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

WHSSC Joint Committee Meeting held in public
Tuesday 10 July 2018 at 13.30

Health and Care Research Wales - Castlebridge 4,
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	13.30 - 13.45
2. Declarations of Interest - Members must declare if they have any personal, business or 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 the Minutes of the Meetings held 15 May 2018 - To **approve** the minutes.	Chair	Att.	
4. Action Log and Matters Arising - To **review** the actions and consider any matters arising.	Chair	Att.	
5. Report from the Chair - To **receive** the report and consider any issues raised.	Chair	Oral / Att.	13.45 - 13.50
6. Report from the Managing Director - To **receive** and **note** the report and consider any issues raised.	Managing Director	Att.	13.50 - 14.00
Items for Consideration and/or Decision			
7. Use of Crizotinib in the treatment of ROS1-positive advanced non small-cell lung cancer - To **note** the information presented within the paper, including the requirement for the manufacturer to offer NHS Wales the same or similar package as NHS England, including price, as part of the managed access agreement; and - To **approve** the funding request for 2018/19 and 2019/20 and beyond. **Contact:** Ian.Langfield@wales.nhs.uk	Acting Director of Planning	Att.	14.00 - 14.15

Item	Lead	Paper / Oral	Time
8. 2018-21 Key Risks - Cystic Fibrosis - To **note** the report and the impact of non-investment and **support** the investment **Contact:** Ian.Langfield@wales.nhs.uk	Acting Director of Planning	Att.	14.15 - 14.30
9. Neuroscience Strategy Delivery Plan - To **support** the delivery plan for the Five Year Strategy for Specialised Neurosciences **Contact:** Ian.Langfield@wales.nhs.uk	Acting Director of Planning	Att.	14.30 - 15.00
Routine Reports and Items for Information			
10. Integrated Performance Report - To **note** the report. **Contact:** Ian.Langfield@wales.nhs.uk	Acting Director of Planning	Att.	15:00 - 15:10
11. Financial Performance Report - To **note** the report. **Contact:** Stuart.Davies5@wales.nhs.uk	Director of Finance	Att.	15:10 - 15:20
12. Reports from the Joint Sub-Committees - To **receive** the reports and consider any issues raised. i. WHSSC Quality and Patient Safety Committee ii. All Wales Individual Patient Funding Request Panel	Joint Sub-Committee Chairs	i. to follow ii. Att.	15:20 – 15:30
13. Reports from the Joint Advisory Groups - To **receive** the reports and consider any issues raised. i. Welsh Renal Clinical Network	Joint Advisory Group Chairs	Att.	
Concluding Business			
14. Date of next meeting - 11 September 2018, 09:30 - Health and Care Research Wales, Castlebridge 4, Cowbridge Road East, 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)".

Minutes of the Meeting of the Welsh Health Specialised Services Committee

held on 15 May 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 Assurance, WHSSC
Stuart Davies	(SD)	Director of Finance, WHSSC
Charles Janczewski	(CJ)	Independent Member/Chair of the WHSSC Quality and Patient Safety Committee
Sian Lewis	(SL)	Managing Director, WHSSC
Steve Moore	(SM)	Chief Executive, Hywel Dda UHB (part meeting)
Tracy Myhill	(TM)	Chief Executive, Abertawe Bro Morgannwg UHB
Len Richards	(LR)	Chief Executive, Cardiff and Vale UHB
Carol Shillabeer	(CS)	Chief Executive, Powys THB
Jennifer Thomas	(JT)	Medical Director, WHSSC
Chris Turner	(CT)	Independent Member/Audit Lead
Allison Williams	(AW)	Chief Executive, Cwm Taf UHB
John Williams	(JW)	Associate Member/Chair of the Welsh Clinical Renal Network

Apologies

Gary Doherty	(GD)	Chief Executive, Betsi Cadwaladr UHB
Steve Ham	(SH)	Chief Executive, Velindre NHS Trust
Ian Langfield	(IL)	Acting Director of Planning, WHSSC
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB
Lyn Meadows	(LM)	Vice Chair

In Attendance

Luke Garthwaite	(LG)	Graduate Trainee
Glyn Jones	(GJ)	Director of Finance, ABUHB (on behalf of Judith Paget)
Julie Keegan	(JK)	Assistant Director of Commissioning, CTUHB
Christopher Markall	(CM)	Senior Finance Manager, CVUHB
Evan Moore	(EM)	Executive Medical Director, BCUHB (on behalf of Gary Doherty)
Claire Nelson	(CN)	Acting Assistant Director of Planning, WHSSC (on behalf of Ian Langfield)
Cath O'Brien	(COB)	Director of the Welsh Blood Service (part meeting)
Matthew Richards	(MR)	Database Developer, WHSSC (part meeting)

Kevin Smith	(KS)	Committee Secretary and Head of Corporate Services, WHSSC
Sandra Tallon	(ST)	Head of Information, WHSSC (part meeting)

Minutes:

Cathie Steele	(CES)	Corporate Governance Manager, WHSSC

The meeting opened at 09:30hours

JC18/016	**Welcome, Introductions and Apologies** The Chair formally opened the meeting and welcomed members. Apologies were noted as above.
JC18/017	**Declarations of Interest** There were no declarations to note. The Joint Committee noted the standing declarations.
JC18/018	**Accuracy of Minutes of the meeting held 27 March 2018** The Joint Committee **approved** the minutes of the meeting held on 27 March 2018 as an accurate record subject to the following: • "Len Richardson" be amended to "Len Richards"; • Amend the health board for Hayley Thomas from Aneurin Bevan UHB (ABUHB) to Powys THB (PTHB). **Action: Committee Secretary**
JC18/019	**Action Log and Matters Arising** The Joint Committee **received** the action log and noted the following updates: **JC17/084 AAC Evaluation** SL reported that this item was included within the Managing Director's Report. **Neurosciences Strategy** SL reported that this report would be presented to a future Joint Committee meeting. **Neonatal Workforce Model** SL reported that a letter had been sent to the Neonatal Network and a reply was awaited. **High Cost Drugs** AW provided the Joint Committee with an update, noting that the Chief Executives would discuss the item at the all Wales Chief Executive's meeting. SL noted that she has raised and discussed this with the Chief Medical Officer at Welsh Government. SD reported that a joint presentation, on the adoption of the new NICE guidelines around high cost drugs, had been given to the all Wales Medicines Strategy Group. **Action Log**

	CJ noted that the action log did not contain updates on the items and expected completion dates. KS reported that the usual practice was to review outstanding actions in Corporate Directors Group catch up meetings ahead of JC meetings; however this sometimes didn't happen due to other pressures. KS undertook to use best endeavours to address this ahead of future JC meetings. **Action: KS** **Matters Arising** There were no matters arising.
JC18/020	**Report from the Chair** The Joint Committee **received** an oral report from the Chair. The Chair reported that she had visited the Rutherford Cancer Centre, Newport where PPI were undertaking Proton Beam Therapy. She also reported that she had attended an Individual Patient Funding Request (IPFR) training day, led by All Wales Therapeutics and Toxicology Committee. She provided feedback on a number of points arising from the day including: • The findings of the random review of cases, noting that there was continuing inconsistency in IPFR decision-making • Engagement of clinicians in England with the agreed process was sometimes poor. The Joint Committee discussed further mechanisms to engage with clinicians in England.
JC18/021	**Report from the Managing Director** The Joint Committee **received** the report of the Managing Director. SL drew attention to the following items within the report which the Joint Committee discussed further: • Bariatric Surgery. Performance had improved but expected demand hadn't been experienced. • Cystic Fibrosis. The Joint Committee discussed receipt of in-year business cases and the need to consider the prioritisation process so that it would not be on a first come first funded basis. • Inherited Bleeding Disorders. The Project Board had asked the WHSS Team to make ABMUHB and CVUHB aware of specific concerns. • Major Trauma. The Joint Committee recommended a Memorandum of Agreement be developed with EASC to ensure clarity on responsibilities. *09:56 Steve Moore joined the meeting*

	• Thrombectomy. The Joint Committee discussed the current capacity, provision and resources, the difficulty experienced accessing current provision, repatriation back to referring hospital following treatment and the impact of the NHS England commissioning requirements • Assisted Automated Communication (AAC). Welsh Government had identified funding and a workshop had been arranged.
JC18/022	**Informatics Demonstration** The Joint Committee **received** a presentation from Sandra Tallon (ST), Head of Information and Matthew Richards (MR), Database Developer. In the presentation ST and MR noted the: • Source and number of datasets received. • Use of the Commissioning Intelligence Portal and WHSSC Information Systems • Ability within the new system to manipulate and extract data for use within reports • Heat map function which highlights the source of activity • Steps taken to reduce the number of incomplete datasets *Cath O'Brien joined the meeting* The Joint Committee discussed the development of the database further noting the: • Ability for use within the LHBs and the ability to use to match the utilisation plan against the needs analysis. • Planned engagement with Management Group. • Link with the quality portal. The Chair thanked ST and MR for the interesting presentation.
JC18/023	**Advanced Therapy Medicinal Products: Enabling Delivery within NHS Wales and Cell and Gene Therapy** The Joint Committee **received** the Advanced Therapy Medicinal Products: Enabling Delivery within NHS Wales and Cell and Gene Therapy report. In introducing the report, Cath O'Brien (COB), Director of the Welsh Blood Service noted the: • Successful bid to have an Advanced Therapy Centre in Wales in collaboration with Birmingham and the plan to develop a Statement of Intent. • Development of clinical pathways and training • Public engagement and perception of these therapies

	• Three products recently approved by NICE as technical appraisals. • Oversight steering group (Innovate UK) • Explanation of the first product to be developed • Learning so far. The Joint Committee discussed the report and noted the: • Joint work with the All Wales Medicines Strategy Group (AWMSG) and economics to understand financial impacts. • Emerging sector and the approaches internationally. • Need to manage expectations (public and clinical). • Ability to maintain JACIE accreditation of CVUHB facilities. • Standards of the facilities that some companies required. • Financial implications. The Joint Committee **agreed** to receive a further report at a future meeting. The Joint Committee **supported** nominations from each LHB to support this work and recommended that correspondence with Judith Paget (JP), Chief Executive of Aneurin Bevan UHB in her role as Chair of the all Wales Chief Executive group. The Joint Committee **agreed** that NICE recommendations on Advanced Therapy Medicinal Products be used at the early stages of this work. The Joint Committee **resolved** to: • **Note** the information presented within the report • **Support** the WHSSC led commission of ATMPs • **Note** the relationship between JACIE accreditation of the CVUHB BMT unit and the ability of Wales to deliver future NICE approved AMTPs.
JC18/024	**Integrated Commissioning Plan 2018-21: Work plan** The Joint Committee **received** the Integrated Commissioning Plan 2018-21: work plan. Claire Nelson (CN), Acting Assistant Director of Planning introduced the report, noting the three schemes scrutinised by the Management Group. The Joint Committee recommended that Management Group undertake scrutiny on all schemes. CN **agreed** to share an overview that included the key milestones with CJ, outside of the meeting, to provide assurance. **Action: CN** Members **resolved** to:

	• Approve the processes, roles and responsibilities for implementing the WHSSC Integrated Commissioning Plan 2018-21.
JC18/025	**Proton Beam Therapy Update** The Joint Committee **received** the Proton Beam Therapy Update report. SL introduced the report drawing the Joint Committee's attention to the new providers coming on line in the year shown in table 3. She provided further detail to support the table. Members **resolved** to: • **Note** the NHS England PBT programme timeline for transition from an overseas to an NHS service; • **Note** WHSSC's process and timeline for commissioning PBT from UK providers; • **Note** that NHS Wales will continue to refer via the UK Proton Clinical Reference Panel; • **Note** some patients may require treatment overseas during the transition to the NHS service depending on capacity and the complexity of the treatment required; • **Note** the evidence base has progressed and new indications for medulloblastoma are currently being considered by NHS • England; and • **Note** the savings from the significant cost advantages associated with commissioning PBT from NHS and European providers, are expected to be sufficient to absorb growth and new indications over 2018/19.
JC18/026	**Integrated Performance Report** The Joint Committee **received** the Integrated Performance Report. CN noted that an updated report with the March position was available and that the performance had improved at the end of March 2018. The Joint Committee requested that Management Group review the tolerances. **Action: IL** Members **resolved** to: • **Note** February performance and the action undertaken to address areas of non-compliance.

JC18/027	**Financial Performance Report** The Joint Committee **received** the Financial Performance Report. SD reported that the financial position reported at Month 12 for WHSSC was a forecast overspend to year-end of £4,451k. The deterioration in the year-end position of £2,606k included deterioration against the English provider position reported in Non-Welsh SLAs and IPFR. He noted that no concerns with the accounts had been raised in the Wales Audit Office. The Joint Committee discussed the: • Risk associated with HRG4+ and the impact. • The ongoing trend in the use of ICDs. CN reported that a paper on this would be presented to Management Group in the near future. The Joint Committee **resolved** to: • **Note** the current financial position and forecast year-end position. • **Note** the residual risks for the year including the HRG4+ risk.
JC18/028	**Reports from the Joint Sub-Committees** **Quality and Patient Safety Committee** The Joint Committee **received** the report. CJ reported that new Independent Members representatives from the LHBs were required to ensure that future meetings were quorate and well attended. The CEOs present **agreed** to assist with seeking additional members from within their LHB for the Committee. The Chair also **agreed** to highlight the issue at the all Wales Chairs Meeting. **Action: CEOs** **Action: Chair** **IPFR** The Joint Committee **received** the report. **Audit Committee** The Joint Committee **received** the report. Chris Turner (CT), Independent Member and Chair of the Audit Committee reported that the committee had received the WHSSC Corporate Risk and Assurance Framework (CRAF), which had allowed the committee to receive the assurance it had been seeking.

	All Wales Gender Identity Partnership Group The Joint Committee **received** the report. Tracy Myhill (TM), Chief Executive of Abertawe Bro Morgannwg UHB and Chair of the Partnership Group noted the slow progress to implement the pathway and new service. She noted receipt of a business case for the all Wales Gender Identity Clinic; however, difficulty had been encountered with the Primary Care aspect of the pathway. The Joint Committee discussed the difficulties and the level of enhanced service (Local Enhanced Service or Directed Enhanced Service). The Joint Committee agreed that a formal letter be sent to Francis Duffy, Welsh Government.
JC18/029	**Any Other Business** The Committee Secretary confirmed that a forward work plan was maintained for the committee and that the Corporate Risk Assurance Framework and associated risk register was scheduled to come to the committee every six months.
JC18/030	**Date and Time of Next Meeting** The Joint Committee noted the date of the next meeting as the 10 July 2018.

The meeting concluded at 12:00hours.

Chair's Signature: .....

Date: .....

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

2018/19 Action Log (MASTER)
Joint Committee Meeting
OPEN ACTIONS AND ACTIONS FOR CLOSURE APPROVAL

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
15.05.18	JC18001	JC18/018 **Accuracy of Minutes of the meeting held 27 March 2018** Amend minutes as agreed.	Committee Secretary	30.06.18	Minutes amended.	CLOSED
15.05.18	JC18002	JC18/018 **Action Log** To address outstanding actions from action log at CDG catch up ahead of future meetings.	Committee Secretary	30.06.18	Issue addressed.	CLOSED
15.05.18	JC18003	JC18/024 **Integrated Commissioning Plan 2018-21: Work plan** Share an overview with CJ that includes the key milestones to provide assurance.	Acting Director of Planning	30.06.18		OPEN
15.05.18	JC18004	JC18/026 **Integrated Performance Report** The Joint Committee requested that Management Group review the tolerances.	Acting Director of Planning	31.07.18		

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
15.05.18	JC18005	JC18/028 **Report from the Quality and Patient Safety Committee** To assist with seeking additional members from within their LHB for the Committee	CEOs	30.06.18		OPEN
15.05.18	JC18006	JC18/028 **Report from the Quality and Patient Safety Committee** To highlight the need for IMs on the Committee at the all Wales Chairs Meeting	Chair	30.06.18	WHSSC Chair has sked health board Chairs for their assistance.	CLOSED

2018/19 Action Log (MASTER)
Joint Committee Meeting
ACTIONS AGREED AS CLOSED BY THE COMMITTEE

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status

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

		Agenda Item	05
Meeting Title	**Joint Committee**	Meeting Date	10/07/2018
Report Title	Report from the Chair: adult thoracic surgery consultation		
Author (Job title)	Corporate Governance Manager		
Executive Lead (Job title)	Chair	Public / In Committee	Public

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Purpose	The purpose of this report is to provide the Members with an update on Chair's action taken concerning the adult thoracic surgery review consultation.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☒	☐	☐	☒

Sub Group /Committee	Joint Committee	Meeting Date	14/06/2018
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the contents of this report; • **Ratify** the Chair's action.		

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

The purpose of this report is to provide the Members with an update on Chair's action taken concerning the adult thoracic surgery review consultation.

2.0 Background

A recommendation for Public Consultation regarding the south Wales Adult Thoracic Surgery Review was presented to an 'In Committee' meeting of the WHSSC Joint Committee on 14 June 2018.

The Joint Committee meeting was inquorate, so it was not possible to approve the recommendation; however with the support of those members who were present, the meeting considered the recommendation and associated papers and suggested various revisions to the papers. I noted that the recommendation required formal approval and agreed to deal with this by Chair's Action, in accordance with the WHSSC Standing Orders.

3.0 Chair's Action

I wrote to Joint Committee Members on 18 June 2018 confirming that, acting in conjunction with Dr Sian Lewis, Managing Director of WHSSC, and Dr Chris Turner, an Independent Member of WHSSC, I had taken Chair's Action to approve the recommendation from WHSSC to the six affected health boards to:

1) Undertake a formal public consultation in line with the proposals outlined in the Draft Public Consultation Plan and Draft Core Consultation Document

2) Approve those documents for use in the consultation exercise and

3) Note the Equality Impact Assessment.

4.0 Recommendations

Members are asked to:

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

5.0 Annexes and Appendices

None.

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Implementation of the Plan
Link to Integrated Commissioning Plan	Delivery of the thoracic surgery review.
Health and Care Standards	Governance, Leadership and Accountability Safe Care Effective Care Timely Care
Principles of Prudent Healthcare	Reduce inappropriate variation
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Improving Patient Experience (including quality and Satisfaction)
Organisational Implications	
Quality, Safety & Patient Experience	The aim of the thoracic surgery review was to make recommendations to ensure the future safety and quality of the service, providing a positive patient experience.
Resources Implications	Further work to be undertaken on the resource implications, pending the outcome of the consultation exercise.
Risk and Assurance	Not applicable
Evidence Base	Not applicable
Equality and Diversity	The process was designed according to good practice to ensure equality and diversity obligations are met.
Population Health	This paper does not directly address issues of population health.
Legal Implications	Specific legal issues or advice are not considered within this report.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Joint Committee	14/06/2018	See background

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

		Agenda Item	06
Meeting Title	**Joint Committee**	Meeting Date	10/07/2018
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

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 Neonatal Interim Work stream

This work has been delegated to the three service providers, with Aneurin Bevan UHB taking the lead along with a nominated representatives from Cardiff and Vale UHB and Abertawe Bro Morgannwg UHB. Providers were asked to consider a cost effective solution for optimising the current model, in year. A proposal had been requested for an in year solution to be considered at the July meeting of the Joint Committee. We are aware that the providers have had a number of meetings on this issue, but no proposal has been received to date.

2.2 Paediatric Rheumatology

Work is underway to finalise a paper setting out service model options for establishing a tertiary Paediatric Rheumatology paper within south Wales. These options will be considered at a future Management Group meeting, prior to submission for consideration for inclusion within the 2019-20 ICP.

2.3 Thrombectomy / Stroke Commissioning

There is no further progress to report on formalising commissioning arrangements with North Bristol NHS Trust. The Trust continues to provide support to the interventional neuroradiology service at UHW.

2.4 Home Parenteral Nutrition

The new contract for HPN will be implemented from the beginning of July after taking the maximum two month extension on the former contract which enabled two months of cost avoidance. WHSSC are currently working with the C&VUHB service on minimising the costs incurred with the new contract by looking at introducing a nursing model on weekends which will look to reduce the reliance on Calea nursing by getting more patients trained to self-administer the treatment, and looking to reduce the surgical waits for those patients on HPN until their intestinal failure surgery is undertaken. The intention is to use any underspend achieved on the Intestinal Failure inpatient contract to fund these spend to save initiatives.

2.5 Proton Beam Therapy

WHSSC is currently taking forward a procurement process to evaluate the PBT service at the Rutherford Cancer Centre against the quality standards within the WHSSC PBT service specification. The process commenced on Thursday 21st June when the documentation was issued via the eTender Wales portal. The outcome of the procurement process will inform a decision over which PBT centres will be commissioned providers for the population of Wales. The current timeline is to complete the procurement

process over June to August, and to make a recommendation on future commissioning arrangements to Management Group and Joint Committee in September 2018.

2.6 Inherited Bleeding Disease

The second meeting of the Project Board for the re-commissioning IBD services project took place on 22nd June. A concern was raised by clinicians and service users regarding whether the current timeline to report in September will allow sufficient time to ensure robust proposals are developed for the future service model, given the other commitments of key individuals and the upcoming holiday period. We are therefore going to review the timeframe to allow the service model working group the time it requires to develop proposals while aligning the project outputs with the IPC process for 2019/20.

2.7 Sickle Cell and Thalassaemia

Welsh Government has asked that WHSSC undertake work to bring sickle cell and thalassaemia under its remit. Some initial scoping work has been undertaken and a working group of clinicians and patients has been established. The first meeting is being held on 29th June. The working group will advise on risks in the service, the development of the specification and options for the future service model. The aims for this work are:

- 2018/19: to develop the service specification, future service model and proposals to address any urgent risks for consideration in the ICP 2019/20.
- 2019/20: complete transfer of resources to WHSSC / inclusion of proposals as required to address risk and achieve standards, via the ICP process 2020/21
- 2020/21: full commissioning under WHSSC

2.8 BAHA and Cochlear

WHSSC have requested a plan from Cardiff and Vale UHB setting out how they will achieve the 26 week RTT target for adult patients by the end of 2019/20. An informal plan was sent by the Health Board in late May setting out the likely increased funding required in order to achieve 50% of the backlog by the end of 2018/19. The service has also identified significant numbers of patients with BAHA implants that are due to become obsolete in December 2018 and 2019. In light of these significant issues the WHSSC have requested a comprehensive briefing from the Health Board, and provide further updates to the Management Group / Joint Committee.

2.9 Critical Care

Cardiff and Vale UHB has reported significant over-performance of specialist services against the critical care bed day contract, and highlighted quality issues within the service primarily as a result of staffing and bed constraints. WHSSC are awaiting a proposal from the health board outlining solutions to address the capacity shortfalls and quality concerns.

2.10 Thoracic Surgery Consultation

A verbal update will be provided at the Committee.

2.11 Cardiac Surgery RTT Performance

On the 27th June I received a letter from the Heads of Major Conditions and Scheduled Care, Welsh Government, requesting that WHSSC report compliance against the 26 week RTT, in addition to the 36 week RTT. This request was made after the current report (April 2018) had been prepared and considered by Management Group for submission to Joint Committee, therefore it has not been possible to update the report on today's agenda. A verbal update on the current position will be provided at the meeting, and all future performance reports from May 2018 onwards will include this measure.

2.12 WHSSC Corporate Values

A verbal update will be provided at the Committee.

3.0 Recommendations

Members are asked to:

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

4.0 Annexes and Appendices

None.

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	07
Meeting Title	**Joint Committee**	Meeting Date	10/07/2018
Report Title	Use of crizotinib in the treatment of ROS1-positive advanced non small-cell lung cancer		
Author (Job title)	Assistant Director, Evidence Evaluation; Head of Genetics Laboratory, UHW; Acting Assistant Director of Planning		
Executive Lead (Job title)	Director of Finance	Public / In Committee	In Committee

Purpose				
RATIFY ☐	APPROVE ☒	SUPPORT ☐	ASSURE ☐	INFORM ☐

Sub Group /Committee	Management Group	Meeting Date	21/06/2018
	Choose an item.	Meeting Date	Click here to enter a date.
Recommendation(s)	Members are asked to: • **SUPPORT**: the funding for ROS1 gene fuse analysis to allow implementation of the NICE Final Appraisal Document (FAD) for the use of crizotinib in the treatment of ROS1 positive advanced non-small cell lung cancer.		

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 On the 31st May 2018 NICE issued the following Final Appraisal Document guidance (FAD) for the use of crizotinib in the treatment of ROS1-positive advanced non-small-cell lung cancer (NSCLC) [see: ID1098].

- Crizotinib is recommended for use within the Cancer Drugs Fund as an option for treating ROS1-positive advanced non-small-cell lung cancer (NSCLC) in adults, only if the conditions in the managed access agreement are followed.

1.2 When a NICE technology appraisal recommends the use of a drug or treatment, or other technology, for use within the Cancer Drugs Fund, the NHS in Wales must usually provide funding and resources for it within 2 months of the first publication of the FAD or agreement of a managed access agreement by the NHS in Wales, whichever is the latter.

1.3 Fusion analysis is required in order to assess whether a patient has a gene rearrangement/mutation in the ROS1 gene and is therefore eligible to receive crizotinib. The All Wales Genetics Laboratory will provide testing using fluorescent in situ hybridisation (FISH) analysis. However, to meet the required 60-day timeline a short-term plan will be required. In addition, there is a backlog of NSCLC patients who will also require testing.

1.4 In January 2018 NICE issued negative advice on the use of crizotinib in the treatment of ROS1-positive advanced NSCLC as part of an appraisal consultation document (ACD). Following consultation and further input from the manufacture a positive FAD was published in May. Publication of the FAD was not known to WHSSC until March 2018 so is not accounted for within the ICP 2018-21.

2.0 Background

2.1 ROS1 gene rearrangements will be detected in 1.1-1.8% of all NSCLC patients with non squamous tumours (adenocarcinoma, adeno-squamous or 'not otherwise specified' (NOS) histology).

2.2 ROS1 should be tested 'up front' and at the same time as EGFR and ALK in patients with advanced NSCLC. This is estimated to apply to approximately 650 patients per annum in Wales.

2.3 ROS1 gene fusion analysis may be tested by FISH (gold standard) or immunohistochemistry (IHC). When using IHC, positive cases should be confirmed by FISH as IHC will detect a number of false-positives (approximately 17% of cases will test as a 'false positive' by IHC) as well as

the 'true positives' (1.1-1.8%).

2.4 Crizotinib is innovative as it represents a first in class step-change in the targeted treatment of ROS1-positive advanced NSCLC. It is administered orally and offers a marked improvement in quality of life. Using crizotinib in a managed approach will also encourage standardisation of ROS1 status testing in non-squamous NSCLC.

2.5 The drug acquisition cost (no discount applied) is £4,689 for 60 250mg tablets. Patients usually receive crizotinib 250mg twice daily (500mg). However there is likely to be a significant discount applied the drug cost as part of a managed access agreement (see below).

2.6 The terms of the New Treatment Fund require testing to be delivered within two months of publication of the FAD in order to implement the NICE guidance and ensure crizotinib can be made available to people with a positive ROS1 gene mutation.

2.7 However Crizotinib can only be provided if the manufacturer offers NHS Wales the same or similar package as NHS England, including price, as part of the managed access agreement.

2.8 The All Wales Medicines Procurement Specialist Pharmacist has informed WHSSC that agreement has been reached with the manufacture (Pzifer) to provide crizotinib at the same price and under the same terms and conditions as NHS England. Formal, written conformation is expected by the end of June 2018. Given that NHS Wales does not have full access to Blueteq the manufacturer have agreed that NHS Wales do not need to provide data as part of the managed access agreement.

3.0 Assessment

3.1 **FISH**

This test can be set up and validated within a couple of weeks by the All Wales Genetics Laboratory (AWGL) at a cost of £120 per sample. Staff in AWGL have considerable experience of using this technique and already process NSCLC samples for both EGFR and ALK mutations.

3.2 **IHC**

This technique needs to be undertaken by Cell Pathology laboratories who do not currently provide IHC for ALK gene mutations. The AWGL are currently trying to encourage Cell Pathology laboratories across Wales to adopt IHC for ALK gene mutations. It is hoped that the Cell Pathology laboratories will be able to offer IHC for ROS1 from 2019/20, but it would be challenging for them to implement IHC for ALK and ROS1 before this.

IHC is cheaper than FISH (£90 per sample) but requires the confirmation of

putative positive results in approximately 17% of cases. This still presents a cost saving on purely using FISH outlined below, but would add another stage in the patient pathway. Current turnaround times for IHC are 2-3 days whereas FISH can take up to 10 days.

3.3 ROS1 gene fusion analysis using FISH is already established in AWGL and can therefore meet the NICE guidance immediately. The Genetics Service estimate that 650 new patients per annum will be eligible at £150 per test (Table 1).

Table 1

	Estimated number of samples per annum	Total annual cost
ROS1 gene fusion analysis (FISH)	650	£78,000

3.4 It should be noted that the AWGL will not be able to recruit staff for the delivery of the ROS1 FISH service within the required timelines. The AWGL does not have sufficient staff capacity to meet the demands of ROS1 testing on a short-term basis without a significant impact on other critical services (e.g. HER-2 or BRCA testing). Therefore a short-term plan is proposed.

3.5 **Short-term plan**

To achieve ROS1 gene fusion testing within 60 days (testing to be available from 27/07/2018) the Genetics Service recommend that staff overtime is used within AWGL until members of the team can be appointed. It estimated that overtime will be required for two months. The estimated costs for this approach are presented in Table 2.

Table 2

	Samples analysed for two months (Aug – Sep 2018)	Staff cost (overtime)	Cost of reagents	Total
ROS1 gene fusion analysis (FISH)	108	£5,400	£12,960	£18,360

3.6 Once staff have been recruited and are in post the cost for the remainder of 2018/19 (Oct-Mar) will be approximately £39,000.

3.7 **Backlog of NSCLC patients requiring ROS1 gene fusion testing**

Those NSCLC patients who have previously tested normal for both EGFR mutations and the ALK gene fusion, and remain sufficiently fit for treatment, will be eligible for testing for ROS1 (and treatment with crizotinib if positive). This group is estimated to comprise approximately 500 patients (Table 3). For this group, lung cancer multidisciplinary teams will be required to

request that a sample is sent by pathology to the AWGL for analysis.

Table 3

	Backlog of samples	One-off cost
ROS1 gene fusion analysis (FISH)	500	£60,000

3.8 Total costs for 2018/19

Data in Table 4 summarise the total estimated costs of providing appropriate genetic testing for the ROS1 gene in people with NSCLC in order to establish their eligibility to receive crizotinib.

Table 4

Year	Estimated costs	Total
2018/19	• £18,360 (Aug-Sep) • £39,000 (Oct-Mar) • £60,000 (patient backlog)	£117,360
2019/20 If using just FISH	• £78,000	£78,000
If using IHC and FISH	• £58,500 + £13,260	£71,760

4.0 Recommendations

4.1 Members are asked to:

- **Note** the information presented within the paper, including the requirement for the manufacturer to offer NHS Wales the same or similar package as NHS England, including price, as part of the managed access agreement.
- **Approve** the funding request for 2018/19 and 2019/20 and beyond.

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Choose an item. Choose an item.
Link to Integrated Commissioning Plan	This scheme was not accounted for within the ICP 2018-21
Health and Care Standards	Effective Care Safe Care Staff and Resourcing
Principles of Prudent Healthcare	Only do what is needed Care for Those with the greatest health need first Choose an item.
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	This report addresses the benefits to Quality and Patient Experience that this gene analysis and subsequent treatment of ROS-1 positive advanced non-small-cell lung cancer brings to patients.
Resources Implications	The resource implications of implementing the genetic analysis to allow for crizotinib to be utilised are outlined in this paper.
Risk and Assurance	Risks to not supporting the funding are outlined in this paper.
Evidence Base	The evidence base supporting this case is outlined in this paper.
Equality and Diversity	There are no implications for equality and diversity in this report.
Population Health	There are no implications of population health in this report.
Legal Implications	The known legal implications which would be in not supporting this request for funding and allowing the NICE FAD to be implemented are outlined in this report.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Choose an item.		
Choose an item.		

		Agenda Item	08
Meeting Title	**Joint Committee**	Meeting Date	10/07/2018
Report Title	2018-21 ICP Key Risks expected to emerge in year – Cystic Fibrosis		
Author (Job title)	Specialised Planning Manager		
Executive Lead (Job title)	Director of Planning	Public / In Committee	Choose an item.

Purpose	To set out the investment requirements for the All Wales Adult Cystic Fibrosis Centre to address the immediate clinical risk and service sustainability issue, and support the ongoing development of the service.			
RATIFY ☐	APPROVE ☒	SUPPORT ☒	ASSURE ☐	INFORM ☐

Sub Group /Committee This links to additional information provided on last page	Choose an item.	Meeting Date	Click here to enter a date.
	Choose an item.	Meeting Date	Click here to enter a date.
Recommendation(s)	Members are asked to: • **Note** the information presented in the report and the impact of non-investment. • **Approve** the investment in the MDT on a recurrent basis, and the part year effect of the Premixed IV Antibiotic Service.		

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
	YES	NO		YES	NO		YES	NO

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Resources Implications	√		Risk and Assurance	√		Evidence Base		
Equality and Diversity	YES	NO	Population Health	YES	NO	Legal Implications	YES	NO

1.0 Situation

1.1 The current infrastructure limitations at the All Wales Adult Cystic Fibrosis Centre (AWACFC) based at the University Hospital Llandough (UHL) are recognised as a high risk in terms of their impact on quality and sustainability due to increased demand from population growth, increased life expectancy due to advances in medical care and treatment and a lack of appropriate in-patient facilities to care for a high risk patient cohort.

1.2 There is also a gap in meeting a number of the Cystic Fibrosis Trust Standards which was highlighted in their Peer Review in 2015. A gap analysis was undertaken on the provision of Cystic Fibrosis in Wales compared to NHS England providers. This also highlighted a shortfall in access to and the provision of Cystic Fibrosis services for patients in Wales.

1.4 This paper sets out the investment requirements to support the expansion of the AWACFC to manage and mitigate the risks with the current service and future demand to ensure that the service delivers in line with the Cystic Fibrosis Trust Standards.

1.5 The 2018-21 ICP highlighted CF as a key risk that was likely to present in year and require funding due to the service already exceeding the number of patients for the size/staffing of its service.

2.0 Background

2.1 Cystic Fibrosis (CF) is a complex, multisystem, progressive and ultimately fatal condition; a genetic disease affecting the body's ability to control the movement of salt and water between cells. People with CF experience a build-up of thick sticky mucus in the lungs, digestive system and other organs causing a wide range of challenging symptoms affecting the entire body. The airways become clogged with thick sticky mucus, which impairs the clearance of microorganisms. This leads to recurrent infection, inflammation, bronchial damage, bronchiectasis and eventually death from respiratory failure. Patients are often infected with Staphylococcus aureus and Pseudomonas aeruginosa but also by a number of other organisms, some of which are resistant to many antibiotics.

2.2 The adult service is provided by the AWACFC and the management of CF requires multi-disciplinary input with patients being susceptible to chronic infection, reduced lung function, digestive difficulty, diabetes and exacerbations resulting in frequent hospitalisation.

2.3 In July 2017, Cardiff and Vale University Health Board submitted a business case to WHSSC outlying the requirements for revenue investment for:

- The expansion of the multi-disciplinary staffing resource that supports CF patients.

- A proposal for formal provision of a prepared drug service at home for patients receiving IV antibiotics in line with CF Standards of Care.

- The establishment and associated costs of a proposed expansion from a 7 bedded to a 16 bedded unit. The expansion would also address the urgent improvement required in order to provide segregated care in ensuite cubicles, to reduce the risk of cross-infection and to meet the standards expected of a CF Centre.

2.4 The CF proposal was presented to a Management Group workshop in September 2017 where the key risks were highlighted and discussed with the Lead Clinician of the Centre. The workshop concluded that further information was required and a number of actions were agreed including a revised business case which would better reflect the model of care and a plan for implementing a phased approach to the investment.

2.5 CAVUHB submitted an addendum to the business case in April 2018. The addendum reiterated the significant risk within the current service, the case for investment and a phased approach to the investment.

3.0 Assessment

3.1 The CF Service at CAVUHB does not comply with the CF Trust Standards of Care and investment is required to deliver 3 key objectives.

- To increase the multi-disciplinary team to be able to match the minimum CF Trust Standards and deliver care and support to the current patient cohort of circa 300 and enable growth up to circa 350 patients.

- To develop and deliver the formal provision of a pre-mixed IV antibiotic drug service at home using ambulatory devices delivered by a Home Care company in line with other CF centres.

- To provide increased nursing and medical staff to support the proposed capital case to increase the current numbers of inpatient beds to 16.

It is proposed that the investment and development of the service to meet the 3 objectives is undertaken in a 2 phased approach.

- Phase 1 - Investment in multi-disciplinary staff to address the immediate high risk and development of the satellite clinics, virtual clinics and home visits by the MDT to support patients receiving pre-mixed IV antibiotics at home (2018/21)

- Phase 2 - Investment in ward staff to support an increased bed base (2019/22).

Phase 1 and 2 are inherently linked in order to ensure the ongoing sustainability of the service. However whilst Phase 2 is referred to within this paper the intention is to take this forward within the planning for the 2019/2022 ICP.

3.2 Current Service Model

3.2.1 The CF Centre at CAVUHB is the all-Wales provider for adults although North Wales have access the Liverpool Heart and Chest Hospital and Powys patients access Heart of England NHS Foundation Trust. Since 2004 the patient numbers have grown substantially from 104 patients to its current level of 293 and is projected to reach circa 350 patients by 2023. Growth is consistent with circa 15 patients per annum

3.2.2 The Cardiff Adult Service is expecting just over 65 paediatric transfers over the next 5 years. This taken in to consideration with patients who transfer in and out of the service and patient deaths the forecast patient population for the service by 2023 is 350 patients. The continued growth in the service is resulting in delays for in-patient treatment and a lack of capacity to deliver timely assessment and follow up care.

Table 1 depicts the current patient cohort number by patient bandings; a measure of progression, acuity and resource requirement.

Table 1

Resident Health Board	Band 1	Band 2	Band 3	Band 4	Band 5	Total Patients
ABMU	5	19	15	9	5	53
ABUHB	19	31	19	4	2	75
CAVUHB	15	36	15	6	6	78
CTUHB	5	15	12	4	1	37
HDUHB	2	18	6	2	0	28
PTHB	0	4	5	0	0	9
BCUHB	0	2	0	0	0	2
Total	**46**	**125**	**72**	**25**	**13**	**282**

This number does not include English patients cared for at the AWACFC.

3.2.3 Outpatient Clinics are held daily at UHL. Additionally, but not formally commissioned by WHSSC a joint CF Diabetes clinic is held monthly at the CF Centre. This has historically been provided on a goodwill basis; given the growth in patient numbers and their need for associated joint management, this is no longer sustainable.

3.2.4 A specialist clinic is undertaken monthly in Carmarthen by 0.025 WTE Physiotherapist and 0.025 Clinical Nurse Specialist. However this is provided in addition to day to day workload.

3.2.5 Inpatient care is provided through a dedicated bed base of 7 beds (only 1 bed has en-suite facilities) within the CF Unit and a dedicated cubicle on an outlying ward. This is the lowest bed base per patient ratio in any CF Centre in the UK and is the only adult CF Centre in the UK where patients are still sharing bathrooms. This issue was highlighted as requiring urgent resolution in the 2015 Peer Review undertaken by the CF Trust.

3.2.6 Medical care is provided by the consultant team and 1 middle grade doctor and supported by trainees. Out of hours clinical cover is provided by the UHB on call junior doctor team and by the CF consultant team. Out of Hours Consultant cover is not currently funded.

3.2.7 A pharmacy home care treatment is provided as described below:

- Intravenous antibiotic therapy, drawn up and self-administered by patients using drugs provided by UHL pharmacy. Patients collect the drugs and return for follow up care. There are patients who without formal arrangements for prepacked drugs are not suitable for treatment in this way and this provides further pressures on beds

- Inhaled prophylactic therapy provided by a homecare provider and consistent with NICE and WHSSC access policy

- Provision of Ivacaftor for a small cohort of patients who meet WHSSC access policy

3.2.8 There is a significant shortfall in the current service model when benchmarked against the CF Trust standards of care pro-rated to 300 patients (Table 2)

Table 2

Staff Group	UHL CF Centre	CF Trust SOC (300 patients)	WTE increase to meet CF SOC
Consultant	2.7	3	0.3
Middle grade	1.0	2.4	1.4
Specialist Nurse	5.4	6	0.6
Physiotherapist	5.0	7.2	2.2
Dietician	2.0	2.4	0.4
Social Worker	1.0	2.4	1.4
Psychologist	1.1	2.4	1.3
Pharmacist	1.0	1.2	0.2
Secretary	2.0	2.4	0.4
Data Clerk	0.6	1.2	0.6
CF Centre Manager	1.0		
Dietetic Assistant	0.5		
Physio assistant	1.8		
Outpatient / clerk /receptionist	1.0		
Total			**8.8**

3.2.9 During 2015/16, in order to start addressing the recommendations of the peer review, investment was secured to support the appointment of a middle grade doctor and enhanced pharmacy support to 1 WTE.

3.3 Service Model requirements for sustainability and growth– investment in MDT staffing

The phase 1 multidisciplinary staff investment will increase capacity for clinical decision making, management, monitoring and follow up care. The investment will strengthen the existing clinics and enable MDT clinics to be established to concentrate specialist expertise in a single setting closer to home. The specialist joint clinics will be supported by the following staff:

- Consultant/Middle Grade Doctor
- CF Clinical Nurse Specialist
- Specialist Physiotherapist
- Dietician

Location for the new clinics will need to be considered further and in discussion with Health Boards but would likely be based on geographical demand.

3.3.1 The development of virtual clinics which enable the stable patient to be reviewed by the whole MDT without having to travel long distances has been positively received by patients. Whilst this is a developing additional model of outpatient care, 23% of patients have accepted the offer of a virtual clinic and this is expected to rise to 50% over the next year.

3.3.2 In order to sustain and increase support in clinics and ward support, formalisation of the arrangements for providing liver and diabetes care to CF patients is fundamental in order to stabilise the service. This would be provided through 0.20 WTE increase Diabetes Nurse Specialist support and 0.01 and 0.20 WTE liver and diabetes consultant sessions. Demand has increased and funding would enable an increase in the joint diabetes clinics from 1 per month to 2 per month and also provide support for ward reviews, drop-ins and enable patients to be followed up in a more timely manner as per CF Trust guidelines. The benefits of joint working arrangements has been demonstrated by reduced number of DNA's at separate clinics and ensured appropriate follow-up management. Previously patients would have increased exacerbations of their CF relating to repeated hyperglycaemic events resulting in poor diabetic control.

3.3.3 Over the last year the need for input from palliative care has increased significantly with post lung transplant rejection patients requiring optimisation of pain relief and support as their near end of life. Additionally with the increasing prevalence of mycobacterial infections the need for prolonged emetogenic eradication therapies has increased. Input from the palliative care team is invaluable.

3.2.4 Due to the continued growth in patient numbers, and no increase in adult Clinical Nurse Specialist support the service requires additional specialist nursing care to ensure adequate capacity throughout the year. The service is seeking funding for the appointment of one nurse specialist to increase provision to support the current patient numbers and in line with the recognised growth. This post will also support the development of the increased outreach clinics, virtual clinics and the patient training needs.

3.3.5 An additional Outpatients Health Care Support Worker will meet the demands of the current outpatient clinics and support the proposed increase in the number of outreach clinics.

3.3.6 CAVUHB has appointed 0.6 Data Entry post at risk in order to comply with the CF Trust standards to ensure accurate and timely submission of the required data and have been incurring costs since 2016. In order to provide appropriate cover and the submission of timely data 1.0 WTE investment is sought.

3.3.7 The AWACFC is managed by a dedicated centre manager. In line with other centres and in recognition of the roles and responsibilities of the post holder, this post has been recently rebanded from Band 6 to Band 7. CAVUHB seek support for the uplift in costs of this post. An example of the value in this post has been demonstrated by the successful application of grants which has resulted in circa £100k funding to support the purchase of equipment for development of the virtual clinics and for individual patients which would otherwise be sought from NHS funding.

3.3.8 Due to the current number of patients and the recognised growth the case asks for 1 wte specialist doctor to support the ward, provide cover and support clinics including outreach and virtual clinics.

3.3.9 Physiotherapy is a critical part of the daily treatment regime required to keep people with cystic fibrosis (CF) as healthy as possible. Currently there is a gap of 2 wte physiotherapists to meet the needs of the current patient cohort. CF patients require intensive physiotherapy and regular assessment and monitoring is necessary during physiotherapy treatment as the patient may require supplemental oxygen, especially in advanced cystic fibrosis. For few or no lung secretions, treatment sessions may only need to last 10–15 minutes, but if there are many it could take 45–60 minutes. Patients are taught by specialist physiotherapists to undertaken their own therapy at home but often require intensive support when admitted for exacerbations. The investment in physiotherapy time will support the current patient numbers and enable the service to increase the outreach and virtual clinics.

3.4 Service Model requirements for sustainability and growth – investment in home IV antibiotic service

3.4.1 The implementation of a formal home pre-mixed IV antibiotic service using ambulatory devices and delivered by a Home Care company will ensure that patients no longer have to draw up and administer their IV antibiotics, thus reducing risk and enhancing the patient experience. The provision of this service will also enable those patients who are unable to draw up and administer their IV antibiotics the ability to have treatment at home, releasing pressure on in-patient beds. This service will be supported by the increased outreach and virtual clinics described above.

3.4.2 The proposed model of care enables patients to be managed within their own homes and facilitates earlier discharge of patients from the inpatient bed base. Patients are taught to attach the prepared drugs and care for lines themselves under strict aseptic technique; this can be to 3-4 times per day.

3.4.3 Whilst it is recognised that Home Care services are established in local health boards, home IV treatment for CF patients requires support from the tertiary centre as patients require close and careful monitoring around their

condition. This level of monitoring can only be provided by staff with the appropriate specialist knowledge. The patients require regular review of their individual response to treatment and swift intervention as patients may need rapid transfer to inpatient care if their condition changes or if treatment does not have the expected impact. This model mirrors other CF services across the UK.

3.5 Investment Sought

Phase 1 –Investment in multi-disciplinary staff

Table 3

MDT and Outpatient Staff Requirement	WTE	Band	Recurrent Cost (£'000)	2018-19	2019-20	2020-2021	Comments
Outpatient nurse	1	2	22	22	22	22	Costs incurred from 01.04.18
Data Entry (Port CF)	1	2	22	22	22	22	Costs incurred from 01.04.18
Clinical Nurse Specialist	1	6	45	15	45	45	In post from 01.12.18
CF Centre Manager Uplift	0	7	9	9	9	9	Costs incurred from 01.04.18
Diabetes Consultant sessions	0.2	Cons	25	25	25	25	Costs incurred from 01.04.18
Diabetes Specialist Nurse	0.2	6	9	9	9	9	Costs incurred from 01.04.18
Physiotherapist	2	7	106	35	80	106	In post from 01.12.18
Palliative Care	0.02	Cons	3	3	3	3	Costs incurred from 01.04.18
Liver care	0.01	Cons	2	2	2	2	Costs incurred from 01.04.18
Clinical Psychologist	1	8b	66	11	66	66	In post from 01.02.19
Specialist Registrar	1	Sp.Dr	73	12	73	73	In post from 01.02.19
Staff related non pay			12.00	5	12	12	
Total	**7.43**		**394**	**171**	**368**	**394**	

***Table* 3** sets out the detail of what the investment would provide in terms of uplifting the clinical workforce in line with the standards of care and service requirements in a phased approach to the implementation of the investment from 2018 to 2019. For PYE 2018/19 it shows that there is a need for **171k** with a recurring costs of **£394k from 2020/21**.

The investment sought for 2018/19 is intended to:

- Appoint to the most urgently required members of the multi-disciplinary team to improve the standard of care delivered to the current patient cohort and enhance their experience. The investment will also enable the team to deliver against the CF Trust Standards.

- Increase the number of Outpatient Clinics and enable implementation of formal specialised outreach clinics and virtual clinics for patients to be cared for closer to home.

- Provide support to the delivery of the proposed Premixed IV antibiotic service in terms of the specialised monitoring of patients.

Phase 1 investment will stabilise the infrastructure for the current and expected patient growth for 2018/19 (circa 320). Further investment for 2019/20 and 2020/21 will build on 2018/19 investment and provide flexibility to support the required increase in bed capacity and manage the forecasted growth of the service (350 patients).

3.6 Phase 1 – Provision of a Premixed IV Antibiotic Service

3.6.1 As previously described the current home care service is recognised as a significant risk.

3.6.2 In a situation where the number of beds being proposed (phase2) is lower than what is nationally recommended, this additional service enables an increase in capacity to deal with both the current inpatient waiting list and the expected increase in numbers of patients managed within the CF service.

3.6.3 Table 4 sets out the proposed costs of delivering an IV home care service.

Table 4

Investment	2018-2019 (PYE)	2019-2020 (£'000)	2020-2021 (£'000)	Comments
Premixed IV Service	83	500	500	Service to commence from 01.02.19

For 2018/19 an indicative cost of £83k has been included. Costs are based on the assumption that the service would be commenced in February 2019 following competitive tendering. An indicative cost of £0.500m has been incorporated into the full funding requirement as it is difficult to benchmark and compare homecare companies due to commercial and marketing confidence. The requirement reflects the net costs of introducing the

prepacked IV antibiotic service, including pharmacy savings inclusive of VAT through the reduction in hospital issues.

3.6 Total Investment Required Phase 1

Table 5 depicts the total investment required for Phase 1.

Table 5

Investments	2018-19 (£'000)	2019-20 (£'000)	2020-2021 (£'000)
MDT	171	368	394
IV Service	83	500	500
Total	**254**	**868**	**894**

3.7 Current contracting arrangements

3.7.1 The service is currently funded through a cost and volume model based on a registered cohort of patients grouped into relevant bands (Table 1); a measure of their progression, acuity and resource requirement. Variations in performance have a 50% marginal cost applied and growth has historically been funded on the same basis through the LTA cost and volume contract.

3.7.2 The bandings reflect the UK National standards with the exception that the CF Trust introduced 1A and 2A some years ago with 1A reflecting those patients who become infected and may require short term nebulised antibiotics or a course of IVs to eradicate with no other complications and very mild disease overall. 2A includes patients who require a short number of IVs but are on relatively costly nebulised therapies.

3.8 Implications of not approving the investment

The AWACFC will remain unsustainable for current service and patient needs. The risk to the sustainability and quality of the service has been recorded on the CAVUHB's risk register as an extreme risk rating of 20 and this is the same risk rating on the WHSSC risk register. The current level of service provided will remain below the expectation of the CF Trust Standards and continue to benchmark poorly with other similar sized CF units across the UK. Specific risks are described below:

- Closure of the AWACFC to new patients at 300 (service currently at 293). Adult Welsh patients will need to be referred to receive care in English CF Centres. However not all English Centres are receiving new patients due to capacity i.e. Birmingham, which would impact on the Welsh service.

- Patients will continue to receive suboptimal care, including those with related complications e.g. diabetes and liver disease. Such complications will also continue to increase in current patients as longevity continues to rise.

- Patients will continue to wait up to 2 weeks for admission with the continued risk of deterioration. This situation is unacceptable given the high risk patient cohort.

- The satellite services, expansion of virtual clinics and provision of pre-mixed IV antibiotics at home would not be introduced which would not only fail to expand patient services closer to home, but would also leave patients self-administering treatments at home with insufficient monitoring and increased clinical risk.

4.0 Recommendations

4.1 This proposal was considered at the June meeting of the WHSSC Management Group. Following discussion, members recognised the fragility of the current service, and the need to stabilise the infrastructure in order that it is able to manage the existing patient cohort and the expected patient growth within 2018/19. However, members ask that further work was undertaken by the provider to clarify the model and full year costs of the Premixed IV Antibiotics Service.

4.2 Members recommended investment in the MDT and the part year effect of the Premixed IV Antibiotics Service, subject to the provider undertaking further work on the model and full year costs, and resubmitting for consideration as part of the next planning round.

4.3 Members are asked to:

- **Note** the information presented in the report and the impact of non-investment

- **Approve** the investment in the MDT on a recurrent basis, and the part year effect of the Premixed IV Antibiotic Service.

5.0 Appendices / Annexes

5.1 Adult Cystic Fibrosis – Quality, Sustainability and Growth, Cardiff and Vale UHB Business Case

5.2 Cystic Fibrosis Business Case Addendum – Cardiff and Vale UHB

Link to Healthcare Objectives	
Strategic Objective(s)	Organisation Development Governance and Assurance Choose an item.
Link to Integrated Commissioning Plan	The 2018-21 ICP highlighted CF as a key risk that was likely to present in year and require funding.
Health and Care Standards	Safe Care Effective Care Staff and Resourcing
Principles of Prudent Healthcare	Choose an item. Reduce inappropriate variation Only do what is needed
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Improving Health of Populations Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	Quality, Safety and Patient Experience will all be improved with the additional multi-disciplinary staff. The service will be able to provide a safe and sustainable service to the current patient cohort whilst enabling the service to meet the projected growth in patient numbers. The service will meet the requirements as laid out by the CF Trust
Resources Implications	The purpose of this paper is to seek a phased investment in the All Wales Adult Cystic Fibrosis Centre
Risk and Assurance	The risks within the current service and the impact of non-investment are highlighted
Evidence Base	
Equality and Diversity	North Wales patients have access to the Adult Cystic Fibrosis service in Liverpool, which meets all the staffing requirements for a specialist CF unit.
Population Health	
Legal Implications	No legal implications are noted

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Management Group	21/06/2018	Recommend approval at Joint Committee to fund MDT and the part year impact of the Premixed IV Antibiotic Service as part of the WHSSC contingency for 2018/19. Cardiff to undertake further work on the model and full year costs of the Premixed IV Antibiotic Service and resubmit, along with the Phase 2 proposal for consideration in the 2019-22 Integrated Commissioning Plan
Choose an item.		

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Annual Revenue Requirement	**First Year (£) 2018/19**	**Recurrent (£)**
	£1.044m	£2.215m
Capital Requirement (£)	TBC – Full case submission to Welsh Government pending	

Context

Cystic Fibrosis (CF) is a complex, multisystem, progressive and ultimately fatal condition; a genetic disease affecting the body's ability to control the movement of salt and water between cells. People with CF experience a build-up of thick sticky mucus in the lungs, digestive system and other organs, causing a wide range of challenging symptoms affecting the entire body.

Services for adults are provided through the All Wales Adult Cystic Fibrosis Centre (AWACFC) at University Hospital Llandough, and are commissioned by WHSSC. Management of CF requires multi-disciplinary input, with patients susceptible to chronic infections, reduced lung function, digestive difficulty, diabetes and exacerbations resulting in frequent hospitalisation.

Services are funded through a 'cost and volume' model based on the patients' bandings; a measure of their progression, acuity and resource requirement. Growth has historically been funded on a 50% marginal cost basis through the LTA, with certain prophylactic drug regimes paid for separately.

Population growth, advances in medical care slowing disease progression and the resultant increase in life expectancy of CF patients has placed compounded demand pressures on the service. The AWACFC cohort has nearly trebled in the last 13 years, and the service now faces several quality and sustainability challenges. These were highlighted through a CF Trust Peer Review Report in 2015.

The key areas of concern directly affecting patients are:

- the need for a substantial increase in inpatient capacity
- the need for improvement in facilities to, for example, avoid cross infection
- the need to increase and strengthen staff resource across various disciplines
- the lack of formal homecare support for IV therapies and associated risks
- a failure to meet CF Trust Standards of Care

Proposal
This case sets out the need for the associated revenue expense in association with the expansion of the multi-disciplinary staffing resource that supports CF patients, as well as the establishment and associated cost of a proposed expansion from a 7 bedded to an 18 bedded unit. It further considers the option of formal homecare support for patients receiving IV antibiotics as part of the model of care.

Investment to support the expansion of the team and the provision of a homecare service will provide qualitative benefits to the current CF service. The investment aims to align current staffing levels, to match as a minimum to CF standards for 250 patients, to support the current patient cohort of circa 300 patients with scope to accommodate growth and provide equitable access to formal homecare services as provided by other CF centres. The requested investment into ward staffing would provide both qualitative enhancements as well as supporting capacity expansion.

Multi-disciplinary staffing specific benefits:

- Increased resource to provide a safe/sustainable service
- Meets CF Trust, Standards of Care Guidelines
- Meets CF Trust Peer Review 2015 recommendations
- Patients will receive access to clinical input in a timely manner
- Ensures operational services are maintained to a high level
- Expansion of clinics to include outreach clinics, virtual clinics, supportive (palliative) care, joint CF-Related Liver Disease (CFLD) and joint CF-Related Diabetes (CFRD) clinics

Ward specific benefits:

- Reduced risk of Welsh CF patients being transferred to English CF centres (15-20 per annum to 0)
- Reduced admissions waiting list to under 24 hours
- Meets CF Trust Peer Review report recommendations and Standards of Care guidelines
- Minimises cross infection risk
- Reduction in waiting list for admissions (at the point of need)
- Equitable care for all Welsh adult patients

Homecare specific benefits:

- Reduce some of the pressure on inpatient beds
- Meets CF Trust Peer Review report recommendations and Standards of Care guidelines
- Reduces clinical risk in patients drawing up and self-administering treatments
- Increased capacity in order to ensure timely reviews
- Reduces patient travel times and improves quality of life
- Satisfies the Health Board and Welsh Government vision of providing care closer to home where possible.

Options
This case presents three options;

1. Do nothing
2. Investment in multi-disciplinary staffing resource and ward expansion
3. Investment in Option 2 and formal homecare services.

The table below summarises the recurrent investment requirement to deliver as detailed in the case. The detail of the investment is set out within section 7.

Business case element	Option 1 (£'000)	Option 2 (£'000)	Option 3 (£'000)
Multi-disciplinary staffing resource	-	669	669
Ward expansion requirement	-	1,046	1,046
Pharmacy homecare	-	-	circa 500
Total	**-**	**1,715**	**2,215**

This case recommends the approval of **Option 3**. It also shows that the investment sought benchmarks in line with English tariff arrangements.

Option 1 is not considered viable, presenting unacceptable sustainability and patient safety risks. Option 2 may be considered viable but would require greater reliance on hospital services, inconsistent with other CF Centres and the drive to deliver care at home where best for patients.

Risks
Should the CF service not receive investment for these developments, current inpatient beds will be under increasing pressure, with continued and worsening lengthy waits for admissions with increased clinical risk associated with deteriorating health. Lack of investment will unfortunately see the current service need to 'close doors' to new patient referrals including paediatric transfers, as there is no capacity for further growth in patient numbers within the current facilities and staffing levels.

Current patients will continue to receive sub-optimal care as there will be an inability to deliver sustainable services for those newly diagnosed with CF related complications e.g. diabetes and liver disease; such complications will continue to increase in current patients as longevity continues to rise in patients with CF.

The implications and risks of not progressing the business case elements are as follows:

- Closure of service to new patients including transfers from paediatrics service (circa 15 per annum). Adult Welsh CF patients will need to receive Specialist CF Care in English CF Centres
- Current waiting list (3-12 patients at any given time waiting up to 2 weeks) for admission will continue to rise, increasing risk further
- CF Trust Peer Review report recommendations will not be addressed
- Major cross-infection risk will remain with shared bathroom facilities
- The national all-Wales service at UHL will remain unsustainable for current patient requirements
- Specific risks in some staffing groups will present an inability to provide virtual and satellite clinics and further development of specialised services leading to poorer patient outcomes
- On-going reliance on hospital setting if homecare provider for IV administration not implemented putting further pressure on inpatient beds

2. Introduction and Background

Context

Cystic Fibrosis (CF) is a complex, multisystem, progressive, and ultimately fatal genetic condition affecting more than 10,800 people in the UK. You are born with cystic fibrosis and cannot catch it later in life, but 1 in 25 people carry the faulty gene that causes it, usually without even knowing. The gene affected by CF controls the movement of salt and water in and out of cells.

People with cystic fibrosis experience a build-up of thick sticky mucus in the lungs, digestive system and other organs, causing a wide range of challenging symptoms affecting the entire body. The build-up of mucus in the lungs causes chronic infections, meaning that people with cystic fibrosis struggle with reduced lung function and have to spend hours doing physiotherapy and taking nebulised treatments each day. Exacerbations (a sudden worsening of health, often owing to infection) can lead to frequent hospitalisation for weeks at a time, interfering with work and home life. As the pancreas becomes blocked with mucus, enzymes required for digesting food cannot reach the stomach. People with cystic fibrosis often need to take more than 50 tablets a day to help digest food and keep respiratory symptoms in check.

Cardiff and Vale University Local Health Board ("the UHB") is the all-Wales provider for adult CF services; the service is one of the largest within the UK and has in recent years developed a reputation as a centre of excellence.

Only 1 in 4 GPs will have a patient with CF on their registered list; very few will have experience of CF during training. As a result, most of the primary care support, as well as tertiary specialised care is managed through the All Wales Adult Cystic Fibrosis Centre (AWACFC), where a multi-disciplinary approach is required, given the range of clinical skills essential in delivering effective outcomes to patients.

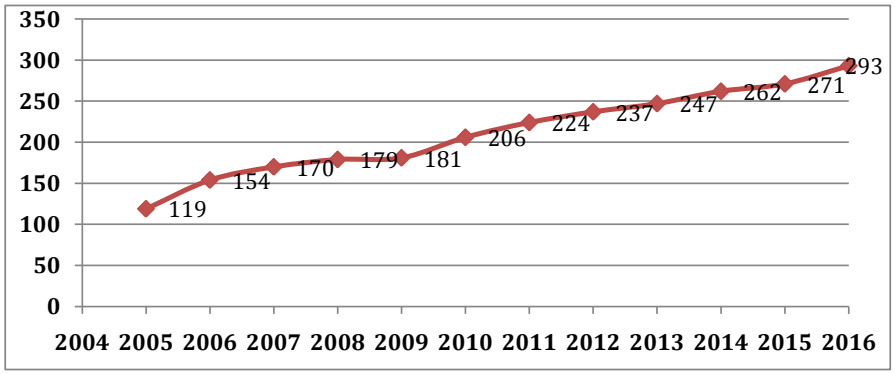
CF patients are commonly categorised into five 'Bandings'. These are reflective of disease progression, acuity and resource requirement in managing a patient's care, with Band 1 being the least severe and Band 5 being the most severe.

Anecdotally, the number of patients in the higher bands of disease severity is likely to rise accordingly as patients continue to live longer, with additional complications, coupled with a greater number of pre and post lung transplant patients.

Growth

Since 2004, the service has expanded from 104 patients to its current level of 293 patients (with a projection of 312 patients by 31st March 2018). Service growth is consistently around 15 new patients per annum.

The graph below shows the historic patient growth since 2005.



Predominantly, growth has been within Bands 2 and 3, although there is an inevitable progression to Band 5, offset by patient deaths or successful lung transplantation.

The table below shows the banding changes since 2010.

Year	Band 1	Band 2	Band 3	Band 4	Band 5	Total pts
2010	44	88	39	24	11	**206**
2011	41	88	60	26	9	**224**
2012	43	91	69	25	9	**237**
2013	46	99	72	20	10	**247**
2014	46	108	73	27	8	**262**
2015	45	117	74	26	9	**271**
2016	46	133	76	24	14	**293**

Patient numbers for 2017 are predicted to rise further with paediatric transfers to adult services. There will also be additional patients including students moving into Wales and patients with newly diagnosed CF further increasing patient numbers.

The following graph profiles the number of paediatric patients who will transfer to the adult service in 2017-18 and subsequent years:

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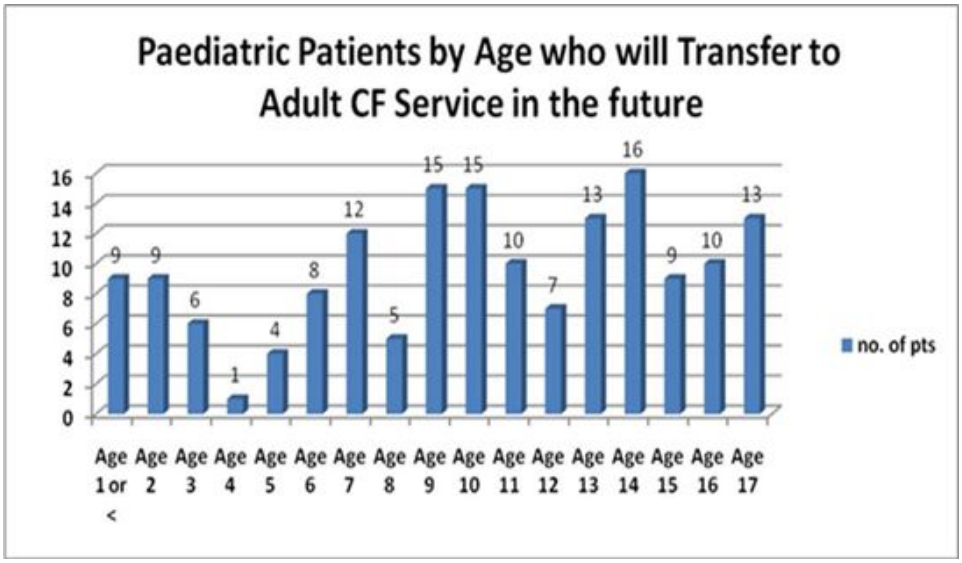
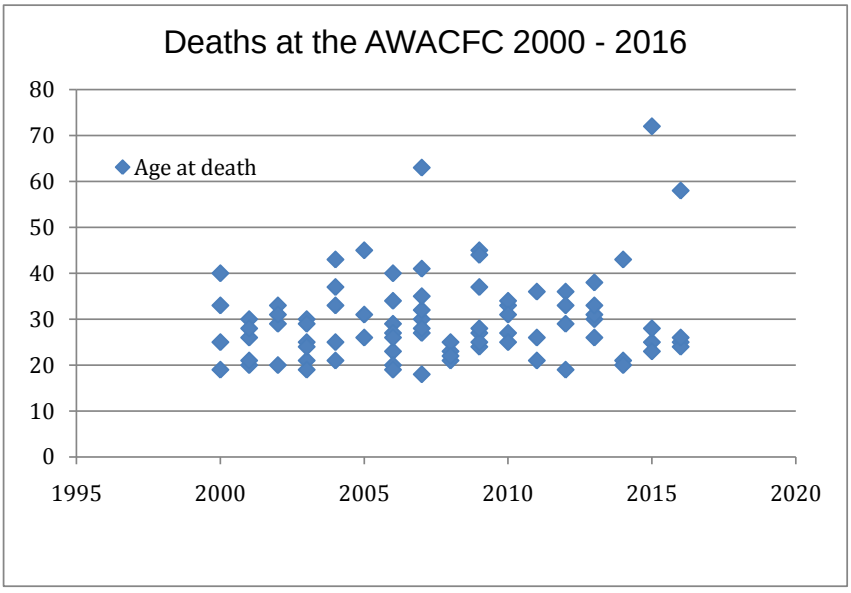


The graph represents 113 transfers in the next 10 years based on those patients turning 17 years old, including a transfer within 2017-18 of 13 patients as a minimum. Some transfers do also occur prior to a patient's 17th birthday. Furthermore, there will be annual net migration to Wales which will increase the patient cohort by 3-5 per annum. The service currently sees 11 patients from England.

With CF specialist centre care, new therapies and lung transplantation, survival in CF continues to increase and, therefore, life expectancy should also be considered when discussing the growth in number of CF patients. As demonstrated in the graph below the number of deaths has decreased in relation to the patient population. Mortality in 2016 was 4/292 patients (1.4%) compared to 8/154 (5.2%) in 2006. Future care will no longer be for 'young adults' but will support an ageing CF patient population, addressing not only the current associated complications linked to CF, but also those of ageing.



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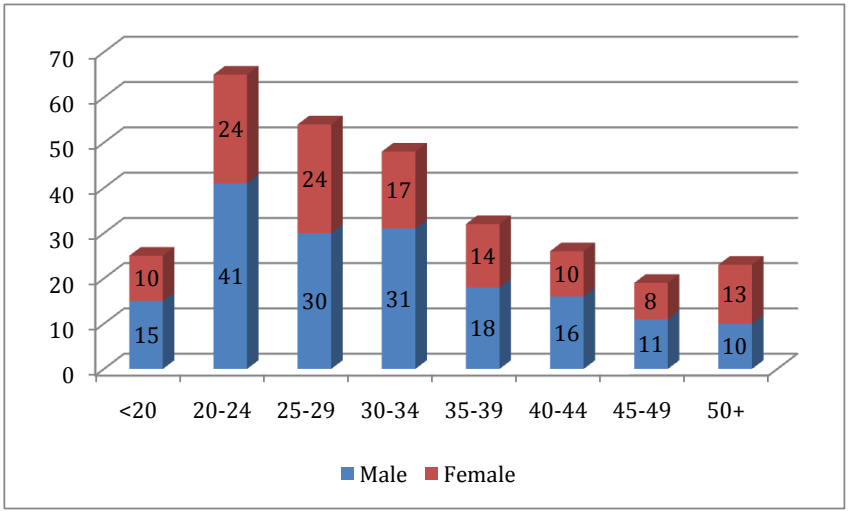
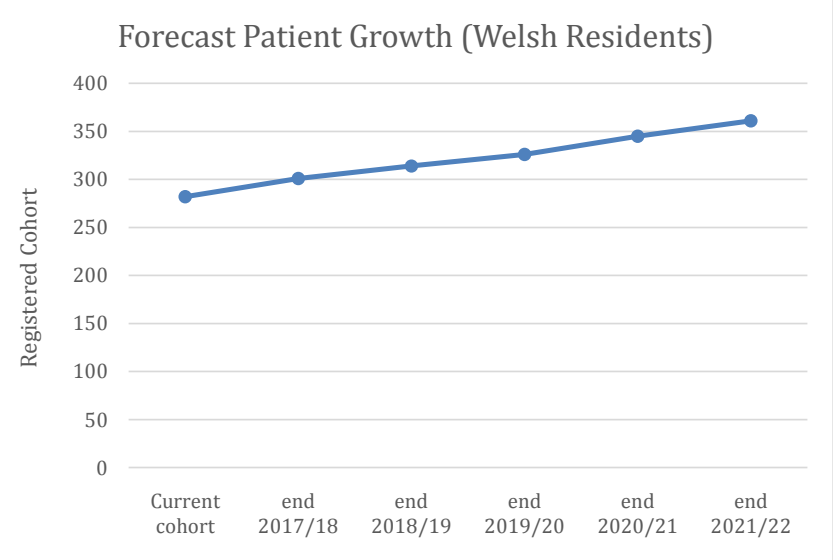
The following graph shows the breakdown of patient numbers by age and sex (2016), further highlighting the ageing demographics.



On balance, given the above, the forecast growth in the registered Welsh resident CF cohort over the next five years is set out below:



Standards

Standards of Care for CF are clearly outlined by the CF Trust. It is recommended that the capacity for any service provider is 250 patients, albeit in reality a small number of very large centres exceed this number, including the AWACFC.

Currently, the CF service in UHL is constrained by a dedicated CF bed base of 7 (only 1 en-suite) within the CF Unit and 1 dedicated cubicle on an outlying ward. The CF Trust has indicated that this results in one of the lowest beds per patient ratio for any centre in the UK and is well below expected standards. In addition, the CF Trust has confirmed it is the only Adult CF Centre in the UK, where patients are still sharing bathroom facilities.

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A CF Trust Peer Review Report (2015) highlighted the following recommendations:

The key recommendations were:

- The inpatient facilities need urgent improvement in order to provide segregated care in en-suite cubicles, to reduce the risk of cross-infection and to meet the standards expected of a CF Centre.
- Further development of the multidisciplinary team is needed for pharmacy, psychology and social work input to bring the service into line with the 'Standards of Care (2011) guidelines.
- The service currently has no middle-grade medical staff. With patient numbers at over 260 and as patient numbers and complexity increases a middle-grade (speciality doctor) should be appointed as a priority. This should be immediate and is absolutely pivotal for continued service development and growth.

The Peer review also provided areas for further consideration:

- Development of a comprehensive home intravenous (IV) antibiotic service with delivery of pre-prepared antibiotics to patients in their homes would help in modernising the delivery of care.
- Consideration of the feasibility of expanding on the out-reach clinic, with more of the specialist team travelling to Carmarthen for clinics, so that some routine care can be provided close to home, reducing the burden of travel for patients.
- Consider formalising the out-of-hours medical cover and developing the weekend physiotherapy service for patients with cystic fibrosis, to ensure sustainability of the service for the future.

In order to begin to address the 2015 peer review recommendations, the CF Centre submitted a business case to WHSSC during 2015/16 and secured additional investment that supported recruitment of a Middle Grade post and enhanced pharmacy support to 1 wte.

In addition to this the UHB prepared a Business Justification Case to Welsh Government for the expansion of the current CF Centre in UHL to allow for the implementation of an improved bed base and one that meets cross infection and segregated care standards noted above. The BJC has been supported by Welsh Government and WHSSC.

The purpose of the CF service development in UHL is to improve the standards of care delivered to patients with CF and to provide an environment that is appropriate to the needs of this specific cohort of patients. This will ensure that patient experience is both improved and met, as well as being able to manage the progression of this disease. The case also supports the further development of the multi-disciplinary team to support a growing patient population, going some way to establish a sustainable service for this expanding patient cohort.

The CF development will also support the successful implementation of the CF Peer review recommendations 2015; as well as providing support to the growing population referenced above. Furthermore, WHSSC has provided the UHB with a letter of support in principle that indicates support to the development of this business case to improve CF services at CAV UHB.

Benchmarking with other Adult CF Centres

For the purpose of this business case, and to ensure that there is equitable care for all adult CF patients in Wales, the Liverpool Adult CF Centre is the most appropriate centre when considering benchmarking. Liverpool is highlighted in the benchmarking table included as ***Appendix A*** for reference against the AWACFC.

Liverpool CF centre cares for North Wales CF patients. With a current bed base of 16, more timely admission at the 'point of need' is the norm for North Wales patients.

SWOT Analysis of Adult CF Service

Strengths	Weaknesses	Opportunities	Threats
Positive patient feedback (WHSSC patient survey 09/14) Patient centred service with daily segregated clinics in a dedicated out-patient area Specialist multidisciplinary team Good external links with paediatric services and other specialist services in Wales Joint working with diabetes, microbiology, palliative care and liver teams Virtual technology linking team to patient at home and Harefield for joint MDT working (pre and post transplant) Strong research and development programme	Inadequate inpatient beds to patient ratio No homecare delivery service Shortfall in some areas of MDT Location of current inpatient CF ward separate from CF centre Untimely review of patients with associated complications of CF i.e. CFRD, CFLD and supported care Underdevelopment of satellite clinics to enhance patient care and promote effective, safe clinical management closer to home Lack of homecare provision to enable some patients to receive IVs in a safe, supported manner Inequitable care with North South divide for inpatient care	Dedicated new ward area identified within existing CF Centre with planning permission approval and WG support Further development of virtual patient clinic reviews Satellite clinics in Carmarthen area and Gwent area Further development of joint clinics in CF/Diabetes, CF/Liver and CF/Supported care Development of a homecare delivery service	Revenue implications Lack of progress with timely submission to WG for funding of refurbishment and expansion of first floor of CF Centre to a fit for purpose 18 bedded

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3. Summary Strategic Context

The case will support the development of safe and sustainable services for CF patients, while simultaneously improving access to specialist MDT colleagues to support their complex pathways.

The CF centre is continuing to develop its technological agenda to be able to deliver remote services to a geographically disparate population, thus bringing care closer to home for patients (where clinically appropriate), making the agenda pertinent to prudent healthcare.

The expansion of the CF centre aligns to the UHB's Shaping Our Future Wellbeing strategy by:

- Avoiding harm, waste and variation
  - Adopt evidence based practice, standardising as appropriate
  - Fully use the limited resources available, living within the total
  - Minimise avoidable harm
  - Achieve outcomes through minimum appropriate intervention
- Home first – enable people to maintain or recover their health in or as close to home as possible
- Improved use of virtual technology to reduce hospital attendance

The WG Tier 1 targets impacted by the CF Centre are outlined below:

- Infection control compliance
- Patient Flow
  - Length of stay
  - Delayed Discharges

The National CF Trust standards provide guidance around:

- Models of care
- Delivery of care
- Principles of care
- Multidisciplinary care

This case aligns with the standards highlighted by the CF Trust.

There are some clear benefits to supporting outreach clinics, accurate bed base, virtual clinics and home care packages:

Centralisation of all inpatient facilities into the CF centre in UHL will allow for the improved use of space and, therefore, the service will have improved layout of clinical and non-clinical services. Thus, increasing patient access and satisfaction. This would bring the CF centre in line with other centres within the UK.

Quantitative benefits will see a potential reduced number of transfers of patients to other CF centres, as well as a reduction in MDT travel to other providers to support patient care. As a result, length of stay figures could be reduced by ensuring timely specialist input and, therefore, timely specialised treatment.

Increasing the bed base of single cubicle beds within CF will support to reduce the risk of cross infection of patients and risk of spread and transmission of infection. This would bring the CF unit into an equal position with other CF centres in the UK.

Providing satellite clinics ensures a sustainable model of care, which is supported through virtual technologies; all of which will enhance care at patient's home, work or place of study.

The infrastructure and service funding requirements for the adult CF centre are equivalent to those required by other large adult CF centres across the UK (see Appendix A).

It is also acknowledged across UK CF Centres that the acuity of patient care has risen in recent years with the routine use of non-invasive ventilation, care of pre-transplant patients awaiting transfer to Harefield Hospital (Transplant Centre) and those stepping down from ITU/HDU. This is driving a need for increased bed capacity for CF services as noted within the benchmarking data for Manchester (Appendix A).

4. Summary Current Service Provision

Activity and Funding

The table below provides a summary of the number of patients currently supported by the CF Centre; the table highlights patients from Wales and their associated disease banding. It should also be noted that the UHB also provides care to 11 patients who are resident in England.

Resident Health Board	Band 1	Band 2	Band 3	Band 4	Band 5	Total Patients
ABMU	5	19	15	9	5	53
Aneurin Bevan	19	31	19	4	2	75
Cardiff & Vale	15	36	15	6	6	78
Cwm Taf	5	15	12	4	1	37
Hywel Dda	2	18	6	2	0	28
Powys	0	4	5	0	0	9
Betsi Cadwaladr	0	2	0	0	0	2
Total	**46**	**125**	**72**	**25**	**13**	**282**

The agreed contract framework for Adult CF is an acuity model reflecting the current number of patients supported by Band, with an agreed annual price per banding category reflecting the annual treatment costs. This ranges from a Band 1 patient, where treatment will typically be outpatient or annual assessment based, with the patient successfully managed on an agreed drug regime, through to a Band 5 patient who is a long-stay hospital inpatient at end stage disease requiring almost back to back intravenous antibiotics and / or on a waiting list for a Bilateral Sequential Lung Transplant.

The contract baseline for CF for 2017/18 reflects the financial assessment under the rebasing exercise to an activity level of 225. Against this, there has been significant marginal growth funding and investment in a couple of specific posts. This equates to a financial baseline of £3.6m. This is set out below by patient band:

Banding	Band 1	Band 2	Band 3	Band 4	Band 5	Total
Registered Patients	40	84	70	22	9	**225**
Rebased Cost Assessment	£96,757	£615,301	£1,067,664	£750,457	£449,237	**£2,979,416**
			Marginal Growth / Other Funding			£620,481
			LTA Baseline			**£3,599,897**

In addition to the contract baseline, funding is received for actual expenditure of Ivacaftor and new Inhaled Therapies, which had a combined funding level in 2016/17 of £1.7m.

Performance is assessed at an historic 50% marginal basis, with activity reported based on a quarterly review of the patient cohort and bandings. The service is materially over-performing against baseline. It is noted that WHSSC and its predecessor have provided funding for elements of recurrent over-performance and this is also considered when calculating current financial year over-performance.

The Cystic Fibrosis Unit

The strategic re-modelling of UHL has incorporated the development of a three-storey CF Centre, which opened in June 2013. This facility has enabled the outpatient clinic infrastructure required to be delivered. The Adult CF Centre enables the entirety of the CF team to be co-located adding to the quality of the multi-disciplinary service provided.

This facility enables more structured planning of the service allowing improved effectiveness in delivery of care, which includes:

- More timely and appropriate patient annual reviews
- More structured follow-up arrangements around complex patients to include pre and post-transplant, special infections, uncontrolled diabetes, low and raised BMI, liver disease and supportive (palliative) care.
- Opportunity to introduce virtual clinics that will contribute to the effective management of patients who live further afield from the tertiary centre.

Current Bed Base

The inpatient service is constrained by a bed base of 7 (historically funded) within the CF Unit and 1 dedicated cubicle on an outlying ward at UHL (for special infection patients). The CF Trust Standards of Care suggests that 6 – 10 inpatient beds reflect the requirements of a centre supporting 100 patients. This results in the CF Unit having the lowest beds per patient ratios for any centre in the UK and is well below expected standards.

Of the 7 beds on the CF Unit:

- 6 are standard side rooms that are not en suite and present infection control risks for patients with CF.
- 1 side room has en suite facilities.

Outside of the CF Unit:

- There is one dedicated CF bed with en suite facilities for special infection CF patients on an outlying ward.
- From time to time the service also makes use of 2 side rooms on another

outlying ward, but admission is competitive with acute general admissions, furthermore, these do not have en suite facilities or educational or recreational facilities that would reasonably be expected for a teenager or young adult spending prolonged periods of time in hospital.

A waiting list for admission of between 3 and 10 patients at any one time has become the norm given capacity pressures on the physical infrastructure.

The CF service requirements have two key components from a staffing infrastructure perspective, the ward infrastructure dependant on the BJC approval and the MDT staffing available to support the ongoing care in every aspect of the current and growing patient cohort.

Current CF Ward Staffing
The current ward staffing is highlighted in the table below:

Band	Current CF Unit (WTE)
Band 7	1.00
Band 6	3.00
Band 5	8.11
Band 2	2.78
Ward Reception	0.75
Staffing Sub-Total	**15.64**

Out of hours clinical cover is currently provided by the UHB hospital on-call junior doctor team and by the CF consultant team, the consultant cover is not funded.

Multi-disciplinary Staffing Resource

The current staffing model is highlighted below with a comparison against pro-rated CF Trust Standards of Care for the staff groups quoted by the CF Trust:

Staff Group	UHL CF Service March 2017 (wte)	CF Trust SOC pro rata to 300 pts. (wte)	WTE increase to pro rata CF SOC (wte)
Consultant	2.7	3.0	0.3
Middle Grade Doctor	1.0	2.4	1.4
Specialist Nurse	5.4	6.0	0.6
Physiotherapists	5.0	7.2	2.2
Dietician	2.0	2.4	0.4
Social worker	1.0	2.4	1.4
Psychologist	1.1	2.4	1.3
Pharmacist	1.0	1.2	0.2
Secretary	2.0	2.4	0.4
Data clerk (Port CF)	0.6	1.2	0.6
CF Centre Manager	1.0		
Dietetic Assistant	0.5		
Physiotherapist Assistants	1.8		
Outpatient clerk/reception	1.0		
Total			**8.8**

NB – CF Trust requirement is for Physiotherapists, the UHB has skill-mixed to Assistants.

The summary above identifies that there is a shortfall for the current CF service provision, when benchmarked against the CF Trust standards of care pro-rated to 300 patients. In particular, the provision of Social Service and Psychological support does not meet standards and the increase in both services is contained within the recommendations of the Peer Review Report 2015.

The Middle Grade position was also within the recommendations of the 2015 Peer Review Report and investment from WHSSC during 2015/16 has provided a middle grade, however, a 1.4 wte gap remains against the CF Trust Standards of Care.

Outpatient Services

Clinics are held daily and are detailed in the table:

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Week 1		Psa only clinic	Annual Review Clinic	Satellite Clinic	ARFU & New Patient Clinic
	Psa only clinic	Virtual MDT clinic with Harefield	Annual Review Clinic	Staph Only clinic Port Clinic	
Week 2		Joint CF/ Diabetic Clinic	Annual Review Clinic	Satellite Clinic	ARFU & New patient Clinic
	Psa only clinic		Annual Review Clinic	M Abs clinic (Main O/P) B.cep clinic	
Week 3		Psa only clinic	Annual Review Clinic	MDT Satellite Clinic	ARFU & New patient Clinic
	Psa only clinic		Annual Review Clinic	Staph / Normal flora Clinic Port Clinic	
Week 4		Psa only clinic Quarterly Joint CF / Liver Clinic	Annual Review Clinic	Satellite Clinic	ARFU & New patient Clinic
	Psa only clinic B. cc clinic (main O/P)		Annual Review Clinic	Staph/Normal flora Clinic Joint CF/Supported care Clinic	

CF-Related Diabetes

A third of CF patients have “CF-related diabetes” (CFRD). Although not formally commissioned by WHSSC, the UHB’s current provision is one joint clinic per month held within the CF centre at UHL. Given the growth in patient numbers and their associated joint management in relation to diabetes provision this service at its current level is not sustainable.

Satellite Out-reach clinics

Some specialist MDT clinics are undertaken in Carmarthen, these sessions are provided through existing job plans. These are undertaken by 0.025wte CNS and 0.025wte physiotherapy, which is in addition to their usual workloads in UHL. These clinics are not sustainable at their current level based on the capacity of the team and patient demand.

Pharmacy Homecare

Current pharmacy home treatment provision falls into two types:

1. Intravenous antibiotic therapy self administered by patients using drugs provided by the UHL Pharmacy.

2. Inhaled prophylactic therapy is a commissioned service provided by a homecare provider consistent with NICE and WHSSC guidance.

3. Provision of Ivacaftor for a small cohort of patients who meet WHSSC's access policy.

This case seeks investment in establishing a formal homecare service for patients to receive intravenous antibiotic therapy and would expand and replace the arrangements described in (1) above.

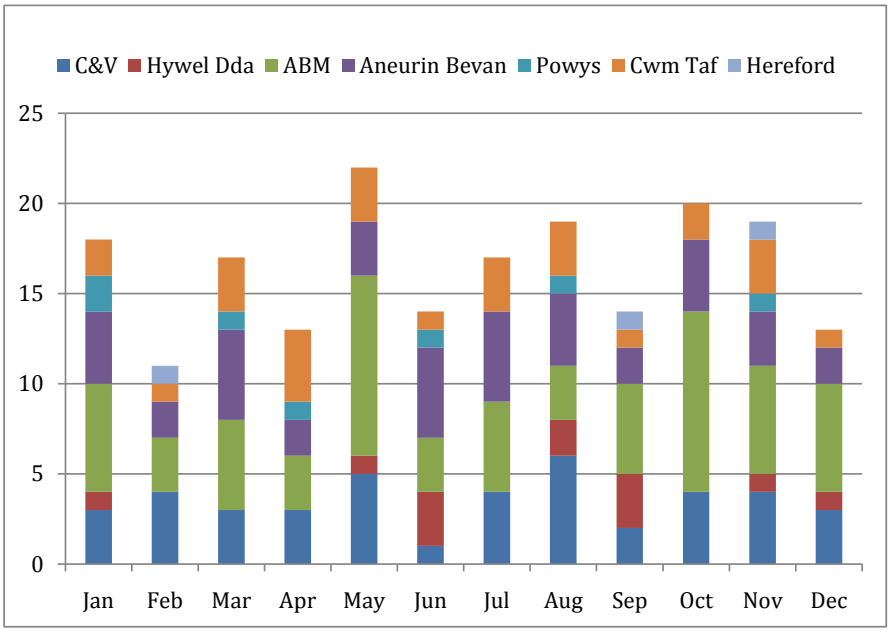
Pharmacy homecare enables patients to be managed within their own homes and facilitates earlier discharge of patients from the inpatient bed base. In a situation where the number of beds being proposed is on the lower end of what is nationally recommended, this additional service enables an increase in capacity to deal with both the current inpatient waiting list and the expected increase in numbers of patients managed within the CF service.

Intravenous Antibiotic Therapy

Currently a small number of patients receive IV antibiotic courses at home, albeit this is currently not provided via a formal homecare arrangement. Patients are drawing up treatments and currently self-administering. Normally, such patients will be admitted for a short period to ensure no reaction to treatment. These drugs are dispensed through UHL pharmacy and patients return for follow-up.

There are patients who without the formal homecare arrangement are not suitable for treatment in this way and this provides further pressure to the bed requirement.

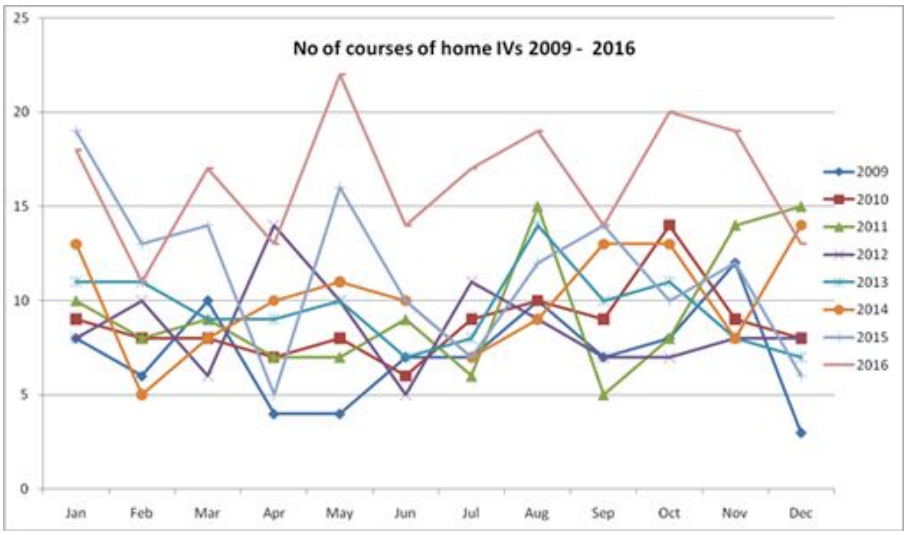
The following graph demonstrates the number of home IV courses dispensed from UHL through 2016:



Number of home IV courses administered 2016.

The total number of courses across the year falls just under 200. The number of patients having this treatment at home is an average of 16 per month. This practice is currently supporting the low bed base.

The graph below shows the homecare access since 2009. The graph identifies growing use across the years with the highest usage reported during 2016.



The service currently has no capacity to increase homecare provision.

8

Inhaled Prophylactic Therapy

Therapies prescribed under NICE include:

- Dry powder Colistin (Colobreathe)
- Inhaled dry powder Tobramycin (TIP)
- Inhaled Aztreonam Lysine (Azli)
- Levofloxacin

A number of these specific treatments are currently delivered via a homecare arrangement. As mentioned above, for the purposes of this paper any changes regarding these drugs are not considered.

Experience of using these therapies suggests the impact of the inhaled drugs therapies contribute towards a slower progression of disease and in most cases improved quality of life. The information did not show a decrease in banding of patients, which would have equated to a direct financial saving or a reduction of inpatient bed days.

Appendix B contains charts that indicate the current and potential banding patient numbers after use of Ivacaftor and inhaled therapies respectively.

Ivacaftor

Ivacaftor is indicated in a small number of eligible patients (15), with the aim of stabilising disease severity. There are two patients within the CF centre who are treated with Ivacaftor and have successfully been removed from the waiting list for a lung transplant.

This treatment for a small number of patients is intended to improve longevity and reduce the severity of the disease the earlier it is administered i.e. paediatric patients overall will gain most benefit as although the lungs start to become damaged from birth, if treatment started in early childhood, by the time that patient reaches adult services they should have minimal lung damage (but will still have all the associated complications of CF such as liver disease, diabetes, CFRLBMD etc.) ***Appendix C*** shows study results from patient use.

4. Case for Change

The following case is based on the ability to support a patient cohort of 300 with flexibility to accommodate growth up to 350 patients. The table below shows the additional posts required to support the development of CF services at Cardiff & Vale UHB in order to deliver safe, quality services and to meet the growing population set out above.

The Centre has referred to the CF Trust Standards of Care (2011) as well as considering the CF Peer Review recommendations (2015) before developing the requirement below:

Qualitative Staff Requirement	WTE	Band	Recurrent Cost (£'000)
Outpatient HCSW	1.0	Band 2	22
Data Entry (Port CF)	1.0	Band 2	22
Clinical Nurse Specialist	1.0	Band 6	45
CF Centre Manager Banding	0	Band 7	9
Diabetes Consultant sessions	0.2	Cons	25
Diabetes Specialist Nurse	0.2	Band 6	9
Microbiologist	0.2	Cons	25
Physiotherapist	2.0	Band 7	106
Dietitian	1.0	Band 7	53
Pharmacy Technician	1.0	Band 3	24
Palliative Care	0.02	Cons	3
Liver care	0.01	Cons	2
Clinical Psychologist	1.0	Band 8b	66
Social Worker	1.0	n/a	45
Pharmacist	0.5	Band 8a	28
Consultant	0.8	Cons	100
Specialist Registrar	1.0	Doctor	73
Staff related non-pay	1		12
Total	***11.93***		**669**

In addition, an increase of **£6k** in the resource to deliver satellite outreach clinics (see **Appendix E** for details)

The requirement and rationale for the above investments is as follows:

- **Outpatient Nurse** – There is currently no dedicated outpatient HCSW nursing to support the expansive weekly clinic template and the patients test and support requirements. This post would provide support to the weekly clinics and ensure the delivery of the appropriate tasks by the appropriate grade. A number of tasks are currently undertaken by Specialist Nurses and Junior Doctors.

- **Data Entry Post** – In line with the CF standards of care there is a need for a full time entry post.

- **Clinical Nurse Specialist (CNS)** - The CNS would provide support for the expansive patient cohort and provide sustainability for the growing cohort.

- **Diabetes Support** - In order to provide sustainable services to support patients to manage their CF-Related Diabetes, additional Consultant and Diabetes Specialist Nurse time is required. The resource would provide an increase in the number of joint Diabetes Clinics (2-3 per month); DSN clinic attendance, drop-ins and ward reviews would be increased as well; allowing for the patients to be followed up in a timely manner as per CF Trust guidelines. Up to one third of patients will have CF related Diabetes.

- **Microbiologist** – The consultant support will provide advice on appropriate treatment, input at MDT meetings and ward consultations.

- **Therapy Support** – like the CNS the therapy posts would provide support for the expansive patient cohort and provide sustainability for the growing cohort.

- **Pharmacy Technician** – In order to support the increase of homecare access further pharmacy support would be required as there is currently no spare capacity. This support can be suitably provided by a pharmacy technician.

- **Palliative Care** – The consultant support would provide sustainable services to support end-stage disease and provide effective management of breathlessness, nausea and vomiting and chronic pain. The above input will provide joint outpatient clinic cover on a monthly basis as well as inpatient review to CF patients.

- **Liver Care** – Liver Consultant input is requested in order to provide sustainable services to manage patients with CF-Related Liver Disease; up to a third of the patient cohort. The above input will provide a joint clinic once every 3 months.

- **Clinical Psychologist, Social Worker, Pharmacist and Specialist Registrar** – these appointments would support achievement of the CF standards of care for a patient cohort of 300 and respond to the recommendations of the CF Peer Review of 2015.

Bed Base

As part of the capital process, there is the capacity to increase the bed base within the CF unit from 7 beds to between 14 and 18 beds (excluding the outlying bed). Given the context of growth the upper limit of 18 beds is the preferred option. This case recognises that 18 beds still does not meet the CF Trust's recommendation for the number of beds based on the predicted 350 population cohort which would suggest a requirement of between 21 to 35 beds; however, there are site space constraints that cap the number of beds at 18.

In the context of limited space the homecare service goes some way towards providing additional capacity to manage increasing demand.

Feb-May 2017
Mean waiting time for available bed = 2.3 days (range 0-24 days)
13 patients waiting >3 days for available bed

A bed base benchmarking summary is shown in the table below:

Large Adult CF Centre Name	Number of patients	Number of inpatient beds	Patients per inpatient bed
Royal Brompton	592	28	21.14
Royal Victoria	267	14	19.07
Leeds	400	18	22.22
Southampton	226	14	16.14
Manchester	420	22	19.09
Papworth	276	14	19.71
Sub-total	**2,181**	**110**	**19.83**

Cardiff March 2017	293	8	36.63
Cardiff if increase to 14 beds on CF Unit (plus cubicle elsewhere)	350	15	23.33
Cardiff if increase to 18 beds on CF Unit (plus cubicle elsewhere)	350	19	18.42

For clarity this case refers to the development of an 18-bedded adult centre. The dedicated outlying bed for special infections will continue to be required and maintained by the service giving a proposed potential total bed base of 19 beds. This number of beds would give a patients to beds ratio of 18.42, which would bring the centre into line with other UK CF centres.

Ward Staffing

The table below presents the ward staffing required for the Centre if it was to have 18 beds:

Band	Revised CF Unit (WTE)	Increase (WTE)	Additional Recurrent Cost (£'000)
Band 7	1.00	-	-
Band 6	4.00	1.0	52
Band 5	15.44	7.33	325
Band 2	5.56	2.78	76
Staff related non-pay			11
Nursing staffing Sub-Total	**26.00**	**11.11**	**464**

The model described should allow for flexibility in staffing ratios and will aim for 4 registered nurses working in the daytime with 1 supporting HCSW and 3 registered at night with 1 supporting HCSW.

Contact has been made with a number of CF centres to ensure ward staffing proposals are appropriately benchmarked (see Appendix A).

Out of Hours Consultant Cover

There is no formal commissioning of out of hours Consultant cover for CF inpatients. In order to provide sufficient cover, Band 1 on call enhancement is required for the three consultants.

Banding	Cost	Total
1	**2,906**	**8,718**

Facilities support for the ward required is described below:

Staffing group	Additional Recurrent Cost (£'000)
Receptionist	11
Catering	5
Housekeeping	20
Other ward staffing Sub-Total	**36**

Non-pay costs for the ward are noted below:

Area	Additional Recurrent Cost (£'000)
General Ward bed-day cost	446
Linen	5
Estates	24
Catering	25
Radiology tests	18
Laboratory tests	20
Non ward infrastructure Sub-Total	**537**

The overall costs associated with increasing to 18 beds is described below:

Element	Additional Requirement (WTE)	Additional Recurrent Cost (£'000)
Nursing staffing	11.11	464
Out of Hours Consultant	n/a	9
Other ward staffing	1.6	36
Non-pay	n/a	537
Total Sub-Total	**12.71**	**1,046**

Pharmacy Homecare

Homecare services are difficult to benchmark and compare with other providing organisations, due to commercial and marketing confidence. Two companies have been contacted but couldn't share any information beyond high level list pricing. A financial estimate based on homecare assumptions and pharmacy price ranges has been put together to help inform the likely requirement to introduce homecare. This is set out in **Appendix D**.

There are a number of variables and, in the absence of a formal tender exercise, it is difficult to determine the true market rates or delivery structures that could be agreed.

For the purposes of this case and the decision making process, an indicative c**£0.500m** has been incorporated into the requirement. This reflects the net cost of introducing formal homecare, including pharmacy savings inclusive of VAT, through a reduction in hospital issues. Whilst there will also be length of stay savings (as shown in the appendix), these will be consumed by the detailed growth and admitted patient care requirement. However, they clearly go to support the challenges of 'living within the bed base' which is very positive.

Investment in homecare will deliver the Peer Review Recommendation of providing care close to home. Homecare has a set eligibility criteria, this will be robustly managed to ensure appropriate patients have access to the service. The CF service is pursuing opportunities with more than one homecare provider.

5. Option Appraisal

The above section highlights the investment required to sustain service delivery and successfully manage 18 beds.

The options table below summarises the options for consideration:

Option 1: Do nothing

Explanation: No investment in services

Benefits:

- No investment required

Constraints:

- CF Trust Peer Review report recommendations not adhered to
- Major cross-infection risk remains with shared bathroom facilities
- Inability to meet the needs of an on-going increase in patient cohort and, therefore, patients will stay at home becoming increasingly unwell.
- The Centre would have to close to new patients beyond 300 as service will be unsustainable beyond this (Birmingham CF Centre has had to do this)
- National All-Wales service at UHL at risk if further capacity not secured
- Specific risks associated with the lack of multi-disciplinary staffing groups will present patient risks
- On-going reliance on hospital setting if out-reach clinics and IV homecare not implemented
- Any medium-term capacity benefits will not be achieved if IV homecare is not implemented

Option 2: Part Investment

Explanation: Investment in multi-disciplinary staffing resource and ward expansion

Benefits:

- Increased multi-disciplinary team to provide a sustainable service
- In line with CF Trust Standards of Care Guidelines
- Meets some of the CF Trust Peer Review 2015 Recommendations
- Patients will receive access to multi-disciplinary skills in a timely manner
- Ensuring operational services are maintained to high level
- Expansion of clinics to include outreach clinics, virtual clinics, supportive (palliative) care, CFLD and CFRD clinics
- Minimises cross infection risk
- Reduction in waiting list for admissions – admission at the point of need

Constraints:

- There will continue to be no formal homecare provision for IV antibiotics and there will be no ability to expand homecare treatments.
- Insufficient inpatient beds available for the patient cohort who would have received their IV antibiotics at home and for a portion who would need to come into hospital
- The risk of patients drawing up and self-administering treatments remains
- It does not meet the Welsh Government vision of providing care closer to home for many patients
- Uplift in patient numbers unlikely

Option 3: Full Investment

Explanation: Investment in Option 2 and Homecare services

Benefits:

- Increased MDT to provide a sustainable service
- Meets CF Trust Standards of Care Guidelines
- Meets the CF Trust Peer Review 2015 Recommendations
- Patients will receive access to multi-disciplinary skills in a timely manner
- Ensuring operational services are maintained to high level
- Expansion of clinics to include outreach clinics, virtual clinics, supportive (palliative) care, CFLD and CFRD clinics
- Minimises cross infection risk
- Reduction in waiting list for admissions – admission at the point of need

Home Care specific benefits:

- Meets CF Trust Peer Review report recommendations and Standards of Care guidelines
- Reduces clinical risk in patients drawing up and self-administering treatments
- On-going MDT service improvements to ensure patient needs are met across the multi- disciplinary settings
- Increased MDT capacity in order to ensure timely reviews are maintained
- Reduces patient travel times and improves quality of life
- Satisfies commissioners and Welsh Government vision of providing care closer to home where possible.

Constraints:

- None

The Preferred option is Option 3.

6. Resource Implications and Affordability of the Recommended Option

The financial plan overleaf summarises the investment required to deliver option 3 as detailed above. The costs below are expected to be incurred recurrently.

The investment requested will align service provision to the CF Trust Standards of Care for 350 patients through the strengthening and uplift to the current staffing resource, the provision of staff to support the proposed ward capacity expansion and the provision of homecare services for IV antibiotic therapy. This will provide the staffing and infrastructure required to support the current and growing cohort.

The table below details the proposed investment profile of services. Assumptions underpinning the profile are also noted. The table following this provides a more detailed breakdown of the investment.

Business case element	2018/19 (£000)	2019/20 (£000)
Multi-disciplinary staffing resource	669	669
Ward requirement	0	1,046
Pharmacy homecare	Circa 375	Circa 500
Total	**1,044**	**2,215**

Assumptions

- The Business case will be approved within the year 2017/18 to allow suitable lead in time to appoint to all aspects of the MDT to commence post in April 2018.
- The home care provision will be commenced from April 2018 and, therefore, costs included represent a part year effect due to the need to set up and implement the new service.
- The ward staffing will be required upon completion of the capital build which is currently estimated as April 2019.

Value for Money

The context of this business case is against clear recommendations and requirements to improve both the quality of services and the capacity to support the current and future CF cohort.

The UHB has undertaken a high level benchmark against the English banding tariffs as an indicative consideration of the requirement. Options 3 holds a recurrent investment requirement of £1.715m (excluding homecare) to manage a cohort of 350 patients. The current income model supporting the CF contract under WHSSC would provide a comparable uplift in funding of £1.678m if the UHB were operating under the tariffs detailed. See ***Appendix F*** for details.

There are subtleties and complexities to the way in which English Trusts are funded and that would need to be considered against the true cost of those Trusts delivering services, given their deficit position etc. However, as proxy, it is considered that the investment requirement represents value for money for commissioners, delivering on key quality and capacity requirements for the Welsh resident population.

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7. Outcomes and Benefits

To achieve the best possible outcomes of care in an environment that delivers care in line with current DOH and the CF Trust Standards of Care in particular in centralisation of all inpatient facilities into the existing CF Centre (one unit). Provision of improved space and layout of service and provision of improved clinical and non-clinical facilities.

Expected outcome will be achieved when new purpose designed facilities are commissioned:

- Providing care at the point of need
- Reduced number of transfers to other CF centres
- A reduction in CF MDT members visiting patients in DGHs to provide input.
- Improved length of stay as specialist treatment can be administered earlier
- Reduction in the potential for cross infection and risk of spread and transmission of infection.

Compliance with Standards of care. Ability to future proof through the provision of additional services and centralised inpatient facilities.

Further investment in MDT staffing will allow for development of satellite clinics, sustainability of current and future services and further development with using virtual technology, to enhance care by linking with patients at home, work or place of study, to ensure and maximise continuity of care and management therein.

Patient reported outcomes will be collected after implementation of proposed changes to services. This would allow a comparison of service provision and admissions to DGHs.

This also applies for length of stay and waiting lists for beds.

8. Impact on Other Services and Engagement

The investment in this case describes enhanced services across a number of functions. The strengthening of the multi-disciplinary will naturally impact on those services affected. In addition the improvement in ward infrastructure will affect the majority of support services including therapies and diagnostics, as well as operational services and estates. Each of these areas has been consulted to note reasonable impact due to the growth in services and the revised ward infrastructure.

The Cystic Fibrosis service through the lead consultant and centre manager, actively consults with other services outside of the main team in order to ensure timely access to services such as radiology, laboratory medicine, estates and patient access.

The nature of the investment required will involve specific dialogue with other hospitals in the Hywel Dda and Aneurin Bevan Local Health Boards in order to host out-reach clinics effectively.

There will need to be on-going dialogue with performance management of any pharmacy homecare provider(s) commissioned to ensure optimised services are provided to patients in their home.

It should be noted that growth has, and would continue regardless of the investment and as such this case serves to assist the supporting services to CF as opposed to providing a risk either financially, clinically or operationally.

9. Interdependencies

The CF service like many others has workforce challenges, both operationally linked to human resource management issues, and also through ability to recruit to certain staff groups.

Given the nature of the investment required there will be interdependencies with other hospitals in order to host out-reach clinics effectively as well as the providers of pharmacy homecare and their performance.

Other support services will need to continue their support of CF in order to ensure timely performance across the CF pathway.

10. Risks

Risks to the delivery of this investment plan are associated with:

- the ability to recruit the identified workforce
- the ability to provide the pharmacy homecare service within specification based on the current process being followed to deliver treatment
- the ability to provide on-going out-reach clinics if there are specific operational pressures e.g. sickness

The CF service continues to use a long term integrated workforce model. This builds upon previous investments and aims to maximise all workforce opportunities, as well as mitigate operational and financial risks whilst delivering a high performing and sustainable service. Examples of this are using different skill-mixes and cross-cover of certain tasks to ensure sustainable service continues when there are periods of staff sickness.

The CF Service together with the UHB pharmacy and procurement departments will aim to ensure that value for money is achieved when tendering for any pharmacy homecare solution. The CF service has already discussed a wide range of issues with regards to the use of out-reach clinics and the aim to have regular stakeholder meetings, to ensure all issues are raised in a timely manner.

The use of IV antibiotics at home without sufficient homecare support is considered a significant risk as detailed within the main body of the paper and the case for change. This is a recognised issue on the Clinical Board risk register. Investment in this case would help to address this risk.

Appendix A

CF Centre	No of pts	No of beds	Staffing per shift	Staffing wte for ward	Other comment
Manchester Adult CF Centre	450	22	1 x qualified nurse to every 5 pts plus HCAs	RN: 28.78 HCSW:16.67 Total: 45.44	Approval given for expansion to allow for a further 6 beds HCT recently acknowledged requirement for 2 CF High Dependency beds on CF ward staffed as 1 x qualified to 2 x pts or 1 to 1 if pt classed as level 2 care
Birmingham Heartlands Adult CF Centre	388	20	Day = 4 qualified and 2 HCAs Night = 4 qualified and 1 HCA	RN: 23.22 HCSW: 8.33 Total: 31.55	Currently 'closed' to new patients due to lack of beds and MDT staffing
Liverpool Adult CF Centre	-	10+6*	Staffing for CF ward 10 beds-weekend and nights = 2 x qualified and 1 HCA Days 2 qualified and 1 HCA plus Band 4 nurse	Band 7 = 1.0 Band 6 = 1.4 Band 5 = 12.0 Band 4 = 1.0 Band 2 = 5.4	*Outlying beds
Royal Brompton Adult CF Centre	600	25	Staffing as per National Recommendations with additional 1-2 qualified nurses for IV administration	No information provided	
Sheffield Adult CF Centre	210	12+4*	2 qualified per shift and 1 HCA	Band 7 = 1.0 Band 6 = 0.8 Band 5 = 11.9 Band 2 = 5.96	*Outlying beds

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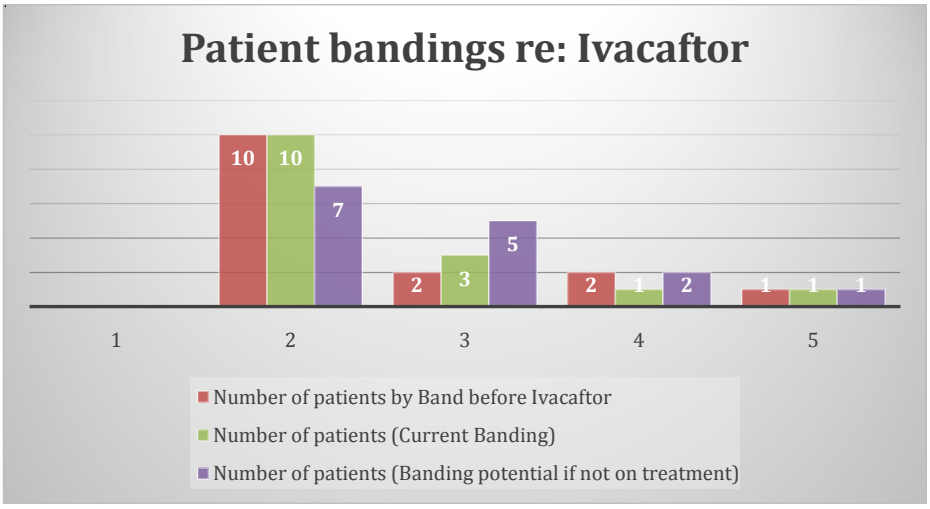
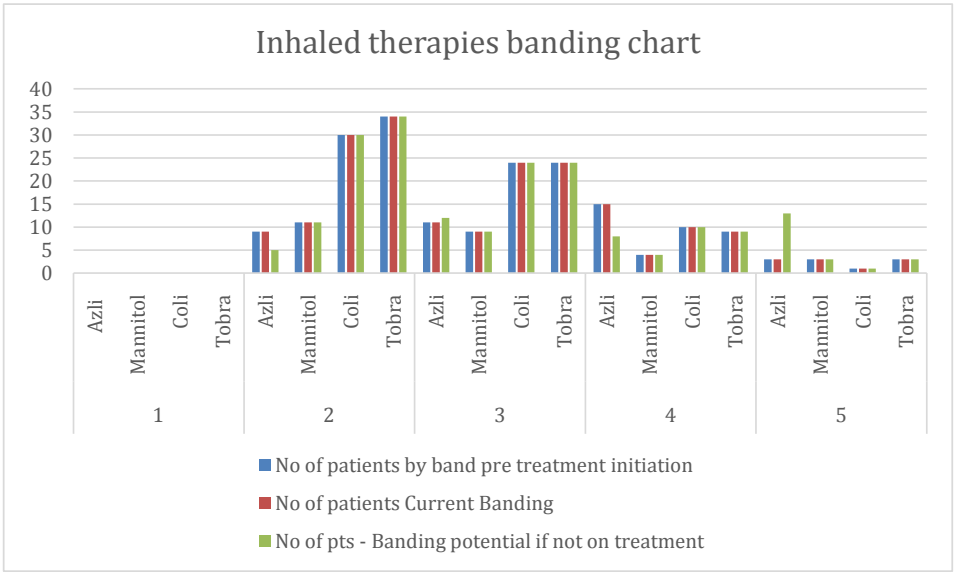
Appendix B

There are 15 patients receiving Ivacaftor.



- The graph above identifies the banding status of patients who commenced treatment and their status whilst continuing with treatment.
- The Banding if treatment was not in place has been estimated based on the patient's disease history.
- As indicated in the main body of the document the graph shows that treatment has supported disease stabilisation and improved quality of life for patients.
- The patient who has moved from Band 4 to Band 3 was a paediatric transfer who was reassessed as an adult.



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Appendix C
Baseline Data – IVs

Name:	Time to 1st Pulmonary exacerbation after starting Ivacaftor	Year prior to starting Ivacaftor – IV courses / days	Year since starting Ivacaftor – IV courses / days	2nd Year of Ivacaftor Tx – IV Courses / days	3rd Year of Ivacaftor Tx – IV Courses / days
Pt1	NA as has not had a pulmonary exacerbation since starting Ivacaftor	0	0	0	0
Pt2	NA as has not had a pulmonary exacerbation since starting Ivacaftor	4 courses/ 19 days	0		
Pt3	NA as has not had a pulmonary exacerbation since starting Ivacaftor	2 courses /30 days	0	0	0
Pt4	NA as in paediatric service	NA as in paediatric service	NA as in paediatric service	3 courses / 28 days	3 courses / 42 days
Pt5	4.5 months (138 days)	4 courses / 42 days	1 course / 14 days	1 course/12 days	2 courses / 23 days

Name:	Time to 1st Pulmonary exacerbation after starting Ivacaftor	Year prior to starting Ivacaftor – IV courses / days	Year since starting Ivacaftor – IV courses / days	2nd Year of Ivacaftor Tx – IV Courses / days	3rd Year of Ivacaftor Tx – IV Courses / days
Pt6	NA as has not had a pulmonary exacerbation since starting Ivacaftor	2 courses / 32 days	0	1 course/10 days	0
Pt8	5 months (141 days)	6 courses / 80 days	2 courses / 20 days	0	0
Pt9	NA as has not had a pulmonary exacerbation since starting Ivacaftor	0	0		
Pt10	3.7 months (104 days)	4 courses / 36 days	1 course / 3 days	1 course/11 days	
Pt11	7 months (251 days)	2 courses / 45 days	1 course / 13 days	0	2 courses / 24 days

Name:	Time to 1st Pulmonary exacerbation after starting Ivacaftor	Year prior to starting Ivacaftor – IV courses / days	Year since starting Ivacaftor – IV courses / days	2nd Year of Ivacaftor Tx – IV Courses / days	3rd Year of Ivacaftor Tx – IV Courses / days
Pt12	NA as has not had a pulmonary exacerbation since starting Ivacaftor	0	0	0	0
Pt13	NA as has not had a pulmonary exacerbation since starting Ivacaftor	0	0	0	0
Pt14	NA as has not had a pulmonary exacerbation since starting Ivacaftor	3 courses / 53 days	0	2 courses / 42 days	2 courses / 35 days
Pt15	NA as has not had a pulmonary exacerbation since starting Ivacaftor	4 courses / 48 days	0	2 courses / 23 days	4 courses / 52 days
Pt16	NA as has not had a pulmonary exacerbation since starting Ivacaftor	3 courses / 41 days	0	0	1 course / 10 days

Appendix D
Homecare Working Assumptions and Costing Estimate

Summary - Homecare Information Review / Costing Estimate							
Patients receive IV 'courses' for 2 weeks (sometime require 3, sometime stop after 10/12 days)							
Patients receive initial doses in hospital setting, that probably wouldn't change (ensure no adverse reaction etc.). Following this, 2 weeks home IV.							
Majority of patients on Tobi/Ceft or Tobi/Merop - CF standards in terms of dosage, Tobi linked to weight							
Meropenem has a short shelf lives so requires four/five deliveries per two weeks							
29 out of 107 admitted patients who received IV would have been able/been suitable/chosen to have home IV - 2015							
55 out of 123 admitted patients who received IV would have been able/been suitable/chosen to have home IV - 2016							
The average length of stay for inpatients receiving IV antibiotics who were deemed possible to receive homecare is 7 days							
It is considered the first 2 days may be incurred either way and the indicative variable cost for those ward stays is £120 / day							
Cost through pharmacy in 2015/16		Tobramycin	£	29,256			
		Meropenem	£	46,727			
2015/16 Review					***2016 provisional Data***		
Number of registered patients			253			272	
Volume who received courses of home IV			66			52	
% patients receiving IV			26%			19%	
Number of courses issued			138			107	
Average course per patient per annum			2.09			2.06	
Average LoS of a CF patient (days)			9.3			8.6	
Admitted patients IV consideration			107			123	
…… of those, deemed eligible, achievable, realistic			29			55	
Example Homecare Costs						**£ / course**	
Ceftazidime (3g) & Tobramycin (600mg) - 2/52			2,579	per course		**2,776**	[42 x Xg and 14 x Ymg]
Meropenem (2g) & Tobramycin (600mg) - 2/52			2,650	per course		**3,142**	[42 x Xg and 14 x Ymg]
Delivery	(per delivery)		98	*assume 5 for Meropenem and 2 for Ceftazidime*			
Meropenem (2g) & Tobramycin (600mg) - 2/52			2,295	per course		**3,170**	[42 x Xg and 14 x Ymg]
Delivery	(per delivery)		175	*assume 5 for Meropenem and 2 for Ceftazidime*			
Example Hospital Costs							
Ceftazidime (1g) & Tobramycin (80mg) - 2/52			318	per course		**318**	[42 x 3g and 112 x 80mg]
Meropenem (1g) & Tobramycin (80mg) - 2/52			504	per course		**504**	[42 x 2g and 112 x 80mg]
							[+ Water + Sodium Chloride]
				Current cohort	**300 Cohort**	**350 Cohort**	
				276	**300**	**350**	
Esimated % of patients who could receive IV				30%	30%	30%	
Assume average number of courses per patient				2.2	2.2	2.2	
Courses				182	198	231	
Gross Homecare cost (£)	*(Assume 50% Ceft, 50% Mero)*			540,311	587,295	685,177	
Less: Savings from Pharmacy Issues (£)				(74,868)	(81,378)	(94,941)	
Net Cost for Business Case (£)				**465,443**	**505,917**	**590,236**	
Net Cost for Business Case (£) - with a 30% discount				***303,350***	***329,728***	***384,683***	
Cost avoidance from APC length of stay (indicative) (£)				(26,179)	(28,456)	(33,199)	*will be negated by demand*
Savings from APC length of stay (indicative) (Beds)				(1.5)	(1.7)	(2.0)	*will be negated by demand*

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Appendix E
Satellite Outreach Clinics

Some specialist MDT clinics are undertaken in Carmarthen, these sessions are provided through existing job plans. These are undertaken by 0.025wte CNS and 0.025wte physiotherapy, which is in addition to their usual workloads in UHL. These clinics are not sustainable at their current level based on MDT capacity and patient demand.

In order to meet rising demand and provide prudent healthcare in line with the Peer Review recommendations expansion of outreach services is essential. The table overleaf highlights the requirement to expand upon the existing limited provision and enable outreach clinic establishment to other areas of Wales as highlighted in the Peer Review report (2015).

Staff Group	wte	Funding requirement (£)
Physiotherapy	0.05	2,063
Dietetics	0.05	2,125
Clinical Nurse Specialist	0.05	2,063
Total	**0.14**	**6,250**

There is an assumption that the CF Centre will absorb any administrative workload.

*The outreach clinics are excluded from overall cost of the MDT input. If the case is fully supported sessions from the MDT will provide the outreach service. If the MDT is not fully supported, the outreach service will require funding.

APPENDIX F – High Level Benchmark

Cystic Fibrosis High Level Benchmark

Band	Price incl. MFF £	Cohort of 300	Total £		Cohort of 350	Total £		*2017/18 Welsh Cohort Month 2*
1	5,459	42	212,915		49	270,002		*39*
1A	8,077	7	48,464		8	61,458		*6*
2	8,077	23	169,625		27	215,105		*21*
2A	13,055	103	1,240,267		120	1,572,802		*95*
3	19,983	83	1,518,681		96	1,925,864		*76*
4	36,038	27	900,943		32	1,142,500		*25*
5	43,446	15	608,247		18	771,328		*14*
Drugs								
INHALED THERAPIES			779,687	***See Att 1***		909,635	***See Att 2***	
TOBRAMYCIN		*Recovered through historic NICE HCD contract wth WHSSC*						
IVACAFTOR		*Recovered through non-LTA arrangements with WHSSC*						
AMPHOTERICIN			2,107			2,107		
CASPOFUNGIN			13,299			13,299		
POSACONAZOLE			47,887			47,887		
VORICONAZOLE			No spend in 2016/17 but would be chargeable					
OTHER EXCLUDED NICE / HCD and DEVICES			May be chargeable under English tariff rules					
English Bandings / Model			**5,542,123**			**6,931,986**		
Current Bandings / Model			**4,669,771**	***See Att 1***		**5,253,796**	***See Att 2***	
Difference			**872,353**			**1,678,190**		
NOTES:								
Cystic fibrosis year of care tariff includes home care support but not the drugs costs which are seperately chargeable.								
Drugs costs have been extrapolated from 2016/17 assume a linear correlation to a total cohort								
MFF has been assumed at UH Bristol's ratio								
Bandings in the English model reflect the latest CF Trust bandings for the C&V cohort								
Current model bandings reflect the service quartley banding assessment								

Cystic Fibrosis Business Case Addendum

The following is a response to the specific queries which have been raised regarding the proposal for phased investment in to the Cystic Fibrosis service. The response aims to reinforce the proposed phasing of the required investment further to the Business Case submitted in August 2017.

As outlined within the business case the revenue investment requested will seek to deliver 3 key objectives:

- To align current MDT staffing, to match as a minimum to CF standards for 250 patients, to support a patient cohort of circa 300.
- To provide formal homecare services as provided by other CF centres.
- To provide staffing investment to support the proposed capital case expansion of CF inpatient beds.

Service Expansion
With regard to the current staffing provision, the case seeks to outline the investment required to bring the CF Service in line with CF standards of Care which is based on 250 patients. This investment would align the current staffing requirements for the patient population being treated circa 300 as outlined in the business case.

It is recognised that the service has operated below the CF Trust Standards of Care and with that acknowledgement the service in Cardiff, like other CF centres would need to continually assess its ability to deliver to a growing CF population. This is in line with practice of other CF centres.

The Cardiff Adult Service is expecting just over 65 paediatric transfers over the next 5 years. This taken in to consideration with patients who transfer in and out of the service and patient deaths the forecast patient population for service by 2023 is 350 patients. Although this patient increase would move the service away from alignment with CF Trust standards the service have assessed the capability to deliver treatment up to this patient cohort as achievable, if the proposed investment was provided.

In addition to the investment aligning the service to the appropriate standards of care, the phase 1 funding will allow the establishment of satellite clinics, expansion virtual clinics and establishment and delivery of a formal homecare service for intravenous antibiotic therapy.

It is important to note that the investment specifically referred to above, is the phase 1 MDT investment. As noted in the recent briefing, phase 2 of the MDT investment will strengthen support for the ward based expansion of inpatient services which is associated with the capital case.

Previous Investments
Previous discrete investments in the service over the last 3 years have included a full time pharmacist and a specialty doctor. The introduction of these posts responded to initial critical elements of the 2015 Peer Review Report. At the time of the peer review the service was providing care for approximately 260 patients.

The report highlighted 3 key recommendations which included:

- The urgent improvement of inpatient facilities
- Development of the MDT team for pharmacy, psychology and social work to bring the service in line with 'Standards of Care, (2011)' Guidelines.
- The immediate appointment of a middle grade doctor due to the size and complexity of the patient service, which as noted at that time was providing a service to approximately 260 patients.

The pharmacy and middle grade support were introduced via the additional funding and responses to the above recommendations. Funding allocated was £74k and £35k respectively.

The new staffing uplift required includes these posts and reflects the growing patient cohort since the Review of 2015 and the remaining gap in alignment to the Cystic Fibrosis Trust Standards of Care.

Homecare Services
The clinical team have been consulted regarding the homecare service proposal and the query raised at the last committee meeting regarding locally provided care.

Although homecare services are established in local health boards, home IV treatment of CF patients would still require support from the tertiary centre as the patients require close and careful monitoring. This level of monitoring and review can only be provided by staff with the appropriate specialist knowledge. The patients will require regular reviews of their individual response to treatment and where required patients may need to be rapidly transferred to inpatient care if their condition changes or if treatment is not having the expected impact. At this point the full MDT service to include physio and dietetic support will become involved in the patient care. It will not be feasible to monitor the patients if the homecare is spread across all local providers.

In the absence of tertiary centre oversight there would be a clinical concern regarding the monitoring and follow up of the patients receiving homecare.

Hopefully the above responds fully to the queries recently raised regarding the Business Case submission and supplementary funding phasing proposal. Please do not hesitate to contact the Health Board if there are any further queries.

		Agenda Item	09
Meeting Title	**Joint Committee**	Meeting Date	10/07/2018
Report Title	Delivery Plan for the Five year Specialised Neurosciences Strategy – south, mid and west Wales		
Author (Job title)	Acting Assistant Director of Planning		
Executive Lead (Job title)	Director of Planning	Public / In Committee	Choose an item.

Purpose	To seek approval from the Joint Committee to take forward the actions specified to deliver the first two years of the Specialised Neurosciences Strategy in south, mid and west Wales.			
RATIFY ☐	APPROVE ☒	SUPPORT ☐	ASSURE ☐	INFORM ☒

Sub Group /Committee This links to additional information provided on last page	Choose an item.	Meeting Date	Click here to enter a date.
	Choose an item.	Meeting Date	Click here to enter a date.
Recommendation(s)	Members are asked to: • **APPROVE:** the delivery plan for first two years of the Specialised Neurosciences Strategy in south, mid and west Wales • **NOTE:** work underway to develop a delivery plan for north Powys and north 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		

9

Equality and Diversity	YES	NO	Population Health	YES	NO	Legal Implications	YES	NO

1.0 Situation

In March 2018 the WHSSC Five year Specialised Neurosciences Strategy was presented to Joint Committee.

At this meeting the Committee requested a subsequent paper to demonstrate how the Strategy would be delivered. Further clarity was also requested on what the return for investment would be for the Neurosciences areas which were recognised as requiring financial support.

The document outlines the delivery plan for the first two years of the strategy in south, mid and west Wales. A similar plan for north Powys and north Wales is under development for consideration at a future Joint Committee meeting. This plan will take account of the different provider arrangements for patients in these areas, and will set out the opportunities, recommendations and key actions for stabilisation, service redesign and re-commissioning.

2.0 Background

In May 2015 the Joint Committee asked for the development of a Neurosciences 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.

A series of papers have been presented to Joint Committee during the development of the Five year Specialised Neurosciences Strategy. These included a Project Initiation Document which outlined the Neurosciences services commissioned directly by WHSSC that the Strategy would focus on:

- Neurosurgery
- Interventional Radiology
- Neuro-rehabilitation
- Spinal Rehabilitation

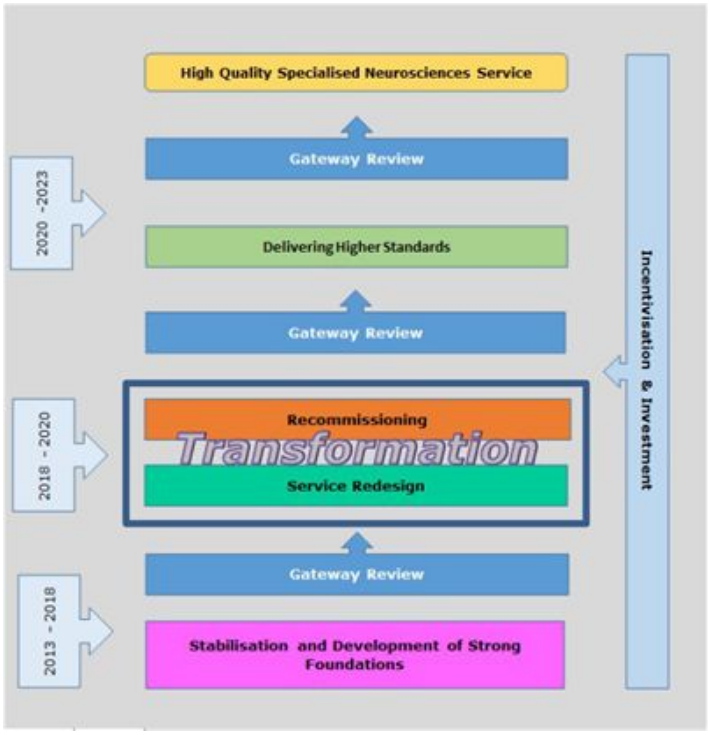
- Paediatric Neurosciences including Paediatric Neurosurgery, Paediatric Neurology and Paediatric Neuro-Rehabilitation.

Subsequent papers described the current service provision of Specialised Neurosciences in NHS Wales and the key service issues taking note of the recommendations from the previous Axford, Steers and Price-Morris reviews and the relative success of their implementation almost ten years on.

The Strategy was considered by the Joint Committee in March 2018, and following discussion members requested a delivery plan, which incorporated further detail on demand and capacity within the service.

3.0 Assessment

The strategy has five key strategic stages as illustrated below:



- **Stabilisation and Development of Strong Foundations –** The initial work will concentrate on stabilising current services, and developing the strong foundations necessary to support the transformation programme.
- **Transformation –** the case for transformation was clearly set out in the Steers and Axford reviews, and the recent assessment of specialised neurosciences services has reaffirmed the necessity to proceed with this at pace. The transformation programme will be underpinned by two workstreams:

  - **Service Redesign –** whilst the service model for neurosurgery was settled in 2010/11, following the outcome of the Steers and Axford reviews, there has been limited progress is aligning the service models of other related services such as neurological rehabilitation.
  - **Recommissioning -** 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 services.
- **Delivering Higher Standards –** following the completion of the transformation programme, services will be in a strong position to deliver care in line with current UK standards.
- **High Quality Specialised Neurosciences Services –** the momentum achieved through the delivery programme will continue to ensure that the services in south Wales have the capacity and capability to deliver high quality and effective care, with the flexibility to respond to future challenges and opportunities.

The delivery plan sets out the actions required over the next two years, to stabilise and strengthen the specialised neurosciences, and start the process of transforming the planning and delivery of care for patients in south, mid and west Wales. This work is essential if services are to respond to new and emerging challenges and opportunities and to ensure that all patients in Wales have access to safe, effective and sustainable services.

At the end of the first two years, a gateway review will be undertake to assess progress, and to inform the development of the plan for the next three years. The following objectives have been set for achievement following the completion of the five year plan:

- all patients in Wales with neurological conditions, are able to access and benefit from the most effective care, delivered at the earliest opportunity, and as close to home as possible.
- Neurosciences services in Wales are at the forefront of leading practice, research, and innovative care within Europe and that we build on academic links within Cardiff University and the other Welsh Universities.
- Neurosciences services in Wales are delivered by highly skilled and motivated workforce, which is able to lead innovation within neurosciences care, and adapt to future challenges and opportunities.
- Neurosciences services for patients in Wales are planned and delivered through a whole system approach across health and social care, underpinned through genuine coproduction with service users.

4.0 Recommendations

Members are asked to:

- **APPROVE:** the Delivery Plan for the Five year Strategy for Specialised Neurosciences.
- **NOTE:** work underway to develop a delivery plan for north Powys and north Wales.

5.0 Appendices / Annexes

5.1 Specialised Neurosciences Services Strategy Delivery Plan 2018 -2020 South, Mid and West Wales

5.2 Five year Specialised Neurosciences Strategy

5.3 Current provision of Specialised Neurosciences in NHS Wales

Link to Healthcare Objectives	
Strategic Objective(s)	Organisation Development Governance and Assurance Development of the Plan
Link to Integrated Commissioning Plan	The 2018-21 ICP includes a number of schemes related to the Specialised Neurosciences Strategy.
Health and Care Standards	Safe Care Effective Care Staff and Resourcing
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Reduce inappropriate variation Only do what is needed
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Improving Health of Populations Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	The Commissioning Strategy has been written with the Quality, Safety and Patient Experience at the forefront.
Resources Implications	There are no direct resource implications included within this paper.
Risk and Assurance	Specific risks to Neurosciences services are referenced within this paper.

Evidence Base	The strategy has been developed with reference to current evidence and standards, and identifies the rapidly developing evidence base within specialised neurosciences and the impact on service delivery
Equality and Diversity	Equality issues have been highlighted for certain disease groups within the strategy.
Population Health	The implications for Population Health are outlined in this strategy.
Legal Implications	There are no known legal implications with the content of this report.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Management Group	21/06/2018	Considered at Management Group Meeting
Choose an item.		

9

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

Specialised Neurosciences Services Strategy Delivery Plan 2018 -2020
South, Mid and West Wales

WHSSC

"On behalf of Health Boards, to ensure equitable access to safe, effective, and sustainable specialised services for the people of Wales."

Status	Draft
Version Number	0.93
Publication Date	26 June 2018

Contents

Executive Summary

This plan sets out the actions, required over the next two years, to stabilise and strengthen the specialised neurosciences, and start the process of transforming the planning and delivery of care for patients in south, mid and west Wales. This is essential if services are to respond to new and emerging challenges and opportunities and to ensure that all patients in Wales have access to safe, effective and sustainable services.

The plan is split into three core stages:

- Stabilisation and Development of Strong Foundations
- Service Redesign
- Recommissioning

At the end of the first two years, a gateway review will be undertake to assess progress, and to inform the development of the plan for the next three years. The following objectives have been set for achievement following the completion of the five year plan:

- all patients in Wales with neurological conditions, are able to access and benefit from the most effective care, delivered at the earliest opportunity, and as close to home as possible.
- Neurosciences services in Wales are at the forefront of leading practice, research, and innovative care within Europe and that we build on academic links within Cardiff University and the other Welsh Universities, e.g. Cardiff University Brain Research Imaging Centre, Wolfson Centre for Clinical and Cognitive Neuroscience at Bangor University, etc.
- Neurosciences services in Wales are delivered by highly skilled and motivated workforce, which is able to lead innovation within neurosciences care, and adapt to future challenges and opportunities.
- Neurosciences services for patients in Wales are planned and delivered through a whole system approach across health and social care, underpinned through genuine coproduction with service users.

1. Introduction and Aim

In March 2018 the WHSSC Five year Specialised Neurosciences Strategy was presented to Joint Committee. This document sets out the delivery plan for the first two years of the strategy and the actions required by both WHSST and Health Boards in enabling its implementation.

The twin aims of the strategy are to ensure:

- specialised neurosciences services are planned and delivered as part of a whole system of health and social system, in order to ensure that they have the capacity and capability to deliver high quality and effective care, with the flexibility to respond to future challenges and opportunities..
- specialised neurosciences services work as part of an integrated system, with primary and secondary care services, to deliver care in the most effective way at the earliest opportunity within the care pathway;

2. Background

In May 2015 the Joint Committee asked for the development of a Neurosciences 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.

A series of papers have been presented to Joint Committee during the development of the Five year Specialised Neurosciences Strategy. These included a Project Initiation Document which outlined the Neurosciences services commissioned directly by WHSSC that the Strategy would focus on:

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

Subsequent papers have described the current service provision of Specialised Neurosciences in NHS Wales and the key service issues taking note of the recommendations from the previous Axford, Steers and Price-Morris reviews and the relative success of their implementation almost ten years on.

In March 2018, the Strategy which posed and answered three key strategic questions in relation to the four main areas of Neurosurgery, Neuro Rehabilitation, Neuro Radiology and Paediatric Neurology, was presented to Joint Committee.

The Strategy concluded that the four areas were core Neurosciences services which should continue to be delivered in south Wales but all required significant service improvement initiatives in order to deliver high quality services.

Within the Strategy there was also the question of whether there were other neuroscience services which would benefit from national commissioning or nationally commissioned services from inside or outside Wales which should be devolved to Health Boards.

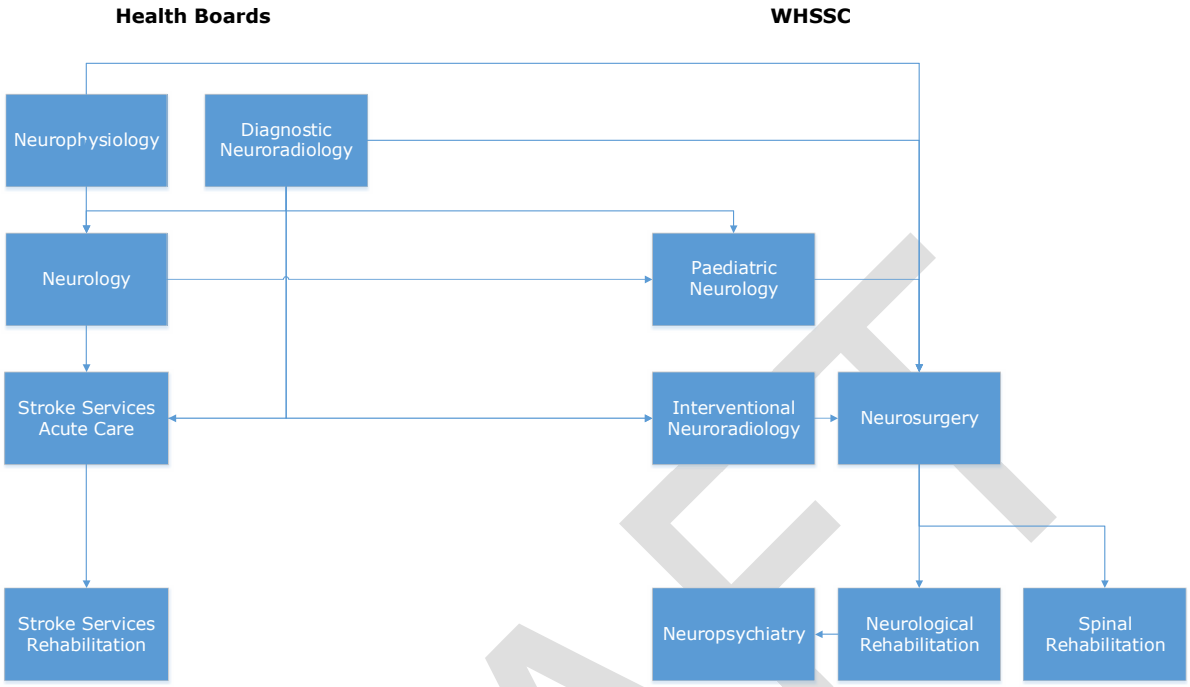
It was identified that there were services currently commissioned by Health Boards including Neurophysiology which had clear links with specialised services and would benefit with being commissioned nationally. From a WHSSC perspective, it was recognised that whilst WHSSC held the contract for Adult Neurology commissioned by Betsi Cadwaladr UHB in the Walton Centre and within C&VUHB for Health Boards in south east Wales, since it had been agreed to transfer Neurology services from WHSSC back to Health Boards in 2011/12, WHSSC were not actively commissioning Neurology merely acting as a conduit for funding.

3.1 Neurosciences and Specialised Neurosciences in 2018

The table below lists the neurosciences services commissioned by WHSSC and Health Boards

Commissioned by HBs	**Commissioned by WHSSC**
Neurology	Neurosurgery inc. Paediatric
Neurophysiology	Interventional Neuroradiology
Diagnostic Neuroradiology	Paediatric Neurosurgery
General rehabilitation	Paediatric Neurology
Stroke services	Neurological rehabilitation
	Spinal rehabilitation
	Neuropsychiatry

The figure overleaf provides an illustration of the links between these services in delivering patient care.



This matrix only illustrates the relationships and interdependencies with neurosciences services, however each service also has a series of relationships and interdependencies with other health and social care services.

It should also be acknowledged that over the next few years, there will be significant developments in the management and care of major trauma patients, as the network and Major Trauma Centre at University Hospital of Wales are established. The challenges and opportunities arising from this development will need to be factored into the transformation of specialised neurosciences, in particular neuro imaging, neurosurgery, and neurological rehabilitation.

In order to ensure that patients are able to access and receive care in the most effective way, at the earliest opportunity within the care pathway, specialised neurosciences need to be planned and delivered as part of a whole system of health and social care. This will ensure that they have the required capacity and capability to deliver high quality and effective, and to be able to respond to future challenges and opportunities.

3.2 Neurosciences in 2023

This delivery plan sets out the actions, required over the next two years, to stabilise and strengthen the specialised neurosciences, and start the process of

transforming the planning and delivery of care for patients in south, mid and west Wales.

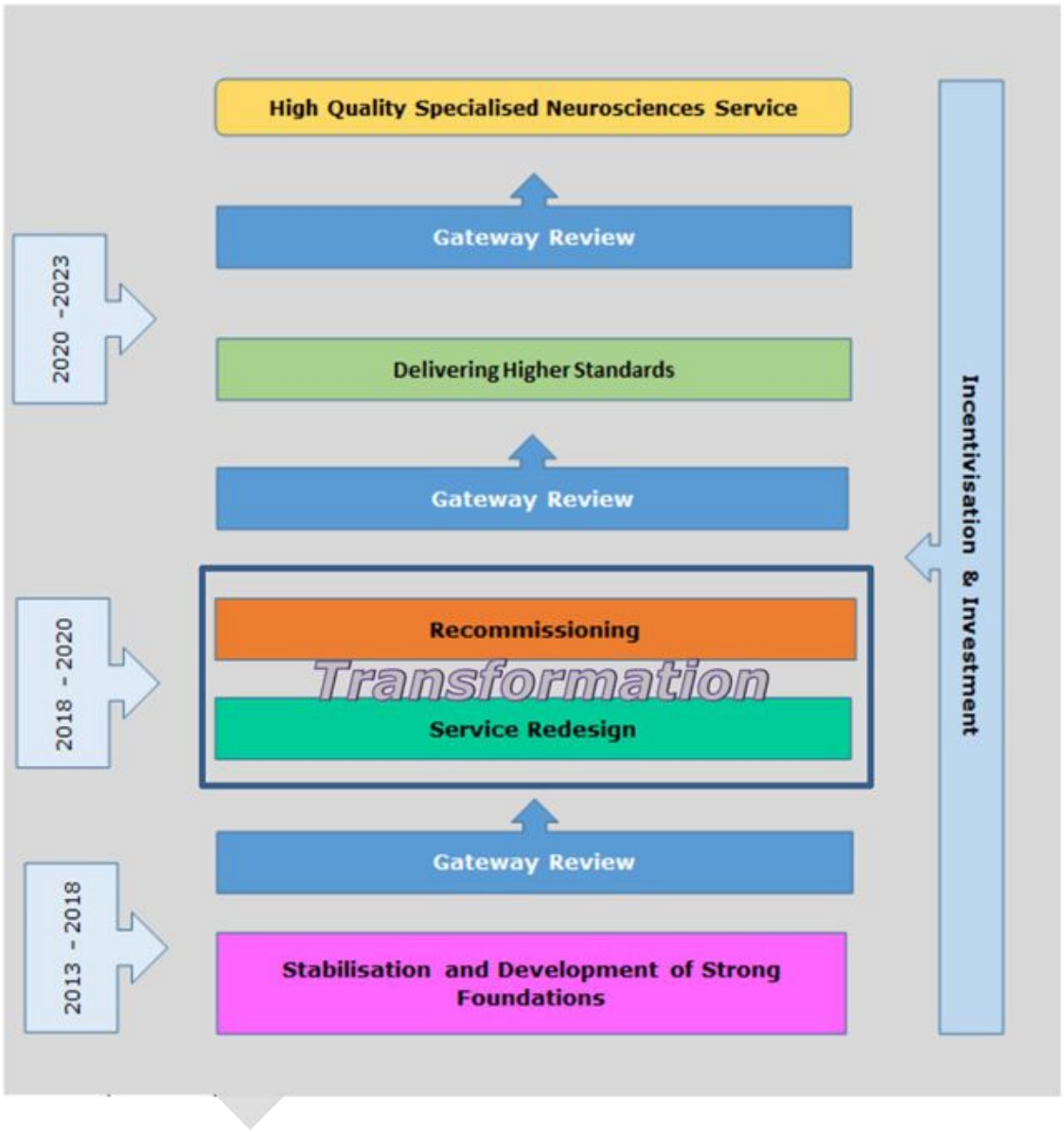
In order to take forward this challenging programme of transformation, it will be necessary for WHSSC to work in partnership with other organisations, including statutory bodies in health, social care, education, supporting organisations and third sector partners.

At the end of the five year programme, the following objectives will have been achieved:

- all patients in Wales with neurological conditions, are able to access and benefit from the most effective care, delivered at the earliest opportunity, and as close to home as possible.
- Neurosciences services in Wales are at the forefront of leading practice, research, and innovative care within Europe
- Neurosciences services in Wales are delivered by highly skilled and motivated workforce, which is able to lead innovation within neurosciences care, and adapt to future challenges and opportunities.
- Neurosciences services for patients in Wales are planned and delivered through a whole system approach across health and social care, underpinned through genuine coproduction with service users.

4 Strategic Priorities

The diagram below illustrates the key strategic priorities and timelines to deliver high quality specialised Neurosciences services.



- **Stabilisation and Development of Strong Foundations –** The initial work will concentrate on stabilising current services, and developing the strong foundations necessary to support the transformation programme.
- **Transformation –** the case for transformation was clearly set out in the Steers and Axford reviews, and the recent assessment of specialised neurosciences services has reaffirmed the necessity to proceed with this at pace. The transformation programme will be underpinned by two workstreams:

  - **Service Redesign –** whilst the service model for neurosurgery was settled in 2010/11, following the outcome of the Steers and Axford reviews, there has been limited progress is aligning the service models of other related services such as neurological rehabilitation.
  - **Recommissioning -** 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 services.
- **Delivering Higher Standards –** following the completion of the transformation programme, services will be in a strong position to deliver care in line with current UK standards.
- **High Quality Specialised Neurosciences Services –** the momentum achieved through the delivery programme will continue to ensure that the services in south Wales have the capacity and capability to deliver high quality and effective care, with the flexibility to respond to future challenges and opportunities.

5 Stabilisation and Development of Strong Foundations

5.1 Investments into Specialised Neurosciences services pre-2018

Additional recurrent funding amounting to approximately £5m has been made in the following areas since 2010:

- Adult Epilepsy to allow repatriation
- Stereotactic Radiosurgery to allow repatriation
- Interventional Neuro-Radiology
- Core Neurosurgery (Clinical Fellows and Nurse Practitioners)
- Neuro-Vascular Multi-Disciplinary Team

Assessment of return on investment: All the investments are currently being scrutinised to establish whether they have fulfilled the aims which were identified to secure funding. For the two services which were repatriated, work within the delivery plan will assess the success with regards delivery of anticipated levels of activity and the proportion of repatriated patients. This work will inform if and how we repatriate other Neurosciences services and whether current models for these services offer long term sustainability.

5.2 Neurosurgery: Meeting shortfalls against standards

There are a number of shortfalls in the performance of the C&VUHB Neurosurgery Centre against the minimum requirements for a Neurosurgical Centre as set out in NHS England's Neurosurgery Service Specification (2013). These are outlined below along with actions being taken to address them. The population count referred to is based on Welsh Government's 'Stats Wales' publication in June 2016 which shows the population of the six Health Boards served by the Neurosurgical Centre in C&VUHB as 2.4million.

Neurosurgeons

An additional 2.5-3 Whole Time Equivalent (WTE) Neurosurgeons are required to bring the Consultant workforce up to 12 Neurosurgeons and meet the standard of 1 WTE Neurosurgeon per 200,000 population.

The standards are a minimum of 12 WTE surgeons for a population of 2.4m. The academic post (Chair in Neurosurgery) could not be counted as 1 WTE as the post holder's job plan has a significant research component. Therefore it is likely we will need an additional 3 WTE neurosurgeons to come up to the 12 WTE standard.

C&VUHB are currently going at risk with 1.5 WTE additional Neurosurgeons bringing their current workforce to 11. One Consultant who recently retired has returned to work to support additional elective activity and a Locum Consultant who was employed to cover the now filled Neurovascular vacancy, has been retained in order to support the single handed Consultant for Spinal Implants.

Further expansion of the Consultant workforce should not be considered at this point as it is important for there to be sufficient bed and theatre capacity rather than dilute existing resources. This was a concern raised by a number of Neurosurgeons who have seen their access to theatre lists reduced over time.

Recommendation:

- Both the outpatient and inpatient/daycase activity generated by the additional 1.5 WTE Consultants will be funded through the WHSSC Neurosurgery contract. Although it is recognised that the Consultant staff levels in C&VUHB are below the minimum recommendations for the population, the current capacity does not allow for further expansion of the workforce.

Bed capacity

An additional 16 level 1 and level 2 beds would be required to bring the current C&VUHB capacity of 54 beds to 72 in line with the standard of 30 neurosurgical level 1 and 2 beds per million population. Given the other constraints in the patient pathway, the increase requires a staged approach and there are plans within C&VUHB to increase the Neurosurgical bed footprint by 4 in line with short term increases in theatres described below. These plans have yet to be shared with WHSSC.

Although there are minimum levels for Critical Care beds set out in the 'Guidelines for the Provision of Critical Care Services' written by the Faculty of Intensive Care Medicine and the Intensive Care Society i.e. four level 3 Neurosurgical Intensive Care Unit beds per million population, Critical Care in C&VUHB does not have dedicated beds, however this is also the case for a number of other Neurosurgical Centres. Neurosurgical Centres which have dedicated Neurosurgical Intensive Care beds describe both negative and positive views of this service model.

Whilst there are significant over-performance issues within the WHSSC Critical Care contract, the bed day activity for Adult ICU for the last two years suggests that C&VUHB is under utilising the level of critical care capacity for their Neurosciences work (9.6 beds) but this is likely to be attributable to overall theatre and bed capacity constraints.

Increased critical care capacity will need to be taken into account when there is any theatre expansion and bed increases.

A proposal has recently been received from C&VUHB to increase bed and theatre capacity on a phased basis within 2018-19, this is not included within the current ICP as it was submitted after the plan had been finalised and approved by the WHSSC Joint Committee.

Recommendation:

- To work with Management Group to develop a recommendation for Joint Committee regarding the recently received proposal from C&VUHB to increase bed capacity to facilitate additional theatre activity on a phased basis within 2018/19.

Theatre capacity
Theatre capacity has been identified as a key constraint to the delivery of neurosurgery RTT targets over the last six years. At least one additional theatre is required to meet standard of Units serving a population of more than 2 million having a minimum of four theatres. An exact assessment of the current activity levels in not possible at present this is because in addition to the two dedicated Neurosurgery theatres, it also has access to the Hospital's General CEPOD theatres and the Day Surgery Unit. Although we are aware that activity through these is small we require activity levels from the Centre to confirm this.

A capital case for an additional Neurosurgical theatre has been put forward by C&VUHB and features on the Welsh Government NHS Wales Capital Programme. In the meantime, C&VUHB have extended theatre lists to three session days. Whilst these were effective at the end of 2017/18 in allowing the service to reduce their RTT waits, these have not been sustained to date in 2018/19 due to staffing constraints within the Theatre Directorate. The extended lists were part of a three year plan to fill the gap until an additional theatre is available. WHSSC are awaiting the details of the three year demand and capacity which will inform future bids for funding to address RTT times.

Recommendations:

- WHSSC to take details of the revenue costs and throughput associated with a third additional theatre through the Management Group assurance and scrutiny process.
- WHSSC consider business case for neurosurgery capacity increase as part of 2019-22 ICP

Neuro-oncology
The NHS England standards for a Neurosurgical centre state that 'Neuro-oncology services should be delivered in accordance with NICE guidance and therefore fully supported by Neuro-oncologists, Neuro-Radiologists, Neuropathologists and Clinical Nurse Specialists'. Whilst WHSSC funds Neuro-oncology treatment as part of its overall Neurosurgery contract, it does not commission the other elements of the Neuro-oncology pathway.

WHSSC is aware that over the course of the next year, NICE is due to be developing guidance on treatments within this field, including a new diagnostic treatment 5-amino-levulinic acid (5-ALA), and DCVax-L for treating newly diagnosed glioblastoma multiforme.

- 5-ALA is used as an adjunct to maximize resection at initial surgery and has been recommended by NICE in their draft clinical guideline '*Brain tumours (primary) and brain metastases in adults*'. Although the guidance is not mandated, NICE has concluded that the addition of 5-ALA probably improves both progression free and overall survival and is highly cost effective compared to standard resection. The final guidance is expected to be published on the 11 July 2018.

- NICE have also recently started to develop technology appraisal (TA) guidance for the use of DCVax-L for the treatment of newly diagnosed glioblastoma multiforme. DCVax-L is a cancer vaccine that stimulates the immune system and enables patients T-cells and antibodies to recognise and destroy the tumour. Publication of the final guidance is expected in May 2019. TA guidance issued by NICE is mandatory in NHS Wales.

A peer review undertaken by the All Wales Cancer Network of Neuro-oncology services in November 2016 raised serious concerns with the staffing shortfalls in the south Wales service and identified significant inequity with the service provided to patients in north Wales at the Walton Centre, Liverpool. The peer review also identified a lack of clarity regarding responsibility for addressing the concerns. Subsequently, WHSSC took ownership of the issue and submitted a scheme for inclusion in the 2017-20 and then 2018-21 Integrated Commissioning Plans. This aimed to address the serious concerns raised which included:

- Insufficient Neuro Radiology funded time to prepare and attend the MDT meetings impeding the planning of essential treatment and causing delays to patient care
- Limited Cancer Nurse Specialist for South West Wales with only a part time CNS covering this area who is not able to attend the MDTs
- Limited Allied Health Professional support

The Neuro-oncology proposal has not been prioritised highly enough to receive funding in the last two years largely because of uncertainty amongst the Associate Medical Directors of the Clinical Impact Assessment Group as to whether the majority of the proposal was tertiary and within the remit of WHSSC.

Recommendation:

- To work with Management Group to develop a recommendation for Joint Committee regarding the commissioning responsibility for Neuro-Oncology and in particular the serious concerns raised by the Cancer Network.
- To develop a commissioning proposal for the introduction of 5-ALA in Wales in-line with NICE guidance.
- To incorporate DCVax into the 2019 ICP (mandatory)

5.3 Neuro Radiology

A shortfall in staffing due to lack of trained staff rather than lack of investment is the primary issue facing the service. WHSSC has funded an additional Consultant and support staff for interventional theatre lists over recent years as well as supported the changes in technology with the funding of flow diversion devices in line with a policy to attract new Consultants.

WHSSC only commissions the interventional element of the Neuro-Radiologists role however there is a large element of diagnostic work, and it is unclear from our perspective how the total service is delivered. Concerns have been expressed by the C&VUHB Radiology department that they are providing specialist diagnostic

work although it is not recognised as such as it is not funded by WHSSC but through individual Health Board contracts. WHSSC is aware that the absence of a dedicated MRI scanner for neurosciences at UHW, means that there is insufficient capacity within the system. Formal commissioning by WHSSC of all the specialist neuroradiology diagnostic work undertaken by Cardiff and Vale UHB would align the financial flows for the service. Changing the commissioning model would provide greater transparency and the transfer of funding from secondary care to WHSSC should be cost neutral, because the work is already being undertaken.

Further concerns have been raised with the model in C&VUHB where all head scans are reported by a Consultant Neuro-Radiologist. This model which is not widely used is not felt to be the most effective and therefore there may be opportunities to use the current staffing resource more effectively. In addition, given the UK wide recruitment challenges, this model is unlikely to increase the attractiveness of posts as it dilutes the specialist role.

If Neuro-diagnostics were to also be commissioned by WHSSC, then it would be necessary to understand the Neuro-diagnostic work undertaken in ABMUHB. This would allow an exploration of the feasibility of a networked rota between the Neuro Radiologists based in C&VUHB and ABMUHB. This was a recommendation within the Axford report which has yet to be implemented.

Given the fragility of the Interventional Neuro-Radiology service we know that a commissioned network internal and external to NHS Wales is required in order to stabilise the current Interventional Neuro Radiology situation and the development of Mechanical Thrombectomy services. Discussions remain ongoing with a number of English providers and Specialised Commissioners.

The Associate Medical Director for Neurosciences is working closely with C&VUHB both to support the second Consultant returning to the Interventional side of the service and looking at options for recruiting to a third post including head heading an experienced candidate.

Recommendations:

- WHSSC to take on the commissioning of Neuro diagnostic Radiology which is an integral part of Interventional Neuro Radiology
- WHSSC to explore a networked Neuro-Radiology rota between ABMUHB and C&VUHB.
- WHSSC to support the provider in strengthening the workforce development and recruitment

5.4 Paediatric Neurology

Like the situation in Neuro-Radiology, there are national shortages of Paediatric Neurologists which has affected C&VUHB's ability to recruit to a recent vacant Consultant post due to re-location, when recently advertised. With a further two of the 3.5 WTE WHSSC funded Consultant body in C&VUHB due to become vacant in the next five years due to retirement, the service is extremely vulnerable.

It is therefore essential to stabilise and strengthen the service in south Wales or there will be a significant risk of service collapse.

The national standards recognise the need for Paediatric Neurology to be based alongside Neurosciences Centres whilst also offering an outreach clinics to provide specialist care as near to patients' homes as reasonably possible. We also know that where we commission elements of Paediatric Neurology services from England, access rates are lower than when accessing Paediatric Neurology services within Wales. This has been attributed to a higher incidence of neurological conditions amongst deprived communities[1] where there are particular obstacles to travelling for treatment. Again similarly to Radiology, the nearest English provider of Paediatric Neurology - Bristol's Children's Hospital, have advised that they do not have the capacity to accept Welsh Paediatric Neurology patients for all but very specialist cases.

A number of actions need to be taken in order to strengthen and stabilise the existing Paediatric Neurology service, some of which only require minimal investment.

Recommendations:

- WHSSC to commission the Paediatric Neurology service provided by ABMUHB by one semi-retired Paediatric Neurologist in order that the service is provided on a pan south and mid Wales basis
- WHSSC to work with the Children's Hospital for Wales on ensuring that they have the facilities and associated staff to provide diagnostics such as video telemetry that are considered core in every Paediatric Neurosciences Centre
- Repatriation of services from England where possible – telemetry, ketogenic diet and neuropsychology.

These recommendations will have a number of benefits including making the service more attractive to medical staff, providing services closer to home for patients and therefore improving access.

5.5 Paediatric MRI waits

For patients in south and mid Wales there are currently waits of up to a year for patients under 8 who require an MRI under General Anaesthetic (GA). For children over the age of 8 who do not require a GA there are waits of up to 6 months. These waits which are projected to reach two years by 2020 have recently been presented to Welsh Government as part of their assessment, led by the Deputy Chief Medical Officer/Head of Healthcare Quality Division of the management of Neurology services in Wales.

NICE recommended in 2004 that paediatric epilepsy multi-disciplinary teams should have access to MRI for diagnosis. The NICE guideline 137, developed to improve the diagnosis of epilepsy, notes that between 5-30% of children diagnosed with

[1] Heaney DC, Macdonald BK, Everitt A et al Socioeconomic variation in incidence of epilepsy:prospective community based study in southeast England, BMJ 2002:325:1013-1016

epilepsy have an incorrect diagnosis. The Joint Epilepsy Council reported that up to 40% of children referred to tertiary epilepsy centres do not have epilepsy. MRI is therefore an essential diagnostic tool. In addition for children that do have epilepsy, delays in them receiving appropriate diagnosis is known to have a detrimental effect on their development and their IQ later in childhood.

A dedicated paediatric MR scanner was included in the build of the Children's Hospital for Wales but is currently only commissioned for six sessions a week.

It is proposed that additional sessions are commissioned in order to reduce the waiting times for paediatric neurosurgical patients and speed up the diagnosis of paediatric epilepsy patients.

The model for undertaking MRIs in paediatrics also needs to be agreed. In both Manchester and Sheffield, 90% of MRIs in children under 8 are carried out with sedation provided by nurses rather than general anaesthetics. This has a number of benefits:

- Reduced anaesthetic support requirements
- Higher throughput of patients on sessions
- Reduced requirement for ward beds

Recommendations:

- WHSSC to commission additional MRI lists to increase capacity and reduce current waiting times.
- WHSSC to explore the sedation model which is not currently used within the Children's Hospital of Wales.

Key actions

Key actions:

1. Analysis of the return on investment made in Neurosciences since 2010.
   Timescale: September 2018

2. WHSSC with Management Group to review the Neuro-oncology scheme on the RMF and decide route for resolution i.e. advise on elements that require strengthening for it to be considered again within the WHSSC ICP process or delegate to Regional Planning Groups.
   Timescale: July 2018 Management Group

3. WHSSC to develop a commissioning proposal for 5-ALA treatment if NICE recommend its use in their clinical guideline '*Brain tumours (primary) and brain metastases in adults*' (as identified within the ICP 2018-21).
   Timescale: NICE clinical guideline due to be published on 11 July 2018

4. WHSSC to introduce DCVax-L for the treatment of newly diagnosed glioblastoma multiforme, if its use is recommended within a mandatory NICE technology appraisal.
   Timescale: NICE final guidance is expected in May 2019

5. WHSSC and C&VUHB to continue regular RTT and quality performance meetings with the C&VUHB Neurosurgery and Neuro-Radiology services to monitor current waiting list volumes and times and increase efficiencies including theatre utilisation and bed cancellations.
   Timescale: Ongoing

6. WHSSC to take a collective commissioning approach to Diagnostic Radiology.
   Timescale: November 2018

7. WHSSC to explore the feasibility of a Neuro-Radiology rota across South and Mid Wales.
   Timescale: October 2018

8. WHSSC to begin discussions with ABMUHB regarding the formal commissioning of specialised Paediatric Neurology which they provide on behalf of ABMUHB and HDUHB.
   Timescale: August 2018

9. WHSSC to work with C&VUHB on staffing options for the recently vacated Consultant Paediatric Neurologist post.
   Timescale: Meeting arranged with C&VUHB 19 July 2018

10. WHSSC to re-visit the business case for providing Video Telemetry in Wales to be considered as a scheme in the 2019-22 ICP.
    Timescale: September 2018

11. WHSSC to develop a business case for additional MRI capacity to be considered as a scheme in the 2019-22 ICP.
    Timescale: September 2018

12. WHSSC to explore with clinicians in C&VUHB the option to introduce sedation in cases which would increase the throughput of patients
    Timescale: September 2018

Outcome indicators and assurance measures:

- Improvement against RTT targets
- Increased sustainable capacity
- Increase in services provided locally
- Reduction in waiting times for diagnostics

6 Service Redesign

6.1 Neuro-Rehabilitation

The Steers Review and subsequent working groups highlighted the importance of establishing network arrangements within Neuro-rehabilitation. Work is underway on standardising both the referral and discharge processes across the two rehabilitation services in South Wales and there is a Task and Finish Group meeting in July with previous attendees of the WHSSC Rehabilitation Audit and Outcomes Day and members of the Neurological Conditions Implementation Group (NCIG) are invited. Discussion is planned around strengthening the in and out reach models of delivering neuro-rehabilitation and from this it is anticipated that a previously submitted and unfunded ICP scheme will be re-visited and include a nursing or AHP Co-ordinator post to work across the Service Delivery Network ensuring flow from specialised to secondary care services.

Recommendation:

- That a Service Delivery Network for Specialised Rehabilitation be established in south and mid Wales.
- That funding of an AHP co-ordinator be considered in the 2019-22 ICP

6.2 Paediatric Neurology

Changes in the commissioning of Paediatric Epilepsy in NHS England with the establishment of four designated centres including Bristol requires us to re-consider the historical pathway for Welsh to Great Ormond Street Hospital, London. A service specification has been drafted for the service and will be ready for consultation following discussions with Bristol to confirm whether, as previously indicated, they are able to provide Paediatric Epilepsy surgery to NHS Wales.

Recommendation:

- That WHSSC commissions Paediatric Epilepsy primarily from Alderhey and Bristol for Welsh patients.

Actions

1. WHSSC to standardise processes across the two Neuro-rehabilitation Units as the first stage of a Network approach to Neuro-Rehabilitation across south and mid Wales.
   Timescale: 28th June 2018 Task & Finish Group meeting

2. Provider and Commissioner Health Boards to implement the WHSSC Specialised Rehabilitation policies to promote flow across the patient pathway.
   Timescale: Published March 2018

3. WHSSC to re-visit the Neuro-rehabilitation scheme to include a Network co-ordinator post to be considered in the 2019-22 ICP.

Timescale: September 2018

4. WHSSC to meet with University Hospitals Bristol (UHB) to determine that they will accept Welsh patients for paediatric epilepsy surgery and the pathway for this.
   Timescale: Meeting arranged with UHB 2nd August 2018

Outcome indicators and assurance measures:

- Standardised referral and discharge processes into the two Neuro Rehabilitation Units
- Reduced delayed transfers and inappropriate stays within specialised neuro-rehabilitation beds
- Establishment of a Service Delivery Network for Specialised Rehabilitation across South and Mid Wales
- Benchmarking data from UKROC
- Clear pathway for commissioning of Paediatric Epilepsy surgery

7 Recommissioning

7.1 Neurosurgery

Spinal Surgery
It is recognised in the NHS England Neurosurgery service specification (2013) that Neurosurgical centres are undertaking increasing amounts of secondary spinal care in additional to tertiary care work. Analysis of the spinal procedures on the neurosurgical waiting list at C&VUHB has also identified what can be considered secondary care procedures. A number of NHS England centres, including Birmingham, from whom we also commission spinal surgery, have transferred secondary care activity to secondary care providers. We are aware in NHS Wales that there are a variety of clinical pathways and that spinal surgery is undertaken by Neurosurgeons and Orthopaedic surgeons in ABMUHB and C&VUHB and Orthopaedic Surgeons in ABUHB. The option therefore of moving activity should be considered and whilst such a shift would not release funding in the overall NHS system, it would release tertiary Neurosurgery theatre capacity.

We also know that there is variation in practice around the use of alternatives to surgery such as Physiotherapy and Pain Management. These options are available within the C&VUHB service, but not consistently utilised by all Consultants in the centre. The development of a WHSSC service specification will promote a more clinically consistent and cost effective pathway. Investment is likely to be required in order to deliver best practice within Spinal Surgery but this will only be considered as part of the WHSSC ICP process.

Recommendation: WHSSC to publish the Spinal Surgery service specification clarifying the optimal clinical pathway.

Neuro-modulation
There are notable gaps in the neuro-modulation MDT which has been the subject of a scheme proposed for inclusion in the WHSSC ICP since 2015/16. This relates to Psychology and Physiotherapy input which, like that in spinal surgery, can reduce the number of patients undergoing very costly spinal implant surgery by offering an alternative method of managing pain. This therefore offers an opportunity for clinical incentivisation by generating savings from high cost devices and investing these into the MDT.

Recommendations:

- WHSSC to work with Procurement and C&VUHB to ensure that only the most clinically and cost effective spinal implants are used.
- WHSSC to reinvest any savings generated from changing devices to pump prime Psychology and Physiotherapy staff which are shown in other Centres to reduce the number of patients who undergo spinal implant surgery.

7.2 Neuro-Rehabilitation

The British Society of Rehabilitative Medicine advises that 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 specialised rehabilitation a highly cost effective intervention.

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.

The recently published suite of Neuro and Spinal Rehabilitation policies recognise that the money should follow the patient as they progress through their rehabilitation pathway. The intention is to improve flow, and provide the evidence to support the financial case for the developing appropriate complimentary levels of rehabilitative care within Health Boards. It is proposed that these arrangements are implemented on a shadow basis initially, and that this period is used as an opportunity to collect and review data to inform future Health Board planning assumptions.

A further financial incentive that would benefit both Providers and Commissioners, is the pump priming of administrative support for the two Rehabilitation Units to enter their details into UK Rehabilitation Outcomes Collaborative (UKROC). This would allow WHSSC to benchmark the Welsh Rehabilitation services with rehabilitation services across the UK and for the service demonstrate shortfalls in comparisons with other services that need to be addressed.

Recommendation: The WHSSC policies on specialised rehabilitation, published in March 2018, should be implemented in shadow form for the next six months, prior to full implementation.

Actions

1. WHSSC to consult on the draft Spinal Surgery service specification to formalise commissioned pathways.
   Timescale: August 2018

2. WHSSC to engage Shared Services Procurement in reviewing the procurement options for spinal implant devices.
   Timescale: July 2018

3. WHSSC to reinvest savings from the Spinal Implants Procurement exercise into key posts within the Neuro-modulation MDT.
   Timescale: September 2018

4. WHSSC to make the case for funding an administrative post to ensure that data is entered onto the UKROC system allowing benchmarking of the South Wales services with those across the UK.
   Timescale: For consideration in 2019-22 ICP

5. Use benchmarking results provided by UKROC to determine the priorities for staffing of the two Neuro-rehabilitation Units.
   Timescale: Following agreement of funding 2019

Outcome indicators and assurance measures:

- Clear commissioning position on specialised Spinal Surgery procedures and pathways
- Ensuring best value through evidence based procurement of spinal implants
- Submission of welsh data into UKROC

8 Stakeholder Engagement

To inform and deliver this delivery plan, WHSSC will widen its current rolling programme of engagement to include the following stakeholders:

- Service users and carers –clarifying the health and wellbeing outcomes which matter to people, and using that information to support improvement and better collaborative decision making.
- Third sector organisations – exploring opportunities to work closer together in the planning and delivery of services.
- Universities – working with Welsh Universities to identify and build upon synergies within specialised neurosciences e.g. Cardiff University Brain Research Imaging Centre, Wolfson Centre for Clinical and Cognitive Neuroscience at Bangor University, etc.
- NHS Wales providers – including providers of neurosciences and specialised neurosciences services, as well as Velindre NHS Trust, and Wales Ambulance Service Trust.
- NHS England providers, including
    - The Walton Centre NHS Foundation Trust – delivering specialised neurosciences services for patients in north Wales
    - North Bristol NHS Trust – delivering Deep Brain Stimulation surgery, and supporting the delivery of neurovascular services for patients in south, mid and west Wales
    - University Hospitals Birmingham NHS Foundation Trust – delivering neurosurgery services for patients from Powys
    - Sheffield Teaching Hospitals NHS Foundation Trust – supporting the delivery of stereotactic radiosurgery for patients with complex arteriovenous malformations
- NHS Wales supporting organisations
    - Emergency Ambulance Services Committee – identifying opportunities for integrating planning across the whole of the patient care pathway
    - Health Education and Improvement Wales – working in partnership to develop and recruit a highly skilled and motivated workforce
    - National Wales Informatics Services – identifying opportunities to support the services data requirements
    - NHS Wales Shared Services Partnership – identifying opportunities to improve procurement of devices and equipment
    - NHS Wales Health Collaborative – working in partnership with the National Imaging Board to support the development of the imaging programme across Wales, and working in collaboration with the Clinical Networks to align objectives and priorities
- Local Health Boards
    - All Health Boards - working with all Health Boards to align the planning of specialised neurosciences with local planning for their population, as well as:
        - Regional Partnership Boards – identifying impacts on health and social care, and identifying solutions that can be delivered across health and social care services

- Joint Regional Planning and Delivery Committee – exploring opportunities for planning and delivery care on a regional footprint
- Powys Teaching Health Board – working in partnership to clarify and formalise the referral pathways for patients living in Powys
- Betsi Cadwaladr University Health Board – supporting the North Wales Neuroscience Network to inform the planning of neurosciences and specialised neurosciences services

9 Monitoring and Assurance

The delivery of the workplan will be monitored through the Neurological and Complex Conditions Commissioning Team Meeting on a monthly basis, and updates will be provided to the WHSSC Corporate Directors Group, Management Group, and Joint Committee on a quarterly basis.

A gateway review will be conducted following the completion of the transformation programme, this will be an independent and confidential peer review to provide assurance to the Joint Committee on:

- The implementation of the key actions – and the alignment of the delivery plan with NHS Wales strategic objectives
- The outcome of the investments made in the first three phases of the strategy
- The progress of the strategy against the agreed timeline and budget

A proposal for establishing this review will be presented to the Joint Committee for consideration in early 2019.

Annex i Action Plan

Stabilisation and Development of Strong Foundations

Key Actions	Timescale
Analysis of the return on investment made in Neurosciences since 2010.	September 2018
WHSSC with Management Group to review the Neuro-oncology scheme on the RMF and decide route for resolution i.e. advise on elements that require strengthening for it to be considered again within the WHSSC ICP process or delegate to Regional Planning Groups.	July 2018
WHSSC to develop a commissioning proposal for 5-ALA treatment if NICE recommend its use in their clinical guideline 'Brain tumours (primary) and brain metastases in adults' (as identified within the ICP 2018-21)	11 July 2018
WHSSC to introduce DCVax-L for the treatment of newly diagnosed glioblastoma multiforme, if its use is recommended within a mandatory NICE technology appraisal.	May 2019
WHSSC and C&VUHB to continue regular RTT and quality performance meetings with the C&VUHB Neurosurgery and Neuro-Radiology services to monitor current waiting list volumes and times and increase efficiencies including theatre utilisation and bed cancellations.	Ongoing
WHSSC to take a collective commissioning approach to Diagnostic Radiology.	November 2018
WHSSC to explore the feasibility of a Neuro-Radiology rota across South and Mid Wales.	October 2018
WHSSC to begin discussions with ABMUHB regarding the formal commissioning of specialised Paediatric Neurology which they provide on behalf of ABMUHB and HDUHB.	August 2018
WHSSC to work with C&VUHB on staffing options for the recently vacated Consultant Paediatric Neurologist post.	19 July 2018
WHSSC to re-visit the business case for providing Video Telemetry in Wales to be considered as a scheme in the 2019-22 ICP.	September 2018
WHSSC to develop a business case for additional MRI capacity to be considered as a scheme in the 2019-22 ICP.	September 2018
WHSSC to explore with clinicians in C&VUHB the option to introduce sedation in cases which would increase the throughput of patients	September 2018

Service Redesign

Key Actions	Timescale
WHSSC to standardise processes across the two Neuro-rehabilitation Units as the first stage of a Network approach to Neuro-Rehabilitation across south and mid Wales.	28th June 2018
Provider and Commissioner Health Boards to implement the WHSSC Specialised Rehabilitation policies to promote flow across the patient pathway.	March 2018
WHSSC to re-visit the Neuro-rehabilitation scheme to include a Network co-ordinator post to be considered in the 2019-22 ICP.	September 2018
WHSSC to meet with University Hospitals Bristol (UHB) to determine that they will accept Welsh patients for paediatric epilepsy surgery and agree the pathway.	2nd August 2018

Re-commissioning

Key Actions	Timescale
WHSSC to consult on the draft Spinal Surgery service specification to formalise commissioned pathways.	August 2018
WHSSC to engage Shared Services Procurement in reviewing the procurement options for spinal implant devices.	July 2018
WHSSC to reinvest savings from the Spinal Implants Procurement exercise into key posts within the Neuro-modulation MDT.	September 2018
WHSSC to make the case for funding an administrative post to ensure that data is entered onto the UKROC system allowing benchmarking of the South Wales services with those across the UK.	For consideration in 2019-22 ICP
Use benchmarking results provided by UKROC to determine the priorities for staffing of the two Neuro-rehabilitation Units.	Following agreement of funding 2019

Annex ii Five year Specialised Neurosciences Strategy

Annex iii Current provision of Specialised Neurosciences in NHS Wales

Annex ii

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

Specialised Neurosciences Services Strategy

WHSSC

"On behalf of Health Boards, to ensure equitable access to safe, effective, and sustainable specialised services for the people of Wales."

Status	Draft
Version Number	1.1
Publication Date	26 June 2018

Contents

1.0 Introduction

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 Strategic Questions

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?

4.0 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.

4.1 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.

4.2 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.

4.3 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.

4.4 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.

4.5 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. Assessment of C&VUHB's performance against NHS England's minimum recommendations for a Neurosurgical Centre

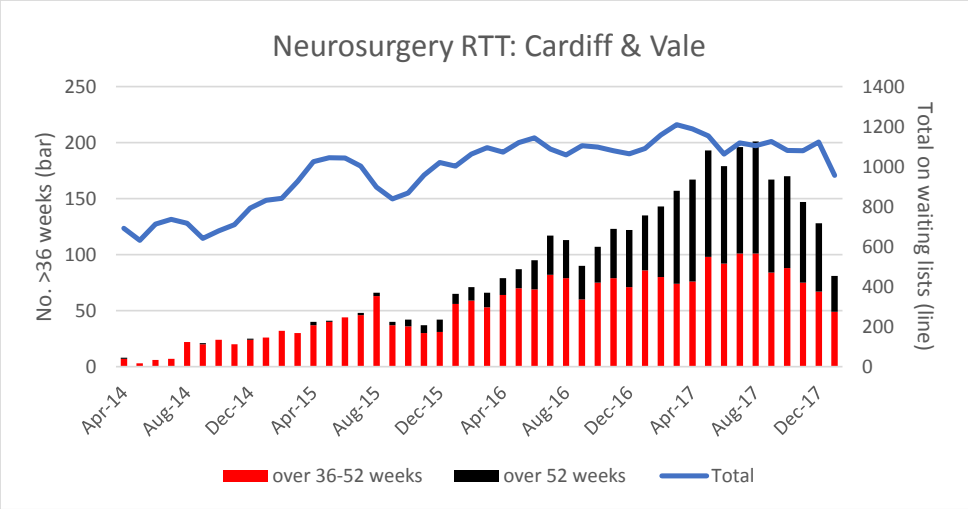
Minimum requirement	C&V's achievement of minimum target
1 whole time equivalent (wte) Neurosurgeon for full 24hr Consultant led service per 200,000 population (equivalent to 10 Neurosurgeons for C&V's tertiary population)	✓

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

4.6 Referral to treatment times

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.

4.7 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.

4.8 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.

5.0 Neuro Rehabilitation

5.1 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.

5.2 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.

5.3 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.

5.4 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	✓	✓
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 - Act as a resource for research and development, as well as education and training	In part In part	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.

5.5 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.

5.6 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.

5.7 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.

6.0 Neuroradiology and Interventional Neuro-radiology

6.1 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.

6.2 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.

6.3 Interdependencies

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

6.4 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.

6.5 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.

7.0 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

7.1 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.

7.2 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.

7.3 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.

7.4 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

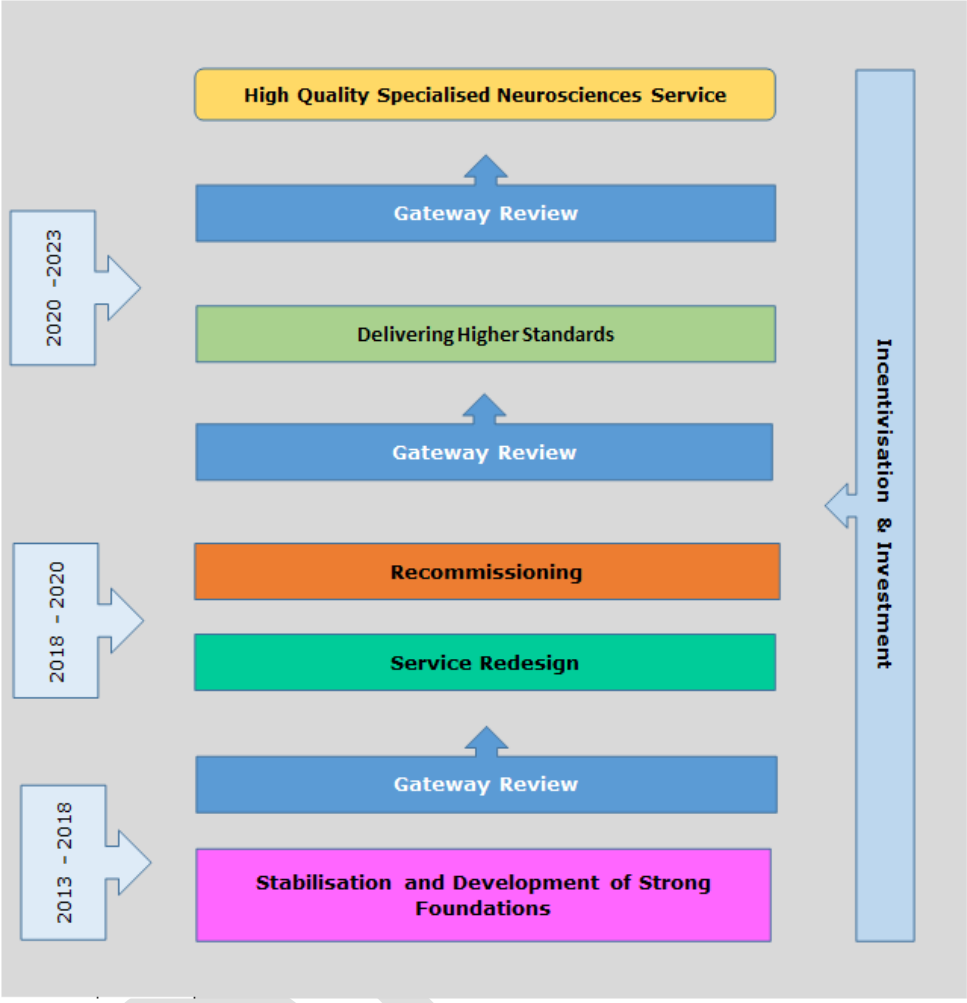
specialist centre without access to video telemetry, resulting in patients having to go to Oxford to receive this five day diagnostic (Bristol Children's Hospital have advised that they do not have capacity to accept Welsh patients for this).

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.

7.5 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.

8.0 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

9.0 Neuro-Rehabilitation service improvement

9.1 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.

9.2 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.

10.0 Paediatric Neurology service improvement

10.1 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 specialty 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.

11.0 Neuro Radiology

11.1 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.

11.2 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.

12.0 Neurosurgery

12.1 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.

11.2 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.

11.3 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.

13.0 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.

14.0 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.

15.0 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 the next section

16.0 Recommendations

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 Arrangements and Financial Head of Agreement.	2019/20
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.	

		Agenda Item	09
Meeting Title	**Joint Committee**	Meeting Date	30/05/2017
Report Title	Current provision of Specialised Neurosciences in NHS Wales to inform the Commissioning Strategy		
Author (Job title)	Specialised Planner, Neurosciences		
Executive Lead (Job title)	Acting Director of Planning	Public / In Committee	**Public**

Purpose	This paper sets out the current provision of Specialised Neurosciences which will inform a five year Commissioning Strategy for Specialised Neurosciences by the end of 2017.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Not Applicable	Meeting Date	
Recommendation(s)	Members are asked to: • **Note** the current provision of Specialised Neurosciences for patients in NHS Wales which will inform the Five year Commissioning Strategy; • **Support** the urgent establishment of network arrangements with NHS England providers for Neuro-Radiology; • **Support** the establishment of an operational delivery network for Specialised Rehabilitation in South Wales; • **Support** the collective approach to the commissioning of Paediatric Neurology in both North and South Wales; and • **Support** the proposal to implement a service specification for Specialist Spinal Surgery and a Phased implementation of application of this to the listing of specialist spinal patients within Neurosurgery.		

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	✓	
	YES	NO	Population Health	YES	NO		YES	NO

9

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

Equality and Diversity	✓			✓		Legal Implications		✓

1.0 Purpose

The purpose of this report is to present the Five year Commissioning Strategy for Specialised Neurosciences to the WHSSC Corporate Directors Group.

The paper sets out:

- the background for initiating the Five year Commissioning Strategy for Specialised Neurosciences;
- an assessment of the implementation of recommendations from the Steers, Axford and Price-Morris Reviews of Neurosciences for patients within NHS Wales;
- the details of the three work-streams established including the membership, terms of reference and outputs;
- how services are currently commissioning and delivered for patients in NHS Wales;
- a map of the current provision of Specialised Neurosciences in terms of activity and financial costs; and
- recommendations on the future delivery and commissioning of Specialised Neuroscience services.

2.0 Background

WHSSC were asked by Joint Committee in 2015 to develop a clear strategy for specialised Neuroscience services for patients from NHS Wales, in order to set the direction for specialised and non-specialised services in this area. This was in response to:

- The emergence of a number of Neurosciences service issues that required financial support outside of Integrated Commissioning Plans;
- Three Service Reviews: Steers (2008), Axford (2009) and Price-Morris (2009) which highlighted areas within Neurosciences that required development;
- The fragility of the Neuro Interventional-Radiology service in Cardiff;
- 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 June 2016 Joint Committee members approved the Project Initiation Document (PID) which described the development of a Specialised Neurosciences Strategy. The PID is attached as Annex 1. It was acknowledged that the Strategy would only take into consideration those services commissioned directly by WHSSC and clarification was sought as to what these services were. The WHSSC commissioned services were broadly outlined as:

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

2.1 Recommendations from previous reviews

2.1.1 Steers and Axford

In 2007, the Welsh Assembly Government commissioned James Steers to undertake a review of neurosciences in Wales. The final report was published in three parts, North Wales, South & Mid Wales and All Wales, in September 2008.

Following the publication of the Steers Review, Dr Alan Axford was asked by the Minister for Health and Social Services to make specific recommendations for implementing the Steers findings for Mid & South Wales.

Dr Axford made 19 key recommendations which were taken forward through the Mid & South Neurosciences Implementation Programme. The 1st phase of this programme focused on the transfer of neurosurgery to a single site at the University Hospital of Wales, Cardiff. This had been precipitated by the removal of neurosurgery training from Morriston and the transfer was completed in 2010, with a small number of neurosurgeons opting not to transfer to UHW, rather to remain at ABMUHB as part of the spinal surgery service. WHSSC does not commission any of the activity undertaken by the neurosurgeons at ABMUHB. Furthermore, the service at ABMUHB is not designated as a neurosurgery unit, and as such the surgeons do not participate in the National Neurosurgery Audit programme (NNAP).

The 2nd phase of the implementation programme commenced in December 2010 with the aim of implementing the wider Axford recommendations for spinal surgery, neurology, rehabilitation and diagnostics by September 2011.

An update report describing the achievements of the 2nd phase of this work was presented to Management Group in September 2011. The report highlighted the achievements of the 2nd phase of work as –

For Spinal Surgery

- Implementation of a formal 24/7 provision of acute spinal surgery across Mid & South Wales.

For Adult Rehabilitation and Supportive Care

- Development of detailed proposals for a network to provide community based rehabilitation support for patients with acquired neurological and spinal injuries across Mid & South Wales.
- The mapping of Adult rehabilitation services for spinal cord and acquired brain injury across all Mid and South Wales NHS organisations.

Neurology

- Agreement across the 6 HBs to appoint two additional consultant neurologists for Mid & South Wales with appointments expected by December 2011.
- Needs assessment completed by Public Health Wales.
- Development of a model for neurology services and network across Mid & South Wales.

Diagnostics and Transport

- Sustainable neuro-radiology service across Mid & South Wales secured through closer working between neuro-radiology services in ABM UHB and C&V UHB.
- Established on-call neuro-radiology advice systems in place (separately for East and West): with work in progress to provide a single on-call rota across South Wales.

2.1.2 Price-Morris

The Minister for Health and Social Services also asked Mr Elwyn Price-Morris to make specific recommendations for implementing the Steers findings for North Wales. The Price-Morris report set out 26 key recommendations, outlined in Annex 2 of which four were highlighted as key:

- A North Wales Neurology Service should be established within an appropriate location for patient access from which medical neurology, stroke management and neurophysiology would be delivered with enhanced services at other main sites.
- A managed clinical network for neurosciences for North Wales should be established linking Bangor, Glan Clwyd and Wrexham together with the existing tertiary centres.
- An in-patient neuro-rehabilitation centre should be established in North Wales.
- A non-complex spinal injury surgery service should be established in North Wales.

Of the four key Price-Morris recommendations, both the managed clinical network for Neurosciences and a non-complex spinal injury pathway have been implemented.

Unlike the original Steers recommendations which were directed to organisations other than Health Boards including WHSSC and Welsh Government, the Price-Morris recommendations focussed on actions to be taken by Betsi Cadwaladr.

2.1.3 Conclusion of the Strategic Reviews

Following the conclusion of the strategic reviews of neurosciences services in both North and South Wales, it is evident that few of the recommendations have been effectively implemented. Those that remain prominent issues today include:

- Establishment of an integrated spinal and Neuro-Rehabilitation network;
- Appointment of a consultant in Rehabilitation Medicine to lead the development of a North Wales Neuro-Rehabilitation service and specialist in-patient service;
- Establishment of specialised community outreach teams for acquired brain injury and spinal injury;
- Establishment of a network to plan and deliver neurology services; and
- Integration of Neuro-Radiology services across Abertawe Bro Morgannwg UHB and Cardiff and Vale UHB.

One of the initial pieces of work recently undertaken by the Working Groups (described in 2.4) was to assess the recommendations from the Axford and Steers Reviews in terms of whether they had been implemented and if not, still needed to be. The full set of recommendations and progress against them following discussion in the three working groups, is outlined in Annex 3.

2.2. Needs Assessment

WHSSC initially envisaged in its Project Initiation Document for the Neurosciences Review that Public Health Wales (PHW) would be able to carry out a Needs Assessment for Neurosciences for the population of Wales and provide the following –

1. Current activity and access information (including consideration of the patient pathways);
2. Predicted levels of demand based on population demographics (and any changes since the last review);
3. Assessment of unmet need based on current activity or inequity of access
4. Published evidence regarding population numbers and optimal service models;

5. Horizon scanning of new technologies, procedures within the specialised neurosciences domain over the next five to ten years.

In a meeting between WHSSC and PHW, PHW advised that they could provide the following –

- Neurosciences activity which would be broken down into a number of fields including hospital accessed including English Trusts, residence of patient by Health Board, primary and secondary diagnosis of patient and treatment by procedure code;
- A review of published evidence of population numbers (epidemiology) including: incidence, mortality, prevalence and survival; and
- A review of optimal service models both nationally and internationally.

2.2.1 Information provided

Public Health Wales have been able to provide Neurosciences activity by Finished Consultant Episode (FCE) which provides us with a dataset for Inpatient and Daycase activity undertaken. Unfortunately further data was not readily available to them. Such information is considered to be an integral part of a Commissioning Strategy and we have tried to source this data by other means including from national databases such as UK Rehabilitation Outcomes Collaborative (UKROC).

One National Database the UK Rehabilitation Outcomes Collaborative (UKROC) were unable to provide data on the Rehabilitation Units in Wales and how they benchmark with other Units across the UK advising that neither Welsh Unit has submitted any information for such comparative information to be produced.

Until this data is available, we have made reference to the Public Health Wales Needs Assessment published in December 2015 which provides an overview of the burden of neurological conditions across Wales and description of the service provision and utilisation.

2.3 Working Groups

Three of the four working groups outlined in the Project Initiation Document – Neurosurgery, Neuro-diagnostics and Neuro-rehabilitation have held a series of meetings. Nominations for the initial three groups came from Health Boards who were written to with advice as to who had been involved with scoping work to date.

As the priorities for the Strategy are being developed and the contracting information for Neurosciences fully established, the fourth working group for

Finance is in the process of being set up with a terms of reference drafted (Annex 4) and nominations being sought from Health Board Finance and Commissioning representatives. A baseline assessment which detailed contracting and financial arrangements for all Specialised Neurosciences was presented to the April Management Group meeting (Annex 5). This paper also outlines the investments that have been made in Specialised Neurosciences since the Steers Review and subsequent transfer of Neurosurgery from Swansea to Cardiff. The purpose of the Finance Group is to ensure that all funding mechanisms align with commissioning responsibilities and reflect the five year Commissioning Strategy.

Due to the geographical spread and the differences in arrangements between South and North Wales, separate working groups were requested to be established for North Wales and a list of nominations for these groups provided by Betsi Cadwaladr UHB's Director of Neurosciences. Almost all the nominees have been consulted with on an individual or organisational basis, but have not been brought together in the suggested Groups. It was felt by a number of the nominees themselves that they had very different issues to highlight i.e. the three nominations for the BCUHB Neurosurgery working group consisted of: a Neurosurgeon from the Walton Centre, a Paediatrician based in BCU and the Clinical Director for Neurosurgery and Neurology from Alderhey and it would be helpful to meet with their separate teams/Management Leads when the need arose.

Similarly, due to distance and limited dedicated staff for Neurosciences, representatives from Hywel Dda UHB and Powys tHB did not attend the working group meetings but were included in the correspondence for the Groups and met with separately in their Health Boards. It was suggested by the Executive Lead for Neurosciences for Hywel Dda who is also Programme Director of the Mid Wales Healthcare Collaborative, that WHSSC attend a future meeting of the Mid Wales Healthcare Collaborative to feedback details of the Strategy once agreed.

2.4 External support to Strategy

The British Society of Rehabilitation Medicine and Society of British Neurological Surgeons who were involved in the previous reviews of Neurosciences have agreed to participate in the development of five year Strategy for Neurosciences. We will be calling on their expertise where relevant, on specific priorities.

The Royal College of Radiologists advised that they do not provide a consultancy role other than to undertake full service reviews. Contact with the National Imaging Programme Board who agreed with their members to help identify potential partners, was not forthcoming.

2.5 Assessment of current services

The assessment of current services focuses on the three main specialities of –

- Neurosurgery
- Neuro-diagnostics
- Neuro-Rehabilitation

Meetings with stakeholders for each of the three specialities and sub specialities took place in order to gain an understanding of their current status and priorities for the next five years. Their responses are outlined below, grouped under the three headings of Neurosurgery, Neuro-diagnostics and Neuro-Rehabilitation. The details of the individuals and organisations that have been consulted with are outlined in Annex 6.

3.0 Assessment

Through engagement with stakeholders from across all Health Boards, relevant NHS Trusts in England and Third Sector representatives, the Neurosciences and Complex Conditions programme team have been able to:

- provide an update on the progress made since the three reviews;
- Identify the best practice and are starting to share this where relevant across services;
- develop a schedule of schemes that outlines the priorities for services and workplan for the WHSSC Programme Team over the next five years.

The increased engagement particularly with English providers has led to changes to contracts, notably with Robert Jones Agnes Hunt. There has been a reduction in the bed day rates due to managing patients more effectively. We are working with the Walton Centre to introduce a bed day rate within Neuro-rehabilitation which will again reduce spend.

There have been improvements made to the Gate-keeping arrangements, so that Lead Consultants for their specialities are being made aware of referrals outside of their service. This is encouraging improved retention of patients locally which will consequently avoid increased costs of sending patients to NHS England.

During 2016-17 there have also been changes to the Neurosurgery contract within Cardiff, moving from a block contract of emergency and electives to a more reflective case-mix contract. The contracting details were presented to the Joint Committee in March 2017. Increased engagement with relevant Consultants on this work is leading to improved coding of cases ensuring that the contract is truly reflective of the work undertaken.

3.1 Schedule of schemes

Engagement through individual discussions and the meetings of the three work-streams set up specifically for Neurosurgery, Neuro-diagnostics and Neuro-Rehabilitation, has led to the development of a schedule of schemes for the five year duration of the Strategy which is outlined in Annex 7. The 54 schemes which are broken down into the three focus areas, can also be categorised into 42 work-plan and 12 requiring financial input, although it is likely that as the work-plan is undertaken, that more schemes will need to be quantified financially.

The schemes include recommendations from the Steers, Axford and Price-Morris reviews, which are still felt to be outstanding and requiring implementation.

It is anticipated that the schedule will continually evolve and although we have undertaken horizon scanning, within the five years there are likely to policy developments and other external influences which will need to be considered for inclusion.

3.2 Priorities for 2017-18

A number of priorities were submitted for inclusion within the WHSSC 2017-20 Integrated Commissioning Plan with the proposal that this would be year one of the five year Strategy. These priorities were:

- Neuro-Rehabilitation;
- Spinal Rehabilitation;
- Neuro-oncology; and
- Neuro-modulation.

However, with no funding allocated for highlighted priorities for Neurosciences and minimal funding for any Programme team proposals within 2017-18, we are viewing this 2017-18 as year zero of the five year Strategy and focussing on key priorities that can be worked through with minimal financial requirements.

Whilst all the specialties and sub specialties of Neurosciences are outlined in this Strategy, it has been identified that there are a number of issues which impact on wider pathways across Wales and span across both WHSSC and Health Board Commissioning. This work will be undertaken alongside the development of the Strategy can be rolled out to other areas which have been highlighted through the discussions with Stakeholders and working group meetings. There is also the opportunity to strengthen the proposals for those areas that we know are in urgent need of funding to bring the services up to national standards and in line with services provided in NHS England.

The ongoing consultation identified four immediate areas of focus which represent a cross section of the Specialised Neurosciences programme. Focussing on these areas in 2017/18 will help to stabilise not only these services directly, but also other specialised Neurosciences services commissioned by WHSSC and individual Health Boards. The schemes have been selected from the 54 schemes that have been discussed to date, which when worked through over the next five years, will help in sustaining Specialised Neurosciences for NHS Wales:

1. Provision and utilisation of Specialised Rehabilitation Services
2. Provision of Paediatric Neurology
3. The delivery of Neuro-Radiology
4. Provision of Spinal Surgery

3.3 Specialised Rehabilitation Services

Scoping work and assessments of specialised rehabilitation services provided to patients from NHS Wales, including benchmarking against the British Society of Rehabilitative Medicine standards, present a picture of overwhelmed services, which are unable to meet demand and provide timely rehabilitation. The principle reasons for this are inadequate staffing levels and 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 lack of appropriate beds for these patients due to lack of provision of DGH beds within C&VUHB and BCUHB to perception of appropriately trained staff to manage the patients locally in other Health Boards.
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.

3.3.1 South Wales provision of Neuro Rehabilitation

Within South Wales, acute and post acute neuro-rehabilitation is provided in Rookwood and Neath Port Talbot Hospital.

The Neuro-Rehabilitation Unit in Rookwood which consists of 18 beds, is due to relocate to Llandough Hospital in 2018. WHSSC has provided commissioning support to the re-provision of Neuro and Spinal Rehabilitation in Llandough in order to mitigate the poor physical infrastructure issues experienced in Rookwood. This is viewed as a short term solution whilst a more appropriate location for delivering Specialised Rehabilitation services is found. The Llandough proposal requires current services to be delivered differently due to the changing model which will include an increase of single rooms rather than nightingale wards and the services being provided over two floors. WHSSC has been made aware that there will be additional revenue consequences of managing the transfer of patients from the ward area to therapy rooms within this new footprint, but the detail of this has not yet been fully described. WHSSC are being involved in the planning process for this transfer so will be able to highlight the revenue requirements through the Integrated Commissioning Plan process.

The Neath Port Talbot Rehabilitation Unit consists of 12 beds which is below the recommended guidance for minimum number of beds for a Unit, by the British Society for Rehabilitation Medicine. This supports the model recommended in the Axford review of the two Units in South Wales working in collaboration, although such network arrangements have yet to be established. Concerns have been raised over the utilisation of the Neath Port Talbot rehabilitation capacity for other patients, notably for Intrathecal pump trials and spasticity management which is not commissioned by WHSSC. This

highlights potential issues with the charges made to the bed day contract and more importantly, inappropriate use of the WHSSC specialised rehabilitation capacity. These issues are currently being raised by WHSSC with Senior Management in Abertawe Bro Morgannwg UHB.

3.3.2 Lack of Level 2 Rehabilitation in North Wales

For patients from North Wales, access to level 2 rehabilitation is limited to what is commissioned from NHS England, as the Price-Morris review recommendation for an inpatient rehabilitation centre to be established in North Wales has yet to be implemented. When funding was made available by Welsh Government through the Neurological Conditions Implementation Group for rehabilitation schemes that would benefit patients who had suffered from both stroke and neurological conditions, BCUHB submitted a proposal for a level 2 Rehabilitation Unit to be established in Llandudno. Unfortunately the sum of the bid was higher than the total monies available. BCUHB were however allocated a portion of funding for capital and a Project Manager to scope out the work required to establish a Rehabilitation Unit.

In terms of the English contracts, delays in discharging patients to appropriate beds results in higher spend and a threat of limiting the number of Welsh patients who can be accommodated by a provider at any one time.

WHSSC's annual Audit Day for Specialised Rehabilitation in November 2016 saw all of the NHS England providers present highlighting the issue of delays in patients being appropriately repatriated. This was leading to longer than necessary lengths of stay and patients distance from their family and friends which is recognised as key for improvements in rehabilitation.

3.3.3 Lack of cohesion in Commissioning of Rehabilitation

There are also delays for patients from Powys and BCU UHB under the care of NHS Trusts in England when determining if required specialised rehabilitation placements will be funded by Health Boards or WHSSC. This is due to rehabilitation provision being commissioned by both Health Boards and WHSSC depending on the site.

There is a proposal within 2017/18 to work with the relevant Commissioning Leads in BCUHB and Powys tHB on exploring the consolidation of the specialised rehabilitation contracts that they hold, including with Clatterbridge Rehabilitation Centre as part of the Wirral University Teaching Hospitals NHS Foundation Trust and University Hospitals of North Midlands NHS Trust. Apart from resolving the issue outlined around unclear lines of responsibility for commissioning, there could also be financial efficiencies from such consolidation.

3.3.4 Effect of rehabilitation delays in South Wales

For the South Wales services, such bottlenecks also have an effect earlier in a patient's pathway, with cancellations of elective admissions and patients waiting in excess of the referral to treatment targets for Neurosurgery.

Measures have already been taken through the revision of the Specialised Rehabilitation policy to re-affirm WHSSC's commissioning intentions and introduce a system which will highlight patients who have completed their specialised rehabilitation but due to delayed discharges remain in a specialised unit. However, the amendment of the policy only goes part way to produce whole system change.

There are opportunities of improving patient flow throughout the whole Neurosciences system by reducing the time to discharge once a patient's rehabilitation is complete. Improved flow would allow patients to receive rehabilitation earlier in their pathway which is proven to be more effective and consequently reduces the burden of disease on both health and social care. Further investigation in the current flow for Rehabilitation of North Wales patients is required with a view to redesigning the delivery model of Rehabilitation following this work. Proposals have been received from both the Sid Watkins Unit, the Walton Centre and Robert Jones Agnes Hunt Orthopaedic Hospital to increase their level 2 provision which makes up for the shortfall of this capacity within BCUHB.

The Neurosurgery service in Cardiff would also benefit from improved flow to the Rehabilitation wards with the service regularly having to cancel surgery due to unavailability of beds. A scheme to reduce the long waits within Neurosurgery through increased theatre capacity was proposed for inclusion in the 2017/18 ICP. However as one of the main reasons for not being able to meet the targets is unavailability of beds and this scheme does not address this specific issue, the decision was taken to remove the scheme from the ICP until the wider capacity issues begin to be addressed.

3.3.5 Spinal Injuries Rehabilitation

3.3.5.1 Spinal Injuries Unit, Rookwood

The Spinal Injuries Unit in South Wales consists of 26 beds and between 110-120 referrals each year managed by one Spinal Injuries Consultant who is also the Clinical Lead for Rookwood. The bed numbers were reduced from 36 in 2010/11 in order to establish community rehabilitation teams. The impact of these community teams is not known and will be assessed.

The Axford Review advised that there should be additional Consultant support in the spinal unit, as the reliance of one Consultant made cover of the Unit itself vulnerable and did not allow for outreach working. This is echoed in national benchmarking which the Unit underwent alongside other Spinal

Injury Units in England, which showed that due to limited numbers of staff across the whole Multi-disciplinary team, the service was only able to help 44% of patients with spinal cord injuries.

3.3.5.2 Robert Jones Agnes Hunt, Oswestry

The Spinal Injuries Unit consists of 44 of beds and in 2015/16 received 5 referrals from Welsh Hospitals, 4 from BCU and 1 from Hywel Dda. A case was submitted by Robert Jones Agnes Hunt as part of the 2017/18 IMTP process, for additional beds in a 'step-down' facility. This was in order to try and manage the increase in the number of delayed discharges the service was encountering from both English and Welsh patients.

3.3.6 Updating of Specialised Rehabilitation Policy

The Specialised Rehabilitation Policy which applied to the services of Neuro-Rehabilitation, Spinal Rehabilitation and Neuropsychiatry was due for review in July 2016. Following discussions with Stakeholders in formulating this Strategy, a session of the Specialised Rehabilitation Audit Day in November 2016 was allocated to discuss the policy. All providers of Specialised Rehabilitation were present and all Health Boards had been invited to attend the Day.

Two changes to the Policy were proposed by WHSSC for discussion:

1. to split the policy into two in order to represent Rehabilitation and Neuro-psychiatry separately; and
2. to introduce a time limit for WHSSC funded specialised rehabilitation which would help to highlight the patients experiencing a delayed transfer of care to Health Boards. The relevant clinical team would advise after a 12 week period if the patient still required specialised rehabilitation and if not, the patient's Health Board would be advised and given 8 weeks to find a suitable placement for the patient or be charged for the ongoing specialised rehabilitation that was deemed as unnecessary.

A similar process for highlighting of delays in repatriation is applied in low secure mental health services and led to significant reductions in the number of patients with delayed discharges.

Formal consultation of the policy has been completed and the policy is due to be ratified at the June meeting of the Management Group.

3.3.7 Neuropsychiatry

The Neuropsychiatry service that has recently moved to Llandough Hospital is a tertiary service for the whole of the South of Wales. The service is

unique being the only one in Wales but also because it treats patients with Neuropsychiatry, Neuro-behavioural and Neuropsychological conditions. In NHS England these three services are often managed separately with dedicated staff and facilities for each. The service only has one Consultant medical post, a Consultant Neuro-psychiatrist, although it has recently recruited to a part time junior registrar post to provide support.

WHSSC commissions 10 inpatient beds and also funds the out-patient service at the Llandough site. Despite the service having new facilities, compared to the previous site in Whitchurch, the layout is quite isolating, without the communal lounge which encouraged integration and communication.

The patients referred require more than neuropsychiatry support as they are primarily transferring from neuro-rehabilitation centres. In order to replicate the level of care that patients at the neuro-rehabilitation centres receive, the Directorate advise there is a need for more equipment and an increase in staffing although this has not been formally outlined in a business case.

Therapies staff are also shared between sites and it is felt that their infrastructure is not sufficient to provide a robust and comprehensive package of care for very complex patients. We are looking at benchmarking this service in terms of staffing but as stated previously, Neuropsychiatry services are delivered very differently across the country.

The primary concern of the service is timely discharge and the impact that this has on the flow of patients in and out of the facility which does have a waiting list. We have recently part funded, along with the resident Health Board for a patient to receive inpatient treatment in a private facility due to being inappropriate for a rehabilitation bed, but unable to access a bed on this Unit.

The contracting mechanisms for Neuropsychiatry are also historical and no longer reflect way in which the service is delivered. Whilst those that require inpatient care appear to be of an increasingly higher acuity, there is also a shift from day care provided on site to support provided in local communities. Work is required to benchmark these changes in activity before making any contract adjustments.

3.3.7.1 North Wales Neuropsychiatry provision

There is currently no clear pathway in place for the Neuropsychiatry treatment for patients from North Wales. Whilst patients from North Wales are able to access the service from Llandough hospital, over recent months only one Individual Patient Funding Request has been received for a North Wales patient to access this service. It is currently unclear how many

patients are in need of this service from North Wales and therefore further exploration is required. Discussions with relevant clinicians including the Clinical Lead for the North Wales Brain Injury service advise that there is certainly unmet demand for this speciality.

Assessment of whether a service based in Llandough is appropriate for patients in North Wales given the distance and the fact that for many other such specialist services, contracts are in place with providers in North England also needs to be taken into consideration.

The Clinical Director for Mental Health in BCU has advised that although they the Health Board has Consultant Psychiatrists with an interest in Neurological conditions, dedicated Neuropsychiatry support is required. Until recent years, there was a part time Consultant Neuro-psychiatrist who worked between BCU and Bangor University but following the post-holder's re-location to Cardiff University, no replacement has been made.

3.4 Provision of Paediatric Neurology

The provision of specialised Paediatric Neurology in South Wales is vulnerable with 50% of the Consultant body due to retire within the next five years and the services being commissioned by both WHSSC and a Health Board, which restricts a pan South Wales approach to recruitment and retention. As Paediatric Neurology is a fundamental element of Paediatric Neurosciences, any shortfalls within it, will have a profound effect on the whole Paediatric Neurosciences system and the ability to deliver it within Wales. 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.

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.

3.4.1 Paediatric Neurology in South and Mid Wales

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.

3.4.2 Paediatric Neurology for patients in North Wales

In North Wales, Paediatric Neurology support is provided by Alderhey in terms of both inpatient care and outreach clinics and ongoing locally by Consultant Community Paediatricians. The long standing Lead Paediatrician with a special interest in Neurology retired completely from the service in April 2017, but has been replaced with another Paediatrician with an interest in Neurology. There have been discussions around a joint Consultant Paediatric Neurologist post between BCU and Alderhey which has the potential to minimise admissions to Alderhey and reduce patients overall length of stay, with specialist support provided within North Wales.

3.5 The delivery of Neuro-Radiology services

Specialised Neuro-Radiology services are provided in both ABM UHB and C&V UHB although at a reduced level from when Neurosurgery was provided on both sites.
All the activity undertaken within ABMUHB is Health Board commissioned.

Although Neuro-Radiology is considered a specialised service with only C&VUHB and ABMUHB employing Consultants with this sub specialty training, there are no Neuro-Interventional Radiologists employed by ABMUHB. WHSSC does not currently commission Neuro-diagnostics but given that this is a essential element of the Neuro-Interventional Radiologist and it is categorised as specialised work, the commissioning of Neuro-diagnostics does need to be considered by WHSSC. As part of this consideration, WHSSC would need to understand why the C&VUHB is the only Radiology Department in the country which directs all Head scans to be reported by a Neuro-Radiologist. Given the current shortfall in such specialists, this creates a risk for the reporting of what elsewhere is a department wide activity.

WHSSC is only responsible for commissioning Neuro-Radiology as part of a Neurosurgery episode with the remaining and majority of work undertaken in C&VUHB commissioned by Health Boards.

For patients in North Wales, dedicated 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.

3.5.2 Neuro-Radiology in Cardiff

WHSSC is only directly responsible for funding the Consultant Neuro-Interventional Radiologist post that was agreed in 2015/16 in C&VUHB. This was following the resignation of one of two Consultant Interventional Radiologists. This resignation had resulted in the Interventional Radiology service temporarily being suspended in Cardiff and provided in Bristol. The WHSSC funded post increased the number of Neuro-Interventional Radiologists to three which aimed to stabilise the Neuro-Radiology service

and the intrinsically linked WHSSC commissioned Sub-Arachnoid Haemorrhage service. A case to fund the support staff to work alongside the Consultant post which was part of the original case in 2015/16 was approved as part of the 2016/17 IMTP. This removed the need for the service to displace Radiological lists for other services such as ERCP in order to utilise the additional Neuro-Interventional Radiologist's time to carry out interventions.

In March 2017 we were advised that resignations had been received from two of the three Consultant Neuro-Interventional Radiologists, leaving one substantive post-holder. Although advised that the post-holders end dates were at the end of May/beginning of June, due to leave entitlements both post-holders finished working for C&VUHB week ending 12th May. A Locum Consultant was recruited prior to these post-holders leaving, with a second Locum Consultant currently being secured. Currently this loss of staff leaves the Neuro-Radiology rota for South East Wales extremely vulnerable with lack of cover on a recent weekend and Monday and this week, requiring the Health Board to confirm support from NHS England. Bristol as the nearest provider of Neuro-Interventional Radiology was unable to help over the weekend due to a Major Incident associated with the recent cyber attacks, but arrangements were put in place with Birmingham where one patient was successfully transferred for treatment. Contigency arrangements for this current week of the Locum absence are still to be confirmed by C&VUHB.

3.5.2.1 On call rota

The Steers Review highlighted the need to establish a single on call rota across South Wales but this has not been introduced to date. The C&VUHB rota which provides cover for South East Wales, is a 1 in 6 rota for Neuro-Radiology so when all in post, consists of three Neuro-Interventional Radiologists and three Neuro-Diagnostic Radiologists who do not undertake Interventional procedures. Any such procedures that are required when the Diagnostic only Consultants are on call, were prior to the recent resignations, undertaken by the three Interventional Radiologists on a goodwill basis.

Given the sustainability issues that have arisen revisiting of the Steers recommendation needs to be considered, along with formal networking arrangements with either Bristol or Birmingham to ensure that Neuro-Interventional provision is available seven days a week.

The Walton Centre runs a dedicated Neuro-Interventional rota and the benefits and effectiveness of this should also be looked into.

3.5.2.2 Imaging capacity in South Wales

Insufficient imaging capacity in C&VUHB, the only tertiary provider of Neurosciences in South Wales, has been raised by a number of individuals during the scoping work for this Strategy.

The Cardiff service which has three adult Magnetic Resolution Imaging (MRI) scanners and one paediatric MRI scanner across its two main sites has the oldest MRI scanners within Wales, with all the adult scanners being obsolete. Waiting times for standard diagnostics such as cerebral arteriograms are over 6 months which is unacceptable, particularly when comparing with the waiting times of equivalent diagnostics in Cardiology. It is estimated that it undertakes 66% of all Neuro MRIs within Wales.

A paper submitted to the National Imaging Programme Board (NIPB) in September 2012 highlighted the increase in demand on radiology services and that resources were stretched. The paper also highlighted that a seven-day scanning service at major acute hospitals has yet to be implemented across Wales. We are aware that Cwm Taf is the only Health Board in South East Wales outside of Cardiff that have a 24 hour on call rota for Radiographers.

The South Wales Imaging Collaborative (SWIC) undertook a review of Radiological equipment in 2015, the purpose of which was to provide an all-Wales view of the usage of imaging equipment and to determine what capacity was available to move toward a seven-day imaging service. The report highlighted the increased use of equipment will lead to the increased need to replace machines in the coming years, the data shows that 87% of imaging department machines/scanners will require replacement by 2017.

The National Audit Office's report *"Managing high value equipment in the NHS in England"* (2011)[1] examined the management of three types of high value equipment in the NHS, including MRI and CT scanners. It stated that value for money was not being achieved in the planning, procurement and use of high value equipment. There certainly does not appear to be a collective approach from NHS Wales and Welsh Government in establishing a clear programme for the purchasing of MRI scanners.

3.5.2.3 Utilisation of CUBRIC

The Cardiff University Brain Research Imaging Centre (CUBRIC) has the same number of MRI scanners but of a far higher specification than the Cardiff NHS service. The potential for NHS Wales to utilise these facilities is being explored.

3.5.3 Introduction of Clot Retrieval/Mechanical Thrombectomies

[1] Department of Health "Managing high value equipment in the NHS in England" (2011) https://www.nao.org.uk/ wp-content/uploads/2011/03/1011822.pdf

One of the main developments within Interventional Radiology is the emerging technologies in clot retrieval treatments for strokes. The treatment for acute stroke was approved by NICE in Feb 2016 and led to the publication of Interventional Procedures guidance "Mechanical Clot Retrieval for treating acute ischaemic stroke".

The procedures are undertaken by the Interventional Radiologists although there are discussions around Cardiologists increasingly undertaking this work in the future. Although stroke services and treatments are not commissioned by WHSSC, the treatment is high cost and similar to interventions used within Neuro-Radiology and is using the skill set and capacity of Consultants that are primarily employed for Interventional Neuro-Radiology.

The service has been developed locally in Cardiff and Vale UHB by existing Neuro-interventional Radiologists and Stroke Consultants for patients from across the six Health Boards in South and East Wales, with Health Boards charged on an individual patient basis following the undertaking of the emergency procedure. The procedure has not been introduced as a WHSSC commissioned service although a proposal from C&VUHB and strongly supported by the Clinical Lead of the Stroke Implementation Group was submitted for inclusion in this year's ICP. It is unlikely given the limited resource that has been invested and the recent staff departures, that all those who would benefit from the treatment are receiving it.

In order for the service to be formally commissioned by WHSSC it would require agreement by Joint Committee.

3.5.3.1 Access to treatment by North Wales patients

Patients in North Wales have had limited access to this treatment in the Walton Centre to date, with the Centre reporting at the end of March 2017, that they had undertaken less Thrombectomies during the year on both English and Welsh patients, than the Cardiff service. However, NHS England's announcement in early April 2017 that they will be commissioning mechanical thrombectomies from the twenty-four Neurosurgery centres across England will certainly change this. The treatments are expected to be phased in later in the year which gives time to understand the effect that this will have for patients in North Wales and the increased inequity that this will bring with the service not being formally commissioned for patients in Mid and South Wales.

Whilst the expansion of the provision in England has to be viewed as positive, such an increase in the recruitment of Neuro-Interventional Radiologists to undertake these procedures is likely to impact conversely on

the ability of the Cardiff service to recruit from an already limited number of specialists.

3.5.4 Reviews of Neuro-Radiology in Cardiff

The Radiology service in Cardiff in its entirety has undergone a number of reviews in recent years, with the highest profiled Service Review conducted by NHS England. This concluding that whilst the service has the potential to be leaders in health provision with an excellent calibre of clinical staff, sub-specialisation has achieved clinical excellence at a cost of providing a DGH service to the local population. Whilst mindful not to repeat this work, it is recommended that a Peer Review process is used to undertake an over-arching review of the two Specialised Neuro-Radiology services to understand the priorities for the service.

3.6 Scoping of other Neuroscience specialities

3.6.1 Neurosurgery

Benchmarking undertaken by the Society of British Neurosurgeons (SBNS) has shown that for the population and levels of activity undertaken in Cardiff, there should be at least 14 Consultant Surgeons and three theatres with the capacity to work seven days a week. Currently in the C&VUHB service there are 9.5wte Consultant Surgeons and two theatres which run for two sessions a day, five days a week.

Phase one of the Core Neurosurgery case which was agreed in 2016/17 looked to address the immediate staffing shortfalls in junior medical staff and nurse practitioner support. Phase 2 of the Core Neurosurgery case which C&VUHB is currently developing is looking to improve the sustainability of core neurosurgery by increasing both the theatre and bed capacity of the service. Given the known capacity shortfalls in Theatres in C&VUHB and likely need of a capital build to increase the theatre capacity for Neurosurgery, it is imperative that the planning for this resource commences. Although efficiencies could be made with existing resource such as running three session days, this would not be a long term solution. The impact of introducing a third session day in other specialties has shown that it doesn't 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.

As a Welsh Government priority 1 target that has not been achieved in the Cardiff Neurosurgery Service for at least the last five years, it is imperative that a scheme to address the deteriorating performance against the maximum target of 36 week Referral to Treatment (RTT) target is included in the priorities for 2017/18.

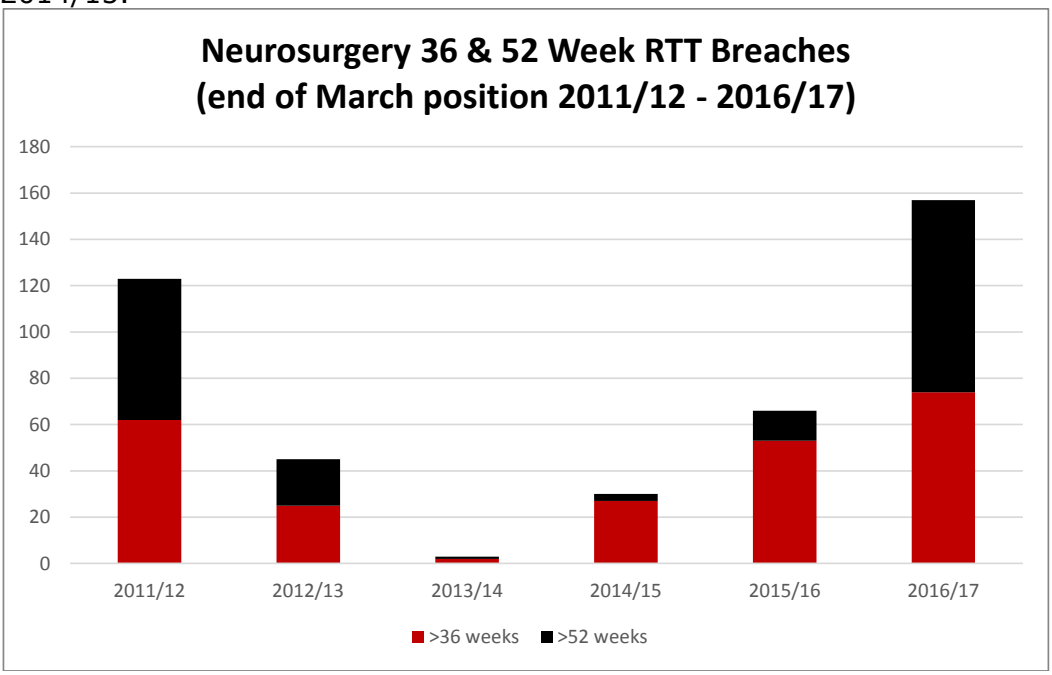
On average, 98% of patients from North and Mid Wales who undergo their neurosurgical treatment in NHS England are receiving treatment within the 26 week RTT target.

With a significant number of patients waiting over 52 weeks for surgery, solutions needs to be identified that will reduce the waiting list backlog and sustain at least a 36 week maximum wait for Neurosurgery patients, working towards the maximum wait of 26 weeks RTT in line with the Welsh Government guidance and the maximum waits experienced by North and Mid Wales patients in NHS England.

The graph below shows the C&VUHB Neurosurgery performance against the 36 week RTT target over the last five years.

Whilst the overall over 36 week waiting list position in 2016/17 was only a slight deterioration on the end of 2015/16, the number of patients waiting over 52 weeks was significantly higher than in previous years, with the longest wait over 120 weeks.

The table below shows the number of Neurosurgery patients waiting over 36 weeks split by >36 weeks-51 weeks and >52 weeks. There has a been a significant deterioration in the waiting list volume and position since 2014/15.



Monthly performance meetings with the Specialised Services Clinical Board have advised that the long waits can be attributed to delays in receiving Surgery and Radiology (predominantly in the form of cerebral angiograms) interventions and additional capacity in both these areas needs to be

sought. An increase in Neurosurgery emergencies and delayed transfers of care have led to cancellations of elective surgery due to bed unavailability, however, these difficulties have only worsened an existing capacity shortfall.

3.6.1.2 North Wales

The Walton confirmed that currently they are the only service within the UK meeting the NHS England target of spinal surgeries undertaken within 18 weeks of referral. The service is also meeting this target for Welsh patients. It is important to note that this is in a context where they have no Accident and Emergency and therefore for do not suffer the adverse affects of high levels of emergency cases As they are a stand alone facility they also do not have medical outliers.

3.6.2 Paediatric Neurosurgery

Within the Cardiff service there are three paediatric Neuro-surgeons undertaking on average, 100-150 cases a year. The Lead Surgeon advises that the elective: emergency split is 90:10 when it should be 70:30. The service provides 2 outreach clinics a month in Swansea.

The service is looking to develop in three areas that will bring a number of benefits, notably repatriating activity from England which in turn, increases the service's elective throughput and sustainability.

- **Baclofen pumps**. Spasticity activity is currently carried out in Bristol and Birmingham. The service has the surgical expertise in both Neurosurgery and Orthopaedics to provide Baclofen pumps and with the recent addition of a part time Consultant Paediatric Neurologist, there is potential capacity within the Paediatric Neurology team to input into the required Multi-disciplinary team.
- **Simple cranio-facial work**. Activity is currently carried out in Birmingham but repatriation of this work would reduce the travel time for patients and increase the sustainability of the service.
- **Paediatric epilepsy surgery** is currently commissioned from Great Ormond Street although Bristol is another of the four centres designated as a Children's Epilepsy Surgical Service (CESS) by NHS England. The Cardiff service has the expertise and equipment required to undertake such surgery on children over 3 years old, although investment would be required to increase capacity in job plans and infrastructure. The demand for the service is estimated to be 35 patients investigated each year for treatment, with 20 of these going on to surgery which for 75% of cases, can resolve the illness.

The main problem area for the service is lack of General Anaesthetic (GA) MRI capacity, with the current waiting list of up to a year for under 8s (children over 8 are able to tolerate an MRI without a GA). There is a need

to explore opportunities for increasing MRI throughput as well as look at increasing the number of lists. There is a dedicated paediatric MRI scanner within the Children's Hospital which is not currently commissioned five days a week, so there is the capacity for additional lists if staffing levels were increased. We are advised that Manchester's Children's Hospital changed the model of delivering MRI from general anaesthetic to sedation which increased throughput on existing lists, but required a different staffing model which we need to understand.

3.6.3 Neuro-Oncology

The all Wales Cancer Network undertook their first peer review of a tertiary cancer, within Neuro-oncology in November 2016.

A number of key issues and significant resource shortfalls in the South were identified as the outcome of the review. The review noted significant inequity in the services provided to patients in the North of Wales who access the Walton Centre to patients in South and West Wales who access their services from UHW, Singleton Hospital and Velindre. The stark difference in staffing and provision available at the Walton compared to that in the South was evidenced as part of the peer review.

The review also identified a number of key risks in particular:

- Limited CNS resource does not support the service and the level of risk increases due to absence of the South West CNS form all MDT's.
- Radiological delays impede the planning of essential treatment and causes delays to patient care.
- No Allied Healthcare Professional (AHP) input impacts on the treatment for patients, absence from the MDT also delays recovery and increases length of hospital stay.

In light of the findings and subsequent risks, a proposal has been included in the 2017/18 IMTP to seek to stabilise the service with formal arrangements and inclusion of duties within job planning. It also seeks to increase the level of CNS support in the South West region to ensure attendance at the MDT and better support for patients. The scheme also seeks to ensure AHP attendance at the MDT with a dedicated support within the service.

This scheme is the first phase of addressing these issues and there are subsequent schemes being discussed by the Working Groups and representatives from North Wales.

The all Wales Cancer Network are due to undertake their first peer review of a tertiary cancer, within Neuro-oncology in November 2016. This will involve the only Welsh Neuro-oncological service in Wales based in Cardiff and the Walton Centre which serves the North Wales population. WHSSC

are participating in this review as the commissioner for Neuro-oncology services for both providers.

The review, like those that have already taken place for common cancers, will consist of two elements; a requirement for the MDTs to respond to a range of qualitative and quantitative questions in advance of a site visit where the members of the MDT are 'interviewed' by a number of peers. Following this visit, the Cancer Network will construct a written board which in turn should generate a response by way of an action plan from the relevant Health Board and WHSSC in the case of a specialised service which they commission. These documents are in the public domain with the expectation that they are updated at least annually.

The report is likely to highlight the shortfalls that the service in Cardiff has already identified to WHSSC as part of this scoping work. The shortfalls include –

- Lack of access to a Neuro-oncology Clinical Nurse Specialist in West Wales. This issue was raised in a patient survey undertaken by the Brain Tumour Charity.
- 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.

3.6.4 Deep Brain Stimulation

For patients in South and Mid Wales, the Deep Brain Stimulation service from pre-operative to post-operative care is currently provided on a prior approval basis from North Bristol NHS Trust. Whilst the referrals to the service are closely monitored through a Consultant Neurologist Gatekeeper, there are efficiencies than could be gained by undertaking elements of the pre and post operative care of patients in Local Health Boards. Whilst WHSSC is supportive of this proposal, the details of it have yet to be worked through and feature as one of the schemes on the Neurosciences Strategy workplan.

3.6.5 Spinal Surgery

Although a Spinal Neurosurgery Service exists in Swansea, following the transfer of Neurosurgery from Swansea to Cardiff, WHSSC does not commission any Neurosurgery from ABM UHB.

Whilst WHSSC does not have a service specification or policy for Spinal Surgery, NHS England published a Complex Spinal Surgery service specification in 2013.

It stated that "delivery of complex spinal surgery services must recognise the shared involvement of both orthopaedic and neurosurgical specialties"[2]. Although Spinal Surgery undertaken by a Neurosurgeon is commissioned by WHSSC, Spinal Surgery carried out by an Orthopaedic Surgeon is commissioned by Health Boards and is managed under the Surgical Clinical Board rather than the Specialised Services Clinical Board in C&VUHB. Both the separate commissioning and management arrangements were highlighted as a concern during a meeting of the Neurosurgery working group.

The NHS England service specification details the procedure codes for specialised and standard spinal procedures. When cross checking the C&VUHB waiting list against these codes, 70 cases currently listed would be considered standard rather than specialised. As the longest waits currently on the C&VUHB Neurosurgery waiting list are predominantly patients awaiting spinal procedures, introduction of a similar specification would have a significant impact on both the volume and times of the waiting list.

The Spinal work-stream of the South Wales Collaborative has been developing a draft service model based on the NHS England service specification outlined abovel. Although the document was discussed at one of the WHSSC Neurosurgery working groups, it had not been signed off by all Consultants involved and could not be shared outside of the Spinal work-stream.

Discussions with United Hospitals Birmingham NHS Trust also advised that they have introduced a number of alternative treatments such as Pain Management and Physiotherapy support in order to ensure that only patients for whom there is no alternative to manage their pain, undergo spinal surgery under the care of Neurosurgeons. We understand that this intervention work is commonly applied to Orthopaedic pathways and will explore this being utilised within Neurosurgical lists in C&VUHB.

3.6.6 Skull based Surgery

Prior to one of the most recent Consultant appointments in Cardiff, skull based surgery for patients in South Wales, was undertaken in London and Cambridge as well as Cardiff. This activity has been repatriated with plans to also repatriate the activity from Sheffield to Velindre following the establishment of a Stereotactic Radiosurgery (SRS) service in 2014/15. Cardiff is funded directly by Velindre who are funded by WHSSC for SRS activity, for the Consultant Surgeon's time.

[2] NHS England *"NHS Standard Contract for Complex Spinal Surgery"* (2013) https://www.england.nhs.uk/wp-content/uploads/2013/06/d14-comp-spinal-surg.pdf

A phased approach to repatriation from Sheffield to Velindre was agreed with completion due in 2016/17. However, the number of SRS cases carried out in Sheffield increased from 15 in 2015/16 to 28 in 2016/17. It is hoped that with the recent appointment of a substantive Neuro-Vascular Consultant in C&V that repatriation will be completed in 2017/18 but a meeting with Velindre and the relevant Neurosurgeons is being convened to understand their recent underperformance.

Demand for skull based surgery is high with many cases requiring a three session theatre list, when all theatre lists within Neurosurgery are only funded for two sessions a day. There is little flexibility and opportunity within the system to undertake additional lists due to the limited theatre capacity described in previously.

There is a requirement for skull based cases to be monitored in theatre by a Neurophysiologist, but there are insufficient Neurophysiologists in Cardiff to undertake this work. A theatre company representative is currently aiding in the monitoring of cranio-nerve surgery undertaken free of charge, but this support will not continue indefinitely.

Best practice for patients undergoing cranial and neuro-oncology cases is to receive imaging 72 hours post surgery. This has not possible due to lack of MRI capacity which is raised as a wider issue.

The insufficient level of Neurophysiology support and post surgery imaging is believed to have arisen from the fact that the current Consultant's role utilised funding from a retired Consultant of a different subspecialty and there was less requirement for these elements. A case for effectively commissioning a skull based service has not presented to WHSSC for consideration.

3.6.7 Epilepsy Surgery

There is currently one part time Epilepsy Neurosurgeon in the Cardiff service funded by the NHS and Cardiff University respectively. This service was repatriated from Queen's Square, University College London's Hospital and required set up costs for additional staffing in order to be established. Currently the service is not undertaking the levels of Surgery undertaken.

An estimated 50% of patients assessed go forward for surgery. WHSSC only fund the assessment for those patients that go on to have surgery. This restricted assessments for only those who showed potential for surgery in their initial referral letter, has therefore hidden demand.

Assessments undertaken by the Neurosurgeon, Neurologist and Neurophysiologists include EEG and Telemetry, the latter carried out on the inpatient ward for a five day 24 hour recording and analysis.

Currently patients that require intracranial electroencephalogram (EEG)as part of their epilepsy diagnosis and treatment, undergo two separate surgeries; the first to attach the electrodes and the second surgery to remove them only or to remove and perform the epilepsy surgery. The department has received a donation of a *Neuromate Robot* to carry out Stereo EEG. The Robot which reduces the need for two separate surgeries saving theatre time and bed days and is less invasive for patients has just begun to be utilised.

3.7 Major Trauma Centre

As both the location and commissioning arrangements for the Major Trauma Centre have yet to be decided, the impact that this would have on Neurosurgery in Cardiff and Neuro-Rehabilitation in both Cardiff and Neath Port Talbot is not fully described in this outline document.

Given that the Department has already seen their Neurosurgery waiting list position deteriorate due to the increase of emergency patients who commonly have a longer length of stay, compared to elective patients, there is concern that the predicted increased numbers of patients will cause the waiting times to deteriorate further if additional capacity is not identified. Similarly for Neuro-rehabilitation, we have already described that the current service is overwhelmed due to staffing shortfalls and difficulties in discharging patients following completion of their specialised rehabilitation.

3.8 Neuropathology

Following the retirement of a Consultant Neuropathologist in 2013, there has only been one Neuropathologist in Wales, employed 50:50 by Cardiff University and the NHS respectively. Patients in North Wales are served by the Neuropathology service in the Walton.

The issues within Neuro-pathology are due to a limited medical workforce in this area rather than a lack of financial resources. There are a limited number of Neuro-pathologists being trained and posts have historically been part academic and research orientated, although research has decreased in recent years and it is not an area that attracts private practice. There have been a number of attempts to recruit to an additional Consultant post, with difficulty in navigating the GMC system and lengthy recruitment process highlighted as two areas that have exacerbated an already difficult process.

There have been recent internal developments within the Cardiff service in order to meet the standards of the Laboratory Inspection with a new dedicated Neuro-pathology laboratory and additional support staff planned. This will help to make the service more attractive to Consultant candidates

but until an appointment is made, options for strengthening the service further by collaborating with Bristol are being explored.

4.0 Next steps

Over the course of next six months we will use this detailed provision of Specialised Neurosciences services in NHS Wales to inform the five year Commissioning Strategy. We will clearly outline our commissioning intentions for Neurosciences services in NHS Wales; it is clear from this paper outlining the current provision that the services that we are currently commissioning are not delivering at the desired levels of quality and sustainability. This Strategy will be ready for implementation from 2018-19 when we aim to be in a position to financially support those services identified as high risk in the 2017-20 Integrated Commissioning Plan.

Through the financial working groups we will establish if our current contracts are providing value for money or if innovative ways of delivering them need to be considered. The work to date has identified areas of good practice and we will work with providers and Health Boards to roll these out.

As part of the final Strategy we will set out our work-plan on an annual basis for the course of the five years and details of the ongoing monitoring of the work.

Alongside the Strategy, we will begin work on the priorities outlined in this paper, notably:

- Respond to the urgent need to establish network arrangements with NHS England providers for Neuro-Interventional Radiology and request a review from the Royal College of Radiologists into how Neuro-Radiology can be effectively and sustainably delivered in South Wales.
- Ensure that the Neath Port Talbot Rehabiliation Unit is providing a service in line with standards, we will seek to create an Operational Delivery Network with service provided in Rookwood Cardiff.
- Appropriately commission specialist spinal surgery through publishing a service specification outlining our commissioning intentions for this specialty and work with providers to implement the necessary changes to listing patients for surgery under the care of Neurosurgery.

5.0 Recommendations

Members are asked to:

- **Note** the current provision of Specialised Neurosciences for patients in NHS Wales which will inform the Five year Commissioning Strategy;

- **Support** the urgent establishment of network arrangements with NHS England providers for Neuro-Radiology;
- **Support** the establishment of an operational delivery network for Specialised Rehabilitation in South Wales;
- **Support** the collective approach to the commissioning of Paediatric Neurology in both North and South Wales; and
- **Support** the proposal to implement a service specification for Specialist Spinal Surgery and a Phased implementation of application of this to the listing of specialist spinal patients within Neurosurgery.

Link to Healthcare Objectives	
Strategic Objective(s)	Development of the Plan Organisation Development Governance and Assurance
Link to Integrated Commissioning Plan	The Neurosciences Commissioning Strategy is to inform future Integrated Commissioning Plans.
Health and Care Standards	Staff and Resourcing Effective Care
Principles of Prudent Healthcare	Public & professionals are equal partners through co-production Reduce inappropriate variation Only do what is needed
Institute for HealthCare Improvement Triple Aim	Improving Health of Populations Improving Patient Experience (including quality and Satisfaction) Reducing the per capita cost of health care
Organisational Implications	
Quality, Safety & Patient Experience	The Commissioning Strategy has been written with the Quality, Safety and Patient Experience at the forefront.
Resources Implications	Whilst this paper does not have any direct resource implications, its presentation of a number of Neurosciences services being significantly under-resourced, particularly in comparison with similar services in NHS England, recommends that resources are put into Neurosciences services.
Risk and Assurance	There is risk to patient safety as a number of services within Neurosciences for patients across Wales are not sustainable.
Evidence Base	A gap analysis was undertaken on the South Wales service compared to the English service specification which highlighted deficits in the provision of Neurosurgery compared to English counterparts such as the Walton Centre.
Equality and Diversity	There are clear inequities with the services that patients receive geographically in terms of Neurosurgery with the service received by patients in North Wales in the Walton Centre and in South Wales received in Cardiff. There are also notable reduce inequities between West and East Wales in accessing other services such as acute neuro-rehabilitation.
Population Health	There are no known effects on Population Health associated with this paper.
Legal Implications	There are no known legal implications associated with this paper.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	17/05/2017	Include recommendations for each of the five years of the Strategy

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

		Agenda Item	10
Meeting Title	**Joint Committee**	Meeting Date	10/07/2018
Report Title	April 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 April 2018 and details the action being undertaken to address areas of non-compliance.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☒	☐	☐	☒

Sub Group /Committee	Choose an item.	Meeting Date	Click here to enter a date.
		Meeting Date	
Recommendation(s)	Members are asked to: • **Note** April 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

April 2018

WHSSC

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APRIL 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 April 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 3rd visit has already taken place with the CAMHS service provider in North and updated action plan agreed. The action plan has been developed with BCUHB and significant improvements have been made in both capacity and workforce. There is however still workforce issues with medical staffing and interim plan has been implemented whilst long term options are considered. Following the visit in April consideration was being given to de-escalation from level 3 but service informed WHSSC of further capacity issues at end of April due to further qualified nurse vacancies.

The CAMHS service in South Wales at Ty Llidiard was escalated straight to level 4 following an inpatient serious event. The Unit was temporarily closed for admissions until a visit from the Quality Assurance & Improvement Team took place and a report drafted. Site visit and findings from QAIT report led to unit being reopened to admissions on case by case basis and de-escalated to Level 3 with action plan developed.

A commissioning quality re-visit recently took place to the Paediatric Surgery service. The notes and action plan are in draft form and will be shared with the provider in due course.

Regular performance meetings with the Lymphoma Panel are in place and an inaugural audit day is being planned for June 2018. Turnaround times in February show an improvement compared to January.

The Bariatric surgery service at ABMUHB is currently at escalation level 4. There has been significant improvement over the last 6 months. ABMUHB have recently provided a self-assessment against the service specification, demand and capacity and outcome data to WHSSC. There is a meeting scheduled in April to discuss this in order for a further assessment to be undertaken with a view to potential de-escalation if the service demonstrate to the Joint Committee the ability to meet the requirements and standards set by WHSSC.

All Plastic Surgery pathway workshops have now taken place. The final clinical summit meeting will take place at the end of April.

Paediatric Intensive Care has been placed at escalation level 2. Monthly meetings are taking place with the service and information to be submitted agreed.

3.0.1 Services in Escalation

Specialty	Level of Escalation	Current Position	Movement from Last Month
Cardiac Surgery	2	Monthly performance meetings continue with C&VUHB and bi-monthly with ABMUHB.	⇨
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	3	An assessment of evidence has been undertaken and the bariatric service was de-escalated from level 4 to 3 in April. Bi-monthly performance meetings to take place from June.	⇧
Plastic Surgery	2	Monthly performance meetings continue with ABMUHB	⇨
Neurosurgery	3	The Commissioning Quality visit is on hold until the Paediatric Quality process has been completed.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.	⇨
	3	The CAMHS service in South Wales at Ty Llidiard was escalated straight to level 4 following inpatient incident leading to a temporary closure of the unit. Site visit and findings from QAIT report led to unit being reopened to admissions on case by case basis and de-escalated to Level 3 with action plan developed.	⇨
Paediatric Surgery	3	A commissioning quality re-visit took place on the 16th of May. The outcome of the visit will be shared with the HB imminently.	⇨
Paediatric Intensive Care	2	Monthly performance meetings are scheduled to take place with the service.	⇨

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, 13 (68.4%) remain in breach at end of April 2018.

4.1 Section 1 Service Dashboard

Commissioning Team	Specialty	WHSSC Indicator Ref	Measure		Tolerance Levels			Provider	Feb-18	Mar-18	Apr-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%	All		0%			⇩
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%	96%		⇩
	Lung Cancer	*E02D*	Mthly	USC lung resection < 62 days	>0	N/A	0	All	1	2	-		⇩
		E02E	Mthly	NUSC lung resection < 31 days	>0	N/A	0	All	1	2	-		⇩
	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%	98%		⇨
	Plastic Surgery	E05	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	96%	97%	96%		⇩
	Lymphoma	E06	Mthly	Specimens tested ≤10 days	<90% within 10 days	N/A	=,>90% within 10 days	All	81%	-			⇧
Neuro	**Neurosurgery**	E07	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	95%	97%	94%		⇩
	Adult Posture & Mobility	E08	Mthly	RTT < 26 weeks	<85% within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	All	83%	84%	84%		⇨
	Paediatric Posture & Mobility	E09	Mthly	RTT < 26 weeks	<85% within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	All	94%	95%	94%		⇩
Mental Health	**CAMHS**	E10	Mthly	OOA placements	>16	>14, <16	=,<14	All	9	7	8		⇩
		E10i	Mthly	NHS Beddays	<85%,>105%	< 90%, >100%	90% - 100%	All	91%	91%	91%		⇩
		E10ii	Mthly	NHS Home Leave	<20%, >40%	<25%, >35%	25%-35%	All	85%	34%	28%		⇧
	Adult Medium Secure	E11	Mthly	NHS Beddays	<90%, >110%	< 95%, >105%	95% - 105%	All	91%	95%	91%		⇩
Women & Children	**Paediatric Surgery**	E12	Mthly	RTT < 36 weeks	<100%	N/A	100%	All	97%	100%	97%		⇩
	IVF	*E13*	Mthly	IVF patients waiting for OPA	<95% within 26 weeks	95%-99% within 26 weeks	100% within 26 weeks	All	100%	100%	100%		⇨
		E13i	Mthly	IVF patients waiting to commence treatment	<95% within 10 weeks	95%-99% within 10 weeks	100% within 10 weeks	All	38%	41%	35%		⇩
		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	26%	31%	21%		⇩

Please note there is a delay for Lung Cancer data as this is currently being submitted to WHSSC by Welsh Government. Lymphoma is to be reported quarterly from April 2018.

4.2 Key Issues for April 2018

Cardiac
There continues to be small numbers of patients waiting over the 36 weeks maximum waiting time target for cardiac surgery patients. C&VUHB reported 13 breaches, ABMUHB reported 2 breaches, and LHCH reported 5 breaches in April. LHCH is now also at Stage 2 of the escalation process and joint performance meetings with BCUHB will take place bimonthly from June.

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 has been provided by ABMUHB and an assessment of this information has been undertaken and the outcome of this being that the bariatric service was de-escalated from level 4 to 3 in April 2018.

Neurological & Chronic Conditions
Neuro-Radiology: 35 patients were waiting for a DSA procedure at the end of April, with the longest wait of over 38 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 17 of the number of patients waiting over 36 and 52 weeks. In April 18, there were 43 patients waiting over 36 weeks of which 9 of these patients were over 52 weeks.

CAMHS
CAMHS Out of Area (OoA) performance is much improved and has consistently been below target for last 6 months. This is despite both NHS services being at level 3 escalation and reflects the new investment and increased capacity and capability of the intensive community support teams. The North Wales unit is still working its way back towards full commissioned capacity and the recent escalation of Ty Llidiard may lead to short term pressure on new OoA referrals. Despite this the total number of OoA placements at the end of April (8) remains well below target (14).

Women & Children
Paediatric Surgery: The Health Board have reported an increase in the number of patients waiting over 36 weeks for treatment, the number has increased from zero to 33.

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 scheduled in June with Shrewsbury to better understand their reporting processes and numbers

Link to Healthcare Objectives	
Strategic Objective(s)	**Governance and Assurance** **Implementation of the Plan** Choose an item.
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** Choose an item. Choose an item.
Principles of Prudent Healthcare	Choose an item. Choose an item. Choose an item.
Institute for HealthCare Improvement Triple Aim	Choose an item. Choose an item. Choose an item.
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**

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

		Agenda Item	07
Meeting Title	**Joint Committee**	Meeting Date	10/07/2018
Report Title	Financial Performance Report – Month 2 2018/19		
Author (Job title)	Assistant Director of Finance		
Executive Lead (Job title)	Director of Finance	Public / In Committee	Choose an item.

Purpose	The purpose of this report is to set out the estimated financial position for WHSSC for the 2nd month of 2018/19. There is no corrective action required at this point. The financial position is reported against the 2018/19 baselines following provisional approval of the 2018/19 Technical Plan by the Joint Committee in March 2018.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

Sub Group /Committee	Corporate Directors Group Board	Meeting Date	Click here to enter a date.
	Joint Committee	Meeting Date	Click here to enter a date.
Recommendation(s)	Members are asked to: • **NOTE** the current financial position and forecast year-end position.		

Considerations within the report (tick as appropriate)

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

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1. Situation

The purpose of this report is to provide the current financial position of WHSSC together with outturn forecasts for the financial year.

2. Background

The financial position is reported against the 2018/19 baselines following provisional approval of the 2018/19 Technical Plan by the Joint Committee in March 2018.

There remains material uncertainty regarding the risk of HRG4+ price increases proposed and reported by NHS England providers and their applicability to Wales. The reporting methodology used by WHSSC has been discussed and it has been agreed with Welsh Government finance officials to continue for month 2 pending progress on further formal discussions with NHS England. For NHS England providers the year to date position includes all volume and HRG4+ costs for reference purposes. In line with methodology agreed by the Joint Committee in previous months the forecast outturn for 2018/19 has been amended to adjust out HRG4+ price increases which remain the subject of dispute. The full year outturn HRG4+ risk will be disclosed in full in the risk section of the report in coming months and accompanying financial schedules submitted to Health Boards.

3. Assessment

The financial position reported at Month 2 for WHSSC is an overspend to year-end of £576k.

The movements are across various budget headings, improvements in Welsh contracts and deteriorations in Non Welsh contracts and IPFR.

4. Recommendations

Members of the appropriate Group/Committee are requested to:

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

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Development of the Plan Choose an item.
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 Choose an item. Choose an item.
Principles of Prudent Healthcare	Only do what is needed Choose an item. Choose an item.
Institute for HealthCare Improvement Triple Aim	Reducing the per capita cost of health care Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	
Resources Implications	**This document reports on the ongoing financial performance against the agreed IMTP**
Risk and Assurance	**This document reports on the ongoing financial performance against the agreed IMTP**
Evidence Base	
Equality and Diversity	
Population Health	
Legal Implications	

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board		
Joint Committee		

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

FINANCE PERFORMANCE REPORT – MONTH 2

1. Situation / Purpose of Report

The purpose of this report is to set out the estimated financial position for WHSSC for the 2nd month of 2018/19 together with any corrective action required.

The narrative of this report excludes the financial position for EASC, which includes the WAST contracts, the EASC team costs and the QAT team costs, and have a separate Finance Report. For information purposes, the consolidated position is summarised in the table below.

Table 1 - 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	577,884	96,314	95,411	(903)	(676)	576	(134)
Sub-total WHSSC	**577,884**	**96,314**	**95,411**	**(903)**	**(676)**	**576**	**(134)**
WAST	148,758	24,793	24,793	0	0	0	0
Quality Assurance Team	738	123	123	0	0	0	0
EASC - staffing and other non-pay	479	80	80	0	0	0	0
Unscheduled Care team	0	0	0	0	0	0	0
EMRTS - ABMU	2,925	488	488	0	0	0	0
Sub-total WAST / EASC / QAT	152,901	25,483	25,483	0	0	0	0
Total as per Risk-share tables	730,785	121,797	120,894	(903)	(676)	576	(134)

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 2018/19 baselines following provisional approval of the 2018/19 Technical Plan by the Joint Committee in March 2018. 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 2 is an underspend of £903k to date, with a forecast year-end overspend of £576k.

The majority of NHS England is reported in line with the previous month's activity returns (Months 12 of 2017/18 or Month 1 of 2018/19). WHSSC continues to commission in line with the contract intentions agreed as part of the IMTP and standard Pbr rules, and declines payment for activity that is not compliant with the business rules related to out of time activity. WHSSC does not pay CQUIN payments for the majority of the English activity.

The inherent increased demand led-financial risk exposure from contracting with the English system remains but it is planned that this will have been mitigated to a greater extent in 2018/19 as financial baselines have been uplifted to more realistic levels based on historic activity. Reported variances are currently in line with this intention.

3. Governance & Contracting

All budgets have been updated to reflect the 2018/19 provisional IMTP, including the full year effects of 2017/18 Developments. Inflation has been allocated to the position, but work on this will be ongoing in future months. The IMTP sets the baseline for all the 2018/19 contract values. This will be translated into the new 2018/19 contract documents.

Distribution of the reported position has been shown using the 2016/17 risk shares based on 2015/16 outturn utilisation, and work is ongoing to move these to the 2016/17 outturn utilisation in future months. The Finance Working Group is working on validating prospective changes to the risk-sharing process, and any update will be shared with Management Group for agreement. Until there is formal agreement from Joint Committee on a change to the risk sharing process the current system will remain in operation.

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

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	192,376	32,063	32,018	(45)	94	453	1,115
Abertawe Bro Morgannwg Univ Health Board	96,161	16,027	15,560	(467)	(25)	(342)	(299)
Cwm Taf University Health Board	7,602	1,267	1,189	(78)	24	0	36
Aneurin Bevan Health Board	7,890	1,315	1,296	(19)	4	(116)	46
Hywel Dda Health Board	1,515	253	253	0	0	0	0
Betsi Cadwaladr Univ Health Board Provider	39,462	6,577	6,585	8	(27)	(329)	(329)
Velindre NHS Trust	39,599	6,600	6,596	(4)	0	(24)	0
Sub-total NHS Wales	**384,605**	**64,101**	**63,496**	**(605)**	**69**	**(358)**	**569**
Non Welsh SLAs	101,609	16,935	17,310	375	52	316	(133)
IPFR	31,486	5,248	5,432	185	0	698	0
IVF	4,608	768	774	6	1	0	0
Mental Health	30,781	5,130	4,770	(360)	(277)	(207)	(77)
Renal	5,900	983	817	(166)	(12)	(364)	(141)
Prior Year developments	8,406	1,401	1,265	(136)	(37)	198	199
2016/17 Plan Developments	6,851	870	638	(232)	(40)	0	0
Direct Running Costs	3,638	606	638	31	16	292	292
Reserves Releases 2016/17	0	0	0	0	0	0	0
Phasing adjustment for Developments not yet implemented ** see below	0	272	272	0	0	0	0
Total Expenditure	**577,884**	**96,314**	**95,411**	**(903)**	**(227)**	**575**	**710**

The reported position is based on the following:

- NHS Wales activity – based on Month 1 data or Annual Plan values if deemed to vary from the 2017/18 outturn.
- NHS England activity – based on Month 1 data or Annual Plan values if this data was not available; work is ongoing to analyse the final performances against the 2017/18 Balance Sheet Reserves.
- IVF – one NHS Wales contract, with some NHS England activity and IPFR approvals. As of reporting Month 1, no invoices for actual 2018/19 activity would have been received, we have one prior approval procedure that gives rise to the slight YTD over performance.

- IPFR – reporting is usually 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 2 contracts are being finalised.
- Developments – variety of bases, including agreed phasing of funding. Financial impacts of approved funding releases are currently accounted for in the forecasts.

  ** Please note that Income is collected from LHB's in equal 12ths, therefore there is usually an excess budget in Months 1-11 which relates to Developments funding in future months. To keep the Income and Expenditure position equal, the phasing adjustment is shown on a separate line for transparency and is accrued to date to avoid a technical underspend.

5. Financial Position Detail - Providers

5.1 NHS Wales – Cardiff & Vale contract:

Various over and underspends from the Month 1 data have been extrapolated to a total reported month 2 position of £45k under spent and a year-end position of £453k over spent. These figures include the net effect of the development and savings funding available to the LHB. It should be noted that as month 1 reporting was largely based on month 12 17/18 data, some positions have moved as we now have month 1 data to base month 2 reporting on. The position includes the following areas:

- Cardiology – across the 5 sub headings, the YTD overspend stands at £45k with a year-end forecast of £410k over spent. This is a large change from month 1 as £749k has been moved from the SLA baseline into developments funding and ABM Cardiology in this contract has a baseline of 3 procedures for the year, the service have carried out 2 procedures in month 1 which has somewhat skewed the figures. Development funding is available that will offset this overspend.

- TAVI – the full year forecast has been moved back to breakeven as development funding is available for this service. The YTD figure has increased as approximately 30% of the baseline activity has been carried out in month 1.

- Neurosurgery – elective activity underperformance is being offset by emergency activity overperformance and thus driving the YTD over spend. The full year forecast is moved to straight line due to this.

- ISAT – the YTD figure has jumper to £93k over spent using month 1 data. This is a volatile service and thus the situation will be monitored over the coming months to extract a meaningful forecast, this has been left at breakeven for now.

- ALAS – as above an extremely volatile service and the month 1 data shows a YTD underspend of £110k. Given the experience of last year where the service ended the year with a significant over spend, the full year forecast has been left at breakeven and the situation will be monitored over the coming months.

- Haemophilia – the YTD position has moved to £70k overspend, mostly as a result of some high costs patients in month 1 data. The full year forecast remains unchanged and is based upon 17/18 outturn.

- AICU - an extremely volatile service and the month 1 data shows a YTD underspend of £95k. Given the experience of last year where the service ended the year with a significant over spend, the full year forecast has been left at breakeven and the situation will be monitored over the coming months. Development funding will offset any over performance in this service.

5.2 NHS Wales – ABM contract:

Various over and underspends from the Month 1 data have been extrapolated to a total reported month 2 position of £467k under spent and a year-end position of £342k under spent. These figures include the net effect of the development and savings funding available to the LHB. It should be noted that as month 1 reporting was largely based on month 12 17/18 data, some positions have moved as we now have month 1 data to base month 2 reporting on. The position includes the following areas:

- Cardiac Surgery – YTD underperformance moved to £253k, which is a result of underperformance on emergency activity. The full year forecast is moved to £489k underspend which is based on 700 procedures, the movement from last month's forecast is due to the previous forecast being based upon 17/18 outturn which was 676 procedures.

- Cardiology – the YTD position is breakeven currently as angiography data was not available for this month's reporting. We know historically that this service overperforms and see no reason why this would change this year hence the forecast of £251k over spent. Development funding exists to offset the overperformance in this service.

- Thoracic – the YTD position is £37k underperformance but this is not a continuing trend for the year and thus the forecast is £173k overspent based on 17/18 outturn net of the increase in baseline given for this financial year.

- Plastics – the YTD position now stands at £136k underspent and full year forecast is moved to £458k under spent. This is in line with the trends we would expect to see with this service as the emergency activity is offsetting elective underperformance.

5.3 NHS Wales – BCU contract:
Angioplasty has moved into overperformance YTD as they are 2 procedures over the activity baseline for month 1. The full year forecast has been left at 17/18 outturn level at the moment but the YTD data will be monitored over the coming months to assess if this is still prudent.

5.4 NHS Wales – Cwm Taf contract:
CAMHS YTD position has deteriorated in month 1 and now stands at £77k under spent. This is a very volatile service and a large number of admission in any month can wipe out an underperforming position. Due to this, the full year forecast has been left at breakeven. The ICD forecast position has been moved back to breakeven given the reported month 1 data also shows a breakeven position.

5.5 NHS Wales – Aneurin Bevan contract:
YTD cardiology has slipped into an under-performing position of £15k which has in turn resulted in the full year forecast moving to £88k under spent. This will be monitored over the coming months.

5.6 NHS Wales – Hywel Dda contract:
Reported to break-even position at this point pending 2018/19 data.

5.7 NHS England contracts:
Total £375k overspend to month 2 with a full year forecast £316k over budget. The English position has been reported either based on an extrapolation of month 1 reported actual data or a combination of 17/18 or plan data where actuals have not yet been provided. The treatment of HRG4+ remains consistent with the approach taken last year for both year to date figures and full year forecasting.

The larger reported movements/variances are:

- Alder Hey – the trust has a reported YTD overspend of £278k and a full year forecast of £224k as a result of reporting the baseline funding gap that exists.

- Central Manchester – the YTD position remains at an under spend of £29k but the full year forecast has been moved to an over spend position of £223k. This is due to a long stay HDU patient that was discharged in May and will cost approximately £250k.

- Christie – the YTD and full year forecast positions have both moved to a position of overspend, standing at £55K and £43k respectively. This is a result of a BMT patient and a Leukaemia patient in month 1 data.

- Imperial – YTD the trust now stands at £99k underspent and the full year forecast is £94k underspent. This is due to moving a BMT patient and £22k of spend relating to gender out of the figures.

- North Staffs – YTD and full year forecast positions have both moved to positions of under spend and both stand at £48k. This is because there has been very low activity in month 1 which is consistent with what happened in 17/18. Activity did pick up during the year last year so this situation will need to be monitored.

- Walton – a movement of more than £70k in both YTD and full year forecast figures now sees both figures at an overspend position of £127k and £72k respectively. This is largely a result of month 1 data containing a coiling patient with critical care for 30 days and 2 long stay rehab patients.

5.9 IPFR:

A combined overspend of £185k to date has been reported in the Month 2 position with a forecast of £698k. This largely related to general non contract activity approvals of £464k and a new approval of a £250k Eculizumab patient being offset by an under in ERT of £300k forecast.

The methodology used to forecast this position will include higher levels of emergency activity relating to 2017/18 quarter four activity.

5.10 IVF:

Reported to break-even position at this point pending 2018/19 data apart from one prior approval procedure that gives rise to the slight YTD over performance.

5.11 Mental Health:

Various budgets totalling an underspend to date of £360k and a year-end forecast underspend of £207k. These budgets include:

- Adult Mental Health has a £51k underspend reported YTD and a £648k year-end forecast underspend, based on current and expected patients. The main drivers for this are discharges through the early part of 2018 in Forensic Mental Health offset by a higher number of Perinatal out of area admissions across the same period.

- South Wales CAMHS and All-Wales FACTS inpatient budgets have continued low activity and currently have a combined underspend of £145k to date but the forecast now includes a £400k cost pressure as

WHSSC are anticipating charges relating to two high cost patient places.

- High Secure block contracts at Ashworth & Rampton – both these contracts are currently being finalised. Ashworth is based on a rolling 3 year patient number average in comparison to NHS England patients, and is currently expected to be set for 2018/19 at £10,767k.

5.12 Renal:
Reported as per the Renal Plan.

5.13 Reserves:
Reserves from the 17/18 Balance Sheet will be analysed over the coming months as final 17/18 charges are received. Any developments will be reported as soon as possible.

5.14 Developments:
There is a total of £13,548k funded developments in the 2018/19 position, £8,506k of which relates to developments from prior years. Further details will be provided in future months as 2018/19 develops as the workplan is being progressed and approved with the WHSSC Management Group.

To note, TAVI has been phased in this month ahead of plan to offset reported overperformances within Welsh provider positions. WHSSC is working with clinical representatives to agree expansion criteria and projections in terms of activity for this service.

5.15 Direct Running Costs (Staffing and non-pay):
The running cost budget is currently £31k overspent. This is due to historic overspends in the area of Core non-pay which have continued into 18/19. The year-end forecast stands at £292k overspent which is a combination of an overspend on Cwm Taf hosting fees and the filling of several staff vacancies with staff taking up post very early in 18/19.

Discussions about a move of premises are ongoing and the report will be updated as the situation and negotiations mature.

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 M2	(903)	(384)	(381)	(211)	(192)	(246)	(85)	595
Variance M1	(229)	(189)	(87)	(51)	3	(17)	2	109
Movement	(674)	(195)	(294)	(161)	(195)	(229)	(86)	486

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 M2	576	(1,858)	(143)	344	244	211	(24)	1,802
EOY forecast M1	708	(1,422)	(311)	335	744	135	28	1,199
EOY movement	(132)	(436)	168	9	(500)	76	(52)	603

Material reporting positions or movements include:

At this point, there are no significant variances in the position to date. The usual detail by specific commissioners will be provided in future months when there is more data behind the monthly position to report on.

7. Income / Expenditure Assumptions

7.1 Income from LHB's

The table below shows the level of current year outstanding income from Health Boards in relation to the IMTP and in-year Income adjustments. There are no notified disputes regarding the Income assumptions related to the WHSSC IMTP.

Please note that Income for WHSSC/EASC elements has been separated, although both organisations share one Bank Account. The below table uses the total Income to allow reconciliation to the MMR returns; please refer to the Income tab on the monthly risk-sharing file to see all the details relating to the Commissioner Income if necessary.

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

	2018/19 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	122,930	20,488	19,595	681	213	20,489	(143)			122,787
Aneurin Bevan	135,058	22,510	21,647	609	254	22,510	244			135,302
Betsi Cadwaladr	165,167	27,528	27,528	0	0	27,528	1,802			166,969
Cardiff and Vale	121,923	20,320	19,273	865	182	20,320	(1,858)			120,065
Cwm Taf	67,852	11,309	10,728	468	111	11,308	344			68,196
Hywel Dda	83,846	13,974	13,277	489	208	13,974	211			84,057
Powys	34,008	5,668	5,450	105	113	5,668	(24)			33,984
Public Health Wales						0				0
Velindre						0				0
WAST						0				0
Total	**730,785**	**121,797**	**117,499**	**3,217**	**1,081**	**121,797**	**576**	**0**	**0**	**731,360**

Additional columns relating to Other Sundry Income and secondment recharge invoices will be 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.

Invoices over 11 weeks in age detailed to aid LHB's in clearing them before Arbitration dates:

None

8. Overview of Key Risks / Opportunities

The key risks remain consistent with those identified in the annual plan process to date.

The additional risk and opportunities highlighted in this report are:

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

- Dealing with in year service risks associated with schemes which are yet to be funded.
- The impact of HRG4+ on non-Welsh contracts and thus the overall position.

Risks identified in the March Submission of the IMTP:

	March 2018 IMTP	
Risk Areas:	**£ ('000)**	**Comments**
RTT Pressures Cleft, lip and palate, IVF & Neurosurgery	-995	
Specialist Service risks identified but unfunded: PET capacity to achieve target rates	-290	
Treatments for GvHD	-75	
Cystic fibrosis	-700	
Cleft lip and palate	-113	
BCU ALAS - war veterans	-72	
Fetal medicine	-225	
Bevacizumab (V.S. in neurofibromatosis type 2)	-14	
Neuro rehabilitation	-100	
Neuro-oncology	-100	
NICU - ABM HDU capacity	-2570	
Neuroendocrine tumours	-225	

9. Public Sector Payment Compliance

As at month 2 WHSSC has achieved 99.5% compliance for NHS invoices paid within 30 days by value however, by number WHSSC is currently falling behind target at 82.4%. It is anticipated that an improvement will be sought on finalising of the first quarter.

For non NHS invoices WHSSC has achieved 99.8% in value for invoices paid within 30 days but again falling behind on the number with only 69.3%.

Monitoring information has been introduced for WHSSC this financial year and therefore, the finance team is working on how we can use this information to better improve our process.

10. Responses to Action Notes from WG MMR responses

Action Point 1.1 – HRG 4+ continues to be a risk and a meeting is being arranged with cross border NHS Wales organisations and Welsh Government to discuss next steps. An update on this will be provided in Month 3 narrative report.

An analysis consistent with the methodology provided in 2017/18 has been sent to Welsh Government colleague separately. At this point in the year the figures are highly subjective. It is anticipated that WHSSC finance colleagues continue to refine this over the next couple of reporting periods when "fixed" month end monitoring reports are received from English providers.

Action Point 1.2 – Consistent with previous years, the MMR has been adjusted to ensure a breakeven position is reported.

Action Point 1.3 – Amended in MMR Month 2

Action Point 1.4 – Income/Expenditure Assumptions (Table D) - Amended in MMR Month 2

Action Point 1.6 – Risks analysis from IMTP – has been included and will be monitored from now on in the risk section 8 of this report.

Action Point 1.7 – Month 12 Narrative – Apologies for the oversight. Sent separately.

Action Point 1.8 - LTA Sign Off - WHSSC has agreed baselines with all seven Welsh providers and documentation has been sent. One provider has returned a signed LTA and discussions are ongoing with the remainder. WHSSC is anticipating all seven LTAs signed by end of June 2018.

11. 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)

Agenda Item 12.2
WHSSC Joint Committee
10 July 2018

Reporting Committee	**All Wales Individual Patient Funding Request (IPFR) Panel**
Chaired by	**Brian Hawkins (Vice Chair)**
Lead Executive Director	**Director of Nursing and Quality Assurance**
Date of last meeting	**30 May 2018**

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

The Panel meeting held on 30 May 2018 were quorate in relation to Health Board representation and clinical representation.

10 Cases were considered by Panel
8 Cases were considered as a Chair action

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

IPFR Quarterly Audit report (January to March 2018)

The IPFR Audit Panel met on 25 April 2018 and specifically highlighted the following areas of improvement for WHSSC:

- The timing of receipt of the request to the requested time for consideration by the All Wales IPFR was breached.

  This is an issue across WHSSC and the Health Boards and IPFR co-ordinators have since been reminded to complete the "submission completed" field on the IPFR database to reflect when IPFR is completed and is ready to be progressed and not the date received.

- The IPFR form did not have a clinical signature

  The form only had the typed name of the referring clinician. Future applications will be checked for signature.

- Minutes of meetings should reflect discussions around value for money/ reasonable cost in comparison to expected clinical benefit.

Discussion has since been held by the IPFR network around formulating further all-Wales guidance to assist clinicians with documenting value for money.

Self-Assessment
The Panel will be undertaking a self-assessment in the coming weeks the results of which will be relayed to the Joint committee in September 2018 as part of the All Wales Panel Annual report.

Chair actions The revised WHSSC PET Policy (CP50) has now been published. It is anticipated that this will result in a reduction of PET requests considered as Chair actions.
Matters requiring Committee level consideration and/or approval
• None
Matters referred to other Committees
None
Confirmed Minutes for the meeting held 30 May 2018 are available on request.

Date of next meeting	**27 June 2018**

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

Agenda Item 13
WHSSC Joint Committee
10 July 2018

Reporting Committee	**Welsh Renal Clinical Network**
Chaired by	**Chair, Welsh Renal Clinical Network**
Lead Executive Director	**Director of Finance**
Date of last meeting	**21 May 2018**

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

- A business case from Cardiff and Vale has been approved by Welsh Government for progression of the capital bid for refurbishment to the main unit in UHW
- The business case to expand the Llandrindod expansion is progressing and will be submitted to Welsh Government in June 2018
- A definition of Acute vs Chronic dialysis has been agreed across the renal units. This is particularly important in relation to funding streams for commissioning purposes (WRCN responsible for funding chronic dialysis, acute dialysis funded directly by the LHBs).
-

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

- The end of year financial position was balanced 17/18.
- There has been an unexplained growth in renal replacement requirements in South and West Wales. This will need investigating and the growth forecast for 18/19 will need to be revised accordingly
- There are issues in each of the provider units relating to Vascular Access Services. The most critical of these are in BCU and ABMU, WRCN are exploring ways to resolve this. It has been escalated to WHSSC QPS.
- A procurement exercise is ongoing in North Wales to refurbish existing units in Bangor, Alltwen, Wrexham and Welshpool with a new unit planned for Mold.

Matters requiring Committee level consideration and/or approval

-

Matters referred to other Committees

Annexes:

Date of next meeting	**10 Sept 2018**