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

# WHSSC Joint Committee Meeting held in public
# Tuesday 23 July 2019 at 13:30

Education Centre, University Hospital Llandough, Penlan Road, Penarth, CF64 2XX

## Agenda

| Item | | Lead | Paper / Oral | Time |
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| **1.** | **Preliminary Matters** | | | |
| **1.1** | Welcome, Introductions and Apologies | Chair | Oral | 13:30 - 13:45 |
| **1.2** | Declarations of Interest | Chair | Oral | |
| **1.3** | Accuracy of the Minutes of the Meetings held 14 May 2019 and 28 June 2019 | Chair | Att. | |
| **1.4** | Action Log and Matters Arising | Chair | Att. | |
| **1.5** | Report from the Managing Diretor | Managing Director | Att. | 13:45 – 13:50 |
| **2.** | **Items for Consideration and/or Decision** | | | |
| **2.1** | Adult Thoracic Surgery for south Wales | Director of Planning | Att. | 13:50 – 14:15 |
| **2.2** | Major Trauma Services Update | Director of Planning | Att. | 14:15 – 14:45 |
| **2.3** | Cystic Fibrosis Business Case | Director of Planning | Att. | 14:45 – 15:15 |
| **3.** | **Routine Reports and Items for Information** | | | |
| **3.1** | Integrated Performance Report | Director of Planning | Att. | 15:15 - 15:25 |
| **3.2** | Financial Performance Report | Director of Finance | Att. | 15:25 - 15:35 |
| **3.3** | Reports from the Joint Sub-Committees<br>i. Management Group Briefings<br>ii. All Wales Individual Patient Funding Request Panel<br>iii. Integrated Governance Committee<br>iv. Quality & Patient Safety Committee | Joint Sub-Committee Chairs | Att. | 15:35 – 15:40 |

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| **4.** | **Concluding Business** | | |
| **4.1** | Any Other Business | Chair | Oral |
| **4.2** | Date of next meeting (Scheduled)<br>- 10 September 2019, 13:30 – 17:00<br>- To be confirmed | 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 14 May 2019 at 09:30
at National Imaging Academy Wales, Pencoed Business Park, Bridgend, CF35 5HY

**Members Present:**

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| Vivienne Harpwood | (VH) | Chair |
| Carole Bell | (CB) | Director of Nursing and Quality Assurance, WHSSC |
| Stuart Davies | (SD) | Director of Finance, WHSSC |
| Gary Doherty | (GD) | Chief Executive, Betsi Cadwaladr UHB (by VC) |
| Paul Griffiths | (PG) | Independent Member/Audit Committee Representative |
| Charles Janczewski | (CJ) | Independent Member/Chair of the WHSSC Quality and Patient Safety Committee |
| Sian Lewis | (SL) | Managing Director, WHSSC |
| Tracy Myhill | (TM) | Chief Executive, Swansea Bay UHB |
| Steve Moore | (SM) | Chief Executive, Hywel Dda UHB |
| Judith Paget | (JP) | Chief Executive, Aneurin Bevan UHB |
| Carol Shillabeer | (CS) | Chief Executive, Powys THB |
| Jennifer Thomas | (JT) | Medical Director, WHSSC |
| Allison Williams | (AW) | Chief Executive, Cwm Taf Morgannwg UHB |

**Deputies Representing Members:**

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| Peter Durning (for LR) | (PD) | Clinical Director, Cardiff & Vale UHB |

**Apologies:**

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| Kieron Donovan | (KD) | Associate Members / Chair of the Welsh Clinical Renal Network |
| Ian Phillips | (IP) | Independent Member |
| Len Richards | (LR) | Chief Executive, Cardiff and Vale UHB |

**In Attendance:**

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| Karen Preece | (KP) | Director of Planning, WHSSC |
| Kevin Smith | (KS) | Committee Secretary & Head of Corporate Services, WHSSC |

**Observers:**

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| Simon Dean | Welsh Government |
| Chris Markall | Head of Finance, CVUHB |
| Reza Rahman | Mallinckrodt Pharmaceuticals |

**Minutes:**

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| Michaella Henderson | (MH) | Corporate Governance Officer, WHSSC |

The meeting opened at 09:30

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| JC19/001 | **Welcome, Introductions and Apologies**<br>The Chair formally opened the meeting and welcomed members.<br><br>Apologies were noted as above. |
| JC19/002 | **Declarations of Interest**<br>The Joint Committee noted the standing declarations. There were no additional declarations to note.<br><br>VH reminded the Independent Members of their obligation under the Standing Order 1.3.2 to act in a balanced manner, ensuring any opinion expressed is impartial and based on the best interests of the health service across Wales.<br><br>VH reminded all Members of their obligation under Standing Order 7.3.1 that individual board members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the Joint Committee and as a member of the Board of an LHB that provides specialised and tertiary services.<br><br>VH also reminded Members of Standing Order 7.3.3 whereby any Health Board Chief Executive who feels conflicted about the matter under discussion, in the event of a vote, they must abstain from voting. |
| JC19/003 | **Minutes of the meeting held 22 January 2019 and 26 March 2019**<br>Members noted that the Joint Committee had supported the minutes of the meeting held on 22 January 2019 at the meeting on 26 March 2019 and that, as that meeting had not been quorate, the minutes would be referred to the next meeting for formal approval.<br><br>The Joint Committee **approved** the minutes of the meetings held on 22 January 2019 and 26 March 2019 as true and accurate records. |
| JC19/004 | **Action Log and Matters Arising**<br><br>**JC18016 – Reports from the Joint Sub-Committees**<br>VH reported that the letter to Gail Williams offering congratulations on behalf of the Joint Committee on her award (Renal Nurse of the Year) had been drafted and would be sent shortly. **Action closed**<br><br>There were no matters arising not dealt with elsewhere on the agenda. |

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| JC19/005 | **Report from the Chair**<br>The Joint Committee **received** the report from the Chair that reminded Members of the various appointments to the Joint Committee, Welsh Renal Clinical Network and the Quality & Patient Safety Sub-Committee discussed at the last meeting and approved by Chairs action on 28 March 2019.<br><br>Members resolved to:<br>• **Note** the content of the Report; and<br>• **Ratify** the Chair's Action. |
| JC19/006 | **Report from the Managing Director**<br>The Joint Committee **received** the report from the Managing Director. SL drew attention to the following items within the report which the Members discussed further:<br><br>***Mother and Baby Unit***<br>SL reported that Management Group had requested more work be done around the staffing model and revenue costs, and a contracting framework be agreed by the Finance Sub-Group, before a full paper is presented to Joint Committee at the September meeting.<br><br>Members noted SD was liaising with Welsh Government regarding funding for the Mother and Baby Unit.<br><br>***Potential Data Sharing Issue***<br>SL reported the potential data sharing issues had been resolved although there was still an underlying legislative issue to be resolved by Welsh Government.<br><br>Members resolved to:<br>• **Note** the content of the Report. |
| JC19/007 | **Thoracic Surgery Update**<br>The Joint Committee **received** the report the purpose of which was to<br><br>• Outline the latest information regarding the thoracic surgery cover arrangements for the Major Trauma Centre ('MTC'), including the workforce arrangements suggested by the medical directors of Swansea Bay UHB (SBUHB) and Cardiff and Vale UHB (CVUHB), and provide a commissioning assessment of those arrangements;<br>• Provide assurance on the arrangements for addressing the further issues raised by the affected health boards as part of their conditional approval of the recommendation for a single adult thoracic surgery centre based in Morriston Hospital, Swansea;<br>• Highlight the key lessons learned from the review of the conduct of the engagement exercise and public consultation; |

- Note the development of the thoracic surgery commissioning plan;
- Note the implementation project has been established by SBUHB; and
- Seek support from Joint Committee for the recommendations to go forward to the six affected health boards and that they be asked to confirm their unconditional approval for a single adult thoracic surgery centre based in Morriston Hospital, Swansea.

Members discussed a number of matters relating to the number of thoracic surgeons required to provide safe cover for the MTC and the pros and cons of delaying a decision on the workforce model until the publication of new guidelines by the Society of Cardiothoracic Surgeons of the UK and Ireland.

It was reported that the chair of CVUHB had expressed concerns particularly relating to delays and patient safety.

**ACTION: It was agreed that the Chair of WHSSC would discuss this with the chair of CVUHB to gain a better understanding of those concerns.**

After careful consideration, Members:

- Requested Dr Sian Lewis (and the WHSS Team) bring a WHSSC commissioning proposal back to the Joint Committee by the end of June 2019 that would take into consideration a number of matters and some uncertainties raised in the paper and during the meeting, related to workforce arrangements that had been developed to provide thoracic surgical cover from Morriston Hospital, Swansea, for the MTC in UHW, Cardiff;
- Noted and received assurance that arrangements are in place to address the further issues raised by the affected health boards in November 2018;
- Supported the recommendations arising from the assessment of lessons learned from the engagement exercise and public consultation;
- Noted the development of the thoracic surgery commissioning plan; and
- Noted the implementation project led by SBUHB has commenced with project board and stakeholder meetings already held.

Consideration of the final recommendation set out in the paper was postponed to the June meeting.

The indicative scope of work for the WHSS Team included:

1. Detail regarding the anticipated demand for thoracic surgery in south Wales, this would include out-patient and surgical activity and allow for the planned 20% increase in activity;

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| | 2. Expert advice on the level of activity required to maintain consultant thoracic surgeons' skills;<br>3. Development of indicative job plans for consultant thoracic surgeons to inform an assessment of the appropriate number of consultants;<br>4. Detailed costings for any proposed increase in consultant thoracic surgeons above the original WHSSC recommended level of six consultants;<br>5. Clarity on the role of trauma surgeons in the immediate management of emergency trauma patients and the requirement for input from thoracic surgeons (e.g. telephone advice or on site input); and<br>6. Clarity on the interface of thoracic surgeons in managing trauma patients with other specialties (e.g. rib fixation with orthopaedic surgeons). |
| JC19/008 | **South Wales Blood and Marrow Transplant Programme – Review of Investment: Review of Investment – Haematology Pathways**<br>The Joint Committee **received** the paper the purpose of which was to:<br><br>• Outline the investment made in the south Wales BMT programme between 2014/15 and 2016/17, and outline the purpose of this investment;<br>• Set out what has been achieved with the additional investment with regard to meeting patient need and delivering on quality standards to meet the service specification and JACIE accreditation requirements;<br>• Describe the clinical outcomes achieved by the south Wales BMT service;<br>• Note current risks in the service and the plans to address these risks; and<br>• Note future service developments.<br><br>Members noted the service had excellent clinical outcomes but poor infrastructure and that CVUHB was undertaking work to improve the infrastructure.<br><br>Members noted:<br>• The investment made in the south Wales BMT programme;<br>• The confirmation that the investment has been implemented.<br>• The increase in capacity to meet patient need and the achievement of the quality standards in the service specification and JACIE accreditation requirements;<br>• The excellent clinical outcomes achieved by the service and published by the British Society for BMT;<br>• The current risks and the plans to address these risks; and<br>• The future service developments. |

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| JC19/009 | **Welsh Renal Clinical Network – Terms of Reference**<br>The Joint Committee **received** the paper that proposed revised Terms of Reference for the Welsh Renal Clinical Network ('WRCN') Board.<br><br>Members noted that, in accordance with the WHSSC Governance and Accountability Framework, the WRCN, as a sub-committee of WHSSC, was required to review the WRCN Board Terms of Reference annually. Members noted the review process had been completed and the WRCN Board approved, on 10 April 2019, all amendments as highlighted in the appended document.<br><br>Members resolved to:<br>• **Approve** the revised WRCN Board Terms of Reference. |
| JC19/010 | **Review of Governance and Accountability Framework**<br>The Joint Committee **received** a paper that presented proposed amendments to the WHSSC Governance and Accountability Framework.<br><br>Members noted the WHSS team was looking at whether the Mental Health and Learning Disabilities Collaborative Commissioning Group was still fit for purpose given it hadn't met in the previous financial year and would bring their evaluation back to a future meeting.<br><br>Members resolved to:<br>• **Note** the contents of this paper;<br>• **Approve** the proposed amendments to the WHSSC Governance and Accountability Framework; and<br>• **Support** the amended WHSSC Governance and Accountability Framework being taken forward for ratification by local health boards. |
| JC19/011 | **Joint Committee Annual Business Cycle 2019-20**<br>The Joint Committee **received** the paper the purpose of which was to provide Members with the Draft Joint Committee Annual Business Cycle 2019-20.<br><br>Members resolved to:<br><br>• **Note** and **support** the content of the report, including the schedule of meetings for 2019-20. |
| JC19/012 | **Corporate Risk Assurance Framework**<br>The Joint Committee **received** the paper the purpose of which was to provide Members with an update on the WHSSC risk management framework as at 31 March 2019. |

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| | Members noted the large number of risks shown in the report and KP reported that work was underway to remove provider risks from the corporate risk register. KP further noted that the CRAF should be read in conjunction with the Integrated Performance Report and that a detailed risk discussion was planned for a future Management Group meeting.<br><br>Members noted the escalation process was being reviewed and as a result clarity would be provided around the de-escalation process.<br><br>Members resolved to:<br><br>• **Note** the update provided within the report; and<br>• **Receive assurance** that risks were being appropriately assessed and managed. |
| JC19/013 | **Integrated Performance Report**<br>The Joint Committee **received** the report the purpose of which was to provide members with a summary of the performance of services commissioned by WHSSC for February 2019 and details the action being undertaken to address areas of non-compliance.<br><br>Members resolved to:<br>• **Note** February performance and the actions undertaken to address areas of non-compliance. |
| JC19/014 | **Finance Report Month 12 2018-19**<br>The Joint Committee **received** the report the purpose of which was to set out the financial position for WHSSC for the 12th month of 2018-19.<br><br>Members noted the financial position reported at Month 12 for WHSSC was an under spend of £2,589k and for EASC an under spend of £603k giving a total under spend of £3,192k.<br><br>Members resolved to:<br>• **Note** the current financial position and year-end position. |
| JC19/015 | **Reports from the Joint Sub-Committees**<br><br>**Management Group Briefings**<br>The Joint Committee **received** the Management Group Briefings from the meetings held on 28 March 2019 and 25 April 2019.<br><br>**All Wales Individual Patient Funding Request Panel**<br>The Joint Committee **received** the report.<br><br>**Integrated Governance Committee**<br>The Joint Committee **received** the report. |

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| | **Quality and Patient Safety Committee**<br>The Joint Committee **received** the report.<br><br>**Welsh Renal Clinical Network**<br>The Joint Committee **received** the report. |
| JC19/016 | **Date and Time of Next Meeting**<br><br>The Joint Committee noted an extraordinary meeting would be organised for the end of June 2019 and Members notified of the date, time and location. |

The meeting closed at 12:20

**Chair's Signature: .....**

**Date: .....**

# Minutes of the Meeting of the Welsh Health Specialised Services Committee

at held on 28 June 2019 at 14:00hrs
at Health and Care Research Wales, Castlebridge 4, 19-15 Cowbridge Road East
Cardiff, CF11 9AB

**Members Present:**

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| Vivienne Harpwood | (VH) | Chair |
| Carole Bell | (CB) | Director of Nursing and Quality Assurance, WHSSC |
| Stuart Davies | (SD) | Director of Finance, WHSSC |
| Gary Doherty | (GD) | Chief Executive, Betsi Cadwaladr UHB (by VC) |
| Paul Griffiths | (PG) | Independent Member/Audit Committee Representative |
| Sharon Hopkins | (SH) | Interim Chief Executive, Cwm Taf Morgannwg UHB |
| Charles Janczewski | (CJ) | Independent Member/Chair of the WHSSC Quality and Patient Safety Committee |
| Sian Lewis | (SL) | Managing Director, WHSSC |
| Tracy Myhill | (TM) | Chief Executive, Swansea Bay UHB |
| Steve Moore | (SM) | Chief Executive, Hywel Dda UHB (by VC) |
| Judith Paget | (JP) | Chief Executive, Aneurin Bevan UHB |
| Ian Phillips | (IP) | Independent Member |
| Len Richards | (LR) | Chief Executive, Cardiff and Vale UHB |
| Carol Shillabeer | (CS) | Chief Executive, Powys THB |
| Jennifer Thomas | (JT) | Medical Director, WHSSC |

**Apologies:**

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| Kieron Donovan | (KD) | Affiliate Member/ Chair of the Welsh Clinical Renal Network |

**In Attendance:**

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| Kevin Smith | (KS) | Committee Secretary & Head of Corporate Services, WHSSC |

**Minutes:**

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| Michaella Henderson | (MH) | Corporate Governance Officer, WHSSC |

The meeting opened at 14:05hrs

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| JC19/017 | **Welcome, Introductions and Apologies**<br>The Chair formally opened the meeting and welcomed members.<br><br>The Chair welcomed IP to his first meeting.<br><br>Apologies were noted as above. |
| JC19/018 | **Declarations of Interest**<br>The Joint Committee noted the standing declarations. There were no additional declarations to note.<br><br>The Chair reminded the Independent Members of their obligation under the Standing Order 1.3.2 to act in a balanced manner, ensuring any opinion expressed is impartial and based on the best interests of the health service across Wales.<br><br>The Chair reminded all Members of their obligation under Standing Order 7.3.1 that individual board members must demonstrate, through their actions, that their contribution to the Joint Committee's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the Joint Committee and as a member of the Board of an LHB that provides specialised and tertiary services.<br><br>The Chair also reminded Members of Standing Order 7.3.3 whereby any Health Board Chief Executive who feels conflicted about the matter under discussion, in the event of a vote, may need to abstain from voting.<br><br>The Chair noted Members responsibilities to consider all relevant matters in an open, balanced, objective and unbiased manner, and to determine the relative weighting to be given to the evidence of the independent experts and the health board Medical Directors, to avoid potential legal challenge.<br><br>The Chair explained that the whole adult thoracic surgery review process had been transparent, had involved engagement and formal consultation, and the latest paper reflected the output from actions agreed at the previous meeting of the Joint Committee. |
| JC19/019 | **Thoracic Surgery Workforce Planning**<br>The Joint Committee received the paper the purpose of which was to:<br><br>1. To re-confirm the advice from the provider Medical Directors and to provide the Joint Committee with further information regarding the thoracic surgery consultant workforce arrangements required for a single service located at Morriston Hospital, Swansea and the cover arrangements for the Major Trauma Centre (MTC). This included: |

- Detail regarding the anticipated demand for thoracic surgery in south Wales, this included out-patient and surgical activity and allowed for the planned 20% increase in activity;
- Expert advice on the level of activity required to maintain consultant thoracic surgeons' skills;
- Development of indicative job plans for consultant thoracic surgeons to inform an assessment of the appropriate number of consultants;
- Detailed costings for any proposed increase in consultant thoracic surgeons above the original WHSSC recommended level of six consultants;
- Clarity on the role of trauma surgeons in the immediate management of emergency trauma patients and the requirement for input from thoracic surgeons (e.g. telephone advice or on site input); and
- Clarity on the interface of thoracic surgeons in managing trauma patients with other specialties (e.g. rib fixation with orthopaedic surgeons).

2. To make recommendations regarding the future consultant workforce model and emergency cover of the MTC.

The Chair directed members to the Recommendations section (section 4.0) of the paper and identified what was being asked of members.

SL summarised the key points set out in the paper.

Members noted there was currently no increasing trend in thoracic surgery activity but accepted the service would need to be able to react if such a trend developed.

Members noted that the experts' opinions indicated that, in order to maintain their surgical skills, each consultant thoracic surgeon would need to perform at least 50 primary lung resections per annum and have at least one full day of operating in theatre per week, also, in their view, eight surgeons would mean this target may be difficult to meet, thus compromising patient safety. Furthermore they felt that it was neither desirable nor necessary to operate a two rota system. On this basis they felt that, based on current activity and a planned 20% increase, the right number was six consultant thoracic surgeons.

SL confirmed that, when making their own recommendations, the independent experts were aware of the recommendations of the provider health board Medical Directors and that the Thoracic Surgery Centre and the MTC would be 45 miles apart.

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| | SL confirmed thoracic surgeons on site at University Hospital Wales would be used to maintain local thoracic clinics, support the MTC and provide ongoing support for thoracic patients on trauma wards.<br><br>Members noted it was anticipated 3–12 patients per annum would require an immediate thoracic surgery intervention at the MTC but that other patients might simply need stabilising immediately and could then be dealt with by a thoracic surgeon during their next scheduled daytime shift.<br><br>Members noted that it was expected that thoracic out-patient clinics would be run in CVUHB so patients wouldn't have to travel to SBUHB for these clinics.<br><br>Members discussed the differences in the advice given by the health board medical directors and independent experts, as set out in the paper. Members agreed the engagement of the service's clinicians would be the key to a successful service change. Members were generally supportive of a review during the 12 months prior to opening the new Thoracic Surgery Centre to determine the appropriate number of consultant thoracic surgeons engaged in the service but had differences of opinion as to whether the starting number of eight proposed by the provider Medical Directors was necessary.<br><br>Members discussed the potential risks in the seventh consultant post being a locum appointment and suggested it should be a substantive appointment instead.<br><br>LR reported that CVUHB was supportive of the recommendation for an extra consultant thoracic surgeon being appointed at UHW from April 2020 to support the MTC, subject to subsequent review.<br><br>Members agreed quality of service and patient safety should be paramount in any decisions taken.<br><br>TM reported that she did not have the support of the SBUHB Medical Director for the recommendations set out in the paper.<br><br>Members carefully considered the information provided in the paper and, after protracted discussion, SL, with the approval of the Chair, withdrew the motions set out in the paper. Members then proposed and seconded two alternative motions that were voted on, being:<br><br>**Motion A:** To acknowledge and support the views of the Medical Directors and clinical body across CVUHB and SBUHB, balanced with the independent experts' opinions; at this stage committing to the appointment of an additional consultant thoracic surgeon to support |

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| | implementation of the MTC from April 2020 and thereafter to act on the real world experience from the MTC and updated activity figures to ensure that we have the appropriate number of consultant thoracic surgeons in place by the time of opening the new Thoracic Surgery Centre at Morriston Hospital, Swansea.<br><br>**Motion B:** To accept and support the recommendations of the Medical Directors and clinical body across CVUHB and SBUHB, balanced with the independent experts' opinions; at this stage committing to 7 consultant thoracic surgeon posts with effect from April 2020 with phasing to 8 (or the appropriate final number required) as demonstrated by the real world experience from the MTC and updated activity figures, based on needs and succession planning, to ensure that we have the appropriate number of consultant thoracic surgeons in place by the time of opening the new Thoracic Surgery Centre at Morriston Hospital, Swansea.<br><br>Members voted as follows on the alternative motions:<br><br>Motion A For – PG, IP, CS, JP, VH, SL, SD, CB = 8<br>Motion A Against – TM, LR, SH, SM, GD, JT, CJ = 7<br><br>Motion B For - TM, LR, SH, SM, GD, JT, CJ = 7<br>Motion B Against - PG, CS, JP, VH, SL, SD, CB = 7<br>Motion B Abstention – IP<br><br>Neither motion achieved the required two-thirds majority to succeed.<br><br>**ACTION: It was agreed the Managing Director of WHSSC would seek advice from Welsh Government on next steps.** |
| JC19/020 | **Date and Time of Next Meeting**<br><br>The Joint Committee noted the next scheduled meeting would take place at 13:30hrs on 23 July 2019 at Education Centre, University Hospital Llandough, Penlan Road, Penarth, CF64 2XX. |

The meeting closed at 16:15hrs

**Chair's Signature: ……**

**Date: ……**

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

# 2019/20 Action Log July 2019
# Joint Committee Meeting
# OPEN ACTIONS AND CLOSURES FOR APPROVAL

| Meeting Date | Action Ref | Action | Owner | Due Date | Progress | Status |
|---|---|---|---|---|---|---|
| 28.06.19 | JC19002 | **JC19/019 - Thoracic Surgery Workforce Planning**<br><br>Members carefully considered the information provided in the paper and, after protracted discussion, SL, with the approval of the Chair, withdrew the motions set out in the paper. Members then proposed and seconded two alternative motions that were voted on, neither of which achieved the required two-thirds majority to succeed.<br><br>**ACTION:** It was agreed the Managing Director of WHSSC would seek advice from Welsh Government on next steps. | SL | July 2019 | **23.07.19 –** Advice sought. Agenda Item 2.1. Action closed | **CLOSED** |

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

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| | | Agenda Item | 1.5 |
| Meeting Title | **Joint Committee** | Meeting Date | 23/07/2019 |
| 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 | |

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

**Considerations within the report** (tick as appropriate)

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

## 1. 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. UPDATES

**Radiofrequency Ablation for Barrett's Oesophagus**

There is currently no Radiofrequency Ablation (RFA) service for treating patients with Barrett's Oesophagus in south and mid Wales; patients suitable for this treatment are referred to Gloucestershire Hospital NHS Foundation Trust. The proposed service change is the development of a new RFA service within Wales for patients living in the health board regions of Aneurin Bevan, Abertawe Bro Morgannwg, Cwm Taf, Cardiff and Vale, Hywel Ddda and some parts of Powys.

WHSSC was asked by the Collaborative Executive Group to facilitate joint work with Health Boards to assess the feasibility and options for a Wales-based RFA service. The scope of the project includes estimating the patient need, agreeing a commissioning policy and service specification based on current relevant guidelines, appraising the options for the service delivery model and making a recommendation on the model as well as the location(s) of the treatment centre(s). A commissioning policy and service specification were issued for stakeholder consultation during April and May and finalised by the WHSSC policy group in July 2019.

WHSSC had committed to recommending the service model by July 2019. The finalised service specification includes the requirement for RFA to be located at a tertiary referral centre for oesophageal cancer, which limits potential sites to UHW in Cardiff and Morriston in Swansea. An expression of interest from one of these providers has been confirmed but they have indicated that planning for implementation will take longer. At the current point in time, WHSSC is awaiting a detailed response from this provider on its proposal.

This service development is under the scrutiny of a Cross Party Parliamentary Group and they have indicated that they will be writing to the Minister for health and Social Services regarding the current delay and their expectation that a finalised model can be agreed at the September Joint Committee. The service development is anticipated to be cost neutral or cost saving.

## 3. RECOMMENDATIONS

Members are asked to:

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

| Link to Healthcare Objectives | |
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| 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)

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| | | Agenda Item | 2.1 |
| Meeting Title | **Joint Committee** | Meeting Date | 23/07/2019 |
| Report Title | Adult Thoracic Surgery for South Wales – Consultant workforce | | |
| Author (Job title) | Director of Planning | | |
| Executive Lead (Job title) | Managing Director | Public / In Committee | Public |

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| Purpose | • To **summarise** for members the outstanding issues from the November 2018 Joint Committee meeting regarding the single site model for thoracic surgery based at Morriston Hospital, Swansea and the progress in addressing those issues.<br><br>• To **make recommendations** regarding the future thoracic surgery consultant workforce model and emergency thoracic surgery cover for the Major Trauma Centre (MTC). |

| RATIFY | APPROVE | SUPPORT | ASSURE | INFORM |
|---|---|---|---|---|
| ☐ | ☐ | ☒ | ☐ | ☒ |

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| Sub Group /Committee | Corporate Directors Group Board | Meeting Date | 08/07/2019 |
| Recommendation(s) | Members are asked to:<br><br>• **Note** the work that has been undertaken by the medical directors of CVUHB and SBUHB as well as the WHSS Team to develop workforce proposals for the consultant thoracic surgical service;<br>• **Support** the appointment of an additional consultant thoracic surgeon, funded through the MTC work stream, to support implementation of the MTC from April 2020 initially on an interim basis, pending clarity of the level of need;<br>• **Support** the allocation of funding for an additional two consultant surgeons (in addition to the existing establishment of six) from the MTC business case when the new single centre at Morriston Hospital is opened – the funding release for which will be dependent on consideration by the Joint Committee of the real world experience of the MTC, updated activity figures, a clearer understanding of the strategic issues highlighted above and the formal | | |

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| | professional advice of the SCTC on emergency cover for major trauma centres;<br>• **Note** the information set out in the May Joint Committee paper which provided assurance around the caveats identified by the affected health boards and the requirement for a report on the lessons learned from the engagement and consultation exercises; and<br>• **Support** the recommendations going forward to the six affected health boards and agree that they be asked to confirm their unconditional approval for a single adult Thoracic Surgery Centre based at Morriston Hospital, Swansea. |

**Considerations within the report** (tick as appropriate)

| | YES | NO | | YES | NO | | YES | NO |
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| 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

At an extra-ordinary meeting held on 28 June 2019, the Joint Committee received a paper that addressed the brief agreed at the meeting held in May 2019. This was for the WHSSC Team to develop a commissioning proposal which would provide the Joint Committee with additional information and clarification, building on the work of the CVUHB and SBUHB medical directors, enabling members to make a decision regarding future consultant work force planning for thoracic surgery services when they are located at a single site at Morriston Hospital, Swansea.

However, after protracted discussion and careful consideration, members proposed two alternative motions that were voted on but neither motion achieved the required two-thirds majority to succeed. Members agreed that the Managing Director of WHSSC would seek advice from Welsh Government on next steps. This latest paper therefore takes into consideration the discussion at the previous meeting and advice from Welsh Government and seeks to present recommendations that reflect much of the common ground between the differing views of members and commences by reflecting on the matters presented at the May and June meetings.

Additionally it should be noted that a requirement was identified in the November 2018 meeting that the above issue, as well as assurance around the caveats identified by the affected health boards and the requirement for a report on the lessons learned from the engagement and consultation exercises *(Report attached as Appendix A for ease of reference)*, should be formally considered by the Joint Committee to allow a recommendation to be made to the six affected health boards in order that they can confirm their unconditional approval for a single adult Thoracic Surgery Centre based at Morriston Hospital, Swansea. Details regarding these other issues can be found in the table attached as Appendix B for ease of reference, which was considered by the Joint Committee in May 2019.

## 2.0 BACKGROUND

At the May meeting the Joint Committee was presented with a workforce proposal for consultant thoracic surgeons developed by the medical directors of CVUHB and SBUHB *(Proposal attached as Appendix C for ease of reference)*. The Joint Committee, however, requested that the WHSS Team undertake further work to provide additional information and clarification regarding the work force model for thoracic surgery for consideration at the June meeting to enable members to take a decision. This additional information *(which can be found in Appendices D, E and F)* was considered, however members could not achieve the necessary two-thirds majority to reach a decision; therefore the WHSSC Managing Director was asked to seek advice from Welsh Government.

## 3.0 ASSESSMENT

### 3.1 Advice from Welsh Government

Following the June meeting advice on the next steps was sought from Welsh Government representatives. They indicated that it was their expectation that the recommendation to the six affected health boards would go through normal WHSSC processes and therefore the matter would need be reconsidered at the next Joint Committee meeting. They confirmed that they expected Joint Committee members to ensure that in coming to a recommendation they balanced the risks and benefits to the wider population of south and mid Wales. They also stated that they recognised the challenge of implementing two major service changes in similar timescales and confirmed that they supported consideration of the appointment of additional consultant thoracic surgical staff for the new MTC through the MTC business case. This arrangement would need to be closely monitored by WHSSC and kept under review as part of the developments of both the major trauma network and the final thoracic surgery provision.

### 3.2 Key points of discussion at June 2019 meeting

There was consensus at the June Joint Committee meeting that the appointment of an additional (fourth) consultant surgeon, at the University Hospital of Wales, prior to the opening of the MTC in 2020 would be important in supporting the establishment the new major trauma service. This post has subsequently been included in the MTC business case submitted to the MTN Programme Board.

There was disagreement on the optimal number of consultant surgeons to support the new single centre based at Morriston Hospital, Swansea when it opens, which is anticipated to be in around two years' time. The recommendation from the CVUHB and SBUHB medical directors is that eight surgeons are needed; however work undertaken by the WHSS Team using current activity data, taking into account a 20% increase in activity, benchmarking and external advice, is that approximately, six surgeons are needed. This discrepancy appears to have arisen because of uncertainty regarding future strategic challenges and was reflected in differing views amongst committee members on the optimal number of surgeons to support the single centre.

### 3.3. Conclusion

Building on the consensus regarding the additional (fourth) post, to support the opening of the MTC, and the content of the letter from Dr Andrew Goodall, NHS Wales Chief Executive, funding for the post within the MTC business case should be approved for 12 months. This appointment would need to be subject to an ongoing evaluation and extended if necessary. Also during this time the two thoracic centres would develop plans to work together developing a single emergency rota. The cost of the locum appointment is estimated to be

£135,000 based on £125,000 salary (including associated on costs) and would be funded from the MTC work stream.

Because of the uncertainty regarding the future consultant workforce requirements for the single thoracic surgery unit at Moriston Hospital, it is proposed that additional funding for two posts is allocated with the MTC business case when it is considered in September 2019. This would be in addition to the existing establishment of six posts. However funding release is dependent on an ongoing review of the real world experience from the MTC, updated activity figures, a clearer understanding of the strategic issues highlighted above and the formal professional advice of the SCTC on emergency cover for major trauma centres. This will ensure that a fully informed recommendation can be brought back to the Joint Committee well in advance of the move to a single site and that the new centre opens with the right number of consultant thoracic surgeons to ensure a safe and sustainable service.

## 4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the work that has been undertaken by the medical directors of CVUHB and SBUHB as well as the WHSS Team to develop workforce proposals for the consultant thoracic surgical service;
- **Support** the appointment of an additional consultant thoracic surgeon, funded through the MTC work stream, to support implementation of the MTC from April 2020 initially on an interim basis, pending clarity of the level of need;
- **Support** the allocation of funding for an additional two consultant surgeons (in addition to the existing establishment of six) from the MTC business case when the new single centre at Morriston Hospital is opened – the funding release for which will be dependent on consideration by the Joint Committee of the real world experience of the MTC, updated activity figures, a clearer understanding of the strategic issues highlighted above and the formal professional advice of the SCTC on emergency cover for major trauma centres.
- **Note** the information set out in the May Joint Committee paper which provided assurance around the caveats identified by the affected health boards and the requirement for a report on the lessons learned from the engagement and consultation exercises; and
- **Support** the recommendations going forward to the six affected health boards and agree that they be asked to confirm their unconditional approval for a single adult Thoracic Surgery Centre based at Morriston Hospital, Swansea.

## 5.0 APPENDICES / ANNEXES

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| **Appendix A** | Thoracic Surgery Post Public Consultation Lessons Learned Report |
| **Appendix B** | Arrangements for addressing the additional assurances requested by Health Boards |
| **Appendix C** | Consultant workforce arrangements suggested by the medical directors of SBUHB and CVUHB |
| **Appendix D** | Detailed workforce planning document |
| **Appendix E** | Comments received on draft workforce planning document and WHSSC responses |
| **Appendix F** | Notes from the discussion with external expert panel |

| Link to Healthcare Objectives | |
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| Strategic Objective(s) | Development of the Plan<br>Implementation of the Plan<br>Governance and Assurance |
| Link to Integrated Commissioning Plan | Re-configuration of existing service |
| Health and Care Standards | Safe Care<br>Effective Care<br>Timely Care |
| Principles of Prudent Healthcare | Public & professionals are equal partners through co-production<br>Care for Those with the greatest health need first<br>Reduce inappropriate variation |
| Institute for HealthCare Improvement Triple Aim | Improving Patient Experience (including quality and Satisfaction)<br>Improving Health of Populations<br>Choose an item. |
| **Organisational Implications** | |
| Quality, Safety & Patient Experience | |
| Resources Implications | |
| Risk and Assurance | |
| Evidence Base | |
| Equality and Diversity | |
| Population Health | |
| Legal Implications | |

| Report History: | | |
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| **Presented at:** | **Date** | **Brief Summary of Outcome** |
| Corporate Directors Group Board | 08 July 2019 | Reviewed and approved |
| Choose an item. | | |

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)

Welsh Health Specialised Services Committee (WHSSC)

# Thoracic Surgery Public Engagement & Consultation

## A Review of the conduct of the project and key lessons learned

**Paul Williams (Cwm Taf LHB - Welsh Health Specialised Services Committee )**

Abstract: This document provides an overview of the delivery of a formal public consultation on the location of adult thoracic surgery services for the population of South Wales together with a description of the lessons learned during the conduct of the project.

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| Project Title: | Thoracic Surgery Public Consultation |
| Program Title: | Provision of Adult Thoracic Surgery in South Wales |
| Author: | Assistant Planning Manager WHSSC |
| Report Title | Review of the conduct of the project and key lessons learnt |
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| Brief description of context | WHSSC is a Joint Committee of the seven Local Health Boards (LHBs) in Wales. The seven LHBs are responsible for meeting the health needs of their resident population, and have delegated the responsibility for commissioning a range of specialised services to WHSSC.<br><br>Specialised services generally have a high unit cost as a result of the nature of the treatments involved. They are a complex and costly element of patient care and are usually provided by the NHS. The particular features of specialised services, such as the relatively small number of centres and the unpredictable nature of activity, require robust planning and assurance arrangements to be in place to make the best use of scarce resources and to reduce risk. Specialised services have to treat a certain number of patients per year in order to remain sustainable, viable and safe. This also ensures that care is both clinically and cost effective.<br><br>Thoracic surgery is one of the specialised services that WHSSC commissions for the people of Wales. For patients living in North Wales this service is provided by Liverpool Heart and Chest Hospital NHS Foundation Trust. This is one of the largest thoracic surgical centres in the United Kingdom, with six consultant surgeons, serving a catchment area that spans across the north west of England and North Wales. Patients in northern Powys access the thoracic surgery service at Heartlands Hospital, Birmingham, which has recently become part of the University Hospitals Birmingham NHS Foundation Trust. By contrast, in South Wales there are two smaller services based at Morriston Hospital, Swansea and the University Hospital of Wales, Cardiff. The service at Morriston has two consultant surgeons, whereas the service at the University Hospital of Wales, has three consultant surgeons. There has been concern for a number of years that these two smaller services are not sustainable, and may not be able to fully meet the needs of the population of South Wales. |

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| | The Thoracic Surgery Review Project comprised two distinct stages. Stage One aim was to determine the service model for South Wales, i.e. one thoracic surgery centre or two and depending on the outcome of Stage One, Stage Two's aim was be to determine the location of the service centre.<br><br>A Project Board was established to form recommendations on the future provision of adult thoracic surgery in South Wales. The Project Board was informed by a review of the adult thoracic surgery services which was undertaken by the Royal College of Surgeons. Following an extensive engagement exercise across South Wales, in which the views of service users and other stakeholders were sought on the information required in order to make a recommendation on the future provision of thoracic surgery services in South Wales, the Project Board recommended that a single thoracic surgery centre should be developed for South Wales. WHSSC sought advice from the Board of Community Health Councils and Legal Services on the requirement to engage or consult on each of these two stages. The advice provided for stage one was that whilst it is not necessary to carry out formal consultation, engagement was necessary.<br><br>Following the recommendation from the Project Board, an Independent Panel was convened to review the options for locating the centre and to make a recommendation on the preferred location for the single thoracic surgery centre. The Independent Panel recommended that Morriston Hospital should be the location for the proposed single thoracic surgery centre.<br><br>The recommendation from the Project Board and the recommendation from the Independent Panel were considered and endorsed by the WHSSC Joint Committee for further consideration by the six affected health boards, subject to further discussions with the Community Health Councils about the need for public consultation.<br><br>Following the discussions with the Community Health Councils, it was agreed that the affected health boards, with assistance from WHSSC, should be asked to consider undertaking a formal public consultation in which they would ask the public, staff and interested organisations for their views on the recommendations of the Independent Panel to locate the single thoracic surgery centre at Morriston Hospital. |
| Brief description of project | WHSSC in order to support the decision making process for the review of Thoracic Surgery services in South Wales entered into a period of public engagement utilising public meetings and digital channels throughout the South Wales region.<br><br>Responses were requested for four questions |

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| | 1. Is there any other information you think we should consider to decide whether we need one or two thoracic surgery centres in South Wales?<br>2. Is there any other information you think we should include in the criteria that will be used by the independent panel?<br>3. Do you have comments on the process we are using to inform recommendations on future thoracic surgery services?<br>4. Do you have any other comments on the information presented in this document?<br><br>In total we received 78 responses including feedback captured during the public meetings the most common themes were<br>• Travel impact<br>• Co-location with other services and infrastructure<br>• Capacity in general with current services and ability to deliver a future high class service.<br>• Comments on the process and or documentation adopted.<br><br>The recommendation from the Project Board and the recommendation from the Independent Panel were considered and endorsed by the WHSSC Joint Committee for further consideration by the six affected health boards, subject to further discussions with the Community Health Councils about the need for public consultation.<br>Following the discussions with the Community Health Councils, it was agreed that the affected health boards, with assistance from WHSSC, should be asked to consider undertaking a formal public consultation in which they would ask the public, staff and interested organisations for their views on the recommendations of the Independent Panel to locate the single thoracic surgery centre at Morriston Hospital.<br>To ensure the consultation process was meaningful, consideration was given to key messages to be shared with the public and the evidence available to support the proposed development of a single adult thoracic surgery centre at Morriston Hospital, serving patients from South Wales.<br>The key messages included:<br>• Over the last year, patients in Wales with lung cancer have waited longer than they should have for surgery<br>• Patients in Wales with lung cancer have some of the lowest survival rates in Europe, although we know we have expert surgeons<br>• Patients who need surgery, but do not have lung cancer, have very long waiting times, and our doctors and nurses tell us this is affecting the quality of care they can provide<br>• Thoracic surgery is becoming increasingly specialised and better outcomes come from larger centres (elsewhere in the UK and Europe, services are being reorganised into larger centres) and |

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| | • Changes in the way surgeons practise mean we cannot continue to staff our two units in the way we have done in the past<br><br>• The Royal College of Surgeons undertook a review of the services in south Wales and recommended that in order to provide sustainable and high-quality thoracic surgery, there should only be one hospital delivering the adult service – "It is the review team's recommendation that WHSSC adopts a single site thoracic surgery service model for South Wales. The review team considered that this reconfiguration was in the best interests of patient care and was the most sustainable option for thoracic surgery going forward. It was considered that changes to cardiac and adult thoracic surgery would mean there would not be a staffing resource that could adequately sustain a two site model in the future..."<br><br>• An Independent Panel, made up of a range of clinical experts from north Wales and England, patients or their relatives, an equalities representative, representatives from the third sector (voluntary and charity organisations) and an independent Chairperson, were asked to look at the options and make recommendations on the location for the single centre using the criteria developed during the engagement process and agreed by the Project Board. The Independent Panel recommended that Morriston Hospital should be the location for the proposed single adult thoracic surgery centre.<br><br>• The surgical element of care forms only one part of the overall service patients will receive, and patients will continue to see their local respiratory consultant and have their diagnostic tests at the same hospital where they would currently.<br><br>• Patients resident in the areas served by Abertawe Bro Morgannwg University Health Board (ABMUHB), Hywel Dda University Health Board (HDUHB) or those areas of Powys Teaching Health Board where patients receive their secondary care at either ABMUHB or HDUHB, would continue to have their thoracic surgery at Morriston Hospital, Swansea.<br><br>• Patients who would have had their thoracic surgery in UHW, Cardiff, would in future receive their surgical care at Morriston Hospital, Swansea. This includes patients who live in the areas covered by Aneurin Bevan University Health Board, Cardiff & Vale University Health Board, Cwm Taf University Health Board and parts of Powys Teaching Health Board where patients receive their secondary care at one of these health boards.<br><br>• Evidence shows that thoracic surgery patients are likely to have better outcomes (survive longer, with fewer complications from their disease or treatment) and quicker recovery when treated in larger thoracic surgery centres;<br><br>• A larger single adult thoracic surgery centre will be more resilient, i.e. more able to cope with unpredictable changes such as episodes of staff sickness, vacancies and changes to national government policy.<br><br>The consultation asked people to respond to two questions:<br><br>1 The Independent Panel recommended that the adult thoracic surgery centre serving patients from South and West Wales and South Powys should be located in Morriston Hospital Swansea. Do you agree or disagree with the proposal? |

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| | 2 If we develop the adult thoracic surgery centre for South East and West Wales and South Powys in Morriston Hospital in Swansea, what are the important things that you would like us to consider about the planning and delivery of the new service?<br><br>The consultation plan outlined the methods and proposed process for the consultation that will support delivery of the following objectives:<br><br>• To seek the views of stakeholders on the proposed model for delivering adult thoracic surgery services in South Wales.<br><br>• To describe and explain the proposed model for delivering adult thoracic surgery services in South Wales.<br><br>• Ensure awareness and information about the consultation reaches the majority of health board stakeholders and provides opportunities for feedback.<br><br>• Provide stakeholders with a range of opportunities, taking account of accessibility, for staff and other key stakeholders to give their views by the close of the consultation exercise<br><br>• To ensure that the consultation process complies with legal requirements, Welsh Government guidance and duties.<br><br>Advice on the documentation was sought from the Health Boards and Community Health Councils within the regions, in order to ensure that it was fit for purpose.<br><br>WHSSC was responsible for printing and distributing hard copies of the consultation document, which was available in Welsh and Easy Read formats.<br><br>The consultation document detailed:<br>• The background to the consultation<br>• The need for change<br>• The proposals for change and rationale for the proposed model<br>• How people can participate in the consultation and give their views<br><br>The full consultation document in English and Welsh was available in standard and easy read versions also in electronic format. Versions were available in Audio (in English and Welsh) and British Sign Language format on the website. All |

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| | versions of the document included details of how people could respond online, by email, by phone or by freepost. Other formats would be produced as appropriate on request.<br><br>A full range of supporting and technical documents were available online, providing background information to support and inform the public consultation. These included:<br>• Equality Impact Assessment;<br>• Pre-consultation documents and reports;<br>• Relevant documentation from national bodies (e.g. Royal College of Surgeons);<br>• Other information to inform the decision making process and demonstrate that the options have been thought through and can be implemented;<br>• An initial list of frequently asked questions which were updated as queries arise during the consultation<br><br>In addition to these documents, a standard presentation was compiled and made available for health boards to use at public and stakeholder events.<br><br>Alongside the main consultation document the following methods for sharing information were employed:<br><br>• Website<br>A web page for the consultation was created via WHSSC at the following address:<br>http://www.whssc.wales.nhs.uk/thoracic-surgery-services-in-south-wales<br><br>There was both an English and Welsh web page and a short film produced outlining the key elements of the consultation.<br><br>• Public Sessions<br>Across the consultation period there are a number of planned sessions led by health boards in each region. This provided the opportunity for staff, stakeholders and the wider public to provide feedback on the proposals in the consultation document. Members of the WHSSC Executive team supported these sessions.<br><br>• Mid-Point Review<br>A formal review meeting was held approximately half way into the consultation to consider responses to the consultation, address any issues of concern and consider the need to make adjustments to the approach for the |

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| | remainder of the consultation period. This was coordinated by WHSSC, and included the engagement leads from each of the health boards, as well as representatives from the Community Health Councils. A report was produced following the meeting, summarising the key themes from the responses received to date, and was shared with the health boards and Community Health Councils. The report identified a number of actions including additional work around a key issue that had emerged during the first half of the consultation around the arrangements for delivering Thoracic Surgery support to the Major Trauma Centre. This work was subsequently included in the evidence pack provided to HBs with the consultation outcome.<br><br>• Post Consultation Phase<br><br>804 responses were received with the majority being submitted via the online form. Each individual response was recorded on a log which was regularly shared with affected health boards and CHC's<br>Where notes from staff or public events were provided these were also captured and included within the analysis and consideration of implementation actions but were not been recorded as individual responses.<br><br>On behalf of the six affected health boards, WHSSC received and logged responses to the consultation, the outcomes of which was reported to the WHSSC Joint Committee in September, prior to submission to each of the health boards, together with a recommendation on the proposal, for consideration at public board meetings to be held before the end of October 2018.<br>WHSSC worked with the health board engagement leads, and provided them with the responses specific to their health board area and region.<br>WHSSC officers reviewed, collated and analysed the responses and outcomes with regards to any national, regional or crosscutting themes, in order to enable the Joint Committee and affected health boards to have an informed discussion on the outcome of the consultation.<br><br>WHSSC officers shared all of the responses with the Community Health Councils and health board engagement leads, and reviewed and collated the responses and outcome for each health board area. This information was also shared with the Community Health Councils for consideration as part of their role in reviewing and formulating an official response to the consultation. |
| | Final Project Review<br>A formal review meeting was held in the spring of 2019 to consider conduct of the consultation and address any issues of concern. |

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| | This was coordinated by WHSSC, and included the engagement leads from each of the health boards, as well as representatives from the Community Health Councils.<br><br>This report was produced following the review meeting, and summarises the key findings under four headings<br><br>• Key project successes<br>• Project shortcomings and solutions<br>• Lessons learnt<br>• Follow-up Actions |
| Key project successes | **Please describe what has worked well.**<br>**What have been the key successes of this project?**<br><br>• The primary success of the process was to deliver a regional engagement and consultation.<br><br>• There was a due regard to equity of opportunity, the approach adopted resulted in a wide range of stakeholders sharing their views. This was supported by the availability of materials in multiple formats.<br><br>• As themes and questions developed throughout the consultation period WHSSC worked collaboratively with CHC's and HB's to produce a living Frequently Asked Questions process to signpost or address issues raised.<br><br>• High Response Rate with 804 individual responses across all affected populations. Strong engagement with clinicians.<br><br>• Feedback from CHC's and HB's was that WHSSC demonstrated a genuine desire to engage and consult, as evidenced by WHSSC Executive support at public and staff meetings.<br><br>**What factors supported this success?**<br><br>The adoption of a two stage process with engagement followed by consultation allowed WHSSC to refine and adapt internal processes and in particular shape its communication strategy. |

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| | There was an opportunity to learn from the public consultation on Major Trauma and in particular the approach to collaborative working. Regular contact with Health Board and CHC's was a core component of the process and space was created to have conversations throughout the consultation period.<br>The Mid-Point Review was very useful in framing the quantitative and qualitative approach taken and offering an opportunity to discuss and tailor the process, including providing the opportunity to undertake additional work on a specific issue in response to feedback received during the first half of the consultation.<br>As noted above there was a genuine desire to engage and consult and WHSSC executive team took an active leadership role throughout the process.<br>There was a recognition that subject matter experts existed within the HB's and CHC's, collaborative working and transparency were taken as key lessons from the major trauma consultation and informed the WHSSC process throughout. |
| Project shortcomings and solutions | **Please describe what have been the main challenges of this activity?**<br><br>Above all else the fact that conducting a two stage engagement and consultation process was a new endeavour for WHSSC.<br>When planning the process and materials to be adopted consideration was given to build sufficient flexibility in the timeline to ensure all activity was completed in order to account for the agreed recommendation and decision making processes within Joint Committee and the Health Boards. However, it is recognised that the pre consultation stage included a number of challenges which resulted in the timeline being stretched, in effect the contingency was utilised at the start of the process. Examples of early pressures within the timeline included;<br>There was a degree of uncertainty regarding the need for a public consultation. Time was lost when WHSSC were gathering the views of the CHC's. Engagement leads felt that their earlier involvement would have been beneficial, building on their expertise and local relationships. Timescales need to take account of the decision-making timescales for CHCs as well as HBs.<br>Once the need for a consultation was agreed there was a significant amount of activity dedicated to producing and reaching consensus on the material. The decision to include an agree/disagree question was an example of early uncertainty over what was being consulted upon.<br>Post consultation there were challenges over the governance and decision making process and in particular the ability to share materials with CHC's prior to the HB meetings.<br><br>**How were they overcome (if they were)?** |

In recognition of the uniqueness of the activity from a WHSSC perspective collaboration with Health Boards and CHC's was adopted throughout the process.

The timeline although stretched did have a sufficient contingency to allow the process to be completed in time.

The governance around the recommendation and decision making process was complex and reflected the uniqueness of WHSSC's position outside but acting on behalf of the Health Boards. To mitigate WHSSC continued to engage with Health Boards and CHC's throughout the process, for example by providing regular copies of the responses logged. The mid-point review was extremely helpful in enabling joint working to resolve a number of issues.

**Were the project objectives attained? If not, what changes need to be made to achieve these results in the future?**

**Objective 1: To seek the views of stakeholders on the proposed model for delivering adult thoracic surgery services in South Wales.**

804 responses have been received, with the majority being submitted via the online form. Each individual response was recorded on a log which was regularly shared with affected health boards and CHC's.

Where notes from staff or public events were provided, these have also been captured and included within the analysis and consideration of implementation actions, but they have not been recorded as individual responses.

In response to the question

The Independent Panel recommended that the adult thoracic surgery centre serving patients from South and West Wales and southern Powys should be located in Morriston Hospital, Swansea. Do you agree or disagree with the proposal?

- 339 or 42.16% agreed with the proposal.
- 428 or 53.23% disagreed with the proposal.
- 34 or 4.23% neither agreed nor disagree with the proposal.
- 3 or 0.37% did not answer the question.

A number of themes were identified when analysing the responses. These "key" themes have been used as the basis of analysis of the responses.

Many of the 804 respondents expressed multiple views across their responses and therefore the total number of issues identified within the themes is 1,441.

The key themes were as follows:

- Implementation and Improvement
- Accessibility

- Major Trauma Centre
- Workforce
- Other

**Objective 2: To describe and explain the proposed model for delivering adult thoracic surgery services in South Wales.**

Advice on the documentation was sought from the health boards and Community Health Councils within the regions, in order to ensure that it was fit for purpose.

WHSSC was responsible for printing and distributing hard copies of the consultation document, which will be available in Welsh and Easy Read formats.

The consultation document detailed:

- The background to the consultation
- The need for change
- The proposals for change and rationale for the proposed model
- How people can participate in the consultation and give their views

The full consultation document in English and Welsh was available in standard and easy read versions in both hard copy and electronic format. Versions were also be available in Audio (in English and Welsh) and British Sign Language format on the website. All versions of the document included details of how people could respond online, by email, by phone or by freepost. There were no requests for other formats although the plan included provision for them to be produced as appropriate on request.

A full range of supporting and technical documents were available online, providing background information to support and inform the public consultation. These included:

- Equality Impact Assessment;
- Pre-consultation documents and reports;
- Relevant documentation from national bodies (e.g. Royal College of Surgeons);
- Other information to inform the decision making process and demonstrate that the options have been thought through and can be implemented;
- An initial list of frequently asked questions which was updated as queries arose during the consultation

In addition to these documents, a standard presentation will be compiled and made available for health boards to use at public and stakeholder events.

A review was held at the half way point of the consultation with representation from the affected health boards and CHCs to consider the processes and responses to date in light of the consultation plan and national guidance.

Actions arising from the mid-way review were:

- A mechanism was agreed for reporting by health boards of any exceptions to the published consultation plan;
- An agreement was reached for the provision of the verbatim responses, together with high level quantitative analysis, to health boards and CHCs on a weekly basis;
- The addition of a new FAQ relating to the requirements of the Major Trauma Centre for emergency support from consultant thoracic surgeons;
- The addition of a new FAQ relating to the lay membership of the Independent Panel;
- Steps were taken to ensure that work was undertaken to provide outline arrangements for delivering thoracic surgery support to the Major Trauma Centre (for the small number of cases where this may be required). This information was included in the evidence pack that will be submitted to health boards with the consultation outcome.

**Objective 3: Ensure awareness and information about the consultation reaches the majority of health board stakeholders and provides opportunities for feedback.**

In order to assess the public reach of the consultation, respondents were asked if they were an employee of the NHS. Respondents were also asked if they were replying on behalf of an organisation. Where respondents indicated that they were replying on behalf of a health board this has been discounted from the organisation's total number in recognition that any staff responding were doing so as an individual/group and not corporately.

| Not specified | NHS Employee | Organisation | Elected Representative | Grand Total |
|---|---|---|---|---|
| 416 | 369 | 16 | 3 | 804 |
| 51.74% | 45.90% | 1.99% | 0.37% | 100% |

In line with the statutory duty placed on each health board under the Wales Public Sector Equality Duty 2011, an equality impact assessment (EIA) was undertaken on the proposals for a single adult thoracic surgery centre for South Wales

At the consultation mid-way review, held in July 2018, the opportunity was taken to review the characteristics of respondents to assess whether the consultation was reaching the relevant groups. No issues were identified at the mid-way review which required changes to the consultation plan process. The distribution of responses across the protected characteristics did not change significantly from this point.

The equality monitoring process indicates that overall the consultation did have broadly representative input from affected protected categories and from the relevant age distribution.

**Objective 4: Provide stakeholders with a range of opportunities, taking account of accessibility, for staff and other key stakeholders to give their views by the close of the consultation exercise.**

The table below quantifies the response method used

| Health Board of Residence | Email | Hard Copy | Online form | Grand Total |
|---|---|---|---|---|
| Abertawe Bro Morgannwg UHB | 8 | 13 | 177 | 198 |
| Aneurin Bevan UHB | 2 | 8 | 44 | 54 |
| Cardiff & Vale UHB | 12 | 32 | 291 | 335 |
| Cwm Taf UHB | 1 | 16 | 25 | 42 |
| Hywel Dda UHB | 1 | 38 | 66 | 105 |
| Powys THB | 2 | 4 | 6 | 12 |
| Not indicated | 12 | 9 | 37 | 58 |
| **Grand Total** | **38** | **120** | **646** | **804** |

Public events were arranged throughout the consultation period and a schedule was published on the WHSSC website.

Attendees were asked to submit their individual responses and a record of themes identified has been provided. No themes were identified which have not been represented in the analysis of responses from the standard response methods.

A number of staff and stakeholder events were held through the consultation period. Attendees were asked to submit their individual responses and a record of themes identified has been provided. There were no themes identified which have not been represented in the analysis of responses from the usual response methods.

| | |
|---|---|
| | **Objective 5: To ensure that the consultation process complies with legal requirements, Welsh Government guidance and duties.**<br><br>A consultation plan was developed, in collaboration with health board engagement leads, to support the consultation process.<br><br>The consultation document, response form and covering letter were prepared by WHSSC and formally approved by the six affected health boards at board meetings in June 2018. The consultation document was also available in the Welsh language, an Easy Read format and as a BSL signed video.<br><br>An Equality Impact Assessment ("EIA") was also completed and used to inform the consultation plan and the stakeholders that should be consulted. In order to assess the demographic profiles of respondents, the hard copy and online versions of the consultation document included a series of survey questions in multiple choice format<br><br>The consultation was developed to meet the requirements of the framework for Welsh NHS bodies and Community Health Councils established in 'Guidance on Engagement and Consultation on Changes to Health Services' issued by Welsh Government in March 2011 and the principles in 'National Principles for Public Engagement in Wales' developed by Participation Cymru and endorsed by Welsh Government in 2011.<br><br>In addition, the consultation was designed to satisfy the 'Sedley criteria' (often referred to as the 'Gunning principles') originally set out in 1985 and endorsed by the Supreme Court in *R (Moseley) v Haringey London Borough Council in 2014* and subsequent judicial developments in which guidance on the requirements of fair consultation was set out and which has also been taken into account. |
| Lessons learnt | **What could have been done differently/ better?**<br><br>This was a new endeavour for WHSSC and it was a steep learning curve for organisational understanding of the complexities of delivering a regional engagement and consultation. The support and advice of the subject matter experts was sought at an early stage as was the views of the CHC's. It is recognised by WHSSC that the advice of engagement experts regarding the need for public consultation should have been accepted at an earlier stage. A greater understanding of the role of the CHC's would have avoided delay at the outset. |

| | |
|---|---|
| | The process delivered a regional consultation but delivery was undertaken at a local level and although the process included regular checks and updates the activity undertaken locally reflected local circumstances and therefore included inherent inconsistencies. A suggested approach would to be adopt a program management approach with a fully developed handling plan to account for and where possible remove any inconsistencies. Such an approach would ensure greater clarity on roles and responsibilities and facilitate robust governance in relation to reporting, escalation and communication across the programme.<br><br>Transparency was at the heart of the process up to the decision making stage at Health Boards. There is a recognition of some frustrations within CHC's with the ability to obtain, assess and comment on material before it is public.<br><br>Although every effort was made to identify an effective communication strategy within the overall consultation plan there were a few examples, where communication between stakeholders could have been improved:<br><br>• Communication management around the alignment of the publication of recommendations and decisions statements from different health boards could have been better aligned?<br>• Improving the communication between the local CHCs and their Health Boards for example by establishing a formal communication channel via the Directors of Planning at each Health Board<br>• Clarity of communication and explanation of the Gunning principles<br><br>**What would you recommend to improve future programming or for other similar projects elsewhere**<br><br>A theme that emerged from the Major Trauma consultation was around the need for improved collaborative working across NHS bodies. This has led to the establishment of a Cross Health Board Consultation working group which includes representation from WHSSC. The conduct of the engagement and consultation has always been mindful of the guidance and relevant legislation and case law but there is a gap in the guidance on collaborative which should be addressed.<br><br>NHS bodies should engage with the Consultation Institute and consider the commissioning of training for all staff to increase awareness of the law and guidance regarding engagement and consultation.<br><br>**What mistakes should be avoided if the initiative were to be replicated?** |

| | |
|---|---|
| | The recommendation and decision making process was reflective of this being a regional process and it is recognised that there were frustrations with CHC's with regard to the availability of the supporting material before it was made public. Consideration should be made to detailing the flow of information and gaining commitments on confidentiality if shared prior to being in the public domain.<br>The overall timeline of the activity was flexed early and without scope for extension due to the agreed decision making process deadlines significant pressure was placed on the analysis of the data. This pressure was exacerbated by a large number of late submissions. Although overcome by allocating additional resource future program management should include a strategy for mitigation for slippage in the timeline. |
| Follow-up Actions | As part of the Final Review, follow-up actions and areas for exploration were:<br>• WHSSC to contribute to the Cross Health Board Consultation Working Group<br>• Regular meetings to be held between WHSSC and HB Engagement Leads<br>• Regular meetings to be held between WHSSC and the CHC's<br>• Improved communication between WHSSC and the HB DoPs<br>• Agreement that to avoid the issue around information in the public domain the process is adopted that it can be shared in confidence to the CHC executive.<br>• WHSSC to engage with all staff to increase awareness of engagement. |

## Appendix B : Arrangements for addressing the additional assurances requested by Health Boards

| Health Board | Further Assurance Required | Ownership | How the issues are being addressed and actions taken |
|---|---|---|---|
| Hywel Dda UHB | To clarify arrangements for families of thoracic patients as to whether they would have access to family accommodation on the Morriston site. | Thoracic Surgery Implementation Project Board | Update from SBUHB:<br>The existing accommodation for relatives provided at the bottom of the Morriston site will be available for families of thoracic patients, the level of demand required for the expanded thoracic service will be considered according to the agreed service model and if necessary additional accommodation will be included in the business case which will be developed by ABMU for the provision of the new Thoracic Unit. |
| Hywel Dda UHB | To give further consideration to the issues of transport as raised by people in the Hywel Dda area. | Thoracic Surgery Implementation Project Board | Further work will be undertaken with NEPT when the commissioning framework has been agreed. The commissioning framework will include an assessment of patient numbers and will form the basis on which the NEPT service can be planned. The commissioning framework will be completed by May of 2019. |
| Hywel Dda UHB | As it was noted that the response provided by WHSSC did not address concerns about parking, WHSSC to provide a response to the issue of | Thoracic Surgery Implementation Project Board | Update from SBUHB:<br>The Health Board confirms that over recent months the parking issues at Morriston had greatly improved due to the demolition of empty accommodation and outdated |

| | | | |
|---|---|---|---|
| | parking raised by people in the Hywel Dda area. | | buildings on the site. In addition work is underway to improve access to the Morriston site which will enable planning permission to be sought to further improve car parking on the site. |
| Hywel Dda UHB | It was noted that there was a lack of clarity on whether appropriate services in Hywel Dda were ready and established to provide onward care after local people had been discharged back to their own Health Board and as such a response is required as to how local services receiving patients discharged from Morriston will provide adequate care. | Thoracic Surgery Implementation Project Board | The implementation project board, led by SBUHB, is establishing a service model working group to develop the detail of how the service will be organised to deliver the service specification. This will include the pathway for discharge back to local services following admission for thoracic surgery. |
| Hywel Dda UHB | In addition, concerns were expressed around the pathway, with this process offering the opportunity to consider pathways and improve the patient journey. Reference was made to a risk of an over-focus on certain services, such as those relating to cancer, when there are others which are significant, such as benign respiratory disease. | Thoracic Surgery Implementation Project Board | The implementation project board, led by SBUHB, is establishing a working group specifically for benign conditions. |
| | | | |
| Swansea Bay UHB | The CHC has asked that ABMU Health Board provide more detail to assure the public in the ABM area that any further costs identified during implementation | WHSSC to SBUHB | Under the governance process for implementation of the single thoracic surgery centre, the business case will be developed through the implementation board, on which all involved Health Boards |

| | | | |
|---|---|---|---|
| | would be met by all involved health boards and not solely by ABMU. | | are represented, agreed by SBUHB Board and finally approved by the Joint Committee. The costs will be agreed as part of this scrutiny and approval process. The revenue costs of service delivery will be funded by the 6 Health Boards that refer into the service according to the risk share mechanism for specialised services.<br><br>Any additional costs that will be incurred during the transition period (as the previous services are decommissioned and the new service commissioned) will be identified through the implementation project and funding agreed through the Joint Committee and allocated according to the risk share. |
| Swansea Bay UHB | The CHC has asked the Health Board to clarify whether families of thoracic patients would have access to existing family accommodation on the Morriston site and to give further consideration to the issues of transport and accommodation raised by people in the ABM area; | SBUHB to provide to WHSSC | The existing accommodation for relatives provided at the bottom of the Morriston site will be available for families of thoracic patients, the level of demand required for the expanded thoracic service will be considered according to the agreed service model and if necessary additional accommodation will be included in the business case which will be developed by SBUHB for the provision of the new Thoracic Unit. |

| | | | |
|---|---|---|---|
| | | | SBUHB already offers flexible visiting hours which enables families and visitors to attend anytime from 11am to 8pm, 7 days a week, which can improve access for them to see relatives/loved ones. Assistance with travelling costs for those patients who use their own or a family member's transport will be able to reclaim mileage if they are on any of the recognised benefits under the "help with health costs" scheme (including income support, universal credit, pension credit guarantee or if you live permanently in a care home where the Local Authority helps with your costs). |
| Swansea Bay UHB | The CHC have asked that the Health Board provide a response to the issue of parking raised by people in the ABM area | SBUHB to provide to WHSSC | The Health Board confirms that over recent months the parking issues at Morriston had greatly improved due to the demolition of empty accommodation and outdated buildings on the site. In addition work is underway to improve access to the Morriston site which will enable planning permission to be sought to further improve car parking on the site. |
| Swansea Bay UHB | Co-dependencies of services: the CHC have asked the Health Board to give further consideration to the issues raised and provide assurance that any impact and necessary mitigation has been considered. | SBUHB to provide to WHSSC | The requirement for additional theatres, critical care capacity, pathology, radiology and other clinical services which will need additional capacity to underpin the new thoracic centre, and the costs associated with these, will be incorporated into the |

| | | | |
|---|---|---|---|
| | | | business case being developed by SBUHB and the costs therefore incorporated into the WHSSC IMTP so that the costs are shared across the involved Health Boards and not borne only by SBUHB. |
| Swansea Bay UHB | Staffing: The CHC considered that the response from WHSSC did not fully address concerns about the need for a strong multi-disciplinary team or respond to concerns that staff may not transfer from Cardiff. Therefore the CHC have asked that the Health Board give this further consideration. | SBUHB to provide to WHSSC | Careful staff consultation processes will be developed and undertaken jointly by SBUHB and CVUHB to ensure any issues with continuity and sustainability of staffing for the single unit are identified early and actions taken to mitigate appropriately. We will ensure that appropriate staffing options for minimising risks of loss of staffing are included in the business case as appropriate. |
| | | | |
| Cwm Taf Morgannwg UHB | The Health Board requested that that they receive a progress report from WHSCC in 6 months' time. | WHSSC to provide progress report | The report to Joint Committee in May 2019 will be forwarded to Health Boards for their May Board meetings. |
| Cardiff & Vale UHB | After careful consideration of all of the issues and listening to the representations made from both the Senior Clinical Consultant body and the Community Health Council the Board approved all of the recommendations with the caveat to ensure patient safety, the board would regularly be reviewing the detailed workforce model and medical rotas to provide 24/7 thoracic surgery cover for the Major Trauma | WHSSC to CVUHB | The current position with regard to the issue of thoracic surgical cover for the MTC is included in the Joint Committee report May 2019. |

| | | | |
|---|---|---|---|
| | Centre and if it was not assured within six months the Board would withdraw its approval. | | |
| ABUHB | ABUHB confirmed no additional assurances were required by the Board. | | |
| Powys THB | The Thoracic Surgery developments should not negatively impact on other services for Powys residents from Morriston Hospital; reassurances that outreach/outpatient services would be maintained at Nevill Hall and Glangwili [if the main adverse impact is around travel, and the main mitigation is to keep as much of the pathway as close to home as possible, then we need a level of reassurance that neighbouring service reconfigurations won't lead to these services moving from the nearest hospitals for our residents] | Thoracic Surgery Implementation Board | The implementation project, led by SBUHB, has held a clinical summit where the model was discussed, and is establishing a service model working group to develop the detail. This work will design a model to meet the service specification which requires that out-reach clinics form a key part of the service. |

# Thoracic Surgery Single Site Consultant Workforce Model- Consultation 07.06.19

## Context

The Joint Committee of Welsh Health Specialised Services Committee (a committee of all the health board chief executives and 3 independent members) considered in November 2018 the recommendations that thoracic surgery should move to a single site model and that single site should be located at Morriston Hospital, Swansea. The committee supported this recommendation but asked for a number of assurances regarding the future model and specifically asked for a workforce plan, within 6 months, which described how thoracic surgical cover would be provided to the Major Trauma Centre at UHW, Cardiff.

In May 2019 a proposal regarding the workforce model was submitted by the two provider (Swansea Bay and Cardiff and Vale University Health Board) medical directors to the Joint Committee however the committee deferred a decision and requested that Dr Sian Lewis (and the WHSS Team) bring a WHSSC workforce assessment back to the Joint Committee by the end of June 2019. They asked that this assessment take into consideration a number of matters and some uncertainties raised in the paper and during the meeting.

This paper summarises this initial assessment of the optimal consultant work force model. There are a number of assumptions in this modelling work and this paper is therefore being circulated for comments which will be incorporated into the final submission to the Joint Committee. In addition the WHSS team is establishing a panel of expert external advisors who will also provide feedback.

The timescale for this consultation process is extremely challenging; we apologise for this but we are working within the requirements of the Joint Committee. To help with this rapid turn-around it is important that your comments are returned on the attached template and reference the relevant line within the paper. Also it is important that you provide wherever possible independent evidence rather than opinion to substantiate your comments.

## Background

The following assessment is based on;

- a number of points made in the RCS Invited Review 2016,
- the WHSSC Service Specification for Thoracic Surgery
- NHS England Service Specification for Thoracic Surgery
- The current activity levels of the two units plus 20% additional workload

The Thoracic Surgery Implementation Group is working to define the service model so this assessment is also based on a number of assumptions. These assumptions come from comparators with other thoracic surgery centres, presentations made by two consultants (MK and PK) at the recent thoracic clinical summits in March and May 2019.

The RCS Invited Review (2016) stated that;

"In line with units of a similar size it was considered that five consultant thoracic surgeons were required to service a population of 2.4 million people safely. This would provide adequate emergency on-call cover as well as other services to ensure adequate patient throughput. RCS Invited Review 2016".

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

The RCS also recommended that;

Five consultant thoracic surgeons should be employed to meet service demands. Each of the consultants' job plans should include:

- one in five on-call duty which includes weekend cover
- At least one specified operating day
- Fair distribution of MDTs with adequate cross-over cover
- Attendance at out-patient clinic

It is acknowledged that at this point the location of the MTC had not been determined.

The independent panel and the final recommendation from Joint Committee including further mitigations required by Health Boards means that there are other fixed points;

- A commitment to 6 consultant on the basis that this would allow 9.00am to 5.00pm onsite cover at the UHW site and an additional 20% workload (based on outturn + 20%).
- A commitment to the development of the skills of the trauma team to manage immediate thoracic trauma.
- That there will be an on-call thoracic surgery rota which also provides cover to the MTC, and will be in the form of remote advice to the trauma team 24/7 plus attending the MTC in the rare event that their specialist surgical intervention skills are required to support the trauma team;
- There will be a thoracic surgery presence on the University Hospital of Wales site 5 days a week for advice and support for major trauma and other clinical services as required.
- That we will obtain and act upon advice from the Wales Cancer Network to improve the way our multi-disciplinary teams work, ensuring that wherever possible care is delivered closer to home.

Further advice provided to WHSSC at the time of the consultation noted that the Intercollegiate Surgical Curriculum Programme has recently been updated (16th November 2017) to include the requirement that surgeons trained in trauma will allow them to practice independently for injuries to the thorax.

The extant Thoracic Surgery Service Specification Version: 1.0 notes the following key points

With regard to minimum volumes (these are based on the NHS England Service specification)

- The thoracic surgery unit should undertake a minimum of 150 primary lung resections per year.
- The thoracic surgery unit should have a minimum of 3 full time general thoracic surgeons.

Regarding emergency cover and on-call arrangements

- Providers are required to have 24/7 emergency cover by general thoracic surgical consultants with or without mixed-practice cardiothoracic surgical colleagues.
- The surgeons on the rota should be able to deal with the full range of thoracic surgical emergencies.
- Cross cover of rotas from consultants with a purely cardiac practice or from consultants from other specialities is unacceptable.
- A sustainable on call rota should not be more frequent that 1 in 4.

**Assessment**

**Demand Analysis**

This demand analysis is based on an estimated population of 2.2 million people.

The table below shows the activity outturn for all procedures over the last 3 years

**Table 1 Thoracic Surgery Outturn by Centre**

| | SBUHB | CVUHB | Total |
|---|---|---|---|
| 2016/17 | 421 | 615 | 1036 |
| 2017/18 | 474 | 646 | 1120 |
| 2018/19 | 422 | 672 | 1094 |

Source: Provider contract monitoring returns to WHSSC

This shows a fairly static position of approximately 1100 cases per year. For planning purposes this would mean approximately 1300 cases based on outturn plus 20%.

Table 2 shows the casemix for the two centres combined as reported to the Society for Cardiothoracic Surgery in 2017/18.

**Table 2 Casemix for Morriston/UHW Combined 2017/18**

| **Procedure** | Number of Cases |
|---|---|
| Lung resections – primary malignant | 458 |
| Lung Resection – others | 101 |
| Mesothelioma Surgery | 16 |
| Pleural procedures | 170 |
| Chest wall/diaphragmatic | 97 |
| Mediastinal | 57 |

| | |
|---|---|
| Other | 10 |
| Endoscopic | 62 |
| **Total** | **971** |

**Table 3 Number of primary lung resections**

| Year and Source | SBUHB | CVUHB | Combined |
|---|---|---|---|
| 2016/17 SCTS* | 159 | 194 | 353 |
| 2017/18 SCTS* | 162 | 279 | 441 |
| 2018/19 WHSSC | 168 | 273 | 441** |

*excludes exploratory procedures with no resection
** forecast from M11

Surgical resection is currently the only curative option for lung cancer, therefore long term survival rates are closely related the number of resections carried out at a centre. The table below shows the resection rate for patients across south Wales based on the hospital of referral. This shows a significant variance in lung resection rates from 27% to 13%. The best resection rate across the UK is reported from Papworth Hospital at 28%. The aim with a single centre is to consistently increase the resection rate to be amongst the best in the UK and to do this across the region.

**Table 4 Lung Cancer Audit 2018 (2017 data)**

| | Resection rate | Total cases | Number resected |
|---|---|---|---|
| Bronglais General Hospital | 15.40% | 56 | 9 |
| Prince Philip Hospital | 18.40% | 188 | 35 |
| Withybush General Hospital | 15.10% | 97 | 15 |
| Princess of Wales Hospital | 27.00% | 106 | 29 |
| Morriston Hospital | 22.90% | 294 | 67 |
| University Hospital Llandough | 17.10% | 290 | 50 |
| The Royal Glamorgan Hospital | 23.10% | 152 | 35 |
| Prince Charles Hospital Site | 18.30% | 133 | 24 |
| Nevill Hall Hospital | 13.10% | 106 | 14 |
| Royal Gwent Hospital | 18.80% | 268 | 50 |
| **South Wales** | **19.40%** | **1690** | **328** |
| **Wales** | **18.30%** | **2179** | **399** |

## Proposed Activity Requirements

### MDTs

At the recent clinical summit meetings the two clinical leads suggested the following MDT configuration based on six surgeons with two surgeons covering each MDT to ensure that there is always a surgical presence at the MDT and to improve consistency of decision making.

| Lung Cancer MDT | New Cases/Year (NLCA) 2015) | Surgeon Responsible | Surgeon Cover |
|---|---|---|---|
| SBU HB Morriston MDT (Singleton, Morriston, Neath) | 311 | Surgeon 1 | Surgeon 4 |
| Hywel Dda MDT GGH (GGH, BGH, WGH,PPH) | 311 | Surgeon 2 | Surgeon 5 |
| CTM HB MDT POW | 108 | Surgeon 3 | Surgeon 6 |
| Prince Charles MDT | 126 | Surgeon 4 | Surgeon 1 |
| ABUHB NHH, Gwent | 257 | Surgeon 5 | Surgeon 2 |
| Royal Glamorgan & C&V MDT | 407 | Surgeon 6 | Surgeon 3 |

With the advent of the new Cwm Taf Morgannwg Univeristy Health Board it could be feasible that PoW, Prince Charles and Royal Glamorgan join as one MDT but for planning purposes the arrangement suggested by the Clinical Summit have been used. It will however be important that any agreed final model reflects the input of the All Wales Cancer Network and the output of their peer review programme.

As suggested also by the two clinical leads, if six surgeons were in post this would provide each surgeon with the following new cases.

| Lung cancer MDTs | Total New Cases (NLCA 2015) |
|---|---|
| Surgeon 1 | 311 + 126 = 437 |
| Surgeon 2 | 311 + 257 = 568 |
| Surgeon 3 | 108 + 407 = 515 |
| Surgeon 4 | 126 + 311 = 437 |
| Surgeon 5 | 257 + 311 = 568 |
| Surgeon 6 | 407 + 108 = 515 |

**Outpatient and Pre-assessment Clinics**

The 2018/19 contract monitoring returns for the two centres for outpatient activity is as follows

**Cardiff & the Vale University Health Board**

New outpatients: 521

Follow Up: 1085

**Swansea Bay (inc Bridgend)**

New outpatients: 313

Follow Up: 616

Based on the information from other centres in England pre-assessment/outpatient clinics need to run daily and this is usually at the thoracic centre so in this case Morriston. Additionally the two clinical leads further proposed the need for clinics in the peripheral hospitals for cases identified at the MDT. The suggestion is therefore that in addition to the daily clinics in Morriston there are:

- two clinics/week in Cardiff
- one each in the other Health Board areas which could rotate around the hospitals within the Health Board. This would need to be confirmed once the implementation group have finalised their work on the service model.

**Pre-habilitation**

It is proposed that this occurs at all hospitals but is not consultant led.

**Operating Lists**

The RCS recommended that each surgeon should have at least one operating list per week. Information from the surgeons at both UHW and Morriston suggest that the most efficient way is to run a long list, essentially equivalent to 3 consultant session days. Advice from both centres also suggests that around 4 cases per long day is an appropriate number.

The planned activity is around 1300 cases/ year, although it is likely to be less than this at the outset based on current figures. So for 4 cases per 3 session list = 325lists/year = 6.25 lists/week.

**On call**

The RCS report suggested a one in five on-call duty which includes weekend cover for five surgeons so it is proposed that this is a one in six for six surgeons which with prospective cover would equate to around 1 in 5.

**Major Trauma Centre**

The concerns about cover for the major trauma are acknowledged and it is understood that the "go live" date of April 2020 is a key driver for the urgency required in agreeing the consultant workforce configuration.

Advice provided by the Major Trauma Network Clinical Lead suggests that a thoracic surgeon would need to attend the MTC to deal with an emergency 3 to 8 times per year.

Advice from the two thoracic centres varies one centre stating that they are rarely called in out of hours and the other suggesting that they are called 1 to 2 times per month.

Should there only be one on call rota covering the thoracic surgical centre and the MTC the concern is clearly that the surgeon will be required in both places at the same time. The analysis below is based on the NCEPOD Report from 2003 which carried out a comprehensive review of non-elective surgery. The analysis is based on the figures quoted in that report which are for combined cardiothoracic surgery. We have taken advice from the President of the Society of Cardiothoracic Surgeons regarding the relevance of this analysis to current clinical practice and whilst there have been some changes, including increasing use of rib fixation, it was felt that there was unlikely to be a material difference in the frequency of clinical emergencies. These figures, because they include cardiac emergencies are therefore likely to overestimate of the thoracic surgery emergency workload.

From this analysis, the probability of a thoracic surgery emergency and an MTC emergency arising on the same day is 1 in every 429 days.

The probability of this occurrence in the same hour i.e. at exactly the same time is 1 in every 6,857 days i.e. once every 18.8 years.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Calculation of Thoracic Surgery On Call Probability | | | | | | | | | |
| | | | | | | | | | |
| **NCEPOD 2003 Non Elective Surgery in the NHS** | | | | | | | | | |
| | | | | | | | | | |
| **Percentage of Non-elective operating** | | | | | | | | | |
| Cardiothoracic surgery | 17.10% | | | | | | | | |
| | | | | | | | | | |
| Operating Time of Day | | | | | | | | | |
| | Weekday 08:00 to 17:59 | Weekday 18:00 to 23:59 | Weekend 08:00 to 17:59 | Weekend 18:00 to 23:59 | Night 00:00 to 07:59 | Total | | | |
| Cardiothoracic (n) | 120 | 21 | 13 | 2 | 9 | 165 | | | |
| Percentages | 72.7% | 12.7% | 7.9% | 1.2% | 5.5% | 100.0% | | | |
| Total Percentage On call window | | | | | | 27.3% | | | |
| | | | | | | | | | |
| South Wales Thoracic Surgery total | | | | | | 1,100 | | | |
| Non elective @17.1% based on cardiothoracic average NEL | | | | | | 188 | | | |
| | | | | | | | | | |
| Estimated allocation to time of day | 137 | 24 | 15 | 2 | 10 | 188 | | | |
| Total in on call window | | | | | | 51 | | | |
| | | | | | | | | | |
| Probability per day of thoracic case on call | | | | | | **0.1397** | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **Major Trauma Thoracic Surgery Activity** | | | | | | 8 | per annum | | |
| Weekend | | | | | | 2.3 | per annum | | |
| Weekday | | | | | | 5.7 | per annum | | |
| Weekday out of hours | | | | | | 3.8 | per annum | | |
| Total major trauma estimated for weekend and out of hours | | | | | | 6.1 | per annum | | |
| | | | | | | | | | |
| Probability per day of major trauma thoracic case on call | | | | | | **0.0167** | | | |
| | | | | | | | | | |
| Cumulative probability of thoracic case on call and major trauma thoracic case same day | | | | | | **0.0023** | | | |
| Estimated frequency of occurrence same day - 1 in every | | | | | | 429 | days | 1.2 | years |
| Estimated frequency of occurrence same hour (day * 16 hours) - 1 in every | | | | | | 6,857 | days | 18.8 | years |
| | | | | | | | | | |
| *Assumptions* | | | | | | | | | |
| *1. Thoracic non elective rate equivalent to average across cardiothoracic surgery - in practice cardiac likely to be higher* | | | | | | | | | |
| *2. Assumes all cases performed by surgeon visiting on site and not by advice* | | | | | | | | | |
| *3. Both of these assumptions likely to overstate frequency of occurrence* | | | | | | | | | |

On this basis and given the commitment to the development of the skills of the trauma team to manage immediate thoracic trauma the likelihood of the surgeon being required to be in both centres at the same time during the night or on weekends ie when there is no surgeon on site at UHW is extremely low. It is therefore suggested that both the MTC and the thoracic surgical centre can be covered by one on call rota once the surgical centre is established.

**Required Consultant Workload Total number of Sessions/week**

The following table takes all the analysis above and provides a breakdown across the activities of the number of consultant sessions required per week.

| **Activity** | **Per Week** | **Total sessions Per week** |
|---|---|---|
| Theatre sessions | 6.25 X 3 session lists | 18.75 |
| Pre-assessment and Outpatient clinics | Morriston daily<br>Cardiff 2/week<br>Glangwili/PPH (alternate weeks)<br>Gwent/NHH (alternate weeks) | 10 |

| | | |
|---|---|---|
| | PoW/PCH/RGH (1 every 3 weeks) | |
| MDT | 6 (not full sessions) | 3 |
| On call | Intensity Payment | Intensity Payment |
| Travel | 5 estimate | 5 |
| Ward Rounds M-F | 5 | 5 |
| Admin | 5 | 5 |
| **Total** | | **46.75** |

Admin and SPAs will need to be added to the above depending upon the number of surgeons.

**Specimen Job Plan – 10.5 sessions 7.5:3 split**

Theatre 3.0
OPD/pre-assessment 1.0
MDT 0.5
Admin 1.0
Ward Round 1.0
Travel 1.0
SPA 3.0

Based on the above split then 6.2 consultants would be required.

On an 8.5 session DCC with 2 SPAs

Theatre 3.0
OPD 2.0
MDT 0.5
Admin 1.0
Ward Round 1.0
Travel 1.0
SPA 2.0

Based on the above then 5.5 consultants would be required.

We do not know the number of sessions included in the current establishment of thoracic surgeons but we do know that the Welsh average is over 10 and the average number of SPAs is less than 3.

**Covering the MTC from April 2020**

As stated the planned go live date for the MTC is April 2020. It is not expected that the thoracic surgical centre will be established for around 2 years as capital infrastructure is required.

There is a clear level of anxiety about how the thoracic work will be covered at the MTC from April 2020 especially given that the trauma teams and the resuscitative surgeons may not be experienced in working in an MTC. Additionally the majority of work for thoracic surgeons in an MTC is rib fixations. It is suggested that similar to other centres, rib fixations can be undertaken by

orthopaedic surgeons. However it is recognised that this will take some time to become practice at the MTC and that thoracic surgeons are likely to be required to undertake the rib fixations in the short term.

Given all this the recommendation is that an additional locum thoracic surgeon is appointed at UHW for between 6 and 12 months in the first instance, to provide additional support from April 2020 and that the two thoracic consultant teams develop plans to work together. During this time where there are regular reviews of the emergency activity levels.

The advantage of this recommendation is that the MTC is better supported and that during the period that the locum is in place some of the assumptions in this paper can be tested especially regarding the need for a thoracic surgeon to attend the MTC in an emergency. It will also allow the thoracic surgery implementation group to complete its work on the model and will then allow a further discussion at Joint Committee on the long term model including consultant workforce when the implementation business case is presented.

Cost of additional locum – this is estimated to be in the order of £150,000 including on-costs, travel, intensity allowance etc.

**Recommendation**

To note the analysis and that this would draw the conclusion that the number of thoracic consultant surgeons required for the workload is around 5.5 to 6.2 wte consultants required depending upon exact job plan and DCC/SPA split.

To note that the amount of operating time is the crucial driver and that for the predicted activity (outturn plus 20%) 6.25 lists will be required every week. To enable every surgeon to have one full operating list this means that around 6 surgeons will be required.

Given the low probability of the surgeon being required to attend the MTC and the thoracic surgery centre at exactly the same time that there should be one call rota.

In recognition of the concerns regarding support to the MTC when it opens in April 2020 that a short term locum consultant is appointed in UHW. This will not impact on the total recommended numbers of consultants but will enable support for the MTC and to test and build confidence in the system whilst the final service model is being determined. Also that during this time the two thoracic centres develop plans to work together.

**Appendix 1**

**The Liverpool Thoracic Centre Model**
**(presented at Clinical Summit May 2019)**

Information from the Liverpool thoracic centre was presented at the Clinical Summit in May 2019. It was noted at this meeting that for a population of around 2.8 million people Liverpool have

5.5 wte thoracic surgeons working on a team based approach

They operate on a hub and spoke model which supports 10 peripheral hospitals

Weekly Clinics with attendance in person by thoracic surgeon.

- All new patients travel to LHCH.

Weekly Lung MDTs:

- 4 major MDTs with direct attendance & cross cover.
- Others by VC.

- MDTs: High Risk cases MDT, Lung cancer MDTs and Specialist MDTs.

## Trauma support

- Trauma centre is 7 miles away.
  - Self-sufficient and independent.
- Chest trauma cases -
  - Phone Thoracic Consultants directly.
  - Thoracic Surgeons only contacted after local decision to open chest has been made.
  - Occasionally have to go to site.
  - Clinic every Thursday am. Patients seen by MS.
- Rib Fractures delt by Orthopaedic Surgeons who are now self-sufficient.

## Golden Jubilee Hospital Clydebank

This centre covers a population of around 2.2m people. They are currently advertising for a consultant thoracic surgeon to join their team.

They have 4 full time thoracic surgeons + 1 mixed practice. (their current advert is for a vacancy in their full time establishment)

They cover 9 MDTs

1:4 on call with prospective cover & part of trauma team with MTC in Glasgow

**Addendum Following Consultation**

To note that surgery is not the only cure for lung cancer as there are radiotherapy techniques that are also curative but recognising that surgery has the best 5 year survival rates.

Clarity that the proposal, subject to fully being agreed via the implementation group, is that each MDT is supported by 2 surgeons.

The MDT numbers for Aneurin Bevan are not correct.

**Other Changes Recommended Following Consultation**

The locum consultant should be appointed for 12 months and not 6 to 12 months.

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

# Thoracic Surgery Single Site Consultant Workforce Model

## Consultation on draft Thoracic Surgery Single Site Consultant Workforce Model

## Stakeholder comments table

## 14th June 2019

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 1. | Medical Director 1 | 2 | 21-23 | | The outturn + 20% is likely to be at the lower end of potential activity increase. | We agree, however it is difficult to predict when this will happen and currently activity is relatively stable. We will suggest a further assessment 6 months pre implementation and ongoing review as normal part of WHSSC processes. |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 2. | Medical Director 1 | 2 | 30-32 | | This advice and support could be provided virtually and without the physical presence of a thoracic surgeon. | This was agreed through consultation. However the interim model suggested would allow further evaluation of the demand and if needed reconsideration by boards in the future. |
| 3. | Medical Director 1 | 4 | 14-15 | Table 4 | The figures across sites differ greatly reflecting both the case mix and the risk approach of individual surgeons. UK guidelines promote offering surgery to higher risk groups, so increasing resection rates. This stance needs to be encouraged in the single site model, properly supported by detailed patient discussion, full physiological assessment and with extensive pre-habilitation. | We agree. This is one of the opportunities of a new service and the presence of 2 surgeons in each MDT. |
| 4. | Medical Director 1 | 7 | 1-10 | | Three session days are advantageous though would require careful job plan diary work to ensure adequate lower intensity clinical activities on preceding and following days. Three session days place extra pressures on theatre staff however and also potentially compromise time for training of junior staff. | The RCS review recommended this as the optimal model for efficiency. This can be revisited during implementation. |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 5. | Medical Director 1 | 7 | 15 et seq | Major Trauma Centre | The quoted and extrapolated figures reflect my experience in supporting major trauma. Additionally, the specific skills required in a thoracic surgical emergency context are straightforward and trauma surgeons can be instructed in these. | The external expert advisors supported your view. |
| 6. | Medical Director 1 | 8 | 6-8 | | I would fully endorse this view. | Thank you |
| 7. | Medical Director 1 | 10 | 4-17 | | I would fully endorse this view and for the reasons outlined | Thank you |
| 8. | Medical Director 1 | 10 | 21-27 | | I would fully endorse the view that 6 thoracic surgeons wold be the acceptable number to provide a comprehensive thoracic surgical service for the relevant population. | Thank you |
| 9. | Consultant Respiratory Physician 1 | 2 | 30 | | Is this a realistically a good use of a consultants time, 9-5 delivering advice and "waiting" for something to happen. This needs more robust thinking as to how the clinician would function in UHW if required to be there. | This was agreed through consultation. However the interim model suggested would allow further evaluation of demand and if needed reconsideration by boards in the future. |
| 10. | Consultant Respiratory Physician 1 | 4 | 6 | | Surgery isn't the only cure as there are radiotherapy techniques that have radical intent. However, it has the best 5 year survival rates | We agree and will correct this. |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 11. | Consultant Thoracic Surgeon 1 | General | | | We are very excited to take part in this consultation and assist in shaping a single thoracic surgery centre of excellence for South Wales. In order to do that and provide Wales with an innovative, safe and sustainable single centre we would like to present our comments to the workforce model consultation. | Thank you |
| 12. | Consultant Thoracic Surgeon 1 | 3 | 25 | | Although the estimated amount of activity is calculated to be 1300 per year, we estimate it to be at least 1500 cases, (so 30% of current activity as presented in the thoracic clinical summit), taking into consideration the predicted increase of activity due to lung cancer screening in Wales (10-20% Manchester experience), the 2019 NICE guidelines that will increase the cohort of the operable patients and the predicted increase of activity due to awareness campaign by public health wales. We should also take into consideration the discussed and agreed need to increase surgery for benign disease (Estimated 100-150 new patients) | We agree, however it is difficult to predict when this will happen and currently activity is relatively stable. We will therefore suggest a further assessment 6 months pre implementation and ongoing review as normal part of WHSSC processes |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 13. | Consultant Thoracic Surgeon 1 | | | | In order to accommodate the above needs, we will need 2 theatre rooms available every day, working 8am - 5pm (as per England's specification) corresponding to 3 DCC because they include preoperative and postoperative management of the patients. A long 12 hours list is neither acceptable nor recommended as it impacts on all staff and their work-life balance and creates recruitment and retention issues. 12 hour thoracic list in Morriston is done only because of lack of theatre capacity and it's against any accepted practice. This could have a negative impact on patients' safety. | The RCS review recommended this was the optimal model. This can be revisited during implementation. The implementation group is identifying theatre requirements and current planning is based on two as described at the Clinical summit in March although this will need to be finalised. The exact operating times will need to be agreed with the surgeons at implementation to achieve the greatest efficiency balanced with workforce well-being considerations. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 14. | Consultant Thoracic Surgeon 1 | | | | The proposal of 6 theatre days per week is inadequate as it is below the present theatre availability. Presently in UHW, we have 4 theatre lists per week and we additionally covered 34 extra theatre lists and cross covered 28 lists (leave). That corresponds to 5 theatre lists per week. Despite this we still have long waiting lists and breachers. Morriston has 2 long lists per week and a regular waiting initiative list on Saturdays. This corresponds to 3 theatre lists per week. Overall between UHW and Morriston presently we have access to 8 theatre lists. According to our calculations of 1500 cases per year and 2,5 cases per list we would need 10-11 lists weekly. | The suggestion in the paper is that each theatre list is 3 consultant sessions ie 3 x 3.75 hours. This was based on current practice at one of the centres. Regardless of how lists are configured there is a need to deliver 1100 procedures currently, rising to 1300 in line with 20% increase that is being used for planning purposes. This may rise in the future as you suggest and we will constantly keep this under review as we would for any of our commissioned services. Our external advice suggests that for the number of primary lung resections that are currently being undertaken in south Wales and allowing for a 20% increase then 6 surgeons would give sufficient operating time. Their view was that increasing this number based on current and 20% projected increase would be at the margins of acceptable operating numbers per surgeon. We acknowledge that if lung cancer screening is introduced (estimated to be at least 3 years away) then the number of primary lung resections may increase and should this happen we will review the number of surgeons required. |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 15. | Consultant Thoracic Surgeon 1 | | | | We believe that it's unsafe and against current guidelines (Major Trauma Centre specification, GIRFT report) and recommendations to provide cover from a 42 miles distance. | Our external advice (see separate appendix) says that GIRFT is opinion rather than evidence based guidance and the advice from professional bodies is more relevant. The advice from the SCTS is that given the rare need for a thoracic surgeon to attend the MTC in an emergency then it is not a good use of resource to appoint additional consultants simply to cover this rare event. The clinical Lead for Major Trauma Networks in England also supported this view. We recognise however that support to the MTC when it opens in April 2020 is of significant concern and that is why we are recommending the appointment of a locum thoracic surgeon at UHW from April 2020 to provide this support and to develop and test the system so that we have much greater clarity on the requirements and we recommend that the workforce model is re-assessed prior to the thoracic surgery centre opening. |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 16. | Consultant Thoracic Surgeon 1 | | | | The appointment of the 4th consultant will be essential to facilitate 1 in 5 on call rota and maintain the high-quality patient care and outcomes during this transitional period. This would require investment in infrastructure as additional ward beds, outpatients' clinic, theatre equipment, secretarial support and two additional theatre lists would be essential. It should be advertised as a locum for 6-12 months initially with view to substantive post. This would make the post attractive and would make recruitment easier in view of shortage of thoracic surgeons in UK. This transitional phase with 4 consultants in UHW would allow us to prospectively evaluate the needs of the MTC and Thoracic services in general. | We agree that an interim appointment has many advantages. We are however unable to commit to the job description without agreement with the provider organisation. |
| 17. | Consultant Thoracic Surgeon 1 | | | | The appointment of the 4th consultant would be ideal if infrastructure can be provided. If not available, we respectfully propose that the two surgeons from nearby centres provide cover for 2 in 5 days of on call. This would help evaluate the feasibility of providing an on call service for the MTC from a distance. | We agree and have suggested that both options are developed. |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 18. | Consultant Thoracic Surgeon 1 | | | | As a centre of excellence we should cover all the specialized MDTs such as interstitial lung disease, mesothelioma, COPD, chest wall deformities, sarcoma, metastatic (G.I.) etc. There was also the recommendation that we have 2 surgeons per MDT which doesn't reflect on the document. The need for high risk MDT/second opinion was also emphasized in many occasions including our recent thoracic workshops. This should be weekly with attendance of all the consultants. | Apologies if the document was not clear, the intention is that there are 2 surgeons covering each MDT. The cover for specialised MDTs will need to be agreed as part of implementation. Additionally advice from the Welsh cancer Network suggests that the number of MDTs could be rationalised from that suggested in the paper although they welcome the model of 2 surgeons/MDT. |
| 19. | Consultant Thoracic Surgeon 1 | | | | PAs are not calculated correctly in the WHSCC proposal, since they don't include on call supplement, correct number of MDTs ,theatre sessions and outpatient clinics, and the presence in UHW from 9-5. In the proposal from WHSCC, the activity is even lesser than the current one. Proposed revised level of activity for the single Thoracic surgery centre is provided below. | This raises questions as to how the current service can be delivered and does not bench mark with any other centre in the UK. |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|

| Activity | Per Week | Total sessions per week |
|---|---|---|
| Theatre sessions | 10 x 3 DCC(8am -5pm) | 30 |
| Pre assessment and outpatient clinics | **-**Morriston daily 6 per week<br>-LLandough 1 per week<br>UHW 1 per week<br>-Gwent 1 per week<br>-WEST SOUTH WALES MDT**?** | 9 + west south wales |
| MDT | 6 x 2 (2 surgeons per MDT)<br>High risk MDT(6 X 0.5)<br>6 specialised MDT(monthly) | 6<br>3<br>1.5 |
| On call | 1 in 6 (1-2 according to amount of work required) | 6-12 |
| Travel | 5 | 5 |
| Ward rounds | 6 | 6 |
| Admin | 6 | 6 |
| UHW 9-5 cover | 10 | 10 |
| Cross cover clinic and theatre | ? | ? |
| **Total** | | **83.5 – 89.5 ?+** |

Appendix E

**CONFIDENTIAL** Comments forms with attachments such as research articles, letters or leaflets were not accepted

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 20. | Consultant Thoracic Surgeon 1 | | | | 15 sessions are required per week for UHW 9-5 cover without calculating cross-cover. | Questions have been raised during this consultation on the need for 5 day cover at UHW. However it is acknowledged that this was part of the original considerations by Boards. Cover at UHW is however not expected to be additional to out-patients etc. If surgeons are based at UHW it could reasonably be expected that they would be doing some type of activity – out-patients, preassessment, admin, MDTs etc. |
| 21. | Consultant Thoracic Surgeon 1 | | | | In conclusion for a single centre to excel we will need at least 10-12 theatre lists per week and a service equivalent to 83-89 PAs at a consultant level. We should not embark on a centre of excellence with suboptimal provisions. | These calculations do not bench mark with any other centre in the UK. |
| 22. | Trauma Network | 1 | 38 | Background | Needs to include the NHSE quality indicators and service specification for major trauma services. | Accept that the Trauma Network should be delivered based on recommended standards. Joint Committee at its meeting in March 2019 however confirmed that a phasing of standards was expected. The expert advice on the models and requirements in England is provided in appendix G. |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 23. | Trauma Network | 2 | 24 | Background | This is part of the trauma team and has a limited application. It is not a substitute for having a thoracic surgeon for performing an Emergency Thoracotomy in theatre. | We discussed this with external advisors including the Clinical Lead for Major Trauma in England and representatives from the SCTS. Their advice and comments are provided in Appendix G but to summarise their advice was that the need for a thoracic surgeon to attend the MTC in an emergency would be rare and as such recruiting additional surgeons to cover this eventuality would not be a good use of resource nor would the jobs be attractive and we would be unlikely to recruit to such posts. |
| 24. | Trauma Network | 2 | 36 | Background | This is not the case. The presence of a trauma surgeon is not a replacement for the presence of a thoracic surgeon | See the comments above. |
| 25. | Trauma Network | 7 | 16 | Major Trauma Centre | This may well be a driver, but WHSSC should recognise as the principle commissioning body for the MTN that South Wales is the only region in the UK, where funding has not been secured for a MTN. South Wales is the only outlier and this poses significant clinical, strategic, reputational and political risks. | The need for an MTN has been recognised by WHSSC. |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 26. | Trauma Network | 7 | 19 | Major Trauma Centre | This needs further clarification and should be edited as follows – "estimates from providers in NHSE indicates 2-5 cases/year for Resuscitative Thoracotomy and 5-8 cases/year for Emergency Thoracotomy. In total 7-13 cases, which may potentially require intervention from a thoracic surgeon. This is more comparable with UHW data. | We will note based on your advice. The Clinical Lead for Major Trauma in England suggested that there would be likely to be a requirement to attend the MTC at UHW in an emergency around 4 times/year based on experience in his own trauma centre. However our recommendation is that an additional locum surgeon is appointed at UHW from April 2020 and this will allow the need to be tested and we recommend that the workforce model is re-assessed in the months prior to the thoracic surgical centre go live date. |
| 27. | Trauma Network | 7 | 22 | Major Trauma Centre | The information contained in comment number 5 is more in keeping with the lower end of the obtained English data. Ultimately changes in patient flow with the development of the MTN will be accurately captured in year 1 (TARN dataset) and visible to WHSSC to give a much more informed picture. However, see caveat under comment number 8. | We propose that the interim model will allow formal assessment. |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 28. | Trauma Network | 7 | 25 | Major Trauma Centre | I am not convinced that you can base the analysis on data that is based 16-year-old data – the incidence of penetrating trauma has increased in that time. Again, changes in patient flow with the development of the MTN will be accurately captured in year 1 (TARN dataset) and visible to WHSSC to give a much more informed picture.<br>However, see caveat under comment under 8 (*comment 29 in this table)*. | The advice we have taken supports the analysis that this would be a rare event. However we support your view that this needs testing hence the recommendation regarding the appointment of an additional locum surgeon. |

| | | | | | | |
|---|---|---|---|---|---|---|
| 29. | Trauma Network | 10 | 4 | Covering the MTC from April 2020 | The appointment of locum consultant for 6-12mths based at the MTC is welcome and will allow the MTC to go live next year from a thoracic cover perspective. The risks of not establishing the MTN next year are significant and cannot be justified based on the current impasse.<br>However, the assessment needs to include some information on the chances of successful recruitment to a locum post over a substantive post. The paper states that it will be around 2 years until centralisation occurs, so a 2- year appointment would be sensible. Data on activity cannot be determined accurately over 1 year – variation exists year by year and therefore a longer period would be required to assess activity.<br>In the event that this post is unfilled, the current impasse will continue. Recruitment into a substantive post will be more attractive and could invite the opportunity to appoint a lead surgeon to take forward the service change. Whilst this may exceed the total number of recommended consultants, it serves to bring a number of other advantages. | We have been informed that there is a potential locum candidate. The advice we have been given is that the amount of operating is the crucial factor in successful recruitment and if there is unsufficient operating available this would have a detrimental effect on ability to recruit as the job would be unattractive, |

Appendix E

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| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 30. | Consultant Medical Oncologist | 4 | 6 | Primary lung resections | It isn't true that "Surgical resection is currently the only curative option for lung cancer". Series show an 11% 10 year survival for chemoradiotherapy in inoperable tumours. It is accepted that the highest cure rates come from surgery. | We agree and will correct |
| 31. | Consultant Medical Oncologist | 5 | 12 | MDTs | Could add that the lung cancer services are due to be peer reviewed in Q3 2019 | Point noted thank you and explored with the Welsh Cancer Network. The peer review will be useful to inform the implementation process. |
| 32. | Wales Cancer Network | 3 | 24/25/26 | Demand Analysis | These figures do not consider the requirement of the Single Cancer Pathway in Wales and implementation of National Optimal Pathway for lung cancer. Surgical treatment will need to be performed within a maximum of 62 days from point of suspicion, ideally treating within 49 days. Evidence in recent studies indicate delaying surgery beyond 37 days from diagnosis leads to a worsening of long term overall survival (Yang et al 2016) | We agree, however it is difficult to predict when this will happen and currently activity is relatively stable. We will therefore suggest a further assessment 6 months pre implementation and ongoing review as normal part of WHSSC processes |

Appendix E

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| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 33. | Wales Cancer Network | 3 | 24/25 /26 | Demand Analysis | These figures do not factor the recent international evidence for low dose CT screening for lung cancer in a high risk population (targeted lung health check programme). NELSON (as well as other trials) presentation data suggests a 50% increase in surgical resection numbers following implementation of a target health check programme. | See above |
| 34. | Wales Cancer Network | 6 | 6-7 | Table MDTs | While this table uses 2015 'new referral' numbers and Table 4 2018 uses 'total cases' numbers I presume these should be roughly the same. However, when looking at the table on this page the total added numbers do not correlate e.g. ABUHB =257 although Royal Gwent/Neville = 268 + 106 | The referenced year in each of the two tables is different, hence the numbers are different. |
| 35. | Medical Director 2 | General | | | The field of lung cancer and requirements for the management of patients with lung cancer may change in the next few years for example if lung cancer screening is adopted in Wales and the approach to workforce model considerations and arrangements needs to allow some flexibility | We agree, however it is difficult to predict when this will happen and currently activity is relatively stable. We will therefore suggest a further assessment 6 months pre implementation and ongoing review as normal part of WHSSC processes |

Appendix E

**CONFIDENTIAL** Comments forms with attachments such as research articles, letters or leaflets were not accepted

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 36. | Medical Director 2 | General | | | There is likely to be a different requirement for thoracic surgery input during the initial year or so of the MTC becoming operational (ie whilst orthopaedic surgeons are trained in rib fixation etc) compared to when the MTC is established. | We agree and that is why we propose an interim arrangement |
| 37. | Medical Director 2 | General | | | The actual activity of the proposed thoracic surgeon based at UHW in the daytime when the MTC is established would need to be specified clearly as there is a risk that activity could be minimal if it only involved input for patients with complex major trauma. | This was agreed through consultation. However the interim model suggested would allow further assessment and if needed reconsideration by boards in the future. See also response above. |
| 38. | Medical Director 2 | General | | | The establishment of a single site thoracic surgery centre is extremely important for our population and for South Wales, as is the establishment of the Trauma Network and the MTC. Both are long overdue for Wales, and there is likely to need to be a degree of compromise to ensure that progress on both programmes of work are not delayed. | We agree |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 39. | Consultant Thoracic Surgeon 2 | 2 | 16 to 17 | MTC | Agree that the location of the MTC had not been determined at that time. However, the RCS clearly stated that Thoracic Surgery does not need to be at the same site as the MTC. This was known to UHW, Cardiff at the time of their bid for the MTC. Did they give plans on how the UHW Health Board would arrange Thoracic surgery cover for the MTC if thoracic surgery were to move to Swansea? | This is outside the scope of this paper |
| 40. | Consultant Thoracic Surgeon 2 | 2 | 21, 22, | | Do not agree and will not support …all 6 surgeons being involved with "onsite cover" for UHW site. For a fair equitable service across South Wales the surgeon covering the UHW lung MDT should be the surgeon available to cover UHW once a week as is the practice at Liverpool Heart and Chest Hospital (LHCH) for the MTC there. | Point noted. The exact job plan configuration would need to be agreed at the implementation stage. The working assumption however is that the thoracic surgical team will operate as 1 team and will cross cover to deliver the service model. |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 41. | Consultant Thoracic Surgeon 2 | 2 | 30, 31 | | Do not agree and will not support …surgeons providing a thoracic surgery "presence" at UHW 5 days a week for advice and support (but will back 5 days a week on call telephone support for advice).<br>Comment: This is totally unfair on hospitals in other Health Boards. May be ok for a physician but for a surgeon is a complete waste of time. Time that will be better spent in theatre ensuring timely surgery for cancer and other patients. | This was agreed through consultation. However the interim model suggested would allow further assessment and if needed reconsideration by boards in the future. Also see response above. |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
|---|---|---|---|---|---|---|
| 42. | Consultant Thoracic Surgeon 2 | 2 | 36 to 39 | | Strongly agree and fully support that trauma surgeons appointed at MTC Cardiff are trained and able to practice independently for injuries to the thorax. A positive step in making the MTC Cardiff an independent, self-reliant flag ship specialty and not dependant on help from elsewhere (for example, Swansea or Bristol). An "on site on call thoracic surgeon" may not necessarily be available immediately but a thoracic trained trauma surgeon will be immediately available. Appointing an interested thoracic surgeon who is also trained in trauma (Thoraco-Trauma Surgeon) as a member of the trauma team will help him/her support and train the team and colleagues. This may give an opportunity for any current thoracic surgeon not wishing to move to Swansea a chance to stay back at UHW Cardiff and be part of the Major Trauma Team. | Thank you |

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| 43. | Consultant Thoracic Surgeon 2 | 3 | 11, 12 | | (Instead of "the full range") Should read as, "Surgeons on the rota should be able to deal with "**a"** range of thoracic surgical emergencies, **excluding** oesophageal injuries, which will be dealt by upper GI surgeons, great vessel injuries, which will be dealt by cardiac surgeons, Tracheal neck injuries, which will be dealt by ENT surgeons and paediatric injuries, which will be dealt by the MTC at Bristol. Help from allied specialties, for example, ENT and cardiac surgery for thoracic tracheal and hilar injuries will be required as patients may have to be placed on cardio-pulmonary bypass to deal with these extremely rare situations. Paediatric cardiothoracic trauma will be dealt by MTC Bristol.<br>COMMENT: It is highly important for the UHW Cardiff Health Board, which is demanding an on site Thoracic surgery cover, to seriously consider the fact that Thoracic surgeons currently working in South Wales do not meet this requirement of "…able to deal with a full range of thoracic surgical emergencies." They either have no experience or very little experience in dealing with such injuries in the past 10- 15 years. It is unsafe and unreasonable of the UHW Health Board Management to expect from thoracic surgeons in this disposition | Point noted. The expert advice suggested that there were a range of professionals who could and should support thoracic surgical emergencies dependent upon their nature.<br><br>This was agreed through consultation. However the interim model suggested would allow further assessment and if needed reconsideration by boards in the future. |

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| | | | | | to attend to and deal with major thoracic injuries in a completely alien theatre or emergency room environment and work with an unfamiliar trauma team staff safely. It is much better and a unique opportunity for the UHW HB Management team to embrace the proposition of training the MTC Trauma Surgeons to deal with such emergencies (ref page 2 line 37 and 38), and help develop an independent, self-reliant, highly skilled Trauma Team making the MTC at UHW a flag ship MTC for the UK. There will be a 24/7 thoracic on call telephone back-up support for advice from the Single Thoracic Centre at Swansea. | |
| 44. | Consultant Thoracic Surgeon 2 | 3 | 13, 14 | | Training the Trauma surgeons or appointing "Thoraco-Trauma" surgeons by the MTC Cardiff as described above will help address this. | We agree |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
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| 45. | Consultant Thoracic Surgeon 2 | 5 | 6,7 | MDTs | Some MDTs will have to merge. Support of the chest physicians and the cancer network will be essential to achieve this, so that there are 6 major MDTs across South Wales.<br>The table is a guidance and combinations can change to make the cover practical. However, it will be important to ensure that for each surgeon there is equity of number of new cases discussed at each MDT. | We agree and this point has been supported by the representative from the Cancer Network who suggested that the number of MDTs should be no more than 6 but could potentially be fewer. |
| 46. | Consultant Thoracic Surgeon 2 | 6 | 25 | Prehabilitation | COMMENT: To add that the prehab service will work with thoracic nurses, allied health practitioners, dieticians, Macmillan nurses, pain team etc to help the single centre provide a complete package of holistic care to patients along the entire patient pathway. | Point noted. |

| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
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| 47. | Consultant Thoracic Surgeon 2 | 7 | 3, 4,5 | Operating Lists | Taking into consideration that the single centre will be a teaching centre and following LHCH model, the most efficient way to run theatres will be "a minimum of" one full day and one half day per surgeon with 3 cases per full day list (two long and one short) running from 8:00am to 6:30 pm (including post op care). An ideal model would be two theatre days per surgeon per week.<br>EVIDENCE: Taking into consideration future impact of lung cancer screening and expected increase in number of lung resections, the centre will be expected to perform ~1300 cases per year. Dividing this by three cases equals 433.3 cases. Over 50 weeks per year this works out to 8.6 lists per week. Taking into account cancellations due to theatre staff sickness, bank holidays, audit days, Hospital Infections, etc., = 10 lists per week or 2 theatres running 5 days a week for elective and emergency work is what it will take to provide timely high standard of surgical care to patients and training to future surgeons and staff. | The RCS review recommended this as the optimal model for efficiency. This can be revisited during implementation. There are clearly a range of views (see comments above) and the exact configuration will need to be agreed as part of implementation taking into consideration optimal efficiency and staff well-being. |

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| 48. | Consultant Thoracic Surgeon 2 | 7 | 15-40 | MTC | Brilliant piece of work – shows the reality of the situation! Shows that having a surgeon on site 5 days a week at UHW provides miniscule patient care if any, and is a complete waste of money and time. | Point noted. |
| 49. | Consultant Thoracic Surgeon 2 | 8 | 13 | Required Consultant Workload- Theatre sessions | Theatre sessions per week 6.5 is not adequate. Minimum 8.6 x4 sessions per week<br>EVIDENCE: As demonstrated above under "Operating Lists" | See response above. |

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| 50. | Consultant Thoracic Surgeon 2 | 9 | 5-12 | Job Plan | …7.5:3 split then "6.2 consultants would be required."<br>EVIDENCE/COMMENT: theatre sessions per surgeon required = 4 and NOT 3.0 as described under "Operating Lists."<br>Also job plan in SBUHB Wales is 7:3 with 3 SPAs for each consultant. Unlike NHS England where each session is 4 hours long, each session in NHS Wales is 3 and a half. So cannot compare work covered by NHS England consultants with NHS Wales's consultants. The RCS and NHS England thoracic surgeons should be always made aware of this when obtaining any consultation regarding job plans, theatre lists etc from them. | Points noted however the advice we have received is that 6 surgeons is sufficient to cover the anticipated thoracic surgical workload. Comparison with other centres also support 6 surgeons as being sufficient. |

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| 51. | Consultant Thoracic Surgeon 2 | 9 | 8 | MDT | Disagree with MDT 0.5<br>EVIDENCE:<br>DCC does not take into account other specialist MDTs that will need cover. For example, Sarcoma MDT; Interstitial Lung Disease MDT; Mesothelioma MDT; Colo-rectal MDTs per Health Board; Emphysema-LVR MDT; Radiology MDT; Base hospital Specialist MDT. | Point noted. This was based on the advice we received from other centres. This can be reviewed. |
| 52. | Consultant Thoracic Surgeon 2 | 9 | 14 | | COMMENT: Based on the above split then a minimum of 7.3 consultants would be required.<br>Eliminating UHW MTC cover every week (which is a complete waste of good money, time and does not make any sense whatsoever) will bring the number of consultants required to ~6 consultants. | Point noted. |

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| 53. | Consultant Thoracic Surgeon 2 | 10 | 19, 22 | Recommendations | Disagree with, " ..workload is around 5.5 to 6.2." Should read, " minimum 6.5 to 7.5."<br>EVIDENCE: As described above.<br>COMMENTS- RECOMMENDATIONS:<br>Each consultant covers two Lung cancer MDTs (visiting the main peripheral MDT and cross covering the second with V/C link); two clinics (visiting one peripheral clinic of the main MDT and servicing the second base hospital clinic for other MDTs and emergency work arising from on-call); minimum one full day and one half day theatre (ideally two lists per week); each surgeon covers one or two specialist MDTs; and 1:5 on call.<br>Note: In the process of visiting the peripheral MDT and its clinic the visiting thoracic surgeon will face requests for advice and opinion from chest physicians and others and many times see inpatients, A&E trauma and other patients. This will take up DCC time. This has not been considered.<br>EVIDENCE: First-hand experience when working for Birmingham Heartlands Hospital, Southampton and the Royal Brompton Hospital. Visiting peripheral MDTs many times involved seeing patients in the ward, ED for opinion and management. | Point noted and see response above. Benchmarks from other centres and the advice we have received suggests that 6 surgeons is sufficient. This can be tested and re-assessed however prior to implementation. |

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| 54. | Consultant Thoracic Surgeon 2 | 9 | 19 | OPD | **All surgeons will NOT provide UHW onsite cover**. This should be provided by the surgeon covering the UHW Lung MDT and its clinic once a week as is done by Mr M Shackcloth once a week at Liverpool Heart and Chest Hospital for the MTC there. It is mandatory that patients from all of South Wales Health Boards covered by the Single Site Thoracic Service at SBUH receive a fair and equitable service. UHW Cardiff should not get any preferential, special treatment – No post code lottery care! | Please see response above. |
| 55. | Consultant Thoracic Surgeon 2 | 9 | 40,41 | MTC work | Totally agree. This can and should be dealt by Trauma and Orthopaedics as is done at LHCH. | Thank you |
| 56. | Consultant Thoracic Surgeon 2 | FINAL COMMENT | | | Thank you for your hard work. | Thank you |
| 57. | Health Board CEO 1 | 1 | 8 | Context | Each of the Welsh Health Boards considered the WHSSC recommendation and agreed this subject to a number of conditions being met. | Point noted. |

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| 58. | Health Board CEO 1 | 1 | 14 | | It would be useful to make clear that the two medical directors provided the paper as requested by WHSS (letter dated 28th December 2018 from Sian Lewis to Dr Shortland and Dr Evans). | Point noted and is reflected in the conclusions in the Joint Committee paper. |
| 59. | Health Board CEO 1 | 1 | 19 | | The matters and uncertainties referred to should be included. | They are included in the Joint Committee paper |
| 60. | Health Board CEO 1 | 1 | 24<br>25 | | The establishment of an Expert Panel does seem at variance with the timing of the Consultation document. | We were constrained by the very tight timescales |
| 61. | Health Board CEO 1 | 1 | 37-38 | | There should be a note that neither of these documents include support required for an MTC | Both the English and Welsh Service Specifications went to widespread stakeholder consultation. This was not raised in our consultation as an issue. It is only since the recommendation to locate at Morriston this has been raised. |
| 62. | Health Board CEO 1 | 1 | 41 | | It would be helpful if the assumptions are made clear within the document | Apologies if this is not clear. |
| 63. | Health Board CEO 1 | 2 | 16 | Backgro und | It is important that the opinions of the RCS Invited Review are considered in the context that they were made prior to the decision to locate the MTC in a different Health Board to the site of the Thoracic Centralisation. | The RCS were aware of the work around the location of the MTC as were the Independent Panel |

Appendix E

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| 64. | Health Board CEO 1 | 2 | 39 | Background | We have been unable to find any reference within the Intercollegiate Surgical Curriculum Programme that describes surgeons being trained to "practice independently for injuries to the thorax". The curriculum describes training to include a subset of thoracic surgical skills, this does not equate to a mandate for independent practice. | https://www.iscp.ac.uk/static/public/Trauma_Surgery_TIG_Syllabus_2018.pdf |
| 65. | Health Board CEO 1 | 7 | 9 | Operating lists | The calculation of 6.25 lists per week seems overly optimistic. C&V currently run 4 lists per week delivering 672 cases per annum. On a simplistic basis, the forecast activity of 1300 cases would suggest that circa 8 operating lists would be required per week. | See response above. The calculations were done on a long day and 4 cases per 3 sessions ie 11.15 hours. The operating hours at the two centres are different currently and the sessions are currently being calculated differently at both sites. |
| 66. | Health Board CEO 1 | 3 | 7, 13-14<br><br>7 | | This guidance regarding emergency cover needs to be referenced from the source Cardiothoracic Surgery GIRFT Programme National Specialty Report 2018.<br>Please can it be clarified that the specification does not deal with thoracic cover to an MTC | Point noted however please see response above regarding the status of the GIRFT report. |

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| Comment number | Name of stakeholder organisation / individual | Page No. | Line No. | Section | Comments | WHSSC response |
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| 67. | Health Board CEO 1 | 7 | | Major Trauma Centre | There is no reference in this section to the NHSE standards for Major Trauma that have been agreed as the standards for commissioning in the Wales Trauma Network.<br>The standards clearly document the need for a Cardiothoracic surgeon to be available within 30mins to attend a trauma patient and this is not reflected anywhere in the paper. | Point noted however the paper refers to cardiothoracic surgeons and the issue here relates to thoracic surgeons which needs to be emphasised. Please also see appendix G which gives detail on the advice we have received regarding thoracic surgeons need to attend the MTC in an emergency. |
| 68. | Health Board CEO 1 | 7 | 19 | Major Trauma Centre | Figures supplied by the existing thoracic Surgeons in C&V suggest this is an underestimate and the more likely volume is 5-11 p.a. | The development of an interim model will allow this to be fully assessed |

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| 69. | Health Board CEO 1 | 7 | 22 | Major Trauma Centre | It would have been helpful if the centres providing these two varying opinions were clarified. Indeed it is most common in Cardiff and Vale that currently Thoracic trauma is most often managed by our Cardiac surgeons. This is not a sustainable position going forward as new and recent Cardiac Surgeons being appointed are not skilled in thoracic trauma.<br>The GIRFT report specifically recommends ending the practice of using dedicated cardiac surgeons to provide emergency thoracic cover.<br>Furthermore the SAC and SCTS UK Cardiothoracic Surgery Workforce Report 2019 describes increasing practice of splitting the specialty into cardiac and thoracic surgery | Please see appendix G which gives further advice from the SCTS and the National Clinical Director for Trauma for England. |
| 70. | Health Board CEO 1 | 8 | 3 | Major Trauma Centre | See comment 3 above<br>The coverage of the MTC by a single rota from the surgical centre, when established, does not provide thoracic surgical cover consistent with the standards of a MTC and best practice. | Please see response above and the further advice in appendix G |

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| 71. | Health Board CEO 1 | 9 | 39 | Covering the MTC from April 2020 | The MTC has described the development of a tier of resuscitative surgeons within the existing workforce to cover the general surgical element of major trauma operating. We have not proposed that these surgeons are on an on-call rota to cover thoracic surgery as this would directly contradict the recommendations of the Cardiothoracic Surgery GIRFT Programme National Specialty Report 2018?<br>The trauma team already have the skill to perform resuscitative thoracotomy (open the chest and perform a limited range of interventions). It is the arrangements beyond this that are of concern. It is not in the remit of the trauma team to go beyond these initial limited interventions and provide definitive thoracic surgery. | Please see response above. |

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| 72. | Health Board CEO 1 | 11 | All | The Liverpool model | Based on the data presented at the Summit in May we have concerns about generalising the Liverpool experience to the WTN. The activity levels 2011-16 in UHW were significantly higher than Liverpool and it is only 7 miles away from its MTC. The description of trauma support to the MTC lacks meaningful detail. | Please see response above |
| 73. | Health Board CEO 2 | 2 | 16-17 | Background | The statement that "the location of the MTC had not been determined" should have been followed by a clarification that this materially affects the consultant workforce plans, particularly in regard to providing cover for 2 separate sites. | The advice we have been given is that the location of the MTC should not affect the consultant numbers. |
| 74. | Health Board CEO 2 | 7 | 1-9 | Operating lists | Current operating lists on each site average approximately 3 cases per list, which would equate to the need for 8-9 lists per week when job plans are annualised.<br>The calculations of workload for surgery do not factor-in pre-operative and post-operative care. | The RCS review recommended this as the optimal model for efficiency. This can be revisited during implementation. |

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| 75. | Health Board CEO 2 | 7 | 16-40 | Major Trauma Centre | The calculation of work associated with the requirement to cover out-of-hours 7 days/week 365 days/year fails to adequately recognise the burden of work at evenings and weekends: Firstly, the establishment of a single thoracic surgical centre on one site will substantially increase the probability of post-operative complications from elective cases which would require consultant input during evenings and weekends. Secondly, the stated infrequency of phone calls or call-outs in the out-of-hours period is immaterial in relation to the essential requirement – which is to be available immediately when requested. For the person who is on-call on any given day, the expectation is that they will be able to attend either unit in the event of an emergency and must therefore make adequate provision in their home/family lives in order to travel at any hour to the relevant site. This is a significant burden and not recognised adequately in the proposal. | The advice we have received is that the burden of out of hours work is low. We have also been advised that operating 2 rotas is neither desirable or required and would be difficult to recruit to. |

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| 76. | Health Board CEO 2 | General | | | It is disappointing that the paper underestimates the volume of work and the challenge of providing consultant cover for the establishment of two high-profile and geographically separate services. We do not consider that 6 consultants would be able to provide this sustainably. The paper prepared by the Medical Directors, which might usefully have been included as an appendix in order to compare and contrast the different approaches, recommended a total of 8 consultants and made adequate provision for out-of-hours cover. We believe that a total of 8 consultants remains the most pragmatic solution to establish the service safely.<br><br>The paper noted the requirement for 8 surgeons to adequately cover the MTC:<br>"that the sessions are distributed as part of a wider group job plan amongst the new posts and all existing post-holder, to ensure equal distribution of workload supporting the MTC as well as tertiary activity. It is anticipated this would be accommodated with a 1 in 8 "hot" on-call covering the Thoracic Centre in Morriston Hospital and a separate quieter 1 in 8 on-call covering the Cardiff and Vale MTC | We came to our conclusion regarding the optimal number of consultants based not only on mathematical modelling of the clinical activity but benchmarking with a range of providers across the UK. In addition we subsequently tested this model with the President of the SCTS and an expert panel of thoracic surgeons who are members of the SCTS who also support the conclusion. |

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| | | | | | at the University Hospital of Wales. This would mean an on call overall of 1 in 4 and means there would not be a situation where either centre is not physically covered by a Consultant Thoracic Surgeon"<br><br>The proposal is based on a tight mathematical calculation of sessions but leaves very little room for the eventuality that the workload is higher than anticipated and/or sessions cannot be practically worked as described. The proposal lacks a pragmatic perspective of the wider picture: that this is a shortage specialty; that it is more difficult to recruit to Wales; and that the current workforce is fragile. The existing Thoracic surgeons are currently highly engaged in the process and are actively contributing to the Thoracic workshops – this could easily be lost and would be difficult to retrieve. | |
| 77. | Consultant Cardiothoracic Surgeon | General | | | Largely very supportive of the proposals but with the following comments: | Thank you |

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| 78. | Consultant Cardiothoracic Surgeon | | | | The main issue is the basic activity plan on which the modelling is based i.e. 4 case per theatre list is unrealistic. The most efficient of list in either of the HB delivers just over 3 case prelist on an extended days working 8-630 theatre and quite often we struggle to get to 2.5 case per list – developing these calculation leads to consultant workforce between 6.5-7.5 surgeons. | The RCS review recommended this as the optimal model for efficiency. This can be revisited during implementation. |
| 79. | Consultant Cardiothoracic Surgeon | | | | The annual activity on the SCTS report would suggest annualised case throughput per surgeon of somewhere between 150+/-50 cases depending on the case mix developing this calculation would suggest that 8 surgeons would be needed especially if the MTS is to be supported between 9-5 | This does not benchmark with any other UK centre and is not consistent with the advice we have been given. Please see responses above. |
| 80. | Consultant Cardiothoracic Surgeon | | | | Are we modelling on 42, 50 week per year of activity? | 52 weeks per year with prospective cover which benchmarks with other UK centres. |
| 81. | Consultant Cardiothoracic Surgeon | | | | The need to upskill trauma surgeons at the MTC needs to be supported by the Consultant Thoracic Workforce | We agree and have therefore suggested an interim arrangement with an additional thoracic surgeon located at the MTC from April 2020. |

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| 82. | Consultant Cardiothoracic Surgeon | | | | Equity of access to surgical treatment for chest wall injury across the trauma network in south wales can best be delivered by chest trauma MDT bases approach where all significant chest wall injury cases are reviewed. | We suggest this should be looked at via implementation. |
| 83. | Medical Director 3 | 1 | 39 | Background | Also need to take into account the potential introduction of a targeted lung cancer screening programme in Wales - increase in number of patients with early stage disease treated by surgery | We have discussed this with the representative from the Cancer Network. Lung cancer screening is unlikely to be introduced for another 3 years and as we do with all other commissioned services, we will review any activity changes regularly. |
| 84. | Medical Director 3 | 2 | 22 | Background | Only 2 OP clinics per week proposed on this site, so not sure what the consultants are going to do with the rest of their time? | This point has been noted. |
| 85. | Medical Director 3 | 4 | 6 | Demand Analysis | Cure can also be obtained from treatment with radical radiotherapy | Point noted. |
| 86. | Medical Director 3 | 5 | 6 (Table) | MDTs | 411 patients within ABUHB in 2015 | Point noted. We will amend the figures. |
| 87. | Medical Director 3 | 6 | 1 (Table) | MDTs | Requires recalculation to 722 - significantly more than any other pair of surgeons, which may place ABUHB at a disadvantage | Point noted. Information was based on that presented at the March clinical summit. The distribution between the surgeons will need to be amended as part of the implementation process. |

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| 88. | Medical Director 3 | 6 | 23 | MDTs | Anticipate no change to weekly surgical clinic at RGH | Point noted. |
| 89. | Medical Director 3 | 8 | 13 | Required Consultant Workload Total number of Sessions /week | Why daily at Morriston if patients are to be seen closer to home - could there not be a pre-assessment service in Cardiff? | Accept this point and this would be the aspiration but we are advised will depend upon the availability of anaesthetists. |
| 90. | Medical Director 3 | 10 | 5 | Covering the MTC from April 2020 | Clarification is required as to whether this is a 4th surgeon at UHW | Yes that is the recommendation to support the concerns being expressed regarding the MTC. |
| 91. | Medical Director 3 | 10 | 27 | Recommendation | Does this take into account speed of access? The National Optimal Lung Cancer Pathway requires surgery with 21 days of decision to treat. | In discussion with the representative from the Cancer Network this suggested number of surgeons and anticipated activity does take this into account. |

Appendix E

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**Thoracic Surgery Consultant Work-force Model Expert Advice.**

**Teleconference 18.06.19**

Attending:

**Chris Moran**, NHS England National Clinical Director

**Rajesh Shah,** Clinical Lead for Thoracic Surgery Manchester NHS Foundation Trust, Chair of the Specialty Advisory Committee on Training and co-opted member of the Society of Cardiothoracic Surgeons (SCTS) Executive Committee.

**Juliet King,** Thoracic Surgeon, Guys & St Thomas NHS Foundation Trust, member of the SCTS Thoracic Committee

**Steve Woolley,** Thoracic Surgeon, Liverpool Heart & Chest Hospital, Co-chair of Thoracic Committee, SCTS and co-opted member of SCTS Executive Committee

**Sian Lewis,** Managing Director, WHSSC

**Karen Preece,** Director of Planning, WHSSC

**Background:**

Members of the panel were each provided with the consultation document in advance of the meeting and further background information was provided by Karen Preece at the start.

Below is a summary of the discussion organised into themes rather than a chronological summary of the discussion.

1. **Clarity on the interface of thoracic surgeons in the immediate management of trauma patients:**

There was unanimous agreement amongst the thoracic surgeons present that the Getting it Right First Time (GIRFT) review 2018 recommendation that thoracic trauma should only be covered by thoracic surgeons and not by cardiac surgeons reflected an opinion and did not have an underlying evidence base. They expressed the view that the professional perspective of the SCTS which is that surgeons on the Trauma Team should have training and the competence to perform resuscitative thoracotomy in ED or the operating theatre and that both cardiac and thoracic surgeons are competent to stop bleeding within the thorax, was more relevant.

There are just over one hundred thoracic surgeons in the UK. There are 22 Major Trauma Centres for adults in England, 1 in Northern Ireland and proposals for 3 in Scotland and 1 in Wales. It is highly unlikely that 100 surgeons will be able to provide comprehensive thoracic trauma care for 27 MTCs in the UK, either in the short or medium term. Thus, suggested by GIRFT cannot be delivered. The position of the SCTS is therefore that a pragmatic approach should be taken to providing cover by trained cardiac and thoracic surgeons.

The **Chair of the SAC** noted that the current training programme means that both cardiac and thoracic trainees have the competency to manage emergency thoracic trauma and all existing consultants should have this competency. If they do not then they should be offered the opportunity of further training.

He suggested there were 2 models of care for emergency thoracic surgery, first resuscitative trauma surgeons, secondly, on-site cardiac or thoracic surgeons if present. He emphasised again both cardiac and thoracic surgeons should be competent and stated that dual cover was not a good use of resources. His view was that thoracic trauma requiring immediate surgical intervention was rare and that this was best managed by resuscitative trauma surgeons with input from onsite cardiac or thoracic surgeons for the very rare event when additional support is needed. He noted there is a wide variation across the UK in models of cover and highlighted that Brighton was a MTC with no thoracic surgeons and only cardiac surgeons. He emphasised there was no single right answer and suggested we request sight of the draft guidance from the SCTS on the management of thoracic trauma. (***Paper requested; not yet available)***

The **National Clinical Director (NCD) for Trauma in England** explained that the commissioning standard in England was that MTCs have the capability within the Trauma Team to undertake resuscitative thoracotomy and that cardiac and thoracic surgeons were not part of the Trauma Team (available within 5 minutes) but should be available within 30 minutes to attend an emergency case. There are a number of working models in England with some MTCs having both cardiac and thoracic surgery on site and others having cover from a separate hospital site. The requirement for resuscitative thoracotomy is rare in MTCs that mainly deal with blunt trauma (as is the case in south Wales) and he estimates four times per year for the south Wales population.

**The Co-chair of the SCTS Thoracic Committee** noted that the one of the centres in the UK with the most experience of penetrating trauma injuries was Kings College Hospital in London and that in this centre support was provided by cardiac surgeons. This model works well there as they have no on site thoracic cover.

**The member of the SCTS thoracic committee** noted that the way in which cardiothoracic trauma is covered in the UK is variable, and likely to change further as cardiac and thoracic services become independent of each other. However in setting up the new South Wales service it would be important to have clear local guidance and rostering as to who is contacted in the event of major thoracic trauma where specialist intervention may be required. She believed that this would not necessitate a thoracic surgeon being on site at the MTC.

2. **Clarity on the interface of trauma surgeons in managing trauma patients with other specialties:**

Rib fracture fixation is rarely required as an emergency procedure within a few hours of injury but MTCs need the capability to provide this operation within 48

hours of the decision to operate. It must be performed by surgeons competent in this technique. Ideally, the service is provided jointly by thoracic and orthopaedic surgeons but this service may be provided by thoracic surgeons alone or by orthopaedic surgeons as long as thoracic surgical advice and back-up is available. All three models are in service in the UK with successful outcomes. Given the service requirement and geographical separation, the provision of rib fracture surgery by trained orthopaedic surgeons with back-up from the thoracic surgeons may be the best service model for South Wales.

**The member of the SCTS thoracic committee** suggested that providing an on-site thoracic surgeon at the opening of the MTC offered a fantastic opportunity for training and development of trauma and orthopaedic teams. She emphasised the importance of support for poly-trauma patients and that regular trauma ward rounds from thoracic surgeons would be important when services were centralised at Swansea. She felt this could be undertaken to coincide with clinics being held at UHW. It would be very important to ensure that onsite out of hours cover is provided at Swansea and that robust rostering should be made explicit in job plans.

The **NCD Trauma in for England** said that it is a pre-requisite in England that trauma teams have the capability for resuscitative thoracotomy and thoracic surgeons have a role to support this training.

3. **Expert advice on the level of activity required to maintain a consultant surgeons skills:**

**The SAC Chair** stated that thoracic surgeons need at least one full day operating time and that the evidence is that the greater number of operations the surgeons undertake, the better the outcomes. He felt that 8 surgeons would mean that the operating time for individual surgeons would be too low. In addition it would not represent a good use of resources. He suggested it might be a problem to recruit into such a post.

**The member of the SCTS thoracic committee** explained that a thoracic surgeon needs to undertake at least 50 primary lung resections per year and in her view 8 surgeons would mean this target may be difficult to meet. This view was supported by the Co-Chair of the SCTS Thoracic Committee. Although planning predicts a 20% increase in activity it is not clear at this stage whether this will mean a significant increase in the primary lung resections.

4. **Development of indicative job plans for consultant thoracic surgeons**

**The member of the SCTS thoracic committee** noted that 6 surgeons represented a "good number" and would allow sufficient time for Supporting Professional Activity sessions (SPAs).

The **Chair of the SAC** confirmed that in his centre there were 6 thoracic surgeons for a population of around 3.2 million.

There was agreement by **all thoracic surgeons** present that on current activity 6 surgeons represented the right number however there should be a further assessment if activity changes for example due to lung cancer screening.

There was discussion around the likely volume of out of hours work at the future single centre. The consensus was that this depended on adequate theatre capacity and if this was in place then semi-elective surgery would take place within working hours and there would be relatively little out of hours work. The **Chair of the SAC** advised that operating two rotas was unnecessary and not a good use of time, emphasising that well trained trauma surgeons or cardiac surgeons were competent in stopping bleeding.

**Summary:**

**Chris Moran NCD for Trauma NHS England** noted the discussion had been very helpful for him as MT Lead and summarised as follows:

1. The professional advice is that 6 thoracic surgeons is the right number
2. Trauma Teams must have the capability to perform resus thoracotomy
3. Cardiac surgeons at the MTC need to provide emergency assistance to stem massive thoracic haemorrhage
4. A rib fracture fixation service in Cardiff needs to be based in orthopaedics with back-up from thoracic surgery
5. The thoracic surgeons need to take ownership of complex thoracic trauma and this will require good communication and regular ward rounds in the MTC (probably best coincided with the days that thoracic outreach clinics are scheduled at the MTC).

(18.06.19)

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

| | | | |
|---|---|---|---|
| | | Agenda Item | 2.3 |
| Meeting Title | **Joint Committee** | Meeting Date | 23/07/2019 |
| Report Title | **Cystic Fibrosis:** 2019-20 ICP Strategic Priority | | |
| Author (Job title) | Specialised Services Planning Manager | | |
| Executive Lead (Job title) | Director of Planning | Public / In Committee | |

| | |
|---|---|
| Purpose | The purpose of this paper is to:<br>• Provide an **update** on the implementation of Phase 1 investment for the All Wales Adult Cystic Fibrosis Centre<br>• To **request approval** for the release of funding for the Adult Cystic Fibrosis Service 2019/20 |

| RATIFY | APPROVE | SUPPORT | ASSURE | INFORM |
|---|---|---|---|---|
| ☐ | ☒ | ☐ | ☐ | ☒ |

| | | | |
|---|---|---|---|
| Sub Group /Committee | | Meeting Date | |
| Recommendation(s) | Members are asked to:<br>• **Note** the information presented in the report<br>• **Approve** the release of funding for 2019/20 to recruit to the remaining posts in Phase 2 Part A to support the current cohort and the continued development of the satellite clinics<br>• **Support** taking forward the case for a recurrent Home IV service and additional staffing aligned to the capital development for the new ward to the 2020/21 ICP, in the event that Welsh Government declined separate 'Healthier Wales' funding | | |

**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 | √ | | IHI Triple Aim | √ | | Quality, Safety & Patient Experience | √ | |
| Resources Implications | √ | | Risk and Assurance | √ | | Evidence Base | √ | |
| Equality and Diversity | | √ | Population Health | | | Legal Implications | | √ |

**Commissioner Health Board affected**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Aneurin Bevan | ✓ | Betsi Cadwaladr | ✓ | Cardiff and Vale | ✓ | Cwm Taf Morgannwg | ✓ | Hywel Dda | ✓ | Powys | ✓ | Swansea Bay | ✓ |

**Provider Health Board affected** (please state below)

Cardiff and Vale

## 1.0 SITUATION

The WHSSC ICP 2018-21 highlighted the Cystic Fibrosis service (CF) as a key risk that was likely to present in year, requiring funding due to the service exceeding the number of patients for the size/staffing of its service and the risk identified from the lack of a home prepared IV antibiotic service.

A 2 phased approach to the total investment required was agreed due to the substantial investment within the original business case (£2.215m) and lack of clarity around the timeline for CAVUHB submission of a capital business case to Welsh Government for the increased inpatient capacity.

**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)**

The phase 1 proposal was presented to Joint Committee in July 2018. Joint Committee subsequently approved the release of £171k in 2018/19 (PYE) for the multi-disciplinary staff and an additional non-recurrent £83k in 2018/19 for the provision of the Premixed IV Antibiotic Service.

Joint Committee requested CAVUHB to undertake further work on the model and full year costs of the Premixed IV Antibiotic Service and to resubmit the business case for further funding, along with the phase 2 proposal for the investment in ward staff to support an increased bed base for consideration in the 2019-22 Integrated Commissioning Plan development and investment process.

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

A business case was not submitted in time for consideration of the ICP 2019/22.

However investment in Phase 2 is required to fully address the overall service sustainability issues, the expected growth in the patient cohort and to ensure that the All Wales Adult Cystic Fibrosis Centre (AWACFC) meets the Cystic Fibrosis Trust Standards of Care.

This paper provides an update on Phase 1 implementation, and requests the release of funding for Phase 2 (part A).

## 2.0 BACKGROUND

### Service Provision

The AWACFC at CAVUHB is the Wales provider for adults, although North Wales have access to the Liverpool Heart and Chest Hospital and Powys patients' access to 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.

The Adult Cystic Fibrosis service has a high profile within Welsh Government with regular requests from the Director General Health and Social Services for progress reports on the revenue funding and the development of a capital business case to expand in-patient capacity.

### CF Trust Standards

The AWACFC at CAVUHB does not currently comply with the CF Trust Standards of Care and investment is required to deliver the following 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 on a dedicated unit.

### Phasing of Funding

It is important to note that prior to the phase 1 investment the CF Centre had been close to declining further patients into the service due to the clinical risks and whilst phase 1 investment has stabilised the infrastructure for the current and expected patient growth for 2018/19 without further investment a risk will remain.

CAVUHB proposal for phase 2 was submitted to WHSSC in December 2018, post prioritisation but due to the number of risks regarding the sustainability of the service, the case for Phase 2, has subsequently been included within 2019/21 ICP as a strategic priority.

Phase 1 and 2 are intrinsically linked in order to ensure the ongoing sustainability of the service. As described above in Section 1, Joint Committee agreed the funding of Phase 1 in July 2018, requesting CAVUHB to undertake further work

on the costs of the Home IV antibiotic service and to resubmit this along with the proposal for staffing an increase in bed base.

The case has highlighted the 3 key priorities for investment in 2019/20:

- Recurrent provision of a home IV antibiotic service
- Phase 2 (part A) staffing costs to further support the satellite clinics and a medical on call rota for Cystic Fibrosis
- Phase 2 (part B) additional staffing aligned to the capital development for new ward

It should be noted that not all the required posts outlined in the business case were prioritised for investment in phase 1 and are therefore now being requested for phase 2 (part A).

## 3.0 ASSESSMENT

### 3.1 Assessment of Phase 1

The AWACFC service have made good progress with implementation of Phase one (appendix 5.1). Recruitment to some posts has been challenging due to the highly specialist nature of the posts and recruitment to the remaining posts is ongoing.

### 3.2 Current Patient Numbers and Growth

***Table 1 - Current Patient Numbers and Growth***

| | Welsh | English | Total |
|---|---|---|---|
| Baseline registered patient | 225 | | 225 |
| Current registered patients | 285 | 13 | 298 |
| 2005/06 registered cohort | | | 119 |
| Growth rate p.a. | | | 7.3% |
| Projected 350 patients | | | circa 3 years |

The Welsh activity is 60 patients over baseline, with growth funded at marginal rate through the LTA. There is no automatic additional support for infrastructure or to meet CF Trust Standards of Care. The growth rate has been less than predicted over the last 2 years due to an unusual high number of transplants and registered patient deaths.

***Table 2* - Breakdown of Current Patient Numbers by Health Board**

| LHB | Number of Patients |
|---|---|
| Abertawe | 52 |
| Aneurin Bevan | 78 |
| Betsi Cadwaladr | 3 |
| C&V | 72 |
| Cwm Taf | 38 |
| Hywel Dda | 32 |
| Powys | 10 |
| **Total** | **285** |

## 3.3 Funding Required for Phase 2 (Part A)

### 3.3.1 Satellite clinics and supporting ward infrastructure

The Phase 1 investment released in July 2018 was primarily to support recruitment of additional MDT staff to meet CF Trust Standards of Care Guidelines for staffing of a large national CF centre, and to develop local community care. Satellite clinics have been agreed for Hywel Dda and commenced in January 2019, with final plans being agreed for Aneurin Bevan and Cwm Taf.

CAVUHB are now seeking funding for the remaining posts not funded in the Phase 1 priority in order to support the current cohort of patients and to further develop the virtual clinics and satellite outpatient service.

To deliver these clinics in line with SOC Guidelines there is an immediate need for a dietitian, consultant and social worker/youth worker to ensure patients are able to access all members of the MDT at every satellite clinic. As outlined above these posts were identified within the original business case but agreed to carry over to phase 2 investment.

The nature and complexity of cystic fibrosis and the associated complications for inpatients requires specialist out of hours input as per CF Trust Standards of Care Guidelines with provision made for twenty-four hours a day, seven days a week clinician cover for urgent patient needs.

One of the key recommendations of the CF Trust Peer Review of September 2015 was the formalisation of an out-of-hours CF medical rota to ensure sustainability of the service for the future. Inpatient care is a fundamental part of the management of CF. Currently there is no formal rota in place to provide expert advice and patient management out of hours and relies solely on the goodwill of the existing consultants.

Table 3 reflects those elements of the business case, which are sought in 2019/20.

***Table 3 – Funding Phase 2 (part A)***

| Resource | WTE | Band | Cost (PYE 2019/20) | Cost (FYE 2020/21 |
|---|---|---|---|---|
| ***Multi-Disciplinary Team*** | | | | |
| Consultant | 0.8 | Consultant | 50 | 100 |
| Dietician | 1 | 7 | 27 | 54 |
| Social/ Youth Worker | 1 | 6 | 23 | 46 |
| **Sub-total** | **2.8** | | **100** | **200** |

| Resource | WTE | Band | Cost (PYE 2019/20) | Cost (FYE 2020/21 |
|---|---|---|---|---|
| ***Out of Hours*** | | | | |
| Out Of Hours Cons/Speciality Dr rota | 0 | Band 1 OOH for 6 people rota | 9 | 18 |
| **Total** | **2.8** | | **109** | **218** |

It is anticipated that due to recruitment that only part year effect will be required during 2019/20. The service has confirmed that appointment to these posts are a key priority for this year.

### 3.3.2 Home IV antibiotic Service

This supporting 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. Without the Home IV service the centre would be likely to require a further 1-2 beds to manage the patient growth up to 350.

Since the submission of the revised case the WHSS team have worked with colleagues at CAVUHB to better understand the requirements for a home IV service, the number of patients who would be suitable to access this service and how the service would be implemented. The full costs of providing the Home IV service are outlined in Table 4.

***Table 4 - Home IV prepared Antibiotic Service costs***

| | 300 cohort | 350 cohort |
|---|---|---|
| | 300 | 350 |
| Estimated % of patients who could receive IV | 30% | 30% |
| Assume average number of courses per patient | 2.2 | 2.2 |
| Courses | 198 | 231 |
| **Gross Homecare cost Company A** | £583,834 | £681,546 |
| Gross Homecare cost Company B | £876,790 | £1,023,908 |
| Less: Savings from pharmacy issues | £113,726 | £134,399 |
| **Net cost for business case Company A** | **£470,108** | £547,147 |
| Net cost for business case Company B | £763,064 | £889,509 |

The service is currently undergoing a trial of a pre-prepared home IV service and plan to undertake an evaluation later in 2019/20 when sufficient patients have accessed the service. Therefore it is proposed that this trial is continued during 2019/20 and a full proposal based on the evidence base from the trial is submitted in time for the 2020/2013 ICP.

### 3.3.3 *Phase 2 (part B) additional staffing aligned to the capital development for new ward*

CAVUHB submitted the Business Justification Case for the capital element of the scheme to Welsh Government in May 2019 following the tender for the project contract.

It is difficult to predict the absolute completion date for the new ward as this is dependent on the timings around Welsh Government approval of the BJC but it is likely to be late summer 2020.

CAVUHB propose that initially the ward would open to 12 beds (transfer of the existing 7 beds from the current CF Unit and an additional 5). The remaining 4 beds would then open in Quarter 3 of 2020/21. The rationale for phasing the opening of the beds is to enable timely recruitment in line with anticipated completion of works, with a planned phasing in of the new beds as staffing allows.

Table 5 reflects those elements of the business case for Part B, which are sought from 2020/21.

***Table 5 – Investment required to align with the capital development of the ward***

| | WTE | Band | 2020/21 (£000) | Recurrent cost (£000) |
|---|---|---|---|---|
| ***CF ward staffing*** | | | | |
| Ward Nursing | 1.0 | Band 6 | 52 | 52 |
| Ward Nursing | 7.33 | Band 5 | 276 | 325 |
| Ward Nursing | 2.78 | Band 2 | 76 | 76 |
| Receptionist | 0.25 | Band 2 | 11 | 6 |
| Microbiologist | 0.20 | Consultant | 25 | 25 |
| Pharmacy Technician | 1.00 | Band 5 | 35 | 35 |
| Pharmacist | 1.00 | Band 8a | 56 | 56 |
| Catering | - | - | 5 | 5 |
| Housekeeping | - | - | 20 | 20 |
| Staff Related Non Pay | | | 14 | 14 |
| ***Subtotal ward staffing*** | ***13.56*** | | ***570*** | ***614*** |
| ***Non-pay costs*** | | | | |
| General Ward bed-day cost | - | - | 347 | 446 |
| Linen | - | - | 4 | 5 |
| Estates | - | - | 19 | 24 |
| Catering | - | - | 19 | 25 |
| Radiology tests | - | - | 14 | 18 |
| Laboratory tests | - | - | 16 | 20 |
| ***Subtotal non-pay*** | | | ***418*** | ***538*** |
| **Total** | | | **988** | **1,152** |

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 All Wales Adult Cystic Fibrosis Centre.

Currently, the AWACFC 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 Standards of Care indicate that this results in one of the lowest beds per patient ratio for any centre in the UK and is well below expected standards (6–10 inpatient beds reflect the requirements of a centre supporting 100 patients). The AWACFC remains the only Adult CF Centre in the UK, where patients are still sharing bathroom facilities.

As part of the capital process there is capacity to increase the beds on a dedicated CF unit to 16. However this still does not meet the CF Trusts recommendation for the number of beds based on the predicted 350 population cohort which would suggest a requirement of between 21 to 35 beds. Therefore the current outlying bed on West 6 would remain and there is an opportunity to upgrade the 2 beds on West 1 to 3 en-suite rooms

giving a total of 20 beds. This would give a mid-range of 8 beds per 100 patients and would enable the AWACFC to be in line with large CF centres.

In 2017 CAVUHB undertook a bed base bench marking exercise (Table 6).

***Table 6***

| **Large adult CF Unit** | **Number of Patients** | **Number of In-patient beds** | **Patients per in-patient beds** |
|---|---|---|---|
| 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 (2019) | 289 | 8 | 37.25 |
| | 300 | 13 (existing 8 + 5 new) | 23.07 |
| example of bed numbers to patient ratio based on growth | 320 | 13 | 24.61 |
| | 320 | 16 | 20.00 |
| | 350 | 16 | 21.87 |
| | 350 | 20 | 17.50 |

The modelling above shows a range of patient numbers compared to bed capacity in order to demonstrate where Cardiff would benchmark against the other large adult CF centres.

The number of beds proposed is mainly based on the modelling and recommendations of the CF Trust, however on a daily basis there remains between 3 and 10 patients waiting a mean of 2.3 days for a bed (range of 0-24). Further modelling is required around the bed numbers and the phased approach to the opening of the beds as currently proposed by CAVUHB.

### 3.3.4 Financial Summary

As the phase 2 business cases for the home IV antibiotic scheme and in patient development were not received from the provider in time for consideration against priorities, provision was made in the plan for a phased development of the in patient service with some priming in 2019-20 and step up through years 2 and 3.

Meetings between the WHSS and CAVUHB teams have determined that for 2019/20 the key priorities for investment in the service to continue to manage the current cohort of patients and expand the implementation of the satellite clinics is to invest in the remaining MDT posts to support the current cohort and full implementation of the satellite clinics.

Whilst there is sufficient funding in the ICP to enable the release of funding for 2019/20, the proposal above does not align with the original plan.

In consideration of the above points, the proposed phasing of the Cystic Fibrosis developments across the 2019-22 ICP are outlined below in table 7:

***Table 7 – CF Business Case Phasing***

| | | | | |
|---|---|---|---|---|
| **CF Business Case Phasing** | **2018-19** | **2019-20** | **2020-21** | **2021-22** |
| | **£k** | **£k** | **£k** | **£k** |
| **Funding in WHSSC ICP** | **254** | **641** | **993** | **1,439** |
| | | | | |
| Implementation by service since funding release: | | | | |
| Phase 1 Staff Infrastructure FUNDED | 55 | 282 | 393 | 393 |
| Home IV service trial - FROM IN YEAR SLIPPAGE | 83 | 250 | 0 | 0 |
| Phase 2 Part A Satellite Clinics - FROM IN YEAR SLIPPAGE | | 109 | 0 | 0 |
| **Total CF Scheme expenditure** | **138** | **641** | **393** | **393** |
| Phase 2 Part B Ward | | | 600 | 1,046 |
| **Total CF With Ward infrastructure** | **138** | **641** | **993** | **1439** |
| (Slippage) / Requirement against 2019/22 ICP Provision | (116) | 0 | 0 | 0 |

| **Total recurrent funding to be considered for 2020/23 ICP /Strategic Development** | **£k** | **£k** | **£k** | **£k** |
|---|---|---|---|---|
| Home IV service - recurrent funding pending trial outcome | | | 470 | 470 |
| Phase 2 Part A Satellite Clinics recurrent funding | | | 218 | 218 |
| **Total for CIAG prioritisation / Strategic Development 2020/23** | | | **688** | **688** |

In supporting the approach outlined above there would be a further requirement for **£688k** to be sought through the 2020/23 ICP to fund the posts and the home

IV service recurrently (this investment requirement is within the overall costs outlined in the original business case (£2.215m).

## 4.0 CONCLUSION AND RECOMMENDATIONS

This proposal was considered at the June meeting of the WHSSC Management Group. Members noted CVUHB was the only Cystic Fibrosis Unit not offering a Home IV service.

It was noted that funding for additional staffing aligned to the capital case for ward expansion has been secured through the 2019/22 ICP. Following discussion, members agreed to support the staffing for the satellite clinics and continued home IV antibiotics trial from in year slippage, but as the recurrent revenue implications requested are higher than the allocated resources within the ICP requested it be considered and approved by Joint Committee.

It was also agreed the WHSS Team would approach Welsh Government under 'Healthier Wales' for funding for the Home IV service as an alternative to considering it under the 2020-21 ICP.

Members are asked to:

- **Note** the information presented in the report; and
- **Approve** the release of funding from 2019/20 ICP slippage to recruit to the remaining posts in Phase 2 Part A to support the current cohort and the continued development of the satellite clinics; and
- **Support** taking forward the case for a recurrent Home IV service and satellite clinic staff to the 2020/21 ICP, in the event that Welsh Government declined separate 'Healthier Wales' funding.

## 5.0 APPENDICES

**5.1** CAVUHB update on Phase 1 and Phase 2 timelines

| Link to Healthcare Objectives | |
|---|---|
| Strategic Objective(s) | Implementation of the Plan |
| Link to Integrated Commissioning Plan | CF investment has been included in the 2019/2022 as a strategic priority |
| Health and Care Standards | Safe Care<br>Timely Care<br>Staff and Resourcing |
| Principles of Prudent Healthcare | Care for Those with the greatest health need first<br>Reduce inappropriate variation |
| Institute for HealthCare Improvement Triple Aim | Improving Patient Experience (including quality and Satisfaction)<br>Improving Health of Populations |
| **Organisational Implications** | |
| Quality, Safety & Patient Experience | Quality, Safety and Patient Experience will all be improved with the requested additional investment in 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. |
| Resources Implications | The purpose of this paper is to seek the second part of a 2 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 | The service will meet the requirements as laid out by the CF Trust |
| 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 | There are no legal implications considered in the report |

| Report History: | | |
|---|---|---|
| **Presented at:** | **Date** | **Brief Summary of Outcome** |
| Corporate Directors Group Board | 11.06.19 | Supported to take forward to MG |
| Management Group | 27.06.19 | To be considered by Joint Committee as the recurrent revenue implications requested are higher than the allocated resources within the ICP. |

# Development of the All Wales Adult Cystic Fibrosis Centre

## Update on Phase 1 Implementation and Phase 2 Timelines

**Introduction**

The full business case for investment into the sustainability and development of services at the All Wales Adult Cystic Fibrosis Centre, currently caring for 299 adults with cystic fibrosis, was agreed in principle by WHSSC in 2017. There were three interconnecting parts to the business case:

- Multi-disciplinary staffing resource
- Pharmacy homecare
- Ward expansion requirement

Following significant dialogue over the funding requirement and profile for delivery, WHSSC proposed and requested a two phase approach to the investment, with Phase 1 agreed for release in July 2018 and Phase 2 to be incorporated into the 2019/20 Integrated Commissioning Plan.

This short briefing paper provides an update on the status of Phase 1, and the latest timeline for Phase 2.

**Update on Phase 1 Implementation**

The first phase focused on a number of posts within the recurrent multi-disciplinary staffing (MDT) requirement, with a small non-recurrent provision for the costs of homecare in 2018/19. The staffing for the ward expansion is in the second phase and timed to match the anticipated completion of the capital development.

*Multi-disciplinary staffing*

An update of the implementation of Phase 1 by respective element is provided below. The financial impact of the part-year effect will be discussed between finance colleagues for incorporation into the LTA position as appropriate.

| MDT & Outpatient Staff Funding Approval | WTE | Band | Investment and Implementation Progress to date |
|---|---|---|---|
| Outpatient Nurse (HCA) | 1.0 | 2 | Appointed TP to post costs incurred from 01.04.18 |
| Data Entry (UKCF Registry) | 1.0 | 2 | Appointed HF 0.6wte costs incurred from 01.04.18<br>Appointed NB for 0.4wte from end December 2018 |
| Clinical Nurse Specialist | 1.0 | 6 | Post awaiting advertisement November 2018 anticipated start date January/February 2019 |
| CF Centre Manager Uplift | 0 | 7 | Uplift in banding to LS costs incurred from 01.04.18 |
| Diabetes Consultant Sessions | 0.2 | Cons | Anticipated March/April 2019 |
| Diabetes Specialist Nurse | 0.2 | 6 | Post awaiting advertisement November 2018 anticipated start date January/February 2019 |

| MDT & Outpatient Staff Funding Approval | WTE | Band | Investment and Implementation Progress to date |
|---|---|---|---|
| Physiotherapist | 2.0 | 7 | 1.0wte Band 7 currently advertised; anticipated to be in post January 2019.<br>1.0wte physiotherapist to be advertised March 2019. |
| Palliative care | 0.02 | Cons | Dr AB appointed to sessions (joint CF/palliative-supported care clinics) |
| Liver Care | 0.01 | Cons | Dr AY provides joint CF/Liver clinics |
| Clinical Psychologist | 1.0 | 8b | Awaiting advertisement, anticipated start in post date of February 2019. |
| Speciality Doctor in CF (Registrar grade)) | 1.0 | Sp. Dr | Advertisement closing date for post 19 November 2018. Anticipated start date of February 2019 if suitable candidate appointed. |
| **Total** | **7.43** | | |

*Pharmacy homecare*

As part of Phase 1, WHSSC made a non-recurrent provision of £83,000 for the costs of homecare in 2018/19, pending further work being undertaken to establish the full year costs of an antibiotic service.

Further work on the provision of a homecare provider for home intravenous antibiotic administration as requested in the agreed funding investment for CF Phase 1 MDT and premixed IV antibiotic service document of July 2018 was undertaken. Future model and full year costs of an intravenous antibiotic service (appendix 1) were quoted from two provider companies. Net costs for Company A and B were as follows:

| Company | 300 pts net cost | 350 patients net cost |
|---|---|---|
| Company A | £470, 108 | £547,147 |
| Company B | £763, 064 | £889,509 |

On the basis of the quote from Company A, then the estimate in the business case of circa £500k for a full year, would seem reasonable.

**Phase 2 Timeline**

Phase 2 can be split into two parts:

i) *Part A*: staffing costs requiring investment in the 2019/20 financial year, to allow the establishment of:
   a. satellite clinics with multi-disciplinary staffing input; and
   b. a medical on-call rota for cystic fibrosis; and

ii) *Part B*: staffing costs requiring investment in 2020/21, aligned to the capital development for a new ward and the phased and opening of the additional beds.

*Part A*

As outlined in the full business case the establishment of satellite clinics, to bring some elements of outpatient care closer to home was crucial to the further development of the service. Many patients travel long distances for routine clinic appointments, which could be delivered by the specialist team more locally. Part of the phase 1 investment was primarily to support recruitment of additional MDT staff to not only meet

Standards of Care Guidelines for staffing of a large national CF centre, but also for consideration of bringing some aspects of care into the community. In January 2019, satellite clinics will begin in Hywel Dda, closely followed by Aneurin Bevan and Cwm Taf. It is envisaged that a further satellite clinic will be set up in ABMU, based on patient feedback questionnaires regarding satellite clinics and bringing some elements of outpatient care closer. The impact of this for patients will mean less time off work, university or college and improved quality of life with less travel time. However, to be able to deliver these clinics in line with SOC Guidelines there is an immediate need for a dietitian, consultant and social worker/youth worker to ensure patients are able to access all members of the MDT at every satellite clinic.

The nature and complexity of cystic fibrosis and the associated complications for inpatients requires specialist out of hours input as per CF Trust Standards of Care Guidelines with provision made for twenty-four hours a day, seven days a week clinician cover for urgent patient needs. Following the CF Trust Peer Review of September 2015, one of the key recommendations for further consideration was the formalisation of out-of-hours CF medical cover to ensure sustainability of the service for the future. Inpatient care is a fundamental part of the management of CF. An out of hour's formal consultant/Speciality Doctor on-call service will be planned to begin as soon as a funding stream is approved; allowing for a comprehensive out of hours on-call rota for the current and new ward. This is in keeping with other large specialist CF Centre out of hours cover, as benchmarked.

The business case had envisaged the three current consultants providing the on call cover. However, if there was approval for a fourth consultant and with the inclusion of the two specialty doctors, there would be 6 people on the rota. This increases the investment originally sought by £9,000 to £18,000.

The following table reflects those elements of the business case, which are sought in 2019/20.

| **Element** | **WTE** | **Band** | **Cost (£000)** |
|---|---|---|---|
| *Multi-disciplinary team* | | | |
| Consultant | 0.8 | Consultant | 100 |
| Dietitian | 1.0 | Band 7 | 54 |
| Social Worker/Youth Worker | 1.0 | Band 6 | 46 |
| *Subtotal* | *2.8* | | *200* |
| *On call rota* | | | |
| Out Of Hours Consultant/Speciality Dr rota | 0.0 | Band 1 Out of Hours for 6 people | 18 |
| **Total** | **2.8** | | **218** |

*Part B*

As explained in the business case, there are currently 7 beds on the CF Unit (which is situated near to the CF Centre) and outside of the CF Unit the service is able to access three beds:

- a dedicated CF bed with en-suite facilities on ward West 6; and
- in competition with acute general admissions, two side rooms on ward West 1.

The capital plans are for a new ward within the CF Centre with 16 en-suite rooms, plus the refurbishment of space on ward West 1 to replace two side rooms with three en-suite rooms. The dedicated CF bed with en suite facilities on ward West 6 would remain and the 7 beds on the CF Unit will be closed and de-commissioned. Therefore, on completion, the total bed base of 20 en-suite rooms for delivery of inpatient care, will be crucial to the further acceptance of welsh patients as the service exceeds 300; as previously outlined in the Business Case.

The tender for the project for the new ward will go out in the last week of November, with the project contract awarded in January 2019. The Business Justification Case (BJC) will subsequently be submitted to WG in February/March 2019; it is expected work will begin in summer 2019 (July/August), with a formal handover 6 months later. In view of this it is anticipated that investment in the ward staffing will be required from April 2020.

Whilst it is difficult to give an absolute completion date for the new ward, as this is dependent on a rapid approval by WG of the BJC. It is absolutely certain that given WG have been waiting for the BJC for >18 months and are constantly chasing up the expected date for submission of the business case therein, there is not likely to be any unforeseen delay in approving the funding required for the development of the CF Centre. Much time has been spent ensuring the BJC is robust in the information provided to ensure there will be few, if any questions back from WG for further clarity around certain elements of the case, which could potentially cause a delay. Therefore, as outlined above the plans are to start work on the new ward in July/August 2019. The building period is expected to last 6 months, which would require recruitment of additional nursing staff for a 'phasing-in' approach, to be able to open 12 beds in the first instance by ~ April 2020. This will immediately increase the CF ward bed-base from 7 to 12, allowing admission at the point of need; rather than current practice of a waiting list for admission to begin intravenous antibiotics for infective exacerbations.

The rationale for splitting the nursing element for the new ward will allow for timely recruitment in line with anticipated completion of works, with a planned phasing in of the new beds as staffing allows i.e. 12 beds immediately open with the remaining 4 beds open in the third quarter of the 2020/21 financial year.

The following table reflects those elements of the business case for Part B, which are sought from 2020/21.

| | **WTE** | **Band** | **2020/21 (£000)** | **Recurrent cost (£000)** |
|---|---|---|---|---|
| *CF ward staffing* | | | | |
| Ward Nursing | 1.0 | Band 6 | 52 | 52 |
| Ward Nursing | 7.33 | Band 5 | 276 | 325 |
| Ward Nursing | 2.78 | Band 2 | 76 | 76 |
| Receptionist | 0.25 | Band 2 | 11 | 6 |
| Microbiologist | 0.20 | Consultant | 25 | 25 |
| Pharmacy Technician | 1.00 | Band 5 | 35 | 35 |
| Pharmacist | 1.00 | Band 8a | 56 | 56 |
| Catering | - | - | 5 | 5 |
| Housekeeping | - | - | 20 | 20 |
| Staff Related Non Pay | | | 14 | 14 |
| *Subtotal ward staffing* | *13.56* | | *570* | *614* |
| *Non-pay costs* | | | | |
| General Ward bed-day cost | - | - | 347 | 446 |
| Linen | - | - | 4 | 5 |
| Estates | - | - | 19 | 24 |
| Catering | - | - | 19 | 25 |
| Radiology tests | - | - | 14 | 18 |
| Laboratory tests | - | - | 16 | 20 |
| *Subtotal non-pay* | | | *418* | *538* |
| **Total** | | | **988** | **1,152** |

**Conclusion**

Phase 2 Investment will ensure welsh CF patients continue to receive care in Wales and closer to home, allowing further expansion of services providing care at the point of need, in a centre, fit for purpose, meeting all SOC Guidelines for the equitable specialist care of adult cystic fibrosis patients.

| | | | |
|---|---|---|---|
| | | Agenda Item | 3.1 |
| Meeting Title | **Joint Committee** | Meeting Date | 23/07/2019 |
| Report Title | April 2019 Integrated Performance Report | | |
| Author (Job title) | Performance Analyst | | |
| Executive Lead (Job title) | Director of Planning | Public / In Committee | In Committee |

| | | | | |
|---|---|---|---|---|
| Purpose | The attached report provides members with a summary of the performance of services commissioned by WHSSC for April 2019 and details the action being undertaken to address areas of non-compliance. | | | |
| RATIFY ☐ | APPROVE ☐ | SUPPORT ☐ | ASSURE ☐ | INFORM ☒ |

| | | | |
|---|---|---|---|
| Sub Group /Committee | | Meeting Date | |
| Recommendation(s) | Members are asked to:<br>• **Note** April performance and the actions 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 | | ✓ |

# WHSSC Integrated Performance Report

April 2019

WHSSC

**Table of Contents**

# APRIL 2019 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 2019.

## 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. The services Neurosurgery, CAMHS and Paediatric Surgery services are at stage 3 and are being managed in line with the WHSSC escalation process.

The ongoing increasing number of breaches for Cardiac Surgery in C&VUHB remains a concern. The Health Board is at escalation stage 3 and a commissioning quality visit took place on the 19th February 2019. The NHS England Getting It Right First Time (GIRFT) team are progressing with the work required for the assessment of quality and performance of both of the Cardiac Units in C&VUHB and SBUHB.

Further visits have been made to the CAMHS service provider in North and updated action plan has been agreed. The action plan has been developed with BCUHB and significant improvements have been made in both capacity and workforce. The service continues to operate with 10 beds and whilst workforce issues remain an interim plan using a non-medical clinical lead has been implemented whilst longer term options are considered. Following the most recent visit and significant improvements in the service consideration was being given to de-escalation from stage 3 but ongoing workforce restraints and support from adult services e.g. access to age appropriate bed has led to WHSSC to continue with current level pending further progress. There is uncertainty on status BCUHB proposal to move CAMHS services into adult MH which may have helped address some of the above concerns. This will be followed up in next escalation meeting planned for 6th June.

The CAMHS service in South Wales at Ty Llidiard was escalated straight to stage 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 stage 3 with action plan developed. The unit's ability to manage admissions in line with agreed operating model is being adversely affected by environmental issues that require capital solution. This was been escalated to the LHB Directors of Planning at SBUHBU & Cwm Taf and Welsh Government have now confirmed support for the requested capital funding. The work appears to have been delayed due to the LHB asset ownership and the Bridgend boundary change. This has been raised directly with CTMUHB DPCMH and work expected to commence in April 2019. On completion of these works WHSSC will re-consider the escalation level.

Quarterly performance meetings with the Lymphoma Panel are in place.

Plastic surgery remains in level 2 escalation, with monthly performance meetings in place with SBUHB, due to continued breaches of 36 weeks (134 patients in March).

Paediatric Surgery has been de-escalated to level 2. A letter has been sent to C&VUHB in April following consideration by CDG in March to de-escalate.

For Paediatric Intensive Care, the first escalation meeting has taken place. This has identified additional monitoring requirements which WHSSC are discussing with the service to finalise.

The BMT service in south Wales is also in level 2 escalation to explore further concerns raised in relation to the following: i) risks to post transplant patients from delayed laboratory turnaround times; ii) risks to pre transplant patients from delayed admission during peaks in referrals; iii) potential infection risk due to sub-optimal environment. Quarterly meetings are in place.

## 3.0.1 Services in Escalation

| Specialty | Level of Escalation | Current Position | Movement from Last Month |
|---|---|---|---|
| **Cardiac Surgery** | 2 | Performance meetings continue bi-monthly with SBUHB. | ➡ |
| | 3 | Monthly performance meetings continue with C&VUHB. | ➡ |
| | 2 | Performance meetings continue bi-monthly with LHCH. | ➡ |
| **Thoracic Surgery** | 2 | Bi-monthly performance meetings continue with SBUHB and C&VUHB. | ➡ |
| **Lymphoma Panel** | 2 | Performance meetings are in place with the All Wales Lymphoma Panel (CVUHB and SBUHB). | ➡ |
| **Bariatric Surgery** | 2 | The bariatric service at SBUHB was de-escalated from level 3 to 2 in December. Bi-monthly performance meetings are continuing to take place. | ➡ |
| **Plastic Surgery** | 2 | Monthly performance meetings continue with SBUHB | ➡ |
| **Neurosurgery** | 2 | Neurosurgery is at level 2 escalation with the only breaches relating to a Consultant being on long term sickness and the remaining Consultant predominantly covering the urgent tumour work. | ➡ |
| **Adult Posture & Mobility** | 2 | Quarterly meetings occur with all three providers however there is closer monitoring of the BC UHB service, as the service is still not meeting the 90% RTT target. However in recent months, the service have demonstrated that the waiting time performance has improved due to the appointment of key staff with the aim to achieve RTT by March 2019. | ➡ |
| **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** | 2 | Paediatric Surgery has been de-escalated to level 2. A letter has been sent to C&VUHB in April following consideration by CDG in March to de-escalate. | ⬆ |
| **Paediatric Intensive Care** | 2 | The first escalation meeting has taken place. This has identified additional monitoring requirements which WHSSC are discussing with the service to finalise. | ➡ |
| **BMT** | 2 | The BMT service in south Wales has recently been placed into level 2 escalation to explore further concerns raised. | ➡ |
| **IVF Shrewsbury** | 2 | Following April's escalation meeting WHSSC are working with the service to ensure consistently accurate recording of RTT. | ➡ |
| **Sarcoma** | 2 | WHSSC has arranged weekly input into MDT from surgeon at Royal Orthopaedic. WHSSC is coordinating discussions with health board leads for cancer and radiology to reach an agreement on the diagnostic pathway in south east Wales. | ➡ |

## 4.0 PROVIDER PERFORMANCE

The trend for performance for all provider services has largely remained unchanged moving into the new financial year 2019/20. Of the 27 provider service targets that were monitored by WHSSC, 20 (74.1%) remain in breach at end of April 2019 compared to 74.1% at the end of March 2019.

## 4.1 Section 1 Service Dashboard

| Commissioning Team | Specialty | WHSSC Indicator Ref | Measure | | Tolerance Levels | | | Provider | Feb-19 | Mar-19 | Apr-19 | 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 | 95% | 97% | 96% | | |
| | | E01 | Mthly | RTT < 26 weeks | <95% | N/A | >=95% | All | 86% | 85% | 84% | | |
| | **Bariatric Surgery** | E03 | Mthly | RTT < 36 weeks | <100% | N/A | 100% | All | 94% | 98% | 97% | | |
| | | E03 | Mthly | RTT < 26 weeks | <95% | N/A | >=95% | All | 88% | 97% | 94% | | |
| **Cancer & Blood** | **Thoracic Surgery** | E02 | Mthly | RTT < 36 weeks | <100% | N/A | 100% | All | 100% | 100% | 100% | | |
| | | E02 | Mthly | RTT < 26 weeks | <95% | N/A | >=95% | All | 93% | 92% | 99% | | |
| | **Lung Cancer** | *E02D* | Mthly | USC lung resection < 62 days | >0 | N/A | 0 | All | 1 | 1 | - | | |
| | | *E02E* | Mthly | NUSC lung resection < 31 days | >0 | N/A | 0 | All | 1 | 0 | - | | |
| | **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 | 95% | 96% | 96% | | |
| | **Plastic Surgery** | E05 | Mthly | RTT < 36 weeks | <100% | N/A | 100% | All | 94% | 95% | 94% | | |
| | | E05 | Mthly | RTT < 26 weeks | <95% | N/A | >=95% | All | 85% | 86% | 84% | | |
| | **Lymphoma** | E06 | Mthly | Specimens tested ≤10 days | <90% within 10 days | N/A | =,>90% within 10 days | All | | | | | |
| **Neuro** | **Neurosurgery** | E07 | Mthly | RTT < 36 weeks | <100% | N/A | 100% | All | 99% | 99% | 99% | | |
| | | E07 | Mthly | RTT < 26 weeks | <95% | N/A | >=95% | All | 93% | 94% | 93% | | |
| | **Adult Posture & Mobility** | E08 | Mthly | RTT < 26 weeks | <85% within 26 weeks | 85-89% within 26 weeks | =,>90% within 26 weeks | All | 87% | 87% | 88% | | |
| | **Paediatric Posture & Mobility** | E09 | Mthly | RTT < 26 weeks | <85% within 26 weeks | 85-89% within 26 weeks | =,>90% within 26 weeks | All | 94% | 96% | 96% | | |
| **Mental Health** | **CAMHS** | E10 | Mthly | OOA placements | >16 | >14, <16 | =,<14 | All | 8 | 7 | 9 | | |
| | | E10i | Mthly | NHS Beddays | <85%,>105% | < 90%, >100% | 90% - 100% | All | 89% | 82% | 76% | | |
| | | E10ii | Mthly | NHS Home Leave | <20%, >40% | <25%, >35% | 25%-35% | All | 29% | 32% | 25% | | |
| | **Adult Medium Secure** | E11 | Mthly | NHS Beddays | <90%, >110% | < 95%, >105% | 95% - 105% | All | 79% | 88% | 114% | | |
| **Women & Children** | **Paediatric Surgery** | E12 | Mthly | RTT < 36 weeks | <100% | N/A | 100% | All | 100% | 100% | 100% | | |
| | | E12 | Mthly | RTT < 26 weeks | <95% | N/A | >=95% | All | 91% | 86% | 86% | | |
| | **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 | 34% | 57% | 42% | | |
| | | *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 | 65% | 81% | 69% | | |
| | **Cochlear Implants** | *E14A* | Mthly | Adult Cochlear Implant patients to be waiting < 26 weeks | <95% within 26 weeks | N/A | >=95% within 26 weeks | All | 77% | 83% | 79% | | |
| | | *E14B* | Mthly | Paediatric Cochlear Implant patients to be waiting < 26 weeks | <95% within 26 weeks | N/A | >=95% within 26 weeks | All | 100% | 100% | 90% | | |

***Please note there is a delay for Lung Cancer data as this is currently being submitted to WHSSC by Welsh Government. No Lymphoma data submitted for Quarter 4.***

## 4.2 Key Information for April 2019

### Cardiac Surgery

The ongoing under performance and increasing number of breaches at C&VUHB continues to be a concern. In April the Health Board reported 45 patients waiting over 26 weeks and 19 over 36 weeks. Reporting an increase in the overall number of patients waiting over 36 weeks compared to March. The Health Board was placed at Stage 3 of the WHSSC escalation process in July 2018 due to the increased length of time a high risk cohort of patients are waiting for Cardiac Surgery. A meeting took place in October with WHSSC and the NHS England Getting It Right First Time (GIRFT) team and it was agreed that the GIRFT team would undertake an assessment of both the South Wales Cardiac Centres; it is anticipated that the assessment will commence in September 2019.

LHCH continue to report low numbers of patients waiting over 26 weeks. In April 9 patients were reported as waiting over 26 weeks and 3 patients waiting over 36 weeks. The breach position has worsened slightly compared to the March position. LHCH remain at stage 2 of the escalation process and joint performance meetings with BCUHB take place bi-monthly.

### Plastic Surgery

Patients continue to breach maximum waiting times for hand and breast surgery at SBUHB. In March, there were 134 patients waiting in excess of 36 weeks, 30 of whom were in excess of 52 weeks. SBUHB is taking forward plans to increase capacity through an additional day case area (which will support an increase in throughput, treating cases under local anaesthetic that are currently being undertaken in theatre). It is also exploring options through SBUHB's outsource contract arrangements to help address the backlog through outsourcing clinically appropriate cases.

### Thoracic Surgery

SBUHB continues to meet RTT targets for Thoracic Surgery and in April there were no breaches of the 36 week target at CVUHB either. WHSSC continues to hold performance meetings with both south Wales providers on a bi-monthly basis. There were no breaches at LHCH.

### Lymphoma

The current KPIs (turnaround times) are drawn from Royal College of Pathology (RCP) standards. These standards have been under review by the RCP since it is recognised that the current turnaround time targets are designed for general pathology tests and are not appropriate for the more complex testing undertaken by the lymphoma panel. New RCP standards are expected to be published shortly. At the last AWLP quarterly performance meeting in April, it was agreed to assess the service against the new turnaround time targets once these are published.

## Neurological & Chronic Conditions

**Neurosurgery:** Three patients were waiting over 36 weeks at the end of March, with the three breaches all attributed to pressures in the service due to the long term sickness of one of the Skull Base Surgeons.

### Posture & Mobility: Adult & Paediatric

**Adult:** BCUHB continue to improve against the 90% compliance with the complex adult 26 week RTT target whilst Cardiff and Swansea continue to operate above the target.

**Paediatric:** All centres continue to operate above the 90% RTT target.

### CAMHS

CAMHS Out of Area (OoA) performance is much improved over the last year and following a spike in the Summer has returned below target. This is likely to reflect the issues of both NHS services being at level 3 escalation which had been offset by 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 has led to short term pressure on new OoA referrals. Despite this the total number of OoA placements at the end of April (9) remains comfortably below the target (14). A review of gatekeeping will take place shortly and incorporate the changes to Consultant staffing in our Tier 4 units.

### Women & Child

Paediatric Surgery: The waiting list performance at the end of April was reported as 0 patients waiting over 36 weeks at C&VUHB. It was agreed at CDG to de-escalate the service to level 2 as the service had met the performance requirements and the two quality patient safety issues. The service will continue to be monitored with bi monthly performance meetings to ensure the position is maintained and sustainable.

### IVF

The Shrewsbury service was place in escalation level 2 due to the reported waiting times in excess of agreed Referral to treatment times, which is inequitable with patients accessing services in Liverpool. Regular performance meetings are being held with the service to improve and ensure that the performance data is robust and meets WHSSC reporting requirements.

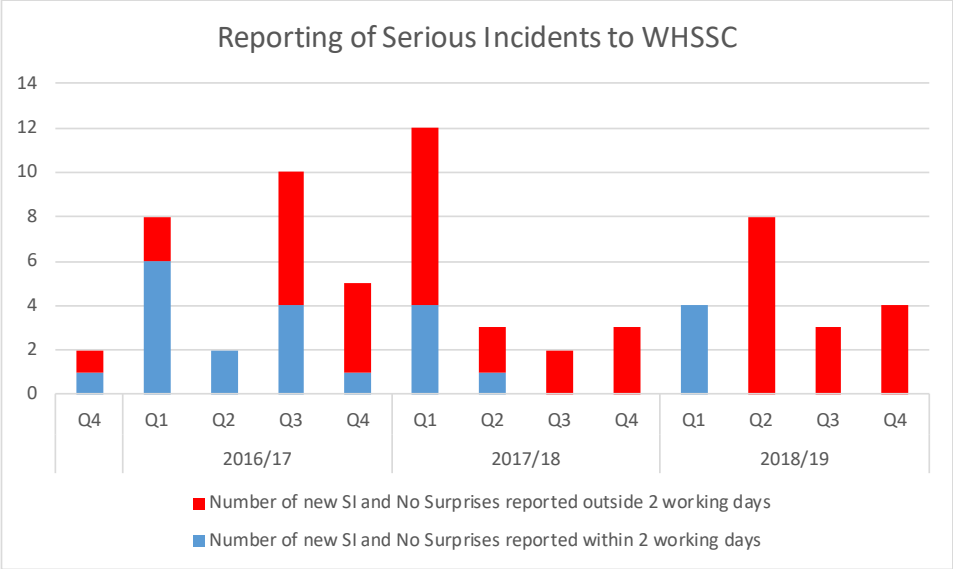
### Cochlear and BAHA

The service have reported that with the additional investment in 2018/19 and 2019/20 to deliver the 26 week RTT target will be achieved by 31 March 2020.

## 4.3 Section 2 Individual Services

## S01: SERIOUS INCIDENTS

### Current Trend




### Current Performance

During 2018/19 there have been 19 incidents.
15 have been reported outside the 48 hours, with 4 reported within 48 hours.

### What actions are WHSSC taking?

# E01: CARDIAC SURGERY

Provider(s): C&VUHB; SBUHB; Liverpool Heart & Chest

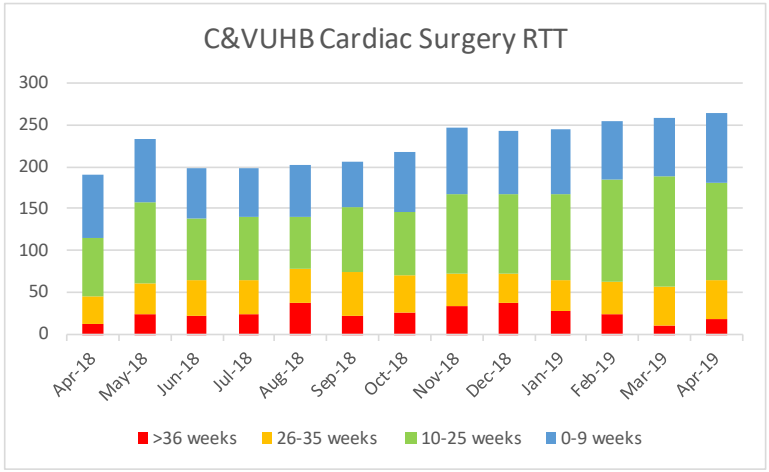
## Current Trend – RTT Performance

C&VUHB:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| C&VUHB | Cardiac surgery patients to be waiting < 26 weeks | 75% | 78% | 76% | ↓ |

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| C&VUHB | Cardiac surgery patients to be waiting < 36 weeks | 90% | 96% | 93% | ↓ |

C&VUHB Cardiac Surgery Waiting list analysis:




Residing LHB Split April >36 cohort:

| Residing LHB | C&VUHB >36 week breaches |
|---|---|
| Swansea Bay University Local Health Board | 0 |
| Aneurin Bevan Local Health Board | 7 |
| Betsi Cadwaladr University Local Health Board | 0 |
| Cardiff and Vale University Local Health Board | 5 |
| Cwm Taf Morgannwg Local Health Board | 5 |
| Hywel Dda Local Health Board | 0 |
| Powys Teaching Local Health Board | 2 |

## Current Performance

C&VUHB reported a total patient cohort of 265 at the end of April; a slight increase of 7 patients in comparison to the number of patients waiting in March. The Health Board reported 45 patients waiting over 26 weeks and 19 waiting over 36 weeks (64 breaches). Reporting an increase in the overall number of patients waiting over 36 weeks compared to the March position.

The cardiac surgery activity at C&VUHB continues to underperform against planned activity. The overall trend is showing a slight decrease throughout the year.

C&VUHB have reported the ongoing issues with late referrals changes, scrub staff and pressures on ITU beds as the main areas impacting on performance.

## What actions are WHSSC taking?

**C&VUHB:**

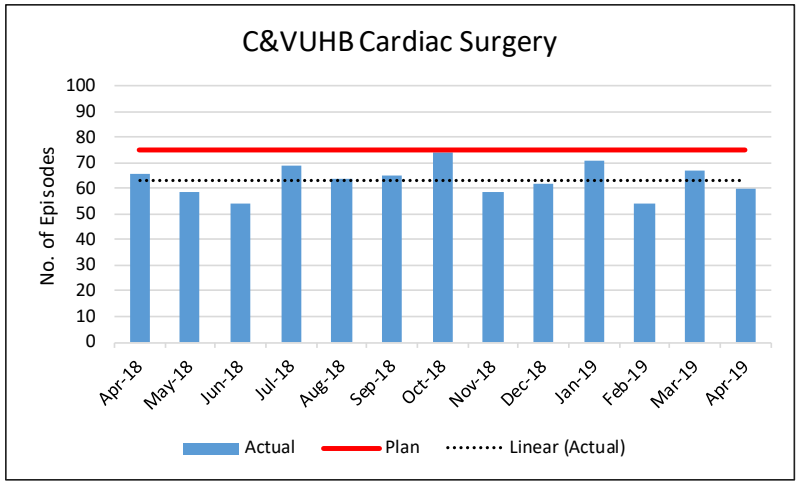
- Continued implementation of enhanced monitoring of the service with monthly submission of waiting list profile and activity performance against the weekly delivery plan.
- Continued implementation of monthly executive level performance management meetings for C&VUHB.
- C&VUHB have been placed into stage 3 of the escalation process.
- A Commissioning quality visit took place on the 19th February and it was agreed in the meeting that the Health Board would undertake a number of further actions including the development of an action plan to address the capacity issues i.e. ITU beds and scrub staff that are impacting on the waiting times. The action plan has been developed and delivery of the actions are monitored in the monthly performance meetings with the Health Board.

## What are the main areas of risk?

**C&VUHB**:

- Theatre staff capacity (nurses and ODAs).

C&VUHB activity:




- These constraints lead to a poorer patient experience due to the impact on waiting times and increased burden of morbidity on the waiting list.
- Failure to achieve maximum waiting times target.

## E01 (cont'd): CARDIAC SURGERY

Provider(s): C&VUHB; SBUHB; Liverpool Heart & Chest

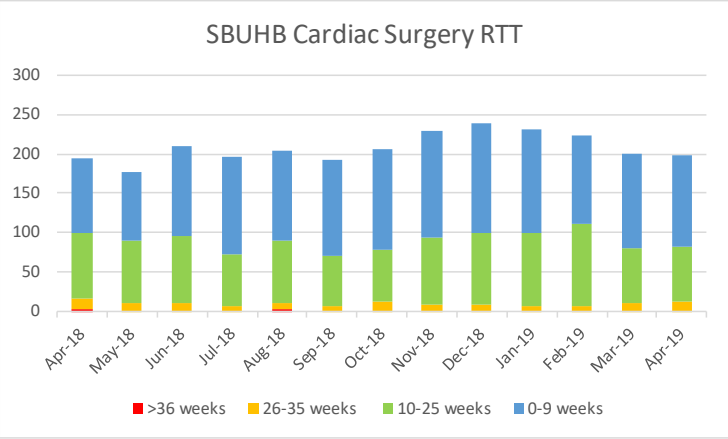
### Current Trend – RTT Performance

SBUHB:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *SBUHB* | Cardiac surgery patients to be waiting < 26 weeks | 97% | 95% | 94% | ↓ |

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *SBUHB* | Cardiac surgery patients to be waiting < 36 weeks | 100% | 100% | 100% | → |

SBUHB Cardiac Surgery Waiting list analysis:




Residing LHB Split April >36 cohort:

| Residing LHB | SBUHB >36 week breaches |
|---|---|
| Swansea Bay University Local Health Board | 0 |
| Aneurin Bevan Local Health Board | 0 |
| Betsi Cadwaladr University Local Health Board | 0 |
| Cardiff and Vale University Local Health Board | 0 |
| Cwm Taf Morgannwg Local Health Board | 0 |
| Hywel Dda Local Health Board | 0 |
| Powys Teaching Local Health Board | 0 |

### Current Performance

SBUHB reported a total patient cohort of 198 for April a reduction (3 cases) compared to the March position. The Health Board reported 12 patients waiting over 26 weeks and 0 patients waiting over 36 weeks.

SBUHB are currently just below planned activity, however there is an overall increasing trend in activity.

### What actions are WHSSC taking?

**SBUHB:**

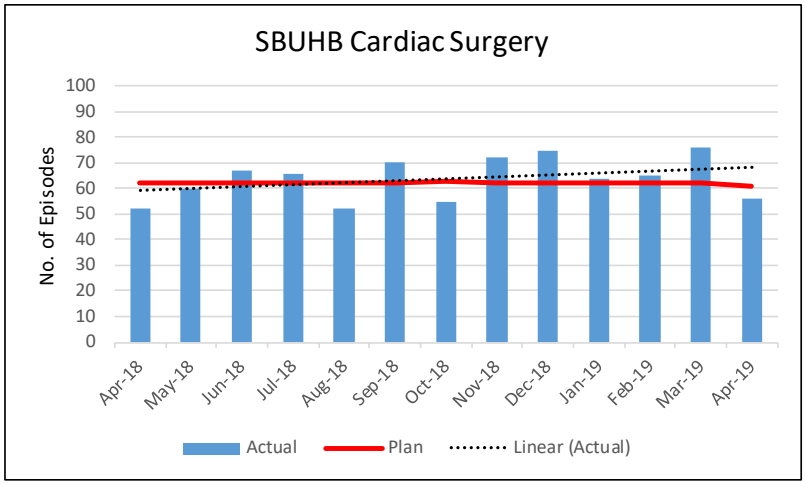
- Continued implementation of enhanced monitoring of the service with monthly submission of waiting list profile and activity performance against the weekly delivery plan.
- Continued implementation of bi-monthly executive level performance management meetings

### What are the main areas of risk?

**SBUHB**:

- Key constraints to delivery: consultant anaesthetic capacity and theatre staff capacity (nurses).

SBUHB activity:



# E01 (cont'd): CARDIAC SURGERY

Provider(s): C&VUHB; SBUHB; Liverpool Heart & Chest

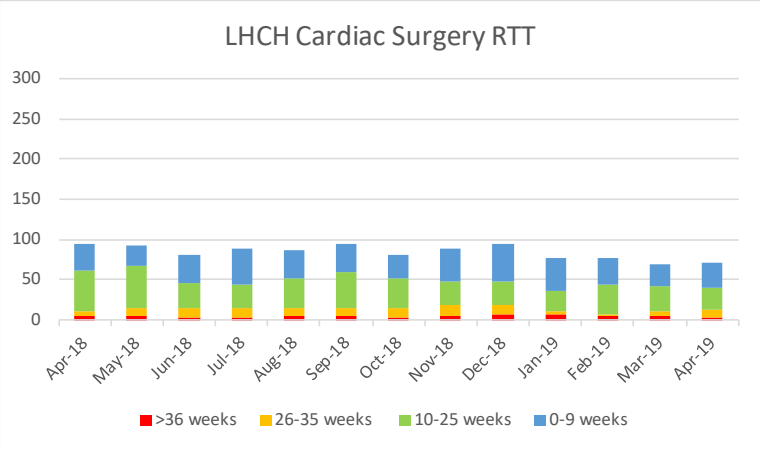
## Current Trend – RTT Performance

LHCH:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *LHCH* | Cardiac surgery patients to be waiting < 26 weeks | 91% | 86% | 83% | ↓ |

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *LHCH* | Cardiac surgery patients to be waiting < 36 weeks | 93% | 93% | 96% | ↑ |

LHCH Cardiac Surgery Waiting list analysis:




Residing LHB Split April >36 cohort:

| Residing LHB | LHCH >36 week breaches |
|---|---|
| Swansea Bay University Local Health Board | 0 |
| Aneurin Bevan Local Health Board | 0 |
| Betsi Cadwaladr University Local Health Board | 5 |
| Cardiff and Vale University Local Health Board | 0 |
| Cwm Taf Morgannwg Local Health Board | 0 |
| Hywel Dda Local Health Board | 0 |
| Powys Teaching Local Health Board | 0 |

## Current Performance

LHCH reported a total patient cohort of 71 for April compared to 70 in March position. The Health Board reported 9 patients waiting over 26 weeks and 3 patients waiting over 36 weeks, which is a reduction compared to March's breach position.

LHCH have reported that the ongoing issue of late referrals from BCUHB is impacting on performance.

## What actions are WHSSC taking?

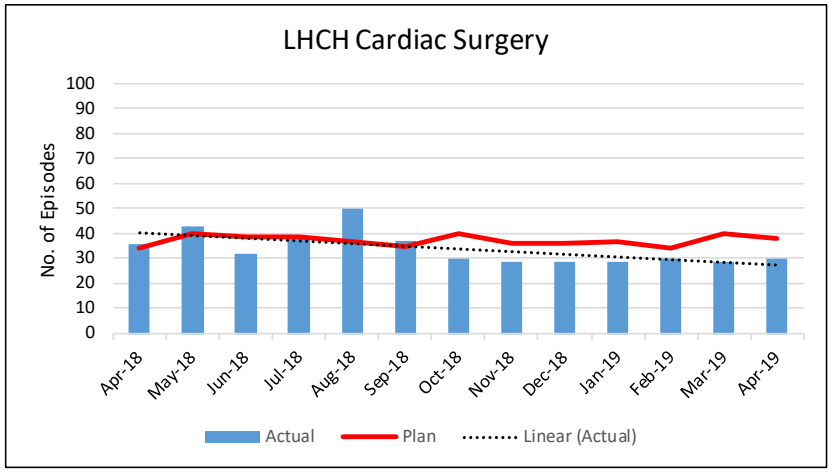
**North Wales**

- LHCH has reported that late referrals from BCUHB remains the principle cause of the recent increase in breaches. BCUHB is currently experiencing constraints in capacity which have increased out-patient waiting times which is in turn affecting waiting times performance.
- Continued implementation of bi-monthly executive level performance management meetings for LHCH and BCUHB.

## What are the main areas of risk?

- Failure to achieve waiting times target.

LHCH activity:



# E02: THORACIC SURGERY

Provider(s): CVUHB, SBUHB & Liverpool Heart & Chest

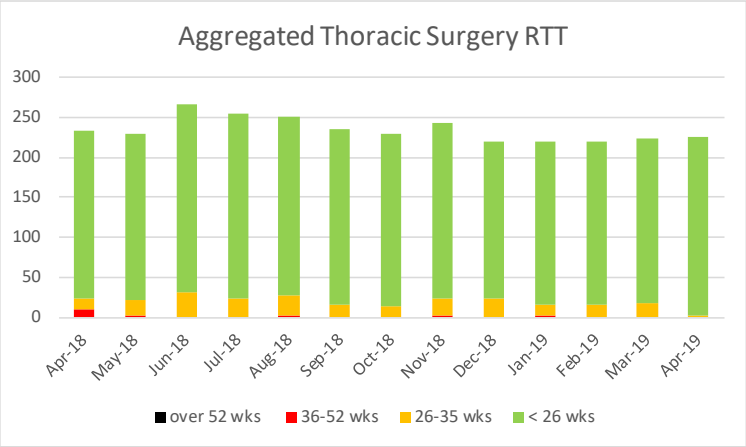
## Current Trend – RTT Performance

All provider for Welsh patients:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| C&VUHB | Thoracic surgery patients to be waiting < 26 weeks | 89% | 90% | 99% | ↑ |
| SBUHB | Thoracic surgery patients to be waiting < 26 weeks | 100% | 100% | 100% | → |
| LHCH | Thoracic surgery patients to be waiting < 26 weeks | 96% | 92% | 100% | ↑ |

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| C&VUHB | Thoracic surgery patients to be waiting < 36 weeks | 100% | 100% | 100% | → |
| SBUHB | Thoracic surgery patients to be waiting < 36 weeks | 100% | 100% | 100% | → |
| LHCH | Thoracic surgery patients to be waiting < 36 weeks | 100% | 100% | 100% | → |

Aggregated Thoracic Surgery Waiting list analysis:




## Current Performance

The total waiting list at CVUHB in April was 142 cases, compared to 154 in March. The cohort under 26 weeks increased slightly; 2 patients have been waiting over 26 weeks.

The waiting list at SBUHB and LHCH remains stable with no patients waiting longer than 26 weeks.

## What actions are WHSSC taking?

SBUHB:

- Bi-monthly performance meetings remain in place at the current time.

CVUHB:

- Bi-monthly performance meetings remain in place.

## What are the main areas of risk?

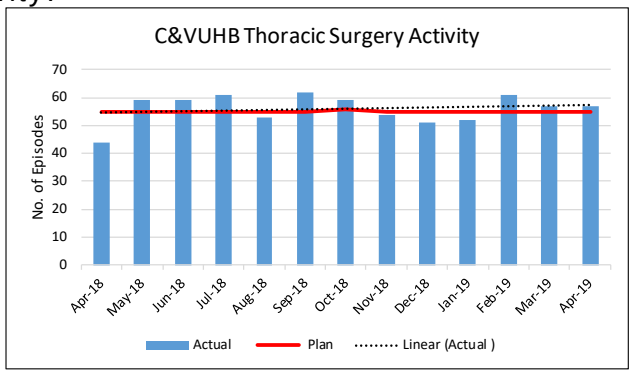
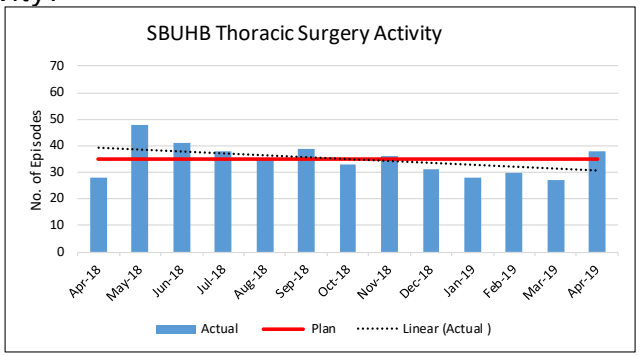
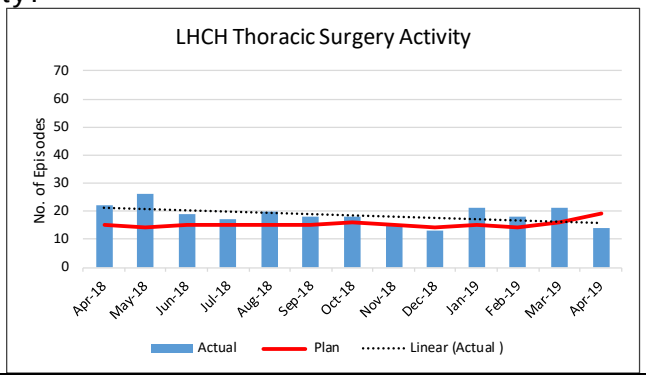
- Previously long waits for cohort of elective patients waiting for surgery at CVUHB (mostly pectus). At the current time, this has mostly resolved although occasional breaches still occur.
- CVUHB - Risks to delivery plan:
  - Additional theatre list that was agreed as part of the 2016/17 investment is yet to be implemented due to theatre staff availability.

Residing LHB Split April >36 cohort:

| Residing LHB | C&VUHB >36 week breaches | ABMUHB >36 week breaches | LHCH >36 week breaches |
|---|---|---|---|
| Swansea Bay University Local Health Board | 0 | 0 | 0 |
| Aneurin Bevan Local Health Board | 0 | 0 | 0 |
| Betsi Cadwaladr University Local Health Board | 0 | 0 | 0 |
| Cardiff and Vale University Local Health Board | 0 | 0 | 0 |
| Cwm Taf Morgannwg Local Health Board | 0 | 0 | 0 |
| Hywel Dda Local Health Board | 0 | 0 | 0 |
| Powys Teaching Local Health Board | 0 | 0 | 0 |

## E02: THORACIC SURGERY (cont'd)

Provider(s): CVUHB, SBUHB & Liverpool Heart & Chest

| Current Trend – Activity | Current Performance |
|---|---|
| CVUHB activity:<br>  <br><br>SBUHB activity:<br>  <br><br>LHCH activity:<br>  <br> | LHCH are under plan for April. Overall contract performance is on a slightly decreasing trend at LHCH. CVUHB are on a slightly increasing trend above plan overall, whilst SBUHB are on a steeper decline. |

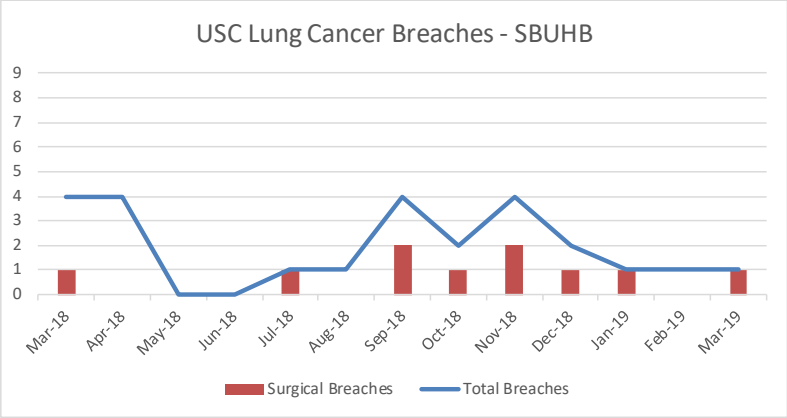
## E02D: THORACIC SURGERY – PRIMARY LUNG CANCER - URGENT SUSPECTED CANCER (USC)

Provider(s): CVUHB, SBUHB, LHCH

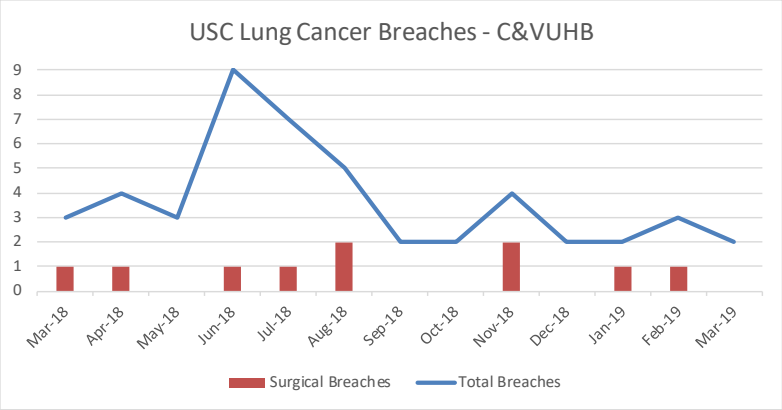
### Current Trend – Cancer Pathway Performance

All providers for Welsh patients:

USC Lung Cancer Pathway for South West – March 2019




USC Lung Cancer Pathway for South East – March 2019




### Current Performance

Validated Cancer Breach Reporting:
(**Data provided by Welsh Government. Available to February only**.)

There was 1 USC breach attributed to surgical delays reported in March at SBUHB. The breach was due to a complex pathway with a total wait of 96 days.

### What actions are WHSSC taking?

- Bi-monthly thoracic surgery performance meetings with SBUHB and CVUHB.

### What are the main areas of risk?

- Having sufficient capacity to sustainably manage demand and fluctuations in referrals to maintain achievement of targets.

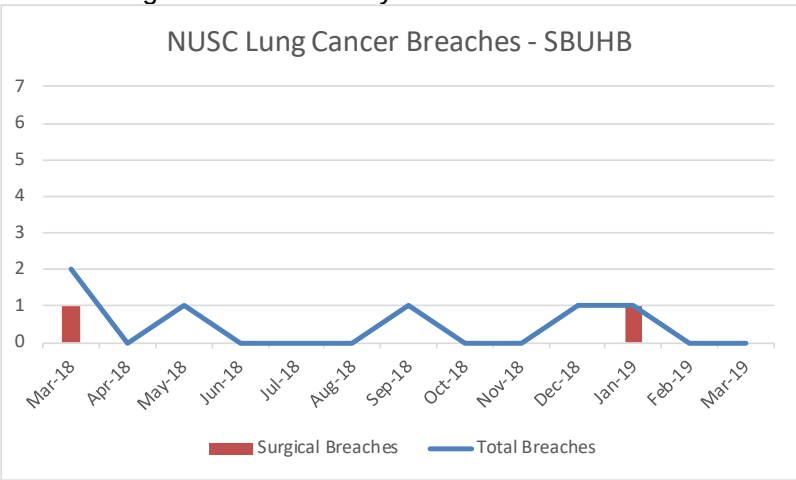
## E02E: THORACIC SURGERY – PRIMARY LUNG CANCER – NON-URGENT SUSPECTED CANCER (NUSC)

Provider(s): CVUHB, SBUHB, LHCH

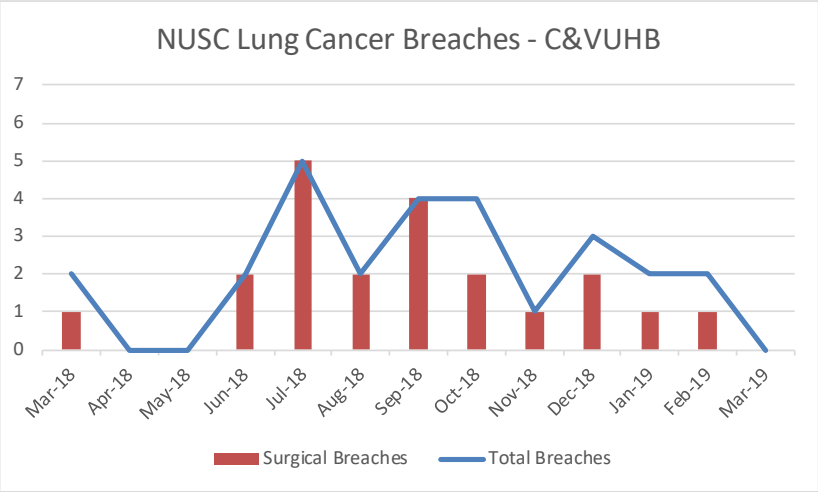
### Current Trend – Cancer Pathway Performance

All providers for Welsh patients:

NUSC Lung Cancer Pathway for South West – March 2019




NUSC Lung Cancer Pathway for South East – March 2019




### Current Performance

Validated Cancer Breach Reporting:

**(Data provided by Welsh Government. Available to February only.)**

There was zero NUSC breach attributed to surgical delays reported in March for both south centres.

### What actions are WHSSC taking?

- Bi-monthly thoracic surgery performance meetings with SBUHB and CVUHB.
- Data submissions: While information requirements have been sent to Health Boards to request surgical lung cancer breach data is submitted directly to WHSSC, this has been unsuccessful to date. Data has been provided by Welsh Government, but this is often delayed. Further escalation to CEOs will be now be undertaken to request that lung cancer breach data for surgical patients is submitted to WHSSC as part of routine cancer reporting.

### What are the main areas of risk?

- Having sufficient capacity to sustainably manage demand and fluctuations in referrals to maintain achievement of targets.

# E03: BARIATRIC SURGERY

Provider(s): SBUHB; Salford Royal

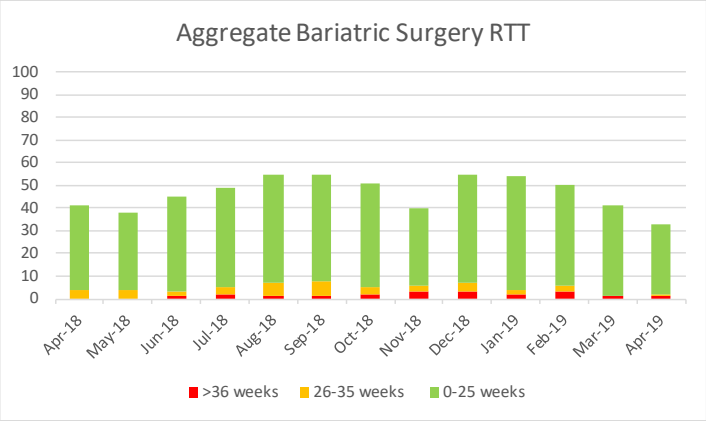
## Current Trend – RTT Performance

All provider for Welsh patients:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *SBUHB* | Bariatric surgery patients to be waiting < 26 weeks | 89% | 100% | 95% | ↓ |
| *Salford Royal* | Bariatric surgery patients to be waiting < 26 weeks | 83% | 93% | 92% | ↓ |

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *SBUHB* | Bariatric surgery patients to be waiting < 36 weeks | 97% | 100% | 100% | → |
| *Salford Royal* | Bariatric surgery patients to be waiting < 36 weeks | 83% | 93% | 92% | ↓ |

Aggregated Waiting list analysis:




## Current Performance

SBUHB have reported 21 patients in the total waiting list cohort; SBUHB reported 1 patient waiting over 26 weeks and 0 patients waiting over 36 weeks for April.

Salford have 12 patients in the total waiting list cohort for April, a slight decrease compared to March's position. The reported position for April was 0 patients waiting over 26 weeks and 1 patient waiting over 36 weeks.

## What actions are WHSSC taking?

SBUHB

SBUHB was de-escalated from stage 4 to stage 3 in April 2018 due to the improvement in performance. SBUHB have continued to maintain their 0 breach position for several months and the service was further de-escalated to stage 2 in November 2018. The level of escalation will be reviewed in July 2019 including an assessment of whether any further actions are required.

Salford

There has been a deterioration in waiting times at Salford over the last 3 months. A visit to Salford took place on the 22nd May.

Residing LHB Split April >36 weeks:

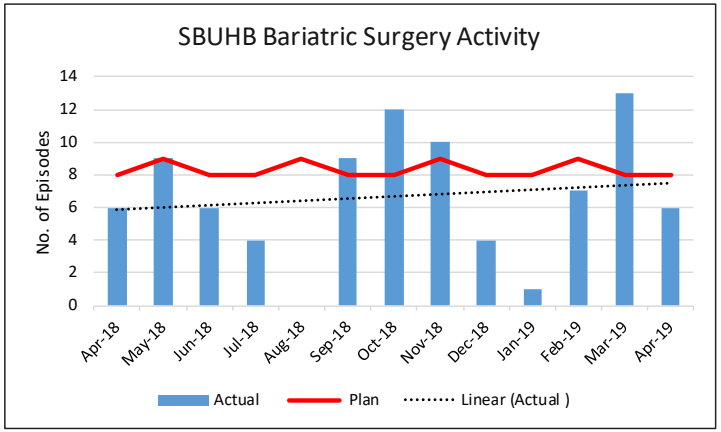
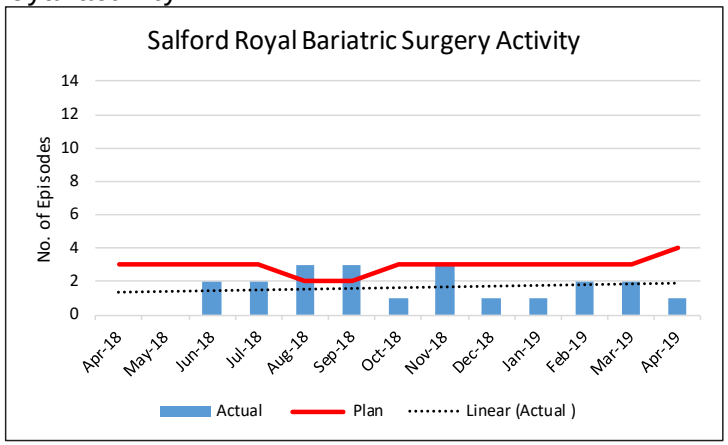
| Residing LHB | SBUHB >36 week breaches | Salford >36 week breaches |
|---|---|---|
| Swansea Bay University Local Health Board | 0 | 0 |
| Aneurin Bevan Local Health Board | 0 | 0 |
| Betsi Cadwaladr University Local Health Board | 0 | 1 |
| Cardiff and Vale University Local Health Board | 0 | 0 |
| Cwm Taf Morgannwg University Local Health Board | 0 | 0 |
| Hywel Dda Local Health Board | 0 | 0 |
| Powys Teaching Local Health Board | 0 | 0 |

**What are the main areas of risk?**

- Lack of on-site critical care (national UK standards for a bariatric surgery centre require on-site HDU/ITU), however WHSSC has received assurance from SBUHB that there is safe robust transfer protocols in place to mitigate this risk;
- Low levels of patient referrals for bariatric surgery to meet the commissioning intentions and contracting arrangements.

## E03: BARIATRIC SURGERY (cont'd)

Provider(s): SBUHB; Salford Royal

| Current Trend – Activity | Current Performance |
|---|---|
| SBUHB activity:<br>  <br><br>Salford Royal activity:<br>  <br> | SBUHB activity remains below plan but has increased in the latter months of 2018 and March 2019. April's activity was below plan. Referrals into the service remain low.<br><br>Salford activity level for April has decreased, with an overall underperformance against the planned activity levels. |

# E04: PET SCANS – CANCER PATIENTS

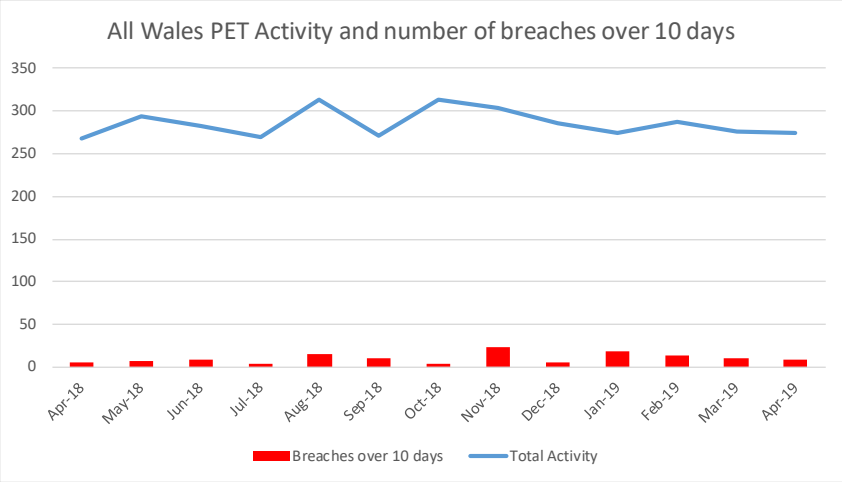
Provider(s): CVUHB & SBUHB (Combined); BCUHB

## Current Trend – Activity

All provider for Welsh patients:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *PETIC* | Cancer patients to receive a PET scan within 10 days from referral to electronic receipt of image and report by the referring clinician - South Wales | 96% | 95% | 96% | ↑ |
| *BCUHB* | Cancer patients to receive a PET scan within 10 days from referral to electronic receipt of image and report by the referring clinician - North Wales | 93% | 100% | 100% | → |

Aggregated PET Activity/Breach analysis:




Residing LHB Split April >10 days:

| Residing LHB | PETIC >10 days | BCUHB >10 days |
|---|---|---|
| Swansea Bay University Local Health Board | 1 | 0 |
| Aneurin Bevan Local Health Board | 3 | 0 |
| Betsi Cadwaladr University Local Health Board | 0 | 0 |
| Cardiff and Vale University Local Health Board | 2 | 0 |
| Cwm Taf Morgannwg Local Health Board | 2 | 0 |
| Hywel Dda Local Health Board | 1 | 0 |
| Powys Teaching Local Health Board | 0 | 0 |

## Current Performance

There were 0 breaches at BCUHB in April meaning that 100% of patients received a PET scan within 10 days of referral.

There were 9 breaches at PETIC in April, 2 of which were patients waiting for a choline scan. This is due to significant supply issues from the commercial manufacturers of $^{18}$F Choline. The remaining breaches were due to difficulties in contacting patients, awaiting further information from referring clinician or due to patients being unable to attend an earlier appointment.

## What actions are WHSSC taking?

No specific actions are being taken with respect to current delivery since a capacity and delivery plan is currently in place to meet demand under the commissioning policy.

## What are the main areas of risk?

No risk identified for delivery in the very short term. However, the expansion in commissioned indications is expected to reach the capacity of the current south Wales service within the medium term. In addition, the PET scanner is coming to the end of its life, increasing the risk of breakdown. These issues are being addressed through the PET strategy developed by the All Wales PET Advisory Group.

## E05: PLASTIC SURGERY

Provider(s): SBUHB; Birmingham Children's; Royal Free; Wye Valley; St Helens

### Current Trend – RTT Performance

All provider for Welsh patients:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *SBUHB* | Plastic surgery patients to be waiting < 26 weeks | 84% | 85% | 84% | ↓ |
| *Birmingham Children's* | Plastic surgery patients to be waiting < 26 weeks | 100% | 100% | | → |
| *Royal Free* | Plastic surgery patients to be waiting < 26 weeks | - | - | | |
| *Wye Valley* | Plastic surgery patients to be waiting < 26 weeks | 83% | 82% | | ↑ |
| *St Helens* | Plastic surgery patients to be waiting < 26 weeks | 98% | 98% | | → |
| *Alder Hey* | Plastic surgery patients to be waiting < 26 weeks | 100% | 100% | | → |
| *Manchester* | Plastic surgery patients to be waiting < 26 weeks | 78% | - | | ↑ |
| *North Midlands* | Plastic surgery patients to be waiting < 26 weeks | 100% | 100% | | → |

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *SBUHB* | Plastic surgery patients to be waiting < 36 weeks | 94% | 95% | 94% | ↓ |
| *Birmingham Children's* | Plastic surgery patients to be waiting < 36 weeks | 100% | 100% | | → |
| *Royal Free* | Plastic surgery patients to be waiting < 36 weeks | - | - | | |
| *Wye Valley* | Plastic surgery patients to be waiting < 36 weeks | 100% | 100% | | → |
| *St Helens* | Plastic surgery patients to be waiting < 36 weeks | 99% | 99% | | → |
| *Alder Hey* | Plastic surgery patients to be waiting < 36 weeks | 100% | 100% | | → |
| *Manchester* | Plastic surgery patients to be waiting < 36 weeks | 78% | - | | ↓ |
| *North Midlands* | Plastic surgery patients to be waiting < 36 weeks | 100% | 100% | | → |

### Current Performance

The waiting list at SBUHB has increased between March and April, with 2472 waiting in March and 2349 in April. The number of over 36 week breaches has decreased to 135 of which 34 have been waiting in excess of 52 weeks.

In April, Wye Valley had a small number of breaches (<5) over 36 weeks.

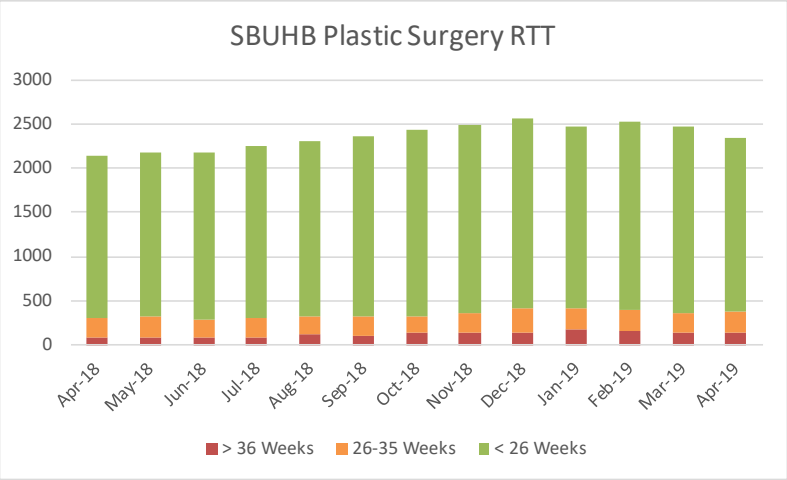
### What actions are WHSSC taking?

- Performance meetings between WHSSC and SBUHB are in place.
- Workshops: A series of workshops have taken place between SBUHB and individual Health Boards to review the treatment pathways for hand and breast surgery. This is in recognition that referral rates and referral indications to the plastic surgery services vary across Health Boards and may reflect differences in local service provision and referral pathways. The findings of the workshops were discussed at a Clinical Summit on 9th July 2018. Further work is planned in 2019/20.

### What are the main areas of risk?

- Hand surgery: current dependence on an individual surgeon to treat the long waiters due to needs of patients and surgical skill mix.
- Minimal scope for catch up if the delivery plan for hand and breast surgery falls behind for any reason.

SBUHB Plastic Surgery Waiting list analysis:

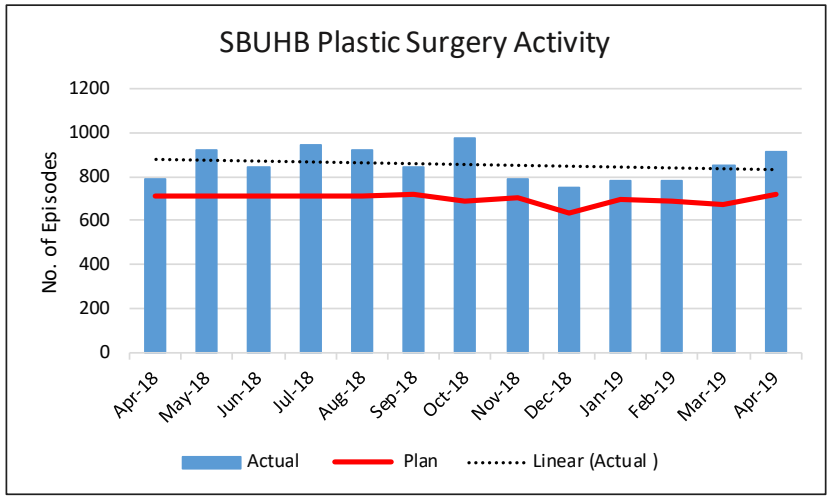



Residing LHB Split April/March >36 cohort:

| Residing LHB | SBUHB >36 week breaches | St Helen's & Knowsley >36 week breaches (March) | Manchester >36 week breaches (March) |
|---|---|---|---|
| Swansea Bay University Local Health Board | 38 | 0 | 0 |
| Aneurin Bevan Local Health Board | 33 | 0 | 0 |
| Betsi Cadwaladr University Local Health Board | 2 | 1 | 0 |
| Cardiff and Vale University Local Health Board | 25 | 0 | 0 |
| Cwm Taf Morgannwg Local Health Board | 19 | 0 | 0 |
| Hywel Dda Local Health Board | 16 | 0 | 0 |
| Powys Teaching Local Health Board | 2 | 0 | 0 |

## E05: PLASTIC SURGERY (cont'd)

Provider(s): SBUHB; Birmingham Children's; Royal Free; Wye Valley; St Helens

| Current Trend – Activity | Current Performance |
|---|---|
| SBUHB activity:<br>  <br> | The activity at SBUHB illustrates that there is over performance against the profile. The 12 month trend shows a slight decrease in activity through the year but overall remains above profile. |

## E06: LYMPHOMA

Provider(s): CVUHB / SBUHB

### Current Trend

**Target turnaround time: 90% of tests reported within 10 days** from receipt of specimen by the AWLP.

**Specimens tested at C&V UHB**

| | Apr | May | Jun |
|---|---|---|---|
| **Total cases*** | 109 | 113 | 89 |
| **% reported in ≤10 days** | 43% | 27% | 40% |

*All cases (Immunohistochemistry and genetic tests)

**Specimens tested at SBUHB**

| | Apr | May | Jun |
|---|---|---|---|
| **Total cases*** | 87 | 92 | 80 |
| **% reported in ≤10 days** | 62% | 63% | 74% |

*All cases (Immunohistochemistry and genetic tests)

**To be reported quarterly from April 2018**

### Current Performance

**No data received for Q4**

### What actions are WHSSC taking?

- Lymphoma panel data will be reported to WHSSC quarterly.
- Quarterly performance meetings are in place.

### What are the main areas of risk?

- Despite high turnaround times, prioritisation of cases for MDT remains to be successful resulting in a high level of cases being ready for MDTs or with sufficient information for clinically meaningful provisional pathological opinion.
- Assurance has been provided to WHSSC that clinically urgent cases are prioritised and reported within a clinically appropriate timeframe.
- The immunohistochemistry section of the laboratory at UHW has recently recruited new members of staff to vacant posts. This is expected to improve turnaround times significantly as the service will have a full complement of staff;
- A number of key diagnostic antibodies are still being sent out to external laboratories (UCL) with a turnaround time of 3 weeks;
- Introduction of these antibodies into panels in Cardiff will be facilitated by the recent recruitment of staff;
- The Consultant sessional allocation remains adequate and all cases are reported promptly once they are technically completed.

## E07: NEUROSURGERY

Provider(s): South Wales – CVUHB; North Wales – University Hospital of Birmingham, The Walton; Powys – CVUHB, UHB, Walton

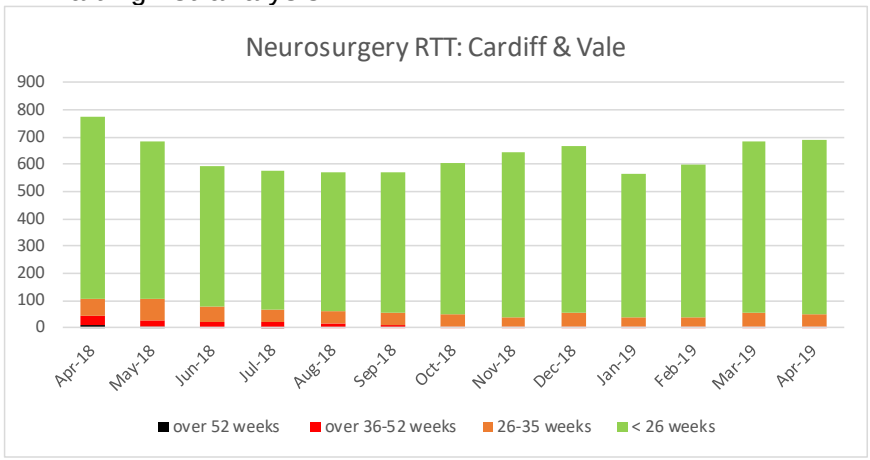
### Current Trend – RTT Performance

All provider for Welsh patients:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *C&VUHB* | Neurosurgery patients to be waiting < 26 weeks | 93% | 92% | 93% | ↑ |
| *UH Birm* | Neurosurgery patients to be waiting < 26 weeks | 85% | 91% | | ↓ |
| *The Walton* | Neurosurgery patients to be waiting < 26 weeks | - | 97% | | → |
| *North Midlands* | Neurosurgery patients to be waiting < 26 weeks | 100% | 100% | | → |

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *C&VUHB* | Neurosurgery patients to be waiting < 36 weeks | 99% | 99% | 99% | → |
| *UH Birm* | Neurosurgery patients to be waiting < 36 weeks | 90% | 95% | | ↑ |
| *The Walton* | Neurosurgery patients to be waiting < 36 weeks | - | 100% | | → |
| *North Midlands* | Neurosurgery patients to be waiting < 36 weeks | 100% | 100% | | → |

C&VUHB Waiting list analysis:




### Current Performance

The service reported that there were 4 patients waiting over 36 weeks and no patients waiting over 52 weeks. There were continued pressures due to the absence of one of the Skull Base Surgeons and a number of patients were transferred to Manchester for surgery. These surgeries were funded by C&VUHB through RTT monies received from WG in 2018/19.

17 operations were cancelled in month, the primary reason being emergency admissions the night before.

**Neuroradiology Service**

There are currently 18 patients on the waiting list for an angiogram, a reduction due to a number of WLIs being undertaken. The service is booking new patients for April. 29 patients are awaiting embolization which is an increase on previous months. New referrals are being booked into July/August although there is a waiting list initiative booked for the 13th April.

**Devices for Intra cranial Aneurysms Policy – CP 101**

This policy is still being updated to include a prior approval form and reporting arrangements to enable closer monitoring of the increased activity and spend in this area.

### What actions are WHSSC taking?

>36 cohort:

| Residing LHB | C&VUHB >36 week breaches | UHNM >36 week breaches (March) | UH Birmingham >36 week breaches (March) |
|---|---|---|---|
| Swansea Bay University Local Health Board | 1 | 0 | 0 |
| Aneurin Bevan Local Health Board | 1 | 0 | 0 |
| Betsi Cadwaladr University Local Health Board | 0 | 0 | 0 |
| Cardiff and Vale University Local Health Board | 0 | 0 | 0 |
| Cwm Taf Morgannwg Local Health Board | 1 | 0 | 0 |
| Hywel Dda Local Health Board | 1 | 0 | 0 |
| Powys Teaching Local Health Board | 0 | 0 | 1 |

- Due to the improving waiting list position with understandable reasons for the patients working in excess of 36 weeks, the service has been de-escalated in terms of meetings, with meetings taking place bi-monthly rather than monthly.
- Weekly Neuroradiology performance reports are sent to WHSSC from the Directorate.
- Discussions are ongoing at Executive level to understand how C&VUHB are working to support the INR workforce issues to improve its stability.
- A proposal for recurrently increasing Neurosurgery bed and theatre capacity has been included for funding within the WHSSC 2019-22 ICP with the case due at Management Group in May 2019.
- Repatriations are improving month on month. In March the greatest delays were with Aneurin Bevan Health Board, with delays in acceptance of patients and lack of clarity over which hospital one would be suitable for.

**What are the main areas of risk?**

**Neuroradiology:**

- The service remains fragile with a sole Consultant undertaking the majority of activity with the second Consultant not due to start until October 2019.

**Neurosurgery C&V UHB**

- The number of bed days lost in March was 75 days; which was a 50% reduction from the previous month.

## Repatriation of patients from Neurosurgery, UHW to Health Boards

| Patient Home HB | Med Fit | Date Med Fit | Date Repat referral Sent | Accepted | Date accepted | Accepting HB | Accepted within 24hrs | Date transferred | If Declined reason why | Bed Days lost |
|---|---|---|---|---|---|---|---|---|---|---|
| ABHB | Yes | 01/03/2019 | 01/03/2019 | Yes | 05/03/2019 | ABHB | No | 08/03/2019 | | 8 |
| Cwm Taff | Yes | 05/03/2019 | 06/03/2019 | Yes | 06/03/2019 | C&V | Yes | 06/03/2019 | | 1 |
| ABMU | Yes | 13/03/2019 | 15/03/2019 | Yes | 16/03/2019 | ABMU | Yes | 11/04/2019 Ward 2 POW | based on acceptance by ward mgr - accepted 18/03/2019 | 28 |
| ABHB | Yes | 18/03/2019 | 18/03/2019 | Yes | 18/03/2019 | ABHB | Yes | | declined for YYF, referred to RGH | 16 |
| Cwm Taff | Yes | 22/03/2019 | 22/03/2019 | Yes | 26/02/2019 | Cwm Taff | No | 28/03/2019 Ward D4 Y\cr | | 7 |
| ABHB | Yes | 22/03/2019 | 22/03/2019 | Yes | 22/03/2019 | ABHB | Yes | 27/03/2019 | | 6 |
| ABHB | Yes | 25/03/2019 | 26/03/2019 | Yes | 02/04/2019 please see notes | ABHB | no | 03/04/2019 | | 9 |

- We are continuing to commission inequitable Neurosurgery services for the population of Wales with longer waits than recommended guidance for patients in South and Mid Wales.

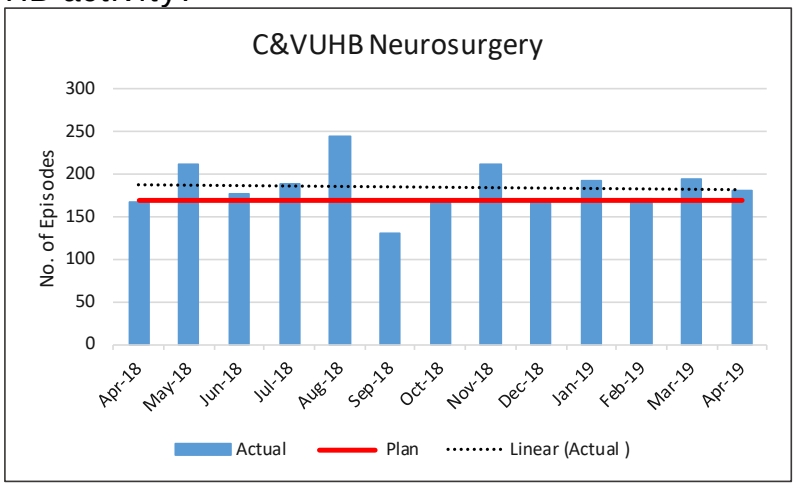
## Rehabilitation Delayed Discharges from Specialised Centres to LHBs

| Specialty | Patient Home HB | Date Med Fit | 8 week notice period ends | Bed days lost after Med Fit | Bed Days lost after the 8 week notice period has ended. | Cum. Spend |
|---|---|---|---|---|---|---|
| Neuropsy | SBUHB | 01/03/2018 | 26/05/2018 | 365 | 309 | £129,471 |
| Neuropsy | C&V | 22/08/2018 | 16/10/2018 | 221 | 166 | £69,554 |
| Neuro RehabSBU HB | SBUHBU | 18/02/2019 | 08/04/2019 | 42 | 0 | £0 |
| Neuro RehabSBU HB | SBUHBU | 25/02/2019 | 15/04/2019 | 35 | 0 | £0 |
| Neuro RehabSBU HB | SBUHBU | 06/03/2019 | 01/05/2019 | 26 | 0 | £0 |
| Neuro RehabSBU HB | SBUHBU | 28/03/2019 | 23/05/2019 | 4 | 0 | £0 |
| Neuro RehabSBU HB | SBUHBU | 04/04/2019 | 30/05/2019 | 0 | 0 | £0 |
| Spinal Injury | CT | 07/03/2019 | 30/04/2019 | 25 | 0 | £0 |

A paper on Specialised Rehabilitation went to Joint Committee and Management Group in March 2019 and set out the specific work being undertaken with the Neuropsychiatry service to understand the reasons for the long delays in that area.

## E07: NEUROSURGERY (cont'd)

Provider(s): South Wales – CVUHB; North Wales – University Hospital of Birmingham, The Walton; Powys – CVUHB, UHB, Walton

| Current Trend – Activity | Current Performance |
|---|---|
| C&VUHB activity:<br>  <br> | Performance against the LTA shows that Cardiff continues to underperform against elective and over-perform against emergency surgery. |

# E08: POSTURE & MOBILITY – ADULT

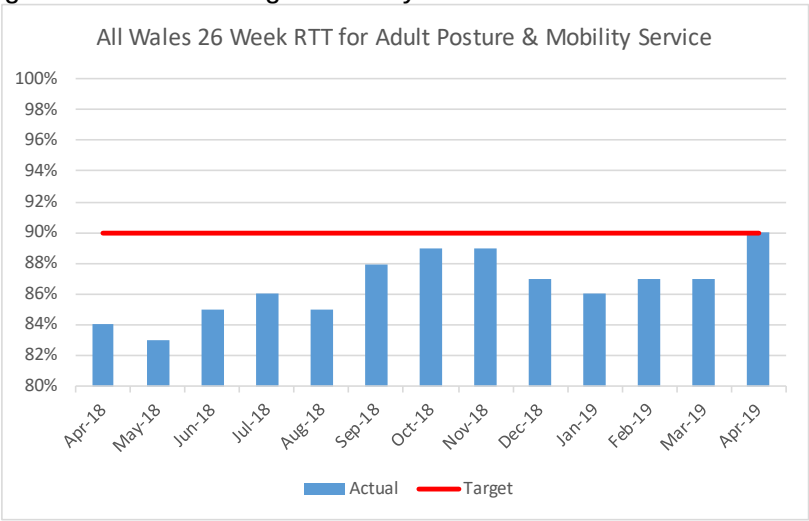
Provider(s): C&VUHB; BCUHB; SBUHB

## Current Trend – RTT Performance

All providers for Welsh patients:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *C&VUHB* | Delivery of 26 week RTT target for adult posture & mobility service in Cardiff | 90% | 89% | 91% | ↑ |
| *SBUHB* | Delivery of 26 week RTT target for adult posture & mobility service in Swansea | 98% | 98% | 98% | → |
| *BCUHB* | Delivery of 26 week RTT target for adult posture & mobility service in North Wales | 81% | 82% | 87% | ↑ |

Aggregated ALAS Waiting list analysis:




Residing LHB Split >26 cohort:

| Residing LHB | SBUHB >26 week breaches | C&VUHB >26 week breaches | BCUHB >26 week breaches |
|---|---|---|---|
| Swansea Bay University Local Health Board | 1 | 12 | 0 |
| Aneurin Bevan Local Health Board | 0 | 28 | 0 |
| Betsi Cadwaladr University Local Health Board | 0 | 0 | 77 |
| Cardiff and Vale University Local Health Board | 0 | 26 | 0 |
| Cwm Taf Morgannwg University Local Health Board | 0 | 15 | 0 |
| Hywel Dda Local Health Board | 0 | 11 | 2 |
| Powys Teaching Local Health Board | 0 | 3 | 6 |

## Current Performance

Aggregated, ALAS within Wales are complying with the waiting list targets for adult wheelchairs and individually are all meeting the paediatric targets.

BCUHB's performance in April has remained below the 90% but they advised in the bi monthly performance meeting that they are hoping to meet the 90% target for adults by June 2019. Underperformance of this service is linked to the previous workforce issues however these have been resolved.

## What actions are WHSSC taking?

- Bi - monthly meetings take place with the three service providers to discuss performance against RTT and key performance indicators.
- The current risk associated with the North Wales service has been reviewed and remains in escalation 2, as the service are still not meeting the 90% RTT target.

## What are the main areas of risk?

As highlighted in the Wheelchair Replacement paper that was considered at Management Group in March, the biggest risks within the ALAS service, aside from the BCU non-compliance with the Adult RTT target, is the overspend within the C&VUHB service which is attributed to an increase in the complexity of chair required rather than increased activity.

# E09: POSTURE & MOBILITY – PAEDIATRIC

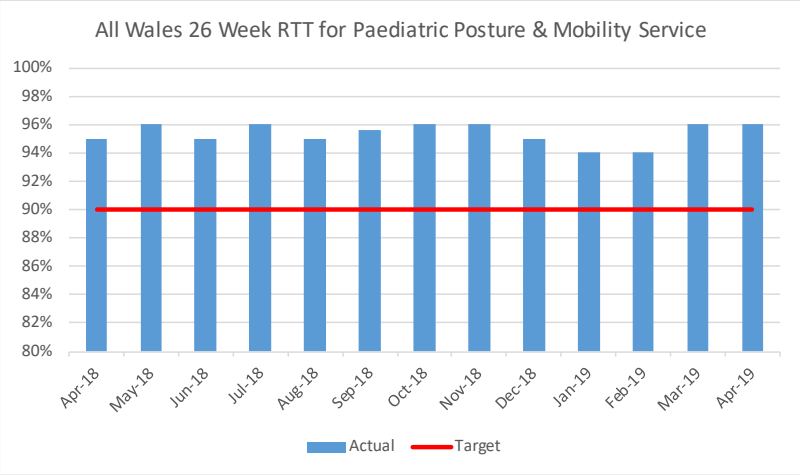
Provider(s): C&VUHB; BCUHB; SBUHB

## Current Trend – RTT Performance

All providers for Welsh patients:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *C&VUHB* | Delivery of 26 week RTT target for paediatric posture & mobility service in Cardiff | 92% | 94% | 94% | → |
| *SBUHB* | Delivery of 26 week RTT target for paediatric posture & mobility service in Swansea | 96% | 100% | 100% | → |
| *BCUHB* | Delivery of 26 week RTT target for paediatric posture & mobility service in North Wales | 99% | 100% | 99% | ↓ |

Aggregated ALAS Waiting list analysis:




Residing LHB Split >26 cohort:

| Residing LHB | SBUHB >26 week breaches | C&VUHB >26 week breaches | BCUHB >26 week breaches |
|---|---|---|---|
| Swansea Bay University Local Health Board | 0 | 1 | 0 |
| Aneurin Bevan Local Health Board | 0 | 4 | 0 |
| Betsi Cadwaladr University Local Health Board | 0 | 0 | 1 |
| Cardiff and Vale University Local Health Board | 0 | 9 | 0 |
| Cwm Taf Morgannwg University Local Health Board | 0 | 2 | 0 |
| Hywel Dda Local Health Board | 0 | 1 | 0 |
| Powys Teaching Local Health Board | 0 | 0 | 0 |

## Current Performance

Performance of the Paediatric ALAS service has been maintained within the 90% of patients tailored for within 26 weeks.

## What actions are WHSSC taking?

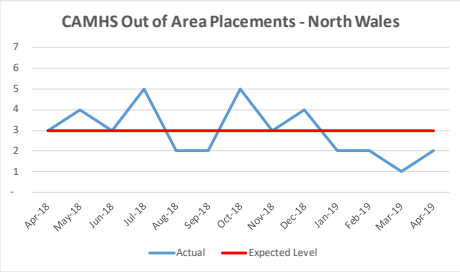
Continue to monitor through bi-monthly performance meetings with the three services.

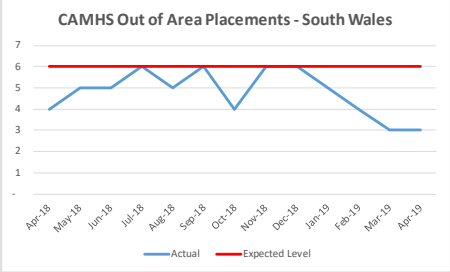
## E10: CAMHS - NHS & OUT OF AREA (OoA)

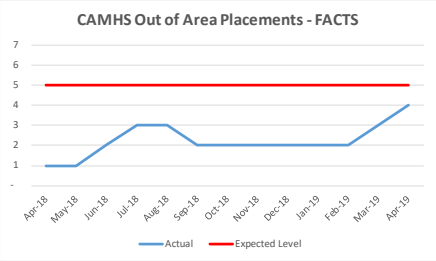
Provider(s): Cwm Taf UHB; BCUHB

### Current Trend – Activity

September OoA placement trends by area:




NHS CAMHS Beddays as a percentage against planned:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *Cwm Taf* | CAMHS NHS Beddays - South | 99% | 92% | 89% | ↓ |
| *Cwm Taf* | CAMHS NHS Home Leave - South | 23% | 38% | 30% | ↑ |
| *BCUHB* | CAMHS NHS Beddays - North | 80% | 72% | 65% | ↓ |
| *BCUHB* | CAMHS NHS Home Leave - North | 38% | 21% | 16% | ↓ |

### Current Performance

OoA performance has been stable below target for an extended period and at end April there were 9 out of area placements. Of these 9 placements 4 patients are FACTS (all South) and 5 are CAMHS patients (3 South and only 2 North). The workforce and capacity issues at the NHS units continues to be closely monitored on regular basis to get early warning of any detrimental effect on OoA referrals.

### What actions are WHSSC taking?

The BCU service remains at Level 3 due to new medical staffing issues with no substantive Consultant cover (1 long term sick & 1 leaver). Interim solution is in place with non-medical clinical lead and will be monitored closely. There continues to be issue with ability of unit to admit more complex patients. The South Wales service was escalated straight to Level 4 following patient suicide but has subsequently been reduced to Level 3 following independent assessment report from QAIT. However additional individual risk assessments are being undertaken in regard to environmental concerns raised in report. New capital funding has been promised from WG to address the above. Work is now progressing following the transfer of Bridgend assets to Cwm Taf from 1st April 19 and monitored through the escalation arrangements.

### What are the main areas of risk?

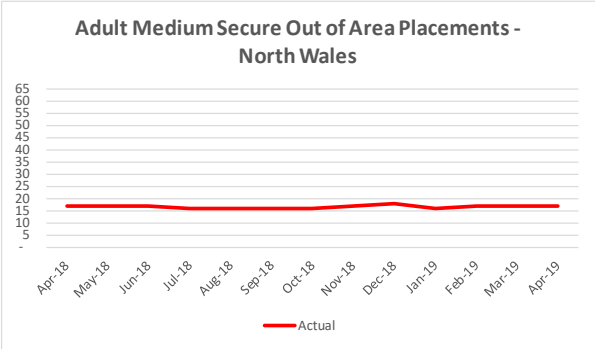
- Financial risk to all South Wales LHBs if OoA placements increase significantly due to restricted admissions. BCU stand own risk with different risk share arrangements.
- Clinical impact on patients and families being placed so far away from home area and/or outside Wales.

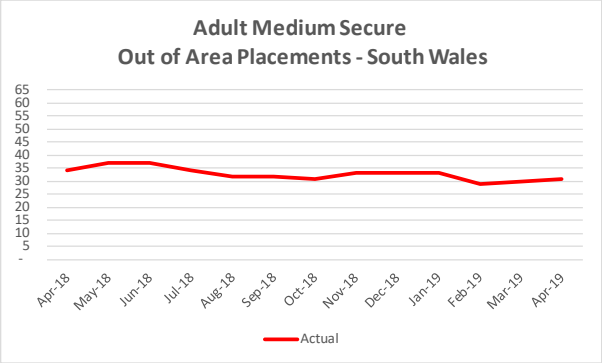
## E11: ADULT MEDIUM SECURE - NHS & OUT OF AREA (OoA)

Provider(s): BCUHB; SBUHB

### Current Trend – Activity

December OoA placement trends by area:




NHS MS Beddays as a percentage against planned:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *North* | Adult Medium Secure NHS Beddays - Ty Llywelyn | 83% | 81% | 160% | ↓ |
| *South* | Adult Medium Secure NHS Beddays - Caswell Clinic | 68% | 91% | 95% | ↑ |

### Current Performance

Ty Llewelyn unit in North has increased capacity back to the commissioned 25 beds with additional access to seclusion. All patients placed OoA in North have been reviewed and repatriated where appropriate. Discussions are continuing with BCUHB on long term use of capacity and issues with medical and qualified nursing vacancies. A new clinical lead post for forensic services has also been recruited.

The Caswell unit in South Wales continues to operate in line with agreed targets. The overall use of OoA placements continues to fall with significant input from the new case monitoring teams. This is due to both reductions in delayed discharges and overall lengths of stay particularly in South Wales.

### What actions are WHSSC taking?

The issues in North have been discussed with BCU Director of MH and will be followed up as required.

The clinical lead has overseen the OoA reviews as agreed and repatriated patients if approprioate following increase in capacity.

### What are the main areas of risk?

- Financial risk of over-performance on all Wales out of area risk share and potential of South Wales supporting North Wales reduced following reopening of full capacity in North.
- Temporary loss of LD gatekeeping expertise due to career break and previous interim plan of support from England reactivated.

# E12: PAEDIATRIC SURGERY

Provider(s): CVUHB; Alder Hey

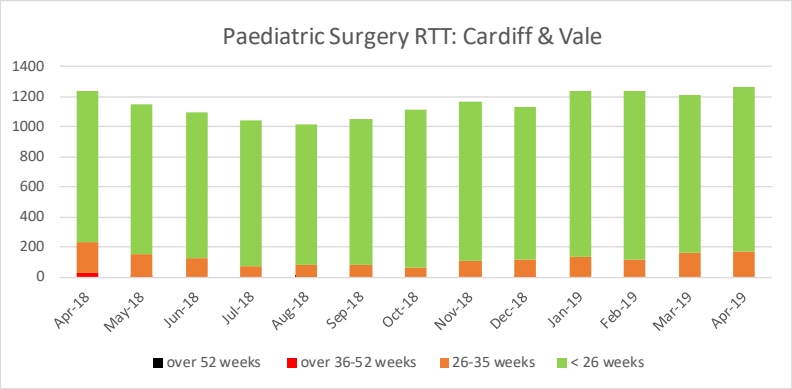
## Current Trend – RTT Performance

All provider for Welsh patients:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| C&VUHB | Paediatric surgery patients to be waiting < 26 weeks | 91% | 86% | 86% | → |
| Alder Hey | Paediatric surgery patients to be waiting < 26 weeks | 98% | 100% | | ↓ |
| Birmingham Children's | Paediatric surgery patients to be waiting < 26 weeks | 75% | 75% | | ↓ |
| UH Bristol | Paediatric surgery patients to be waiting < 26 weeks | 75% | 100% | | → |

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| C&VUHB | Paediatric surgery patients to be waiting < 36 weeks | 100% | 100% | 100% | → |
| Alder Hey | Paediatric surgery patients to be waiting < 36 weeks | 100% | 100% | | → |
| Birmingham Children's | Paediatric surgery patients to be waiting < 36 weeks | 100% | 75% | | ↓ |
| UH Bristol | Paediatric surgery patients to be waiting < 36 weeks | 100% | 100% | | → |

CVUHB Paediatric Surgery Waiting list analysis:




## Current Performance

There are 0 patients waiting over 36 weeks at Cardiff and Vale UHB in April 2019. This is the tenth consecutive that the service have achieved this position except for the month of December. There were no breaches of 36 weeks reported at Alder Hey, and UH Bristol at the end of March 2019. Birmingham Women's and Children's had 1 breach of 36 weeks.

The recent performance meeting highlighted an issue with patients accessing the Urodynamics (UDS) service. The service reported that there has been a new consultant appointment in 2019 who has reviewed the waiting list and reduced it significantly to support a current wait of 8 weeks for diagnostics. New consultant job plans and the utilising of any vacant Tuesday UDS sessions has assisted in improving the position.

## What actions are WHSSC taking?

- Bi-monthly Executive level performance meetings with CVUHB.
- Waiting list profile received and monitored via monthly reports to ensure the position is maintained.
- Enhanced monitoring with monthly update reports from Child Health Directorate in CVUHB.
- A paper was presented at WHSSC Corporate Directors meeting on 25th March to discuss the escalation level of the Paediatric Surgery service. There were two issues for consideration. A formal letter was sent in April 2019 de-escalating the service to level two.
- Currently the service are overperforming against all areas of the LTA.

## What are the main areas of risk?

- Insufficient theatre staffing; Demand of emergency v elective cases competing for theatre capacity

## E12: PAEDIATRIC SURGERY (cont'd)

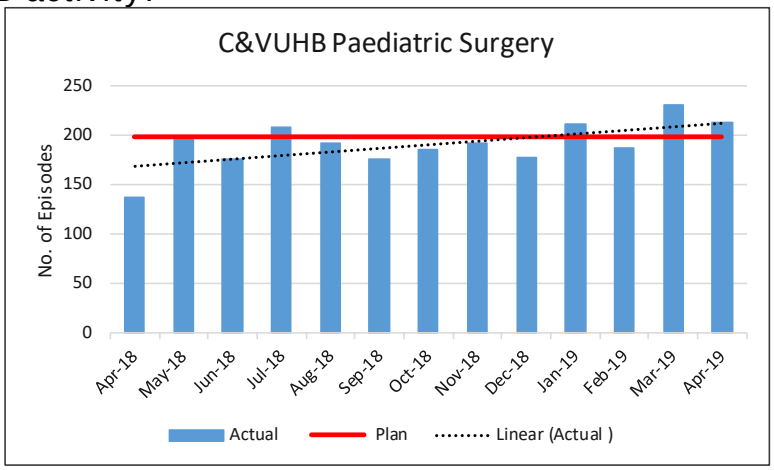
Provider(s): CVUHB, Alder Hey

| Current Trend – Activity | Current Performance |
|---|---|

Residing LHB Split C&VUHB >36 week cohort:

| Residing LHB | C&VUHB >36 week breaches | Birm W&C >36 week breaches (March) |
|---|---|---|
| Swansea Bay University Local Health Board | 0 | 0 |
| Aneurin Bevan Local Health Board | 0 | 0 |
| Betsi Cadwaladr University Local Health Board | 0 | 0 |
| Cardiff and Vale University Local Health Board | 0 | 1 |
| Cwm Taf Morgannwg Local Health Board | 0 | 0 |
| Hywel Dda Local Health Board | 0 | 0 |
| Powys Teaching Local Health Board | 0 | 0 |

CVUHB activity:



## E13: IVF

Provider(s): SBUHB (Neath & Cardiff WFI); Liverpool Women's; Shrewsbury

### Current Trend – RTT Performance

All providers for Welsh patients:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *WFI Neath* | IVF patients waiting for Outpatient Appointment | 100% | 100% | 100% | → |
| *WFI Neath* | IVF patients waiting to commence treatment | 35% | 88% | 48% | ↓ |
| *WFI Neath* | IVF patients accepted for 2nd cycle waiting to commence treatment | 100% | 97% | 63% | ↓ |
| *WFI Cardiff* | IVF patients waiting for Outpatient Appointment | 100% | 100% | 100% | → |
| *WFI Cardiff* | IVF patients waiting to commence treatment | 38% | 72% | 59% | ↓ |
| *WFI Cardiff* | IVF patients accepted for 2nd cycle waiting to commence treatment | 67% | 100% | 86% | ↓ |
| *Liverpool* | IVF patients waiting for Outpatient Appointment | 100% | 100% | 100% | → |
| *Liverpool* | IVF patients waiting to commence treatment | 100% | 100% | 36% | ↓ |
| *Liverpool* | IVF patients accepted for 2nd cycle waiting to commence treatment | 100% | 100% | 100% | → |
| *Shrewsbury* | IVF patients waiting for Outpatient Appointment | 100% | 100% | 100% | → |
| *Shrewsbury* | IVF patients waiting to commence treatment | 26% | 0% | 6% | ↑ |
| *Shrewsbury* | IVF patients accepted for 2nd cycle waiting to commence treatment | 30% | 33% | 63% | ↑ |

### Current Performance

Delivery against the 26 week 1st outpatient appointment standard is being achieved at all centres.

There continues to be a large number of patients waiting to commence 1st and 2nd cycles with the longest waits at Shrewsbury.

### What actions are WHSSC taking?

- The Shrewsbury service has been placed in escalation stage 2, monthly performance meetings have been initiated 27th February 2019, 3rd April with a further meeting scheduled for the 19th June 2019.
- Shrewsbury have validated their waiting list and are confident they are now accurately recording RTT.
- Shrewsbury continue to provide demand capacity profile on a monthly basis.
- Due to inaccuracies in the recording of the waiting list noted during the escalation visit there is unlikely to be shortfall in capacity. The demand-capacity gap will be reviewed when WHSSC are assured the waiting list in Shrewsbury is consistently being accurately recorded and managed.
- The service were informed that consideration would be given to de-escalate in June 2019 providing the service had produced robust waiting list data, which meets WHSSC reporting requirements.

### What are the main areas of risk?

- Capacity gap at Shrewsbury to be reviewed in line with the escalation;
- Deteriorating RTT position.

## E14A: ADULT COCHLEAR IMPLANTS

Provider(s): C&VUHB; BCUHB

### Current Trend – RTT Performance

All providers for Welsh patients:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *North* | Adult Cochlear Implant patients to be waiting < 26 weeks | 100% | 100% | 100% | → |
| *South* | Adult Cochlear Implant patients to be waiting < 26 weeks | 73% | 81% | 75% | ↓ |

### Current Performance

The South Wales service have reported that they will achieve 26 week RTT by 31st March 2020 and have submitted a demand capacity profile.

The North Wales service have a zero breach 26 week position for adult patients.

### What actions are WHSSC taking?

- A funding proposal has been agreed by Management Group in September 2018 to meet 50% of the 26 week RTT target by the end of 2018/19.
- Funding has been agreed for 2019/20 to target the outstanding 50% breached patients, this will ensure that the 26 week RTT target will be achieved by 31st March 2020. WHSSC will continue to monitor the performance of the service through regular performance meetings.
- The Cochlear Implant policy has been updated to reflect the NICE Guidance changes on the eligibility criteria which takes effect from 5th March 2019. A paper will be submitted to Management Group in May detailing the implementation of the of the NICE TA (TA566).
- The revised policy has been submitted to the Policy Group and is due to be consulted upon.

### What are the main areas of risk?

- Inequity for patients in the South Wales
- Long waiting times for patients that impacts directly on their quality of life.

## E14B: PAEDIATRIC COCHLEAR IMPLANTS

Provider(s): C&VUHB; BCUHB

### Current Trend – RTT Performance

All providers for Welsh patients:

| Provider | Measure | Feb-19 | Mar-19 | Apr-19 | Latest Movements |
|---|---|---|---|---|---|
| *North* | Paediatric Cochlear Implant patients to be waiting < 26 weeks | - | - | - | |
| *South* | Paediatric Cochlear Implant patients to be waiting < 26 weeks | 100% | 100% | 90% | |

### Current Performance

There are no paediatric patients currently breaching 26 weeks.

Patients in North Wales access services at Manchester Royal Infirmary. We do not currently receive data however we are unaware of any patients waiting in excess of 26 weeks for treatment.

### What actions are WHSSC taking?

- A funding proposal was agreed by Management Group in September 2018 to meet 50% of the 26 week RTT target.
- Updates against this target continue to be provided within this report.
- The existing WHSSC policy for the use of Cochlear Implants for children and adults with severe to profound deafness (CP35) has been revised to incorporate new NICE TA recommendations and will be presented at the WHSSC Policy Group on 10 May 2019; to proceed to a four week consultation. It is anticipated that the revised policy will be published on the WHSSC website by the end of July 2019.
- A paper will be submitted to Management Group in May detailing the implementation of the of the NICE TA (TA566).

### What are the main areas of risk?

- Inequity for patients in the South Wales
- Long waiting times for patients that impacts directly on their quality of life.

| Link to Healthcare Objectives | |
|---|---|
| Strategic Objective(s) | **Governance and Assurance**<br>**Implementation of the Plan** |
| Link to Integrated Commissioning Plan | This report monitors the delivery of the key priorities outlined within WHSSCs Integrated Commissioning Plan. |
| Health and Care Standards | **Governance, Leadership and Accountability** |
| Principles of Prudent Healthcare | |
| Institute for HealthCare Improvement Triple Aim | |
| **Organisational Implications** | |
| Quality, Safety & Patient Experience | The report will monitor quality, safety and patient experience. |
| Resources Implications | There are no resource implications at this point |
| Risk and Assurance | There are no known risks associated with the proposed framework There are reputational risks to non-delivery of the RTT standards. |
| Evidence Base | N/A |
| Equality and Diversity | The proposal will ensure that data is available in order to identify any equality and diversity issues. |
| Population Health | The core objective of the report is to improve population heath through the availability of data to monitor the performance of specialised services. |
| Legal Implications | There are no legal implications relating to this report. |

| **Report History:** | | |
|---|---|---|
| **Presented at:** | **Date** | **Brief Summary of Outcome** |
| Corporate Directors Group Board | 08/07/2019 | |
| Management Group | 18/07/2019 | |

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

| | | | |
|---|---|---|---|
| | | Agenda Item | 3.2 |
| Meeting Title | **Joint Committee** | Meeting Date | 23/07/2019 |
| Report Title | Financial Performance Report – Month 3 2019/20 | | |
| Author (Job title) | Finance Manager - Contracting | | |
| Executive Lead (Job title) | Director of Finance | Public / In Committee | |

| | |
|---|---|
| Purpose | The purpose of this report is to set out the financial position for WHSSC for the 3rd month of 2019/20. This position forms the basis of WHSSC's final accounts.<br><br>The financial position is reported against the 2019/20 baselines following approval of the 2019/20 WHSSC Integrated Commissioning Plan by the Joint Committee in January 2019. |

| RATIFY | APPROVE | SUPPORT | ASSURE | INFORM |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☒ |

| | | | |
|---|---|---|---|
| Sub Group /Committee | Corporate Directors Group Board | Meeting Date | |
| | Joint Committee | Meeting Date | |
| Recommendation(s) | Members are asked to:<br>• **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 | | ✓ |

## 1.0 SITUATION

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

## 2.0 BACKGROUND

The financial position is reported against the 2019/20 baselines following approval of the 2019/20 WHSSC Integrated Commissioning Plan the Joint Committee in January 2019.

In line with the cross border agreement reached with NHS England, the English SLA position reported is adjusted down to 18/19 prices until central funding & commissioner 2% inflation to cover the 19/20 tariff uplift and HRG4+ has flowed through into WHSSC income position. On this basis there should be no material impact of both HRG4+ and 19/20 tariff uplift, this will be aligned to income once funding is finalised.

## 3.0 ASSESSMENT

The financial position reported at Month 3 for WHSSC is a forecast year end under spend of £2,831k.

There is movement across various budget headings. The forecasted overspend within Welsh & English providers, IPFR and DRC is being offset by underspend movements in mental health, developments and the release of prior year reserves.

## 4.0 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<br>Development of the Plan |
| Link to Integrated Commissioning Plan | **This document reports on the ongoing financial performance against the agreed IMTP** |
| Health and Care Standards | Governance, Leadership and Accountability |
| Principles of Prudent Healthcare | Only do what is needed |
| Institute for HealthCare Improvement Triple Aim | Reducing the per capita cost of health care |
| **Organisational Implications** | |
| Quality, Safety & Patient Experience | |
| Resources Implications | **This document reports on the ongoing financial performance against the agreed IMTP** |
| Risk and Assurance | **This document reports on the ongoing financial performance against the agreed IMTP** |
| Evidence Base | |
| Equality and Diversity | |
| Population Health | |
| Legal Implications | |

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

# Finance Performance Report – Month 3

## 1. Situation / Purpose of Report

The purpose of this report is to set out the estimated financial position for WHSSC for the 3rd month of 2019/20 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 | 618,720 | 154,680 | 154,092 | (588) | (201) | (2,832) | (3,024) |
| EASC (WAST, EMRTS, NCCU) | 164,045 | 41,011 | 41,011 | 0 | 0 | 0 | 0 |
| Total as per Risk-share tables | 782,765 | 195,691 | 195,104 | (588) | (201) | (2,832) | (3,024) |

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 2019/20 baselines following approval of the 2019/20 ICP by the Joint Committee in January 2019. 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 3 is an underspend of £588k year to date with a forecast year end underspend of £2,831k

The majority of NHS England is reported in line with the previous month's activity returns. WHSSC continues to commission in line with the contract intentions agreed as part of the IMTP and historic standard PbR principles, 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.

## 3. Governance & Contracting

All budgets have been updated to reflect the 2019/20 ICP, including the full year effects of 2018/19 Developments. Inflation framework agreements have been allocated within this position. The agreed ICP sets the baseline for all the 2018/19 contract values which have been transposed into the 2019/20 contract documents.

The Finance Sub Group has developed a new risk sharing framework which has been agreed by Joint Committee was implemented in April 2019. This is based predominantly on a 2 year average utilisation calculated on the latest available complete year's data. Due to the nature of highly specialist, high cost and low volume services, a number of areas will continue to be risk shared on a population basis to avoid volatility in commissioner's position.

# 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 | 206,497 | 51,624 | 51,721 | 97 | 69 | 1,084 | 47 |
| Swansea Bay Univ Health Board | 98,662 | 24,666 | 24,474 | (192) | (174) | (337) | (21) |
| Cwm Taf Morgannwg University Health Board | 9,614 | 2,404 | 2,406 | 3 | (47) | 158 | 0 |
| Aneurin Bevan Health Board | 8,147 | 2,037 | 2,057 | 20 | 0 | 0 | 0 |
| Hywel Dda Health Board | 1,581 | 395 | 395 | 0 | 0 | 0 | 0 |
| Betsi Cadwaladr Univ Health Board Provider | 41,049 | 10,262 | 10,319 | 57 | 0 | 0 | 0 |
| Velindre NHS Trust | 43,193 | 10,798 | 10,798 | 0 | 0 | 0 | 0 |
| **Sub-total NHS Wales** | **408,743** | **102,186** | **102,171** | **(15)** | **(152)** | **905** | **26** |
| Non Welsh SLAs | 103,120 | 25,780 | 26,083 | 303 | 145 | 303 | 145 |
| IPFR | 38,714 | 9,678 | 10,501 | 822 | 306 | 300 | 0 |
| IVF | 4,734 | 1,184 | 1,205 | 21 | 0 | 0 | 0 |
| Mental Health | 30,889 | 7,722 | 7,101 | (621) | (367) | (400) | (100) |
| Renal | 5,056 | 1,264 | 1,210 | (54) | (106) | 36 | (46) |
| Prior Year developments | 2,463 | 616 | 316 | (300) | (200) | (1,200) | 0 |
| 2019/20 Plan Developments | 21,191 | 2,872 | 2,871 | (0) | 0 | (0) | 0 |
| Direct Running Costs | 3,810 | 953 | 940 | (12) | (13) | 153 | 165 |
| Reserves Releases 2018/19 | 0 | 0 | (732) | (732) | 0 | (2,927) | 0 |
| Phasing adjustment for Developments not yet implemented ** see below | 0 | 2,426 | 2,426 | 0 | 0 | 0 | 0 |
| **Total Expenditure** | **618,720** | **154,680** | **154,092** | **(588)** | **(387)** | **(2,831)** | **190** |

The reported position is based on the following:

- NHS Wales activity – based on Month 2 data or Annual Plan values if deemed to vary from the 2018/19 outturn.
- NHS England activity – based on Month 2 contract monitoring data or Annual Plan values if this data was not available.
- IVF – 2 NHS England and 1 NHS Wales contract provider, with some IPFR approvals.
- IPFR – reporting is based on approved Funding Requests; recognising costs based on the usual lead times for the various treatments, unclaimed funding requests are 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 based blocks based on 3 year rolling averages.
- Developments – variety of bases, including agreed phasing of funding.

** 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 2 data have been extrapolated to a total reported month 3 position of £97k over spent and a year-end position of £1,084k over spent. These figures include the net effect of the development and savings funding available to the LHB. The position includes the following areas:

- Cardiology for AB – the YTD position has increased to an overspend of £88k as a result of 24 more PCI procedures than last month being carried out. Given this increase and the trend from last year, the forecast position has been set to match 18/19 outturn and thus stands at £244k over spent.

- Cwm Taf Cardiology ICDs – the trend of overperformance from last year has also continued with this service. The YTD position stands at £79k overspent as a result of 4 ICD procedures in month. To be prudent, the forecast has been set at 18/19 outturn levels and shows an overspend of £274k.

- Cardiac Surgery – the YTD increase this month is due to a reporting error last month. The position will fall back as the year progresses as the case numbers have been static for a numbers of years. The forecast has been set to the 18/19 outturn as a result of this trend and stands at £462k underspent.

- Thoracic Surgery – the YTD position has fallen back by £95k this month and now stands at an underspend of £64k. This is a result of 8 less complex and 8 less intermediate procedures than last month. As a result of this volatility, the forecast has been set to break-even level.

- Spinal Implants – the trend of overperformance with this service continues and stands at £16k YTD. In order to be prudent, the forecast is set at £182k overspent which matches 18/19 outturn.

- Neuro Rehab – the trend of material underperformance in this service continues this year with the YTD position falling back further and

standing at £29k underspent. The forecast is set to straight line and is £115k underspent.

- Renal – the trends within this service area remain consistent with YTD overspends in surgery, home dialysis and hospital dialysis which are partially offset by underspends in nephrology, CAPD and transplants. These figures have been extrapolated on a straight line basis to form the forecast but it should be noted that a growth provision for 19/20 to offset hospital dialysis has been released within Developments.

- Haemophilia – a YTD underspend of £152k exists mainly as a result of reductions in spend for Benefix and Refacto but it should also be noted that last year's overperformance was driven by a high cost trails patient. C&V are investigating this figure to ensure accuracy and thus the forecast is set to breakeven until this is complete.

- BMT – the service is currently £88k underspent YTD which equates to 6 procedures under the activity baseline. The forecast is set to breakeven to be prudent at this early stage of the year as we still await an accurate activity forecast from the service.

- Paeds Renal – YTD the overspend stands at £77k and is driven mostly by inpatient activity. The forecast has been set at the YTD level as this is not materially different from 18/19 outturn.

- Paeds Neurology – the YTD performance stands at a £17k underspend which has led to a straight line extrapolated forecast of £68k underspent. This underperformance is driven by reductions in inpatient and day case activity.

- UK GTN send out tests – the YTD position stands at £67k overspent and is mainly a result of new tests that are now available to consultant geneticists. The forecast has been set at the YTD level as this is not materially different to the 18/19 outturn.

- Home TPN – a £43k overspend exists for the YTD position as the service is currently 99 days above their activity baseline. Due to the trend of overperformance in this service, the forecast is set to the 18/19 outturn.

- Liver Cancer Development – YTD the service is £40k underspent as they are 5 procedures under the activity baseline. This is a volatile service and thus to be prudent, the forecast has been set at the 18/19 outturn due to the trend of underperformance.

- NICE/High Cost Drugs – YTD the overperformance has fallen by £17k and stands at £34k due to ataluren being removed from the SLA reporting as it is funded/settled via development funding.

**5.2 NHS Wales – SB contract:**

Various over and underspends from the month 2 data have been extrapolated to a total reported month 3 position of £192k under spent and a year-end position of £337k under spent. These figures include the net effect of the development and savings funding available to the LHB. The position includes the following areas:

- Renal – YTD and full year forecast overspends stand at £107k and £426k respectively and are largely a result of dialysis activity. As with the C&V service, a growth provision for 19/20 to offset this has been released within Developments.

- Cardiac Surgery – the YTD underspend stands at £158k and is a result of activity underperformance in virtually all areas of this service. This is a historic trend for the service and thus the full year forecast has been set at 18/19 outturn.

- Plastics – the service has moved into overspend this month and stands at £31k as a result of a £48k movement in the position. This is a result of an increase in emergency and day case activity that is partially offset by decreasing elective activity. Due to the volatility of this service the forecast has been left at breakeven.

- Burns – the YTD underspend has increased by £25k and now stands at £79k as a result of falling in patient activity. This is another volatile service that is hard to accurately forecast and thus the full year forecast has been left at break even.

- Bariatrics – activity has fallen again this month and the YTD position stands at an underspend of £38k. The forecast has been set at 18/19 outturn due to the historic trend of underperformance in this service.

**5.3 NHS Wales – BCU contract:**

The angioplasty service have reported 8 procedures over the activity baseline and thus YTD are £24k overspent. ICD activity is showing the same trend and stands at £61k overspent reflecting 5 procedures over the activity baseline this month. These position are partially offset by a £29k underspend in haemophilia. These services are all set to breakeven forecast due to their volatility and will be monitored over the coming months.

**5.4 NHS Wales – Cwm Taf Morgannwg contract:**

The CAMHS position remains consistent at £47k underspent which is offset by a £50k overspend in ICD activity. This is due to activity being 3

procedures over baseline this month and thus the full year forecast is set at 18/19 outturn to be prudent.

**5.5 NHS Wales – Aneurin Bevan contract:**
The cardiology service are 11 procedures over the activity baseline YTD which equates to a £25k overspend. The forecast has been left at breakeven and will be monitored over the coming months.

**5.6 NHS Wales – Hywel Dda contract:**
Reported to break-even position at this point pending 2019/20 data.

**5.7 NHS Wales – Velindre contract:**
Reported to break-even position at this point pending 2019/20 data.

**5.8 NHS England contracts:**
Total £303k overspend to month 3 with the full year forecast being reported at the same level. The English position has been reported either based on an extrapolation of month 2 reported actual data or plan data where actuals have not yet been provided.

The larger reported movements/variances are:

- Alder Hey – YTD and full year forecasts are breakeven, a reduction of £70k from last month as a result of adjusting the position down to 18/19 prices.

- Birmingham Women's & Children's – YTD and full year forecasts have reduced by £59k and are now £8k overbudget. This is mainly a result of a long stay patient that was discharged last month and no corresponding activity this month.

- Manchester University – YTD and full year forecasts are £116k underspent. This is an underspend reduction of £64k due to high cochlear activity and a pancreas transplant in month.

- Christie – both YTD and forecast positions have moved by £110k and now stand at breakeven. In month there has been high non elective activity and 3 BMT procedures.

- Robert Jones – this month has seen a £149k movement in both YTD and forecast positions and they now stand at £188k underspent. This is simply low monthly activity this year.

- Royal Brompton – a £95k reduction in both YTD and forecast positions means the current reported figure is an underspend of £95k. This is a result of high month 1 activity that has not been matched this month.

- University Bristol – the position has moved from breakeven to a reported £84k overspend. This position includes a £323k adjustment of anticipated funding to cover 19/20 tariff uplift.

- University North Midlands – the reported YTD and forecast figures are both £123k overspent which is an increase of £118k over last month. This is a result of a high cost PICU patient, major trauma patient and an emergency cardiac patient in month.

- Walton – a £65k increase in the position this month has moved the trust into a £38k overspend this month. This month has seen 3 high cost coiling patients and 3 neurosurgery patients causing this movement.

Triangulation of alternative methods of forecasting informs the degree of risk at any time and are reviewed each month. The current reported forecast outturn position is prudent compared with straight line forecasting.

**5.9 IPFR:**

The total over spend at month 3 is £822k with a full year forecast reported at £300k overspent. The year to date variance consists of an over spend on non-contract activity due to high numbers of paediatric BMT approvals, the impact of new Burosumab approvals in June and an increase in HPN spend, this is partially offset by underspends in all other areas based upon invoices received to date. The forecast increase is based upon 18/19 activity for non-contract activity, offset by underspend forecasts for Eculizumab and PHT.

**5.10 IVF:**

YTD the position ash moved from breakeven to a £21k overspend. This is a result of a £119k increase in the non Welsh position due to high activity in Shrewsbury which is partially offset by an underspend in the Welsh service. Forecast is reported to break-even position at this point as activity in all contracts is expected to move to this figure throughout the year.

**5.11 Mental Health:**

Various budgets totalling an underspend to date of £621k and a year-end forecast underspend of £400k. These budgets include:

- Adult Mental Health has a £508k underspend reported year to date and £400k for year end forecast. The main driver for this underspend is discharges in Forensic Mental Health. The costs in this area are significantly lower than 18/19 so WHSSC assume that case management and gatekeepers continue to yield savings.

- CAMHS and Eating Disorders have a £113k under spend reported year to date with a breakeven year end forecast. The under spend is spread

across all areas within this service and is based on invoices/commitments received to date.

**5.12 Renal:**

There has been an adverse movement in both YTD and forecast positions this month of £52k and £82k respectively. The YTD position is £54k underspent and the forecast is £36k overspent. The main drivers behind this movement are 3 transplants taking place in Royal Liverpool & Broadgreen and an increase in immunosuppression activity in UHW.

**5.13 Reserves:**

A release of 18/19 non recurrent structural reserves has been made into the position in month 3 totalling £2,927k for year end. This will be released evenly through the year. Further reserve releases will be made as they are analysed throughout the year.

**5.14 Developments:**

There is a total of £23,654k funded developments in the 2019/20 position, £2,463k of which relates to developments from prior years, £6,050k relates to 2019/20 CIAG Schemes (£700k has been moved to the C&V SLA for AAC), £7,135k relates to 2019/20 New Specialised Services & Strategic Priorities and £1,200k relates to Horizon Scanning. The remaining £6,806k are marginal performance provision for activity within C&V and SB providers.

The YTD and forecast variance for Dialysis Growth has a cost neutral impact overall as there is a corresponding increase in the C&V and SB SLA for this service.

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

The running cost budget is currently £12k underspent YTD with a forecast position of £153k overspent. This is mainly due to historic underfunding of the non-pay budgets which has continued into 19/20, partially offset by renal network underspend.

WHSSC have exchanged contracts for the new building in Treforest Industrial Estate and the anticipated moving date at present is towards the end of August/early September. Further updates on the progress of the move will be given in subsequent reports.

## 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 £'000 | Cardiff and Vale £'000 | SB £'000 | Cwm Taf Morgannwg £'000 | Aneurin Bevan £'000 | Hywel Dda £'000 | Powys £'000 | Betsi Cadwaladr £'000 |
| Variance M3 | (588) | (63) | (151) | 28 | (74) | (242) | 59 | (145) |
| Variance M2 | (387) | 33 | (51) | (31) | (6) | (74) | 42 | (300) |
| Movement | (201) | (96) | (100) | 59 | (68) | (169) | 17 | 155 |

**Table 4 – End of Year Forecast by LHB**

| | Allocation of Variance | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Total £'000 | Cardiff and Vale £'000 | SB £'000 | Cwm Taf Morgannwg £'000 | Aneurin Bevan £'000 | Hywel Dda £'000 | Powys £'000 | Betsi Cadwaladr £'000 |
| EOY forecast M3 | (2,832) | (593) | (431) | 132 | (911) | (428) | (138) | (464) |
| EOY forecast M2 | 192 | 75 | 55 | 62 | 37 | 51 | 63 | (151) |
| EOY movement | (3,024) | (668) | (486) | 71 | (948) | (480) | (200) | (313) |

## 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.

This is the first month under the rebased risksharing financial framework and a cost neutral allocation adjustment is anticipated to realign commissioner funding with the WHSSC income expectations.

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 further details relating to the Commissioner Income.

**Table 5 – 2019/20 Commissioner Income Expected and Received to Date**

| | 2019/20 Planned Commissioner Income £'000 | Income Expected to Date £'000 | Actual Income Received to Date £'000 | Accrued Income - WHSSC £'000 | Accrued Income - EASC £'000 | Total Income Accounted to Date £'000 | EOY Comm'er Position £'000 |
|---|---|---|---|---|---|---|---|
| **SB** | 95,871 | 23,968 | 23,315 | 668 | (15) | 23,968 | (431) |
| **Aneurin Bevan** | 142,629 | 35,657 | 35,657 | 0 | 0 | 35,657 | (911) |
| **Betsi Cadwaladr** | 175,633 | 43,908 | 43,909 | 0 | 0 | 43,909 | (464) |
| **Cardiff and Vale** | 126,218 | 31,555 | 31,555 | 0 | 0 | 31,555 | (593) |
| **Cwm Taf Morgannwg** | 111,470 | 27,868 | 27,739 | 113 | 15 | 27,867 | 132 |
| **Hywel Dda** | 94,015 | 23,504 | 23,503 | 0 | 0 | 23,503 | (428) |
| **Powys** | 36,929 | 9,232 | 9,232 | 0 | 0 | 9,232 | (138) |
| **Public Health Wales** | | | | | | 0 | |
| **Velindre** | | | | | | 0 | |
| **WAST** | | | | | | 0 | |
| **Total** | **782,765** | **195,691** | **194,910** | **782** | **0** | **195,692** | **(2,832)** |

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 moving forward to next financial year are:

- 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.
- Exposure to unplanned NICE approvals and generic price increases in contract prices.

## 9. Public Sector Payment Compliance

As at month 3 WHSSC has achieved 99.2% compliance for NHS invoices paid within 30 days by value and 99.6% by number.

For non NHS invoices WHSSC has achieved 98% in value for invoices paid within 30 days and 99.7% by number.

Further 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 2.3

The SLA with Velindre has now been agreed and signed by both parties.

### Action Point 2.4

Please see section 11 below.

### Action Point 2.5

Table B1 in the MMR returns has now been updated.

### Action Point 2.6

The pay spend has now been updated and the reduction reported last month no longer exists.

## 11. SLA 19/20 status update

TO BE UPDATED

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

**Sian Lewis,**
**Managing Director, WHSSC**

**Stuart Davies,**
**Director of Finance, WHSSC**

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

# CORE BRIEF TO MANAGEMENT GROUP MEMBERS

## MEETING HELD ON 23 MAY 2019

This briefing sets out the key areas of discussion and decision. It aims to ensure the Management Group members have a common core brief to disseminate within their organisation.

### 1. Welcome and Introductions

The Chair welcomed members to the meeting.

### 2. Minutes of the Previous Meeting and Action Log

The minutes of the meeting held on 25 April 2019 were approved subject to minor revisions.

Members noted the action log and received updates on:

- MG086 IVF: Royal Shrewsbury Hospital RTT Escalation - De-escalation will not take place until WHSSC receives consistent information from the provider.
- MG121 Lynch Syndrome - Information not received on business case from CVUHB. Proposal expected to be presented at June meeting.
- MG129 Thomas Report - CN currently drafting WHSSC response.
- MG130 Shrewsbury and Telford NHS Trust - Renal Network has picked up issues and will report back on recommended pathway change.
- MG131 Welsh Language Standards - Work on standard templates carried out by health boards. Changes will not be ready for this year's SLA process.
- MG132 Lynch Syndrome - NHSW Collaborative papers have been circulated.

### 3. Report from the Managing Director

Members received the Managing Director's report, which included:

- **Cystic Fibrosis - Business Case Update** Assurance had been received around a number of points but further work was required; a consolidated report would be brought back to the next meeting.
- **Hyperbaric Oxygen Therapy (HBOT)** The private provider in Cardiff was reported to be working at a loss but proposed to service south Wales from its Plymouth unit. Members agreed with this proposal. WHSSC to amend contract accordingly to ensure access.
- **Bariatric Surgery** Due to improved performance the service had been taken out of the WHSSC Escalation Process.

- **Implementation of ICP 2019-22** There had been a delay in bringing funding releases to MG during April and May but the majority of these would be presented to the June meeting.
- **Low Dose Rate Brachytherapy for Prostate Cancer** Velindre had reported that it would no longer be providing this service and proposed that patients be referred to Bristol under an outsource arrangement. Subject to due diligence of the Bristol service the proposed transfer was supported in principle. Velindre would, however, be developing a business case for high dose brachytherapy service for prostate cancer patients. This case will need to be considered through the ICP process as a new service. The WHSSC team will investigate whether Bristol are able to provide low dose brachytherapy and will review the commissioning policy in the context of the changing pattern of demand and provision.

## 4. Major Trauma Network - Presentation

Members received a presentation on establishing the Major Trauma Network for south, mid and west Wales.

## 5. Implementation of the Revised WHSSC Policy Proposal for Cochlear Implants for Children and Adults with Severe to Profound Deafness

Members received a paper on the implementation of the revised WHSSC policy proposal for cochlear implants for children and adults with severe to profound deafness.

Members resolved to approve the recommendation and noted the pressure on the NICE contingency budget.

## 6. Tertiary Cardiology - Commissioning a Complex Device service at Aneurin Bevan University Health Board

Members received a paper on the proposed commissioning of a tertiary cardiology complex device service at Aneurin Bevan University Health Board for its resident population.

Members resolved to approve the recommendation subject to receipt of assurance that the service is meeting the standards for implanting.

## 7. Inherited Bleeding Disorders – Request for Funding Release

Members received a paper that requested approval for the release of funding to implement the Integrated Commissioning Plan scheme 19/280 Inherited Bleeding Disorders: south Wales.

Members approved the request, subject to assurances around equity for PTHB patients accessing care from English providers via the implementation of a standard service specification.

## 8. Predicting the future impact of Advanced Therapeutic Medicinal Products (ATMPs) in NHS Wales

Members received the paper which provided an overview of the work done to date by the WHSS Team. This work would be progressed further and has been shared with Welsh Government, receiving positive feedback.

## 9. Tier 4 Specialist Perinatal Mental Health in Wales

Members were advised that a paper was due to come to Management Group but was not yet ready.

## 10. WHSSC Policy Group: Update

Members received a paper on the work of the WHSSC Policy Group and noted the information presented within the report.

## 11. Integrated Performance Report

Members received a report that provided a summary of the performance of services commissioned by WHSSC for March 2019 and noted the actions being undertaken to address areas of non-compliance.

## 12. Finance Report 2019-20 Month 1

Members received a report that set out the financial position for WHSSC for the first month of 2019-20, being an underspend of £112k. Members received an update from the Director of Finance on the agreed position in respect of cross border contracting flows and that this will require further funding from health boards equivalent to 2% of cross border baselines. WHSSC will share the final impact assessment.

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

# CORE BRIEF TO MANAGEMENT GROUP MEMBERS

## MEETING HELD ON 27 JUNE 2019

This briefing sets out the key areas of discussion and decision. It aims to ensure the Management Group members have a common core brief to disseminate within their organisation.

### 1. Welcome and Introductions

The Chair welcomed members to the meeting.

### 2. Mechanical Thrombectomy

In response to a request from ABUHB, an oral update was given on the current provider status for mechanical thrombectomy for Welsh residents. A written update would follow.

### 3. Neonatal Transport

Members were advised that the proposal for a 24 hour service was identical to the one already seen by Management Group, which was considered not to benchmark well on cost and to be unaffordable; discussions were continuing with the Network and providers. Dr Fox had begun the external review; any recommendations would be considered through the ICP prioritisation process.

### 4. Minutes of the Previous Meeting and Action Log

The minutes of the meeting held on 23 May 2019 were approved.

Members noted the action log and received updates on:

- MG121 Lynch Syndrome – Proposal from CVUHB awaited and expected to be presented at July meeting.
- MG129 Thomas Report - CN currently working on WHSSC response.
- MG130 Shrewsbury and Telford NHS Trust - Renal Network has picked up issues and will report back via the WHSSC Quality & Patient Safety Committee. Action closed.
- MG134 Cystic Fibrosis – Meeting with CVUHB colleagues took place. Action closed.

### 5. Report from the Managing Director

Members received the Managing Director's report, which included:

- **Radio Frequency Ablation for Barrett's Oesophagus Update** It was likely that a proposal to Joint Committee would be delayed beyond July 2019.

- **Hereditary Anaemias** At the request of Welsh Government the WHSS Team was developing a proposal that would be considered through the 2020-21 ICP process.

## 6. ICP 19-293 PET New Indications for 2019-20

Members received a paper that (1) outlined the scheme ICP19-23 to fund additional PET indications and confirmed it is within the funded ICP 2019-20, (2) confirmed that the PET policy has been updated to include the new indications and published on the WHSSC website, and (3) outlined the financial and contract arrangements to support implementation of the additional indications for PET.

Subject to clarification that the paper covered the All Wales position, members (1) noted the scheme ICP19-293 PET new indications is included within the funded plan, (2) noted the revised PET policy has been approved by WHSSC Policy Group and published on the WHSSC website in June 2019, and (3) noted the financial provision within the ICP for the additional indications and that work is in progress to incorporate the revised baseline within provider contracts.

## 7. ICP 19-285 Adoption of NHS England Genetic Test Directory

Members received a paper that requested approval for the release of funding to implement Year 1 of the Integrated Commissioning Plan scheme 19/285 Adoption of the NHS England Genetic Test Directory.

Members approved the release of funding to implement Year 1 of the Integrated Commissioning Plan scheme 19/285 Adoption of the NHS England Genetic Test Directory.

## 8. Funding Release for Cleft Lip and Palate MDT

Members received a paper that requested support for the release of funding to address patients accessing a comprehensive MDT for the Cleft Lip and Palate service to ensure that services can be delivered sustainably in line with national standards and improve the quality of the service. Members requested inclusion of a requirement for the service to provide PREMS and PROMS data.

Members resolved to approve the release of funding, part year in 2019-20 and recurrent funding from 2020-21, to ensure patients can access a fully functioning MDT for the Cleft Lip and Palate service, in order to deliver a safe, sustainable quality service and meets national standards.

## 9. Funding Release for Cleft Lip and Palate Adult RTT Scheme

Members received a paper that requested approval for the release of funding to implement the ICP RTT scheme for the adult Cleft Lip and Palate service in south Wales. Members requested three-monthly updates on actual performance against the recovery plan.

Members approved the request of funding to reduce the backlog of Cleft Lip and Palate adult patients waiting for surgery and progress towards achieving the 26 week RTT target.

## 10. Funding Release for Paediatric Rheumatology Service in South and Mid Wales

Members received a paper that requested approval for the release of funding to establish a tertiary Paediatric Rheumatology service for south and mid Wales.

Members approved (1) approved the funding release for Paediatric Rheumatology, (2) noted the comparison with the Paediatric Rheumatology service in Alder Hey Children's Hospital for the population of north Wales, and (3) note the evidence that there is a more rigorous performance management process being established for rheumatology service.

## 11. Funding Release for Paediatric Endocrinology Service in South and Mid Wales

Members received a paper that sought support for the release of funding for the Paediatric Endocrine service to be formally commissioned by WHSSC to ensure safe and effective clinical services can be provided to all Paediatric Endocrine patients across South and Mid Wales. It was agreed that the service would be reviewed after one year.

Members approved the release of funding for the Paediatric Endocrinology Service in south Wales for 2019-20 (part year) and recurrent funding from 2020-21.

## 12. Funding Release for Neuro-Rehabilitation Service in South Wales

Members received a paper that sought support for the release of funding for the Neuro-Rehabilitation service based in Rookwood, Cardiff.

Members approved the release of funding for the Neuro-Rehabilitation service as provided in the WHSSC Integrated Commissioning Plan 2019-22.

## 13. Funding Release and Update on Cystic Fibrosis Service in South Wales

Members received a paper that (1) provided an update on the implementation of Phase 1 investment for the All Wales Adult Cystic Fibrosis Centre, and (2) requested approval for the release of funding for the Adult Cystic Fibrosis Service 2019-20. Members suggested that the WHSS Team approach WG for 'value based' funding for the Home IV service as an alternative to considering it under the 2020-21 ICP.

Members (1) noted the information presented in the report, (2) approved referral to Joint Committee (because of the risk on the recurrent funding requirement) of the release of funding for 2019-20 to recruit to the

remaining posts in phase 2, part A, to support the current cohort and the continued development of the satellite clinics, and (3) supported taking forward the case for a recurrent Home IV service and additional staffing aligned to the capital development for the new ward to the 2020-21 ICP, in the event that WG declined separate 'Healthier Wales' funding.

## 14. Major Trauma Contracting Framework

Members received a paper that set out the options considered and recommendations made by the Finance Sub Group for the contracting framework in relation to the Major Trauma Centre and Major Trauma Network.

The recommended Option E (block contract with variation) with a view to transitioning to Option C (cost and volume contract) after an appropriate evaluation period was approved.

## 15. Major Trauma Update

Members received a presentation that gave an indication of providers' estimated costs for establishing the MTC and TUs. It was noted that the estimated costs were well in excess of those previously anticipated and would need to be subjected to considerable scrutiny and benchmarking.

## 16. Veterans' Trauma Network

Members received a paper recommending approval of the proposal for WHSSC to commission a new Veterans Trauma Network for Wales (VTN). The VTN will be hosted by the Major Trauma Network to facilitate appropriate connection to providers in the NHS Wales Trauma Network and referral into the NHS England VTN. The proposal is consistent with Welsh Government policy. The proposal fits with WHSSC's existing commissioning roles related to care for veterans with prosthetics and the armed forces fast track.

Members (1) approved the proposal that WHSSC commission the Veterans Trauma Network for Wales (2) approved that WHSSC will commission the VTN from the Major Trauma Network who will act as host to the VTN, (3) received assurance that the proposed VTN will be either resource neutral or of minimal net financial cost, (4) noted that the proposed establishment of the VTN is consistent with the principles of value based healthcare by ensuring better coordination of care and consequent avoidance of harm and waste.

## 17. WHSSC Policy Group Update

Members received a paper on the work of the WHSSC Policy Group and noted the information presented within the report.

## 18. Integrated Performance Report

Members received a report that provided a summary of the performance of services commissioned by WHSSC for April 2019 and noted the services in escalation and actions being undertaken to address areas of non-

compliance. The Bariatric Surgery service had been de-escalated in June 2019 following improvements in service.

## 19. Finance Report 2019-20 Month 2

Members received a report that set out the financial position for WHSSC for the second month of 2019-20, being an under spend of £387k and forecast overspend of £192k for the full year. It was noted that all Welsh contracts for 2019-20 had now been signed.

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|---|---|
| **Reporting Committee** | **Integrated Governance Committee** |
| **Chaired by** | **WHSSC Chair** |
| **Lead Executive Director** | **Committee Secretary** |
| **Date of last meeting** | **26 June 2019** |
| **Summary of key matters considered by the Committee and any related decisions made.** | |
| Members reviewed the Committee's Terms of Reference.<br><br>Members agreed to postpone the annual self-assessment by 3 months as a number of the Members were new to the Committee. | |
| **Key risks and issues/matters of concern and any mitigating actions** | |
| As recorded above | |
| **Matters requiring Committee level consideration and/or approval** | |
| As recorded above | |
| **Matters referred to other Committees** | |
| None | |
| Confirmed Minutes for the meeting are available on request | |
| **Date of next meeting** | **13 August 2019** |

**WHSSC Joint Committee**
**23 July 2019**
**Agenda Item 3.3**

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|---|---|
| **Reporting Committee** | **Quality Patient Safety Committee** |
| **Chaired by** | **Charles Janczewski** |
| **Lead Executive Director** | **Director of Nursing & Quality** |
| **Date of Meeting** | **11 June 2019** |

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

## 1. Renal Network Report

Members received the report which provided a briefing on quality patient safety issues within services. Members received further information on the:

- Provision of vascular service for patients requiring renal replacement service in Wales
- Transplant for haemodialysis patients

## 2. Updates from the Commissioning Teams

Updates were received from each of the commissioning teams and Members noted the information presented in the reports.

- Cancer and Blood
- Cardiac
- Mental Health
- Neurosciences and Complex Conditions
- Women and Children
- Major Trauma
- Summary of Services in Escalation

## 3. Patient Story

Members heard from a patient about her experiences of the Neuro Endocrine Service.

## 4. Corporate Risk and Assurance Framework

Members **received assurance** that risks were being appropriately assessed and managed.

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

None

**Matters requiring Committee level consideration and/or approval**

None

| **Matters referred to other Committees** | |
|---|---|
| None | |
| Confirmed Minutes for the meeting are available on request | |
| **Date of next meeting:** | 13 August 2019 |

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|---|---|
| **Reporting Committee** | **Integrated Governance Committee** |
| **Chaired by** | **WHSSC Chair** |
| **Lead Executive Director** | **Committee Secretary** |
| **Date of last meeting** | **26 June 2019** |
| **Summary of key matters considered by the Committee and any related decisions made.** | |
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| **Key risks and issues/matters of concern and any mitigating actions** | |
| As recorded above | |
| **Matters requiring Committee level consideration and/or approval** | |
| As recorded above | |
| **Matters referred to other Committees** | |
| None | |
| Confirmed Minutes for the meeting are available on request | |
| **Date of next meeting** | **13 August 2019** |