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

WHSSC Joint Committee Meeting held in public
Tuesday 10 March 2020 at 13:30

NCCU, Unit 1 Charnwood Court, Heol Billingsley,
Parc Nantgarw, Cardiff, CF15 7QZ

Agenda

Item		Lead	Paper / Oral	Time
1.	**Preliminary Matters**			
1.1	Welcome, Introductions and Apologies	Chair	Oral	13:30 – 13:40
1.2	Declarations of Interest	Chair	Oral	
1.3	Accuracy of the Minutes of the Meeting held 28 January 2020	Chair	Att.	
1.4	Action Log and Matters Arising	Chair	Att.	
1.5	Report from the Chair	Chair	Att.	13:40 – 13:50
1.6	Report from the Managing Director	Managing Director	Att.	13:50 – 14:00
2.	**Items for Consideration and/or Decision**			
2.1	Major Trauma Commissioning Assurance and Governance Arrangements	Director of Planning	Att.	14:00 – 14:20
2.2	Value Based Commissioning Plan	Director of Planning	Att.	14:20 – 14:40
2.3	Neonatal Transport Review Recommendations	Director of Planning	Att.	14:40 – 15:00
2.4	Annual Cycle of Business	Committee Secretary	Att.	15:00 – 15:10
3.	**Routine Reports and Items for Information**			
3.1	Integrated Performance Report	Director of Planning	Att.	15:10 - 15:20
3.2	Financial Performance Report	Director of Finance	Att.	15:20 – 15:30
3.3	Reports from the Joint Sub-Committees i. Management Group Briefings ii. Individual Patient Funding Request Panel	Joint Sub-Committee Chairs	Att.	15:30 – 15:35

4. Concluding Business			
4.1	Any Other Business	Chair	Oral
4.2	Date of next meeting (Scheduled) - 12 May 2020 at 09:30 - Conference Room, WHSSC, Unit G1 The Willowford, Main Avenue, Treforest, CF37 5YL	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 WHSSC Joint Committee Meeting held in public on Tuesday 28 January 2020 at Unit G1, The Willowford, Main Ave, Treforest Industrial Estate, Pontypridd, CF37 5YL

Members Present:

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 Officer, BCUHB
Paul Griffiths	(PG)	Independent Member/Audit and Risk Committee Representative
Sharon Hopkins	(SH)	Interim Chief Executive, Cwm Taf Morgannwg UHB (for part)
Sian Lewis	(SL)	Managing Director, WHSSC
Steve Moore	(SM)	Chief Executive, Hywel Dda UHB
Tracy Myhill	(TM)	Chief Executive, Swansea Bay UHB
Judith Paget	(JP)	Chief Executive, Aneurin Bevan UHB (by VC)
Ian Phillips	(IP)	Independent Member
Len Richards	(LR)	Chief Executive, Cardiff and Vale UHB
Jenny Thomas	(JT)	Medical Director, WHSSC

Deputies Representing Members:

Hayley Thomas	(HT)	Director of Planning and Performance, Powys THB

Apologies:

Carol Shillabeer	(CS)	Chief Executive, Powys THB

In Attendance:

Kieron Donovan	(KD)	Interim Chair, Welsh Renal Clinical Network
Christopher Markall	(CM)	
Urvisha Perez	(UP)	Wales Audit Office (Observer)
Karen Preece	(KP)	Director of Planning, WHSSC
Andrea Richards	(AR)	Planning Manager, WHSSC
Kevin Smith	(KS)	Committee Secretary & Head of Corporate Services, WHSSC
Simon Dean	(SD)	Welsh Government (Observer)

Minutes:

Michaella Henderson	(MH)	Corporate Governance Officer, WHSSC

The meeting opened at 09:35hrs

JC19/064	**Welcome, Introductions and Apologies** The Chair formally opened the meeting and welcomed members. Apologies were noted as above.
JC19/065	**Declarations of Interest** The Joint Committee noted the standing declarations. No additional declarations were made.
JC19/066	**Integrated Performance Report – November 2019** The Joint Committee received a report which provided members with a summary of the performance of services commissioned by WHSSC for October 2019 and details the action being undertaken to address areas of non-compliance. KP reported continuing concern over cardiac surgery performance in south Wales. KP reported that the WHSS Team had a positive meeting with the CVUHB Team on 31 December 2019, that CVUHB was progressing outsourcing to North Staffordshire (Stoke) and that the CVUHB Clinical Team was developing an action plan. Members noted more information would be provided at Agenda Item 2.2. KP reported continuing concern over waiting list times for the plastic surgery service at SBUHB particularly with the opening of the Major Trauma Centre where the plastic surgeons recruited would not be appointed until after the Centre's opening. KP noted SBUHB was developing a plan to help mitigate the issue and that she had requested early sight of that plan so that it could be presented at both Management Group and Joint Committee for discussion at the March meetings. TM reported the SBUHB Plastic Surgeon job description had received approval in principle from the Royal College of Surgeons at the end of the previous week and that SBUHB was now in a position to advertise and recruit. TM reported SBUHB would look to confirm contingency plans by mid-February and that the impact on RTT could be better assessed at that stage. KP reported the Bridgend Cochlear service at Prince of Wales Hospital was still suspended with patients having been referred to CVUHB and that CVUHB was confident all patients would be treated before the end of March 2020. LR reported a routine meeting would be taking place between CVUHB and the cochlear service team at CTMUHB on 29 January 2020 and long term planning was on the agenda for discussion. KP reported the WHSS Team would be organising a workshop on the same subject and LR agreed to

	provide the meeting feedback to KP for integration into the workshop planning. Members resolved to: • **Note** October performance and the actions undertaken to address areas of non-compliance.
JC19/067	**Finance Report Month 9 2019-20** The Joint Committee received a report setting out the financial position for WHSSC for the ninth month of 2019-20. Members noted the financial position reported at Month 9 for WHSSC was a year to date under spend of £5,096k and forecast year end under spend of £3,312k. SD reported the performance on NHS England contracts was in balance and the WHSS Team was working with CVUHB on their over performance position. PG noted the year on year variance had doubled over the last 3 months and SD explained that it was due to a number of planned developments taking effect in last quarter of the financial year. Members resolved to: • **Note** the current financial position and year end forecast.
JC19/068	**Corporate Risk Assurance Framework** The Joint Committee received a report providing Members with an update on the WHSSC risk management framework as at 30 November 2019. KP reported work was ongoing around PET, including a proposal for an interim model for use when the south Wales PETIC scanner was unavailable and an All Wales PET Programme looking at broader capacity issues which would be available in time for the results to be factored into Health Board IMTPs for 2021-24. KP reported that the WHSS Team had received a business plan from BCUHB, working with Liverpool and Alder Hey, for an Inherited Bleeding Disorder service to cover north Wales which would be presented at the February Management Group meeting for approval. JT reported good progress was being made with the south Wales soft tissue sarcoma service but it was necessary to ensure this was sustainable. KP noted increasing risk in the Posture and Mobility service and that work was underway to manage and mitigate some of that risk within the 2021-

	24 Integrated Commissioning Plan. Actions would be taken to reduce the differential waiting times between the north Wales and south Wales services. PG reported the CTMUHB Audit Committee was now called the Audit and Risk Committee and had taken responsibility for risk from the former Quality, Safety & Risk Committee. KP agreed to update the relevant references in the report. Members noted the report was missing the 'risk on a page' for CAMHS issues at BCUHB as shown in the Escalation Table on page 6 of the report. **ACTION:** It was agreed KP would update the report template to include the missing page. LR noted there were a number of capacity constraints at Ty Llidiard that were resulting in children being treated in the wrong environment. CB provided assurance that the WHSS Team was aware of the issues within the CAMHS service and working to resolve them. CB reported she would share the 'No Surprises' report CTMUHB submitted to Welsh Government. **ACTION:** CB to circulate the CTMUHB CAMHS 'No Surprises' report to all Members. KP reported Management Group had considered a revised CAMHS Tier 4 Inpatient Service Specification at its meeting on 23 January 2020 and had requested further work at which, once completed, would potentially increase the number of eligible patients who could be placed in both units. Members resolved to: • **Note** the update provided within the report. • **Receive assurance** that risks are being appropriately assessed and managed.
JC19/069	**Reports from the Joint Sub-Committees** **Management Group** The Joint Committee received the November and December 2019 briefings. **All Wales Individual Patient Funding Request Panel** The Joint Committee received the report of the 27 November 2019 and 11 December 2019 meetings. **Quality and Patient Safety Committee**

	The Joint Committee received the report of the 21 January 2020 meeting, together with a schedule of services in escalation. CB noted work was ongoing with BCUHB to resolve issues with the provision of neonatal transport data. **Welsh Renal Clinical Network** The Joint Committee received the report of the meeting of 27 November 2019. Members resolved to: • **Note** the content of the reports from the Joint Sub-Committees
JC19/070	**Minutes of the meetings held 12 November 2019 and 06 January 2020** The Joint Committee **approved** the minutes of the meetings held on 12 November 2019 and 6 January 2020, subject to minor changes relating to attendees, as a true and accurate record.
JC19/071	**Action Log and Matters Arising** The Joint Committee noted: **2020-23 Integrated Commissioning Plan ('ICP')** SL noted the Joint Committee had approved the ICP in principle at the meeting held on 6 January 2020 subject to number of caveats which had subsequently been addressed. Members resolved to: • **Ratify** unconditional approval of the 2020-23 Integrated Commissioning Plan. There were no matters arising not dealt with elsewhere on the agenda.
JC19/072	**Chair's Report** The Joint Committee received the Chair's Action in respect of the appointment of Emrys Elias, Vice Chair, Aneurin Bevan UHB as an Independent Member of the Joint Committee and Chairman of the WHSSC Quality and Patient Safety Committee with effect from 1 December 2019. Members resolved to: • **Ratify** the Chair's Action. VH reported on her recent appraisal with the Minister who was generally pleased with WHSSC's progress, particularly with Major Trauma, Thoracic Surgery and WHSSC's collaborative approach to working with the Health Boards. VH explained that the Minister had expressed concern at the

	number of CAMHS Out of Area (OoA) placements, particularly for young people. SL noted that OoA placement numbers had reduced significantly with only five placements still active, all of which required specialist care outside of Wales. VH reported the Minister had also raised Perinatal Mental Health as a concern; this would be discussed further under Agenda Item 2.6.
JC19/073	**Report from the Managing Director** The Joint Committee received a report from the Managing Director. Members noted that the all Wales medical genomics service had recently won an Efficiency through Technology Programme High Impact Award relating to the development of a non-invasive pre-natal test, the first of its kind in the United Kingdom, and thanked the service for their work. Members noted the test had been fully evaluated through a pilot scheme before full implementation a benefits appraisal evaluation would follow. **ACTION:** Results of benefits appraisal evaluation to be reported at the next meeting for information purposes. Members resolved to: • **Note** the contents of the report
JC19/074	**Cystic Fibrosis – Update on the Home IV Antibiotics Service** The Joint Committee received a report updating Members on the implementation of a prepared home IV antibiotics service for patients with Cystic Fibrosis in South Wales and Southern Powys. AR reminded Members that the CVUHB Cystic Fibrosis unit was the only unit in the UK without a home IV antibiotics service. AR reported the evaluation of 26 patients had produced positive results and indicated a saving of 798 bed days. AR reported that the Phase 2 plan included a lower number of beds than nationally recommended but the evaluation of the home IV antibiotics service supported this. Members resolved to: • **Note** the information presented within the report • **Support** taking forward the case for a recurrent Home IV service and satellite clinic staff to the 2020-21 ICP; and • **Support** further evaluation of the impact on inpatient demand to inform the planned bed base to be supported by WHSSC within Phase 2 of the business case

JC19/075	**Cardiac Surgery Performance** The Joint Committee received a report providing members with an update on Cardiac Surgery performance in south Wales. Members noted that CVUHB was progressing an arrangement to outsource to University Hospitals of North Midlands NHS Trust, Stoke, and that SBUHB had a plan to eliminate 36 week RTT waiting time breaches by 31 March 2020. AR reported a workshop would be taking place on 13 February 2020, supported by the Delivery Unit, working with the Health Board and that a separate piece of work would be undertaken with north Wales. Members acknowledged that waiting times were being adversely impacted by late transfers from cardiology to cardiac surgery, and that the lack of recorded pathway start dates for some referrals meant waiting lists have probably been understated for at least the last two years. Members noted the WHHS Team had undertaken work on the Aortic Stenosis pathway with the objective of further reducing waiting times for these critically ill patients and that, in summary, plans were now in place to address waiting time breaches within the foreseeable future. Members resolved to: • **Note** the information presented within the report.
JC19/076	**Neonatal Transport Review Recommendation** The Joint Committee received a report setting out the key recommendations from the Review of the south Wales neonatal transport service and seeking support for the next steps to develop a 24 hour neonatal transport service. Members noted that the Neonatal Network had historically suggested duplication of the existing service as a solution to providing a 24 hour service but this was considered neither cost effective nor clinically effective when previously considered through the prioritisation process. KM reported the WHSS Team had submitted comments on the draft Review to Dr Fox for his consideration before its finalisation but that the recommendations were unlikely to change so had been shared and were clear on the single site model with a suggestion that the commissioning of the service might be better suited to EASC. KP updated Members on the discussions held at the Management Group meeting on 23 January 2020 where Members expressed a preference for WHSSC to remain as commissioners of the 24 hour service initially and look at transferring responsibility to EASC in due course. Members broadly supported the view expressed by Management Group.

	KP reported that Welsh Government had indicated that its Quality Delivery Board members wished to see interim arrangements introduced as soon as possible, so as to minimise the risks of further avoidable harm being caused by the absence of a 24 hour service. Members agreed that prioritising a permanent 24 hour solution was preferable, provided there was no further significant delay. **ACTION:** KP agreed to circulate Dr Fox's final report to Members as soon as it was available. Members resolved to: • **Note** the draft recommendations within the report; and • **Support** the development of future commissioning arrangements for neonatal transport services in south Wales with an outline plan and timeline being brought back to Joint Committee in March.
JC19/077	**Major Trauma Network Programme Business Case** The Joint Committee received a report updating Members on the non-financial caveats raised by Health Boards in their support of the major trauma network programme business case at their November 2019 meetings; recruitment and acknowledgement of the responsible recruitment process and the NHS Wales Budget Allocation 2020/21 as it relates to major trauma. Members noted the outcomes of the health boards' consideration of the Major Trauma Network Programme Business Case and the progress made to address the non-financial caveats raised at the meeting of 6 January 2020. Members also noted the NHS Wales Budget Allocation 2020-21 as it related to major trauma. Members noted that positive work was being done on ongoing recruitment, the patient repatriation process and rehabilitation and that some governance arrangement proposals were being developed and would be brought back to Joint Committee in due course. Members acknowledged the responsible recruitment process and noted that recruitment to the Major Trauma Network was progressing well against plan and that the weekly recruitment flash reports supported this. **ACTION:** It was agreed KP would circulate the latest weekly flash recruitment report to Members and provide a summary of the recruitment position at future meetings.
JC19/078	**WRCN Transformation Fund** The Joint Committee received an oral report on the successful WRCN Transformation Fund application, the objective of which was to roll out

	the Vital Data application for electronic patient records for renal dialysis patients, developed in SBUHB, across the whole of Wales. KD reported the initiative was expected to result in improved patient safety, drug administration benefits and cost savings on drug procurement. Members received assurance from KD any new system or application being rolled out would interface with existing NHS Wales IT systems and the wider National ICT strategy. KD reported that SBUHB employees affected by the changes in their own health board had agreed to share their real life experiences with employees from other health boards to aid transition. **ACTION:** Members agreed that the Welsh Information Governance Board should be informed of the application and asked to comment as appropriate.
JC19/079	**Tier 4 Perinatal Mental Health in Wales** The Joint Committee received a report seeking approval for an interim option for a Mother & Baby Unit located in south Wales. Members acknowledged that travel distance for patients and their families was an issue. CB reported that family facilities were provided under the current arrangements and would continue to be available for both the interim and permanent solutions in south Wales. In response to a question from PG, TM advised that it was not yet clear how the investment in the interim solution would be treated if the permanent solution was based at a different location. SD reported that, should the Joint Committee decide the permanent solution was a new build facility, it was anticipated that it would be at least two and a half years from the decision being made to opening the facility, subject to any other issues that might arise and add to that timeframe. KP noted that the task and finish group would be expected to report by the end of April 2020; then the project would progress through the normal capital funding route. KP further noted that the Tonna site would continue to be a SBUHB asset and therefore would continue to be included in SBUHB's long term strategic plans. Members resolved to: • **Support** the proposed option from SBUHB for an interim 6 bedded Mother & Baby unit at Tonna Hospital;

	• **Support** the urgent development and submission of Business Justification Case to Welsh Government in order to secure capital funding; and • **Approve** the establishment of a task and finish group to review the options for a permanent solution.
JC19/080	**Adult Thoracic Surgery Service for South Wales** The Joint Committee received a report updating Members on the position in relation to the development of a single Adult Thoracic Surgery Service for south Wales based at Morriston Hospital and the network of services which are required to support this. It was noted that good progress had been made with excellent clinical engagement and collaboration between CVUHB and SBUHB. Members resolved to: • **Note** the information presented within the report from the Thoracics Programme Implementation team.
JC19/081	**Any Other Business** **Coronavirus** SD reported that a Welsh patient had been assessed with a negative result the previous week via NHS England and the WHSS Team had put contractual arrangements in place with NHS England for any future cases.
JC19/082	**Date and Time of Next Scheduled Meeting** The Joint Committee noted the next scheduled meeting would take place at 13:30hrs on 10 March 2020 in the Conference Room, WHSSC, Unit G1 The Willowford, Treforest, CF37 5YL.

The meeting ended at 11:25hrs.

Chairman .....

Date.....

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

2019-20 Action Log (MASTER)
Joint Committee Meeting

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
06.01.20	JC19008	**JC19/062 - 2020-23 Integrated Commissioning Plan** **ACTIONS:** Members agreed the following actions for the WHSS Team: Bring a paper to the March Joint Committee meeting on the savings plan and the value based commissioning work that is being undertaken with particular reference to accelerating the work on pathways within the integrated healthcare system (this paper will reference the outputs from the value based commissioning workshop scheduled with Management Group for 4 February 2020).	KP	Mar 2020	**10.03.20** – Agenda Item 2.1.	**OPEN**

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
28.01.20	JC19015	**JC19/068 - Corporate Risk Assurance Framework** Members noted one BCUHB risk on a page was missing. **ACTION:** It was agreed KP would update the report template to include the missing page.	KP	Feb 2020	**10.03.20** – Report template updated. Action closed.	**CLOSED**
28.01.20	JC19017	**JC19/076 – Neonatal Transport Review Recommendations** **ACTION:** KP agreed to circulate the full report to Members as soon as it becomes available.	KP	Feb 2020	**20.02.20 –** Report circulated. Action closed.	**CLOSED**
28.01.20	JC19018	**JC19/076 – Neonatal Transport Review Recommendations** **ACTION:** It was agreed the WHSS Team would check the governance around a possible transfer of responsibility to EASC.	SD / KS	Feb 2020	No longer required. WHSSC to commission service. If there is a subsequent proposal for the handover of commissioning responsibility to EASC, the governance will be checked at that time. Action closed.	**CLOSED**

Meeting Date	Action Ref	Action	Owner	Due Date	Progress	Status
28.01.20	JC19019	**JC19/077 - Major Trauma Network Programme Business Case** **ACTION:** KP to circulate weekly flash report to Members and provide a summary of recruitment at future meetings.	KP	Feb 2020	**27.02.20** – MH circulated on behalf of KP. Action closed.	**CLOSED**

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

		Agenda Item	1.5
Meeting Title	**Joint Committee**	Meeting Date	10/03/2020
Report Title	Report from the Chair		
Author (Job title)	Chair		
Executive Lead (Job title)		Public / In Committee	Public

Purpose	The purpose of this paper is to provide Members with an update of the key issues considered by the Chair since the last report to Joint Committee.			
RATIFY ☐	APPROVE ☐	SUPPORT ☐	ASSURE ☐	INFORM ☒

		Meeting Date	
Recommendation(s)	Members are asked to **note** the contents of the report.		

Considerations within the report (tick as appropriate)

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

1.0 SITUATION

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

2.0 BACKGROUND

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

3.0 ASSESSMENT

3.1 Welsh Clinical Renal Network - Chairman

Members will recall that Dr Kieron Donovan was appointed last year as Interim Chair of the Renal Network for 12 months commencing 01 April 2019.

I am pleased to announce that, in accordance with the WHSSC Standing Orders and the WCRN Terms of Reference, I have appointed Kieron as Chair of the Renal Network for three years commencing 01 April 2020. This took into account Kieron's performance over the last year as Interim Chair and recommendations from Dr Sian Lewis, as Managing Director of WHSSC, and Stuart Davies, as Executive Lead for WCRN.

3.2 Vice Chair

I am conscious that we have been without a named Vice Chair for some time, which was a result of changes to the Independent Members. I will now take soundings and come back to Members with a recommendation for appointment of a Vice Chair from the Independent Member cohort.

4. RECOMMENDATIONS

Members are asked to **note** the contents of the report.

5. APPENDICES / ANNEX

None.

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance
Link to Integrated Commissioning Plan	Approval process
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	Not applicable
Institute for HealthCare Improvement Triple Aim	Not applicable
Organisational Implications	
Quality, Safety & Patient Experience	The report suggests that there are some relevant issues that impact Quality, Safety & Patient Experience.
Resources Implications	The report suggests that there are some relevant issues that impact on resources.
Risk and Assurance	The report suggests that there are some relevant issues that impact on risk and assurance.
Evidence Base	Not applicable
Equality and Diversity	Not applicable
Population Health	Not applicable
Legal Implications	Not applicable

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

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

		Agenda Item	1.5
Meeting Title	**Joint Committee**	Meeting Date	10/03/2020
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	

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

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☐	☐	☒

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

Considerations within the report (tick as appropriate)

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

1. 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

2.1 Thoracic surgery and major trauma service specifications

In July 2019, a paper was presented to Joint Committee which summarised 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, and made recommendations regarding the future thoracic surgery consultant workforce model and emergency thoracic surgery cover for the Major Trauma Centre (MTC). In an appendix to the paper it stated that WHSST had requested sight of, but had not yet received, draft guidance from the Society of Cardiothoracic Surgeons on the management of thoracic trauma.

This guidance has now been received and will be reflected in the thoracic surgery and major trauma service specifications. The relevant recommendations are provided below:

1. Given the variation in trauma cover by cardiothoracic surgical units throughout the United Kingdom & Ireland, it is not appropriate to be prescriptive about the required model of care. Nevertheless, it is vitally important that MTCs know how to obtain rapid cardiothoracic surgical advice and help when necessary. Therefore, all cardiothoracic units should publish a rota or rotas detailing the arrangements for covering cardiothoracic trauma. This may take the form of separate thoracic and cardiac surgical rotas with both specialties taking equal responsibility. Alternatively, units may prefer to have one specialty 'first on-call' with the other reserved for specific cases and to be contacted by the first on-call service when needed. The first on-call service can be provided by either cardiac or thoracic surgery.

2. It is not practical for on-call cardiothoracic surgeons to be able to attend in an appropriate timeframe for salvage procedures (i.e. immediately). They should, however, be available for immediate telephone advice and attend urgently when available.

3. MTCs should ensure that there are on-site trauma teams available to perform salvage incisions, control major haemorrhage, relieve tamponade and insert chest drains. This should be the responsibility of the trauma team. Cardiothoracic surgeons, however, will be involved in the training of these trauma teams.

3. RECOMMENDATIONS

Members are asked to:

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

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

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

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

		Agenda Item	2.1
Meeting Title	**Joint Committee**	Meeting Date	10/03/2020
Report Title	Major Trauma Commissioning Assurance and Governance Arrangements		
Author (Job title)	Planning Manager Major Trauma		
Executive Lead (Job title)	Director of Planning	Public / In Committee	In Committee

Purpose	The purpose of this paper is to provide a description of the proposed commissioning governance structure and interfaces with operational delivery for the South Wales Trauma Network.			
RATIFY ☐	APPROVE ☒	SUPPORT ☐	ASSURE ☐	INFORM ☐

Sub Group /Committee	Choose an item.	Meeting Date	Click here to enter a date.
Recommendations	Members are asked to: • **Note** the information presented within the report; and • **Approve** the proposed commissioning governance structure for the South Wales Trauma Network.		

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)

Aneurin Bevan, Cardiff and Vale, Cwm Taf Morgannwg, Hywel Dda, Powys, Swansea Bay

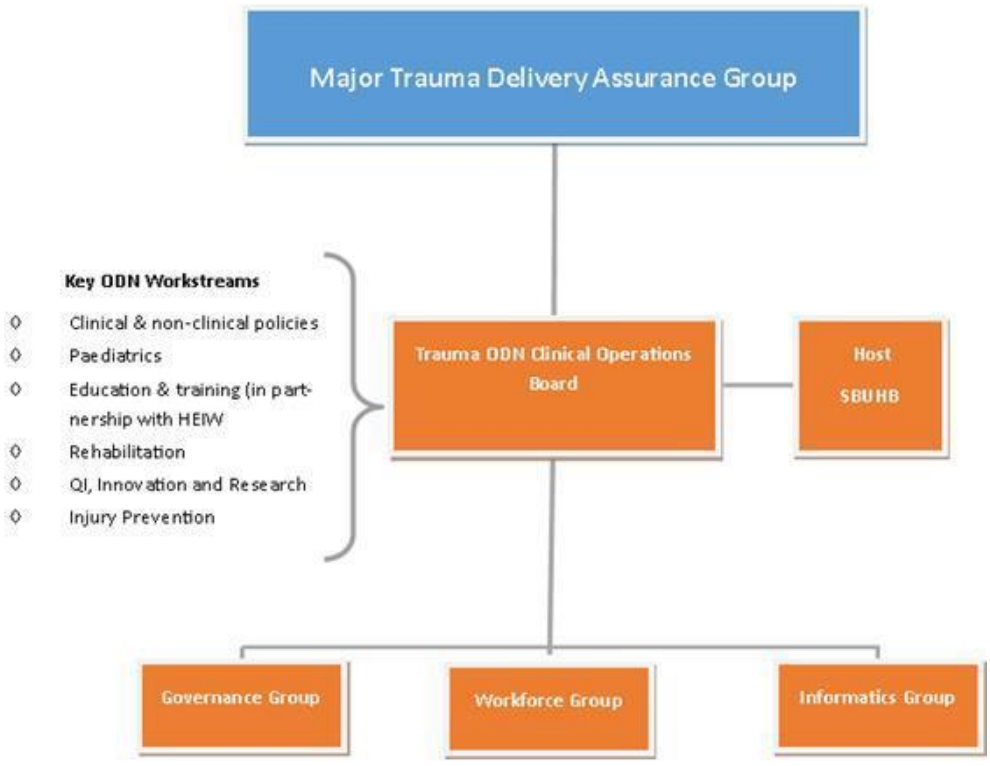
1. SITUATION

This paper requests **approval** of this proposed commissioning governance structure for the South Wales Trauma Network, noting the proposal that both WHSSC and EASC use the same governance structure. It has been discussed and supported by the Major Trauma Implementation Board in February 2020.

2. BACKGROUND

Within the major trauma network system, WHSSC has the responsibility to commission the operational delivery network (ODN), the major trauma centre (MTC) and the specialist services that are delivered as part of the MTC. EASC has the responsibility to commission the services provided by the Welsh Ambulance Services Trust (WAST).

The South Wales Trauma Network Programme Business Case (PBC) describes the management structure of the Operational Delivery Network (ODN) as illustrated below.

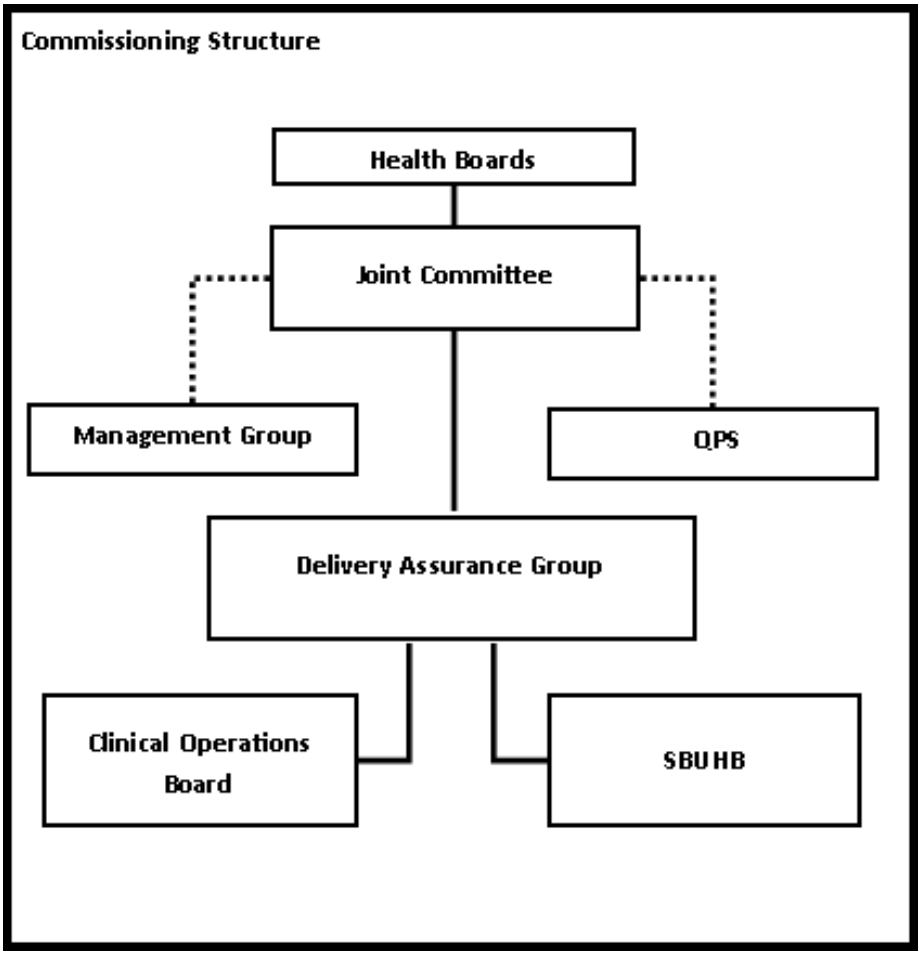


A meeting between the WHSS team and the Chief Ambulance Service Commissioner discussed the following principles to be incorporated into the governance framework:

- There has to be a clear separation of SBUHB as host of the Operational Delivery Network (ODN) and as provider of trauma services within the South Wales Trauma Network.
- There needs to be a clear distinction between operational delivery and commissioning functions.
- Clinical governance will remain the responsibility of the provider Health Board with the ODN being responsible for ensuring regular and complete reporting clinical governance relating to the trauma network. Accordingly clinical governance for the ODN specifically will be facilitated through the host organisation.
- The ODN is central to the development of the trauma network for south Wales, west Wales and south Powys and involves cross-organisation and multi-professional working through a whole system collaborative approach ensuring the delivery of safe and effective services across the patient pathway.
- As evidenced by the repatriation policy to be adopted through the South Wales Trauma Network, operational delivery will be underpinned by principles of collaborative working with the ODN developing, agreeing and implementing lines of reporting, communication and escalation throughout the network.
- The ODN will through the Trauma Network Clinical Operations Board (COB) report the performance of all components of the network for example, against key performance indicators, standards, quality indicators, clinical governance, quality and patient safety and financial, together with an agreed minimum data set.
- Assurance to Health Boards relating to the effectiveness of commissioning arrangements will be provided by a Delivery Assurance Group (DAG) which will report to the Joint Committees of WHSSC and EASC.
- To ensure a streamlined reporting and governance structure, the COB will report on network performance, variation and corrective action and provide assurance on implementation of commissioning arrangements to the DAG.
- Joint Committee will delegate authority as appropriate to its sub committees for example Management Group, for scrutiny and assurance on changes to commissioning arrangements and Quality and Patient Safety committee for quality and patient safety matters.

3. ASSESSMENT

The diagram below provides a high level representation of the proposed Commissioning Governance structure which has been designed with existing WHSSC processes at its core.



—— Reporting and communication
---- Delegated authority to provide scrutiny and assurance regarding commissioning, performance and quality matters.

The Delivery Assurance Group sits as a sub-committee of the WHSSC Joint Committee. It will provide the mechanism for clear lines of accountability and responsibility across the pathway. As with other WHSSC sub-committees such as the Integrated Governance Committee, it will be subject to the established and robust WHSSC governance framework.

This structure will need to be considered alongside the operational structure and hosting arrangements for the ODN which is described further in section 3.2.

3.1 Description of organisational roles within the WHSSC/EASC structure

3.1.1 Delivery Assurance Group

The Trauma Network Delivery Assurance Group (DAG) will assure the Joint Committee on issues regarding the development of Major Trauma

services for Wales and suitability of commissioning arrangements. The purpose of the DAG is to review the direction, delivery and performance of the Major Trauma Network across Wales and to ensure that the benefits of working collaboratively are realised.

The DAG will report to the Health Boards through the WHSSC Joint Committee.

The DAG will meet bi-monthly in first year and quarterly thereafter. Chaired by a WHSSC Executive Director it will be accountable as a sub group of the WHSSC Joint Committee. It is proposed that the Chief Ambulance Services Commissioner will be act as Vice Chair. The proposed membership of the Group is as follows;

- Executive Director WHSSC Chair
- Chief Ambulance Service Commissioner Vice Chair
- SBUHB, Senior Hosting Representative
- Senior representative from the MTC
- Senior nominated representative from each Health Board
- Welsh Government representative
- ODN Clinical Director
- ODN Network Manager
- Senior nominated representative from Welsh Ambulance Service Trust.
- Senior nominated representative from the Emergency Medical Retrieval Transport service (EMRTS).

The representatives from Health Boards should as far as possible be Directors with appropriate authority and understanding of major trauma, its related pathways and commissioning arrangements.

The DAG will report directly to the Joint Committees through the WHSSC and EASC structures, matters that pertain to commissioning and service delivery, planning and performance or any wider system related issues. The DAG will also ensure that clear and appropriate hosting arrangements for the Major Trauma ODN are in place. The DAG will consider any clinical and operational governance issues that have been raised by the Trauma Network COB and where appropriate, request assurance that appropriate action is taken from the respective organisational executive leads for major trauma.

In discharging its assurance role the DAG will;

- Bring any significant matters under consideration by the DAG to the relevant Joint Committee's attention.
- Seek assurance that actions have been taken to alert the relevant and appropriate Executive (Health Board and Commissioners) of any urgent or critical matters that may compromise patient care

and affect the operation or reputation of NHS Wales.

3.1.2 WHSSC/EASC Management Groups

Requests for approval of decisions at Joint Committee level will usually be informed by the Management Group, which is made up of commissioners and finance representatives from each health board and provides a scrutiny and assurance function to items such as performance reports and business cases requesting funding. Joint Committee will when appropriate, delegate authority to Management Group particularly with regards to its scrutiny function.

3.1.3 WHSSC/EASC Quality and Patient Safety Sub-Committee.

The purpose of the Quality and Patient Safety Sub-Committee is to provide timely assurance to the Joint Committee that it is commissioning high quality and safety services. This will be achieved by:

- Providing advice to the Joint Committee, including escalation of issues that require urgent consideration and action by the Joint Committee;
- Addressing concerns delegated by the Joint Committee; and
- Ensuring that Health Board Quality and Patient Safety Committees are informed of any issues relating to their population.

3.1.4 WHSSC/EASC Joint Committee

The Joint Committee is established as a Statutory Sub Committee of each of the health boards in Wales. It is led by an Independent Chair, appointed by the Minister for Health and Social Services, and membership is made up of three Independent Members, one of whom is the Vice Chair, the chief executives of the Local Health Boards, Associate Members and a number of Officers.

Whilst the Joint Committee acts on behalf of the seven health boards in undertaking its functions, the responsibility of individual health boards for their residents' remains and it is Health Boards that are therefore accountable to citizens and other stakeholders for the provision of major trauma services.

The Joint Committees of both WHSSC and EASC are the ultimate decision makers within their delegated authority and will therefore be accountable for performance management and future developments of the elements of the trauma network for which it is lead commissioner.

3.2 Descriptions of interfaces between commissioning and operational delivery organisations.

3.2.1 Trauma Network Clinical & Operations Board

The Trauma Network Clinical & Operations Board (COB) will be responsible for operational delivery, and ensuring timely escalation, management and

resolution of operational issues. The Board will meet monthly and be chaired by a lead Chief Operating Officer. It will have a performance management function and maintain operational authority and will therefore receive a review of all operational authority decisions made across the network. To ensure a streamlined reporting and governance structure the COB will report on network performance, variation and corrective action and provide assurance on implementation of commissioning arrangements to the Delivery Assurance Group (DAG).

The COB will report to the DAG the performance of all components of the network for example, against kpi's, standards, quality indicators, clinical governance, quality and patient safety and financial, together with providing an agreed minimum data set.

3.2.2 Operational Delivery Network (ODN)

The ODN team hosted by Swansea Bay UHB will be commissioned by WHSSC through an agreed Service Level Agreement, and underpinned by quality and performance indicators. The ODN Management team will be accountable to SBUHB with Executive responsibility provided by a nominated Senior Responsible Officer.

The ODN will discharge its governance responsibilities within SBUHB by means of reporting to the Senior Leadership Team (SLT) on a quarterly basis with an annual Governance Return provided to the Director of Corporate Governance.

3.2.3 Host Organisation Swansea Bay University Health Board

As the host organisation, Swansea Bay UHB (SBUHB) will provide all organisational supporting arrangements. SBUHB will report to DAG all matters which pertain to enabling or support functions for the delivery of the network.
These are presently described in the PBC as including:

- HR and workforce
- Financial and procurement
- Project and programme management
- Health and safety
- Statutory and mandatory training for ODN staff
- Risk and incident management
- Planning and managerial support

Executive responsibility for the Operational Delivery Network will provided by a nominated Senior Responsible Officer (SRO). The SRO when necessary will escalate issues which have been raised within the COB or in accordance with the ODN escalation process.

The hosting arrangements which will be agreed between SBUHB and the constituent Health Boards within the South Wales Trauma Network will

describe how as host SBUHB will ensure the ODN discharges its responsibilities appropriately including the mechanism by which decisions relating to commissioning and service delivery are appropriately implemented.

4. RECOMMENDATIONS

Members are asked to:

- **Note** the information presented within the report; and
- **Approve** the proposed commissioning governance structure for the South Wales Trauma Network

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Implementation of the Plan Choose an item.
Link to Integrated Commissioning Plan	Major Trauma is a key service area within the 2019-22 and 2020-23 ICPs
Health and Care Standards	Governance, Leadership and Accountability Choose an item. Choose an item.
Principles of Prudent Healthcare	Reduce inappropriate variation Choose an item. Choose an item.
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Improving Health of Populations Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	The establishment of appropriate governance structures will ensure that the MTN is reporting on quality, safety and patient experience.
Resources Implications	There are no resource implications within this paper.
Risk and Assurance	The governance structure will report on risk within the system and aim to assure that any risks are being appropriately managed.
Evidence Base	This paper has referred to the Delivery Assurance Group arrangements previously established for EMRTS.
Equality and Diversity	There are no implications for equality and diversity within this paper.
Population Health	There are no implications for population health in this paper.
Legal Implications	There are no legal implications within this paper.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	03/02/2020	Supported.
Management Group	20/02/2020	Proceed to Joint Committee

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

		Agenda Item	2.2
Meeting Title	**Joint Committee**	Meeting Date	10/03/2020
Report Title	Value Based Commissioning Plan		
Author (Job title)	Planning Manager for Cancer		
Executive Lead (Job title)	Director of Finance	Public / In Committee	Choose an item.

Purpose	The purpose of this report is to: • **Advise** Joint Committee of the efficiency savings achieved in 2019/20; • **Describe** the approach and process WHSSC has followed to develop the value based commissioning plan 2020/23; • **Outline** the priority initiatives within the value based commissioning plan identified for 2020/21 and how these initiatives provide value to patients, families and the health service.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☒

Sub Group /Committee	Choose an item.	Meeting Date	Click here to enter a date.
Recommendation(s)	Members are asked to: • **Note** the efficiency savings achieved in 2019/20; • **Note** the efficiency savings already incorporated within the ICP 2020/23; • **Note** the approach and process WHSSC has followed to develop the value based commissioning plan 2020/23; • **Note** that at this point only provisional highly prudent values have been assigned to these schemes pending further detailed examination by the WHSSC team; • **Support** the priority value based commissioning initiatives identified for implementation in 2020/21; • **Support** that the WHSSC team progress enabling actions including necessary contracting changes via the Finance Sub Group.		

Considerations within the report (tick as appropriate)								
Strategic Objective(s)	YES ✓	NO	Link to Integrated Commissioning Plan	YES	NO	Health and Care Standards	YES	NO
Principles of Prudent Healthcare	YES	NO	IHI 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

Commissioner Health Board affected												
Abertawe Bro Morgannwg	✓	Aneurin Bevan	✓	Betsi Cadwaladr	✓	Cardiff and Vale	✓	Cwm Taf	✓	Hywel Dda	✓	Powys	✓

Provider Health Board affected (please state below)

1. SITUATION

In January, the Joint Committee requested a paper is brought to their next meeting in March 2020 to outline the savings plan for 2020/21 and the value based commissioning work that is being undertaken with particular reference to accelerating the work on pathways within the integrated healthcare system that exists within NHS Wales. The purpose of this report is to:

- Advise Joint Committee of the efficiency savings achieved in 2019/20;
- Describe the approach and process WHSSC has followed to develop the value based commissioning plan 2020/23;
- Outline the priority initiatives within the value based commissioning plan identified for 2020/21 and how these initiatives provide value to patients, families and the health service (including cost savings where applicable).

2. BACKGROUND

In order to develop a value based efficiency programme WHSSC has been building up the knowledge of value based healthcare via a series of development meetings over the last year. This has helped provide a theoretical foundation within the organisation. The method used to develop a value based efficiency programme for WHSSC is summarised as:

- The principles of the NHS Wales efficiency framework were reviewed and converted to produce a matrix of opportunities from a commissioning perspective.
- A series of internal workshops were held to scope out a long list of opportunities by commissioning programme area together with further cross cutting themes arising from discussion.
- This long list of opportunities was then further reviewed to provide more detail on the nature of the opportunity, the scale, the probability of success and risks.
- In order not to limit ideas, WHSSC used the wider definition of value in order to capture those opportunities which produced improved value across the whole pathway.
- Opportunities for improving outcomes at same cost were also captured as these were of considered of equal importance.
- WHSSC then held a workshop with Management Group members and the wider WHSSC team to further explore and test opportunities.
- The next stage will be to produce a consolidated plan which will prioritise the actions needed to deliver improved value and efficiency.

The efficiency and value themes from a commissioning perspective, which were used to inform discussion, are summarised below.

Initial Scoping of Efficiency & Value Themes

- Procurement: review the procurement opportunities that could be available in specialised services taking a national perspective on issues such as device procurement and volumes.
- Efficiency: review the relative efficiency of provision of services with the goal of increasing delivery outputs for the same or reduced cost.
- Rationalisation: review the opportunities for rationalising provision in Wales where there is more than one provider and to review the current dispersal of services to improve outcomes or reduce costs.
- Access Criteria: review the scope of access criteria to review the levels of provision related to current evidence of clinical and cost effectiveness and affordability. To include a review of ability to benefit including frailty and procedures of limited utility.
- Repatriation: review the opportunities for repatriating services to NHS Wales provision either to existing or new/enhanced local services.
- Disinvestment: review the range of specialised services to examine the scope for disinvestment including INNU (Interventions not normally undertaken).

3. ASSESSMENT

3.1 Savings plan 2019/20

Table 1 details the efficiency savings schemes included in the 2019-22 Integrated Commissioning Plan and the savings delivered against each scheme. Overall the planned savings of £3.25m are forecast to be over-achieved by £0.15m.

Table 1. 2019/20 Efficiency Savings monitoring

WHSSC ICP 19/20 Efficiency Savings	2019/20 Target Saving £m		Savings to date January 2020 £m	Y/E Forecast Saving £m	Scheme Status	Scheme Description
IBD Trials Savings	(0.700)	Target	(0.583)	(0.700)	Achieved	Emicizumab patient commenced November 18, saving compares 19/20 cost of Emicizumab compared to trial factor 8 expenditure in same period of 18/19. Therefore saving yields from November 18 - November 19
		Achieved	(0.709)	(0.709)		
		Variance	(0.126)	(0.009)		
IBD Factor 9 Price savings	(0.100)	Target	(0.083)	(0.100)	Achieved	New framework price for Factor 9 products from March 2019
		Achieved	(0.177)	(0.212)		
		Variance	(0.093)	(0.112)		
Mental Health - Forensic case management	(0.500)	Target	(0.417)	(0.500)	Achieved	Continued reduction in medium secure placements, due to case management and gatekeeping teams at SB and BCU.
		Achieved	(1.060)	(1.210)		
		Variance	(0.643)	(0.710)		
Perinatal Repatriation (contingent on welsh unit)	(0.350)	Target	(0.292)	(0.350)	N/A	Target based on OOA savings in perinatal placements if Welsh unit was open. However no revenue costs incurred for Welsh unit in 19/20 therefore net saving against plan
		Achieved	(0.188)	(0.225)		
		Variance	0.104	0.125		
Medicines Management - PAS	(0.250)	Target	(0.208)	(0.250)	Achieved	PAS Asfotase Alfa rebate from Alexion secured in August 2019
		Achieved	(0.217)	(0.267)		
		Variance	(0.009)	(0.017)		
Referral Management Centre	(0.250)	Target	(0.208)	(0.250)	Part Achieved	Work plan on going, initial schemes identified focussing on vascular referrals, some savings last quarter from repatriation of UH Bristol activity
		Achieved	0.000	(0.055)		
		Variance	0.208	0.195		
Outpatient Management Scheme	(0.250)	Target	(0.208)	(0.250)	Not Achieved	Work on going, no savings declared to date, but anticipated in 20/21 through rationalisation of outreach clinics
		Achieved	0.000	0.000		
		Variance	0.208	0.250		
IMD switching & HCD review	(0.500)	Target	(0.417)	(0.500)	Achieved	ERT drug switching continues at Cardiff, in addition to 3 patients on commercial trials at Royal Free (£450k). Further trials anticipated to commence in Cardiff later in year
		Achieved	(0.417)	(0.570)		
		Variance	0.000	(0.070)		
De-Prioritisation	(0.200)	Target	(0.167)	(0.200)	Not Achieved	HIPEC procedures through IPFR may be reduced if access policy changed. Clinical evidence review scored low in 18-19 prioritiasation. No change in policy to date.
		Achieved	0.000	0.000		
		Variance	0.167	0.200		
NHS England Market Forces Factor (applied to NHS E tariff)	(0.150)	Target	(0.125)	(0.150)	Achieved	Market Forces Factor reduction for 19-20 distributed across NHS England LTAs, London contracts yield largest proportion of MFF reduction
		Achieved	(0.125)	(0.150)		
		Variance	0.000	0.000		
Total Efficiency Savings 19/20	(3.250)	**Target**	**(2.708)**	**(3.250)**	Achieved	
		Achieved	**(2.892)**	**(3.398)**		
		Variance	**(0.184)**	**(0.148)**		

3.2 Savings plans included in 2020-23 Integrated Commissioning Plan

The planned initial savings target of £2.75m included in the ICP is equivalent to 0.4% of 20/21 total specialised services budget of £666.1m. This is in the context of:

- Low risk of delivery
- Relative cost growth containment in comparison to NHS England.
- WHSSC does not apply arbitrary savings targets to Welsh provider contracts, acknowledging that providers make internal efficiency savings to contain costs within their contracted budget baselines.

Therefore excluding schemes which reduce the volume of specialised activity, the cost base from which commissioner savings can be realised is traditionally

restricted to efficiency or price discounts on pass through drugs and devices. It is estimated that this cost base is closer to £230m.

There is further potential value to be unlocked through revising contracting mechanisms to dis-aggregate device costs from current contract currencies, enabling commissioners to access historic procurement savings that would fall to providers. These opportunities are being reviewed through a number of contract rebasing work streams through the WHSSC finance sub group.

Table 2 details the initial efficiency savings schemes included in the 2020-23 Integrated Commissioning Plan.

Table 2. 2020/21 Schemes in Plan

Value Based Commissioning Workstreams	2020/21 £m	Value Themes	Scheme overview	Risk Assessment of Scheme Delivery
Patient Access Scheme - Pharma Supplier Rebate	(0.600)	Technical Efficiency, Procurement	Biomarin supplier rebate on Brineura, applicable after NICE approval	Rebate and ongoing discount secured, but at 39% rate and only backdated to FAD date. Forecast actual saving £440k
ERT Commercial Trials	(0.500)	Patient Value / Provider Relationship	C&V service to enter commercial trials for ERT patients, potential 20/21 savings range between £469k - £634k including costs of investment in research nurse and research fellow £97k	Risk if provider does not enrol patients in trials within proposed timeline. Less than 3 patients enter trials
Mental Health - Forensic case management	(1.000)	Allocative Value & Patient Value	Continued reduction in medium secure placements, patients in most appropriate care setting.	National OOA Medium Secure capacity is limited - Activity would need to exceed 19/20 levels by £0.7m to not deliver
Referral Management Centre	(0.250)	Allocative Value & Patient Value	Continuation of 19/20 workstream to enhance WHSSC gatekeeping and referral process	Activity is diverted to other providers at equivalent cost / new pathways are established
Medicines Management	(0.400)	Technical Efficiency, Procurement	Benefit by change of funding flow for Vertex CF products, £400k saving between funding and 18/19 baseline expenditure. Further potential £1m benefit to commissioners from previous investment above allocation levels	Secured
Total ICP Savings	**(2.750)**			

3.3 Additional Value Based Commissioning Schemes 2020/21

3.3.1 Long List

The long list of potential additional value based commissioning schemes is attached as annex 1. Potential schemes have been described across a number of fields including how they contribute value (for example, by reducing cost while maintaining outcomes), relevant value theme (for example, efficiency or procurement), achievability and financial value (for schemes with a potential cost reduction impact). The full list of fields for capturing the features of each scheme on the long list are shown in table 3.

Table 3: VBC scheme description fields

- Clinical area and commissioning team
- Scheme description
- Value definition (same outcome/cost reduction; better outcome/cost reduction; better outcome/cost same)
- Value theme (procurement, efficiency, rationalisation, repatriation, access criteria)
- Estimated value of cost saving (cost reduction schemes)
- Type of outcome improvement (better outcome schemes)
- Year scheme commences
- Savings area (health board or WHSSC)
- Scheme achievability (high, medium, low)
- Financial columns to profile estimated savings over the 3 years of the ICP.

3.3.2 Management Group Workshop

A workshop was held with Management Group on 4th February to receive feedback on the long list of schemes generated by the WHSSC team and to receive suggestions for any additional schemes that should be considered.

The feedback from the workshop confirmed that the items included on the long list of schemes captured the main opportunities for increasing value from specialised services investments.

A few additional suggestions were made that included exploring whether there were potential procurement gains in some further areas and conducting a benchmarking exercise utilising CHKS to identify if there were further areas for potential efficiency gains. These have been added to the long list of schemes for further work to explore and identify the likely benefits.

Management Group also provided feedback on practical considerations relating to deliverability that will inform implementation of the action plans to deliver the prioritised schemes.

3.3.2 Priority VBC Schemes 2020/21

The following schemes have been identified as a priority to commence within the WHSSC work programme 2020/21:

- Schemes assessed as being of high achievability;
- Selected medium and low achievability schemes based on their potential to yield high value or as schemes that were already identified as issues to be taken forward within commissioning team work plans.

Priority schemes: cost savings

Table 4 below outlines the high deliverability schemes that aim to generate cost savings. It includes a description of the scheme and whether the resulting savings accrue to WHSSC or directly to health boards as savings in secondary care. The estimated savings associated with these schemes over the 3 years of the ICP are shown in Appendix 1. For schemes where current information does not allow precise estimates, indicative values based on a likely range have been used. It should be noted that at this stage highly prudent estimates have been used to assign financial values. These will be subject to further work to scope the full range of possible values.

In addition to the schemes in table 4, work is in progress, or will be commenced, on selected schemes assessed as of medium or low achievability. These are described in Appendix 2. These schemes, if achieved, will generate further savings. Examples of these schemes include:

- Medicines management: WHSSC has seconded a pharmacist to scope the potential opportunities from improved prices for high cost drugs. This scoping work is currently in progress.
- Exploring opportunities for improved prices for cardiac (and other) devices through procurement at a national level.
- Exploring potential areas for efficiency gains through CHKS benchmarking.
- Ensuring that WHSSC contract values are reflected in the financial resources available to services and that CIPs have not been applied and retained by providers.

Table 4: High deliverability schemes that aim to generate cost savings (while maintaining or improving outcomes)

	Team	Scheme Title	Scheme Description	Theme	Savings to WHSSC/Health Board
A25	Adult Mental Health	Charging for DTOCs	Review policy re charging for DTOCs	Rationalisation	WHSSC
A28	Cancer & Blood	Repatriation of genetic tests	To capture cost advantage of providing tests at the AWGS (two sources: i) tests currently outsourced by AWGS; ii) tests for patients in NHSE pathways charged to WHSSC contracts)	Repatriation	WHSSC
A68	Cancer & Blood	IBD: home delivery of blood products (north Wales)	To achieve savings from prescribing home delivery of blood products by north Wales clinicians (savings on admin and VAT charges currently paid to Liverpool)	Repatriation	WHSSC
A35	Cancer & Blood	PET	To describe the value and savings obtained through the pathway impacts of introducing PET for new indications (in particular through avoiding unnecessary surgery).	Rationalisation	Health Board

A67	Cardiac	CRTD device - longer lasting implant.	Enduroliife CRTD device - longer lasting implant: potential to make savings through a reduction in the need for replacement procedures. This will also improve the patient experience by reducing the number of procedures they require.	Procurement	WHSSC
A13	Neuro & LTC	Wheelchairs seating contract	Wheelchairs savings on seating contract (restricting specification) seating contract commenced Sept 2019 to 31st August 2021.	Procurement	WHSSC
A17	Neuro & LTC	Spinal implants	There has been a change in the contract volumes from patients being implanted with a drug pump previously to a Spinal Cord Stimulator. Although the cost of the stimulator was previously more expensive, the unit price of the stimulator has reduced due to the increase in volumes purchased. There is therefore cost avoidance due to the improved price.	Procurement	WHSSC

A10	Referral Management	"Do not do" NHS Wales providers	Add into contracts that WHSSC will not pay for procedures designated as 'Do Not Do' in Wales unless approved under an IPFR. Note the Finance Delivery Unit have also passed on analytics on these to Health Boards for them to analyse and progress internally.	Access criteria	WHSSC
A48	Women & Children	Paediatric endocrine	The Paediatric Endocrine service in south wales is looking at reducing drug spend by prescribing the most cost efficient growth hormone drugs whilst complying with NICE guidance (no impact on effectiveness). This is not a saving that will be seen directly at tertiary level but there are significant savings predicted in secondary care (shift prescribing from primary to secondary). This model could be replicated for north wales patients. The service are also looking at what other drugs this methodology can be replicated for.	Procurement	Secondary

Impact on WHSSC's Savings Plan

The impact on WHSSC's overall savings plan over the 3 years of the ICP is shown below. This includes the high achievability value based commissioning schemes only.

Table 5: Indicative impact of VBC cost saving schemes on WHSSC savings plan ICP 2020-23

	2020/21 (£m)	2021/22 (£m)	2022/23 (£m)
ICP savings plan	2.750 (0.44%)	2.750	2.750
Additional VBC plan (high achievability schemes)	0.833	1.549	1.563
Percentage of WHSSC budget	0.57%	0.68%	0.68%

Better outcomes / same cost

A number of schemes have been identified that are not expected to generate savings but which aim to improve value for patients and for services. These are described in table 6 below. These schemes are being taken forward within commissioning team work plans in 2020/21.

Table 6: Schemes that aim to improve value for the service and patients (including patient experience) while maintaining cost

Achievability	Scheme	Team	Scheme Description	Value Theme
High	A33	Cancer & Blood	To measure the value provided by the increase in plastic surgeons employed to deliver the major trauma service (inc. support for delivering activity within the core plastics contract).	Efficiency
	A64	Cardiac	ECMO: To address differential use - Potential to deliver an improved referral pathway to a designated centre in NHS England.	Rationalisation
Medium	A30	Cancer & Blood	AWGS to introduce operational measures to improve patient/family attendance at appointments and reduce the currently high DNA rate for medical genetics.	Efficiency
Medium	A31	Cancer & Blood	To explore the variation in utilisation of plastic surgery to inform dialogue with health boards on appropriate pathways and use of scarce clinical skills, and on ensuring equitable access to specialist plastic surgery for those patients that need it. To inform review of optimal commissioning arrangements for plastic surgery.	Rationalisation
Medium	A32	Cancer & Blood	To revise the contracting currency for plastic surgery in order to better reflect case complexity and cost of specialist and non-specialist surgery.	Rationalisation
Medium	A34	Cancer & Blood	To clarify current provision and associated commissioning arrangements for the care of BMT patients experiencing complications post 100 days following transplant in order to inform consideration of changes that may improve patient pathways, experience of care and efficiency of resource utilisation.	Rationalisation
Medium	A37	Women & Children	Neonatal - lack of maternity capacity leading to mothers who need NIC being transferred out of area.	Repatriation
Medium	A40	Women & Children	NICU/PICU: issue of timing of appropriate transfer time, step down time	Rationalisation
Medium	A58	Cardiac	To maximise the delivery of home IV to improve the patient experience of care through reducing reliance on in-patient care.	Efficiency
Medium	A59	Cardiac	Inherited cardiac conditions. Benefit of improved pathways, less waste, duplication of appointments etc.	Efficiency

3.3.3 Health Board schemes

A couple of schemes have been identified through the process of creating the long list, and discussed with Management Group at the workshop, that relate to initiatives within secondary care. These are:

i) The introduction of CT angiography across Wales to substitute for a proportion of traditional angiography. This both reduces cost and improves patient experience reducing the need for an invasive procedure. The estimated cost saving across Wales is £0.281k rising to £0.563k in the 2021-22.

ii) The repatriation of paediatric surgery from NHS England into north Wales, reducing costs and improving accessibility for families. This will directly impact on expenditure within WHSSC contracts held with NHSE Trusts which will be passed to BCUHB through the risk share.

3.3.5 Enabling actions

Through the process of developing this plan, WHSSC has begun to identify enablers that are required to capture and achieve some of the value opportunities. Two of these include: i) restructuring contracts so that devices or other consumables are charged on a pass through basis (for example, cardiac devices or cochlear implants) rather than incorporated in an overarching price; ii) securing agreement around principles for aligning financial incentives within the system where it comes to boundaries between levels of care (for example, step up/down for mental health services).

3.3.6 Monitoring and reporting progress

WHSSC will develop a monitoring template for progress against the identified priority value based commissioning schemes that it is proposed to take forward in 2020/21. Progress will be reported to Management Group and at each Joint Committee meeting.

4. RECOMMENDATIONS

Members are asked to:

- **Note** the efficiency savings achieved in 2019/20;
- **Note** the efficiency savings already incorporated within the ICP 2020/23;
- **Note** the approach and process WHSSC has followed to develop the value based commissioning plan 2020/23;
- **Note** that at this point only provisional highly prudent values have been assigned to these schemes pending further detailed examination by the WHSSC team;
- **Support** the priority value based commissioning initiatives identified for implementation in 2020/21;
- **Support** that the WHSSC team to progress enabling actions including contracting changes via the Finance Sub Group.

5. APPENDICES / ANNEXES

Appendix 1: Priority schemes cost savings (high achievability)
Appendix 2: Priority schemes descriptions (medium / low achievability)
Annex 1: Long list of VBC schemes

Appendix 1: Priority schemes cost savings (high achievability)

	Team	Scheme Title	Savings to WHSSC/Health Board	2020-21	2021-22	2022-23
A25	Adult Mental Health	Charging for DTOCs	WHSSC	0.028	0.056	0.056
A28	Cancer & Blood	Repatriation of genetic tests	WHSSC	0.066	0.131	0.131
A68	Cancer & Blood	IBD: home delivery of blood products (north Wales)	WHSSC	0.066	0.131	0.131
A35	Cancer & Blood	PET	Health Board	0.066	0.131	0.131
A17	Cardiac	CT angiography replacing angiography	Health Board	0.281	0.563	0.563
A67	Cardiac	CRTD device - longer lasting implant.	WHSSC	0	0.014	0.028
A13	Neuro & LTC	Wheelchairs seating contract	WHSSC	0.131	0.131	0.131
A17	Neuro & LTC	Spinal implants	WHSSC			
A10	Referral Management	"Do not do" NHS Wales providers	WHSSC	0.066	0.131	0.131
A48	Women & Children	Paediatric endocrine	Secondary	0.130	0.260	0.260
				0.833	1.549	1.563

Appendix 2: Medium and low achievability schemes that aim to generate cost savings

Table A2a: Medium deliverability schemes that aim to generate cost savings (while maintaining or improving outcomes)

Med	Team	Scheme Title	Scheme Description	Savings to WHSSC/Health Board	2020-21	2021-22	2022-23
A24	Adult Mental Health	Mental health contract	To benchmark prices at the local provider, Caswell. Preliminary analysis indicates relatively high prices compared to services in England.	WHSSC	0	0.044	0.088
A27	Cancer & Blood	Precision medicine	The application of genetic tests to enable therapy to be targeted to those patients with cancers that will respond to treatment (and to avoid treatment for patients where risks outweigh benefits).	Secondary	0	0	0
A01	Cardiac	Cardiac device procurement	ICD TAVI PCI: to explore potential for procurement gains through an all Wales purchasing approach. This process would also consider whether there is value in specifying a specific valve to be commissioned.	WHSSC	0	0	0
A03	Cardiac	PCI stent choice	To explore the potential of commissioning specific stents to obtain a better price.	WHSSC	0	0.002	0.003
A19	Neuro & LTC	Thrombectomy – invest to save	Actively progress establishment of the service in Cardiff therefore avoiding premium costs in Bristol as well as improving the patient experience in terms of travel times etc.	Secondary	0.094	0.188	0.188
A70	Referral Management	General procurement	To work with Shared Services to explore the potential for further procurement gains across all pathways and commissioning teams.	WHSSC	0	0	0
A39	Women & Children	Cochlear implants	Cochlear implants: north and south using different implants with different costs. Issue of device cost and procurement as volumes increase.	WHSSC	0	0.002	0.003
A45	Women & Children	PICU / HDU balance	To explore the issue of whether paed HDU has sufficient capacity. WHSSC does not currently commission HDU in the Children's Hospital for Wales thought it is commissioned from England. In the Children's hospital the units are co-located therefore	WHSSC	0.004	0.009	0.009

			there are efficiencies in commissioning it as one. Work is currently being progressed by C&V HB.				
A46 & A47	Women & Children	Paediatric surgery service specification	The forthcoming GIRFT National Report for Paediatric Surgery and work on defining childhood surgery in Wales being undertaken by the Collaborative, will inform the future planning and provision of tertiary paediatric surgery through defining which procedures will be carried out in secondary care. This will eventually lead to a reduction in spend as surgeries will be carried out in the most appropriate setting (DGH / Tertiary Centre).	Health Board	0	0	0
A54, 55 & 56	Women & Children	IVF contracts and policy	This includes rationalisation of contracts (to address price variation), policy revision and addressing variation in provision across centres.	WHSSC	0	0	0
A20	Unallocated	Burns service	To clarify how long stay patients from outside of Wales are charged for. (Example of how Swansea were being asked to 'keep' a patient as another hospital didn't have a psychologist.)	WHSSC	0	0	0
A61	Referral Management	Medicines Management	To review and benchmark prices and expenditure for high cost drugs commissioned by WHSSC to ensure value for money and adherence to policy.	WHSSC	0.004	0.009	0.009
A79	Unallocated	Benchmarking efficiency	Benchmark services using CHKS to identify areas of potential efficiency gains	WHSSC	0	0	0
					0.104	**0.255**	**0.302**

Low	Team	Scheme Title	Scheme Description	Savings to WHSSC/Health Board	2020-21	2021-22	2022-23
A14	Referral Management	CIPs	Confirming service costs compared with WHSSC funding: is specialised funding going to specialised services or has it been subject to CIPs?	WHSSC	0	0.038	0.075

Annex 1: Long list of VBC schemes

Scheme	Clinical area	Scheme Description	Value definition	Value Theme	Year scheme commences	Savings Area	Achievability
A01	Cardiac	ICD TAVI PCI: procurement gains through all Wales approach	Same outcome - cost reduction	Procurement	2021-22	WHSSC	Medium
A02	Cardiac	TAVI specifying particular valve for commissioning to save money. Both SW Centres using different devices	Same outcome - cost reduction	Efficiency	2020-21	WHSSC	Medium
A03	Cardiac	PCI - choice of stent, cost-effectiveness	Same outcome - cost reduction	Efficiency	2021-22	WHSSC	Medium
A04	Cardiac	ICD - choice of device type, cost-effectiveness	Same outcome - cost reduction	Efficiency	2020-21	WHSSC	Low
A05	Cardiac	New NICE guidance re NSTEMI - watch and wait	Same outcome - cost reduction	Efficiency	2021-22	WHSSC	Low
A06	Cardiac	Explore the opportunities to increase CT angiography - avoids need for more costly and invasive angiography	Same outcome - cost reduction	Efficiency	2020-21	Secondary	High
A08	Cardiac	Cardiac rebasing to capture savings from device costs	Same outcome - cost reduction	Efficiency	2020-21	WHSSC	Other

A09	Cardiac	VAD - explore criteria given mortality rate.	Better outcome - better cost	Access Criteria		WHSSC	Low
A10	Do Not Do Procedures	NHS Wales providers - add into contracts that WHSSC will not pay for procedures designated as 'Do Not Do' in Wales, unless approved under an IPFR. Note the Finance Delivery Unit have also passed on analytics on these to Health Boards for them to analyse and progress internally.	Same outcome - cost reduction	Access Criteria	2020-21	WHSSC	High
A11	Wheelchairs	Wheelchairs - procurement gains - contract likely to cost more. How to influence the procurement process - benchmarking current expenditure with Scotland and NI. Rationalisation of products. Collaborative working with other home nations. Review non category items and rationalise products.	Same outcome - cost reduction	Procurement	2021-22	WHSSC	Low
A12	Wheelchairs	Wheelchairs - re-conditioning of chairs is already happening across the sites. Limited by companies making a number of models obsolete leading to the replacement wheelchair programme. This should however see a reduction in repair costs whilst under warranty.	Same outcome - cost reduction	Efficiency	2020-21	WHSSC	Low
A13	Wheelchairs	Wheelchairs savings on seating contract (restricting specification) seating contract commenced Sept 2019 to 31st August 2021. WHSSC not identified on the Procurement savings programme.	Same outcome - cost reduction	Procurement	2019-20	WHSSC	High
A14	General CIP's	Confirming service costs compared with WHSSC funding … is specialised funding going to specialised services or has it been subject to CIPs? A general issue to apply to new developments.	Same outcome - cost reduction	Efficiency	2021-22	WHSSC	Low
A15	Neuro	Intracranial devices - benchmark spend of Cardiff Consultants now there are two with each other and with the Walton. Forwarding details of products to procurement to establish whether rationalisation of products could be done.	Same outcome - cost reduction	Rationalisation	2021-22	WHSSC	Low

A16	Neuro	Rehabilitation - repatriation of patients when medically fit. Reduce delayed discharges particularly with the introduction of a single point of contact when Major Trauma network is set up.	Better outcome - same cost	Repatriation	2021-22	WHSSC	Low
A17	Neuro	There has been a change in the contract volumes from patients being implanted with a drug pump previously to a Spinal Cord Stimulator. Although the cost of the stimulator was previously more expensive, the unit price of the stimulator has reduced due to the increase in volumes purchased. There is therefore cost avoidance due to the improved price.	Same outcome - cost reduction	Procurement	2021-22	WHSSC	High
A18	AAC/EAT	AAC/EAT efficiencies - Cardiff moving to combining stock for the two services as they overlap in terms of patients able to use same equipment for AAC and EAT issues. Collaborative working with procurement.	Better outcome - better cost	Procurement	2021-22	WHSSC	Low
A19	Neuro	Thrombectomy invest to save - actively progress establishment of the service in Cardiff therefore avoiding premium costs in Bristol as well as improving the patient experience in terms of travel times etc.	Same outcome - cost reduction	Repatriation	2020-21	Secondary	Medium
A20	Burns	Burns network: how are long stay patients from outside of Wales charged for? Example of how Swansea were being asked to 'keep' a patient as another hospital didn't have a Psychologist	Same outcome - cost reduction	Rationalisation		WHSSC	Medium
A21	Burns	Understanding the funding streams for the Swansea Burns service particularly from NHSE with Swansea the tertiary centre for the Wales and south west network.	Same outcome - cost reduction	Rationalisation	2021-22	WHSSC	Low
A22	Cystic Fibrosis	CF bandings: comparison with CF Trust rates	Same outcome - cost reduction	Efficiency	2020-21	WHSSC	Low

A23	Mental health	Organisational commissioning boundaries creating perverse financial incentives that may lead to delayed step down in care. Review of options for alternative finance arrangements including an element of funding following patient to be explored further	Same outcome - cost reduction	Rationalisation	2021-22	WHSSC	Low
A24	Mental health	The local service is expensive when compared to NHS benchmarking and independent sector Medium Secure bed-day rates for Framework providers.	Same outcome - cost reduction	Efficiency	2021-22	WHSSC	Medium
A25	Mental health	Reduction in timescale for penalty recharging from current 3 months. Blanket policy could create winners and losers and would not be subject to individual case review.	Same outcome - cost reduction	Rationalisation	2020-21	WHSSC	High
A26	Genetics	The application of whole Genome Sequencing can provide early diagnosis for acutely unwell babies significantly reducing the time to diagnosis, saving costs associated with an often protracted investigations and diagnostic pathway, improving the experience of families and enabling appropriate management decisions at an earlier stage leading to better outcomes.	Better outcome - better cost	Rationalisation	2021-22	Secondary	Low
A27	Genetics	The application of genetic tests to enable therapy to be targeted to those patients with cancers that will respond to treatment (and to avoid treatment for patients where risks outweigh benefits).	Better outcome - better cost	Efficiency	2020-21	Secondary	Medium
A28	Genetics	Repatriation to Wales of genetic tests previously outsourced.	Same outcome - cost reduction	Repatriation	2020-21	WHSSC	High

A29	Genetics	To map and describe the impact of new testing panel for intellectual delay on the diagnostic and intervention pathway for affected individuals and families. The introduction of this panel has the potential to shorten the time to diagnosis, improving the experience of families and enabling appropriate management decisions at an earlier stage leading to better outcomes.	Better outcome - better cost	Rationalisation	2021-22	Secondary	Low
A30	Genetics	AWGS to introduce operational measures to reduce the currently high DNA rate for medical genetics.	Better outcome - same cost	Efficiency	2020-21	WHSSC	Medium
A31	Plastics	To explore the variation in utilisation of plastic surgery to inform dialogue with health boards on appropriate pathways and use of scarce clinical skills, and on ensuring equitable access to specialist plastic surgery for those patients that need it. To inform review of optimal commissioning arrangements for plastic surgery.	Better outcome - same cost	Rationalisation	2021-22	WHSSC	Medium
A32	Plastics	To revise the contracting currency for plastic surgery in order to better reflect case complexity and cost of specialist and non-specialist surgery.	Better outcome - same cost	Rationalisation	2021-22	WHSSC	Medium
A33	MTC	To measure the value provided by the increase in plastic surgeons employed to deliver the major trauma service (inc. support for delivering activity within the core plastics contract).	Better outcome - same cost	Efficiency	2020-21	WHSSC	High
A34	BMT	To clarify current provision and associated commissioning arrangements for the care of BMT patients experiencing complications post 100 days following transplant in order to inform consideration of changes that may improve patient pathways, experience of care and efficiency of resource utilisation.	Better outcome - same cost	Rationalisation	2020-21	Secondary	Medium
A35	PET	To describe the value obtained through the pathway impacts of introducing PET for new indications, in particular through informing patient management decisions.	Better outcome - better cost	Rationalisation	2020-21	Secondary	High

A37	Neonatal	Neonatal - lack of maternity capacity leading to mothers who need NIC being transferred out of area.	Better outcome - same cost	Repatriation	2020-21	WHSSC	Medium
A39	Cochlear Devices	Cochlear implants: north and south using different implants with different costs. Issue of device cost and procurement as volumes increase.	Better outcome - better cost	Procurement	2021-22	WHSSC	Medium
A40	Neonatal	NICU/PICU: issue of timing of appropriate transfer time, step down time	Better outcome - same cost	Rationalisation	2022-23	WHSSC	Medium
A41	Neonatal	In-utero transfers: benefit from moving the mother before birth?	Better outcome - same cost	Rationalisation	2021-22	Secondary	Low
A45	PICU	PICU / HDU balance: issue of whether paediatric HDU has sufficient capacity	Better outcome - better cost	Efficiency	2020-21	WHSSC	Medium
A46	Paediatric surgery	Paediatric surgery GIRFT report: action to review for any potential issues	Better outcome - better cost	Access Criteria	2021-22	Secondary	High
A47	Paediatric surgery	Paediatric surgery service specification and specialist/secondary care split - **This is linked with A46**	Better outcome - better cost	Access Criteria	2022-23	Secondary	Medium
A48	Paediatric endocrine	Paediatric endocrine: cost avoidance by prescribing cheaper versions of same compound.	Better outcome - better cost	Procurement	2021-22	Secondary	High
A49	Referral management	Check Paediatric activity in NHS England are being referred back to Wales when they transition to Adults, not other NHS England organisations	Better outcome - same cost	Repatriation	2022-23	WHSSC	Low

A50	Referral management	Non specialist activity - scope for repatriation (vascular surgery, ENT, colorectal, gastro, general surgery, general medicine, neurology)	Same outcome - cost reduction	Repatriation	2020-21	WHSSC	Low
A51	Referral management	Specialist activity - scope for repatriation (Cochlear & BAHA, ERT, Adult Cystic Fibrosis, Paediatric Endocrine)	Same outcome - cost reduction	Repatriation	2020-21	WHSSC	Low
A52	Referral management	Gate-keeping process improvements including non-specialist services. Explore reasons why GPs are referring directly to some contracts	Same outcome - cost reduction	Access Criteria	2020-21	WHSSC	Low
A53	Non specialist activity CHKS		Same outcome - cost reduction	Efficiency	2020-21	WHSSC	Other
A58	Cystic Fibrosis	To maximise the delivery of home IV to improve the patient experience of care through reducing reliance on in-patient care.	Better outcome - same cost	Efficiency	2021-22	WHSSC	Medium
A59	Cardiac	Inherited cardiac conditions. Benefit of improved pathways, less waste, duplication of appointments etc.	Better outcome - same cost	Efficiency	2021-22	Secondary	Medium
A60	Cardiac	To explore the potential for reducing length of stay for TAVI and SAVR for Aortic stenosis as compared to peers (drawing on CHKS data).	Better outcome - better cost	Efficiency	2020-21	WHSSC	Low
A61	Medicine Management	Medicine Management pharmacist tbc	Same outcome - cost reduction	Efficiency	2020-21	WHSSC	Other
A62	Paediatric surgery	North Wales: paediatric surgery repatriation	Same outcome - cost reduction	Repatriation	2021-22	WHSSC	High

A63	General	Reduce Transport/hotel beds costs for NHS England patients, as passed through the provider contracts. This is linked to repatriation i.e. if a patient's follow ups are repatriated, the associated transport costs would too.	Same outcome - cost reduction	Repatriation	2020-21	WHSSC	Medium
A64	Cardiac	ECMO: To address differential use - Potential to deliver an improved referral pathway to a designated centre in NHS England.	Better outcome - same cost	Rationalisation	2020-21	Secondary	High
A65	Cardiac	An improved pathway to reduce waiting times and referral to cardiac surgery	Same outcome - cost reduction	Efficiency	2020-21	Secondary	Low
A67	Cardiac	Endurolife CRTD device - longer lasting implant-may make saving through a reduction in the need for replacement procedures.	Same outcome - cost reduction	Procurement	2021-22	WHSSC	High
A68	IBD	To achieve savings from prescribing home delivery of blood products by north Wales clinicians (savings on admin and VAT charges)	Same outcome - cost reduction	Repatriation	2020-21	WHSSC	High
A69	IBD	To measure value achieved through the IBD investment 2019/20 including more efficient utilisation of blood products and benefits from introducing a virtual consultations and advice service at the specialist centre.	Same outcome - cost reduction	Efficiency	2022-23	WHSSC	Low
A70	All Commissioning Teams	Procurement gains across all pathways and commissioning teams	Same outcome - cost reduction	Procurement	2020-21	WHSSC	Medium
A71	Paediatric Radiology	Health boards to delivery local DGH standards for paediatric radiology to include x-ray, ultrasound and CT and only refer appropriate cases to tertiary centres	Same outcome - cost reduction	Access Criteria		WHSSC	Low

A73	Prosthetics	Introducing a multi supplier framework. Collaborative working with the 3 centres and procurement. Containing costs. Hard to establish a savings target but once this is established there will be a project for rationalisation of products.	Same outcome - cost reduction	Procurement	2021-22	WHSSC	Low
A74	Do Not Do Procedures	NHS England providers - add into contracts that WHSSC will not pay for procedures designated as 'Do Not Do' in Wales, unless approved under an IPFR.	Same outcome - cost reduction	Access Criteria	2020-21	WHSSC	Low
A75	Plastics	Procurement gains for prostheses used in plastic surgery	Same outcome - cost reduction	Procurement	2021-22	WHSSC	Low
A76	PET	Procurement gains for consumables used in PET scanning	Same outcome - cost reduction	Procurement	2022-23	WHSSC	Low
A78	ATMPs	Ensure application of policies and measurement of patient outcome	Better outcome - better cost	Access Criteria	2020-21	Secondary	High
A79	All Commissioning Teams	Benchmark services using CHKS to identify areas for potential efficiency gains	Same outcome - cost reduction	Efficiency	2020-21	WHSSC	Medium
A80	All Commissioning Teams	Atlas of variation: to explore inclusion of activity in NHSE to enable valid assessment of variation in access to specialised services across Wales.	Better outcome - same cost	Access Criteria	2020-21		Medium

Link to Healthcare Objectives	
Strategic Objective(s)	Development of the Plan Choose an item. Choose an item.
Link to Integrated Commissioning Plan	This links to WHSSC's intention to develop a value based commissioning agenda within its work programme 2020/23.
Health and Care Standards	Effective Care Dignified Care Timely Care
Principles of Prudent Healthcare	Only do what is needed Reduce inappropriate variation Choose an item.
Institute for HealthCare Improvement Triple Aim	Reducing the per capita cost of health care Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	This paper outlines opportunities for increasing the value obtainable from the investment in specialised services. This includes schemes that aim to improve outcomes for patients while maintaining costs.
Resources Implications	Potential resource savings associated with the value based commissioning high priority schemes have been identified within the report.
Risk and Assurance	Risk in terms of scheme deliverability is a factor taken into account to determine priorities for the value based commissioning plan.
Evidence Base	The commissioning and financial knowledge of the WHSSC team has informed the development of the plan.
Equality and Diversity	No specific equality and diversity issues have been identified within the report.
Population Health	The value based commissioning schemes identified in this report aim to maintain outcomes but at lower cost, or to improve outcomes for the same cost.
Legal Implications	No legal issues have been identified.

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	02/03/20	Approved for submission to Joint Committee

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

		Agenda Item	2.3
Meeting Title	**Joint Committee**	Meeting Date	10/03/2020
Report Title	Neonatal Transport Review Recommendations		
Author (Job title)	Specialised Planning Manager for Women and Children		
Executive Lead (Job title)	Director of Planning	Public / In Committee	Public

Purpose	The purpose of the paper is to set out the key recommendations from the Review of the South Wales Neonatal Transport Service and seek support for the implementation process to commission a permanent 24 hour Neonatal transport service. The paper also updates Joint Committee on consideration of the review • at the Extraordinary Management Group on 27 February 2020. The core brief issued following this meeting is attached (Appendix 2); and • at the Neonatal Transport Sub Group (a sub group of the Maternity and Neonatal Network) on 28 February 2020. Additionally the paper updates Joint Committee on the steps discussed with Management Group and the Neonatal Transport Sub Group on the development of an interim solution.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☒

Sub Group /Committee	Choose an item.	Meeting Date	Click here to enter a date.

Recommendation(s)	Members are asked to: • **Note** the Independent Review of the South Wales Neonatal Services; and • **Support** the recommendations made by Management Group at the extraordinary meeting on 27th February 2020 (Appendix 2). Specifically Joint Committee is asked to: • **Support** the requirement for a 24/7 neonatal transport service for south and west Wales, noting that residents from the BCU Health population already have a 24/7 service; • **Support** Management Group recommendations that the future model will be commissioned from a lead provider; • **Support** the establishment of a Task and Finish Group to develop a service specification for the service and implementation process for a 24/7 model; • **Support** further work to be undertaken by the Finance Sub Group to define and clearly set out the funding of the clinical components of a 24 hours service on the principle will be that the commissioning of a 24 hour service will not de-stabilise the current neonatal intensive care units; • **Support** the request that in parallel, the Maternity and Neonatal Network undertake demand and capacity modelling of both the number of maternity beds and cots required across the region; and • **Approve** delegated authority to Management Group to agree an interim solution on the basis that this will be within the resource identified within the 2020/21 Integrated Commissioning Plan (ICP).

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)

Aneurin Bevan, Cardiff and Vale and Swansea Bay

1. SITUATION

A review of the current Neonatal Transport service in Wales was agreed by Joint Committee in November 2018. The review was commissioned by WHSSC during 2019 and a final report has recently been issued to WHSSC. The full report is attached (Appendix 1).

This paper updates Joint Committee on consideration of the review

- at the Extraordinary Management Group on 27 February 2020. The core brief issued following this meeting is attached (Appendix 2); and
- at the Neonatal Transport Sub Group (a sub group of the Maternity and Neonatal Network) on 28 February 2020.

2. BACKGROUND

Neonatal transport services across South Wales are provided by Cymru Inter Hospital Transfer Service (CHANTS). WHSSC commissions the CHANTS service for 12 hours per day, 7 days per week. This service runs on a 1 week in 3 rotational basis between the 3 Neonatal Intensive Care Units (NICU's), Aneurin Bevan, Swansea Bay and Cardiff & the Vale. Each day there is a neonatal transport nurse, neonatal consultant dedicated to the service and the dedicated vehicle and driver provided by Welsh Ambulance Service Trust (WAST).

The CHANTS service model was established in 2010, following the allocation of additional recurrent funding from Welsh Government. The three service providers in South Wales were allocated £364,000 each in order to deliver a 12 hour neonatal transport service. In addition there is the cost of the ambulance and ambulance staff which is provided by WAST for £200,000. This takes the total cost of the transport service to £1,292,000.

Below is a brief timeline of what actions and processes have been carried out since the implementation of the 12 hour service.

2010	BAPM Published Service standards for hospitals providing neonatal care (3rd edition).
2011/12	Establishment of CHANTS and allocation of funding.
2012	The Childrens' and Young People Committee, as part of their Inquiry into Neonatal Care recommended to the Minister that options for costing and extending the service should be explored.

2013	Paper to MG seeking support the development of the Neonatal Transport Service to 24 hours however funding was not approved. MG requested further information on the impact of not implementing a 24 hour service on babies and how the funding request aligned with the wider WHSSC financial priorities.
ICPs 2014/17 – 2016/19	Not included within the WHSSC ICP over these periods.
2016	Bliss published 'Time for Change in Wales' and recommended a 24 hour transport service is implemented as a matter of urgency.
2017/20 ICP	The 2017/20 ICP was a technical rather than Commissioning Plan due to no financial provision for additional schemes being made available by Health Boards. Neonatal Transport was included within the work-plan as a high risk service.
2017	Publication of the All Wales Neonatal Standards (3rd Edition) – notes a 24 hour service is needed.
2018	Workshop hosted by WHSSC to develop a 24 hour transport service.
2018/21 ICP	A formal proposal from the provider organisations was not submitted as part of the process. It was recommended that a comprehensive review was undertaken of the current system in order to inform the development of a 24 hour service. Therefore it was removed prior to the prioritisation process.
2018	Case note review commissioned in light of 21 DATIX reports raised related to a lack of 24 hour service.
2019/22 ICP	Funding allocated within the plan and a commitment made to work on an interim solution to be considered as part of the 2020/23 prioritisation process.
2019	Final version of the commissioned independent review in to Neonatal Transport Service is South Wales.

3. ASSESSMENT

The review of the current Neonatal Transport Service was undertaken throughout the summer and autumn of 2019. The final report was received on 17 February 2020 and is attached (Appendix 1).

The recommendations within the report were discussed with Management Group at an extraordinary meeting on 27 February 2020. Prior to the meeting management group representatives from Health Boards providing the neonatal transport service had received feedback from their providers. All six affected Health Boards were represented at the extraordinary meeting and were able to agree the following:

- Support the direction of travel of the report
- Clear endorsement of a 24/7 model
- Agreement to establish a Lead Provider for Neonatal Transport noting that from a Commissioning perspective this model would:

    - provide a single governance framework with clear lines of accountability;
    - give assurance of systems management for the service; and
    - allow for further development of the Neonatal Transport service through a defined processes of engagement.

The core brief issued following the extraordinary Management Group meeting is attached (Appendix 2).

Management Group were supportive of a comprehensive appraisal of delivery options using the conclusions and recommendations from the review to guide and inform this work.

Management Group therefore supported the following approach:

- WHSSC develop commissioning intentions and a service specification utilising the support of the Maternity and Neonatal Network as a source of professional advice.
- These documents to inform the development of an options appraisal stemming from the options set out in the Independent Review and any other options presented.
- A Task & Finish Group is established with commissioning, clinical and managerial representatives. The Group will consider how best to utilise the existing workforce with the proposed delivery model and also outline developments required for the future workforce.

The funding model for the Neonatal Transport service has been a subject of debate for a number of years and was specifically referenced in the review. The Maternity and Neonatal Network and clinicians operating the service have expressed concerns that the current transport service funding allocation is needed to not only deliver transport services but as top up funding to maintain safe staffing levels in the associated Neonatal Intensive Care Units (NICUs). Throughout the process of developing the 24 hour model concerns have been raised regarding the potential to de-stabilise NICUs if additional funding is not provided over and above that currently in place.

Management Group therefore also supported:

- Further work to define and clearly set out the funding of the clinical components of a 24 hours service to be undertaken by the WHSSC Finance Working Group.

However they also requested (and in accordance with the recommendations in the Review) that

- In parallel, the Maternity and Neonatal Network undertake demand and capacity modelling of both the number of maternity beds and cots required across the region.

The Director of Planning at WHSSC met with the Neonatal Transport Sub Group on 28 February 2020. This was a very positive meeting and all present at the meeting gave their unequivocal support to the establishment of a 24/7 neonatal transport service to be operational as quickly as possible but no later than March 2021.

The Neonatal Transport Sub Group also supported a lead provider model and agreed to engage in a Task and Finish Group to be established by WHSSC which would undertake an option appraisal, as suggested above by Management Group, and agree an implementation process and timeline to deliver a 24/7 service.

As a sub group of the Maternity and Neonatal Network, the Transport Sub Group also agreed to provide professional advice in the development of a service specification for a 24/7 service and that this would be basis on which future options for the service would be judged.

They agreed that the review gave a good direction of travel to support this work.

At their last meeting, Joint Committee members will recall the letter received from Welsh Government officials expressing their concern regarding the timeline for implementing a permanent solution. Joint Committee supported delivering a permanent solution as quickly as possible and were concerned that the shift of focus to an interim solution could potentially add to delay. However given that the implementation timeline is likely to be around 12 months, further communication from Welsh Government officials has asked that an interim solution is given further consideration. The Neonatal Transport Sub Group has therefore been asked to propose an interim 24/7 service and provide a timeline for implementation. It is expected that this proposal will be received by the end of March 2020.

4. RECOMMENDATIONS

Members are asked to:

- **Note** the Independent Review of the South Wales Neonatal Services;
- **Support** the recommendations made by Management Group at the extraordinary meeting on 27 February 2020 (Appendix 2)

Specifically Joint Committee is asked to:

- **Support** the requirement for a 24/7 neonatal transport service for south and west Wales, noting that residents from the BCU Health population already have a 24/7 service;
- **Support** Management Group recommendations that the future model will be commissioned from a lead provider;
- **Support** the establishment of a Task and Finish Group to develop a service specification for the service and implementation process for a 24/7 model;
- **Support** further work to be undertaken by the Finance Sub Group to define and clearly set out the funding of the clinical components of a 24 hours service to be undertaken by the WHSSC Finance Working Group but that the principle will be that the commissioning of a 24 hour service will not de-stabilise the current neonatal intensive care units;
- **Support** the request that in parallel, the Maternity and Neonatal Network undertake demand and capacity modelling of both the number of maternity beds and cots required across the region; and
- **Approve** delegated authority to Management Group to agree an interim solution on the basis that this will be within the resource identified within the 2020/21 Integrated Commissioning Plan (ICP).

5. APPENDICES / ANNEXES

The following Annexes are attached:

Appendix 1 – The Independent Review of the South Wales Neonatal Transport Service
Appendix 2 – Core Brief from Extraordinary Management Group 27 February 2020

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Implementation of the Plan Development of the Plan
Link to Integrated Commissioning Plan	The development of a 24 hour neonatal transport service featured in the WHSSC ICP for 2018/19 and is included in the development of the 2019/20 plan.
Health and Care Standards	Safe Care Effective Care Timely Care
Principles of Prudent Healthcare	Care for Those with the greatest health need first Reduce inappropriate variation Choose an item.
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Improving Health of Populations Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	A number of Datix incident reports have been raised by Health Boards in South Wales due to the lack of 24 hour service. A case note review in to these incidents was carried out in 2018 and an action plan is in place and reported to the WHSSC QPS on a regular basis.
Resources Implications	There is a provision for additional neonatal transport funding included in the WHSSC Integrated Commissioning plan 2020/21 with £0.450m available in year, increasing to a recurrent £0.6m full year effect from 2021/22 onwards
Risk and Assurance	The lack of 24 hour Neonatal Transport service has been a high risk on the W&C commissioning team risk register since April 2017.
Evidence Base	The case note review and the full review have been commissioned by two experts in the Neonatology transport field.
Equality and Diversity	There are no equality and diversity implications.
Population Health	
Legal Implications	There are no legal implications

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Corporate Directors Group Board	11/02/2020	Proceed to Management Group
Management Group	20/02/2020	Revisit timelines and discuss further at extraordinary meeting.
Management Group	27/02/2020	Supported at the extraordinary meeting.

REVIEW OF THE SOUTH WALES NEONATAL TRANSPORT SERVICE (CHANTS) IN ORDER TO RECOMMEND FUTURE MODELS OF DELIVERY FOR A 24 HOUR TRANSPORT SERVICE

Grenville Fox
Consultant Neonatologist, Guy's & St.Thomas NHS Foundation Trust,
Clinical Director London Neonatal Operational Delivery Network and NHS England Neonatal Critical Care Clinical Reference Group (CRG) Member

Laura Kelly
Lead Nurse, London Neonatal Transfer Service

On behalf of the Welsh Health Specialised Services Committee (WHSSC)

December 2019

Contents

1. Executive Summary

1. The Cymru inter-Hospital Acute Neonatal Transfer Service (CHANTS) has provided a 12-hour, 7-day per week neonatal transfer service (NTS) for South and South West Wales since 2011. CHANTS is currently the only NTS in the United Kingdom with limited out-of-hours provision and this presents a significant clinical risk to babies born in the region.
2. Despite a number of detailed proposals being made over many years, financial constraints and / or concerns regarding the total cost have precluded establishing a 24-hours per day NTS for South and South West Wales.
3. An independent external case review in 2018 identified a number of cases where there was a risk of clinical harm as a result of the lack of a 24-hours per day NTS and one case where a baby died in a non-NICU setting following an overnight transport team attendance delay of more than 7 hours.
4. A letter from the Royal College of Paediatrics and Child Health (RCPCH) earlier in 2018 had highlighted '..serious concerns around infant safety..' due to the restricted hours of neonatal transfer service operation in Wales and strongly recommended that a solution was found urgently.
5. Support and commitment for how to provide a high quality 24-hours per day neonatal transfer service for South and South West Wales should continue from all stakeholders so that this is operational within 6-12 months of the date of this report.
6. Funding for the clinical components of a 24-hours per day service needs to be clearly defined and transparent, and separate from Neonatal Intensive Care Unit (NICU) or other service funding, with funding for the Ambulance and transport costs agreed between the Welsh Health Specialised Services Committee (WHSSC) and the Wales Ambulance Service NHS Trust (WAST).
7. It is recommended that a future service model should have either co-location or close proximity location of ambulance and clinical teams.
8. A detailed demand and capacity review should be undertaken jointly between the Wales Neonatal Network and WHSSC, to ensure that capacity transfers

within and out of the network are minimised. Acceptance and refusal policy and pathways should also be considered as part of this review.

9. Further work is required by the Wales Neonatal Network to continue to establish a single point of contact system for all emergency transfer referrals, including in-utero transfers.

10. The current CHANTS service has many positive attributes, including a safe and sustainable staffing model and excellent clinical outcomes, taking into account the limited hours of operation. Any future service model should consider how to best utilise current CHANTS staff, so that as many as possible are able to continue contributing to a clinically excellent expanded 24-hours per day service.

11. It is recommended that a 24-hours per day service would be best provided by current CHANTS staff, but from a single-site provider, co-located or closely located to a dedicated ambulance and ambulance staff.

12. Implementation of this option would require commitment to increased funding from WHSSC as it is clear that to find the additional funds from within current NICU and CHANTS funding is not possible without significant compromise to clinical standards of core NICU activity.

13. This option would also require some flexibility from Health Board staff due to reconfiguration, although a sustainable workforce for both NICUs and an extended CHANTS service should be achievable within a relatively short timeframe.

14. A more detailed review of out-of-hours supplements paid to consultant neonatologists contributing to a future CHANTS rota is required (Health Boards) in order to determine a more precise estimate of funding required.

15. The establishment of a new 24-hours per day service will need to include a new staffing model for the ambulance drivers.

2. Rationale for change

Since around 2003, neonatal transfer services across the United Kingdom have been provided by dedicated transfer services on a regional basis. The Cymru inter-Hospital Acute Neonatal Transfer Service (CHANTS) has been commissioned by the Welsh Health Specialised Services Committee (WHSSC) to provide a 12-hour, 7-day per week neonatal transfer service for South and South West Wales since January 2011. This is currently the only neonatal transfer service in the United Kingdom (out of 15) with limited out-of-hours provision.

The current limited hours operational arrangement is in breach of the British Association of Perinatal Medicine (BAPM) Standards (2010)[1] and the All Wales Neonatal Standards – 3rd Edition (2017)[2]. The inequity of access for babies who require transfer outside of the current 12-hour service has been criticised by a number of national bodies over many years including Bliss in their response to the Health, Wellbeing and Local Government Committee (National Assembly for Wales) inquiry into Neonatal Care (2010).[3] In February 2018, a letter to WHSSC from the President of the Royal College of Paediatrics and Child Health (RCPCH) noted '…serious concerns around infant safety because of the continued restriction of neonatal transport capability in South Wales due to a 12-hour rather than a 24-hour service'. This letter also referred to the Children and Young People Committee (National Assembly for Wales) Inquiry into Neonatal Care (September 2012)[4] recommending that 'A 24-hour neonatal transport would strengthen neonatal care (in Wales) and should be established without further delay'.

Following clinical concern regarding a lack of progress to agree commissioning of a 24-hour service, Datix clinical incident reports were submitted from the Wales Neonatal Network to WHSSC. In response, WHSSC commissioned an independent expert case review, from Dr Victoria Puddy, Consultant Neonatologist, Princess Anne Hospital, Southampton, which reported in September 2018.[5] The case review analysed 14 of 18 cases reported between September 2017 and March 2018 and identified a number of cases where there was a risk of clinical harm as a result of the lack of a 24-hours per day NTS and one case where a baby died in a non-NICU setting following an overnight transport team attendance delay of more than 7 hours. The review recommended that a 24-hour neonatal transfer service should be commissioned. WHSSC agreed that in order to develop a safe, high quality and

efficient 24-hour service an external review would be carried out in order to determine the best model for this.

3. Aims of this report

- To review the current neonatal transfer service provision for South and South West Wales
- To consider and advise on how a safe, effective and sustainable 24-hour, 7-day per week neonatal transfer service for South and South West Wales could be provided in the near future

4. Terms of Reference

Terms of reference for this review were provided by the Welsh Health Specialised Services Committee (WHSSC)

a) Purpose

The purpose of the terms of reference is to set out the role and remit of the independent review team, commissioned to advise WHSSC on a safe, high quality and efficient model of delivery for a 24-hour neonatal transport service.

In particular the Review will:

i) Consider and advise on suitable future models for the delivery of a 24-hour transport service in South Wales, with reference to:

- the delivery of safe, high quality and timely patient care;
- accessibility and equitability;
- patient experience;
- sustainability (including training);
- cost-effectiveness;
- effective co-operation with other services; and
- an effective staffing model (including the wider MDT).

ii) Make recommendations for the consideration of the Welsh Health Specialised Services Committee on the development of a commissioning plan for a 24-hour neonatal transport service in South Wales.

iii) Comment on any additional issues that may arise during the review.

In undertaking the review and recommendations for a 24-hour model, the Review Team will need to consider the current delivery of the Neonatal Transport Service in South Wales, with reference to:

- the delivery model of the current service including its development history;
- referral pathways;
- how the current model performs against published best practice and national standards;
- current patient outcomes and experience;
- the current staffing configuration in place to deliver the service; and
- the sustainability of the current model.

b) Principles

The review process will be conducted in accordance with the following principles:

i) Independence – The review team must have no vested interest in achieving particular outcomes.

ii) Confidentiality – The review team must sign and conform to the confidentiality agreement issued by WHSSC.

iii) Timescale – It is anticipated that the review will be completed within 3 months.

c) Methodology

It is proposed the review will be undertaken in five key stages:

i) Desktop review – consider annual reports, historic audits and reviews.

ii) Stakeholder mapping - engage with all stakeholders; Neonatal Network, WAST, EASC, EMRTS, parents and parent representative groups.

iii) Stakeholder interviews – consultant staff (including clinical leads at both provider and referrer HBs), nursing staff, managerial staff and the Neonatal Network (including the Network Board members).

iv) Stakeholder workshop – representation from all Stakeholders.

v) Recommendations – models of delivery recommended by the review team to WHSSC.

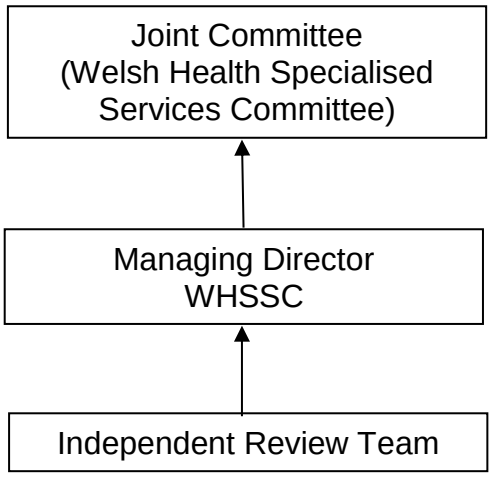
d) Administrative and Process Support

A project manager will be identified from the WHSSC Team to support the Review.

e) Accountability

The Review has been commissioned by WHSSC and as such will be conducted under the governance and decision-making processes that govern WHSSC. The reporting arrangements for the Review is through to Joint Committee as detailed in the diagram below.

The outcome of the Review is clearly important to the Neonatal Network Board and there will be on-going discussions with them throughout the Review process. The final report will be shared with the Neonatal Network Board.



5. Methodology

Detailed information was collated from all relevant stakeholders in 5 phases:

a) An **initial desktop review** considered service annual reports, historic audits and any external service reviews (April-June 2019)

b) A **stakeholder workshop** was held on 3 July 2019 with representation from all stakeholders, including clinicians and service management from the Wales Neonatal Network, clinicians from all 5 Health Boards, WHSSC, the Welsh Ambulance Service Trust (WAST), the Wales Emergency Ambulance Service Committee (EASC), the Emergency Medical Retrieval and Transfer (EMRTS) in Wales, the Wales and West Acute Transport for Children Service (WATCh) and Bliss.

c) **Stakeholder interviews and stakeholder mapping**.

Face to face stakeholder interviews were held with neonatal medical and nursing leads or representatives from all 5 provider and referral Health Boards on 31 July 2019:

Swansea Bay University Health Board

- Amit Kandhari (Consultant Neonatologist) / Helen James (NICU Matron)

Cardiff and Vale University Health Board

- Jenny Calvert (Consultant Neonatologist and Clinical Lead) / Jo Clements (Senior NICU Nurse)

Aneurin Bevan University Health Board

- Sunil Reddy (Consultant Neonatologist and CHANTS Clinical Lead) / Jane Lewis (Senior NICU and CHANTS Nurse)

Cwm Taf Morgannwg University Health Board

- Kate Creese (Consultant Paediatrician)

Hywel Dda University Health Board

- Prem Kumar Pitchaikani (Consultant Paediatrician) / Karen Jones (Neonatal Nurse) / David Morrisey (Neonatal Service Delivery Manager)

Further telephone interviews were held between August-December 2019 with:

- Karen Preece (Director of Planning, WHSSC)
- Helen Fardy (Associate Medical Director Women and Children's Services, WHSSC)
- Elizabeth Gallagher (Wales Maternity & Neonatal Network Manager, NHS Wales Health Collaborative)
- Claire Richards (Lead Neonatal Nurse / CHANTS Service Manager Wales Maternity & Neonatal Network, NHS Wales Health Collaborative
- James Tooley (Clinical Lead for Neonatal Transport, Newborn Emergency Stabilisation and Transport Team (NEST), Bristol)
- Patrick Turton (Lead Nurse for NEST)
- Dora Wood (Clinical Lead, Wales and West Acute Transport for Children Service (WATCh))
- Claire Perrett (Lead Nurse WATCh)
- Parent users of CHANTS (names withheld for confidentiality)

d) A **further desktop review** of information, including available benchmarking data from other UK neonatal transfer services, was carried out in November 2019.

e) Collation of **conclusions and recommendations** of options for future service delivery models took place to complete the report on 6 December 2019.

6. Current service arrangements

a) The Wales Neonatal Network

For the past 10-15 years, Neonatal care in the UK has been arranged around clinical or operational delivery networks. Neonatal networks have improved neonatal care by providing consistent pathways of care in a hub and spokes arrangement, so that a high quality, equitable, safe and sustainable services can be provided to babies and their families. Neonatal transfer services have been developed to underpin neonatal network arrangements in all areas of the UK.

Approximately 29,000 babies are born each year across Wales, with the majority delivered in 10 hospitals with obstetric-led and neonatal unit facilities. Around 1,000 babies are born each year in midwifery-led maternity units and a further 400 in a hospital with obstetrics facilities but no neonatal unit. Most of the maternity units without neonatal facilities have very low delivery rates and have relatively remote geographical locations (Table 1).

The Wales Neonatal Network was established in 2010 and aims to ensure that neonatal care in Wales is provided according to the All Wales Neonatal Standards (updated 2017; Appendix 2).[2] The Network is made up of 4 Health Communities, across 10 hospitals with neonatal unit facilities and staff (Table 2 and Figure 1). Clinical pathways are in a hub and spokes model, so that, whenever possible, babies born in Wales receive the majority of their care in hospitals within their Health Community.

In North Wales, some babies receive specialist neonatal care at Liverpool Women's Hospital as part of their normal care pathway. Babies born to mothers resident in Powys may receive care in any of the Welsh neonatal units, however a proportion of babies are cared for in neonatal units in England as part of their normal care pathway. Babies in South and South West Wales requiring surgical care are transferred in- or ex-utero to the University Hospital of Wales, Cardiff and those in North Wales to Alder Hey Children’s Hospital, Liverpool. Specialist cardiac care is provided at Bristol Children's Hospital for babies born in South Wales and Alder Hey Children’s Hospital for North Wales.

Table 1. Annual births in Wales by maternity unit - 2017-18 data from Stats Wales (Welsh Government)

Hospital	Health Board	NNU service	Births (2017-18)
Royal Gwent (Newport)	Aneurin Bevan	NICU	2,969
Nevill Hall (Abergavenny)	Aneurin Bevan	SCU	1,838
Ysbyty Ystrad Fawr (Hengoed)	Aneurin Bevan	MLU only	270
Ysbyty Aneurin Bevan (Ebbw Vale)	Aneurin Bevan	MLU only	5
Powys Maternity Units	Powys	MLU only	212
University of Wales (Cardiff)	Cardiff & Vale	NICU	5,477
Royal Glamorgan (Llantrisant)	Cwm Taf	MLU only	1,929*
Prince Charles (Merthyr Tydfil)	Cwm Taf	SCU	1,650
Princess of Wales (Bridgend)	Cym Taf	SCU	2,141
Not stated	Cym Taf	-	46
Singleton (Swansea)	Swansea Bay	NICU	2,897
Neath Port Talbot (Port Talbot)	Swansea Bay	MLU only	422
Glangwili General (Carmarthen)	Hywel Dda	SCU	2,520
Withybush (Haverfordwest)	Hywel Dda	MLU only	167
Bronglais (Aberystwyth)	Hywel Dda	CLOU/MLU only	410
Wrexham Maelor (Wrexham)	Betsi Cadwaladr	SCU	2,381
Ysbyty Glan Clwyd (Rhyl)	Betsi Cadwaladr	SuRNICU	1,688
Ysbyty Gwynedd (Bangor)	Betsi Cadwaladr	SCU	1,707
WALES			**28,729**

MLU = Midwifery-Led Unit; CLOU = Consultant-Led Obstetrics Unit; NICU = Neonatal Intensive Care Unit; SuRNICU = Sub-regional NICU; SCU = Special Care Unit

*Obstetrics and NNU facilities at the Royal Glamorgan Hospital were transferred to Prince Charles Hospital in March 2019

The Welsh Neonatal and Maternity Network Board is accountable to NHS Wales through the NHS Wales Health Collaborative Executive Group (i.e. the 7 Health Board Chief Executives), which in turn reports to the Collaborative Leadership Forum (Health Board Chairs and Chief Executives). The Network Board meets quarterly and is currently chaired, on behalf of NHS Wales, by the Director of Planning & Performance of the Aneurin Bevan University Health

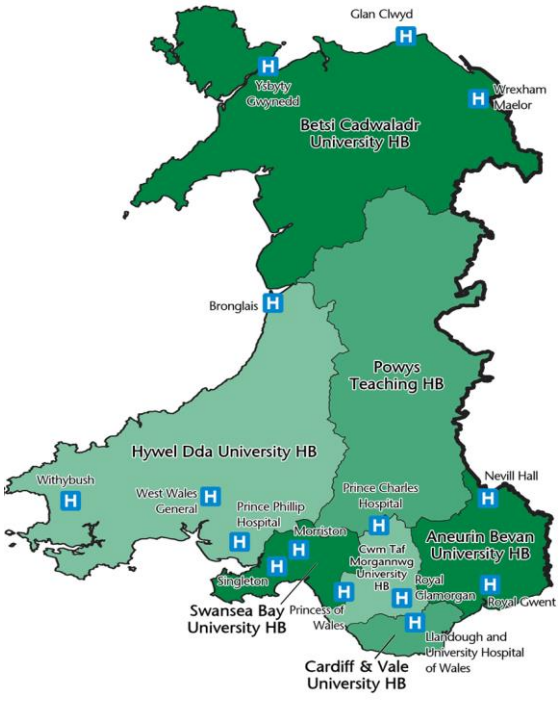
Board. The Welsh Neonatal and Maternity Network has a memorandum of understanding with WHSSC and provides a report to the WHSSC Quality and Patient Safety Committee. The WHSSC Director of Planning is a member of the Network Board.

Table 2. Wales Neonatal Network Health Communities

South East	South Central	South West	North
Royal Gwent (Newport)	**University of Wales (Cardiff)**	**Singleton (Swansea)**	*Ysbyty Glan Clwyd (Rhyl)
Nevill Hall (Abergavenny)	Prince Charles (Merthyr Tydfil)	Princess of Wales (Bridgend)	Wrexham Maelor (Wrexham)
		Glangwili General (Carmarthen)	Ysbyty Gwynedd (Bangor)

NICUs in bold**. *** = SuRNICU

Figure 1. Wales Health Boards map



Activity and cot occupancy levels for Wales NICUs are shown in table 3. below.

Table 3. Activity and cot occupancy for Wales NICUs (2017)[6]

	Royal Gwent	UHW	Singleton	Total
Admissions	472	497	455	1,424
VLBW admissions	92	123	87	302
NICU cot days	1,535	2,058	1,624	5,217
NICU occupancy	70.1%	93.9%	63.6%	75.2%
HDU cot days	2,110	2,872	2,015	6,997
HDU occupancy	82.6%	78.7%	138%	91.3%
SCBU cot days	3,503	3,187	3,003	9,693
SCBU occupancy	160%	108.8%	74.8%	106.2%
Total cot days	7,148	8,117	6,642	21,907
Total occupancy	103.1%	92.6%	82.7%	92.3%

'Sub-scale' NICU activity or over-occupancy shown in red

Overall occupancy within the NICUs is high and would be considered too high with respect to optimisation of outcomes and minimisation of capacity transfers within the network and avoidance of capacity transfers out of Wales. Evidence suggests that neonatal mortality is likely to be worse if average occupancy is >80%. This threshold is probably most appropriate for the avoidance of capacity transfers also.

Occupancy in network LNU and SCBUs ranges between 65.2-93.2% (mean 76.1%), leaving little capacity elsewhere for stepdown transfers to create capacity in the NICUs. Travel distance for parents also needs to be considered for stepdown capacity transfers.

Around 40 capacity transfers per year occur to English NICUs, mainly to Bristol in the South West Operational Delivery Network. This results in a net loss of approximately 490 cot days (180 NICU cot days, 140 HDU cot days and 170 SC cot days).

Activity within the 3 network NICUs is relatively low compared to other UK NICUs (table 3.). The recent NHS England Neonatal Critical Care

Transformation Review has suggested minimum activity levels for NICUs, unless geographical constraints preclude these. The foundation for these recommendations was evidence based and consistent with BAPM guidance, recognising that outcomes are improved if NICUs look after at least 100 very low birth weight (VLBW) infants (<1500g) and perform >2000 intensive care days per year. Two of the three Welsh NICU would be considered sub-scale in this regard. Reducing the number of NICUs in Wales could be considered but this would require very significant capital funding and could be highly risky with respect to sustainability of staffing. This could be particularly so for the neonatal nursing workforce. South Wales has a reasonably stable neonatal nursing workforce across the three NICUs, with recruitment close to establishment at higher bandings qualified and experienced in specialty. Furthermore, plans to relocate the consultant-led maternity services to the Royal Gwent Hospital from Nevill Hall in 2020 along with plans to increase cot numbers in the NICU at the Royal Gwent will increase activity there so that levels will be close to the minimum recommended for NICUs. It would be reasonable to consider the Singleton Hospital NICU as being geographically remote and serving an even more remote part of the network to preclude inclusion in any NICU reconfiguration in Wales.

Although it is beyond the remit of this review to make detailed recommendations regarding any future configuration of NICU services in Wales, these factors do need to be considered as any major reconfiguration would have a profound effect on the neonatal transfer service required to underpin the network.

b) CHANTS service history

The Cymru inter-Hospital Acute Neonatal Transfer Service (CHANTS) has been commissioned to provide a dedicated neonatal transport service since January 2011.

Since it was established, CHANTS has provided a neonatal transfer service for South and South West Wales, with referrals currently from the 7 hospitals with neonatal units (NNUs), across 5 of the 6 Welsh Health Boards: Aneurin Bevan, Powys, Cardiff and Vale, Cym Taf, Swansea Bay and Hywel Dda. Babies may also be referred to CHANTS from Bronglais Hospital, which has a small obstetrics service and neonatal stabilisation facilities only. Powys Teaching Health Board has no obstetrics-led maternity hospitals, but several hundred low-risk births occur in a number of small midwifery-led units. There are therefore no referrals to CHANTS from Powys. The small number of babies born in MLUs (or at home) who require emergency care (17 over the past 22 months) are transferred to a hospital site by WAST or EMRTS (with paramedic support). This is a similar arrangement to other parts of the UK.

Operational responsibility for CHANTS is shared on a one week in three rotational basis between the three NICU providers: Aneurin Bevan University Health Board, based at the Royal Gwent Hospital, Newport, Cardiff and Vale University Health Board, based at the University Hospital of Wales, Cardiff and Swansea Bay University Health Board, based at the Singleton Hospital, Swansea.

A dedicated ambulance and team of ambulance drivers are provided by the Welsh Ambulance Service Trust (WAST), under contract from WHSSC. The ambulance and drivers are based at the Bryncethin Ambulance Station, rather than a hospital site.

The unique geography of the CHANTS region is a significant operational challenge. Mean referrer to recipient journey time is approximately 1 hour (range 37 minutes - 3 hours) but may be much longer for transfers out of Wales due to Welsh NNU capacity constraints, if highly specialised intensive care is required or occasionally if a baby requires repatriation to an English NNU.

In North Wales (Betsi Cadwaladr University Health Board) the neonatal transfer service is jointly provided from Ysbyty Glan Clwyd Hospital, Rhyl and the CONNECT North West Neonatal Transport Team, based at the Central Manchester NHS Foundation Trust. CONNECT perform transfers outside weekday 08:00-20:00 hours, as well as for babies less than 26 weeks gestation or with other more complex clinical problems. Data with the number of transfers performed by CONNECT from North Wales was not available for this review.

c) Current service operational times

CHANTS is currently commissioned by WHSSC to provide a service 12 hours a day, 365 days a year, operating between 08:00 - 20:00 hours.

Out-of-hours transfers are carried out according to ad hoc arrangements between the referring and accepting NNUs, although a clear, up to date network guideline is in place. Time critical transfer requests received after 19:00 hours, are accepted depending on the ability of the ambulance driver to work within WAST regulations and other team members to work beyond their duty hours. If it is not possible for CHANTS to perform the transfer, the referring NNU team is directed to their nearest NICU, according to cot capacity.

There is currently an unwritten agreement from the Newborn Emergency Stabilisation and Transport Team (NEST), based at St.Michael's Hospital in Bristol to provide what is described as a 'mercy mission' response to out-of-hours requests from CHANTS. This has been clarified to the reviewers by NEST as 'provided that NEST are not committed to another transfer, they would potentially agree to assist a transfer in South Wales if not doing so would result in likely patient harm'. In reality, this rarely happens, with only two transfers performed by NEST so far in 2019 and none in 2018. NEST have expressed concern regarding this arrangement with respect to their inability to guarantee a response due to their own workload, limited knowledge regarding the Wales Neonatal Network, a lack of clarity around clinical responsibility and decision-making regarding the transfer, as well as a lack of an agreed feedback infrastructure.

Non-time critical transfer requests received after 19:00 hours are deferred to the following day. Requests for repatriation and capacity transfers require

consideration of sufficient time to complete the transfer, including the return of clinical and ambulance teams to base, within working hours. Although these and other efforts are made to avoid significant over running of the service as far as possible, over running is inevitable and occurs on a regular basis. If the transport team works beyond their 12-hour shift, they may opt to start later the following day in recompense. This and the non-hospital base location of the ambulance vehicle and staff at Bryncethin, appear to reduce the actual operational time of service provision to considerably less than 12 hours per day.

d) Medical staffing

Medical staffing for CHANTS is provided almost exclusively by consultant neonatologists. This arrangement is unique in UK neonatal transfer services, but necessary due to lower numbers of deanery specialty training posts and reduced ability to recruit to non-training junior doctor posts in Wales.

A consultant delivered service is likely enhance patient safety and efficiency of transfers. It also has the additional benefit of ensuring that NICU junior doctor tier 2 (i.e. 'middle-grade') rotas are recruited as close as possible to establishment, sustainable and compliant with British Medical Association (BMA) contract recommendations.

The 12-hour per day service needs 42.11 PAs (4.211 WTE consultants), not allowing for any net overrunning of shifts (see calculation in 9a) below).

A total of 22 consultant neonatologists and 1 Associate Specialist contribute to the current CHANTS medical rota, with 9 based at the Royal Gwent Hospital NICU, 5 based at the University Hospital of Wales NICU, Cardiff and 9 based at the Singleton Hospital, Swansea.

Current consultant job plans include 26.97 Direct Clinical Care (DCC) Programmed activities (PAs). This equates to 21.81 DCC PAs in order to provide the CHANTS service over 52 weeks (Table 4).There is a discrepancy of consultant PAs allocated for CHANTS between the 3 provider services, with only 6.0 PAs from the Royal Gwent Hospital and 8.3 PAs from Singleton Hospital. The reason for this is unclear, but likely to be explained by the lack of clarity around the initial historical funding allocation from WHSSC to the 3

Health Boards prior to setting up CHANTS in 2010 (See Service commissioning and funding below).

The currently commissioned 12-hours per day service results in a significant number of overruns and transfers undertaken by CHANTS consultants outside the commissioned 12-hour day. Consultants at all three provider sites have indicated that this is not accounted for within their job plans and out-of-hours service time currently provided is rarely taken back as time off in lieu.

Table 4. NICU Consultant PAs allocated to CHANTS (2019)

Hospital	Consultant	PAs/week (in 42 week job plan)	PAs/week (for 52 week service)
Royal Gwent	1*	0.78	0.63
	2	1.36	1.10
	3	0.75	0.61
	4	0.75	0.61
	5	0.75	0.61
	6	0.75	0.61
	7	0.75	0.61
	8	0.75	0.61
	9	0.75	0.61
		Total	6.00
UHW	1	2.56	2.07
	2	1.68	1.36
	3	1.68	1.36
	4	1.68	1.36
	5	1.68	1.36
		Total	7.51
Singleton	1	2.06	1.66
	2	1.03	0.83
	3	1.03	0.83
	4	1.03	0.83
	5	1.03	0.83
	6	1.03	0.83
	7	1.03	0.83
	8	1.03	0.83
	9	1.03	0.83
		Total	8.3
TOTAL	**23**	**26.97**	**21.81**

*Also 1PA for CHANTS Clinical Lead

e) Nurse staffing

Neonatal transfer services require specialist neonatal nurses working at Band 6/7 level. The current 12-hours CHANTS service requires approximately 3 WTE neonatal nurses. This is inclusive of an operational uplift of 27% for annual, study, sickness and maternity leave and specialist and mandatory training, as well as some time for overrunning of shifts (see calculation in 9b) below). Each site should therefore be funded for 1 WTE post, ring-fenced for CHANTS provision, although posts are not unreasonably combined with non-transport NICU shifts so that each provider NICU has 7-10 nurses, sharing the 365 12-hour shifts per year across the three sites. A total of 26 nurses contribute to the current CHANTS service nursing rota.

All three provider services have indicated that, although there are some vacancies for the NICU service at the band 5 level, recruitment is almost full to establishment at band 6 and 7 for both NICU and CHANTS. Although staffing transport weeks can be an additional challenge, CHANTS shifts are always staffed and there have been no occasions when transfers have not been performed due to unavailability of a transport nurse during the current 12-hour operational limits.

Ad hoc transfers performed by one of the three provider NICUs outside normal CHANTS operational hours, result in nurses being taken away from in-house NICU duties, meaning that BAPM nurse to patient ratio recommendations are breached.

As with medical staff, due to the current 12-hour service, CHANTS nursing shifts often over run and it is not always possible to take compensatory time off in lieu.

f) Other CHANTS staff

The current CHANTS Service Manager is also the Lead Nurse for the Wales Neonatal Network. This dual-role post is funded by the Wales Neonatal Network.

Each provider Health Board employs a 0.5 WTE Administration Assistant (i.e. 1.5 WTE in total) for CHANTS.

g) Ambulance provision and equipment

The Welsh Ambulance Services NHS Trust (WAST) provide a dedicated ambulance and 4 drivers for CHANTS. A new bespoke neonatal transfer ambulance has been available for all CHANTS transfers since 2018. A replacement vehicle is also available, but this is not bespoke for neonatal transfers and has some limitations related to medical gas supplies on longer journeys. All locking systems on WAST vehicles are identical, so that incubator trolleys can be secured in vehicles safely.

The vehicle and drivers are based at Bryncethin Ambulance Station. Although the ambulance base location is almost equidistant between the 3 NICU centres, journey times are variable, with road distance and approximate journey times to NICU hospitals from Bryncethin as follows:

Royal Gwent Hospital	28 miles (approx. 37 minutes)
University Hospital of Wales	26 miles (approx. 32 minutes)
Singleton Hospital	25 miles (approx. 44 minutes)

The offsite location of the ambulance and drivers increases emergency response times and reduce the actual operating time to less than 12 hours per day. CHANTS clinical teams do use this time as effectively as possible to prepare and plan transfers and clean equipment. However, there does remain a concern amongst some referrer clinical teams that this arrangement is suboptimal.

The three provider teams all have their own transport incubator. Maintenance of these is carried out by a bioengineer on each site on a weekday basis. The majority of equipment is consistent between the three providers, although there are some differences, including two different types of ventilator, three different types of syringe drivers and some differences of single-use items. This was highlighted as a risk in the recent case note review, acknowledged by the Network and an action plan agreed.

h) Transfers by air

Joint CHANTS and EMRTS air (helicopter and fixed wing) transfers are also performed when clinically indicated, depending on weather and other logistic constraints. 15-20 joint air transfers (i.e. around 3-4% of total CHANTS transfers) are performed per year on average. This is a higher proportion of total transfers than all other UK NTSs, apart from Scotland.

i) Activity

There are around 15,000 inter-hospital neonatal transfers per year in the UK performed by neonatal transfer services (NTSs). Activity varies considerably between the 15 NTSs (Figure 2), with a mean for each service of around 1000 transfers per year (range 130-1920). Regional geography and population density appear to be the main determinants of activity levels. CHANTS currently perform around 500 transfers per year (i.e. ~3.3% of the total) and is therefore one of the smaller NTSs. The percentage of ventilated transfers also varies between NTSs (mean 24%; range 6-42%), again depending on geography and service configuration, with some services performing nearly all repatriation transfers for their region (e.g. ScotSTAR at 13%). Around 20% of CHANTS transfers are ventilated.

Details of all CHANTS transfers are recorded on to the BadgerNet database and categorised according to the UK Neonatal Transport Group (NTG) Categories of Care. These reflect British Association of Medicine (BAPM) categories of neonatal care as well as the clinical and operational reason for transfer and the time response of this.

CHANTS activity levels have remained relatively unchanged since 2011 (Table 5.), as have the proportion of each NTG category of transfer, apart from capacity transfers, which have increased marginally in number over recent years. The proportion of capacity transfers is high (23% over the past 3 years) compared to other UK neonatal transfer services. This is likely to reflect a lack of NICU capacity across the network, although it may be also be influenced by policy regarding threshold for capacity transfer and the number of any delayed transfers of care. Of note, other UK regions with significant capacity constraints

have a much lower proportion of capacity transfers (e.g. London – estimated 38 cot shortfall in capacity but <10% capacity transfers).

Figure 2. Total transfers per UK NTS January-June 2018

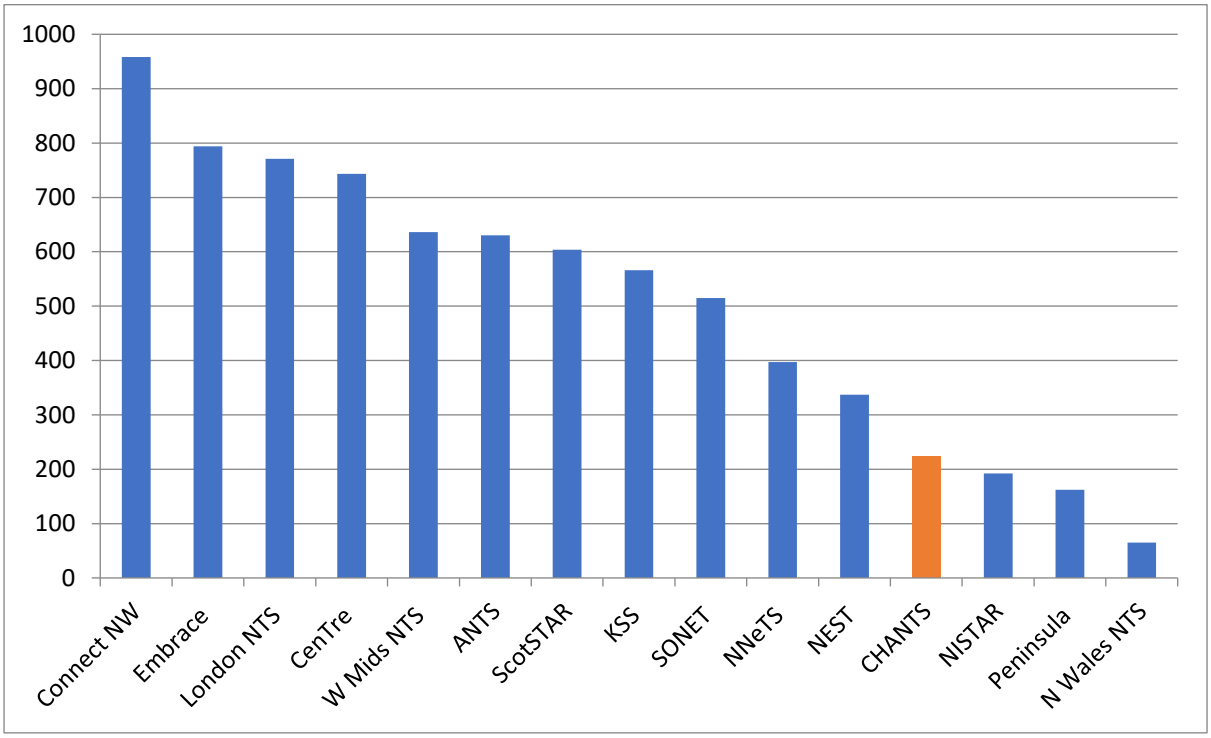


Table 5. CHANTS transfer activity 2011-2018 (data from CHANTS annual reports)

	Uplift	Repatriation	Capacity	Out-patient	Total
2011	n/a	n/a	32 (7%)	n/a	**475**
2012	n/a	n/a	78 (15%)	n/a	**530**
2013	178 (32%)	227 (41%)	102 (18%)	5	**552**
2014	183 (39%)	219 (47%)	63 (13%)	2	**467**
2015	185 (35%)	222 (42%)	121 (23%)	0	**528**
2016	171 (31%)	235 (43%)	135 (25%)	0	**541**
2017	167 (33%)	241 (47%)	101 (19%)	3	**512**
***2018**	186 (41%)	n/a	n/a	n/a	**452**

*Extrapolated to full year from 1st January-30th June data

j) Service commissioning and funding

Since 2010/11 CHANTS has been commissioned by WHSSC to deliver a 12-hours per day neonatal transfer service for £1,092,000 per year. It is understood that this funding also included an additional amount to support the NICU services across the network, which were, at the time over-capacity and unable to comply with the All Wales Neonatal Standards. Contribution to this funding is made by the six South Wales Health Boards on an estimated per capita basis, as follows:

Aneurin Bevan	£269,461
Powys	£56,326
Cardiff & Vale	£198,701
Cwm Taf	£147,953
Swansea Bay	£240,871
Hywel Dda	£178,688

£364,000 per year (i.e. one third of total) is then allocated to each of the three NICU / CHANTS provider Health Boards. However, it is unclear how much of this funding is ring-fenced for CHANTS only or provided for CHANTS and some NICU service costs, within each Health Board.

Table 6. Minimum staff costs for CHANTS (2018 12-hour per day service)

	Aneurin Bevan	Swansea Bay	Cardiff & Vale	Total
Consultant Neonatologists	1.47* WTE £192,013	1.37 WTE £178,951	1.37 WTE £178,951	**4.21 WTE** **£549,915**
Neonatal Nurses	1.0 WTE £46,341	1.0 WTE £46,341	1.0 WTE £46,341	**3.0 WTE** **£139,023**
Admin. assistants	0.5 WTE £12,550	0.5 WTE £12,000	0.5 WTE £11,319	**1.5 WTE** **£35,869**
Total staff cost	£250,904	£237,292	£236,611	**£724,807**
Allocated from WHSSC for CHANTS+NICU[$]	£364,000	£364,000	£364,000	**£1,092,000**
Maximum surplus to support NICU	£113,096	£126,708	£127,389	**£367,193**

*Includes 1 PA for CHANTS Service Clinical Lead
[$]In addition to other NICU funding

As calculated in d) and e) above, for the current 12-hours per day CHANTS service, minimum required staff costs (excluding WAST staff) based upon 2018 actual costs are approximately as shown in table 5.

In reality, the total CHANTS service cost is considerably more than the total staff costs indicated in table 5, as staff time for teaching, training, outreach support, equipment maintenance etc. is not included in transport shift time. There are also additional costs to the provider Health Boards for overheads and other non-pay, including consumables. The likely 'surplus' indicated above is therefore considerably less than the £367,193 indicated. However, it is clear that any surplus is currently used to support core NICU activity.

The lack of clarity regarding whether the £1,092,000 funding should be ring-fenced for CHANTS or partly used to support core NICU service activity is a major issue, which appears to have delayed agreement as to how a 24-hour neonatal transport service for Wales should be funded. There is a clear disagreement upon this issue, with WHSSC on one side and the provider Health Boards and CHANTS staff on the other. The WHSSC view appears to be that an extended hours service could be funded from existing resources, already paid to the three provider Health Boards. This view has been communicated to stakeholders at a South Wales Neonatal Transport Workshop (February 2018), with detail suggesting that 1176 consultant PAs and 5476 nursing hours per year were 'unaccounted for', if it was assumed that all of the £1,092,000 was used to fund CHANTS only. This assumption appears to have been based on correspondence between WHSSC and the Directors of Planning of the three provider Health Boards, suggesting that the cost of CHANTS across the three Health Boards at that time was £1,159,816. It can only be assumed that this was a misunderstanding, as subsequent detailed analysis by the Neonatal Transport Working Group (Report of the Neonatal Transport Working Group, July 2018) acknowledged that any of the 'unaccounted for' consultant PAs and nursing hours were being used to support core NICU activity. This report also concluded that despite this 'additional' funding, the three NICUs were still unable to meet staffing standards as defined by the All Wales Neonatal Standards and BAPM, with a shortfall of at least 6 WTE neonatal nurses and 2 WTE Consultant Neonatologists. Whilst the

consultant staffing standards referred to were for NICUs with greater than 2500 NICU days per year, in the current era, it is not unreasonable to apply them when NICU activity levels are lower due to recent difficulties ensuring service provision by junior doctors. This is consistent with NICU staffing policy in other parts of the UK.

Furthermore, the report identified an annual financial deficit of £2.133 million and £2.531 million for two of the NICUs, with detail unavailable at the time of writing for the third NICU. Although this was not an independent analysis, it does suggest significant financial challenges for the NICU services, likely to preclude investment in service extension without additional funding.

It is clear from this that there are limited opportunities to fund an extended 24-hour CHANTS service from existing budgets without destabilising the NICU services across South Wales. Additionally, NICU and CHANTS funding does not appear to have been uplifted specifically for the purpose of extending CHANTS operational hours since the original business case in 2010.

k) Clinical governance arrangements

Neonatal care in Wales is underpinned by the All Wales Neonatal Standards. These were first published in 2008 as part of a series of Standards for specialised services for children and young people in Wales. The current standards are based on recommendations from a number of reviews and on the best practice principles published by the British Association of Perinatal Medicine (BAPM): Standards for Hospitals Providing Neonatal Care (2010).[1] The All Wales Neonatal Standards were recommended by the Minister for Health and Social Services and provide a framework for the planning and delivery of effective neonatal care and a mechanism for assessing the quality and safety of neonatal services in Wales. Responsibility for implementing the Standards lies primarily with Health Boards and WHSSC and monitoring compliance against the Standards has been undertaken by the Wales Neonatal Network since 2010.

Governance reporting arrangements for CHANTS are via the Transport Subgroup of the Wales Neonatal Network Board. The reporting governance structure of the Neonatal Network Board is as described in 6a) above.

Clinical incident reporting is via each provider Health Board datix system. Datix forms are collated locally and sent to the CHANTS manager and clinical lead. All incidents are reviewed at quarterly Wales Neonatal Network Transport Subgroup meetings.

There is a very comprehensive and up to date set of clinical guidelines and operational policies and it is clear that CHANTS staff have worked extremely hard to establish and update these regularly. Of note, and relevant to this report, is a recently updated guideline titled 'Escalation of Care of Neonates in South Wales who Require an Uplift in Care to NICU when the Neonatal Transport Team is not Available'. For referrals between 20:00 and 08:00 hours, this recommends that the SCBU/LNU consultant should telephone the consultant at their local NICU for clinical advice on ongoing management. Possible alternatives stated, are:

- Baby remains at the local hospital with no further NICU support if clinically appropriate
- Baby remains at the referring unit with ongoing telephone advice and support from the NICU consultant overnight, then discuss with CHANTS at 8am whether transport to an NICU is required, based on the baby's clinical condition at that time
- Baby is transferred urgently to an NICU. This occurs around 20 times per year, with most transfers performed by Wales Neonatal Network NICU consultants on an unpaid basis and nurses from the NICUs, thereby depleting staff from core hospital duties. As stated in c) above, urgent out-of-hours transfers are rarely performed by NEST, with none being performed in 2018 and 2 so far in 2019.

l) Key performance indicators and other outcomes

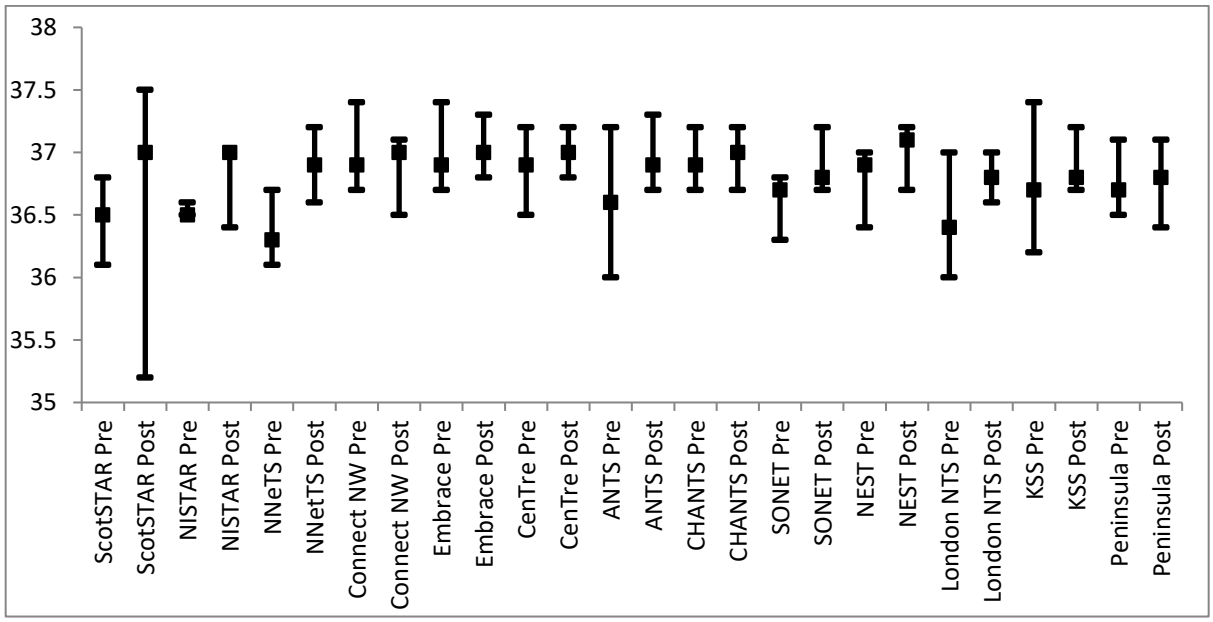
A short-term outcome dataset is submitted annually to the UK Neonatal Transport Group (UKNTG), based on January to June activity. Benchmarked outcomes are then presented at an annual national meeting. Outcomes include response standards and short-term clinical measures, reflecting the quality of transfer. CHANTS performs well compared to all other UK NTSs for clinical outcomes. (Table 7 and Figure 3). Response standards also compare well,

apart from the percentage of uplift transfers performed within the CHANTS catchment area. This standard is obviously significantly compromised by the lack of a 24-hour per day service.

Table 7. Comparison of CHANTS v other UK NTS benchmarks reported to UKNTG 2016-2018

	CHANTS	UK NTG	
		Mean	Range
%time critical transfers with team mobile <60 mins.	94%	83%	36-100%
%IC uplifts completed <3.5 hrs. after referral	85%	82%	74-100%
%uplifts within defined catchment area	82%	94%	82-100%
%optimal blood gases after ventilated transfer	89%	89%	83-93%

Figure 3. UK NTS pre- and post-transfer temperature for 23^{+0}-26^{+6} week gestation uplifts 2018 (mean+25/75th centile; target temp. 36.5-37.5°C)



m) Education and training

CHANTS staff provide and are involved in a range of formal education and training activities throughout each year:

- An annual training event occurs for CHANTS staff, including mandatory and equipment training.
- An annual CHANTS conference is organised and attended by a wider stakeholder group.
- Attendance and presentation at annual UK NTG Conference.
- Stabilisation road-shows (~2 per year) at referring hospitals, focussing on case reviews, shared learning and improving practice.
- An annual resuscitation training day for CHANTS ambulance drivers and WAST paramedics.
- Regular EMRTS flight review sessions held between CHANTS and EMRTS staff.
- New CHANTS staff receive flight safety and incubator training by EMRTS crew.
- CHANTS support newly appointed EMRTS crew members with training and experience in neonatal transport as part of their induction.
- Both formal and informal feedback from CHANTS training and study days and the annual conference is good. However, roadshows at some of the smaller hospital centres have been poorly attended due to difficulty releasing staff from clinical duties, although they are well appreciated.

7. Possible future service models

A number of possible service configurations have been considered previously, over many years and at considerable effort by all involved. Proposals were submitted to WHSSC by the Neonatal Network in 2013 and 2014 and rejected due to funding not being agreed. A further proposal was submitted in 2016 for NEST to perform out-of-hours transfers for the Wales Neonatal Network. This was approved by WHSSC but in 2017 it became clear that NEST was unable to deliver the service. In January 2019, a further interim proposal for an extended hours CHANTS service was submitted by the network and rejected by WHSSC, again on the grounds of unaffordability and also due to unsustainability of future funding, with a further suggestion that the network consider an 18-hours per day interim solution. Not unreasonably, this was considered to be totally unacceptable option both for patient safety and impossibility of staffing.

A number of possible options for future service models have been considered by this review. Each has been assessed with respect to patient safety, quality and parent experience, accessibility and access to the right care at the right time, in the right place, staffing, including sustainability and training, cost-effectiveness and affordability and co-operation with other services. Some of the options described below require more detailed description, regarding various exact alternative models, if they are to be considered as a realistic option. The potential for any merger or provision of services from outside Wales have been limited to South West England (i.e. NEST and WATCh) as others from further afield were not considered to be realistic options due to the distances involved and other logistics.

Option 1. Status quo – continue with 12-hour only NTS provided by CHANTS	
Safety, quality & patient experience	Concerns regarding delayed time-critical and other acute transfers, with continuation of clinical risks highlighted in recent datix incident reports and case review. Poor patient experience regarding parents of babies with delayed acute transfers. Clinical risk to NICUs currently providing an unfunded ad hoc out-of-hours service. Potential clinical risk to non-Wales NTS services occasionally providing out-of-hours transfers within Wales on an uncommissioned and ad hoc basis.
Accessibility & equity	Inequitable service between babies born in NTS service hours and outside NTS service hours, with delayed access to right care in the right place delivered by the right staff. Inequity between service available to babies born in South Wales compared to that delivered in all other parts of the UK.

Staffing, sustainability & training	Unsustainability of NICU staff providing current ad hoc out-of-hours service, with consultant neonatologists doing this on an unpaid 'goodwill' basis and depletion of NICU nurse core hospital duties. Unsustainability of non-Wales NTS services occasionally providing out-of-hours transfers within Wales on an uncommissioned and ad hoc basis. Unsustainability of referral hospital staff managing a potentially unstable baby for longer times due to lack of out-of-hours NTS availability. Existing high-quality staff training opportunities are already in place and require very little enhancement or modification.
Cost-effectiveness & efficiency	No additional funding required. The direct cost of the current consultant delivered service is relatively expensive compared to other NTSs but is likely to provide a higher quality, safer, more efficient and more sustainable model of care.
Co-operation with other services	Likely negative impact on relationship between CHANTS / NICU teams and referrer hospitals due to unavailability of service out-of-hours. Likely negative impact on relationship between CHANTS and neighbouring NTS services who may be requested to provide uncommissioned ad hoc cover out-of-hours.

Option 2. Current CHANTS 3-centre service extended to 24 hours/day	
Safety, quality & patient experience	The patient safety concerns due to limited operational hours could be addressed rapidly if the current service model was extended to 24 hours/day. A safe and high-quality NTS, with good patient satisfaction is currently provided for 12 hours/day. There is no reason to believe that this would be diminished by extending the service to 24 hours/day using the existing infrastructure developed over the past 9 years. Some concern has been expressed by referring clinicians at LNUs and SCBUs across the network and from the recent external case review that the current three provider site model is confusing at times due to different guidelines between the three teams. Although the written guidelines are very clear and comprehensive, it is obvious that the three provider teams do operate differently from each other.
Accessibility & equity	Babies requiring acute transfer would receive the right care in the right place at the right time when at all possible. Transfer times would be quicker than if the service was delivered from outside of Wales, but not as quick as a single site service collocated with the ambulance. Babies in South Wales would have access to NICU care on an equitable basis compared to those in the rest of the UK.
Staffing, achievability, sustainability & training	NICU services in Wales have good recruitment to nursing establishment compared to many other parts of the UK, therefore recruiting the additional nurses required to extend the current CHANTS service to 24 hours/day is likely to be possible within a relatively short period of time. Recruitment of NICU middle-grade (tier 2) medical staff has been problematic in Wales for a number of years and changes to postgraduate medical training and other factors mean that this is not likely to improve and may worsen in the future. Consultant Neonatologist recruitment is less problematic, and the current consultant delivered NTS service is likely to be sustainable in a future 24 hour/day model given the number contributing to the rota.

	Existing high-quality staff training opportunities are already in place and require very little enhancement or modification. There is obvious benefit and less likely to be any duplication of teaching and training across the network compared to 4, 5 and 6. This model is probably the most achievable of all the new options to make operational quickly as most of the staff are already in place and little reconfiguration is required.
Cost-effectiveness & efficiency	The direct cost of a consultant delivered service is relatively expensive compared to other NTSs but is likely to provide a higher quality, safer, more efficient and more sustainable model of care.
Co-operation with other services	Likely positive impact on relationship between CHANTS / NICU teams and referrer hospitals due to availability of service out-of-hours. Likely positive impact on relationship between CHANTS and neighbouring NTS services who currently may be requested to provide uncommissioned ad hoc cover out-of-hours.

Option 3. Reconfigured CHANTS single centre providing 24 hours/day service	
Safety, quality & patient experience	The patient safety concerns due to limited operational hours would be addressed relatively quickly if the current service model was extended to 24 hours/day. A safe and high-quality NTS, with good patient satisfaction is currently provided for 12 hours/day. There is no reason to believe that this would be diminished by extending the service to 24 hours/day using the existing infrastructure developed over the past 9 years, but centralising it to a single provider site. Patient safety may be enhanced compared to the current three provider model by reducing the number of service interfaces for referrers and reducing any potential variability of equipment, staff training, guideline interpretation and staff management. NTS mobilisation times for time-critical and other acute transfers are likely to be improved, particularly if the NTS ambulance is co-located onto a single provider site. Concerns regarding differences in clinical practice between multiple providers would be eliminated with this option. Any clinical governance concerns regarding which provider has overall clinical governance responsibility would also be addressed with this option.
Accessibility & equity	Babies requiring acute transfer would receive the right care in the right place at the right time when at all possible. Transfer times would be quicker than if the service was delivered from outside of Wales. Babies in South Wales would have access to NICU care on an equitable basis compared to those in the rest of the UK.
Staffing, achievability, sustainability & training	NICU services in Wales have good recruitment to nursing establishment compared to many other parts of the UK, therefore recruiting the additional nurses required to extend the current CHANTS service to 24 hours/day is likely to be possible within a relatively short period of time. Recruitment of NICU middle-grade (tier 2) medical staff has been problematic in Wales for a number of years and changes to postgraduate medical training and other factors mean that this is not likely to improve and may worsen in the future. Consultant Neonatologist recruitment is less problematic and the current

	consultant delivered NTS service is likely to be sustainable in a future 24 hour/day model given the number contributing to the rota. Existing high-quality staff training opportunities are already in place and require very little enhancement or modification. There is obvious benefit and less likely to be any duplication of teaching and training across the network compared to options 4-6. Although this model is probably less achievable to make operational quickly compared to maintaining the three provider site model, it is likely to be achievable in a relatively short time, as most of the staff are already in post but some would be required to travel to a single site, which may be up to 52 miles (approximately 1 hour 15 minutes driving time) further than they currently travel to their base site. As medical staff would need to be available within around 30 minutes of a night-time transfer being requested, a small number of staff may need to stay overnight nearer to the CHANTS base. This is an arrangement that works well for other transport services (e.g. in Bristol, where some staff are funded to stay overnight in a hotel and therefore be available on-call at a safe distance). All three NICUs have indicated that they would be confident that they would be able to staff a single site 24-hour service, but this is likely to depend on some staff travelling from the other two NICU to contribute to the CHANTS medical and nursing rotas. There was some concern expressed that staff retention may be adversely affected by any single provider reconfiguration. The current 3 provider site model is unusual compared to other UK NTS services and was justified when CHANTS was established on the basis that a single provider would potentially destabilise staffing in the other two NICUs. This has not been the experience elsewhere in the UK and therefore should not be a concern in Wales.
Cost-effectiveness & efficiency	The direct cost of a consultant delivered service is relatively expensive compared to other NTSs but is likely to provide a higher quality, safer, more efficient and more sustainable model of care.
Co-operation with other services	Likely positive impact on relationship between CHANTS / NICU teams and referrer hospitals due to availability of service out-of-hours. Likely positive impact on relationship between CHANTS and neighbouring NTS services who currently may be requested to provide uncommissioned ad hoc cover out-of-hours. There is a potential (small) risk of possible deterioration between the single provider site and the other 2 NICUs, but this is likely to be avoidable if transition to a single site provider is managed appropriately within the network.

Option 4. Merged NEST/CHANTS service providing 24 hours/day service for SW England and S Wales	
Safety, quality & patient experience	The patient safety concerns due to limited operational hours would be addressed but setting up this model is likely to take longer than options 2 and 3. However, once established, this option is likely to provide a safe and high-quality NTS, with good patient satisfaction NTS dispatch and travel times for time-critical and other acute transfers are likely to be worse if the provider site was in Bristol.

	This model would increase the number of service interfaces, particularly if a variation of the model continued with CHANTS being provided from all three NICU sites.
Accessibility & equity	Babies requiring acute transfer are likely to receive the right care in the right place at the right time when at all possible. Babies in South Wales would have access to NICU care on a similarly equitable basis compared to those in the rest of the UK. There may be potential inequity and poorer access to babies in South Wales from a service operated from outside Wales if babies from the host NTS region are more likely to be prioritised when there are concurrent requests for transfer. The geography of South and West Wales and South West England is not ideal for a merged NTS due to the distances and road system involved.
Staffing, achievability, sustainability & training	Many current CHANTS medical and nursing staff have indicated that they would not be prepared to travel to an NTS base outside Wales and therefore staffing for this option may be reliant on additional recruitment from Bristol. The tier 2 medical rota for NEST, which also relies on ANNP recruitment, is likely to have less long-term sustainability than the consultant delivered CHANTS model. Wales and England have some differences in their Health Services which may provide complications or even barriers to an integrated service. Some opportunities for joint network NICU and NTS joint teaching and training provision to referrer LNUs and SCBUs may be lost if the NTS is provided from outside the network.
Cost-effectiveness & efficiency	NEST have indicated that to increase their capacity to cover South and West Wales as well as South West England for 24 hours/day would require establishing another whole team. It is therefore unlikely that there would be significant cost savings with this joint or integrated model, apart from some minor economies of scale. These are likely to be negated by increased travel times and loss of other efficiencies.
Co-operation with other services	This option would reduce the direct interface and communication between the NICUs in Wales and referring LNUs and SCBUs, with likely loss of networking and teaching and training opportunities.

Option 5. Continue current CHANTS 12 hours/day service and commission NEST to provide 8pm-8am service covering SW England and S Wales	
Safety, quality & patient experience	The patient safety concerns due to limited operational hours would be addressed but setting up this model is likely to take longer than options 2 and 3. However, once established, this option is likely to provide a safe and high-quality NTS, with good patient satisfaction NTS dispatch and travel times for time-critical and other acute transfers between 8pm and 8am are likely to be worse than in options 2 and 3 if the provider site was in Bristol. This model would increase the number of service interfaces, particularly if a variation of the model continued with CHANTS being provided from all three NICU sites. A four-site service is likely to be confusing for referrers and parents of babies being transferred. A two-site variation of this option

	(i.e. with daytime transfers being performed by a CHANTS single-site reconfiguration) would therefore be a better than option 2 in this regard.
Accessibility & equity	Babies requiring acute transfer are likely to receive the right care in the right place at the right time when at all possible. Babies in South Wales would have access to NICU care on a similarly equitable basis compared to those in the rest of the UK. There may be potential inequity and poorer access to babies in South Wales from a service operated from outside Wales at night if babies from the host NTS region are more likely to be prioritised when there are concurrent requests for transfer. The geography of South and West Wales and South West England is not ideal for a single NTS service, even at night when demand is less, due to the distances and road system involved.
Staffing, achievability, sustainability & training	Many current CHANTS medical and nursing staff have indicated that they would not be prepared to travel to an NTS base outside Wales and therefore staffing for this option would be reliant on additional recruitment from Bristol. The tier 2 medical rota for NEST, which also relies on ANNP recruitment, is likely to have less long-term sustainability than the consultant delivered CHANTS model. Furthermore, a previously accepted proposal for NEST to deliver an out-of-hours service for Wales failed as NEST were unable to deliver the service. Revisiting this model would therefore have significant risks for sustainability of staffing. Wales and England have some differences in their Health Services which may provide complications or even barriers to an integrated service.
Cost-effectiveness & efficiency	NEST have indicated that to increase their capacity to cover South and West Wales as well as South West England between 8pm and 8am would require establishing another whole 12 hours/day team. It is therefore unlikely that there would be significant cost savings with this joint or integrated model, apart from some minor economies of scale. These are likely to be negated by increased travel times and loss of other efficiencies compared to an out-of-hours service being provided from within Wales.
Co-operation with other services	This option is likely to have little impact on co-operation with other services but may reduce the enhanced networking opportunities with referrer LNUs and SCBUs, which options 2 and 3 are likely to provide.

Option 6. Combined Paediatric Intensive Care/Neonatal Intensive Care (PIC/NIC) service	
Safety, quality & patient experience	Whilst combined PIC and NIC transfer services have been established in other parts of the UK (Embrace in Yorkshire and Humber) and elsewhere in the World (e.g. Toronto), it is questionable that they provide equivalent levels of patient safety. Although there are some transferable skills and overlap of clinical knowledge, PIC and NIC are distinct and separate specialties. The majority of paediatric intensivists and PIC nurses would feel uncomfortable caring for even mildly preterm babies and those who are extremely preterm are likely to present a greater challenge. Neonatologists and neonatal nurses would have similar issues caring for older children, with very different pathologies. There would also be concern that older children may be more likely to be prioritised over and extremely preterm baby in the event of concurrent requests for transfer. Fully

	integrated PIC and NIC transfer services have been considered and rejected by most other regions in the UK, including London and Scotland, but appear to be best suited to densely populated urban regions, with access to several large hospital centres for staff training. Embrace have 4 daytime emergency teams and 2 at night. This allows for the flexibility required to ensure patient safety by having the correct skill mix of staff on each shift, so that those with greater expertise in NIC can be deployed on more complicated neonatal transfers. This would be much more difficult to ensure in Wales (plus or minus South West England), due to the much lower total population and population density. There are other examples of a single service which has separate NIC, PIC and adult intensive care staff (ScotStar), but share hosting infrastructure, equipment and road and air transportation systems. This also has the added benefit of NIC and PIC staff sharing responsibility for term neonates and babies up to a few weeks old, adding additional flexibility to the system.
Accessibility & equity	Once established, this option would ensure that babies in South Wales would be transferred on an equitable basis compared to those in the rest of the UK. There would be some concern regarding possible prioritisation of older children to some preterm patients. A combined PIC/NIC transfer service provided from outside Wales (i.e. WATCh from Bristol) is likely to increase transfer times and babies and children from the host region may be prioritised when there are concurrent requests for transfer. The geography of South and West Wales and South West England is not ideal for a single transfer service.
Staffing, achievability, sustainability & training	A fully integrated transfer service would require an extensive training programme for both PIC and NIC staff. This is likely to be expensive and would delay the 24-hour service implementation considerably. There is an almost unanimous view of current CHANTS staff that they would not be prepared to undergo the extensive training required for them to be competent in the transfer of older children if there was a fully integrated PIC/NIC transfer service for Wales. This model is likely to have significant risks for sustainability of staffing.
Cost-effectiveness & efficiency	In the long term, this option may have some financial benefit due to economies of scale, although these are likely to be minimal due to the step change required in the number of teams on each shift. For South and South West Wales only, it is likely that two daytime and one night-time team would be required. Both NEST and WATCh have indicated that to perform night transfers for South and South West Wales as well as their own region would require one additional 12-hour team. It is therefore doubtful that significant financial benefit would be produced with these options. Additionally, there would be considerable training costs involved to establish any integrated PIC/NIC transfer service. Such a service would also need to be standalone rather than ward based, which would be less efficient during times between transfers, particularly at night.
Co-operation with other services	An integrated PIC/NIC service could improve co-operation between NIC and PIC services but would reduce the interface between the NICUs and referring LNUs and SCBUs across the neonatal network.

8. Conclusions and recommendations

a. Support for how to provide a high quality 24-hours per day neonatal transfer service for South Wales should continue from all stakeholders, in order to ensure the best possible clinical outcomes to babies born in the region, with equitability of access, similar to all other parts of the United Kingdom. The need to change the current service arrangements in order to achieve this should not be questioned and are urgent.

b. With respect to the urgency required to change the current service arrangements, a timeline needs to be defined by WHSSC. The reviewers suggest that 24-hours per day service provision is operational within no more than 6-12 months from the date of this report.

c. Funding for the clinical components of a 24-hours per day service needs to be clearly defined and transparent, so that this is completely separate from NICU or other service funding. This will require agreement between WHSSC and all Health Boards initially, and then between WHSSC and the CHANTS provider Health Board(s).

d. Funding for the Ambulance and transport costs of a 24-hours per day service need to be considered separately and agreed between CHANTS (i.e. preferably by a single provider Health Board) and the Wales Ambulance Service NHS Trust (WAST), with additional agreement of costs by WHSSC.

e. The current service model, with ambulance teams being based at distance from all three provider sites, causes unacceptable delays to transfer team mobilisation times, as well as limiting service provision to considerably less than 12-hours per day. The clinical risks associated with this are obvious, and have been highlighted by an external case review, completed in August 2018. A future service model with either co-location or close proximity location of ambulance and clinical teams is recommended.

f. The proportion of capacity transfers performed as emergencies in South Wales is excessive when compared to neonatal networks in other parts of the UK. A demand and capacity review, including consideration of the transfer acceptance policy and pathway, is required to fully assess NICU occupancy levels. This is likely to identify a need to increase cot numbers

at the NICU centres across the network. Commissioning of the required number of cots would improve clinical outcomes, reduce the need for families to travel longer distances to access the care their baby needs as well as reducing the burden on CHANTS and avoid delay to clinically urgent transfers. The proportion of babies less than 27 weeks gestation born in maternity centres with NICU facilities across the network has improved recently but was low (around 70%) as recently as 2017. Clearly some effective work has been carried out in conjunction with maternity services to ensure that extremely preterm babies are born in the right place, but this needs to be advanced further by ensuring that capacity constraints are minimised. A reduced number of postnatal transfers will decrease CHANTS activity, but more importantly, recent evidence suggests improved outcomes for extremely preterm babies when postnatal transfer is avoided.[7]

g. A single point of contact system is required for all emergency referrals. It is understood that this is currently being progressed by the Wales Neonatal Network. This should also include emergency referrals for in-utero transfers, by providing a call-handling and liaison service, so that capacity for maternal transfer and potential NICU admission is identified. Use of an App or web-based portal such as Cot Locator should be used to facilitate this process but would require the engagement of all maternity and neonatal teams across the network. The single point of contact system should be integral to the neonatal transport service and facilitate conference calls between the referring clinicians, transport team and the receiving NICU, preferably at consultant to consultant level, so that advice and information to referring clinical teams is safe, clear and unambiguous. A single point of contact for referrals should mean that referrers are only required to make one phone call in order to arrange transfer of a patient (i.e. mother and/or baby) and that for ex-utero transfers they are updated regularly by the NTS regarding the estimated time of arrival and for clinical advice.

h. The current CHANTS service has many positive attributes, despite formal agreement not being in place for 24-hours per day provision.

   All clinically important key performance indicators compare favourably to other neonatal transfer services after taking into account the lack of an out-

of-hours service. Service user feedback from parents has been positive to date and feedback from referring clinicians is also positive apart from the obvious issue with the lack of a night-time service and some concerns regarding variation of clinical practice between the three providers.

i. Medical staffing is almost entirely consultant delivered and experienced senior neonatal nurses are available for all shifts. Service delivery has not been stood down due to staff sickness, absence or unavailability for any shifts over many years. Clinical and ambulance staff shift overruns occur on a regular basis and clinical staff do provide an unofficial out-of-hours service on an ad hoc basis, largely based on goodwill. The service is highly organised and well-managed but has significant challenges and constraints due to the current limited hours operational model. Staff remain extremely proud of their service despite expressing concern and frustration due to the limited hours of provision. It is recommended that any future service model should consider how to best utilise current CHANTS staff, so that as many as possible are able to continue contributing to a clinically excellent expanded 24-hours per day service.

j. The current three site provider model clearly has some advantages with respect to availability of medical and nursing staffing, and a similar arrangement does work well for shared out-of-hours transfers in one neonatal transport service in the South of England (Kent, Surrey and Sussex (KSS) Neonatal Transfer Service). However, this region is considerably different to South Wales, which has a significantly lower population density, lower activity volumes and more challenging geographical constraints. These factors appear to have contributed to difficulty in co-location of the ambulance service and NICUs, as well as availability of ambulance and clinical staff out-of-hours.

   Furthermore, the recent external case review suggested variability between the three providers with respect to mobilisation times and clinical practice. WHSSC have also expressed concern regarding the split in clinical governance responsibilities between the three providers, and although CHANTS have provided what appears to be a reasonable response to this, an element of concern persists.

On balance, the opinion of the reviewers is that from a clinical perspective, a 24-hours per day service would be best provided by a single-site and single-point of contact provider, co-located or closely located to a dedicated ambulance and ambulance staff. This model is also likely to be sustainable from a workforce recruitment and retention, education and training perspective.

k. Of the models described in 7. above, option 3 would appear to provide the best solution to establishing a 24-hour NTS for South and West Wales. Although this requires some reconfiguration and flexibility from existing staff, it could be established relatively quickly once funding has been agreed. It is clear that additional funding must be provided to avoid destabilising the three NICUs. It is also clear that the alternative, as has been suggested, to find the additional funds from 'within the system' is not possible without forcing the NICUs to significantly deviate from being able to operate in accordance to national standards. These standards are evidence based or by professional consensus where evidence is unavailable and are upheld in other parts of the UK where at all possible. Reducing these standards would present significant clinical risk for babies born in Wales.

l. Implementation of this option would require significant compromise from all stakeholders, with commitment to increased funding from WHSSC and acceptance of the relatively limited service reconfiguration by Health Board staff, so that the staffing models for both NICUs and CHANTS are safe and sustainable 24 hours per day on a long term basis in order to maximise patient benefit.

m. Estimated maximum likely total additional staff costs are outlined in section 9. below. It should be stressed that these are the maximum likely costs as further detail of current consultant out-of-hours supplementary availability payments need to be obtained as well as more detailed contract negotiation with WAST regarding ambulance staff. In reality, it is likely that the final agreed additional staff costs will be considerably less than those outlined below.

9. Requirements for 24-hour service based on recommended model of service

a) Medical staffing (Consultant Neonatologists)

- Current daytime service (08:00-20:00 hours) requires 4380 hours per year
- Accounting for hours required outside Monday-Friday 07:00-19:00 hours, each PA = 3.613 hours
- Therefore need 1212 PAs per year = 23.24 PAs per week over 52 weeks
- Correcting for annual, study, professional leave and bank holidays (i.e. total 10 weeks per year) = 28.78 DCC PAs per week in 42-week job plans
- If each WTE = 7DCCs + 3SPAs (i.e. current Wales standard), 12-hour/day service needs 41.11 PAs (4.111 WTE consultants), not allowing for any net overrunning of shifts
- 1 PA is allocated to a Clinical Lead. This is equivalent on a proportionate basis to other UK Neonatal Transfer Services.
- Therefore total PAs required currently = 42.11
- Extended 24-hour service performing approximately one transfer per week and assuming each transfer approximately 8 hours, would require an additional 416 hours per year
- Accounting for hours required outside Monday-Friday 07:00-19:00 hours, each PA = 3 hours
- Therefore need 138.67 PAs per year = 2.67 PAs per week
- Correcting for annual, study, professional leave and bank holidays (i.e. total 10 weeks per year) = 3.302 DCC PAs per week
- Correcting for SPA allowance in job plans (7:3 DCC:SPA ratio) = 4.717 PAs
- Total DCC PAs required for extended 24-hour service = 42.11 + 4.717 = 46.83 PAs per week (not allowing for any net overrunning of shifts)
- An additional on-call availability payment would be required for each consultant on a future CHANTS 24-hour service rota. The NHS Wales annual salary uplift for Band A (i.e. highest intensity) out-of-hours availability supplement for this would be £8,889.21 per consultant (including NI, superannuation and

apprentice levy). Obtaining detailed information regarding which current CHANTS consultant staff already receive this supplement as part of their hospital on-call availability remuneration has not been possible during this review, despite best efforts to do so. However, it is understood that University Hospital of Wales consultants do already receive this supplement, whereas those at Royal Gwent and Singleton Hospitals may not. This is consistent with the estimated costs of extending CHANTS operational hours from a paper drafted in 2013 by the Wales Neonatal Network, which estimated a cost of £145,800 per year for additional consultant on-call availability. Any consultant already receiving the maximum availability supplement would not receive anything in addition to this for contributing to an out-of-hours CHANTS rota. In reality, the 23 consultant neonatologists currently contributing to the CHANTs rota would not be asked to commit to an overburdensome out-of-hours rota, both in terms of availability and actual call-out time – i.e. 1 in 23 availability and approximately 2 actual call-outs / transfers per year each, assuming that all 23 continue to contribute to the rota.

b) Nurse staffing (Band 6/7 and ANNPs)

- The current daytime service (08:00-20:00 hours) requires 84 hours per week
- Each WTE = 37.5 hours / week, therefore service requires 2.24 WTE + 27% operational uplift (to account for annual, study, sick and maternity leave etc.)
- Therefore, current daytime service requires 2.84 WTE nurses
- Allowing for 6 hours per week of overruns would ‘round up’ to 3 WTE nurses (i.e. 1 WTE per provider NICU)
- An extended 24-hour service could be staffed by neonatal nurses on call or by flexible use of float nurses
- Nursing pay structures make it difficult, if not impossible to pay for an on-call service. NICUs also require float nurses, as unlike PICUs and AICUs, care is not delivered to all patients on a 1:1 basis. Flexible use of float nurses would allow the provider NICU to employ a float nurse on each shift who would be available for a CHANTS transfer. This is a model used in some other patient transport services in the UK (KSS NTS, South London Retrieval Service). The

Neonatal Network has already attempted to provide an alternative model of out-of-hours neonatal nursing provision but as noted above, this has not been possible.

- An extended 24-hour service therefore requires 168 hours per week of 'non-NICU case loading' (i.e. supernumerary) neonatal nurses
- Each WTE = 37.5 hours / week, therefore service requires 4.48 WTE + 27% operational uplift (to account for annual, study, sick and maternity leave etc.)
- Therefore, an extended 24-hour service requires 5.68 WTE nurses
- Allowing for 12 hours per week of overruns / handover would 'round up' to 6 WTE nurses (i.e. 3 additional nurses)

c) Ambulance staff

WAST have initially indicated that 2.7 WTE dedicated Ambulance drivers (i.e. supernumerary when not performing a transfer). However, the possibility of provision of drivers on an 'as required' basis should be investigated further, as there would be significant 'down time' (more than 6 whole nights per week on average) with this arrangement, which would not be at all efficient. The additional ambulance driver provision requires more in-depth discussion and contract negotiations between WHSSC and WAST. Total costs may therefore be less than indicated in table 6. below.

Table 8. Estimated maximum likely total additional staff cost of extended 24-hour CHANTS

	WTE	Cost / WTE	Total cost
Consultants	0.472	£130,621	£61,653
Consultant on-call availability supplement			£145,800
Nurses (Band 6)	3	£58,072	£174,216
WAST drivers (Band 3)	2.7	£36,685	£99,050
Total	6.172		£480,719

The estimated maximum expected total additional staff cost of extending the service to 24-hours per day is shown in table 6. above. However, total costs may be considerably less as explained above.

10. References

1. Service Standards for Hospitals Providing Neonatal Care 3rd edition. 2010. A BAPM Framework for Practice. https://www.bapm.org/resources/32-service-standards-for-hospitals-providing-neonatal-care-3rd-edition-2010
2. All Wales Neonatal Standards. 3rd edition, 2017. http://www.walesneonatalnetwork.wales.nhs.uk/all-wales-neonatal-standards
3. Inquiry into Neonatal Care Health. National Assembly for Wales Health, Wellbeing and Local Government Committee. 2010.
4. Inquiry into Neonatal Care. National Assembly for Wales Children and Young People Committee. 2012.
5. South Wales Neonatal Transport Case Review Report. Puddy VF. 2018.
6. Wales Neonatal Network Annual Report 2017 / 2018. http://www.walesneonatalnetwork.wales.nhs.uk/sitesplus/documents/1034/AnnualReport2017V01.00.pdf
7. Helenius K, Longford N, Lehtonen L, Modi N, Gale C. Association of early postnatal transfer and birth outside a tertiary hospital with mortality and severe brain injury in extremely preterm infants: observational cohort study with propensity score matching. *BMJ* 2019; 367 :l5678

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

WELSH HEALTH SPECIALISED SERVICES COMMITTEE EXTRAORDINARY MANAGEMENT GROUP MEETING 27 FEBRUARY 2020

This briefing sets out the key areas of discussion relating to Neonatal Transport at the Extraordinary Management Group meeting held on 27 February 2020.

Members representing the six affected Health Boards, received the Final Report of the 'Independent Review of the south Wales Neonatal Transport Service (CHANTS) in order to recommend future models of delivery for a 24 hour transport service' and a paper setting out the key recommendations from the review and a proposed implementation timetable to commission a permanent 24 hour Neonatal Transport service in south Wales.

Members agreed that:

1. They were supportive of the direction of travel of the report and clearly endorse a 24/7 model.

2. They were looking to establish a Lead Provider for Neonatal Transport. From a Commissioning perspective this model would:

   - provide a single governance framework with clear lines of accountability; and
   - give assurance of systems management for the service; and
   - allow for further development of the Neonatal Transport service through defined processes of engagement.

   Members noted that there were lead provider models already being utilised to manage services in Wales, including the established successful lead provider model for the Emergency Medical Retrieval Transport Services (EMRTS) and the Operational Delivery Network currently being developed for Major Trauma. Management Group wanted to understand what aspects of these models could be useful in the delivery of a lead provider model for neonatal transport services.

3. WHSSC will develop commissioning intentions and a service specification utilising the support of the Maternity and Neonatal Network as a source of professional advice. These documents will inform the development of an options appraisal stemming from the options set out in the Independent Review and any other options presented.

4. WHSSC will establish a Task & Finish Group with commissioning, clinical and managerial representatives. The Group will consider how best to utilise the existing workforce with the proposed delivery model and also outline developments required for the future workforce.

5. In parallel, the Maternity and Neonatal Network would undertake demand and capacity modelling of both the number of maternity beds and cots required across the region.

6. Further work to define and clearly set out the funding of the clinical components of a 24 hours service needs to be undertaken by the WHSSC Finance Working Group.

		Agenda Item	2.4
Meeting Title	**Joint Committee**	Meeting Date	10/03/2020
Report Title	WHSSC Joint Committee Annual Business Cycle 2019-20		
Author (Job title)	Corporate Governance Officer		
Executive Lead (Job title)	Committee Secretary & Head of Corporate Services	Public / In Committee	Public

Purpose	The purpose of the paper is to provide Members with the Draft Joint Committee Annual Business Cycle 2020-21.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	☒	☐	☒

Sub Group /Committee	Integrated Governance Committee	Meeting Date	26/03/2019
Recommendation(s)	Members are asked to: • **Note** and **support** the content of the report, including the schedule of meetings for 2020-21		

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 present the draft Business Cycle for the Joint Committee covering the period 2020-21.

2.0 BACKGROUND

Good governance practice dictates that Boards and Committees should be supported by an annual cycle of business that sets out a coherent overall programme for meetings. The forward plan is a key mechanism by which appropriately timed governance oversight, scrutiny and transparency can be maintained in a way that doesn't place an onerous burden on those in executive roles or create unnecessary or bureaucratic governance processes.

It is recognised that the business cycle does not contain all items that will be considered by the Joint Committee. It is intended to provide a broad framework to support the agenda planning process. The document will be reviewed and modified as new issues develop.

3.0 ASSESSMENT

In summary, the Joint Committee has three key functions;

- To set strategy;
- To ensure accountability by:
  - holding the organisation to account for the delivery of the strategy;
  - being accountable for ensuring the organisation operates effectively and with openness, transparency and candour; and
  - Seeking assurance that the systems of control are robust and reliable; and
- To shape culture.

The Financial Reporting Council Guidance on Board Effectiveness outlines that *"Well informed and high quality decision making is a critical requirement for a board to be effective."* Therefore, by taking the time to plan their decision processes, Boards can minimise the risk of poor decisions.

3.1 Meeting Schedule

The draft meeting schedule for the Joint Committee has been arranged to ensure there are no clashes with Local Health Board meetings.

As previously agreed, the Joint Committee for Welsh Health Specialised Services (WHSSC) and Emergency Ambulance Services Committee (EASC) will be held on the same day.

The schedule of WHSSC Joint Committee meeting dates for 2020-21 is as follows:-

Date	Time
12 May 2020	09.30
14 July 2020	13:30
08 September 2020	09:30
10 November 2020	13:30
19 January 2021	09:30
16 March 2021	13:30

The Joint Committee Work Plan will be subject to change throughout the year, but will steer agenda planning.

In addition to the specific papers detailed within the Joint Committee Work Plan, the Joint Committee will also:

- Routinely consider members' interests at the start of each meeting.
- Receive minutes from the previous meeting and an update against an on-going log of agreed actions.
- Receive summary reports from each of its Sub-committees in order to demonstrate that delegated responsibilities are being effectively discharged.

A schedule of meetings has been produced (annex (i)) which includes dates for the following key meetings:

- Corporate Directors Group Board Meeting
- Management Group Meetings (and workshops)
- Joint Committee
- Quality and Patient Safety Committee
- Integrated Governance Committee

The schedule has been developed so that the Management Group that takes place the month before the Joint Committee will consider items going to the next Joint Committee.

3.2 Joint Committee Work Plan

The Joint Committee Work Plan (annex (ii)) provides an overview of the scheduled items for 2020-21.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the content of the report content of the report, including the schedule of meetings for 2020-2021.

5.0 APPENDICES / ANNEXES

5.1 Annex (i) – Schedule of WHSSC Meetings 2020-21
5.2 Annex (ii) – Joint Committee Work Plan 2020-21

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Development of the Plan Implementation of the Plan
Link to Integrated Commissioning Plan	An annual plan of work provides each committee/group with an indication of the planned work for the year. This will also enable WHSSC to operate a more efficient way and support delivery of the Integrated Commissioning Plan.
Health and Care Standards	Governance, Leadership and Accountability
Principles of Prudent Healthcare	Only do what is needed
Institute for HealthCare Improvement Triple Aim	Not applicable
Organisational Implications	
Quality, Safety & Patient Experience	Strong governance mechanisms will indirectly improve quality of service and patient safety and experience.
Resources Implications	Not applicable
Risk and Assurance	There is a requirement to ensure that committees/groups are have a clear understanding of their expected annual work plan to ensure that the correct governance process can be followed and appropriate, well informed and timely decisions can be made.
Evidence Base	Financial Reporting Council: Guidance on Board Effectiveness March 2011
Equality and Diversity	Not applicable
Population Health	Not applicable
Legal Implications	Not applicable

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

	Corporate Directors Group Board	Quality and Patient Safety Committee	Integrated Governance Committee	Management Group Workshop	Management Group	Joint Committee
Apr-20	06				23	
May-20	05				21	12
Jun-20	08	09	09		25	
Jul-20	29/06				16	14
Aug-20	03	11	11		20	
Sep-20	07				24	08
Oct-20	05	13	13		22	
Nov-20	09				26	10
Dec-20	30/11				17	
Jan-21	04	18	18		21	19
Feb-21	08				25	
Mar-21	08	23	23		25	16

Item	Exec Lead	12-May	14-July	08-Sept	10-Nov	19-Jan	16 - Mar
Preliminary Matters							
Report from the Chair of WHSSC (incl report from Integrated Governance Committee)	CS	x	x	x	x	x	x
Report from the Managing Director of WHSSC	MD	x	x	x	x	x	x
Items for Decision and Consideration							
Strategy for Specialised Services	MD	x					
Integrated Commissioning Plan 2021-24	DoP				x		
Governance							
Corporate Risk and Assurance Framework	CS	x			x		
Annual Reports from the Chairs of the joint sub-committees and advisory Groups	CS	x					
Integrated Performance Report	DoP	x	x	x	x	x	x
Financial Performance Report	DoF	x	x	x	x	x	x
Committee Governance							
WHSSC Joint Committee Annual Cycle of Business	CS						x
Annual self-assessment	CS		x				
Minute of the last meeting held	CS	x	x	x	x	x	x
Action log	CS	x	x	x	x	x	x
Declarations of interest	CS	x	x	x	x	x	x
Reports from the Joint Sub-committee Chairs							
Quality and Patient Safety Committee	DoNQ	x	x	x	x	x	x
Management Group	CS	x	x	x	x	x	x
All Wales Individual Patient Funding Request Panel	DoNQ	x	x	x	x	x	x
Welsh Renal Clinical Network	DoF	x	x	x	x	x	x
Reports from the Joint Advisory Group Chairs							
All Wales Gender Identity Partnership Group	DoNQ	x	x	x	x	x	x
All Wales Mental Health and Learning Disabilities Collaborative	DoP	x	x	x	x	x	x
All Wales Posture Mobility Partnership Board	DoP	x	x	x	x	x	x

		Agenda Item	3.1
Meeting Title	**Joint Committee**	Meeting Date	10/03/2020
Report Title	December 2019 Integrated Performance Report		
Author (Job title)	Assistant Director of Planning and Performance Analyst		
Executive Lead (Job title)	Director of Planning	Public / In Committee	In Committee

Purpose	This report provides members with a summary of the performance of WHSSC commissioned services that are in escalation in December 2019. The preceding SBAR highlights the changes that have been made to the report as a first step to making it more accessible and proposed future changes to its presentation.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☒	☒	☐	☒

Sub Group /Committee	Choose an item.	Meeting Date	Click here to enter a date.
Recommendation(s)	Members are asked to: • **Note** the December performance and the actions undertaken to address areas of non-compliance; and • **Approve** the changes that have been made to the presentation of information within the report; and • **Support** the next steps proposed to be made to further update the report.		

Considerations within the report (tick as appropriate)

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

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)

N/A

1. SITUATION

This report provides an overview on the performance of providers for services commissioned by WHSSC for the period December 2019.

The formatting of the report has been modified from its presentation of the November 2019 position, starting the process of making it more accessible and meaningful. The process of updating the report is planned to be formative with a proposed number of changes made to it over the coming months.

2. BACKGROUND

The performance report is presented on a monthly basis to the WHSSC Corporate Directors and Management Group members with a bridged version presented at the bi-monthly Joint Committee meetings. The purpose of the report is to provide a monthly overview of the performance of specialised services and the measures that are being taken by the WHSST team with the provider if they are not performing in line with national targets such as the Referral to Treatment (RTT) and Cancer waiting times.

There have been a number of formats used to present the performance information in an attempt to make it more accessible. These include adding summaries and dashboards at the start of the paper to provide an overview, but which has had the adverse effect of lengthening the overall report.

The Director of Planning has requested that the format of the report be reviewed and updated whilst ensuring that the performance information presented continues to be accurate, highlights areas of risk and concern and assures Commissioners that performance is being effectively managed.

3. ASSESSMENT

3.1 Case for change

A review of the last three months WHSSC performance reports and informal discussions with members of staff in Information and Planning who are responsible for contributing to them, has indicated that the current's report format was repetitive and lengthy having the potential to discourage readers from reviewing the entire report.

A review of the performance reports timetabled at all the Health Boards and a number of our main providers in NHS England (University Hospitals Bristol and University Hospitals Birmingham) Board meetings, found that all reports were lengthy in composition, appreciating that these organisation reports covered a greater spectrum of information than the WHSSC report. There was a similar

approach in all reports of having a dashboard summary at the start of the report followed by more in depth information on particular areas, where possible, with a page per service area/target. It was felt that there was little 'best practice' that could be taken from these reports and applied to the WHSSC performance report.

The proposal for changing the WHSSC report is for incremental changes to be implemented on a monthly basis and following them being accepted or rejected by Corporate Directors and Management Group, applied to the reports thereafter. Further changes will continue to be applied until the report is felt to be a valuable method of assuring commissioners of the appropriate performance management of WHSSC services.

3.2 Changes made to the presentation of the December 2019 report

The following changes have been made to how the information is presented:

- Removing one of the two escalation tables that were duplicated. The tables both contained information regarding which of the WHSSC services were in escalation with the only notable difference being one showed the movement since the last report visually and the other as narrative.
- Prioritising the order in which the service specific information is presented starting with the specialities in the highest level of escalation on the basis that it is these areas that will be of the highest concern to readers. The order of priority will be dynamic, changing when service performance improves or deteriorates and will be actively managed by the Performance Analyst to reflect these changes.
- Re-organising of the dashboard so that performance against the 36 week Referral to Treatment (RTT) is reported first across all specialties on the basis that this is the primary target being worked towards by Health Boards, followed by performance against the 26 week RTT target and then the remaining targets.
- Visuals relating to services where targets are consistently being met i.e. Neurosurgery in Walton Centre, Liverpool have been removed on the basis of not demonstrating any variation, whilst the performance is still reported in the narrative. This also aids in reducing the length of the report.

3.3 Proposal to re-assign presentation of information to another report

Compliance in the reporting of serious incidents to WHSSC within the target of two days was a standing item in monthly performance reports at an overview rather than provider level, on a quarterly basis on a rolling two year period. The duration of reporting is more in-keeping with the timelines of information presented to the Quality and Patient Safety Committee (QPS) who meet quarterly. Also, for the last three months which was the duration of performance reports reviewed for the work of updating this performance report, there was no narrative provided on what actions were being taken with providers to improve this compliance so the section had little value other than evidence that WHSST was collating this data. As this is the only information in the monthly performance report that requires completion by the WHSSC Quality Team, it is perhaps more

appropriate for this section to be removed from the monthly performance report and presented in the quarterly QPS reports in which the Quality team provide a more active role in drafting.

4. NEXT STEPS

- When reviewing the performance report, it is obvious that it is a report written 'by Committee' or more accurately by relevant Planners. There needs to be some consistency applied i.e. agreeing the order of the time range in which performance is reported i.e. reporting number of breaches over 52 weeks before the number of 36 week breaches and the number of 26 week breaches.
- Establish whether both the *Escalation of Services* table which provides an overview of services and the *Key Information of services* section are required as there is some similar information in both. If both are believed to be useful, it would be useful to stipulate what information is required in the 'current information' section of the *Escalation of Services* table as for some services the frequency of the escalation meetings is being noted and for others the number of breaches in month.
- Continue to review the service information on a page to ensure that it is readable and adds value
- Explore whether there is the need for providing a focussed individual service level report rotationally on a monthly basis
- Understand why some performance information for services commissioned by WHSSC is not readily available i.e. Non Urgent Suspected Cancer (NUSC) data and look to resolve this.
- Establish how performance against the Single Cancer Pathway can be accessed and presented in this report for relevant services.

5. RECOMMENDATIONS

Members are asked to:

- **Note** the December performance and the actions undertaken to address areas of non-compliance; and
- **Approve** the changes that have been made to the presentation of information within the report; and
- **Support** the ongoing work to make further improvements to the format of the report and presentation of performance.

WHSSC Integrated Performance Report

December 2019

WHSSC

Table of Contents

1. Overview of 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).	⇨
Plastic Surgery	2	Monthly performance meetings continue with SBUHB	⇨
Neurosurgery	2	The zero breaches over 36 weeks continues to be maintained for a 3rd month and we will be looking to de-escalate the service if improvements continue to be made in reducing the number of patients waiting over 26 weeks.	⇨
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	The service has reported 48 breaches over 36 weeks. The service remains in escalation level 2.	⇨
Paediatric Intensive Care	2	The 7th bed has now opened within the unit. The service remains at level 2 and will continue to be monitored until the effects of the additional capacity is noted.	⇨
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.	⇨
Alternative Augmentative Communication (AAC)	2	Bi-monthly meetings being reinstated with the service from December 2019 to understand the reasons why patients are waiting in excess of the 26 week RTT target.	⇨
CTMUHB Cochlear Service	4	There has been a temporary suspension of the cochlear services in CTM UHB which has been made by the commissioner, as a result of staffing shortfalls. There have been a series of discussions between the CTM and Cardiff and Vale UHB regarding the future short and medium term delivery plan for the service.	⇩

2. Key Information for December 2019

The trend for performance for all provider services has largely remained unchanged during 2019/20. Of the 26 provider service targets that were monitored by WHSSC, 19 (73.1%) remain in breach at end of December 2019 compared to 81.5% at the end of November 2019. Ten services improved in performance from November to December, nine services deteriorated, whilst the remaining seven saw no change.

Cardiac Surgery: In December the Health Board reported 45 patients waiting over 26 weeks, 23 patients over 36 weeks and 6 over 52 weeks. Discussions have been ongoing with the service in regards to outsourcing to University Hospital North Midlands and plans are being progressed to agree the patient cohort with a view to commence in March 2020

SBUHB position improved in December with 28 patients waiting over 26 weeks, 8 patients over 36 weeks and 0 over 52 weeks. HMRC pension issue continue to impact on the availability of anaesthetic staff.

Plastic Surgery: Patients continue to breach maximum waiting times for hand and breast surgery at SBUHB. In December, there were 268 patients waiting in excess of 36 weeks, 94 of whom were waiting in excess of 52 weeks. Both rooms in the Plastic Surgery Treatment Centre are now operational, averaging the expected 3 cases per room per list. This is providing increased day case capacity and supporting an increase in throughput, treating cases under local anaesthetic which are currently being undertaken in theatre.

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 September, it was agreed to assess the service against the expected turnaround time targets until these are published. Indicative data against the new targets has been received and further validation is currently taking place.

PET: There were 87 breaches at PETIC in December, and 13 breaches at BCUHB PET.

Paediatric Surgery: The end of December position was 53 patients waiting over 36 weeks. There were capacity issues early in the financial year, due to two consultant vacancies, impacting on waiting list times more significantly than expected. The Health Boards reported position is zero breaches > 36 weeks by 31st March 2020 and a robust recovery plan is in place to achieve this target. Bi-monthly meetings continue to be held with the service until it is consistently meeting the 36 week RTT target.

Paediatric Intensive Care Unit: The service has confirmed that the 7th bed has opened. Bi monthly meetings are continuing to be held with the service as the service is still in escalation level 2.

Bariatric Surgery: SBUHB reported 35 patients in the total waiting list cohort; SBUHB reported <5 patients waiting over 26 weeks and <5 patients waiting over 36 weeks for December.

Neurosurgery: The C&VUHB service reported that there were zero patients waiting over 36 weeks at the end of December and 45 patients waiting over 26 weeks.

IVF: Delivery against the 26 week 1st outpatient appointment standard is being achieved by all centres except Liverpool.

Thoracic Surgery: In December there were no breaches of the 36 week target at either CVUHB or SBUHB. WHSSC continues to hold performance meetings with both south Wales providers on a bi-monthly basis.

CAMHS: CAMHS Out of Area (OoA) performance is much improved and has been consistently below target for an extended period. Part of the improvement is due to increase in capacity at the North Wales unit that is now working at its full commissioned capacity (subject to acuity levels) following successful recruitment. Ty Llidiard has continued to experience some short term pressure on new OoA referrals due to restrictions on admissions linked to delayed discharges. The environment works have now been completed and unit is back operating in line with policy. Despite this the total number of OoA placements at the end of December (11) remains comfortably below the target (14). A new inpatient service specification is due for publication imminently and will be followed by a review of gatekeeping arrangements.

Adult Medium Secure: 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.
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.

2.1 Services Achieving Targets

ALAS: As of the end of December all services within Wales are complying with the waiting list targets for adult and paediatric wheelchairs.

Cochlear and BAHA: There has been a temporary suspension of the cochlear services in CTM UHB which has been made by the commissioner, as a result of staffing shortfalls. There have been a series of discussions between the CTM and Cardiff and Vale UHB regarding the future short and medium term delivery plan for the service. The surgical plan for the delivery of the 26 week RTT target across the South Wales programme is being progressed Cardiff and Vale and a robust plan is in place. The service have provided assurances that there are two be zero breaches for both adult and paediatrics by the 31st of March 2020.

3. Services Dashboard

Specialty	Measure		Tolerance Levels Red	Amber	Green	Oct-19	Nov-19	Dec-19	Latest Status	Latest Trend
Cardiac Surgery	Mthly	RTT < 36 weeks	<100%	N/A	100%	94%	92%	93%		⇧
Thoracic Surgery	Mthly		<100%	N/A	100%	98%	98%	100%		⇧
Bariatric Surgery	Mthly		<100%	N/A	100%	100%	100%	96%		⇩
Plastic Surgery	Mthly		<100%	N/A	100%	92%	92%	91%		⇩
Neurosurgery	Mthly		<100%	N/A	100%	99%	99%	100%		⇧
Paediatric Surgery	Mthly		<100%	N/A	100%	98%	97%	97%		⇨
Cardiac Surgery	Mthly	RTT < 26 weeks	<95%	N/A	>=95%	81%	77%	79%		⇧
Thoracic Surgery	Mthly		<95%	N/A	>=95%	90%	93%	94%		⇧
Bariatric Surgery	Mthly		<95%	N/A	>=95%	93%	88%	80%		⇩
Plastic Surgery	Mthly		<95%	N/A	>=95%	84%	83%	82%		⇩
Neurosurgery	Mthly		<95%	N/A	>=95%	92%	95%	93%		⇩
Paediatric Surgery	Mthly		<95%	N/A	>=95%	84%	87%	89%		⇧
Adult Posture & Mobility	Mthly		<85% within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	95%	95%	95%		⇨
Paediatric Posture & Mobility	Mthly		<85% within 26 weeks	85-89% within 26 weeks	=,>90% within 26 weeks	97%	96%	96%		⇨
Adult Cochlear Implants	Mthly		<95% within 26 weeks	N/A	>=95% within 26 weeks	49%	55%	55%		⇨
Paediatric Cochlear Implants	Mthly		<95% within 26 weeks	N/A	>=95% within 26 weeks	40%	50%	50%		⇨
Lung Cancer	Mthly	USC lung resection < 62 days	>0	N/A	0	<5	<5			⇨
Lung Cancer	Mthly	NUSC lung resection < 31 days	>0	N/A	0	<5	<5			⇧
Cancer patients - PET scans	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	-	71%	66%		⇩
CAMHS	Mthly	OOA placements	>16	>14, <16	=,<14	9	11	11		⇨
CAMHS	Mthly	NHS Beddays	<85%,>105%	< 90%, >100%	90% - 100%	65%	79%	67%		⇩
CAMHS	Mthly	NHS Home Leave	<20%, >40%	<25%, >35%	25%-35%	27%	23%	35%		⇧
Adult Medium Secure	Mthly	NHS Beddays	<90%, >110%	< 95%, >105%	95% - 105%	99%	96%	100%		⇧
IVF	Mthly	IVF patients waiting for OPA	<95% within 26 weeks	95%-99% within 26 weeks	100% within 26 weeks	99%	99%	99%		⇨
IVF	Mthly	IVF patients waiting to commence treatment	<95% within 10 weeks	95%-99% within 10 weeks	100% within 10 weeks	52%	51%	64%		⇧
IVF	Mthly	IVF patients accepted for 2nd cycle waiting to commence treatment	<95% within 10 weeks	95%-99% within 10 weeks	100% within 10 weeks	60%	64%	49%		⇩

E01: CARDIAC SURGERY

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

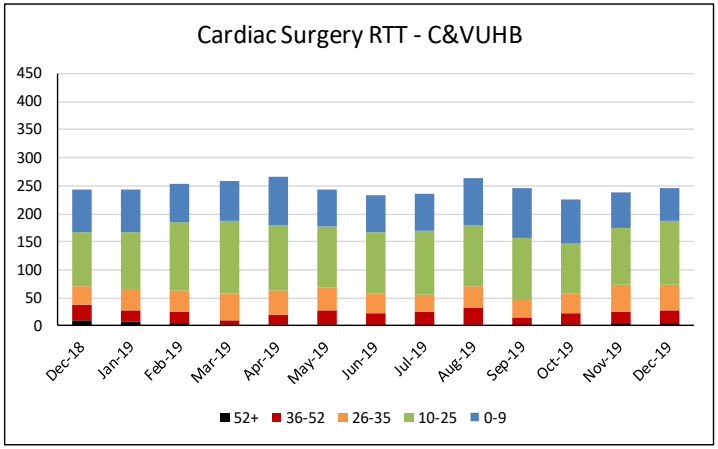
Current Trend – RTT Performance

C&VUHB:

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
C&VUHB	Cardiac surgery patients to be waiting < 26 weeks	75%	69%	70%	⇧

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
C&VUHB	Cardiac surgery patients to be waiting < 36 weeks	90%	89%	88%	⇩

C&VUHB Cardiac Surgery Waiting list analysis:



Residing LHB Split December >36 cohort:

Residing LHB	C&VUHB >36 week breaches
Swansea Bay University Local Health Board	0
Aneurin Bevan Local Health Board	12
Betsi Cadwaladr University Local Health Board	0
Cardiff and Vale University Local Health Board	7
Cwm Taf Morgannwg Local Health Board	9
Hywel Dda Local Health Board	0
Powys Teaching Local Health Board	<5

Current Performance

The total patient cohort has stabilised but the increase in the stage 4 cohort has risen incrementally over the last 4 months.

The cardiac surgery activity at C&VUHB continues to underperform against planned contracted activity.

C&VUHB continue to report late referrals to cardiac surgery from cardiology, scrub staff and pressures on ITU beds as the main areas impacting on performance. HMRC issues continue to impact due to a reduced availability of consultant anaesthetic and surgical staff to backfill lists.

What actions are WHSSC taking?

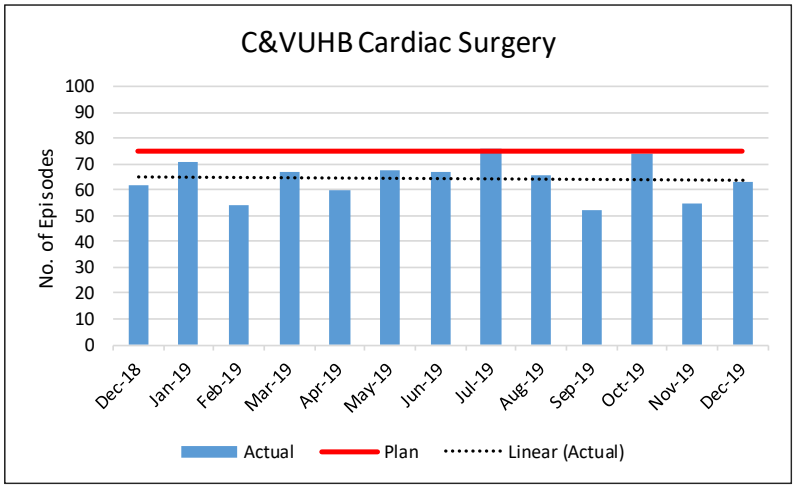
C&VUHB:

- Continued enhanced monitoring of the service with monthly submission of waiting list profile and activity performance against the weekly delivery plan.
- Continued monthly executive level performance management meetings for C&VUHB in line with stage 3 of the escalation process.
- Outsourcing to other centres is being scoped with a plan being discussed with Stoke.

What are the main areas of risk?

C&VUHB:

- Theatre staff capacity (nurses and ODAs).
- 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.

C&VUHB activity: 	The activity at C&VUHB illustrates that there is significant under performance against the profile. The 12 month trend shows a slight decrease in activity throughout the year. Elective and Non-Elective split is not available at present.

E01 (cont'd): CARDIAC SURGERY

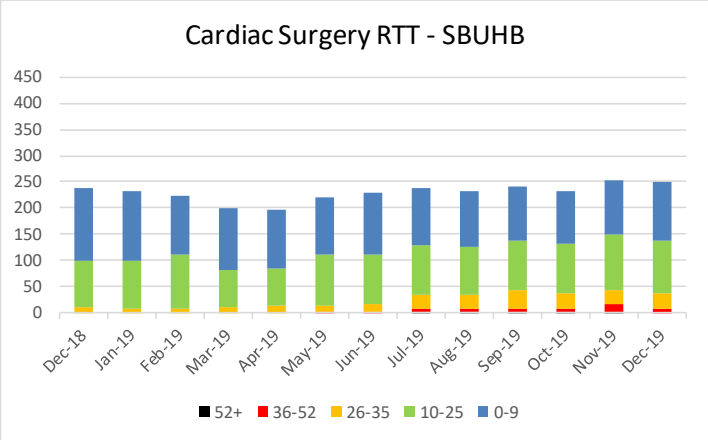
Provider(s): SBUHB

Current Trend – RTT Performance

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
SBUHB	Cardiac surgery patients to be waiting < 26 weeks	84%	83%	86%	⇧

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
SBUHB	Cardiac surgery patients to be waiting < 36 weeks	97%	94%	97%	⇧

SBUHB Cardiac Surgery Waiting list analysis:



Residing LHB Split December >36 cohort:

Residing LHB	SBUHB >36 week breaches
Swansea Bay University Local Health Board	5
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	<5
Powys Teaching Local Health Board	0

Current Performance

SBUHB total patient cohort remain relatively static over the last 6 months. A reduction in the number of breaches was seen in December.

SBUHB are currently below planned activity.

What actions are WHSSC taking?

SBUHB:

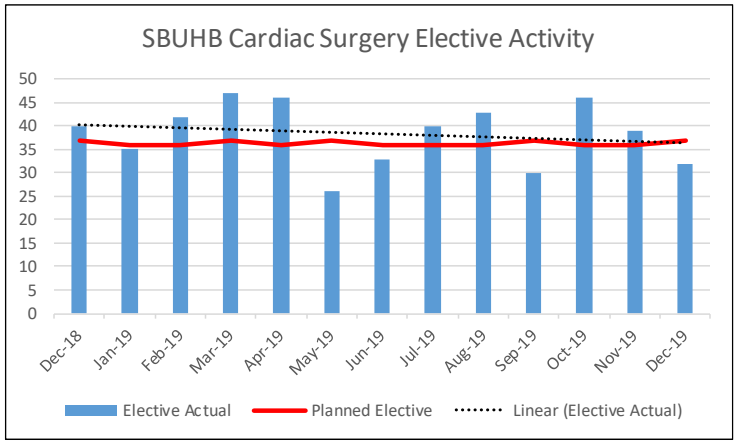
- Continued enhanced monitoring of the service with monthly submission of waiting list profile and activity performance against the weekly delivery plan.
- Continued bi-monthly executive level performance management meetings.
- WHSSC have received a delivery plan to reach a 0 breach position by end of March 2020.

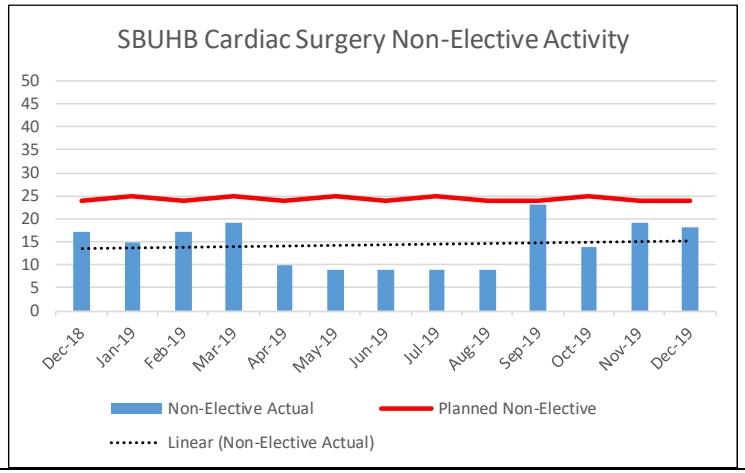
What are the main areas of risk?

SBUHB:

- Key constraints to delivery: consultant anaesthetic capacity and theatre staff capacity (nurses).
- Understated waiting times due to missing Pathway Start Dates

SBUHB activity:





The activity at SBUHB illustrates that within the last 6 months there is significant under performance against the profile. The 12 month trend shows a decrease in elective activity through the year. Non-elective activity is lower than what has been profiled.

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	Oct-19	Nov-19	Dec-19	Latest Movements
SBUHB	Plastic surgery patients to be waiting < 26 weeks	83%	82%	81%	↓
Birmingham Children's	Plastic surgery patients to be waiting < 26 weeks	71%	67%		↓
Royal Free	Plastic surgery patients to be waiting < 26 weeks	-	-		
Wye Valley	Plastic surgery patients to be waiting < 26 weeks	80%	83%		↑
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	100%	100%		→
North Midlands	Plastic surgery patients to be waiting < 26 weeks	100%	100%		→
UH Birmingham	Plastic surgery patients to be waiting < 26 weeks	100%	89%		↓

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
SBUHB	Plastic surgery patients to be waiting < 36 weeks	91%	91%	90%	↓
Birmingham Children's	Plastic surgery patients to be waiting < 36 weeks	86%	83%		↓
Royal Free	Plastic surgery patients to be waiting < 36 weeks	-	-		
Wye Valley	Plastic surgery patients to be waiting < 36 weeks	80%	83%		↑
St Helens	Plastic surgery patients to be waiting < 36 weeks	100%	100%		→
Alder Hey	Plastic surgery patients to be waiting < 36 weeks	100%	100%		→
Manchester	Plastic surgery patients to be waiting < 36 weeks	100%	100%		→
North Midlands	Plastic surgery patients to be waiting < 36 weeks	100%	100%		→
UH Birmingham	Plastic surgery patients to be waiting < 36 weeks	100%	100%		→

Current Performance

The waiting list at SBUHB has decreased between November and December, with 2838 waiting in November and 2777 in December. The number of over 36 week breaches has increased slightly to 268 of whom 94 have been waiting in excess of 52 weeks.

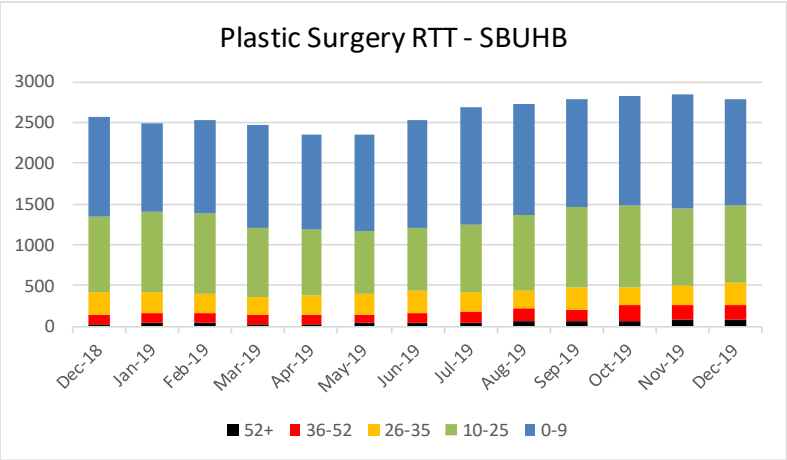
What actions is WHSSC taking?

- Performance meetings between WHSSC and SBUHB are in place.
- Review of patients waiting more than36 weeks to identify the patient impact and risks associated with the long waiting times to inform priorities for treatment.

What are the main areas of risk?

- Hand and breast surgery, although hand is improving with the appointment of a locum.
- Minimal scope for catch up if the delivery plan for hand and breast surgery falls behind for any reason.

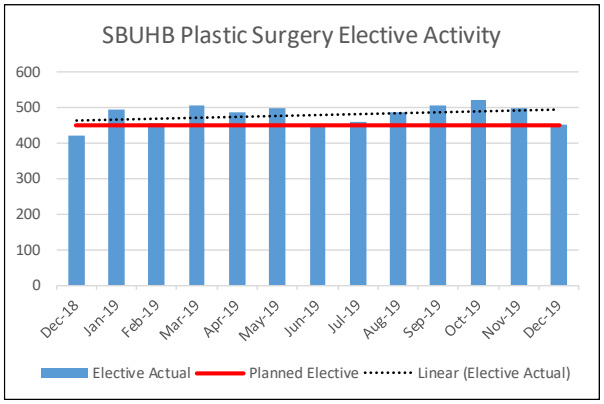
SBUHB Plastic Surgery Waiting list breakdown by times:

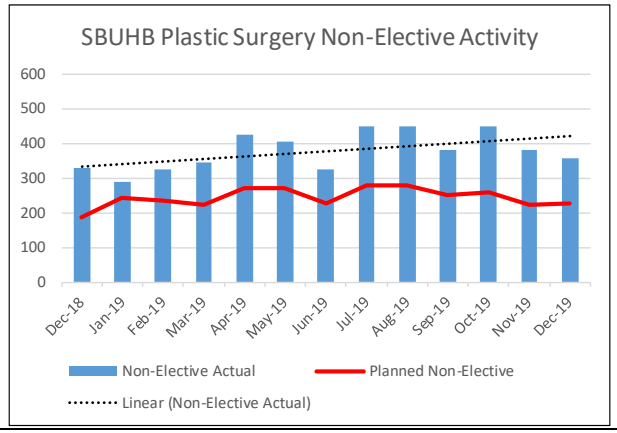


Residing LHB Split December/November >36 cohort:

Residing LHB	SBUHB >36 week breaches	Birmingham Womens and Childrens >36 week breaches (November)	St Helen's & Knowsley >36 week breaches (November)	Manchester >36 week breaches (November)
Swansea Bay University Local Health Board	93	0	0	0
Aneurin Bevan Local Health Board	58	0	0	0
Betsi Cadwaladr University Local Health Board	<5	0	<5	0
Cardiff and Vale University Local Health Board	48	0	0	0
Cwm Taf Morgannwg Local Health Board	24	0	0	0
Hywel Dda Local Health Board	37	<5	0	0
Powys Teaching Local Health Board	6	0	0	0

SBUHB activity:





E02D: THORACIC SURGERY – PRIMARY LUNG CANCER - URGENT SUSPECTED CANCER (USC)	
Provider(s): CVUHB, SBUHB, LHCH	
Current Trend – Cancer Pathway Performance	**Current Performance**
	Validated Cancer Breach Reporting: (**Data provided by Welsh Government. Available to November)**. There was <5 USC breaches attributed to surgical delays at SBUHB during November. Within the last 12 months the South West has seen <5 breaches each month, whilst in the South East breaches has exceeded 5 once.
	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	**Current Performance**
	Validated Cancer Breach Reporting: **(Data provided by Welsh Government. Available to November.)** There were <5 NUSC breaches attributed to surgical delays reported in November at CVUHB. In both regions, within the last 12 months, breaches have been <5 each month.
	What actions is WHSSC taking?
	• Bi-monthly thoracic surgery performance meetings with SBUHB and CVUHB. • Data submissions: WHSSC does not have direct access to cancer breach data and has encountered difficulties at times with timely access to this information. We are currently exploring options to improve the reliability of the submission to us of cancer performance data.
	What are the main areas of risk?
	• Having sufficient capacity to sustainably manage demand and fluctuations in referrals to maintain achievement of targets.

E04: PET SCANS – CANCER PATIENTS

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

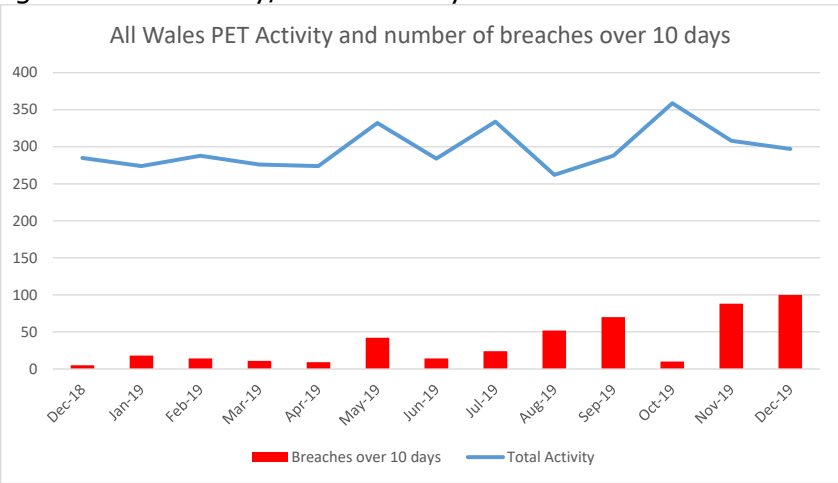
Current Trend – Activity

No PETIC data for October

All provider for Welsh patients:

Provider	Measure	Oct-19	Nov-19	Dec-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		70%	62%	↓
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	86%	76%	81%	↑

Aggregated PET Activity/Breach analysis:



Residing LHB Split December >10 days:

Residing LHB	PETIC >10 days	BCUHB >10 days
Swansea Bay University Local Health Board	Breach Breakdown not provided	0
Aneurin Bevan Local Health Board		0
Betsi Cadwaladr University Local Health Board		13
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

There were 13 breaches at BCUHB in December. A total of 70 scans were performed which meant that 81% were treated within target.

There were 87 breaches at PETIC in December.

What actions is WHSSC taking?

Additional capacity is being commissioned via a mobile unit to address immediate capacity constraints to ensure patients are scanned in a timely way. The service has also moved to 4 extended days to maximise throughput and Saturday scanning sessions have been arranged throughout January.

What are the main areas of risk?

The current south Wales service has now reached capacity. 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 development of a PET strategy.

E12: PAEDIATRIC SURGERY

Provider(s): CVUHB; Alder Hey

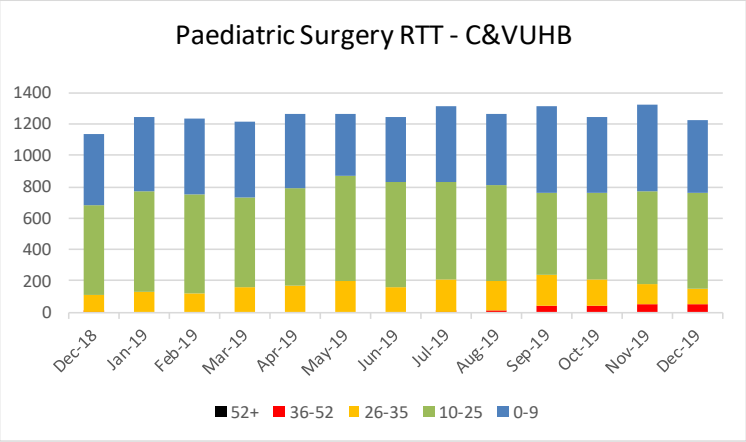
Current Trend – RTT Performance

All provider for Welsh patients:

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
C&VUHB	Paediatric surgery patients to be waiting < 26 weeks	83%	86%	88%	↑
Alder Hey	Paediatric surgery patients to be waiting < 26 weeks	100%	100%		→
Birmingham Children's	Paediatric surgery patients to be waiting < 26 weeks	100%	100%		→
UH Bristol	Paediatric surgery patients to be waiting < 26 weeks	86%	93%		↑

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
C&VUHB	Paediatric surgery patients to be waiting < 36 weeks	97%	96%	96%	→
Alder Hey	Paediatric surgery patients to be waiting < 36 weeks	100%	100%		→
Birmingham Children's	Paediatric surgery patients to be waiting < 36 weeks	100%	100%		→
UH Bristol	Paediatric surgery patients to be waiting < 36 weeks	100%	100%		→

CVUHB Paediatric Surgery Waiting list analysis:



Current Performance

The end of December position for C&VUHB was 53 patients waiting over 36 weeks and zero breaches over 52 weeks. There have been continuing difficulties with achieving a zero breach position due to capacity issues early in the financial year, due to two consultant vacancies. The Health Board's reported position is zero breaches > 36 weeks by 31st March 2020 and a robust recovery plan is in place to achieve this target.

The Cardiff service reported an over performance on the contract due to an increase in the number of emergency cases. When comparing FCE's by point of delivery it identified that emergency cases for the first six months of 2019/20 compared to the same period in the previous year had increased by 20%. This increase could be attributed to the establishment of the Children's Acute Theatre, whereas previously cases would need to be accommodated in the main hospital theatre suite with adults. Analysis of the contract variation has been requested from the service.

All English providers were achieving 36 week RTT target.

What actions are WHSSC taking?

- Bi-monthly level performance meetings with CVUHB will continue until the 36 week target is consistently being achieved and there are no other service issues to report.

What are the main areas of risk?

- As with many other services, the lack of additional lists being staffed by Consultant Anaesthetists due to the changes in their contract is an area of risk.

E03: BARIATRIC SURGERY

Provider(s): SBUHB; Salford Royal

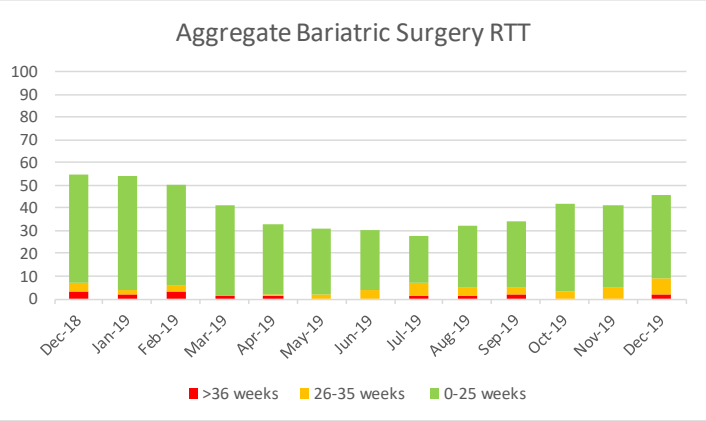
Current Trend – RTT Performance

All provider for Welsh patients:

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
SBUHB	Bariatric surgery patients to be waiting < 26 weeks	93%	89%	83%	↓
Salford Royal	Bariatric surgery patients to be waiting < 26 weeks	92%	85%	73%	↓

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
SBUHB	Bariatric surgery patients to be waiting < 36 weeks	100%	100%	94%	↓
Salford Royal	Bariatric surgery patients to be waiting < 36 weeks	100%	100%	100%	→

Aggregated Waiting list analysis:



Current Performance

SBUHB reported 35 patients in the total waiting list cohort; SBUHB reported <5 patients waiting over 26 weeks and <5 patients waiting over 36 weeks for December.

Salford have 11 patients in the total waiting list cohort for December. The reported position for December was <5 patients waiting over 26 weeks with 0 over 36 weeks.

What actions are WHSSC taking?

SBUHB

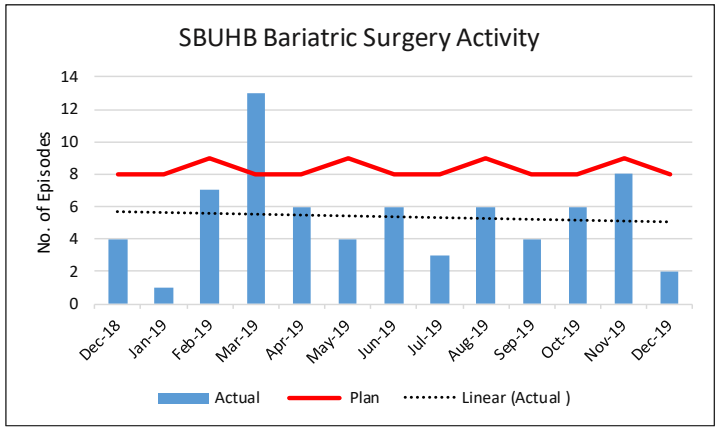
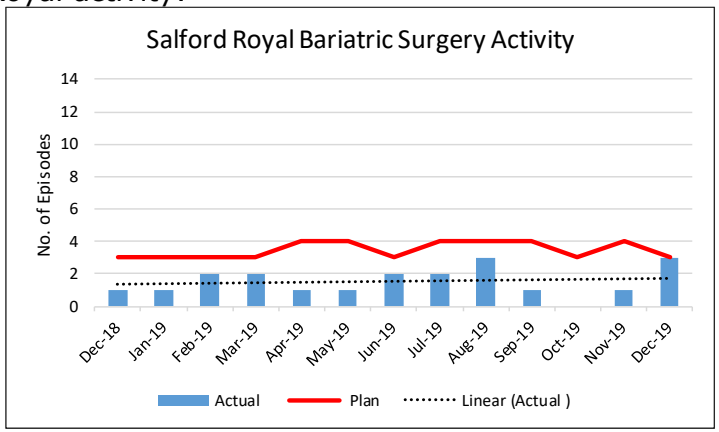
Monthly monitoring of RTT and dialogue with the WIMOS

Salford

There has been an improvement in waiting times at Salford following a small number of breaches over the last year following resolution of staffing issues. Regular contact is maintained with Salford team.

What are the main areas of risk?

Low levels of patient referrals for bariatric surgery to meet the commissioning intentions and contracting arrangements.

Current Trend – Activity	Current Performance
SBUHB activity:  	The activity at SBUHB illustrates that there is under performance against the profile. The 12 month trend shows a decrease in activity through the year but overall remains under profile
Salford Royal activity:  	The activity at Salford also illustrates that there is under performance against the profile. The 12 month trend shows a decrease in activity through the year.

E07: NEUROSURGERY

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

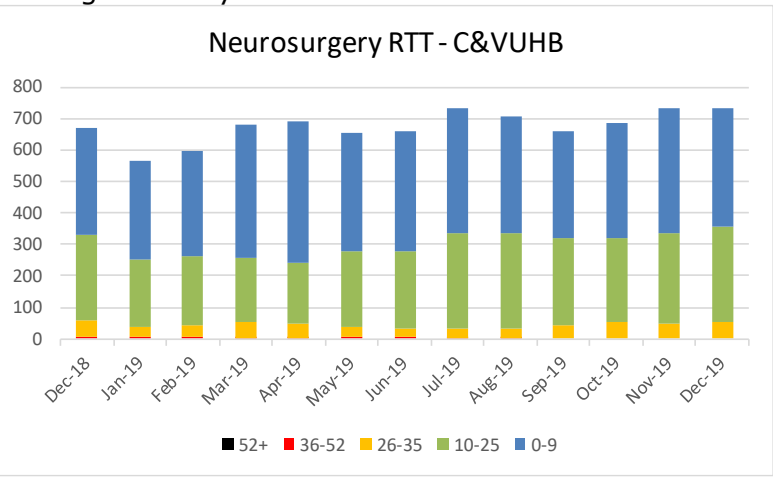
Current Trend – RTT Performance

All provider for Welsh patients:

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
C&VUHB	Neurosurgery patients to be waiting < 26 weeks	92%	94%	92%	↓
UH Birm	Neurosurgery patients to be waiting < 26 weeks	90%	92%		↑
The Walton	Neurosurgery patients to be waiting < 26 weeks	98%	99%		↑
North Midlands	Neurosurgery patients to be waiting < 26 weeks	100%	100%		→
Alder Hey	Neurosurgery patients to be waiting < 26 weeks	100%	100%		→

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
C&VUHB	Neurosurgery patients to be waiting < 36 weeks	100%	100%	100%	→
UH Birm	Neurosurgery patients to be waiting < 36 weeks	95%	95%		→
The Walton	Neurosurgery patients to be waiting < 36 weeks	100%	100%		→
North Midlands	Neurosurgery patients to be waiting < 36 weeks	100%	100%		→
Alder Hey	Neurosurgery patients to be waiting < 36 weeks	100%	100%		→

C&VUHB Waiting list analysis:



Current Performance

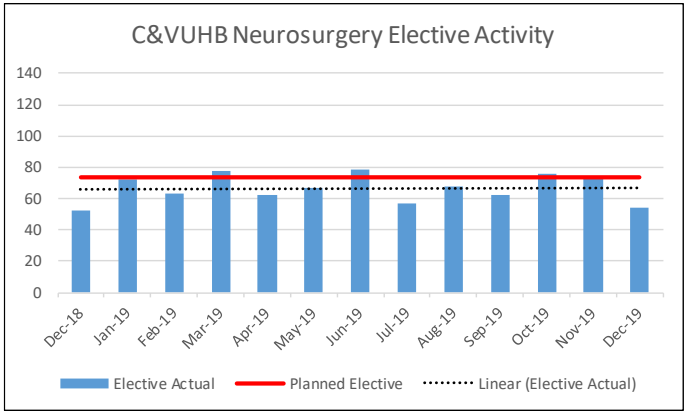
The service reported that there were zero patients waiting over 36 weeks at the end of December and 45 patients waiting over 26 weeks. The table below shows the spread of patients waiting across each Health Board.

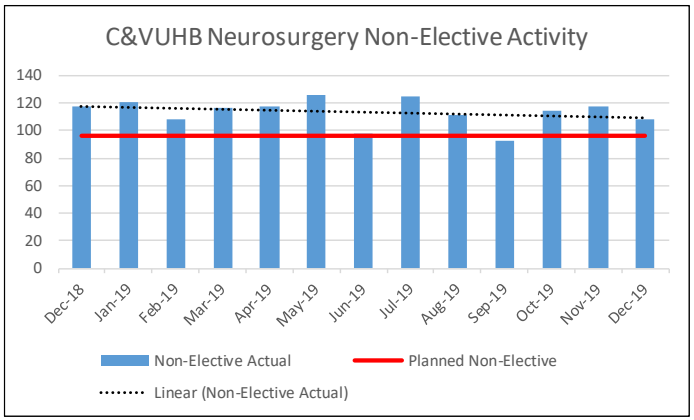
Health Board	26 Week breaches
ABUHB	5
Swansea Bay	12
C&V UHB	11
Cwm Taf Morgannwg HB	8
Hywel Dda	8
Powys	<5

There were 20 operations cancelled in December in Cardiff and Vale UHB. Most of the cancellations were as a result of an emergency patient being admitted the night before and the majority of patients were from two Health Boards; CTM and Cardiff and Vale UHB.

Emergency activity continues to over perform against the contract baseline with the theatre utilisation performing 15% below the performance target of 84%. This will be further discussed at the next performance meeting with the service.

UH Birmingham have 2 patients waiting in excess of 26 weeks.





What actions are WHSSC taking?

- Bi-monthly meetings with the service until the service is consistently meeting the RTT targets.

What are the main areas of risk?

Neurosurgery C&V UHB

- 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.

Activity

Performance against the LTA shows that Cardiff continues to underperform against elective and over-perform against emergency surgery. WHSSC are still looking to introduce a case-mix contract in the near future. Elective and Non-Elective split is not available at present.

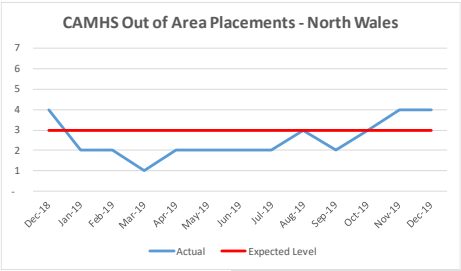
E07: NEURORADIOLOGY, NEURO-REHABILITATION AND NEUROPSYCHIATRY	
Provider(s): South Wales – CVUHB; North Wales – University Hospital of Birmingham, The Walton; Powys – CVUHB, UHB, Walton	
Current performance At the end of December there were 24 patients awaiting a date for embolization and 37 waiting for angiogram. There is an increase in the number of patients awaiting angiograms due to a change in protocol which is seeing a daycase bed required for the procedure which previously was not requested. The reasons for this change in protocol are being discussed with the service. **Actions being taken** Weekly Neuroradiology performance reports are sent to WHSSC from the Directorate to advise on waiting times and any patients that were required to be outsourced. **Risks to the service** • The service remains fragile although a second Consultant took up post in October. The optimum number of Consultants for the service is three but recruitment remains a challenge due to the limited number of Interventional Neuro Radiology trainees.	**Neuro-rehabilitation** Repatriation of patients from Neurosurgery, UHW to Health Boards and Rehabilitation Delayed Discharges from Specialised Centres to LHBs available on request. **Neuropsychiatry** WHSSC are continuing to work with the Neuropsychiatry team to improve discharge times and access into the service. An Acuity tool (PCAT) has recently been introduced into the service to determine the complexity of patient need and progress of rehabilitation to support this process.

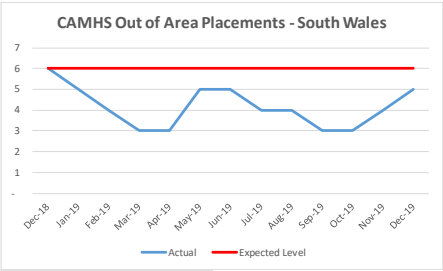
E10: CAMHS - NHS & OUT OF AREA (OoA)

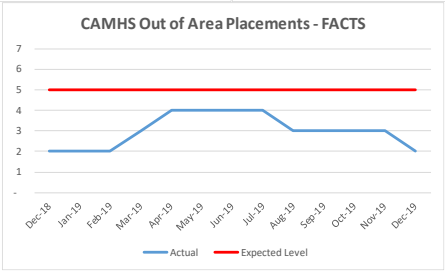
Provider(s): Cwm Taf UHB; BCUHB

Current Trend – Activity

September OoA placement trends by area:







NHS CAMHS Beddays as a percentage against planned:

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
Cwm Taf	CAMHS NHS Beddays - South	77%	90%	66%	↓
Cwm Taf	CAMHS NHS Home Leave - South	31%	24%	43%	↑
BCUHB	CAMHS NHS Beddays - North	53%	69%	68%	↓
BCUHB	CAMHS NHS Home Leave - North	21%	22%	22%	→

Current Performance

OoA performance has been stable below target for an extended period and at end December there were 11 out of area placements. Of these 11 placements <5 patients are FACTS (all South) and 9 are CAMHS patients.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 escalation level of the BCU service is being reviewed with view to reducing current Level 3 mark. 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. The environment works identified by QAIS have been completed and the unit is back operating in line with policy. New service specification will be discussed with provider LHBs with view to introducing from April 20 for existing services. Progress continues to be monitored through the escalation arrangements.

What are the main areas of risk?

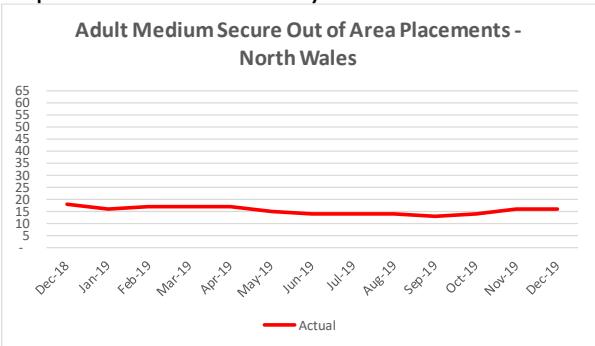
- Financial risk to all South Wales LHBs if OoA placements increase significantly due to restricted admissions. BCU stand own risk with different risk share arrangements.
- Clinical impact on patients and families being placed so far away from home area and/or outside Wales.

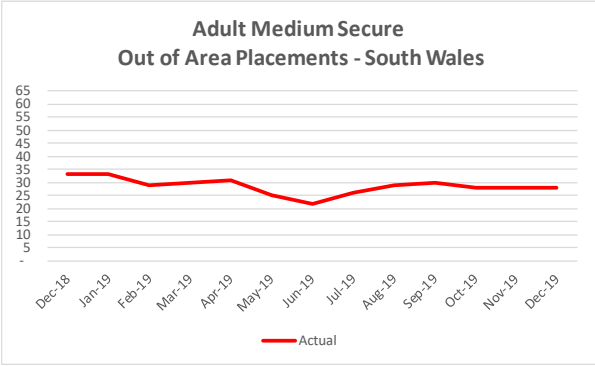
E11: ADULT MEDIUM SECURE - NHS & OUT OF AREA (OoA)

Provider(s): BCUHB; SBUHB

Current Trend – Activity

December OoA placement trends by area:





NHS MS Beddays as a percentage against planned:

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
North	Adult Medium Secure NHS Beddays - Ty Llywelyn	102%	95%	97%	⇧
South	Adult Medium Secure NHS Beddays - Caswell Clinic	92%	96%	102%	⇧

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 been established.

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 appropriate 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.

E13: IVF

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

Current Trend – RTT Performance

All providers for Welsh patients:

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
WFI Neath	IVF patients waiting for Outpatient Appointment	100%	100%	100%	→
WFI Neath	IVF patients waiting to commence treatment	68%	70%	70%	→
WFI Neath	IVF patients accepted for 2nd cycle waiting to commence treatment	57%	63%	79%	↑
WFI Cardiff	IVF patients waiting for Outpatient Appointment	100%	100%	99%	↓
WFI Cardiff	IVF patients waiting to commence treatment	64%	56%	65%	↑
WFI Cardiff	IVF patients accepted for 2nd cycle waiting to commence treatment	50%	70%	83%	↑
Liverpool	IVF patients waiting for Outpatient Appointment	43%	75%	100%	↑
Liverpool	IVF patients waiting to commence treatment	21%	21%	46%	↑
Liverpool	IVF patients accepted for 2nd cycle waiting to commence treatment	25%	25%	100%	↑
Shrewsbury	IVF patients waiting for Outpatient Appointment	100%	100%	100%	→
Shrewsbury	IVF patients waiting to commence treatment	100%	100%	88%	↓
Shrewsbury	IVF patients accepted for 2nd cycle waiting to commence treatment	74%	70%	8%	↓

What are the main areas of risk?

Over performance on the Shrewsbury contract which led to a number of submissions for Prior Approval during the third quarter of the financial year. Discussions in December looked to establish the reason for the over performance and what actions the service were taking to control activity levels.
Demand capacity plan requested.

There were a number of staffing recruitment issues, which the WFI service has had to manage during the early part of 2019/20.

Current Performance

Delivery against the 26 week 1st outpatient appointment standard is being achieved by all centres except Liverpool. Liverpool women's hospital have two issues for patients waiting for MESA/TESA/PESA. The surgeon has been on long term sick; although he has now returned to work, the absence caused a backlog of patients on the waiting list. The second issue is unsuitable provision of accommodation for male patients requiring treatment. The Liverpool service are considering alternative accommodation arrangements.

There was a significant underperformance on the WFI contract as a result of medical staff sickness early in the financial year. There was however good performance on FET's and cryopreservation.

What actions are WHSSC taking?

WHSSC met with the Shrewsbury provider in December and has arranged to meet again in March to further discuss the activity and financial performance of their contract. Referrals are currently being directed to Liverpool to manage waiting times and to ensure equity of waiting time to patients. A formal demand and capacity return has been requested in order to make an informed discussion on when referrals can be accepted by the Shrewsbury provider.

E02: THORACIC SURGERY

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

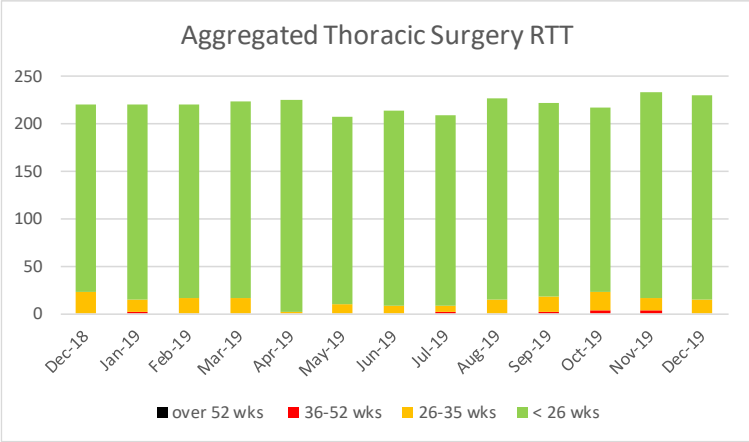
Current Trend – RTT Performance

All provider for Welsh patients:

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
C&VUHB	Thoracic surgery patients to be waiting < 26 weeks	93%	96%	97%	↑
SBUHB	Thoracic surgery patients to be waiting < 26 weeks	89%	88%	89%	↑
LHCH	Thoracic surgery patients to be waiting < 26 weeks	67%	100%	89%	↓

Provider	Measure	Oct-19	Nov-19	Dec-19	Latest Movements
C&VUHB	Thoracic surgery patients to be waiting < 36 weeks	97%	99%	100%	↑
SBUHB	Thoracic surgery patients to be waiting < 36 weeks	100%	98%	100%	↑
LHCH	Thoracic surgery patients to be waiting < 36 weeks	92%	100%	100%	→

Aggregated Thoracic Surgery Waiting list analysis:



Current Performance

At CVUHB in December there were no patients waiting over 36 weeks and 5 patients waiting over 26 weeks.

The waiting list at SBUHB remains stable; there are no patients waiting over 36 weeks and 8 patients waiting longer than 26 weeks.

LHCH has <5 patient waiting over 26 weeks.

What actions is WHSSC taking?

SBUHB:

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

CVUHB:

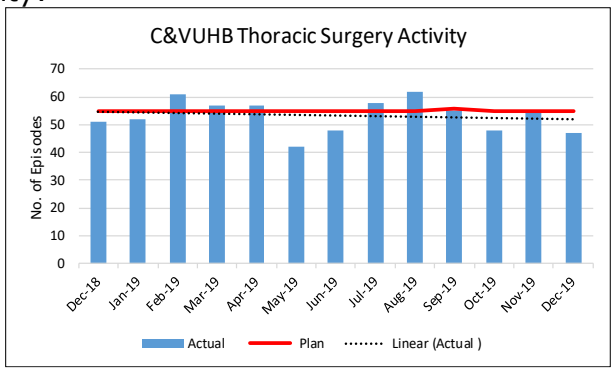
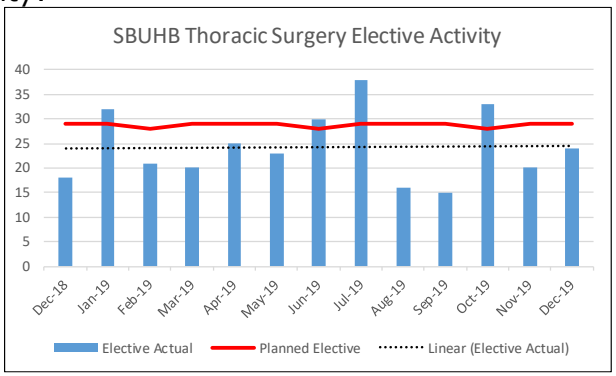
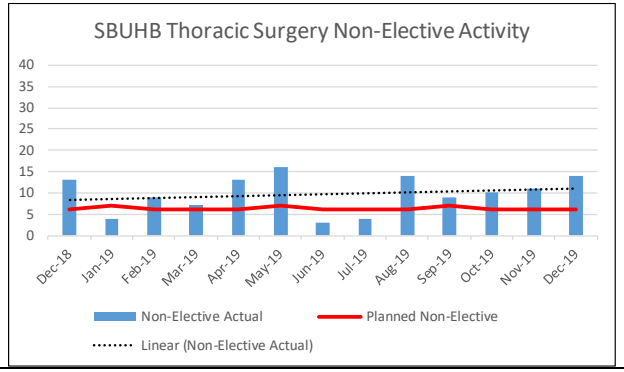
- Bi-monthly performance meetings remain in place.

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.

E02: THORACIC SURGERY (cont'd)

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

Current Trend – Activity	Current Performance
CVUHB activity:  	Overall contract performance is on a slight increasing trend at SBUHB. C&VUHB activity has stabilised. Elective and Non-Elective split is not available at present.
SBUHB activity:   	Activity at SBUHB shows an underperformance against the baseline for elective activity and an over performance for non-elective activity.

Link to Healthcare Objectives	
Strategic Objective(s)	Governance and Assurance Implementation of the Plan Choose an item.
Link to Integrated Commissioning Plan	Effective performance management is an integral part of the WHSSC ICP.
Health and Care Standards	Governance, Leadership and Accountability Choose an item. Choose an item.
Principles of Prudent Healthcare	Reduce inappropriate variation Choose an item. Choose an item.
Institute for HealthCare Improvement Triple Aim	Improving Patient Experience (including quality and Satisfaction) Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	The report will monitor quality, safety and patient experience.
Resources Implications	There are no resource implications within this report.
Risk and Assurance	Risks due to poor performance of services are highlighted within this report.
Evidence Base	The performance information in this paper is taken from NWIS, and the individual providers
Equality and Diversity	There are no direct equality and diversity issues reported in this paper.
Population Health	The core objective of the report is to improve population heath through the availability of data to monitor the performance of specialised services.
Legal Implications	There are no legal implications relating to this report.

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

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

		Agenda Item	3.2
Meeting Title	**Joint Committee**	Meeting Date	10/03/2020
Report Title	Financial Performance Report – Month 10 2019/20		
Author (Job title)	Finance Manager - Contracting		
Executive Lead (Job title)	Director of Finance	Public / In Committee	Choose an item.

Purpose	The purpose of this report is to set out the financial position for WHSSC for the 10th month of 2019/20. 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	Choose an item.	Meeting Date	Click here to enter a date.
Recommendation(s)	Members are asked to: • **Note** the current financial position and forecast year-end position.		

Considerations within the report (tick as appropriate)

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

1. SITUATION

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

This report will be shared with WHSSC Management Group on 20 February and Joint Committee on 10 March.

2. 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 includes the HRG4+ and 19/20 tariff uplift and the income assumes the additional WG funding issued and 2% allocation uplift due from HBs has been collected. The forecast position assumes year end provider settlements will exclude the CQUIN element that was rolled into the uplift.

3. ASSESSMENT

The financial position reported at Month 10 for WHSSC is a forecast year end under spend of £4,384k.

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. RECOMMENDATIONS

Members of the appropriate Group/Committee are requested to:

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

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

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

Finance Performance Report – Month 10

1. Situation / Purpose of Report

The purpose of this report is to set out the estimated financial position for WHSSC for the 10th month of 2019/20 together with any corrective action required.

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	631,597	526,331	518,940	(7,391)	(2,295)	(4,384)	(1,072)
EASC (WAST, EMRTS, NCCU)	164,724	137,270	137,270	0	0	0	0
Total as per Risk-share tables	796,321	663,601	656,210	(7,391)	(2,295)	(4,384)	(1,072)

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.

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 10 is an underspend of £7,391k year to date with a forecast year end underspend of £4,384k

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 in line with the new cross border agreement.

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	210,718	175,598	178,106	2,508	2,130	4,513	4,389
Swansea Bay University Health Board	99,588	82,990	83,186	196	151	1,371	789
Cwm Taf Morgannwg University Health Board	9,614	8,012	7,517	(494)	(432)	(447)	(361)
Aneurin Bevan Health Board	8,147	6,790	7,026	237	240	266	290
Hywel Dda Health Board	1,581	1,318	1,343	25	24	25	24
Betsi Cadwaladr Univ Health Board Provider	41,049	34,207	33,815	(392)	(311)	(455)	(397)
Velindre NHS Trust	43,193	35,994	37,858	1,864	1,636	2,471	2,194
Sub-total NHS Wales	**413,889**	**344,908**	**348,851**	**3,944**	**3,439**	**7,744**	**6,929**
Non Welsh SLAs	112,958	94,131	94,832	701	568	122	12
IPFR	39,277	32,731	31,691	(1,040)	104	5	713
IVF	4,777	3,981	3,967	(14)	200	161	155
Mental Health	31,656	26,380	25,147	(1,233)	(995)	(1,318)	(1,205)
Renal	4,816	4,013	3,776	(237)	(156)	(209)	(84)
Prior Year developments	2,463	2,053	1,561	(492)	(531)	(586)	(796)
2019/20 Plan Developments	17,918	14,932	13,507	(1,425)	(2,455)	(1,079)	(1,959)
Direct Running Costs	3,843	3,202	3,350	148	157	177	222
Reserves Releases 2018/19	0	0	(7,742)	(7,742)	(5,428)	(9,401)	(7,298)
Phasing adjustment for Developments not yet implemented ** see below	0	0	0	0	0	0	0
Total Expenditure	**631,597**	**526,331**	**518,940**	**(7,391)**	**(5,096)**	**(4,384)**	**(3,312)**

The reported position is based on the following:

- NHS Wales activity – based on Month 9 data or Annual Plan values if deemed to vary from the 2018/19 outturn.
- NHS England activity – based on Month 9 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 9 data have been extrapolated to a total reported month 10 position of £2,508k over spent and a year-end position of £4,513k over spent. These figures include the net effect of the development and savings funding available to the LHB. The position includes the following areas:

- ALAS – the trend of overperformance continues this month with the YTD position deteriorating by £155k to stand at £511k and the forecast moving to a straight line basis of £613k. The majority of this movement YTD is a result of an increase of approx. £60k on powered wheelchairs compared to a SL trend of last month's YTD figure.

- IBD Service Infrastructure – the forecast under spend has increased this month by £66k to stand at £117k which is a result of project slippage on the CIAG monies that were released to the SLA baseline previously. The YTD figure has deteriorated by £95k this month as infrastructure spend on the contracted baseline accelerates towards year end but is still in under spend at £139k.

- BMT – the YTD position has deteriorated further this month by £184k but still remains in an underspending position of £106k with a full year forecast of £16k. This YTD movement is a result of 3 more patients being treated this month and an increase in drug spend.

- ATMPs – the full year forecast underspend for this service has reduced by £70k and now stands at £202k. This is mainly a result of an increase in non pay costs against the investment included in the SLA baseline this year.

- Clinical Immunology – the full year forecast has been reduced by £160k this month due to lower than anticipated spend YTD and also issues with service receiving invoices and data from the provider, Calea. C&V have reviewed all backing schedules and accrual data and they feel a lower forecast is prudent.

- Paeds Oncology – the YTD and forecast positions have deteriorated this month by £28k and £85k respectively and now stand at £309k

and £371k. This should now be a stable position for the service for the year as reporting issues earlier in the year have now been rectified.

- PICU – the YTD position has deteriorated by £59k this month but still stands at £125k under budget. This move was expected as winter pressures start to have an impact upon the service. The forecast underspend has increased by £72k to £270k as a result of increased slippage against the business case additional funding included in the SLA baseline.

- AICU – both YTD and full year forecasts have moved to a £25k underspend to reflect the service credit received from Cardiff and Vale.

- Cystic Fibrosis – the forecast position has moved by £111k and now stands at an under spend of £31k. This is a combination of increased slippage against business case funding and a fall away in spend on new therapy drugs.

- BAHA & Cochlear – the forecast has been increased to £102 over budget this month to reflect the additional cohort of Bridgend patients.

- Lynch Syndrome – this has been included in the figures for the first time this year and is reported as pure overperformance standing at £138k YTD with a full year forecast of £166k.

5.2 NHS Wales – Swansea Bay contract:

Various over and underspends from the month 9 data have been extrapolated to a total reported month 10 position of £196k over spent and a year-end position of £1,371k over spent. These figures include the net effect of the development and savings funding available to the LHB. The position includes the following areas:

- TAVI – the full year forecast has increased by £167k this month and the overperformance stands at £618k. This is the result of the forecast procedure numbers increasing to 122 this month. Performance provision funding also exists for this service.

- Cardiology – activity for this service remains buoyant in line with the trend seen throughout the year with the forecast overspend increasing by £117k to stand at £790k. The majority of the activity increase is accounted for by ICD and ablation activity and an coding lag on angio activity.

- Plastics – the full year forecast for the service has been moved by £200k in order to mirror the YTD position of £300k over budget. The usual winter fall away in activity has not happened this year as the

new treatment centre has increased secondary care capacity thus releasing capacity available for specialist activity.

- NICE Drug spend – this month has seen an increase in the forecast overspend of £85k so it now stands at £162k. This is a result of an increase in actual activity for this service above forecasted levels.

5.3 NHS Wales – Betsi Cadwaladr contract:
The YTD underspend has increased by £80k this month mainly due to lower activity levels in angioplasty. This trend is mirrored in the forecast position which has seen a £59k increase in the underspend for the same reasons quoted above. This figure now stands at an underspend of £455k.

5.4 NHS Wales – Cwm Taf Morgannwg contract:
YTD and full year forecast underspends have grown by £63k and £86k respectively this month and now stand at £494k and £447k. Neonatal activity underperformance has continued the year long trend this month with the underspend increasing by £35k to £506k and CAMHS admissions remain low resulting in a £51k underspend increase to £225k. YTD admissions are 42 with 4 happening in December.

5.5 NHS Wales – Aneurin Bevan contract:
Nothing to note this month.

5.6 NHS Wales – Hywel Dda contract:
Nothing to note this month.

5.7 NHS Wales – Velindre contract:
The YTD and forecast overspends have continued to grow this month, respectively increasing by £228k and £277k to stand at a total of £1,864k YTD and £2,471k forecast. The main reasons for this overspend growth is a £62k increase reported in cancer services and a £173k growth in melanoma pathway drugs reported by the provider.

5.8 NHS England contracts:
Total £701k overspend to month 10 with the full year forecast being reported at a £122k overspend. The English position has been reported either based on an extrapolation of month 9 reported actual data or plan data where actuals have not yet been provided. CQUIN has been removed from the forecast position.

The larger reported movements/variances are:

- Birmingham Women's & Children's – this month has seen an adverse movement of £59k in the forecast position with the total overspend now standing at 157k. The increase this month is mostly a result of a £107k PICU costs in December.

- Manchester University – the YTD and forecast positions have moved adversely this month to overspending positions of £340k and £307k respectively, an increase over last month of approximately £590k. This is the result of £170k of activity that WHSSC are currently disputing with the provider and £488k transfer of service back to Betsi Cadwaladr for non specialist activity. The issue around this is that the provider cannot yet split this activity in the contract monitoring returns so all activity is being reported by WHSSC with a corresponding reduction in the figure BCU will report locally.

- Guy's & St Thomas – the forecast has moved adversely by £192k this month giving a total year end overspend of £347k. The movement is a result of several in month emergencies and two ECMO patients costing £88k.

- King's College – this month has seen a decrease in the reported YTD and forecast positions. They have both moved by £11k and stand at £34k and £38k under spent respectively. This activity increase is mainly a result of a £137k endovascular patient, of which £110k were critical care costs.

- Leeds – both YTD and forecast overspends have grown by £123k this month. This is the result of the inclusion of a BMT patient who is yet to be discharged with forecast costs of £117k.

- Royal Brompton – this month the YTD and forecast under spends have increased once more as activity has been low since month 5 at the trust with no transplants since month 1. Both positions stand at £820k under budget but have the potential to move adversely as the transplant waiting list contains 8 active lung transplant patients and one heart patient.

- University Hospital Bristol – a £464k reduction in the positions this month has meant both YTD and forecast over spend positions falling to currently stand at £131k. The main reason for this is generally low activity at the trust as this data is based upon December activity, with paeds cardiology and PICU falling by around £200k this month.

- University Hospitals Birmingham – the YTD and full year forecast under spends have both decreased by around £130k this month and stand at £131k and £197k respectively. This trust has reported generally low activity over the past several months with the exception of last month which did buck the trend of underperformance.

- University North Midlands – the forecast overspend has fallen back slightly this month by £60k and now stands at £225k. This is mostly

due to the data being December with the only spend of note being a £20k trauma patient.

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:

A material reduction in both YTD and forecast positions is being reported this month as a result of high cost drug recharges for quarter 3 being substantially reduced. YTD the reported figure is an underspend of £1,040k with the full year forecast of £5k over spend, this represents movement of £1,144k and £708k respectively.

5.10 IVF:

The YTD position has reduced by £214k and moved to an underspending position of £14k. The majority of this YTD movement is a result of 98 cycles lower activity this month due to the 2 week closure of the service over the Christmas period. The forecast position has not moved materially this month.

5.11 Mental Health:

Various budgets totalling an underspend to date of £1,233k, a £238k increase in the underspend from last month and a year-end forecast underspend of £1,318k which is a £113k increase in the underspend from last month's reported figure. These budgets include:

- High Secure has no material movements this month in either YTD or full year forecast positions.

- Adult Mental Health YTD has seen an underspend increase of £134k which is made up of small movements across all reported areas. The forecast position has only moved £11k but this is made up of a £173k deterioration in the medium secure mental health position which is more than fully offset by smaller movement sin all other service areas.

- CAMHS and Eating Disorders has no material movements this month in either YTD or full year forecast positions.

5.12 Renal:

Both YTD and full year forecast underspends have increased this month by £82k and £126k respectively and stand at £237k and £209k. The main driver for this is transplant activity decreases at Royal Liverpool & Broadgreen.

5.13 Reserves:

A release of 18/19 non recurrent structural reserves was made into the position in month 3 totalling £2,927k. A further release relating to 18/19 HRG4+ settlement of £1,493k was released into the month 4 position and at month 6, further releases relating to NHS England contract settlements and IPFR high cost releases totalling £2,328k have been identified. Month 8 has seen a further release of £550k for Mental Health. A further reserve release of £2,103k has been identified at month 10 relating to NHS England contracts. All reserves will be released evenly through the year.

5.14 Developments:

There is a total of £20,381k funded developments in the 2019/20 position, £2,463k of which relates to developments from prior years, £3,726k relates to 2019/20 CIAG Schemes, £6,618k relates to 2019/20 New Specialised Services & Strategic Priorities (month 10 has seen the addition of £1,176k added for Major Trauma Centre) and £1,200k relates to Horizon Scanning. The remaining £6,374k are marginal performance provision for activity within C&V and SB providers.

YTD and full year forecast underspend positions have decreased this month by £784k and £1,090k respectively to currently stand at £1,917k and £1,665k. The key movements accounting for these figures are as follows:

- £200k forecast increase in Asfotase Alfa due to a new patient being identified
- £165k forecast increase on the implementation of genetics test directory
- £75k slippage in ACHD as no business case has yet been submitted
- £67k forecast increase for IBD (BCU provider) as the funding release is due for February
- £75k slippage in neonatal transport
- £468k for provision of excess costs of providing Home TPN

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

There has been no material movement in this area for month 10.

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 M10	(7,391)	(254)	(870)	(424)	(624)	(1,307)	(631)	(3,282)
Variance M9	(5,096)	(55)	(369)	(217)	(135)	(955)	(249)	(3,116)
Movement	(2,295)	(198)	(501)	(207)	(489)	(352)	(382)	(165)

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 M10	(4,384)	478	(188)	317	35	(674)	(679)	(3,674)
EOY forecast M9	(3,312)	475	32	415	308	(535)	(357)	(3,651)
EOY movement	(1,072)	3	(219)	(99)	(273)	(139)	(322)	(23)

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	97,110	80,925	80,924	(4)	6	80,926	(188)
Aneurin Bevan	144,411	120,342	119,994	318	31	120,343	35
Betsi Cadwaladr	180,995	150,829	150,829	(11)	11	150,829	(3,674)
Cardiff and Vale	127,698	106,415	106,194	196	26	106,415	478
Cwm Taf Morgannwg	113,362	94,468	94,468	(7)	7	94,468	317
Hywel Dda	95,069	79,224	79,224	(6)	6	79,224	(674)
Powys	37,675	31,396	31,396	(2)	2	31,396	(679)
Public Health Wales						0	
Velindre						0	
WAST						0	
Total	**796,321**	**663,601**	**663,029**	**484**	**88**	**663,601**	**(4,384)**

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 additional risk and opportunities effecting this financial year are:

- Growth in activity for Velindre Melanoma drugs and ATMP patients above that projected in the IMTP.
- The North Wales Cochlear service risk has been removed from the tables as a paper is being sent to Management Group this month and funding is included in the IMTP for next year.
- An opportunity has been added relating to the excess costs of HPN service provision as a result of the Calea issues. The full cost of this has been included in the risk share tables for month 10 but Welsh Government may provide resource support for the pharmacy element of the incurred costs.

9. Public Sector Payment Compliance

As at month 9 WHSSC has achieved 99.3% compliance for NHS invoices paid within 30 days by value and 94.5% by number.

For non NHS invoices WHSSC has achieved 97.6% in value for invoices paid within 30 days and 98.6% by number.
This data is updated on a quarterly basis.

Further monitoring information has been introduced for WHSSC this financial year and therefore, the finance team will utilise this information to better improve the process.

10. Responses to Action Notes from WG MMR responses

Action Point 9.1

The removed opportunities were included within the reported position for the month.

11. SLA 19/20 status update

All Welsh SLAs are signed. Please see appendix 1 below for an update on the status of the English SLAs with each trust.

12. Confirmation of position report by the MD and DOF

Sian Lewis,
Managing Director, WHSSC

Stuart Davies,
Director of Finance, WHSSC

Appendix 1

PROVIDER	PROPOSAL RECEIVED FROM PROVIDER	DATE SLA TO BE SENT TO PROVIDER	DATE SLA SENT TO PROVIDER	SLA SIGNED & RECEIVED	Last SLA Meeting Date	Next Planned SLA Meeting	Reason for SLA not signed
Alder Hey Children's NHS Foundation Trust	Yes		01-Sep-19		20-May-19	Date to be confirmed	Discussions ongoing around level of PICU activity.
Birmingham Women's &Children's Hospital NHS Foundation Trust	Yes		30-Jul-19		10-Jul-19	Date to be confirmed	No official communication from NHSI/E around CQUIN
Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's)	No		30-Aug-19			Dealt with By E mail	CQUIN Has been agreed 19/11/19.
Manchester University NHS Foundation Trust (previously Central & South)	Yes		29-Oct-19		30-Oct-19	30-Oct-20	Discussions on going regarding data split now trusts have merged. Need to ensure specialsit/non specialist split is correctly reported in proposal.
(The) Christie NHS Foundation Trust	Yes		01-Sep-19		20-Mar-19	20-Mar-20	Awaiting proposal that does not include CQUIN.
DDRC	No		30-Oct-19				Private Provider
Great Ormond Street Hospital for Children NHS Foundation Trust	Yes		30-Jun-19		18-Jun-19	TBC 29/30 Jun 2020	Difference around how long the CQUIN arrangemnet is for.
Guy's and St Thomas' NHS Foundation Trust	Yes		30-Jun-19		18-Jun-19	TBC 29/30 Jun 2020	No official communication from NHSI/E around CQUIN
Heart of England NHS Foundation Trust	Yes		30-Jul-19		10-Jul-19	Date to be confirmed	No official communication from NHSI/E around CQUIN
Imperial College Healthcare NHS Trust	Yes		30-Jun-19		11-Nov-19	TBC 29/30 Jun 2020	No official communication from NHSI/E around CQUIN
King's College Hospital NHS Foundation Trust	Yes		30-Jun-19		17-Jun-19	TBC 29/30 Jun 2020	No official communication from NHSI/E around CQUIN
Leeds Teaching Hospitals NHS Trust	No		06-Nov-19		12-Mar-19	12-Mar-20	Awaiting response to SLA document sent to the trust.

Liverpool Heart and Chest Hospital NHS Foundation Trust	Yes		02-Jul-19	10-Sep-19	10-Dec-19	24-Mar-20	Signed
NHS Blood & Transplant - National Organ Donation	Yes		30-Apr-19	01-May-19	10-Oct-19	Jan-2020	No Issue Signed
(The) Newcastle Upon Tyne Hospitals NHS Foundation Trust			30-Sep-19			Dealt with By E mail	No Response
Papworth Hospital NHS Foundation Trust	Yes		30-Aug-19		18-Feb-19	Date to be confirmed	CQUIN Accepted working on the wording within the document
(The) Robert Jones and Agnus Hunt Orthopaedic Hospital NHS Foundation Trust	Yes		14-Aug-19	21-Oct-19	24-May-16	None planned	Signed
Royal Brompton & Harefield NHS Foundation Trust	Yes		30-Jun-19		18-Jun-19	TBC 29/30 Jun 2020	CQUIN Accepted working on the wording within the document
Royal Free London NHS Foundation Trust (Hampstead)	Yes		30-Jun-19		17-Jun-19	TBC 29/30 Jun 2020	No official communication from NHSI/E around CQUIN
(The) Royal Liverpool and Broadgreen University Hospitals NHS Trust	Yes		06-Nov-19		18-Jul-18	Date to be confirmed	Discussions ongoing re activity levles in SLA proposal.
(The) Royal Marsden NHS Foundation Trust	Yes		30-Jun-19		17-Jun-19	TBC 29/30 Jun 2020	CQUIN Accepted working on the wording within the document.
(The) Royal Orthopaedic Hospital NHS Foundation Trust	No		30-Aug-19		18-Jul-18	Date to be confirmed	Awaiting Official response
Salford Royal NHS Foundation Trust	No		03-Oct-19		30-Oct-19	30-Oct-20	Awaiting provider proposal.
Sheffield Teaching Hospitals NHS Foundation Trust	Yes		03-Oct-19		Audio 14/05/2019	Date to be confirmed	Wording differences within the SLA document are being discussed with the provider.
St Helens and Knowsley Teaching Hospitals NHS Trust	No		14-Oct-19		27-Nov-18	Date to be confirmed	Wording differences within the SLA document are being discussed with the provider.
University College London Hospitals NHS Foundation Trust	Yes		30-Jun-19		25-Jul-18	TBC 29/30 Jun 2020	CQUIN agreed in principle.
University Hospitals Bristol NHS Foundation Trust	Yes		30-Oct-19		07-Nov-19	18-Jan-20	CQUIN agreed. Wording of the agreement in the Quality section
University Hospitals Birmingham NHS Foundation Trust	Yes		30-Jul-19		10-Jul-19	Date to be confirmed	No official communication from NHSI/E around CQUIN

University Hospitals of North Midlands NHS Trust	Yes		30-Sep-19	31-Jan-20	26-Sep-19	Date to be confirmed	Wording within the SLA Document. CQUIN agreed in principle
(The) Walton Centre NHS Foundation Trust	Yes		09-Aug-19		19-Nov-19	19-Mar-20	Awaiting resposne from provider regarding WHSSC SLA proposal.
Wye Valley NHS Trust (Hereford)	Yes		30-Aug-19	31-Jan-20		Dealt with By E mail	No CQUIN Issue. Awaiting response around wording
PETIC	No		30-Oct-19				Private Provider

Appendix 2 – 2019/20 WSC ICP Value & Efficiency savings schemes financial monitoring

Efficiency Savings Schemes	2019/20 Target Saving £m	Budget Profile	2019/20 Savings to date M10 £m	2019/20 Forecast Saving £m	Narrative
IBD Trials Savings	(0.700)	Target	(0.583)	(0.700)	Emicizumab patient commenced November 18, saving compares 19/20 cost of Emicizumab compared to trial factor 8 expenditure in same period of 18/19. Therefore saving yields from November 18 - November 19
		Achieved	(0.709)	(0.709)	
		Variance	(0.126)	(0.009)	
IBD Factor 9 Price savings	(0.100)	Target	(0.083)	(0.100)	New framework price for Factor 9 products from March 2019
		Achieved	(0.177)	(0.212)	
		Variance	(0.093)	(0.112)	
Mental Health - Forensic case management	(0.500)	Target	(0.417)	(0.500)	Continued reduction in medium secure placements, due to case management and gatekeeping teams at SB and BCU.
		Achieved	(1.060)	(1.210)	
		Variance	(0.643)	(0.710)	
Perinatal Repatriation (contingent on welsh unit)	(0.350)	Target	(0.292)	(0.350)	Target based on OOA savings in perinatal placements if Welsh unit was open. However no revenue costs incurred for Welsh unit in 19/20 therefore net saving against plan
		Achieved	(0.188)	(0.225)	
		Variance	0.104	0.125	
Medicines Management - PAS	(0.250)	Target	(0.208)	(0.250)	PAS Asfotase Alfa rebate from Alexion secured in August 2019
		Achieved	(0.217)	(0.267)	
		Variance	(0.009)	(0.017)	
Referral Management Centre	(0.250)	Target	(0.208)	(0.250)	Work plan on going, initial schemes identified focussing on vascular referrals, no savings declared to date - but anticipated in 2020/21
		Achieved	0.000	0.000	
		Variance	0.208	0.250	
Outpatient Management Scheme	(0.250)	Target	(0.208)	(0.250)	Work on going, no savings declared to date, but anticipated in 20/21
		Achieved	0.000	0.000	
		Variance	0.208	0.250	
IMD switching & HCD review	(0.500)	Target	(0.417)	(0.500)	ERT drug switching continues at Cardiff, in addition to 3 patients on commercial trials at Royal Free (£450k). Further trials anticipated to commence in Cardiff later in year
		Achieved	(0.417)	(0.500)	
		Variance	0.000	0.000	
De-Prioritisation	(0.200)	Target	(0.167)	(0.200)	Scheme assumed HIPEC procedures through IPFR may be reduced if policy changed. Clinical evidence review scored low in 18-19 prioritisation. No change in policy to date.
		Achieved	0.000	0.000	
		Variance	0.167	0.200	
NHS England Market Forces Factor (applied to NHS E tariff)	(0.150)	Target	(0.125)	(0.150)	Market Forces Factor reduction for 19-20 distributed across NHS England LTAs, London contracts yield largest proportion of MFF reduction
		Achieved	(0.125)	(0.150)	
		Variance	0.000	0.000	
Total Efficiency Savings	(3.250)	**Target**	**(2.708)**	**(3.250)**	
		Achieved	**(2.892)**	**(3.273)**	
		Variance	**(0.184)**	**(0.023)**	

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

WELSH HEALTH SPECIALISED SERVICES COMMITTEE EXTRAORDINARY MANAGEMENT GROUP MEETING 27 FEBRUARY 2020

This briefing sets out the key areas of discussion relating to Neonatal Transport at the Extraordinary Management Group meeting held on 27 February 2020.

Members representing the six affected Health Boards, received the Final Report of the 'Independent Review of the south Wales Neonatal Transport Service (CHANTS) in order to recommend future models of delivery for a 24 hour transport service' and a paper setting out the key recommendations from the review and a proposed implementation timetable to commission a permanent 24 hour Neonatal Transport service in south Wales.

Members agreed that:

1. They were supportive of the direction of travel of the report and clearly endorse a 24/7 model.

2. They were looking to establish a Lead Provider for Neonatal Transport. From a Commissioning perspective this model would:

   - provide a single governance framework with clear lines of accountability; and
   - give assurance of systems management for the service; and
   - allow for further development of the Neonatal Transport service through defined processes of engagement.

   Members noted that there were lead provider models already being utilised to manage services in Wales, including the established successful lead provider model for the Emergency Medical Retrieval Transport Services (EMRTS) and the Operational Delivery Network currently being developed for Major Trauma. Management Group wanted to understand what aspects of these models could be useful in the delivery of a lead provider model for neonatal transport services.

3. WHSSC will develop commissioning intentions and a service specification utilising the support of the Maternity and Neonatal Network as a source of professional advice. These documents will inform the development of an options appraisal stemming from the options set out in the Independent Review and any other options presented.

4. WHSSC will establish a Task & Finish Group with commissioning, clinical and managerial representatives. The Group will consider how best to utilise the existing workforce with the proposed delivery model and also outline developments required for the future workforce.

5. In parallel, the Maternity and Neonatal Network would undertake demand and capacity modelling of both the number of maternity beds and cots required across the region.

6. Further work to define and clearly set out the funding of the clinical components of a 24 hours service needs to be undertaken by the WHSSC Finance Working Group.

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

CORE BRIEF TO MANAGEMENT GROUP MEMBERS

MEETING HELD ON 23 JANUARY 2020

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 from Previous Meeting and Action Log

The Minutes from the meetings held on 12 December 2019 were noted.

Members noted the action log and received updates on:

- **MG172** – 2020-23 ICP: Public Health input – SL invited to attend LHB directors of public health meeting, date to be confirmed. A Public Health secondee would be joining WHSSC for six months and a consultant had been identified who might be available to do additional work with WHSSC.
- **MG179** – Redesign of cardiac pathway: CTMUHB Board paper – item deferred to February 2020.
- **MG191** – Provision of Funding for Paediatric Activity Blades: circulate patient numbers by ALAS Centre - difficulty in obtaining information, action deferred to February 2020.

3. Report from the Managing Director

Members received the Managing Director's report and in particular noted an update on the Investment in Phase 1 Adult Congenital Heart Disease, where the provider health boards had confirmed that the original activity agreed in the business case was greater than could be realistically achieved in practice partly due to over-ambitious scheduling of work but also due to staff absences and the impact of 'DNAs'. WHSST would pursue improvements and report back in around six months.

4. CAMHS Tier 4 Inpatient Service Specification

Members received a paper that sought approval for publication of a new Tier 4 CAMHS service specification and support for the proposed implementation process. Members expressed some reservations as to whether all of SBUHB colleagues' issues raised through consultation had been addressed; it was also acknowledged that there could be some cost pressures around implementation of the new specification that needed to

be explored with the providers through a mapping exercise that may identify gaps.

Members were supportive of the proposed new service specification in principle but it was agreed that a dialogue with SBUHB regarding any remaining clinical concerns was required together with a gap analysis for phases 1 and 2; following which the proposal should be brought back for approval.

5. Cystic Fibrosis - Home IV Antibiotics Service

Members received a paper that provided an update on the implementation of a prepared Home IV antibiotics service for patients with Cystic Fibrosis in south Wales and Southern Powys. It was noted that this service had been considered separately from the case for an MDT and extra beds and that this was not ideal from a commissioning perspective.

Members:

- Noted the information presented within the report;
- Supported taking forward the case for a recurrent Home IV service and satellite clinic staff to the 2020/21 ICP; and
- Supported further evaluation of the impact on inpatient demand to inform the planned bed base to be supported by WHSSC within Phase 2 of the business case.

6. Aortic Stenosis Clinical Pathway Update

Members received a paper that provided an update on the development of a clinical pathway for the treatment of Aortic Stenosis. The importance of the pathway had been acknowledged at a recent joint meeting of Cardiology and Cardiac Surgery colleagues at CVUHB. It was noted that much of the pathway sat in secondary care services but Joint Committee had made it clear that it wanted the WHSS Team to be more involved in overall pathway design. NICE had recently published helpful guidance which provided the basis of the care pathways.

Members noted the progress in the development of a clinical pathway treatment of Aortic Stenosis; and supported the further work required to agree and implement the proposed pathway and to seek support through the Heart Conditions Implementation Group (HCIG).

7. Cardiac Magnetic Resonance Imaging (MRI)

Members received a paper that provided them with the current position with regards to the commissioning and monitoring of Cardiac MRI. The paper informed members about concerns raised by the Cardiac Network through the HCIG regarding the uncertainties around the health boards' progress against the 5 Year plans as neither the data sharing nor the discussions regarding future commissioning intentions appear to have been progressed. HCIG agreed that the Cardiac Network would seek WHSSC support in taking forward the issues, particularly in relation to recording data.

Members noted the information presented within the report but referred the issues regarding data collection back to HCIG as it was felt that this was not a matter for WHSSC.

8. Interim Mobile Positron Emission Tomography (PET) Unit

Members received a paper that provided an overview on the process of commissioning additional interim PET-Computer Tomography (PET-CT) capacity for the south Wales population via a mobile PET-CT scanner. The paper also outlines the advantages and disadvantages of continuing to commission a mobile scanner after the replacement PETIC scanner is installed in Cardiff. Members sought assurance that the commissioning of additional interim capacity for south Wales wouldn't be inconsistent with work being done on the all Wales strategy for PET capacity and that the detailed financial assumptions supported the utilisation of a mobile PET scanner.

Members noted the information presented within the report and provided feedback asking for the detailed financial assumptions to be taken through the finance sub-group and clarification that the proposed commissioning of additional interim capacity for the south Wales population via a mobile PET-CT scanner would not be at odds with the all Wales strategy for PET-CT scanning, and for the proposal to be brought back to the February meeting.

9. Extracorporeal Photopheresis (ECP)

Members received a paper that informed members that a proposal to provide ECP for patients in south Wales with chronic graft versus host disease (GvHD) at the University Hospital of Wales (UHW) as an outreach service delivered by NHS Blood & Transplant (NHSBT) has been approved by WHSSC Corporate Directors Group.

Members noted that the proposal to provide ECP for patients in south Wales with chronic GvHD at UHW as an outreach service delivered by NHSBT has been approved by WHSSC Corporate Directors Group.

10. Replacement Wheelchair Programme for North Wales

Members received a paper that requested approval for the release of funding for the BCUHB Wheelchair Replacement Scheme as included in the 2018-21 Integrated Commissioning Plan.

Members:

- Approved the release of funding for the replacement wheelchair programme in North Wales for 2019/20 (part year) and recurrent funding for 2020/21 and 2021/22); and
- Noted the evidence that there is a more rigorous performance management process being established for the posture and mobility wheelchair service.

11. Neonatal Transport Review Recommendations

Members received a paper that set out the key recommendations from the Review of the South Wales Neonatal Transport Service and sought support for the next steps to develop a 24 hour neonatal transport service. It was noted that the Neonatal Network had historically suggested duplication of the existing service but this was neither cost effective nor clinically effective and that the recommendations from the Review were different to this.

The paper included a suggestion that the commissioning of the service might be better suited to EASC. Members generally expressed a preference for WHSSC to commission the 24 hour service initially and possibly transfer responsibility, after this, to EASC.

Welsh Government had indicated that its Quality Delivery Board members were united in a wish to see interim arrangements introduced as soon as possible, so as to minimise the risks of further avoidable harm being caused by the absence of a 24 hour service. Members agreed that prioritising a permanent 24 hour solution was preferable, provided there was no further significant delay.

Members noted the draft recommendations within the report; and supported the development of future commissioning arrangements for neonatal transport services in south Wales.

12. 2020-20 Integrated Commissioning Plan (ICP)

Members received the latest version of the ICP that was being considered by the Boards of LHBs together with a supporting paper outlining the actions to be taken by the WHSS Team in relation to the ICP following its approval in principle by the Joint Committee on 6 January 2020. Members noted that the ICP was being recommended for approval by all seven LHBs.

13. WHSSC Policy Group Update

Members received a paper on the work of the WHSSC Policy Group and noted the information presented within the report. It was agreed to reduce the frequency of reporting to quarterly.

14. Integrated Performance Report

Members received a report on the performance of services commissioned by WHSSC for October 2019 and noted the services in escalation and actions being undertaken to address areas of non-compliance.

In particular it was noted that cardiac surgery performance in south Wales was a continuing concern but that CVUHB was progressing outsourcing to North Staffordshire (Stoke), also that SBUHB had a plan to eliminate 36 week RTT breaches by 31 March 2020. The plastic surgery service at SBUHB was still a cause for concern with some very long waiting times. The cochlear service at POW hospital in Bridgend was still suspended.

15. Finance Report 2019-20 Month 9

Members received a report on the financial position for WHSSC for the ninth month of 2019-20 showing an under spend of £5.1m year to date and forecast underspend of £3.3m for the full year.

16. Other business

Perinatal Mental health – Mother and Bay Unit Members noted a letter from the Minister for Health & Social Services asking WHSSC to proceed with an interim option, being a six bedded unit at Tonna Hospital.

Coronavirus A Welsh patient had been assessed with a negative indication the previous week via NHSE. The WHSS Team had put contractual arrangements in place with NHSE for any future cases.

Shrewsbury and Telford Hospital NHS Trust (SaTH) It was noted that some CAMHS cases were being held in inappropriate beds in ED at this Trust which was in special measures.

Major Trauma Network (MTN) – Recruitment It was reported that recruitment to the MNT was progressing well and that weekly flash reports supported this.

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

WHSSC Joint Committee
10 March 2020
Agenda Item 3.3.2

Reporting Committee	**All Wales Individual Patient Funding Request (IPFR) Panel**
Chaired by	**Professor Vivienne Harpwood**
Lead Executive Director	**Director of Nursing and Quality Assurance**
Date of last meeting	**25 February 2020**

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

The Panel held on 22 January 2020 was quorate in terms of Health Board representatives. One Lay member was in attendance. 9 requests were considered by the Panel. The meeting was Chaired by Dr Chris DV Jones.

The Panel held on 25 February 2020 was quorate in terms of Health Board and lay representation.

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

AWTTC IPFR Workshop, Monday 4th May 2020, Cardiff City Stadium

The Annual All Wales Therapeutics and Toxicology Centre (AWTTC) workshop will be held on 4 May 2020 at Cardiff City Stadium. The Event will be Chaired by Dr James Coulson, AWTTC and include dedicated training sessions for clinicians covering how to make an IPFR application, providing evidence reviews, ethical issues and keeping the patient informed. The afternoon session will consist of mock delegate Panels who will be asked to discuss and determine outcomes and rationales for the decision on 4 real-life anonymised cases.

Matters requiring Committee level consideration and/or approval

- None

Matters referred to other Committees

None

Confirmed Minutes for the meetings held on 22 January 2020 and 25 February 2020 are available on request.

Date of next meeting	**25 March 2020**