by Management Group members as the highest priority amongst specialised services due to amongst other reasons, waits in excess of 100 weeks.

3.6.4.2 Re-commissioning

Spinal Surgery which in the Centre has the longest waits for surgery of all Neurosurgical procedures can be delivered through range of different

commissioned models as Clinical Commissioning Groups in England have shown. It is recognised in the NHS England Neurosurgery service specification (2013) that changes in service provision nationally have resulted in Neurosurgical Units undertaking increasing amounts of secondary spinal care in addition to specialist tertiary care. Whilst WHSSC only commissions spinal Surgery undertaken by Neurosurgeons based at C&VUHB, secondary spinal surgery is also undertaken in Abertawe Bro Morgannwg UHB (ABMUHB) by Neurosurgeons and Orthopaedic surgeons and Aneurin Bevan UHB (ABUHB) by Orthopaedic Surgeons. However, analysis of the spinal procedures on the C&VUHB waiting list have shown a number of what would be considered secondary care spinal procedures. There are decisions that could be implemented which would shift activity that can be delivered by Orthopaedic Surgeons as well as Neurosurgeons to secondary care providers. Whilst this would not directly release money, it could release tertiary capacity. There are also alternatives to surgery that could be mandated for consideration before proceeding to surgery – pain management, physiotherapy. This practice is evident within the Cardiff centre and Neurosurgical centres across the country but not consistently applied by all Consultants in the centre. This is an immediate service improvement to be instigated.

3.6.4.3 Incentivisation

Neuro-modulation has been proposed for inclusion in the WHSSC ICP and receive additional funding to approve its MDT function for the last number of years. With the continued growth in the service's use of spinal implants despite a change in Consultant practice following the departure of a Consultant and the service temporarily being provided by North Bristol NHS Trust, work needs to be undertaken to understand the reasons for the growth and savings opportunities to be made. The incentivisation opportunity here is for savings generated to be used to support gaps within the MDT notably psychology which in itself could reduce the number of patients receiving spinal implant surgery as they consider other ways of managing their condition. Both the Adult and Paediatric services in C&VUHB have access to a Neuropsychology service. The service is an essential and integral support to the Neurosciences service. The services across South Wales are insufficiently resourced but it is widely recognised that early intervention with these types of treatment maximises the chances of recovery and leads to better outcomes for patients, which in turn delivers savings for health care services.

3.7 Services that could be commissioned nationally

There are a number of key services within Neurosciences that WHSSC does not have commissioning responsibility for, including Neurophysiology and Neuro-muscular services although there are clear links with the services commissioned as specialised services. The approach to the planning of these services on a regional basis would allow for greater engagement with WHSSC providing the tertiary services and the Health Board divisions who provide the secondary and primary neurological care. This is part of a longer term planning approach.

3.8 Services commissioned nationally that could benefit from Local Health Board or regional commissioning

There are services currently commissioned by WHSSC that could benefit from Local Health Board or regional commissioning. Neurology is a service previously commissioned by WHSSC for all of Wales but which was re-designated as a Health Board responsibility many years ago. Aneurin Bevan, Abertawe Bro Morgannwg and Hywel Dda Health Boards have all taken back to responsibility for commissioning the service. There are concerns that no active commissioning is being undertaken for Neurology services within Betsi Cadwaladr as WHSSC purely acts as a conduit for the funding of the service to the Walton Centre as part of its overall contract with them.

Elements of the Neuro-oncology proposal submitted to the WHSSC Integrated Commissioning Plans 2017-20 and 2018-21 including clinical nurse specialist support for patients in south west Wales have been suggested for consideration under regional planning rather than national commissioning.

4.0 Timeline for the Neurosciences Strategy

Although the nature of Healthcare services is dynamic and different risks and consequently priorities will emerge, there are a number of areas that can be mapped as requiring action over the next five years. It is anticipated that the schedule will continually evolve and although horizon scanning has been undertaken, within the five years there are likely to policy developments and other external influences which will need to be considered for inclusion.

Areas of service redesign that require investment will follow the due process of being proposed for inclusion in WHSSC Integrated Commissioning Plan or if of a more urgent nature, will be submitted to Joint Committee for approval.

The schemes of work within the Neurosciences Strategy by work category (service redesign, delivering higher standards and re-commissioning) and year, are outlined in Annex 1.

5.0 Recommendations

Members are asked to:

- **Note** the Five year Strategy for Specialised Neurosciences.

Annex 1: Schemes of work within the Specialised Neurosciences Strategy by year

Timeline for Neurosciences Strategy			
Classification	**Organisation**	**Aim**	**Year**
Service re-design			
Interventional Neuro Radiology	C&V	Project manage task and finish group to strengthen network arrangements, to support value based health care commissioning.	2018/19
Diagnostic Neuro Radiology	ABMU, C&V	Project manage task and finish group to strengthen network arrangements, to support value based health care commissioning.	
Paediatric Epilepsy	Bristol	Revise the commissioning arrangements.	
Paediatric Neurology	North Wales with Alderhey South Wales between ABM and C&V	Review the commissioning arrangements and support the development of network links with NHS England and third sector.	
Rehabilitation network in South Wales	ABM, C&V	Set up a Task and Finish Group with key providers of the service to develop a network model. Plans.	

Neuropsychiatry service in North Wales	BCUHB	Review commissioning arrangements.	
Standards			
Specialised Rehabilitation - Policy - Adult Neuro-rehabilitation - Paediatric Neuro-rehabilitation - Neuropsychiatry - Spinal Injuries	ABM, C&V	Completed policy development and ratified by WHSSC Policy Group. Ongoing discussions with the service regarding operationalisation of the policy.	
Neurosurgery RTT - Demand and capacity - Additional Theatre - Coding issues - Delayed discharges	C&V		
Neuro – oncology • 5ALA	AMBU, C&V	ICP 18-21 – Business Case development with the service	
Spinal Rehabilitation – MDT • phase 1 additional Consultant	C&V	ICP 18-21 – Business Case development with the service	
Neuro- Rehabilitation - MDT – phase 1 - Prolonged Disorder of Consciousness (PDOC) – service specification	C&V	ICP 18-21 – Business Case development with the service. Service Specification completed. Policy consultation.	
Re-commissioning			

Clot Retrieval / Mechanical Thrombectomy	C&V	Policy and Service Specification Development.	
Neuromodulation – Use and procurement of spinal implants MDT	C&V	Recommissioning and Value Based Healthcare.	
Review of Gatekeeping arrangements to inform Referral Management Directory	All Health Boards	Completed	
Devices used in Subarachnoid Haemorrhage treatment	C&V	Policy and Service Specification Development.	
Pipeline Embolisation Devices	C&V	Review existing policy and consult with the service.	
Arteriovenous Malformation Surgery	Velindre, Sheffield	Review commissioning arrangements. Heavily reliant on the INR service in C&V. Policy Development.	
Inpatient Neuro-Rehabilitation facilities in North Wales	BCUHB	Review the commissioning arrangements.	
Major Trauma	C&V	Project manage Commissioning of the service.	
Selective Dorsal Rhizotomy – Service Specification	C&V	Policy Development	
Paediatric Neuro-Rehabilitation - 3 year evaluation	C&V		
Service redesign			
Adult Epilepsy	C&V	Review the Commissioning	2019/20

		Arrangements and Financial Head of Agreement.	
Consultation on need for Neurosciences or 'Brain' Network in South Wales	All Health Boards in South Wales	Project manage a Task and Finish Group.	
Standards			
Neuro- oncology - MDT	C&V	Policy Development and Service Specification.	
Neurosurgery - Spinal Surgery - Post-operative MRI scan within 72 hours - Intra–operative monitoring	C&V	Policy Development and an Investment bid for improving the quality of service. To be included in the ICP Planning process.	
Re-commissioning			
Paediatrics - Paediatric Spasticity/ Intrathecal Baclofen pumps - Paediatric Cranio-facial procedures - Paediatric MRI	C&V	Recommissioning and Value Based Healthcare. Policy Development – service specification	
Deep Brain Stimulation - Pathway work on pre and post-operative care - Formal contracting arrangements	C&V	Review commissioning arrangements.	

with North Bristol			
Service re-design			
Neurophysiology - Commissioning responsibility - Adult Telemetry - Paediatric Telemetry	C&V	Review commissioning arrangements and an Investment bid to be included in the ICP Planning process.	2020-2023
Standards			
Sustainability of the workforce (managing retirements, demands in services, training opportunities)	All Health Boards	Support providers with the development of Business cases.	
Spinal Surgery	C&V	Policy Development and an Investment bid for improving the quality of service. To be included in the ICP Planning process.	
Neurosurgery - Post-operative MRI scan within 72 hours - Intra – operative monitoring	C&V	Policy Development and an Investment bid for improving the quality of service. To be included in the ICP Planning process.	
Neurorehabilitation - Palliative Care - Rookwood services to transfer	ABMU, C&V All Health Boards	Policy Development Support the project Management	

- Rehabilitation for Tracheostomy patients - Neuro-Rehabilitation - MDT phase 2	ABMU, C&V	process and consultation. Review service provision and workforce skills. Inclusion in the ICP. Investment bid.	
Spinal Rehabilitation - MDT – Phase 2	C&V	Inclusion in the ICP. Investment bid.	

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	Safe Care Effective Care Staff and Resourcing
Principles of Prudent Healthcare	Care for Those with the greatest health need first Reduce inappropriate variation 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)
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 are no direct resource implications included within this paper.
Risk and Assurance	Specific risks to Neurosciences services are referenced within this paper.
Evidence Base	
Equality and Diversity	Equality issues have been highlighted for certain disease groups within this report.
Population Health	The implications for Population Health are outlined in this report.
Legal Implications	There are no known legal implications with the content of 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	8
Meeting Title	**Joint Committee**	Meeting Date	27/03/2018
Report Title	Neonatal Workforce Planning Update		
Author (Job title)	Neonatal Network Manager		
Executive Lead (Job title)	Managing Director WHSSC	Public / In Committee	Public

Purpose	The purpose of this paper is to provide the Joint Committee with the updated position on the issues relating to the Neonatal Intensive Care medical workforce planning across South Wales as requested in March 2017

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☒

Sub Group /Committee		Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the updated workforce position on neonatal medical workforce planning issues across South Wales • **Support** the recommendation that the South Central Alliance Group be asked to take over the management of an Alliance Workforce Model		

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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 is to provide the Joint Committee of the updated position on the following issues relating to the Neonatal Intensive Care workforce planning across South Wales

1.2 The paper will include the following:

- An update on the vacancy position at all three tiers of medical rota
- Appointments made and staff who took up post as a result of the BAPIO supported and College Medical Training Initiative (MTI) recruitment programs
- Plans for medical staff recruitment in 2018 / 19
- Progress made in delivering an alliance workforce model of workforce planning as approved by the Joint Committee in March 2017

2.0 Background

2.1 The Joint Committee will recall that in 2016 WHSSC managed the process to determine the ongoing placement of Wales Deanery Post Graduate trainees as of March 2017

2.2 As part of this process, the fragility of the neonatal medical workforce was exposed, with rotas on Neonatal Intensive Care Units showing significant gaps.

2.3 The Joint Committee requested a Workforce Planning Task and Finish Group be established to ensure that all three NICUs were supported in their plans to deliver a sustainable workforce

2.4 In January 2017, the Joint Committee received assurance that the predicted workforce was sustainable in the short term and that the BAPIO recruitment process had resulted in 18 offers of appointment

2.5 In March 2017, the joint Committee approved the functions of an Alliance model for neonatal workforce planning be handed to the South Central Alliance Workforce Task and Finish Group

3.0 Assessment

3.1 **Updated Vacancy Position –** For the purpose of this paper, each of the three NICUs were asked to provide an update of the current medical workforce situation, identifying their rota gaps at each of its three tiers.

3.2 Table 1 identifies the current rota gaps for each of the three tiers of medical staff by unit. The units identified that their current workforce position has minimal gaps across all three tiers.

Table 1

Unit	Tier 1	Tier 2	Tier 3
UHW	0.6	0.8	2 (locums in place)
RGH	0	0	0
Singleton	0	1	1
Total gaps	0.6	1.8	3 (2 locums in post)

3.3 **BAPIO Supported and College Recruitment Programs –** In 2016 a coordinated approach to oversees recruitment was undertaken to support the 2017 medical workforce.

3.4 In total 18 offers of employment were made following the interview process, to be shared across Neonatal and Paediatric services, with 12 allocated to the NICUs in South Wales. Following the initial offer, each health board had the responsibility to follow through the recruitment process.

3.5 Health boards were also been part of the college recruitment of MTI candidates, with varying degrees of success.

3.6 Table 2 identifies that of the 12 BAPIO posts allocated to the three NICUs only 4 completed the recruitment process and took up post in a unit. The College MTI recruitment proved to be more successful at health board level, particularly in ABUHB.

Table 2

	BAPIO 2017 MTI		College MTI	
Unit	Recruited	In post	Recruited	In post
UHW	2	0	2	1
RGH	4	2	12	7
Singleton	6	2	1	1

3.7 Table 3 shows the unit plans for recruitment to support rotas in 2018. Again ABUHB have a positive response to MTI recruitment.

Table 3

Unit	Recruitment plans for 2018
UHW	Consultant AAC 28th February BAPIO 2018 : 2 MTIs recruited (1 fallen through, 1 awaiting IELTS)
RGH	10 staff recruited to commence September 2018 (outside MTI process)
Singleton	BAPIO 2018: 3 MTIs recruited 0 College interviews

3.4 **Implementation of an Alliance Workforce Model** – In March 2017 the Committee gave approval for an Alliance Workforce Model to be implemented across the NICUs in South Wales with its functions being taken forward by the South Central Alliance Neonatal Task and Finish Group. Specifically the recommendations were:

- 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
- Monitor the success of the Alliance model and to report back to Joint Committee in 12 months

3.5 Following discussion at the South Central Acute Care Alliance Group (SCACAG) meeting on 4th July 2017, there was apparently concern expressed by CEOs that the existing governance structure for the SWP implementation and emerging regional planning committee requirements may not provide the appropriate governance support to effectively discharge these responsibilities

3.6 This was then followed up by correspondence from the SCACAG stating that this was under consideration and that the WHSS team would be updated on the final position. It appears however that in the interim, no coordinated medical workforce planning process has been put in place, however health boards have been successful at recruitment for individual units.

4.0 Recommendations

5.1 Although currently there are no significant recruitment issues across the 3 NICUs this remains a significant service risk because of the UK wide workforce shortages in the specialty. It is therefore recommended that the South Central Alliance Group be asked again to take over the management of an Alliance Workforce Model.

4.1 Members are asked to:

- **Note:** the updated workforce position on neonatal medical workforce planning issues across South Wales

- **Approve:** the recommendation that the South Central Alliance Group be asked again to take over the management of an Alliance Workforce Model.

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 Timely Care
Principles of Prudent Healthcare	Reduce inappropriate variation Care for Those with the greatest health need first
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Improving Health of Populations
Organisational Implications	
Quality, Safety & Patient Experience	Ensuring adequate staffing levels is essential to ensure quality and patient safety are maintained
Resources Implications	None
Risk and Assurance	Recruitment risks will be reduced
Evidence Base	None
Equality and Diversity	None
Population Health	None
Legal Implications	None

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

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

		Agenda Item	9
Meeting Title	**Joint Committee**	Meeting Date	27/03/2018
Report Title	High cost drugs and new medicines		
Author (Job title)	Dr Sian Lewis, Dr Andrew Champion, Professor Dyfrig Hughes		
Executive Lead (Job title)	Dr Sian Lewis	Public / In Committee	Public

Purpose	• To confirm to the Joint Committee that a paper summarising the policy tensions around high cost drugs and the introduction of new medicines within Wales has been developed and submitted to the NHS Wales executive team

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee		Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** that a paper summarising the policy tensions within Wales regarding the introduction and management of high cost drugs has been submitted to the NHS Wales executive team.		

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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	✓	

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

1.0 Situation

1.1 A paper was presented at the Joint Committee of Welsh Health Specialised Services Committee (WHSSC) in November 2017 which demonstrated that there are increasing budget pressures related to mandated high cost drugs in NHS Wales and that this has a potentially destabilising effect on wider NHS services. It was noted that this pressure may be counter to other NHS policy developments which promote the principles of Quadruple Aim and Prudent Health Care.

2.0 Background

2.1 The nature of high cost mandated drugs is that many but not all sit within specialised services. The 2018/19 planning process has identified a predicted spend for 2018/19 requiring an uplift of £18.6M. Of this uplift £5.2M (28%) is related to high cost drugs. The opportunity costs of some of these drugs are very significant, for example the cost of Ivacaftor (a drug used for treating patients with Cystic Fibrosis) per year per patient is equivalent to 5 heart transplants per year or 25 hip replacements per year.

2.2 There is increasing divergence between NHS Wales and NHSE regarding the policy approach to the introduction of new medicines.

2.3 There is increasing divergence between the policy approach of AWMSG and other policy positions in NHS Wales

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3.0 Assessment

3.1 The attached paper (Appendix A) was developed with support from Professor Dyfrig Hughes Bangor University.

3.2 The paper asks for WG support in ensuring the AWMSG strategy addresses the policy divergence and that the parliamentary review is used to address the organisational arrangements which underpin the introduction and management of high cost new medicines.

4.0 Recommendations

- **Note** that a paper summarising the policy tensions within Wales regarding the introduction and management of high cost drugs has been submitted to the NHS Wales executive team.

5.0 Appendices / Annexes

5.1 Appendix A - High Cost Drugs and New Medicines: Policy Tensions in Wales

Link to Healthcare Objectives	
Strategic Objective(s)	Implementation of the Plan Development of the Plan
Link to Integrated Commissioning Plan	The 2018/19 planning process has identified a predicted spend for 2018/19 requiring an uplift of £18.6M. Of this uplift £5.2M (28%) is related to high cost drugs.
Health and Care Standards	Governance, Leadership and Accountability Staff and Resourcing Effective Care
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Care for Those with the greatest health need first Reduce inappropriate variation
Institute for HealthCare Improvement Triple Aim	Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	No direct implication
Resources Implications	Recommendations to WG potentially provide cost savings
Risk and Assurance	No direct implications
Evidence Base	Current policy positions in NHS Wales and NHSE
Equality and Diversity	No direct implications
Population Health	No direct implications
Legal Implications	No direct implications

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	12.03.2018	Supported

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

Appendix A

High Cost Drugs and New Medicines: Policy Tensions in Wales

1. Introduction:

This paper has been developed in response to concerns highlighted at the Joint Committee of Welsh Health Specialised Services Committee (WHSSC) in November 2017 where it was recognised that there was an increasing budget pressure related to mandated high cost drugs in NHS Wales and that this has a potentially destabilising effect on wider NHS services. This pressure may be counter to other NHS policy developments which promote the principles of Quadruple Aim and Prudent Health Care.

2. NHS Wales – policy imperatives:

To improve equity and to ensure clinical and cost effective use of healthcare, the NHS in the UK has either directly or indirectly devolved decision making regarding the introduction of new drugs and new drug indications into arms' length organisations such as the National Institute for Health and Care Excellence (NICE), the Scottish Medicines Group (SMG) and the All Wales Medicines Strategy Group (AWMSG). These organisations make recommendations which are based on clinical and cost effectiveness but provide a rarity premium. This premium recognises that we often know less about rare conditions and their treatment, the costs of treatment tend to be higher and historically there has been less market interest. It is, however, relevant to note that recent evidence suggests companies which are marketing authorisation holders of orphan drugs are more profitable than companies which are not. https://doi.org/10.1371/journal.pone.0164681.

NICE recognises this rarity premium through the evaluation of certain drugs via the Highly Specialised Technology (HST) process. Similar criteria are used by AWMSG in their orphan and ultra-orphan appraisals. The position in Wales is that recommendations from NICE HST appraisals and Technology Assessment Guidance (TAG) are mandatory (WHC (2005) 22) and AWMSG recommendations are ratified by the Cabinet Secretary on the vast majority of occasions. Only once in 15 years has a contrary decision been made.

There are however rising tensions related to these processes in Wales where they potentially cut across other NHS Wales policies. In addition there is now

inequity between AWMSG processes and those of NICE, where, in collaboration with NHS England (NHSE), specific consideration of the budget impact, linked to price discounts, has been introduced: https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-technology-appraisal-guidance/consultation-on-changes-to-technology-appraisals-and-highly-specialised-technologies.

Specific issues relate to:

1. Prudent Health Care Principles (2014) http://www.prudenthealthcare.org.uk/
2. A Revolution from Within: Transforming Health and Care in Wales (2018) http://gov.wales/docs/dhss/publications/180116reviewen.pdf
3. Collaboration between NHSE and NICE to manage the introduction of high cost drugs and drugs with a high budget impact to optimise the financial sustainability of the NHS (April 2017) https://www.nice.org.uk/Media/Default/About/what-we-do/NICE-guidance/NICE-highly-specialised-technologies-guidance/HST-interim-methods-process-guide-may-17.pdf
4. The introduction of complex NHSE/NICE Managed Access Agreement processes to support the above
5. The New Treatment Fund which commits to the early introduction of new drugs for patients in Wales http://gov.wales/topics/health/nhswales/fund/?lang=en

3. Decision making in Wales:

Between 1 April 2013 and 31 March 2017, AWMSG carried out 162 appraisals of which 147 (91%) medicines were approved for use within NHS Wales. All recommendations subsequently received Ministerial ratification.

The AWMSG draft strategy consultation document (2018-2023) highlights that there has been improved access to new medicines during 2013–2018 by increasing the role of clinical and public opinion. The document specifically cites the following achievements during 2013-2018:

- Strengthened clinical expert engagement in the appraisal process.
- Review of the process for appraising orphan and ultra-orphan medicines, and medicines developed specifically for rare diseases.
- Establishment of the Clinician and Patient Involvement Group (CAPIG).
- Improved equity of access by enabling the appraisal of medicines within Wales where a medicine has received a negative recommendation from NICE but is available via an alternative commissioning route in England.
- Reviewed end-of-life processes.

Importantly the strategy has not included any balancing of the role of opinion with increased rigour around the consideration of evidence of clinical and cost effectiveness.

The strategy also does not address the issue of pre 2011 AWMSG recommendations which have never been updated and remain extant. This

includes some extremely high cost drugs with very significant budget impact for example some Enzyme Replacement Therapies which in adults have a budget impact of between £450K and £500K per year per patient.

The strategy does not address the issue of managing budget impact and optimising NHS Wales' financial stability. Currently there is a lack of clarity as to how budget impact should be taken into account within the AWMSG recommendation process which is unlike the positon recently agreed between NHSE and NICE. Although it should be noted that Wales benefits financially from the NHSE position.

Finally the orphan and ultra-orphan processes have not taken into account existing evidence which suggests that a rarity premium is not supported by the generally public. Instead the strategy suggests that further evidence should be collected rather than providing the leadership which would allow a widening the debate around this difficult and emotive area. The published evidence is summarised in the table below.

Country	Number surveyed	Main finding
UK	4118	No support for the special funding status for treatments of rare diseases
UK	3950	UK general public does not consider rarity in itself as being sufficient to justify special consideration for additional NHS funding
Norway	1547	Little evidence of a preference for rarity if treatment is at the expense of those with common disease
Canada	2005	A larger proportion of respondents preferred to fund common-disease patients
Australia	3080	A large proportion of respondents favoured equal allocation of funds between medicines for rare versus common diseases
Sweden	1270	No support for the existence of a general preference for rarity when setting health care priorities

4. Policy level issues:

4.1 Prudent Health Care:

In 2014 the then Minister for Health launched Prudent Health Care. This policy position set out four key principles of effective health care. The four principles are outlined below:

- Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production
- Care for those with the greatest health need first, making the most effective use of all skills and resources
- Do only what is needed, no more, no less; and do no harm
- Reduce inappropriate variation using evidence based practices consistently and transparently.

Specifically tensions with regarding the introduction of new medicines relate to the first 2 principles:

- The lack of engagement with the public regarding the rarity premium in the true spirit of co-production
- The cost effectiveness thresholds currently in use mean that we may not be making the most effective use of all our resources. Currently drugs recommended through NICE and AWMSG processes sit outside normal NHS Wales processes for prioritisation because they are mandated.

4.2 A Revolution from Within: Transforming Health and Care in Wales (2018)

In January 2018 the parliamentary review on Health and Social Care in Wales reported. This review was established, with cross party support, to look at the key challenge of how public services might better anticipate and address new demands upon them effectively. A number of the recommendations create similar tensions to those highlighted above:

- Recommendation 1: '……delivering what users and the wider public say really matters to them…'
- Recommendation 2: The Quadruple Aim for all Underpin the "one System" vision with four aims - the Quadruple Aim. That is, health and care staff, volunteers and citizens should work together to deliver clear outcomes, improved health and wellbeing, a cared for work force, and better value for money.
- Recommendation 8: Align system design to achieve results Design the system better to achieve faster progress. Given the need for transformative change, at national level there should be focus on designing a more effective blend of incentives, regulation, planning, targets and performance management.

4.3 NHS England and NICE policy position:

In March 2017 the board of NICE agreed a policy position regarding the introduction of new drugs. This was developed through collaboration with NHSE and a public consultation process. The stated aim was to allow the introduction of new technologies in a way that is both good for UK business and, at the same time, optimise the financial sustainability of the NHS. There are 4 key elements to the policy:

- Introduce a 'fast track' NICE technology appraisal process for the most promising new technologies, which fall below an incremental cost-effectiveness ratio of £10,000 per QALY (quality adjusted life year), to get these treatments to patients more quickly

- To operate a 'budget impact threshold' of £20 million, set by NHSE, to signal the need for a dialogue with companies to agree special arrangements to better manage the introduction of new technologies recommended by NICE

- To vary the timescale for the funding requirement when the budget impact threshold is reached or exceeded, and there is therefore a compelling case that the introduction of the new technology would risk disruption to the funding of other services

- Automatically fund, from routine commissioning budgets, treatments for very rare conditions (highly specialised technologies) up to £100,000 per QALY (5 times greater than the lower end of NICE's standard threshold range), and provide the opportunity for treatments above this range to be considered through NHSE's process for prioritising other highly specialised technologies.

NHS Wales benefits financially from the agreed NHSE and NICE policy described above however this is not the case with respect of AWMSG processes. AWMSG requires the appraisal committee to take into account the budget impact by requiring more certainty around the cost effectiveness (ICER) however there are no agreed definitions and there is no QALY threshold for very high cost drugs.

5. Practical implication of the policy tensions

5.1 Budget impact:

The nature of these drugs is that many but not all sit within specialised services. The 2018/19 planning process has identified a predicted spend for 2018/19 requiring an uplift of £18.6M. Of this uplift £5.2M (28%) is related to high cost drugs. The opportunity costs of some of these drugs are very significant, for example the cost of Ivacaftor (a drug used for treating patients with Cystic Fibrosis) per year per patient is equivalent to 5 heart transplants per year or 25 hip replacements per year.

5.2 Inequity of market access:

As described in section 4.3 NHSE have engaged with NICE and introduced a policy position which includes QALY thresholds and budget impact management. AWMSG does not have equivalent thresholds and therefore considers drugs which would not be considered within NHSE. A recent practical example is for the treatment of adult patients with cystic fibrosis who have an *R117H* mutation in the *CFTR* gene [AWMSG Reference 2680] which is now prescribed in Wales but not Scotland or England.

5.3 Managed Access Agreements:

The new policy regarding QALY thresholds and budget impact have led to development of complex managed access agreements between NHSE and pharmaceutical companies. This is managed on an all England basis by NHSE. In Wales this needs to be managed on a Health Board by Health Board basis which creates significant duplication and risks losing substantial savings opportunities. The complexities of these negotiations may put at risk the commitment of the New Treatment Fund to ensure new drugs are available within 60 days of the Final Appraisal Determination/Final Evaluation Determination (FAD/FED) being issued. Whilst not a strategic issue the practical implications is that this could undermine the implementation of strategic commitments.

5.4 Future challenges:

There are a number of challenges on the horizon related to the introduction of new drugs into NHS Wales.

1. NICE have recently consulted on whether to increase their capacity to publish 75 Technology Assessments per year. It is unclear on the likely impact on NHS Wales and AWMSG workload.
2. There is a drive from the pharmaceutical industry to develop indication based pricing which will add a significant level of complexity to both the appraisal process and implementation of the access agreements.
3. Personalised medicine is emerging as important opportunity for more effective treatment however this also brings with it new challenges for the appraisal process and the need for alignment with diagnostic services.
4. The first gene therapy treatment assessed through the NICE HST process (Strimvelis: NICE HST7) has just been approved. This is likely to be the first of many cell and gene therapy treatments presenting extremely high 'one off costs'. There is currently no framework for managing the introduction of such treatments in Wales which fall outside the NICE HST process. This is identified within the AWMSG strategy however the key stakeholder are identified as the Welsh Blood Service and the wider NHS is not included. In addition the target date is March 2019 despite a number of therapies emerging within the next 12 months.

It is clearly critical that the processes in Wales are fit for these challenges and that this is addressed in the strategies of both AWMSG and the wider NHS in Wales.

6. Conclusions

High cost drugs and new medicines represent a significant challenge in NHS Wales and, as is accepted in England, risks destabilising the NHS service because of the budget impact. To ensure that Wales can meet this challenge it is essential that policy and processes are fit for purpose. The current AWMSG strategy review provides an ideal opportunity to address these issues. Specifically WHSSC recommends the following areas should be included within the review:

1. Budget impact and ICER thresholds within the AWMSG appraisal process and alignment with NHSE. This will involve collaboration with both WG and NHS Wales.
2. The rarity premium and providing leadership on a public dialogue.
3. The balance of subjective and objective evidence consideration within the AWMSG appraisal process.
4. Introducing processes which ensure all pre-2011 AWMSG extant recommendations are considered for review.
5. Ensuring the strategy around the processes for the introduction of novel treatments such as cell and gene therapy involves a wider group of stakeholders and that this work is expedited.

In addition the Parliamentary Review which suggests a stronger executive NHS function provides an opportunity to address to the practical issues around complex managed access agreements to optimise the financial opportunities for NHS Wales and to ensure that the commitment of the New Treatment Fund is not undermined. It also provides an opportunity to consider the optimal

governance arrangements around 'arm's length' organisations such as AWMSG and Health Technology Wales.

05.03.18

Dr Sian Lewis Mb BCh MBA
Managing Director Welsh Health Specialised Services Committee. Honorary Professor Swansea University

Andrew Champion PhD, BSc (Hons)
Assistant Director, Evidence Evaluation and Effectiveness

Professor Dyfrig Hughes PhD FFRPS FBPhS FLSW
Co-Director, Centre for Health Economics & Medicines Evaluation, Bangor University. Honorary Professor, Department of Molecular and Clinical Pharmacology, University of Liverpool

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

		Agenda Item	10
Meeting Title	**Joint Committee**	Meeting Date	27/03/2018
Report Title	Thoracic Surgery Review: Implementation Plan Update		
Author (Job title)	Assistant Planning Manager (Cancer & Blood)		
Executive Lead (Job title)	Managing Director	Public / In Committee	Public

Purpose	To provide an update to Joint Committee members on actions taken in relation to the thoracic surgery review following the decisions made at the January meeting.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee		Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the information presented within the report		

10

Considerations within the report (tick as appropriate)

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

1.0 Situation

1.1 The purpose of this paper is to provide an update to Joint Committee members on actions taken in relation to the thoracic surgery review following the decisions made at the January meeting.

2.0 Background

2.1 In January 2018, the Joint Committee received a recommendation from the Thoracic Surgery Review Project Board to deliver thoracic surgery services from a single centre in south Wales. This recommendation was made further to consideration of a number of pieces of evidence on which feedback had been requested via an engagement exercise.

2.2 At the same meeting, the Joint Committee received a recommendation from an Independent Panel to site the single centre at Morriston Hospital in Swansea. This recommendation was made further to consideration of evidence against five non-financial criteria which were developed with the aid of public engagement.

2.3 Members of the Joint Committee felt the case for change was compelling and founded on non-financial information that was evidence based and patient centred.

2.4 Members approved the recommendations and requested a detailed implementation plan be submitted to its meeting in May 2018, put together by ABMUHB and CVUHB, working in conjunction with the WHSS Team, and led by a Clinical Implementation Lead, who will be appointed through a competitive process. The plan should identify any capital costs, demonstrate ongoing revenue cost neutrality or better, value for money, continued quality to meet patient needs and focus on developing a strong clinical network across south Wales with care provided locally, wherever possible, for non-surgical parts of the patient pathway. It was acknowledged that there may be transitional costs.

3.0 Assessment

3.1 Further to approval by the Joint Committee, a letter was sent by the Managing Director to ABMUHB and CVUHB. The letter provided a timeline for the submission of the implementation plan and made a number of suggestions to support the process. A copy of the letter is included in Annex (i).

3.2 It has been agreed that the responsibility for the appointment of a clinical lead to oversee the implementation phase lies with ABMUHB.

3.3 A series of meetings between WHSSC, ABMUHB and CVUHB have been arranged to support the implementation process.

4.0 Recommendations

4.1 Members are asked to:

- **Note** the information presented within the report.

5.0 Appendices / Annexes

5.1 Annex (i) Letter to NHS Wales thoracic surgery providers outlining timeline and support for implementation

Link to Healthcare Objectives	
Strategic Objective(s)	Implementation of the Plan
Link to Integrated Commissioning Plan	Implementation of the strategic review of thoracic surgery.
Health and Care Standards	Effective Care Safe Care Timely Care
Principles of Prudent Healthcare	Reduce inappropriate variation
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations
Organisational Implications	
Quality, Safety & Patient Experience	The consideration of service quality and safety, and patient experience, has been integral to the conduct of the strategic review of thoracic surgery. These principles will inform the development of the implementation plan by the service provider.
Resources Implications	The resource implications will be described within the implementation plan being developed by the service provider.
Risk and Assurance	The implementation plan will highlight the milestones and key risks to implementation.
Evidence Base	The implementation plan is being developed in the context of a robust evidence base supporting change in the service model for thoracic surgery in south Wales.
Equality and Diversity	No equality and diversity issues have been identified.
Population Health	The implementation plan is being developed as part of the overall strategic review of thoracic surgery to improve the outcomes of patients in Wales.
Legal Implications	No legal implications have been identified.

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

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

Your ref/eich cyf:
Our ref/ein cyf:
Date/dyddiad: 23 February 2018
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Fax/ffacs: 029 2080 7854
Email/ebost: sian.lewis100@wales.nhs.uk

Ms Tracy Myhill, CEO, Abertawe Bro Morgannwg University Health Board
Mr Len Richards, CEO, Cardiff & Vale University Health Board

Dear Colleagues

Thoracic Surgery Review: Implementation Plan

As you are already aware, on 29 January 2018, the Joint Committee approved the recommendations to provide thoracic surgery from a single site, and that the new unit should be based at Morriston Hospital in Swansea. Members of the Joint Committee have requested that a detailed implementation plan should be submitted to its meeting in May 2018.

This plan will need to be developed in partnership by ABMUHB and CVUHB, working in conjunction with the WHSS Team, and supported by a Clinical Implementation Lead, who should be appointed through a competitive process.

As noted in the Joint Committee brief, the plan should:

- identify capital costs;
- demonstrate ongoing revenue cost neutrality or better;
- demonstrate value for money, and continued quality to meet patient needs; and
- focus on developing a strong clinical network across south Wales with care provided locally, wherever possible, for non-surgical parts of the patient pathway.

In order to support you in the preparation of the implementation plan, we would like to propose the following:

1. Members of your finance team liaise with James Leaves, WHSSC Finance Manager (James.Leaves@wales.nhs.uk) and would request that you submit the value for money element to him by Monday 30th April. WHSSC will ensure that feedback is provided by Wednesday 2nd May, so that any further work can be completed to ensure that the papers can be circulated to Joint Committee members on Tuesday 8th May.

Welsh Health Specialised Services Committee
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Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru
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Chair/Cadeirydd: *Professor Vivienne Harpwood*
Managing Director of Specialised and Tertiary Services Commissioning/Rheolwr Gyfarwyddwr Comisiynu Gwasanaethau Arbenigol a Thrydyddol: *Dr Sian Lewis*

2. Members of your teams working on the plan have a fortnightly catch up with the WHSSC team; Luke Archard, Planning Manager for Cancer & Blood (Luke.Archard@wales.nhs.uk) will be in contact with your teams in order to arrange this.

3. We will arrange a halfway point meeting to review progress during the last week in March.

A summary of the key dates referenced above is as follows:

Week commencing 26 March 2018	Meeting to review progress on implementation plan
Monday 30 April 2018	Providers submit value for money assessment to WHSSC Finance
Wednesday 2 May 2018	WHSSC provide feedback on value for money assessment
Tuesday 8 May 2018	Submission deadline for implementation plan
Tuesday 15 May 2018	Joint Committee meeting

We understand that the appointment of the Clinical Implementation Lead is being taken forward by providers but are happy to provide support as necessary.

A copy of the thoracic surgery service specification is enclosed for your reference. Please do not hesitate to contact me or my team if we can be of help in this process.

Yours sincerely

Sian Lewis
Managing Director, WHSSC

cc Sian Harrop-Griffiths, Director of Strategy, ABM UHB
Abigail Harris, Executive Director of Planning, CV UHB
Neil Miles, Associate Service Director, ABM UHB
Paula Good, Interim Director of Operations, CV UHB
Charlie Mackenzie, Head of SLR and External Commissioning, ABM UHB
Hywel Pullen, Assistant Director of Finance, CV UHB

WHSSC Executive Directors
Luke Archard, Planning Manager, WHSSC
James Leaves, Finance Manager, WHSSC

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

		Agenda Item	11
Meeting Title	**Joint Committee**	Meeting Date	27/03/2018
Report Title	Development of a Specialised Services Commissioning Strategy		
Author (Job title)	Managing Director WHSSC		
Executive Lead (Job title)	Managing Director WHSSC	Public / In Committee	Public

Purpose	To provide the Joint Committee with a proposal for developing a specialised services commissioning strategy for Wales

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☐

Sub Group /Committee		Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Support** the proposed approach to developing a specialised services commissioning strategy for Wales		

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		✓

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1.0 Situation

The last specialised services strategy was published in 2012. During the intervening period there has been significant challenge related to the pace of development of innovative treatments and an increasingly austere financial climate. We also know that more patients require specialised services as the population ages and advances in medical technology mean that there are an increasing number of treatment options for patients with more advanced disease. These are challenges found in all modern health care systems but it is relevant to note that there is increasing disparity across the UK with a cumulative gap in annual growth since 2013/14 increasing to a range of between 8-10% between Wales and England. To ensure that despite these challenges Wales can continue to offer specialised health care which meets the principles of the Quadruple Aims will require a coherent a focused strategic approach.

2.0 Background

2.1 This strategy development proposal is limited to commissioned specialised services. The Governance arrangements of the Welsh Health Specialised Services Committee (WHSSC) are therefore outside the scope of this work although as the Committee will be aware, in January 2018, an independent parliamentary review into health and social care in Wales report included reference to these arrangements. The report stated that: *Specialist service hosting and governance arrangements need to be revisited, and the merits of consolidating these in one national location – the national executive of NHS Wales – assessed, looking at the bundle of operational and commissioning functions that need a different national home/system such as NWIS, NHS Wales Shared Services Partnership (NWSSP), specialised services and EASC.* The report is currently being considered by Welsh Government (WG) and it is expected that a formal response will be published in late April 2018.

2.2 In addition the Welsh Health Specialised Services Team (WHSST) has been undertaking work to address issues related to the interface between the WHSST and the Health Boards (HBs) described in a number of external reviews, however, because this overlaps with the WG led governance review this work will be paused and considered after April 2018.

2.3 Alongside the development of the commissioning strategy WHSST are undertaking related work to define the values of the organisation. This will involve stakeholder engagement which will also be used to feed into strategy development.

3.0 Assessment

3.1 In 2014 the then Minister for Health launched the Prudent Health Care Principles (2014) http://www.prudenthealthcare.org.uk/ . These have now stood the test of time and continue to underpin NHS Wales' policy development. The proposal is therefore that a series of strategic questions are developed, which reflect these principles, and that these questions are used as the basis of a stakeholder engagement exercise which will inform the future strategy. This approach has been tested informally with a number of stakeholder and executive peer groups and been received positively.

3.2 This document will describe the proposed questions, the stakeholders with whom the questions will be tested and process by which the strategy will be agreed.

3.3 The 4 key themes of the Prudent Principles and the proposed strategic questions falling out of the principles are summarised below:

3.3.1 **Principle 1. Do only what is needed, no more, no less; and do no harm:**

- Should the WHSS Team carry out a root and branch review of services currently commissioned to ensure we only commission those services where the WHSS Team adds significant value e.g. are there services where regional/HB commissioning would be more effective; are there services currently commissioned by HBs which would benefit from national commissioning?

- Should the WHSS Team investigate the feasibility of moving to outcome based commissioning? Currently in Wales we commission by agreeing the funded activity inputs rather than the outcomes.

- Are there existing commissioning levers (quality monitoring, policy development or contracting mechanism) which we need to use more of to ensure that our providers meet this principle? Are there other leavers that WHSST should develop to do this?

3.3.2 **Principle 2. Care for those with the greatest health need first, making the most effective use of all skills and resources:**

- Should Directors of Public Health within the HBs or Public Health Wales have a closer relationship with specialised commissioning? If so, how could this best be achieved?

- Should we more systematically join up national commissioning with national planning?

- A current example of where such closer alignment could be of value would be the commissioning of thrombectomy services for stroke and the Hyper Acute Stroke Unit model.
- How can we release value from the whole patient pathway by better alignment of specialised care and primary and secondary care planning? A current example would be streamlining the Aortic Stenosis pathway.
- If we wanted to do this more systematically what organisational arrangements would we need?

- Should WHSST carry out a systematic review of services with mapping of interdependencies to identify which current services should continue to be commissioned from providers within Wales and which elements should no longer be commissioned from within Wales? This might be the case if there was a lack of significant service interdependency and insufficient case load related to population size or new evidence for the benefits of super-specialisation*. This would also prioritise the need for future investment if there were significant issues of service sustainability.

3.3.3 **Reduce inappropriate variation using evidence based practices consistently and transparently:**

- The WHSS Team has already established an evidence based process for prioritisation of new interventions and recently established an Service Level Agreement with Cedar (Centre for Evidence Evaluation- a joint venture between Cardiff University and NHS Wales) to provide systematic evidence reviews. In addition we are developing a relationship with Health Technology Wales (HTW). Is there anything we should be doing to strengthen our approach to embedding evidence based practice into our approach to commissioning?

- WHSST are setting up quality monitoring systems which will allow us to better understand inequity of patient access. Do you have a view as to how WHSST should feed this back into local planning when we know there are variations in local systems which reduce patient's access to specialised care?

3.3.4 **Achieve health and wellbeing with the public, patients and professionals as equal partners through co-production:**

- It is a widely accepted that increased public and patient participation is important however one of the challenges for a specialised service commissioner is to achieve engagement from the public regarding strategic or technical commissioning matters rather than from a particular disease perspective. Is

there a particular approach which you think would be appropriate for the WHSST to use? Are there organisations within Wales with expertise from WHSST would learn?

- WHSST recognises the importance of value based commissioning and the key role of the patient perspective. Through which mechanisms should WHSSC engage with provider organisations and patients to agree outcome measures and what levers should be used to ensure compliance from providers with outcome measurement?
- Where different providers deliver different patient outcomes or do not benchmark well on measures of performance such as waiting times or cost what is the role, in an integrated health system, for the commissioner of a service to undertake service improvement including redesign, recommissioning of interventions and incentivisation through non-financial and/or strengthened financial measures.

3.4 **Stakeholders:**

WHSST has identified the following key stakeholders in the development of its strategy:

- CHCs
- Provider organisations (management and clinical teams)
- Commissioning HBs via Joint Committee and Management Group
- Policy section WG
- NHS Executive WG
- Medical Directors Peer Group
- Planning Directors Peer Group
- Finance Directors Peer Group
- Swansea Centre for Health Economics
- Cell and gene therapy team (WBS)
- Health Improvement and Education Wales
- NHS England and NHS Scotland
- *Patient/public focus groups regarding specific (non-technical strategic) questions?

3.5 **Process for agreeing a specialised services strategy:**

3.5.1 It is proposed that a formal consultation process is undertaken which uses a blended approach of written/electronic feedback and feedback from stakeholder meetings. Focus Groups will be established to capture patient and public feedback.

3.5.2 This feedback will be used to develop a draft strategy document for consideration by both the Joint Committee and WG. The timetable for this

work will need to be confirmed when the arrangements for the Thoracic Surgery Consultation process are agreed.

4 Recommendations

4.3 That the Joint Committee consider this approach to strategy development for specialised services

4.4 Members are asked to:

- **Support** the proposed approach to developing a specialised services commissioning strategy for Wales

5 Appendices / Annexes

5.3 There are no appendces

Link to Healthcare Objectives	
Strategic Objective(s)	Organisation Development
Link to Integrated Commissioning Plan	
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Only do what is needed
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Improving Health of Populations Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	Influenced by organisational strategic priorities
Resources Implications	Influenced by organisational strategic priorities
Risk and Assurance	Influenced by organisational strategic priorities
Evidence Base	Influenced by organisational strategic priorities
Equality and Diversity	Influenced by organisational strategic priorities
Population Health	Influenced by organisational strategic priorities
Legal Implications	Influenced by organisational strategic priorities

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

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

		Agenda Item	12
Meeting Title	**Joint Committee**	Meeting Date	27/03/2018
Report Title	January 2018 Integrated Performance Report		
Author (Job title)	Performance Analyst		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	Public

Purpose	The attached report provides members with a summary of the performance of services commissioned by WHSSC for January 2018 and details the action being undertaken to address areas of non-compliance.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☒	☐	☐	☒

Sub Group /Committee		Meeting Date	
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** January 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		✓

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WHSSC Integrated Performance Report

January 2018

WHSSC

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Table of Contents

JANUARY 2018 WHSSC PERFORMANCE REPORT

1.0 Situation

The purpose of this report is to provide an overview on the performance of providers for services commissioned by WHSSC for the period January 2018.

2.0 Structure of report

ESCALATION

The escalation section provides a summary of the services that are in escalation and the level of escalation.

PROVIDER PERFORMANCE

Section 1 Provider Dashboard

The report includes an integrated provider 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.

The dashboard has the following domains:

- Indicator Reference;
- Provider – In section 2 aggregate data is used from all providers, in sections 4 onwards, is the exception report providing further detail on services that are not meeting targets;
- 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; and
- Latest Movement – this shows movement from the previous month.

Section 2 Individual Service Sheets

Further detail for each service is provided on an individual sheet and covers current performance against RTT that includes a three month trend, a summary of key issues and details the action being undertaken to address areas of non-compliance.

3.0 Escalation

The table below shows the current services that WHSSC has placed at Stage 2 and above of the escalation process. Although the Bariatric Surgery service remains at a static position at Stage 4, the services for Neurosurgery, CAMHS and Paediatric Surgery services are at Stage 3 which require Commissioning Quality Visits as part of the WHSSC escalation process.

A 2nd visit has already taken place with the CAMHS service provider resulting in an agreed action plan with next meeting planned in March as part of the Level 3 escalation process. The action plan has been developed with BCUHB and significant improvements have been made in both capacity and workforce. There is however a new issue with medical staffing and interim plan has been implemented whilst long term options are considered.

The next visit scheduled will be to the Paediatric Surgery service provider and is planned for January 2017 with the Neurosurgery Service visit to take place later in the New Year.

The first performance meeting with regard to the Lymphoma Panel was held on Friday 1st December. Assurance was provided that while turnaround times have worsened due to laboratory staff sickness, patient clinical outcomes have not been compromised. Turnaround times are expected to improve over the next couple of months as staff return from sickness leave. A full report on the Lymphoma Panel performance will be provided within the next month's performance report.

The Bariatric surgery service at ABMUHB is currently at escalation level 4. WHSSC's intention is to tender for the future provision of the service. However, due to the significant improvement in performance in recent months, WHSSC has paused the tender while a process is implemented to assess the ABMUHB service against the service specification and delivery requirements, with a view to potential de-escalation. This is provided the service can demonstrate to the Joint Committee the ability to meet the requirements and standards set by WHSSC.

The majority of the Plastic Surgery pathway workshops have been held; two workshops (breast surgery at Cwm Taf, and hand surgery at Cardiff & Vale) are still outstanding. These are being re-scheduled to take place in January/February. The final clinical summit meeting will take place following the conclusion of the workshops.

Paediatric Intensive Care has been placed at escalation level II and the service was issued with a letter on the 21st of December notifying them of this. The next step is for a performance meeting to take place with the service and this is in the process of being scheduled for late January.

3.0.1 Services in Escalation

Specialty	Level of Escalation	Current Position	Movement from Last Month
Cardiac Surgery	2	Monthly performance meetings continue with ABMUHB and C&VUHB.	⇨
Thoracic Surgery	2	Monthly performance meetings continue with ABMUHB and C&VUHB.	⇨
Lymphoma Panel	2	Performance meetings are in place with the All Wales Lymphoma Panel (CVUHB and ABMUIHB).	⇨
Bariatric Surgery	4	WHSSC has paused the tender while a process is implemented to assess the ABMUHB service against the service specification and delivery requirements	⇨
Plastic Surgery	2	Monthly performance meetings continue with ABMUHB	⇨
Neurosurgery	3	The Commissioning Quality visit is on hold until the Paediatric Quality has been completed in January.This is to ensure that the planning and the lessons learnt from these visits are consistent across all the WHSSC services.	⇨
Adult Posture & Mobility	2	Quarterly meetings occur with all three providers but discussions have taken place separately with North Wales regarding their worsening position.	⇨
CAMHS	3	An action plan has been developed with BCUHB and significant improvements to workforce issues have been made in last 3 months.	⇨
Paediatric Surgery	3	The commissioning quality visit took place on the 26th of January, the actions are currently being finalised with the HB. An outcome letter will be sent to the provider in due course.	⇨
Paediatric Intensive Care	2	The first performance meeting took place on the 30th of January and these will continue to take place on a monthly basis to seek assurance from the service.	⇨

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4.0 PROVIDER PERFORMANCE

The trend for performance for all provider services has largely remained unchanged for the three quarters of 2017/2018. Of the 19 provider service targets that were monitored by WHSSC, 12 (71%) remain in breach at end of January 2018.

4.1 Section 1 Service Dashboard

Commissioning Team	Specialty	WHSSC Indicator Ref	Measure		Tolerance Levels			Provider	Nov-17	Dec-17	Jan-18	Latest Status	Latest Trend
					Red	Amber	Green						
Quality	**Serious Incidents**	S01	Qrtly	Number of new Serious Incidents reported to WHSSC by provider within 48hours	<50%	50-99%	100%			50%			⇧
Cardiac	**Cardiac Surgery**	E01	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	96%	97%	96%		⇩
Cancer & Blood	**Thoracic Surgery**	E02	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	99%	99%	99%		⇨
	Lung Cancer	*E02D*	Mthly	USC lung resection < 62 days	>0	N/A	0	All	-	-	-		⇩
		E02E	Mthly	NUSC lung resection < 31 days	>0	N/A	0	All	-	-	-		⇩
	Bariatric Surgery	E03	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	100%	100%	100%		⇨
	Cancer patients - PET scans	E04	Mthly	Cancer patients to receive a PET scan < 10 days from referral	<90% within 10 days	90-95% within 10 days	=,>95% within 10 days	All	100%	98%	99%		⇧
	Plastic Surgery	E05	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	94%	94%	95%		⇧
	Lymphoma	E06	Mthly	Specimens tested ≤10 days	<90% within 10 days	N/A	=,>90% within 10 days	All	60%	52%	-		⇩
Neuro	**Neurosurgery**	E07	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	90%	92%	92%		⇨
	Adult Posture & Mobility	E08	Mthly	RTT < 26 weeks	<85% within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	All	86%	86%	85%		⇩
	Paediatric Posture & Mobility	E09	Mthly	RTT < 26 weeks	<85% within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	All	94%	93%	94%		⇧
Mental Health	**CAMHS**	E10	Mthly	OOA placements	>16	>14, <16	=,<14	All	12	11	10		⇧
		E10i	Mthly	NHS Beddays	<85%,>105%	< 90%, >100%	90% - 100%	All	79%	68%	79%		⇧
		E10ii	Mthly	NHS Home Leave	<20%, >40%	<25%, >35%	25%-35%	All	22%	35%	30%	4	⇩
	Adult Medium Secure	E11	Mthly	NHS Beddays	<90%, >110%	< 95%, >105%	95% - 105%	All	85%	90%	94%		⇧
Women & Children	**Paediatric Surgery**	E12	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	96%	98%	96%		⇩
	IVF	*E13*	Mthly	IVF patients waiting for OPA	<95% within 26 weeks	95%-99% within 26 weeks	100% within 26 weeks	All	100%	100%	-		⇨
		E13i	Mthly	IVF patients waiting to commence treatment	<95% within 10 weeks	95%-99% within 10 weeks	100% within 10 weeks	All	72%	55%	-		⇩
		E13ii	Mthly	IVF patients accepted for 2nd cycle waiting to commence treatment	<95% within 10 weeks	95%-99% within 10 weeks	100% within 10 weeks	All	53%	35%	-		⇩

Please note there is a delay for Lung Cancer data as this is currently being submitted to WHSSC by Welsh Government.
IVF data has not been received for January.
Lymphoma is to be reported quarterly for future iterations.

4.2 Key Issues for January 2018

Cardiac
There continues to be small numbers of patients waiting over the 36 weeks maximum waiting time target for cardiac surgery patients at CVUHB and Liverpool. Improvement has been made in ABMU with no breaches in January. A letter has been written to Liverpool Heart and Chest informing them of WHSSC intention to place the Cardiac Surgery Service at Stage 2 of the escalation process

Plastic Surgery
Patients continue to breach maximum waiting times for hand and breast surgery at ABMUHB. While the delivery plan for 2017/18 set out a profile to eliminate breaches of 36 weeks by March 2018, the forecast year end position is that this will not be achieved.

Bariatric surgery
Currently there are no breaches at either centre; however, ABMUHB is currently underperforming against the baseline. Further information regarding demand, activity and capacity is expected from ABMU in order to inform the next steps.

Neurological & Chronic Conditions
Neuro-Radiology: 36 patients were waiting for an embolization at the end of January, with the longest wait of over 39 weeks on the Neurosurgical waiting list. Additional Saturday lists were being considered, as a plan to manage the angiogram waiting list. The proctorship arrangement with Birmingham is working well; this arrangement would continue to manage the complex cases.
Neurosurgery: There has been a continued downward trend, since September of the number of patients waiting over 36 and 52 weeks, with 84 patients waiting over 36 weeks in January compared to 128 patients in December. Of the 2 patients waiting over 100 weeks, both have dates for procedures to be undertaken in March.

CAMHS
CAMHS Out of Area (OoA) performance is starting to improve as the North Wales unit increases capacity back towards the commissioned level. The increase in OoA placements was linked directly to reduced capacity in the North Wales unit due to severe staff shortages. The position has now stabilised and the total number of OoA placements has fallen from 17 in July to 11 in January.

Women & Children
Paediatric Surgery: The Health Board reported 0 patients waiting over 52 weeks and 51 patients waiting over 36 weeks, this is an increase on previous months. The Commissioning Quality Visit took place on the 26th of January 2018, the action notes and log are in the process of being agreed.

IVF
The Hewitt Fertility Centre in Liverpool have no reported waiting list, however activity has been higher than anticipated leading to capacity constraints within the funding available. Discussions are underway to identify the funding required to maintain the

service, balanced with the significant waiting times reported in Shrewsbury for which further information has also been requested. A meeting is being scheduled with Shrewsbury to better understand their reporting processes and numbers.

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

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

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

		Agenda Item	13
Meeting Title	**Joint Committee**	Meeting Date	27/03/2018
Report Title	Financial Performance Report – Month 11 2017/18		
Author (Job title)	Assistant Director of Finance		
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 11th month of 2017/18. There remains material uncertainty regarding the risk of HRG4+ price increases proposed by NHS England providers and their applicability to Wales. The financial position is reported against the 2017/18 baselines following provisional approval of the 2017/18 Technical Plan by the Joint Committee in March 2017.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Joint Committee	Meeting Date	
	Management Group	Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the current financial position and forecast year-end position. • **Note** the residual risks for the year including the HRG4+ risk.		

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		✓

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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

2.1 The financial position is reported against the 2017/18 baselines following provisional approval of the 2017/18 Technical Plan by the Joint Committee in March 2017.

2.2 There remains material uncertainty regarding the risk of HRG4+ price increases proposed and reported by NHS England providers and their applicability to Wales. To avoid duplication, please see section 5.8 regarding NHS England as a Provider in the main body of this report for further detail.

2.3 The risk shares percentages utilised in this financial year remains unchanged from 2016/17 as WHSST are concluding a risk share review of the current mechanism. To maintain financial sustainability, this has been agreed with the WHSST Finance Working Group that no updates are required in this year in order to achieve a consistent financial framework.

3.0 Assessment

3.1 The financial position reported at Month 11 for WHSSC is a forecast overspend to year-end of £1,845k.

The deterioration in the year end position of £2,130k includes deterioration against the Welsh contracts mainly Cardiff and Vale and Velindre and Non Welsh SLAs and IPFR. Small improvements were reported in Mental Health and Development lines.

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.
- **Note** the residual risks for the year including the HRG4+ risk.

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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.

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	Reported performance is based on reported financial and activity schedules underpinned by contracting information and communications from provider organisations.
Equality and Diversity	There is a greater financial risk exposure to the populations of North Wales and Powys from contractual relationships with NHS England providers. However, there is a lower service sustainability risk exposure in these areas from access to services which are typically have larger critical mass serving larger populations.
Population Health	Not applicable
Legal Implications	Not applicable

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

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Finance Performance Report – Month 11

1. Situation / Purpose of Report

The purpose of this report is to set out the estimated financial position for WHSSC for the 11th month of 2017/18 together with any corrective action required.

The narrative of this report excludes the detailed 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 only, the consolidated position is summarised in the table below.

Table 1 - WHSSC / EASC split

	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	556,564	510,184	512,112	1,929	2,156	1,845	2,130
Sub-total WHSSC	**556,564**	**510,184**	**512,112**	**1,929**	**2,156**	**1,845**	**2,130**
WAST	139,871	128,215	128,215	0	0	0	0
EASC team costs	390	358	372	14	5	0	0
QAT team costs	709	650	664	14	5	0	0
Sub-total WAST / EASC / QAT	140,970	129,223	129,251	28	10	0	0
Total as per Risk-share tables	697,534	639,406	641,363	1,957	2,166	1,845	2,130

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 2017/18 baselines following provisional approval of the 2017/18 Technical Plan by the Joint Committee in March 2017. 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 11 is an overspend of £1,929k to date, with a forecast year-end underspend of £1,845k.

The majority of NHS England is reported in line with the previous month's activity returns (Month 10). WHSSC continues to commission in line with the contract intentions agreed as part of the IMTP and 2016/17 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 partially mitigated in 2017/18 as financial baselines have been uplifted based on historic activity. Reported variances are currently in line with this intention.

In general terms, due to the highly specialist nature of services commissioned via WHSSC on behalf of Health Boards, the last quarter of the financial tends to be particularly volatile as winter pressures emerge across specialist providers. This year has been no exception to that and data is now starting to show some one off high costs patients relating to respiratory conditions such as ECMOs and PICU as well as high admissions to ITU and HDU units has been a consistent trend throughout the year.

In addition, the Department of Health has announced a decision to slow elective routine procedures through January 2018. The outcome of this decision will not be known to commissioners for Welsh patients until March 2018 when the January activity data has been cleansed.

3. Governance & Contracting

All budgets have been updated to reflect the 2017/18 approved IMTP, including the full year effects of 2016/17 Developments. The IMTP sets the baseline for all the 2017/18 contract values. This has been translated into the new 2017/18 contract documents.

Distribution of the reported position has been shown using the 2016/17 risk shares based on 2015/16 outturn utilisation. The Finance Working Group has worked on validating prospective changes to the risk-sharing process, and ongoing updates are being shared with Management Group and Joint Committee regularly. To maintain financial sustainability, it has been agreed with the WHSST Finance Working Group that no updates are required to distribution shares in this year in order to achieve a consistent financial framework. A meeting was held of the Joint Committee in January 2018 whom discussed the final proposal of the risk share mechanism. This latest proposal has now been approved in line with the discussions held between the WHSST Director of Finance and Welsh Government, Joint Committee, All Wales Directors of Finance, WHSSC Management Group supported by the work of the WHSSC Finance Working Group.

WHSST is currently working through implementation of this decision in due course. This will not impact on the WHSSC 2017/18 financial position by Heath Board.

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

Table 2 - Expenditure variance analysis

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	187,484	171,860	174,243	2,383	1,397	2,766	1,996
Abertawe Bro Morgannwg Univ Health Board	95,832	87,846	88,876	1,030	943	1,190	1,243
Cwm Taf University Health Board	7,452	6,831	7,045	213	52	232	79
Aneurin Bevan Health Board	8,833	8,097	8,267	170	89	175	89
Hywel Dda Health Board	1,486	1,362	1,456	94	120	94	120
Betsi Cadwaladr Univ Health Board Provider	38,137	34,959	34,919	(40)	(7)	(44)	(9)
Velindre NHS Trust	38,421	35,219	35,720	501	(12)	540	(22)
Sub-total NHS Wales	**377,645**	**346,175**	**350,526**	**4,351**	**2,581**	**4,953**	**3,497**
Non Welsh SLAs	95,774	87,793	94,360	6,567	6,108	5,317	5,013
IPFR	28,458	26,087	26,462	375	95	987	509
IVF	4,375	4,010	4,334	324	231	305	188
Mental Health	32,681	29,958	27,138	(2,819)	(2,242)	(3,009)	(2,744)
Renal	5,121	4,694	4,435	(259)	(337)	(276)	(361)
Prior Year developments	5,514	5,054	4,426	(628)	(545)	(566)	(499)
2016/17 Plan Developments	3,395	3,112	2,650	(463)	(660)	(440)	(560)
Direct Running Costs	3,601	3,301	2,995	(306)	(289)	(212)	(161)
Reserves Releases 2016/17	0	0	(5,214)	(5,214)	(5,168)	(5,214)	(5,168)
Phasing adjustment for Developments not yet implemented ** see below	0	0	0	0	0	0	0
Total Expenditure	**556,564**	**510,184**	**512,112**	**1,929**	**(228)**	**1,845**	**(286)**

The reported position is based on the following:

- NHS Wales activity – based on Month 10 data.
- NHS England activity – Month 10 data in most cases.
- IVF – Month 10 data and prior approval requests.

- IPC/IPFR – based on approved Funding Requests; reporting dates based on usual lead times for the various treatments, with unclaimed funding being released after 36 weeks.
- Renal – a variety of bases; please refer to the risk-sharing tab for Renal for more details on the various budgets and providers.
- Mental Health – live patient data as at the end of the month, plus current funding approvals. This excludes High Secure, where the Merseycare contract is calculated using the previous 3 years average occupancy and thus block for the year.
- Developments – variety of bases, including agreed phasing of funding. Financial impacts of approved funding releases are currently accounted for in the forecasts.

5. Financial position detail - Providers

5.1 NHS Wales – Cardiff & Vale contract:

Various over and underspends from the Month 10 data have been extrapolated to a total Month 11 position of £2.383m overspent, with a year-end forecast of £2.766m overspent. These figures include the net effect of the development and savings funding available to the LHB. The position includes the following areas:

- Cardiology – activity remains buoyant in this area (particularly with PCI and ICD procedures). The overperformance has reduced slightly in month with the overspend now standing at £707k across all 5 sub-headings which is a decrease of £27k over last months figures due to a slight reduction in ICD activity. This overperformance is a continuing trend (as it was last year) and the increase can be attributed in the most part to a new embedded process of intensive post op review and thus faster discharge of PCI patients. WHSSC is working with the programme team and the network to assess this area. Please note that budget for 16/17 planned recurrent overperformance has been moved to the Developments area whilst the policy is reviewed. The growth in activity for 17/18 is currently above these levels and the year end forecast, including development funding currently stands at a £1.9m overperformance.

- Cardiac Surgery – low activity means the trend of underperformance remains in this area with the YTD underspend across the 3 sub headings increasing to £653k. This position is unlikely to improve as the service have confirmed that the number of cases "lost" year to date will not be recovered. Theatre team availability is still an issue and the year end forecast will worsen as AMBU referrals to Cardiff & Vale stopped at month 3. The year end forecast now stands at £712k underspent.

- TAVI – WHSSC has reviewed the position in relation to C&Vs contractual requirement to seek prior approval for TAVI procedures. The LHB has not complied with WHSSC policy or the signed Service Level Agreement in relation to this and have been submitting IPFR documentation in relation to TAVI procedures retrospectively. This has not been in some isolated cases but rather a continued and systematic failure to comply with the policy this financial year. As such, WHSSC has taken the decision not to exercise it's full contractual rights and decline all funding, but offer to fund 50% of all TAVI procedures from 1st April to Jan 31st 2018 as a gesture of goodwill. This has resulted in a £412k reduction in TAVI spend YTD (£42k removed from Cardiology and

£370k from the TAVI line). These reductions have been extrapolated into the forecast position.

- Neurosurgery – the service continues to overperform and the YTD and full year variances have increased to £84k and £85k respectively. The numbers for INR outsourcing now include patients referred to The Walton and thus account for the increase. This position also includes declared slippage by the LHB on the core neurosurgery and neurovascular surgery investments.

- ISAT - Coils – the YTD and full year forecast positions have both swung dramatically this month. They now stand at £136k and £90k respectively. This is a result of a more realistic price per device for the INR outsourced patients and the fact that the Walton patients have now been included in the figures. This means we have 34 patients YTD and 38 as a full year forecast.

- Haemophillia – the volatility in this service has come to bear this month with the figures still in overperformance but falling by £96k YTD and £129k full year. The over spends now stand at £130k and £142k respectively.

- BMT– the YTD figure remains in an underspend and has moved by £92k in month to £482k. The forecast from the service remains at 131 cases as per data from the service. The monthly profile of this forecast is not known and thus explains the YTD volatility but the stability of the full year forecast.

- PICU – the YTD underspend remains constant in this area, currently standing at £157k. The forecast has been moved to mirror the YTD position as the winter pressures have not hit the service as predicted. The activity within the service has not declined but rather they are caring for English patients and HDU patients that do not fall under the WHSSC contract.

- Clinical Immunology – the overspend has increased YTD and full year and now stands at £300k and £408k respectively. This is a result of invoices received from LHBs that C&V were not expecting or informed of. The forecast is based on C&V calculation.

- ALAS – the YTD position has increased this month and now stands at £288k overspent, an increase of £83k over last month. The overperformance seems to be a result of increased staffing levels as a result of maternity leave ending and thus unplanned chair replacement cycles increasing. The spend on Communication Aids is covered by a balance sheet provision and is thus removed from the figures. The full year forecast is moved to straight line and stands at £400k in order to be prudent.

- AICU – the YTD position has increased by £131k and now stands at £897k overspent. The forecast position has been moved to £1.146m as a result of a more detailed forecast being provided by the LHB. The position is driven by 4 long stay patients who are over 100 days, one patient is yet to be discharged. The outsourced INR patients referred to The Walton have now been included in the figures and thus increase the YTD position more than the full year forecast as we are assuming there will be no more patient flows this year. The YTD and full year forecast are partially offset by development. Due to the increase in performance over previous years, WHSSC are investigating the data with the LHB and are meeting the service this month.

- NICU – activity has increased this month that has meant the model has applied a different marginal rate to C&V activity resulting in the £314k movement YTD with the figure now standing at a £302k underspend. C&V have spoken to the service about this activity and have obtained figures that show this will be a continuing trend and thus mean the figures should not swing back next month.

5.2 NHS Wales – ABM contract:
Various over and underspends from the Month 10 data have been extrapolated to a month 11 position of £1.030m overspent, with a year-end forecast of £1.190m overspent. These figures include the net effect of the development and savings funding available to the LHB. The position includes:

- Cardiology – the YTD position has increased this month by £112k and now stands at £558k overspent (£942k in total with £479k offset by development funding). This is a result of an increase in defibs and the risk around ablation increase to meet RTT pressure materialising. This translates into the full year forecast standing at £1.130 m overspent in total which is partially offset by development funding.

- Thoracics – the year to date position has grown again this month by £49k and now stands at an overspend of £529k. This is a result of extra resections undertaken by the service and they have continued to advise this is unsustainable throughout the year but the YTD data does not support this statement and thus the full year forecast is moved to £577k overspent.

- TAVI – the YTD position has increased by £42k to an overspend of £324k. The forecast remains at £347k, 44 procedures, with development funding partially offsetting this.

- Plastics – activity has fallen sharply this month by £172k and currently stands at an underspend of £210k YTD. The forecast has been moved to mirror this and ABMU are looking into the data to ensure this sharp drop is accurate.

- Burns – the service continues in it's current trend of overperformance, albeit with a slowdown this month. The YTD position now stands at £267k over budget and thus the forecast has been increased to £275k to be prudent.

- Cardiac Surgery – underperformance has increased this month to £494k. The forecast has been increased this month to £509k underspent, the forecast numbers of 680 procedures remains but the casemix has changed.

5.3 NHS Wales – BCU contract:
There has been a further deterioration in the angioplasty position this month meaning the underperformance has grown to £246k. This trend is at odds with other LHBs and is being investigated by WHSSC. The forecast for the service has been left constant and stands at £268k under budget. The trend for ICDs is at odds with this as overperformance has grown this month to £264k and the full year forecast remains static and stands at £288k over budget.

5.4 NHS Wales – Cwm Taf contract:

There has been a large spike in CAMHS activity this month with 15 admissions resulting in a £163k increase in overperformance meaning the YTD position stands at £224k overspent. The forecast has been moved to £240k to take account of this.

5.5 NHS Wales – Aneurin Bevan contract:
Cardiology now stands at an overperformance figure of £70k and the forecast position has been extrapolated to £76k. Neonatal care has increased YTD and now stands at £113k over budget. Cwm Taf and Powys are the largest user of this service relative to their respective baselines.

5.6 NHS Wales – Hywel Dda contract:
No material variances to report at this point in the year.

5.7 NHS Wales – Velindre contract:
The Velindre forecast over performance of £540k is due to a significant increase in the reported Melanoma drug spend. The volatility in Velindre's monitoring of £690k between November and December is due to a change in the reporting methodology. This also reflected by a decrease drug spend within the HB - Velindre LTA's. Therefore the overall impact should be neutral for commissioners.

5.8 NHS England contracts:
The total overspend to month 11 is £6,567k, which is an improvement of £459k from Month 10. The year-end forecast has moved from £5,013k last month to £5,317k, a deterioration of £304k.

The English position has been reported using Month 10 monitoring returns in most cases, and encompasses the two separate issues of:

- additional activity/growth
- increased costs relating to the new HRG 4+ coding system

The additional costs relating to HRG 4+ have been reported in full within the year to date position of £6,567k, but have been, in the main, excluded from the year-end forecasts with those providers that are overspending. The costs have NOT been excluded where the extraction of the HRG 4+ price impact would reduce the reported position on an individual provider from an overspend to an underspend, these positions have been set to breakeven. Where the extraction would cause the underspend to increase, these positions have not been moved; these non-excluded costs amount to £2,566k of the £5,317k forecast. Hence, the forecast overspend costs related just to growth in activity total £2,751k. At a subjective level, the £2,751k will include some additional pricing increase, which will either be as a result of activity growth in year or potential 'up-coding' of activity due to the new grouper attracting higher prices. This is explained in the high level analysis sent separately. WHSST is still working with NHS Improvement and its provider organisation to articulate the impact HRG4+. Provider organisations are getting increasingly more concerned as year end approaches. Activity increases in 2017/18 are not part of the HRG 4+ discussion with Welsh Government and NHS

Improvement and therefore will need to be included in the forecast position and provided for by Health Boards.

The total overall impact from proposals for HRG 4+ has remained at £6,302k. WHSST has completed a high level review of the methodology used to analyse the forecast of which includes HRG 4+. This has resulted in some movement in ratios between price and volume which have been updated in the separate return to Welsh Government; however, this did not materially change the split for most contracts. WHSST will complete further work coming up to year end. The decision made by the Department of Health to slow elective activity for January 2018 may not have affected all English contracts WHSST holds. Some providers brought more capacity on line to be able to cope with Non-Elective work whilst maintaining Elective lists. From the data provided to WHSST, a higher level of non-elective activity has been reported for month 10. WHSST will consider how these impacts on the year end position and the impact this type of activity may have had on other areas e.g. ITU. By way of a note, this will transfer an element of risk into the 2018/19 financial position as the elective activity trajectory is profiled.

As at Month 11, the residual risk of HRG 4+ exposure stands at circa. £3,736k (£6,302k-£2,566k) which is not reported in the financial forecast position and has been reported in our Table G in the Monitoring Returns. If all these forecast costs materialise, on top of the some activity outstanding on transplant waiting lists etc and increased emergency related activity, it would create a total overspend on NHS England of £9,903.

This reporting methodology used by WHSSC has been discussed and it has been agreed with Welsh Government finance officials and the Joint Committee to continue for month 11 pending progress on further formal discussions with NHS England. A meeting has been held between NHS Wales finance colleagues from Welsh Government, Health Board representatives, WHSST and NHS Improvements but no conclusion was reached.

At this point WHSST will retain the agreed reporting methodology until further notice.

Separate 'High Level' schedules will be sent to LHB's showing these figures reconciled to all the NHS England providers, along with the split across the individual LHB's. Please note that The schedule breaks down the elements that are HRG4+ related and then the remainder that are either driven by price, volume or a combination of both. The split between price and volume impacts is an assessment done by WHSSC based on our experience of the contracts. Whilst this has been reviewed this month, please bear in mind that these are still subjective as we're currently working with the providers to attribute whether an increase in volume/price is down to coding or the new groupers which is resulting in higher casemix levels compared to last year.
Regarding activity growth, there is a further most prudent forecast of an additional £850k relating to unprecedented activity growth and seasonal variation particularly relating to through cost areas such as drugs. This has been included

in the Risks Table G in the Monitoring Returns, but is not part of the financial forecasts. If these further prudent costs materialised, it would create a total overspend on NHS England of £9,903k (the previous total of £10,862k).

The larger reported variances include:

- Alder Hey Children's Core contract – forecast overspend of £1,680k. WHSST have worked with BCUHB in the last month to agree a year end settlement with Alder Hey to minimise further volume and demand risk. Corrective action is required by the Health Board to reduce this further into next year. In addition, the level of overperformance in this contract, was raised and disputed by the provider's Director of Finance to be brought in line consistent with their English commissioners. This month's position reflects the agreed year end settlement and therefore mitigates any further disputes relating to this for this financial year.

  Blood Factors – overspend of £132k to date due to one high cost patient and was included in the settlement.

- Central Manchester – returned to a forecast underspend of £124k being a improvement of £210k from previous month. This contract remains extremely volatile and has experienced large movement over the last couple of months. Activity for Month 10 was much lower than expected.

- Christie – Forecast at breakeven at Month 11 which is an improvement of £95k. Again another extremely volatile contract with peaks and troughs this year month on month. Contract is subject to low volume high cost cases and therefore accurate forecasting is difficult.

- Imperial – forecast overspend of £706k, deterioration of £114k in the forecast represents a prudent estimate for the drug growth for the remainder of 17/18. In month, a high cost over £100k cardiac patient has caused the movement.

- Liverpool Heart & Chest - the reported over performance of 1,439k to date which is mainly an HRG 4+ issue. A fully adjusted forecast for HRG4+ would take the contract to an underspend position. In the context of the overall contract which is exposed to winter pressures, it is highly likely that activity will increase in the later part of the year and therefore have returned the forecast to break-even.

- Royal Brompton – A slight improvement in the overspend this month reducing by £100k. Generally the overperformance on this contract is mainly due to activity, and not HRG 4+ issues as such. The cost of activity outside the national tariff is currently higher than in 2016/17. Therefore whilst this contract has been adjusted for HRG 4+, an additional value has also been included to take into account the non PBR overperformance. This element is

reflected in the year-end forecast which includes additional lung transplants as well as a provision for ECMO WIP. The current waiting list has 12 lung transplants. General increase in cardiothoracic transplant costs and high levels of ITU above baseline are also included.

- University Hospital Bristol - the reported over performance of 574k to date relates to the HRG 4+ issue. Congenital Heart surgery remains high in 17/18 with a number of high cost patients. Activity to month 10 stands at 240 at a cost of £3.508m in 17/18, against 104 and £1.545m in 16/17. However the last 2 months have seen a drop off in the number of procedures undertaken. PBR activity is currently £1,207k higher this year 17/18 than at the same point in 16/17. Non PBR activity is currently £693k lower this year to date when compared to the same position in 2016/17. This contract has been offset by a saving in appropriate bed utilization i.e. HDU beds being used where appropriate as they were admitted to PICU previously which was double the cost. Forecast is based on reversing out HRG4+ until we reach breakeven.

- Walton Centre – overspend to date of £1,220k with M10 being the highest level of activity to date mainly due to non elective Neurosurgical cases being both high volume and high cost. This has caused a swing of £294k. Activity to M10 includes NICE drug overperformance of £260k. In addition previous months have included increased Neuro Rehab costs have been reported this month. Whilst the remaining overperformance appears to be tariff driven and has been adjusted out in the forecast position this does not correlate with the providers assessment of the HRG 4+ comparison. Therefore the pricing impact for this provider is likely to be understated.

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 and are shared for transparency.

5.9 IPFR:

Various budgets totalling an overspend to year-end of £987, a movement of £477k mainly relating to the core non contracting activity line. As experience in other contracting areas, non elective activity has increased in Month 10 and therefore it is expected in this area. Please note that all forecasts are extrapolated from the to-date positions except the VAD and ECMO lines, where the underspend to date has been lower compared to 2016/17. As lower activity in the first few weeks of the year does not indicate this will continue for this small patient cohort, the assumption is that future months will mirror last year.

5.10 IVF:

An overspend of £305k has been reported against English and private providers for year-end as activity is expected to increase beyond planned level for the year.

5.11 Mental Health:
Various budgets totalling an underspend to date of £2,242k and a year-end forecast underspend of £2,744k. This has been in part enabled by the effect of the £500k invested in the Case Management team, and illustrates the benefits of effective investment for both financial and quality (right care level, right time) reasons.

The MH financial position includes:

- The High Secure contract with Ashworth has been finalised for 2017/18 as £10,656k, against the Annual Plan budget of £10,767k, leading to a small underspend for the year. The Rampton budget is also underspent due to NHS England continuing to pay for one Welsh DSPD patient this year in line historic agreements in this care category.

- Medium Secure has a reported underspend of £2,098k to date, based on current and expected patients. This area is currently forecast to have a year-end underspend of £2,375k due to several discharges so far this year.

  The new Case Management teams funded in 2016/17 are now progressing through their recruitment, and it was expected that the increased clinical support in this area would reduce patient numbers going forward as staff come into post. The investment of £500k has saved in excess of £1.25m for South Wales within the Medium Secure costs, with the added positive factor of patients receiving appropriate care. BCU now have clinical leads in post and further savings are anticipated.

  DTOC recharges totalling £167k to two LHB's have been raised to date in respect of 7 patients, who have now all been discharged from Medium Secure.

- South Wales CAMHS and All-Wales FACTS inpatient budgets have continued low activity and currently have a combined underspend of £476k to date and projected £520k year-end.

- The BCU CAMHS inpatient budget has an overspend of £274k to Month 11 due to high occupancy at the start of the year. However, following on from the escalation process, the actions outlined by the unit to increase nurse staffing and return to funded capacity have started to take positive effect, and the current year-end forecast position is £203k overspent based on current occupancy remaining static.

5.12 Renal:
Regarding the devolved renal funding held by the WRCN, cross border services provided by NHS England continue to be lower than expected. Renal transplant services provided by the Royal Liverpool and Broadgreen Trust are continuing to be lower than predicted in their service delivery plan, which has created a significant in year financial underperformance. Although the assumptions in their

plan remain robust, the availability of suitable organs and donor matching has been lower than expected. Offsetting this reduced activity, 5 renal transplants have been undertaken by University Hospitals Birmingham and 5 have been undertaken by Central Manchester University Hospitals. For both Trusts, although the numbers may seem small, this is an unprecedented level of activity and provides reassurance that access to transplant services is fully available to all Welsh patients. Meanwhile, cross border dialysis services are broadly balancing out across providers.

The WRCN is taking on board significant activity increases and associated cost pressures experienced by ABMU relating to the West Wales dialysis units and from Cardiff and Vale relating to the SE Wales units. As part of the 17-18 WHSSC ICP process the Joint Committee was asked to support increases in the numbers of patients across Wales requiring chronic renal dialysis. As this is a necessary life sustaining therapy, the Joint Committee agreed to set aside recurrent funding for the additional activity. Validation exercises have been undertaken by both providers to support their reported activity increases, which are now fully reflected in the WRCN and WHSSC financial reporting.

As with the Liverpool service, the number of transplants undertaken by the Cardiff transplant team since April is lower than predicted. However, data received by the service confirms that this is not having an adverse impact on waiting list numbers which remain stable and continue to be among the lowest in the UK.

The growth in the number of renal transplants received by Welsh residents in recent years is now putting pressure on the provider immunosuppression drugs budgets across Wales. At the moment, this cost pressure is being passed to the WRCN. The WRCN is actively working with service providers, pharmaceutical suppliers and NHS Wales Shared Services Procurement to ensure that best practice in drugs procurement is being applied across NHS Wales renal services.

5.13 Reserves:

Reserves from the 16/17 Balance Sheet have been analysed in detail, and an initial release of £2m was processed into the Month 5 position. This relates to IPFR, Development, IVF and Mental Health accruals from last year.

A further £1m was released in the Month 7 position, £786k in Month 8 and £1.2m in Month 9 - all related to NHS England accruals. The 16/17 Balance Sheet is now completely clear except for the Dilapidations Reserve reported in the 16/17 Annual Accounts of £96k.

5.14 Developments:

There is a total of £9,430k funded developments in the 2017/18 position, £6,035k of which relates to developments from prior years for high cost drugs and new

technology investments. The current year-end forecast position is £1,006k underspent, a deterioration of £54k, which is due to INR costs.

The assumptions in the performance provision have been maintained in the month 11 position, with planned performance spend offsetting LTA reported expenditure. A new provision of £399k for the excess costs incurred by C&V as a result of the INR out sourcing has been included.

The forecast Ivacaftor spend for the R117 mutation indication has reduced by £276k due to eligible patients awaiting baseline tests before commencing treatment.
Of the new 2017/18 developments work is currently ongoing to correlate planned genetics scheme spend with funding from the genomic strategy. It is anticipated £50k will be utilised for CGH arrays backlog. The £800k provision for dialysis growth has been reported as a full underspend offsetting the growth reported within the provider LTA lines.

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

The running cost budget is currently £306k underspent. This is due to the significant staffing vacancies the organisation is currently running with; some should be appointed to shortly.

Non-pay overspends include the Cwm Taf hosting fee. Netting off the non-pay forecast overspend with the staffing forecast underspend gives a current year-end forecast of £212k underspent.

Please note that the lease on the current Caerphilly office expires in March 2018, and new premises are being sourced. A provision for dilapidations was entered in the 2016/17 Annual Accounts for £96k which will mitigate much of this risk.

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 M11	1,929	644	94	180	(197)	210	(269)	1,266
Variance M10	(227)	(54)	(301)	(99)	(723)	89	(330)	1,190
Movement	2,156	698	395	279	527	121	61	75

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 M11	1,845	2,983	376	333	(32)	(102)	(298)	(1,414)
EOY forecast M10	(286)	250	65	95	(557)	272	(347)	(64)
EOY movement	2,131	2,733	310	237	525	(374)	49	(1,350)

Material reporting positions or movements include:

6.1 Cardiff & Vale LHB:

- Welsh contracts - no major movements in the forecast. Main movement in the Cardiff contract deterioration of £168k mainly in NICU.
- Velindre forecast has deteriorated due to the Melanoma drugs which will impact across all South Wales commissioners.
- English contracts – deterioration in Year End forecast £173k pertaining to mainly The Walton Centre.

6.2 ABM LHB:

- ABM contract – no major movements in the forecast position for the provider contract for the commissioning position.
- Cardiff contract – movements of £190k adverse pertaining largely to the ISAT Coils pass through costs.
- English contracts – no material movements in forecast position overall.
- Mental Health –£53k improvement to forecast.

6.3 Cwm Taf LHB:

- Cardiff contract – deterioration of £125k to year-end, primarily on NICU. However, this remains a risk to the forecast position as the provider currently disputes WHSSTs position on TAVI non-payment in addition to WHSST being informed that the Cardiff NICU units live data suggests an increase in activity for actual month 10.

- Velindre forecast has deteriorated due to the Melanoma drugs which will impact across all South Wales commissioners.
- English contracts – no material movements
- IPM – no material movements

6.4 Aneurin Bevan LHB:

- Cardiff contract – adverse movements of £156k to year-end including ISAT Coils and Hospital Renal Dialysis.
- Aneurin Bevan provider contract has moved adversely by £77k relating to NICU and Cardiology.
- Velindre forecast has deteriorated due to the Melanoma drugs which will impact across all South Wales commissioners.
- IPM has deteriorated the position by £90k for year end forecasts.
- English contracts – no material movements.
- Developments improvements in year end forecast of £34k.

6.5 Hywel Dda LHB:

- Hywel Dda provider contract has seen an improved forecast in the NICU line of £67k
- Cardiff contract deterioration of £116k mainly in ISAT Coils and Clinical Immunology. This is offset by a small improvement in the ABMU contract.
- IPM deterioration in non-contracted activity of £36k and £19k on Proton Beam activity.

6.6 Powys LHB:

- Overall deterioration of £49k linked to movements in the IPM non contracted activity.

6.7 BCU LHB:

- BCU contract – improvement of £35k to forecast position, mainly relating to haemophilia.
- Overall deterioration of £132k linked to movements in the IPM non contracted activity.
- NHS England - £144k deterioration to the year-end forecast across various providers. The largest movements include:
    - Alderhey main contract - £140k due to year end settlement
    - CMMC - £184k improvement for lower activity present this month.
    - Christie – £91k adverse movement relating to high level of BMT activity
    - RJAH - £62k improvement due to negotiated tolerances on contract
    - Walton - £292k year-end forecast adverse movement due to high activity, high costs neurosurgical activity.
      Please refer to the risk-share tables to see further details of the NHS England position.
- Mental Health – underspend movements of £63k forecast.

Under the agreed mechanism WHSST can agree variations in financial risk within individual Health Boards via agreement between all parties. This month we have actioned movements in risk share distributions with such agreements.

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.

An additional column relating to Other Sundry Income has been 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. Please note that secondment income is netted against the payroll spend and is therefore included in our Expenditure figures.

Table 5 – 2017/18 Commissioner Income Expected and Received to Date

	2017/18 Planned Commissioner Income	Income Expected to Date	Actual Income Received to Date	Accrued Income - WHSSC	Accrued Income - EASC	Total Income Accounted to Date	EOY Comm'er Position	Other sundry Income (invoiced)	Second-ment recharge (netted off in risk-share position)	EOY total expected income
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ABM	117,550	107,754	107,755	(3)	3	107,755	376	80		118,006
Aneurin Bevan	129,850	119,029	117,641	1,237	151	119,029	(32)	0	107	129,925
Betsi Cadwaladr	158,113	144,937	144,937	(15)	15	144,937	(1,414)	0		156,699
Cardiff and Vale	115,640	106,004	106,004	(3)	3	106,004	2,983	87		118,711
Cwm Taf	64,207	58,857	58,857	(4)	4	58,857	333	28		64,568
Hywel Dda	79,619	72,984	72,984	(6)	6	72,984	(102)	0		79,517
Powys	32,554	29,841	29,838	0	3	29,841	(298)	0		32,256
Public Health Wales						0			108	108
Velindre						0				0
WAST						0				0
Total	**697,534**	**639,406**	**638,016**	**1,207**	**184**	**639,406**	**1,845**	**194**	**215**	**699,788**

Sundry invoices raised:
Cwm Taf - £19,152 relating to EASC Chair WG Allocation 17/18
Cwm Taf - £8,372 relating to WHSSC Chair WG Allocation 17/18
Cardiff & Vale - £87,160 relating to MH DTOC recharges
ABM - £79,610 relating to MH DTOC recharges
Total sundry invoices - £194,294

Invoices over 11 weeks in age detailed to aid LHB's in clearing them before Arbitration dates:
None

7.2 Expenditure with LHB's

A full breakdown of the expected expenditure across LHB's and budget headings is included as Annex A. 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.

8. Overview of Key Risks / Opportunities

The key risks remain consistent with those identified in the Annual Plan process to date:

- Phasing of Development funding as projects start; possible slippage in start dates leading to non-recurrent in-year savings.
- Growth in all activity above that projected in the IMTP.

Schemes deemed unaffordable at the time of IMTP approval that are being monitored through the risk management framework, the two highest risks for the 2017/18 plan being Cardiac Ablation capacity and Wheelchair replacement. Funding for these schemes has now been provisionally approved in the draft 2018-19 Integrated Commissioning Plan.

The additional risks and opportunities highlighted are:

- HRG4+ - the total estimated HRG 4+ risk is currently £3,736k, which relates to the (£6,302k-£2,566k). **Please see section 5.8 regarding NHS England for a detailed update. A definitive position from NHS England is still awaited.**
- NHS England – using the most prudent forecast would result in a reduction of £959k spend on activity from last month. This is the difference between the total most prudent forecast of £9.903m month 11 less the current HRG4+ inclusive forecast being used of £10.862m month 10. The overall risk therefore of volume growth relates to circa £0.850m at month 11 year end forecast.

- The release of OPCS 6.4 this year has resulted in a significant coding risk as Specialist activity seems to be attracting the higher level tariff. In addition, the changes to Specialist top-ups are also putting financial pressures in the system.
  Please note there is an assumption that this is somewhat mitigated by decreasing costs in local Health Board contracts for non-specialist activity.
- Medium secure – new risk of delays in approving step down from medium secure to lower levels of security arising from reported MOJ capacity constraints. The risk is being investigated and will be quantified in the light of findings, but is expected to be containable given the low amount of MH DTOC patients and actions already taken by MOJ to address capacity.

All the areas which are quantifiable have been entered in Table G of the MMR tables.

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 10.3 - (difference between Table B and Table E) – all secondment recharges are netted against the staffing expenditure, as we have significant secondments in relation to the total number of staff, so this "income" appears within the spend section of Table B. This has been the methodology for a number of years, including in our Annual Accounts. However, in line with the recent instructions to have nil inter-organisation figures on Table E, the recharge has been reflected within the Income side for PHW and Anuerin Bevan to reflect the LHB's treatment of these amounts.

Action Point 10.4 – the Balance Sheet for 16/17 is indeed completely clear. Table G has been amended to reflect this in the M11 tables.

Action Point 10.4 – The Director of Finance of WHSST and Cardiff have agreed the financial arrangements to settle the excess costs of the outsourcing of interventional radiology service. A provision has been included in this month finance report of circa £400k.

11. Responses to Action Notes from WG IMTP responses

Action Point 1 – The inflationary uplift has now been included in the IMTP March 18 submission. WHSST is currently drafting the SLA documentation for 2018/19 with the aim to get signed off by June 18.

Action Point 2 - The March 18 submission of the WHSSC IMTP includes a starting position of Month 10 outturn for English SLAs. This position inherently includes an estimated £2.4m that could be used to cover some of the HRG4+ risk for 2017/18 which has been made recurrent in the 18/20 IMTP. The financial plan also estimates that a further £5.8m risk relating to price and growth in 2017/18 is below the agreed funded position for WHSSC. The reported 2017/18 price increase relating to the introduction of HRG4+ is a two year fixed position and therefore further price growth is not anticipated for 2018/19 – however, it is understood that this may only cover a 1% pay award and agreement beyond this may result in an additional national price increase.

Therefore, the current plan does not include any future growth for price or volume from 18/19 onwards. A detailed explanation is provided in the March submission of the WHSSC IMTP.

Action Point 3 – The financial risk identified that has not been approved for funding by Health Boards is provided in the WHSSC financial plan and distribution shares by Health Board. Of the £6.3m total HRG4+ impact, £2.4m included in the Month 10 roll over position and £3.9m in the £5.8m not included and below the line.

Action Point 4 – WHSSC has held a Management Group IMTP Workshop with Health Boards to provide an updated position by commissioner. It is anticipated that the Health Boards provision is in line with the updated March submission and any material variances are eliminated.

Action Point 5 – the 2018/19 projected savings of £3.060m relate to:

- £1.7m Mental Health Case Management savings which is a recurrent saving linked to the achievements to date.
- £0.5m relate to Recommissioning work of Cardiology pathway and Spinal Rehabilitaion service. These are new projections and are prudent estimates of what can be delivered.
- £0.4m relates to national procurement framework price agreements that providers are expected to achieve that will flow back to commissioners through WHSSC. This work is underway and benefits are starting to be realised for e.g. haemophilia blood products.
- £0.5m policy reviews for example, there is a national policy review of peptide receptor radionuclide therapy where a decision could be reached to not routinely commission or to routinely commission with significantly reduced cost to align QALY's.

Action Point 6 – WHSST is working to reconcile the I&E position with Health Boards in time for the March 18 submission. There are no known material disputes.

Action Point 6, 7, 8, 9 – Amended for in the attached version.

12. Confirmation of position report by the MD and DOF:

Sian Lewis,
Managing Director, WHSSC

Stuart Davies,
Director of Finance, WHSSC

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

Annex A - 2017/18 Expected Expenditure

	2017/18 Baseline contract £'000	2017/18 Contract EOYF variance £'000	IPFR £'000	IVF £'000	Mental Health £'000	Renal £'000	Develo-pments & Reserves £'000	WHSSC/ EASC/QAT Running Costs (includes Secondment income) £'000	Add back Second-ment recharges netted in risk-share tables £'000	2017/18 Sub-Total Other Spend £'000	2017/18 Total expected spend £'000
ABM	95,833	1,243	1,468	2,940	333	813	601	27	0	7,425	103,258
Aneurin Bevan	8,833	89	2			142		(109)	0	124	8,957
Betsi Cadwaladr	38,137	(9)	1,313		168	682	0	(71)	0	2,082	40,220
Cardiff and Vale	187,484	1,996	8,921			1,051	5,320	39	0	17,327	204,811
Cwm Taf	7,452	79	6		27	0		518	0	630	8,082
Hywel Dda	1,486	120	36			544		0	0	700	2,186
Powys			0			0		23	0	23	23
Public Health			8			0		(108)	0	(100)	(100)
Velindre	38,421	(22)	14			105	123	(91)	0	129	38,549
WAST (managed by EASC)	139,479	0	0			37		0	0	37	139,516
Total	517,125	3,497	11,769	2,940	527	3,374	6,044	227	0	28,377	545,502

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

Agenda Item 14.1
WHSSC Joint Committee
27 March 2018

Reporting Committee	**All Wales Individual Patient Funding Request (IPFR) Panel**
Chaired by	**Brian Hawkins**
Lead Executive Director	**Director of Nursing and Quality Assurance**
Date of last meeting	**28 February 2018**

Summary of key matters considered by the Committee and any related decisions made.

The Panel meetings held in January and February 2018 were quorate in relation to Health Board representation and clinical representation.

In January 2018

- Panel considered 8 requests
- 7 requests for PET scanning where considered as Chair Actions
- 1 urgent request reconsidered as a Chair Action

In February 2018

- Panel considered 8 requests
- 6 requests for PET scanning where considered as Chair Actions
- 1 case reconsidered by a virtual panel
- 2 Urgent requests considered as Chair Actions

Key risks and issues/matters of concern and any mitigating actions

Individual Patient Funding Request (IPFR) Quality Assurance (QA) Group Audit – 31 January 2018

One of the roles of this group is to consider an anonymised random sample of IPFR reports (one from each IPFR panel in Wales) in relation to their completeness, timeliness and efficiency of communication in line with the NHS Wales IPFR policy process.

Detailed feedback is provided to each panel and the group also report to the Head of Pharmacy and Prescribing Policy at the Welsh Government and any significant issues are brought to the attention of the Deputy Chief Medical Officer.

In quarter Oct – Dec 2017 47 requests where considered by the Panel

14.1

This summary for WHSSC was included in the report for Welsh Government: *The majority of the quality criteria were met. The information provided to the panel was considered to be well documented. The application went to panel outside of the urgency stipulated and there was no clarity around the rationale for not meeting timelines. A letter was not sent to the patient although the clinician was informed that the patient would not receive a letter. There was some discussion around the volume of IPFRs considered by WHSSC and whether a monthly meeting was sufficient to deal with requests with more urgent timelines.* The next QA Audit will take place in April 2018.
Matters requiring Committee level consideration and/or approval
• None
Matters referred to other Committees
None
Confirmed Minutes for the meeting held 28 February are available on request.

Date of next meeting	**28 March 2018**

14.1

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

Agenda Item 14.2
WHSSC Joint Committee
27 March 2018

Reporting Committee	**Welsh Renal Clinical Network**
Chaired by	**Chair, Welsh Renal Clinical Network**
Lead Executive Director	**Director of Finance**
Date of last meeting	**5th February 2018**

Summary of key matters considered by the Committee and any related decisions made.

- A business case from Cardiff and Vale has been submitted to Welsh Government for progression of the capital bid for expansion to the main unit in UHW.
- The business case to expand the Llandrindod expansion is progressing and will be submitted to Welsh Government at the start of the financial year.
- A procurement exercise is underway to increase capacity in North Wales. This includes the refurbishment of existing units in Bangor, Alltwen, Welshpool and Wrexham and the provision of a new satellite unit in the area of Mold.
- Cardiff Transplant Unit has been awarded European Board of Surgery Accreditation for training for kidney transplantation and organ retrieval. This is the first unit in the UK to have achieved this.
- A presentation was received by Professor Roy Thomas responding to the Parliamentary Review – "Pioneering for Patients, Health Professionals and Carers".

Key risks and issues/matters of concern and any mitigating actions

- The provision set aside via the WHSSC ISP for growth and ISP inflation is predicted to be sufficient for 17/18.
- There are issues in each of the provider units relating to Vascular Access Services. The most critical of these is in BCU and WRCN are exploring ways to resolve this. It has already been escalated to WHSSC QPS.

Matters requiring Committee level consideration and/or approval

- None

Matters referred to other Committees

- None

Annexes: None

Date of next meeting	**21 May 2018**

14.2